Our Vision:
Healthy People in Vibrant Communities

Board of Health Meeting
Woodstock Location: Oxford County Administration Building
21 Reeve Street, Woodstock, ON N4S 7Y3
Virtual Participation: Microsoft Teams
April 25, 2024 at 1:00 p.m.

AGENDA			
ITEM	**AGENDA ITEM**	**LEAD**	**EXPECTED OUTCOME**
1.0 CONVENING THE MEETING			
1.1	Call to Order, Recognition of Quorum • Introduction of Guests, Board of Health Members and Staff	Bernia Martin	
1.2	Approval of Agenda	Bernia Martin	Decision
1.3	Reminder to disclose Pecuniary Interest and the General Nature Thereof when Item Arises including any related to a previous meeting that the member was not in attendance for.	Bernia Martin	
1.4	Reminder that Meetings are Recorded for minute taking purposes	Bernia Martin	
2.0 APPROVAL OF MINUTES			
2.1	Approval of Minutes: March 28, 2023	Bernia Martin	Decision
3.0 APPROVAL OF CONSENT AGENDA ITEMS			
4.0 CORRESPONDENCE RECEIVED REQUIRING ACTION			
5.0 AGENDA ITEMS FOR INFORMATION.DISCUSSION.ACCEPTANCE.DECISION			
5.1	Presentation: Audited Financial Statements ending December 31, 2023	Graham Scott Enns	Decision
5.2	Chief Executive Officer's Report for April 25, 2024	Cynthia St. John	Decision
5.3	Medical Officer of Health's Report for April 25, 2024	Dr. Ninh Tran	Decision
6.0 NEW BUSINESS/OTHER			
7.0 CLOSED SESSION ***That the Board of Health move to closed session in order to consider one or more the following as outlined in the Ontario Municipal Act, S.O. 2001, c. 25, s. 239.(2).***			
8.0 RISING AND REPORTING OF THE CLOSED SESSION			
9.0 FUTURE MEETINGS & EVENTS			
9.1	Board of Health Orientation: Thursday, May 23, 2024, at 12:00 pm Board of Health Meeting: Thursday, May 23, 2024, at 1:00 pm • 1230 Talbot St. St. Thomas, ON • Virtual Participation: MS Teams	Bernia Martin	Decision
10.0 ADJOURNMENT			

March 28, 2024

Board of Health Meeting

Open Session Minutes

A meeting of the Board of Health for Oxford Elgin St. Thomas Health Unit was held on Thursday, March 28, 2024 commencing at 1:00 p.m.

PRESENT:

Ms. C. Agar	Board Member
Mr. D. Mayberry	Board Member
Mr. J. Herbert	Board Member
Mr. G. Jones	Board Member (Vice-Chair)
Ms. B. Martin	Board Member (Chair)
Mr. S. Molnar	Board Member
Mr. M. Peterson	Board Member
Mr. L. Rowden	Board Member
Mr. M. Ryan	Board Member
Mr. D. Shinedling	Board Member
Mr. D. Warden	Board Member
Ms. C. St. John	Chief Executive Officer (ex officio)
Dr. N. Tran	Medical Officer of Health (ex officio)
Ms. W. Lee	Executive Assistant

GUESTS:

Ms. M. Cornwell*	Manager, Communications
Ms. J. Gordon	Administrative Assistant
Mr. P. Heywood	Program Director
Ms. S. MacIsaac	Program Director
Mr. D. McDonald	Director, Corporate Services and Human Resources
Ms. M. Nusink	Director, Finance
Ms. C. Richards*	Manager, Foundational Standards
Mr. I. Santos	Manager, Information Technology
Mr. D. Smith	Program Director

MEDIA:

Mr. R. Perry*	Aylmer Express

**represents virtual participation*

REGRETS:

Mr. J. Couckuyt	Board Member
Mr. J. Preston	Board Member

REMINDER OF DISCLOSURE OF PECUNIARY INTEREST AND THE GENERAL NATURE THEREOF WHEN ITEM ARISES

1.1 CALL TO ORDER, RECOGNITION OF QUORUM

The meeting was called to order at 1:09 p.m.

AGENDA

Resolution # (2024-BOH-0328-1.2)
Moved by D. Mayberry
Seconded by D. Warden

That the agenda for the Southwestern Public Health Board of Health meeting for March 28, 2024 be approved.

Carried.

1.3 Reminder to disclose Pecuniary Interest and the General Nature Thereof when Item Arises.

1.4 Reminder that meetings are recorded for minute-taking purposes.

2.0 APPROVAL OF MINUTES

Resolution # (2024-BOH-0328-2.1)
Moved by M. Peterson
Seconded by S. Molnar

That the minutes for the Southwestern Public Health Board of Health meeting for February 22, 2024 be approved.

Carried.

3.0 CONSENT AGENDA

D. Mayberry proposed an addendum to the motion that would indicate that the issues raised by Southwestern Public Health's initial letter to the ministry remain unaddressed by the response from Minister Bethlenfalvy.

S. Molnar and G. Jones indicated their support for additional correspondence from the Board of Health, specifying that the Minister of Health be addressed directly as well.

P. Heywood noted the initial letter was directed to the Minister of Finance (MOF) as the consultation process had been assigned to the MOF portfolio, whereby communications and responses from public health were thus directed to that office.

Resolution # (2024-BOH-0328-3.1)
Moved by D. Mayberry
Seconded by M. Peterson

> That the Board of Health for Southwestern Public Health receive consent agenda item 3.1, Minister of Finance Peter Bethlenfalvy's Alcohol Policy Reply to Southwestern Public Health, and further that SWPH respond, expressing its concern that the issues raised by public health remain unaddressed.

Carried.

AGENDA ITEMS FOR INFORMATION.DISCUSSION.DECISION

5.1 Southwestern Public Health Engagement with Local First Nations Report for March 28, 2024

C. St. John reviewed the report, noting it was prompted by D. Shinedling's question raised in October regarding the degree of SWPH's engagement with local First Natons communities and populations.

The group inquired about the use of urban indigenous to reference First Nations populations that do not live on reserves. C. St. John indicated she would provide further information regarding its use and appropriateness.

C. St. John noted the urban indigenous individuals in the SWPH region comprise of approximately 2.3% of its overall population.

M. Ryan praised the report for its openness to engage in relationships and discussions with First Nations communities. D. Shinedling noted his appreciation for the development of the report. D. Mayberry hoped to hear more from local First Nations communities about their experiences and expectations of public health in the future.

Resolution # (2024-BOH-0328-5.1)
Moved by M. Peterson
Seconded by D. Warden

That Board of Health for Southwestern Public Health accept the Southwestern Public Health Engagement with Local First Nations Report for March 28, 2024.

Carried.

5.2 Medical Officer of Health's Report

Dr. Tran reviewed his report.

Dr. Tran highlighted 9 measles cases reported in Ontario as of March 13, including at least one case not related to international travel.

He noted the importance of preparing for potential measles outbreaks by vaccinating and testing individuals, noting that all measles cases in Canada are born after 1970, highlighting the importance of vaccination. Currently, the greatest concern is to ensure children under 12 are vaccinated fully.

M. Peterson asked if there is sufficient herd immunity in the community to contain an outbreak. Dr. Tran responded that herd immunity target coverage of 95% works well uniformly; however, there are no uniform areas of coverage. Dr. Tran noted that pockets of lower vaccination rates in areas can be a point of vulnerability in the community, citing the pertussis outbreak in the region last year.

M. Ryan noted his frustration and concern over lower immunization rates, asking if there has been sufficient messaging from the province. He identified a growing trend to discount the effectiveness of vaccinations.

J. Herbert referenced the Immunization of School Pupils Act (ISPA) and asked how effective it is in ensuring good vaccine rates. Dr. Tran responded that there is an option for a family to not be vaccinated via vaccine exemption, thus accounting for lower vaccination rates.

D. Shinedling asked if there is a falling trend in vaccinations. Dr. Tran noted SWPH vaccination rates are stable, but that there has been a slight increase in exemptions. He noted that some health units completely suspended ISPA during Covid-19, whereas SWPH at the time offered school vaccine programs throughout the pandemic which was a positive decision. SWPH's confirmed vaccination rates were one of the highest in immunization coverage during the pandemic.

D. Warden questioned a growing reluctance to being vaccinated, citing failing rates of Covid-19 vaccine uptake with each iteration. Dr. Tran noted the level of confidence in vaccines may have decreased as indicated by number of exemptions. He notes the impact of Covid-19's vaccine efficacy may have influenced public opinion about other historically effective vaccines.

D. Shinedling noted that vaccination is an easy solution to prevent complicated health problems, and asked what else could be done to support vaccine push-out.

S. Molnar asked if there have been comparisons with other health units to assess their strategies and effectiveness of their outreach.

C. St. John indicated she would discuss with program staff.

B. Martin suggested S. MacIsaac provide an update to her vaccination presentation to the Board from last year.

Resolution # (2024-BOH-0328-5.2)
Moved by J. Herbert
Seconded by M. Peterson

That Board of Health for Southwestern Public Health accept the Medical Officer of Health's report for March 28, 2024.

Carried.

5.3 Chief Executive Officer's Report

C. St. John reviewed her report.

S. Molnar asked if there was any comment about the provincial budget that was released on March 27, 2024. C. St. John noted that overall provincial health funding does not keep pace with population increase and inflation. She also acknowledged that the budget was just released the day prior and associations such as alPHa have not had full opportunity to review its contents as it relates to public health.

D. Warden asked for clarity regarding the appointment of members to the board. C. St. John noted that, when required, Board members are identified and appointed through an expression of interest and skills matrix process (a requirement of SWPH's accountability framework); however, municipal appointees are set by municipal council and provincial appointments are assigned by the province. The expression of interest process that SWPH has provides support to SWPH in identifying the skills and experience that is needed on the board and that SWPH sends a letter to the Public Appointment Secretariat requesting consideration of particular individuals that have been vetted by the process described.

D. Warden suggested reviewing the appointment process for this and future boards, asking for further clarification regarding experience and qualifications.

Resolution # (2024-BOH-0328-5.3-2.1)
Moved by M. Peterson
Seconded by J. Herbert

That the Board of Health approve the revised Terms of Reference for the Special Ad Hoc Strengthening Public Health Committee, effective March 28, 2024.

Carried.

Resolution # (2024-BOH-0328-5.3-3.1)
Moved by D. Shinedling
Seconded by M. Ryan

That the Board of Health ratify the signing of the Annual Service Plan for 2024.

Carried.

Resolution # (2024-BOH-0328-5.3)
Moved by S. Molnar
Seconded by L. Rowden

That Board of Health for Southwestern Public Health accept the Chief Executive Officer's report for March 28, 2024.

Carried.

6.0 NEW BUSINESS

7.0 TO CLOSED SESSION

Resolution # (2024-BOH-0328-C7)
Moved by D. Shinedling
Seconded by M. Peterson

That the Board of Health move to closed session in order to consider one or more the following as outlined in the Ontario Municipal Act:

(a) the security of the property of the municipality or local board;
(b) personal matters about an identifiable individual, including municipal or local board employees;
(c) a proposed or pending acquisition or disposition of land by the municipality or local board;
(d) labour relations or employee negotiations;
(e) litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board;
(f) advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
(g) a matter in respect of which a council, board, committee or other body may hold a closed meeting under another Act;
(h) information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them;
(i) a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the municipality or local board, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization;
(j) a trade secret or scientific, technical, commercial or financial information that belongs to the municipality or local board and has monetary value or potential monetary value; or
(k) a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board. 2001, c. 25, s. 239 (2); 2017, c. 10, Sched. 1, s. 26.

Other Criteria:

(a) a request under the *Municipal Freedom of Information and Protection of Privacy Act*, if the council, board, commission or other body is the head of an institution for the purposes of that Act; or
(b) an ongoing investigation respecting the municipality, a local board or a municipally-controlled corporation by the Ombudsman appointed under the *Ombudsman Act*, an Ombudsman referred to in subsection 223.13 (1) of this Act, or the investigator referred to in subsection 239.2 (1). 2014, c. 13, Sched. 9, s. 22.

Carried.

8.0 RISING AND REPORTING OF CLOSED SESSION

Resolution # (2024-BOH-0328-C8)
Moved by S. Molnar
Seconded by D. Warden

That the Board of Health rise with a report.

Carried.

Resolution # (2024-BOH-0328-C3.1)
Moved by J. Herbert
Seconded by M. Ryan

That the Board of Health for Southwestern Public Health approve the Special Ad Building Committee Report for March 28, 2024.

Carried.

Resolution # (2024-BOH-0328-C3.2)
Moved by D. Warden
Seconded by M. Peterson

That the Board of Health for Southwestern Public Health accept the Chief Executive Officer's Report for March 28, 2024.

Carried.

9.0 FUTURE MEETING & EVENTS

M. Ryan asked to set a meeting date prior to the regular April 25, 2024 Board of Health meeting. The Chair will review that suggestion and may schedule a meeting prior to the next regularly scheduled meeting.

10.0 ADJOURNMENT

The meeting adjourned at 3:28 p.m.

Resolution # (2024-BOH-0328-10)
Moved by M. Peterson
Seconded by M. Ryan

That the meeting adjourns to meet again on Thursday, April 25, 2024, at 1:00 p.m. or earlier at the call of the Chair.

Carried.

Confirmed: _____

CEO REPORT

Open Session

MEETING DATE:	April 25, 2024
SUBMITTED BY:	Cynthia St. John, Chief Executive Officer (written as of April 17, 2024)
SUBMITTED TO:	Board of Health
PURPOSE:	☐ Decision ☐ Discussion ☒ Receive and File
AGENDA ITEM #	5.1
RESOLUTION #	**2024-BOH-0425-5.1**

1.0 PROGRAM UPDATES (RECEIVE AND FILE):

1.1 PEDIATRIC OUTREACH PROGRAM

Recently, across the province, select Community Health Centres (CHCs) were provided funding by Ontario Health West (OHW) to increase access to preventive and health promotion care and services for children aged 0 to 5 years, specifically for those without access to primary care and/or are without a health card. Services provided will be well baby/child assessments, referrals, and immunizations. West Elgin Community Health Centre (WECHC) and Oxford County Community Health Center (OCCHC) reached out to Southwestern Public Health (SWPH) to collaborate on this initiative. As a result, SWPH will be providing the use of clinical space at the St. Thomas site for WECHC to run its programs on Tuesdays. The Healthy Growth & Development (HGD) program will be supporting the CHCs with educational resources. The Healthy Babies Healthy Children's (HBHC) program will refer eligible clients to the CHC programs and the CHCs will reciprocate with referring clients they see to the HBHC program.

WECHC will be offering the "First Five West" program though its use of SWPH's clinical services space in St. Thomas beginning late April.

OCCHC's "First Five" program will operate its clinics through EarlyON Centres (Tillsonburg (Tuesday), Woodstock (Wednesday), Ingersoll (Thursday)). The soft launch of the program begins April 17th.

This collaborative effort between our local CHCs and SWPH demonstrates our mutual commitment to improving access to essential healthcare services for parents and young children in our community.

1.2 PROGRAM PLANNING 2025

I am excited to update you on our plans for program planning in 2025. This year, our annual program planning will kick off internally in May. Our dedicated teams will be drafting evidence-informed interventions and activities in alignment with the Ontario Public Health Standards (OPHS). These plans will undergo thorough review and approval processes in the fall, with budgets slated for presentation to SWPH's Board of Health (BOH) before the end of 2024.

A key focus of this year's program planning continues to be on the integration of health equity concepts into our program plans. We recognize the importance of addressing disparities and ensuring equitable access to public health services (across our communities). To measure our impact, we are crafting meaningful indicators that will track progress toward creating positive change at the population health level. These refined indicators will be instrumental in regularly reporting on our progress to the Board and community and refining our strategies as needed.

In addition to our emphasis on health equity, we are committed to building staff awareness in several key areas pertaining to program design and evaluation. This includes enhancing our staff's skills in crafting effective population health objectives, conducting comprehensive situational assessments, and fostering collaboration across teams working on similar local needs. By strengthening these capabilities, we aim to amplify the impact of our programs and services for the communities we serve.

1.3 IPAC HUB

The number of service requests for the Southwest IPAC (Infection Prevention and Control) Hub remained constant during each month of the first quarter (Jan-Mar), totalling 144 requests. The IPAC Hub proactively reached out to some Long-Term Care Homes, Retirement Homes and Congregate Living Settings and supported with on-site IPAC assessments. Shelters are one of the sectors that have not been interacting with the IPAC Hub. Staff will continue to reach out to this group to determine their IPAC needs.

The IPAC Hub newsletter was developed and released for the first quarter. This was developed jointly with Huron Perth Public Health (HPPH) and Middlesex-London Health Unit (MLHU). The IPAC Hub continues to promote and offer services that look beyond Covid-19 and outbreak preparedness. With the newly announced extension of ongoing funding and new staff joining the team, a letter will be sent out to facilities to introduce our staff and to remind them of services that are offered by the IPAC Hub. What is most important is that we not lose sight of the gains we made during Covid about the importance of infection prevention and control practices and this ongoing base funding will help achieve our goal.

1.4 COVID RESPONSE

The Spring 2024 COVID-19 campaign will run from April – June 2024. Eligible individuals include adults 65 years and older, adult residents of long-term care homes and other congregate living settings for seniors, individuals 6 months of age and older who are moderately to severely immunocompromised (due to an underlying condition or treatment), and individuals 55 years and older who identify as First Nations, Inuit, or Metis and their non-Indigenous household members

who are 55 years and older. SWPH will offer ½ day clinics once a month for 11 years and younger. All others will be referred to pharmacy partners.

The focus for SWPH this Spring is to support congregate livings settings in their Covid vaccination efforts:

- Provide in-person sessions for all LTCH homes to give them resources to prepare for independent administration of the Spring dose of COVID-19 vaccine. The SWPH team will assist in administration if necessary.
- Reach out to all retirement homes within the region to determine if support is needed for administration and arrange for SWPH or a pharmacy partner to administer doses if needed.

There has been a decrease in cases of Covid-19 and associated hospitalizations, but four deaths since Feb 2024 in which Covid-19 was the cause or contributed, underlining the importance of our continued Covid outreach and vaccination efforts.

2.0 GOVERNANCE MATTERS (DECISION):

2.1 NOMINATION OF THE BOARD OF HEALTH CHAIR TO THE ALPHA EXECUTIVE BOARD (DECISION):

The Association of Local Public Health Agencies (alPHa) has just released its call for nominations for the alPHa Board of Directors and alPHa Board of Health Section Executive Committee, for the period of 2024-2026 including a position for a member from the South West region. alPHa plays an important role in the public health dialogue in Ontario. The Association has positioned itself well as the go-to resource for public health decision makers at the local and provincial level. I reached out to Board Chair Bernia Martin to see if this role was of interest to her and she confirmed it is, subject to the Board of Health's discussion and potential endorsement. Nominations close Friday, May 31, 2024 and it is recommended that if the SWPH Board is supportive of advancing Bernia Martin's name for consideration to the alPHa Board, the SWPH Board will make that decision at this April meeting to ensure adequate time to complete the submission. From a cost perspective, there are adequate budget dollars within our mandatory budget to offset any travel expenses that a SWPH Board of Health member would have in their role on the alPHa Board. Many of the commitments are virtual. Please see the attached call for nominations for more details.

As a reminder, (alPHa) is a membership-based organization in support of local public health agencies (LPHAs) across Ontario. Currently, all 34 local public health agencies in Ontario are members. I presently sit on the alPHa Board of Directors and the alPHa Executive Committee based on my role with the Association of Ontario Public Health Business Administrators (AOPHBA). Dr. Tran is a member of the Council of Ontario Medical Officers of Health (COMOH) Section within alPHa. There is a very active Board of Health Section of alPHa as well. It would be within this Board of Health Section where a South West representative would contribute in addition to the Board of Directors.

MOTION: 2024-BOH-0425-5.1-2.1
That the Board of Health for Southwestern Public Health approve the nomination of Bernia Martin to the alPHa Board of Directors and alPHa Board of Health Executive for the 2024-2026 period and further that two Board of Health members sign the nominations form as sponsors of this nomination.

2.2 ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES (ALPHA) AGM & CONFERENCE (RECEIVE AND FILE):

alPHa's 2024 Annual General Meeting and Conference in Toronto, Ontario will continue the important conversation of the role and focus of local Public Health agencies (LPHAs) in the province. Board members are invited to attend the conference on Thursday, June 6th, 2024, and the half-day Board of Health section meeting on Friday, June 7th. SWPH's annual budget includes members' attendance; please reach out if you are interested in attending. The program has been appended for your information.

2.3 RECONVENING SWPH'S GOVERNANCE STANDING COMMITTEE

In May, I will undertake a comprehensive review of Board of Health policies to ensure they align with our current objectives and regulatory requirements. This includes evaluating the effectiveness of existing policies and identifying areas that may require updates or new policy development. The board will also be called on to participate in a survey to gather insights and feedback on various aspects of governance and strategic direction. The survey will serve as a valuable tool for assessing the board's performance and identifying any opportunities for improvement.

At the January 2023 BOH meeting, the Board recommended standing down the Governance Standing Committee (GSC) to provide new members an opportunity to understand the full scope of SWPH's governance practices, policies, and procedures. In light of the Board's greater understanding and experiences over the past 15 months and with the support of the Chair, I propose to re-convene the Governance Standing Committee (see the attached Terms of Reference).

By re-establishing the committee, we ensure transparency and accountability in our governance practices, providing a focused platform for the regular review and oversight of various strategic initiatives that include but are not limited to:

- Review and development as needed of BOH policies and bylaws.
- Development of SWPH's yearly comprehensive risk register to identify and mitigate potential risks to the organization's governance structure and operations.
- Assessment of the Board's skill set to identify any gaps and develop strategies for addressing them.
- Review of public appointments and re-appointments to the Board of Health.
- Evaluation of board meeting effectiveness to streamline processes and optimize decision-making.

Importantly, by discussing and resolving governance matters in the Governance Standing Committee meetings, it helps shorten regular BOH meetings, allowing members to focus more on

key reports and substantive matters. By reconvening the GSC, we reaffirm our commitment to adhering to best practices in governance, demonstrating our dedication to upholding SWPH's high standards of integrity and accountability in all our operations.

MOTION: 2024-BOH-0425-5.1-2.3
That the Board of Health for Southwestern Public Health approve the re-convening of the Governance Standing Committee, effective April 25, 2024.

3.0 FINANCIAL MATTERS (DECISION):

3.1 AUDITED FINANCIAL STATEMENTS (DECISION):

I am pleased to report that the audit of our financial records for the period ending December 31, 2023, has been completed by Graham Scott Enns. The audit was managed again this year by Scott Westelaken and overseen by Jennifer Buchanan.

The audited statements are attached for your review. There were no issues and no material errors noted. Graham Scott Enns will be presenting the draft audited statements at the board meeting for your review and approval.

As part of the approval process of the statements, the board is required to sign the findings letter which is attached for your review. The findings letter highlights any significant matters related to the statements. There are none that were noted for the 2023 statements.

MOTION: 2024-BOH-0425-5.1-3.1
That the Board of Health for Southwestern Public Health approve the audited financial statements for the period ending December 31, 2023.

3.2 APPOINTMENT OF AUDITORS (DECISION):

Each year, the Board of Health is required to formally appoint an auditing firm for the next fiscal period. Staff are recommending that Graham Scott Enns be appointed as the auditing firm for 2024. They are a firm that is local within the geographic area serving SWPH, they have experience working with the existing public health finance staff, and they have a thorough understanding of the many different funding envelopes for public health.

MOTION: 2024-BOH-0425-5.1-3.2
That the Board of Health appoint Graham Scott Enns as the auditing firm for the year ending December 31, 2024.

3.3 REVISED 2023 FUNDING LETTER (RECEIVE AND FILE):

On March 28, 2024, we received a revised 2023 funding letter (see attached) which included the following:

- Covid-19 General Program Extraordinary Costs (100%) for the period of January 1, 2023 to December 31, 2023 in the amount of $175,000.
- Covid-19: Vaccine Program Extraordinary Costs (100%) for the period of January 1, 2023 to December 31, 2023 in the amount of $464,100.
- Covid-19: Vaccine Program Enhancement (100%) for the period of January 1, 2024 to March 31, 2024 in the amount of $257,800.
- Respiratory Syncytial Virus (RSV) Adult Prevention Program (100%) for the period of September 1, 2023 to March 31, 2024 in the amount of $313,000.
- Strengthening Public Health: Merger Planning (100%) for the period of April1, 2023 to March 31, 2024 in the amount of $75,000.

The Covid funding received for 2023 will be returned to the Ministry as we did not require the full amount approved and the fiscal year has been closed. The funds for 2024 will support our programs and services budget.

3.4 INTERNAL CONTROLS AND PROCESSES (RECEIVE AND FILE):

Under the Ontario Public Health Standards and Accountability Framework, the Board is required to ensure that administration implements appropriate financial management and oversight including creating a process for internal financial controls. Attached is Southwestern Public Health's monthly financial control checklist which is completed to ensure all month end procedures are done accurately and timely. I can confirm that SWPH followed the internal financial control checklist without issue.

MOTION: 2023-BOH-0425-5.1-3.4
That the Board of Health for Southwestern Public Health accept SWPH's Monthly Financial Control Checklist for April 25, 2024.

3.5 UPDATED CREDIT FACILITY (DECISION):

Attached is the updated Credit Facility Agreement with RBC which is required to be signed by the Board of Health. The reason for the revised Credit Agreement is that our swap agreement (this is essentially our mortgage) currently uses CDOR/BA for its rates. On May 16, 2022, Refinitiv Benchmark Services (UK) Limited announced that CDOR (Canadian Dollar Offered Rate) will be discontinued as of June 28, 2024. This is the benchmark reference rate for Banker's Acceptance (BA) borrowings and other short-term lending products.

Canadian Overnight Repo Rate Average (CORRA), an overnight or forward-looking rate, will replace CDOR as the primary reference rate. Banks and other financial institutions will be transitioning CDOR/BAs to CORRA for loans, deposits and derivative contracts over the coming months. This is a regulatory change and therefore must be complied with.

As you can see below, this does not result in a change to our overall rate. Indicative details of the transition vs. the current loan and swap pricing are below:

	Currently	*After Transition*
	CDOR/BA	*CORRA*
Final Swap Rate	2.85%	2.56%
Credit Spread (1yr)	0.40%	0.69%
All-in Rate	**3.25%**	**3.25%**

MOTION: 2023-BOH-0425-5.1-3.5
That the Board of Health for Southwestern Public Health approve the revised Credit Facility Agreement with RBC for April 25, 2024.

MOTION: 2024-BOH-0425-5.1
That the Board of Health for Southwestern Public Health accept the Chief Executive Officer's Report for April 25, 2024.

CALL FOR BOARD OF HEALTH NOMINATIONS
2024-2026
alPHa BOARD OF DIRECTORS

*alPHa is accepting nominations for **three** Board of Health representatives to fill positions on its Board of Directors from the following regions and for the following terms:*

1. ***East*** 2. ***Central West*** 3. ***South West***	***Two-year term each*** *(June 2024 to June 2026)*

See the attached appendix for Boards of Health in each of these regions.

Each position will fill a seat on the Boards of Health Section Executive Committee and a seat on the alPHa Board of Directors. If you are an active member of a Board of Health/Regional Health Committee who is interested in running for a seat, please consider standing for nomination.

Qualifications:

- Active member of an Ontario Board of Health (or Regional Public Health Committee) that is a member organization of alPHa.
- Knowledge and skills in the areas of not-for-profit governance: policy, finance, programs, and human resources.
- Previous volunteer leadership experience in a not-for-profit is an asset but not a requirement.
- Strong commitment to public health and the work of the organization.

An election to determine the representatives will be held at the Boards of Health Section Meeting on Friday, June 7, 2024. All nominees must be present.

*Nominations clos*e on **Friday, May 31, 2024, at 4:30 p.m. Candidates are encouraged to submit well in advance of the deadline to ensure they have a complete application package. Only complete nomination packages will be considered.**

Serving on the alPHa Board is an important opportunity for you to:

- Play a part in making alPHa a stronger leadership organization for public health agencies in Ontario.
- Represent your colleagues at the provincial level.
- Participate in discussion reflecting common concerns of public health agency management across the province.
- Expand your contacts and strengthen relationships with Medical Officers of Health, public health unit senior staff and Board of Health members and lend your expertise to

the development of alPHa position papers and official responses to issues affecting all public health agencies.
- Participate on provincial ad hoc or advisory committees.

Duties of a Director:

- Make decisions in the best interest of the Association's long and short-term goals, objectives, priorities, and initiatives using a thorough understanding of alPHa's Constitution, Strategic Plan, and policies and procedures, including the Code of Conduct.
- Prepare for, attend, and actively participate in Board meetings and the Annual General Meeting.
- Approve Strategic Plan, Annual Budget, and Annual Report.
- Review and approve major contracts and grants.
- Complete tasks as assigned by the Executive Committee.
- Provide written and verbal reports, as appropriate.
- Participate in ad hoc committees and sub-committees, as appropriate.
- Provide input and consultation to the alPHa Executive Committee and Executive Director, as needed.
- Hire and evaluate the Association's Executive Director.
- Serve as a public figure and spokesperson for the Association, as appropriate.

How is the alPHa Board structured?

- There are twenty-one directors on the alPHa Board.
    - Seven from the Boards of Health Section (BOH Section).
    - Seven from the Council of Ontario Medical Officers of Health Section (COMOH Section).
    - One from each of the seven Affiliate Organizations of alPHa.
- There are three committees of the alPHa Board: Executive Committee, Boards of Health Section Executive, and COMOH Executive.

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

- This is a committee of the alPHa Board of Directors comprising seven Board of Health representatives.
- It includes a Chair and Vice-Chair who are chosen by the Section Executive members; and
- Members of the Section Executive attend all alPHa Board meetings.

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

- A full term is two years with no limit to the number of consecutive terms.
- Mid-term appointments will be for less than two years.

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

- alPHa Board meetings are held online approximately six times a year; a sixth and final meeting is held in-person at the June *Annual Conference*.
- Boards of Health Section Executive Committee meetings are held online approximately five times a year.
- The Chair of the Boards of Health Section Executive and two other members participate

in the alPHa Executive Committee's monthly online meetings. Other ad hoc meetings may be held.

- Attendance and participation at meetings are a key aspect of the positions. Candidates should give careful consideration as to their availability for these meetings prior to committing to putting their name forth for a position.

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

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

How do I stand for consideration for appointment to the alPHa Board of Directors?
Submit a completed Form of Nomination and Consent along with a biography of your suitability for candidacy (maximum 200 words) and a copy of the motion from your Board of Health supporting your nomination to alPHa by **Friday, May 31, 2024, at 4:30 p.m. Candidates are encouraged to submit well in advance of the deadline to ensure they have a complete application package. Only complete nomination packages will be considered.**

- **All nominees are required to attend and participate in the alPHa Boards of Health Section Executive Elections on June 7, 2024.**

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

- Loretta Ryan, Executive Director, alPHa at loretta@alphaweb.org.

Appendix to Nomination and Consent Form – alPHa Board of Directors 2024-2026

East Region

Boards of health in this region include:

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

Central West Region

Boards of health in this region include:

Brant
Haldimand-Norfolk
Halton
Hamilton
Niagara
Waterloo
Wellington-Dufferin-Guelph

South West Region

Boards of health in this region include:

Chatham-Kent
Grey Bruce
Huron Perth
Lambton
Middlesex-London
Southwestern
Windsor-Essex

alPHa
Association of Local PUBLIC HEALTH Agencies

FORM OF NOMINATION AND CONSENT
alPHa Board of Directors 2024-2026

_____, a Member of the Board of Health of
(Please print nominee's name)

_____, is HEREBY NOMINATED
(Please print health unit name)

as a candidate for election to the alPHa Board of Directors for the following Boards of Health Section Executive seat from (*choose one using the list of Board of Health Vacancies on previous pages)*:

- ❑ **East (two-year term)**
- ❑ **Central West (two-year term)**
- ❑ **South West (two-year term)**

SPONSORED BY:

1) _____
(Signature of a Member of the Board of Health)

2) _____
(Signature of a Member of the Board of Health)

Date: _____

I, _____, HEREBY CONSENT to my nomination
(Signature of nominee) and agree to serve as a **Director of the alPHa Board** if appointed.

Date: _____

IMPORTANT:

1. Nominations close on **Friday, May 31, 2024, at 4:30 p.m.** and must be submitted to alPHa by this deadline. **Candidates are encouraged to submit well in advance of the deadline to ensure they have a complete application package. Only complete nomination packages will be considered.**
2. A **biography** of the nominee outlining their suitability for candidacy, as well as a **motion passed by the sponsoring Board of Health** (i.e. record of a motion from the Clerk/Secretary of the Board of Health) must also be submitted with this nomination form on separate pages by the deadline. **There is a 200-word limit for the biography. Links may be included in the biography but not attachments. Candidates are encouraged to include a photo.**
3. Email the completed form, biography and copy of Board motion**,** to Loretta Ryan at loretta@alphaweb.org.

June 5th: Walking Tour 2 p.m. to 4 p.m. & Opening Reception 5 p.m. to 7 p.m. EDT
June 6th: AGM & Conference 8 a.m. to 4:45 p.m. EDT
June 7th: BOH Section & COMOH Section Meetings 9 a.m. to 12 p.m. EDT
The Pantages Hotel is the location for the events and the starting point for the walking tour.
The hotel is located at 200 Victoria Street, Toronto, ON M5B 1V8.
Draft as of April 11, 2024

June 5th	
Walking Tour Featuring Toronto Public Health Heritage Plaques For more than 140 years, Toronto Public Health has worked hard to advance the health of all those who live, work, and play in Toronto. These efforts focus on keeping people safe from illnesses, preventing diseases, and promoting good health. Join your colleagues for a guided walk to learn more about the many ways that public health has helped to make Toronto a better and healthier place to live.	2 p.m. – 4 p.m.
Opening Reception Come and join colleagues, old and new, at a reception with a cash bar and light snacks. This is an excellent opportunity to connect and reconnect with colleagues at this unique venue overlooking Massey Hall.	5 p.m. – 7 p.m.
June 6th	
A light breakfast will be available at 7:30 a.m.	7:30 a.m. – 8 a.m.
Call to Order, Opening Remarks, and Land Acknowledgement Conference Chair: Dr. Charles Gardner, President, alPHa Board of Directors	8 a.m. – 8:05 a.m.
Medicine Bag Workshop Facilitator: Marc Forgette, Makatew Workshops Marc Forgette is a noted Indigenous speaker who works with organizations from across Canada. In this workshop, each participant will assemble their own medicine bag. During the workshop, Marc will share his thoughts on several topics including the difference between cultural appropriation versus appreciation, terminology, and the Truth and Reconciliations' 94 Calls to Action.	8:05 a.m. – 9 a.m.

Remarks from the Premier of Ontario alPHa is pleased to announce the Premier of Ontario, the Hon. Doug Ford, will give remarks at the conference. **Remarks from the Minister of Health (invited)** The Hon. Sylvia Jones, Deputy Premier and Minister of Health, has been invited to give remarks at the conference.	9 a.m. – 9:30 a.m.
Chief Medical Officer of Health's Annual Report Speaker: Dr. Kieran Moore, Chief Medical Officer of Health Moderator: Dr. Charles Gardner, President, alPHa Board of Directors Ontario's Chief Medical Officer of Health's 2023 Annual Report, *Balancing Act: An All-of-Society Approach to Substance Use and Harms*, is a call for an all-of-society approach to reduce substance use harms. Come and hear about this important report with its emphasis on addressing mood altering substances such as cannabis, alcohol, opioids, and tobacco/vaping products.	9:30 a.m. – 10 a.m.
Networking Break	10 a.m. – 10:15 a.m.
Combined alPHa Business Meeting and Resolutions Session Conference Chair: Dr. Charles Gardner, President, alPHa Board of Directors Resolutions Chair and Parliamentarian: Dr. Robert Kyle, MOH, Durham Region Health Department	10:15 a.m. – 12:15 p.m.
Lunch, Distinguished Service Awards, and Board Recognition Speakers: Dr. Charles Gardner, President, alPHa Board of Directors and Loretta Ryan, Executive Director, alPHa The Distinguished Service Award (DSA) is given by alPHa to individuals in recognition of their outstanding contributions to public health in Ontario by board of health members, health unit staff, and public health professionals. The Award is given to those individuals who have demonstrated exceptional qualities of leadership in their own milieu, achieved tangible results through long service or distinctive acts, and shown exemplary devotion to public health.	12:15 p.m. – 1:45 p.m.
Proposed Voluntary Public Health Unit Mergers Speakers: Dr. Lianne Catton, Medical Officer of Health & CEO, Porcupine Health Unit Wess Garrod, Chair, Kingston, Frontenac, Lennox & Addington Public Health Bonnie Clark, Board member, Peterborough Public Health Moderator: Dr. Eileen de Villa, Treasurer, alPHa Board of Directors One-time funding, resources, and supports are being offered by the Province of Ontario to local public health agencies that voluntarily merge to streamline and reinvest back into strengthening and enhancing programs and services. Come and hear about three proposed voluntary mergers of public health units. Speakers will discuss the rationale for the proposed mergers and what brought them to the decision to move forward.	1:45 p.m. – 2:15 p.m.

Update on Strengthening Public Health Speakers: • Liz Walker, Executive Lead, Office of the Chief Medical Officer of Health • Colleen Kiel, Director, Public Health Strategic Policy, Planning and Communications Branch • Brent Feeney, Director, Accountability and Liaison Branch Moderator: Paul Sharma, Affiliate Representative, alPHa Board of Directors The Province of Ontario's Strengthening Public Health initiative aims to have a stronger public health system that will support Ontario communities for years to come. The province is working with partners to refine and clarify the roles of local public health units, to reduce overlap of services, and focus resources on improving people's access to programs and services. Come and hear the latest updates from staff from the Office of the Chief Medical Officer of Health.	2:15 p.m. – 3 p.m.
Networking Break	3 p.m. – 3:30 p.m.
Two Years In and Two Years Out – *What's in Store at Queen's Park* Speakers: Sabine Matheson, Principal, StrategyCorp and John Perenack, Principal, StrategyCorp Raconteur: Dr. Charles Gardner, President, alPHa Board of Directors The current provincial government is two years into its mandate with two years left to go. Hear about what to expect regarding the public policy climate and key political issues impacting public health agencies and their local boards of health. *Attendees will have an opportunity to pose questions in advance and at the conference. Please send advance questions to communications@alphaweb.org on or before May 24.*	3:30 p.m. – 4:35 p.m.
Wrap Up Conference Chair: Dr. Charles Gardner, President, alPHa Board of Directors	4:35 p.m. – 4:45 p.m.
June 7th	
Section Meetings: *Members of the BOH Section and COMOH Section will meet the next day. There are separate agendas for these meetings.* ***A light breakfast will be available starting at 8:30 a.m.***	9 a.m. – 12 p.m.

The 2024 Conference is co-hosted by alPHa and Toronto Public Health.

TORONTO Public Health

alPHa Association of Local PUBLIC HEALTH Agencies

Governance Standing Committee
Terms of Reference

Membership:
A minimum of 5 and a maximum of 6 Board members one of which must be the Chair or Vice Chair of the Board of Health serves as Chair of this Committee.
The Chair of this Standing Committee cannot serve as the Chair of the other Board Standing Committee (Finance and Facilities).

In addition, the Chief Executive Officer is an ex-officio member of the Committee, non voting. Other staff may attend as required and are non-voting.

Purpose:
1. Act in an advisory capacity to the Board of Health (BOH) on matters related to good governance.
2. Ensure that the Board of Health fulfils its legal, ethical and functional responsibilities through adequate governance policy development, board member recruitment strategies, board training programs, monitoring board activities and evaluation of board members' participation.
3. Oversee the nomination process for Order in Council appointments.

Duties and Responsibilities:
- Review the number of members on the BOH and recommend changes as needed,
- Review the orientation plan for new board members and continuing education program plan for existing board members which includes a framework for what and how information is shared with the BOH,
- Oversee and advise on the selection of Board members for its standing Committees,
- Oversee the process for recruiting and recommending public appointees to the Public Appointment Secretariat,
- Ensure there is a current inventory of Board member knowledge and skills related to Board functions,
- Review and recommend revisions, where necessary, to Board of Health by-laws, policies and procedures,
- Advise the Board or a standing Committee of the Board of all corporate governance issues that the Committee determines ought to be considered by the Board or Committee,
- Ensure there is a process for assessing the effectiveness of the Board and its Committees,
- Identify opportunities for the Board to participate in collaborative governance opportunities within the community that will promote and protect the health of the

population,
- Review and recommend to the BOH a risk register for the Health Unit which includes but is not limited to the areas of human resource succession planning, information technology, surge capacity planning, operational risks and legal issues, and
- Ensure performance development reviews for the CEO and the MOH are completed in accordance with policy.

Meetings:
Approximately three to four meetings will be held annually, with additional meetings at the call of the Chair. Meetings of this committee will be held virtually or in person at one of the public health offices.

Specific Roles and Responsibilities:

1. Chair (Board Chair):
    a. Chair meeting in accordance with current procedural Bylaw No. 1 Conduct of the Affairs,
    b. Guide the meeting according to the agenda and time available,
    c. Provide an opportunity for all members of the Committee to participate in the discussion,
    d. Ensure adherence to the Terms of Reference,
    e. Review and approve the draft minutes before distribution to the Committee members, and
    f. Review draft reports to the Board of Health of Committee discussions and recommendations.

2. Committee Members:
    a. Prepare for each meeting by thoroughly reading all pre-circulated reports in advance of the meetings,
    b. Attend and actively participate in the discussion and business of the Committee, and
    c. Speak as a collective (with one voice) following Committee decisions on matters.

3. Chief Executive Officer:
    a. Update Governance Standing Committee of any relevant concerns or issues as they arise,
    b. Provide written reports regarding strategic deliverables to the Committee in advance of each meeting, and
    c. Draft written Committee updates regarding achievements to Board of Health as directed.

4. Recorder of the Meeting:
    a. Schedule meetings as needed,
    b. Book room for meetings,
    c. Request agenda items in advance of the meeting,
    d. Post agenda and committee packages to the portal at least 3 days prior to the meeting, and
    e. Record minutes.

Terms of Office:
Members shall serve a minimum of two years to provide continuity within the Committee. The term of office for a member may be extended with the approval of the Board of Health.

Minutes:
Minutes of the Committee shall be taken by the Executive Assistant, reviewed by the CEO, approved by the Committee Chair, signed by the Committee Chair, and posted to the portal within two weeks following the meeting.

Quorum:
A quorum of members must be present either in person or via electronic means, before a meeting can proceed. Quorum shall be a majority of the members of the Committee (50% + 1 of committee members appointed).

A scheduled meeting will be cancelled if the Chair is unable to confirm that a quorum of members can attend. This decision will be based on the members' replies to the meeting invitation.

Decision Making:
The Committee will endeavour to reach consensus related to its governance decisions and recommendations and in accordance with OESTHU Bylaw No. 1 - Conduct of the Affairs.

Accountability:
This Committee reports and makes recommendations to the Board of Health and/or the Chief Executive Officer.

Confidentiality:
Each member of the Committee has a duty to keep confidential any information which the Committee has identified as such or at the request of the Board of Health.

Date adopted:
Tentatively: April 5, 2018 by Transition Governance Committee
Officially: May 1, 2018 by OESTHU Board of Health
Revision: February 3, 2022 by OESTHU Board of Health
(Motion #2022-BOH-0203-5.1)

OXFORD ELGIN ST. THOMAS HEALTH UNIT

Operating as

SOUTHWESTERN PUBLIC HEALTH

Financial Statements

December 31, 2023

SOUTHWESTERN PUBLIC HEALTH

Financial Statements

For the Year Ended December 31, 2023

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MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying financial statements are the responsibility of the management of Southwestern Public Health and have been prepared in accordance with Canadian public sector accounting standards.

These financial statements include:

- Independent Auditors' report
- Statement of Financial Position
- Statement of Operations and Accumulated Surplus
- Statement of Change in Net Financial Debt
- Statement of Remeasurement Gains and Losses
- Statement of Cash Flows
- Notes to the Financial Statements
- Schedule of Expenditures

The Chief Executive Officer and the Chief Financial Officer are responsible for ensuring that management fulfills its responsibility for financial reporting and is ultimately responsible for reviewing the financial statements before they are submitted to the Board for approval.

The integrity and reliability of Southwestern Public Health reporting systems are achieved through the use of formal policies and procedures, the careful selection of employees and an appropriate division of responsibilities. These systems are designed to provide reasonable assurance that the financial information is reliable and accurate.

The financial statements have been audited on behalf of the Board of Health, Inhabitants and Ratepayers of the participating municipalities of the County of Oxford, County of Elgin and City of St. Thomas by Graham Scott Enns LLP in accordance with Canadian generally accepted auditing standards.

Cynthia St. John
Chief Executive Officer

Monica Nusink
Chief Financial Officer

St. Thomas, Ontario
April 25, 2024

GRAHAM SCOTT ENNS LLP
CHARTERED PROFESSIONAL ACCOUNTANTS

P. 519-633-0700 · F. 519-633-7009
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25 John Street South, Aylmer, ON N5H 2C1

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INDEPENDENT AUDITORS' REPORT

To the **Board of Health, Members of Council, Inhabitants and Ratepayers** of
the participating municipalities of the County of Oxford, County of Elgin and City of St. Thomas:

Opinion
We have audited the financial statements of **Southwestern Public Health**, which comprise the statement of financial position as at December 31, 2023, and the statement of operations and accumulated surplus, statement of changes in net debt, statement of remeasurement gains and losses, statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the organization's financial statements present fairly, in all material respects, the financial position of the organization as at December 31, 2023, and the results of its operations and its cash flows for the year then ended in accordance with Canadian Public Sector Accounting Standards.

Basis for Opinion
We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditors' Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the organization in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements
Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian Public Sector Accounting Standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the organization's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the organization or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the organization's financial reporting process.

Auditors' Responsibilities for the Audit of the Financial Statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

GRAHAM SCOTT ENNS LLP
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INDEPENDENT AUDITORS' REPORT (CONTINUED)

Auditors' Responsibilities for the Audit of the Financial Statements (Continued)
Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the organization's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the organization's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the organization to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

St. Thomas, Ontario

April 25, 2024

Graham Scott Enns LLP

CHARTERED PROFESSIONAL ACCOUNTANTS
Licensed Public Accountants

SOUTHWESTERN PUBLIC HEALTH

Statement of Financial Position
December 31, 2023

	2023	2022
	$	$
FINANCIAL ASSETS		
Cash	**3,991,551**	8,167,225
Accounts receivable	**424,800**	302,365
Government remittance receivable	**117,509**	126,255
	4,533,860	8,595,845
FINANCIAL LIABILITIES		
Accounts payable and accrued liabilities	**1,391,252**	1,760,170
Deferred revenue (Note 5)	**1,823,921**	1,840,083
Due to Province of Ontario	**836,517**	4,752,223
Long-term debt (Note 7)	**6,929,000**	7,170,000
Derivative (Note 1 & 8)	**371,197**	-
	11,351,887	15,522,476
NET FINANCIAL DEBT (PAGE 6)	**(6,818,027)**	(6,926,631)
NON-FINANCIAL ASSETS		
Prepaid expenses	**80,364**	63,530
Tangible capital assets (Note 6)	**9,381,629**	9,299,868
	9,461,993	9,363,398
TOTAL NET ASSETS	**2,643,966**	2,436,767
TOTAL NET ASSETS IS COMPRISED OF THE FOLLOWING:		
ACCUMULATED SURPLUS (NOTE 4)	**3,015,163**	2,436,767
ACCUMULATED REMEASUREMENT GAINS AND LOSSES (PAGE 7) (NOTE 1)	**(371,197)**	-
	2,643,966	2,436,767

Approved by the Board:

_____ Director

_____ Director

The accompanying notes are an integral part of these financial statements.

SOUTHWESTERN PUBLIC HEALTH

Statement of Operations and Accumulated Surplus
For the Year Ended December 31, 2023

	(Note 15) Budget 2023 $	**2023 $**	2022 $
REVENUES			
Operating grants			
Municipal:			
County of Elgin	1,251,537	**1,351,194**	1,187,287
City of St. Thomas	1,032,821	**1,115,063**	922,650
County of Oxford	2,935,996	**3,169,783**	2,628,966
Province of Ontario (Note 9)	24,019,971	**17,209,082**	20,516,291
Public Health Agency of Canada (Note 10)	198,620	**182,940**	262,765
Locally Driven Collaborative Projects	38,744	**4,894**	-
Student Nutrition (Note 11)	-	**-**	165,597
Total operating grants	29,477,689	**23,032,956**	25,683,556
Other			
Other fees and recoveries	51,875	**121,776**	95,779
Clinics	30,000	**23,880**	28,916
Interest	35,000	**221,209**	128,942
Total other revenue	116,875	**366,865**	253,637
TOTAL REVENUES	29,594,564	**23,399,821**	25,937,193
EXPENDITURES - SCHEDULE (PAGE 24)	29,594,564	**22,821,425**	25,986,487
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENDITURES	-	**578,396**	(49,294)
ACCUMULATED SURPLUS, BEGINNING OF YEAR	2,436,767	**2,436,767**	2,486,061
ACCUMULATED SURPLUS, END OF YEAR (NOTE 4)	2,436,767	**3,015,163**	2,436,767

The accompanying notes are an integral part of these financial statements.

SOUTHWESTERN PUBLIC HEALTH

Statement of Change in Net Financial Debt
For the Year Ended December 31, 2023

	(Note 15) Budget 2023 $	**2023 $**	2022 $
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENDITURES	-	**578,396**	(49,294)
Amortization of tangible capital assets	-	**604,734**	754,397
Acquisition of tangible capital assets	-	**(686,495)**	(469,014)
Change in prepaid expenses	-	**(16,834)**	1,633
Remeasurement gains (loss)	-	**271,154**	-
DECREASE IN NET FINANCIAL DEBT	-	**750,955**	237,722
NET FINANCIAL DEBT, BEGINNING OF YEAR	(6,926,631)	**(6,926,631)**	(7,164,353)
ADOPTION OF PS3450 (NOTE 1)	-	**(642,351)**	-
NET FINANCIAL DEBT, END OF YEAR	(6,926,631)	**(6,818,027)**	(6,926,631)

The accompanying notes are an integral part of these financial statements.

SOUTHWESTERN PUBLIC HEALTH

Statement of Remeasurement Gains and Losses
For the Year Ended December 31, 2023

	(Note 1) 2023 $	2022 $
ACCUMULATED REMEASUREMENT GAINS AND (LOSSES), BEGINNING OF YEAR	**(642,351)**	-
Unrealized gains attributable to derivatives	**271,154**	-
ACCUMULATED REMEASUREMENT GAINS AND (LOSSES), END OF YEAR	**(371,197)**	-

The accompanying notes are an integral part of these financial statements.

SOUTHWESTERN PUBLIC HEALTH

Statement of Cash Flows
For the Year Ended December 31, 2023

	2023 $	2022 $
OPERATING ACTIVITIES		
Excess (deficiency) of revenues over expenditures	**578,396**	(49,294)
Items not involving cash:		
Amortization of tangible capital assets	**604,734**	754,397
Unrealized gain on derviative (Note 1)	**(371,197)**	-
	233,537	754,397
Change in non-cash working capital balances:		
Accounts receivable	**(122,435)**	(208,829)
Government remittances receivable	**8,746**	5,547
Prepaid expenses	**(16,834)**	1,633
Accounts payable and accrued liabilities	**(368,918)**	(117,858)
Deferred revenue	**(16,162)**	(176,817)
Due to Province of Ontario	**(3,915,706)**	4,191,979
Derivative (Note 1)	**371,197**	-
	(3,248,179)	4,400,758
CAPITAL ACTIVITIES		
Net acquisition of tangible capital assets	**(686,495)**	(469,014)
	(686,495)	(469,014)
FINANCING ACTIVITIES		
Repayment to long-term debt	**(241,000)**	(232,000)
	(241,000)	(232,000)
NET CHANGE IN CASH DURING THE YEAR	**(4,175,674)**	3,699,744
CASH, BEGINNING OF YEAR	**8,167,225**	4,467,481
CASH, END OF YEAR	**3,991,551**	8,167,225

The accompanying notes are an integral part of these financial statements.

PURPOSE OF ORGANIZATION

Southwestern Public Health (the "organization") provides public health services to the residents of the City of St. Thomas, County of Elgin and the County of Oxford and is accountable to the Province of Ontario as outlined in the Health Protection and Promotion Act.

1. CHANGE IN ACCOUNTING POLICIES

On January 1, 2023 Southwestern Public Health adopted accounting policies to conform to new standards issued under Canadian public sector accounting standards. The organization adopted the following standards which had the following impact:

- PS 1201 - Financial Statement Presentation - resulting in presentation of a new statement of remeasurement gains and losses. This change has been applied retrospectively.
- PS 3280 - Asset Retirement Obligations - require reporting of any asset retirement obligations as tangible capital assets and their liabilities and associated policies. It is managements opinion that no asset retirement obligations exist as at December 31, 2023. This change has been applied retrospectively.
- PS 3450 - Financial Instruments - reporting new disclosures regarding financial instrument risks and the restatement of the opening accumulated surplus. This change has been applied prospectively.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The financial statements of the organization are prepared by management in accordance with Canadian Public Sector Accounting Standards. Significant aspects of the accounting policies adopted by the organization are as follows:

Basis of Accounting

The financial statements are prepared using the accrual basis of accounting. The accrual basis of accounting records revenue as it is earned and measurable. Expenses are recognized as they are incurred and measurable based upon receipt of goods or services and/or the creation of a legal obligation to pay.

Revenue Recognition

Government transfers are recognized in the financial statements as revenues in the financial period in which events giving rise to the transfer occur, providing the transfers are authorized, any eligibility criteria have been met including performance and return requirements, and reasonable estimates of the amounts can be determined. Any amount received but restricted is recorded as deferred revenue in accordance with Section 3100 of the Public Sector Accounting Handbook and recognized as revenue in the period in which the resources are used for the purpose specified.

Unrestricted contributions are recognized as revenues when received or receivable if the amount to be received is reasonable estimated and collection is reasonable assured.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Accounting Estimates

The preparation of these financial statements is in conformity with Canadian Public Sector Accounting Standards which requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenditures during the current period. These estimates are reviewed periodically and adjustments are made to income as appropriate in the year they become known.

In particular, the organization uses estimates when accounting for certain items, including:

Useful lives of tangible capital assets
Employee benefit plans

Tangible Capital Assets

Tangible capital assets are recorded at cost, which includes all amounts that are directly attributable to acquisition, construction, development or betterment of the asset. The cost, less residual value, of the tangible capital assets, excluding land are amortized on a straight-line basis over their estimated useful lives as follows:

Land improvements	20 years
Building	40 years
Roof	20 years
Component equipment	24 years
Computer equipment	4 years

Amortization begins the first month of the year following the year the asset is placed in service and to the year of disposal. Assets under construction are not amortized until the asset is available for productive use.

Deferred Revenue

The organization administers other public health programs funded by the Province of Ontario and reported on a Provincial fiscal year end of March 31st. Any unexpended funding for these programs at December 31st is reported as deferred revenue on the statement of financial position. Additionally the organization receives certain grants and other funding from external sources for administering public health programs and may defer funds not spent at December 31st if the respective funding agreement has a term beyond the year end.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Financial Instruments

The organization's financial instruments consist of cash , accounts receivable, accounts payable and accrued liabilities, deferred revenues, due to Province, and long-term debt.

The organization's financial instruments are measured as follows:

i. Cash at fair value;
ii. Portfolio investments at fair value (if any);
iii. Accounts receivable at amortized cost;
iv. Accounts payable and accrued liabilities at amortized cost;
v. Long-term debt at amortized cost;
vi. Derivative at fair value.

The fair value is determined as follows:

i. Level 1 - Fair value measurements are those derived from quoted prices (in active markets);
ii. Level 2 - Fair value measurements are those derived from inputs other than quoted prices included within Level 1 that are observable for the assets, either directly (i.e. as prices) or indirectly (i.e. derived from prices);
iii. Level 3 - Fair value measurements are those derived from valuation techniques that include inputs for the asset that are not based on observable data (unobservable inputs).

For financial instruments measured using amortized cost the transaction costs and any other fees are expensed as incurred.

Unrealized gains and losses from changes in the fair value of financial instruments are recognized in the statement of remeasurement gains and losses.

All financial assets are tested annually for impairment. When financial assets are impaired, impairment losses are recorded in the statement of operations.

The organization uses derivative financial instruments, including an interest rate swap agreement, in its management of exposures to fluctuations in interest rates. An interest rate swap is a derivative financial contract between two parties who agree to exchange fixed rate interest payments for floating rate payments on a predetermined notional amount and term. Derivatives are recorded at fair value and in determining the fair value, the credit risk of both counterparts are considered.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Employee Benefit Plans

The organization accounts for its participation in the Ontario Municipal Employees Retirement System (OMERS), a multi-employer public sector pension fund, as a defined contribution plan. The OMERS plan specifies the retirement benefits to be received by the employees based on the length of service and pay rates. Employee benefits include post employment benefits. Post employment benefits are subject to actuarial valuations and are accrued in accordance with the projected benefit method, prorated on service and management's best estimate of salary escalation and retirement ages of employees. Any actuarial gains and losses related to past service of employees are amortized over the expected average remaining service period.

Asset retirement obligations

The organization may be exposed to obligations of remediation associated with their tangible capital assets. If a legal obligation exists of remediation for a tangible capital asset then the organization would be required to set up an estimated future cost and liability associated with these obligations. As at December 31, 2023 there were no tangible capital assets that organization has controlled, constructed, owned or used that would have a legal obligation of remediation.

3. RECONCILIATION FOR MINISTRY OF HEALTH SETTLEMENT PURPOSES

	2023	2022
	$	$
Excess (Deficiency) of Revenues over Expenditures	**578,396**	(49,294)
Reconciling items:		
Principal portion of long-term debt	**(241,000)**	(232,000)
Vacation and compensating time change	**25,506**	(130,258)
Amortization	**604,734**	754,397
Eligible expenses transferred to tangible capital assets	**(686,495)**	(374,498)
Excess (Deficiency) of Revenues over Expenditures for Ministry of Health Purposes	**281,141**	(31,653)

4. ACCUMULATED SURPLUS

The accumulated surplus consists of the following individual fund surplus/(deficit) and reserves as follows:

	2023 $	2022 $
SURPLUS		
General reserve	**307,034**	306,899
Levy to be returned to municipalities	**255,500**	-
Invested in tangible capital assets	**9,381,629**	9,299,868
	9,944,163	9,606,767
AMOUNTS TO BE RECOVERED		
Net long-term debt	**(6,929,000)**	(7,170,000)
ACCUMULATED SURPLUS	**3,015,163**	2,436,767

5. DEFERRED REVENUE

	2023 $	2022 $
Ontario Seniors Dental Care Program Capital:		
New Fixed Site (March 31, 2024)	**1,540,000**	-
Low German Needs Assessment	**67,392**	84,269
IPAC Hub Infection (March 31, 2024)	**65,073**	-
Locally Driven Collaborative Projects (March 31, 2024)	**53,222**	-
Healthy Babies Healthy Children (March 31, 2024)	**41,503**	
Needle Syringe Program (March 31, 2024)	**29,643**	-
Sewage Inspection Program	**17,175**	17,175
Public Health Agency of Canada	**9,067**	9,067
Prenatal and Postnatal Nurse Practitioner (March 31, 2024)	**846**	-
Ontario Seniors Dental Care Program Capital:		
New Fixed Site (March 31, 2023)	**-**	1,155,004
Mobile Dental Clinic (March 31, 2023)	**-**	500,000
Healthy Babies Healthy Children (March 31, 2023)	**-**	57,529
Needle Syringe Program (March 31, 2023)	**-**	17,039
Total Deferred Revenue	**1,823,921**	1,840,083

6. TANGIBLE CAPITAL ASSETS

December 31, 2023

Cost	Opening	Additions	Disposals	**Ending**
	$	$	$	**$**
Land	572,909	-	-	**572,909**
Land improvements	161,330	-	-	**161,330**
Building	7,971,153	13,560	-	**7,984,713**
Roof	157,000	-	-	**157,000**
Building component equipment	1,934,844	549,265	-	**2,484,109**
Computer equipment	2,586,298	123,670	-	**2,709,968**
	13,383,534	686,495	-	**14,070,029**

Accumulated Amortization	Opening	Amortization	Disposals	**Ending**
	$	$	$	**$**
Land improvements	64,536	8,067	-	**72,603**
Building	1,511,069	199,279	-	**1,710,348**
Roof	62,800	7,850	-	**70,650**
Building component equipment	538,406	66,165	-	**604,571**
Computer equipment	1,906,855	323,373	-	**2,230,228**
	4,083,666	604,734	-	**4,688,400**

Net Book Value	**Opening**	**Ending**
	$	**$**
Land	572,909	**572,909**
Land improvements	96,794	**88,727**
Building	6,460,084	**6,274,365**
Roof	94,200	**86,350**
Building component equipment	1,396,438	**1,879,538**
Computer equipment	679,443	**479,740**
	9,299,868	**9,381,629**

6. TANGIBLE CAPITAL ASSETS (CONTINUED)

December 31, 2022

Cost	Opening	Additions	Disposals	**Ending**
	$	$	$	**$**
Land	572,909	-	-	**572,909**
Land improvements	161,330	-	-	**161,330**
Building	7,932,066	39,087	-	**7,971,153**
Roof	157,000	-	-	**157,000**
Building component equipment	1,644,296	290,548	-	**1,934,844**
Computer equipment	2,446,919	139,379	-	**2,586,298**
	12,914,520	469,014	-	**13,383,534**

Accumulated Amortization	Opening	Amortization	Disposals	**Ending**
	$	$	$	**$**
Land improvements	56,469	8,067	-	**64,536**
Building	1,312,767	198,302	-	**1,511,069**
Roof	54,950	7,850	-	**62,800**
Building component equipment	473,260	65,146	-	**538,406**
Computer equipment	1,431,823	475,032	-	**1,906,855**
	3,329,269	754,397	-	**4,083,666**

Net Book Value	**Opening**	**Ending**
	$	**$**
Land	572,909	**572,909**
Land improvements	104,861	**96,794**
Building	6,619,299	**6,460,084**
Roof	102,050	**94,200**
Building component equipment	1,171,036	**1,396,438**
Computer equipment	1,015,096	**679,443**
	9,585,251	**9,299,868**

7. LONG-TERM DEBT

The balance of long-term debt reported on the Statement of Financial Position is made up of the following:

	2023	2022
	$	$
RBC bankers' acceptance to finance construction of new office building	**7,300,197**	7,170,000
Fair value of financial derivative (Note 1 & 8)	**371,197**	-
Long-term debt	**6,929,000**	7,170,000

Principal payments relating to the long-term debt outstanding are due as follows:

2024	2025	2026	2027	2028	Thereafter	Total
$	$	$	$	$	$	$
248,000	257,000	265,000	274,000	283,000	5,973,197	7,300,197

On January 2, 2014 the organization converted the short term construction loan into long-term financing. The organization was advanced $9,000,000 in a 32 day banker acceptance notes at the CDOR rate of 1.22% plus a stamping fee of 0.40%. The organization at the same time entered into an interest rate swap contract to fix the interest rate on their long-term financing at 2.85% for a 30 year time frame. As a result of these transactions, the organization had fixed their rate on this debt obligation at 2.85% plus the stamping fee. The stamping fee is reviewed every fifteen years to determine if the risk assessment of the organization has changed from the last review at which point the rate could increase if additional risk is determined.

8. DERIVATIVES

The organization has entered into an interest rate swap agreement as a result of the debt disclosed in Note 7). As a result if the organization were to repay the long-term debt at December 31, 2023 an additional cost of $371,197 would be incurred. The organization intends to carry the long-term debt to full maturity thereby eliminating the loss.

	2023	2022
	$	$
Fair value of Fiancial Derivaties Beginning of Year	**642,351**	-
Unrealized (Gain)/Losses	**(271,154)**	-
Fair Value of Financial Derivatives (Note 1)	**371,197**	-

Financial Derivatives are classifed as Level 3

9. PROVINCE OF ONTARIO

	2023 $	2022 $
COST SHARED PROGRAMS		
General Public Health Programs	**12,667,878**	12,557,250
OTHER PROGRAMS AND ONE TIME FUNDING		
Ministry Programs - 100% Funding		
Infection Prevention and Control Hub (March 31, 2022)	**-**	548,744
Infection Prevention and Control Hub (March 31, 2023)	**24,787**	660,213
Infection Prevention and Control Hub (March 31, 2024)	**371,805**	-
Medical Officer of Health Compensation Initiative	**62,632**	21,990
Merger Costs (March 31, 2022)	**-**	60,609
Mobile Dental Clinic (March 31, 2023)	**453,910**	-
Needle Syringe Program (March 31, 2022)	**-**	9,818
Needle Syringe Program (March 31, 2023)	**25,099**	10,336
Needle Syringe Program (March 31, 2024)	**11,606**	-
Ontario Seniors Dental Care Program	**1,061,106**	1,021,144
Public Health Inspector Practicum Program (March 31, 2023)	**393**	19,606
Public Health Inspector Practicum Program (March 31, 2024)	**20,000**	-
School-Focused Nurses Initiative (March 31, 2022)	**-**	204,492
School-Focused Nurses Initiative (March 31, 2023)	**225,000**	672,000
School-Focused Nurses Initiative (June 30, 2023)	**225,000**	-
COVID-19: Extraordinary Costs	**-**	2,818,925
COVID-19: Vaccine Program (December 31, 2023)	**219,547**	-
Temporary Retention Incentive for Nurses (March 31, 2022)	**-**	436,716
Vaccine Fridge (March 31, 2024)	**32,600**	-
Total Ministry Programs- 100% Funding	**2,733,485**	6,484,593
Other Programs		
Prenatal and Postnatal Nurse Practitioner Services (March 31, 2023)	**34,744**	139,008
Prenatal and Postnatal Nurse Practitioner Services (March 31, 2024)	**103,410**	-
Healthy Babies Healthy Children (March 31, 2022)	**-**	152,820
Healthy Babies Healthy Children (March 31, 2023)	**470,919**	1,182,620
Healthy Babies Healthy Children (March 31, 2024)	**1,198,646**	-
Total other programs	**1,807,719**	1,474,448
Total Province of Ontario grants	**17,209,082**	20,516,291

10. PUBLIC HEALTH AGENCY OF CANADA

The organization receives funding from the Public Health Agency of Canada for funds to carry out the Smoking Cessation (previously Creating Connections) project. Any unexpended funding for this program at December 31st is reported as deferred revenue on the statement of financial position.

	2023	2022
	$	$
Revenue		
Revenue (March 31, 2022)	**-**	157,132
Revenue (March 31, 2023)	**62,974**	105,633
Revenue (March 31, 2024)	**119,966**	-
	182,940	262,765
Expenditure		
Purchased services (March 31, 2022)	**-**	56,352
Purchased services (March 31, 2023)	**46,102**	39,321
Purchased services (March 31, 2024)	**52,132**	-
Salaries (March 31, 2022)	**-**	6,066
Salaries (March 31, 2023)	**14,952**	58,322
Salaries (March 31, 2024)	**55,643**	-
Benefits (March 31, 2022)	**-**	198
Benefits (March 31, 2023)	**1,792**	7,677
Benefits (March 31, 2024)	**12,012**	-
Travel (March 31, 2023)	**127**	313
Travel (March 31, 2024)	**180**	-
	182,940	168,249
Capital expenditures (March 31, 2022)	**-**	94,516
Program excess of revenue over expenditures	**-**	-

11. STUDENT NUTRITION

The organization receives funding from a number of external agencies including the United Way and VON to provide healthy foods to participating schools in Oxford County. 2022 was the final year of the program, unspent funds at the year end have been included in the payables balance to the new organizer.

	2023	2022
	$	$
Revenue	**-**	165,597
Expenditure		
Program supplies	**-**	165,597
Program excess of revenue over expenditures	**-**	-

12. CASH FLOW FROM THE PROVINCE OF ONTARIO MINISTRIES OF HEALTH AND CHILDREN, COMMUNITY AND SOCIAL SERVICES

The organization receives annual funding and one time funding ("OTF") from the Province of Ontario Ministry of Health ("MOH") and the Ministry of Children, Community and Social Services ("MCCSS") to carry out general public health programs and related health programs and services. Funding provided from the Ministry for the year ended December 31, 2023 is as follows:

	MOH $	MCCSS $
COVID - Extraordinary Costs (March 31, 2023)	137,497	-
General Public Health Programs	12,667,878	-
Infection Prevention and Control Hub (March 31, 2023)	171,244	-
Infection Prevention and Control Hub (March 31, 2024)	436,878	-
Medical Officer of Health Compensation Initiative	179,305	-
Needle Syringe Program - OTF (March 31, 2023)	9,125	-
Needle Syringe Program - OTF (March 31, 2024)	41,249	-
Ontario Senior Dental Care Program	1,061,106	-
Ontario Seniors Dental Care Program Capital:		
New Fixed Site - OTF (March 31, 2024)	384,996	-
Public Health Inspector Practicum Program OTF (March 31, 2023)	5,003	-
Public Health Inspector Practicum Program OTF (March 31, 2024)	14,998	-
School-Focused Nurses Initiative (March 31, 2023)	225,000	-
School-Focused Nurses Initiative (June 30, 2023)	225,000	-
Temporary Retention Incentive for Nurses (March 31, 2023)	96,506	-
Vaccine Fridge (March 31, 2024)	24,447	-
Healthy Babies Healthy Children (March 31, 2023)	-	413,382
Healthy Babies Healthy Children (March 31, 2024)	-	1,240,149
Prenatal and Postnatal Nurse Practitioner (March 31, 2023)	-	34,752
Prenatal and Postnatal Nurse Practitioner (March 31, 2024)	-	104,256
	15,680,232	1,792,539

13. PUBLIC SECTOR SALARY DISCLOSURE ACT 1996

The Public Sector Salary Disclosure Act, 1996 (the "Act") requires the disclosure of the salaries and benefits of employees in the public sector who are paid a salary of $100,000 or more in a year. The organization complies with the Act by providing the information to the Ontario Ministry of Health for disclosure on the public website at www.fin.gov.on.ca.

14. PENSION AGREEMENTS

The organization makes contributions to the Ontario Municipal Employees Retirement Fund (OMERS), which is a multi-employer plan, on behalf of members of its staff. The plan is a defined benefit plan which specifies the amount of the retirement benefit to be received by the employees based on the length of service and rates of pay. Each year, an independent actuary determines the funding status of OMERS Primary Pension Plan (the Plan) by comparing the actuarial value of invested assets to the estimated present value of all pension benefits the members have earned to date. The most recent actuarial valuation of the Plan was conducted December 31, 2023, and the results of this valuation disclosed actuarial liabilities of $136.2 billion in respect of benefits accrued for service with actuarial assets at that date of $132 billion leaving an actuarial deficit of $4.2 billion.

Since any surpluses or deficits are a joint responsibility of all Ontario municipalities and their employees, the organization does not recognize any share of the OMERS Pension surplus or deficit in these financial statements.

The amount contributed to OMERS for the year ended December 31, 2023 was $1,271,862. OMERS contribution rates for 2023 and 2022 depending on income level and retirement dates ranged from 9% to 15.8%.

15. BUDGET FIGURES

The operating budgets approved by the organization and the Province of Ontario for 2023 are reflected on the statement of operations and are presented for comparative purposes.

16. OPERATING LEASES

The organization leases two buildings from the County of Oxford at $49,007 per month plus HST on an ongoing monthly basis to April 30, 2024. On an annual basis the landlord increases the annual rent by the percentage increase of the Consumer Price Index.

The minimum annual lease payments required in the next three years in respect of operating leases are as follows:

	$
2024	621,218
2025	637,785
2026	212,595

Subsequent to year end the organization signed new lease agreements for the two buildings with the County of Oxford at $53,149 per month plus HST on an ongoing monthly basis to April 30, 2026.

17. FINANCIAL INSTRUMENTS

Risks and Concentrations

The organization is exposed to various risks through its financial instruments. The following analysis provides a measure of the organization's risk exposure and concentrations at the statement of financial position date.

Liquidity Risk

Liquidity risk is the risk that the organization will encounter difficulty in meeting obligations associated with financial liabilities. The organization doesn't believe that liquidity risk is a significant risk as no financial liabilities of the is organization were in default during the period and was no subject to any covenants during the period.

Credit Risk

Credit risk is the risk that one party to a financial instrument will cause a financial loss for the other party by failing to discharge an obligation. The organization's main credit risk relate to its accounts receivable.

At year end, the organization has no significant risk as the organization does not expect any issues with the collections of these balances.

Interest Rate Risk

Interest rate risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market interest rates. The organization is exposed to interest rate risk on its fixed and floating interest rate financial instruments. Given the current composition of long-term debt (proportion of debt at a fixed interest rate compared to a floating interest rate), fixed-rate instruments subject the organization to a fair value risk while the floating-rate instruments subject it to a cash flow risk. This is risk is offset by the use of the interest swap derivative.

It is management's opinion that the entity is not exposed to any significant foreign currency or price risk.

There have been no changes to the assessed levels of theses risks in the year.

SOUTHWESTERN PUBLIC HEALTH

Schedule of Expenditures
For the Year Ended December 31, 2023

	(Note 15) Budget 2023 $	**2023 $**	2022 $
GENERAL PUBLIC HEALTH PROGRAMS			
SALARIES AND WAGES			
Management	3,641,085	**3,775,666**	3,425,822
Nursing	3,868,826	**3,599,795**	2,858,884
Inspection and environment	1,335,063	**1,254,873**	1,129,003
Clerical and support	1,105,594	**937,653**	808,059
Health promotion	841,083	**825,097**	609,941
COVID-19	2,839,295	**1,166,234**	4,175,339
	13,630,946	**11,559,318**	13,007,048
FRINGE BENEFITS			
Group pension	1,718,729	**1,542,065**	1,407,479
Canada pension plan	578,000	**600,455**	664,368
Extended health care	627,500	**561,971**	505,861
Long term disability	366,000	**340,132**	336,817
Employer health tax	263,500	**268,282**	310,418
Employment insurance	205,500	**214,712**	228,982
Dental plan	236,000	**208,402**	190,792
Workplace safety insurance	134,000	**142,707**	95,202
Part-time benefits	44,945	**111,806**	102,285
Group life insurance	64,500	**60,220**	56,233
Supplementary unemployment benefits	79,000	**28,476**	81,987
Employee assistance programs	8,900	**8,226**	7,858
Benefits to other programs	(1,005,119)	**(1,055,002)**	(1,594,411)
COVID-19	809,973	**141,192**	876,706
	4,131,428	**3,173,644**	3,270,577
FEES AND HONORARIA			
Labour relations	99,595	**119,859**	156,815
Audit and legal	106,000	**42,691**	45,528
Meeting expense	16,800	**18,817**	12,454
Honorarium	22,000	**16,179**	15,618
Services fees	6,650	**8,053**	6,429
	251,045	**205,599**	236,844
COVID-19 EXPENSES OTHER THAN PAYROLL	2,137,251	**69,108**	646,660

SOUTHWESTERN PUBLIC HEALTH

Schedule of Expenditures
For the Year Ended December 31, 2023

	(Note 15) Budget 2023 $	**2023 $**	2022 $
TRAVEL	216,151	**135,302**	92,478
EQUIPMENT	797,987	**635,865**	645,736
PROGRAM SUPPLIES	460,824	**544,407**	457,339
AMORTIZATION	-	**604,734**	754,397
RENT AND UTILITY SERVICES			
Building and facilities rental	1,205,608	**833,519**	774,814
Interest on long-term debt	239,000	**230,506**	262,604
	1,444,608	**1,064,025**	1,037,418
ADMINISTRATIVE			
Telephone	196,110	**164,655**	164,173
Insurance	154,450	**132,719**	112,296
Professional development	131,328	**96,502**	68,795
Fees and subscriptions	45,385	**74,999**	53,533
Public awareness, promotion and engagement strategies	178,105	**73,788**	61,291
Printing and postage	39,125	**24,880**	24,398
	744,503	**567,543**	484,486
TOTAL COST SHARED PROGRAM EXPENDITURES	23,814,743	**18,559,545**	20,632,983

SOUTHWESTERN PUBLIC HEALTH

Schedule of Expenditures
For the Year Ended December 31, 2023

	(Note 15) Budget 2023 $	**2023 $**	2022 $
OTHER PROGRAMS AND ONE TIME EXPENDITURES			
MINISTRY PROGRAMS - 100% FUNDED			
COVID Vaccine Program (March 31, 2024)	329,400	**219,547**	-
Infection Prevention and Control Hub (March 31, 2022)	-	**-**	548,745
Infection Prevention and Control Hub (March 31, 2023)	685,000	**24,787**	660,213
Infection Prevention and Control Hub (March 31, 2024)	436,875	**371,805**	-
Medical Officer of Health Compensation Initiative	156,043	**62,632**	21,990
Merger Costs (March 31, 2022)	-	**-**	60,610
Mobile Dental Clinic (March 31, 2023)	500,000	**865**	-
Needle Syringe Program Initiative (March 31, 2022)	-	**-**	9,818
Needle Syringe Program Initiative (March 31, 2023)	36,500	**25,099**	10,335
Needle Syringe Program Initiative (March 31, 2024)	55,000	**11,605**	-
Ontario Senior Dental Care Program	1,061,100	**1,062,845**	899,204
Public Health Inspector Practicum Program (March 31, 2022)	-	**-**	19,607
Public Health Inspector Practicum Program (March 31, 2023)	20,000	**393**	-
Public Health Inspector Practicum Program (March 31, 2024)	20,000	**20,000**	-
School-Focused Nurses Initiative (March 31, 2022)	-	**-**	204,492
School-Focused Nurses Initiative (March 31, 2023)	225,000	**225,000**	672,000
School-Focused Nurses Initiative (June 30, 2023)	225,000	**225,000**	-
Temporary Retention Incentive for Nurses (March 31, 2022)	-	**-**	436,715
Total Ministry Programs - 100% Funded	3,749,918	**2,249,578**	3,543,729
OTHER PROGRAMS			
Healthy Babies Healthy Children	1,653,539	**1,669,436**	1,335,575
Public Health Agency Canada	198,620	**182,941**	168,248
Prenatal and Postnatal Nurse Practitioner Services	139,000	**138,154**	139,000
Low German Partnership	-	**16,877**	1,355
Student Nutrition	-	**-**	165,597
Locally Driven Collaborative Projects (March 31, 2024)	38,744	**4,894**	-
Total other programs	2,029,903	**2,012,302**	1,809,775
TOTAL EXPENDITURES	29,594,564	**22,821,425**	25,986,487

GRAHAM SCOTT ENNS LLP
CHARTERED PROFESSIONAL ACCOUNTANTS

P. 519-633-0700 · F. 519-633-7009
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April 25, 2024

Southwestern Public Health
1230 Talbot Street
St. Thomas, ON, N5P 1G9

Dear Board of Directors:

Re: Audit Findings

This letter has been prepared to assist you with your review of the financial statements of Southwestern Public Health for the period ending December 31, 2023. We look forward to meeting with you and discussing the matters outlined below.

Significant Matters Arising

Changes to Audit Plan

There were no changes to the audit plan (as previously presented to you).

Other Matters

We have not identified any other significant matters that we wish to bring to your attention at this time.

Significant Difficulties Encountered

There were no significant difficulties encountered during our audit.

Comments on Accounting Practices

Accounting Policies

The significant accounting policies used by the entity are outlined in Note 1 to the financial statements.

- There were no significant changes in accounting policies [other than the adoption of PS 1201 - Financial Statement Presentation, PS 3280 - Asset Retirement Obligations, and PS-3450 - Financial Instrument. See Note 1 to the financial statements for further information. .
- We did not identify any alternative accounting policies that would have been more appropriate in the circumstances.
- We did not identify any significant accounting policies in controversial or emerging areas.

Significant Accounting Estimates

There were no significant estimates/judgements contained in the financial statements.

Significant Financial Statement Disclosures

We did not identify any financial statement disclosures that are particularly significant, sensitive or require significant judgments, that we believe should be specifically drawn to your attention.

Uncorrected Misstatements

We accumulated no significant uncorrected misstatements during our audit.

Significant Deficiencies in Internal Control

A deficiency in internal control exists when a control is designed, implemented or operated in such a way that it is unable to prevent, or detect and correct, misstatements in the financial statements on a timely basis, or when a control necessary to prevent, or detect and correct, misstatements in the financial statements on a timely basis is missing.

A significant deficiency in internal control is defined as a deficiency or combination of deficiencies in internal control that, in the auditor's professional judgment, is of sufficient importance to merit the attention of those charged with governance.

To identify and assess the risks of material misstatement in the financial statements, we are required to obtain an understanding of internal control relevant to the audit. This understanding is used for the limited purpose of designing appropriate audit procedures. It is not used for the purpose of expressing an opinion on the effectiveness of internal control and, as a result, we do not express any such opinion. The limited purpose also means that there can be no assurance that all significant deficiencies in internal control, or any other control deficiencies, will be identified during our audit.

We did not identify any control deficiencies that, in our judgment, would be considered significant deficiencies.

Written Representations

In a separate communication, as attached, we have requested a number of written representations from management in respect to their responsibility for the preparation of the financial statements in accordance with Canadian accounting standards for not-for-profit organizations.

Other Audit Matters of Governance Interest

We did not identify any related party relationships or transactions that were previously undisclosed to us.

We did not identify any other matters to bring to your attention at this time.

We would like to thank management and staff for the assistance they provided to us during the audit.

We hope the information in this audit findings letter will be useful. We would be pleased to discuss them with you and respond to any questions you may have.

This letter was prepared for the sole use of those charged with governance of Southwestern Public Health to carry out and discharge their responsibilities. The content should not be disclosed to any third party without our prior written consent, and we assume no responsibility to any other person.

Sincerely,

GRAHAM SCOTT ENNS LLP
Chartered Professional Accountants

Jennifer Buchanan, CPA, CA

Partner

Acknowledgement of Board of Directors:

We have read and reviewed the above disclosures and understand and agree with the comments therein:

Per: Southwestern Public Health

Signed: _____ Date: _____

Print Name: _____

Ministry of Health

Office of the Deputy Premier
and Minister of Health

777 Bay Street, 5th Floor
Toronto ON M7A 1N3
Telephone: 416 327-4300
www.ontario.ca/health

Ministère de la Santé

Bureau du vice-premier ministre
et du ministre de la Santé

777, rue Bay, 5e étage
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Ontario

March 28, 2024

e-Approve-72-2024-632

Mayor Joe Preston
Chair, Board of Health
Oxford Elgin St. Thomas Health Unit
1230 Talbot Street
St. Thomas ON N5P 1G9

Dear Mayor Joe Preston:

I am pleased to advise you that the Ministry of Health will provide the Board of Health for the Oxford Elgin St. Thomas Health Unit up to $406,475 in additional base funding for the 2023-24 funding year, up to $1,219,425 in additional base funding for the 2024-25 funding year, and up to $955,500 in additional one-time funding for the 2023-24 funding year to support the provision of public health programs and services in your community.

These approvals support the government's commitment towards Strengthening Public Health, including restoring provincial base funding to the level previously provided under the 2020 cost-share formula, effective January 1, 2024, and providing 1% growth base funding for the 2024 calendar year.

The Executive Lead of the Office of Chief Medical Officer of Health, Public Health Division will write to the Oxford Elgin St. Thomas Health Unit shortly concerning the terms and conditions governing the funding.

Thank you for the important service that your public health unit provides to Ontarians, and your ongoing dedication and commitment to addressing the public health needs of Ontarians.

Sincerely,

Sylvia Jones
Deputy Premier and Minister of Health

.../2

Mayor Joe Preston

c: Dr. Ninh Tran, Medical Officer of Health, Oxford Elgin St. Thomas Health Unit
Cynthia St. John, Chief Executive Officer, Oxford Elgin St. Thomas Health Unit
Dr. Kieran Moore, Chief Medical Officer of Health and Assistant Deputy Minister
Elizabeth Walker, Executive Lead, Office of Chief Medical Officer of Health, Public Health

New Schedules to the
Public Health Funding and Accountability Agreement

BETWEEN THE PROVINCE AND THE BOARD OF HEALTH

(BOARD OF HEALTH FOR THE OXFORD ELGIN ST. THOMAS HEALTH UNIT)

EFFECTIVE AS OF THE 1ST DAY OF JANUARY 2023

Issued March 2024

Schedule A
Grants and Budget

Board of Health for the Oxford Elgin St. Thomas Health Unit

DETAILED BUDGET - MAXIMUM BASE FUNDS (GRANTS TO BE PAID SEMI-MONTHLY, FOR THE PERIODS OF JANUARY 1ST TO DECEMBER 31ST AND APRIL 1ST TO MARCH 31ST)			
Programs / Sources of Funding	**Grant Details**	**2023 Grant ($)**	**2023-24 Grant ($)**
Mandatory Programs (Cost-Shared)	• The 2023 Grant includes a pro-rated increase of $83,175 for the period of April 1, 2023 to December 31, 2023 • Per the August 22, 2023 Funding Letter, the 2023-34 Grant includes an annualized increase of $110,900 for the period of April 1, 2023 to March 31, 2024	11,168,975	11,196,700
MOH / AMOH Compensation Initiative (100%)	Cash flow will be adjusted to reflect the actual status of Medical Officer of Health (MOH) and Associate MOH positions, based on an annual application process.	178,700	178,700
Ontario Seniors Dental Care Program (100%)		1,061,100	1,061,100
Total Maximum Base Funds		**12,408,775**	**12,436,500**

DETAILED BUDGET - MAXIMUM ONE-TIME FUNDS (GRANTS TO BE PAID SEMI-MONTHLY, FOR THE PERIOD OF APRIL 1, 2023 TO MARCH 31, 2024, UNLESS OTHERWISE NOTED)			
Projects / Initiatives			**2023-24 Grant ($)**
Cost-Sharing Mitigation (100%) (For the period of January 1, 2023 to December 31, 2023)			1,498,900
Mandatory Programs: Needle Syringe Program (100%)			55,000
Mandatory Programs: New Purpose-Built Vaccine Refrigerators (100%)			32,600
Mandatory Programs: Public Health Inspector Practicum Program (100%)			20,000
COVID-19: General Program Extraordinary Costs (100%) (For the period of January 1, 2023 to December 31, 2023)			175,000
COVID-19: Vaccine Program Extraordinary Costs (100%) (For the period of January 1, 2023 to December 31, 2023)			464,100
COVID-19: Vaccine Program Enhancement (100%) (For the period of January 1, 2024 to March 31, 2024)			257,800
Infection Prevention and Control Hubs (100%)			582,500
Respiratory Syncytial Virus (RSV) Adult Prevention Program (100%) (For the period of September 1, 2023 to March 31, 2024)			313,000
School-Focused Nurses Initiative (100%) (For the period of April 1, 2023 to June 30, 2023)	# of FTEs	9	225,000
Strengthening Public Health: Merger Planning (100%)			75,000
Total Maximum One-Time Funds			**3,698,900**

Total Maximum Base and One-Time Funds[1]	**16,135,400**

2022-23 CARRY OVER ONE-TIME FUNDS[2] (CARRY OVER FOR THE PERIOD OF APRIL 1, 2023 to MARCH 31, 2024)		
Projects / Initiatives	**2022-23 Grant ($)**	**2023-24 Approved Carry Over ($)**
Ontario Seniors Dental Care Program Capital: New Fixed Site - Oxford County Dental Suite (100%)	1,540,000	1,540,000
Total Maximum Carry Over One-Time Funds	**1,540,000**	**1,540,000**

NOTES:

(1) Cash flow will be adjusted when the Province provides a new Schedule "A".

(2) Carry over of one-time funds is approved according to the criteria outlined in the provincial correspondence dated March 17, 2023.

SCHEDULE B

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base Funding***

Provincial base funding is provided to the Board of Health for the purposes of delivering public health programs and services in accordance with the Health Protection and Promotion Act (HPPA), Regulations under the HPPA, Ontario Public Health Standards, and the Agreement. Provincial base funding is also provided to the Board of Health for the purposes of delivering related public health programs and initiatives in accordance with Schedule B.

Mandatory Programs: Harm Reduction Program Enhancement

The scope of work for the Harm Reduction Program Enhancement is divided into three components:

1. Local Opioid Response;
2. Naloxone Distribution and Training; and,
3. Opioid Overdose Early Warning and Surveillance.

Local Opioid Response

Base funding must be used to build a sustainable community outreach and response capacity to address drug and opioid-related challenges in their communities. This includes working with a broad base of partners to ensure any local opioid response is coordinated, integrated, and that systems and structures are in place to adapt/enhance service models to meet evolving needs.

Local response plans, which can include harm reduction and education/prevention, initiatives, should contribute to increased access to programs and services, and improved health outcomes (i.e., decrease overdose and overdose deaths, emergency room visits, hospitalizations). With these goals in mind, the Board of Health is expected to:

- Conduct a population health/situational assessment, including the identification of opioid-related community challenges and issues, which are informed by local data, community engagement, early warning systems, etc.
- Lead/support the development, implementation, and evaluation of a local overdose response plan (or drug strategy). Any plan or initiative should be based on the needs identified (and/or gaps) in your local assessment. This may include building community outreach and response capacity, enhanced harm reduction services and/or education/prevention programs and services.
- Engage stakeholders – identify and leverage community partners to support the population health/situational assessment and implementation of local overdose response plans or initiatives. Community stakeholders, including First Nations, Métis and Inuit communities and persons with lived experience, should be meaningfully engaged in the planning and implementation of all initiatives, where appropriate.

Type of Funding	***Base Funding***

- Adopt and ensure timely data entry into the Ontario Harm Reduction Database, including the Transition to the Ontario Harm Reduction Database and ensure timely collection and entry of minimum data set as per direction from the Province.

Naloxone Kit Distribution and Training

The Board of Health (or their Designate) must be established as a naloxone distribution lead/hub for eligible community organizations, as specified by the Province, which will increase dissemination of kits to those most at risk of opioid overdose.

To achieve this, the Board of Health is expected to:

- Order naloxone kits as outlined by the Province; this includes naloxone required by eligible community organizations distributing naloxone.
- Coordinate and supervise naloxone inventory, including managing supply, storage, maintaining inventory records, and distribution of naloxone to eligible community organizations, and ensuring community organizations distribute naloxone in accordance with eligibility criteria established by the Province.
- With the exception of entities (organizations, individuals, etc.) as specified by the Province:
    - Train community organization staff on naloxone administration, including how to administer naloxone in cases of opioid overdose, recognizing the signs of overdose and ways to reduce the risk of overdose. Board of Health staff would also instruct agency staff on how to provide training to end-users (people who use drugs, their friends and family).
    - Train community organization staff on naloxone eligibility criteria, including providing advice to agency staff on who is eligible to receive naloxone and the recommended quantity to dispense.
    - Support policy development at community organizations, including providing consultation on naloxone-related policy and procedures that are being developed or amended within the eligible community organizations.
    - Promote naloxone availability and engage in community organization outreach, including encouraging eligible community organizations to acquire naloxone kits for distribution to their clients.

Use of naloxone (NARCAN® Nasal Spray and injectable naloxone formulations)

The Board of Health will be required to submit orders for naloxone to the Province in order to implement the Harm Reduction Program Enhancement. By receiving naloxone, the Board of Health acknowledges and agrees that:

Type of Funding ***Base Funding***

- Its use of naloxone is entirely at its own risk. There is no representation, warranty, condition or other promise of any kind, express, implied, statutory or otherwise, given by her Majesty the Queen in Right of Ontario as represented by the Ministry of Health, including Ontario Government Pharmaceutical and Medical Supply Service in connection with naloxone.
- The Province takes no responsibility for any unauthorized use of naloxone by the Board of Health or by its clients.
- The Board of Health also agrees to:
    - Not assign or subcontract the distribution, supply or obligation to comply with any of these terms and conditions to any other person or organization without the prior written consent of the Province.
    - Comply with the terms and conditions as it relates to the use and administration of naloxone as specified in all applicable federal and provincial laws.
    - Provide training to persons who will be administering naloxone. The training shall consist of the following: opioid overdose prevention; signs and symptoms of an opioid overdose; and, the necessary steps to respond to an opioid overdose, including the proper and effective administration of naloxone.
    - Follow all provincial written instructions relating to the proper use, administration, training and/or distribution of naloxone.
    - Immediately return any naloxone in its custody or control at the written request of the Province at the Board of Health's own cost or expense, and that the Province does not guarantee supply of naloxone, nor that naloxone will be provided to the Board of Health in a timely manner.

<u>Opioid Overdose Early Warning and Surveillance</u>

Base funding must be used to support the Board of Health in taking a leadership role in establishing systems to identify and track the risks posed by illicit opioids in their jurisdictions, including the sudden availability of illicit synthetic opioids and resulting opioid overdoses. Risk based information about illicit synthetic opioids should be shared in an ongoing manner with community partners to inform their situational awareness and service planning. This includes:

- Surveillance systems should include a set of "real-time" qualitative and quantitative indicators and complementary information on local illicit synthetic opioid risk. Partners should include, but are not limited to: emergency departments, first responders (police, fire and ambulance) and harm reduction services.
- Early warning systems should include the communication mechanisms and structures required to share information in a timely manner among health system and community

partners, including people who use drugs, about changes in the acute, local risk level, to inform action.

Mandatory Programs: Healthy Smiles Ontario Program

The Healthy Smiles Ontario (HSO) Program provides preventive, routine, and emergency and essential dental treatment for children and youth, from low-income families, who are 17 years of age or under.

In addition to the program requirements under the Ontario Public Health Standards, the Board of Health must ensure that the following requirements are met:

- The Board of Health is responsible for ensuring promotional/marketing activities have a direct and positive impact on meeting the objectives of the HSO Program.
- The Board of Health is reminded that HSO promotional/marketing materials approved by the Province and developed provincially are available for use by the Board of Health in promoting the HSO Program.
- The overarching HSO brand and provincial marketing materials were developed by the Province to promote consistency of messaging, and "look and feel" across the province. When promoting the HSO Program locally, the Board of Health is requested to align local promotional products with the provincial HSO brand. When the Board of Health uses the HSO brand, it is required to liaise with the Ministry of Health's Communications Division to ensure use of the brand aligns with provincial standards.
- The Board of Health is required to bill back relevant programs for services provided to non-HSO clients. All revenues collected under the HSO Program, including revenues collected for the provision of services to non-HSO clients such as Ontario Works adults, Ontario Disability Support Program adults, municipal clients, etc., must be reported as income in financial reports as per Schedule C of the Agreement.
- For the purposes of reporting and monitoring for the HSO Program, the Board of Health must use the following provincial approved systems or mechanisms, or other as specified by the Province.
    - Aggregate screening, enrolment, and utilization data for any given month must be submitted by the 15th of the following month to the ministry in the ministry-issued template titled Dental Clinic Services Monthly Reporting Template.
    - Client-specific clinical data must be recorded in either dental management software (e.g., ClearDent, AbelDent, etc.) or in the template titled HSO Clinic Treatment Workbook that has been issued by the ministry for the purposes of recording such data.
- The Board of Health must enter into Service Level Agreements with any partner organization (e.g., Community Health Centre, Aboriginal Health Access Centre, etc.)

delivering services as part of the HSO Program. The Service Level Agreement must set out clear performance expectations, clearly state funding and reporting requirements between the Board of Health and local partner, and ensure accountability for public funds.

- Any significant change to previously approved HSO business models, including changes to plans, partnerships, or processes, must be approved by the Province before being implemented. Any contract or subcontract entered into by the Board of Health for the purposes of implementing the HSO Program must be conducted according to relevant municipal procurement guidelines.

Mandatory Programs: Nursing Positions

Base funding may be utilized to support Chief Nursing Officer, Infection Prevention and Control, and Social Determinants of Health Nursing positions, as well as other nursing positions at the Board of Health.

The Board of Health shall only employ a Chief Nursing Officer with the following qualifications:

- Registered Nurse in good standing with the College of Nurses of Ontario;
- Baccalaureate degree in nursing;
- Graduate degree in nursing, community health, public health, health promotion, health administration or other relevant equivalent OR be committed to obtaining such qualification within three years of designation;
- Minimum of 10 years nursing experience with progressive leadership responsibilities, including a significant level of experience in public health; and,
- Member of appropriate professional organizations (e.g., Registered Nurses' Association of Ontario, Association of Nursing Directors and Supervisors in Official Health Agencies in Ontario-Public Health Nursing Management, etc.).

The Chief Nursing Officer role must be implemented at a management level within the Board of Health, reporting directly to the Medical Officer of Health or Chief Executive Officer and, in that context, will contribute to organizational effectiveness.

The Board of Health shall only employ an Infection Prevention and Control Nurse with the following qualifications:

- The position is required to have a nursing designation (Registered Nurse, Registered Practical Nurse, or Registered Nurse in the Extended Class); and,
- Certification in Infection Control (CIC), or a commitment to obtaining CIC within three years of beginning of employment.

SCHEDULE B

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base Funding***

The Board of Health shall only employ a Social Determinants of Health Nurse with the following qualifications:

- The position is required to be to be a Registered Nurse; and,
- The position is required to have or be committed to obtaining the qualifications of a public health nurse as specified in section 71(3) of the HPPA and section 6 of Ontario Regulation 566 under the HPPA.

Mandatory Programs: Smoke-Free Ontario

Smoke-Free Ontario is a comprehensive approach that combines programs, policies, social marketing, and legislation to reduce the use of tobacco and vapour products and lower health risks by protecting Ontarians from second-hand smoke and vapour, and to keep harmful products out of the hands of children and youth.

In addition to the program requirements under the Ontario Public Health Standards, the Board of Health must ensure that it complies with any written directions provided by the Province on the interpretation and enforcement of the Smoke-Free Ontario Act, 2017.

Medical Officer of Health / Associate Medical Officer of Health Compensation Initiative (100%)

The Province provides the Board of Health with 100% of the additional base funding required to fund eligible Medical Officer of Health (MOH) and Associate Medical Officer of Health (AMOH) positions within salary ranges initially established as part of the 2008 Physician Services Agreement and continued under subsequent agreements.

Base funding must be used for costs associated with top-up for salaries and benefits, and for applicable stipends, to eligible MOH and AMOH positions at the Board of Health and cannot be used to support other physicians or staffing costs. Base funding for this initiative continues to be separate from cost-shared base salaries and benefits.

The maximum base funding allocation in Schedule A of the Agreement does not necessarily reflect the cash flow that the Board of Health will receive. Cash flow will continue to be adjusted regularly by the Province based on up-to-date application data and information provided by the Board of Health during a funding year. The Board of Health is required to notify the Province if there is any change in the eligible MOH and/or AMOH(s) base salary, benefits, FTE and/or position status as this may impact the eligibility amount for top-up.

The Board of Health must comply and adhere to the eligibility criteria for the MOH/AMOH Compensation Initiative as per the Policy Framework on Medical Officer of Health

Type of Funding	***Base Funding***

Appointments, Reporting, and Compensation, including requirements related to minimum salaries to be eligible for funding under this Initiative.

Ontario Seniors Dental Care Program (100%)

The Ontario Seniors Dental Care Program (OSDCP) provides comprehensive dental care to eligible low-income seniors to help reduce unnecessary trips to the hospital, prevent chronic disease and increase quality of life for seniors. The program is being implemented through a phased approach.

The government announced the launch and staged implementation of the OSDCP on November 20, 2019. During the first stage of implementation, dental services were available for eligible seniors through Boards of Health, participating Community Health Centres and Aboriginal Health Access Centres. Through Stage 1, dental care was initiated and provided to eligible low-income seniors through Boards of Health, participating Community Health Centres, and Aboriginal Health Access Centres based on increasing Board of Health operational funding and leveraging existing infrastructure. The second stage of the program, which began in winter 2020, expanded the program by investing in new dental clinics to provide care to more seniors in need. This included new dental services in underserviced areas, including through mobile dental buses and an increased number of dental suites in Boards of Health, participating Community Health Centres, and Aboriginal Health Access Centres. The second stage of the program will continue throughout 2023-24, with consideration being given to the implementation challenges following the COVID-19 response.

<u>Program Enrolment</u>

Program enrolment is managed centrally and is not a requirement of the Board of Health. The Board of Health is responsible for local oversight of dental service delivery to eligible clients under the program within the Public Health Unit area.

In cases where eligible seniors present with acute pain and urgent need, and are not already enrolled in the program, OSDCP providers, at the clinical discretion of the attending dental care provider, may support timely access to emergency dental treatment by providing immediate services following the seniors' signing of an emergency need and eligibility attestation. This attestation and enrollment process is to be administered at the local level. Following the delivery of emergency treatment, all seniors will need to submit an OSDCP application, be determined eligible, and be enrolled to receive any further non-emergency dental care through the OSDCP.

SCHEDULE B

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base Funding***

Program Delivery

The OSDCP is delivered through Boards of Health, participating Community Health Centres, and Aboriginal Health Access Centres across the province. These service delivery partners are well positioned to understand the needs of priority populations and provide high quality dental care to low-income seniors in their communities.

With respect to Board of Health service delivery under the OSDCP, the Board of Health may enter into partnership contracts with other entities/organizations or providers/specialists as needed (e.g., to address potential access issues) to provide services to enrolled clients in accordance with the OSDCP Schedules of Services for Dentist and Non-Dentist Providers on behalf of the Public Health Unit.

Where OSDCP client service access issues exist, as evidenced by waiting lists, for example, the Board of Health must take prompt action as feasible to establish OSDCP partnership agreements to address these access issues, including engaging in outreach and consultation with local dental providers and in compliance with the Board of Health or municipal procurement processes.

Base funding for the OSDCP must be used in accordance with the OSDCP-related requirements of the Oral Health Protocol, 2018 (or as current), including specified requirements for service delivery, oral health navigation, and data collection and analysis. The Board of Health may allocate base funding for this Program across the program expense categories, with every effort made to maximize clinical service delivery and minimize administrative costs.

Planning for delivery of the OSDCP began when the program was announced in April 2019 with clinical service delivery beginning with the program launch in November 2019.

As part of implementation, eligible expense categories under this Program also include:

- *Clinical service delivery costs*, which are comprised of:
    - Salaries, wages, and benefits of full-time, part-time, or contracted staff of the Board of Health or local service delivery partner which provide clinical dental services for the Program.
    - Salaries, wages, and benefits of full-time, part-time, or contracted staff of the Board of Health or local service delivery partner which undertake ancillary/support activities for the Program, including: management of the clinic(s); financial and programmatic data collection and reporting for the clinic(s); and, general administration (e.g., reception services) at the clinic(s).

Type of Funding	***Base Funding***

- Overhead costs associated with the Program's clinical service delivery such as: clinical materials and supplies; building occupancy costs; maintenance of clinic infrastructure; staff travel associated with clinical service delivery (e.g., portable clinics, mobile clinics, long-term care homes, if applicable); staff training and professional development associated with clinical staff and ancillary/support staff, if applicable; office equipment, communication, and information and information technology.

- *Oral health navigation costs*, which are comprised of:
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff engaged in: client enrolment assistance for the Program's clients (i.e., assisting clients with enrolment forms); program outreach (i.e., local-level efforts for identifying potential clients); and, oral health education and promotion to the Program's clients.
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff that undertake the following ancillary/support activities related to oral health navigation: management, financial and programmatic reporting, and general administration (if applicable).
  - Overhead costs associated with oral health navigation such as: materials and supplies; building occupancy costs incurred for components of oral health navigation; staff travel associated with oral health navigation, where applicable; staff training and professional development associated with oral health navigation and ancillary/support staff, if applicable; office equipment, communication, and information and information technology costs associated with oral health navigation.
  - Client transportation costs in order to address accessibility issues and support effective program delivery based on local need, such as where the enrolled OSDCP client would otherwise not be able to access dental services. Boards of Health will be asked to provide information on client transportation expenditures through in-year reporting and should track these expenditures and the number of clients accessing these services accordingly.

Operational expenses that are not eligible under this Program include:

- Staff recruitment incentives;
- Billing incentives; and,
- Costs associated with any activities required under the Ontario Public Health Standards, including the Oral Health Protocol, 2018 (or as current), which are not related to the OSDCP.

Type of Funding	***Base Funding***

Other Requirements

Marketing

- When promoting the OSDCP locally, the Board of Health is required to align local promotional products with the provincial Program brand and messaging. The Board of Health is required to liaise with the Province to ensure use of the brand aligns with provincial standards.

Revenue

- While priority must be given to clients eligible under this Program, the Board of Health may provide services to non-OSDCP clients using resources under this Program. If this occurs, the Board of Health is required to bill-back relevant programs for services provided to non-OSDCP clients using resources under this Program. All revenues collected under the OSDCP, including revenues collected for the provision of services to non-Program clients such as Ontario Works adults, Ontario Disability Support Program adults, Non-Insured Benefits clients, municipal clients, HSO clients, etc., with resources under this Program must be reported as an offset revenue to the Province. Priority must always be given to clients eligible under this Program. The Board of Health is required to closely monitor and track revenue from bill-back for reporting purposes to the Province.
- A client co-payment is required on new denture services. Co-payment amounts are specified by the Province in Appendix A of the OSDCP Denture Services Factsheet for Providers (Factsheet), which applies to both dentists and denturists. It is the Board of Health's responsibility to collect the client co-payment for the codes outlined in Appendix A of the Factsheet. The Board of Health may determine the best mechanism for collecting co-payments, using existing payment and administration processes at the local level, in collaboration with OSDCP service delivery partners (e.g., Community Health Centre, Aboriginal Health Access Centre), as needed. The remaining cost of the service, after co-payment, is to be absorbed by the Board of Health through its operating base funding for the OSDCP. The revenue received from client co-payments for OSDCP service(s) is to be used to offset OSDCP program expenditures. Co-payment revenues are to be reported as part of the financial reporting requirements to the Province.

Community Partners

- The Board of Health must enter into discussions with all Community Health Centres and Aboriginal Health Access Centres in their catchment area to ascertain the feasibility of a partnership for the purpose of delivering this Program.

SCHEDULE B

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base Funding***

- The Board of Health must enter into Service Level Agreements with any partner organization (e.g., Community Health Centres, Aboriginal Health Access Centres) delivering services under this Program. The Service Level Agreement must set out clear performance expectations, clearly state funding and reporting requirements between the Board of Health and the local partner, and ensure accountability for public funds.
- The Board of Health must ensure that base funding is used to meet the objectives of the Program, with a priority to deliver clinical dental services to clients, while staying within the base funding allocation.

Type of Funding	***One-Time Funding***

Cost-Sharing Mitigation (100%)

One-time cost-sharing mitigation funding must be used to offset the increased costs of municipalities as a result of the cost-sharing change for mandatory programs.

Mandatory Programs: Needle Syringe Program (100%)

One-time funding must be used for extraordinary costs associated with delivering the Needle Syringe Program. Eligible costs include purchase of needles/syringes, associated disposal costs, and other operating costs.

Mandatory Programs: New Purpose-Built Vaccine Refrigerators (100%)

One-time funding must be used for the purchase of 2 new purpose-built vaccine refrigerator(s) used to store publicly funded vaccines. The purpose-built refrigerator(s) must meet the following specifications:

a. Interior
   - Fully adjustable, full extension stainless steel roll-out drawers;
   - Optional fixed stainless-steel shelving;
   - Resistant to cleaning solutions;
   - Ongoing positive forced fan air circulation to ensure temperature uniformity at all shelf levels;
   - Fan is either encased or removed from the chamber. Fan auto shut-off when door is opened; and,
   - Walls are smooth, scratch and corrosion resistant painted interior and exterior surfaces.

b. Refrigeration System
   - Heavy duty, hermetically sealed compressors;
   - Refrigerant material should be approved for use in Canada;
   - Advanced defrost sensor(s) to manage the defrost cycle and minimize trace amounts of frost build-up; and,
   - Evaporator operates at +2°C, preventing vaccine from freezing.

c. Doors
   - Full view non-condensing, glass door(s), at least double pane construction;
   - Option spring-loaded closures include ≥90º stay open feature and <90º self-closing feature;
   - Door locking provision;
   - Option of left-hand or right-hand opening; and,
   - Interior cabinet lights with door activated on/off switch, as well as, an independent external on/off.

d. Tamper Resistant Thermostat
    - The thermostat should be set at the factory to +5ºC with a control range between +2ºC to +8ºC but this could be done at the time of delivery/installation at no additional cost.

e. Thermometer
    - An automatic temperature recording and monitoring device with battery backup;
    - An external built-in visual digital display thermometer independent of the temperature recording and monitoring device which has a digital temperature display in Celsius and temperature increment readings of 0.1ºC;
    - The external built-in digital thermometer must also be able to record and display the maximum, minimum and current temperatures and allow the user to easily check and reset these recordings as required; and,
    - The automatic temperature recording and monitoring device and digital display thermometer must be calibrated/accurate within +/- 0.5ºC or better.

f. Alarm Condition Indicator
    - Audible and visual warnings for over-temperature, under-temperature and power failure;
    - Remote alarm contacts;
    - Door ajar enunciator; and,
    - Alarm testing system.

g. Top or Bottom Mounted Compressors/Condensers
    - Compressor mounted at top or bottom but not in rear.

h. Noise Levels
    - The noise produced by the operation of the refrigerator shall not exceed 85 decibels at one metre. Specifications of the refrigerator must include the noise level measured in decibels of sound at one metre from the refrigerator.

i. Locking Plug
    - Power supply must have a locking plug.

j. Castors
    - Heavy duty locking castors either installed at the factory or upon delivery.

k. Voltage Safeguard
    - Voltage safeguard device capable of protecting against power surges related to the resumption of power to the refrigerator.

l. Warranty
    - The warranty should include, from date of acceptance, a five-year comprehensive parts and labour warranty with the stipulation that a qualified service representative shall be on-site no later than 12 hours after the service call

was made. Software upgrades provided free of charge during the warranty period.

m. Electrical Equipment

- All electrically operated equipment must be UL, CSA and/or Electrical Safety Authority approved and bear a corresponding label. The equipment should specify the electrical plug type, voltage and wattage rating, and the recommended breaker size for the circuit connection.

Mandatory Programs: Public Health Inspector Practicum Program (100%)

One-time funding must be used to hire at least one (1) or more Public Health Inspector Practicum position(s). Eligible costs include student salaries, wages and benefits, transportation expenses associated with the practicum position, equipment, and educational expenses.

The Board of Health must comply with the requirements of the Canadian Institute of Public Health Inspectors Board of Certification for field training for a 12-week period; and, ensure the availability of a qualified supervisor/mentor to oversee the practicum student's term.

COVID-19: General Program Extraordinary Costs (100%)

One-time funding must be used to offset extraordinary costs associated with preventing, monitoring, detecting, and containing COVID-19 in the province (excluding costs associated with the delivery of the COVID-19 Vaccine Program). Extraordinary costs refer to the costs incurred over and above the Board of Health's existing funding/approved budget for mandatory programs in organized and unorganized areas (where applicable).

Eligible costs include, but are not limited to:

- Staffing – Salaries and benefits, inclusive of overtime for existing or redeployed Board of Health staff (including management staff directly engaged in COVID-19 activities); staff redeployed from associated regional governments; new temporary or casual staff; salaries and benefits associated with overtime worked by indirect staff (e.g., finance, human resources, legal, communications, etc.) and management staff (where local Board of Health policies permit such arrangements) that have not been redeployed directly to COVID-19, but have incurred overtime due to working on COVID-19 related activities.
- Travel and Accommodation – for staff delivering COVID-19 service away from their home office location, or for staff to conduct infectious disease surveillance activities (swab pick-ups and laboratory deliveries).
- Supplies and Equipment – small equipment and consumable supplies (including laboratory testing supplies and personal protective equipment) not already provided by

Type of Funding	***One-Time Funding***

the Province, and information and information technology upgrades related to tracking COVID-19 not already approved by the Province.

- Purchased Services – service level agreements for services/staffing with community providers and/or municipal organizations, professional services, security services, cleaning services, hazardous waste disposal, transportation services including courier services and rental cars, data entry or information technology services for reporting COVID-19 data to the Province (from centres in the community that are not operated by the Board of Health) or increased services required to meet pandemic reporting demands, outside legal services, and additional premises rented by the Board of Health.
- Communications – language interpretation/translation services, media announcements, public and provider awareness, signage, and education materials regarding COVID-19.
- Other Operating – recruitment activities, staff training.

Other requirements of this one-time funding include:

- The Board of Health must ensure that any goods and services acquired with this one-time funding are procured through an open and competitive process that aligns with municipal and provincial procurement directives to the greatest extent possible.
- The Board of Health must enter into a Memorandum of Understanding / Service Level Agreement (or other similar arrangement) with any partner organization delivering services under this program (this includes services provided by a municipality of which a Public Health Unit is a part of). The Memorandum of Understanding / Service Level Agreement must set out clear performance expectations, clearly state funding and reporting requirements between the Board of Health and the local partner, and ensure accountability for the funds (value for money). Funding included as part of a Memorandum of Understanding / Service Level Agreement must NOT exceed those that would have been paid if the transaction was at “arm’s length” (and is subject to provincial audit or assessment). Copies of these agreements must be provided to the Province upon request.

The following are examples of non-admissible expenditures:

- Costs associated with delivering other public health programs and services.
- Lost revenues for public health programs and services not considered a direct COVID-19 cost, including lost revenue claimed by another organization and/or third party.
- Any COVID-19 costs directly incurred by other organizations and/or third parties (i.e., long-term care homes, hospitals, municipalities). However, if a Board of Health is entering into an agreement with another organization and/or third party, then those costs would be admissible if a Memorandum of Understanding / Service Level

Agreement is in place that sets out clear performance expectations and ensures accountability for the funds, as noted above.

- Sick time and vacation accruals, or banked overtime (funding of these items will be considered only when these amounts are paid).
- Costs that are reimbursable from other sources.
- Costs associated with COVID-19 case and contact management self-isolation sites.
- Costs associated with municipal by-law enforcement.
- Electronic Medical Record systems.

The Board of Health is required to track COVID-19 spending separately and retain records of COVID-19 spending.

COVID-19: Vaccine Program Extraordinary Costs (100%)

One-time funding must be used to offset extraordinary costs associated with organizing and overseeing the COVID-19 immunization campaign within local communities, including the development of local COVID-19 vaccination campaign plans. Extraordinary costs refer to the costs incurred over and above the Board of Health's existing funding/approved budget for mandatory programs in organized and unorganized areas (where applicable).

Eligible costs include, but are not limited to:

- Staffing – salaries and benefits, inclusive of overtime, for existing staff or redeployed Board of Health staff (including management staff directly engaged in COVID-19 activities); staff redeployed from associated regional governments; new temporary or casual staff; and, salaries and benefits associated with overtime worked by indirect staff (e.g., finance, human resources, legal, communications, etc.) and management staff (where local Board of Health policies permit such arrangements) that have not been redeployed directly to COVID-19, but have incurred overtime due to working on COVID-19 related activities. Activities include providing assistance with meeting provincial and local requirements for COVID-19 surveillance and monitoring (including vaccine safety surveillance, adverse events and number of people vaccinated), administering the COVID-19 vaccine, managing COVID-19 Vaccine Program reporting requirements, and planning and deployment of immunization/ vaccine clinics.
- Travel and Accommodation – for staff delivering COVID-19 Vaccine Program services away from their home office location, including transporting vaccines, and transportation/accommodation for staff of mobile vaccine units.
- Supplies and Equipment – supplies and equipment associated with the storage and handling of the COVID-19 vaccines (including vaccine refrigerators, freezers, coolers, etc.), small equipment and consumable supplies (including personal protective

Type of Funding	***One-Time Funding***

equipment) not already provided by the Province, supplies necessary to administer the COVID-19 vaccine (including needles/syringes and disposal, sterile gauze, alcohol, bandages, etc.) not already provided by the Province, information and information technology upgrades related to tracking COVID-19 immunization not already approved by the Province.

- Purchased Services – service level agreements for services/staffing with community providers and/or municipal organizations, professional services, security services, cleaning services, hazardous waste disposal, transportation services (e.g., courier services, transporting clients to vaccination clinics), data entry or information technology services for reporting COVID-19 data related to the Vaccine Program to the Province from centres in the community that are not operated by the Board of Health or increased services required to meet pandemic reporting demands, outside legal services, and additional premises leased or rented by the Board of Health.
- Communications – language interpretation/translation services, media announcements, public and provider awareness, signage, and education materials regarding COVID-19 immunization outreach.
- Other Operating – recruitment activities, staff training.

Other requirements of this one-time funding include:

- The Board of Health must ensure that any goods and services acquired with this one-time funding are procured through an open and competitive process that aligns with municipal and provincial procurement directives to the greatest extent possible.
- The Board of Health must enter into a Memorandum of Understanding / Service Level Agreement (or other similar arrangement) with any partner organization delivering services under this program (this includes services provided by a municipality of which a Public Health Unit is a part of). The Memorandum of Understanding / Service Level Agreement must set out clear performance expectations, clearly state funding and reporting requirements between the Board of Health and the local partner, and ensure accountability for the funds (value for money). Funding included as part of a Memorandum of Understanding / Service Level Agreement must NOT exceed those that would have been paid if the transaction was at “arm’s length” (and is subject to provincial audit or assessment). Copies of these agreements must be provided to the Province upon request.

The following are examples of non-admissible expenditures:

- Costs associated with delivering other public health programs and services.
- Lost revenues for public health programs and services not considered a direct COVID-19 cost, including lost revenue claimed by another organization and/or third party.

Type of Funding	***One-Time Funding***

- Any COVID-19 costs directly incurred by other organizations and/or third parties (i.e., long-term care homes, hospitals, municipalities). However, if a Board of Health is entering into an agreement with another organization and/or third party, then those costs would be admissible if a Memorandum of Understanding / Service Level Agreement is in place that sets out clear performance expectations and ensures accountability for the funds, as noted above.
- Sick time and vacation accruals, or banked overtime (funding of these items will be considered only when these amounts are paid).
- Costs that are reimbursable from other sources.

The Board of Health is required to track COVID-19 spending separately and retain records of COVID-19 spending.

COVID-19: Vaccine Program Enhancement (100%)

One-time funding must be used by the board of health to address COVID-19 Vaccine Program operations, including the wind-down of the fall vaccine campaign and preparation for the spring campaign, for the period of January 1, 2024 to March 31, 2024.

Eligible costs align with those outlined as part of the COVID-19 Vaccine Program.

Infection Prevention and Control Hubs (100%)

One-time funding must be used by the Board of Health for the Infection Prevention and Control (IPAC) Hubs, to enhance IPAC practices in congregate living settings in the Board of Health's catchment area. Congregate living settings (CLSs) include, but are not limited to:

- Long-Term Care Homes;
- Retirement Homes;
- residential settings funded by the Ministry of Health (the ministry);
- Residential settings for adults and children funded by Ministry of Children, Community and Social Services (MCCSS);
- Shelters; and
- Supportive Housing.

Out-of-scope settings* include:

- Childcare settings;
- Day camps;
- Farms;
- Non-Ministry funded congregate living settings;
- Personal Service Settings (PSS);

Type of Funding	***One-Time Funding***

- Hospitals;
- Primary care offices;
- Correctional facilities;
- Offices and workplaces;
- Schools; and,
- Hospices

*This is not an exhaustive list of out-of-scope settings. Please seek clarification/guidance from the ministry.

The IPAC Hubs may receive requests to support an out-of-scope setting due to pressures faced in the community / setting. The supports being offered, and the degree of Hub involvement should be discussed with the ministry for guidance / situational awareness and to minimize any potential duplication of services/support.

If the IPAC Hub is unable, or is not supporting, one of the in-scope CLSs listed above, discussion should take place with the ministry for guidance / situational awareness.

The IPAC Hub will be required to provide IPAC supports and services to CLSs in its catchment. The type, amount, and scheduling of services provided by the IPAC Hub to CLSs will be based on the need, as identified by any of the following: the congregate living settings, the IPAC Hub, and IPAC Hub networks. IPAC Hubs that were previously operating as satellite or sub-hubs are expected to continue working within their core Hub networks. The IPAC Hub will conduct an assessment to determine the allocation and priority of services.

These services include provision of the following IPAC services supports either directly or through partnership with Hub Partners (other local service providers with expertise in IPAC):

- Deliver education and training;
- Host community/ies of practice to support information sharing, learning and networking to congregate living settings;
- Support the development of IPAC programs, policy and procedures within sites/organizations;
- Support assessments and audits of IPAC programs and practices;
- Provide recommendations to strengthen IPAC programs and practices;
- Mentor those with responsibilities for IPAC within congregate living settings;
- Support the development and implementation of outbreak management plans (in conjunction with public health partners and congregate living settings); and,
- Support congregate living settings to implement IPAC recommendations.

SCHEDULE B
RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***One-Time Funding***

Recognizing that IPAC Hub staff often have dual roles, **out of scope functions / services for IPAC Hubs include, but are not limited to:**

Clinical support and other services

- Offering testing or swabbing supports for COVID-19 or other respiratory viruses
- Offering vaccines / vaccine clinics
- Providing medical assessments
- Prescribing antivirals
- Inspections (e.g., as necessary for relicensing requirements)

Outbreak management:

- Leading outbreak management teams (unless delegated by Public Health Unit)
- Defining isolation periods for residents during an outbreak
- Declaring outbreaks / declaring outbreaks over

Degree of Coverage:

- Evening and weekend on-call support

The ministry is mindful that a transition period is likely required to stop providing some of the out-of-scope functions / services. If required, this transition should be discussed with the ministry.

The IPAC Hubs will operate during regular business hours. On-call and weekend coverage is not required. There may be unique emergent situations where after hours support is required and in these situations the ministry should be notified for situational awareness.

At all times, the congregate living organization will retain responsibility and accountability for their organization's IPAC program.

One-time funding must be used for the provision of expertise, education, and support related to the work of the IPAC Hubs to congregate care settings and be subject to review by the ministry. Funding must be used as directed by the ministry and may not be used for other programs or flow through to other organizations outside of the Board of Health without the expressed written permission by the ministry. As appropriate to the jurisdiction, other health partners may also be engaged (e.g., Public Health Ontario and other Public Health Units).

In addition, the Board of Health (Hub) will be required to provide status reports, per the requirements in Schedule C.

Admissible expenditures are those considered by the ministry to be reasonable and necessary for IPAC Hubs to achieve and/or maintain ongoing IPAC support for CLSs in their region.

SCHEDULE B
RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***One-Time Funding***

One-Time funding may be used for:

- IPAC Hub staff salaries, wages, and benefits
- Overhead costs associated with IPAC Hub delivery services such as: administrative overhead; building occupancy costs; PPE for IPAC Hub staff
- Professional development for IPAC staff (e.g., membership in IPAC Canada, tuition for IPAC course, CIC reimbursement, conferences, etc.)
- Office equipment, communication, and I & IT
- Mileage costs / car rentals / meal allowance as indicated

Non-admissible expenditures are those considered by the ministry to be unrelated to the provision of work of the IPAC Hubs. Examples of non-admissible expenditures include, but are not limited to:

- **Administrative Services on Behalf of Third Parties** – Ministry policy does not permit the use of ministry funds to provide administrative services on behalf of third parties (e.g., payroll).
- **Alcoholic Beverages** – Any expenses related to alcoholic beverages are not considered to be an admissible expense and will not be funded. IPAC Hubs will follow their host organizations Travel, Meal and Hospitality Expenses Directive.
- **Capital expenditures** – any costs related to capital infrastructure.
- **Grants to stakeholders / organizations** - Grants flowed or given to stakeholders/organizations
- **Depreciation on Capital Assets / Amortization** – All types of depreciation and amortization are non-admissible expenses and will not be funded.
- **Donations to Individuals or Organizations** – Ministry policy does not permit the use of government funds to provide donations.
- **Physical items provided to CLSs** (e.g., UV lights for monitoring of environmental cleaning; PPE).

Respiratory Syncytial Virus (RSV) Adult Prevention Program (100%)

One-time funding must be used by the Board of Health to offset extraordinary costs associated with delivering the Respiratory Syncytial Virus (RSV) vaccine.

The RSV Adult Prevention Program is intended for adults aged 60 years and older, living in high-risk settings, including residents living in long-term care homes (LTCHs), Elder Care Lodges, and retirement homes licensed to provide dementia care services. As per other vaccination programs, these settings may rely on varied public health unit support during the roll-out of the RSV vaccine program, including assistance in vaccine administration. Boards of health should refer to the implementation package materials provided with the October 25,

Type of Funding	***One-Time Funding***

2024 memorandum from the Chief Medical Officer of Health for operational details of the RSV Adult Prevention Program.

Eligible costs include:

- Staffing – Salaries and benefits for existing staff or new temporary or casual staff to implement the RSV Adult Prevention Program. Activities include administering the GSK RSV vaccine, meeting provincial and local requirements for surveillance and monitoring, and managing reporting requirements (i.e., activities completed, outcomes such as number of homes visited, number of vaccines administered).
- Travel - Travel expenses for staff delivering services under the RSV Adult Prevention Program away from their home office location.
- Distribution/Transport/Cold Storage Costs – Costs related to public health units completing cold-chain and logistics work (e.g., delivery) of the GSK RSV vaccine to specific high-risk settings, including LTCHs, Elder Care Lodges, and some retirement homes.
- Supplies – Supplies necessary to administer the GSK RSV vaccine (including needles/syringes and disposal, sterile gauze, alcohol, bandages, etc.).
- Communications/Data Processing – Costs related to language interpretation/translation services, media announcements, public and provider awareness, signage, and education materials directly related to RSV immunization outreach.
- Purchased Services - Service level agreements for services/staffing with community providers and/or municipal organizations, hazardous waste disposal, transportation services (e.g., courier services, transporting clients to vaccination clinics), data entry or information technology services for reporting RSV data related to the RSV Adult Prevention Program to the Province from centres in the community that are not operated by the public health unit, outside legal services.
- Other Operating – Recruitment activities, staff training relevant to vaccine administration under the RSV Adult Prevention Program.

Boards of health are expected to be cost efficient and incorporate RSV vaccine activities, including administration supports, into their regular vaccine program activities, as much as possible.

School-Focused Nurses Initiative (100%)

The School-Focused Nurses Initiative was created to support additional nursing FTE capacity in every Board of Health to provide rapid-response support to school boards and schools, child care, and camps in facilitating public health preventative measures related to the COVID-19, including screening, testing, tracing, vaccination, education and mitigation strategies.

Type of Funding	***One-Time Funding***

The school-focused nurses contribute to the following activities in support of school boards and schools:

- Providing support in the development and implementation of COVID-19 health and safety plans;
- Providing sector specific support for infection prevention; vaccinations, surveillance, screening and testing; outbreak management; case and contact management; and,
- Supporting communication and engagement with local school communities, as well as the broader health care sector.

While the priority focus is on the COVID-19 response, the additional nurses may also support the fulfilment of Board of Health requirements to improve the health of school-aged children and youth as per the School Health Program Standard and related guidelines and protocols under the Ontario Public Health Standards. The additional FTEs may also support childcare centres, home childcare premises and other priority settings relating to the health of school-aged children and youth.

The initiative is being implemented with the following considerations:

- Recruitment of Registered Nurses to the extent possible;
- French language and Indigenous (First Nation, Métis, Inuit) service needs;
- Capacity for both in-person and virtual delivery;
- Consistency with existing collective agreements; and,
- Leveraging the Chief Nursing Officer role as applicable in implementing this initiative, as well as coordinating with existing school health, nursing, and related programs and structures within the Board of Health (e.g., School Health Teams, Social Determinants of Health Nurses, Infection Prevention and Control Nurses, and school-based programs such as immunization, oral and vision screening, reproductive health, etc.).

Qualifications required for these positions are:

- Current registration with the College of Nurses of Ontario (i.e., Registered Nurse, Registered Practical Nurse, or Registered Nurse in the Extended Class).

One-time funding must be used to continue the new temporary FTEs for school-focused nurses as specified in Schedule A of the Agreement. Funding is for nursing salaries, wages, and benefits only and cannot be used to support other operating costs. Additional costs incurred by the Board of Health to support school re-opening initiatives that cannot be managed within the existing budget of the Board of Health, are admissible through the COVID-19 extraordinary costs process.

Type of Funding	***One-Time Funding***

Strengthening Public Health: Merger Planning (100%)

One-time funding must be used by the Board of Health to offset extraordinary costs associated with merger planning, feasibility assessments, and development of a merger business case. Eligible costs for merger planning include consultant services and staffing resources including salaries and benefits, inclusive of overtime, for current or temporary staff to support merger planning activities.

Costs related to merger implementation are not admissible. Implementation costs can be submitted as part of the Board of Health's Voluntary Merger Business Case to support merger implementation and/or business continuity/stabilization costs.

Boards of health are expected to streamline costs, seek efficiencies within existing processes, work collaboratively with other boards of health exploring mergers, and share reports and outcomes of merger planning/feasibility assessments with the Province.

Type of Funding ***Other***

Infectious Diseases Programs Reimbursement

Funding for Infectious Diseases Programs will be provided on a case-by-case basis through direct reimbursement. These funds are provided to offset the costs of treatment medications not made available through the Ontario Government Pharmaceutical and Medical Supply Service (OGPMSS).

To be reimbursed, original receipts and client identification information needs to be submitted to the Infectious Diseases Section of the Health Protection and Surveillance Policy and Programs Branch (Office of Chief Medical Officer of Health, Public Health). Clients will not be directly reimbursed.

Questions about the reimbursement process and expense eligibility can be submitted to the following email: IDPP@ontario.ca.

Leprosy

The Board of Health may submit claims on a case-by-case basis for medication costs related to the treatment of Leprosy. As per Chapter A: Leprosy, of the Infectious Diseases Protocol, 2018 (or as current), treatment should be under the direction of an infectious disease specialist and should refer to World Health Organization (WHO) treatment recommendations.

Tuberculosis

The Board of Health may submit claims on a case-by-case basis for second-line and select adjunct medications related to the treatment of active tuberculosis and latent tuberculosis infection. For more information on the reimbursement process, see section 9 of the Tuberculosis Program Guideline, 2018 (or as current).

Vaccine Programs Reimbursement

Funding on a per dose basis will be provided to the Board of Health for the administration of influenza, meningococcal, and human papillomavirus (HPV) vaccines.

In order to claim the vaccine administration fees, the Board of Health is required to submit, as part of the Standards Activity Reports or other reports as requested by the Province, the number of doses administered. Reimbursement by the Province will be made on a quarterly basis based on the information.

The Board of Health is required to ensure that the vaccine information submitted in the Standards Activity Reports, or other reports requested by the Province, accurately reflects the vaccines administered.

Type of Funding ***Other***

Influenza

- The Province will continue to pay $5.00/dose for the administration of the influenza vaccine.
- All doses administered by the Board of Health to individuals aged 6 months or older who live, work or attend school in Ontario.

Meningococcal

- The Province will continue to pay $8.50/dose for the administration of the meningococcal vaccine.
- Routine immunization program: Doses administered as part of the grade 7 school-based or catch-up program for eligible students up to grade 12.
- Men-C-C doses if given in substitution of Men-C-ACYW135 for routine doses.

Note: Doses administered through the high-risk program are not eligible for reimbursement.

Human Papillomavirus (HPV)

- The Province will continue to pay $8.50/dose for the administration of the HPV vaccine.
- Routine immunization program: Doses administered as part of the grade 7 school-based or catch-up program for eligible students up to grade 12.
- High-risk program: MSM <26 years of age.

SCHEDULE C
REPORTING REQUIREMENTS

The reports mentioned in this Schedule are provided for every Board of Health Funding Year unless specified otherwise by the Province.

The Board of Health is required to provide the following reports/information in accordance with direction provided in writing by the Province (and according to templates provided by the Province):

Name of Report	Reporting Period	Due Date
1. Annual Service Plan and Budget Submission	For the entire Board of Health Funding Year	March 1 of the current Board of Health Funding Year
2. Quarterly Standards Activity Reports		
Q2 Standards Activity Report	For Q1 and Q2	July 31 of the current Board of Health Funding Year
Q3 Standards Activity Report	For Q3	October 31 of the current Board of Health Funding Year
Q4 Standards Activity Report	For Q4	January 31 of the following Board of Health Funding Year
3. Annual Report and Attestation	For the entire Board of Health Funding Year	April 30 of the following Board of Health Funding Year
4. Annual Reconciliation Report	For the entire Board of Health Funding Year	April 30 of the following Board of Health Funding Year
5. Infection Prevention and Control Hubs	For the period of April 1, 2023 to March 31, 2024	As directed by the Province
6. MOH / AMOH Compensation Initiative Application	For the entire Board of Health Funding Year	As directed by the Province
7. Other Reports and Submissions	As directed by the Province	As directed by the Province

Definitions

For the purposes of this Schedule, the following words shall have the following meanings:
"Q1" means the period commencing on January 1st and ending on the following March 31st
"Q2" means the period commencing on April 1st and ending on the following June 30th
"Q3" means the period commencing on July 1st and ending on the following September 30th
"Q4" means the period commencing on October 1st and ending on the following December 31st

Report Details

Annual Service Plan and Budget Submission

- The Annual Service Plan and Budget Submission Template sets the context for reporting required of the Board of Health to demonstrate its accountability to the Province.
- When completed by the Board of Health, it will: describe the complete picture of programs and services the Boards of Health will be delivering within the context of the Ontario Public

Health Standards; demonstrate that Board of Health programs and services align with the priorities of its communities, as identified in its population health assessment; demonstrate accountability for planning – ensure the Board of Health is planning to meet all program requirements in accordance with the Ontario Public Health Standards, and ensure there is a link between demonstrated needs and local priorities for program delivery; demonstrate the use of funding per program and service.

Quarterly Standards Activity Reports

- The Quarterly Standards Activity Reports will provide financial forecasts and interim information on program achievements for all programs governed under the Agreement.
- Through these Standards Activity Reports, the Board of Health will have the opportunity to identify risks, emerging issues, changes in local context, and programmatic and financial adjustments in program plans.
- The Quarterly Standards Activity Reports shall be signed on behalf of the Board of Health by an authorized signing officer.

Annual Report and Attestation

- The Annual Report and Attestation will provide a year-end summary report on achievements on all programs governed under the Agreement, in all accountability domains under the Organizational Requirements, and identification of any major changes in planned activities due to local events.
- The Annual Report will include a narrative report on the delivery of programs and services, fiduciary requirements, good governance and management, public health practice, and other issues, year-end report on indicators, and a board of health attestation on required items.
- The Annual Report and Attestation shall be signed on behalf of the Board of Health by an authorized signing officer.

Annual Reconciliation Report

- The Board of Health shall provide to the Province an Annual Reconciliation Report for funding provided for public health programs governed under the Accountability Agreement.
- The Annual Reconciliation Report must contain: Audited Financial Statements; and, Auditor's Attestation Report in the Province's prescribed format.
- The Annual Reconciliation Report shall be signed on behalf of the Board of Health by an authorized signing officer.

COVID-19 Reporting

- The Board of Health shall complete and submit actual and forecasted expenditures associated with COVID-19 extraordinary costs (for both the COVID-19 Vaccine Program and the COVID-19 General Program) through the submission of a COVID-19 Expense Form as part of financial reports to the Province.
- Reports shall be signed on behalf of the Board of Health by an authorized signing officer.

SCHEDULE C
REPORTING REQUIREMENTS

Infection Prevention and Control (IPAC) Hub Reports

- The Board of Health shall provide to the Province quarterly status reports for one-time funding provided for the Infection Prevention and Control (IPAC) Hub in addition to identifying concerns and emerging issues in a timely way and contribute to shared problem solving. Reports will include:
    - Operational targets and progress; and
    - Changes in human resources within the IPAC Hub.

MOH / AMOH Compensation Initiative Application

- The Board of Health shall complete and submit an annual application to participate in this Initiative and be considered for funding.
- Supporting documentation such as employment contracts must be provided by the Board of Health, as requested by the Province.
- Application form templates and eligibility criteria/guidelines shall be provided by the Province.

SCHEDULE D

BOARD OF HEALTH FINANCIAL CONTROLS

Financial controls support the integrity of the Board of Health's financial statements, support the safeguarding of assets, and assist with the prevention and/or detection of significant errors including fraud. Effective financial controls provide reasonable assurance that financial transactions will include the following attributes:

- **Completeness** – all financial records are captured and included in the Board of Health's financial reports;
- **Accuracy** – the correct amounts are posted in the correct accounts;
- **Authorization** – the correct levels of authority (i.e., delegation of authority) are in place to approve payments and corrections including data entry and computer access;
- **Validity** – invoices received and paid are for work performed or products received and the transactions properly recorded;
- **Existence** – assets and liabilities and adequate documentation exists to support the item;
- **Error Handling** – errors are identified and corrected by appropriate individuals;
- **Segregation of Duties** – certain functions are kept separate to support the integrity of transactions and the financial statements; and,
- **Presentation and Disclosure** – timely preparation of financial reports in line with the approved accounting method (e.g., Generally Accepted Accounting Principles (GAAP)).

The Board of Health is required to adhere to the principles of financial controls, as detailed above. The Board of Health is required to have financial controls in place to meet the following objectives:

1. Controls are in place to ensure that financial information is accurately and completely collected, recorded, and reported.

Examples of potential controls to support this objective include, but are not limited to:

- Documented policies and procedures to provide a sense of the organization's direction and address its objectives.
- Define approval limits to authorize appropriate individuals to perform appropriate activities.
- Segregation of duties (e.g., ensure the same person is not responsible for ordering, recording, and paying for purchases).
- An authorized chart of accounts.
- All accounts reconciled on a regular and timely basis.
- Access to accounts is appropriately restricted.
- Regular comparison of budgeted versus actual dollar spending and variance analysis.
- Exception reports and the timeliness to clear transactions.
- Electronic system controls, such as access authorization, valid date range test, dollar value limits, and batch totals, are in place to ensure data integrity.
- Use of a capital asset ledger.
- Delegate appropriate staff with authority to approve journal entries and credits.
- Trial balances including all asset accounts that are prepared and reviewed by supervisors on a monthly basis.

2. Controls are in place to ensure that revenue receipts are collected and recorded on a timely basis.

Examples of potential controls to support this objective include, but are not limited to:

- Independent review of an aging accounts receivable report to ensure timely clearance of accounts receivable balances.
- Separate accounts receivable function from the cash receipts function.
- Accounts receivable sub-ledger is reconciled to the general ledger control account on a regular and timely basis.
- Original source documents are maintained and secured to support all receipts and expenditures.

3. Controls are in place to ensure that goods and services procurement, payroll and employee expenses are processed correctly and in accordance with applicable policies and directives.

Examples of potential controls to support this objective include, but are not limited to:

- Policies are implemented to govern procurement of goods and services and expense reimbursement for employees and board members.
- Use appropriate procurement method to acquire goods and services in accordance with applicable policies and directives.
- Segregation of duties is used to apply the three (3) way matching process (i.e., matching 1) purchase orders, with 2) packing slips, and with 3) invoices).
- Separate roles for setting up a vendor, approving payment, and receiving goods.
- Separate roles for approving purchases and approving payment for purchases.
- Processes in place to take advantage of offered discounts.
- Monitoring of breaking down large dollar purchases into smaller invoices in an attempt to bypass approval limits.
- Accounts payable sub-ledger is reconciled to the general ledger control account on a regular and timely basis.
- Employee and Board member expenses are approved by appropriate individuals for reimbursement and are supported by itemized receipts.
- Original source documents are maintained and secured to support all receipts and expenditures.
- Regular monitoring to ensure compliance with applicable directives.
- Establish controls to prevent and detect duplicate payments.
- Policies are in place to govern the issue and use of credit cards, such as corporate, purchasing or travel cards, to employees and board members.
- All credit card expenses are supported by original receipts, reviewed and approved by appropriate individuals in a timely manner.
- Separate payroll preparation, disbursement and distribution functions.

4. Controls are in place in the fund disbursement process to prevent and detect errors, omissions or fraud.

Examples of potential controls include, but are not limited to:

- Policy in place to define dollar limit for paying cash versus cheque.
- Cheques are sequentially numbered and access is restricted to those with authorization to issue payments.
- All cancelled or void cheques are accounted for along with explanation for cancellation.
- Process is in place for accruing liabilities.
- Stale-dated cheques are followed up on and cleared on a timely basis.
- Bank statements and cancelled cheques are reviewed on a regular and timely basis by a person other than the person processing the cheques / payments.
- Bank reconciliations occur monthly for all accounts and are independently reviewed by someone other than the person authorized to sign cheques.

Southwestern Public Health (SWPH)

January 2024

Control	Description	Completed at Month End Y/N/NA	Responsibility
CASH			
Deposit of cheques/cash	Mail is opened by the Corporate Services Executive Assistant. Any cash payments are processed in the cash register by frontline staff. Daily closing of the cash register is processed by the Payroll & Benefits Administrator (St. Thomas) and the Administrative Assistant (Woodstock). The Accounting Supervisor prepares the deposits and Journal Entry summary which is approved by the Director of Finance.		Acct Supervisor
Bank Reconciliations	Bank reconciliations are prepared monthly by the Accounting Supervisor for all accounts. The Director of Finance reviews the reconciliations to identify any unusual reconciling items. Director of Finance reviews and initials the bank deposits.		Acct Supervisor
Cheques	the Accounting Supervisor ensures all outstanding cheques less than six months old. The Director of Finance reviews all outstanding cheques along with the bank reconciliations.		Acct Supervisor
Petty Cash	The Accounting Supervisor reconciles petty cash monthly if used (Petty cash on hand + reimbursement vouchers = Balance per G/L) and the Director of Finance initials the reconciliation.		Acct Supervisor
ACCOUNTS RECEIVABLE			
Receivables	Receivables are tracked in excel monthly by the Accounting Supervisor and they are supported by detailed schedules that reflect all transactions that have occurred in the month (includes taxes, employees etc.) The Director of Finance agrees to financials monthly.		Acct Supervisor
Sub ledger	No subledger exists; therefore no reconciliation performed		Director of Finance
INVENTORY			
Inventory	Inventory is currently maintained in central supply. Access is restricted by use of a FOB and access is granted only to Managers, Program Assistants, and CEO. A perpetual inventory control system is in place.		Director of Finance
PREPAIDS			
Prepaids	All prepaids are tracked monthly by the Accounting Supervisor and they are amortized over their remaining useful life. All prepaids are agreed to supporting invoices. The Director of Finance agrees to financials monthly.		Acct Supervisor
FIXED ASSETS			
Fixed assets subledger	The Office Manager maintains the fixed asset listing. The Director of Finance reviews the fixed asset subledger quarterly for accuracy and completeness. All transactions are tracked in an excel spreadsheet and agreed to invoices and compared to the budgeted amounts.		Director of Finance
Write-offs	All assets that have been sold, damaged or are no longer in use are written off by the Director of Finance when informed by the manager after and after review and approval from the Chief Executive Officer.		Director of Finance and the CEO
Repairs & maintenance	The Director of Finance reviews the repair and maintenance accounts monthly to ensure all expenditures have been accounted for in accordance with SWPH's capital policy.		Director of Finance
ACCOUNTS PAYABLE			

Processing Accounts Payable	POs are generated for all purchases in accordance with SWPH's procurement policy (see "Procurement Policy") for authorization levels. Goods that are received must have an initial on the purchase order/ paper requisition (if applicable). All invoices whether attached to a packing slip or not are sent to the appropriate personnel and signed to verify the goods were received and the pricing terms are correct. Invoices are then sent to the Accounting Supervisor who codes the invoices and sends them to the Director of Finance for review. The Director of Finance reviews the allocation to the G/L, pricing, terms, ensures authorized approval and initials them.		Accounting Supervisor
Payment of Accounts Payable	Cheque runs are printed twice a month – on the 5th and 20th of the month and additional runs, as required. The Accounting Supervisor processes the cheques/EFTs to be signed and attaches a copy of each cheque/EFT to the appropriate invoice and sends it to be signed. The Director of Finance reviews and signs the cheques/EFTs and ensures again that the invoices have been approved for payment. She also reviews the cheque register provided with the cheque run. Once the Director of Finance has reviewed, the cheques and invoices are sent to CEO for review and signature. The CEO sets aside any unusual items if she feels they need a further explanation. All cheques require dual signatures (one of which must be CEO). Cheques are kept in a locked cabinet accessible only by the Accounting Supervisor or the Director of Finance. The computer processes the numbers on the cheques and does not allow for duplication.		Accounting Supervisor
Sub ledger	The Accounts Payable subledger is reviewed monthly by the Director of Finance and agreed to the Accounts Payable balance.		Director of Finance
Invoices compared to PO's	Each time EFTs/cheques are issued the Payroll and Benefits Administrator will randomly select 5 invoices and ensure there is an approved PO attached, ensure the PO is dated prior to the invoice date, and that the purchase was with the approved authority schedule and limits		Administrative Assistant
Vendor Purchase Summary	Quarterly the Acct Supervisor/Payroll Coordinator will summarize total purchases by vendor and ensure the value of the purchases fall in line with the procurement policy.		Administrative Assistant
ACCRUED LIABILITIES			
Accrued liabilities	The Accounting Supervisor tracks all accrued liabilities monthly in an excel spreadsheet and agrees to the GL. The Director of Finance verifies to monthly financial statements.		Accounting Supervisor/Dir of Finance
PAYROLL			
Processing Payroll	All employees must record their time daily in Dayforce. The CEO, Authorized Directors and Managers have access to the Dayforce system and can view time reports at any time. Supervisors must approve each of their assigned staffs timesheets. If the timesheets are not approved, the Payroll & Benefits Administrator will follow-up with the Supervisor to ensure hours are correctly recorded. At the end of the pay period the Payroll & Benefits Administrator reviews all the time entries to ensure all are approved and identify any issues. The Payroll & Benefits Administrator then makes any necessary adjustments to payroll such as mileage claims, expenses, etc.		Payroll and Benefits Administrator
Payroll Approval	Once all payroll information is entered, the Payroll & Benefits Administrator provides the Director of Finance with a copy of the preview for review. Once approved, the Payroll & Benefits Administrator processes the payroll and completes the required journal entries monthly. The Director of Finance reviews the manual information and signs off on the final submitted payroll register.		Payroll and Benefits Administrator

Payroll Approval - One-Offs	Whenever there is a special pay (e.g. overtime payout, responsibility pay), the appropriate Laserfiche form must be completed and signed by the Chief Executive Officer. Any payments beyond a certain threshold must also be reviewed and initialed by a second person (either the Accounting Supervisor or the Director of Finance).		Payroll and Benefits Administrator
Source Deductions	All Source deductions are remitted after each payroll by "Ceridian Dayforce", the company used to process our payroll. The Director of Finance receives and reviews the monthly statement provided by the Government confirming remittance (online).		Payroll and Benefits Administrator
Pension Filings	The Payroll & Benefits Administrator prepares and submits the pension filings monthly. The amounts are reconciled by employee to the payroll register and submitted via EFT.		Payroll & Benefits Administrator
Balance Sheet Reconciliation	The Payroll & Benefits Administrator reconciles the balance sheet and ensures they agree to the GL balances.		Payroll & Benefits Administrator
Benefits Reconciliations	The Payroll & Benefits Administrator reconciles the benefits invoice from Sunlife monthly to ensure only active employees are included and each employee is correctly categorized.		Payroll & Benefits Administrator
MISCELLANEOUS			
HST	The HST return is completed quarterly by the Accounting Supervisor and reviewed and initialed by the Director of Finance after the Accounting Supervisor files. The Accounting Supervisor then books the necessary journal entries when the funds are received.		Accounting Supervisor
Corporate Credit Cards	There are four corporate credit cards. The Accounting Supervisor reconciles them monthly and processes them the same as accounts payable (see AP above for detailed procedures).		Accounting Supervisor
Staff Expenses	All staff expenses are processed through payroll. Staff must complete an expense form which is signed and approved by their supervisor. The form is then submitted to the Payroll & Benefits Administrator for processing with payroll. The Director of Finance reviews along with the payroll register.		Payroll & Benefits Administrator
Settlement Forms	Settlement forms are completed annually by the auditors. Upon completion the forms are reviewed by the Director of Finance, reviewed and approved by CEO before providing to the Board for final approval.		Director of Finance and the CEO
FINANCIAL STATEMENTS			
Monthly internals	Financial statements are generated monthly and are compared to budget. The financials are provided to the appropriate Directors/Managers to review their financials and note any reasons for variances to budget. The internals along with summary notes are provided to the CEO monthly to review as well and discuss with direct reports.		Accounting Supervisor and CEO
Board Statements	Financial statements are generated Quarterly and provided to the Board of Health. CEO reviews them at the Board of Health and highlights any discrepancies. During the Board meeting any additional questions are asked and the statements are approved.		Director of Finance and the CEO
Mandatory Quarterly Reporting to the Ministry	Quarterly financial reports are completed by the Director of Finance in the template provided by the Ministry. Once complete, the CEO reviews and approves before the forms are electronically submitted to the Ministry.		Director of Finance and the CEO
HBHC, PPNP, and Quarterly Reporting	Quarterly financial reports are completed by the Director of Finance and then reviewed by the Program Manager. Once complete, the CEO reviews and approves before the forms are electronically submitted to the Ministry.		Director of Finance and the CEO

ATTENTION TO RELATIONSHIP MANAGER

As per the approved CCR in connection with the attached credit agreement, your client may have a BA credit facility in combination with an interest rate swap.

Prior to providing this credit agreement to your client, please engage your partners in the Risk Solutions Group to ensure amendments to both the loan and swap contracts are coordinated to avoid a rate mismatch.

Derivative Solutions contacts:

B.C. and Ontario Real Estate: Irshad Khan and Nathasha Nguyen
AB and MSNWO: Quinn Durrant, Muskaan Gauri
Ontario and Atlantic: Jon Jonsson, Lana Difrancescomarino and Nathasha Nguyen
Quebec: Jean-François Dépelteau and Karen Théorêt

Royal Bank of Canada
Commercial Financial Services
148 Fullarton ST
London, ON N6A 5P3

Private and Confidential

April 8, 2024

OXFORD ELGIN ST. THOMAS HEALTH UNIT
1230 Talbot Street
St. Thomas, ON
N5P 1G9

ROYAL BANK OF CANADA (the **"Bank"**) hereby confirms the credit facilities described below (the **"Credit Facilities"**) subject to the terms and conditions set forth below and in the attached Terms & Conditions and Schedules (collectively the **"Agreement"**). This Agreement amends and restates without novation the existing agreement dated January 9, 2019 and any amendments thereto. Any amount owing by the Borrower to the Bank under such previous agreement is deemed to be a Borrowing under this Agreement. Any and all security that has been delivered to the Bank and is set forth as Security below, shall remain in full force and effect, is expressly reserved by the Bank and, unless expressly indicated otherwise, shall apply in respect of all obligations of the Borrower under the Credit Facilities. Unless otherwise provided, all dollar amounts are in Canadian currency.

The Bank reserves all of its rights and remedies at any time and from time to time in connection with any or all breaches, defaults or Events of Default now existing or hereafter arising under this Agreement or any other agreement delivered to the Bank, and whether known or unknown, and this Agreement shall not be construed as a waiver of any such breach, default or Event of Default.

BORROWER: Oxford Elgin St. Thomas Health U (the **"Borrower"**)

CREDIT FACILITIES

Facility #1: $800,000.00 revolving demand facility by way of:

a) RBP based loans (**"RBP Loans"**)

Revolve in increments of:	$5,000.00	Minimum retained balance:	$0.00
Revolved by:	Bank	Interest rate (per annum):	RBP – 0.25%

PURPOSE
Facility #1

Finance general operating requirements.

AVAILABILITY
The Borrower may borrow, repay and reborrow up to the amount of this facility provided this facility is made available at the sole discretion of the Bank and the Bank may cancel or restrict the availability of any unutilized portion at any time and from time to time without notice.

REPAYMENT
Notwithstanding compliance with the covenants and all other terms and conditions of this Agreement, Borrowings under this facility are repayable on demand.

GENERAL ACCOUNT
The Borrower shall establish a current account with the Bank (the **"General Account"**) for the conduct of the Borrower's day-to-day banking business. The Borrower authorizes the Bank daily or otherwise as and when determined by the Bank, to ascertain the balance of the General Account and:

a) if such position is a debit balance the Bank may, subject to the revolving increment amount and minimum retained balance specified in this Agreement, make available a Borrowing by way of RBP Loans under this facility;
b) if such position is a credit balance, where the facility is indicated to be Bank revolved, the Bank may, subject to the revolving increment amount and minimum retained balance specified in this Agreement, apply the amount of such credit balance or any part as a repayment of any Borrowings outstanding by way of RBP Loans under this facility;
c) if such position is a credit balance, where this facility is indicated to be Borrower revolved, the Bank will apply repayments on such facility only if so advised and directed by the Borrower.

Facility #2: $6,868,000.00 non-revolving term facility by way of:

a) RBP Loans	Interest rate (per annum):	RBP + 0.50%
b) Daily Simple CORRA based loans (**"Daily CORRA Loans"**)	Interest rate (per annum):	Daily Simple CORRA + 0.69%
c) Term CORRA based loans (**"Term CORRA Loans"**)	Interest rate (per annum):	Term CORRA Rate + 0.69%

PURPOSE
Facility #2

Finance owner occupied real estate.

AVAILABILITY
This facility is fully drawn by way of BAs. The Borrower may convert (in the case of a CORRA Borrowing, not before its expiry) up to the amount of this term facility provided this facility is made available at the sole discretion of the Bank and the Bank may cancel or restrict availability of any unutilized portion of this facility at any time from time to time without notice.

REPAYMENT
Borrowings under this facility are repayable by consecutive monthly principal payments, as per schedule to be provided by RBC Capital Markets, based on a maximum amortization of 360 months. All Borrowings then outstanding under this facility, together with all accrued but unpaid interest, costs, expenses and fees owing thereon, are due and payable on January 2, 2029.

OTHER FACILITIES
The Credit Facilities are in addition to the following facilities (the **"Other Facilities"**). The Other Facilities will be governed by this Agreement and separate agreements between the Borrower and the Bank. In the event of a conflict between this Agreement and any such separate agreement, the terms of the separate agreement will govern.

a) Credit Card to a maximum amount of $115,000.00 available in Canadian currency and US currency;

b) All Interest Rate and Commodity Derivatives outstanding at any time and from time to time.

OTHER FEES
Renewal Fee:
If the Bank renews or extends any term facility or term loan beyond its Maturity Date, an additional renewal fee may be payable in connection with any such renewal in such amount as the Bank may determine and notify the Borrower.

SECURITY
Security for the Borrowings and all other obligations of the Borrower to the Bank, including, without limitation, any amounts outstanding under any Leases, if applicable, (collectively, the **"Security"**), shall include:

a) General security agreement on the Bank's form 924 signed by the Borrower constituting a first ranking security interest in all personal property of the Borrower.

REPORTING REQUIREMENTS
The Borrower will provide the following to the Bank:

a) Annual audited financial statements for the Borrower, within 180 days of each fiscal year end;

b) Annual budget for the Borrower, for the next following fiscal year, within 180 days of each fiscal year end; and

c) such other financial and operating statements and reports as and when the Bank may reasonably require.

CONDITIONS PRECEDENT

In no event will the Credit Facilities or any part thereof be available unless the Bank has received:

a) a duly executed copy of this Agreement;

b) the Security provided for herein, registered, as required, to the satisfaction of the Bank;

c) such financial and other information or documents relating to the Borrower or any Guarantor if applicable as the Bank may reasonably require; and

d) such other authorizations, approvals, opinions and documentation as the Bank may reasonably require.

Additionally:

e) all documentation to be received by the Bank shall be in form and substance satisfactory to the Bank;

GOVERNING LAW JURISDICTION

Province of Saskatchewan.

ACCEPTANCE

This Agreement is open for acceptance until May 8, 2024 after which date it will be null and void, unless extended by the Bank in its sole discretion.

ROYAL BANK OF CANADA

Per: _____
Title: Vice President

RBC Contact: Nathan Cross

/rn

We acknowledge and accept the terms and conditions of this Agreement on this _____ day of _____, _____.

OXFORD ELGIN ST. THOMAS HEALTH UNIT

Per: _____
Name:
Title:

Per: _____
Name:
Title:

I/We have authority to bind the Borrower.

/attachments:
Terms and Conditions
Schedules:

- Definitions
- Calculation and Payment of Interest and Fees
- Notice Requirements
- Additional Borrowing Conditions

TERMS AND CONDITIONS

The Bank is requested by the Borrower to make the Credit Facilities available to the Borrower in the manner and at the rates and times specified in this Agreement. Terms defined elsewhere in this Agreement and not otherwise defined in the Terms and Conditions below or the Schedules attached hereto have the meaning given to such terms as so defined. In consideration of the Bank making the Credit Facilities available, the Borrower agrees, and if the Borrower is comprised of more than one Person, such Persons jointly and severally agree, or in Quebec solidarily agree, with the Bank as follows:

REPAYMENT
Amounts outstanding under the Credit Facilities, together with interest, shall become due in the manner and at the rates and times specified in this Agreement and shall be paid in the currency of the Borrowing. Unless the Bank otherwise agrees, any payment hereunder must be made in money which is legal tender at the time of payment. In the case of a demand facility of any kind, the Borrower shall repay all principal sums outstanding under such facility upon demand. Where any Borrowings are repayable by scheduled blended payments, such payments shall be applied, firstly, to interest due, and the balance, if any, shall be applied to principal outstanding. If any such payment is insufficient to pay all interest then due, the unpaid balance of such interest will be added to such Borrowing, will bear interest at the same rate, and will be payable on demand or on the date specified herein, as the case may be. Borrowings repayable by way of scheduled payments of principal and interest shall be so repaid with any balance of such Borrowings being due and payable as and when specified in this Agreement. The Borrower shall ensure that the maturities of instruments or contracts selected by the Borrower when making Borrowings will be such so as to enable the Borrower to meet its repayment obligations. For any Borrowings that are repayable by scheduled payments, if the scheduled payment date is changed then the Maturity Date of the applicable Borrowings shall automatically be amended accordingly. For any Borrowings that are repayable by scheduled blended payments, if the Borrower converts such Borrowings to a CORRA Borrowing , blended principal and interest payments shall no longer apply and the Borrowings shall be repayable by way of principal plus interest payments.

In the case of any reducing term loan and/or reducing term facility (**"Reducing Term Loan/Facility"**), provided that nothing contained in this paragraph shall confer any right of renewal or extension upon the Borrower, the Borrower and the Bank agree that, at the Bank's option, the Bank may provide a letter (**"Renewal Letter"**) to the Borrower setting out the terms upon which the Bank is prepared to extend the Reducing Term Loan/Facility. In the event that the Bank provides a Renewal Letter to the Borrower and the Reducing Term Loan/Facility is not repaid on or before the Maturity Date of the applicable Reducing Term Loan/Facility, then at the Bank's option the Reducing Term Loan/Facility shall be automatically renewed on the terms set out in the Renewal Letter and the terms of this Agreement shall be amended accordingly.

PREPAYMENT
Where Borrowings are by way of RBP Loans, the Borrower may prepay such Borrowings in whole or in part without fee or premium.

The prepayment of any Borrowings under a term facility and/or any term loan will be made in the reverse order of maturity.

EVIDENCE OF INDEBTEDNESS
The Bank shall maintain accounts and records (the **"Accounts"**) evidencing the Borrowings made available to the Borrower by the Bank under this Agreement. The Bank shall record the principal amount of such Borrowings, the payment of principal and interest on account of the Borrowings, and all other amounts becoming due to the Bank under this Agreement. The Accounts constitute, in the absence of manifest error, conclusive evidence of the indebtedness of the Borrower to the Bank pursuant to this Agreement. The Borrower authorizes and directs the Bank to automatically debit, by mechanical, electronic or manual means, any bank account of the Borrower for all amounts payable under this Agreement, including, but not limited to, the repayment of principal and the payment of interest, fees and all charges for the keeping of such bank accounts.

GENERAL COVENANTS

Without affecting or limiting the right of the Bank to terminate or demand payment of, or cancel or restrict availability of any unutilized portion of, any demand or other discretionary facility, the Borrower covenants and agrees with the Bank that the Borrower:

a) will pay all sums of money when due under the terms of this Agreement;
b) will immediately advise the Bank of any event which constitutes or which, with notice, lapse of time or both, would constitute a breach of any covenant or other term or condition of this Agreement or any Security or an Event of Default;
c) will file all material tax returns which are or will be required to be filed by it, pay or make provision for payment of all material taxes (including interest and penalties) and Potential Prior-Ranking Claims, which are or will become due and payable and provide adequate reserves for the payment of any tax, the payment of which is being contested;
d) will comply with all Applicable Laws, including, without limitation, all Environmental and Health and Safety Laws;
e) will immediately advise the Bank of any action requests or violation notices received concerning the Borrower and hold the Bank harmless from and against any losses, costs or expenses which the Bank may suffer or incur for any environment related liabilities existent now or in the future with respect to the Borrower;
f) will deliver to the Bank such financial and other information as the Bank may reasonably request from time to time, including, but not limited to, the reports and other information set out under Reporting Requirements;
g) will immediately advise the Bank of any unfavorable change in its financial position which may adversely affect its ability to pay or perform its obligations in accordance with the terms of this Agreement;
h) will keep its assets fully insured against such perils and in such manner as would be customarily insured by Persons carrying on a similar business or owning similar assets and, in addition, for any buildings located in areas prone to flood and/or earthquake, will insure and keep fully insured such buildings against such perils;
i) except for Permitted Encumbrances, will not, without the prior written consent of the Bank, grant, create, assume or suffer to exist any mortgage, charge, lien, pledge, security interest or other encumbrance affecting any of its properties, assets or other rights;
j) will not, without the prior written consent of the Bank, guarantee or otherwise provide for, on a direct, indirect or contingent basis, the payment of any monies or performance of any obligations by any other Person, except as may be provided for herein;
k) to provide the Bank with prompt written notice if it merges or amalgamates with any other Person;
l) will permit the Bank or its representatives, from time to time, i) to visit and inspect the Borrower's premises, properties and assets and examine and obtain copies of the Borrower's records or other information, ii) to collect information from any entity regarding any Potential Prior-Ranking Claims and iii) to discuss the Borrower's affairs with the auditors, counsel and other professional advisers of the Borrower. The Borrower hereby authorizes and directs any such third party to provide to the Bank or its representatives all such information, records or documentation requested by the Bank;
m) to provide the Bank with prompt written notice of any request, application or decision made pursuant to the *Freedom of Information and Protection of Privacy Act* or other applicable freedom of information legislation that relates or may relate in any way to this Agreement or any Security given in connection therewith;
n) it will ensure that its indebtedness under this Agreement will rank at least pari passu with all its other unsecured and unsubordinated indebtedness from time to time with the exception of its preferred liabilities arising by operation of law; and
o) will not use the proceeds of any Credit Facility for the benefit or on behalf of any Person other than the Borrower.

FEES, COSTS AND EXPENSES

The Borrower agrees to pay the Bank all fees stipulated in this Agreement and all fees charged by the Bank relating to the documentation or registration of this Agreement and the Security. In addition, the Borrower agrees to pay all fees (including legal fees), costs and expenses incurred by the Bank in connection with the preparation, negotiation, documentation and registration of this Agreement and any Security and the administration, operation, termination, enforcement or protection of its rights in connection with this Agreement and the Security. The Borrower shall indemnify and hold the Bank harmless against any loss, cost or expense incurred by the Bank if any facility under the Credit Facilities is repaid or prepaid other than on its Maturity Date. The determination by the Bank of such loss, cost or expense shall be conclusive and binding for all purposes and shall include, without limitation, any loss incurred by the Bank in liquidating or redeploying deposits acquired to make or maintain any facility.

GENERAL INDEMNITY
The Borrower hereby agrees to indemnify and hold the Bank and its directors, officers, employees and agents harmless from and against any and all claims, suits, actions, demands, debts, damages, costs, losses, obligations, judgements, charges, expenses and liabilities of any nature which are suffered, incurred or sustained by, imposed on or asserted against any such Person as a result of, in connection with or arising out of i) any breach of any term or condition of this Agreement or any Security or any other agreement delivered to the Bank by the Borrower or any Guarantor if applicable, or any Event of Default, ii) the Bank acting upon instructions given or agreements made by electronic transmission of any type, iii) the presence of Contaminants at, on or under or the discharge or likely discharge of Contaminants from, any properties now or previously used by the Borrower or any Guarantor and iv) the breach of or non- compliance with any Applicable Law by the Borrower or any Guarantor.

AMENDMENTS AND WAIVERS
Save and except for any waiver or extension of the deadline for acceptance of this Agreement at the Bank's sole discretion, which may be communicated in writing, verbally, or by conduct, no amendment or waiver of any provision of this Agreement will be effective unless it is in writing, signed by the Borrower and the Bank. No failure or delay, on the part of the Bank, in exercising any right or power hereunder or under any Security or any other agreement delivered to the Bank shall operate as a waiver thereof. Each Guarantor, if applicable, agrees that the amendment or waiver of any provision of this Agreement (other than agreements, covenants or representations expressly made by any Guarantor herein, if any) may be made without and does not require the consent or agreement of, or notice to, any Guarantor. Any amendments requested by the Borrower will require review and agreement by the Bank and its counsel. Costs related to this review will be for the Borrower's account.

SUCCESSORS AND ASSIGNS
This Agreement shall extend to and be binding upon the parties hereto and their respective heirs, executors, administrators, successors and permitted assigns. The Borrower shall not be entitled to assign or transfer any rights or obligations hereunder, without the consent in writing of the Bank. The Bank may assign or transfer all or any part of its rights and obligations under this Agreement to any Person. The Bank may disclose to potential or actual assignees or transferees confidential information regarding the Borrower and any Guarantor if applicable, (including, any such information provided by the Borrower, and any Guarantor if applicable, to the Bank) and shall not be liable for any such disclosure.

GAAP
Unless otherwise provided, all accounting terms used in this Agreement shall be interpreted in accordance with Canadian Generally Accepted Accounting Principles, as appropriate, for publicly accountable enterprises, private enterprises, not-for-profit organizations, pension plans and in accordance, as appropriate, with Public Sector Accounting Standards for government organizations in effect from time to time, applied on a consistent basis from period to period. All financial statements and/or reports shall be prepared using one of the above bases of presentation, as appropriate, including, without limitation, the application of accrual accounting. Except for the transition of accounting standards in Canada, any change in accounting principles or the application of accounting principles is only permitted with the prior written consent of the Bank.

SEVERABILITY
The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement and such invalid provision shall be deemed to be severable.

GOVERNING LAW
This Agreement shall be construed in accordance with and governed by the laws of the Province identified in the Governing Law Jurisdiction section of this Agreement and the laws of Canada applicable therein. The Borrower irrevocably submits to the non-exclusive jurisdiction of the courts of such Province and acknowledges the competence of such courts and irrevocably agrees to be bound by a judgment of any such court.

DEFAULT BY LAPSE OF TIME
The mere lapse of time fixed for performing an obligation shall have the effect of putting the Borrower, or a Guarantor if applicable, in default thereof.

SET-OFF
The Bank is authorized (but not obligated), at any time and without notice, to apply any credit balance (whether or not then due) in any account in the name of the Borrower, or to which the Borrower is beneficially entitled (in any currency) at any branch or agency of the Bank in or towards satisfaction of the indebtedness of the Borrower due to the Bank under the Credit Facilities and the other obligations of the Borrower under this Agreement. For that purpose, the Bank is irrevocably authorized to use all or any part of any such credit balance to buy such other currencies as may be necessary to effect such application.

NOTICES
Any notice or demand to be given by the Bank shall be given in writing by way of a letter addressed to the Borrower. If the letter is sent by telecopier, it shall be deemed received on the date of transmission, provided such transmission is sent prior to 5:00 p.m. on a day on which the Borrower's business is open for normal business, and otherwise on the next such day. If the letter is sent by ordinary mail to the address of the Borrower, it shall be deemed received on the date falling five (5) days following the date of the letter, unless the letter is hand-delivered to the Borrower, in which case the letter shall be deemed to be received on the date of delivery. The Borrower must advise the Bank at once about any changes in the Borrower's address.

CONSENT OF DISCLOSURE
The Borrower hereby grants permission to any Person having information in such Person's possession relating to any Potential Prior-Ranking Claim, to release such information to the Bank (upon its written request), solely for the purpose of assisting the Bank to evaluate the financial condition of the Borrower.

NON-MERGER
The provisions of this Agreement shall not merge with any Security provided to the Bank, but shall continue in full force for the benefit of the parties hereto.

JOINT AND SEVERAL
Where more than one Person is liable as Borrower or Guarantor if applicable for any obligation under this Agreement, then the liability of each such Person for such obligation is joint and several (in Quebec, solidarily) with each other such Person.

COUNTERPART EXECUTION
This Agreement may be executed in any number of counterparts and by different parties in separate counterparts, each of which when so executed shall be deemed to be an original and all of which taken together constitute one and the same instrument.

ELECTRONIC MAIL AND FAX TRANSMISSION
The Bank is entitled to rely on any agreement, document or instrument provided to the Bank by the Borrower or any Guarantor as applicable, by way of electronic mail or fax transmission as though it were an original document. The Bank is further entitled to assume that any communication from the Borrower received by electronic mail or fax transmission is a reliable communication from the Borrower.

ELECTRONIC IMAGING
The parties hereto agree that, at any time, the Bank may convert paper records of this Agreement and all other documentation delivered to the Bank (each, a **"Paper Record"**) into electronic images (each, an **"Electronic Image"**) as part of the Bank's normal business practices. The parties agree that each such Electronic Image shall be considered as an authoritative copy of the Paper Record and shall be legally binding on the parties and admissible in any legal, administrative or other proceeding as conclusive evidence of the contents of such document in the same manner as the original Paper Record.

REPRESENTATIONS AND WARRANTIES
The Borrower represents and warrants to the Bank that:
a) it is duly constituted and validly existing under Applicable Laws and is qualified to carry on its operations and activities in all jurisdictions where the nature of its properties, assets or operations make it necessary or desirable to do so;
b) it has all necessary power and capacity to borrow, and to enter into and perform its obligations under this Agreement and the Security;
c) all necessary corporate action has been taken by it to authorize the execution and delivery by it of this Agreement and the Security and the performance of its obligations thereunder, and this Agreement and the Security has have been duly executed and delivered;
d) the execution, delivery and performance by it of this Agreement and the Security do not violate any Applicable Laws or agreements to which it is subject or by which it is bound;
e) its most recent financial statements provided to the Bank fairly present its financial position as of the date thereof and its results of operations and cash flows for the fiscal period covered thereby, and since the date of such financial statements, there has occurred no material adverse change in its operations or financial condition;
f) no event has occurred which constitutes, or which, with notice, lapse of time, or both, would constitute, a breach of any covenant or other term or condition of this Agreement or any Security or any other agreement delivered to the Bank or an Event of Default;
g) there is no claim, action, prosecution or other proceeding of any kind pending or threatened against it or any of its assets or properties before any court or administrative agency which relates to any non-compliance with any Environmental

and Health and Safety Laws which, if adversely determined, might have a material adverse effect upon its financial condition or operations or its ability to perform its obligations under this Agreement or any Security, and there are no circumstances of which it is aware which might give rise to any such proceeding which it has not fully disclosed to the Bank;

h) it has good and marketable title to all of its properties and assets, free and clear of any encumbrances, other than as may be provided for herein;
i) it is in compliance in all material respects with all Applicable Laws including, without limitation, all Environmental and Health and Safety Laws;
j) it has filed all material tax returns which were required to be filed by it, paid or made provision for payment of all taxes and Potential Prior-Ranking Claims (including interest and penalties) which are due and payable, and provided adequate reserves for payment of any tax, the payment of which is being contested; and
k) its indebtedness under this Agreement is its direct, unconditional and general indebtedness and (save for its preferred liabilities arising by operation of law) ranks at least pari passu with all its other unsecured and unsubordinated indebtedness.

Representations and warranties are deemed to be repeated as at the time of each Borrowing and/or Lease hereunder.

LANGUAGE
The parties hereto have expressly requested that this Agreement and all related documents, including notices, be drawn up in the English language. Les parties ont expressément demandé que la présente convention et tous les documents y afférents, y compris les avis, soient rédigés en langue anglaise.

WHOLE AGREEMENT
This Agreement and any documents or instruments referred to in, or delivered pursuant to, or in connection with, this Agreement constitute the whole and entire agreement between the Borrower and the Bank with respect to the Credit Facilities.

EXCHANGE RATE FLUCTUATIONS
If, for any reason, the amount of Borrowings and/or Leases, if applicable, outstanding under any facility in a currency other than Canadian currency, when converted to the Equivalent Amount in Canadian currency, exceeds the amount available under such facility, the Borrower shall immediately repay such excess or shall secure such excess to the satisfaction of the Bank.

JUDGEMENT CURRENCY
If for the purpose of obtaining judgement in any court in any jurisdiction with respect to this Agreement, it is necessary to convert into the currency of such jurisdiction (the **"Judgement Currency"**) any amount due hereunder in any currency other than the Judgement Currency, then conversion shall be made at the rate of exchange prevailing on the Business Day before the day on which judgement is given. For this purpose, "rate of exchange" means the rate at which the Bank would, on the relevant date, be prepared to sell a similar amount of such currency in the Toronto foreign exchange market, against the Judgement Currency, in accordance with normal banking procedures.

In the event that there is a change in the rate of exchange prevailing between the Business Day before the day on which judgement is given and the date of payment of the amount due, the Borrower will, on the date of payment, pay such additional amounts as may be necessary to ensure that the amount paid on such date is the amount in the Judgement Currency which, when converted at the rate of exchange prevailing on the date of payment, is the amount then due under this Agreement in such other currency together with interest at RBP and expenses (including legal fees on a solicitor and client basis). Any additional amount due from the Borrower under this section will be due as a separate debt and shall not be affected by judgement being obtained for any other sums due under or in respect of this Agreement.

EVENTS OF DEFAULT
Without affecting or limiting the right of the Bank to terminate or demand payment of, or to cancel or restrict availability of any unutilized portion of, any demand or other discretionary facility, each of the following shall constitute an **"Event of Default"** which shall entitle the Bank, in its sole discretion, to cancel any Credit Facilities, demand immediate repayment in full of any amounts outstanding under any term facility, together with outstanding accrued interest and any other indebtedness under or with respect to any term facility, and to realize on all or any portion of any Security:

a) failure of the Borrower to pay any principal, interest or other amount when due pursuant to this Agreement;
b) failure of the Borrower, or any Guarantor if applicable, to observe any covenant, term or condition contained in this Agreement, the Security, or any other agreement delivered to the Bank or in any documentation relating hereto or thereto;

c) the Borrower, or any Guarantor if applicable, is unable to pay its debts as such debts become due, or is, or is adjudged or declared to be, or admits to being, bankrupt or insolvent;
d) if any proceeding is taken to effect a compromise or arrangement with the creditors of the Borrower, or any Guarantor if applicable, or to have the Borrower, or any Guarantor if applicable, declared bankrupt or wound up, or to have a receiver appointed for any part of the assets or operations of the Borrower, or any Guarantor if applicable, or if any encumbrancer takes possession of any part thereof;
e) if in the opinion of the Bank there is a material adverse change in the financial condition, ownership or operation of the Borrower, or any Guarantor if applicable;
f) if any representation or warranty made by the Borrower, or any Guarantor if applicable, under this Agreement or in any other document relating hereto or under any Security shall be false in any material respect; or
g) if the Borrower, or any Guarantor if applicable, defaults in the payment of any other indebtedness, whether owing to the Bank or to any other Person, or defaults in the performance or observance of any agreement in respect of such indebtedness where, as a result of such default, the maturity of such indebtedness is or may be accelerated.

Should the Bank demand immediate repayment in full of any amounts outstanding under any term facility due to an Event of Default, the Borrower shall immediately repay all principal sums outstanding under such facility and all other obligations in connection with any such term facility.

INCREASED COSTS
If any change in Applicable Laws or the interpretation thereof after the date hereof (i) imposes or increases taxes on payments due to the Bank hereunder (other than taxes on the overall net income of the Bank), (ii) imposes or increases any reserve or other similar requirement or (iii) imposes or changes any other condition affecting the Credit Facilities, and the result of any of the foregoing results in any additional cost to the Bank of making available, continuing or maintaining any of the Credit Facilities hereunder (or maintaining any obligations to make any such Credit Facilities available hereunder) or results in any reduction in the amount of any sum received or receivable by the Bank in connection with this Agreement or the Credit Facilities made available hereunder, then from time to time, upon written request of the Bank, the Borrower shall promptly pay to the Bank, such additional amount or amounts as will compensate the Bank for any such additional costs incurred or reduction suffered.

CONFIDENTIALITY
This Agreement and all of its terms are confidential (**"Confidential Information"**). The Borrower shall keep the Confidential Information confidential and will not disclose the Confidential Information, or any part thereof, to any Person other than the Borrower's directors, officers, employees, agents, advisors, contractors, consultants and other representatives of the Borrower who need to know the Confidential Information for the purpose of this Agreement, who shall be informed of the confidential nature of the Confidential Information and who agree or are otherwise bound to treat the Confidential Information consistent with the terms of this Agreement. Without limiting the generality of the foregoing, the Borrower shall not issue any press release or make any other public announcement or filing with respect to the Confidential Information without the Bank's prior written consent.

Schedule "A"

DEFINITIONS

For the purpose of this Agreement, if applicable, the following terms and phrases shall have the following meanings:

"Applicable Laws" means, with respect to any Person, property, transaction or event, all present or future applicable laws, statutes, regulations, rules, policies, guidelines, rulings, interpretations, directives (whether or not having the force of law), orders, codes, treaties, conventions, judgements, awards, determinations and decrees of any governmental, quasi-governmental, regulatory, fiscal or monetary body or agency or court of competent jurisdiction in any applicable jurisdiction;

"Available Daily CORRA Tenor" means as to any Borrowing by way of a Daily CORRA Loan, the period commencing on the date of such Borrowing and ending on the numerically corresponding day in the calendar month that is one or three calendar months after the Borrowing of such Daily CORRA Loan as specified in the applicable borrowing request;

"Available Term CORRA Tenor" means as to any Borrowing by way of a Term CORRA Loan, the period commencing on the date of such Borrowing and ending on the numerically corresponding day in the calendar month that is either one or three calendar months after the Borrowing of such Term CORRA Loan as specified in the applicable borrowing request;

"Borrowing" means each use of a Credit Facility, excluding Leases, and all such usages outstanding at any time are **"Borrowings"**;

"Business Day" means a day, excluding Saturday, Sunday and any other day which shall be a legal holiday or a day on which banking institutions are closed throughout Canada, and when used in connection with a CORRA Borrowing, a **"Business Day"** also excludes any day which shall be a legal holiday or a day on which banking institutions are closed in Toronto, Ontario or in the province where the Borrower's accounts are maintained;

"Contaminant" includes, without limitation, any pollutant, dangerous substance, liquid waste, industrial waste, hazardous material, hazardous substance or contaminant including any of the foregoing as defined in any Environmental and Health and Safety Law;

"CORRA" means the Canadian overnight repo rate average administered and published by the CORRA Administrator;

"CORRA Administrator" means the Bank of Canada as administrator of the Canadian Overnight Repo Rate Average (or any successor administrator);

"CORRA Administrator's Website" means the website of the CORRA Administrator, currently at https://www.bankofcanada.ca/rates/interest-rates/corra/, or any successor source for CORRA identified as such by the CORRA Administrator from time to time;

"CORRA Borrowing" means each Borrowing by way of Daily CORRA Loans and/or Term CORRA Loans and all such Borrowings outstanding at any time are **"CORRA Borrowings"**;

"Daily CORRA Interest Payment Date" means the last day of the selected Available Daily CORRA Tenor; provided that, as to any such Daily CORRA Loan if any such date would be a day other than a Business Day, such date shall be extended to the next succeeding Business Day unless such next succeeding Business Day would fall in the next calendar month, in which case such date shall be the next preceding Business Day;

"Daily CORRA Lookback Period" means five (5) Business Days;

"Daily Simple CORRA" means, for any day, CORRA with interest accruing on a daily basis, with conventions for this rate (applying the Daily CORRA Lookback Period) being established by the Bank in accordance with the conventions for this rate selected or recommended by the CORRA Administrator for determining "Daily Simple CORRA" for business loans; provided that if the Bank decides that any such convention is not administratively feasible for the Bank, then the Bank may establish another convention in its reasonable discretion. Daily Simple CORRA shall not in any circumstance be less than zero;

"Environmental Activity" means any activity, event or circumstance in respect of a Contaminant, including, without limitation, its storage, use, holding, collection, purchase, accumulation, assessment, generation, manufacture, construction, processing, treatment, stabilization, disposition, handling or transportation, or its Release into the natural environment, including movement through or in the air, soil, surface water or groundwater;

"Environmental and Health and Safety Laws" means all Applicable Laws relating to the environment or occupational health and safety, or any Environmental Activity;

"Equivalent Amount" means, with respect to an amount of any currency, the amount of any other currency required to purchase that amount of the first mentioned currency through the Bank in Toronto, in accordance with normal banking procedures;

"Guarantor" means any Person who has guaranteed the obligations of the Borrower under this Agreement;

"Lease" means an advance of credit by the Bank to the Borrower by way of a Master Lease Agreement, Master Leasing Agreement, Leasing Schedule, Equipment Lease, Conditional Sales Contract, or pursuant to an Interim Funding Agreement or an Agency Agreement, in each case issued to the Borrower;

"Maturity Date" means the date on which a facility is due and payable in full;

"Permitted Encumbrances" means, in respect of the Borrower:

a) liens arising by operation of law for amounts not yet due or delinquent, minor encumbrances on real property such as easements and rights of way which do not materially detract from the value of such property, and security given to municipalities and similar public authorities when required by such authorities in connection with the operations of the Borrower in the ordinary course of business; and

b) Security granted in favour of the Bank;

"Person" includes an individual, a partnership, a joint venture, a trust, an unincorporated organization, a company, a corporation, an association, a government or any department or agency thereof, and any other incorporated or unincorporated entity;

"Policy" means the Business Loan Insurance Plan policy 52000 and 53000, issued by RBC Life Insurance Company to the Bank;

"Potential Prior-Ranking Claims" means all amounts owing or required to be paid, where the failure to pay any such amount could give rise to a claim pursuant to any law, statute, regulation or otherwise, which ranks or is capable of ranking in priority to the Security or otherwise in priority to any claim by the Bank for repayment of any amounts owing under this Agreement;

"RBP" and **"Royal Bank Prime"** each means the annual rate of interest announced by the Bank from time to time as being a reference rate then in effect for determining interest rates on commercial loans made in Canadian currency in Canada;

"Release" includes discharge, spray, inject, inoculate, abandon, deposit, spill, leak, seep, pour, emit, empty, throw, dump, place and exhaust, and when used as a noun has a similar meaning;

"Term CORRA Administrator" means CanDeal Benchmark Solutions Inc. and TMX Datalinx (or any successor administrator);

"Term CORRA Administrator's Website" means the website of the Term CORRA Administrator, currently at https://www.candeal.com/en/benchmarks, or any successor source for the Term CORRA Reference Rate identified as such by the Term CORRA Administrator from time to time;

"Term CORRA Interest Payment Date" means the last day of the selected Available Term CORRA Tenor; provided that, as to any such Term CORRA Loan if any such date would be a day other than a Business Day, such date shall be extended to the next succeeding Business Day unless such next succeeding Business Day would fall in the next calendar month, in which case such date shall be the next preceding Business Day;

"Term CORRA Lookback Period" means two (2) Business Days before the first day of the selected Available Term CORRA Tenor;

"Term CORRA Reference Rate" means the Canadian forward looking term rate based on CORRA administered and published by the Term CORRA Administrator;

"Term CORRA Rate" means, for the applicable Available Term CORRA Tenor, the Term CORRA Reference Rate for a tenor comparable to the selected Available Term CORRA Tenor (applying the Term CORRA Lookback Period). The Term CORRA Rate shall not in any circumstance be less than zero;

Schedule "B"

CALCULATION AND PAYMENT OF INTEREST AND FEES

LIMIT ON INTEREST
The Borrower shall not be obligated to pay any interest, fees or costs under or in connection with this Agreement in excess of what is permitted by Applicable Law. In no event shall the effective interest rate payable by the Borrower under any facility be less than zero.

OVERDUE PAYMENTS
Any amount that is not paid when due hereunder shall, unless interest is otherwise payable in respect thereof in accordance with the terms of this Agreement or the instrument or contract governing same, bear interest until paid at the rate of RBP plus 5% per annum or the highest premium indicated for any of the Borrower's facilities when in excess of 5%. Such interest on overdue amounts shall be computed daily, compounded monthly and shall be payable both before and after any or all of default, maturity date, demand and judgement.

EQUIVALENT YEARLY RATES
The annual rates of interest or fees to which the rates calculated in accordance with this Agreement are equivalent, are the rates so calculated multiplied by the actual number of days in the calendar year in which such calculation is made and divided by 365, or in the case of Daily SOFR Loans or Term SOFR Loans, if applicable, divided by 360.

TIME AND PLACE OF PAYMENT
Amounts payable by the Borrower hereunder shall be paid at such place as the Bank may advise from time to time in the applicable currency. Amounts due on a day other than a Business Day shall be deemed to be due on the Business Day next following such day. Interest and fees payable under this Agreement are payable both before and after any or all of default, maturity date, demand and judgement.

DAILY CORRA LOANS
The Borrower shall pay interest on each Daily CORRA Loan on the Daily CORRA Interest Payment Date for such Daily CORRA Loan, calculated in arrears. Such interest will accrue daily and shall be calculated on the basis of the actual number of days elapsed from the date of Borrowing of such Daily CORRA Loan, divided by 365.

TERM CORRA LOANS
The Borrower shall pay interest on each Term CORRA Loan on the Term CORRA Interest Payment Date for such Term CORRA Loan, calculated in arrears. Such interest will accrue daily and shall be calculated on the basis of the actual number of days elapsed from the date of Borrowing of such Term CORRA Loan, divided by 365.

RBP LOANS
The Borrower shall pay interest on each RBP Loan, monthly in arrears, on the 26th day of each month or such other day as may be agreed to between the Borrower and the Bank. Such interest will be calculated monthly and will accrue daily on the basis of the actual number of days elapsed and a year of 365 days and shall be paid in the currency of the applicable Borrowing.

Schedule "C"

NOTICE REQUIREMENTS

Notice Requirements for CORRA Borrowings:

Amount	Prior Notice
Any amount	By 12:00 p.m. Eastern Standard Time,1 Business Day prior to the date of Borrowing

Schedule "D"

ADDITIONAL BORROWING CONDITIONS

Maturing BAs:

In the event that on the date of this Agreement the Borrower has an outstanding Borrowing by way of **"BAs"** or **"Bankers' Acceptances"**:

a) the Borrower shall repay such Borrowing on the maturity date thereof fixed between the Borrower and the Bank prior to the date of this Agreement. Repayment may be made using the proceeds of a Borrowing under any Credit Facility;

b) in the event that a demand is made by the Bank hereunder on any (i) demand facility or (ii) any term facility due to an Event of Default, without limiting any other terms or conditions contained herein, the Borrower shall immediately repay all principal sums outstanding under such facility, including, without limitation, an amount equal to the face amount of all BAs which are unmatured or unexpired, which amount shall be held by the Bank as security for the Borrower's obligations to the Bank in respect of such Borrowings; and

c) when used in connection with BAs, a "**Business Day**" also excludes any day which shall be a legal holiday or a day on which banking institutions are closed in Toronto, Ontario or in the province where the Borrower's accounts are maintained.

Daily CORRA Loans:

Borrowings made by way of Daily CORRA Loans will be subject to the following terms and conditions:

a) Daily CORRA Loans shall be issued on a Business Day and shall be made in minimum amounts of $250,000.00;

b) Daily CORRA Loans shall mature, and the Borrower shall repay such Daily CORRA Loan and all outstanding interest, on the last day of the selected Available Daily CORRA Tenor, provided that if any such date would be a day other than a Business Day, such date shall be extended to the next succeeding Business Day unless such next succeeding Business Day would fall in the next calendar month, in which case such date shall be the next preceding Business Day;

c) notwithstanding anything herein to the contrary, Daily CORRA Loans shall not be available under any term facility with weekly, bi-weekly or semi-monthly principal payment frequency;

d) notwithstanding anything herein to the contrary, the Borrower may not select an Available Daily CORRA Tenor for any Daily CORRA Loan issued under any:

    i) term facility that is longer than the principal payment frequency for such term facility and, without limiting the foregoing, that ends after the Maturity Date for such facility;

e) notwithstanding anything herein to the contrary, if the Borrower repays any principal outstanding under a Daily CORRA Loan before the expiration of the tenor for such Daily CORRA Loan, a fee may be payable in connection with such repayment in such amount as the Bank may determine;

f) if the Bank so requests, the Borrower shall enter into a Hedge Contract to hedge the principal and interest of each Daily CORRA Loan against the risk of currency and exchange rate fluctuations. **"Hedge Contract"** means any rate swap, rate cap, rate floor, rate collar, currency exchange transaction, forward rate agreement or other exchange, hedging or rate protection transaction, or any combination of such transactions or agreements or any option with respect to any such transaction now existing or hereafter entered into between the Borrower and the Bank;

g) if the Bank determines, which determination is final, conclusive and binding upon the Borrower, that (each a **"CORRA Unavailability Event"**):

    i) save and except as set out in paragraph (h) below, adequate and fair means do not exist for ascertaining CORRA (including, without limitation, because such rate is not available from or published on a current basis by the services used by the Bank to obtain such rate),

    or

ii) the cost to the Bank of making or maintaining a Daily CORRA Loan does not accurately reflect the effective cost to the Bank thereof or the costs to the Bank are increased or the income receivable by the Bank is reduced in respect of a Daily CORRA Loan,

then:

X) the Bank shall apply RBP (plus the margin applicable to RBP Loans set out in this Agreement) as the applicable interest rate for such outstanding Daily CORRA Loan during the duration of the applicable CORRA Unavailability Event; and

Y) the Bank shall have the right, on written notice to the Borrower, to refuse to make a Daily CORRA Loan during the duration of the applicable CORRA Unavailability Event; and

Z) on issuance of such notice, with respect to any outstanding Daily CORRA Loan, the Borrower shall either (I) provide the Bank with a written request to convert such Daily CORRA Loan to another pricing option under the applicable Credit Facility on the expiration of such Daily CORRA Loan; or (II) repay such Daily CORRA Loan on the expiration thereof. If the Borrower fails to provide such notice or repay such Daily CORRA Loan, the Borrower shall be deemed to have submitted a request to convert such Daily CORRA Loan to a RBP Loan on the expiration thereof.

h) if by 5:00 pm (Toronto, Ontario time) on any day, the CORRA in respect of such day has not been published on the CORRA Administrator's Website, then the CORRA for such day will be the CORRA as published in respect of the first preceding Business Day for which such CORRA was published on the CORRA Administrator's Website so long as such first preceding Business Day is not more than three Business Days prior to such day;

i) any change in Daily Simple CORRA due to a change in CORRA shall be effective from and including the effective date of such change in CORRA without notice to the Borrower; and

j) the Bank shall have the right, at any time on written notice to the Borrower, to amend the Daily CORRA Lookback Period, and such amendment shall apply to the determination of Daily Simple CORRA for all Daily CORRA Loans made after the date on which written such notice is effective.

Term CORRA Loans:

Borrowings made by way of Term CORRA Loans will be subject to the following terms and conditions:

a) Term CORRA Loans shall be issued on a Business Day and shall be made in minimum amounts of $250,000.00;

b) Term CORRA Loans shall mature, and the Borrower shall repay such Term CORRA Loan and all outstanding interest, on the last day of the selected Available Term CORRA Tenor, provided that if any such date would be a day other than a Business Day, such date shall be extended to the next succeeding Business Day unless such next succeeding Business Day would fall in the next calendar month, in which case such date shall be the next preceding Business Day;

c) notwithstanding anything herein to the contrary, Term CORRA Loans shall not be available under any term facility with weekly, bi-weekly or semi-monthly principal payment frequency;

d) notwithstanding anything herein to the contrary, the Borrower may not select an Available Term CORRA Tenor for any Term CORRA Loan issued under any:

i) term facility that is longer than the principal payment frequency for such term facility and, without limiting the foregoing, that ends after the Maturity Date for such facility;

e) notwithstanding anything herein to the contrary, if the Borrower repays any principal outstanding under a Term CORRA Loan before the expiration of the tenor for such Term CORRA Loan, a fee may be payable in connection with such repayment in such amount as the Bank may determine;

f) if the Bank so requests, the Borrower shall enter into a Hedge Contract to hedge the principal and interest of each Term CORRA Loan against the risk of currency and exchange rate fluctuations. **"Hedge Contract"** means any rate swap, rate cap, rate floor, rate collar, currency exchange transaction, forward rate agreement or other exchange, hedging or rate protection transaction, or any combination of such transactions or agreements or any option with respect to any such transaction now existing or hereafter entered into between the Borrower and the Bank;

g) if the Bank determines, which determination is final, conclusive and binding upon the Borrower, that:

   i) save and except as set out in paragraph (h) below, adequate and fair means do not exist for ascertaining the Term CORRA Reference Rate (including, without limitation, because such rate is not available from or published on a current basis by the services used by the Bank to obtain such rate),

   or

   ii) the cost to the Bank of making or maintaining a Term CORRA Loan does not accurately reflect the effective cost to the Bank thereof or the costs to the Bank are increased or the income receivable by the Bank is reduced in respect of a Term CORRA Loan,

   then:

   X) the Bank shall have the right, on written notice to the Borrower, to refuse to make a Term CORRA Loan when the applicable condition (i) or (ii) applies; and

   Y) on issuance of such notice, with respect to any outstanding Term CORRA Loan, the Borrower shall either (I) provide the Bank with a written request to convert such Term CORRA Loan to another pricing option under the applicable Credit Facility on the expiration of such Term CORRA Loan; or (II) repay such Term CORRA Loan on the expiration thereof. If the Borrower fails to provide such notice or repay such Term CORRA Loan, the Borrower shall be deemed to have submitted a request to convert such Term CORRA Loan to a Daily CORRA Loan (or an RBP Loan if a CORRA Unavailability Event has occurred) on the expiration thereof.

h) if by 5:00 pm (Toronto, Ontario time) on any day, the Term CORRA Reference Rate in respect of such day has not been published on the Term CORRA Administrator's Website, then the Term CORRA Reference Rate for such day will be the Term CORRA Reference Rate as published in respect of the first preceding Business Day for which such Term CORRA Reference Rate was published on the Term CORRA Administrator's Website so long as such first preceding Business Day is not more than three Business Days prior to such day; and

i) the Bank shall have the right, at any time on written notice to the Borrower, to amend the Term CORRA Lookback Period, and such amendment shall apply to the determination of the Term CORRA Rate for all Term CORRA Loans made after the date on which written such notice is effective.

Interest Rate and Commodity Derivatives:

"Interest Rate and Commodity Derivatives" means any interest rate swap transaction or commodity derivative, or any derivative or option with respect thereto, or any combination of any of the foregoing, or any other transaction related to financial risk now existing or hereafter developed.

At the Borrower's request, the Bank may agree to enter into Interest Rate and Commodity Derivatives with the Borrower from time to time. The Borrower acknowledges that the Bank makes no formal commitment herein to enter into any Interest Rate and Commodity Derivatives and the Bank may, at any time and at all times, in its sole and absolute discretion, accept or reject any request by the Borrower to enter into any Interest Rate and Commodity Derivatives. If the Bank does enter into Interest Rate or Commodity Derivatives with the Borrower, it will do so subject to the following:

a) the Borrower shall promptly issue or countersign and return a confirmation or acknowledgement of the terms of each such Interest Rate and Commodity Derivatives as required by the Bank;

b) the Borrower shall promptly enter into a master agreement or other agreement in form and substance satisfactory to the Bank including, without limitation, any agreement used by the International Swap Dealers Association, Inc. or any foreign exchange netting and close out agreement;

c) in the event of demand for payment under the Agreement of which this schedule forms a part, the Bank may terminate all or any Interest Rate and Commodity Derivatives. If the agreement governing any Interest Rate and Commodity Derivatives does not contain provisions governing termination, any such termination shall be effected in accordance with customary market practice. The Bank's determination of amounts owing under any terminated Interest Rate and Commodity Derivatives shall be conclusive in the absence of manifest error. The Bank shall apply any amount owing by the Bank to the Borrower on termination of any Interest Rate and Commodity Derivatives against the Borrower's obligations to the Bank under the Agreement and any amount owing to the Bank by the Borrower on such termination shall be added to the Borrower's obligations to the Bank under the Agreement and secured by the Security;

d) the Borrower shall pay all required fees in connection with any Interest Rate and Commodity Derivatives and indemnify and hold the Bank harmless against any loss, cost or expense incurred by the Bank in relation to any Interest Rate and Commodity Derivatives;

e) any rights of the Bank herein in respect of any Interest Rate and Commodity Derivatives are in addition to and not in limitation of or substitution for any rights of the Bank under any agreement governing such Interest Rate and Commodity Derivatives. In the event that there is any inconsistency at any time between the terms hereof and any agreement governing such Interest Rate and Commodity Derivatives, the terms of such agreement shall prevail; and

f) in addition to any security which may be held at any time in respect of any Interest Rate and Commodity Derivatives, upon request by the Bank from time to time, the Borrower will deliver to the Bank such security as is acceptable to the Bank as continuing collateral security for the Borrower's obligations to the Bank in respect of Interest Rate and Commodity Derivatives.

MOH REPORT

Open Session

MEETING DATE:	April 25, 2024
SUBMITTED BY:	Dr. Ninh Tran, Medical Officer of Health (written as of April 15, 2024)
SUBMITTED TO:	Board of Health
PURPOSE:	☐ Decision ☐ Discussion ☒ Receive and File
AGENDA ITEM #	5.2
RESOLUTION #	2024-BOH-0425-5.2

1.0. Chief Medical Officer of Health Report

Please find the attached Chief Medical Officer of Health (CMOH) 2023 Annual Report, titled: *Balancing Act – An All-of-Society Approach to Substance Use and Harms*. A high-level summary of the report is provided below, and I will share additional highlights and key takeaways from this report with the Board of Health (BOH) at the meeting. At a future BOH meeting, there will be a subsequent report when I will present how Southwestern Public Health (SWPH) and our work aligns with the CMOH report and what further work SWPH can do.

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

Measuring Substance Use Harms

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

Addressing Substance Use Harms: A Balancing Act

The challenge is to find the balance between:

- Respecting people's autonomy – including their desire to use substances – and public health's responsibility to protect citizens, families, and communities from substance-related harms.

- The economic and societal benefits of substance use, including the jobs, wealth and enjoyment generated by the regulated alcohol and cannabis industries, and the health and social costs of substance use harms.
- Providing accurate information about the very real risks of substance use without stigmatizing people who use drugs.
- Helping people use substances, including unregulated substances like opioids, more safely while not increasing their use.
- Providing life-saving services to people who use opioids while also ensuring overall community safety.

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

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

The CMOH report challenges key partners – communities, local, provincial, federal, and Indigenous governments and agencies, social services, other organizations involved in reducing substance use harms, people with lived and living experience, the public health sector, and the health care system – to pursue a range of thoughtful, evidence-based strategies designed to address both the upstream and downstream factors affecting substance use and harms. The goals are to:

- Build healthy families and healthy communities.
- Ensure Ontarians have the knowledge, skills, supports, services, and relationships to lead healthy lives and avoid substance use harms.
- Provide harm reduction and treatment services individuals need if they use substances or develop a substance use disorder.

There are multi-pronged substance-specific strategies outlined that use a similar framework and tools, but the specific priorities and recommendations will be different because the threats are different.

2.0 Measles

As of April 10th, 2024, there were 11 laboratory-confirmed cases of measles reported in Ontario of which 10 cases were associated with travel. There have been no cases in the SWPH region at the time of this report.

SWPH continues to participate in provincial and regional discussions with the Ministry as well as with local partners and through internal discussions to ensure we are able to respond to case(s) of measles in our community if or when they arise.

MOTION: 2024-BOH-0425-5.2
That the Board of Health for Southwestern Public Health accept the Medical Officer of Health's Report for April 25, 2024.

Ministry of Health | Office of Chief Medical Officer of Health, Public Health

Chief Medical Officer of Health 2023 Annual Report

Balancing Act: An All-of-Society Approach to Addressing Substance Use and Harms

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

March 2024

Ontario

Purpose

To provide an overview of the CMOH 2023 Annual Report, including:

- Summary of legislated requirements
- Timelines for release
- Summary of the CMOH 2023 Annual Report and next steps
- Communication Plan
- Appendix

Ontario

Legislative Requirements under the *Health Protection and Promotion Act*

Section 81 (4) requires the Chief Medical Officer of Health (CMOH) to develop an annual report on the state of public health in Ontario and deliver the report to the Speaker of the Legislative Assembly.

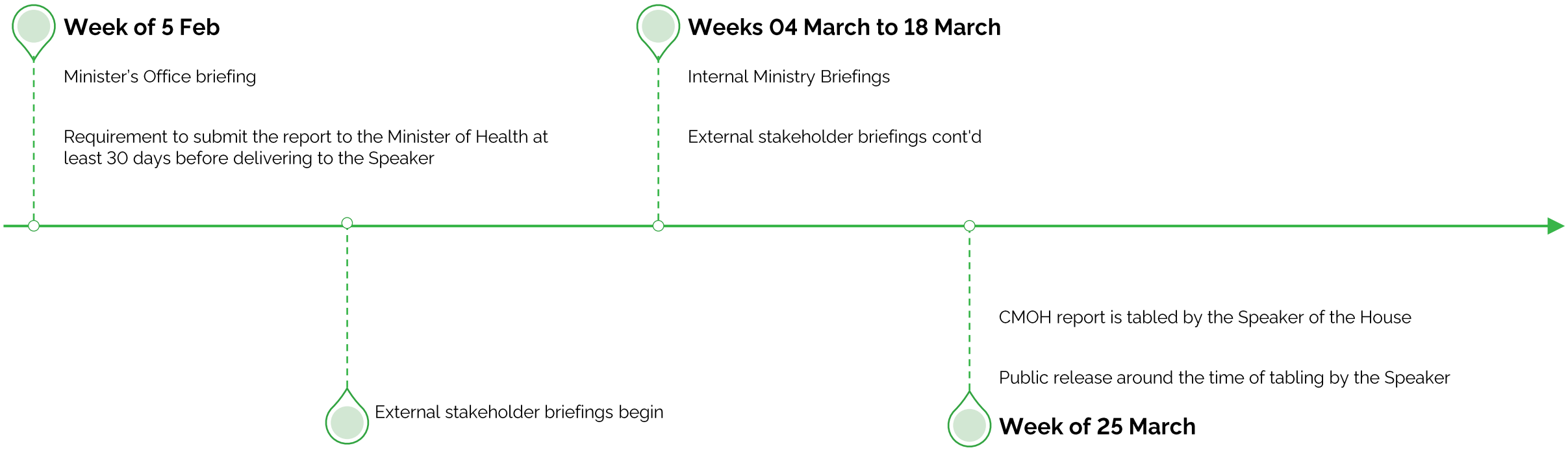
Section 81 (5) requires the Speaker to lay the report before the Assembly at the earliest reasonable opportunity.

Section 81 (6) requires the CMOH to deliver a copy of the report to the Minister at least 30 days before delivering it to the Speaker.

This will be the second annual report from Dr. Kieran Moore as CMOH.

Ontario

Timelines for Release



Ontario

Summary of the CMOH 2023 Annual Report

Balancing Act: An All-of-Society Approach to Addressing Substance Use and Harms

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

Impetus for the CMOH report

- High number of deaths necessitates an urgent response to Ontario's substance use crisis
- Substance use and harms were exacerbated during the COVID-19 pandemic
- Costs are rising in terms of healthcare, lost productivity, criminal justice system, and harms to individuals, families, communities

The goal of this report is to provide **evidence-based recommendations** on effective measures to reduce substance use and its harms in Ontario.

The report includes key trends in substance use and harms in Ontario, including **upstream and downstream factors** contributing to harms and the populations most at risk.

This report focuses on tobacco/vaping products, cannabis, alcohol and opioids – and **recommends specific strategies to adapt our response,** while recognizing the complex policy environment.

Ontario

Engagement with Experts

Engagement of an **External Advisory Committee** of subject matter experts to provide input into the development and content of the report.

+

Engagement of an **Internal Advisory Committee** within the Office of the Chief Medical Officer of Health to review and provide feedback on the content of the report.

- Addictions Division, Centre for Addiction and Mental Health
- Chiefs of Ontario
- Community Addictions and Peer Support Association
- Families for Addictions Recovery
- Indigenous Primary Heath Care Council
- Northwestern Health Unit
- Ontario Health
- Ontario Drug Policy Research Network
- Ontario Federation of Indigenous Friendship Centres
- Public Health Ontario
- Simcoe Muskoka District Health Unit
- Wellesley Institute

Ontario

Costs of substance use

- Every year since 2020, between 2,500 and 3,000 people have died from opioid toxicity in Ontario, with thousands more requiring emergency care due to accidental overdoses.
- Harms are not limited to opioids; impacts of substances like tobacco, alcohol, and cannabis cost billions each year in Ontario.
- The COVID-19 pandemic has exacerbated substance use and harms, and resulted in interrupted prevention and treatment programs.

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

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

Source: https://csuch.ca/explore-the-data/

Ontario

A Balanced All-of-Society Approach

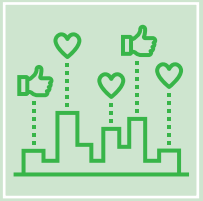
- Substance use is a complex issue that public health cannot address alone. We need an ‘all-of-society' approach to reduce harms from substances.
- This report makes recommendations to our partners and communities to reduce harms, working with people with lived and living experience, using evidence-based strategies.
- We need to strike a delicate balance, respecting individual choices and political interests while protecting public health.

Ontario

Tipping the Balance Towards a Healthier Ontario

Implementing upstream investments alongside downstream risk mitigation ensures a comprehensive approach to fostering healthier individuals, communities, and societies.

This approach respects individual autonomy while fulfilling public health responsibilities.



Upstream Initiatives:

- Addressing social determinants of health such as income, education and housing
- Providing equitable access to resources
- Strengthening social connections

Downstream Policies and Programs:

- Addressing the social environment: acceptance, accessibility, pricing, promotion
- Supporting treatment access
- Addressing the nature of the substance, e.g., toxicity

Ontario

Key Areas for Action: Tobacco/Vaping

- **Ontario to sign on to 2035 national target** of fewer than 5% of the population using tobacco
  - Raise **taxes** (ON second lowest nationally);
  - Increase **age of purchase** (to 21, and then consider generational ban);
  - Expanding availability and cover costs of **smoking cessation treatment**

- **Prevent/reduce** vaping and nicotine use among youth and non-smokers
  - Increase **age of purchase for vaping products** (to 21), impose retail license fee and limit retail locations
  - **Ban flavoured vaping products**
  - **Ban disposable vaping products,** and limit concentration and volume of vaping containers
  - Increase **areas where smoking/vaping is prohibited**, and include **water pipes** in bans

- **Work federally to**
  - **Establish a national nicotine framework** to cover tobacco, vaping and all nicotine products
  - Restrict **online advertising** of tobacco/vaping products
  - Require **in-person age verification** for online sales

Ontario

Key Areas for Action: Cannabis

- **Reduce rising rates of cannabis use** by youth and young adults
  - Increase **age of purchase** (to 21)

- **Increase Awareness of Cannabis Harms**
  - **Rising cannabis- associated mental health ED visits and hospitalizations** among youth/young adults and promote Health Canada's **Low Risk Cannabis Guidelines**
  - Risks of cannabis use during **pregnancy**, **impaired driving,** and polysubstance use
  - **Train more providers** in evidence-based management of cannabis use disorder

- **Reduce risks to young children**
  - Reduce rapidly rising risk of **pediatric poisonings** from edibles by increasing safeguards like **child-proof packaging** and **warning labels**, and reducing the desirability of edibles like use of sweeteners and food-colouring

- **Work federally to:**
  - Restrict **online advertising** of cannabis products
  - Require **in-person age verification** for online sales
  - Set **maximum concentrations of THC**, and consider tiered taxation based on THC content

Ontario

Key Areas for Action: Alcohol

- **Develop a comprehensive provincial alcohol strategy** with key partners
  - Review enhanced surveillance data and monitor burden over time

- **Increase awareness of alcohol-related harms**
  - **Require labelling and signage** that describe risks and harms associated with alcohol use, including cancer risks, risks of drinking and driving, and risks during pregnancy
  - **Promote message** from Canada's new Guidance on Alcohol and Health that "less is better"

- **Protect from harms of alcohol**
  - Protect youth by **banning advertising online and through social media** and **enforcing alcohol regulations** in all outlets where alcohol is sold
  - Strengthen policies to prevent drinking and driving

- Province to implement evidence-based strategies to **limit access to prevent harms**
  - Manage **outlet density, hours of access**
  - Implement **pricing and taxation** strategies such as minimum standard drink pricing

- **Enhance clinical services** including screening and brief interventions, and treatment access for people with alcohol use disorder

Key Areas for Action: Opioids

- **Address determinants of health** including housing, and access to health care and social services
  - **Federal government to decriminalize** the simple possession of substances for personal use to prevent harms associated with criminalization
- **Improve timely access to evidence-based treatment** for people with opioid use disorder.
- **Enhance harm reduction service access**, including naloxone, safer supply, supervised consumption (including for people who smoke drugs), and drug checking services
- **Address the impacts of grief and loss** through services and supports for families and friends of people who have died from toxicity, and for support workers

Next Steps

Stay Focused

Strive to find a balance between substance use benefits and risks, utilizing effective public health interventions for harm reduction and improved health.

Be Nimble

Actively monitor how substances impact health, adapting downstream programs, services, policies, and regulations to counter evolving threats, such as new products and delivery methods – to protect the most vulnerable.

Take Action

Implement concrete steps to reduce harms from tobacco/vaping, cannabis, alcohol, and opioids.

Be Responsive

Ensure access to effective, on-demand harm reduction, and mental health and addiction treatment services for those at risk of or experiencing substance use harms and their families.

Be Strategic

Continuously refine downstream interventions while investing upstream to prevent harmful substance use. Emphasize strong, healthy, connected families and communities as the best antidote for addiction and other substance use harms.

Be Determined

Advocate for health, social, and economic policies at all levels, fostering stronger communities for longer, healthier lives in an all-of-society approach.

Ontario

Communications Plan for release of report

Communications Plan

Stakeholder-focused with targeted media

Objective: Amplify evidence-based recommendations for public policy discussion and implementation

Stakeholder Outreach	Media
Briefings for government officials/policy/decision makers	Targeted media interviews with print, TV and/or radio journalists covering the health file
Brief leaders of the opposition/health critic (as requested)	OCMOH statement/media release issued on Newsroom linking to the annual report
Stakeholder emails: share embargoed copy of the report with select supportive stakeholders in advance	Media lines & Q&As
Continue to reinforce the primary messages of the report at speaking engagements and stakeholder meetings	Web content. Landing page for main report that highlights executive summary. CMOH statement.
	Sustain messages throughout year on appropriate dates (i.e., No Tobacco Day, World Drug Day etc.)

Appendix

Recommendations to adopt an all-of-society approach to reduce the harms associated with substance use

*See report for substance-specific recommendations

All-Of-Society: Communities

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

Ontario

All-Of-Society:

Local, provincial, federal and Indigenous governments and agencies

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

All-Of-Society:

Public health and social services

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

Ontario

All-Of-Society:

Organizations at all levels (local, provincial, national)

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

All-Of-Society:

Public health sector

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

Ontario

All-Of-Society:

Health care system

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

External Advisory Committee Members

1. Nicole Blackman, Indigenous Primary Heath Care Council
2. Leslie Buckley, Addictions Division Centre for Addictions and Mental Health
3. Chelsea Combot, Ontario Federation of Indigenous Friendship Centres
4. Kit Young Hoon, Northwestern Public Health Unit
5. Tessa Jourdain, Ontario Federation of Indigenous Friendship Centres
6. Surkhab Peerzada, Ontario Federation of Indigenous Friendship Centres
7. Gord Garner, Community Addictions and Peer Support Association
8. Tara Gomes, Ontario Drug Policy Research Network
8. Angie Hamilton, Families for Addiction Recovery
9. Erin Hobin, Public Health Ontario
10. Pamela Leece, Public Health Ontario
11. Kwame McKenzie, Wellesley Institute Centre for Addictions and Mental Health
12. Linda Ogilvie, Chiefs of Ontario
13. Bernadette deGonzague, Chiefs of Ontario
14. Hasan Sheikh, Mental Health and Addictions Centre of Excellence, Ontario Health
15. Lisa Simon, Simcoe Muskoka District Health Unit

Balancing Act

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

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

Ontario

2023 ANNUAL REPORT

Of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario

Land Acknowledgement

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

Dedication

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

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

Letter from Dr. Moore

Dear Mr. Speaker,

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

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

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

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

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

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

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

Yours truly,

Dr. Kieran Moore

Contents

Executive Summary

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

Measuring Substance Use Harms

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

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

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

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

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

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

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

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

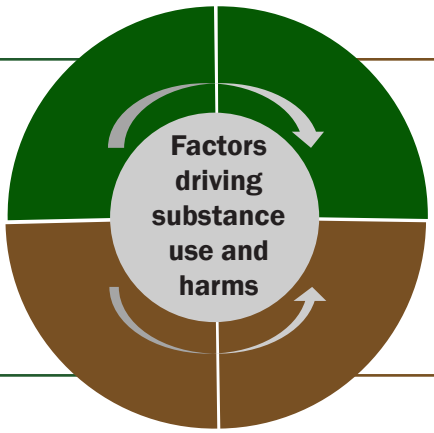
It is time to focus attention on substance use and harms.

The Upstream and Downstream Drivers of Substance Use

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

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

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



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

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

Addressing Substance Use Harms: A Balancing Act

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

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

The challenge is to find the balance between:

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

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

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

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

Substance-Specific Strategies

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

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

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

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

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

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

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

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

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

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

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

The Need to Act Now

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

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

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

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

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

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

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

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

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

Substance Use Harms are an Urgent Public Health Issue

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

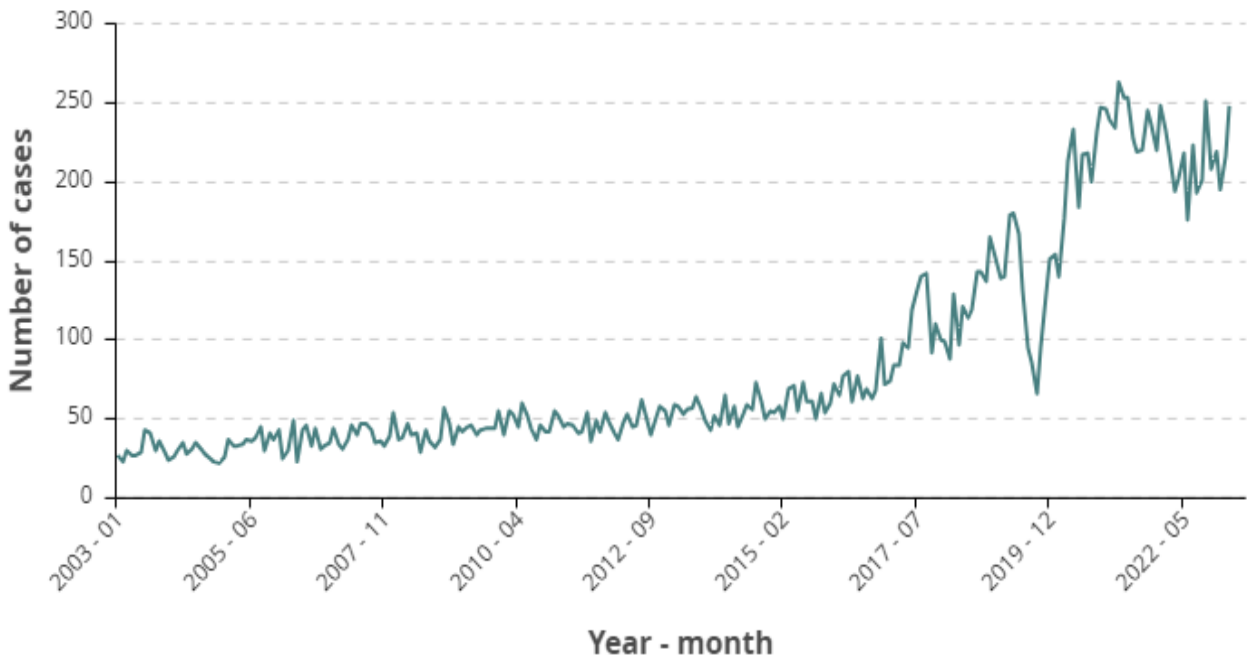
That's one tragic, preventable death from opioids about every three hours – with thousands more Ontarians seeking care in emergency departments and being hospitalized for accidental overdoses each year.

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

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

Ontario Drug Policy Research Network, 2023[5]

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



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

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

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

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

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

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

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

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

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

COVID-19 Exacerbated Substance Use and Harms

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

Smoking rates remain persistently high in Northern Ontario.

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

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

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

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

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

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

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

Polysubstance Use

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

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

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

$18 Billion

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

$1,234 per person

5 X

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

4.5 X

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

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

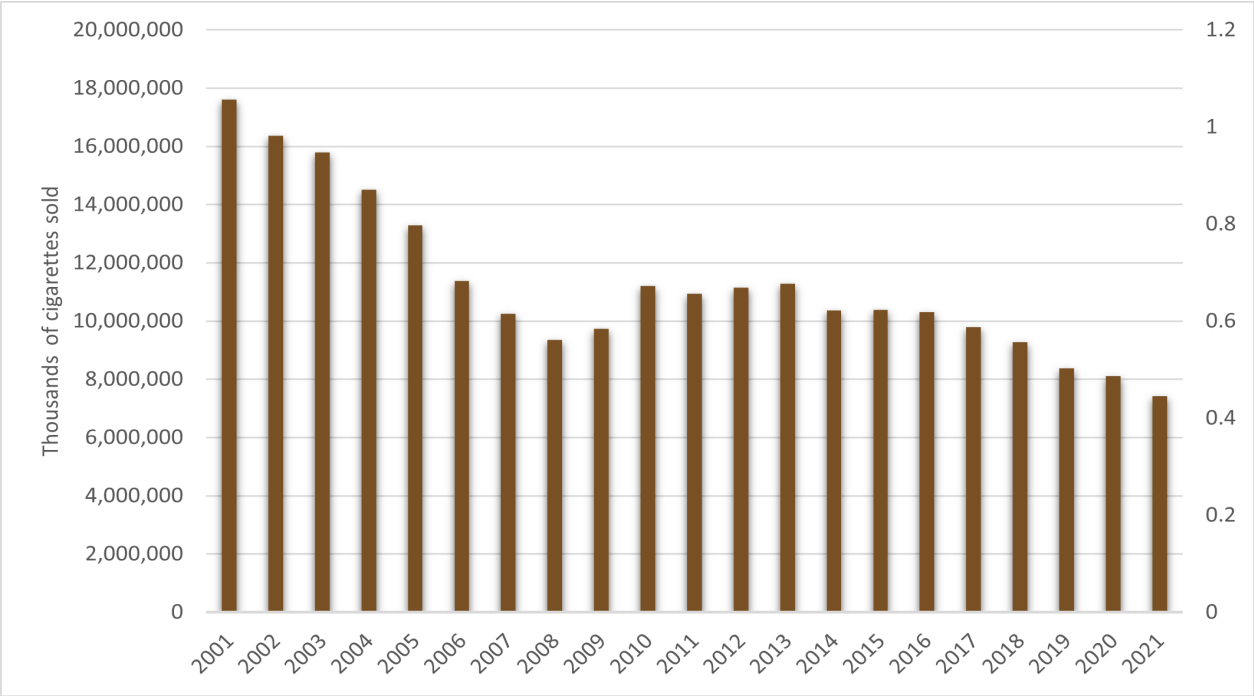
[viii] Income generated by alcohol is based on sales as well as taxes because the provincial government has largely controlled the sale of alcohol through the Liquor Control Board of Ontario (LCBO), while estimated income from tobacco and cannabis is based on taxes on sales only.

Public Health Approaches Can Reduce Substance Use Harms

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

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

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



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

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

Well Intentioned Efforts to Address Substance Use Can Cause Harm

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

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

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

My Call for Health-First Substance Use Policy and Action

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

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

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

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

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

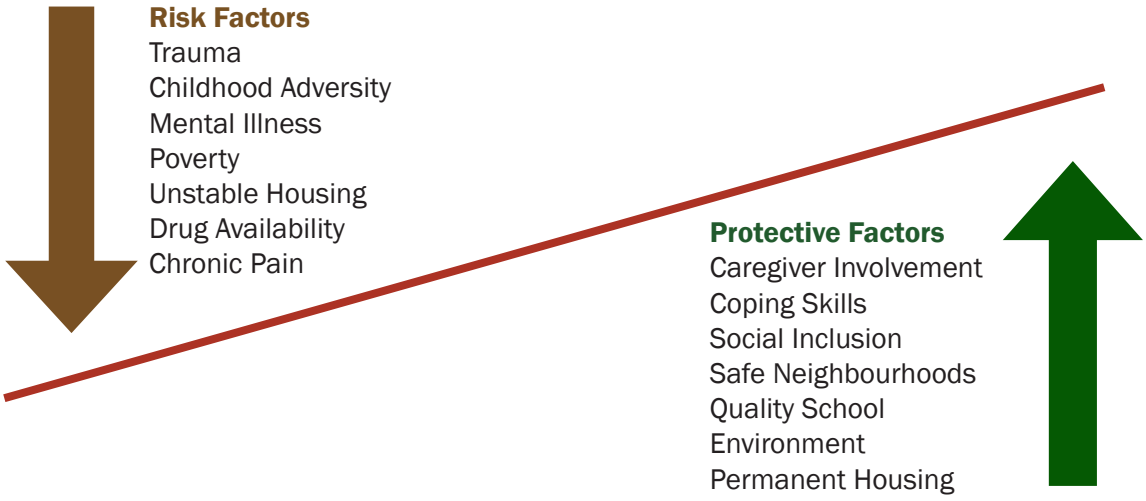
- all levels of government: federal, provincial, territorial, local and Indigenous
- all partners currently involved in substance use issues, including: the regulatory system, the commercial system, finance and taxation systems, the social service system, the child welfare system, the health care system,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

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

I am calling on Ontario to recognize that:

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

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



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

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

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

This report:

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

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

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

I. Understanding Substance Use in Ontario

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

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

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

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

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

What are the Factors Driving Substance Use and Harms?

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

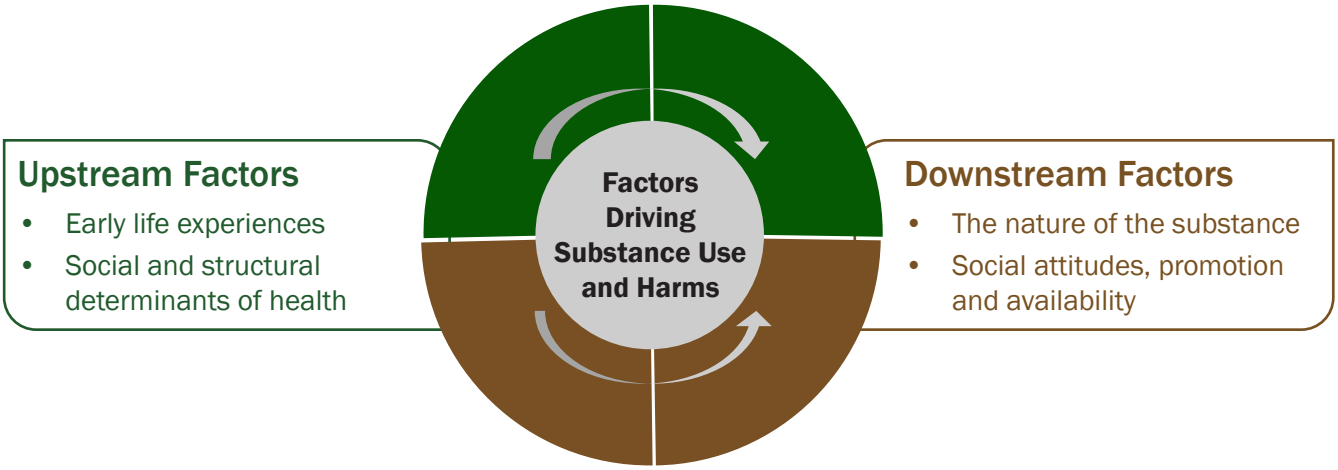
The best antidote to problematic substance use and addiction is connection: connection to family and friends, to community, and to society.

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

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

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

Health Officers of British Columbia, 2011.[36]



Upstream Factors

Early life experiences

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

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

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

Social and structural determinants of health

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

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

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

Public Health Ontario[39]

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

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

Downstream Factors

The nature of the substance

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

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

The Ps that affect substance use and harms:

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

Social attitudes, promotion and availability

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

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

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

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

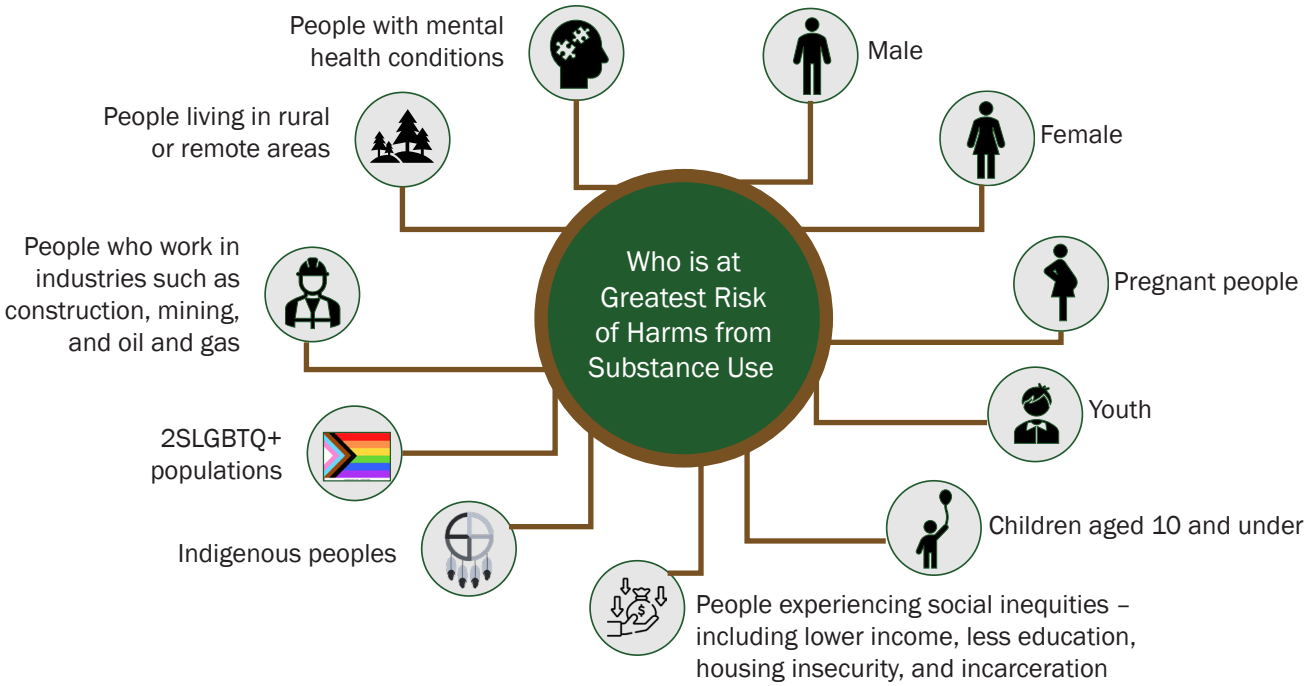
In a soon-to-be published study with people who drink alcohol, 60% were not aware that alcohol causes cancer.

2024 email from E Hobin (Public Health Ontario)

Who is at Greatest Risk of Harms from Substance Use?

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

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



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

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

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

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

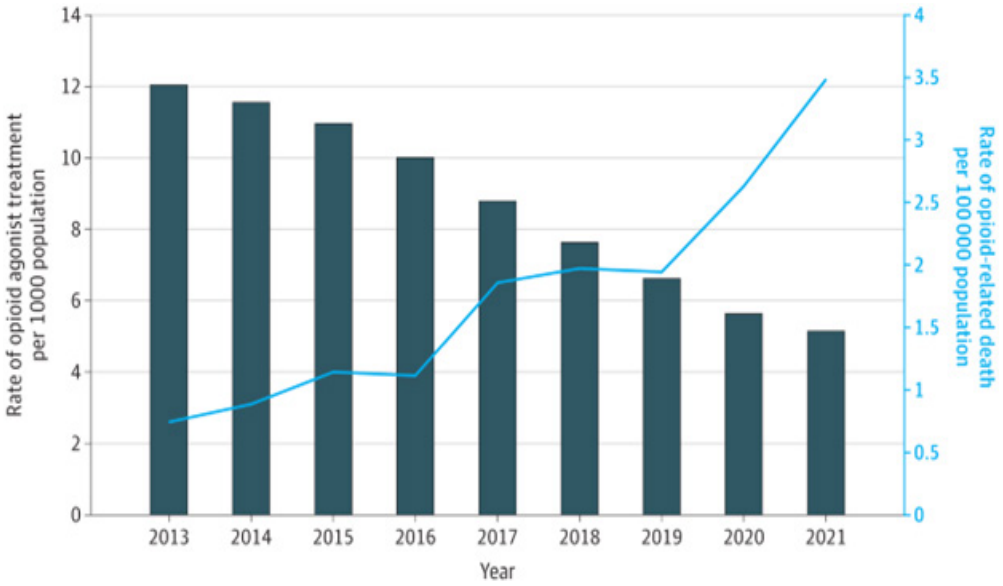
Since the start of the COVID-19 pandemic, 3 in 4 people who died from opioid toxicity in Ontario were male.[11]

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

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

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

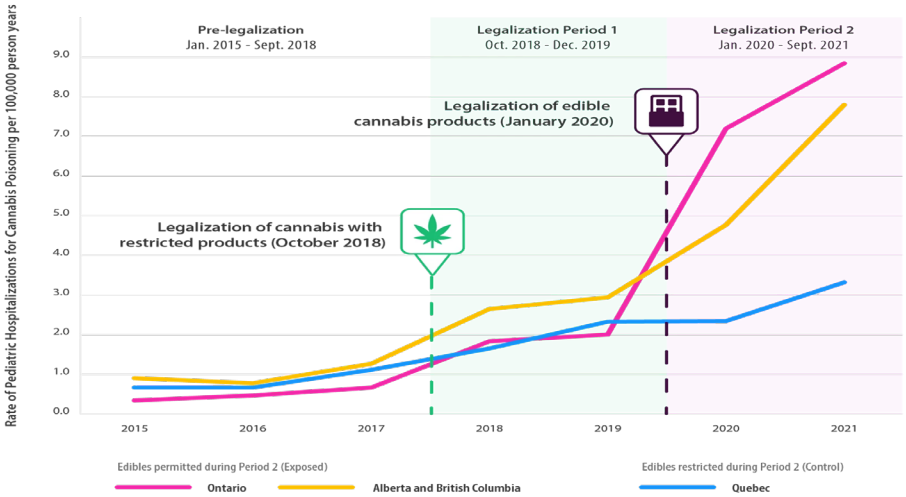
Figure 4: Rates of Opioid Agonist Treatment and Opioid-Related Deaths for Youths in Ontario, Canada, 2013-2021



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

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

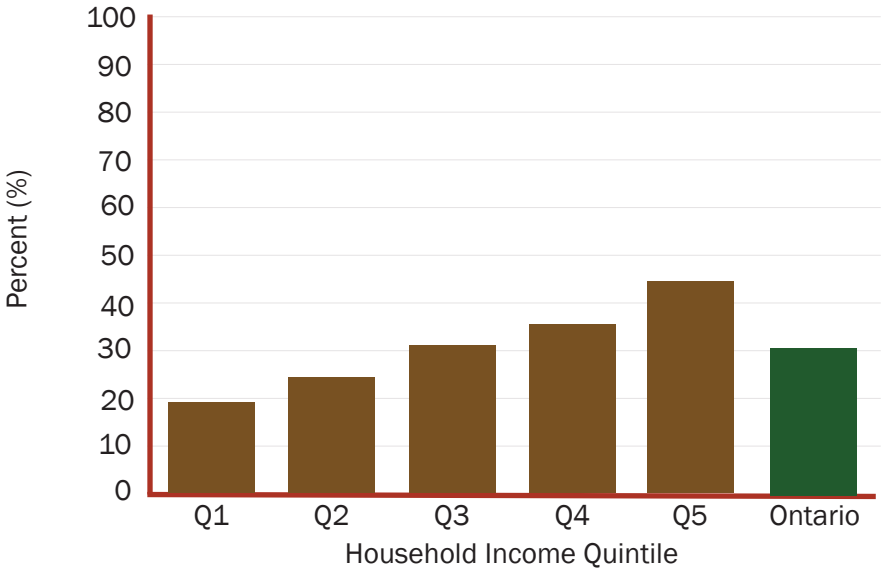
Figure 5: Rate of hospitalizations due to cannabis poisoning in children aged 0-9 years in four Canadian provinces, 2015 to 2021.



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

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

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

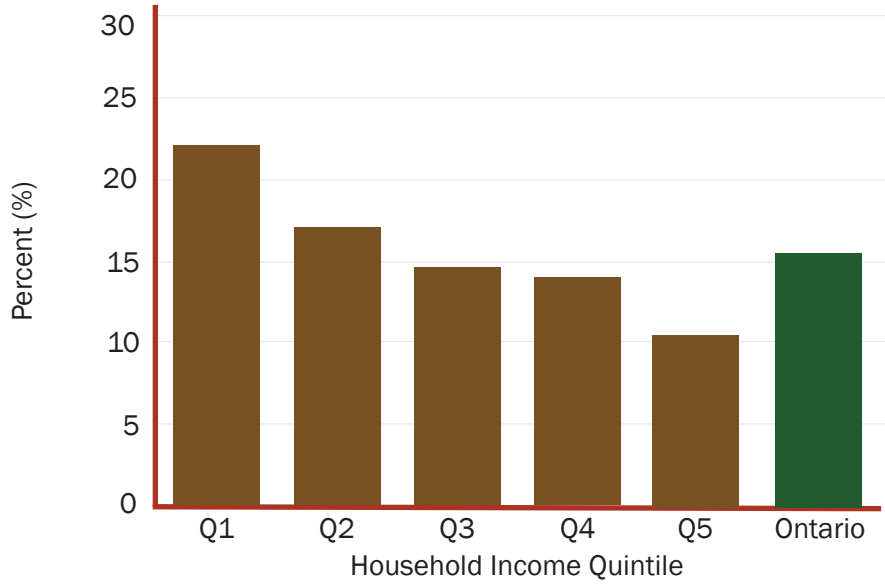


Notes:"Q1" represents the lowest household income quintile and "Q5" represents the highest. Data are presented in Supplementary Table S14. Download supplementary tables at ontariohealth.ca. Estimates are adjusted to the age distribution of the 2011 Canadian polulations.

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

> "The opioid epidemic has been disrupting families and communities across Ontario … The decades long war on drugs has not worked, especially for our people who are already over-represented in the criminal justice system. People need to be supported culturally and spiritually in dealing with mental health and substance use disorders."
>
> Ontario Regional Chief, Glen Hare[62]

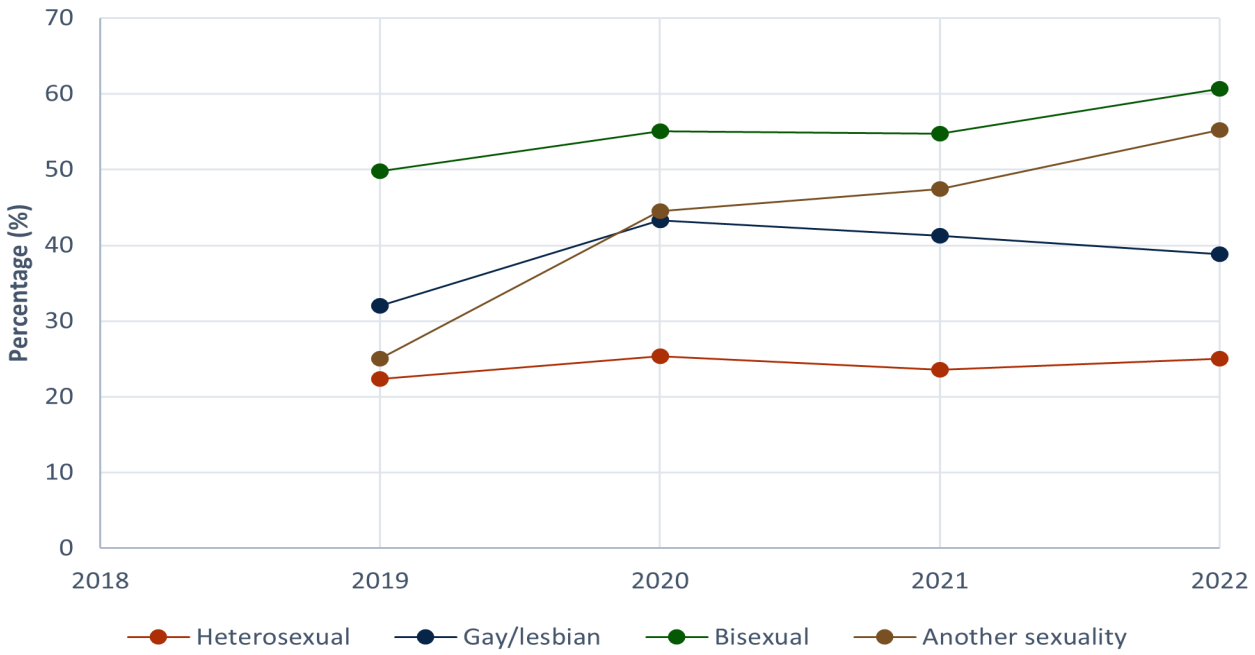
In Ontario, 88% of all Indigenous peoples live off-reserve in cities, towns, and rural communities,[69] and particular attention must be paid to addressing their needs. It is also important to understand that Indigenous people are the fastest growing population and the youngest population in Canada.[70]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

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

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

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

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



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

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

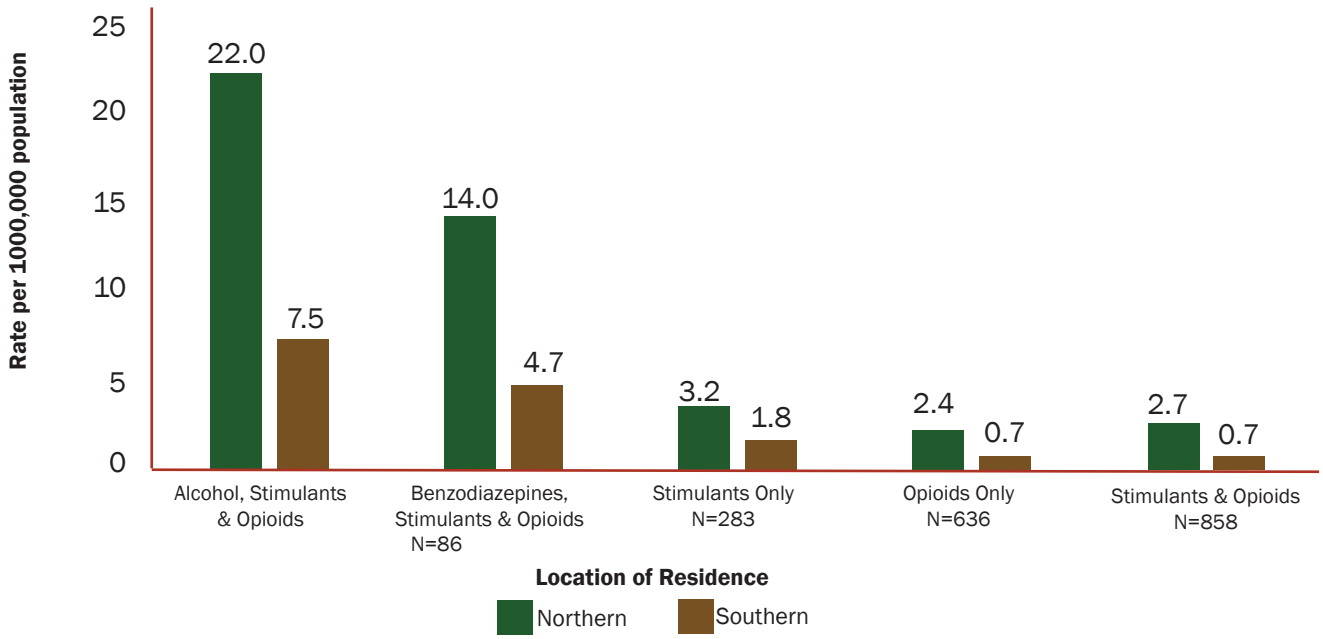
[xi] Two-spirit, lesbian, gay, bisexual, trans, queer plus other gender and sexual identities

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

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

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

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



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

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

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

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

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

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

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

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

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

An effective all-of-society approach requires:

Empathy
for the people and families experiencing substance use harms

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

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

Environments
that support and promote health and connection

Education
to help individuals make healthy choices

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

Engineering
products and processes to reduce harm and risk

Enforcement
of legal measures to reduce harms

Elimination
of harms whenever possible

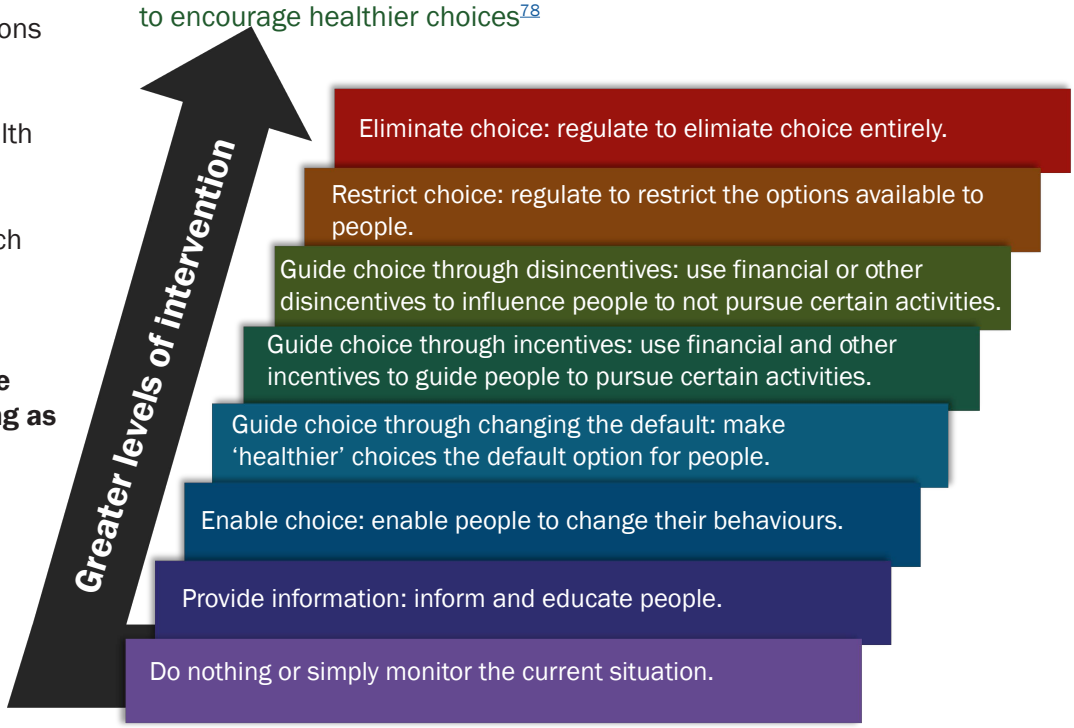
Ontario has already put in place many policies and initiatives designed to influence the drivers of substance use. However, as we learn more about substances and their impact on health, and as the substances themselves, the market for them, and the populations most at risk evolve, we must continually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

Using a Balanced, Progressive Strategy to Reduce Harms

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

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

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



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

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

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

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

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

Effective and Promising Substance Use Interventions

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

Targeting Upstream Drivers

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

Building stronger families

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

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

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

Improving youth mental health

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

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

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

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

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

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

Preventing initiation and escalation of youth vaping

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

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

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

Decolonizing practices and interventions for Indigenous peoples

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

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

> The OFIFC's approach to vaping cessation strategies reflects the community-driven research principles of Utility, Self-Voicing, Accessibility, and Inter-relationality (USAI).
>
> OFIFC. (2012). USAI Framework[92]

Youth-led strategies for vaping cessation

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

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

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

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

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

Building stronger communities

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

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

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

Creating healthier workplaces

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

Diverting people from the justice system to the health system

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

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

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

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

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

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

Targeting Downstream Drivers

Educating people about the risks

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

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

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

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

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

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

Regulatory Measures

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

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

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

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

*increased from 18 on January 1, 2020

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

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

Regulatory systems also:

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

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

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

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

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

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

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

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

Reducing the harms of regulated substances

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

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

Reducing the harms of unregulated substances

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

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

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

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

Providing fast, easy access to evidence-based treatments

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

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

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

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

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

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

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

Recommendations

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

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

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

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

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

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

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

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

The **public health sector** to:

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

The **health care system** to:

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

III. Adapting Our Substance-Specific Responses

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

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

1. Tobacco/Vaping Products

Trends and Health Impact

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

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

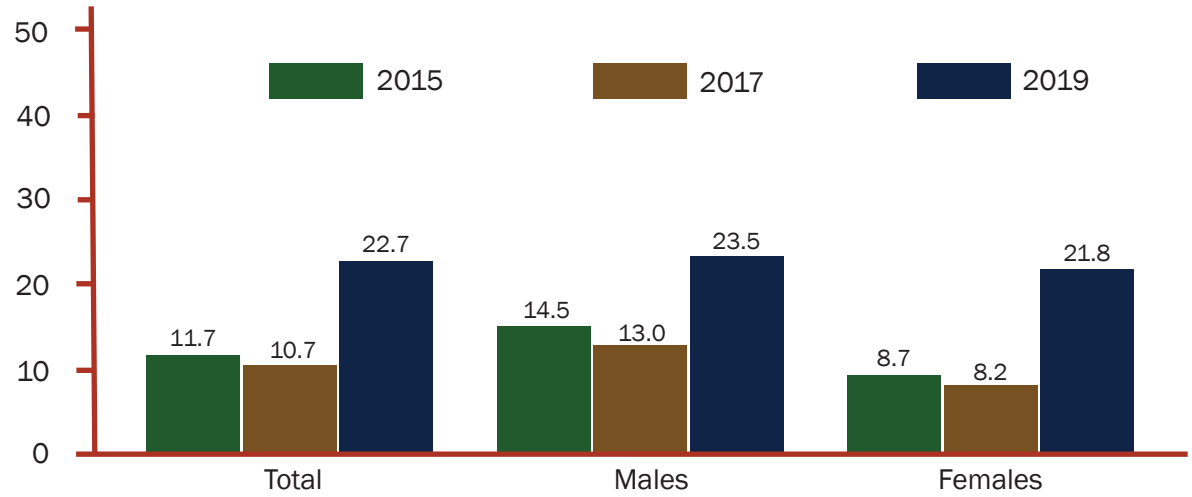
(https://www.cdc.gov/cancer/tobacco/index.htm)[131]

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

PHO, Youth Trends in ON[135]

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

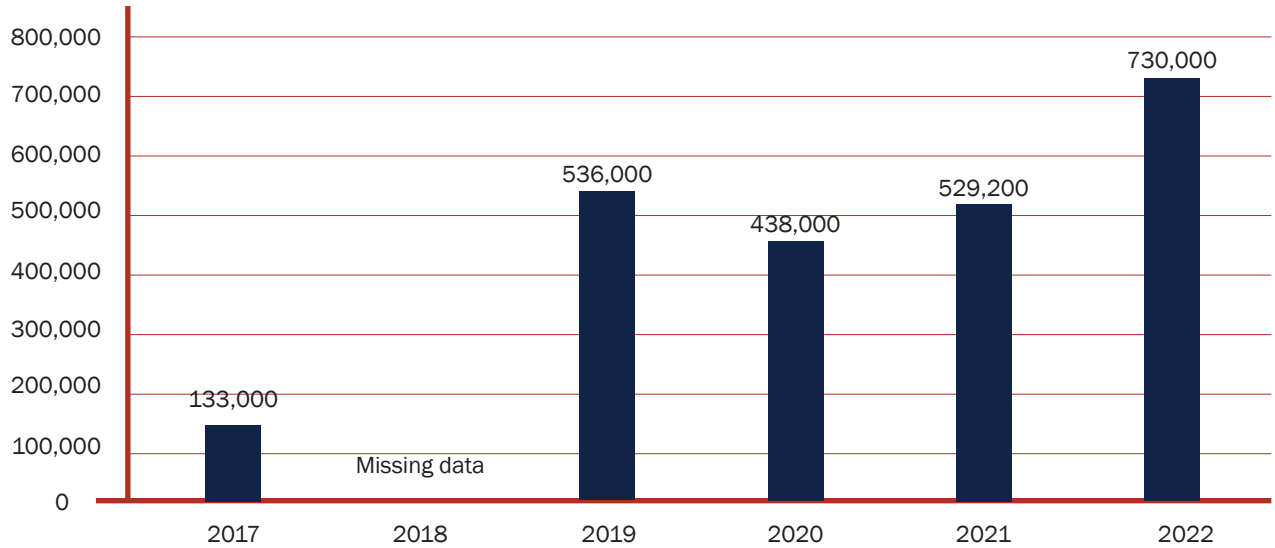
Figure 12: Percentage of high school students (grades 7-12) in Ontario using E-cigarettes (vaping) by sex, 2015, 2017, 2019



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

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

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



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

- A third disquieting trend is the development of non-tobacco nicotine products, such as nicotine pouches, that can lead to nicotine addiction and future tobacco use. These products do not fall under tobacco control legislation and are not adequately regulated. To address this emerging threat to health, Ontario needs a broad, overarching framework for nicotine regulation and control that goes beyond tobacco-based products.[146]
- In addition to containing highly addictive nicotine, most vaping products contain and emit many toxic substances that can affect the respiratory, immune, and cardiovascular systems, cause coughing and wheezing, and exacerbate asthma.[147]

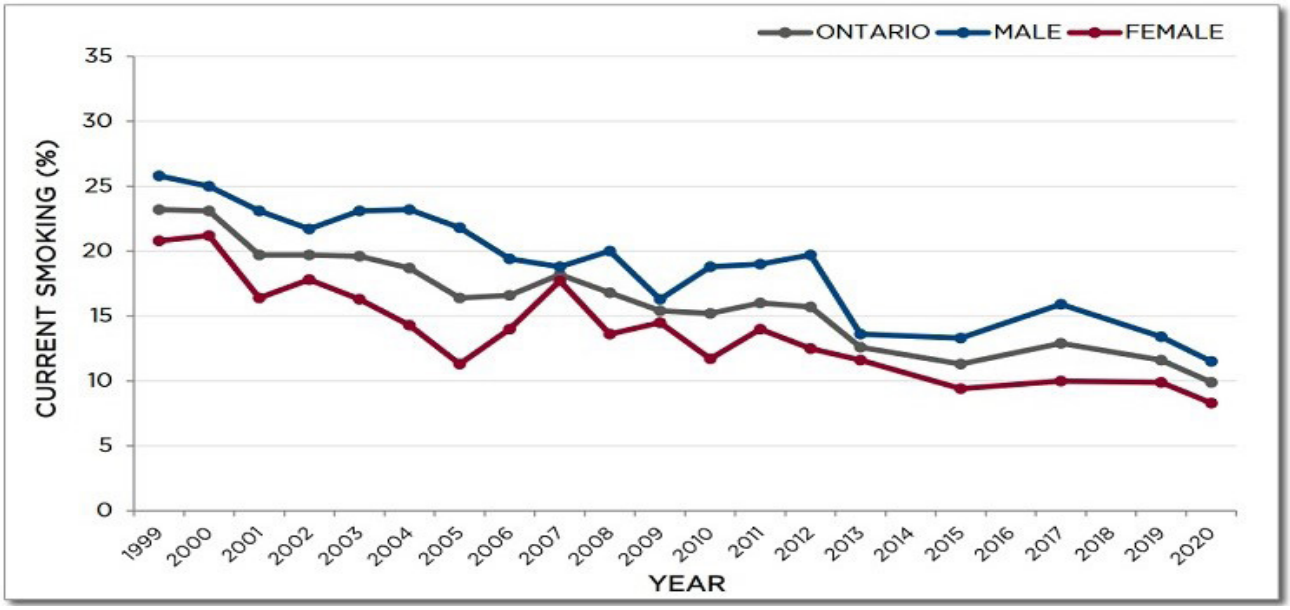
The health effects of exposure to second-hand aerosol from vaping devices are currently unknown.[145]

The Policy Environment/Challenges

Tobacco

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

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

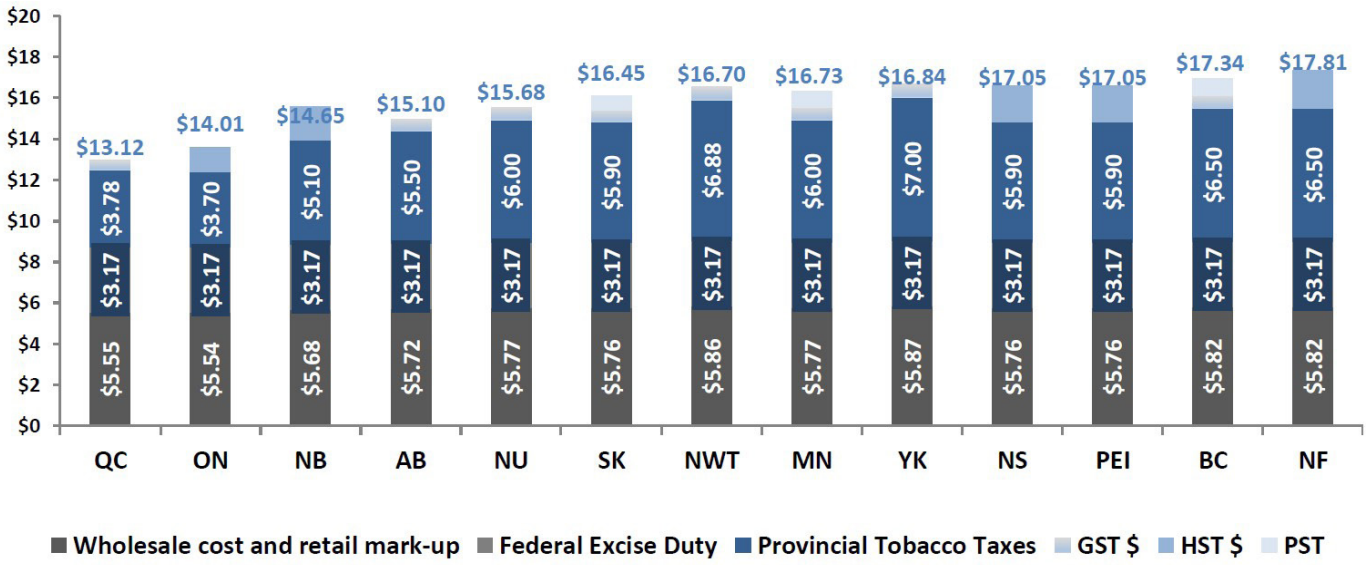


Source: Reid JL, Hammond D, Burkhalter R, Rynard VL. Tobacco use in Canada: patterns and trends: 2022 edition [Internet]. Waterloo, ON: University of Waterloo; 2022 [cited 2024 Feb 8]. Figure 2.15: Current smoking prevalence* among males and females, Ontario, 1999-2020; p.29. Available from: https://uwaterloo.ca/tobacco-use-canada/sites/default/files/uploads/fil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

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

[xiii] Includes both daily and occasional smokers

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



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

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

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

Vaping Products

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

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

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

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

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

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

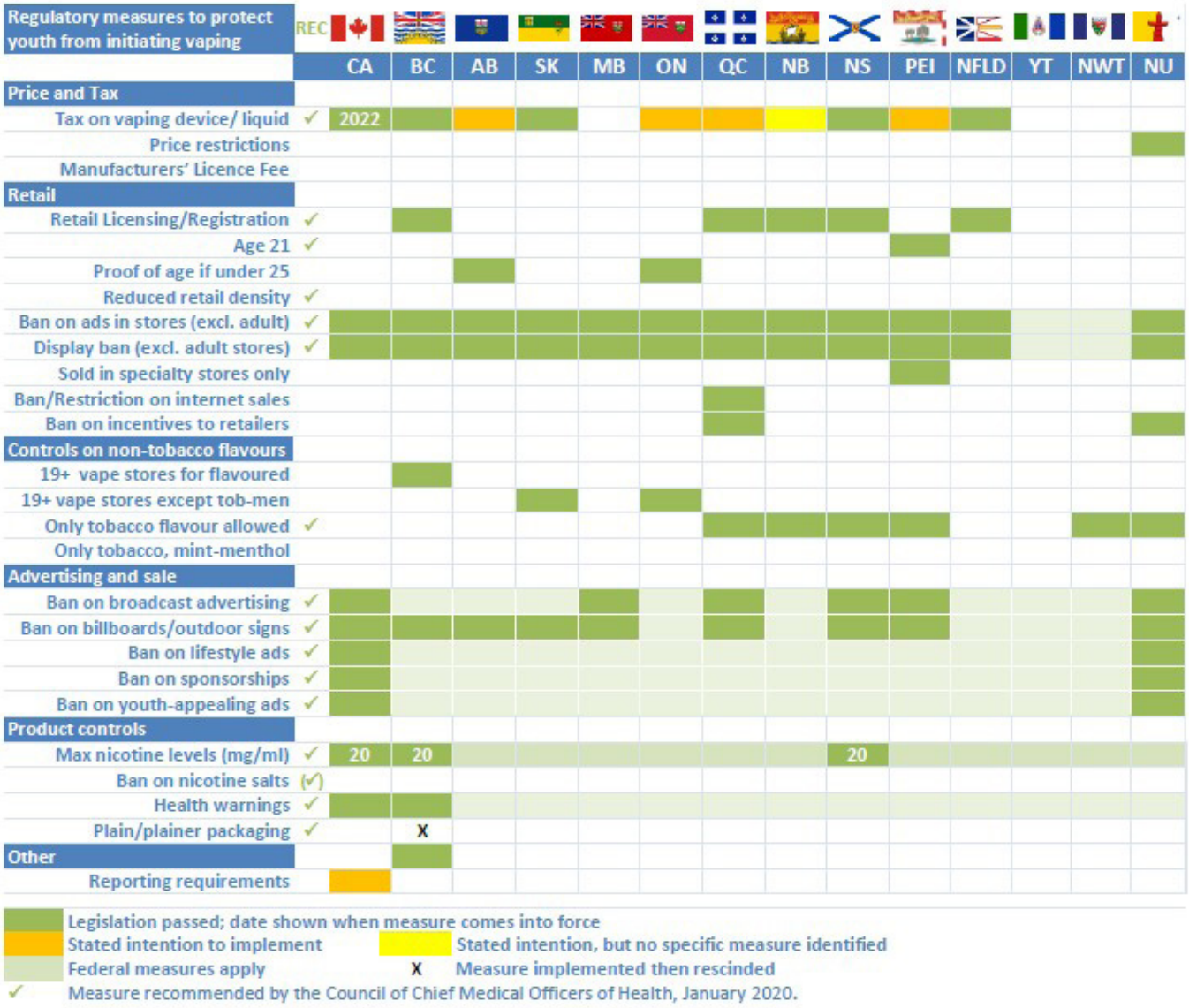
Figure 16 illustrates how Ontario compares to other provinces and territories in terms of regulating the sale of and access to vaping products.

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

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

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

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



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

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

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

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

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

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

Sales banned in these locations

Sales of some flavours banned in these locations (Ontario, British Columbia)

Measures proposed

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

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

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

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

Use banned in these locations by provincial or territorial law.

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

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

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

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

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

Recommendations

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

Targets

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

Health Promotion

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

Regulatory Measures

Minimum legal age of purchase

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

Product Controls

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

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

Availability

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

Pricing and Taxation

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

Promotion

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

Enforcement

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

Treatment

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

Monitoring and Reporting

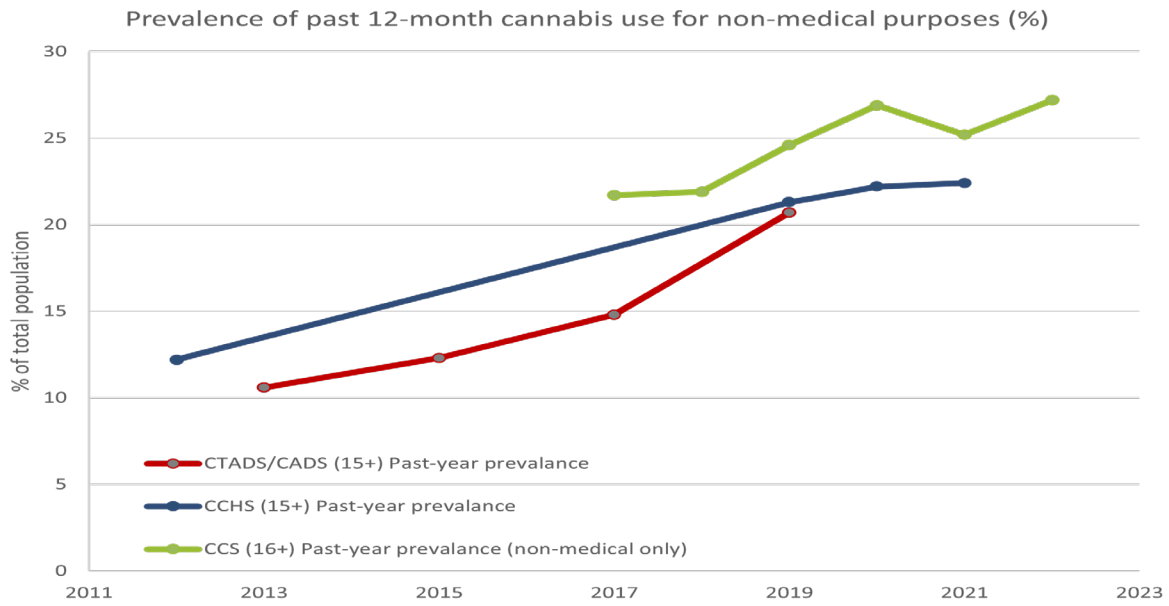
- Establish key performance indicators for public health inspectors and others involved in enforcing tobacco and vaping policies designed to protect minors and non-smokers
- Work with Public Health Ontario and with federal, provincial, territorial and Indigenous partners to continue to:
  - Monitor the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

2. Cannabis

Trends and Health Impact

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

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



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

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

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

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

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

The Policy Environment/Challenges

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

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

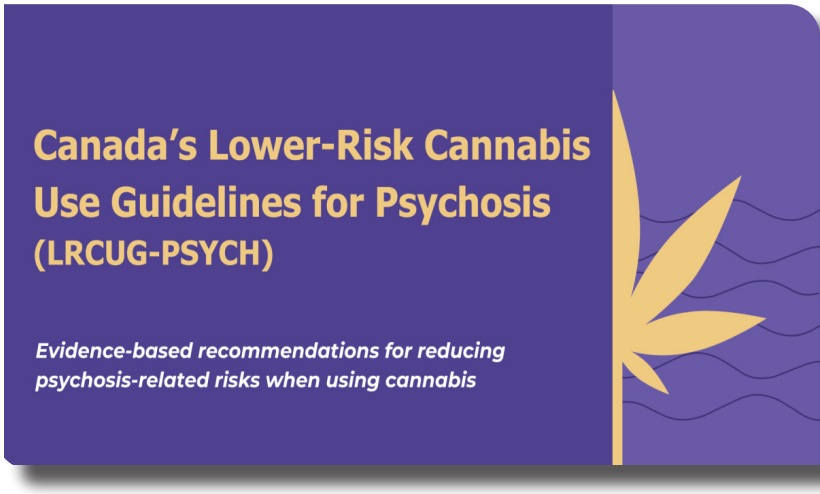
In July 2023, the Council of Chief Medical Officers of Health and Public Health Physicians of Canada submitted a joint statement, that I signed on to, outlining the public health challenges and recommendations for the future of national cannabis policy.[182]

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

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

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

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



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

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

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

Recommendations

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

Health Promotion

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

Regulatory Measures

Minimum legal age of purchase

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

Product Controls

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

Availability

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

Pricing and Taxation

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

Promotion

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

Enforcement

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

Treatment

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

Monitoring and Reporting

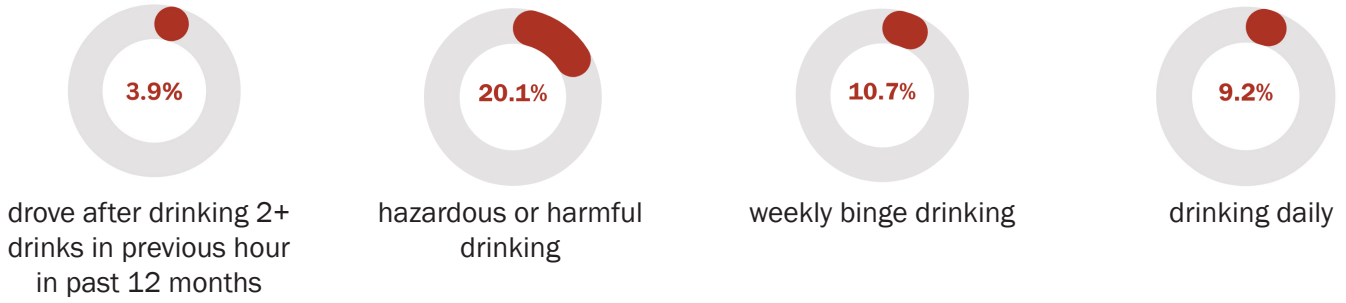
- Establish a "standard unit" of cannabis to improve surveillance and research on cannabis use and its associated harms
- Establish key performance indicators for those involved in enforcing cannabis regulations and policies
- Work with Public Health Ontario and with federal, provincial, territorial,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

3. Alcohol

Trends and Health Impact

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

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



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

- Although men drink more than women on average, women's alcohol consumption and the associated harms have been increasing at a faster rate, and the gender gap is narrowing. Between 2008 and 2018/19, emergency visits and hospitalizations in Ontario related to alcohol use increased by 37% and 300% for females compared to 2% and 20% for males.[191]
- In 2021, 60% of students in grades 7 to 12 reported trying alcohol, 24% using alcohol in the past month, 8% binge drinking (i.e. five or more drinks on one occasion at least once in the past month), and 5% hazardous drinking (i.e. 8 to 14 drinks per week in the past month).[192]
- Alcohol is a leading cause of preventable death in Ontario and a significant cause of serious health harms. In an average year in Ontario, about 4,330 (4.3%) deaths, 22,009 (2.1%) hospitalizations, and 195,693 (3.7%) of emergency department visits among people aged 15 and older can be attributed to alcohol use.[132] Most alcohol-attributable deaths in Ontario are from cancers (e.g. breast, colon, throat, mouth, larynx, esophagus, and liver) while most hospitalizations are for neuro-psychiatric conditions, such as alcohol withdrawal, amnesic syndrome and other mental and behavioural disorders, and most emergency department visits are for unintentional injuries such as falls or alcohol poisoning.[132]
- Even a small amount of alcohol per week (i.e., more than 2 standard drinks) can be damaging to health.[193] And the risk of alcohol-related harm increases with how frequently people drink and the amount they drink at one time.[66]

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

- Although lower levels of alcohol consumption may have a protective effect for some diseases, such as ischemic heart disease, people cannot selectively experience the potential benefits of low alcohol consumption while avoiding its carcinogenic effects. "Less is better" is the best message when talking to patients about alcohol.[194]

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

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

The Policy Environment and Challenges

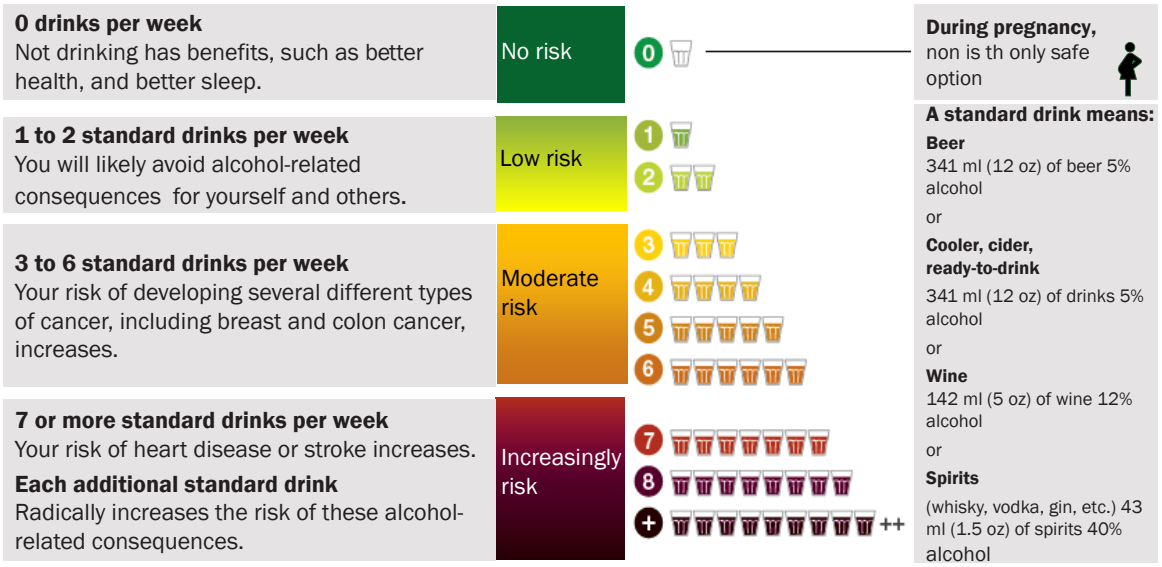
Alcohol is the most commonly used substance in Ontario. Binge drinking and hazardous drinking both increased during the COVID-19 pandemic.

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

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

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

Figure 22: Spectrum of Risk from Alcohol Use



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

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

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

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

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

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

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

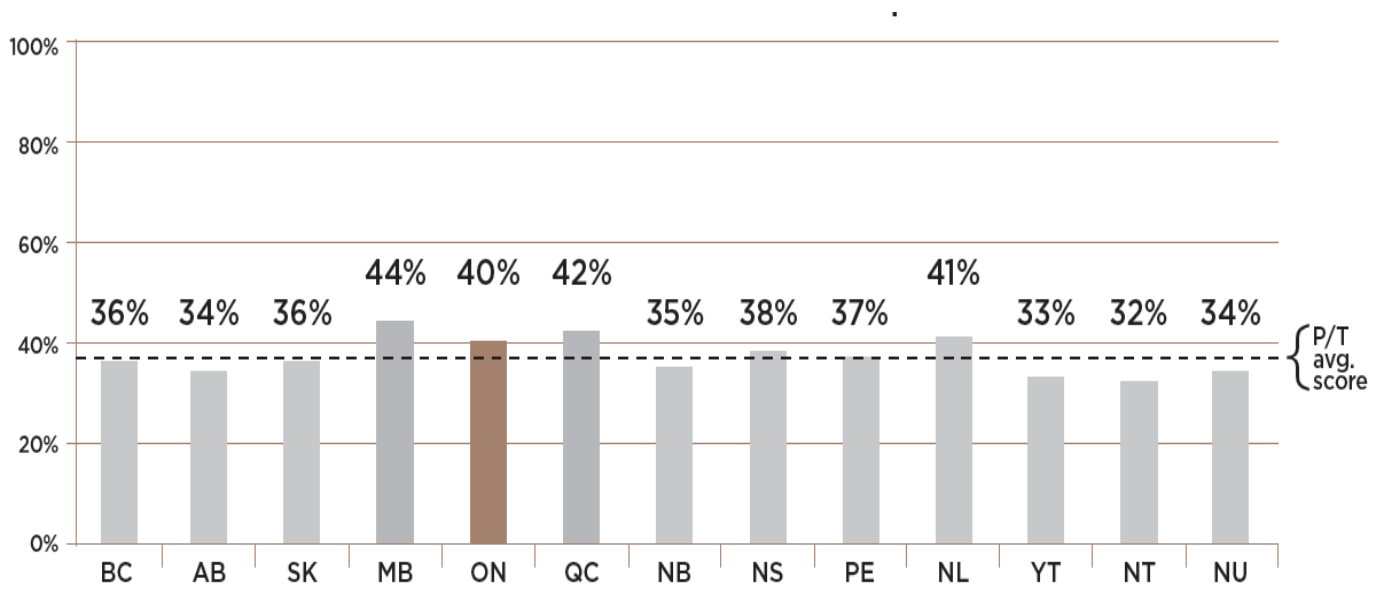
No type of alcohol product (beer, wine, spirits) meets the World Health Organization's recommended minimum unit price of $1.97 per standard drink in 2022 dollars. The gap between the recommended minimum price and the actual retail price in Ontario has been increasing since 2013.[57]

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

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

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

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



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

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

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

Recommendations

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

Health Promotion

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

Regulatory Measures

Minimum legal age of purchase

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

Product controls

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

Availability

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

Pricing and Taxation

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

Promotion

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

Enforcement

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

Treatment

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

Monitoring and Reporting

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

4. Opioids

Trends and Health Impact

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

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

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

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

The Policy Environment/Challenges

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations

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

Health Promotion

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

Regulatory Measures

Decriminalization

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

Toxic Drug Supply Controls/Availability

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

Enforcement

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

Harm Reduction

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

Treatment

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

Services for Families, Friends and Workers

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

Monitoring and Reporting

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

Conclusion

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

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

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

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

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

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

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

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

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

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

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

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Appendix

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

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

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

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

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

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

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

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