Board of Health for
Peterborough Public Health
AGENDA
Board of Health Meeting
Wednesday, September 12, 2018 – 5:30 p.m.
Lower Hall, Administration Building
123 Paudash Street, Hiawatha First Nation

Opening Prayer

1. **Call to Order**
   Councillor Henry Clarke, Chair

   Opening Statement
   We respectfully acknowledge that Peterborough Public Health is located on the Treaty 20 Michi Saagiig territory and in the traditional territory of the Michi Saagiig and Chippewa Nations, collectively known as the Williams Treaties First Nations, which include: Curve Lake, Hiawatha, Alderville, Scugog Island, Rama, Beausoleil, and Georgina Island First Nations.

   Peterborough Public Health respectfully acknowledges that the Williams Treaties First Nations are the stewards and caretakers of these lands and waters in perpetuity, and that they continue to maintain this responsibility to ensure their health and integrity for generations to come. We are all Treaty people.

2. **Confirmation of the Agenda**

3. **Declaration of Pecuniary Interest**

4. **Consent Items to be Considered Separately**

   Board Members: *Please identify which items you wish to consider separately from section 9 and advise the Chair when requested. For your convenience, circle the item(s) using the following list: 9.1 a b 9.2 a b c d e f g h 9.3.1 a b c d 9.4.1 a b c d e 9.4.2 a b c*

5. **Delegations and Presentations**

   5.1. Presentation: Treaty 20
   Chief Laurie Carr, Hiawatha First Nation

5.2. Presentation: Hiawatha Health Programs Update
Tina Howard, Health Manager, Hiawatha First Nation

6. Confirmation of the Minutes of the Previous Meeting

- Cover Report

a. Minutes, June 13, 2018
b. Minutes, June 19, 2018

7. Business Arising From the Minutes

8. Staff Reports

8.1. Staff Presentation: Infectious Disease Programs
Edwina Dusome, Manager, Infectious Disease Programs

- Cover Report

a. Presentation

8.2. Staff Report: Determining the Future of the Peterborough Public Health Travel Clinic
Dr. Rosana Salvaterra, Medical Officer of Health

- Staff Report

8.3. Staff Report: Advancing a Public Health Approach to Drug Policy
Dr. Rosana Salvaterra, Medical Officer of Health

- Staff Report

9. Consent Items

9.1. Correspondence for Direction

a. Pause in Implementation of the SFOA - Peterborough Public Health
b. Cannabis Sales Taxation Revenue – Grey Bruce

9.2. Correspondence for Information

- Cover Report

a. Ministers Elliott and Thompson - Mandatory Food Literacy Curricula
b. Minister Duncan - TRC Call to Action #89
c. Minister Yakabuski - Funding for Cycling Infrastructure

d. Minister McLeod - Ontario Basic Income Pilot Project.
e. alPHa Minister McLeod / Ontario Basic Income Pilot Project
f. alPHa July 2018 e-newsletter
g. alPHa August 2018 e-newsletter
h. Overdose Action Plan – Toronto Public Health

9.3. Staff Reports

9.3.1. Staff Report: Q2 2018 Peterborough Public Health Activities
Donna Churipuy, Director of Public Health Programs
Larry Stinson, Director of Operations

- Cover Report

a. Q2 2018 Programs
b. Q2 2018 Communications and IT
c. Q2 2018 Social Media
d. Q2 2018 Finance

9.4. Committee Reports

9.4.1. Governance Committee
Mayor Mary Smith, Chair, Governance Committee

- Cover Report

a. Minutes, April 3, 2018
b. 2-150 Remuneration of Members
c. 2-340 MOH Performance Appraisal
d. 2-348 Governance Committee, Terms of Reference
e. 2-261 Appointments, Provincial Representatives

9.4.2. Stewardship Committee
Catherine Praamsma, Chair, Stewardship Committee

- Cover Report

a. Minutes, May 1, 2018
b. By-Law 2 Banking and Finance
c. By-Law 9 Procurement of Goods and Services

10. New Business

11. In Camera to Discuss Confidential Matters ***(nil)***

12. Motions for Open Session ***(nil)***

13. Date, Time, and Place of the Next Meeting

Date: October 10, 2018
Location: Dr. J. K. Edwards Board Room, Peterborough Public Health, Jackson Square, 185 King Street, Peterborough

14. Adjournment

ACCESSIBILITY INFORMATION: Peterborough Public Health is committed to providing information in a format that meets your needs. To request this document in an alternate format, please call us at 705-743-1000.

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Board of Health Minutes**

Date: September 12, 2018

Proposed Recommendation:

That the minutes of the meeting held on June 13 and 19, 2018, of the Board of Health for Peterborough Public Health, be approved as circulated.

Attachments:

Attachment A – Board of Health Minutes, June 13, 2018
Attachment B – Board of Health Minutes, June 19, 2018

Board of Health for
Peterborough Public Health
DRAFT MINUTES
Board of Health Meeting
Wednesday, June 13, 2018 – 5:30 p.m.
Curve Lake Health Centre/Oshkiigmong MnoBmaadziwin Gamiing
38 Whetung Street East, Curve Lake First Nation

In Attendance:

Board Members:	**Councillor Henry Clarke**
	Councillor Gary Baldwin
	Mr. Gregory Connolley
	Ms. Kerri Davies
	Deputy Mayor John Fallis
	Ms. Catherine Praamsma
	Mayor Mary Smith
	Mr. Andy Sharpe
	Mr. Michael Williams
	Chief Phyllis Williams
	Councillor Kathryn Wilson
Regrets:	**Councillor Leslie Parnell**
	Mayor Rick Woodcock
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health**
	Mr. Larry Stinson, Director of Operations
	Ms. Natalie Garnett, Recorder

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1. Call to Order

Councillor Clarke, Chair, called the meeting to order at 5:35 p.m.

2. Confirmation of the Agenda

It was noted that item 5.1, presentation "Presentation: Traditional Healing at Curve Lake First Nation Health Centre" was amended to a "Tour and Talk" presented by Marcie Williams and Pamela Johnson, workers at the Health Centre. One item was added as 10.2, regarding the newly elected MPP.

MOTION:
That the agenda be adopted as amended.
Moved: Councillor Baldwin
Seconded: Mayor Smith
Motion carried. (M-2018-054)

3. Declaration of Pecuniary Interest

4. Consent Items to be Considered Separately

MOTION:
That the following items be passed as part of the consent agenda: 9.1a, 9.2a-b, 9.3.1, and 9.3.2.
Moved: Mayor Smith
Seconded: Mr. Connolley
Motion carried. (M-2018-055)

MOTION (9.1.a):
That the Board of Health for Peterborough Public Health: - receive the letter dated May 1, 2018 from the Association of Local Public Health Agencies (alPHa) regarding 2018-19 membership fees for approval; and, - approve the 2018-19 fee in the amount of $10,395.25
Moved: Mayor Smith
Seconded: Mr. Connolley
Motion carried. (M-2018-055)

MOTION (9.2.a-b)
That the Board of Health for Peterborough Public Health receive the following for information:
a. Letter dated April 18, 2018 from the City of Kawartha Lakes to all Ontario Boards of Heath regarding the 2018 Annual Service Plan and Budget.
b. E-mail dated May 09, 2018 from the Ontario Film Review Board, in response to the Board Chair's original letter dated May 3, 2018, regarding smoke-free movies.
Moved: Mayor Smith
Seconded: Mr. Connolley
Motion carried. (M-2018-055)

MOTION (9.3.1.a-b)
That the Board of Health for Peterborough Public Health:
a. Receive the staff report, 2017/2018 Infant and Toddler Development Program Audited Statements and Transfer Payment Annual Reconciliation, for information; and
b. Approve the acceptance of the 2017/2018 Audited Statements and Annual Reconciliation for the Infant and Toddler Development Program.

Moved: Mayor Smith
Seconded: Mr. Connolley
Motion carried. (M-2018-055)

MOTION (9.3.2.a)
That the Board of Health for Peterborough Public Health:

- *Receive the staff report, 2017/2018 Preschool Speech and Language Program Audited Statements, for information; and*
- *Approve the acceptance of the 2017/2018 Audited Statements for the Preschool Speech and Language Program.*

Moved: Mayor Smith
Seconded: Mr. Connolley
Motion carried. (M-2018-055)

5. Delegations and Presentations

5.1 Tour and Talk: Traditional Healing at Curve Lake First Nation Health Centre

MOTION:
That the Board of Health for Peterborough Public Health receive the presentation on Traditional Healing at Curve Lake First Nation Health Centre, for information:
Moved: Mayor Smith
Seconded: Deputy Mayor Fallis
Motion carried. (M-2018-056)

6. Confirmation of the Minutes of the Previous Meeting

6.1 May 9, 2018

MOTION:
That the minutes of the Board of Health for the Peterborough Public Health meeting held on May 9, 2018, be approved as circulated.
Moved: Councillor Baldwin
Seconded: Mr. Williams
Motion carried. (M-2018-057)

7. Business Arising From the Minutes

7.1 Status of Correspondence for Direction – School Curriculum and Food Literacy, Kingston Frontenac and Lennox & Addington Public Health

Dr. Salvaterra, Medical Officer of Health, advised that the correspondence will be sent once the provincial cabinet has been established.

8. Staff Reports

8.1 Staff Presentation: Ontario Public Health Standards – Safe Water

Atul Jain, Manager, Environmental Health, provided a presentation on the Ontario Public Health Standards – Safe Water.

MOTION:
That the Board of Health for Peterborough Public Health, receive the presentation, "Ontario Public Health Standards – Safe Water", for information.
Moved: Deputy Mayor Fallis
Seconded: Chief Williams
Motion carried. (M-2018-058)

8.3 Staff Presentation: Ontario Public Health Standards – Relationship with Indigenous Communities Guideline, 2018

Dr. Salvaterra, Medical Officer of Health, provided a presentation on the Ontario Public Health Standards Relationship with Indigenous Communities Guideline, 2018.

MOTION:
That the Board of Health for Peterborough Public Health, receive the presentation, "Ontario Public Health Standards – Relationship with Indigenous Communities Guideline, 2018", for information.
Moved: Mr. Connolley
Seconded: Mr. Williams
Motion carried. (M-2018-059)

8.3 Presentation: Cancer Care Ontario Report – Prevention System Quality Index: Health Equity

MOTION:
That the Board of Health for Peterborough Public Health receive the presentation "Cancer Care Ontario Report – Prevention System Quality Index: Health Equity", for information.
Moved: Deputy Mayor Fallis
Seconded: Ms. Praamsma
Motion carried. (M-2018-060)

8.4 Committee Report: First Nations Committee

MOTION:

a. *That the Board of Health for Peterborough Public Health receive meeting minutes of the First Nations Committee from March 15, 2018, for information.*

b. *That the Board of Health for Peterborough Public Health approve the renaming of the First Nations Committee to the "Indigenous Health Advisory Circle to the Board of Health".*

c. *That the Board of Health for Peterborough Public Health approve revisions to By-law 3, Calling of and Proceedings at Meetings to allow the Indigenous Health Advisory Circle to develop procedural rules that are better aligned with Indigenous cultural practices, which will be incorporated into its terms of reference and approved by the Board.*

d. *That the Board of Health for Peterborough Public Health approve the appointment of Andy Dufrane from the Mètis Nation of Ontario, to the Indigenous Health Advisory Circle.*

e. *That the Board of Health for Peterborough Public Health approve its inclusion as a signatory on a letter to the Honourable Ahmed D. Hussen, Minister of Immigration, Refugees and Citizenship, regarding the Truth and Reconciliation Commission's Calls to Action #93 and #94.*

f. *That the Board of Health for Peterborough Public Health send a letter to the Honourable Kirsty Duncan, Minister of Science and Minister of Sport and Persons with Disabilities, regarding the Truth and Reconciliation Commission's Call to Action #89.*

Moved:	Councillor Wilson
Seconded:	Mayor Smith
Motion carried.	(M-2018-061)

8.5 Staff Report: Strategic Plan Launch

MOTION:

That the Board of Health for Peterborough Public Health receive the staff report "Strategic Plan Launch", for information; and,

Appoint Ms. Praamsma and Ms. Davies to participate in the steering committee for the duration of the planning process.

Moved:	Mr. Sharpe
Seconded:	Chief Williams
Motion carried.	(M-2018-062)

9. Consent Items

10. New Business

10.1 alPHa Annual General Meeting and Conference – Oral Update

Ms. Praamsma and Dr. Salvaterra provided an update on the alPHa A.G.M.

MOTION:
That the verbal report on the "alPHa Annual General Meeting and Conference", be received for information.

Moved:	Councillor Wilson
Seconded:	Chief Williams
Motion carried.	(M-2018-063)

10.2 Recent Provincial Election

MOTION:
That a letter be sent to Jeff Leal thanking him for all of his efforts on behalf of the Health Unit during his time as MPP;

That letters be sent to MPP elect David Smith, MPP Laurie Scott, and MPP elect David Piccini, congratulating them on their wins and inviting them to dinner and a tour at the Health Unit.

Moved:	Mayor Smith
Seconded:	Mr. Sharpe
Motion carried.	(M-2018-064)

11. In Camera to Discuss Confidential Matters

12. Motions from In Camera for Open Session

13. Date, Time, and Place of the Next Meeting

The next meeting will be September 12, 2018 at the Administrative Building, 123 Paudash Street, Hiawatha First Nation, at 5:30 p.m.

14. Adjournment

MOTION:
That the meeting be adjourned.
Moved by: Mayor Smith
Seconded by: Ms. Davies
Motion carried. (M-2018-065)

The meeting was adjourned at 7:31 p.m.

Chairperson

Medical Officer of Health

Board of Health for
Peterborough Public Health
DRAFT MINUTES
Special Board of Health Meeting
Wednesday, June 19, 2018 – 5:00 p.m.
Dr. J.K.Edwards Board Room, 3rd Floor
Jackson Square, 185 Kiing Street, Peterborough

In Attendance:

Board Members:	**Councillor Henry Clarke**
	Councillor Gary Baldwin
	Mr. Gregory Connolley
	Ms. Kerri Davies
	Deputy Mayor John Fallis
	Councillor Leslie Parnell (5:02 p.m.)
	Mayor Mary Smith
	Mr. Andy Sharpe
	Mr. Michael Williams
	Councillor Kathryn Wilson
Regrets:	**Ms. Catherine Praamsma**
	Chief Phyllis Williams
	Mayor Rick Woodcock
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health**
	Mr. Larry Stinson, Director of Operations
	Ms. Natalie Garnett, Recorder

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1. Call to Order

Councillor Clarke, Chair, called the meeting to order at 5:00 p.m.

2. Confirmation of the Agenda

MOTION:
That the agenda be adopted as circulated.
Moved: Mr. Connolley
Seconded: Deputy Mayor Fallis
Motion carried. (M-2018-066)

3. Declaration of Pecuniary Interest

4. Consent Items to be Considered Separately

5. Delegations and Presentations

6. Confirmation of the Minutes of the Previous Meeting

7. Business Arising From the Minutes

8. Staff Reports

9. Consent Items

10. New Business

11. In Camera to Discuss Confidential Matters

MOTION:
That the Board of Health for Peterborough Public Health go In Camera to discuss one item under Section 239(2)(d), Labour relations or employee negotiations; and one item under Section 239(2)(e), Litigation or potential litigation, including matters before administrative tribunals affecting the Board, at 5:02 p.m.
Moved: Ms. Davies
Seconded: Deputy Mayor Fallis
Motion carried. (M-2017-067)

MOTION:
That the Board of Health for Peterborough Public Health rise from In Camera at 5:27 p.m.
Moved: Mr. Connolley
Seconded: Councillor Parnell
Motion carried. (M-2017-068)

12. Motions from In Camera for Open Session

MOTION:
That the Board of Health for Peterborough Public Health ratify the contract reached with CUPE.
Moved: Councillor Wilson
Seconded: Ms. Davies
Motion carried. (M-2017-069)

13. Date, Time, and Place of the Next Meeting

The next meeting will be September 12, 2018 at the Administrative Building, 123 Paudash Street, Hiawatha First Nation, at 5:30 p.m.

14. Adjournment

MOTION:
That the meeting be adjourned.
Moved by: Councillor Wilson
Seconded by: Mayor Smith
Motion carried. (M-2018-070)

The meeting was adjourned at 5:28 p.m.

Chairperson

Medical Officer of Health

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Staff Presentation – Infectious Disease Programs**

Date: September 12, 2018

Proposed Recommendation:

That Board of Health for Peterborough Public Health receive the following for information:
Staff Presentation – Infectious Disease Programs
Presenter: Edwina Dusome, Manager, Infectious Disease Programs

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Attachments:

Attachment A – Presentation

Infectious Disease Program

Edwina Dusome
Manager, Environmental Health
Board of Health
September 12, 2018

Ontario Public Health Standards

Two Program Standards:

- Immunization
- Infectious and Communicable Diseases Prevention and Control

What's new

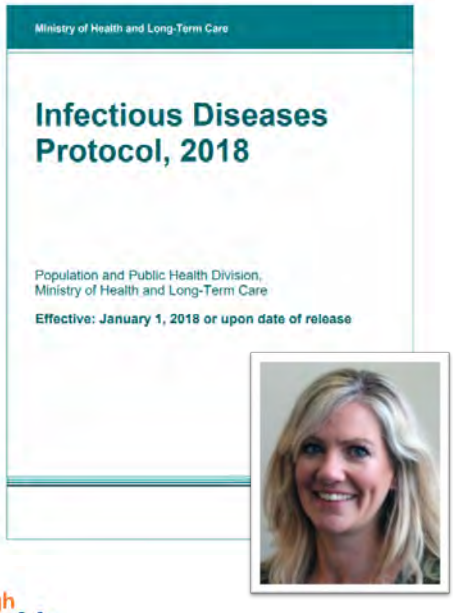
- Updated protocols
- Personal Service Setting Regulation
- New reportable diseases and updated appendices
- ICON- HCP (on hold)
- Disclosure of inspections

Peterborough Public Health

Infectious and Communicable Disease Prevention and Control Standard

- Reporting diseases
- Promotion of infection prevention and control
- Communicate urgent issues
- Outbreak investigations
- Respond to infection control complaints
- Inspect personal service settings
- 24/7 response

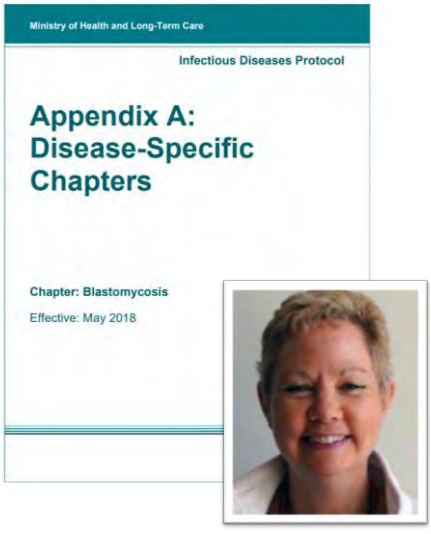
Peterborough Public Health



Peterborough Public Health

Diseases of Public Health Significance:

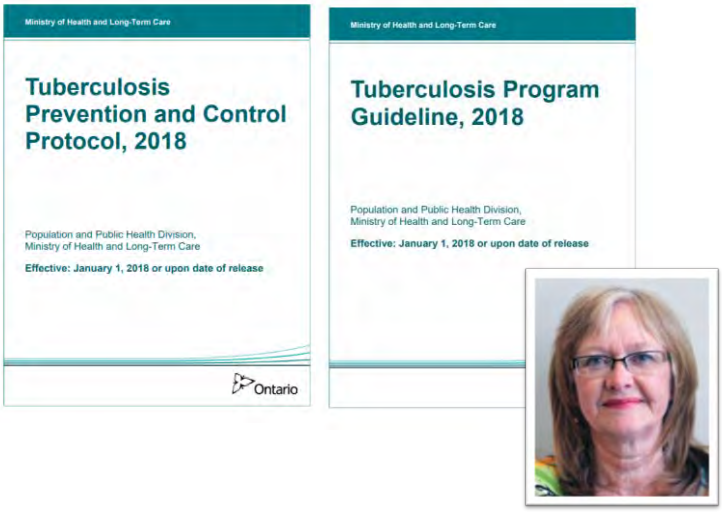
- Blastomycosis
- Botulism
- Carbapenemase-producing Enterobacteriaceae (CPE) infection or colonization
- Diphtheria
- Echinococcus multilocularis infection
- Gastroenteritis Outbreaks in Institutions and Public Hospitals
- *Haemophilus influenzae* disease
- Hepatitis C
- Respiratory Outbreaks in institutions and Public Hospitals



Peterborough Public Health

Peterborough Public Health

Peterborough Public Health



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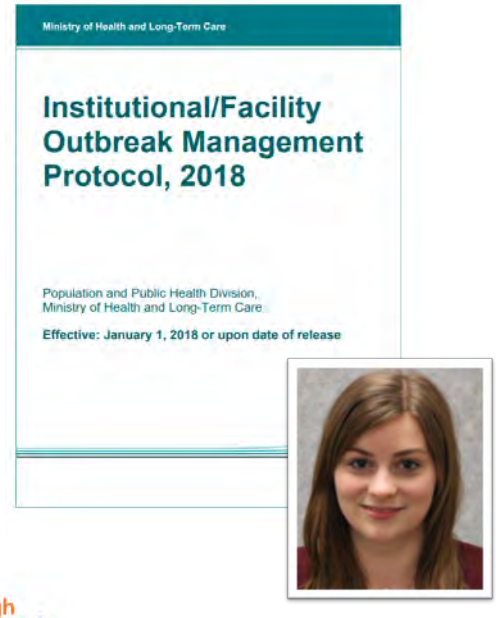
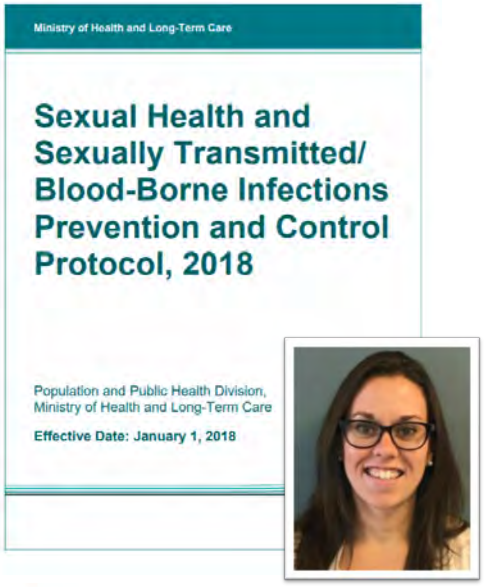
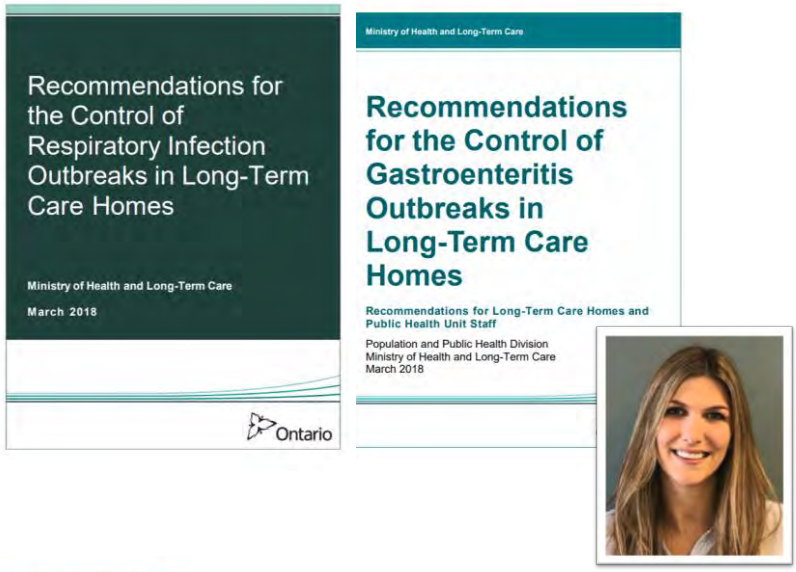


Peterborough Public Health

Peterborough Public Health



Peterborough Public Health



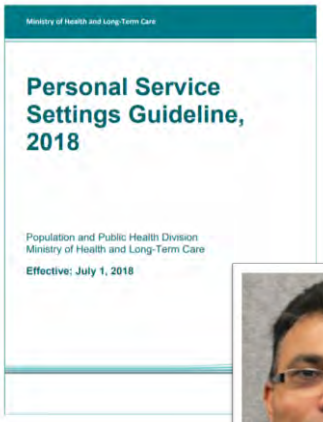
Peterborough Public Health

Peterborough Public Health

Health Protection and Promotion Act

ONTARIO REGULATION 136/18
PERSONAL SERVICE SETTINGS

CONTENTS



Ministry of Health and Long-Term Care

Personal Service Settings Guideline, 2018

Population and Public Health Division
Ministry of Health and Long-Term Care

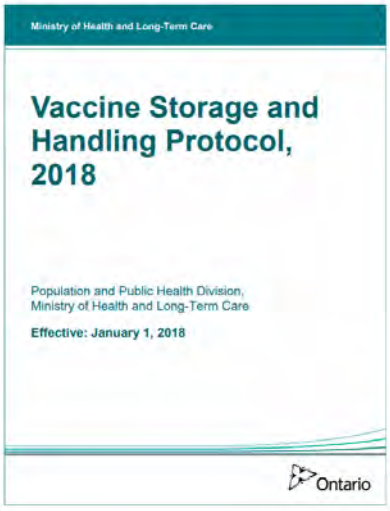
Effective: July 1, 2018

Peterborough Public Health

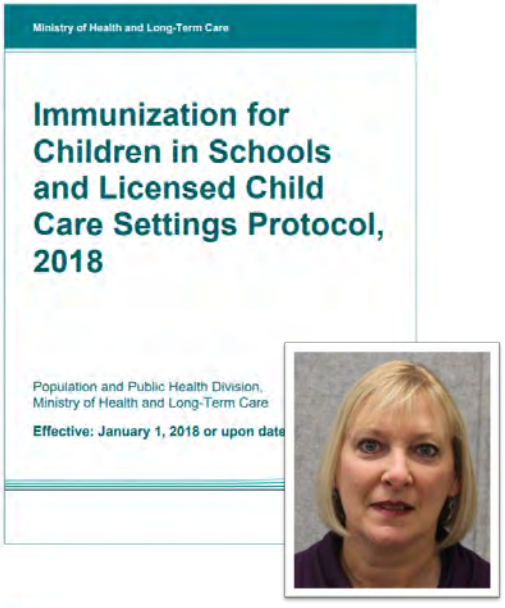
Immunization Standard

- Enforcement of related legislation
- Consultation
- Promotion
- Distribution of vaccine
- Education on storage and handling
- Collect adverse event data
- Provide publicly-funded vaccine

Peterborough Public Health



Peterborough Public Health



Peterborough Public Health

Child Care and Early Years Act, 2014

S.O. 2014, CHAPTER 11
SCHEDULE 1

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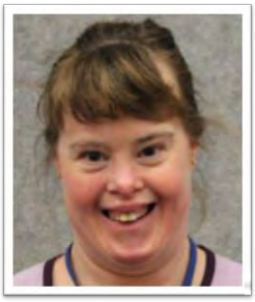
ENFORCEMENT

Peterborough Public Health

Support

Peterborough Public Health

More support…



Questions

Peterborough Public Health

Staff Report

Determining the Future of the Peterborough Public Health Travel Clinic

Date:	September 12, 2018
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Donna Churipuy, Director of Public Health Programs

Proposed Recommendations

That the Board of Health for Peterborough Public Health:

- receive the staff report, *Determining the Future of the Peterborough Public Health Travel Clinic,* for information; and,
- make a decision as to whether this service will be discontinued, as recommended by staff, or offered as a locally-subsidized service.

Financial Implications and Impact

Based on a six-month pilot, this program costs approximately $132,656 annually to deliver (Attachment A). Of this, $5,563 were not covered by administrative fees charged to clients. Although there may be some variance according to seasonal demand, this program does have the potential to present the Board with an annual deficit of at least $10,000 which would require a subsidy from locally funded reserves.

Decision History

In December 2017, the Board of Health approved a budget of $149,900 for a six month Travel Health Clinic Pilot Program in 2018.

Background

Peterborough Public Health (PPH) has operated a Travel Clinic (TC) for over fifteen years. In the past, public health was mandated to ensure TC services were available. This requirement has now been dropped from the Ontario Public Health Standards. In 2017, the Board approved a six-month pilot project to determine the financial sustainability of the clinic if operated on a cost-recovery basis. Shortly after the pilot began, one of the two nurses trained to provide this service left our employment.

PPH offers TC services two days a week out of one room in the Jackson Square Clinic area. A Registered Nurse is assigned to provide the consultations and immunizations, and an Administrative Assistant (AA) is assigned to support travel services (0.4 full-time equivalent (FTE)). A fee schedule has always existed for the TC and this was recently updated for the pilot. Clients are charged for a consultation as well as the cost for each vaccine administered (dependent on the vaccine), the fee includes an administrative cost of 15%. These services are promoted through the PPH website.

During the six-month pilot, of those who used the TC services, 6% were 0-5 years old, 46% were 6-54 years of age, 23% were 55-64 years old and 25% were 65 years or older. Almost 13% of total users resided outside of Peterborough County and City. Table 1 below provides the utilization data over the duration of the pilot.

Table 1: Clinic Utilization Data

	Jan	Feb	Mar	Apr	May	June	Totals
Appointments Booked	64	54	40	41	64	46	309
Appointments Not Filled	11	15	8	13	11	9	67
Number of Clients seen	97	64	42	47	90	57	397
Number of First Consult appointments	40	29	25	26	32	24	176
Number of clients in First Consults	65	42	25	33	52	35	252
Number of vaccine only appointments	24	25	17	15	32	22	135
Number of clients in vaccine only appointments	32	12	17	14	38	22	135
No Shows	2	1	3	2	5	0	13
Cancelled Appointments	12	26	21	20	14	7	100

Based on this utilization, the TC is running a deficit of approximately $5,563. This does not include the time of the Manager or Medical Officer of Health required to support this program.

Rationale

The Board will need to make a decision about whether or not to continue to provide this service to the community. There are two options:

Option 1 would be to continue to offer the TC and to subsidize any deficit from local government sources. The simplest way to do this would be to fund any deficit from local reserves. Given the financial projections for the organization, this would be an additional strain on the organization.

Reasons to continue offering the TC include the fact that it is a benefit to the community, especially to the many families and seniors who travel. This is one of the very few public health services provided to older adults in our community. When clients come for travel advice, they are also assessed for their routine immunizations and these are provided at the same time. Although changes to provincial policy now allow for pharmacists to administer travel vaccines, the PPH TC is the only service that provides a risk-based assessment, as well as access to Yellow Fever vaccine. There are no other travel clinics in Peterborough, with the closest ones located in Bancroft, Lindsay and Cobourg. PPH has invested in staff training for travel-related diseases and vaccinations and has one Registered Nurse who is passionate about her work. We have not done any official polling but perceive that this is a valued service to the community.

Option 2 would be to divest ourselves of the TC with the hope that another agency in the community would step in to fill the gap. This has been the case in other parts of the province where boards of health have discontinued this service. Both private providers as well as not-for-profit agencies offer TCs in other locations.

Advantages of option 2, besides the financial reasons, would be that we could re-deploy our staff person into other immunization programs where we have current demand for staff capacity. With only one trained nurse on staff at the moment, there is no back-up for this position, which means that the service is vulnerable to interruptions due to illness and vacation. And because of the deficit, there is no funding available to train a second nurse in this area of expertise.

If option 2 is chosen, PPH would be willing to work with interested community partners to plan for a transition of the TC to another provider.

Strategic Direction

This decision applies to the Board's strategic direction to address capacity and infrastructure.

Contact:

Dr. Rosana Salvaterra
Medical Officer of Health
(705) 743-1000, ext. 264
rsalvaterra@peterboroughpublichealth.ca

Attachments:

Attachment A – Financial Statement

ATTACHMENT A – Financial Statement

Travel Clinic Pilot Program Financial Statement – Year-to-Date up to June 30/18

Revenue		$**60,765**
Expenditures		
Staffing		$28,375
Clinic Supplies		2,530
Vaccines	$41,888	
Less: Inventory *	(13,845)	28,043
Administration		7,380
Total Expenditures		**66,328**
Net Program Deficit		**($5,563)**

*Inventory is based on the number of vaccine units on hand at June 30/18 based on cost per unit.

The above does not include the Manager's time to ensure policies and procedures are current, administrative tasks, responding to changes in vaccine availability, etc.

Staff Report

Advancing a Public Health Approach to Drug Policy

Date:	September 12, 2018
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Hallie Atter, Manager, Family and Community Health

Proposed Recommendations

That the Board of Health for Peterborough Public Health:

- receive correspondence from the Simcoe Muskoka District Health Unit dated June 20, 2018 regarding a public health approach to drug policy reform, for information;
- receive correspondence from Toronto Public Health dated August 3, 2018, regarding a public health approach to drug policy reform, for information;
- receive the staff report, *Advancing a Public Health Approach to Drug Policy,* for information;
- endorse the recommendations of Canadian Public Health Association's 2017 position statement on the decriminalization of personal use of psychoactive substances;
- request additional institutional and financial supports from the province for local drug strategies across the province to strengthen place-based responses to drug use prevention, treatment, harm reduction, and enforcement;
- direct staff to explore with community partners strategies for a local functional decriminalization approach;
- communicate this decision and request to appropriate federal and provincial ministries, local elected officials and police boards, members of the Municipal Drug Strategy Coordinators Network of Ontario, and public health associations.

Financial Implications and Impact

There are no financial implications arising from this report.

Decision History

At its January, 2016 meeting, in response to correspondence received from the Sudbury and District Health Unit regarding cannabis regulation and control, the Board of Health resolved to:

- Utilize a public health framework on psychoactive substances and their regulation as defined by the Centre for Addiction and Mental Health as an "approach that treats substance abuse as a health issue – not a criminal one. Such an approach is based on evidence-informed policy and practice, addressing the underlying determinants of health and putting health promotion and the prevention of death, disease, injury and disability as its central mission. It seeks to maximize benefit for the largest number of people through a mix of population-level policies and targeted interventions. This philosophy guides Canadian approaches to alcohol and tobacco, and it should guide our approach to cannabis as well."; and
- Apply this framework to future resolutions.

Background

Across Canada there is a growing effort to utilize a public health approach to drug policy. This effort is informed by mounting evidence of the ineffectiveness of current criminal approaches to illicit drug use and signs of success with alternate approaches in other jurisdictions.

In October 2017, the Canadian Public Health Association (CPHA) issued a position statement on the decriminalization of the personal use of psychoactive substances which put forth the following recommendations[1]:

- Decriminalize the possession of small quantities of currently illegal psychoactive substances [IPS] for personal use and provide summary conviction sentencing alternatives, including the use of absolute and conditional discharges;
- Decriminalize the sales and trafficking of small quantities of IPS by young offenders using legal provisions similar to those noted above;
- Develop probationary procedures and provide a range of enforcement alternatives, including a broader range of treatment options, for those in contravention of the revised drug law
- Develop the available harm reduction and health promotion infrastructure such that all those who wish to seek treatment can have ready access;
- Provide amnesty for those previously convicted of possession of small quantities of illegal psychoactive substances; and
- Provide expanded evidence-informed harm reduction options that include, for example, improved access to supervised consumption facilities and drug purity testing services.

The position statement further "recognizes and supports the right of Indigenous communities to respond to psychoactive substance use according to their traditional justice and/or cultural protocols".[2]

Since this time there have been further calls for adopting a public health approach to drug policy, including decriminalizing the possession of all psychoactive substances, from both municipalities and public health agencies across Canada. In March, 2018 the City of Vancouver called on the federal government to decriminalize the personal possession of all drugs.[3] More recently, similar calls have come from the Simcoe Muskoka District Health Unit (SMDHU)[4], Toronto Public Health (TPH)[5], and the Montreal Public Health Department[6].

Reports from both SMDHU and TPH have been circulated to other municipalities, all Ontario boards of health, provincial public health associations, and various other agencies and organizations. Resolutions passed in response to these reports have also generated formal letters to Ministries within both the Federal and Provincial governments.

As recently as July 2018, the federal government has stated that they will not be pursuing the decriminalization or legalization of any drugs other than cannabis.[7] The Ontario provincial government has also recently announced its intention to review the evidence on safe injection sites[8], a service that has been identified by the CPHA as part of a public health approach to drug policy.[9] In this context, local approaches to reducing the harms related to substance use, including those resulting from criminalization, have become ever more important.

The Peterborough Drug Strategy (PDS) is one of approximately 32 local drug strategies currently operating in the province of Ontario. PDS has been in operation since 2010 and represents a "shared effort to mitigate harms related to substance use in our community".[10] Since 2015, PDS has received $570,000 in project based funds and leveraged an additional $30,800 in in-kind contributions from partner agencies (including Peterborough Public Health). While PDS has received some core funding from the City of Peterborough on an annual basis, most local drug strategies operate in the absence of core funding to support ongoing administration and coordination.

With the resources it has received, PDS has shown leadership in supporting the development and implementation of a naloxone distribution program at the Peterborough Regional Health Centre Emergency Department, responding to local opioid-related harms, and developing an advisory panel of people with lived experience of substance use. With membership representing the four pillars of prevention, harm reduction, enforcement and treatment PDS represents the leading edge of evidence-based collaborative action on substance use in our community.

Rationale

Criminalization is currently the principal tool used in Canada to limit the use of the majority of psychoactive substances (excluding alcohol, tobacco, and soon cannabis).[11] However, the use

of illicit psychoactive substances persists in spite of the punitive measures currently in place. According to the 2015 Canadian Tobacco, Alcohol, and Drugs Survey (CTADS) 2% of the population disclosed the use of at least one of five illegal drugs (cocaine or crack, ecstasy, speed or methamphetamines, hallucinogens or heroin), up from an estimated 1.6% in 2013.[12] Illicit drug use also persists at the local level with the Peterborough public health unit showing from 2009-12 the highest rates of self-reported illicit drug use (defined as ever having tried an illicit substance, even once) of all local health units across the province at 55.4%.[13]

Furthermore, a growing body of research is demonstrating significant costs and harms associated with the criminalization of drugs. In Canada in 2014, nearly $9 billion was spent on criminal justice associated with substance use, with cocaine producing the second highest substance use related costs (behind alcohol).[14] Such criminalization is also recognized as contributing to significant harms within the population, particularly among marginalized and racialized communities, including:

- Creating barriers to employment post incarceration
- Perpetuating stigma which may serve to limit an individual's access to prevention and care services
- Promoting and accelerating infections such as HIV and hepatitis C due to stigmatization and legal consequences which result in unsafe use practices[15]

An alternative public health approach to drug policy is possible. As articulated by the CPHA, such an approach "seeks to maintain and improve the health of populations based on the principles of social justice, attention to human rights and equity, evidence-informed policy and practice, and addressing the underlying determinants of health".[16] Within a public health approach to substance use, decriminalization represents a middle ground between the illegal market and a regulated legal market [see figure 1].

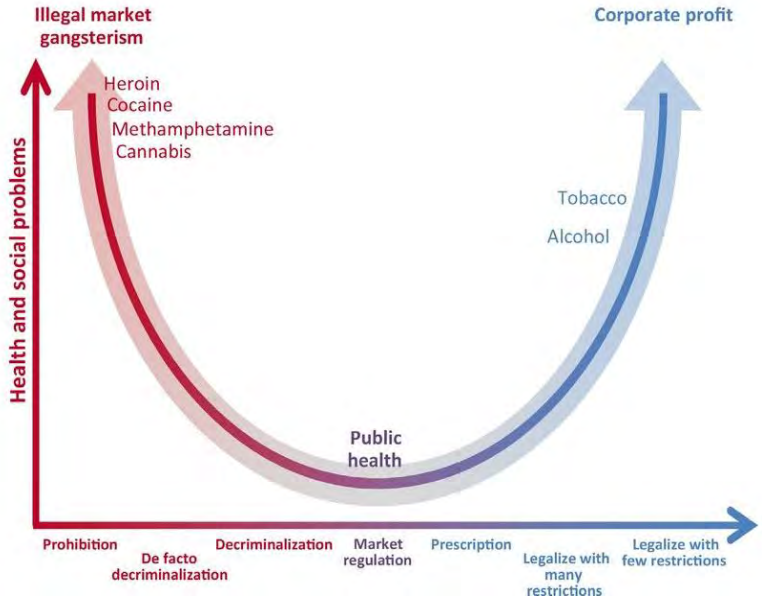


Figure 1: The Paradox of Prohibition[17]

It is estimated that approximately 30 countries around the world have formal decriminalization policies in place, with some countries having never criminalized drug use or possession.[18] As in Canada, interest in such approaches is increasing across the globe, and there is growing evidence that "decriminalization when coupled with investments in harm reduction, and health and social services, can have an extremely positive effect on both individuals who use drugs and society as a whole".[19] For instance Portugal, which reformed its drug policies in 2001 while making significant public health investments, has seen a decrease in drug-related deaths, as well as reduced incidence and improved management of HIV, and increases in the number of people accessing addiction treatment services.[20]

Given the latest research, which indicates that "decriminalization, when implemented effectively does appear to direct more people to treatment, reduce criminal justice costs, improve public health outcomes, and shield many drug users for the devastating impact of a criminal conviction" it is clear that decriminalization represents an evidence-informed public health approach to drug policy.[21] However, such an approach also represents a long-term solution which will require significant political will and investment of time to establish new systems and structures to support implementation.

While there is opportunity to support such an approach at a political level, in the short-term a strong local response is needed in order to mitigate the harms that are currently being shouldered by individuals, families, and communities. Increasing institutional and financial supports for the work of local drug strategies across the province can help support immediate collaborative action across the four pillars of prevention, treatment, harm reduction, and enforcement. The four pillar approach to drug policy is a well-established framework that ensures "a continuum of care for those suffering from substance addiction and communities impacted by those same people".[22] Provincial funding and support for coordination across the province would help ensure the sustainability and deepen the impact of this collaborative approach to mitigating substance use harms in communities across Ontario.

Strategic Direction

This work aligns with the following strategic directions:

Community-Centred Focus; The recommendations included in this report respond to identified needs in the area of substance misuse prevention and harm reduction and build on existing partnerships with members of the PDS.

Determinants of Health and Health Equity; The recommendations included in this report endorse an approach to drug policy that seeks to address the underlying causes of substance misuse (including the social determinants of health) and reduce health inequities that result from criminalization of drug use and possession.

Capacity and Infrastructure; The recommendations included in this report seek to increase provincial investments in public health approaches to drug policy through requests for infrastructure and financial supports for local drug strategies.

Contact:

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(705) 743-1000, ext. 352
scullingham@peterboroughpublichealth.ca

Attachments:

Attachment A – Simcoe Muskoka District Health Unit Correspondence, July 10, 2018
Attachment B – Toronto Public Health Correspondence, August 3, 2018

References:

1. Canadian Public Health Association (2017) *Decriminalization of Personal Use of Psychoactive Substances*. Position Statement. <https://www.cpha.ca/decriminalization-personal-use-psychoactive-substances>

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8. CBC News (July 24, 2018) *Ontario to review safe injection, overdose prevention sites, health minister says* <https://www.cbc.ca/news/canada/toronto/ontario-safe-injection-sites-

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13. Public Health Ontario (2016) *Self-Reported Illicit Drug Use*. Snapshot. <https://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Illicit-Drug-Use.aspx>

14. Canadian Centre on Substance Use and Addiction (2018) Canadian Substance Use Costs and Harms. <http://www.ccdus.ca/Resource%20Library/CSUCH-Canadian-Substance-Use-Costs-Harms-Report-2018-en.pdf>

15. Canadian Public Health Association (2017) *Decriminalization of Personal Use of Psychoactive Substances*. Position Statement. <https://www.cpha.ca/decriminalization-personal-use-psychoactive-substances>

16. Ibid.

17. As adapted from Marks, J. (1993). The paradox of prohibition. In: Brewer, C. (Ed.), Treatment options in addiction: Medical management of alcohol and opiate use, pp. 77-85. London: Gaskell. <https://www.researchgate.net/figure/The-paradox-of-prohibition-Adapted-from-Marks-J-1993-The-paradox-of-prohibition_fig3_323101985>

18. Eastwood, N., Fox, E., and Rosmarin, A. (2016). *A quiet revolution: Drug decriminalization across the globe*.

19. Ibid.

20. Global Commission on Drug Policy (2016) Advancing Drug Policy Reform: A new Approach to Decriminalization: 2016. Report. <http://www.globalcommissionondrugs.org/wp-content/uploads/2016/11/GCDP-Report-2016-ENGLISH.pdf>

21. As adapted from Marks, J. (1993). The paradox of prohibition. In: Brewer, C. (Ed.), Treatment options in addiction: Medical management of alcohol and opiate use, pp. 77-85. London: Gaskell. <https://www.researchgate.net/figure/The-paradox-of-prohibition-Adapted-from-Marks-J-1993-The-paradox-of-prohibition_fig3_323101985>

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simcoe muskoka
DISTRICT HEALTH UNIT

By email at: Ginette.PetitpasTaylor@parl.gc.ca and Jody.Wilson-Raybould@parl.gc.ca

July 10, 2018

The Honourable Ginette Petitpas Taylor
Minister of Health
House of Commons
Ottawa, Ontario
Canada
K1A 0A6

The Honourable Jody Wilson-Raybould
Minister of Justice and Attorney General of Canada
House of Commons
Ottawa, Ontario
Canada
K1A 0A6

Dear Ministers Petitpas Taylor and Wilson-Raybould,

Re: A Public Health Approach to Drug Policy Reform

On June 20, 2018, the Simcoe Muskoka District Health Unit Board of Health (SMDHU BOH) endorsed the recommendations of the Canadian Public Health Association (CPHA) from their 2017 Position Statement, in regards to decriminalization of illicit psychoactive substances (IPS). These recommendations call for a shift from addressing IPS as a criminal issue to that of a pressing public health issue, through implementing the following recommendations:

a) Decriminalize the possession of small quantities of currently illegal psychoactive substances for personal use and provide summary conviction sentencing alternatives, including the use of absolute and conditional discharges;
b) Decriminalize the sales and trafficking of small quantities of IPS by young offenders using legal provisions similar to those noted above;
c) Develop probationary procedures and provide a range of enforcement alternatives including a broader range of treatment options, for those in contravention of the revised drug law;
d) Develop the available harm reduction and health promotion infrastructure such that all those who wish to seek treatment can have ready access;
e) Provide amnesty for those previously convicted of possession of small quantities of IPS; and

f) Provide expanded evidence-informed harm reduction options that include, for example, improved access to supervised consumption facilities and drug purity testing services.

In light of the opioid crisis facing Simcoe and Muskoka, and Canada as a whole, the SMDHU BOH has endorsed this position based on research and evidence that Canada's historical approach to drug policy based on criminalization has created a three-fold problem. The first is the financial burden on our enforcement, justice and corrections infrastructure, estimated at multi-billions of dollars per year[i].

The second is that criminalization has created and perpetuated stigma that alienates those who choose to use drugs, who are often seeking to escape mental or physical pain. This same stigma disproportionately affects marginalized populations such as those living in poverty, those living with mental health issues, and Indigenous communities[ii]. Research identifies how stigma in fact perpetuates drug use by reducing empathy, and drives persons away from supports such as treatment and counselling[iii].

The third aspect of the problem is that exposure to the criminal justice system is harmful to those who use drugs. This approach exposes the person to a wider criminal element, disassociates them from their family or other supports, and creates immense stress[iv]. Additionally, a criminal record impairs a person's ability to find and maintain employment, housing or education. Further, the nature of arrests, penal penalties and court processes further disrupts Opioid Agonist (Replacement) Therapy, exacerbates the incidence of HIV and Hepatitis and worsens management of these conditions, and creates significantly heightened risk for overdose upon release[v].

In light of extensive evidence that criminalization perpetuates problematic drug-use and compounds its associated harms, we strongly urge you to consider decriminalization of illicit psychoactive substances with a concomitant investment in health services. We call upon your government to reform the necessary policies to more effectively and humanely address drug use and addiction as major societal priorities.

Decriminalization of IPS, in order to be most effective, must be accompanied with commensurate investments in harm reduction, treatment and mental health infrastructure. Where this multi-tiered approach has been implemented in other countries, such as in Portugal, measurably positive outcomes have resulted, including pronounced reductions in overdose deaths and substantial increases in entry to drug treatment[vi]. Funds for these health investments would be made available from reduced costs within justice, enforcement and corrections services that are anticipated to result from this shift from a criminalized system to a public health approach.

Please see attached a copy of the 2017 CPHA Position Statement for your reference.

Sincerely,

ORIGINAL Signed By:

Scott Warnock
Board of Health Chair
Simcoe Muskoka District Health Unit

SW:LS:mk

Encl.

c. Honourable Christine Elliott, Minister of Health and Long-Term Care for Ontario
Honourable Caroline Mulroney, Attorney General of Ontario
Dr. David Williams, CMOH
Ms. Roselle Martino, ADM
Ontario Boards of Health
Association of Local Public Health Agencies
Ontario Public Health Association
Canadian Public Health Association
MPs and MPPs in Simcoe Muskoka
Mayors and Councils in Simcoe Muskoka
North Simcoe Muskoka and Central Local Health Integration Network

[i] Department of Justice Canada (2008) *Cost of Crime in Canada*
[ii] Csete J. et. al (2016) The Lancet Commissions. *Public Health and international drug policy*. The Lancet Vol 387, April2, 2016
[iii] Global Commission on Drug Policy (2017). *The World Drug Perception Problem*. 2017 Report. Executive Summary. P.7
[iv] Canadian Mental Health Association (2018). *Care Not Corrections: Relieving the Opioid Crisis in Canada*. April 2018
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simcoe muskoka DISTRICT HEALTH UNIT

BRIEFING NOTE

Item #7.1

A Public Health Approach to Drug Policy Reform

Update: #1 **Date: June 20, 2018**

Issue

A public health approach to all psychoactive substances has been called for by the Canadian Public Health Association [CPHA][i] and was furthered by their position regarding decriminalization of personal use of psychoactive substances[ii].

Decriminalization is an alternate policy choice in addressing possession of illicit drugs for personal use. Historically, Canadian drug policy has focused on reducing the supply of illicit drugs, criminalizing use and possession, and taking a prohibitionist approach to drugs other than tobacco and alcohol. After decades, it has become clear that this approach has contributed to significant harms to drug users and society as a whole while having little effect in terms of decreasing levels of consumption.

Emerging evidence from other countries, as part of a global movement, is illustrating how a public health approach to drug policy - and in particular decriminalization combined with increased health and social supports - can mitigate harms without increasing drug use or exacerbating crimes related to the illicit market.

Recommendations

THAT the Board of Health endorse the recommendations of the CPHA's 2017 position statement on decriminalization of personal use of psychoactive substances as an evidence-informed policy approach for addressing drug use.

AND FURTHER THAT the Board of Health communicate this endorsement through a letter to the Federal and Provincial Ministers of Health and Attorney Generals, with copies to all Ontario Boards of Health, the Association of Local Public Health Agencies, the Ontario Public Health Association, the Canadian Public Health Association, and to all MPs, MPPs, and mayors and councils and Local Health Integration Networks in Simcoe Muskoka.

Current Facts

On November 15, 2017 the Board of Health (BOH) received an update on the opioid issue in Simcoe Muskoka and passed the following motion:

> THAT the Board of Health write a letter to Mayors Gord McKay and Steve Clarke in response to their letter dated Oct 26, 2017, indicating that staff are investigating policy approaches to illicit substance use and that the Board will communicate with Simcoe Muskoka municipalities in future if an advocacy position is taken.

Based on this investigation of policy approaches to illicit substance use, the CPHA recommendations on decriminalization of personal use of psychoactive substances as outlined

in their 2017 position statement[iii] are most relevant and appropriate in considering a public health approach to policy reform. The CPHA recommendations include the following:

a) Decriminalize the possession of small quantities of currently illegal psychoactive substances (IPS) for personal use and provide summary conviction sentencing alternatives, including the use of absolute and conditional discharges;
b) Decriminalize the sales and trafficking of small quantities of IPS by young offenders using legal provisions similar to those noted above;
c) Develop probationary procedures and provide a range of enforcement alternatives including a broader range of treatment options, for those in contravention of the revised drug law;
d) Develop the available harm reduction and health promotion infrastructure such that all those who wish to seek treatment can have ready access;
e) Provide amnesty for those previously convicted of possession of small quantities of IPS; and
f) Provide expanded evidence-informed harm reduction options that include, for example, improved access to supervised consumption facilities and drug purity testing services.

Roughly a quarter billion people around the world use illegal psychoactive substances [IPS], representing an increase of 20% over the last two decades[iv]. It is therefore apparent that traditional methods used to combat this trend in Canada and internationally, such as criminalization of drug use, and attempting to eliminate the drug supply, are not working.

An alternative to prohibition and criminalization exists: a public health approach that is based on the principles of social justice, attention to human rights and equity, evidence-informed policy and practice, and addressing the underlying determinants of health. Such an approach puts health promotion and the prevention of death, disease, injury, and disability as the central mission to guide all related initiatives. It also bases those initiatives on evidence[v].

In September 2016, the BOH advocated for a public health approach to the Federal Government's intention to legalize cannabis through endorsement of the following recommendation:

> THAT the Board of Health send a letter to the Prime Minister to urge the federal government to adopt a public health approach to legalizing cannabis, including strict regulation of non-medical use, as well as the production, distribution, product promotion and sale of cannabis.

Within a public health approach to IPS, decriminalization is best understood as a 'middle position' between an illicit market and a fully legal/regulated market, as illustrated by the figure *The Paradox of Prohibition*, seen below[vi].

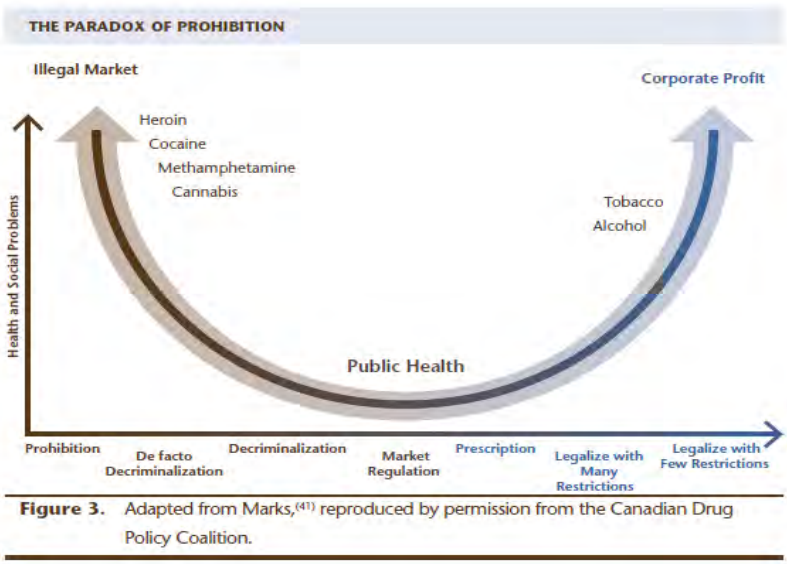

Figure 3. Adapted from Marks,[41] reproduced by permission from the Canadian Drug Policy Coalition.

While it is commonly assumed that most or all illicit drug use is problematic, research shows that only about 11.6% of illicit drug use coincides with problematic use or addiction[vii]. This world-wide figure is comparable within Canada[viii].

A large number of drug-related offenses in Canada are possession offenses, especially relating to 'harder' drugs such as cocaine and opioids, but also cannabis[ix]. While not deterring drug use, these charges create a large fiscal and logistical burden on enforcement, judicial and incarceration services, estimated at $2 billion dollars per year in Canada[x].

Exposure to the criminal justice system is damaging to the health of those who use drugs. When considering those charged for drug use alone (as opposed to trafficking or violent crime), a criminal record and incarceration creates numerous and profound harms to the drug user. These harms include the disruption of treatment for opioid use disorder (such as with Opioid Agonist Therapy), heightened risk for HIV, hepatitis and tuberculosis or management of these conditions, impairment of employment or future income[xi], inducement of stress on relationships, family or children, and significantly heightened risk for overdose[xii].

Punitive approaches disproportionately harm persons or groups already facing marginalization or disadvantage, such as minority groups. In Canada, this particularly affects Indigenous populations, those living with mental health issues or those in poverty[xiii].

Choices to engage in drug use, instead of being deterred by criminalization and the fear of punishments, are instead rooted in broad social, cultural and economic factors. Drug use relates strongly to the social determinants of health: housing, mental health and the underfunding of mental health treatment, early childhood trauma, disparity of income and opportunity, unemployment or underemployment, and stress[xiv].

Many countries have begun to implement alternate approaches to drug policy, such as various forms of decriminalization[xv]. Where these policies have been implemented with a commensurate investment in health, treatment and harm reduction infrastructure and support, measurably positive health outcomes have resulted[xvi].

The most well-known example of this combined approach is in Portugal, which instituted such reforms in 2001 based on the recognition that illegal substance use is first and foremost a health

problem. Since that time, their system has been extensively studied[xvii]. Within the Portuguese system, those charged with possessing IPS meet with a 'Dissuasion Commission', allowing for a wide variety of options including discharge, administrative fines, access to treatment and other options . Importantly, the Portuguese system has provided for a marked decrease in drug induced (overdose) deaths[xix]. Additionally, this system has allowed for reduced incidence and improved management of HIV, hepatitis and tuberculosis[xx], as individuals are brought in contact with the health care system.

Other countries have begun to pursue, or continue to evolve, various approaches to decriminalization such as Switzerland, the Czech Republic, the Netherlands, Norway, Germany and Australia, amongst others[xxi]. As studied from the Portuguese example and elsewhere around the world, where decriminalization has been accompanied by concurrent investments in health infrastructure, harm reduction and campaigns to reduce stigma, there is little to no correlation between decriminalization and increased levels of drug use, or crime related to personal drug use[xxii].

Conversely, research indicates that countries with the highest levels of criminalization and harshest penalties have the highest rates of problematic drug use. These countries also tend to have the highest rates of government and police corruption relating to IPS, imprisonment and prison overcrowding, human rights abuses and other harms to persons who use drugs[xxiii].

Many health-oriented or public agencies throughout Canada have begun to officially adopt supportive positions to decriminalization, as part of a strategy to reduce drug-related harm. These include the Canadian Public Health Association[xxiv], the Canadian Mental Health Association and the City of Vancouver[xxv]. Others are investigating this same strategy and/or engaging the public in dialogue, such as Toronto Public Health[xxvi], and the Canadian Association of Chiefs of Police[xxvii], amongst others. Locally, this trend is noted in the Enforcement Pillar action plan of the Simcoe Muskoka Opioid Strategy, where it is identified that enforcement agencies in Simcoe and Muskoka are already choosing to focus enforcement efforts on drug trafficking rather than possession[xxviii].

The details of any future Canadian drug decriminalization policy would determine its success. The CPHA recommendations are meant to act together as an evidence-informed framework to maximize health for those who use drugs, while minimizing the burden that historical polices have created.

Background

Decriminalization of drugs means the removal of criminal penalties for the possession/use of illicit substances for personal use (only). Decriminalization uses alternate approaches to criminal charges/records and jail time such as diversion to treatment, administrative penalties or fines, engagement in support systems or meetings with professionals to decide the appropriate action.

Another approach to drug policy is legalization, which is the use of law to allow for governments and private industry to sell a substance to the general public, under defined criteria or regulations. Alcohol is an example, and as such can be sold at only certain venues, under conditions such as a minimum drinking age. Cannabis will similarly be legalized and regulated later in 2018. Regulation is a related term that encapsulates various rules and laws that govern how, where, when, how much, and to whom a substance can be sold, possessed, advertised and marketed.

In addition to decriminalization and investment in health infrastructure, addressing the current opioid crisis may also require regulatory changes to permit enhanced harm reduction. For example, amendments to the *Controlled Drugs and Substances Act* may allow for expanded access to a safe supply of opioids to clients as part of Opioid Agonist (Replacement) Therapy,

given that the current illicit supply has been proven to be highly toxic to users, and this toxicity is the key cause of the recent increase in opioid overdoses. Further to that, some experts are now calling for a lower-barrier program for the regulated distribution of pharmaceutical-grade opioids to dependent individuals, as an emergency response to Canada's opioid overdose crisis[xxix]. The need and evidence for such regulatory changes should be monitored, and the need for future related advocacy considered. Separate regulations also apply to the legal framework that governs exemptions for Safe Consumption Sites and Overdose Prevention Sites.

While there is a strong consensus among health professionals and experts on the value of decriminalization as it relates to reducing harms from the use of drugs[xxx], it is important to understand that there are many different approaches to decriminalization internationally, including much variance on the thresholds of amounts for personal use. One constant is that all still hold drug trafficking as illegal.

Contacts

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Dr. Lisa Simon, Associate Medical Officer of Health	Ext. 7244
Janice Greco, Manager, Injury and Substance Misuse Prevention Program	Ext. 7288
Carolyn Shoreman, Director, Community and Family Health	Ext. 7361

References

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TORONTO

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August 3, 2018

SENT VIA E-MAIL

To: Interested Parties

Subject: A Public Health Approach to Drug Policy (Item HL28.2)

The Toronto Board of Health, during its meeting on July 16, 2018, adopted Item HL28.2, as amended, and:

1. Directed that the report (June 28, 2018) from the Medical Officer of Health be forwarded to the following for their information and endorsement:

    a. Ontario-based public health boards, the Boards of Health in the 10 largest Canadian cities, the Ontario Public Health Association, the Association of Local Public Health Agencies, and other appropriate public health bodies; and

    b. key organizations of families of drug users and users of drugs.

2. Called on the federal government to decriminalize the possession of all drugs for personal use and scale up prevention, harm reduction, and treatment services.

3. Called on the federal government to convene a task force, comprised of people who use drugs and their families and policy, research, and program experts in the areas of public health, human rights, substance use, mental health, education, and criminal justice, to explore options, including best practices and equitable measures, for the legal regulation of all drugs in Canada, based on a public health approach.

To view this item and background information online, please visit:
http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2018.HL28.2.

Sincerely,

Julie Lavertu

Julie Lavertu/ar
Secretary
Board of Health

Sent (via e-mail) to the following Boards of Health in Ontario (via e-mails to the Public Health Units), organizations, and individuals:

- Algoma Public Health Unit
- Brant County Health Unit
- Chatham-Kent Health Unit
- Durham Region Health Department
- Eastern Ontario Health Unit
- Grey Bruce Health Unit
- Haldimand-Norfolk Health Unit
- Haliburton, Kawartha, Pine Ridge District Health Unit
- Halton Region Health Department
- City of Hamilton Public Health Services
- Hastings Prince Edward Public Health Unit
- Huron County Health Unit
- Kingston, Frontenac, Lennox & Addington Public Health
- Lambton Public Health
- Leeds, Grenville and Lanark District Health Unit
- Middlesex-London Health Unit
- Niagara Region Public Health Department
- North Bay Parry Sound District Health Unit
- Northwestern Health Unit
- Ottawa Public Health
- Oxford-Elgin-St. Thomas Public Health Unit
- Peel Public Health
- Perth District Health Unit
- Peterborough Public Health
- Porcupine Health Unit
- Public Health Sudbury & Districts
- Renfrew County and District Health Unit
- Simcoe Muskoka District Health Unit
- Thunder Bay District Health Unit
- Timiskaming Health Unit
- Region of Waterloo, Public Health
- Wellington-Dufferin-Guelph Public Health
- Windsor-Essex County Health Unit
- York Region Public Health
- Dr. Mylène Drouin, Directrice régionale de santé publique, Direction régionale de santé publique du CIUSSS du Centre-Sud-de-l'Île-de-Montréal
- Dr. Patricia Daly, Chief Medical Health Officer and Vice President, Public Health, Vancouver Coastal Health
- Dr. David Strong, Zone Lead Medical Officer of Health, Alberta Health Services
- Dr. Vera Etches, Medical Officer of Health, City of Ottawa
- Dr. Chris Sikora, Medical Officer of Health, Edmonton Zone
- Dr. Lawrence Elliott, Regional Medical Officer of Health, City of Winnipeg
- Dr. Elizabeth Richardson, Medical Officer of Health, City of Hamilton
- Dr. Chris Mackie, Medical Officer of Health and CEO, Middlesex-London Health Unit
- Dr. Liana Nolan, Commissioner and Medical Officer of Health, Region of Waterloo
- Dr. Jessica Hopkins, Medical Officer of Health, Regional Municipality of Peel

- Pageen Walsh, Executive Director, Ontario Public Health Association
- Loretta Ryan, Executive Director, Association of Local Public Health Agencies
- Lana McDonald, Administrative Assistant, Urban Public Health Network
- Sheila Jennings, Ontario Leader, Moms Stop the Harm
- Sean O'Leary, Founder, Executive Director, and Outreach and Partnerships Chair, We the Parents
- Steve Cody, Say No for Nick
- Jennifer Johnston, Niagara Area Moms Ending Stigma
- Heather Alce-Steffler, Co-Founder, Tanner Steffler Foundation
- Donna May, Director, Canadian and International Focus, mumsDU
- Andrea Kusters, Grief Recovery After Substance Abuse Passing
- Frank Crichlow, Representative, Toronto Drug Users Union
- Jordan Westfall, President, Canadian Association for People Who Use Drugs

cc (via e-mail):
- Dr. Eileen de Villa, Medical Officer of Health, Toronto Public Health
- Elena Zeppieri, Administrative Assistant to the Medical Officer of Health, Toronto Public Health

TORONTO

REPORT FOR ACTION

A Public Health Approach to Drug Policy

Date: June 28, 2018
To: Board of Health
From: Medical Officer of Health
Wards: All

SUMMARY

Around the world, governments are considering different approaches to drugs. Some countries are decriminalizing drug use and possession while others are legalizing and regulating drugs. In Canada, it will soon be legal for adults to purchase cannabis for personal use. Some health officials and others are calling for changes in our approach to other drugs, especially in the midst of the current opioid overdose crisis.

The *Toronto Overdose Action Plan* recommended that Toronto Public Health conduct a community dialogue on what a public health approach to drug policy could look like for Canada. Toronto Public Health worked with a diverse steering committee to advise on project materials and process. Ipsos Public Affairs was contracted to facilitate community sessions, conduct interviews with people who use drugs, and to host an open online survey and a representative general public survey on this topic.

The evidence on the health and social harms of our current criminalization approach to illegal drugs as well as that of alternative approaches such as decriminalization and legal regulation strongly support the need to shift to a public health approach to drugs in Canada. The community dialogue process confirmed that Torontonians agree the current approach is not working, and we should treat drug use as a public health and social issue, not a criminal issue. Further, a shift in drug policy needs to be comprehensive. Not only do Canada's drug laws need to be changed, but we need to scale up prevention, harm reduction and treatment services to ensure we can provide the supports that people require.

RECOMMENDATIONS

The Medical Officer of Health recommends that:

1. The Board of Health call on the federal government to decriminalize the possession of all drugs for personal use, and scale up prevention, harm reduction and treatment services.

2. The Board of Health call on the federal government to convene a task force, comprised of people who use drugs, and policy, research and program experts in the

areas of public health, human rights, substance use, mental health, and criminal justice, to explore options for the legal regulation of all drugs in Canada, based on a public health approach.

FINANCIAL IMPACT

There is no financial impact associated with this report.

DECISION HISTORY

In March 2017, the Board of Health approved a report and recommendations from the Medical Officer of Health related to the Toronto Overdose Action Plan, including a recommendation for Toronto Public Health to undertake a community dialogue on a public health approach to drugs.
http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2017.HL18.3

In September 2017, the Board of Health approved a motion asking the Medical Officer of Health to develop and present to the Board of Health the best possible public health advice on the issue of the decriminalization of drugs.
http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2017.HL21.1

COMMENTS

Around the world, governments are considering different approaches to drugs. Some countries are decriminalizing drug use and possession while others are legalizing and regulating drugs. In Canada, it will soon be legal for adults to purchase cannabis for personal use. Some health officials and others are calling for changes in our approach to other drugs, especially in the midst of the current opioid overdose crisis.

The *Toronto Overdose Action Plan* recommended that Toronto Public Health conduct a community dialogue on what a public health approach to drug policy should look like for Canada. This recommendation reflected a strong theme raised in the community consultations for the Action Plan, calling for decriminalization or even legal regulation of drugs as criminalization has created significant risk factors for overdose and other health and social harms.

This staff report outlines the evidence about the harms of our current approach to drugs as well as alternative policy approaches, including decriminalization and legal regulation, summarizes the results of the community dialogue process, and makes recommendations for action going forward.

Why should we change our approach to illegal drugs?

People from all walks of life have used alcohol and other drugs throughout history, for many reasons. Most substance use does not harm the individual or anyone else. Some people can develop problematic use or become dependent on drugs. The reasons for this are complex, and include genetic, biological and social factors, including experiences of trauma.

Decisions about the legal status of drugs in Canada, including alcohol, were not based on scientific assessments of their potential for harm. They were often based on moral judgements and racist ideas about people and the drugs they were using.[1] Laws prohibiting the use and possession of cannabis, heroin and other drugs are relatively recent, enacted in the early 1900s. The "War on Drugs," which began in the 1970s, has not been effective in reducing either the supply or demand for drugs. People continue to want to use drugs regardless of their legal status. Alcohol was once illegal in Canada, but people still wanted to consume it. Some turned to the illegal alcohol market, sometimes with tragic results. The federal government soon realized that the health, social and criminal harms of alcohol prohibition far outweighed any benefits. It is for the same reasons that cannabis laws have changed in Canada, and why some want to see similar action for all drugs.

Harms from criminalizing drug use

Research has found that laws that criminalize people simply for using and possessing drugs have resulted in serious health and social harms, including:

- Negative beliefs and stereotypes of people who use drugs from service providers, family members and society at large.[2] [3] People who use illegal drugs are judged more harshly than people who use other drugs such as alcohol[4];
- Criminal records that make it hard for people to find a job and a place to live[5] [6];
- Difficulty accessing harm reduction services, increasing the risk of injury, disease, and other harms[7];
- Forcing people into unsafe spaces and high-risk behaviours, increasing overdose and blood-borne infections like HIV, hepatitis and tuberculosis[3] [7] [8];
- Creating an illegal drug market that produces stronger drugs for higher profits resulting in poisonings, overdoses and other harms[5]; and,
- Costing $2 billion a year for police, courts, and prisons to enforce drug laws[9].

Some people who use drugs are more impacted by our drug laws than others, including people who are homeless/living in poverty, people with mental health and substance use issues, people from racialized groups, Indigenous people, women and youth.

What would a public health approach to drug policy look like?

A public health approach would be comprehensive and based on principles and strategies that have been shown to support healthy individuals, families and communities. Principles include evidence-informed policy and practice, a commitment to social justice and human rights, and addressing the social determinants of health. Strategies include health promotion and protection, prevention, harm reduction and treatment. A public health approach could include the decriminalization of drugs for personal use or the legalization of drugs with strict regulation.

Decriminalization

Decriminalization refers to the removal of criminal penalties for the personal use and possession of drugs, however, the production and sale of drugs is still illegal.[10] There are different models of decriminalization used around the world applied to some or all drugs. For example, Portugal and the Czech Republic have laws that allow the personal use and possession of all drugs (within specified amounts). In the Netherlands, cannabis is still illegal but officials allow it to be consumed and sold in licensed “coffee shops.”[11] Some countries impose administrative penalties such as fines or mandatory

treatment. For example, in Portugal, people found with drugs above permitted amounts twice in a six-month period are referred to a "dissuasion commission" of health/social workers who may issue a fine, refer them to treatment, or take no further action.[12] In Uruguay, there are no penalties for the possession of "a reasonable quantity" of drugs for personal use, but there are criminal penalties for people who produce drugs.[12]

The International Drug Policy Consortium and the Global Commission on Drug Policy recommend a "best practice" model of decriminalization with no penalties for the use or possession of drugs for personal use, although there could be restrictions on activities such as use in public spaces.[12] [13] This model also ensures that evidence-based health, harm reduction, treatment, and support services are available.

Countries that have decriminalized personal drug use and possession and invested in public health interventions have seen results:

- In Portugal, there has been a reduction in drug use among vulnerable populations, and increases in the number of people accessing treatment.[10] There have been significant decreases in HIV transmission (85%), and drug-related deaths.[14]
- In the Czech Republic, HIV rates are less than 1% among people who inject drugs, one of the lowest rates in the region.[15]
- In California, there was $1 billion in savings to the criminal justice system in the 10 years after the possession of cannabis was decriminalized in 1976.[16]
- Police in jurisdictions that have decriminalized drug possession effectively have reported improved community relations because of the reforms.[17]

Legal regulation

While decriminalization can reduce some harms for people who use drugs, they are still dependent on an illegal market where the contents and strength of drugs are unknown. Parts of this unregulated drug supply in Canada have become toxic leading to overdoses and death. Determining how best to regulate all drugs would be complicated and take time. Currently, no country in the world has done this, but most have regulated alcohol, tobacco and pharmaceutical drugs. Medical cannabis is regulated in Canada and elsewhere, and Uruguay, some US states, and now Canada have regulated or are soon to regulate non-medical cannabis.

In a regulated market, how drugs are produced, distributed and sold would need careful consideration, and depend on the drug and its potential for harm. For example, high-risk drugs could be available by prescription-only and distributed through pharmacies. Lower-risk drugs could be sold through government-controlled stores similar to how alcohol is currently sold and cannabis will be sold in Ontario. Under a public health approach to legal regulation, there would be strict government control and regulation of the production (e.g. purity, strength), sale, marketing and consumption of any drug. Developing a regulation framework should also apply lessons learned from what has and has not been effective in the regulation of other drugs, such as alcohol, prescription drugs, and cannabis.

Community dialogue in Toronto

Toronto Public Health convened a diverse steering committee of drug policy experts, including people who use drugs, to support this initiative. This group provided advice on the community dialogue process and activities, and development of a discussion paper

and accompanying fact sheets to inform this initiative. Through a Request for Proposal process, Toronto Public Health secured Ipsos Public Affairs (Ipsos) to facilitate the community dialogue. Ipsos worked with Toronto Public Health and the steering committee to implement this initiative in May 2018.

The full report of the results of the community dialogue prepared by Ipsos is available online at www.tph.to/drugstrategy. Highlights of the report are summarized below:

There were four components of the community dialogue process:

- Two in-person community sessions, one downtown and one in Etobicoke, open to anyone interested in participating;
- Interviews with 20 people who use drugs at four community agencies in the north, central, east and west areas of the city;
- An open online survey available to anyone interested in participating; and,
- A representative general public survey**.**

Toronto Public Health promoted the community dialogue activities through media, social media, distribution lists, websites (both Toronto Public Health and City of Toronto), and information was sent to all members of Council to promote. Toronto Public Health also had a dedicated website with information about how to participate and the discussion paper and fact sheets to inform the dialogue. The general public survey was sent to a pre-established panel of participants selected by Ipsos to provide statistically significant representation across age, gender and region of the city.

Who participated in the community dialogue?

Sixty people participated in the community sessions. Most participants were community members already engaged in this topic (e.g. service providers, family/friends of people who use drugs) and people who use drugs. More than half (63 percent) of participants were women, 27 percent were men, two percent identified as another gender, and eight percent preferred not to answer. They ranged in age from 25 to 55 and over. Participants identified as White North American (48 percent), White European (26 percent), Indigenous (seven percent), and several other groups.

A total of 346 people completed the open online survey. Two-thirds of respondents were female (65 percent), 28 percent were male, three percent identified as another gender, and 4 per cent preferred not to answer. They ranged in age from 18 to 55 and over. Respondents identified as White North American (45 percent), White European (25 percent), Mixed Background (seven percent), East Asian (five percent), Indigenous (two percent), Black Caribbean (two percent), and several other groups,

A total of 20 people with lived experience were interviewed to capture the views of the people most directly affected by our drug laws. Eleven of the people interviewed were male, nine were female. They ranged in age from 25 to 61. Eight participants identified as Mixed Background (e.g. White and Indigenous), six as White European, five as White North American and one as Indian-Caribbean.

The representative general public survey was completed by 503 people (credibility or confidence interval of +/- 5 percent, 19 times out of 20). Among respondents, 53 percent were female, 47 percent were male, and ranged in age from 18 to 55 and over.

Respondents identified as Canadian (37 percent), British origin (27 percent), Asian origin (21 percent), Eastern European origin (12 percent), Western European origin (11 percent), and a range of other groups.

What were people asked about?
A discussion paper and accompanying fact sheets were developed to provide evidence-based information to participants. In addition, a core set of questions were developed for use in the various community dialogue activities in the following areas:

- Opinions of how well our current approach to illegal drugs is working
- Awareness of the health and social harms of existing drug laws
- Level of support for a public health approach to drugs
- Opinion on the federal government consulting with Canadians about decriminalizing the personal use and possession of all drugs
- Opinion on the federal government consulting with Canadians about legally regulating all drugs

At the community sessions, there were presentations by drug policy experts to help inform the discussions. Key topics included an overview of the research on the harms of existing drug laws, what constitutes a public health approach to drugs, and an overview of decriminalization and legal regulation as alternative approaches. The majority of the time was spent in facilitated small group discussions focused on the areas listed above.

Key findings from the community dialogue
The feedback from participants across the community dialogue activities and online surveys was remarkably consistent. There was, of course, a diversity of opinion with respect to details of issues discussed, but broad agreement on the key areas of discussion.

Key themes that emerged from the community dialogue are outlined below.

Canada's current approach to drugs is broken and changes need to be made.

- In the open online survey, 78 percent of respondents felt that Canada's current approach is not working and changes need to be made.
- In the representative general public survey, 74 percent felt changes are needed to our current approach to drugs.
- Reasons why people felt the current approach is not working included: the current approach focuses on the drugs themselves, and not the root causes of drug use; criminalizing drug use leads to incarceration of people who should be offered supports and services instead; and, people who need support are not getting it, and too many are dying as a result.

Any alternative approach to the current policy moving forward should address drug use as a public health and social issue, not a legal or criminal issue.

- Participants noted that alternative approaches on their own are not enough, and that comprehensive strategies that address the social determinants of health are needed to address the complexity of drug use (e.g. adequate incomes, affordable housing, mental health supports, access to primary care, addressing stigma).

- Participants often did not make the distinction between decriminalization and legal regulation as specific options for change. Rather they focused on the urgent need for change, beginning with eliminating stigma and providing necessary prevention, harm reduction and treatment services. Some were confused by the differences between decriminalization and legal regulation.

Decriminalization is a step in the right direction as an alternative approach to the current policy, however, it is not a panacea.

- In the open online survey, 80 percent of respondents felt the federal government should consult with Canadians about decriminalizing the possession of drugs for personal use.
- Participants felt that while decriminalization is necessary to address the stigmatization of drug use, and reduce the harms of people being incarcerated for using drugs, that it will not address all issues.
- Some participants were concerned that changes would stop at decriminalization and not continue toward legal regulation.
- Some felt that while personal drug use should be decriminalized, the production and trafficking of drugs should remain illegal.
- Some also felt that decriminalization would not address the current contaminated drug supply, which is leading to overdoses, while regulation of drugs would.

There is strong support for a public health approach to drugs

- In the open online survey, the vast majority (91 percent), supported a public health approach to drugs, with three-quarters *strongly* supporting this approach. Reasons for support included: support for harm reduction/public health approaches, supporting decriminalization of drugs and opposing the War on Drugs; and, a belief that it will reduce harm, prevent deaths, and stop the stigmatization of people who use drugs.
- In the representative general public survey, support for a public health approach heavily outweighed opposition (61 percent vs. 26 percent). Reasons for support included: that drug use should be treated as an illness, not a crime; would like to try a different approach; and the need to create safe spaces for people to use drugs.

Legal regulation, and a public health approach to drug policy that focuses on harm reduction, is the ideal solution to improving Canada's drug policy.

- Participants acknowledge that this approach will take time, but it is the ultimate goal in changing Canada's approach to drugs.
- In the open online survey, 75 percent of respondents felt the federal government should consult with Canadians about legally regulating all drugs for personal use.
- There were more concerns over the subtleties of what legal regulation might entail (relative to decriminalization). For many, decriminalization is more straightforward while legal regulation is more complex.
- Participants felt having drugs regulated would keep people safer, particularly with respect to more potent drugs.
- There was concern about where any redirected funds might go under legal regulation, and that they should be directed to public health and social services, not to corporate profit.

While many participants agree that the federal government should have an open dialogue and consult with Canadians about decriminalization and legal regulation, some felt the outcome would depend on who was consulted (i.e. their knowledge, experience and attitudes towards drugs and drug use).

Participants also highlighted the need for more education for the general public about drugs, drug use, harm reduction and the overdose crisis to better understand the complexity of the issues. Some participants also felt that young people are not being provided with information that may help them make informed decisions about drug use (e.g. safe use vs. abstinence) and this should go hand-in-hand with decriminalization and removing the stigma of drug use.

Actions going forward

The evidence on the health and social harms of our current criminalization approach to illegal drugs, and alternative approaches to drug policy strongly support the need to shift to a public health approach to drugs in Canada. The community dialogue process undertaken by Toronto Public Health has confirmed that Torontonians also feel the current approach is not working, and that treating drug use as a public health and social issue would be more effective. Further, that a shift in drug policy in Canada needs to be comprehensive in nature. Not only do our drug laws need to be changed, but we also need to scale up prevention, harm reduction and treatment services to ensure we can provide the supports that people require.

The need to change our approach to drugs is a discussion that is happening worldwide. Health and drug policy organizations around the world are calling for a new approach to drugs ranging from decriminalization to legal regulation, including:

- Canadian Public Health Association
- Canadian Drug Policy Coalition
- Canadian Mental Health Association
- Canadian Society of Addiction Medicine
- Centre for Addiction and Mental Health
- Health Officers Council of British Columbia
- American Public Health Association
- Global Commission on Drug Policy
- World Health Organization

The overdose crisis in Toronto and elsewhere in Canada highlights the urgency of the need to change our drug policy. Eliminating criminal sanctions (decriminalization) for the possession of all drugs for personal use will go a long way to reducing the stigma against people who use drugs, and facilitate access to much needed health and social services, including treatment and harm reduction services that need to be enhanced. It is therefore recommended that the Board of Health call on the federal government to decriminalize the possession of all drugs for personal use, and scale up prevention, harm reduction and treatment services.

While decriminalization will help reduce health and social harms for people who use drugs, it does not address the contamination of drugs in the illegal market. There are no controls on the content and purity of drugs in the illegal market. The result of this lack of regulation is that drugs can and are being cut or adulterated with other drugs (e.g.

fentanyl and fentanyl analogues) and toxic substances, and this is the main contributor to the overdose crisis in Canada. It is therefore recommended that the Board of Health call on the federal government to convene a task force to explore options for the legal regulation of all drugs in Canada, based on a public health approach. The task force should include people who use drugs, and policy, research and program experts in the areas of public health, human rights, substance use, mental health, and criminal justice.

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SIGNATURE

Dr. Eileen de Villa
Medical Officer of Health

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15 The National Monitoring Centre for Drugs and Addiction, *Annual Report: The Czech Republic Drug Situation 2013*, 2, as cited in: Global Commission on Drug Policy (2016) *Advancing Drug Policy Reform: A New Approach to Decriminalization.*
16 Aldrich, M.R. & Mikuriya, T. (1988) Savings in California Marijuana Law Enforcement Costs Attributable to the Moscone Act of 1976: A Summary. *Journal of Psychoactive Drugs,* 20 (1):75-81., as cited in: Global Commission on Drug Policy (2016) *Advancing Drug Policy Reform: A New Approach to Decriminalization.*
17 Magson, J. (2014) *Drugs, Crime and Decriminalization: Assessing the Impact of Drug Decriminalization Policies on the Efficiency and Integrity of the Criminal Justice System*, Winston Churchill Fellowship, 27, as cited in: Global Commission on Drug Policy (2016) *Advancing Drug Policy Reform: A New Approach to Decriminalization.*

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: Correspondence for Direction – Pause in the Implementation of the Smoke-Free Ontario Act, 2017 – Peterborough Public Health

Date: September 12, 2018

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive the letter dated July 3, 2018 from the Board Chair to Minister Elliot for information;*
- *share our correspondence with Ontario Boards of Health and the Association of Local Public Health Agencies; and,*
- *direct public health staff to identify opportunities to work with Curve Lake and Hiawatha First Nations and municipal staff to update local smoke-free by-laws.*

Background:

Although provincial smoking rates have dropped to about 16 per cent, the third lowest in the country, rates in Peterborough are much higher, at about 26 per cent. Each day, we estimate that 44 Ontarians die from tobacco-related disease (roughly 128 in Peterborough each year). Likewise, in 2015, 24.1% of youth had tried an e-cigarette, and emerging evidence suggests e-cigarette use leads to conventional cigarette use.

The municipalities in Peterborough City and County have a patchwork of smoke-free by-laws that provide protection from emerging sources of exposures to vapour and nicotine. The modernized Smoke-Free Ontario Act that was set to come into force on July 1, 2018 included protection from e-cigarette vapour and medicinal cannabis smoke, and increased the smoke-free areas in our community that would have further protected residents and visitors where they live, work, and play.

On July 3rd, 2018, the Board Chair wrote to the new Minister of Health and Long-Term Care expressing these concerns. Other local public health agencies have also echoed these concerns, these letters are available upon request.

Peterborough Public Health

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July 3, 2018

Minister Christine Elliott
Minister of Health and Long-Term Care and Deputy Premier
Hepburn Block 10th Floor, 80 Grosvenor St.
Toronto, ON M7A 2C4

Dear Minister Elliott:

The *Smoke-Free Ontario Act* has been in force for 12 years, but much has changed since it was first drafted. E-cigarettes were not captured in the original legislation, which is why the Board of Health for Peterborough Public Health was encouraged by the Executive Steering Committee's "Smoke-Free Ontario Modernization" report. The comprehensive evidence base of the report and recommendations to modernize the Smoke-Free Ontario Strategy to include vaping are important contributions to our understanding of the health impacts of these products. Not only were emerging products like e-cigarettes identified in the updated legislation, the tobacco and vaping industries are recognized as vectors of disease.

There is consensus among health professionals and independent researchers alike that e-cigarettes are less harmful than conventional cigarettes, however, that does not make them inherently harmless. The National Academies of Science, Engineering and Medicine recently published the most thorough evidence review to date, detailing the impact of e-cigarettes on both the user and the bystander. Highlights from the report "Public Health Consequences of E-Cigarettes" demonstrate that:

- "there is conclusive evidence that in addition to nicotine, most e-cigarettes contain and emit numerous potentially toxic substances";
- "there is substantial evidence that e-cigarette use results in symptoms of dependence on e-cigarettes"; and that
- "there is substantial evidence that e-cigarette use increases risk of ever using combustible tobacco cigarettes among youth and young adults."

Recognizing the potential benefits and documented risks of e-cigarettes, a measured response is needed that both protects Ontarians and promotes cessation. The *Smoke-Free Ontario Act*, 2017 regulations that were set to come into force on July 1, 2018, do exactly that and we urge you to reconsider the pause that was placed on their coming into force.

A delay in fully modernizing the *Smoke-Free Ontario Act* will result in more young people developing an addiction to nicotine and expose residents that don't vape or smoke to harmful airborne toxins.

The recommendations proposed by the Executive Steering Committee are in the range of strategies that are critical to meeting Ontario's goal of having the lowest rates of commercial tobacco use in Canada and meeting the tobacco endgame target of less than 5% of the population using tobacco products by 2035. Let's work together to implement these strategies to eliminate the 13,000 preventable deaths from tobacco use annually and achieve the end goal of tobacco-wise living.

Yours in health,

Original signed by

Henry Clarke
Chair, Board of Health

/wf

C: Mr. Dave Smith, MPP, Peterborough-Kawartha
Ms. Laurie Scott, MPP Haliburton-Kawartha Lakes-Brock
Mr. David Piccini, MPP Northumberland-Peterborough South
The Honourable Doug Ford, Premier of Ontario

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: Correspondence for Direction – Cannabis Sales Taxation Revenue, Grey Bruce Health Unit

Date: September 12, 2018

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive the letter dated June 18, 2018 from Grey Bruce Health Unit regarding cannabis sales taxation revenue, for information;*
- *support the resolution from Hastings Prince Edward Public Health and Grey Brice Health Unit urging the provincial government to dedicate a sufficient portion of the cannabis excise tax revenue from the federal government to local public health agencies in Ontario; and,*
- *communicate this support to the Premier's office with copies to relevant provincial ministries, local MPPs, local municipalities and First Nations, the Association of Local Public Health Agencies, and all Ontario Boards of Health.*

Background:

On March 9, 2018 the Ontario Government sent a press release titled "Ontario Supporting Municipalities to Ensure Safe Transition to Federal Cannabis Legislation". In the release it noted that the Government would "provide public health units with support and resources to help address local needs related to cannabis legalization", however no specific revenue allocations were identified.

Since this time, both the Hastings Prince Edward Public Health and Grey Bruce Health Unit have passed motions urging the provincial government to dedicate a portion of the cannabis excise tax revenue to local Public Health agencies to ensure dedicated funding to support the education and enforcement work that will be required with the legalization of cannabis. It is essential to invest in a comprehensive cannabis control strategy that includes prevention, harm reduction, treatment and enforcement. Better resources will ensure the public health agencies can provide the essential public awareness work and education, as well as enforcement.

June 18, 2018

Premier-Elect Doug Ford
Legislative Building
Queen's Park
Toronto ON M7A 1A1

Dear Premier-Elect:

Re: Dedicated Funding For Local Public Health Agencies From Cannabis Sales Taxation Revenue

On April 27, 2018 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Hastings Prince Edward Public Health regarding dedicated funding for local Public Health agencies from cannabis sales taxation revenue. The following motion was passed:

GBHU BOH Motion 2018-39

Moved by: David Inglis Seconded by: Mitch Twolan

"THAT, the Board of Health support the resolution from Hastings Prince Edward Public Health urging the provincial government to dedicate a portion of the cannabis excise tax revenue from the federal government to local Public Health agencies in Ontario."

Carried

Sincerely,

Hazel Lynn, MD, FCFP, MHSc
Acting Medical Officer of Health
Grey Bruce Health Unit

Cc: All Ontario Boards of Health

Encl.

HASTINGS PRINCE EDWARD
Public Health

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TTY: 711 or 1-800-267-6511
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March 28, 2018

Premier Kathleen Wynne
Legislative Building
Queen's Park
Toronto, ON M7A 1A1

Re: Dedicated funding for local Public Health agencies from cannabis sales taxation revenue

Dear Premier Wynne,

At its meeting on March 06, 2018, the Hastings Prince Edward (HPEPH) Board of Health passed the following motion:

THAT the HPEPH Board of Health urge the provincial government to dedicate a portion of the cannabis excise tax revenue from the federal government to local Public Health agencies in Ontario.

On December 12, 2017, the Federal Government announced that the revenue generated from the taxation of cannabis sales will be split with provinces and territories according to the following principals:

- Provinces and territories will receive 75% of this revenue while the federal government will retain 25%.
- The federal portion of cannabis excise tax revenue will be capped at $100 million annually and any revenue above this limit would be provided to provinces and territories.
- With respect to this revenue, provinces and territories will work with municipalities according to shared responsibilities towards legalization.

Subsequently, on March 09, 2018 the Ontario Government sent a press release titled, **"Ontario Supporting Municipalities to Ensure Safe Transition to Federal Cannabis Legalization"**. In the release it was noted that it would: "Provide public health units with support and resources to help address local needs related to cannabis legalization." While this release made no specific reference to how much, or how resources would be invested within the Public Health system, it is reassuring that the Ontario Government recognizes the importance of investment in the comprehensive cannabis control strategy delivered by local public health agencies. To help meet the Government of Ontario's twin goals of creating a safe and sensible framework to

manage legalized cannabis, and of having the lowest provincial/territorial smoking rate in Canada, it is essential to invest in the prevention pillar of the comprehensive cannabis control strategy and to provide adequate resources for the implementation and enforcement of the revised smoke-free legislation that now includes cannabis.

Local Public Health agencies are uniquely placed to increase public awareness of the health risks of cannabis use and driving under the influence of cannabis. Local Public Health agencies are also primed to prevent the renormalization of smoking through the legalization of cannabis. This Public Health work is foundational to helping keep our communities healthy and safe – a goal that we share with the Government of Ontario.

Although local Public Health agencies are partially funded by municipalities, we recognize that their ability to share funding from cannabis excise tax revenue with local Public Health agencies may be limited due to other conflicting priorities. With dedicated funding from this revenue, local Public Health agencies will be better resourced to provide the essential public awareness work, education and enforcement that is required with the legalization of cannabis. It is important that prevention be a pillar of cannabis legalization from the outset and dedicated funding to local Public Health agencies is an important component of supporting and strengthening this pillar.

We urge the Ontario Government to dedicate sufficient resources to local Public Health agencies to ensure that both education and enforcement are a priority.

Thank you for your consideration of this request. Please do not hesitate to contact me if you have any questions or concerns.

Sincerely,

Maureen Piercy

Maureen Piercy
Chair
Hastings Prince Edward Public Health Board of Health

Copy
Honourable Charles Sousa, Provincial Minister of Finance
Honourable Dr. Helena Jaczek, Provincial Minister of Health and Long-Term Care
Mr. Todd Smith, MPP, Prince Edward-Hastings
Mr. Lou Rinaldi, MPP, Northumberland-Quinte West
Association of Local Public Health Agencies
Boards of Health in Ontario
Dr. Ian Gemmill, MOH HPEPH

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: Correspondence for Information

Date: September 12, 2018

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:

a. Letter dated July 16, 2018 to Ministers Elliott and Thompson from the Board Chair regarding mandatory food literacy curricula in Ontario schools.

b. Letter dated July 19, 2018 to Minister Duncan from the Board Chair regarding TRC Call to Action #89.

c. Letter dated July 27, 2018 to Minister Yakabuski from Dr. Salvaterra regarding funding for cycling infrastructure

d. Letter dated August 3, 2018 to Minister McLeod from the Board Chair regarding the cancellation of the Ontario Basic Income Pilot Project.

From the Association of Local Public Health Agencies (alPHa):

e. Letter dated August 2, 2018 to Minister McLeod regarding the cancellation of the Ontario Basic Income Pilot Project.

f. July 2018 e-newsletter

g. August 2018 e-newsletter

From other Local Public Health Agencies:

h. Overdose Action Plan – Toronto Public Health

Peterborough Public Health

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July 16, 2018

Hon. Christine Elliott
Deputy Premier, Minister of Health and Long-Term Care
christine.elliott@pc.ola.org

Hon. Lisa M. Thompson
Minister of Education
lisa.thompson@pc.ola.org

Dear Ministers Elliott and Thompson:

Re: Mandatory Food Literacy Curricula in Ontario Schools

On behalf of our Board of Health, I am writing to you in support of the Kingston, Frontenac, and Lennox & Addington Board of Health's call to examine current school curricula with regards to food literacy, and introduction of food literacy and food skills training as a mandatory component of school curricula.

Our Board is committed to protecting and promoting the health and well-being of our residents. Food literacy has been in decline over the past few decades and the resultant food deskilling has affected all segments of society. It has led to an increase of pre-prepared, packaged and convenience foods, eating outside of the home, and a higher consumption of processed foods that are higher in fat, salt and sugar. These foods are linked to a greater risk of diet-related chronic diseases.

At a time when essential food literacy skills are lacking, it is important to support Ontario students with knowledge and food skills that will lead to developing food literacy and in turn will guide lifelong healthy eating habits. The school setting provides a universal opportunity for students to acquire these skills. While food literacy curriculum is available to students in high school, it is estimated that only one third of Ontarian students who entered grade 9 from the 2005/06 to 2009/10 school years earned one or more credits in a course that included a food literacy component.

We respectfully request that the provincial government examine the current school curricula with regards to food literacy, and introduce mandatory food literacy and food skills training curricula in school.

Yours in health,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

/ag
Encl.

cc: Local MPPs
Ontario Dietitians in Public Health
Association of Local Public Health Agencies
Ontario Boards of Health

Peterborough Public Health

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July 19, 2018

The Honourable Kirsty Duncan
Minister of Science and Sport
House of Commons
Ottawa, ON K1A 0A6
kirsty.duncan@parl.gc.ca

Dear Minister Duncan,

We are writing to you in your capacity as the new Minister responsible for the Physical Activity and Sport Act. This act was identified by the Truth and Reconciliation Commission in its Calls to Action as one place where the federal government could promote physical activity for Indigenous peoples, reduce barriers to sports participation, increase the pursuit of excellence in sport, and build the capacity within Canadian sports and recreation to be more inclusive (Call to Action #89).

The current objects of the legislation are numerous. Under the umbrella of encouraging, promoting and developing physical activity and sport in Canada, most of the stated objects appear relevant for purposes of Indigenous people inclusion. They are:

Object	**Relevance**
(a) *undertake or assist in research or studies in respect of physical activity and sport;*	✓
(b) *arrange for national and regional conferences in respect of physical activity and sport;*	✓
(c) *provide for the recognition of achievement in respect of physical activity and sport by the grant or issue of certificates, citations or awards of merit;*	✓
(d) *prepare and distribute information relating to physical activity and sport;*	✓
(e) *assist, cooperate with and enlist the aid of any group interested in furthering the objects of this Act;*	✓
(f) *coordinate federal initiatives related to the encouragement, promotion and development of physical activity and sport, particularly those initiatives related to the implementation of the Government of Canada's policy regarding sport, the hosting of major sporting events and the implementation of anti-doping measures, in cooperation with other departments or agencies of the Government of Canada;*	✓
(g) *undertake or support any projects or programs related to physical activity or sport;*	✓
(h) *provide assistance for the promotion and development of Canadian participation in national and international sport;*	✓
(i) *provide for the training of coaches and any other resource persons to further the objects of this Act in relation to sport;*	✓
(j) *provide bursaries or fellowships to assist individuals in pursuing excellence in sport;*	✓
(k) *encourage the promotion of sport as a tool of individual and social development in Canada and, in cooperation with other countries, abroad;*	✓

Object	Relevance
(l) *encourage the private sector to contribute financially to the development of sport;*	
(m) *facilitate the participation of under-represented groups in the Canadian sport system;*	✓
(n) *encourage provincial and territorial governments to promote and develop sport;*	✓
(o) *coordinate the Government of Canada's initiatives and efforts with respect to the staging and hosting of the Canada Games; and*	✓
(p) *encourage and support alternative dispute resolution for sport.*	

As the board of health for Peterborough, an area that includes two First Nations and a total Indigenous population of approximately 4,800, we feel that this call to action is worthy of attention and action. We contacted the previous Minister for Sport and Disabilities in May 2017 and did not receive an appropriate response. We then responded to the civil servant who penned the letter in November 2017 and have yet to hear back.

We know that since our first letter on this matter, the Prime Minister has mandated at least two of his Cabinet Ministers with specific responsibility regarding Indigenous youth and sport.

To Minister Hehr, who resigned earlier this year, he has mandated:
"Lead work in co-operation with the Minister of Indigenous Services to leverage investments in Indigenous youth and sport and ensure the promotion of culturally relevant sport as an important means to strengthen Indigenous identity and cultural pride." (https://pm.gc.ca/eng/minister-sport-and-persons-disabilities- mandate-letter)

To Minister Philpott, he has mandated:
"Support the Minister of Sport and Persons with Disabilities to leverage investments in Indigenous youth and sport and ensure promotion of culturally relevant sport as an important means to strengthen Indigenous identity and cultural pride".
(https://pm.gc.ca/eng/minister-indigenous-services-mandate-letter)

In addition to what has been explicitly mandated, we would like to receive the federal government's response to TRC Call to Action #89's requests regarding legislative amendments. We would appreciate receiving a relevant and meaningful response from the most appropriate person on the matters we have raised.

We remain, sincerely yours,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

/ag
Encl.

cc: The Hon. Jane Philpott, Minister of Indigenous Services
Maryam Monsef, MP, Peterborough-Kawartha
Kim Rudd, MP, Northumberland-Peterborough South
Jamie Schmale, MP, Haliburton-Kawartha Lakes-Brock

Peterborough Public Health

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July 27, 2018

Hon. John Yakabuski
Minister of Transportation
77 Wellesley Street West
Ferguson Block, 3rd Floor
Toronto, ON M7A 1Z8
minister.mto@ontario.ca

Dear Minister Yakabuski,

Re: Funding for Cycling Infrastructure

On behalf of the Board of Health for Peterborough Public Health, I am writing today to express our concern for the recent cancellation of the Ontario Municipal Commuter Cycling Program (OMCC). To date, funding from this program has provided $1.1 million to municipalities in our local area to complete cycling-related infrastructure improvement projects. Investments of this kind are crucial for promoting cycling and ensuring the safety of cyclists. As a form of active transportation, cycling has many public health benefits that result in long-term cost savings for both individual Ontarians and our health care system as a whole.

Nearly half of Ontarians 12 years and older report being physically inactive and it is estimated that such physical inactivity results in $2.9 billion in direct and indirect costs to the Province of Ontario.[1] Active transportation can provide an accessible means of daily physical activity, which has been shown to protect against type 2 diabetes, cardiovascular disease and colon cancer.[1] For these reasons, and others, support for active transportation in the form of dedicated funding to municipalities is one of 22 recommendations for taking action on chronic disease put forth by Public Health Ontario and Cancer Care Ontario.[1]

Commuter cycling also translates into direct cost savings for individuals. It's estimated that individual commuters spend approximately $10,500 per year to own and operate their vehicle, while it costs cycling commuters only about $150 per year to own and operate their bicycle.[2] This results in annual cost savings of approximately $10,350 for individual commuters, which translates into tangible savings for the people of Ontario and can be used to support other necessary household expenditures including adequate shelter, healthy food, and clothing.

Investing in cycling related infrastructure is a proven means of promoting cycling as a form of active transportation. Local bicycling counts conducted in the City of Peterborough in 2012 and 2013 indicate a significant increase in the number of cyclists observed after the installation of dedicated bicycling facilities.[2] According to a recent survey of local cycling needs and preferences, over 89% of the 560 respondents stated a preference for dedicated bicycling facilities.[3] These types of facilities have also be proven to reduce crashes and injuries for cyclists.[4] Between 2003 and 2012 there were over 3200 emergency department visits and 130 hospitalizations from cycling-related crashes and injuries in our local area.[2] Reducing the burden of cycling related injuries will alleviate pressure on our health care system and support the government's priority of ending hallway health care.

Funding for commuter cycling infrastructure is good for communities, our government, and the people of Ontario. We urge you to renew support for these critical investments and look forward to working with you to build a healthy and prosperous Ontario.

Sincerely,

Original signed by

Dr. Rosana Salvaterra, MD, MSc, CCFP, FRCPC
Medical Officer of Health

cc: Hon. Christine Elliott, Minister of Health and Long-Term Care
Local MPPs

---

1. Cancer Care Ontario, Ontario Agency for Health Protection and Promotion (Public Health Ontario). Taking action to prevent chronic disease: recommendations for a healthier Ontario. Toronto: Queen's Printer for Ontario; 2012.

2. Peterborough County-City Health Unit, GreenUP, City of Peterborough. 2014 City and County of Peterborough Active Transportation and Health Indicators Report. Peterborough; 2018.

3. Peterborough Bicycle Advisory Committee. (2018). 2017 Peterborough Bicycle Advisory Committee Survey. Available from: http://p-bac.org/2017pbacsurvey/ [Accessed: July, 2018]

4. Reynolds, C., Winters, M., Ries, F. & Gouge, B. (2010). Active transportation in urban areas: Exploring health benefits and risks. Available from: www.ncceh.ca/sites/default/files/Active_Transportation_in_Urban_Areas_June_2010.pdf [Accessed: July, 2018]

Peterborough Public Health

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August 3, 2018

The Honourable Lisa MacLeod
Minister of Children, Community and Social Services
80 Grosvenor Street, 6th Floor, Hepburn Block
Ministry of Community and Social Services
Toronto, ON M7A 1E9
Sent via email: lisa.macleodco@pc.ola.org

Dear Minister MacLeod:

I am writing on behalf of the Board of Health for Peterborough Public Health to urge you to reconsider the recent decision to cancel the Ontario Basic Income Pilot Project. We feel strongly that the Pilot Project offers a well-designed, cost-effective and unique opportunity to determine the contribution of a Basic Income to improving a range of economic, social and health outcomes in Ontario. The 4,000 pilot participants, including 2,000 participants in our neighbouring community of Lindsay, have entered into significant future commitments since the launch of the project, and in good faith have agreed to provide important data on the impact of this poverty reduction approach. We feel it is ethically essential to honour the promise of a full pilot program to them.

Peterborough Public Health has actively supported the concept of the basic income guarantee for many years. In September, 2015, our Board urged the provincial government to undertake a Basic Income initiative in order to address extensive health inequities in our province. Dr. Salvaterra, the Medical Officer of Health, has provided public information and support for the concept in local media. Public health staff also participate in the local Basic Income Peterborough Network. The Network has hosted a number of public education events, including an event featuring Dr. Evelyn Forget to share her analysis of the basic income project in Dauphin Manitoba, which predated the Ontario pilot.

There is an abundance of evidence on the powerful link between income and health, which is supported by data from our local community. Fifteen per cent of the population of Peterborough City and County live in low income. Those living with a lower income in our community are more likely to die earlier than people who are better off financially – females in the highest income group live eight years longer than those in the lowest income group, while males in the highest income group live fourteen years longer than males in the lowest income group. Similarly, individuals living with the lowest incomes have higher rates of chronic disease. Self-reported diabetes in Peterborough among adults aged 50+ in the lowest income group (18%) is more than double that of the highest income group (8%).

It has also been well documented that food insecurity is closely related to poorer health outcomes and higher health care costs. The most recent edition of the Peterborough Limited Incomes/Nutritious Food Basket Report reported that 16.5% of people in Peterborough City and County experience food insecurity. The Report clearly demonstrates that incomes from current social assistance programs and minimum wages from often precarious employment, are insufficient to meet people's basic needs. A Basic Income Guarantee has the potential to dramatically reduce food insecurity in our communities.

Previous research has shown that improved health outcomes are obtained when people receive a liveable basic income. Residents of Dauphin, Manitoba, for instance, saw an 8.5% reduction in hospitalization rates (primarily due to fewer accident and injury hospitalizations and fewer hospitalizations due to mental health issues). These improvements are direly needed in our current situation of significant health inequities.

We firmly believe that the Ontario Basic Income Pilot Project has enormous potential to inform the development of an effective income support system which will directly impact a wide range of key determinants of health and health outcomes. We ask that you allow the pilot and its planned evaluation to proceed as planned and fulfill its considerable potential.

Sincerely,

Original signed by

Councillor Henry Clarke,
Chair, Board of Health

/ag

cc: Honourable Doug Ford, Premier of Ontario
Honourable Christine Elliott, Minister of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
MPP David Piccini
MPP Laurie Scott
MPP Dave Smith
Central-East Local Health Integration Network
Ontario Boards of Health

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa's members are the public health units in Ontario.

alPHa Sections:

Boards of Health Section

Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

Association of Ontario Public Health Business Administrators

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

Health Promotion Ontario

Ontario Association of Public Health Dentistry

Ontario Association of Public Health Nursing Leaders

Ontario Dietitians in Public Health

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E-mail: info@alphaweb.org

August 2, 2018

Hon. Lisa MacLeod
Minister of Children, Community and Social Services
14th Floor, 56 Wellesley St W
Toronto, ON M7A 1E9
lisa.macleod@pc.ola.org

Dear Minister MacLeod,

Re: alPHa Resolution A15-4, Public Health Support for a Basic Income Guarantee

On behalf of the Association of Local Public Health Agencies (alPHa) and its member Medical Officers of Health, Boards of Health and Affiliate organizations, I am writing to express our disappointment with the decision to cancel Ontario's Basic Income Pilot (OBIP).

This project was carefully designed, limited in time and scope and not significantly costlier than the payments that Ontario Works (OW) or the Ontario Disability Support Program (ODSP) would have transferred to those enrolled. It was based on a detailed and well-researched proposal authored by Senator Hugh Segal, which was in turn subject to a broad consultation that received input from over 35,000 Ontarians as well as support from each of the province's major political parties.

Its aim was to investigate the potential for a basic income to improve the income security of vulnerable Ontarians and increase their chances of breaking the cycle of poverty. It was also designed to permit the evaluation of the potential of such an initiative as a simpler and more economically effective form of social assistance than the current OW and ODSP model.

In addition to this, the pilot was intended to measure outcomes in areas such as food insecurity, stress and anxiety, mental health, health and healthcare usage, housing stability, education and training and employment and labour market participation. These are all key determinants of health and are therefore at the root of public health's interest in and strong support of the OBIP.

There is consistent evidence that health outcomes improve as income rises. Lower income people are at far greater risk from a range of preventable medical conditions, including cancer, diabetes, heart disease, and mental illness. We therefore believe that improving incomes is an exceptionally effective public health intervention that also contributes to reducing the burden on Ontario's health care system.

The OBIP is an innovative approach to income security that should be allowed to reach its conclusion so that the evidence can be gathered, analyzed and interpreted to evaluate it against its stated objectives. We ask that you reconsider the decision to cancel the program.

alPHa's 2015 resolution in support of the concept of basic income is attached, and I would welcome the opportunity to discuss this with you and to inform any review of social assistance that your government might undertake. Please contact Loretta Ryan (loretta@alphaweb.org or 647-325-9594), should you be receptive to such a meeting.

Sincerely,

Dr. Robert Kyle
alPHa President

COPY: Hon. Christine Elliott, Minister of Health and Long-Term Care
Helen Angus, Deputy Minister, Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population and Public Health Branch (Health and Long-Term Care)
Dr. Christopher Mackie, Chair, Council of Ontario Medical Officers of Health
Trudy Sachowski, Chair, Boards of Health

ENCL.

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A15-4

TITLE: **Public Health Support for a Basic Income Guarantee**

SPONSOR: **Simcoe Muskoka District Health Unit**

WHEREAS low income, and high-income inequality, have well-established, strong relationships with a range of adverse health outcomes; and

WHEREAS 1,745,900 Ontarians, or 13.9% of the population, live in low income according to the 2011 National Household Survey after-tax low-income measure; and

WHEREAS income inequality continues to increase in Ontario and Canada; and

WHEREAS current income security programs by provincial and federal governments have not proved sufficient to ensure adequate, secure income for all; and

WHEREAS a basic income guarantee – a cash transfer from government to citizens not tied to labour market participation - ensures everyone an income sufficient to meet basic needs and live with dignity, regardless of work status; and

WHEREAS basic income resembles income guarantees currently provided in Canada for seniors and children, which have contributed to health improvements in those age groups; and

WHEREAS there was an encouraging pilot project of basic income for working age adults conducted jointly by the Government of Manitoba and the Government of Canada in Dauphin, Manitoba in the 1970s, which demonstrated several improved health and educational outcomes; and

WHEREAS a basic income guarantee can reduce poverty and income insecurity, and enable people to pursue educational, occupational, social and health opportunities relevant to them and their family; and

WHEREAS the idea of a basic income guarantee has garnered expressions of support from the Canadian Medical Association and the Alberta Public Health Association as a means of improving health and food security for low income Canadians; and

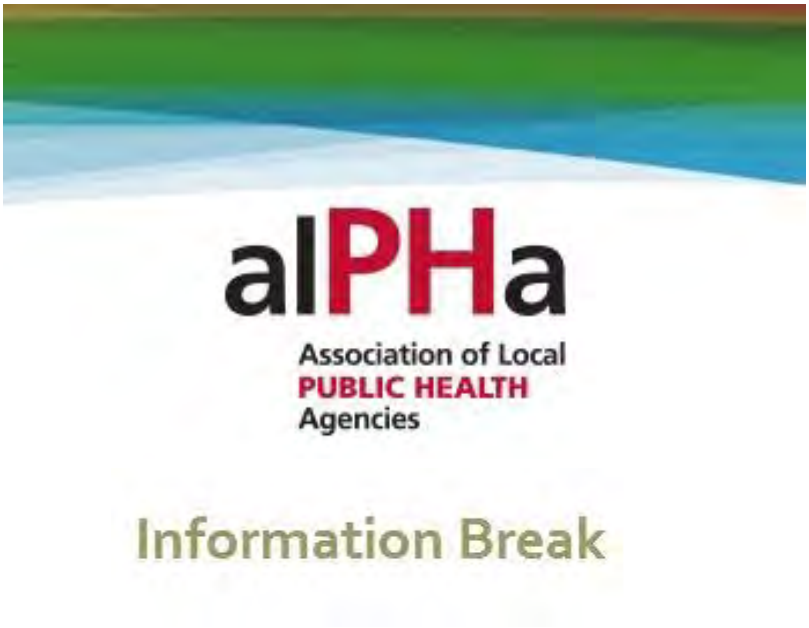
WHEREAS there is momentum growing across Canada from various sectors and political backgrounds for a basic income guarantee;

NOW THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies (alPHa) endorse the concept of a basic income guarantee;

AND FURTHER that alPHa request that the federal Ministers of Employment and Social Development, Labour, and Health, as well as the Ontario Ministers Responsible for the Poverty Reduction Strategy, Seniors, Labour, Children and Youth Services, and Health and Long-Term Care, prioritize joint federal-provincial consideration and investigation into a basic income guarantee, as a policy option for reducing poverty and income insecurity and for providing opportunities for those in low income;

AND FURTHER that the Prime Minister, the Premier of Ontario, the Chief Public Health Officer, the Chief Medical Officer of Health for Ontario, the Canadian Public Health Association, the Ontario Public Health Association, the Federation of Canadian Municipalities, and the Association of Municipalities of Ontario be so advised.

From: info@alphaweb.org [mailto:info@alphaweb.org]
Sent: Tuesday, July 24, 2018 11:45 AM
Subject: alPHa Information Break - July 24, 2018



July 24, 2018

This update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa correspondence and events.

2018 Annual Conference Wrap Up

alPHa wrapped up another successful annual conference, The Changing Face of Public Health, last month in Toronto. More than 100 members from across the province heard a variety of presentations on local public health system sustainability, Indigenous engagement and government relations. Highlights included a pre-conference guided walking tour of the downtown St. Lawrence neighbourhood, a fireside chat with Ontario's Chief Medical Officer of Health and the perennial alPHa Distinguished Service Award presentation. Many thanks goes to the conference planning committee members, speakers, sponsors and exhibitors, and attendees who helped make this a memorable and informative event. alPHa has drafted full conference proceedings which contain links to the slide presentations. The document may be downloaded from the alPHa website at the link below.
View alPHa's 2018 conference proceedings here (login and password required)

2018-2019 alPHa Executive Committee & Board of Directors

At the June annual general meeting, a new slate of officers of the 2018-2019 alPHa Executive were appointed as follows:

President: Dr. Robert Kyle (COMOH, Durham)
Past President: Carmen McGregor (BOH, Chatham-Kent)

Vice President: Wess Garrod (BOH, KFL&A)
Treasurer: Dr. Howard Shapiro (COMOH, Toronto)
BOH Section Chair: Trudy Sachowski (BOH, Northwestern)
COMOH Chair: Dr. Chris Mackie (COMOH, Middlesex-London)
Affiliate Representative: Paul Sharma (OAPHD, Peel)

For a full list of the 2018-2019 Board of Directors, click here

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June 12 Boards of Health Section Meeting

Representatives from 22 boards of health met during the annual conference in Toronto and heard presentations on the tobacco endgame, cannabis, and public health advocacy, among other topics. A link to those presentations is below. Trudy Sachowski was elected to the North West regional seat on the 2018-2019 Boards of Health Section Executive Committee of the alPHa Board of Directors. Acclaimed were David Pickles (Central East) and Gilles Chartrand (North East). The next scheduled BOH Section meeting will take place on February 22, 2019 in Toronto. *Please note there will not be a meeting in the fall of 2018 due to the October 22 municipal election.*
View presentations from the June 12 BOH Section meeting (login and password required)

Resolutions Passed at 2018 Annual Conference

At this year's annual conference alPHa's membership endorsed five resolutions on a number of province-wide issues, ranging from infection control to public health system sustainability. alPHa will be following up on the resolutions and sending them to various government contacts for their consideration and action. Responses are posted on the alPHa website as they become available and are organized by topic.
View the 2018 alPHa Resolutions here

Municipal Election Policy Priorities

Similar to the provincial policy priorities released last fall, alPHa will be developing policy priorities for the October 22 municipal election. A working group has been struck to review and discuss the public health priorities that will be delivered to municipal candidates during the weeks leading up to October 22. Look for further in this space and by email.

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alPHa Website Feature: Consultations

From time to time members of the public, including health unit staff and board of health members, are invited to provide input into consultations on matters of health and public health. alPHa keeps a list of these consultations on its website. Click the link below for more information.
View the Current Consultations web page here

Upcoming Events - Mark your calendars!

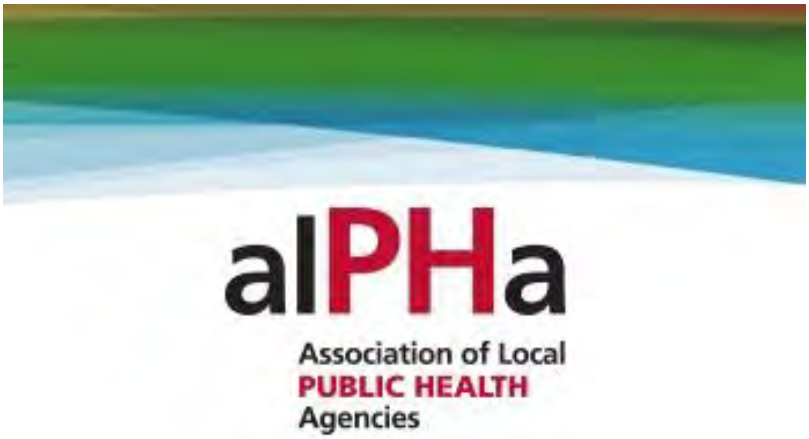
October 30, 2018 - COMOH General Meeting, Toronto, Ontario.

Note: There will no Boards of Health Section Meeting held in Fall 2018 due to the municipal election.

February 21 & 22, 2019 - Winter Symposium, Toronto, Ontario. Includes COMOH Meeting (Feb. 22) and BOH Section Meeting (Feb. 22)

March 27, 28 & 29, 2019 - TOPHC 2019, Toronto, Ontario.

June 9, 10 & 11, 2019 - Annual General Meeting & Conference, Kingston, Ontario. Co-hosted with KFL&A Public Health.



Information Break

August 31, 2018

This update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa correspondence and events.

Municipal Election Policy Priorities

Similar to the provincial policy priorities released last fall, alPHa has developed seven key public health policy priorities for consideration by candidates in the October 22 municipal election. Topics include Alcohol, Cannabis, Food Insecurity, Mental Health, Opioids, Oral Health, and Tobacco. Customizable templates on each priority have been sent to boards of health to assist them in raising these issues with local candidates for awareness and influence on healthy local policy development. Many thanks to the alPHa's Municipal Election Task Force members for their assistance in the development of the priorities and their templates.
View alPHa's 2018 municipal election policy priorities here

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alPHa Annual Report

Check out alPHa's 2017-2018 Annual Report covering the association's activities and achievements over the past year. Thank you to the alPHa Board of Directors, members and staff for their efforts in advancing the public health agenda.
View the 2017-2018 alPHa annual report here
View previous years' annual reports here

Government News Round Up

Canada announces tracking system to monitor movement of legal cannabis -2018/8/29

PM releases federal ministerial mandate letters -2018/8/28

Federal government approves roadside drug screening equipment -2018/8/27

Canada launches first Poverty Reduction Strategy - 2018/8/21

Ontario announces cannabis retail model - 2018/8/13

Province pauses overdose prevention/safe injection sites yet to be approved - 2018/8/11

Ontario cancels Basic Income research project - 2018/7/31

Province introduces legislation to end cap-and-trade carbon tax - 2018/7/25

Ontario to review safe injection/overdose prevention sites - 2018/7/24

Province pauses changes to Smoke-Free Ontario Act - 2018/7/4

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March 27, 28 & 29, 2019 - TOPHC 2019, Beanfield Centre, Toronto, Ontario.

June 9, 10 & 11, 2019 - Annual General Meeting & Conference, Kingston, Ontario. Co-hosted with KFL&A Public Health. Four Points by Sheraton, 285 King St. E., Kingston, Ontario.

TORONTO

City Clerk's Office

Ulli S. Watkiss
City Clerk

Secretariat
Julie Lavertu, Secretary
Board of Health
Toronto City Hall, 10th Floor, West Tower
100 Queen Street West
Toronto, Ontario M5H 2N2

Tel: 416-397-4592
Fax: 416-392-1879
E-mail: boh@toronto.ca
Web: www.toronto.ca/council

August 1, 2018

SENT VIA E-MAIL

To: Interested Parties

Subject: Toronto Overdose Action Plan: Status Report 2018 (Item HL27.1)

The Toronto Board of Health, during its meeting on June 18, 2018, adopted Item HL27.1, as amended, and:

1. Directed that the Board of Health's decision and the report (June 4, 2018) from the Medical Officer of Health be forwarded to all Boards of Health in Ontario for information.

2. Reinforced with provincial and federal governments the urgency of the opioid poisoning emergency, and the critical need to scale up actions in response.

3. Urged the Ministry of Health and Long-Term Care to extend approval of the maximum term for overdose prevention sites from the current 6 months to a 12-month period.

4. Urged the Ministry of Health and Long-Term Care to support urgent implementation of managed opioid programs (i.e., pharmaceutical heroin/diacetylmorphine and/or hydromorphone), including low-barrier options, across Ontario.

5. Reaffirmed its support for a comprehensive, evidence-based response to the opioid overdose crisis that includes prevention, harm reduction, and treatment and, in particular, the critical role that harm reduction measures such as naloxone distribution, peer support, supervised consumption services, and overdose prevention sites, play in saving lives and improving health.

6. Requested that the Medical Officer of Health review the communications and public presentations received at the Board of Health meeting on June 18, 2018 for consideration as to the next steps in developing the Toronto Drug Strategy.

Toronto City Council, during its meeting on June 26-29, 2018, also:

1. Reaffirmed its support for a comprehensive, evidence-based response to the opioid overdose crisis that includes prevention, harm reduction, and treatment and, in particular, the critical role that harm reduction measures, such as naloxone distribution, peer support, supervised consumption services, and overdose

prevention sites, play in saving lives and improving health.

2. Called on the Province of Ontario to continue its response to the opioid overdose crisis by supporting and expanding existing provincially-funded prevention, harm reduction, and treatment measures in the City of Toronto.

3. Requested the Medical Officer of Health to work with the Toronto Community Housing Corporation to train their staff on the safe disposal of drug use equipment and actively participate in the safe disposal of this equipment.

4. Requested the Toronto Community Housing Corporation to require their staff to receive overdose training from Toronto Public Health staff.

5. Requested the Toronto Community Housing Corporation to urgently review their current policies that discriminate against people who use drugs and implement a moratorium on evicting tenants based on drug use during the opioid poisoning crisis.

To view this item and background information online, please visit: http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2018.HL27.1.

Sincerely,

Julie Lavertu

Julie Lavertu/ar
Secretary
Board of Health

Sent to the following Boards of Health in Ontario (via e-mails to the Public Health Units):
- Algoma Public Health Unit
- Brant County Health Unit
- Chatham-Kent Health Unit
- Durham Region Health Department
- Eastern Ontario Health Unit
- Grey Bruce Health Unit
- Haldimand-Norfolk Health Unit
- Haliburton, Kawartha, Pine Ridge District Health Unit
- Halton Region Health Department
- City of Hamilton Public Health Services
- Hastings Prince Edward Public Health Unit
- Huron County Health Unit
- Kingston, Frontenac, Lennox & Addington Public Health
- Lambton Public Health
- Leeds, Grenville and Lanark District Health Unit
- Middlesex-London Health Unit
- Niagara Region Public Health Department
- North Bay Parry Sound District Health Unit
- Northwestern Health Unit

- Ottawa Public Health
- Oxford-Elgin-St. Thomas Public Health Unit
- Peel Public Health
- Perth District Health Unit
- Peterborough Public Health
- Porcupine Health Unit
- Public Health Sudbury & Districts
- Renfrew County and District Health Unit
- Simcoe Muskoka District Health Unit
- Thunder Bay District Health Unit
- Timiskaming Health Unit
- Region of Waterloo, Public Health
- Wellington-Dufferin-Guelph Public Health
- Windsor-Essex County Health Unit
- York Region Public Health

cc (via e-mail):

- Dr. Eileen de Villa, Medical Officer of Health, Toronto Public Health
- Elena Zeppieri, Administrative Assistant to the Medical Officer of Health, Toronto Public Health

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Prepared by: Donna Churipuy, Director of Public Health Programs
Larry Stinson, Director of Operations

Subject: **Report: Q2 2018 Peterborough Public Health Activities**

Date: September 12, 2018

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the report, Q2 2018 Peterborough Public Health Activities, for information.

Attachments:

Attachment A – Program Report
Attachment B – Communications and IT Report
Attachment C – Social Media Report
Attachment D – Finance Report

Peterborough Public Health

Quarter 2 2018 Status Report (April 1 – June 30, 2018)

Overall Compliance Status

Ontario Public Health Standard Mandated Programs	# Requirements Compliant
Program Standards	
Chronic Disease Prevention and Well-Being	3/4
Food Safety	5/5
Healthy Environments	4/10
Healthy Growth and Development	2/3
Immunization	9/10
Infectious and Communicable Diseases Prevention and Control	20/21
Safe Water	8/8
School Health	5/10
Substance Use and Injury Prevention	3/4
Foundational Standards	
Population Health Assessment	5/7
Health Equity	4/4
Effective Public Health Practice	7/9
Emergency Management	1/1
Non-OPHS Mandated Programs	
Infant and Toddler Development	ME
Safe Sewage Disposal	ME

ME: Meeting Expectations PME: Partially Meeting Expectations

Reference: Ontario Public Health Standards ***(web hyperlink)***

Chronic Disease Prevention and Well-Being
Hallie Atter, Manager, Local Programs

Program Compliance:

Requirement #2:
Intended impact statements for this standard have been drafted and a search for and appraisal of strategies will be completed by end of 2018 for implementation in 2019. Only activities that are sun-setting or have had prior commitments made will be implemented for the rest of this year. These activities will cover the areas of Built Environment, Healthy Eating, Healthy Sexuality, Physical Activity and Sedentary Behavior, Substance Use and UV exposure.

Healthy Environments
Atul Jain, Manager, Environmental Health
Hallie Atter, Manager, Family and Community Health Programs

Program Compliance:

Requirement#2: Due to new planning process, new Guidelines, as well as gaps in staffing, a full assessment of needs will not be completed. However, an intended impact statement for the built and natural environment has been drafted and a search for and appraisal of strategies will be completed by end of 2018 for implementation in 2019.

Requirement #3: This requirement has not been met due to insufficient staffing. The plan is to pursue funding opportunities through Health Canada and temporary staffing has been requested.

Requirement #4-7: See Requirement #2.

Healthy Growth and Development

Hallie Atter, Manager, Family and Community Health Programs
Patti Fitzgerald, Manager, Child Health Services

Program Compliance:

Requirement# 2: Intended impact statements for this standard have been drafted and a search for and appraisal of strategies will be completed by end of 2018 for implementation in 2019. Only activities that are sun-setting or have had prior commitments made will be implemented for the rest of this year. These activities will cover the areas of Breastfeeding, Growth and Development, Healthy Pregnancies, Healthy Sexuality, Preconception Health, Pregnancy Counselling, Preparation for Parenting, Positive Parenting and Oral Health.

Immunization:

Edwina Dusome, Manager, Infectious Diseases

Program Compliance

Requirement 1: Unmet due to insufficient staffing.

Infectious and Communicable Diseases Prevention and Control

Atul Jain, Manager, Environmental Health

Program Compliance:

Requirement 15: Communication to local Veterinarians needs to be finalized to inform them of reporting requirements for animal cases of avian chlamydiosis (infection of birds with the causative agent of psittacosis in humans), avian influenza, novel influenza, and Echinococcus multilocularis infection. This should be completed by the beginning of the third quarter.

School Health
Patti Fitzgerald, Manager, Child Health Services
Hallie Atter, Manager, Family and Community Health Programs

Program Compliance:

Requirement 2 to 4: Intended impact statements for this standard have been drafted and a search for and appraisal of strategies will be completed by end of 2018 for implementation in 2019. Only activities that are sun-setting or have had prior commitments made will be implemented for the rest of this year.

Requirement 7: More information is anticipated from the MOHLTC regarding the implementation of Child Visual Health and Vision Screening program. It has just been shared that a training webinar will be presented the week of August 13th to all health units. No further details have been provided at this time.

Requirement 9: Due to the new planning process, new Guidelines, as well as gaps in staffing, interventions will be planned and prioritized, but not implemented in 2018.

Substance Use and Injury Prevention
Hallie Atter, Manager, Family and Community Health Programs

Program Compliance:

Requirement 2: Intended impact statements for this standard have been drafted and a search for and appraisal of strategies will be completed by end of 2018 for implementation in 2019. Only activities that are sun-setting or have had prior commitments made will be implemented for the rest of this year. The focus of the activities will be on Comprehensive Tobacco Control, Substance Use and Road Safety. The delay of the proclamation of the *Smoke-Free Ontario Act* 2017 and related Ontario Regulation 268/18, as well as the legalization of Cannabis will also postpone planned worked to support our communities in the implementation of these two laws.

Foundational Standards
Jane Hoffmeyer, Manager, Foundational Standards

Compliance – Population Health Assessment:

Requirements # 1, 3, 5-7:
Progress has been achieved through the launch of planning to address these new requirements. PPH continues to engage with the CE-LHIN through various committees or providing advice as requested.

Compliance – Health Equity:

Requirements #1-4 Progress has been achieved through the launch of planning to address these new requirements. PPH continues to advance collaborative work

through the Indigenous Health Advisory Circle, Healthy Kids Community Challenge, participation in advisory tables for local municipal Official Plans and various committees of the CE-LHIN.

Compliance – Effective Public Health Practice:

Requirements #1, 3-6, 8

Progress has been achieved through the launch of planning to address these new requirements. Progress continues on the development of a Pan-organizational Training Committee (e.g. terms of reference, logic model, resource allocation, work plan).

Compliance – Emergency Management:

Requirement #1

New OPHS guidelines for emergency management have been received and an analysis completed on gaps in PPH's existing emergency preparedness programming. Progress continues on updating PPH's Continuity of Operations Procedure (COOP). The emergency management policy update affecting the broader health system is still pending.

Communications – Q2 2018

Brittany Cadence, Manager, Communications & IT Services

Media Relations

Activity	Q2 comparison	
	2018	2017
Total media products produced (news releases, audio files, letters to the editor, monthly Examiner columns, op eds, BOH meeting summaries, etc.)	17	53
Number of media interviews	25	24
Number of media stories captured directly covering PPH activities	99	95

Activity	Yearly Totals				
	2018 (ytd)	2017	2016	2015	2014
Press releases/media products issued	53	181	158	165	111
Media interviews	36	86	92	82	109
Number of media stories directly covering PPH activities	272	329	340	540	475
Communications tickets	202	680	n/a	n/a	n/a

Communications Highlights:

- Launch of new PPH website

Information Technology - 2018 Q2

<u>Note:</u> this report is provided from the Information Technology (IT) team and is intended to summarize major projects and provide a snapshot of the overall health of PPH systems.

System Status This Quarter:

Service Description	Planned Outage Time/ % downtime of total	Unplanned Outage Time/ % downtime of total	Total Uptime
MS Exchange Email server	0 hrs	0/0%	100%
Phone server	0 hrs	2 hrs/0%	99.9%
File server	0 hrs	0/0%	100%
Backup server	0 hrs	0/0%	100%

Total Number of Helpdesk Tickets Served:

Activity	Yearly Totals			
	2018 (ytd)	2017	2016	2015
IT Tickets	523	1426	1277	945

IT Highlights:

- Completion of IT Checkup project

Peterborough Public Health

Follow us @Ptbohealth

SOCIAL MEDIA Q1 REPORT

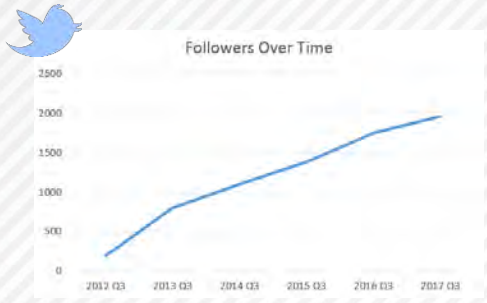
April 1 – June 30/18

Breadth… How many people are connecting with us on our social media channels?

Twitter: In Q1 our followers grew

3.3%

to **2108**



53 tweets ***Q2***

-5

882 fans

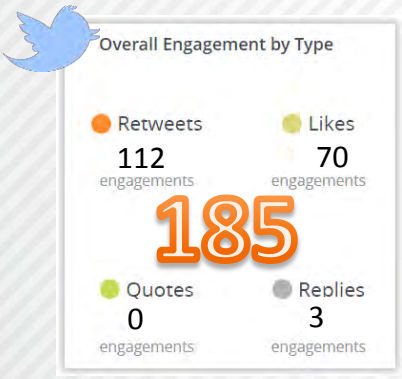
31 new fans

50,826

webpage views

+23.75%

Direct Engagement… How did people interact with us on social media?

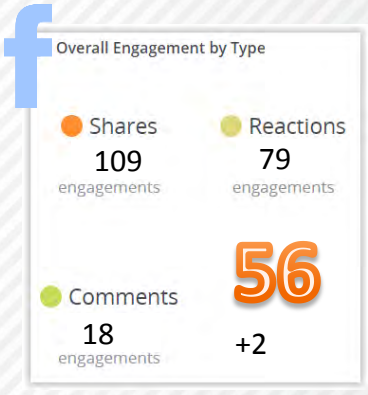


most popular tweet

3.2%

engagement rate

27 engagements



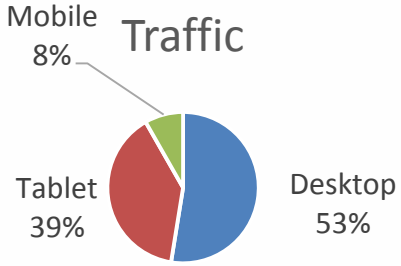
Depth… How are people reaching us and what are they looking for?

TOP 10

pages: peterboroughpublichealth.ca

Homepage: 10455
Employment: 5453
Food Handler Course: 1651
Sexual Health Clinics: 1620
Contact Us: 1308
Alerts: 1160
Outbreak Media Release: 1053
LTCF Alerts: 957
Food Handler Course: 954
Clinics and Classes: 756

website visitors by device



Click throughs from tweet/post to our website

186

161

Loyalty… How are we doing at keeping our visitors engaged?

Steady growth and 0 unfollows

twitter

443 (clicks)

FROM

facebook

www.peterboroughpublichealth.ca

Customer Experience… What are people saying about us on social media?

@MENTIONS

55

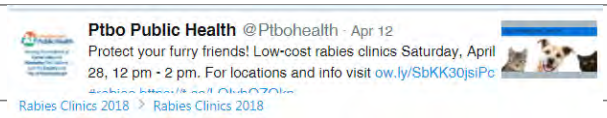
Offices That Work! @OfficesThatWork
Apr 18

Awesome
Great to see our community leaders engaged with local business leaders

@Ptbohealth @wbnptbo @KawarthaSocial @snapdPTBO

Campaigns… How did our coordinated social projects perform?

Ad Campaigns –



Social Media Push Campaigns –

Engagements Total number of times a user interacted with a Tweet.

Engagement rate: Number of engagements divided by impressions

Impression: Times a user is served a Tweet in timeline or search results

Promoted Tweet: Are ordinary Tweets purchased by advertisers who want to reach a wider group of users to spark engagement

Impression: Times a user is served a Tweet in a timeline or search results

Handle: another word for username specific to Twitter and represented by an @ symbol (e.g. @Ptbohealth)

Mention: A Tweet that contains another user's @handle anywhere in the body of the Tweet. Used to "call out" to someone and will land in their notifications timeline.

Financial Update Q2 2018 (Finance: Dale Bolton)

Programs Funded January 1 to December 31, 2018									
	Type	**2018**	**Approved by Board**	**Approved $ by Province**	**Approved by Province**	**Expenditures to Jun. 30**	**% of Budget**	**Funding**	**Comments**
Mandatory Public Health Programs	Cost Shared (CS)	7,720,933	08-Nov-17	7,875,467	7-May-18	3,794,544	48.2%	MOHLTC	Operating within budget. Board approved $7,975,438 which included Small Drinking Water, Vector Borne Disease and Occupancy Cost - See lines below. The Ministry approved a 2% funding increase for Mandatory Programs, resulting in an additional $115,900 in cost-shared funding. Matching funds in the amount of $38,633 received from Local Partners. Addition funds will reduce the budgetted reserves required to balance operations. See Appendix D1 for summary by Program Standard.
Small Drinking Water Systems	CS	90,800	08-Nov-17	90,800	7-May-18	46,063	50.7%	MOHLTC	Operating just above budget.
Vector- Borne Disease (West Nile Virus)	CS	76,133	08-Nov-17	76,133	7-May-18	28,701	37.7%	MOHLTC	Operating within budget. West Nile Virus program measures and students began in May.
Infectious Disease Control	100%	222,300	11-Apr-18	222,300	7-May-18	112,834	50.8%	MOHLTC	Operating just above budget.
Infection Prev. & Control Nurses	100%	90,100	11-Apr-18	90,100	7-May-18	45,681	50.7%	MOHLTC	Operating just above budget.
Healthy Smiles Ontario (HSO)	100%	763,100	11-Apr-18	763,100	7-May-18	340,503	44.6%	MOHLTC	**Operating well within budget. Program expenditures expected to be in line with budget as some planned expenditures for clinic by end of quarter.**

	Type	2018	Approved by Board	Approved $ by Province	Submission Date	Expenditures to Jun. 30	% of Budget	Funding	Comments
Enhanced Food Safety	100%	25,000	11-Apr-18	25,000	7-May-18	13,376	53.5%	MOHLTC	Operating just above budget. Anticipate being in budget by end of year.
Enhanced Safe Water	100%	15,500	11-Apr-18	15,500	7-May-18	6,155	39.7%	MOHLTC	Operating well within budget. Student position commenced in late May.
Needle Exchange Initiative	100%	57,000	11-Apr-18	57,000	7-May-18	13,242	23.2%	MOHLTC	Operating below budget. Year to date expenditures lower as expenditures in first quarter covered through one-time funding approval. Anticipate spending budget by end of year.
Harm Reduction Enhancement	100%	150,000	11-Apr-18	150,000	7-May-18	71,630	47.8%	MOHLTC	Operating within budget.
Social Determinants of Health Nurses Initiative - Nurses Commitment	100%	180,500	11-Apr-18	180,500	7-May-18	73,599	40.8%	MOHLTC	Operating within budget. Year to date underage due to gapping in 2nd quarter.
Chief Nursing Officer Initiative	100%	121,500	11-Apr-18	121,500	7-May-18	58,563	48.2%	MOHLTC	Operating within budget.
Smoke Free Ontario (SFO) - Control	100%	100,000	11-Apr-18	100,000	7-May-18	48,960	49.0%	MOHLTC	Operating within budget.
SFO - Enforcement	100%	202,100	11-Apr-18	202,100	7-May-18	102,201	50.6%	MOHLTC	Operating just above budget.

	Type	2018	Approved by Board	Approved $ by Province	Submission Date	Expenditures to Jun. 30	% of Budget	Funding	Comments
SFO - Youth Prevention	100%	80,000	11-Apr-18	80,000	7-May-18	39,186	49.0%	MOHLTC	Operating within budget.
SFO - Prosecution	100%	6,700	11-Apr-18	6,700	7-May-18	0	0.0%	MOHLTC	Operating within budget based on program demand.
Electronic Cigarettes Act - Protection & Enforcement	100%	29,300	11-Apr-18	29,300	7-May-18	14,535	49.6%	MOHLTC	Operating within budget.
Medical Officer of Health Compensation	100%	51,054	NA	51,054	Submitted 31-Jul with MOH Q2 report	25,527	50.0%	MOHLTC	Operating within anticipated budget based on prior year approval.
Healthy Babies, Healthy Children	100%	928,413	14-Mar-18	928,413	submitted 4 - May	460,679	49.6%	MCYS	Operating within budget.

One-Time Programs Funded April 1, 2018 to March 31, 2019

	Type	2018	Approved by Board	Approved $ by Province	Submission Date	Expenditures to Jun. 30	% of Budget	Funding	Comments
Menu Labelling	100%	111,947	11-Apr-18	12,500	7-May-18	0	0.0%	MOHLTC	Funding for one PHI for 8 weeks during January - March 2019.
PHI Practicum	100%	20,000	11-Apr-18	10,000	7-May-18	0	0.0%	MOHLTC	Funding for 1 practicum PHI student for 12 weeks during January - March 2019.
Vaccine Refrigerators	100%	50,000	11-Apr-18	45,800	7-May-18	0	0.0%	MOHLTC	Funding supports purchase and installation of 4 vaccine fridges.
Recreational Beaches Predictive Model	100%	30,000	11-Apr-18	30,000	7-May-18	0	0.0%	MOHLTC	Funding supports hiring of a student PHI for July through September 2018 and related program resources.

Programs funded April 1, 2018 to March 31, 2019									
	Type	**2018 - 2019**	**Approved by Board**	**Approved $ by Province**	**Approved**	**Expenditures to Jun. 30**	**% of Budget**	**Funding**	**Comments**
Infant Toddler and Development Program	100%	251,422	08-Mar-17	251,422	26-Jun-17	63,286	25.2%	MCSS	Operated just above budget. Anticipate being on budget by end of year.
Speech	100%	12,670	Annual Approval	NA	NA	6,335	50.0%	FCCC	Operating within budget.
Programs funded April 1, 2018 to September 30, 2018									
Healthy Communities Challenge Fund		162,498	NA	NA	NA	57,293	35.3%	MOH/City/ PPH	Operating within budget. Planned expenditures in Q2 and Q3 to spend budget by end of September.

Funded Entirely by User Fees January 1 to December 31, 2018									
	Type	**2018**	**Approved By Board**	**Approved $ by Province**	**Approved By Province**	**Expenditures to Jun. 30**	**% of Budget**	**Funding**	**Comments**
Safe Sewage Program		382,389	12-Nov-14	NA	NA	200,318	52.4%	FEES	Program funded entirely by user fees. Expenditures are slightly above budget. Revenue from User Fees are below budget resulting in a deficit of $42,603. Building activity slower in first quarter of the year, however anticipate increase in revenues as building season commences to offset deficit.
Mandatory and Non-Mandatory Re-inspection Program		97,500	12-Nov-14	NA	NA	26,862	27.6%	FEES	Operating well within budget. Re-inspection program activity begin in late May.

Programs funded through donations and other revenue sources January 1 to December 31, 2018									
	Type	**2018**	**Approved By Board**	**Approved $ by Province**	**Approved By Province**	**Expenditures to Jun. 30**	**% of Budget**	**Funding**	**Comments**
Food For Kids, Breakfast Program & Collective Kitchens		56,604	NA	NA	NA	32,816	58.0%	Donations	Budget based 2017 actuals. Operating above budget. Excess expenditures offset by donations.

To: All Members
Board of Health

From: Mayor Mary Smith, Chair, Governance Committee

Subject: **Committee Report: Governance**

Date: September 12, 2018

Proposed Recommendations:

a. *That the Board of Health for Peterborough Public Health receive meeting minutes of the Governance Committee from April 3, 2018, for information.*

b. *That the Board of Health for Peterborough Public Health approve:*
   - *policy 2-150 Remuneration of Members as amended;*
   - *compensation for community volunteers appointed to its Indigenous Health Advisory Circle (IHAC) equal to Board Member honouraria moving forward; and,*
   - *retroactive compensation for two members previously appointed to the IHAC (formerly the First Nations Committee) to September 2016.*

c. *That the Board of Health for Peterborough Public Health approve policy 2-340 Medical Officer of Health Performance Appraisal as amended;*

d. *That the Board of Health for Peterborough Public Health approve policy 2-348 Governance Committee, Terms of Reference as amended;*

e. *That the Board of Health for Peterborough Public Health approve policy 2-261 Appointments, Provincial Representatives as circulated (no further changes recommended).*

Background:

The Governance Committee met last on June 19, 2018. At that meeting, the Committee requested that these items come forward to the Board of Health.

With respect to item 'b', current Board policy allows for the expenses of Board-appointed volunteers to Committees to be reimbursed with no honorarium for participation in Committee meetings. This has been an oversight on the part of staff and it is recommended that this practice be changed in order to provide better equity between Committee members, keeping in mind that City representatives do not receive an honorarium as Board members but instead receive a small amount of compensation from the City. So while this will not completely address issues of equity, it will ensure that representatives of urban Indigenous organizations

participating in the IHAC receive some compensation, paid either directly to them, or directed to their organization if this is their preference. This compensation would be provided retroactively to the two Board appointees for whom this would be applicable (approximately $1,300 if accepted), and funds can be covered from the Board's 2018 budget.

Attachments:

Attachment A - Governance Committee Minutes, April 3, 2018
Attachment B - 2-150 Remuneration of Members
Attachment C - 2-340 Medical Officer of Health Performance Appraisal*
Attachment D - 2-348 Governance Committee, Terms of Reference
Attachment E - 2-261 Appointments, Provincial Representatives

*Forms associated with this policy remain unchanged and have been removed for this meeting package. Available upon request.

Board of Health for
Peterborough Public Health
MINUTES
Governance Committee Meeting
Tuesday, April 3, 2018 – 5:00 p.m.
Dr. J. K. Edwards Board Room, 185 King Street, Peterborough

Present:	**Mr. Greg Connolley** **Councillor Lesley Parnell** **Mayor Mary Smith, Chair** **Mr. Michael Williams** **Councillor Henry Clarke**
Regrets:	**Mr. Andy Sharpe**
Staff:	**Larry Stinson, Director of Operations** **Ms. Natalie Garnett, Recorder**

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1. Call to Order

Mayor Smith called the Governance Committee meeting to order at 5:00 p.m.

2. Confirmation of the Agenda

MOTION:
That the Agenda be accepted as circulated.
Moved: Councillor Clarke
Seconded: Mr. Williams
Motion carried. (M-2018-017-GV)

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

5. Confirmation of the Minutes of the Previous Meeting

MOTION:
That the minutes of the Governance Meeting held February 6, 2018 be approved as circulated and provided to the Board of Health at its next meeting for information.
Moved: Mr. Connolley
Seconded: Mr. Williams
Motion carried. (M-2018-018-GV)

6. Business Arising from the Minutes

7. Staff Reports

7.1 By-Laws, Policies and Procedures for Review

MOTION:
That the Governance Committee recommend to the Board of Health for Peterborough Public that policy 2-80 – Accessibility, be adopted.
Moved: Mr. Williams
Seconded: Councillor Parnell
Motion carried. (M-2018-019-GV)

MOTION:
That the Governance Committee defer 2-150 Remuneration of Members, 2-192 Donor Recognition and 2-340 Medical Officer of Health Performance Appraisal.
Moved: Mr. Williams
Seconded: Mr. Connolley
Motion carried. (M-2018-020-GV)

MOTION:
That the Governance Committee defer 2-261 Appointments, Provincial Representatives.
Moved: Councillor Clarke
Seconded: Mr. Williams
Motion carried. (M-2018-021-GV)

8. Consent Items

9. New Business

9.1 **Closed Session Training**

MOTION:
That the Governance Committee receive the following items for information and determine timing and content for Board Closed Session Training:
- *Amberley Gavel Closed Meeting Booklet*
- *Ombudsman Ontario Tips for Municipalities – Closed Meetings*

Moved: Councillor Clarke
Seconded: Mr. Connolley
Motion carried. (M-2018-022-GV)

9.2 **Remuneration of First Nations Committee Community Volunteers**

MOTION:
That the report Remuneration of First Nations Committee Community Volunteers be received for information and deferred to a future meeting.
Moved: Councillor Parnell
Seconded: Mr. Connolley
Motion carried. (M-2018-23-GV)

9.3 **Evaluation of Board of Health Committees**

MOTION:
That the Governance Committee recommend that all Board of Health Committees amend their Terms of Reference to include ongoing evaluation of Committee meetings, and provide Committee Chairs with an evaluation form template based on Board of Health meeting evaluations.
Moved: Councillor Clarke
Seconded: Mr. Connolley
Motion carried. (M-2018-24-GV)

9.4 **Appointment to the Board of Health Stewardship Committee**

MOTION:
That the Governance Committee recommend to the Board of Health, the appointment of Kerri Davies to the Stewardship Committee, at its next meeting.
Moved: Councillor Parnell
Seconded: Councillor Clarke
Motion carried. (M-2018-25-GV)

10. In Camera to Discuss Confidential Matters

11. Motions from In Camera for Open Session

12. Date, Time and Place of Next Meeting

The next Governance Committee meeting will be held on Tuesday, June 19, 2018.

13. Adjournment

MOTION:
That the Governance Committee meeting be adjourned.
Moved by: Councillor Parnell
Seconded by: Mr. Connolley
Motion carried. (M-2018-026-GV)

The meeting was adjourned at 5:48 p.m.

Chairperson

Medical Officer of Health

Board of Health
POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-150	**Title:** Remuneration of Members
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 2014-01-08**
Signature:		**Author:** Governance Committee
Date (YYYY-MM-DD)**:** 2016-04-13		
Reference:		

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POLICY

Definitions

"Board" means the Board of Health for Peterborough Public Health;

"Council" means the municipal Councils of the Corporations of the County of Peterborough and the City of Peterborough, and Councils for Curve Lake First Nation and Hiawatha First Nation;

“Committee” means an assembly of two or more members appointed by the Board of Health;

"Meeting" means an official gathering of members of the Board or its committees in one place to transact business; and

"Member" means a person who is appointed to the board by a Council or the Lieutenant Governor-in -Council or a person who is appointed to a committee by the Board.

Policy

1. At its first regular meeting, the Board shall confirm which members shall be remunerated for attending meetings and shall determine the amount of the remuneration. The Board shall be provided with a recommendation from the Governance Committee on proposed adjustments or increases to support their decision.

2. The Board shall reimburse each member for all reasonable expenses incurred as a result of acting in his/her capacity as a member in accordance with the policies of the Board.

3. Community members appointed by the board to its Indigenous Health Advisory Circule will be asked to advise whether they would like to have their honourarium paid to them, or directed to the organization they are representing.

~~3.~~4. The Board shall reimburse each member for all reasonable expenses incurred by the attendance at conventions, conferences, seminars, etc. in accordance with the policies of the Board.

~~4.~~5. An honorarium will be paid to each member of the Board of Health who is eligible for compensation in accordance with the Health Promotion and Protection Act.

~~5.~~6. The amount of the honorarium will be established by the Board of Health at the first regular meeting of the Board of Health each year.

~~6.~~7. The honorarium will be paid to each eligible Board member who attends:

(a) a regular meeting of the Board;
(b) a committee meeting;
(c) a conference or convention; or
(d) a business meeting on behalf of the Board.

~~7.~~8. A Board member who attends one meeting (or consecutive meetings) that extend over six hours, will receive one and one half times the regular honorarium.

~~8.~~9. A Board member will be paid one half of the regular honorarium when required to attend to Board business not covered under item 6. This will include cheque signing when not carried out at regular meetings.

~~9.~~10. Board members will not be compensated for attendance at community events unless representing the Chair of the Board of Health.

~~10.~~11. The quarterly financial report presented to the Board of Health will provide details of all expenses related to the activities of the Board of Health.

~~11.~~12. Meeting attendance by County representatives on the Board of Health will be forwarded to the County Clerk's office on a biannual basis.

Review/Revisions

On (YYYY-MM-DD)**: 2016-04-13**
On (YYYY-MM-DD)**: 2014-01-08**
On (YYYY-MM-DD)**:**
On (YYYY-MM-DD)**:**

Board of Health
POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-340	**Title:** Medical Officer of Health Performance Appraisal
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 2009-02-11**
Signature:		**Author:** Medical Officer of Health
Date (YYYY-MM-DD)**:** 2016-04-13		
Reference: Medical Officer of Health Performance Appraisal Form (available upon request)~~(appended)~~ Medical Officer of Health Performance Planner (available upon request)~~(appended)~~ Medical Officer of Health Position Description (available upon request)		

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POLICY

The Board of Health (BOH) facilitates performance by creating an environment where the Medical Officer of Health (MOH) and all employees of Peterborough Public Health (PPH) achieve their best. A written appraisal system will be used to provide an objective and uniform way to evaluate employees on the job. It is a constructive process to build on strengths, correct weaknesses, and maximize performance.

1. The MOH's performance is to be appraised before the end of the probationary period, in order to recommend to the BOH appointment to regular appointment status, extension of probationary period, or termination of employment.

2. At the beginning and end of each year, the Board Chair will meet with the MOH to set and review an annual work plan which includes professional development goals.

3. The MOH's appraisal will be conducted by a committee of the BOH chaired by the Chair of the BOH every two (2) years.

4. This review is to be conducted by the current Chair, Vice Chair, and a past Chair of the Board, when possible.

5. The Board will incorporate feedback from internal stakeholders such as board of health members and staff as part of the 360° component every ~~two~~ four (~~2~~4) years. If relevant, the MOH may incorporate any such processes from their professional college into this appraisal process.

6. External stakeholders will be approached for feedback by the Board at least every ~~five~~ six (~~5~~6) years and where appropriate.

7. As part of the performance appraisal, the MOH is responsible for completing a self-appraisal.

8. Formal performance appraisals do not take the place of ongoing evaluation and feedback. If the MOH's work is not adequate, the matter is to be dealt with while details and facts are fresh and will not wait for the formal review. The MOH's performance must return to the required standard within a specified time period or further action may be taken by the Board.

PROCEDURE

The Chair of the BOH will:

1. Meet with the MOH at the beginning and end of the Chair's term to review the annual work plan, which includes the setting of professional development goals.

2. Schedule the performance appraisal before the end of the probationary period and then at least every two (2) years, preferably around the MOH's anniversary date.

3. Convene a meeting with the immediate past Chair and the Vice Chair to review the required materials, confirm the process, and develop the timeline. This sub-committee can consult with any other persons they feel could provide relevant input to the performance appraisal, review the job description, operational plans, significant events and any other pertinent items from the period under review.

4. Work with the Secretary of the Board to organize the 360^{o} component of the appraisal. This would begin with a request to the MOH for a list of staff and external stakeholders, when warranted, who could be approached for potential feedback.

5. Conduct the interview. This part may require more than one meeting. Begin the process with the MOH's self-appraisal. Use the information collected from the various sources to grade each factor on the appraisal form, using the definitions included in the performance appraisal form and support the decision with comments and examples wherever possible. When weighing all of the feedback, genuinely consider the MOH's input and make changes/additions to the factor comments, examples and even grading where warranted.

6. Complete the Performance Appraisal Form. The appraisal should also include an assessment of performance relative to any learning or performance objectives set in the previous performance appraisal. In the Board's comments, clearly indicate whether the overall performance is satisfactory or not. For probationary MOHs indicate if probation has been completed satisfactorily.

7. Sign and date the Performance Appraisal Form and have the MOH do the same. The MOH's signature means that they have read and understood the review. Ensure that a signed version of the Confidentiality Agreement is received.

8. Provide the MOH a full copy of the completed Performance Appraisal Form. The Director of Operations is to retain the original including the self-appraisal in the MOH's personnel file.

Review/Revisions

On (YYYY-MM-DD)**:** 2016-04-13 (Board)
On (YYYY-MM-DD)**:** 2015-12-09 (Board; combined with procedure 2-341)
On (YYYY-MM-DD)**:** 2012-12-12 (Board)
On (YYYY-MM-DD)**:** 2012-11-26 (Governance)
On (YYYY-MM-DD)**:** 2010-11-10 (Board)
On (YYYY-MM-DD)**:** 2010-10-27 (By-Laws, Policies and Procedures Committee)

Board of Health
POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-348	**Title:** Governance Committee, Terms of Reference
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 2010-05-12**
Signature:		**Author:** Governance Committee
Date (YYYY-MM-DD)**:** **2016-06-08**		
Reference:		

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Goal

1. To ensure that the Board of Health fulfils its legal, ethical, and functional responsibilities through adequate governance policy development, recruitment strategies, training programs, monitoring of board activities, and evaluation of board members' participation.

2. To promote and ensure effective governance by recommending to the Board of Health, Board of Health By-laws and policies and procedures that are relevant, current, and comprehensive.

Objectives

The Governance Committee will:

1. review and make recommendations to the Board regarding orientation of new members and the ongoing development of existing members;

2. be responsible to ensure that the By-law to select Board members for the Executive positions is followed and that no conflict, or perceived conflict is evident in the selection and voting process;

3. review, prepare and recommend revisions, where necessary, to Board of Health By-laws, policies and procedures;

4. advise the Board or a Board Committee of all corporate governance issues that the Committee determines ought to be considered by the Board or Committee as set out in an annual work plan;

5. oversee and advise on the annual selection of Board members for its standing Committees;

6. establish and administer a process for assessing the effectiveness of the Board, its Committees;

7. establish and administer a process for assessing the effectiveness of the Medical Officer of Health;

8. act as liaison between non-union staff and the Board of Health on matters related to compensation and working conditions.

Membership

The Committee will be composed of a minimum of three Board members in addition to the Chair of the Board.

The Committee will elect its own Chair and Vice-Chair at the first meeting of each calendar year.

Internal staff resources will be provided for the Committee through the Medical Officer of Health and the Director of Operations.

Quorum

A majority of Committee members constitute a quorum.

Reporting

The Committee will provide its minutes, once approved, to the Board of Health at the next scheduled meeting.

The Chair will take motions and/or recommendations deemed appropriate by the Committee forward to the Board of Health at the next scheduled meeting.

Meetings

The Committee will meet a minimum of quarterly and may meet more frequently

Extraordinary meetings to address specific items may be held at the call of the Chair of the Governance Committee.

Time-limited sub-committees may be formed to address specific issues.

The Governance Committee will meet with other Board Committees as required.

Minutes

The Executive Assistant to the Board of Health, or designate, will record the proceedings at meetings and provide secretarial support to the Committee.

The minutes are circulated in draft to Committee members prior to the next Committee meeting. Minutes are corrected and approved at the next meeting of the Committee.

The approved minutes are signed by the recorder and the Chairperson. Original copies of the approved minutes are kept in a binder in the Administration office.

Agendas

Agendas will be prepared and distributed according to the format set forth in Section 4 – Agenda and Order of Business, as written in Board of Health By-Law #3, Calling of and Proceedings at Meetings.

Evaluation

Committee members will be encouraged to complete online meeting evaluations following each meeting. These evaluations will be shared with the Committee Chair no later than two weeks following each meeting. The Chair will be responsible for ensuring that items and concerns arising from these evaluations are addressed in a timely manner.

Terms of Reference

The Terms of Reference of the Board of Health's Governance Committee will be reviewed and updated at the first meeting of each new year or more often as needed.

Review/Revisions

On (YYYY-MM-DD)**: 2016-06-08 (Board)**
On (YYYY-MM-DD)**: 2015-03-11 (Board)**
On (YYYY-MM-DD)**: 2013-02-13 (Board)**
On (YYYY-MM-DD)**: 2013-02-01 (Governance review)**
On (YYYY-MM-DD)**: 2011-09-11 (Board)**
On (YYYY-MM-DD)**: 2011-06-09 (Governance review)**

Board of Health
POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-261	**Title:** Appointments, Provincial Representatives
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 2011-09-14**
Signature:		**Author:** Governance Committee
Date (YYYY-MM-DD)**:** 2013-09-11		
Reference:		

NOTE: This is a **CONTROLLED** document for internal use only, any document appearing in a paper form should **ALWAYS** be checked against the online version prior to use.

PROCEDURE

Objective:

To ensure that all provincial appointments to the Board of Health are dealt with in accordance with Board of Health by-laws, policies, and procedures.

Procedure:

1. Terms for all provincial appointments to the Board of Health are tracked by the Executive Assistant to the Board of Health.

2. The Board Chair will be advised by the Executive Assistant of terms that are due to end one year prior to the expiry of the appointment.

3. The Board Chair will contact the incumbent to discuss his/her intentions.

4. If the member wishes to renew their appointment, and the Board Chair is in agreement, the member must complete a Reappointment Information Form and provide it to the Executive Assistant for submission to the Public Appointments Secretariat (PAS), as well as to the Public Appointments Unit of the Ministry of Health and Long-Term Care, Corporate Management Branch.

5. If the member does not wish to renew their appointment, or if a vacancy is predicted, the Board of Health will conduct a needs assessment and determine priorities for representation.

6. The Board of Health will advertise locally. The Public Appointments Secretariat (PAS) also posts upcoming vacancies on their web site (http://www.pas.gov.on.ca/).

7. The Board of Health Governance Committee will interview and rank potential applicants.

8. The preferred candidate will be directed to apply through the PAS web site.

9. A letter will be sent by the Board Chair to the local Member of Provincial Parliament, with a copy to the Public Appointments Unit of the Ministry of Health and Long-Term Care, Corporate Management Branch, identifying and noting support of the preferred applicant.

Review/Revisions

On (YYYY-MM-DD)**: 2016-04-13** *(Review only, template updated)*
On (YYYY-MM-DD)**: 2013-09-11**
On (YYYY-MM-DD)**: 2011-09-14**
On (YYYY-MM-DD)**:**

To: All Members
Board of Health

From: Catherine Praamsma, Chair, Stewardship Committee

Subject: **Committee Report: Stewardship**

Date: September 12, 2018

Proposed Recommendations:

a. *That the Board of Health for Peterborough Public Health receive meeting minutes of the Stewardship Committee from May 1, 2018, for information.*

b. *That the Board of Health for Peterborough Public Health approve By-Law 2 Banking and Finance as amended; and,*

c. *That the Board of Health for Peterborough Public Health approve By-Law 9 Procurement of Goods and Services as amended;*

Background:

The Stewardship Committee met last on August 23, 2018. At that meeting, the Committee requested that these items come forward to the Board of Health.

Attachments:

Attachment A – Stewardship Committee Minutes, May 1, 2018
Attachment B – By-Law 2 Banking and Finance
Attachment C – By-Law 9 Procurement of Goods and Services

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Stewardship Committee Meeting
Tuesday, May 1, 2018 – 5:00 p.m.
Dr. J.K. Edwards Board Room, 185 King Street, Peterborough

Present:	**Councillor Henry Clarke**
	Mayor Rick Woodcock, Chair
	Councillor Gary Baldwin
	Ms. Kerri Davies
	Ms. Catherine Praamsma
Regrets:	**Chief Phyllis Williams**
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health**
	Ms. Dale Bolton, Manager, Finance and Property
	Mr. Larry Stinson, Director of Operations
	Ms. Alida Gorizzan, Executive Assistant
	Ms. Natalie Garnett, Recorder

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1. Call to Order

Mayor Woodcock called the Stewardship Committee meeting to order at 5:03 p.m.

2. Confirmation of the Agenda

MOTION:
That the agenda be approved as circulated.
Moved: Councillor Clarke
Seconded: Councillor Baldwin
Motion carried. (M-2018-022-SC)

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

5. Confirmation of the Minutes of the Previous Meeting

5.1 **April 10, 2018**

MOTION:
That the minutes of the Meeting of April 10, 2018 be approved as circulated.
Moved: Councillor Baldwin
Seconded: Ms. Davies
Motion carried. (M-2018-023-SC)

6. Business Arising from the Minutes

6.1 **Update on Actions from April 11, 2018 Board Meeting**

Larry Stinson, Director of Operations, provided an update on the activities undertaken following the April Board of Health meeting.

MOTION:
That the Stewardship Committee endorse the resolution submitted to the 2018 alPHa Annual General Meeting directing the provincial association to advocate for sustainable provincial funding for local public health units.
Moved: Ms. Praamsma
Seconded: Councillor Clarke
Motion carried. (M-2018-024-SC)

MOTION:
That the Stewardship Committee receive the verbal update from Mr. Stinson regarding actions taken following the April 11, 2018 Board of Health meeting.
Moved: Councillor Baldwin
Seconded: Ms. Praamsma
Motion carried. (M-2018-025-SC)

7. Staff Reports

7.1 **April 2018 Funding Announcement**

Larry Stinson, Director of Operations, provided an update on the funding announcement from the Ministry of Health and Long-Term Care.

MOTION:
That the Stewardship receive the following for information:
- *Letter dated April 13, 2018 from Minister Jaczek to all Ontario Boards of Health regarding a funding increase to cost-shared programs; and,*
- *A summary of the financial impact of the two-percent increase on the 2018 budget.*

Moved: Ms. Davies
Seconded: Ms. Praamsma
Motion carried. (M-2018-026-SC)

7.2 Staff Report: Increased Proportion of Local Funding for Public Health

Larry Stinson, Director of Operations, provided an overview of "Increased Proportion of Local Funding for Public Health".

MOTION:
That the Stewardship Committee:
- *Receive the staff report, "Increased Proportion of Local Funding for Public Health" for information; and,*
- *Recommend to the Board that the plan be endorsed along with any amendments as required over time; and,*
- *Provide direction to staff regarding the formal requests to local funding partners for increases in funding for the 2019-2021 fiscal years, for Board approval.*

Moved: Ms. Davies
Seconded: Councillor Clarke
Motion carried. (M-2018-027-SC)

8. Consent Items

9. New Business

9.1 Reserves Management

Larry Stinson, Director of Operations, provided a PowerPoint presentation on the report, "Reserves Management".

MOTION:
That the Stewardship Committee direct staff to develop a Board of Health policy:
- *To establish and maintain a minimum reserve balance of $500,000 for Operational Contingency and $250,000 for Capital; and,*
- *That formal Board approval be required for expenditure of funds that would result in balances lower than these amounts.*

Moved: Councillor Baldwin
Seconded: Councillor Clarke
Motion carried. (M-2018-028-SC)

9.2 **Funding Advocacy Work Plan - Discussion**

The Committee discussed the process on funding advocacy for the Health Unit, including approaches to municipal and First Nation partners.

10. In Camera to Discuss Confidential Matters

11. Motions for Open Session

12. Date, Time and Place of Next Meeting

The next meeting of the Stewardship Committee is to be determined.

13. Adjournment

MOTION:
That the meeting be adjourned.
Moved: Ms. Praamsma
Seconded: Councillor Baldwin
Motion carried. (M-2018-029-SC)

The meeting was adjourned at 6:35 p.m.

Chairperson

Medical Officer of Health

Board of Health
POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-110	**Title:** By-Law Number 2 – Banking and Finance
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 1989-10-11**
Signature:		**Author:** Director of Operations~~, Corporate Services~~
Date (YYYY-MM-DD)**:** 201~~87~~-08-~~14-11-12~~		
Reference: **Policy 9-95: Purchasing – Tendering and Calls for Proposals**		

Commented [DB1]: Inserted refence to P & P for Tender

NOTE: This is a **CONTROLLED** document for internal use only, any document appearing in a paper form should **ALWAYS** be checked against the online version prior to use.

By-Law Number 2
Banking and Finance

1. In this By-law:
   1) "Act" means the Health Protection and Promotion Act;
   2) "Board" means the Board of Health for ~~the~~ Peterborough Public ~~County City~~ Health ~~Unit~~;
   3) "Chairperson of the Board" means the Chairperson elected under the Act;
   4) "Vice-Chairperson of the Board" means the Vice-Chairperson elected under the Act;
   5) "Medical Officer of Health" means the Medical Officer of Health of the Board as defined under the Act and Regulations; and
   6) "Director of Operations" ~~, Corporate Services"~~means the business adminstrator of the organization as defined in the Regulations under the Act.

2. The Medical Officer of Health and Director of Operations, shall be authorized to ~~Board shall~~ enter into an agreement with a recognized chartered bank or trust company which will provide the following services:
   1) a current account;
   2) the provision of cancelled cheques on a regular basis together with a statement showing all debits and credits;
   3) the payment of interest at a rate to be negotiated between the Board and the bank or trust company for all surplus funds held in each account;
   ~~4) payroll services;~~
   ~~5)~~4) the lending of money to the Board as required; and
   5) advice and other banking services as required.

3. The Medical Officer of Health and Director of Operations shall be authorized to enter into an agreement with a recognized company to provide additional financial services including but not limited to:
   1) payroll services;
   2) debit card processing; and
   3) corporate credit card for procurement of goods and services.

~~3.~~4. Once every five years a Request for Proposal or tenders shall be called by the Director of Operations~~, Corporate Services~~ for banking services. A recommendation for approval will be provided to the Board of Health by the Medical Officer of Health.

Commented [DB2]: This is noted in reference to the Tender Policy

5. The Chairperson and Vice-Chairperson of the Board, the Medical Officer of Health, Director of Operations or Director of Public Health Programs, shall be authorized to sign cheques drawn on a current account.

6. The Chairperson and Vice-Chairperson of the Board, the Medical Officer of Health, Director of Operations ~~and Director of Public Health Programs~~, shall be authorized to borrow money from a recognized chartered bank or trust company on behalf of the organization not exceeding $100,000. If greater than $100,000, Board approval is required whereby; one of the authorizing signatures must be the Chairperson or Vice-Chairperson of the Board.

7. All cheques shall require two signatures and the Chairperson and Vice-Chairperson of the Board shall not sign the same cheque.

8. No person may approve a payment to themselves.

~~4.~~7. 9. The Medical Officer of Health and the Director of Operations~~, Public Health Programs and Director, Corporate Services~~ shall be authorized:
   1) to deposit with or negotiate or transfer to a bank or trust company (but only for the credit of the Board) any and all cheques, promissory notes, bills of exchange or orders for payment of monies;
   2) to receive all paid cheques and vouchers and to arrange, settle, balance and certify all books and accounts between the Board and the bank or trust company;
   3) to sign the form of settlement of balances and releases of the bank or trust company;
   4) to receive all monies and to give acquittance for the same; and
   5) to invest excess or surplus funds in interest-bearing accounts or short-term deposits.

This By-law shall be deemed to have come in to force on the 11th date of October, 1989.

Dated at the City of Peterborough the 25th date of October, 1989.

Review/Revisions

On (YYYY-MM-DD)**:** 2014-11-12
On (YYYY-MM-DD)**:** 2012-09-12
On (YYYY-MM-DD)**:** 2010-07-07
On (YYYY-MM-DD)**:** 2006-04-12
On (YYYY-MM-DD)**:** 2005-01-12
On (YYYY-MM-DD)**:** 1998-10-28

Board of Health

POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-180	**Title:** By-Law Number 9 – Procurement of Goods and Services
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 2007-10-10**
Signature:		**Author:** Director~~, Corporate Services~~ of Operations
Date (YYYY-MM-DD)**:** ~~2012-12-12~~		Last Review Date: 2014-09-03
Reference: By-Law Number 2 - Banking and Finance Policy 9-95: Purchasing – Tendering and Calls for Proposals		

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By-Law Number 9
A By-Law to Provide for the Procurement of Goods and Services

1. In this By-law:
   (1) "Act" means the Health Protection and Promotion Act.
   (2) "Board" means the Board of Health for the Peterborough Public Health~~County City Health Unit~~; and
   (3) "Medical Officer of Health" means the Medical Officer of Health of the Board as defined under the Act and Regulations.
   (4) "Director of Operations~~, Corporate Services~~" means the business administrator of the Board as defined in the Regulations under the Act.
   ~~(4)~~(5) "Capital Project" means costs incurred to aquire or improve the life expectancy of a long-term capital investment such as equipment or building.

2. Peterborough Public Health ~~The Board~~ shall utilize fair, responsible, and efficient methods to secure the supplies, equipment, accommodation, and services needed to implement the Board's programs and services.

3. Board and organizational policies and procedures shall ensure that purchasing decisions are based on price, suitability, availability, impact o~~n~~f employee health and safety and the environment, and stability and integrity of, and previous experience with, the vendor.

4. The following procurement process shall apply depending upon the value of the goods or services. The procurement process undertaken assumes the purchase has been pre-approved within the

annual program operational budget. All purchases in excess of $5,000, not included in the program operational plan, must be approved by the Director of Operations or delegate.

Appendix "A" to this by-law provides a summary of the Types of Procurement Processes set out in~~.~~

~~4.~~ a) For purchases~~items~~ having an estimated cost of less than $1,000 excluding taxes, no formal quotation process is necessary. The acquisition of goods or services should be through open, fair and competitive pricing in the best interests of the organization. ~~competitive quotations will be obtained where feasible~~. ~~In some circumstances, non-competitive pricing may occur to allow for the procurement of goods and services in an efficient and timely manner.~~

For purchases ~~items costing~~ greater than $1,000 but not exceeding ~~.~~$5,000 excluding taxes, a minimum of two ~~three~~ verbal quotations are obtained and documented. ~~written quotations will be obtained~~. The Program Manager ~~Director, Corporate Services~~ or designate will determine the successful quotation in consultation with the requisitioner. In some circumstances, non-competitive pricing may occur to allow for the procurement of goods and services in an efficient and timely manner.

For purchases ~~items costing~~ greater than $5,000 but not exceeding $30,000 excluding taxes, and as approved within applicable budget, ~~,~~ three documented written quotes shall be obtained. ~~competitive quotes will be called by the Director~~. The Program Manager or designate will determine the successful quotation in consultation with the Director of Operations or delegate.

For purchases greater than $30,000 but not exceeding $100,000, a Request for Proposal or Tender shall be called by the Director of Operations. The Director will determine the successful bidder in consultation with the Medical Officer of Health. Following the awarding of a tender, significant changes to prices or terms previously approved must be submitted to the Director of Operations for approval.

~~-~~For purchases greater than $100,000, a Request for Proposal or Tender shall be called by the Director of Operations ~~Corporate Services or designate~~, for review by the Medical Officer of Health. Recommendations shall be presented to the Board, or designated committee of the Board ~~-~~for consideration and decision. Following the awarding of a tender, significant changes to prices or terms previously approved by the Board must be submitted to the Board for approval.

Calling for quotations and tendering may be waived in emergency and extraordinary circumstances approved by the Medical Officer of Health and the Chairperson of the Board.

Non-competitive procurement through sole or single sourcing may be approved whereby goods and services are unique to a specific vendor and/or can not be obtained through another supplier with a procurement value upto a total purchase value of $ 5,000 by the Program Manager. For goods and

services exceeding $5,000 and upto $100,000, approval must be provided by the Director of Operations or delegate.

For capital projects in excess of $100,000, approval from the Board is required.

The use of credit cards to purchase goods and services, and designation of cardholders, shall be approved by the Director of Operations or designate~~Medical Officer of Health~~. The credit card (s) will have an approved set limit whereby one individual card shall not have a credit limit in excess of $25,000.~~Each credit card shall have a set limit as established by the Board from time to time~~. Increases to the credit card limit must be approved by the Director of Operations. All purchases shall be within the established monthly limit. Credit cards shall only be used by the designated cardholder.

The use of debit cards to purchase goods and services, and designation of cardholders, shall be approved by the Director of Operations. Each debit card account has a maximum of $1,500 of available funds. All purchases shall be within the established available funds. Debit cards shall only be used by the designated cardholder.

To ensure that the Board is receiving the best value and to encourage competition, the Director of Operations~~Board~~ shall review ~~during the annual budget approval process~~:

- ~~audit and~~ banking services in accordance with governing legislation and relevant Board By-laws every five years;
- insurance, audit and legal services at least every three years; and
- ~~laboratory, legal services~~, communications services at least every three years or sooner if deemed necessary. ~~telephone, and utilities~~

This By-law shall be deemed to have come in to force on the 11th day of October, 2007.

Dated at the City of Peterborough the 10th day of October, 2007.

Review/Revisions

On (YYYY-MM-DD)**:**

On (YYYY-MM-DD)**:**

On (YYYY-MM-DD)**:**

Appendix "A" TO BY LAW 9 – PROCUREMENT OF GOODS AND SERVICES

Total Procurement Value	Method of Procurement	Authorization
Upto $1,000	No formal quotation	Program Manager
$1,001 - $5,000	Minimum of two verbal quotes obtained and documented	Program Manager
$5,001 - $30,000	Three written quotes obtained	Director of Operations in consultation with the Program Manger
$30,001 - $100,000	Request for Proposal or Tender	Director of Operations in consulatation with Medical Officer of Health
$100,000 and above	Request for Proposal or Tender	Board of Health or Designated Committee