Our Vision:
Healthy People in Vibrant Communities

BOARD OF HEALTH MEETING
AGENDA

Woodstock Site: Oxford County Administration Building
21 Reeve Street, Woodstock, ON
Virtual Participation: MS Teams
Thursday, February 27, 2025, at 1:00 p.m.

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, and open session portions are publicly available for viewing for 30 days after being posted on Southwestern Public Health's website.	Bernia Martin	
2.0 APPROVAL OF MINUTES			
2.1	Approval of Minutes • January 23, 2025	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	Medical Officer of Health Report for February 27, 2025	Dr. N. Tran	Receive and File
5.2	Chief Executive Officer's Report for February 27, 2025	D. McDonald on behalf of C. St. John	Receive and File
6.0 NEW BUSINESS/OTHER			
7.0 CLOSED SESSION			
8.0 RISING AND REPORTING OF THE CLOSED SESSION			
9.0 FUTURE MEETINGS & EVENTS			

9.1	• Board of Health Orientation: Thursday, March 27, 2025 at 12:00 p.m.
	• Board of Health Meeting: Thursday, March 27, 2025 at 1:00 p.m.
	  ○ St. Thomas Site
	  ○ 1230 Talbot Street, St. Thomas, ON
	  ○ Virtual Participation: MS Teams		

10.0 ADJOURNMENT			

January 23, 2025

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, January 23, 2025 commencing at 1:04 p.m.

**Represents virtual participation*

PRESENT:

Mr. J. Couckuyt	Board Member
Mr. G. Jones	Board Member
Mr. J. Herbert	Board Member
Ms. B. Martin	Board Member (Vice Chair)
Mr. S. Molnar*	Board Member
Mr. M. Peterson	Board Member
Mr. L. Rowden	Board Member
Mr. M. Ryan	Board Member
Mr. D. Warden	Board Member
Ms. C. St. John	Chief Executive Officer
Dr. N. Tran	Medical Officer of Health
Dr. J. Lock	Acting Medical Officer of Health
Ms. W. Lee	Executive Assistant

GUESTS:

Ms. J. Austin	Health Promoter
Ms. B. Boersen	Health Promoter
Ms. J. Gordon	Administrative Assistant
Mr. P. Heywood*	Program Director
Mr. D. McDonald	Director, Corporate Services and Human Resources
Ms. M. Nusink*	Director, Finance
Ms. N. Rowe*	Manager, Communications
Mr. I. Santos	Manager, Information Technology
Ms. M. Van Wylie	Program Manager, Healthy Communities

MEDIA:

Mr. J. Konecny*	Aylmer Express

REGRETS:

Ms. C. Agar	Board Member
Mr. D. Mayberry	Board Member
Mr. J. Preston	Board Member

Mr. D. Shinedling	Board Member
Ms. S. MacIsaac	Program Director
Mr. D. Smith	Program Director

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 1:02pm.

1.2 AGENDA

Resolution # (2025-BOH-0123-1.2)
Moved by M. Ryan
Seconded by D. Warden

> That the agenda for the Southwestern Public Health Board of Health meeting for January 23, 2025 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.

1.5 Election of Officers:

M. Peterson asked G. Jones if he was interested in the position of Chair for 2025, given his role as Vice Chair in 2024. G. Jones respectfully declined the nomination, citing his busy schedule.

G. Jones nominated B. Martin for the position of Chair for 2025. J. Herbert seconded the nomination. B. Martin allowed her name to stand for nomination.

Resolution # (2025-BOH-0123-1.5A)
Moved by G. Jones
Seconded by J. Herbert

> That Bernia Martin be Chair of the Board of Health for Southwestern Public Health for the year of 2025.

Carried.

L. Rowden nominated M. Ryan for the position of Vice-Chair for 2025. M. Ryan respectfully declined the nomination.

D. Warden nominated G. Jones for the position of Vice-Chair for 2025. M. Peterson seconded the nomination. G. Jones allowed his name to stand for nomination.

Resolution # (2025-BOH-0123-1.5B)
Moved by D. Warden
Seconded by M. Peterson

> That Grant Jones be Vice-Chair of the Board of Health for Southwestern Public Health for the year of 2025.

Carried.

Resolution # (2025-BOH-0123-1.5C)
Moved by G. Jones
Seconded by M. Peterson

That the Board of Health Chair for Southwestern Public Health delegate the Chief Executive Office as acting "Head" for the purpose of ensuring day-to-day fulfilment of Southwestern Public Health's compliance obligations under the Municipal Freedom and Information and Protection of Privacy Act (MFIPPA) for the year 2025.

Carried.

D. Warden noted that previous practice had Board Chairs sitting for only one year, apart from the repeated appointment of the same Chair during the Covid pandemic and would now like clarification. C. St. John confirmed that Board policy indicates that the Chair serves for a one (1) year term. The policy does allow for the extension of the Chair role for an additional year provided that the Board votes to do so.

D. Warden asked for confirmation that Southwestern Public Health (SWPH) is a full board. C. St. John clarified that a full Board of Health (BOH) includes eight municipal appointees and up to seven provincial appointees, of which five provincial appointments have been assigned. Of the municipal appointments, the City of St. Thomas and the County of Oxford confirm their Board appointments for the duration of their councillor's term, and the County of Elgin assigns Board appointments on a yearly basis.

2.0 APPROVAL OF MINUTES

Resolution # (2025-BOH-0123-2.1)
Moved by M. Peterson
Seconded by J. Herbert

> That the minutes for the Southwestern Public Health Board of Health meeting for November 28, 2024 be approved.

Carried.

3.0 CONSENT AGENDA

No Items.

4.0 CORRESPONDENCE RECEIVED REQUIRING ACTION

No items.

S. Molnar joined via MS Teams at 1:22pm.

5.0 AGENDA ITEMS FOR INFORMATION.DISCUSSION.DECISION

5.1 SWPH Report on Planet Youth: Implementing the Icelandic Prevention Model, a Community-Based Approach to Reducing Youth Substance Use

Jessica Austin and Brooke Boersen presented the report.

G. Jones asked what percentage of federal funding is available. J. Austin noted the federal government is providing over $20 million in funding at the national level through a competitive application process. Communities can apply based on their specific needs, wherein the exact percentage or dollar amount received depends on the details outlined in the application.

J. Herbert praised the report and inquired about quarterly progress updates. C. St. John replied that the Board will receive regular updates on various program areas, including Planet Youth.

L. Rowden asked what the commitment would be from other organizations regarding the project. J. Austin responded that community partners would contribute their existing resources and expertise to the model. For example, the Community Foundation would manage a flow-through fund and facilitate donor engagement, while Family and Children Services would use data to inform their work and help engage hard-to-reach families. Partners would thus collaborate on knowledge exchange, data collection, and future implementation strategies. This approach is also present in our school system regarding the implementation of programs and opportunities. .

B. Boersen added there would be also different levels of partnership and support as well of different kinds of in-kind contributions at this stage in the project, where the data gathered via these partnerships will be used to identify and refine community priorities and develop evidence-based solutions and programs.

J. Couckuyt praised the report and program, noting there are only 20 in the country, and asked when the survey is happening. J. Austin indicated that, in collaboration with the coalition, region, and all three school boards, it would be a late fall rollout for the survey.

J. Couckuyt noted that SWPH has provided $30,000 for the initial cost of the program so far and asked if there would be any continued cost for the health unit. J. Austin noted that funds have been allocated to support the work.

J. Couckuyt inquired whether the funding for Planet Youth would be ongoing or included as part of the annual budget. C. St. John confirmed that the annual budget requires approval from the Board and noted that there is an allocation for Planet Youth in 2025. Further funding will be evaluated and considered during the budget process annually that comes to the Board.

J. Couckuyt asked if the presenters could provide a concrete example of what data implementation would look like. B. Boersen noted that some communities in Ontario have already begun this process, and they have received data from Planet Youth, which has been fully analyzed. Population Statistics Planet Youth provide a service that includes action planning for each group to determine targeted areas at reducing risk factors or improving protective population factors. For example, Lanark County identified sleep as an issue within their community and are now focusing on policies and programs to improve youth sleep.

M. Ryan asked if there were any opportunities for SWPH to leverage the funding for municipalities' Community Safe and Well-Being plans and if there were ways to expedite the programs more quickly and effectively. J. Austin noted they do aim to collaborate with existing groups that share similar values and strategies focused on advancing youth well-being and would consider Community Safe and Well-Being plans as foundational to their goals and objectives within the community. Regarding the Board's leverage within these networks and discussions, J. Austin indicated that SWPH recently distributed a document containing frequently asked questions about Planet Youth, noting that they are employing a top-down, bottom-up approach when working with local community partners as well as provincial and federal partners.

M. Peterson added his praise for the report, particularly its potential in addressing and preventing issues at formative stages for youth. B. Boersen noted that a cost analysis has indicated a one dollar in prevention will save about $5 - $18 downstream in programs and services, so there is evidence of its economic impact on the community.

M. Ryan asked if SWPH needed support in strengthening their relationship with school boards to enhance their participation. B. Boersen noted they have established a strong working relationship with the research and ethics teams at London District Catholic School Board as well as Thames Valley District School Board. There are also beginning initial discussions with the French school board. Additionally, they have conducted a risk assessment to evaluate the survey's psychometric validity, ensuring there is nothing alarming that could negatively impact youth. The team is also currently developing research and ethics applications with the school boards.

C. St. John added SWPH would be happy to support any opportunity that Board members have regarding schools and entities to talk about substance prevention and the Planet Youth model.

M. Ryan asked for key talking points to reference when speaking with other municipal council members and elected schoolboard representatives. M. Ryan also asked if there was anything that the Board could formally do to engage and unify area councils and school boards. C. St. John agreed there is value is providing key messages that recognize the specific values and priorities of the audience such as an area council and will confer with the team on providing tangible speaking points.

S. Molnar supported demonstrable, operational, and organizational data that would relay realistic savings that could further elicit support. J. Austin noted their access to the expanded

federal knowledge hub will include evaluating potential cost savings. While public health has access to the "Cost of Substance Use in Canada" report, this analysis will focus on local community savings which includes areas such as policing and social services. S. Molnar looks forward to a regional review of financial pressures and benefits.

M. Peterson noted that Oxford County Council would welcome such a report. M. Peterson appreciated the projected cost savings along with its potential benefit for local youth. C. St. John noted that SWPH would be happy to bring this report forward as a delegation to municipal leaders.

G. Jones requested a link to the website to view the slide deck presentation and suggested sharing it on the website. C. St. John made note of this request and will instruct the team to do so.

S. Molnar asked for confirmation that the incoming federal numbers would also provide local data. J. Austin confirmed that they will obtain the report from the contracted knowledge hub experts at the University of Waterloo which will then be provided to the board for review.

S. Molnar referenced the Association of Municipalities of Ontario (AMO) as a future audience for Planet Youth. B. Martin added that Planet Youth has been mentioned to and noted by Minister Tibollo at the recent Rural Ontario Municipal Association (ROMA) conference and could present a path for future advocacy work. J. Austin noted that Planet Youth communities have initiated an endorsement scan noting opportunities at all levels of community partners and government that can be provided to the Board for information when it is complete.

M. Ryan asked if the Board should consider authorizing Planet Youth as part of SWPH's ongoing funding where it would be presented to the funding municipalities as part of its obligated levy. C. St. John indicated she would discuss with staff and provide an update to the Board.

Resolution # (2025-BOH-0123-5.1)
Moved by M. Peterson
Seconded by D. Warden

That Board of Health for Southwestern Public Health receive and file the SWPH Report on Planet Youth: Implementing the Icelandic Prevention Model, a Community-Based Approach to Reducing Youth Substance Use for January 23, 2025.

Carried.

J. Austin, BB, and M. Van Wylie left the meeting at 1:55pm.

B. Martin welcomed Dr. N. Tran upon his return from his parental leave in advance of the next agenda item.

5.2 Acting Medical Officer of Health's Report

Dr. J. Lock reviewed her report.

M. Peterson asked about the incubation period for measles. Dr. Lock noted that from point of contact, you are at risk for 21 days, and there is likely more activity in the community than meets the eye as SWPH can only track cases reported at healthcare facilities.

M. Ryan asked for clarification, noting that SWPH has high rate of measles vaccination and that it seems incongruous that we have so many cases. Dr. J. Lock noted that measles is highly infectious and to avoid an outbreak scenario, the immunization rate for the population would, need to be at 98% to prevent or minimize the number of cases and infection spread.

S. Molnar expressed his appreciation of Dr. J. Lock for her work and report. He commended the recent dissemination of information to both the Board of Health and the general public regarding the measles news releases.

B. Martin extended the Board's thanks to Dr. Lock for her work as the Acting Medical Officer of Health during Dr. Tran's leave.

Resolution # (2025-BOH-0123-5.2)
Moved by G. Jones
Seconded by M. Peterson

> That Board of Health for Southwestern Public Health accept the Acting Medical Officer of Health's report for January 25, 2025.
>
> Carried.

D. Warden left the meeting at 2:31pm.

5.3 Chief Executive Officer's Report

C. St. John reviewed her report.

In addition to highlighting program and service work from her report, C. St. John provided verbal updates regarding recent activities. First that SWPH received an invitation to provide a 3-minute delegation presentation to the Minister of Finance at St. Thomas on January 28, 2025. C. St. John and Dr. N. Tran will attend and speak on the value of public health, its return on investment, and the need for adequate provincial funding to lessen the burden that our local municipalities have been faced with related to supporting public health work.

C. St. John also noted that the Association of Local Public Health Agencies (alPHa) released a letter (after the Board package was sent out), that was submitted to the Minister of Finance regarding their pre budget submission, noting that public health has acknowledged the government's investments in strengthening public health, including voluntary mergers and the

commitment to a funding review. However, there is still a need for increased, sustainable funding from the Ministry of Health to address budget pressures, inflation, and the significant return on investment public health provides. C. St. John called for Board direction to support the alPHa letter in which SWPH would also add local context such as the rising prevalence of mental health and substance use disorders, household food insecurity, climate change impacts, and the importance of surveillance, research, and data analysis to address root causes.

M. Ryan suggested compiling a report on various advocacy positions for the Board to review and approve in advance. This would allow for quicker responses to advocacy opportunities without timing constraints. The Chair and leadership could then act on these positions as needed. C. St. John agreed to take the suggestion back for consideration.

S. Molnar raised a question about whether third-party testing services, such as LifeLabs, would incur costs for the public. Jaime Fletcher, SWPH's Chief Nursing Officer, noted that fees are typically applied when a requisition is provided without a valid health card.

S. Molnar further asked whether individuals seeking testing at SWPH locations would face any charges. Dr. Tran clarified that most testing would not incur fees, as the sexual health program does not require OHIP cards and has an arrangement with Public Health Ontario labs. The exception is Pap tests, which must be sent to external labs like LifeLabs. In those cases, individuals without OHIP may face charges. He noted the "GetaKit" initiative as a way to further reduce barriers by offering mail-in testing options.

S. Molnar asked for clarification regarding the rationale for excluding industry involvement in discussions on alcohol-related harms, suggesting that reasonable industry representatives might provide valuable insights. P. Heywood noted that past experiences with the tobacco and alcohol industries show patterns of manipulation and influence, making it difficult to engage without concerns of interference. P. Heywood cited an example from the Yukon, where industry opposition prevented alcohol labeling policies from advancing.

S. Molnar asked whether transportation costs were factored into food affordability calculations. Peter Heywood noted he would take the question back to his manager's team for confirmation.

Resolution # (2025-BOH-0123-5.3-3.1)
Moved by M. Peterson
Seconded by J. Herbert

That the Board of Health ratify the signing of the IPAC Hub Transfer Payment Agreement for Southwestern Public Health as noted in the CEO report.

Carried.

Resolution # (2025-BOH-0123-5.3-4.1)
Moved by M. Ryan
Seconded by M. Peterson

The Board of Health for Southwestern Public Health support the January 20th, 2025 letter to the Minister of Finance from the Association of Local Public Health Agencies concerning its budget consultation and further in the letter of support it include additional information about Southwestern Public Health's local context to further strengthen its response.

Carried.

Resolution # (2025-BOH-0123-5.3)
Moved by M. Peterson
Seconded by G. Jones

That the Board of Health for Southwestern Public Health accept the Chief Executive Officer's report for January 23, 2025 as amended.

Carried.

6.0 NEW BUSINESS

M. Peterson proposed the introduction of new business related to the duration of the Board chair term, and suggesting the consideration of a two-year Board term. M. Peterson requested that this be taken as direction only, for the Governance Standing Committee's consideration, without the need for a formal resolution.

7.0 TO CLOSED SESSION

No closed session.

8.0 FUTURE MEETING & EVENTS

9.0 ADJOURNMENT

That the meeting adjourns at 3:46 pm to meet again on Thursday, February 27, 2025 at 1:00 pm.

Resolution # (2025-BOH-0123-9.0)
Moved by J. Herbert
Seconded by M. Peterson

That the meeting adjourns at 2:58 p.m.

Carried.

Confirmed: _____

Medical Officer of Health

Report to the Board

MEETING DATE:	February 27, 2025
SUBMITTED BY:	Dr. Ninh Tran, Medical Officer of Health (written as of February 12, 2025)
SUBMITTED TO:	Board of Health
PURPOSE:	☐ Decision ☐ Discussion ☒ Receive and File
AGENDA ITEM #	5.1
RESOLUTION #	2025-BOH-0227-5.1

1.0 Measles

The number of measles cases in our community continues to climb. Since January 1, 2025, there have been 12 confirmed cases as of February 11, 2025—an increase of 11 cases since the last Board of Health report in January.

Rising case numbers locally and in neighboring public health units (PHUs) have led to numerous exposures across different settings, significantly straining our ability to conduct active contact tracing and directly notify those who may have been exposed. Southwestern Public Health (SWPH) and Grand Erie Public Health (GEPH) have held joint media briefings since January 29, during which we both declared measles outbreaks in our communities.

Due to the high number of exposures, SWPH staff are prioritizing contact follow-up for children six years of age and younger who do not have two documented doses of the measles vaccine. The public is being informed of exposures through media releases that provide guidance on symptom monitoring and recommendations. This information is supported by an online Measles Exposure Risk Assessment Tool, launched on February 5, 2025, on our webpage: www.swpublichealth.ca/measles.

We continue to communicate regularly with neighboring PHUs and the province to coordinate and collaborate on our measles outbreak response, including messaging for local health care providers.

2.0 Homeless and Addiction Recovery Treatment Hubs (HART Hubs)

On January 27, 2025, the province announced the 18 successful applications for its HART Hubs funding, including one in the SWPH region: a joint HART Hub application from the Oxford Ontario Health Team (OHT), Woodstock Hospital, and several community partners, including SWPH. Applications were submitted by organizations in both Oxford and Elgin Counties. While the Elgin application was not awarded funding, it successfully brought together many community partners to build a roadmap for collective action.

The Oxford HART Hub is a new initiative designed to address mental health, addiction, and homelessness in Oxford County. It is a collaborative effort between the Oxford Ontario Health Team, Woodstock Hospital, and multiple community partners.

The HART Hub is not a single facility or organization but a coordinated system of care that includes outreach services, residential treatment, transitional housing, and access to mental health and addiction support programs. This initiative will establish dedicated treatment and recovery beds, ensuring seamless, wraparound care for those in need while optimizing community resources and avoiding duplication of services.

SWPH fully supports the HART Hubs initiative and recognizes its vital role in improving health outcomes for individuals struggling with mental health, addiction, and housing insecurity. By strengthening coordination among health and social services, this initiative will provide much-needed support and stability for some of the most vulnerable members of our community.

The proposed services include:

- **System Navigation** – Welcoming each client, co-identifying their needs, and connecting them to the appropriate support services. A mobile outreach component ensures clients receive information and access to resources where they are.
- **Education** – Providing clients with practical tools and strategies to manage their mental health, including guidance on navigating negative self-talk, coping with cravings and triggers, and building resilience.
- **Individual Programming** – Offering personalized support such as counseling, brief therapy, and addiction recovery services tailored to each client's needs.
- **Group Programming** – Creating a supportive environment where individuals can connect, share experiences, and work toward their personal goals in a group setting.
- **Core Addiction Programming** – Supporting clients in the early stages of recovery, including access to medically supported withdrawal management beds and acute services before transitioning to stability-focused programming.

Additional information can be found at: Oxford HART Hub Initiative.

3.0 Ontario Health Team (OHT Updates)

Connecting individuals to a family doctor or primary care team has been a priority for many, if not all, Ontario Health Teams (OHTs), including the Elgin and Oxford OHTs. On January 27, 2025, Ontario Health provided further direction and support to all OHTs, requesting them to focus on developing a local plan to achieve this goal.

3.1 Oxford OHT

Since early summer 2024, Oxford OHT has been addressing the reduction in primary care services in Oxford County, particularly in the Town of Tillsonburg, following the retirement or relocation of multiple family physicians. To support residents without a family physician or nurse practitioner, Oxford OHT has worked to establish a clinic.

OHT partners contributed resources to develop the clinic, including identifying potential locations, providing clinical supplies, and offering nursing support. However, additional funds were needed for health human resources. The Town of Tillsonburg has officially approved funding to cover the outstanding costs required to temporarily launch the clinic, and a project team has been established to implement it.

3.2 Elgin OHT

With funding received from a collaborative submission in 2023, Elgin OHT continues to expand access to local, team-based primary care. Since its opening in September 2024, the new Elgin Community Health Hub has served more than 3,000 individuals who otherwise would not have access to primary care. Many of these individuals are newcomers, people who have gone years without primary care, or those whose family physician or primary care nurse practitioner is located in another region and is inaccessible to them.

The Thames Valley Family Health Team is the primary fund recipient for these efforts, working in collaboration with multiple partners within the Elgin Ontario Health Team.

MOTION: 2025-BOH-0227-5.1
That the Board of Health for Southwestern Public Health accept the Medical Officer of Health's Report for February 27, 2025.

CEO REPORT

Open Session

MEETING DATE:	February 27, 2025
SUBMITTED BY:	D. McDonald on behalf of Cynthia St. John, Chief Executive Officer (written as of February 12, 2025)
SUBMITTED TO:	Board of Health
PURPOSE:	☐ Decision ☐ Discussion ☒ Receive and File
AGENDA ITEM #	5.2
RESOLUTION #	**2025-BOH-0227-5.2**

1.0 PROGRAM AND SERVICE UPDATES (RECEIVE AND FILE):

1.1 COMMUNITY HEALTH STATUS REPORTS

In August 2024, the epidemiologists on the Foundational Standards team began the publication of our updated Community Health Status Reports on the Southwestern Public Health (SWPH) website. We updated the Board on the publication of the first report, the 2024 Community Profile Report, in September 2024. Over the last four months, we have published 7 reports to our website (which are appended to this report for reference):

- Infectious Diseases: An Analysis of Cases and Outbreaks in the Southwestern Public Health Region: This report highlights the infectious diseases that have been circulating in our communities and highlights trends of note when diseases are increasing, decreasing or are significantly different from the patterns seen in the rest of Ontario.
- Adult Substance Use and Harms in the Southwestern Public Health Region: This is a series of 4 smaller reports aimed at describing both substance use trends among adults in the Southwestern Public Health region as well as some associated harms. These reports include:
  - Alcohol
  - Cannabis
  - Tobacco
  - Opioids

- Youth Substance Use and Harms in the SWPH Region: This is a substance use report that focuses specifically on substance use and its associated harms among youth in our region. This report compares findings to the adult reports where applicable.
- Mental Health: An analysis of mental health, illness and wellbeing data in the SWPH Region: This report examines both self-reported survey data and service use data, such as hospitalizations and emergency department visits. It focuses on local data, noting trends over time, between age groups, and males and females.

Future reports on Adverse Childhood Events (ACEs), Maternal Mental Health, Immunization, and Oral Health are in draft stages, with an anticipated publish date in late spring. These reports are intended to serve as resources for community partners, regional committees, and healthcare providers to understand and inform their approach to these important health issues.

1.2 CHRONIC DISEASE AND INJURY PREVENTION

Ontario Dietitians in Public Health Position Statement: *Towards a Weight-Inclusive Approach in Public Health*

Ontario Dietitians in Public Health (ODPH), a collaborative network of Registered Dietitians working in Ontario's Public Health System, recently released a position statement titled *Towards a Weight Inclusive Approach in Public Health*. This position statement identifies weight bias and the resulting stigma and discrimination as a significant public health problem and social justice issue that leads to health inequities. In Ontario, 52.5% of students in grades 7-12 reported being bullied because of their weight in the past year.[1] Locally, 48.7% of youth 12-17 reported a preoccupation with a desire to be thinner.[2] These statistics highlight the pervasiveness of weight bias and the impact it has on health and well-being.

The position statement from ODPH takes a bold approach to facilitate a shift in attitudes and perspectives toward weight. Southwestern Public Health has a position statement titled Health and Wellbeing Philosophy and Approach to Weight (2018) that speaks to the impact of weight stigma and discrimination. Our team is revamping our position statement to reflect updated recommendations by ODPH to ensure our programs and services do not perpetuate weight bias. We look forward to sharing this work further with the Board later this year.

1. Boak, A., & Hamilton, H. A. (2024). The mental health and well-being of Ontario students, 1991–2023: Findings from the Ontario Student Drug Use and Health Survey (OSDUHS). Toronto, ON: Centre for Addiction and Mental Health.
2. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Healthy eating behaviours among 1-17-year-olds using the Canadian Health Survey of Children and Youth. Toronto, ON: King's Printer for Ontario; 2024.

1.3 HEALTH PROTECTION

1.3.1 Infectious Disease and Respiratory Response

The number of respiratory outbreaks in long-term care and retirement homes has stabilized over the past few weeks. As of February 10, 2025, 5 homes were experiencing a respiratory outbreak, while 3 homes had an enteric outbreak. The primary pathogens causing illness remain COVID-19 and influenza A. However, the number of enteric outbreaks has increased recently.

Lab-confirmed cases of influenza in January 2025 were higher than in January 2024, contributing to an increase in influenza A outbreaks during the 2024-25 respiratory season. Notably, one long-term care home was identified as having Tamiflu-resistant influenza A, a rare occurrence in the province of Ontario in recent years. Public Health Ontario provided support to SWPH in managing this outbreak.

There have been no new premises identified with Highly Pathogenic Avian Influenza. Meanwhile, the number of mumps cases in the region has been decreasing.

2024/25 Respiratory Vaccine Campaign – Community

Four follow-up clinics have been held in 2025 for children under five years of age to receive their second required dose of the COVID-19 vaccine. Another clinic is tentatively planned for the end of March in Woodstock.

The National Advisory Committee on Immunization (NACI) has released guidance for 2025 and into the summer of 2026. Funding for the purchase of COVID-19 vaccines will transition from the federal to the provincial government. However, vaccine eligibility and timing have not yet been communicated by the province. NACI continues to recommend an annual dose of the most updated COVID-19 vaccine for individuals 6 months of age and older, with some populations potentially benefiting from a second annual dose in the spring, including:

- Adults aged 80 years and older
- Adult residents of long-term care homes and other congregate living settings for seniors
- Individuals 6 months and older who are moderately to severely immunocompromised
- Previously vaccinated adults aged 65-79 at increased risk of severe COVID-19 disease

Many pharmacies in the SWPH region continue to have both flu and COVID-19 vaccines available.

Local trends can be viewed on the **SWPH Respiratory Virus Activity Dashboard**, which is updated weekly on Tuesdays.

1.3.2 Environmental Health Updates

The shortage of rabies vaccines and immunoglobulin is expected to continue until April 2025. Hospitals and healthcare providers have been strongly encouraged to consult with the Office of the Chief Medical Officer of Health (OCMOH) before administering post-exposure prophylaxis (PEP) to ensure appropriate use and allocation of limited resources. The OCMOH continues to monitor supply levels and provide guidance to healthcare partners as needed.

Elevated levels of fluoride and sodium persist in the drinking water of various communities in Oxford County. As part of SWPH's ongoing public health efforts, an annual public communication and health information advisory was issued on January 28, 2025, informing residents of the potential health implications and recommended precautions. SWPH continues to work closely with municipal water operators and provincial authorities to monitor water quality and provide timely updates to the public.

1.4 STRATEGIC PLANNING UPDATE

We are excited to have completed the second phase of our strategic planning process, Evidence and Engage. During this phase, we gathered input from key stakeholder groups on SWPH's strengths, areas for improvement, potential threats, and future opportunities. We also explored areas of innovation and asked for insights on the public health and organizational priorities that should guide SWPH over the next five years.

Engagement and participation were strong across all groups, including the Board of Health, leadership teams, frontline staff, community partners, and members of the public. The feedback we received has been compiled into a discovery report, which highlights key themes and insights across all stakeholder perspectives. These findings will play a critical role in shaping our next phase, Envision, where we will define and prioritize our strategic goals, priorities, and objectives for the next five years.

As we move forward, we are energized by the ideas and perspectives shared and look forward to shaping a future that reflects the needs of our community.

1.5 HUMAN RESOURCES

1.5.1 Employee Engagement Strategy Update

In January, Human Resources staff presented findings from an all-staff strategy aimed at understanding the overall employee engagement experience at SWPH. The feedback highlighted a strong collective commitment to the organization's mission and a shared desire to enhance collaboration, recognition, and overall engagement.

SWPH first launched a staff engagement initiative in 2021; however, this work was paused due to the COVID-19 pandemic. In early 2024, efforts resumed to assess employee engagement, commitment, and satisfaction. This included both formal survey work and staff focus groups, providing an opportunity to explore ways to strengthen engagement within the organization. Employees were asked a series of questions to help define engagement in a way that reflects the values and aspirations of our workforce.

Our leadership teams are now reviewing proposed solutions, options, and recommendations to address the feedback received. Moving forward, our focus is on building upon existing successes and fostering a workplace culture where all employees—both new and longstanding—feel genuinely engaged, valued, and supported.

1.5.2 Employee Recognition Strategy Update

Frontline staff and leadership teams were introduced last month to a new strategy aimed at fostering a workplace culture of recognition at SWPH. This strategy focuses embedding recognition into our workplace culture and focusing on actions of gratitude and appreciation that are authentic, specific, and meaningful.

Following the results of our recent engagement survey, strengthening recognition emerged as a top organizational priority. As part of this effort, we gathered employee perspectives on where recognition has been effective and where improvements can be made.

By incorporating both formal and informal recognition into this strategy, SWPH is committed to ensuring that future efforts are effective, equitable, and impactful—enhancing employee engagement, retention, and the overall workplace culture.

2.0 SWPH'S PRE-BUDGET CONSULTATION & SUBMISSION TO THE MINISTER OF FINANCE (RECEIVE AND FILE):

SWPH participated in the Ontario Ministry of Finance's pre-budget consultations on January 28, 2025, with CEO Cynthia St. John and Medical Officer of Health Dr. Ninh Tran advocating for sustainable public health funding. Acknowledging Ontario's commitment to strengthening health care through initiatives like *Strengthening Public Health* and *Roadmap to Wellness*, SWPH emphasized the need for greater investment in upstream health interventions that prevent illness and reduce strain on the healthcare system. Public health programs—such as vaccinations, dental care, and youth substance use prevention—are critical to reducing long-term costs, but they require stable funding. SWPH called for a firm commitment to fully fund 75% of public health costs, noting that funding freezes or minimal increases effectively translate to cuts. With inflation averaging over 4% annually since 2020, the province's funding model has shifted the financial burden onto municipalities.

Following the presentation, SWPH submitted a letter to the Minister of Finance reinforcing these concerns. The letter highlighted the urgent need for stable funding and addressed food insecurity, which affects 1 in 4 individuals in the region and increases healthcare costs. SWPH urged the province to increase Ontario Works (OW) and Ontario Disability Support Program (ODSP) rates, align the minimum wage with the regional living wage, and enhance school food programs. An infographic accompanied the submission with the focus on illustrating the cost-effectiveness of public health investments. SWPH emphasized that a fiscally responsible budget must prioritize public health to build a healthier, more equitable Ontario.

MOTION: 2025-BOH-0227-5.2
That the Board of Health for Southwestern Public Health accept the Chief Executive Officer's Report for February 27, 2025.

Infectious Diseases

An analysis of cases and outbreaks in the Southwestern Public Health region

Community Health Status Report
Southwestern Public Health
September 2024

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Contents

Summary

Sexually Transmitted and Blood-borne Infections

- In recent years, the local rates of chlamydia, gonorrhea and infectious syphilis were lower than the provincial rates, however, the rate of hepatitis C was slightly higher locally.
- Chlamydia rates were higher among females, while gonorrhea, infectious syphilis and hepatitis C rates tended to be higher among males. In 2018, SWPH had its first female case of infectious syphilis and since then the rate among females has risen.
- Overall, the local rate of infectious syphilis has been increasing over time, while the rate of hepatitis C has been decreasing. Gonorrhea case counts and rates increased between 2018 and 2022, however, experienced a sharp decrease in 2023.

Vector-borne Disease

- Estimated Lyme disease risk areas grew considerably between 2018 and 2022, expanding into the SWPH region for the first time. The rate of Lyme disease in the SWPH region increased steeply in recent years, surpassing the provincial rate in 2023.

Enteric and Foodborne Diseases

- Campylobacteriosis is the most commonly reported enteric disease in the SWPH region. Since 2019, the local rate of infection has been higher than the province.
- In recent years the local rate of salmonellosis was very similar to the provincial rate, decreasing between 2019 and 2021 and increasing between 2021 and 2022.

Respiratory Diseases

- In 2022 and 2023, COVID-19 hospitalizations peaked in the winter and fall months. More hospitalized cases were in the ICU in 2021 and 2022 compared to 2023. This could indicate that the population has developed immunity (from vaccine or previous illness) or that more recent circulating variants of COVID-19 are less severe.

- During the 2022/23 respiratory season, the local rate of influenza was higher than any other flu season in the 5 years prior. The highest rates of illness were among children 9 years of age and under.
- Pertussis cases tend to come in waves locally that are not seen on a provincial level. Most cases occur among unvaccinated communities within the SWPH region.
- Between 2022 and 2023, the rate of invasive group A streptococcus (iGAS) more than doubled in the SWPH region and Ontario.

Institutional Outbreaks

- The number of confirmed local institutional outbreaks more than doubled in 2022 compared to pre-pandemic in 2019. The pathogen responsible for the majority of outbreaks in 2022 was COVID-19.

Introduction

This report presents local findings for many Diseases of Public Health Significance (DOPHs), examining case counts and rates as well as highlighting differences by age and sex where relevant. Not all DOPHs were included in this report and factors such as the volume of cases reported per year along with major changes to either the rate or demographics were considered when deciding which diseases would be included.

Surveillance data for diseases reported in 2020 and 2021 should be interpreted with caution. During the COVID-19 pandemic, there were many changes in the availability of health care, health seeking behaviour, public health follow-up and case entry. All of these factors had an impact on the data and a decrease in rate was observed for many diseases during this time frame.

Sexually Transmitted and Blood-borne Infections

Chlamydia

Chlamydia is a preventable and curable sexually transmitted infection (STI).[1] It can spread through unprotected vaginal, anal or oral sex with an infected person. It's sometimes referred to as the "silent disease" because many cases of chlamydia are asymptomatic. However, without antibiotic treatment, chlamydia can lead to pelvic inflammatory disease and infertility in women.[1]

Chlamydia is the most commonly reported STI both locally and provincially. While hundreds of cases are reported to Southwestern Public Health (SWPH) per year, the local rate of chlamydia was consistently lower than the provincial rate between 2018 and 2022 (Figure 1 and Figure 2). The rate of chlamydia declined locally and provincially in 2020 and 2021 and increased in 2022.

Figure 1. Confirmed Chlamydia Cases, SWPH region, 2018 - 2022

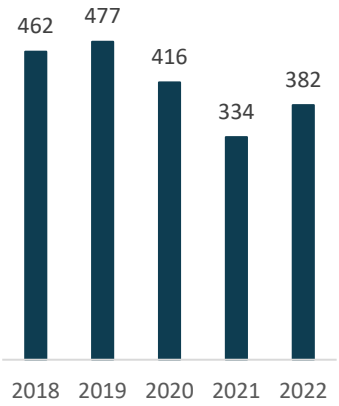
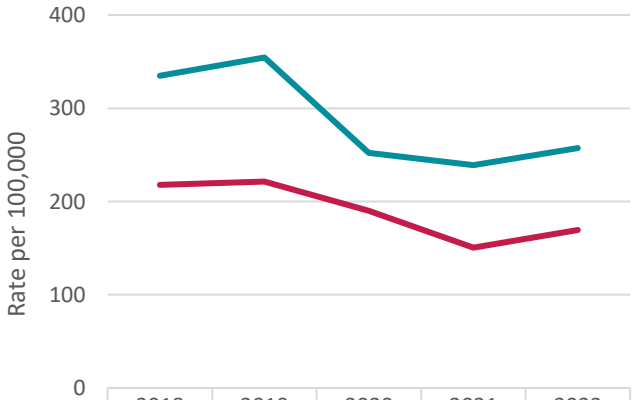


Figure 2. Chlamydia Rates, SWPH region and Ontario, 2018 - 2022



	2018	2019	2020	2021	2022
SWPH Rate	218.0	221.4	190.0	150.5	169.3
Ontario Rate	335.0	354.5	252.1	239.0	257.4

Similar to the province, case counts and rates of chlamydia in the SWPH region were higher among females compared to males (Figure 3 and Figure 4). Between 2018 and 2022, females accounted for 63% of all cases. Locally, the highest rates of chlamydia among females are in a younger age range (15-24 years old) compared to males (20-29 years old).

Figure 3. Confirmed Chlamydia Cases among Males and Females, SWPH region, 2018 - 2022

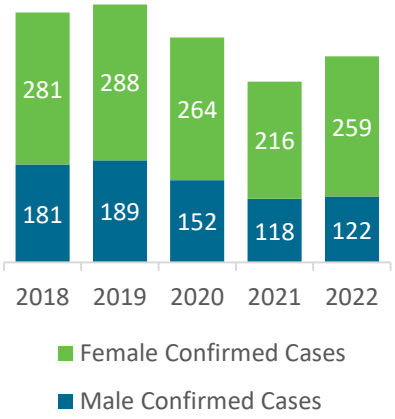
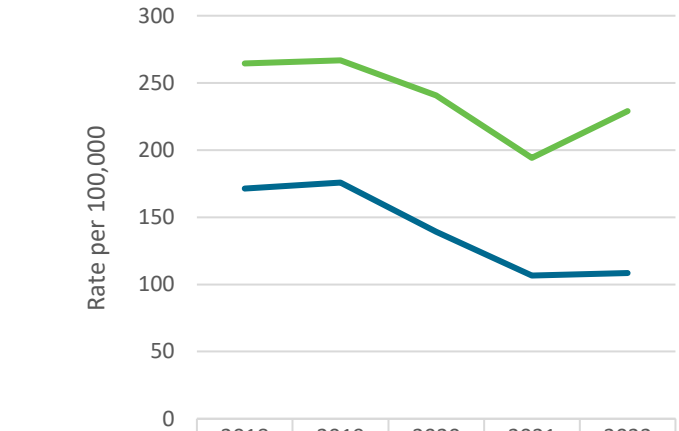


Figure 4. Chlamydia Rates among Males and Females, SWPH region, 2018 - 2022



	2018	2019	2020	2021	2022
Male Rate	171.4	175.8	139.2	106.6	108.4
Female Rate	264.4	266.8	240.7	194.2	229

Gonorrhea

Gonorrhea is a preventable and curable STI.[2] It can spread through unprotected vaginal, anal or oral sex with an infected person. It can also spread from an infected mother to her baby during childbirth. If left untreated, gonorrhea can lead to pelvic inflammatory disease and infertility in females. Although rare, it can also lead to infertility in males. Without antibiotic treatment, it can spread through the blood to other parts of the body, which can be life-threatening.[2] A high proportion of people infected with gonorrhea are at risk of co-infection with chlamydia.[3]

Locally, gonorrhea case counts and rates increased between 2018 and 2022, followed by a sharp decrease in 2023 (Figure 5 and Figure 6). Several other health units also experienced a decline, however provincially, rates climbed in 2023, largely driven by an increase in cases in the Greater Toronto Area. There were no province-wide changes, such as a change in case

definition or lab testing, that would explain the decrease seen by many health units, indicating it is likely a true decline in cases.

Figure 5. Confirmed Gonorrhea Cases, SWPH region, 2018 - 2023

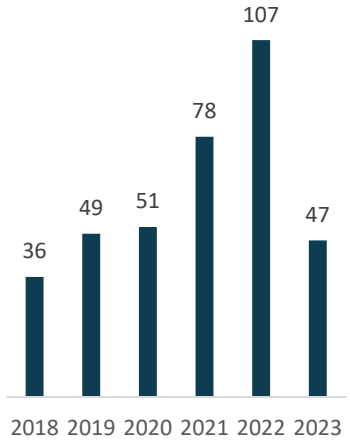
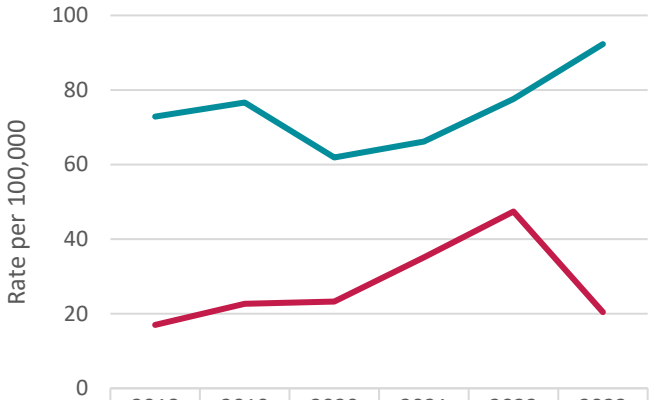


Figure 6. Gonorrhea Rates, SWPH region and Ontario, 2018 - 2023



	2018	2019	2020	2021	2022	2023
SWPH Rate	17.0	22.7	23.3	35.1	47.4	20.4
ONT Rate	72.9	76.6	61.9	66.2	77.6	92.3

Locally, the case count and rate of gonorrhea in males tend to be higher compared to females, however, they were similar in some years examined (Figure 7 and Figure 8). Between 2018 and 2023, the rate of gonorrhea ranged from 1.1x to 2.6x higher among males compared to females.

Figure 7. Confirmed Gonorrhea Cases among Males and Females, SWPH region, 2018 - 2023

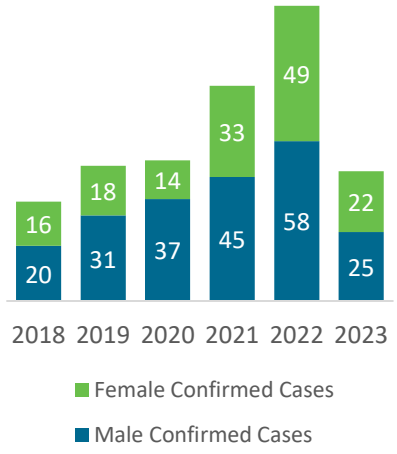
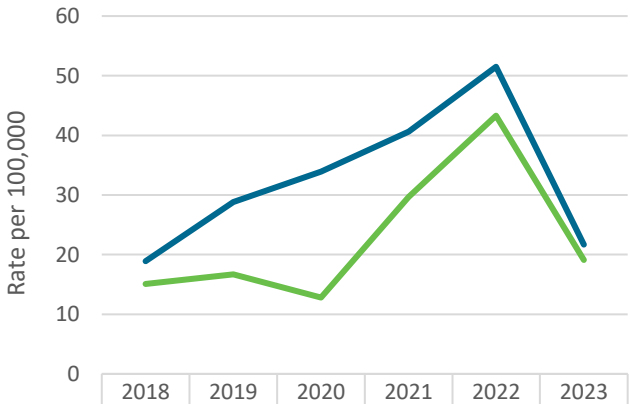


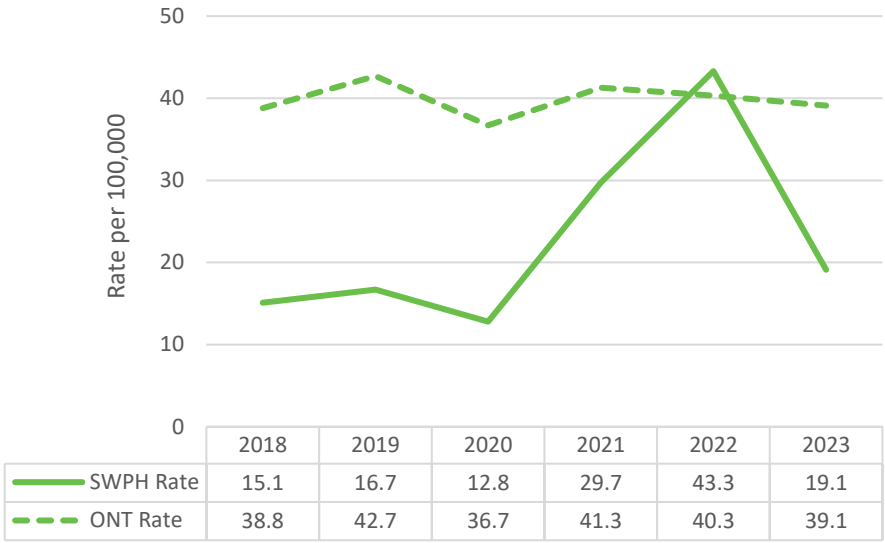
Figure 8. Gonorrhea Rates among Males and Females, SWPH region, 2018 - 2023



	2018	2019	2020	2021	2022	2023
Male Rate	18.9	28.8	33.9	40.6	51.5	21.7
Female Rate	15.1	16.7	12.8	29.7	43.3	19.1

Between 2020 and 2022, the local rate of gonorrhea among females more than tripled, surpassing the provincial rate in 2022 (Figure 9). However, between 2022 and 2023, there was a steep decline in the local rate.

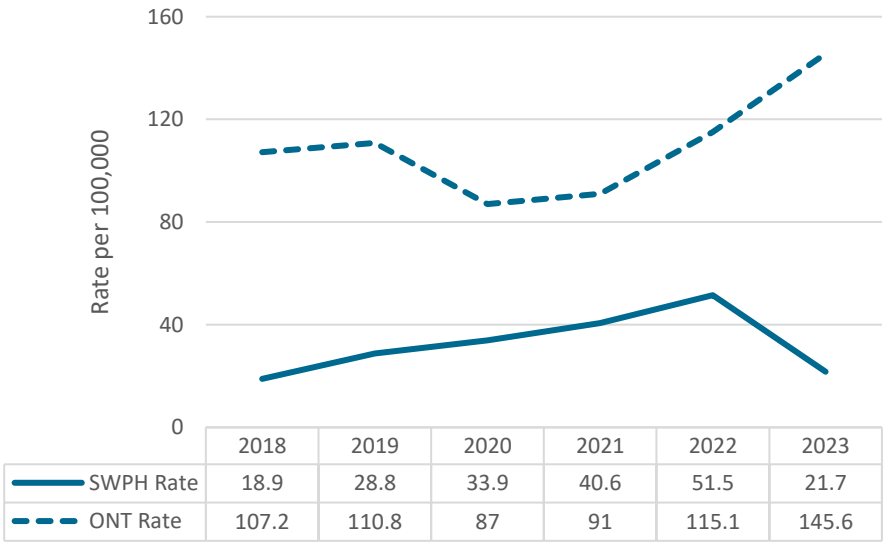
Figure 9. Gonorrhea Rate among Females, SWPH region and Ontario, 2018 - 2023



	2018	2019	2020	2021	2022	2023
SWPH Rate	15.1	16.7	12.8	29.7	43.3	19.1
ONT Rate	38.8	42.7	36.7	41.3	40.3	39.1

In the SWPH region, the rate of gonorrhea among males steadily increased between 2018 and 2022 and declined in 2023 (Figure 10). The rate among males was consistently lower than the provincial rate.

Figure 10. Gonorrhea Rate among Males, SWPH region and Ontario, 2018 - 2023



	2018	2019	2020	2021	2022	2023
SWPH Rate	18.9	28.8	33.9	40.6	51.5	21.7
ONT Rate	107.2	110.8	87	91	115.1	145.6

Infectious Syphilis

Syphilis is a preventable and curable infection that can be spread through vaginal, anal or oral sex.[4] It can also be spread from an infected mother to her baby during pregnancy or childbirth (congenital syphilis). If syphilis is left untreated, the infection can move through 4 stages: primary, secondary, latent and tertiary. Each of these stages is characterized by different signs and symptoms. Generally, syphilis is infectious during the primary, secondary and early latent stages. Tertiary syphilis can cause severe damage to the brain, heart, blood vessels and nervous system and can eventually lead to death.[4]

The data in this section focuses on infectious syphilis only. With the exception of a slight decrease in 2020 (likely influenced by the COVID-19 pandemic), the local rate of infectious syphilis has been increasing, almost doubling between 2018 and 2022 (Figure 12). The local rate was consistently lower than the provincial rate between 2018 and 2022.

Figure 11. Confirmed Infectious Syphilis Cases, SWPH region, 2018 - 2022

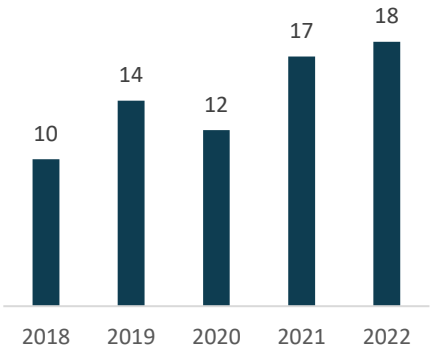
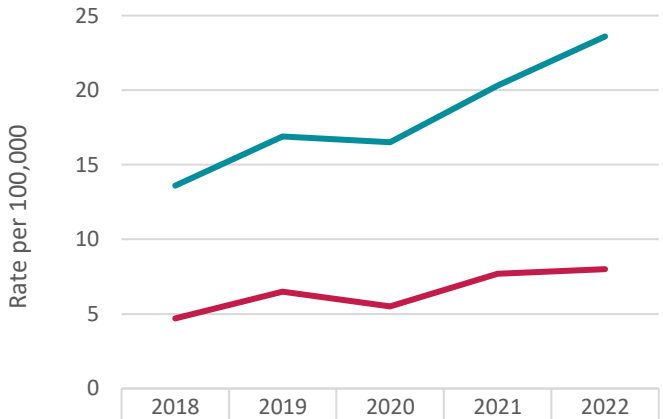


Figure 12. Infectious Syphilis Rates, SWPH region and Ontario, 2018 - 2022



	2018	2019	2020	2021	2022
SWPH Rate	4.7	6.5	5.5	7.7	8.0
ONT Rate	13.6	16.9	16.5	20.3	23.6

In 2018, SWPH had its first female case of infectious syphilis (Figure 13). Between 2018 and 2021, the rate among females grew considerably from 0.9 to 6.3 cases per 100,000 females (Figure 14). However, between 2021 and 2022 the rate declined to 5.3. Locally, the ratio of male-to-female cases has decreased substantially. A similar trend has been seen provincially; the ratio of male-to-female cases decreased from 25:1 in 2014 to 5:1 in 2022 due to steady increases in the incidence of infectious syphilis in females.

Figure 13. Confirmed Infectious Syphilis Cases among Males and Females, SWPH region, 2018 - 2022

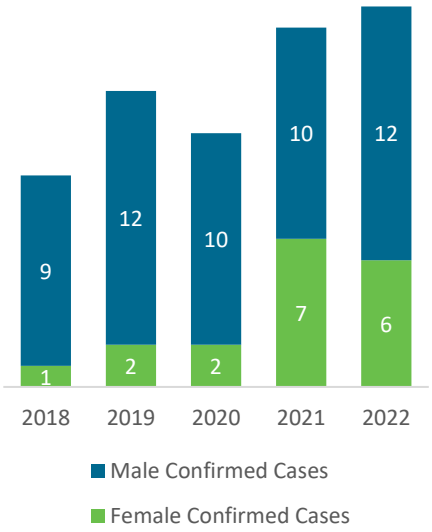
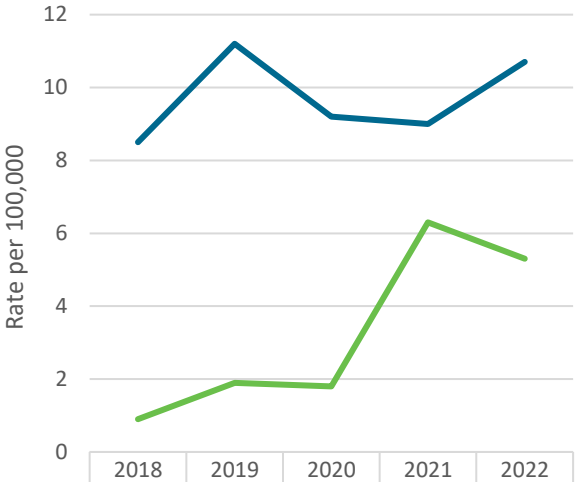


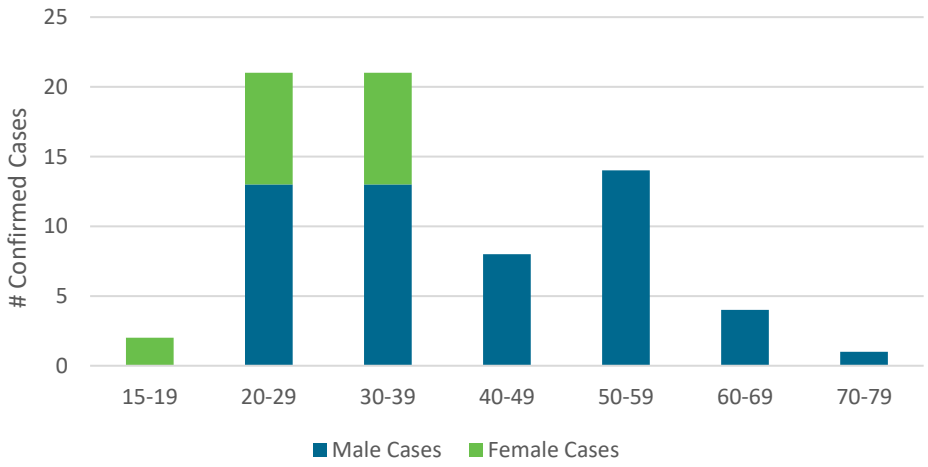
Figure 14. Infectious Syphilis Rates among Males and Females, SWPH region, 2018 - 2022



	2018	2019	2020	2021	2022
Female Rate	0.9	1.9	1.8	6.3	5.3
Male Rate	8.5	11.2	9.2	9.0	10.7

Examining cases of infectious syphilis by sex and age group, it is evident that cases among males are occurring among a wider age range (20-79 years of age) compared to females (15-39 years of age) (Figure 15). Cases among females are occurring among those that are childbearing age, which raises the concern of congenital syphilis among this group.

Figure 15. Confirmed Infectious Syphilis Cases among Males and Females by Age Group, SWPH region, 2018 - 2022



Hepatitis C

Hepatitis C is a liver infection that is caused by the hepatitis C virus.[5] It is most commonly transmitted through infected blood and is often spread through sharing needles or other injection drug equipment. It can also be spread through sexual contact, unsterilized tattoo or body piercing equipment or unsterilized medical equipment, although these methods of transmission are rare. Hepatitis C can be acute or chronic and when left untreated, may lead to cirrhosis of the liver, liver cancer and premature death.[5]

Case counts and rates of hepatitis C have been decreasing over time, both locally and provincially (Figure 16 and Figure 17). The rate of hepatitis C infection decreased by almost 40% locally between 2018 and 2022.

Figure 16. Confirmed Hepatitis C Cases, SWPH region, 2018 - 2022

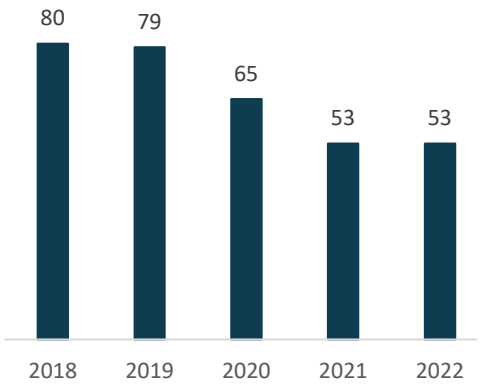
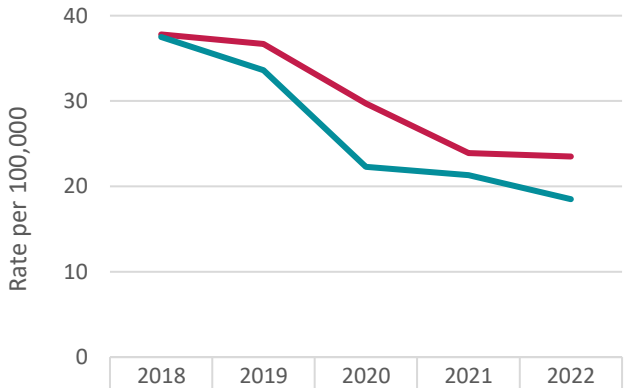


Figure 17. Hepatitis C Rates, SWPH region and Ontario, 2018 - 2022



	2018	2019	2020	2021	2022
SWPH Rate	37.8	36.7	29.7	23.9	23.5
ONT Rate	37.5	33.6	22.3	21.3	18.5

Case counts and rates of Hepatitis C were higher among males compared to females (Figure 18 and Figure 19). Locally, the highest rates among males and females are seen among people aged 25-34.

Figure 18. Confirmed Hepatitis C Cases among Males and Females, SWPH region, 2018 - 2022

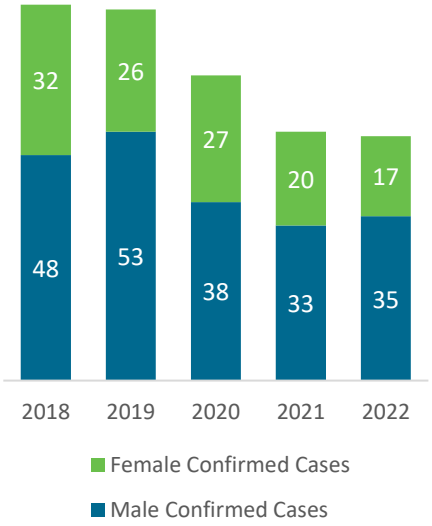
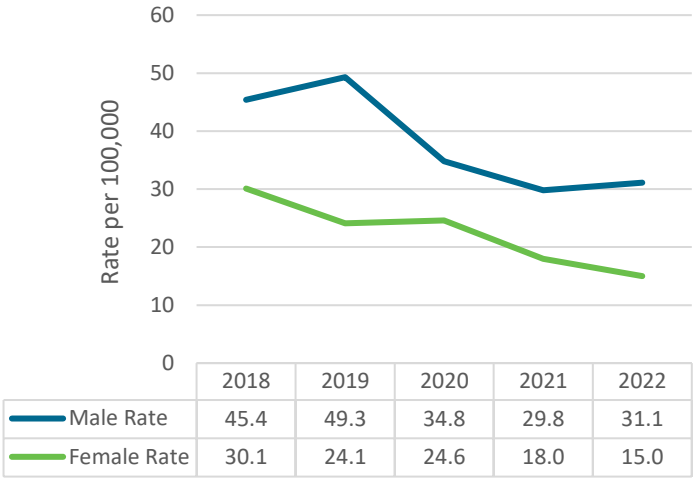


Figure 19. Hepatitis C Rates among Males and Females, SWPH region, 2018 - 2022



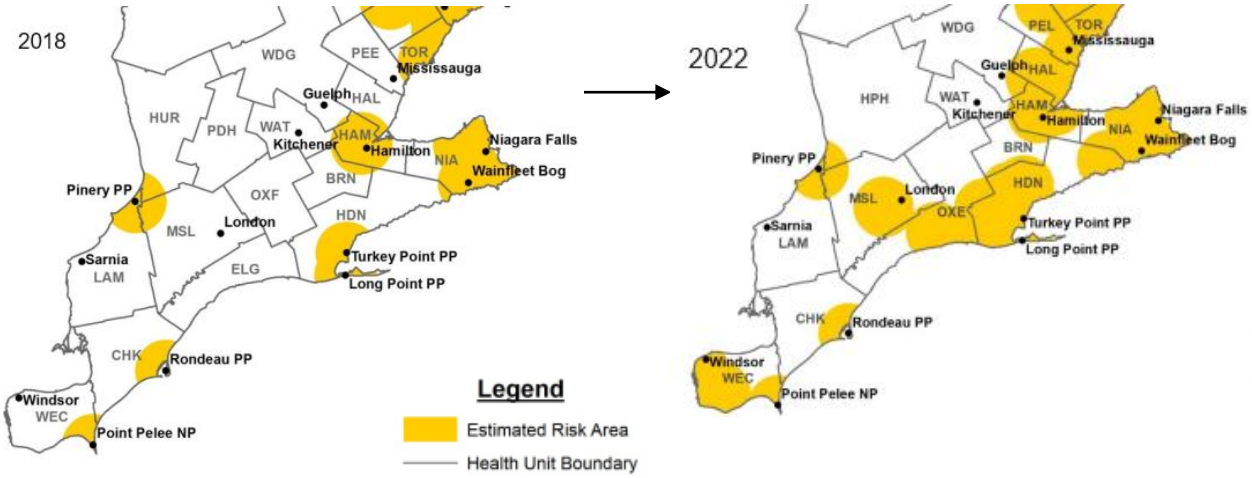
	2018	2019	2020	2021	2022
Male Rate	45.4	49.3	34.8	29.8	31.1
Female Rate	30.1	24.1	24.6	18.0	15.0

Vector-borne Disease

Lyme Disease

Lyme disease is typically spread through the bite of an infected blacklegged tick, also known as a deer tick.[6] Each year, Public Health Ontario releases a map of estimated risk areas that show where people are most likely to come into contact with an infective blacklegged tick in Ontario. The estimated risk areas grew considerably between 2018 and 2022, expanding into the SWPH region (Figure 20).[7,8]

Figure 20. Lyme Disease Risk Area Map, Southern Ontario, 2018 and 2022



The case count and rate of Lyme disease has been increasing both locally and provincially and in 2023 the local rate surpassed the provincial rate (Figure 21 and Figure 22). The rate of Lyme disease in the SWPH region increased steeply in recent years and was over 7x higher in 2023 compared to 2018. In addition, the majority of confirmed cases in 2023 were most likely acquired locally (i.e. the tick bite occurred within the SWPH region).

Figure 21. Confirmed Lyme Disease Cases, SWPH region, 2018 - 2023

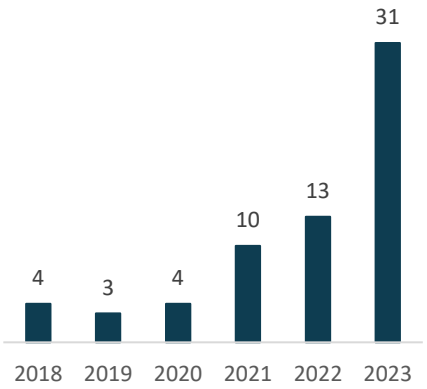
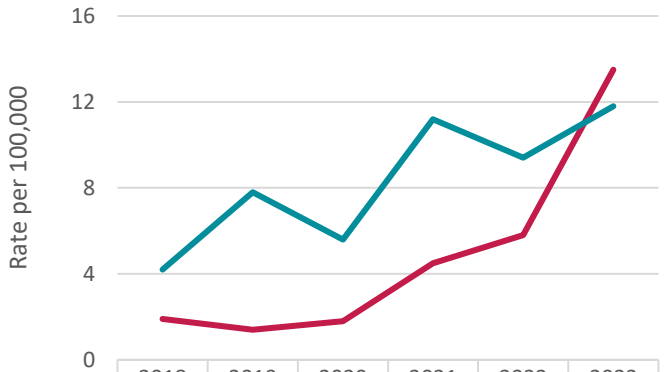


Figure 22. Lyme Disease Rates, SWPH region and Ontario, 2018 - 2023



	2018	2019	2020	2021	2022	2023
SWPH Rate	1.9	1.4	1.8	4.5	5.8	13.5
ONT Rate	4.2	7.8	5.6	11.2	9.4	11.8

Enteric and Foodborne Diseases

Campylobacteriosis and Salmonellosis

Campylobacteriosis and salmonellosis are bacterial infections that can be acquired in several different ways.[9,10] The bacteria are spread through contaminated food or drinks, contact with infected animals or people, or swimming in contaminated water. Symptoms include fever, nausea, vomiting and diarrhea. While most people recover on their own, some people may have more serious illnesses, requiring hospitalization. Those who have a weak immune system are at the highest risk of serious illness, including young children, the elderly and pregnant women.[9,10]

Campylobacteriosis is the most commonly reported enteric disease in the SWPH region. Since 2019, the rate of infection locally has been higher than the province (Figure 24). The local rate increased between 2021 and 2022, while the provincial rate decreased.

Figure 23. Confirmed Campylobacter Cases, SWPH region, 2018 - 2022

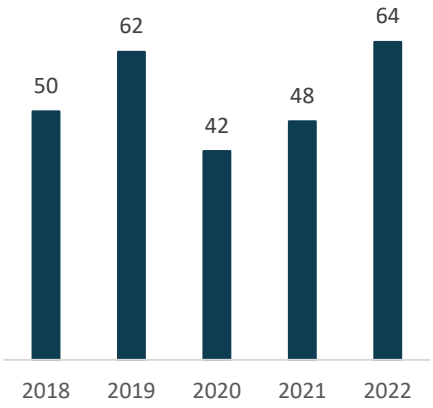
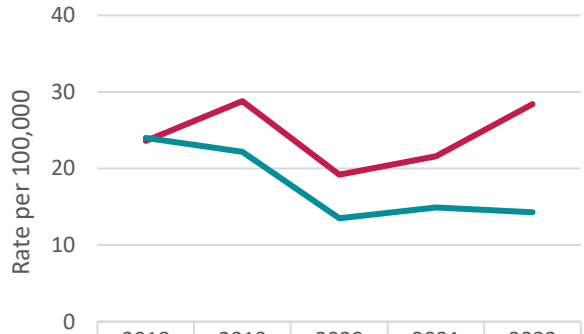


Figure 24. Campylobacter Rates, SWPH region and Ontario, 2018 - 2022



	2018	2019	2020	2021	2022
SWPH Rate	23.6	28.8	19.2	21.6	28.4
ONT Rate	24	22.2	13.5	14.9	14.3

In recent years the local rate of salmonellosis was very similar to the provincial rate (Figure 26). While the rate decreased between 2019 and 2021, there was an increase both locally and provincially between 2021 and 2022.

Figure 25. Confirmed Salmonellosis Cases, SWPH region, 2018 - 2022

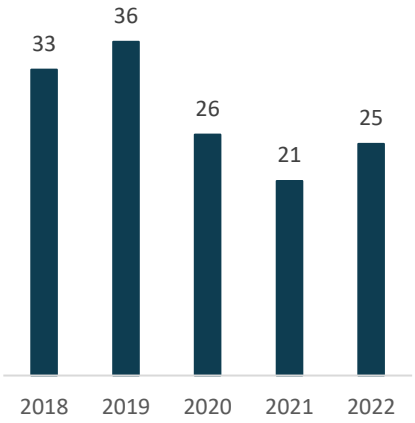
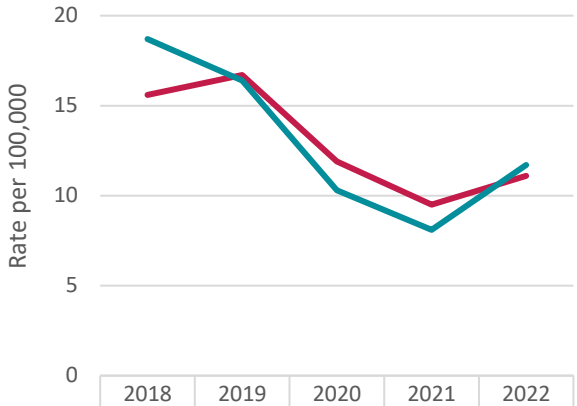


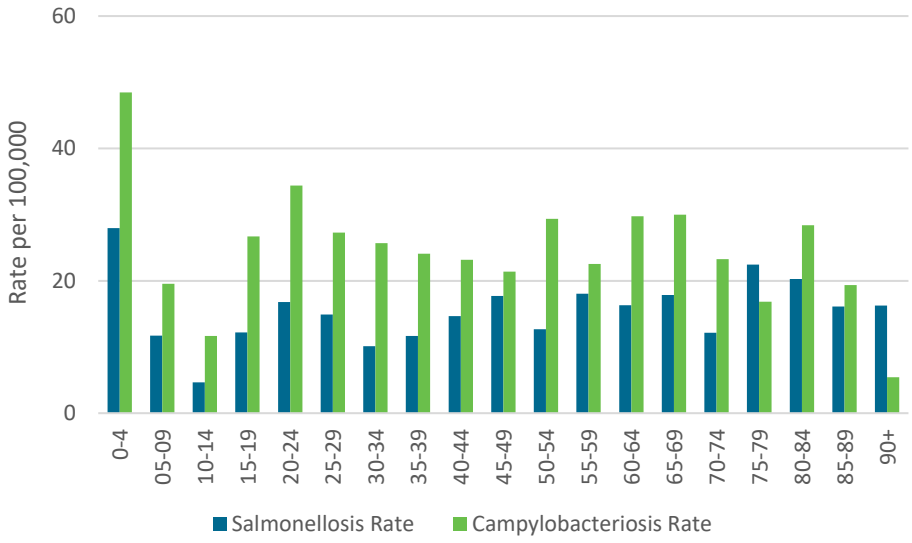
Figure 26. Salmonellosis Rates, SWPH region and Ontario, 2018 - 2022



	2018	2019	2020	2021	2022
SWPH Rate	15.6	16.7	11.9	9.5	11.1
ONT Rate	18.7	16.4	10.3	8.1	11.7

While infection happens among people of all ages, children 4 and under are most likely to have a reported infection (Figure 27).

Figure 27. Campylobacter and Salmonellosis Rates by Age Group, SWPH region, 2013 - 2022



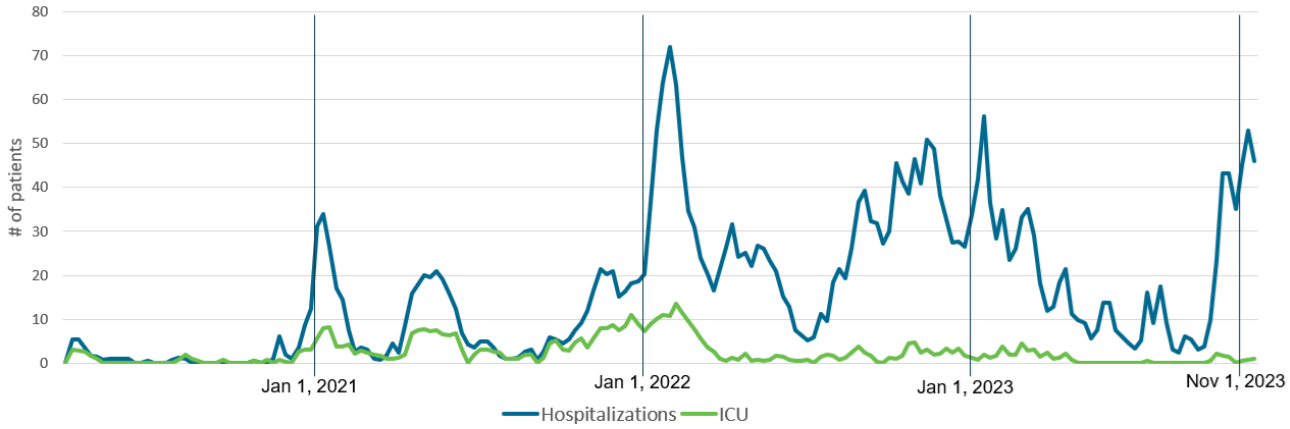
Respiratory Diseases

COVID-19

Coronavirus disease 2019 (COVID-19) is a respiratory illness caused by the SARS-CoV-2 virus. The virus was first detected in China in December 2019 and on March 11, 2020, the World Health Organization declared that there was a pandemic, indicating worldwide spread.[11] On March 20, 2020, the first local case of COVID-19 was reported to SWPH. The disease is spread from an infected person through respiratory droplets and aerosols that are created when they cough, sneeze, talk, breathe or sing.[12] It can also be spread through contaminated surfaces. Disease severity and symptoms vary from person to person. Symptoms can include sore throat, runny nose, headache, cough, shortness of breath and fever. Vaccination reduces the risk of severe illness and death.[12]

Local and provincial COVID-19 case counts and rates are not presented in this report. This data can be difficult to interpret due to frequent changes in eligibility criteria for PCR testing and the introduction of rapid tests later in the pandemic. The results from rapid tests were not routinely reported to SWPH. Instead, hospitalization data is presented to help communicate the severity of COVID-19 in the SWPH region over time (Figure 28). In 2022 and 2023, hospitalizations peaked in the winter and fall months. Proportionately, more hospitalized cases were in the ICU in January 2021 and 2022 compared to January 2023. This could indicate that the population has developed immunity (from vaccine or previous illness) or that more recent circulating variants of COVID-19 are less severe.

Figure 28. COVID-19 Hospitalizations by Week, SWPH region, Mar 2020-Nov 2023



Influenza (flu)

Influenza (flu) spreads person-to-person through talking, sneezing and coughing.[13] Infection can also spread through contaminated surfaces. Influenza symptoms include fever, cough, muscle aches and pain, headache, sore throat and runny nose. While everyone is at risk of getting sick, young children, the elderly and those with weakened immune systems are at highest risk of complications. The annual flu shot is the best way to prevent infection.[13]

During the 2022/23 respiratory season (Sept 1, 2022 – Aug 31, 2023), there were more confirmed influenza cases locally than any other flu season in the time period examined (Figure 29). The rate of influenza locally has followed a similar trend compared to the province (Figure 30).

Figure 29. Confirmed Influenza Cases, SWPH region, 2017/18 – 2022/23

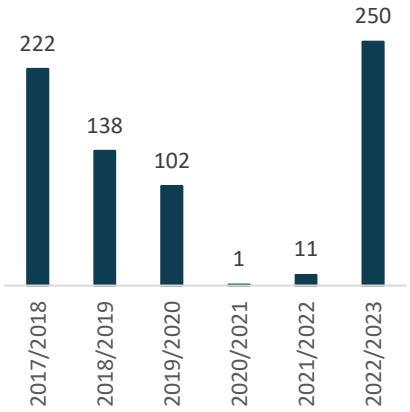
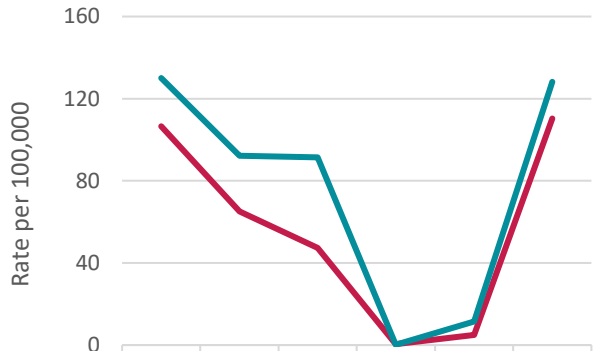


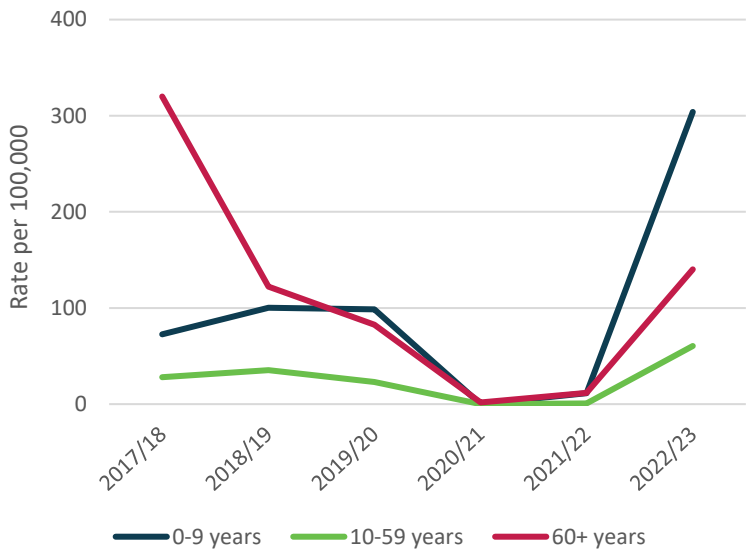
Figure 30. Influenza Rates, SWPH region and Ontario, 2017/18 – 2022/23



	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
SWPH Rate	106.5	65.1	47.3	0.5	4.9	110.3
ONT Rate	130.0	92.1	91.4	0.2	11.5	128.2

In recent years the 2017/18 and 2022/23 respiratory seasons had the highest rates of influenza illness. However, different age groups were hit hardest during each of these seasons. In 2017/18, those 60 years of age and older had the highest rates, while in 2022/23 those 9 and under had the highest rates of illness (Figure 31). In 2017/18 both influenza A and B were circulating, while in 2022/23 the vast majority of cases tested positive for influenza A (96.4%).

Figure 31. Influenza Rates by Age Group, SWPH region, 2017/18 – 2022/23

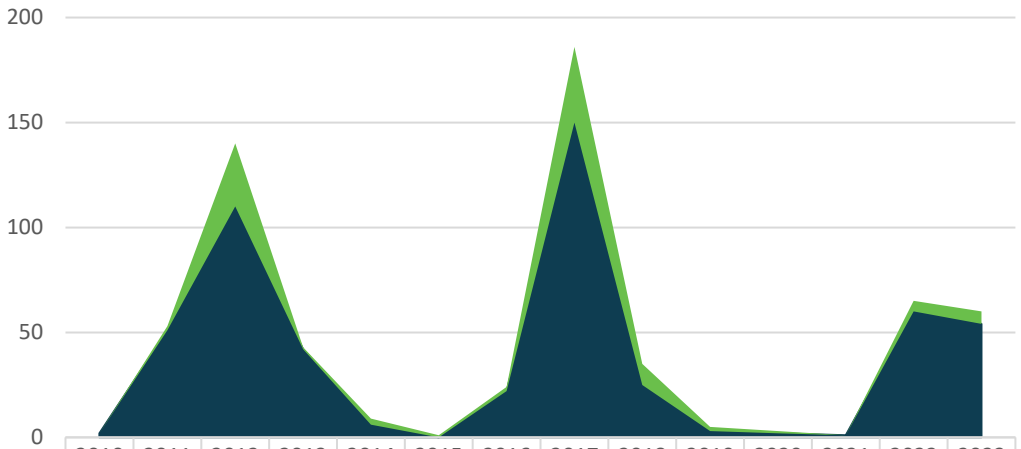


Pertussis (whooping cough)

Pertussis, more commonly known as whooping cough, is a contagious respiratory infection. It causes severe coughing that may lead to choking or vomiting.[14] It spreads through droplets in the air when an infected person coughs or sneezes. Immunization can provide protection against pertussis. Vaccination programs begin at 2 months of age; thus newborns are at the highest risk of infection. The most severe illness is seen among children under 1 year of age, especially among those who are unvaccinated or under-vaccinated.[14]

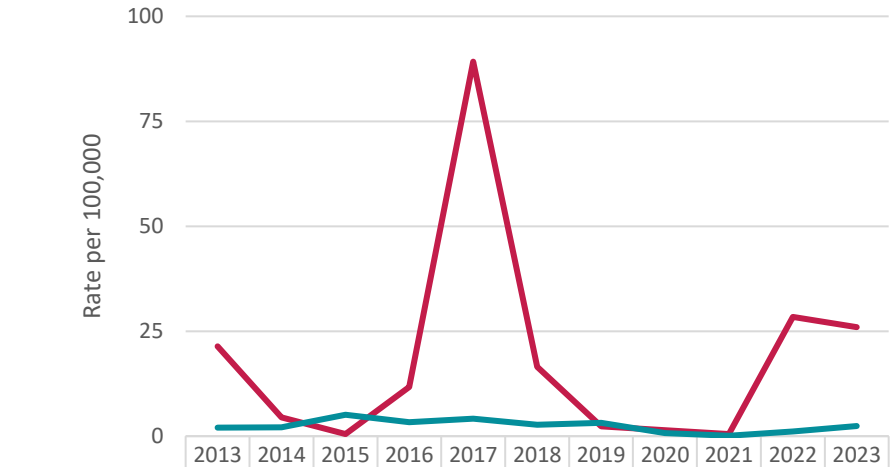
Examining over a decade of data, it is evident that locally, pertussis cases come in waves (Figure 32). These waves of pertussis happen on a local level and are not seen provincially (Figure 33). The majority of cases occur among unvaccinated communities within the SWPH region.

Figure 32. Confirmed and Probable Pertussis Cases, SWPH region, 2010-2023



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Probable Cases	0	2	30	1	3	1	2	36	10	2	1	0	5	6
Confirmed Cases	2	51	110	42	6	0	22	150	25	3	2	1	60	54

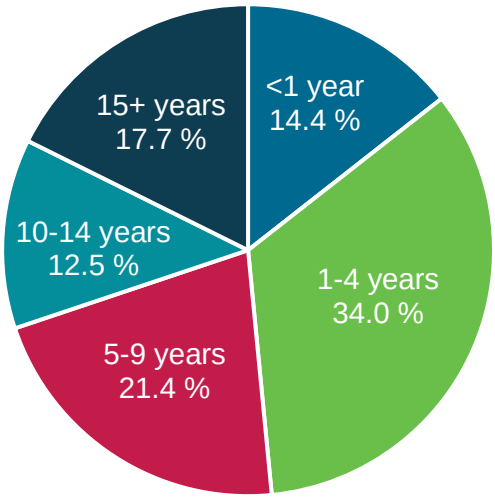
Figure 33. Pertussis Rates, SWPH region and Ontario, 2013-2023



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
SWPH Rate	21.4	4.5	0.5	11.7	89.2	16.5	2.3	1.4	0.5	28.4	26.0
ONT Rate	2.0	2.1	5.1	3.3	4.2	2.7	3.2	0.7	0.1	1.1	2.4

Over 80% of local confirmed pertussis cases are among children and youth 14 years of age and under (Figure 34). This may reflect the difference in severity of symptoms among people of different ages and vaccination status. Many people may not be tested for or know they have whooping cough due to mild symptoms. However, they can still spread the bacteria to vulnerable individuals.[14]

Figure 34. Pertussis Cases by Age Group, SWPH region, 2010-2023



Invasive Group A Streptococcus (iGAS)

Group A streptococcus bacteria can cause mild or moderate infections such as strep throat or impetigo and some healthy people carry these bacteria with no signs or symptoms of infection.[15] Bacteria can spread person-to-person through direct contact. Sometimes these bacteria invade the blood, lungs, brain or other parts of the body where they are not normally found, causing severe life-threatening illness. These are invasive group A streptococcus (iGAS) infections, including necrotizing fasciitis (flesh-eating disease) and complications such as toxic shock syndrome.[15]

In 2023 there was an increase in confirmed iGAS cases and rates, both locally and provincially (Figure 35 and Figure 36). Between 2022 and 2023 the rate of iGAS more than doubled in the SWPH region and in Ontario.

Figure 35. Confirmed Invasive Group A Streptococcus Cases, SWPH region, 2018 - 2023

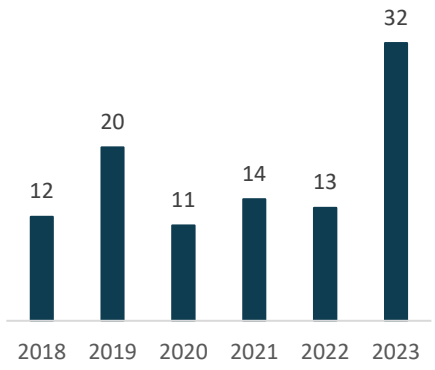
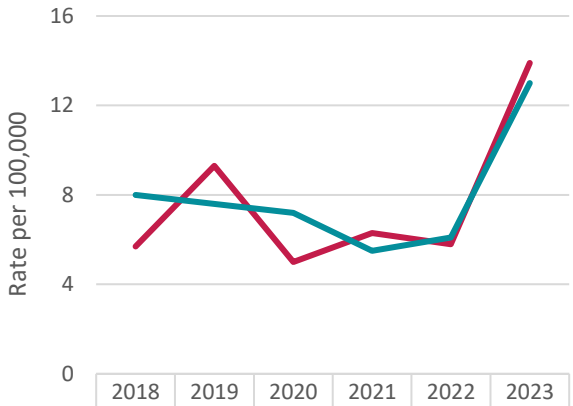


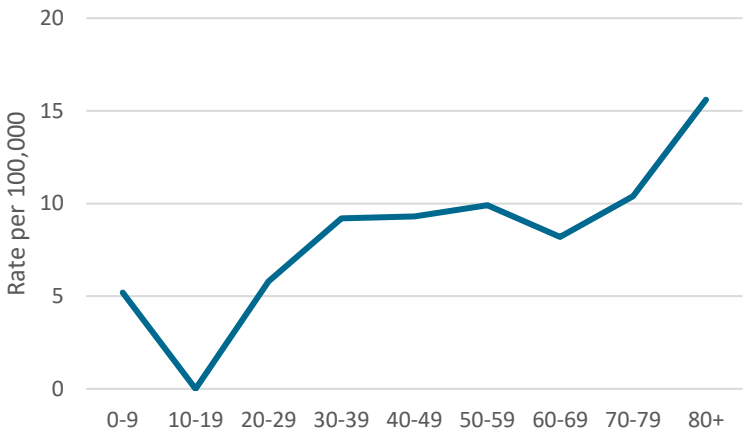
Figure 36. Invasive Group A Streptococcus Rates, SWPH region and Ontario, 2018 - 2023



	2018	2019	2020	2021	2022	2023
SWPH Rate	5.7	9.3	5.0	6.3	5.8	13.9
ONT Rate	8.0	7.6	7.2	5.5	6.1	13.0

With the exception of children aged 9 and under, the rate of iGAS infection tends to increase with age with those 80 years of age and over experiencing the highest rate of infection in the region (Figure 37).

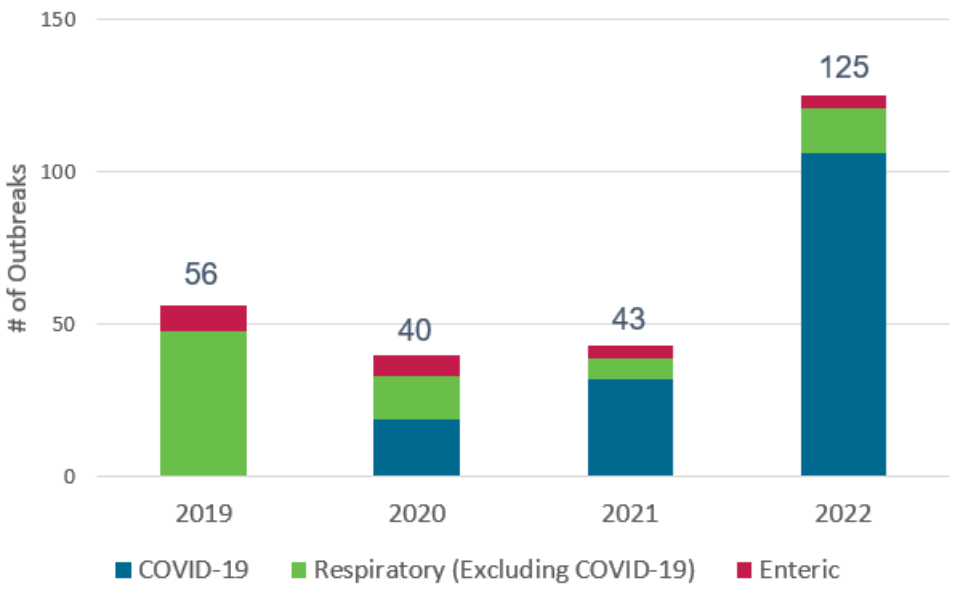
Figure 37. Invasive Group A Streptococcus Rates by Age Group, SWPH region, 2018 - 2023



Institutional Outbreaks

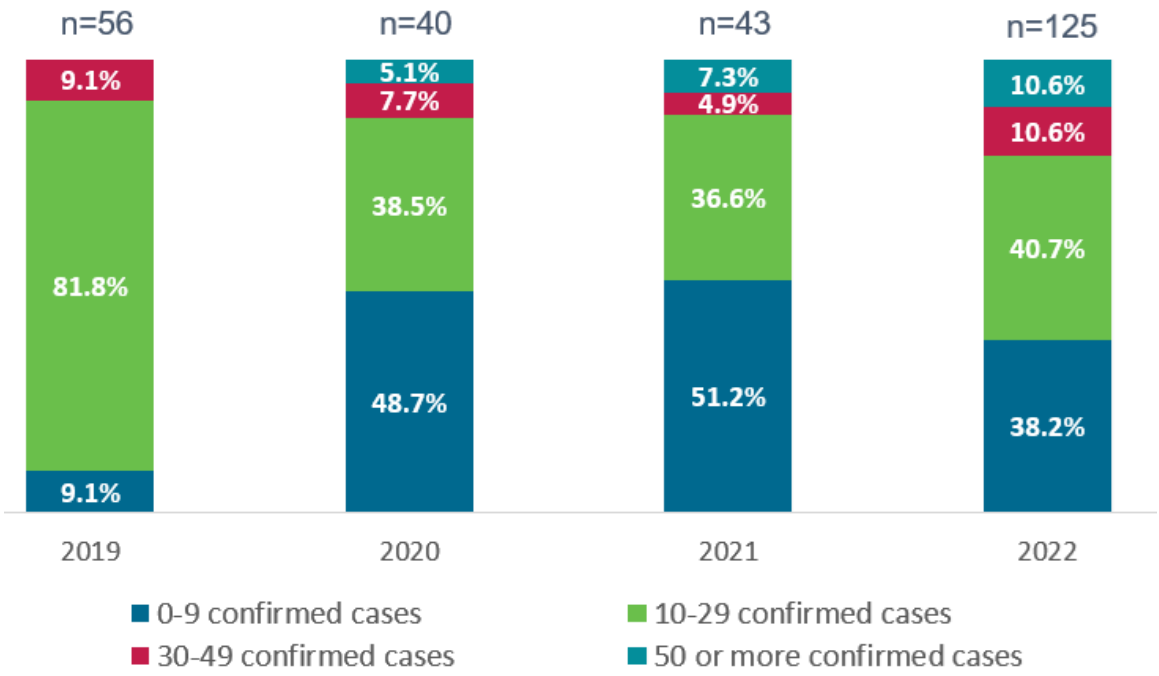
SWPH works with hospitals, retirement homes and long-term care homes (institutions) in the region to prevent, investigate and manage the spread of infectious diseases. The number of confirmed local institutional outbreaks more than doubled in 2022 compared to pre-pandemic in 2019 (Figure 38). The pathogen responsible for the vast majority of outbreaks in 2022 was COVID-19 (84.8%), while enteric and other respiratory pathogens accounted for far less (3.2% and 12.0%, respectively).

Figure 38. Number of Confirmed Institutional Outbreaks, SWPH region, 2019 - 2022



A change in the distribution of institutional outbreak size began in 2020, as the first COVID-19 outbreaks started occurring locally. Small outbreaks with 9 or fewer cases, as well as very large outbreaks with 50 or more cases, became more common (Figure 39).

Figure 39. Confirmed Institutional Outbreaks by Size, SWPH region, 2019 - 2022



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Adult Substance Use & Harms in the SWPH Region

Alcohol

Health Status Report
Southwestern Public Health
July 2024

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Contents

Summary

The proportion of people in the Southwestern Public Health (SWPH) region who reported consuming 7 or more alcoholic drinks in the last week has been decreasing over time. However, as of 2019/2020, there has been little to no change among female residents. In 2021, female residents in the SWPH region also had a steep increase in the rate of mortality due to alcohol (with or without drug involvement).

Although the proportion of SWPH residents reporting risky drinking has decreased over time, more people are reporting being current alcohol drinkers.

This indicates that locally, there is an increasing number of residents who are at risk of health problems and premature death due to alcohol consumption.

Substance Use & Harms Among Adults

Alcohol use

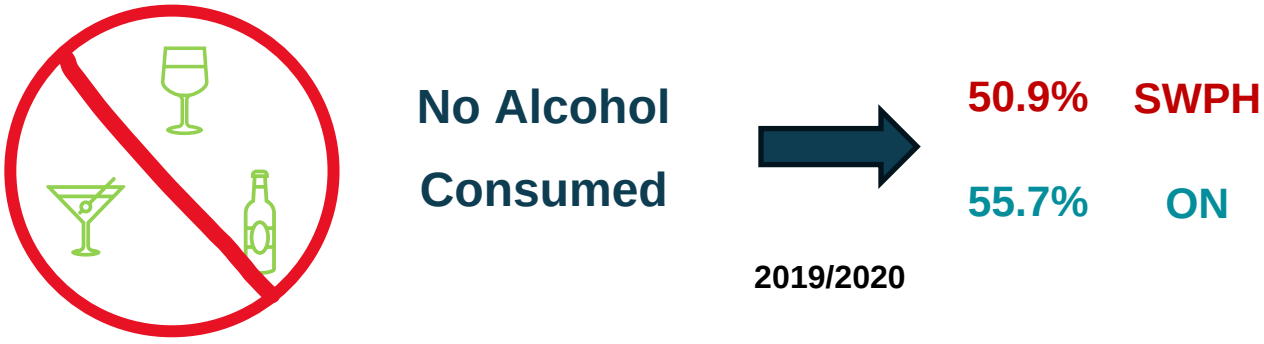
Canada's guidance on alcohol and health

Alcohol consumption is one of the four most common modifiable and preventable risk factors for non-communicable diseases and is the sixth most common cause of disability and death in Canada.[1]

The updated guidance on alcohol, released in 2023, is intended to reduce the health risks resulting from alcohol use by recommending that individuals living in Canada reduce their alcohol use. The guidelines categorize risk into four groupings, similar to the previous recommendations that it replaces. Essentially, with every increase in alcohol intake, the risk of various health conditions also increases. The guidelines state that the only safe amount of alcohol, associated with no risk, is no alcohol.[2]

Abstained from alcohol in the last 7 days (0 alcoholic drinks) – No risk

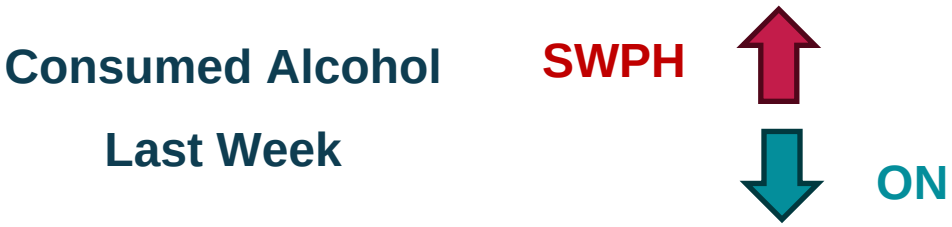
Since 2015/2016, there has been little change in the proportion of SWPH residents who drank alcohol in the last 12 months but who report not having any in the last week. This was 51% of respondents in the SWPH region and which was lower than the rest of the province (**Figure 1**).



Drank alcohol in the last 7 days (1+ alcoholic drinks)

Residents who report having at least one drink in the last week are considered to have exceeded Canada's guidance on alcohol and can be defined as current users. In 2019/2020, the proportion of SWPH residents who drank any alcohol in the last week was 60.3% compared

to 57.0% in 2015/2016. Although the difference over time for Ontario was also marginal, it is decreasing year over year rather than increasing, indicating that fewer residents are consuming any amount of alcohol in the last week (62.1% in 2015/2016 to 58.3% in 2019/2020).



Historically, male residents in the SWPH region report consuming alcohol in the last week more often, compared to females. Male residents across all age groups had increases in any alcohol consumption in the last 7 days of about 7% between 2015/2016 and 2019/2020 (not shown).

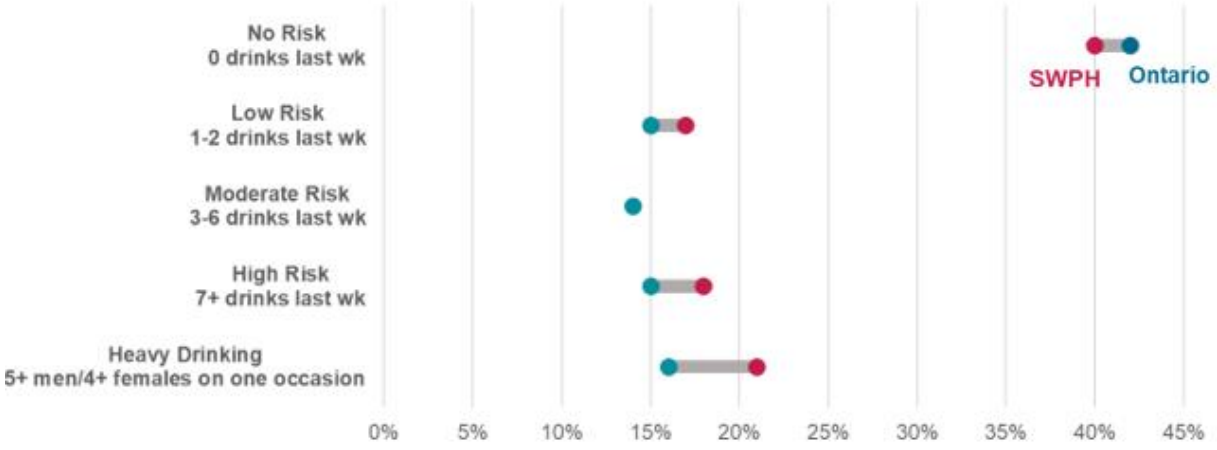
When it came to female residents, those between the ages of 19 and 44 reported having consumed at least one drink in the last week more often than females in other age groups and also had the largest increase over time of approximately 10%.

Low risk (1 to 2 drinks), moderate risk (3 to 6), high risk (7+) drinking in the last 7 days

In 2019/2020, SWPH residents reported having 1 to 2 drinks (low risk) and 7 or more drinks (increasingly high risk) in the last week more often when compared to Ontarians. (**Figure 1**).

Figure 1

In 2019/2020, more SWPH residents reported high-risk and heavy drinking compared to Ontario residents.



Drank 7+ alcoholic drinks in the last week – High risk

Residents who reported having 7 or more drinks in the last week were categorized as "increasingly" high risk because every additional drink beyond 7 puts them at a greater risk of health problems.[1]

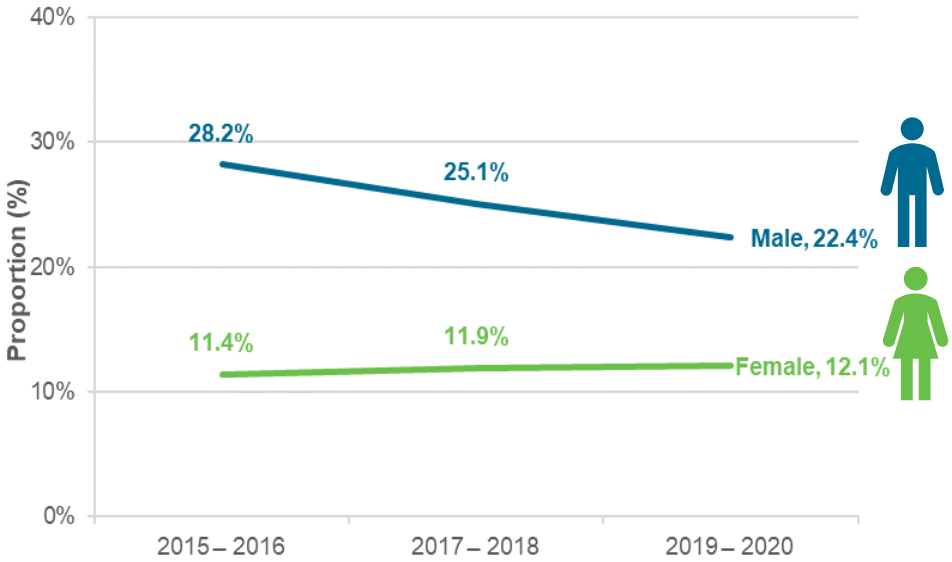
In 2019/2020, a higher proportion of SWPH residents reported having 7+ drinks in the last week (17.8%) compared to Ontario residents (14.9%) (**Figure 1**). However, the proportion of residents at increasingly high risk, both locally and provincially, decreased by approximately 3.0% over time since 2015/2016 (not shown).

Data source:
Canadian Community Health Survey (CCHS). StatsCan.
2015 – 2016
2017 – 2018
2019 – 2020

The proportion of increasingly high risk drinking among male residents has decreased marginally over time between 2015 and 2020 while the proportion among female residents has remained relatively unchanged (**Figure 2**). The difference between male and female residents has also decreased over time, with males reporting a proportion of high risk drinking 10.3% higher than females in 2019/2020; compared to 16.8% in 2015/2016.

Figure 2

The proportion of female SWPH residents who reported high risk drinking has remained relatively unchanged over time, yet it decreased among males.

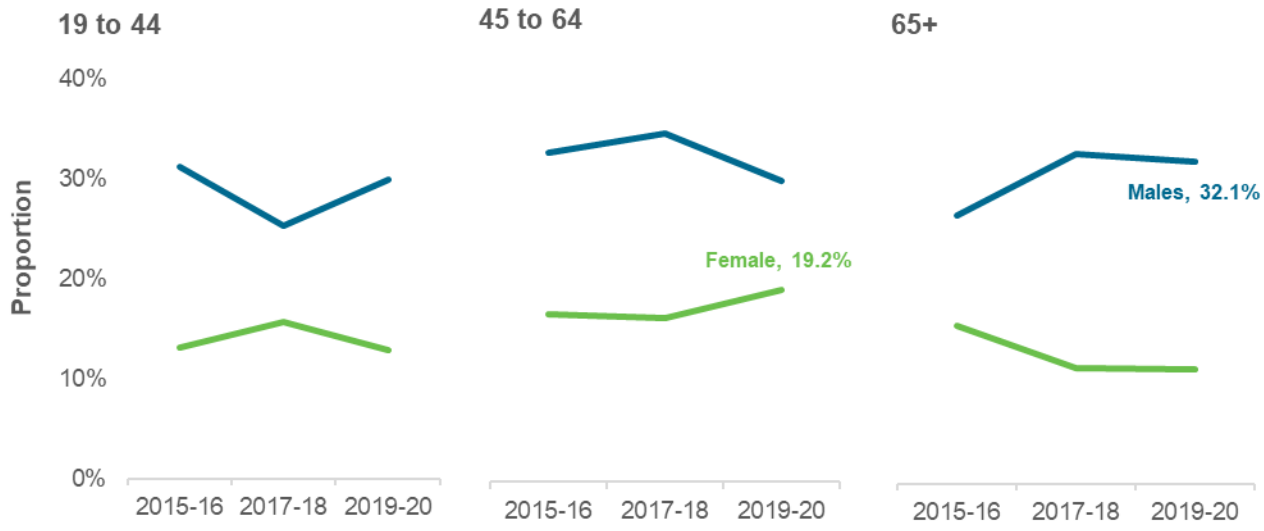


Of note, the local increase in current drinkers indicates that the number of residents in the SWPH region that are at risk for health problems continues to increase even though not all are reporting a high number of alcoholic beverages consumed on a single occasion or over the last week.

Females between the ages of 45 and 64 and males over the age of 65 were the subgroups that stood out the most among SWPH residents. Both of these subgroups reported higher proportions of increasingly high risk drinking in both of the most recent CCHS cycles (2017/2018 and 2019/2020) compared to 2015/2016. Aside from males between the ages of 19 and 44, who also reported an increase in 2019/2020 (25.3% up to 29.9%), all other subgroups saw decreases (**Figure 3**).

Figure 3

Female residents between 45 and 64 reported more high risk drinking over time compared to the other age groups of females and male residents.



Heavy drinking in the last week (5+ for men or 4+ for women alcoholic drinks on one occasion)

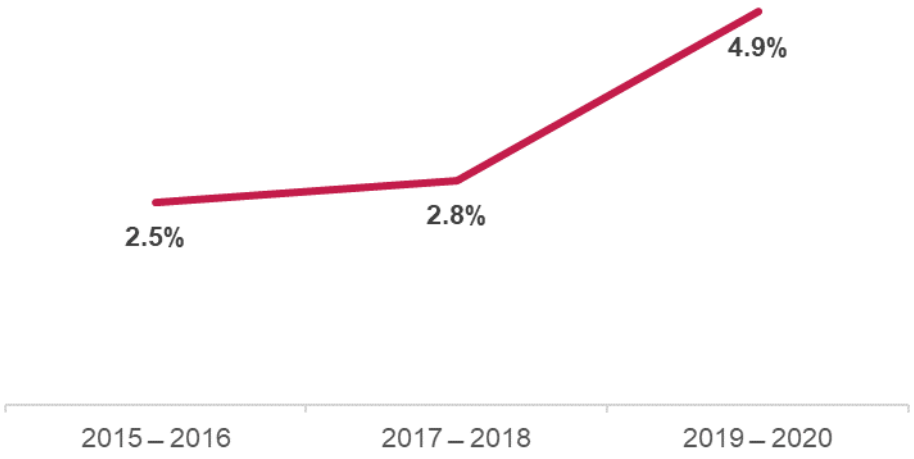
Heavy drinking is defined by the Canadian Institute for Health Information (CIHI) as men who consume 5 or more drinks or women who consume 4 or more drinks on a single occasion at least once a month in the past year.[2]

Heavy drinking has remained relatively consistent at approximately 20% in the SWPH region since 2015/2016. This was higher compared to Ontario residents, 15% of whom reported heavy drinking during the same period.

Unlike the local proportion, the provincial proportion decreased over time (not shown). As a result, the percent difference between the local and provincial proportions has nearly doubled between 2015/2016 and 2019/2020 (**Figure 4**).

Figure 4

The difference between the proportion of residents reporting heavy drinking in the SWPH region and Ontario has grown larger over time, as heavy drinking increases in SWPH and decreases across Ontario.

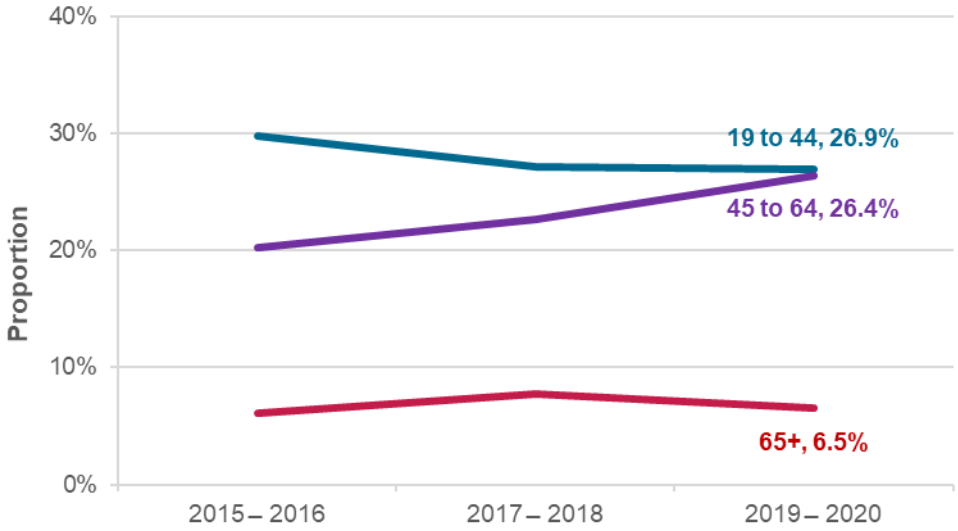


Similar to high risk drinking, male residents in the SWPH region reported proportions of heavy drinking that were approximately 7% higher compared to female residents each year.

Although heavy drinking has decreased overall, SWPH residents between the ages of 45 and 64 years reported more heavy drinking, increasing by nearly 10% between 2015 and 2020. By 2019/2020, residents in this subgroup were reporting nearly as much heavy drinking as residents between the ages of 19- and 44 years (**Figure 5**).

Figure 5

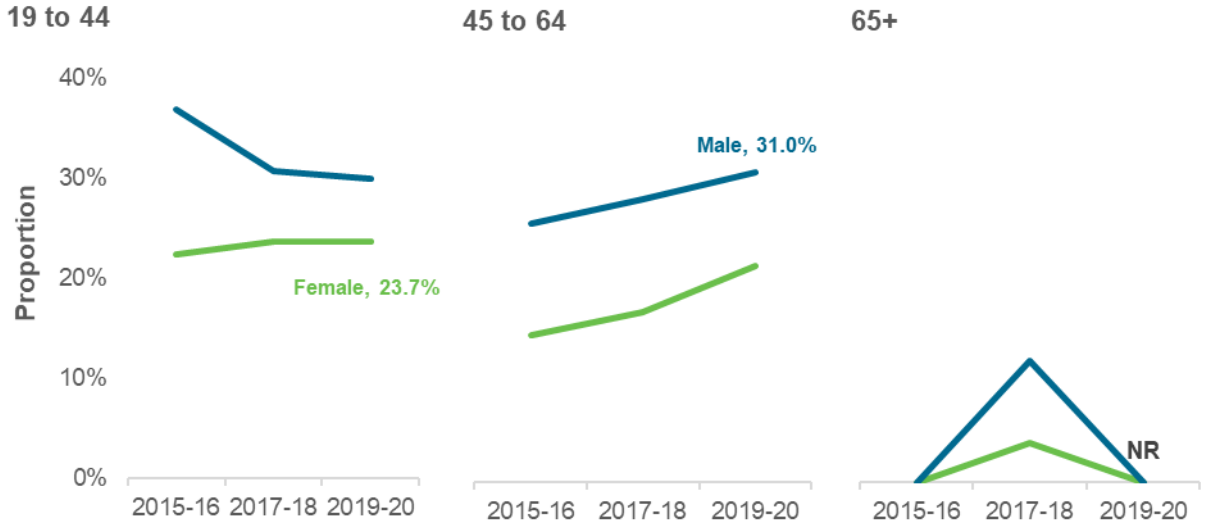
Heavy drinking increased among SWPH residents between the ages of 45 and 64 while decreasing in residents in other age groups.



Females aged 45 to 64 years, reported a slightly steeper increase (7%) over time compared to males (5%) of the same age (**Figure 6**).

Figure 6

Heavy drinking among residents between the ages of 45 and 64 continues to increase for both male and female residents while other age groups decrease.



NR= not reportable

Alcohol-related harms

Emergency department (ED) visits, Hospitalizations, & Mortality

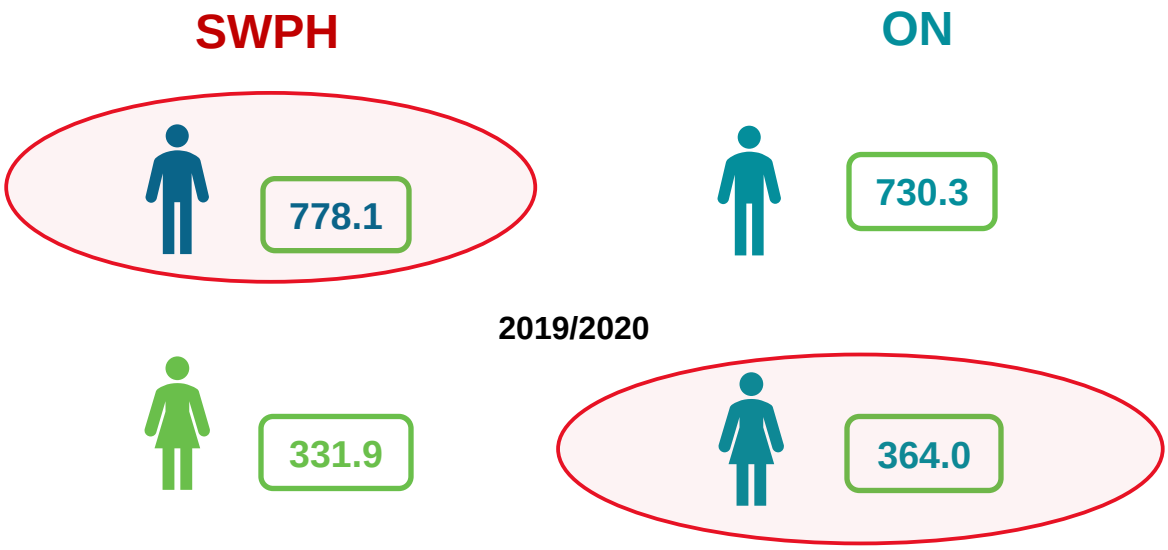
Emergency department (ED) visits for conditions entirely attributable to alcohol

Overall, the local rate of emergency department (ED) visits per 100,000 population for conditions entirely attributable to alcohol (see **Appendix A**) among residents 15 and over has remained relatively consistent over time. As of 2021, the rate was 554.2 visits per 100,000 compared to 543.6 visits per 100,000 across Ontario (not shown).

However, the rate among males in the SWPH region increased over time, going from 706.2 visits per 100,000 in 2017 to 778.1 visits per 100,000 in 2021. This was higher in comparison to males across Ontario (**Figure 7**).

Figure 7

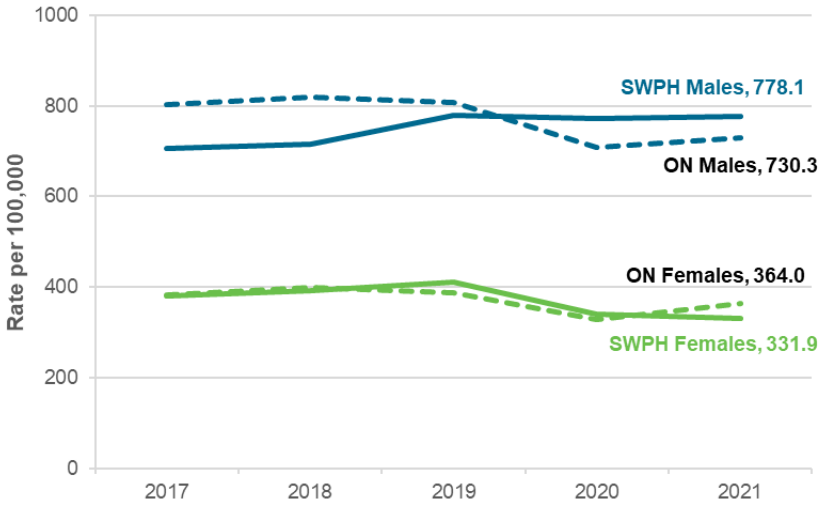
In 2019/2020, males in the SWPH region visited the ED for alcohol-related conditions more than males in Ontario.



The rate among local females increased until 2019, reaching a peak of 411.6 per 100,000. It then dropped below the provincial rate in 2021, decreasing to 331.9 visits per 100,000. This trend is similar to what is reported among females across Ontario, but females provincially saw an increase in 2021 (**Figure 8**).

Figure 8

The rate of alcohol-related ED visits among male residents in the SWPH region surpassed the provincial rate in 2020.

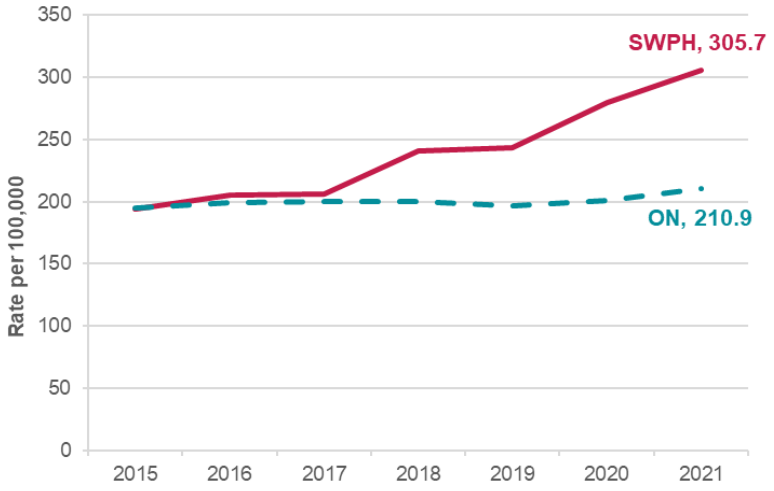


Hospitalizations for conditions entirely attributable to alcohol

Overall, the local rate of hospitalizations per 100,000 population for conditions entirely caused by alcohol has increased over time (see **Appendix A**), while the rate across Ontario has increased only marginally. As of 2021, the rate per 100,000 in SWPH was 1.4x higher than the rate across Ontario (305.7 per 100,000 vs. 219.0 per 100,000, respectively). This was the largest difference between the local and provincial hospitalization rate to date (**Figure 9**).

Figure 9

The SWPH alcohol-related hospitalization rate has remained higher than Ontario since 2017 and is increasing over time while the rate remains consistent over time in Ontario.

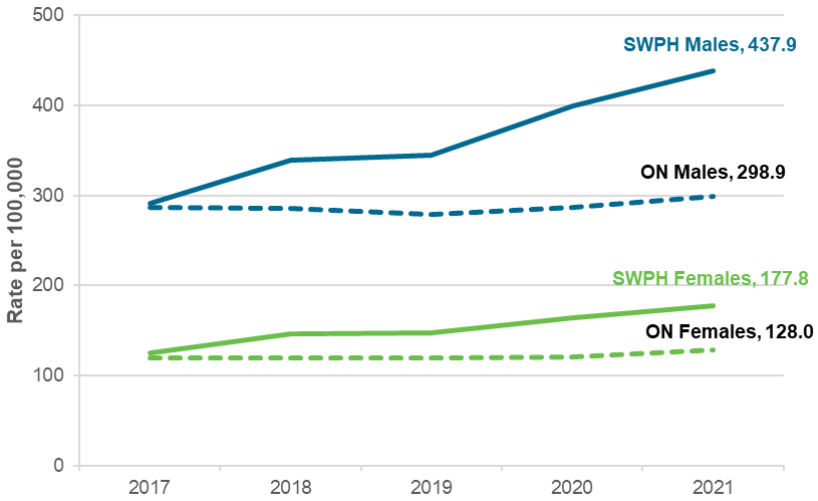


Both males and females in the SWPH region had increased rates of hospitalizations, with males increasing at a faster rate compared to females. In 2019, the hospitalization rate among male residents was 344.2 per 100,000, and then it increased by over 25%, reaching 437.9 hospitalizations per 100,000 in 2021. However, this same rapid increase was not evident among males in Ontario, whose alcohol-related hospitalization rate only increased marginally over time (**Figure 10**).

The hospitalization rate among SWPH female residents increased by only 20% between 2019 and 2021 (147.2 vs. 177.8 per 100,000, respectively). This trend was comparable to females across Ontario (**Figure 10**).

Figure 10

Since 2019, the rate of hospitalizations for conditions entirely caused by alcohol has increased more steeply for males in the SWPH region compared to females.



Mortality from alcohol (with and without drug involvement)

Locally, the rate of deaths due to alcohol (with and without drug involvement) has been on an upward trajectory between 2019 and 2021, more than doubling to reach 3.4 deaths per 100,000 in 2021.

Provincially, the rate decreased to 2.5 deaths per 100,000 in 2021; however, this was still higher than pre-pandemic, where the rate was 2.0 deaths per 100,000 (**Figure 11**).

In comparison to males, local female residents experienced a sharper increase in alcohol-related mortality from 2019 onwards, reaching 3.3 deaths per 100,000 in 2021. This was nearly as high as the male residents (3.5 deaths per 100,00), who historically had a higher mortality rate (**Figure 12**).

The trend among local female residents was unique compared to females across Ontario, who did not increase at such a high rate (1.3 deaths per 100,000 in 2018 to 1.6 deaths per 100,000 in 2021) (**Figure 12**).

Figure 11

The rate of alcohol-related mortality in SWPH doubled between 2019 and 2021, where ON decreased in 2021.

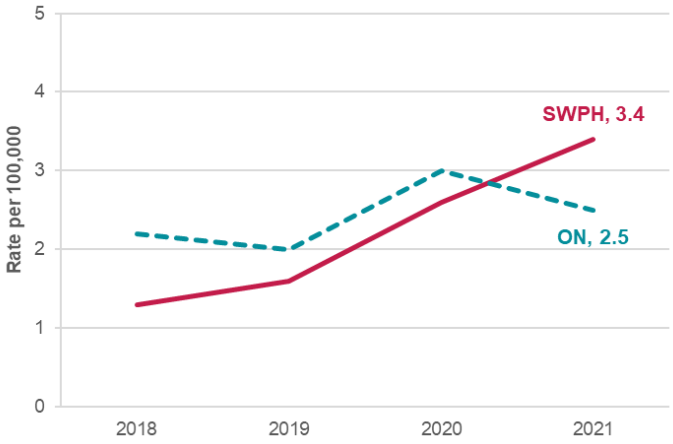
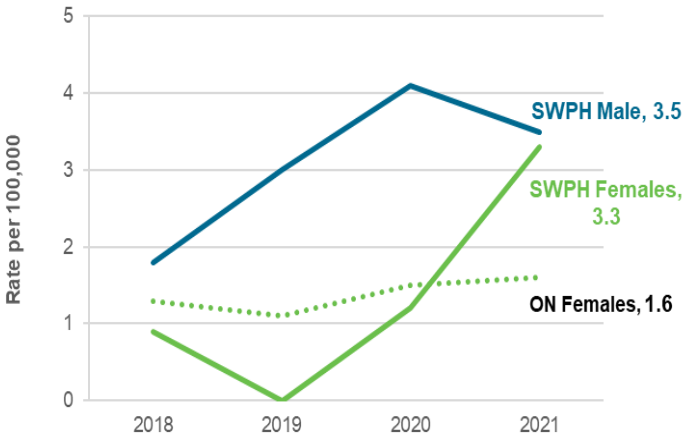


Figure 12

The rate of alcohol-related mortality among females in SWPH has increased over time to nearly match males in 2021.



Conclusion

Although the proportion of SWPH residents reporting risky drinking has decreased over time, more people are reporting being current alcohol drinkers. This indicates that locally, there is an increasing number of residents who are at risk of health problems and premature death due to alcohol consumption.

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Appendix A

Technical appendix – ICD-10 codes

ED visits for conditions entirely caused by alcohol (15+ years old)

- Unscheduled ED visits only
- 3-digit All Dx ICD code
    - F10 (mental and behavioural disorders due to use of alcohol. i.e. acute intoxication, harmful use, withdrawal),
    - K70 (alcoholic liver disease),
    - T51 (toxic effect of alcohol),
    - X45 (accidental poisoning by and exposure to alcohol),
    - X65 (intentional self-poisoning by and exposure to alcohol),
    - Y15 (poisoning by and exposure to alcohol, undetermined intent)
- 4-digit All Dx ICD code
    - E24.4 (alcohol-induced pseudo-Cushing syndrome),
    - G31.2 (degeneration of nervous system due to alcohol),
    - G62.1 (alcoholic polyneuropathy),
    - G72.1 (alcoholic myopathy),
    - I42.6 (alcoholic cardiomyopathy),
    - K29.2 (alcoholic gastritis),
    - K85.2 (alcohol-induced acute pancreatitis),
    - K86.0 (alcohol-induced chronic pancreatitis),
    - O35.4 (maternal care for (suspected) damage to fetus from alcohol),
    - Q86.0 (fetal alcohol syndrome (dysmorphic)),
    - R78.0 (finding of alcohol in blood)

Hospitalizations for conditions entirely caused by alcohol (15+ years old)

- Acute care facilities only
- 3-digit All Dx ICD code = F10, K70, T51, X45, X65, Y15
- 4-digit All Dx ICD code = E24.4, G31.2, G62.1, G72.1, I42.6, K29.2, K85.2, K86.0, O35.4, Q86.0, R78.0
- DSM-IV Axis I Primary or DSM-IV Axis I Sec Dx or DSM-IV Axis I Tert Dx or DSM-IV Axis I Quat Dx or DSM-IV Axis II Other Primary Dx or DSM-IV Axis II Other Sec Dx = 291.0, 291.1, 291.2, 291.3, 291.5, 291.81, 291.82, 291.89, 291.9, 303.00, 303.90, 305.00
- DSM-5 Psychiatric Dx A or DSM-5 Psychiatric Dx B or DSM-5 Psychiatric Dx C or DSM-5 Psychiatric Dx D or DSM-5 Psychiatric Dx E or DSM-5 Psychiatric Dx F = 291.0, 291.1, 291.2, 291.81, 291.82, 291.89, 291.9, 303.00, 303.90, 305.00, F10.0, F10.1, F10.2, F10.3, F10.4, F10.5, F10.6, F10.7, F10.8, F10.9

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Adult Substance Use & Harms in the SWPH Region

Cannabis

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Contents

Summary

Cannabis use has increased across the SWPH region after the introduction of the *Cannabis Act* in 2018.

In 2019/2020, a higher proportion of SWPH residents reported being worried about certain aspects of their cannabis use (i.e. being out of control, missing a dose) or finding it difficult to stop using cannabis compared to Ontarians.

Even after local cannabis use increased, the rate of hospitalizations due to cannabis poisonings decreased at the beginning of the COVID-19 pandemic. However, the trend reversed in 2021 and began to increase, which was not the case for the provincial trend, which remained relatively unchanged over time.

It will be important to continue to monitor local cannabis use and the associated harms over time.

Substance Use & Harms Among Adults

Cannabis use

Health Risks of Cannabis Use

Frequent and intense cannabis use (such as daily use or continued use over a long period of time), is one of the stronger predictors of developing health concerns, including mental health problems or cannabis use disorder. Cannabis use is also associated with an increased risk of other public health concerns, such as impaired driving resulting in injury or death, poor educational outcomes and impaired perception or memory.[1]

Cannabis Legalization & Data Collection

In October 2018, the Government of Canada passed the *Cannabis Act* as a framework to control the production, distribution, and possession of cannabis in Canada.[2]

After the *Cannabis Act* was passed, and cannabis use was legalized, it became essential to understand how increased access may have impacted self-reported use by residents across Ontario. To address this need, Statistics Canada created a new module for the Canadian Community Health Survey (CCHS) regarding cannabis use that was included in the 2019/2020 cycle of the survey. In the 2015/2016 and 2017/2018 cycles of the survey, cannabis use was included in the illicit drug module. Therefore, it is important to note that in this time, residents may not have felt comfortable enough to report using cannabis.

Cannabis use in the last year

The proportion of SWPH residents who reported that they used cannabis more than once in the last 12 months has increased over time and has remained higher than the proportion reported across Ontario in 2019/2020 (45.4% versus 41.3%, respectively).

Between the 2015/2016 and 2019/2020 CCHS cycles, the proportion of local residents who reported using cannabis more than once in the last 12 months increased substantially from 34.6% to 45.4%. This increase was also evident across Ontario; 41.3% of Ontarians reported

having smoked cannabis more than once in the last 12 months in 2019/2020 compared to 33.0% in 2015/2016.

Used more than once in last 12 months

2015/2016 → 2019/2020

+10.8 % SWPH

+11.2% ON

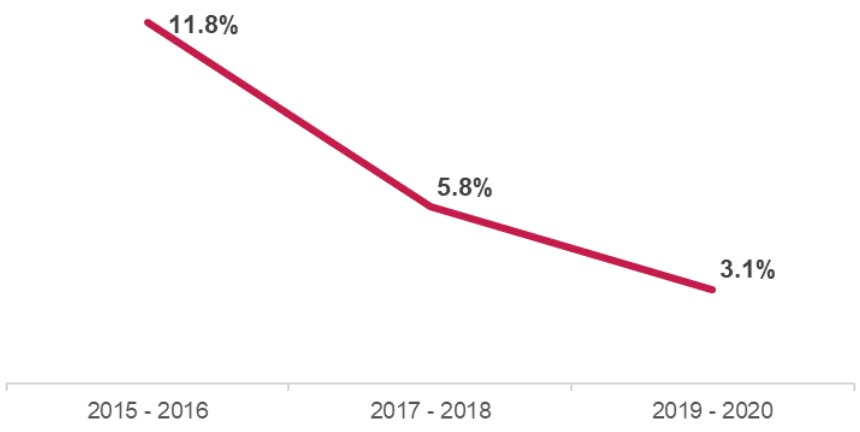
Locally, at least 2 in 5 (40%) males report using cannabis more than once in the last 12 months, which is historically higher compared to females.

However, the proportion of females reporting using cannabis more than once in the last 12 months increased by more than 15% between 2015 and 2020. In comparison, the proportion among males only increased by 7%. This resulted in the difference in the proportion of cannabis use between males and females substantially decreasing over time (**Figure 1**). As of 2019/2020, females reported using cannabis more than once in the last 12 months nearly as much as males (44.2% versus 47.3%, respectively).

Data source:
Canadian Community Health Survey (CCHS). StatsCan.
2015 – 2016
2017 – 2018
2019 – 2020

Figure 1

The difference in the proportion of local males and females who use cannabis is decreasing over time, as the proportion of females that use cannabis increases.



The largest increase in cannabis use in the last 12 months was reported among residents between the ages of 45 and 64 years. There was an 11% increase between 2015/2016 and 2019/2020 (from 28.2% up to 37.6%).

Respondents in the other age groups (ages 20 - 44 and 65+) increased by only 4 to 6%. Those between the ages of 20 and 44 remained relatively unchanged between 2017/2018 and 2019/2020 at around 56%.

Severity of Dependence Scale (SDS)

Following the 2018 *Cannabis Act*, the measurement of harmful consequences associated with cannabis use over time became crucial. In the 2019/2020 cycle, the CCHS included a severity of dependence scale (SDS) module to allow for monitoring consequences related to cannabis, such as addiction and potential risk factors for associated harms.[2]

The SDS module is comprised of 5 items, which can be combined into an overall score to indicate the degree of psychological dependence of respondents. These items included:

- Being worried that cannabis use was out of control in the last 12 months
- Being worried about missing a dose of cannabis in the last 12 months
- Being worried about use of cannabis in the last 12 months
- Wished to stop using cannabis in the last 12 months
- Having difficulty stopping cannabis use in the last 12 months

Data source:
Canadian Community Health Survey (CCHS). StatsCan.
2019 – 2020

Respondents were asked each of these questions in terms of how many times it had occurred (frequency-based). However, for the current report, they were each re-categorized into “yes” or “no/never” rather than frequency-based responses.

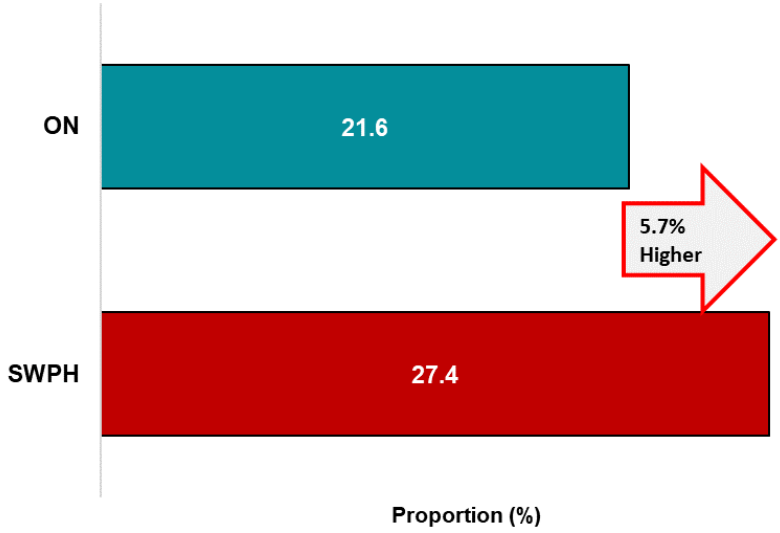
They were then combined to understand any dependence of respondents, potentially indicating signs of addiction, rather than the degree of dependence. Therefore, if respondents stated that they were worried or had difficulty with any of the 5 questions, they were considered “dependent”.

Psychological dependence on cannabis in the last year

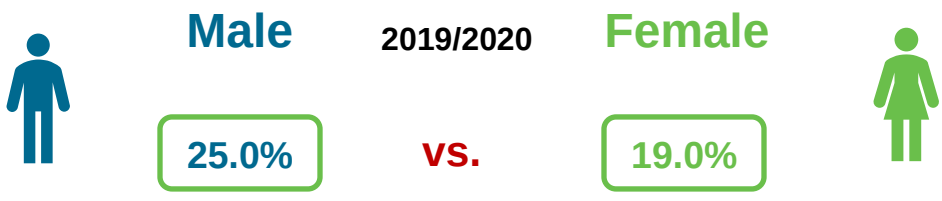
Approximately 5.7% more SWPH residents reported having difficulty with at least one item of the SDS for cannabis (listed above) compared to respondents across Ontario (**Figure 2**). This will be of interest to monitor in coming CCHS cycles to detect an increase in risk for dependence on cannabis over time.

Figure 2

Local respondents report being more psychologically dependent on cannabis in the last 12 months compared to respondents across Ontario.



Similar to cannabis use in the last 12 months, males in the SWPH region reported that they were more psychologically dependent on cannabis compared to females.



More SWPH residents between the ages of 45 and 64 also reported being worried about some aspect of their cannabis use compared to respondents of other age groups (not shown). It is important to note that the proportion among residents 65 and over was very small and therefore, not reportable.

Cannabis-related harms

Emergency department (ED) visits and hospitalizations

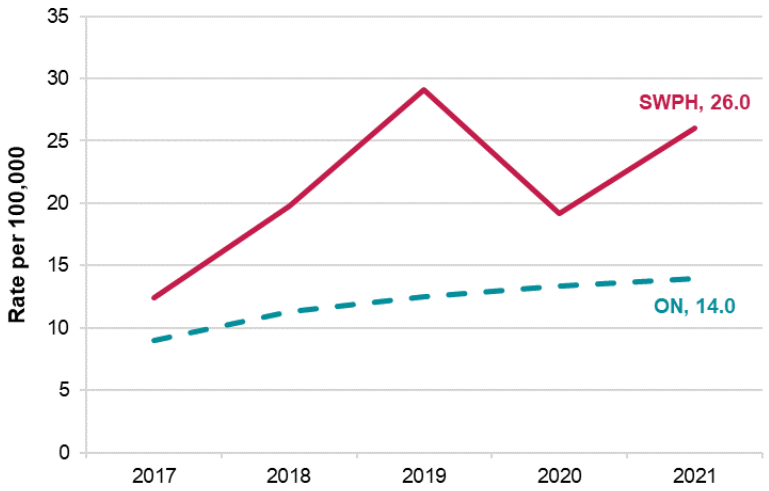
Emergency department (ED) visits for cannabis-related poisonings

Overall, the local rate of emergency department (ED) visits for cannabis-related poisonings (see **Appendix A**) was on an upward trend pre-COVID, increasing sharply in 2019. After a decrease in 2020, the local ED rate increased significantly in 2021. At the same time, the provincial rate only increased marginally (**Figure 3**).

As of 2021, the ED rate for cannabis-related poisonings was 26.0 per 100,000 across the SWPH region compared to 14.0 per 100,000 across Ontario (**Figure 3**).

Figure 3

Locally, after a decrease in the rate of ED visits for cannabis poisonings in 2020, the rate increased steeply in 2021 whereas provincially, the rate only marginally increased.

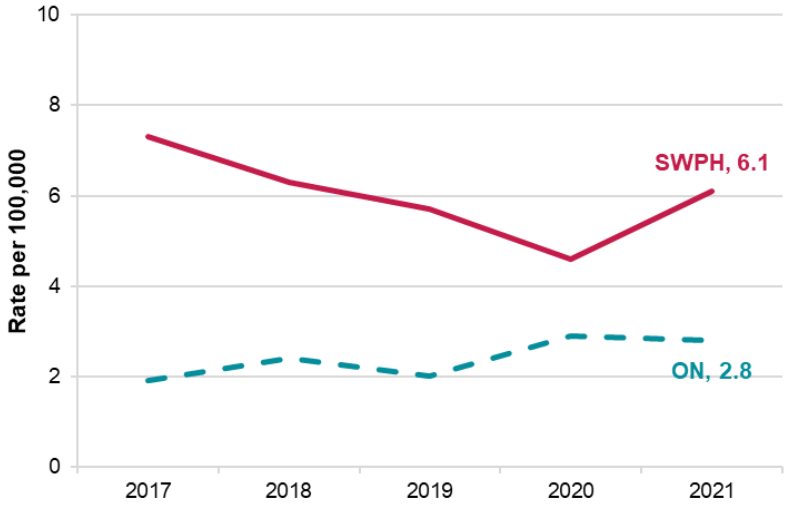


Hospitalizations for cannabis-related poisonings

Overall, the local rate of hospitalizations for cannabis-related poisonings (see **Appendix A**) was decreasing year over year into 2020, even after the legalization of Cannabis in 2018. However, in 2021 it began to increase, reaching a rate of 6.1 per 100,000 which was more than 2x the provincial rate (**Figure 4**). Provincially, the rate decreased marginally to 2.8 per 100,000 in 2021.

Figure 4

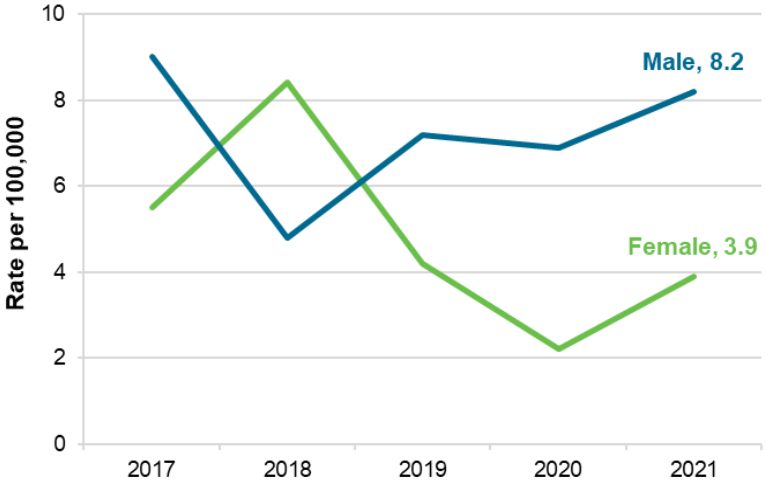
Following a downward trend for several years, the local rate of hospitalizations due to cannabis poisonings increased substantially to 6.1 per 100,000 in 2021 where there was only a marginal increase provincially.



Both males and females in the SWPH region experienced increased rates of hospitalizations in 2021 (reaching 8.2 per 100,000 versus 3.9, respectively). However, for males this is following a sharp increase in 2019 where females had been on a downward trend (**Figure 5**).

Figure 5

Male residents in the SWPH region had a hospitalization rate due to cannabis poisonings that was more than double the rate for female residents in 2021.



Conclusion

Cannabis use has increased across the SWPH region after the introduction of the *Cannabis Act* in 2018. However, it is important to note that prior to this, residents may not have felt comfortable enough to truthfully report using cannabis.

In 2019/2020, a higher proportion of SWPH residents reported being worried about certain aspects of their cannabis use (i.e. being out of control, missing a dose) or finding it difficult to stop using cannabis compared to Ontarians. There has also been an increase in some cannabis-related harms.

It will be important to continue to monitor local cannabis use and the associated harms over time.

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Appendix A

ED visits for cannabis related poisonings (all ages)

- Unscheduled ED visits only
- Excludes suspect/query diagnosis
- 4-digit All Dx ICD code
    - T40.7 (poisoning by narcotics and psychodysleptics, cannabis)

Hospitalizations for cannabis related poisonings (all ages)

- Acute care facilities only
- Excludes suspect/query diagnosis
- 4-digit All Dx ICD code = T40.7

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Contents

Summary

In 2019/2020, the proportion of respondents in the SWPH region who reported being a current daily smoker had increased from the previous cycle of the Canadian Community Health Survey (CCHS) in 2017/2018 to reach 17.2%. During the same period, the proportion of current daily smokers decreased across the province to 10.0%.

There have been increases in current daily smoking among SWPH residents aged 45 to 64 years and over since 2015, especially among males. Although the proportion of pregnant women reporting smoking at admission for birth has decreased over time, as of 2022, over 5% still reported smoking, which increased substantially among young mothers (24 years of age or under).

Targeted local programs and health promotion strategies for priority populations (such as middle-aged males, youth, and pregnant women) could be instrumental in decreasing the proportion of local current smokers.

Substance Use & Harms Among Adults

Tobacco & E-cigarette use

Tobacco Use and Public Health

Source: Government of Canada. Tobacco and Premature Death. 2023

Tobacco use (including e-cigarettes and vaping) is associated with many health risks and is the leading preventable cause of premature death in Ontario and across Canada.[1]

Understanding local trends in tobacco use supports the development of tailored health promotion strategies and local programs geared toward reducing tobacco use. In turn, this would contribute to reducing the risk of tobacco-related morbidity and mortality among Southwestern Public Health (SWPH) residents over time.

Lifetime abstainers

The proportion of respondents who reported that they have never smoked a whole cigarette in their lifetime has increased over time, which was also evident across Ontario. In 2019/2020, 41.6% of SWPH residents reported that they had never smoked a whole cigarette compared to 49.7% of Ontario residents.

Never smoked a whole cigarette

2015/2016 → 2019/2020

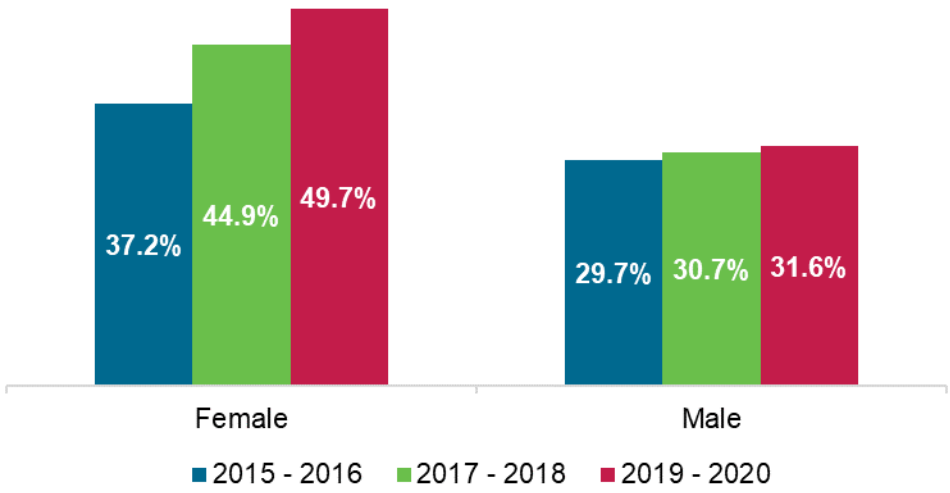
+7.6 % **SWPH**

+4.9% **ON**

In 2019/2020, approximately half (49.7%) of local females reported lifetime abstinence from tobacco cigarettes, which is an increase of more than 10% from 2015/2016. On the contrary, the proportion of male residents reporting never smoking a cigarette remained relatively the same over time with little to no improvement (**Figure 1**).

Figure 1

Locally, an increasing proportion of females reported lifetime abstinence from tobacco cigarettes where there has been minimal change in the lifetime abstinence among male residents.



SWPH residents between the ages of 20 and 44 reported increases in lifetime abstinence from smoking over time. In 2015/2016, 34.3% reported abstaining from smoking, whereas in 2019/2020, 44.7% reported abstinence. This indicates that fewer young adults are initiating tobacco use, or that they are initiating it later in life, as there was not much change among residents between the ages of 45 to 64 and 65 plus.

Data source:
Canadian Community Health Survey (CCHS). StatsCan.
2015 – 2016
2017 – 2018
2019 – 2020

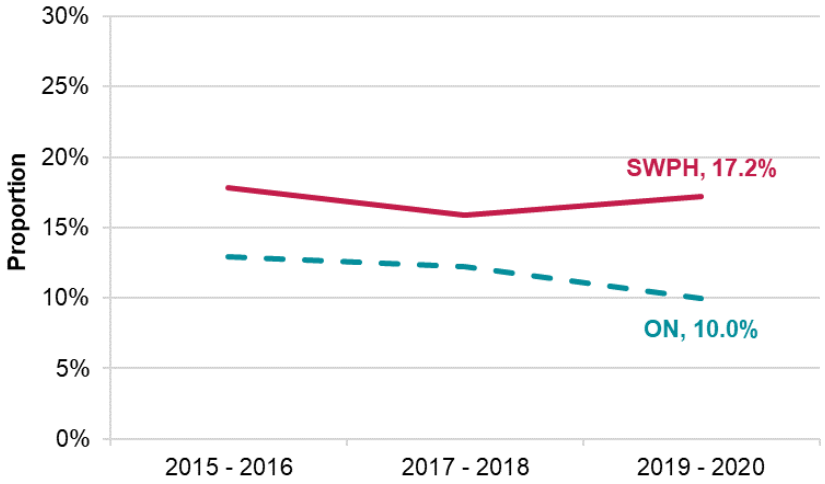
Current daily smoker

Current daily smokers are defined as respondents who reported smoking at least one full tobacco cigarette each day in the last 30 days. Locally, the proportion of residents who report being a current daily smoker has remained relatively consistent over time (17.8% in 2015/2016 versus 17.2% in 2019/2020), with little improvement (**Figure 2**).

This contrasts with the trend across Ontario, which has been decreasing year over year since 2015. However, the decreases were relatively minimal over time (12.9% in 2015/2016 to 10.0% in 2019/2020).

Figure 2

The proportion of residents in the SWPH region who reported being a current daily smoker has remained relatively consistent over time, whereas there was a marginal decrease across Ontario.

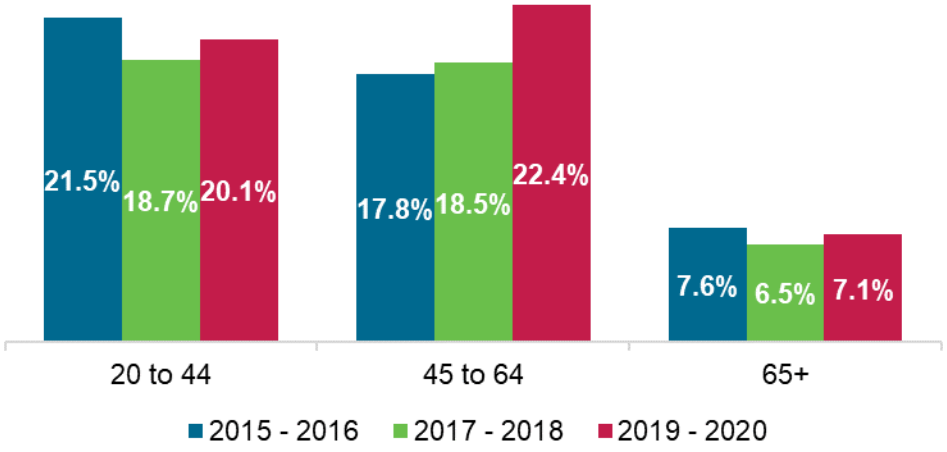


On average, male residents report proportions of current daily smoking are approximately 6% higher compared to female residents between 2015 and 2020 (not shown). As of the 2019/2020 cycle of the CCHS, 21.4% of SWPH males report being a current daily smoker compared to 13.0% of SWPH females.

Locally, only residents between the ages of 45 and 64 reported a significant increase in current daily smoking between 2015 and 2020 (**Figure 3**). In 2019/2020, 22.4% of residents aged 45 to 64 reported being current daily smokers, which was 4.6% higher compared to the 2015/2016 cycle. During that same cycle, male residents between 45 and 64 had the highest proportion of current smokers at 26.8% (not shown).

Figure 3

The proportion of SWPH residents between the ages of 45 and 64 who reported being a current daily smoker has increased year over year since 2015/16, while those of other ages decreased.



Age when smoking began

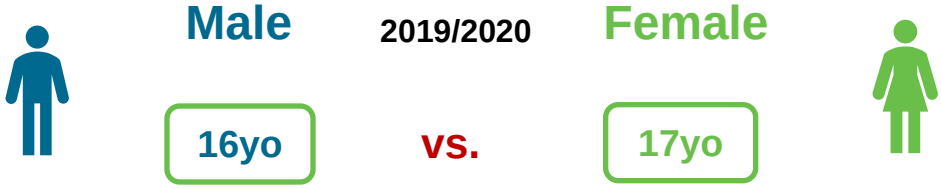
Historically, residents in the SWPH region reported beginning to smoke (i.e. the first time they smoked a whole cigarette) at a younger age compared to residents across Ontario. The average age of initiation did not change over time for either SWPH or Ontario.

Age of Smoking Initiation

SWPH: 16 years old

ON: 17 years old

Locally, male residents first smoked a whole cigarette at a younger age compared to females. On average, males reported smoking a whole cigarette for the first time at 16 years old and females reported doing so at 17 years old.



Age at which daily smoking began

Like the average age of first smoking a whole cigarette, SWPH residents also reported the initiation of daily smoking (among daily and former daily smokers) at a younger age compared to residents across Ontario. The average age of respondents when they began to smoke daily was 18 years old in the SWPH region and 19 years old among Ontarians.

There were no major differences when comparing male and female residents.

Electronic cigarettes

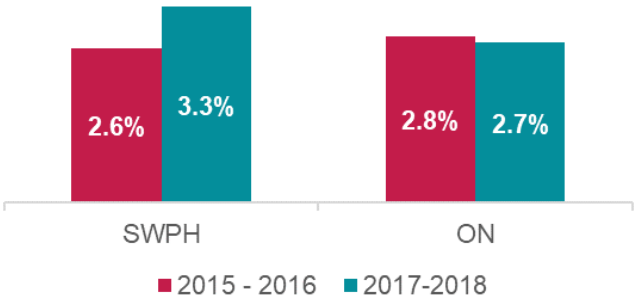
Between 2015/16 and 2017/18, the proportion of SWPH residents who reported using electronic cigarettes (e-cigarettes) in the last 30 days increased slightly, whereas the proportion across Ontario remained the same (**Figure 4**).

However, since the proportions are so small, it is not possible to look at them broken down by either age or gender.

Data source:
Canadian Community Health Survey (CCHS). StatsCan.
2015 – 2016
2017 – 2018

Figure 4

Residents in the SWPH region report having used an e-cigarette in the last 30 days more than residents across Ontario.



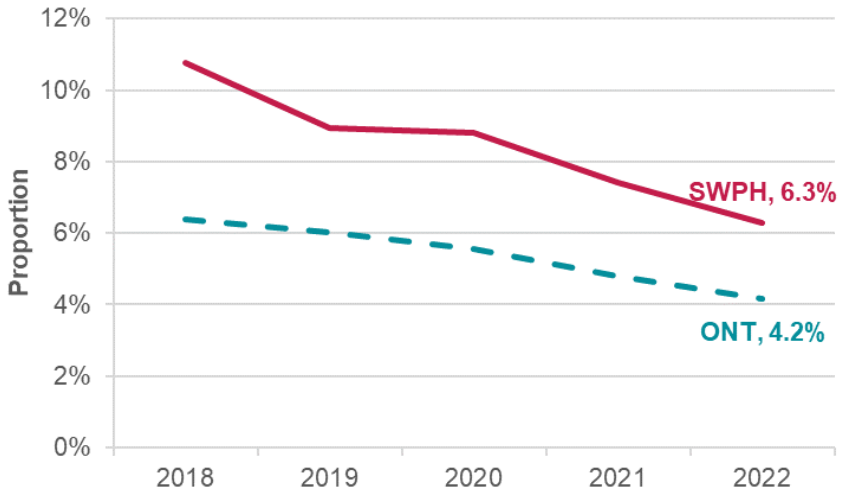
The tobacco alternatives module was not selected for Ontario for the 2019/2020 cycle of the CCHS.

Smoking during pregnancy

Pregnant women in the SWPH region historically reported smoking at admission for birth more often compared to pregnant women across Ontario. Although this has been on a downward trend since 2018, the local proportion remains over 5%. In 2022, 6.3% of pregnant women in the SWPH region reported smoking versus 4.2% in Ontario (**Figure 5**). This proportion doubled among young mothers who were under the age of 25 years old, remaining 12.7% in 2022, which decreased from 18.7% in 2018 (not shown).

Figure 5

More pregnant women in the SWPH region report smoking at admission for birth compared to pregnant women in Ontario.



Conclusion

Targeted local programs and health promotion strategies for priority populations (such as middle-aged males, pregnant women and youth) could be instrumental in decreasing the proportion of local current smokers, which continues to remain high locally.

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Adult Substance Use & Harms in the SWPH Region

Opioids

Health Status Report
Southwestern Public Health
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Contents

Summary

In the Southwestern Public Health Region (SWPH), harm reduction activities have increased over time and at the same time there has been a gradual decrease of new opioid users.

Locally, although there were recent decreases in both opioid-related emergency department (ED) visits and hospitalizations (i.e. opioid poisonings) in 2022, the rates have increased again into 2023. The rate of opioid toxicity deaths continued to decline in 2023, but given the increase in ED visits and hospitalizations, this will be important to monitor over the next year. In general, more males in the SWPH region experience opioid-related harms and make up the vast majority of opioid toxicity deaths (more than 50%).

Opioid agonist therapy (OAT) and other treatment options can be explored in order to decrease these rising opioid-related harms and improve the overall well-being of residents in the SWPH region.

Substance Use & Harms Among Adults

Opioid prescriptions & naloxone distribution

Public Health and Opioids

Both pharmaceutical and non-pharmaceutical opioids can have an impact on the health and wellbeing of the community.[1] However, in recent years the majority of substance-related toxicity deaths are attributable to non-pharmaceutical (or unregulated) opioids, benzodiazepines, and stimulants.[2] This is evident for local opioid toxicity deaths in the SWPH since 2019.

Further, the rising trend in polysubstance use (defined as the co-ingestion of multiple substances during the same instance) is increasing the risk of overdose as well as complicating local treatment and harm reduction responses.[2] SWPH has a role in harm reduction and health promotion activities in our community in order to curb the impact of these opioid and substance-related harms.

Opioids for pain relief

There has been a gradual change in opioid prescribing practice across Canada after 2013, with various provinces introducing prescription guidelines and monitoring programs.[3] This has resulted in decreasing numbers of opioid prescriptions and thus, opioid users.[4] This is evident in the SWPH region.

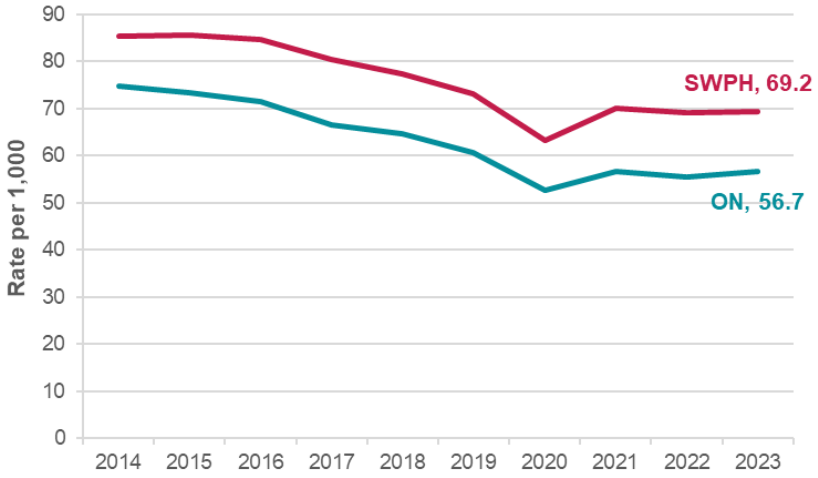
Since 2014, the count and rate of new users of opioids for pain has decreased year over year into the first year of the COVID-19 pandemic in 2020. However, this was followed by the first increase in several years in 2021, reaching 70.1 per 1,000 and remaining approximately the same for the following two years. The same trend was evident across Ontario (**Figure 1**).

Of note is that the overall local rate of new users of opioids for pain has historically always been higher compared to the province.

Data source:
Ontario Drug Policy Research Network. Ontario Opioid Indicator Tool. Toronto, ON.

Figure 1

The rate of new users of opioids for pain decreased into 2020, increasing again in 2021 but remained relatively stable into 2023.

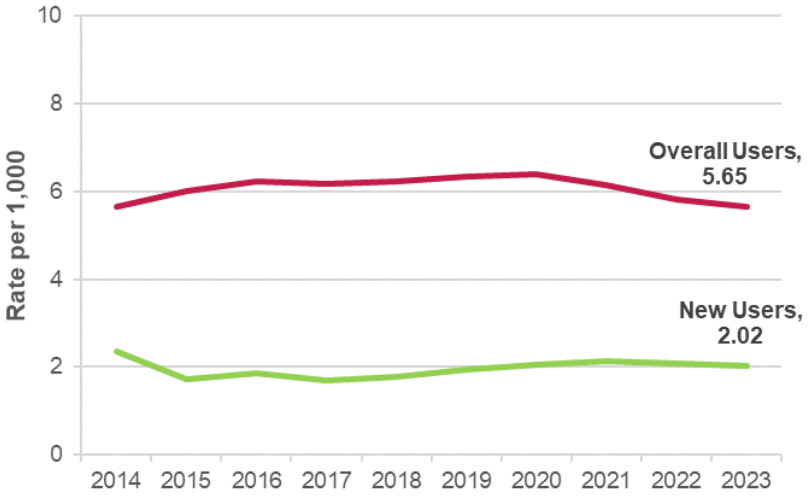


Opioid agonist therapy

Opioid agonist therapy (OAT) is often used to treat addiction to various opioid drugs by preventing withdrawal due to opioids or cravings for opioids.[4] The rate of overall users of OAT decreased slightly in 2021, 2022, and 2023, falling to about 5.7 users per 1,000 population (**Figure 2**). This is consistent with long-term users discontinuing therapy.[4] On the other hand, the trend in new opioid users (pharmaceutical opioids) has been relatively steady over the same period (2021-2023), remaining at about 2.0 new users per 1,000 population.

Figure 2

The rate per 1,000 of overall users of opioid agonist therapy (OAT) in the SWPH region has decreased slightly over time.



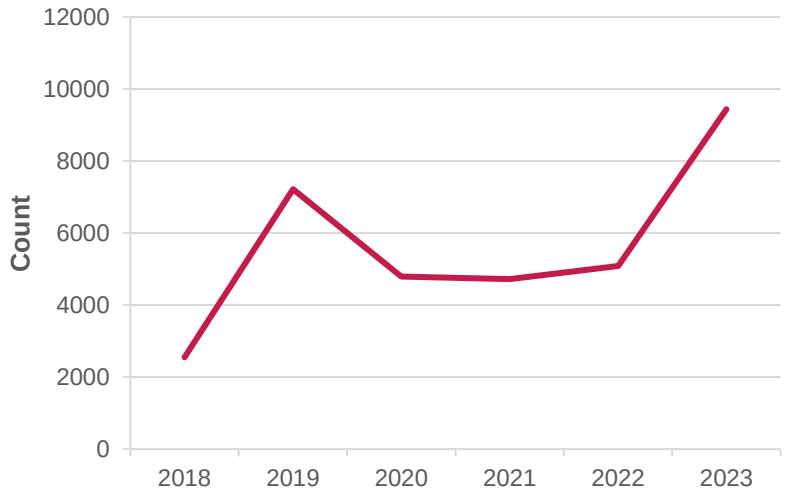
Naloxone distribution

The distribution of naloxone is a key harm-reduction activity in the community to help prevent opioid-related deaths. SWPH and local pharmacies are the main access points to naloxone for SWPH residents. As opioid-related harms became more frequent (covered in the next section of the current report), the number of doses given out by either SWPH, or local pharmacies increased sharply to meet the needs of the community (between 2018 and 2019).

There was a slight decrease in the number of naloxone doses distributed during the COVID-19 pandemic. However, the number rose again in 2022 and shot up to an all-time high in 2023, surpassing the initial jump in naloxone kit distribution in 2019 (**Figure 3**).

Figure 3

The number of naloxone kits being distributed to residents of the SWPH region has increased over time, remaining over 4000 each year since 2019 with a recent all-time high of over 9000 in 2023.



Although interesting, looking at naloxone data in this way does not fully represent the opioid overdose climate in the SWPH region. This is because the number of naloxone kits being distributed does not necessarily mean they were all used. Nor is it possible to determine how many doses were used on a single instance/individual. This is important to keep in mind as in many overdose situations, more than one dose of naloxone is used, especially if the opioid is mixed with other drugs that do not respond to naloxone. It may appear that the initial dose of naloxone is not working, and thus multiple doses are administered.

Opioid-related harms

Emergency department (ED) visits, Hospitalizations, & Mortality

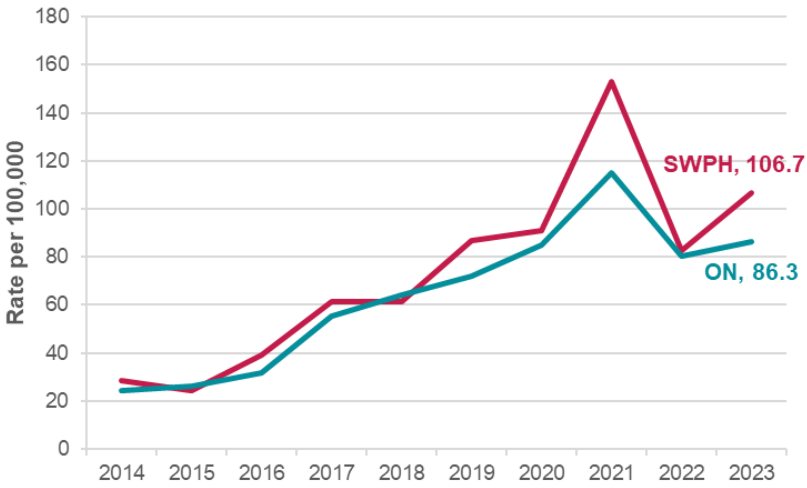
A recent report by the Ontario Drug Policy Research Network (ODPRN) and Public Health Ontario (PHO) reported that 17.5 % of people who died from substance-related toxicity (using alcohol, opioids, stimulants, and benzodiazepines) had visited the emergency department (ED) for a non-fatal substance-related toxicity in the 30 days prior to death.[2] This indicates a missed opportunity for high-risk individuals to be connected with low-barrier access to treatment or harm reduction services such as OAT before they experience a more severe outcome, such as death.[5] As the rate of new users of OAT has not increased and there have been increases in opioid-related harms, this could indicate limited access to treatment for those who need it most. This makes monitoring hospital administrative data an important part of opioid- and substance-related surveillance with the goal of decreasing mortality over time.

Opioid poisoning emergency department (ED) visits

Overall, the local rate of ED visits per 100,000 population for opioid poisonings among residents of the SWPH region has been increasing over time. ED visits reached an all-time high in 2021 of 153.0 visits per 100,000 compared to 115.2 per 100,000 in Ontario. The only decrease was observed in 2022, but this was followed by an increase to 106.7 per 100,000 in 2023. This was still higher compared to the local rate pre-pandemic of 86.8 per 100,000 (2019). The local rate has remained higher than the province almost every year since 2014 (**Figure 4**).

Figure 4

The rate of ED visits for opioid poisonings has been increasing over the last decade with the only significant decrease in 2022. However, this was followed by another increase in 2023.



Although the same trend is evident across both male and female residents in the SWPH region, males have had a higher rate of ED visits for opioid poisonings compared to females since 2015, reaching 134.7 per 100,000 in 2023 compared to 78.8 per 100,000 among females.

Figure 5

In 2023, male residents had an ED rate for opioid poisonings that was 1.7x higher compared to females.

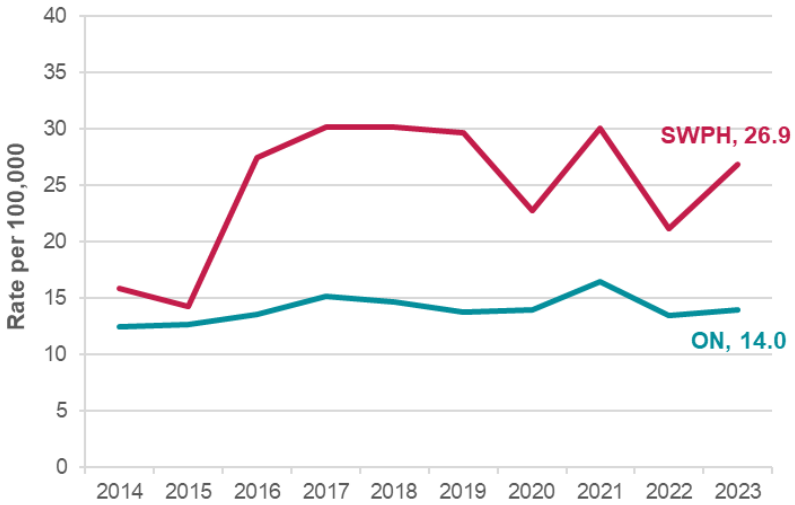
per 100,000

Opioid-related hospitalizations

Overall, the local rate of opioid-related hospitalizations has been unstable since 2020 but for the most part, has remained as high as the rate in 2016 (27.5 per 100,000) which was when the sharpest increase occurred in the SWPH region. This sharp increase was not evident across Ontario, where the increase over time was steady and more marginal (**Figure 6**). Further, despite some decreases in the local rate in 2020 and 2022, there continued to be more opioid-related hospitalizations in the SWPH region compared to Ontario (**Figure 6**).

Figure 6

The local rate of opioid-related hospitalizations sharply increased in 2016 and has remained relatively close to 27 per 100,000 since, although the trend has been a little unstable compared to Ontario.



Unlike with ED visits, the trend in the rate of hospitalizations among males and females was much more erratic over time with no one group being consistently higher compared to the other. Both males and females have also experienced various increases and decreases over time. This differs from the trend in Ontario where males have consistently experienced higher rates of hospitalization compared to females since 2017 (not shown).

Opioid-related deaths

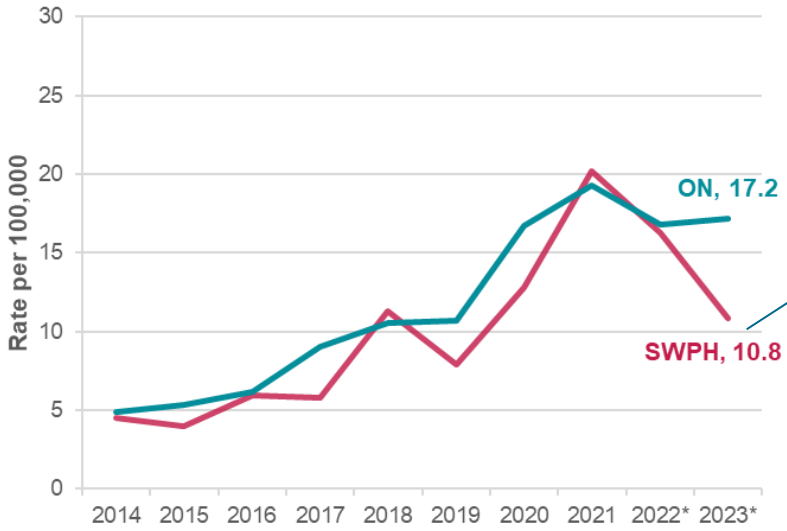
Similar to the provincial situation, the rate of deaths due to opioid toxicity increased dramatically between 2014 and 2017. It remained on an upward trajectory until 2022, with steep increases observed both locally and provincially during the onset of the COVID-10 pandemic in 2020 and 2021, where rates reached all-time highs.

Data source:
Office of the Chief Coroner Ontario.
Toronto, ON.

There was a universal decrease in opioid toxicity deaths in 2022 but in 2023, the provincial rate remained relatively unchanged, whereas the local rate continued to decline. However, it is important to note that both provincial and local rates in 2023 were still approximately 1.5x higher compared to 2019.

Figure 7

The rate of opioid-related deaths was on an upward trend, reaching an all-time high in 2021 (20.2 per 100,000). Although there were decreases in 2022 and 2023, the rate remained higher compared to pre-pandemic.



*2022 and 2023 mortality rates are preliminary and are subject to change

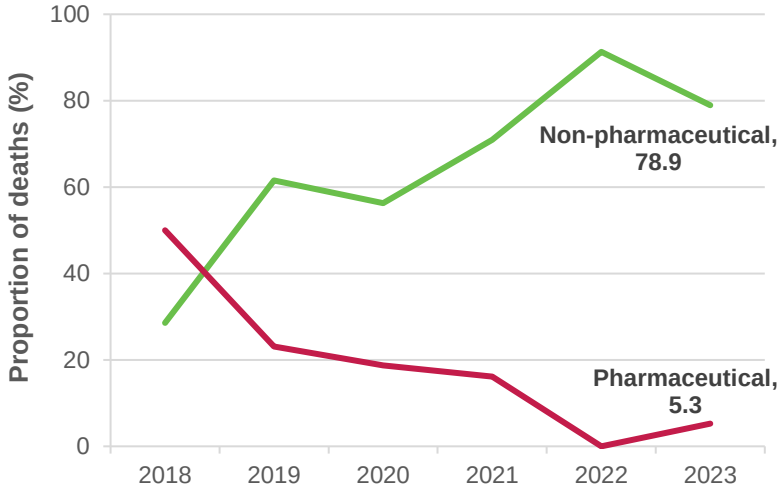
In 2023, **males** had a significantly **higher** mortality rate due to opioid toxicity compared to **females**.

15.6 versus 6.1

In Ontario, approximately 86% of opioid-toxicity deaths involved non-pharmaceutical opioids (i.e. unregulated fentanyl).[3] Locally, there has been a clear shift in the origin of the opioids that directly contributed to opioid toxicity deaths among residents. In 2018, a larger proportion of deaths were associated with prescription opioids accessed through a pharmacy. This changed drastically in 2019 when non-pharmaceutical opioids from unregulated sources represented more than 60% of drugs directly contributing to deaths (**Figure 8**).

Figure 8

In 2018, pharmaceutical opioids contributed to half of opioid toxicity deaths in the SWPH region, but non-pharmaceutical opioids have contributed to over 70% (on average) of opioid toxicity deaths between 2019 and 2023.



*does not equal 100% due to deaths having both types or unspecified types as contributory factors being excluded from the figure

Although the proportion of opioid-related deaths among people who are employed has increased over time, the majority were unemployed at the time of their death (two in three opioid-related deaths in 2023).

Between 2018 and 2023, opioid-related deaths occurred on average, **2.8x** more among the **unemployed**

Conclusion

Although the rate of new opioid users (pharmaceutical) has been decreasing over time, there has been an increase in access to non-pharmaceutical (non-regulated) opioids. There has also been a decrease in new users of OAT. Although not all users have an opioid-use disorder or require treatment, the lack of significant improvement in opioid-related harms could indicate a need for increased assess to opioid and substance use treatments

Therefore, OAT and other treatment options can be explored in order to decrease rising opioid-related harms and improve the overall well-being of residents in the SWPH region.

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Appendix A

Technical appendix – ICD-10 codes

ED visits and hospitalizations for opioid poisonings

- Includes unscheduled ED visits for opioid poisoning (all diagnosis types)
- T40.0 (poisoning by opium),
- T40.1 (poisoning by heroin),
- T40.20-T40.28 (poisoning by codeine and derivatives [T40.20], poisoning by morphine [T40.21], poisoning by hydromorphone [T40.22], poisoning by oxycodone [T40.23], poisoning by other opioids not elsewhere classified [T40.28]),
- T40.3 (poisoning by methadone),
- T40.40-T40.48 (poisoning by fentanyl and derivatives [T40.40], poisoning by tramadol [T40.41], poisoning by other synthetic narcotics not elsewhere classified [T40.48]),
- T40.6 (poisoning by other and unspecified narcotics)
- Excludes cases with a query/suspected diagnosis (diagnosis prefix = Q).

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Youth Substance Use & Harms in the SWPH Region

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Contents

Summary

Local youth report using alcohol, tobacco, e-cigarettes, cannabis, and magic mushrooms more than youth in Ontario. Over half of local youth report drinking alcohol in the last 12 months, approximately 10% higher compared to youth in Ontario. However, the use of tobacco was the most significant with youth in the SWPH region, who reported smoking 2x more than youth in Ontario.

More than 1 in 3 youth in the SWPH region reported using alcohol, cannabis, and smoking a full tobacco cigarette for the first time in grade 9.

As substance-related harms have been increasing among adults in the region, focusing on youth for health promotion and local programs could impact these harms in adults by delaying early initiation and substance use over time.

Substance Use Among Youth

Youth, Substance Use and Public Health

Substance use in youth can have lasting impacts. For example, early initiation and excessive or frequent substance use could lead to certain chronic diseases and substance use disorders later in life.[1] It is also associated with learning and memory problems, impacting educational attainment.[1]

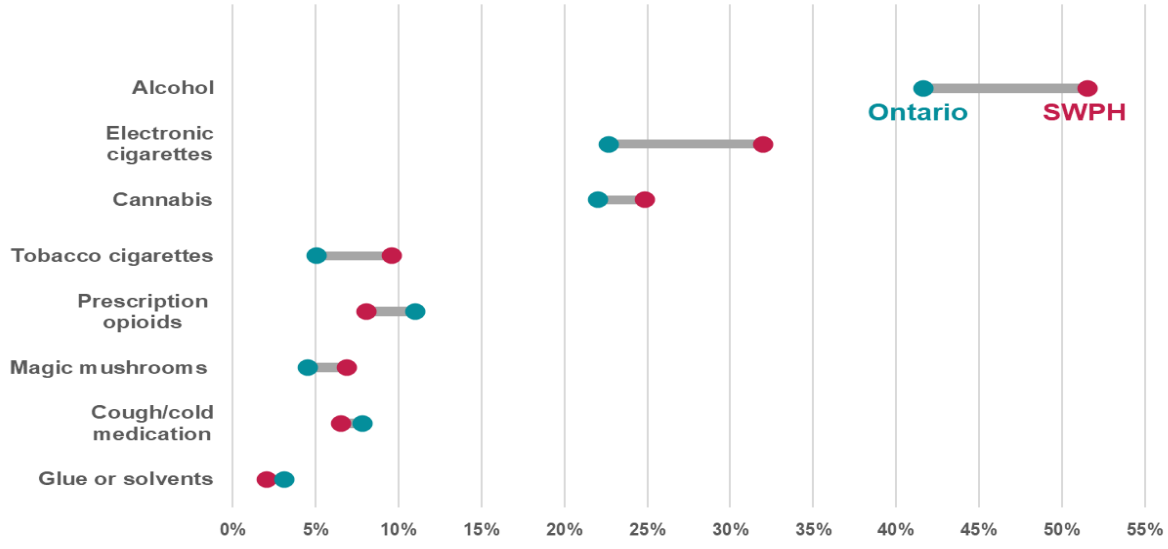
Early intervention is imperative since preventing or reducing substance use among youth may avert long-term negative health impacts.[1]

Self-Reported Substance Use in Youth

In 2019, youth in grades 7 to 12 in the SWPH region were more likely to report using several substances compared to youth across Ontario. This includes alcohol, electronic cigarettes, cannabis, tobacco cigarettes, and magic mushrooms (**Figure 1**). However, only the use of tobacco cigarettes was significantly different from the provincial proportion.

Figure 1

Over 50 percent of SWPH youth report having consumed alcohol in the last 12 months compared to 42 percent of youth across Ontario.

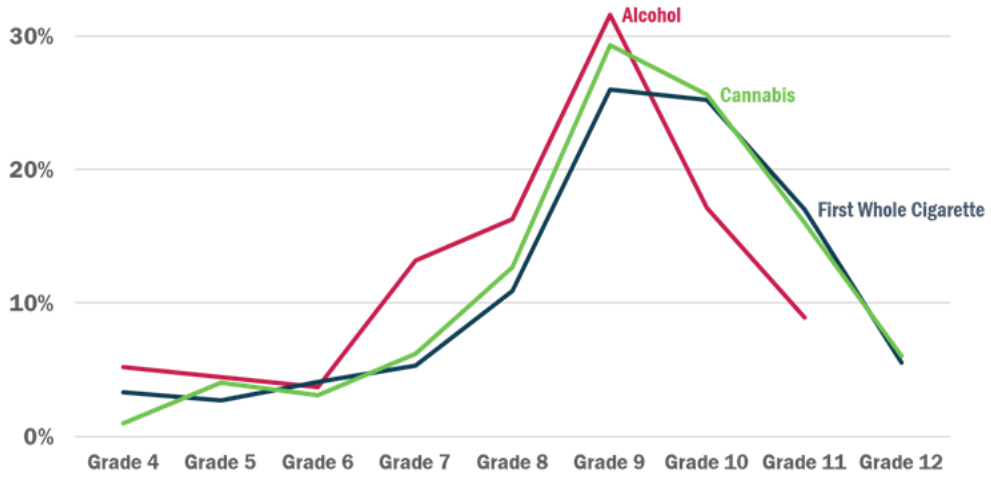


Over half (51.5%) of local youth reported having consumed alcohol (excluding those who only had a few sips to try it) in the last 12 months, which was higher compared to youth in Ontario (41.7%).

Youth who reported having used a substance were also asked when they initiated the use of that substance (used it for the first time). For alcohol, cannabis, and tobacco cigarettes, a large proportion of local youth reported using them for the first time when they began high school in Grade 9 (**Figure 2**). This was comparable to youth in Ontario (not shown). This supports evidence that suggests beginning interventions early would have the most impact on decreasing substance use among youth and it's associated negative health and societal outcomes in adulthood.[2]

Figure 2

Over 30 percent of SWPH youth in grades 9 to 12 who reported using alcohol* said they began doing so in Grade 9.

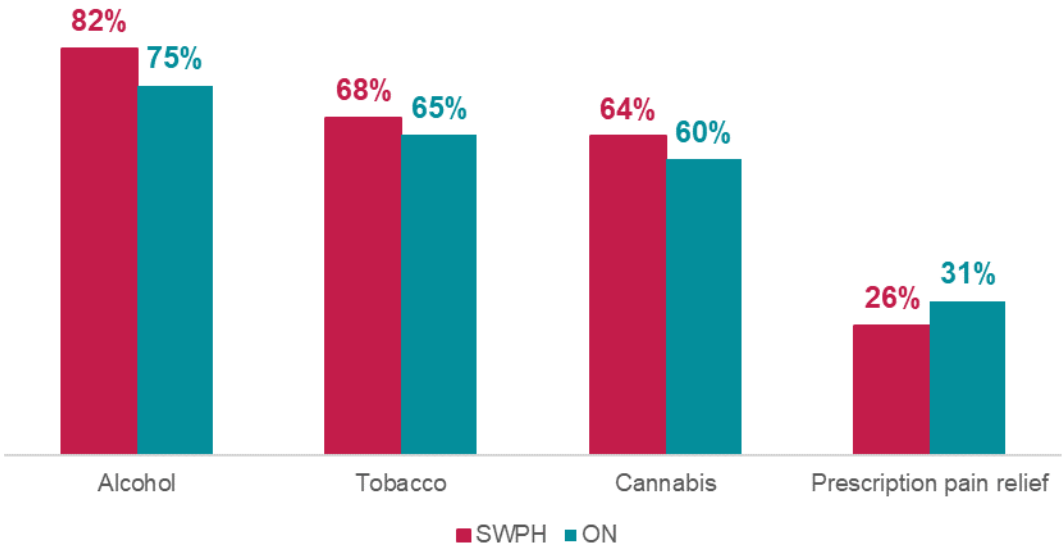


*more than a few sips

Among local youth who reported using substances, a large proportion reported that they felt that many substances were easy to access from various sources (**Figure 3**). Local youth reported ease of access slightly more than youth in Ontario for most substances, aside from prescription pain medications (**Figure 3**).

Figure 3

A large proportion of youth reported that alcohol, tobacco, and cannabis products were easy to access.



Alcohol use

Drank alcohol

In 2019, nearly 3 in 4 youth in grades 7 to 12 reported having consumed alcohol (excluding those who only had a few sips to try it). This was more compared to youth in Ontario (74.7% versus 64.8%, respectively).

In the SWPH region, male youth and female youth were comparable when it comes to ever having alcohol in their lifetime, with female youth reporting drinking alcohol slightly more (see below).

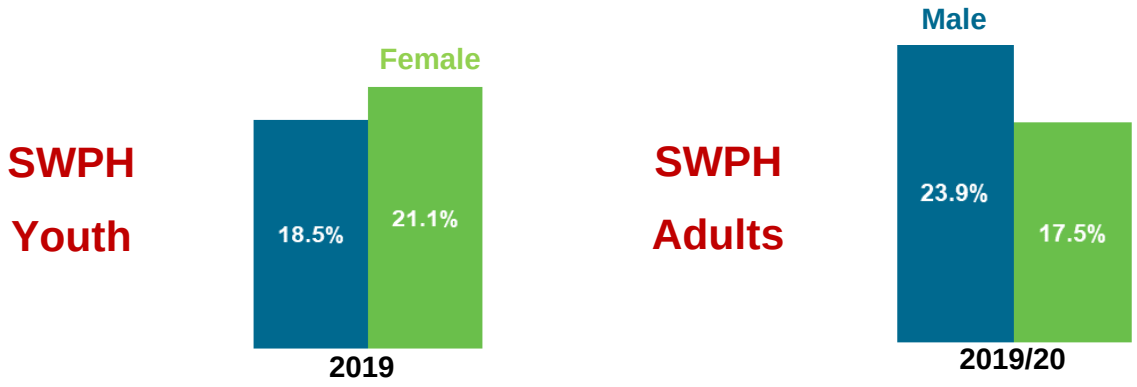
5+ drinks on a single occasion

Youth in the SWPH region also reported heavy or binge drinking in the past month (5+ drinks on a single occasion) more than youth in Ontario. Approximately 20% of local youth reported heavy drinking in 2019 compared to 14.8% of youth in Ontario (not shown).

Female youth reported drinking 5+ drinks on a single occasion in the past month approximately 3% more compared to male youth (21.1% versus 18.5%, respectively). This was different than for adults in the SWPH region, where males consistently reported heavy drinking over 5% more than females between 2015/16 and 2019/20 (**Figure 4**).

Figure 4

In contrast to adults, more female youth reported heavy drinking in the last month compared to male youth.

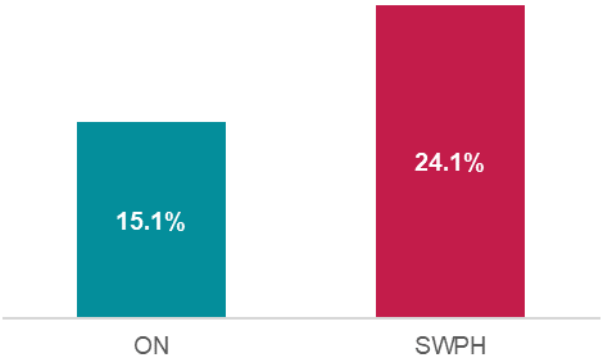


Drank enough alcohol to feel drunk

In 2019, a significantly higher proportion of local youth in grades 7 to 12 reported drinking enough alcohol to feel drunk in the past month compared to youth in Ontario. Nearly 1 in 4 youth report getting drunk compared to about 1 in 6 youth in Ontario (**Figure 5**).

Figure 5

A significantly higher proportion of local youth reported drinking enough alcohol to get drunk in the last 4 weeks compared to youth in Ontario.



Tobacco & e-cigarette use

Smoked a tobacco cigarette

In 2019, youth in the SWPH region also reported smoking tobacco cigarettes significantly more than youth in Ontario (9.6% compared to 5.0%, respectively). Those who only smoked a few puffs were considered 'non-smokers' and were not included.

Data source: The Ontario Student Drug Use and Health Survey (OSDUHS), CAMH, 2019

Male youth reported smoking tobacco cigarettes in the last 12 months more than female youth in the SWPH region (11.7% versus 7.4%, respectively).

About 2% of local youth reported smoking 1 or more tobacco cigarettes daily, which was comparable to youth in Ontario.

Used an electronic cigarette

In 2019, youth in the SWPH region reported having used an electronic cigarette (e-cigarette) beyond just trying it (those who only smoked a few puffs were not included) more than youth in Ontario (**Figure 6**). Unlike tobacco cigarettes, nearly 5% more female youth reported using e-cigarettes compared to male youth in the last year (**Figure 7**).

Figure 6

E-cigarette use among youth in the SWPH region was nearly 10% higher than youth in Ontario.

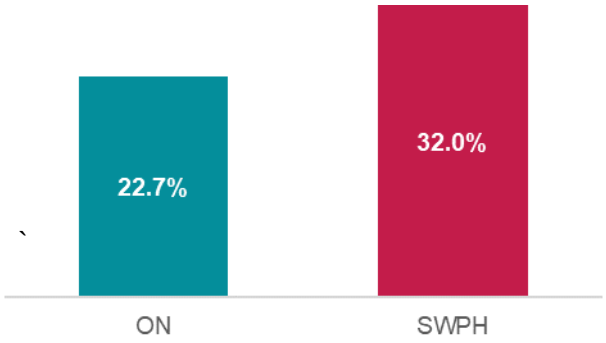
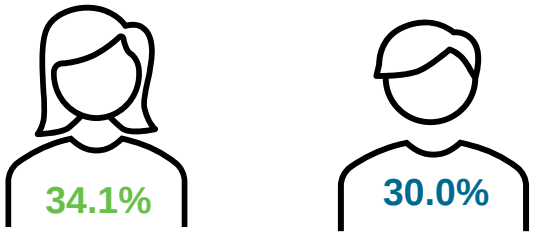


Figure 7

Has used an e-cigarette by sex, SWPH, 2019

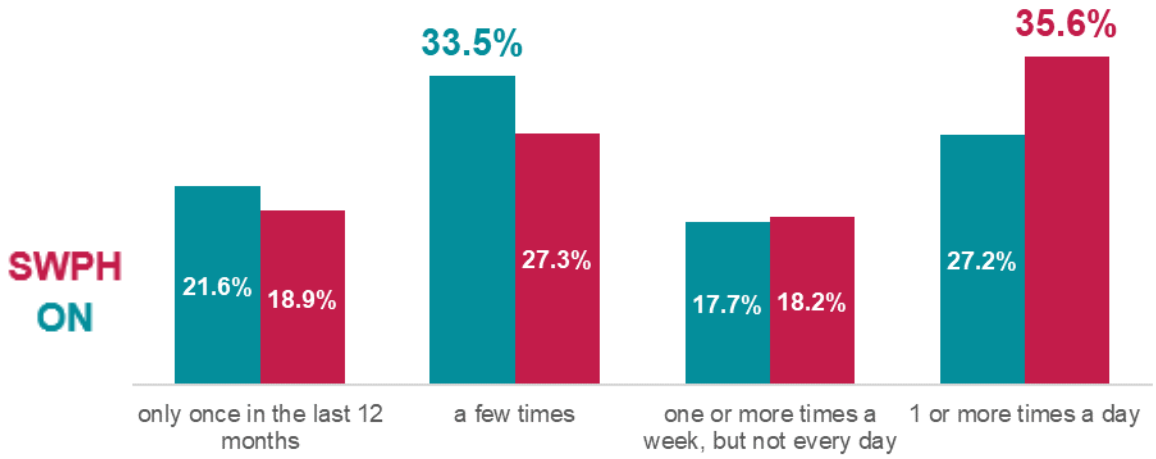


Frequency of electronic cigarette use

Youth who reported having used an e-cigarette in the last 12 months were also asked about their frequency of use. The majority reported that they used an e-cigarette daily while the majority of youth in Ontario reported only using one a few times in the last year (**Figure 8**).

Figure 8

Of youth in the SWPH region who reported having used an e-cigarette in the last 12 months, the majority reported using it daily.



Cannabis use

Cannabis use among youth can be especially harmful and tied to many adverse outcomes. For example, initiating cannabis use early in adolescence as well as continuing use frequently or over a long period of time can increase the risk of addiction into adulthood.[3,4] Further, early initiation has been linked with poor educational outcomes such as difficulty studying and dropping out of school.[3,5]

Frequency of cannabis use

In 2019, approximately 25% of youth in both the SWPH region and Ontario reported using cannabis (marijuana or hashish) in the last year. This was the 3rd most common substance that local youth reported using (behind alcohol and tobacco) and the 2nd most common for youth in Ontario (behind alcohol).

1 in 4
youth use cannabis

Further, youth in the SWPH region reported using cannabis (marijuana or hashish) one or more times a week slightly more than youth in Ontario (7.7% versus 6.8%, respectively).

Used cannabis and alcohol at the same time

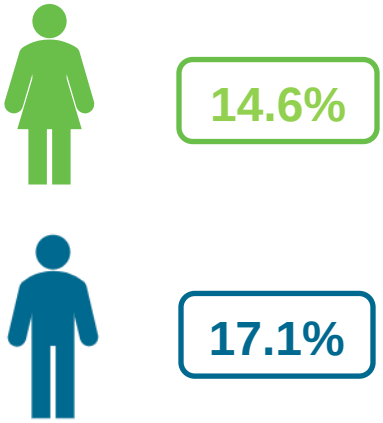
About 1 in 6 youth in grades 9 to 12 in the SWPH region reported using both alcohol and cannabis on the same occasion in the last year. This was slightly more than youth in Ontario (**Figure 9**). Local male youth reported doing so significantly more (17.1%) than female youth (14.6%) (**Figure 10**).

Figure 9

Youth in high school in the SWPH region who reported having used both cannabis and alcohol on one occasion was comparable to youth in Ontario.

Figure 10

Has used cannabis and alcohol on the same occasion, males vs. females, SWPH, 2019



Cannabis Severity of Dependence Scale (SDS)

The Ontario Student Drug Use and Health Survey (OSDUHS) survey includes a severity of dependence scale (SDS), which is comprised of 5 questions. It can be combined into an overall score to indicate the degree of psychological dependence of respondents. This is a universal set of questions that were also used for adults in the *Canadian Community Health Survey (CCHS)* in 2019/2020. The OSDUHS version of these questions were:

1. Being worried that cannabis use was out of control in the last 3 months
2. Being worried about missing cannabis smoke in the last 3 months
3. Being worried about use of cannabis in the last 3 months
4. Wished to stop using cannabis in the last 3 months
5. Having difficulty to stop using cannabis in the last 3 months

Students were asked each of these questions in terms of how often it had occurred (frequency-based), which was the same as for adults in the 2019/2020 CCHS. However, for the current report, they were each re-categorized into “yes” or “no/never” rather than frequency-based responses.

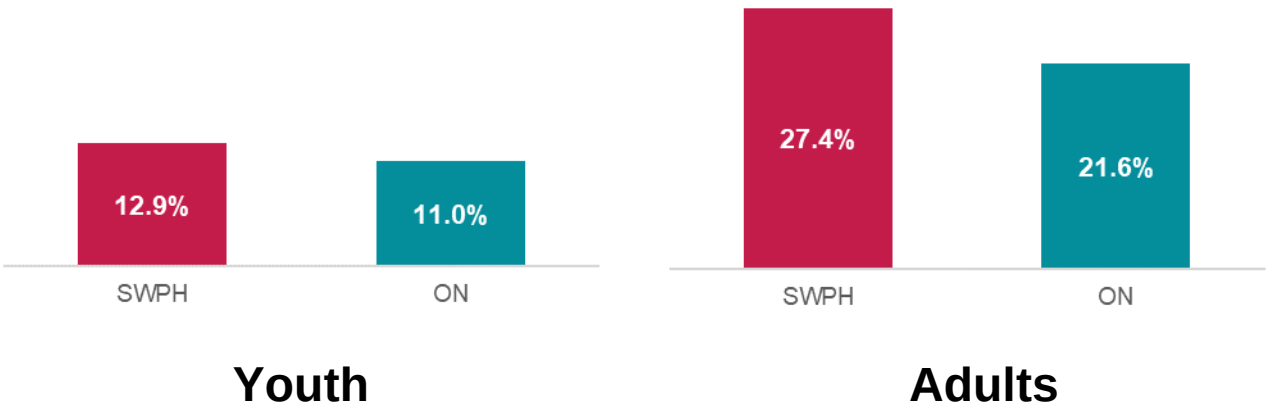
They were then combined to understand any dependence of respondents, potentially indicating early signs of addiction, rather than the degree of dependence. Therefore, if respondents stated that they were worried or had difficulty with any of the 5 questions, they were considered “dependent”.

Psychological dependence on cannabis

Approximately 2% more SWPH youth reported having difficulty with at least one item of the SDS for cannabis (listed above) compared to respondents across Ontario (**Figure 11**). Although this is a marginal difference, it is larger among adults which could indicate that there is increased dependency the longer cannabis is used (**Figure 11**).

Figure 11

Similar to adults, more youth in grades 9 to 12 in the Southwestern Public Health region report having difficulty with at least one item of the severity of dependence scale* for cannabis compared to youth in Ontario.



*Youth – last 3 months
Adults – last 12 months

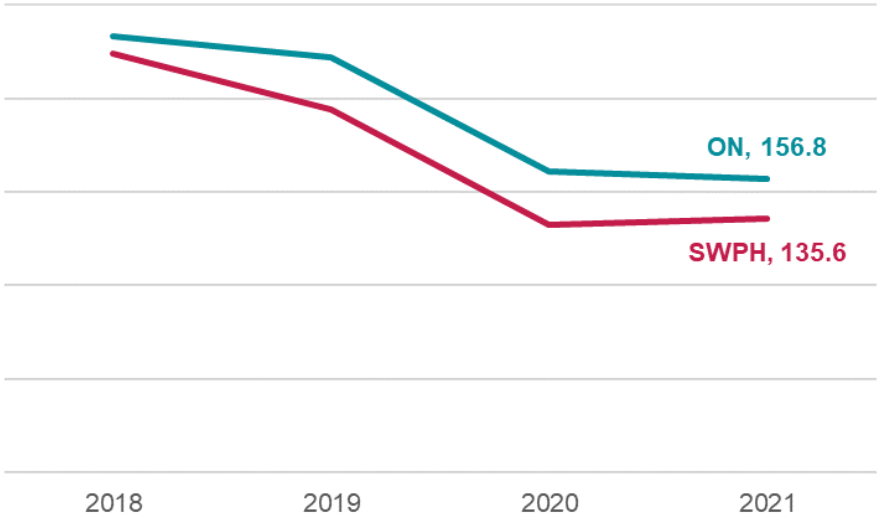
Substance-related harms

Emergency department visits due to alcohol

The rate of emergency department (ED) visits due to conditions attributed to alcohol among youth has declined locally over time, reaching a low of 135.6 per 100,000. This trend is also evident across Ontario and the rate in the SWPH region remains below the provincial rate (**Figure 12**).

Figure 12

The rate of emergency department visits due to alcohol among youth has been declining in the Southwestern Public Health region and in Ontario since 2018.



The decrease in rate in 2020 could be partly due to the COVID-19 pandemic, which could result in the rate over the next few years showing another trend. Therefore, this indicator will be important to monitor in the future.

Hospitalizations due to conditions attributable to alcohol

Between 2011 and 2021, the rate of hospitalizations due to alcohol among youth 19 and under reached a high of 45.9 per 100,000 in 2016 before declining marginally into 2021. This is unlike the rate among adults which increased year over year reaching a high in 2021.

44.5*
per 100,000

*average between 2011 & 2021

Conclusion

Local youth report using substances more often than youth in Ontario and are beginning to do so early on (Grade 9). As substance-related harms have been increasing among adults in the region, focusing on youth for health promotion and local programs could reduce or prevent these harms in adults by delaying early initiation and substance use over time.

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2. Public Safety Canada. School-based drug abuse prevention: Promising and successful programs. 2009. Ottawa, ON. Accessed from: https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/sclbsd-drgbs/index-en.aspx#ch01b

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Data sources

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2. National Ambulatory Care Reporting System (NACRS). 2011-2021 [data file]. Ottawa, ON: Canadian Institute for Health Information [producer]; Toronto, ON: Ontario. Ministry of Health and LongTerm Care, IntelliHealth Ontario [distributor]; [Data accessed July 2023].

3. Discharge Abstract Database (DAD). 2011-2021 [data file]. Ottawa, ON: Canadian Institute for Health Information [producer]; Toronto, ON: Ontario. Ministry of Health and Long-Term Care, IntelliHealth Ontario [distributor]; [Data accessed July 2023].

4. Population Estimates (2011-2021), Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Data accessed: August 2018

Appendix A

Technical appendix – ICD-10 codes

ED visits (unscheduled) for conditions entirely caused by alcohol (15+ years old)

- 3-digit All Dx ICD code
  - F10 (mental and behavioural disorders due to use of alcohol. i.e. acute intoxication, harmful use, withdrawal),
  - K70 (alcoholic liver disease),
  - T51 (toxic effect of alcohol),
  - X45 (accidental poisoning by and exposure to alcohol),
  - X65 (intentional self-poisoning by and exposure to alcohol),
  - Y15 (poisoning by and exposure to alcohol, undetermined intent)
- 4-digit All Dx ICD code
  - E24.4 (alcohol-induced pseudo-Cushing syndrome),
  - G31.2 (degeneration of nervous system due to alcohol),
  - G62.1 (alcoholic polyneuropathy),
  - G72.1 (alcoholic myopathy),
  - I42.6 (alcoholic cardiomyopathy),
  - K29.2 (alcoholic gastritis),
  - K85.2 (alcohol-induced acute pancreatitis),
  - K86.0 (alcohol-induced chronic pancreatitis),
  - O35.4 (maternal care for (suspected) damage to fetus from alcohol),
  - Q86.0 (fetal alcohol syndrome (dysmorphic)),
  - R78.0 (finding of alcohol in blood)

Hospitalizations for conditions entirely caused by alcohol (15+ years old)

- Acute care facilities only
- 3-digit All Dx ICD code = F10, K70, T51, X45, X65, Y15
- 4-digit All Dx ICD code = E24.4, G31.2, G62.1, G72.1, I42.6, K29.2, K85.2, K86.0, O35.4, Q86.0, R78.0
- DSM-IV Axis I Primary or DSM-IV Axis I Sec Dx or DSM-IV Axis I Tert Dx or DSM-IV Axis I Quat Dx or DSM-IV Axis II Other Primary Dx or DSM-IV Axis II Other Sec Dx = 291.0, 291.1, 291.2, 291.3, 291.5, 291.81, 291.82, 291.89, 291.9, 303.00, 303.90, 305.00
- DSM-5 Psychiatric Dx A or DSM-5 Psychiatric Dx B or DSM-5 Psychiatric Dx C or DSM-5 Psychiatric Dx D or DSM-5 Psychiatric Dx E or DSM-5 Psychiatric Dx F = 291.0, 291.1, 291.2, 291.81, 291.82, 291.89, 291.9, 303.00, 303.90, 305.00, F10.0, F10.1, F10.2, F10.3, F10.4, F10.5, F10.6, F10.7, F10.8, F10.9

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Mental Health

An analysis of mental health, illness and wellbeing data in the Southwestern Public Health region

Community Health Status Report
Southwestern Public Health
October 2024

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Contents

Summary

- The data suggests that the mental health of the population has declined in recent years, both locally and provincially
- Poor mental health is more evident in younger age groups
- Rates of intentional self-harm, poor self-reported mental health and suicidal thoughts are highest in younger females
- Parents tend to perceive their youth's mental health as better than youth perceive their own mental health
- Rates of emergency department visits and hospitalizations for mood and anxiety disorders are higher among females, while rates for substance use and addictive disorders are higher among males
- Suicide rates are 4x higher among males compared to females

Introduction

Mental health is the status of one's overall psychological, emotional and social well-being, encompassing one's emotions, feelings of connection to others, thoughts and resilience.[1] Everyone has mental health and experiences it along a continuum throughout their life. A mental illness, such as depression or anxiety, is a disorder or disease that causes disruptions in the way a person thinks, feels and behaves.[2] Although mental health and mental illness are different concepts, they intersect and are related to one another, as illustrated by the *Two Continua Model of Mental Health and Mental Illness* (Figure 1).[2,3] A person may have good mental health with a mental illness or poor mental health without a mental illness.

Figure 1. Two Continua Model of Mental Health and Mental Illness

An individual's mental health can be protected or undermined by a number of complex and interacting factors.[4] These factors can be individual, such as emotional skills or genetics, or structural or social. For example, exposure to poverty, violence or inequality, increase the risk of experiencing poor mental health. Examples of protective factors that strengthen resilience include positive social interactions, strong community and safe neighbourhoods. While risk factors can occur at any point in one's life, those that occur during childhood are especially detrimental. [4]

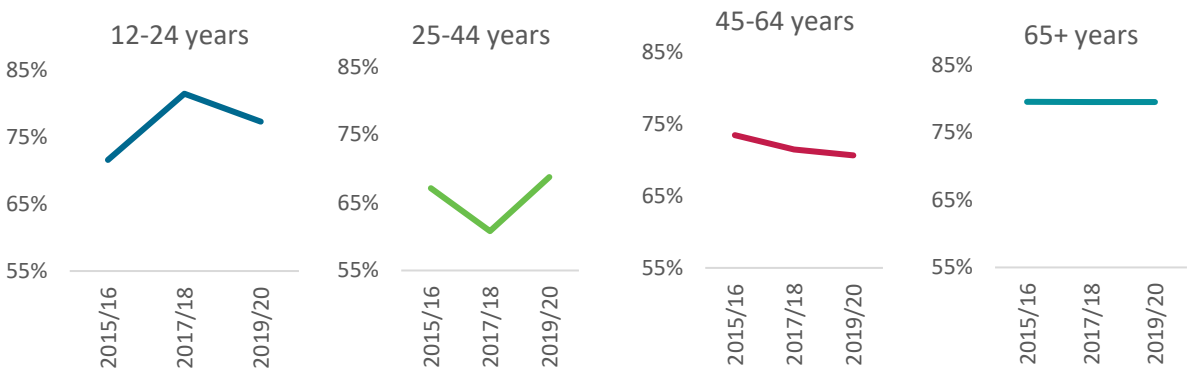
Mental Health, Illness and Wellbeing

Sense of Community Belonging

The Canadian Community Health Survey (CCHS) asks participants how they would describe their sense of belonging to their local community. Just over 7 in 10 Southwestern Public Health (SWPH) residents aged 12+ reported feeling a very strong or somewhat strong sense of belonging to their local community (73.1% in 2019/20). Overall, sense of belonging was highest among SWPH residents aged 65 and over and lowest among those aged 25-44 (Figure 2).

Data Source:
Self-reported mental health, illness and wellbeing data comes from the Canadian Community Health Survey (CCHS) and the Canadian Health Survey on Children and Youth (CHSCY), conducted by Statistics Canada.

Figure 2. Very Strong or Somewhat Strong Sense of Belonging by Age Group, SWPH Region, 2015-2020

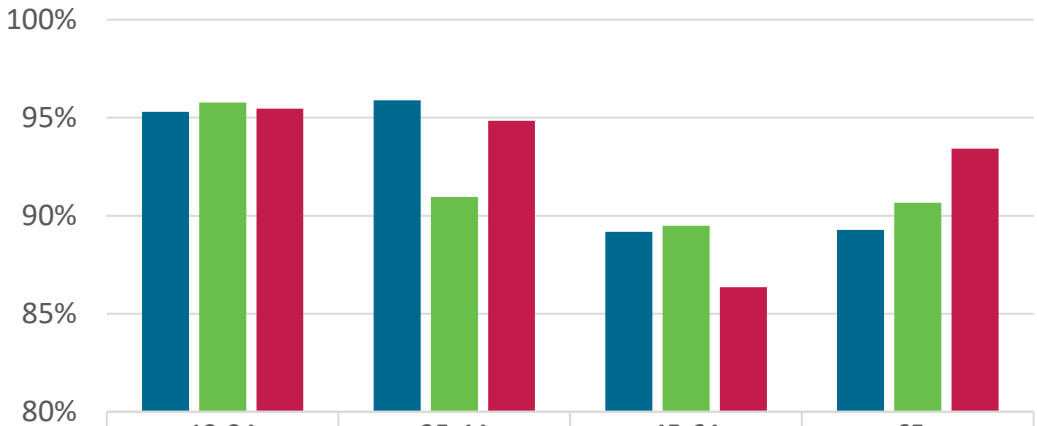


*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Life Satisfaction

Similar to the province, 9 in 10 SWPH residents reported being satisfied or very satisfied with life in general (91.7% in 2019/20). Overall, satisfaction with life was highest among SWPH residents aged 12-24 and lowest among those aged 45-64 (Figure 3). Satisfaction with life has been increasing among those 65 and over since 2015/16 (Figure 3).

Figure 3. Satisfied or Very Satisfied with Life by Age Group, SWPH Region, 2015-2020



	12-24	25-44	45-64	65+
2015/2016	95.3%	95.9%	89.2%	89.3%
2017/2018	95.8%	91.0%	89.5%	90.7%
2019/2020	95.5%	94.9%	86.4%	93.4%

Satisfaction with life was also part of the Canadian Health Survey on Children and Youth (CHSCY) in 2019. Among local youth aged 12-17, males were more likely to report being satisfied or very satisfied with life in general compared to females (91.7% vs. 81.1%, respectively).

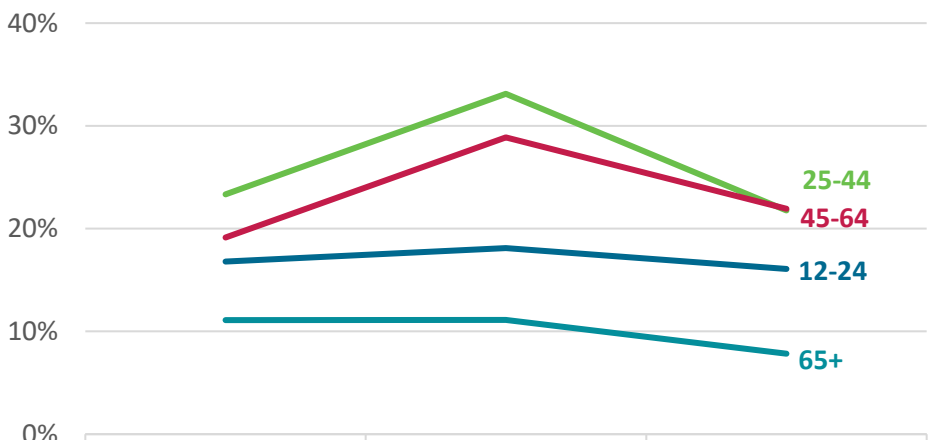
*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Stress

In 2019/20, 17.8% of SWPH residents reported that their life was either extremely stressful or quite a bit stressful. Residents aged 65+ reported the lowest levels of stress, while those aged 25-44 and 45-64 reported the highest stress levels (Figure 4). The sources contributing most to stress varied, with family, work, and financial concerns being the top 3. When asked about stress at work, 22.4% of people in this region reported that most days at work were quite a bit or extremely stressful (2019/20). Females were more likely to report stress at work compared to males (27.2% vs. 18.0%*, respectively).

Among SWPH youth aged 12-17, 17.2%* described most of their days as either quite a bit or extremely stressful. This was higher among female youth at 24.8%* (1 in 4).

Figure 4. Most Days are Quite a Bit or Extremely Stressful by Age Group, SWPH Region, 2015-2020



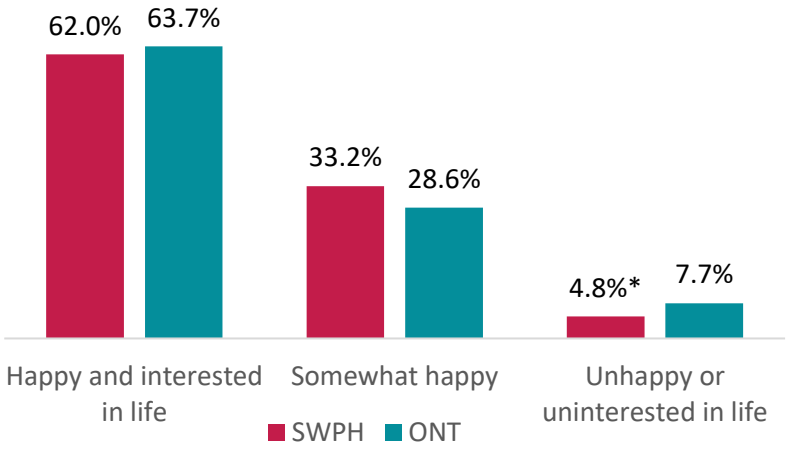
	2015/16	2017/18	2019/20
12-24	16.8%*	18.1%*	16.1%*
25-44	23.3%	33.1%	21.8%*
45-64	19.1%	28.9%	22.0%*
65+	11.1%*	11.1%*	7.8%*

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Youth Happiness, Anxiety and Sadness

In 2019, 62.0% of local youth aged 12-17 described themselves as usually happy and interested in life, which was similar to the province (Figure 5). One third of SWPH youth described themselves as somewhat happy (33.2%). A small percentage of youth (4.8%*) described themselves as usually unhappy or uninterested in life.

Figure 5. Self-perceived Happiness Among Youth Aged 12-17, SWPH Region and Ontario, 2019



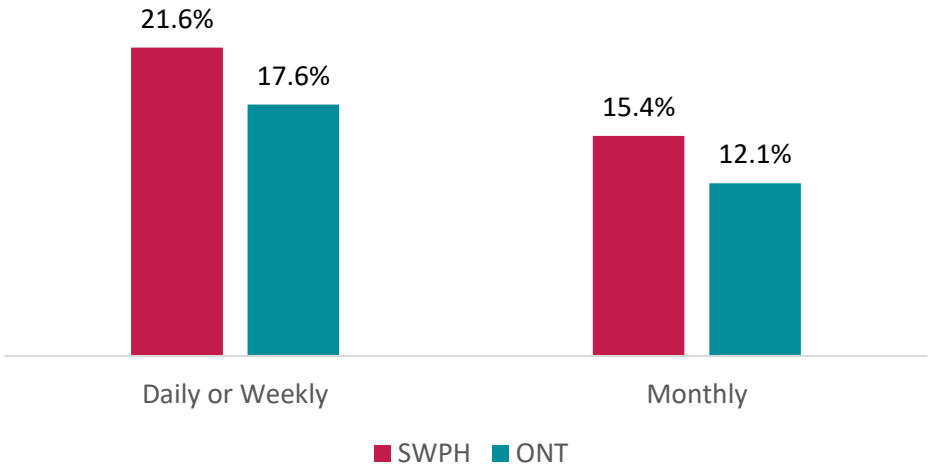
Local youth who live in rural areas were more likely to report that they were usually happy and interested in life (67.9%) compared to youth who live in urban areas (56.2%). For this analysis, urban areas included St. Thomas, Aylmer, Tillsonburg, Ingersoll and Woodstock, while rural areas included all other communities in Oxford and Elgin counties.

In the SWPH region, male youth were more likely to report they are usually happy and interested in life (68.4%) compared to female youth (55.6%).

The CHSCY administers two different questionnaires; one to the 'Person Most Knowledgeable' (PMK) about the selected child or youth and one directly to selected youth aged 12-17. PMKs are typically one of the parents of the child or youth. PMKs were asked how often their child/youth seems very anxious, nervous or worried. Locally, 21.6% of PMKs reported that their child/youth aged 5-17 seems very anxious, nervous or worried on a daily or weekly basis (Figure 6). PMKs of local children/youth living in urban areas were more likely to report that their child/youth appears anxious on a daily or weekly basis (25.6%) compared to those living in rural areas (17.0%*).

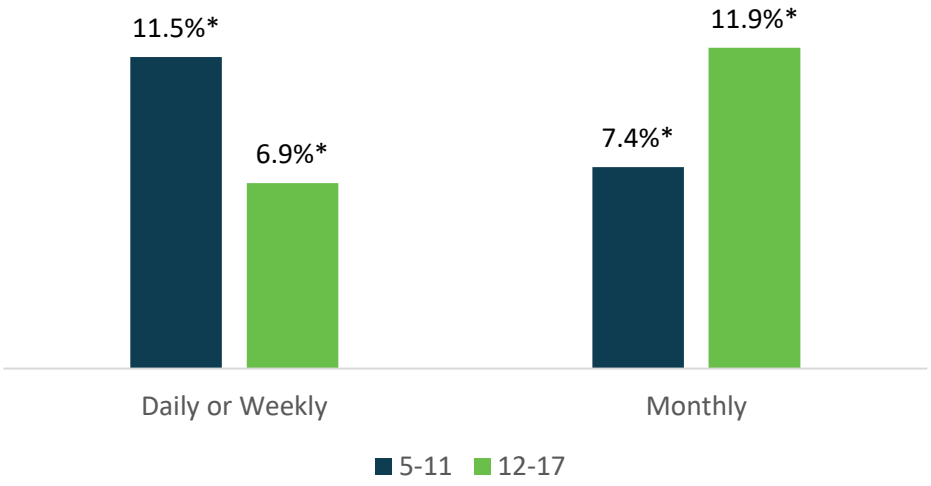
*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Figure 6. Child/Youth Aged 5-17 Appears Anxious, Nervous or Worried, SWPH Region and Ontario, 2019



PMKs were also asked how often their child/youth, aged 5-17, seemed very sad or depressed. SWPH PMKs were less likely to report that their child/youth seemed very sad or depressed on a daily or weekly basis (9.4%*) compared to appearing anxious, nervous or worried (21.6%). Local PMKs of 5–11 year olds were more likely to report that their child seemed sad or depressed on a daily or weekly basis (11.5%*) compared to 12-17 year olds (6.9%*) (Figure 7).

Figure 7. Child/Youth Appears Very Sad or Depressed by Age Group, SWPH Region, 2019

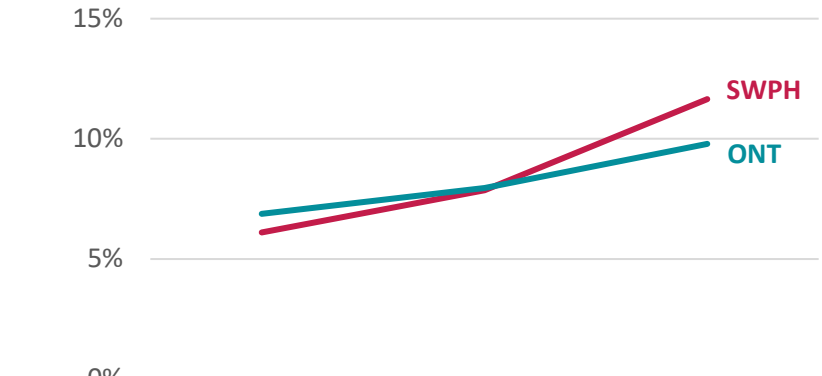


*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Perception of Mental Health

The proportion of respondents, aged 12 and over, who rated their mental health as either fair or poor has increased over time, both locally and provincially. Locally, the proportion almost doubled (6.1% vs. 11.7%) between the 2015/16 and 2019/20 cycles of the CCHS (Figure 8).

Figure 8. Fair or Poor Perceived Mental Health, SWPH Region and Ontario, 2015- 2020

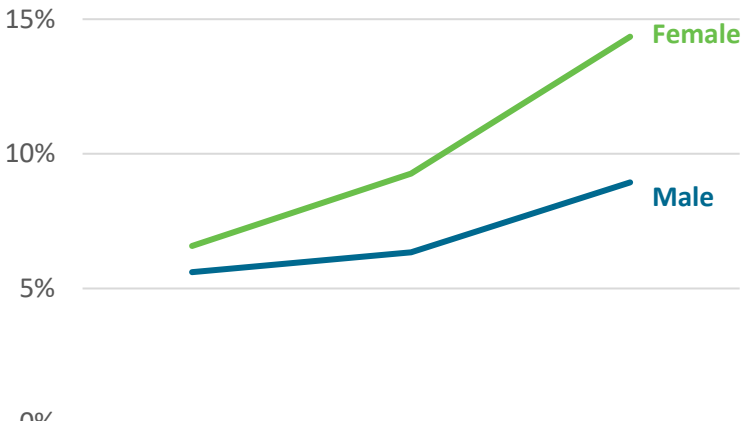


	2015/16	2017/18	2019/20
SWPH	6.1%	7.9%	11.7%
ONT	6.9%	8.0%	9.8%

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Locally, the proportion of females who rated their mental health as fair or poor was higher and increased faster over time compared to males (Figure 9).

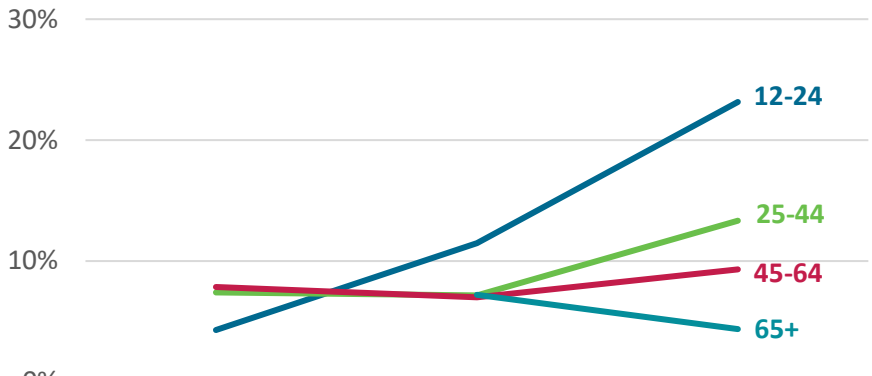
Figure 9. Fair or Poor Perceived Mental Health Among Males and Females, SWPH Region, 2015- 2020



	2015/2016	2017/2018	2019/2020
Male	5.6%*	6.3%*	8.9%*
Female	6.6%*	9.3%	14.4%*

Examining self-perceived mental health by age group, it can be seen that the proportion of respondents aged 12-24 years old who rated their mental health as poor or fair was over 5x higher in 2019/20 compared to 2015/16 (4.3% vs. 23.2%) (Figure 10).

Figure 10. Fair or Poor Perceived Mental Health by Age Group, SWPH Region, 2015- 2020

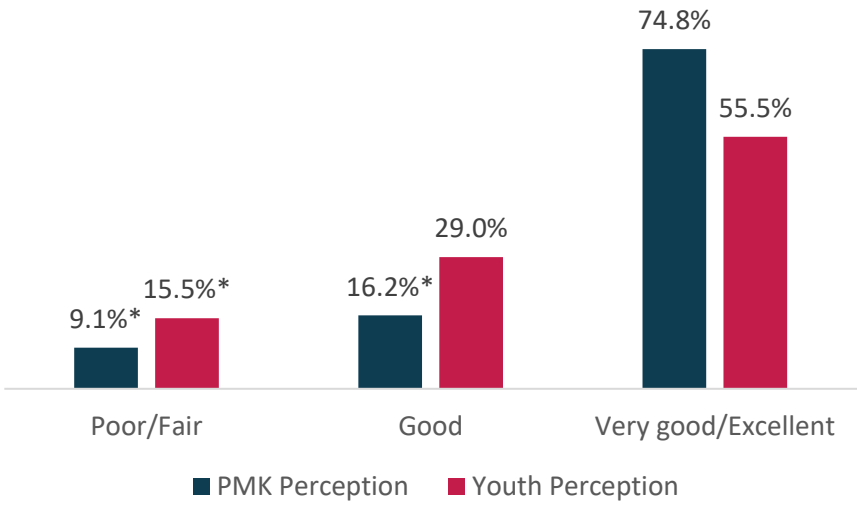


	2015/2016	2017/2018	2019/2020
12-24	4.3%*	11.5%*	23.2%*
25-44	7.4%*	7.2%*	13.3%*
45-64	7.9%*	7.0%*	9.3%*
65+	Unreportable	7.2%*	4.4%*

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

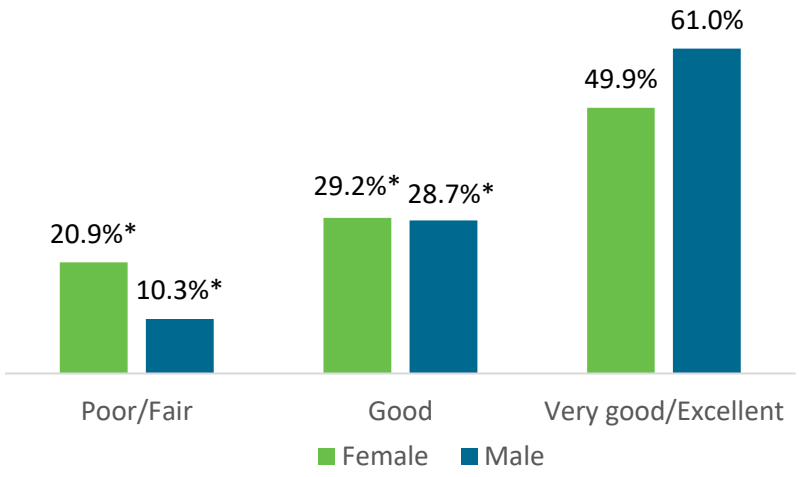
Perception of mental health was also included in the CHSCY. PMKs (typically parents) were asked about their perception of their youth's mental health. Youth aged 12-17 were also surveyed directly and asked how they would rate their own mental health. In 2019, 15.5%* of local youth aged 12- 17 rated their mental health as fair or poor (Figure 11). PMKs of youth aged 12-17 were more likely to perceive their youth's mental health as very good or excellent and less likely to perceive their youth's mental health as poor or fair compared to how youth rated their own mental health (Figure 11).

Figure 11. Perceived Mental Health of Youth Aged 12-17, SWPH Region, 2019



Female youth were twice as likely to rate their mental health as fair or poor compared to male youth (20.9%* vs. 10.3%*) (Figure 12).

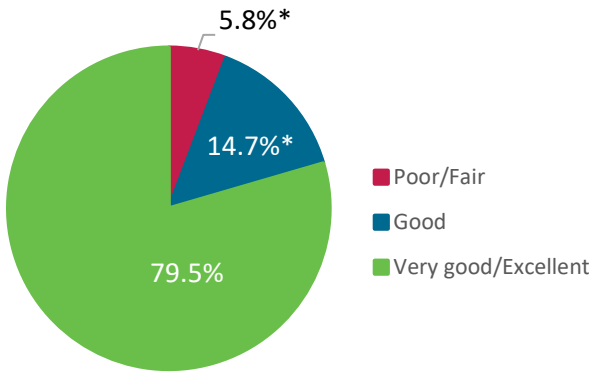
Figure 12. Self-Perceived Mental Health Among Male and Female Youth Aged 12-17, SWPH Region, 2019



*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Children aged 5-11 were not asked directly about their own mental health, however, 4 in 5 local PMKs (79.5%) rated their child's mental health as very good or excellent (Figure 13).

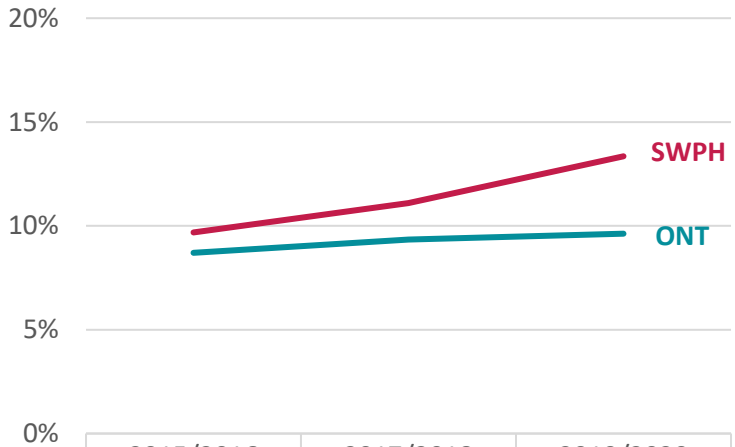
Figure 13. PMK Perceived Mental Health of Children Aged 5-11, SWPH Region, 2019



Anxiety and Mood Disorders

The CCHS asks respondents if they have a mood disorder such as depression, bipolar disorder, mania or dysthymia. In 2019/20, 13.4% of SWPH respondents aged 12 and over reported having a mood disorder which was an increase from previous years and higher compared to the province (Figure 14). It's important to note that anxiety and mood disorders were self-reported and may not have been diagnosed by a healthcare professional.

Figure 14. Mood Disorders, SWPH Region and Ontario, 2015-2020

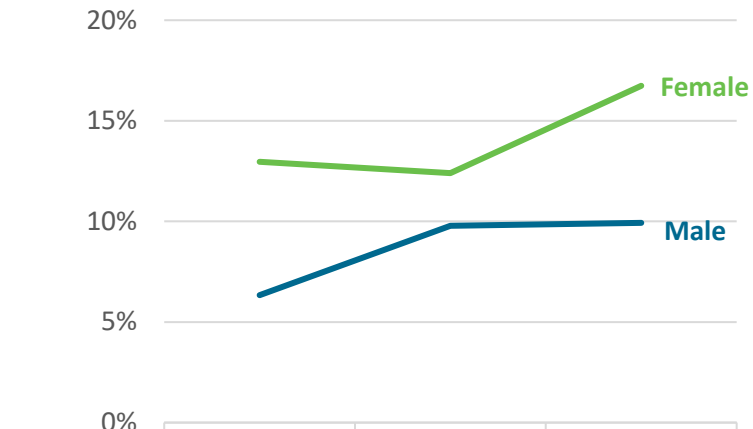


	2015/2016	2017/2018	2019/2020
SWPH	9.7%	11.1%	13.4%
ONT	8.7%	9.3%	9.6%

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Locally, females were more likely than males to report having a mood disorder. In 2019/20, 16.7% of female respondents reported that they had a mood disorder compared to 9.9%* of males (Figure 15).

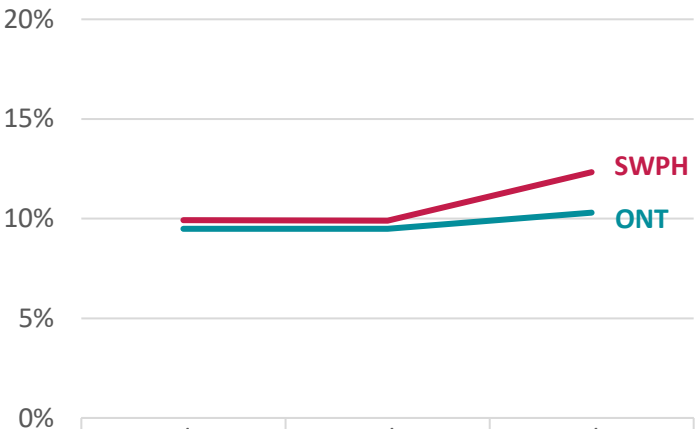
Figure 15. Mood Disorders Among Males and Females, SWPH Region, 2015-2020



	2015/2016	2017/2018	2019/2020
Male	6.3%*	9.8%*	9.9%*
Female	13.0%	12.4%	16.7%

CCHS respondents were also asked if they had an anxiety disorder such as a phobia, obsessive-compulsive disorder or a panic disorder. In 2019/20, 12.3% of SWPH respondents aged 12 and over reported having an anxiety disorder (Figure 16).

Figure 16. Anxiety Disorders, SWPH Region and Ontario, 2015-2020

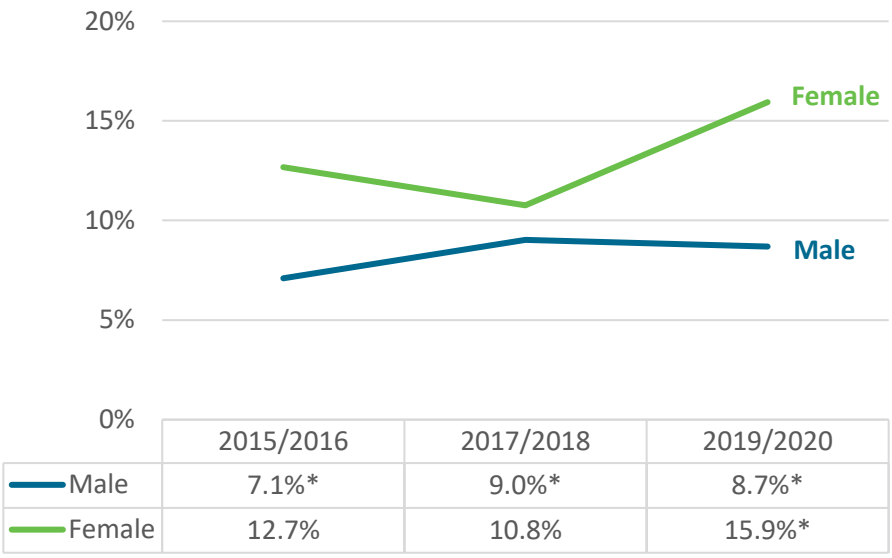


	2015/2016	2017/2018	2019/2020
SWPH	9.9%	9.9%	12.3%
ONT	9.5%	9.5%	10.3%

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Locally, females were more likely to report having an anxiety disorder compared to males. In 2019/20, 15.9%* of female respondents reported that they had an anxiety disorder compared to 8.7%* of males (Figure 17).

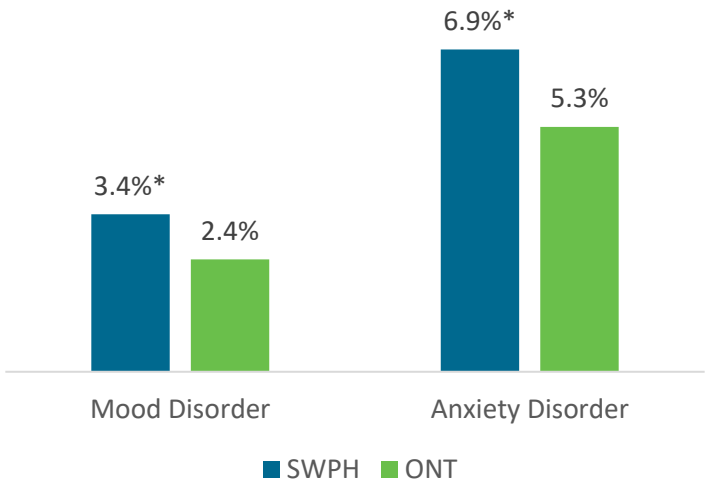
Figure 17. Anxiety Disorders Among Males and Females, SWPH Region, 2015-2020



	2015/2016	2017/2018	2019/2020
Male	7.1%*	9.0%*	8.7%*
Female	12.7%	10.8%	15.9%*

Anxiety and mood disorders were also asked about on the CHSCY. PMKs were asked if their child or youth, aged 5-17 had been diagnosed with a mood or anxiety disorder. Children and youth were more likely to have been diagnosed with an anxiety disorder compared to a mood disorder (6.9%* vs. 3.4%*) (Figure 18).

Figure 18. Mood and Anxiety Disorders Among Children and Youth Aged 5-17, SWPH Region and ONT, 2019

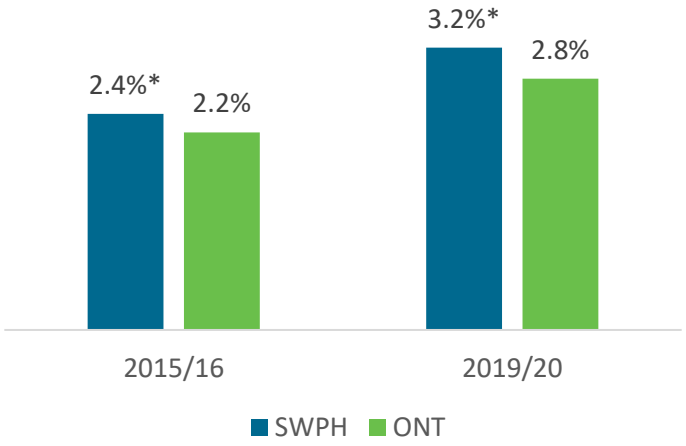


*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Suicidal Thoughts and Feelings of Hopelessness

In 2019/20, 3.2%* of local respondents reported that they had considered suicide in the past 12 months, which was similar to the province at 2.8% (Figure 19).

Figure 19. Considered Suicide in the Past 12 Months, SWPH Region and ONT, 2015-2020



Youth aged 15-17 were asked if, in the past 12 months, they ever felt so sad or hopeless almost every day, for 2 weeks in a row or more, that they stopped doing some usual activities. One in 5 SWPH youth responded 'yes' (19.6%*), which was lower than the province (27.6%). Locally, almost 1 in 3 female youth responded 'yes' (31.8%*).

Youth aged 15-17 were asked if, in the past 12 months, they had ever seriously considered attempting suicide or taking their own life. One in 5 SWPH youth responded 'yes' (20.6%*), compared to about 1 in 6 youth provincially (15.6%) . Among female youth in the SWPH region, 1 in 3 responded 'yes' (33.8%*).

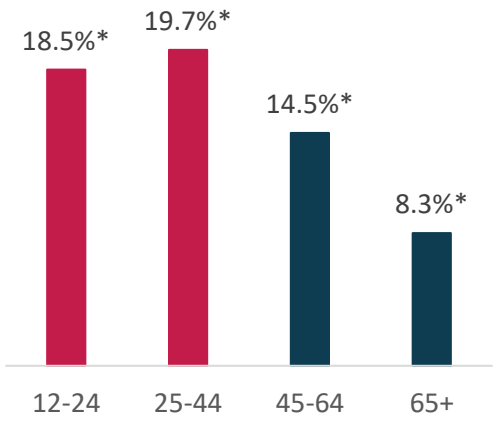
*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Service Use

Consultations with Mental Health Professionals

In 2019/20, 15.3% of SWPH residents reported that they had seen or talked to a health professional about their mental health in the last 12 months. Females were twice as likely to consult with a health professional compared to males (20.2% vs. 10.3%*). Local respondents living in urban areas were more likely to report consulting with a health professional compared to those living in rural areas (19.2% vs. 11.0%*). In addition, those in younger age groups were more likely to report consulting with a mental health professional compared to those in older age groups (Figure 20).

Figure 20. Consulted with a Mental Health Professional in the last 12 months by Age Group, SWPH Region, 2019-2020



Among local PMKs, 6.7%* responded that their child/youth (aged 1-17) required or received services for mental health issues over the past year. Among those who required or received services, 35.2%* reported that they had difficulty accessing these services. The most common difficulty reported was long wait times.

Among PMKs of youth aged 12-17, 9.2%* reported that their youth required or received services for mental health issues over the past year. This is lower than the proportion of youth that reported poor or fair mental health (15.5%*), however, it is similar to the proportion of PMKs that perceive their youth's mental health as poor or fair (9.1%*). This suggests that some youth may

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

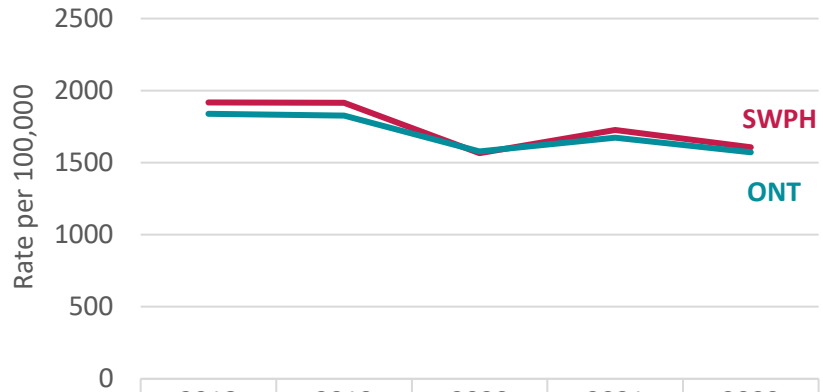
not be getting the help they require because their parents are unaware of their need for services.

Mental Illness Emergency Department Visits

In this report, emergency department (ED) visits for mental illness include visits for conditions such as mood disorders, anxiety disorders and substance-related and addictive disorders, among others. Between 2018 and 2022, the local rate of ED visits for mental illness was similar to the province (Figure 21).

Data Source: Emergency department visit data is from the National Ambulatory Care Reporting System (NACRS), accessed via IntelliHEALTH

Figure 21. Mental Illness Emergency Department Visit Rates, SWPH Region and ONT, 2018-2022

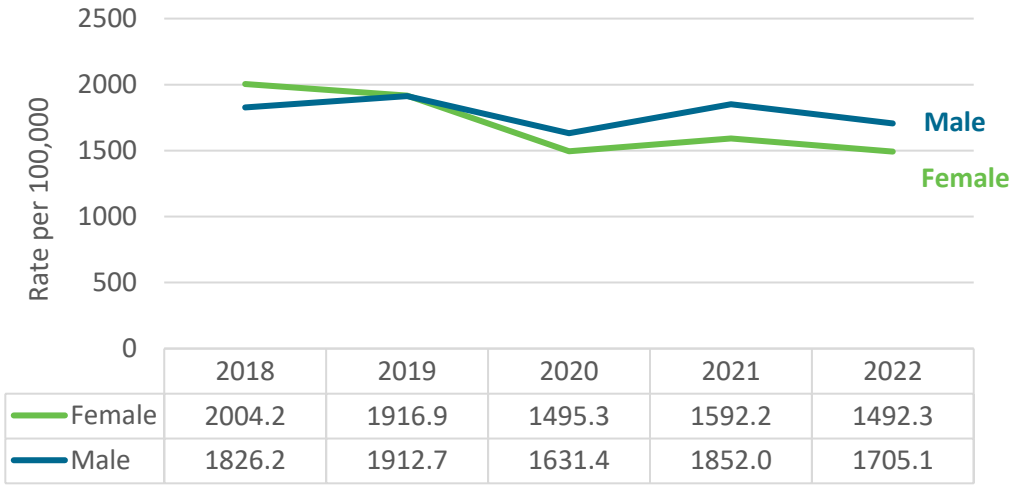


	2018	2019	2020	2021	2022
SWPH	1917.8	1916.2	1565.9	1726.3	1606.9
ONT	1839.0	1826.6	1577.0	1673.3	1572.0

Looking at all mental illness conditions combined, males in the SWPH region have had a slightly higher rate of ED visits compared to females since 2020 (Figure 22).

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

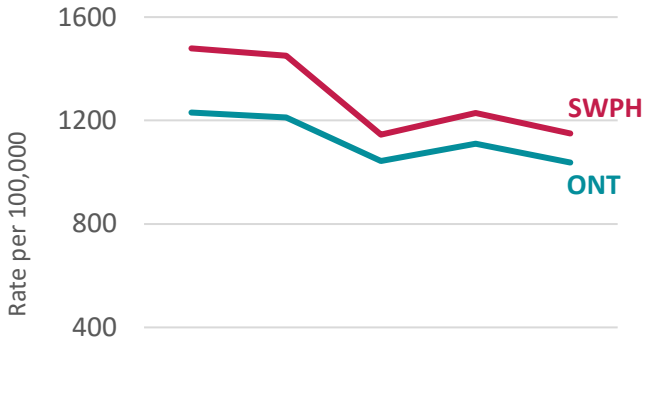
Figure 22. Mental Illness Emergency Department Visit Rates Among Males and Females, SWPH Region, 2018-2022



	2018	2019	2020	2021	2022
Female	2004.2	1916.9	1495.3	1592.2	1492.3
Male	1826.2	1912.7	1631.4	1852.0	1705.1

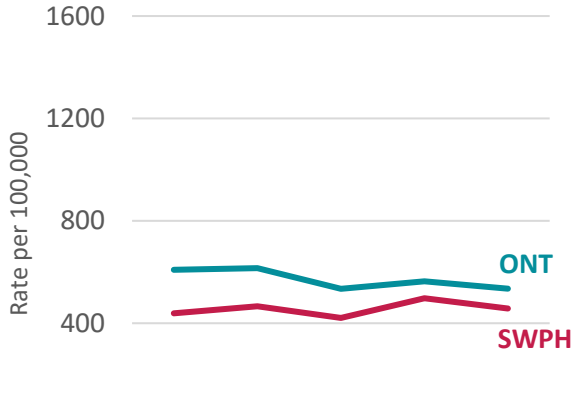
When substance-related and addictive disorders were separated from mood and anxiety disorders, different trends were observed. The rate of ED visits for mood, anxiety, psychotic and personality disorders was higher compared to ED visits for substance-related and addictive disorders (Figure 23 and Figure 24). SWPH residents had a higher rate of ED visits for mood, anxiety, psychotic and personality disorders compared to the province and a lower rate of ED visits for substance-related and addictive disorders (Figure 23 and Figure 24).

Figure 23. Emergency Department Visit Rates for Mood, Anxiety, Psychotic and Personality Disorders, SWPH Region and ONT, 2018-2022



	2018	2019	2020	2021	2022
SWPH	1479.0	1450.3	1145.2	1228.8	1149.2
ONT	1230.7	1211.6	1042.7	1110.0	1037.3

Figure 24. Emergency Department Visit Rates for Substance-Related and Addictive Disorders, SWPH Region and ONT, 2018-2022

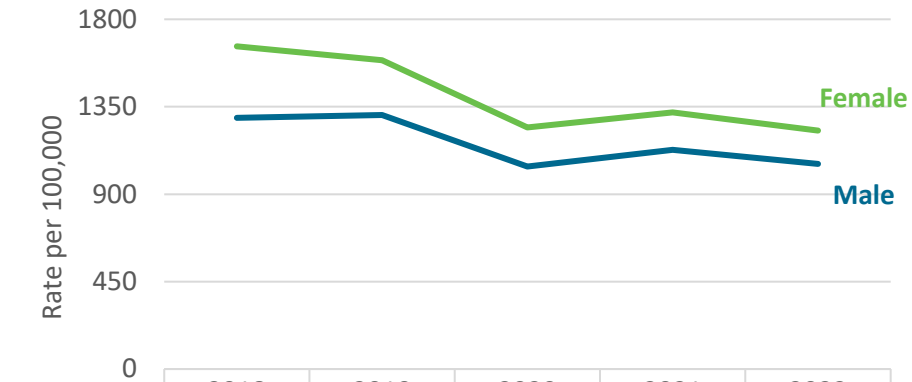


	2018	2019	2020	2021	2022
SWPH	438.9	465.8	420.7	497.5	457.7
ONT	608.2	615.1	534.3	563.4	534.7

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Locally, the rate of ED visits for mood, anxiety, psychotic and personality disorders was higher among females compared to males (Figure 25).

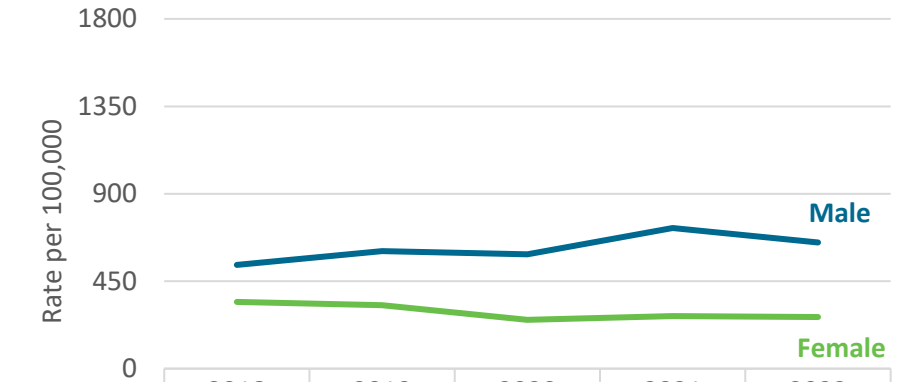
Figure 25. Emergency Department Visit Rates for Mood, Anxiety, Psychotic and Personality Disorders Among Males and Females, SWPH Region, 2018-2022



	2018	2019	2020	2021	2022
Female	1660.7	1590.0	1244.1	1320.8	1227.2
Male	1292.3	1307.3	1042.2	1128.3	1055.9

Locally, the rate of ED visits for substance-related and addictive disorders was higher among males compared to females (Figure 26).

Figure 26. Emergency Department Visit Rates for Substance-Related and Addictive Disorders Among Males and Females, SWPH Region, 2018-2022

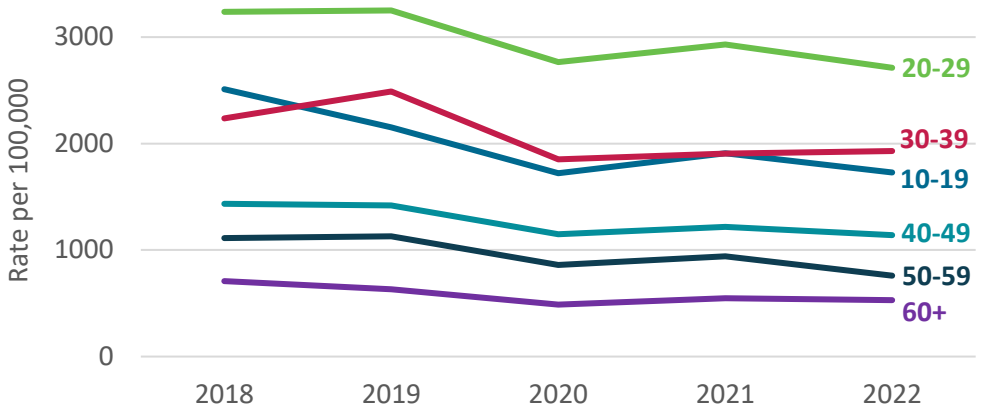


	2018	2019	2020	2021	2022
Female	343.4	326.9	251.2	271.3	265.2
Male	534.0	605.3	589.2	723.7	649.1

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

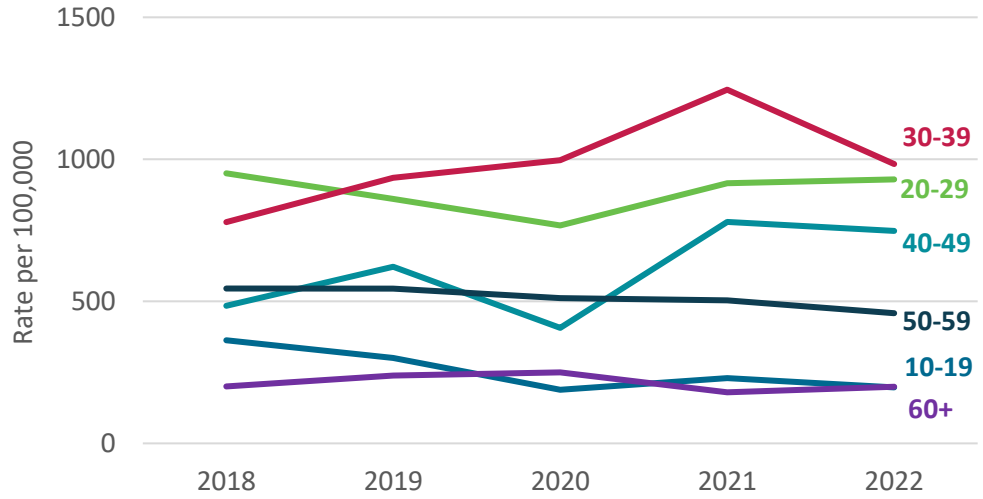
While the rate of ED visits for mood, anxiety, psychotic and personality disorders was highest among those aged 20-29, it did decline between 2018 and 2022 (Figure 27).

Figure 27. Emergency Department Visit Rates for Mood, Anxiety, Psychotic and Personality Disorders by Age Group, SWPH Region, 2018-2022



From 2019 to 2022, the rate of ED visits for substance-related and addictive disorders was highest among the 30-39 age group, followed by those aged 20-29 (Figure 28).

Figure 28. Emergency Department Visit Rates for Substance-Related and Addictive Disorders by Age Group, SWPH Region, 2018-2022



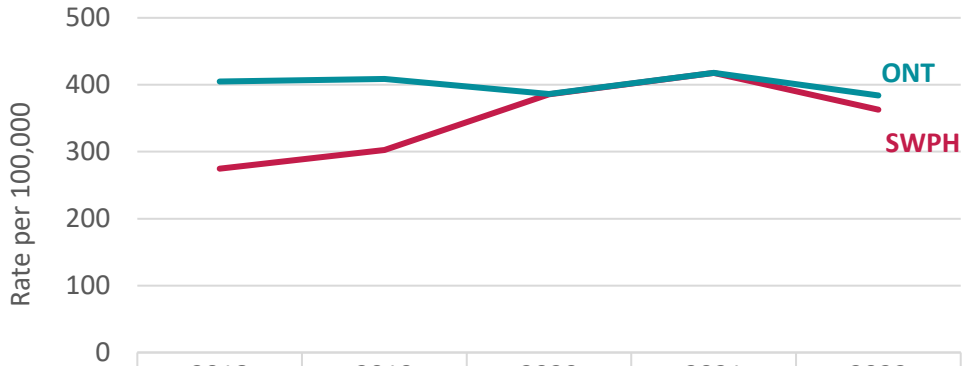
*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Mental Illness Hospitalizations

In this report, hospitalizations for mental illness include hospitalizations for conditions such as mood disorders, anxiety disorders and substance-related and addictive disorders, among others. Locally, there was an increase in the rate of hospitalization for mental illness between 2018 and 2021 (Figure 29).

Data Source: Hospitalization data is from the Discharge Abstract Database (DAD) and the Ontario Mental Health Reporting System (OMHRS), accessed via IntelliHEALTH

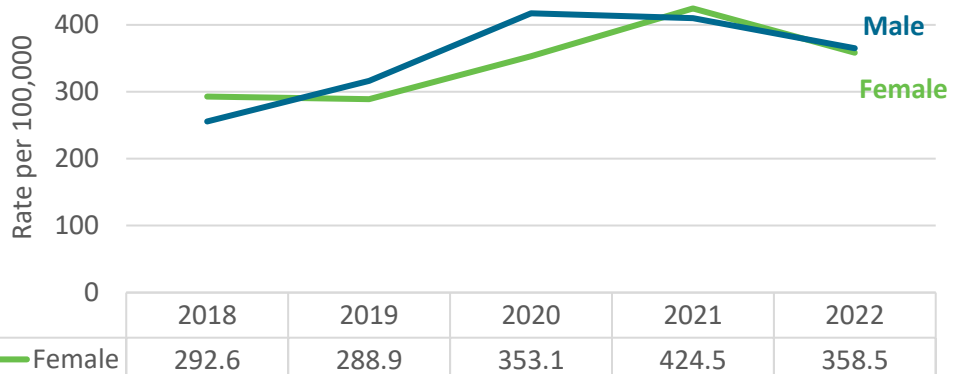
Figure 29. Mental Illness Hospitalization Rates, SWPH Region and ONT, 2018-2022



	2018	2019	2020	2021	2022
SWPH	274.7	302.5	385.5	417.7	362.8
ONT	404.7	408.7	386.0	417.8	384.0

Overall, males and females in the SWPH region have similar rates of hospitalization for mental illness (Figure 30).

Figure 30. Mental Illness Hospitalization Rates Among Males and Females, SWPH Region, 2018-2022

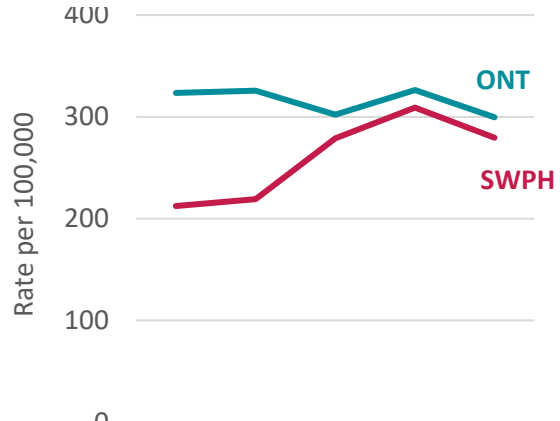


	2018	2019	2020	2021	2022
Female	292.6	288.9	353.1	424.5	358.5
Male	255.6	316.1	417.2	410.0	365.2

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

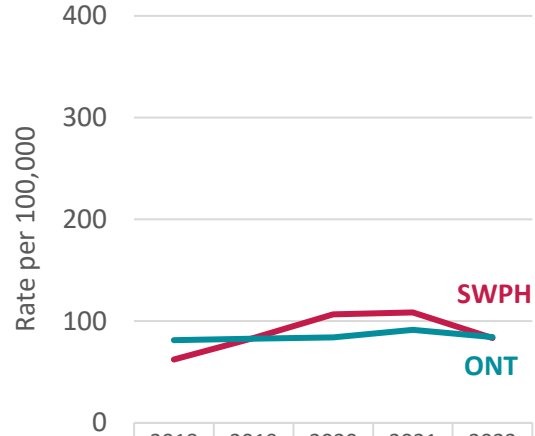
Residents in the SWPH region had a lower rate of hospitalization for mood and anxiety disorders compared to the province in 2018 and 2019, however hospitalizations rates in more recent years were similar (Figure 31). The rate of hospitalizations for mood, anxiety, psychotic and personality disorders was higher compared to hospitalizations for substance-related and addictive disorders (Figure 31 and Figure 32).

Figure 31. Hospitalization Rates for Mood, Anxiety, Psychotic and Personality Disorders, SWPH Region and ONT, 2018-2022



	2018	2019	2020	2021	2022
SWPH	212.4	219.0	278.8	309.1	279.4
ONT	323.4	325.8	302.0	326.3	299.6

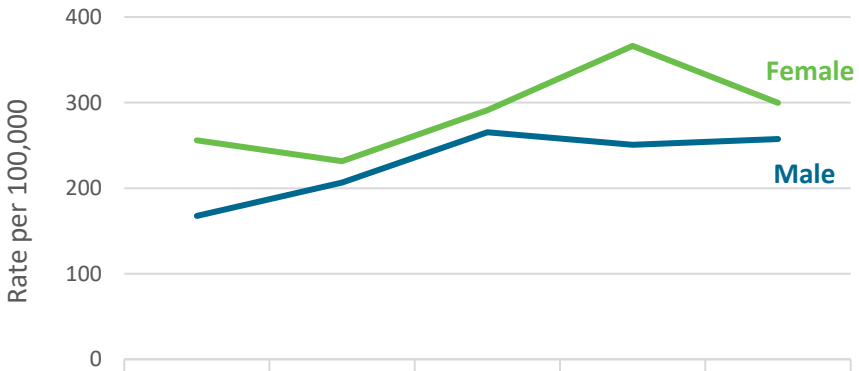
Figure 32. Hospitalization Rates for Substance-Related and Addictive Disorders, SWPH Region and ONT, 2018-2022



	2018	2019	2020	2021	2022
SWPH	62.3	83.5	106.8	108.6	83.4
ONT	81.3	82.9	84.0	91.5	84.5

Locally, females tended to have a higher rate of hospitalization for mood and anxiety disorders compared to males (Figure 33).

Figure 33. Hospitalization Rates for Mood, Anxiety, Psychotic and Personality Disorders Among Males and Females, SWPH Region, 2018-2022

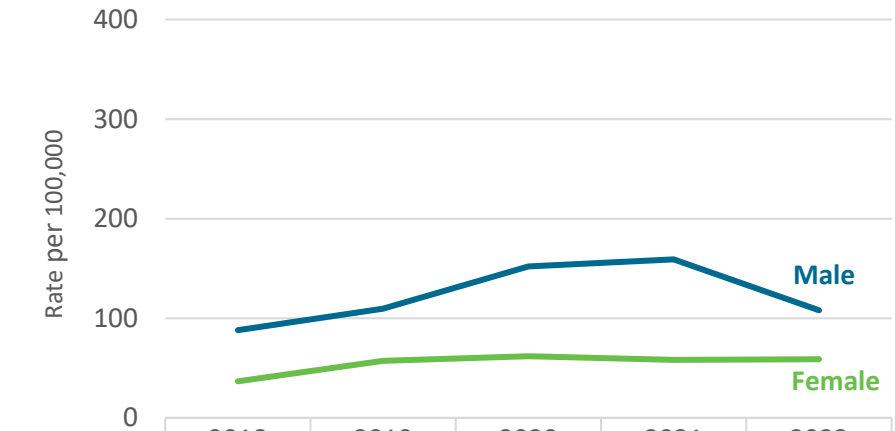


	2018	2019	2020	2021	2022
Female	255.9	231.5	291.2	366.3	299.5
Male	167.6	206.4	265.3	250.8	257.4

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Males had a higher rate of hospitalization for substance-related and addictive disorders compared to females (Figure 34).

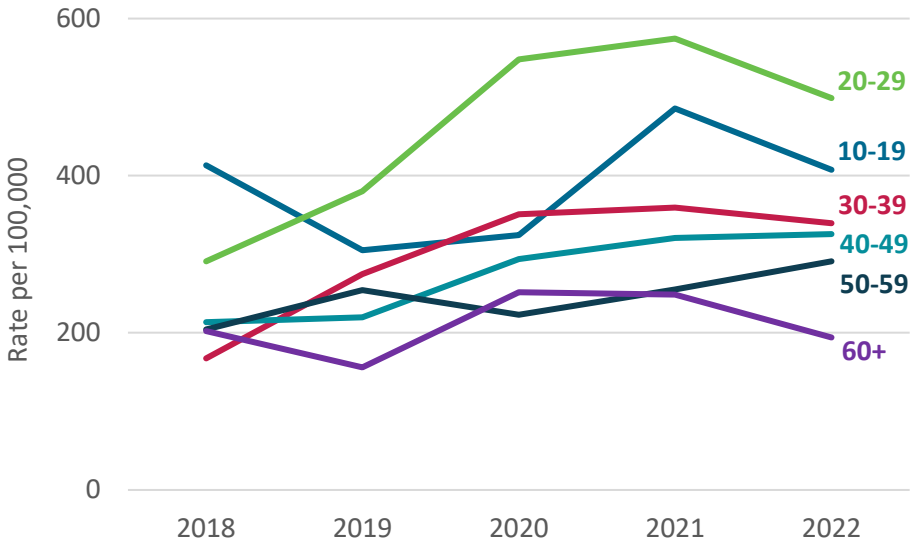
Figure 34. Hospitalization Rates for Substance-Related and Addictive Disorders Among Males and Females, SWPH Region, 2018-2022



	2018	2019	2020	2021	2022
Female	36.7	57.4	61.9	58.2	59.0
Male	88.0	109.7	151.9	159.1	107.9

Between 2019 and 2022, the local rate of hospitalization for mood, anxiety, psychotic and personality disorders was highest among those aged 20-29 and the rate for this age group doubled between 2018 and 2021 (Figure 35).

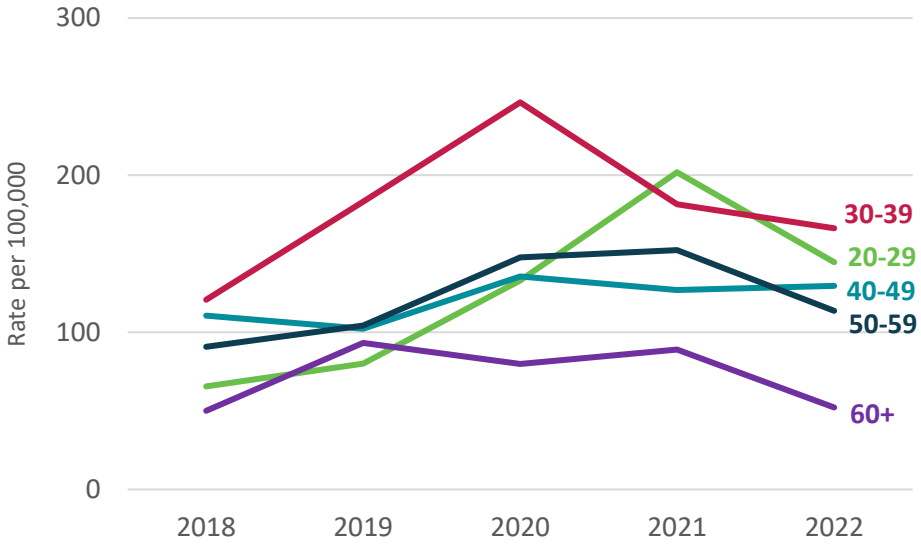
Figure 35. Hospitalization Rates for Mood, Anxiety, Psychotic and Personality Disorders by Age Group, SWPH Region, 2018-2022



*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

The local rate of hospitalization for substance-related and addictive disorders was highest among those aged 30-39 for most years examined and increased steeply among this group between 2018 and 2020 (Figure 36). The rate among those aged 20-29 more than tripled between 2018 and 2021, with this age group having the highest rate in 2021 (Figure 36).

Figure 36. Hospitalization Rate for Substance-Related and Addictive Disorders by Age Group, SWPH Region, 2018-2022+



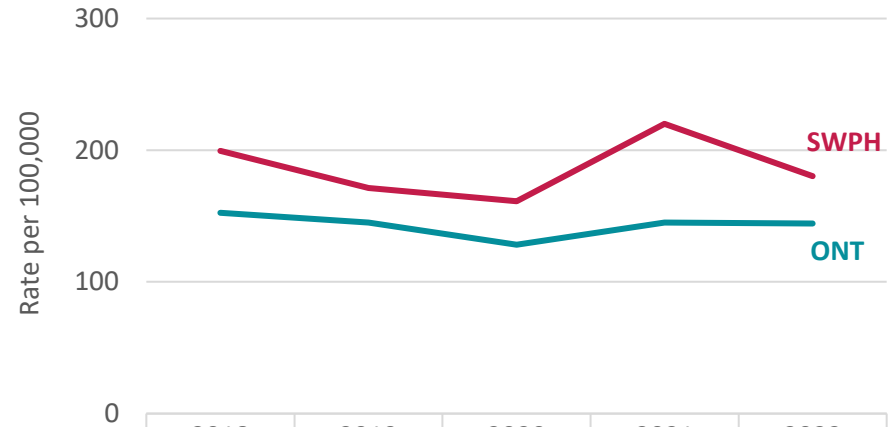
Hospitalization counts among the 10-19 year age group were very low, which created unstable rates that were not included in this figure.

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Intentional Self-Harm Emergency Department Visits

The local rate of ED visits for intentional self-harm has been consistently higher than the provincial rate, peaking in 2021 (Figure 37). In the SWPH region, intentional self-poisoning followed by intentional self-harm with a sharp object were the most common forms of self-harm.

Figure 37. Intentional Self-Harm Emergency Department Visit Rates, SWPH Region and ONT, 2018-2022

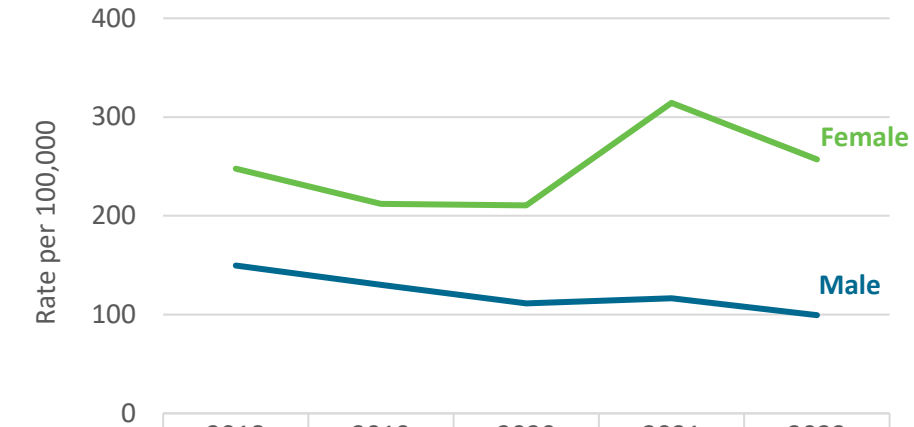


	2018	2019	2020	2021	2022
SWPH	199.5	171.4	161.2	220.0	180.3
ONT	152.5	145.1	128.2	145.1	144.4

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

The rate of ED visits for intentional self-harm in SWPH was lower among males compared to females, which follows the provincial trend. In 2021, the rate peaked among females, which wasn't observed in males.

Figure 38. Intentional Self-Harm Emergency Department Visit Rates Among Males and Females, SWPH Region, 2018-2022

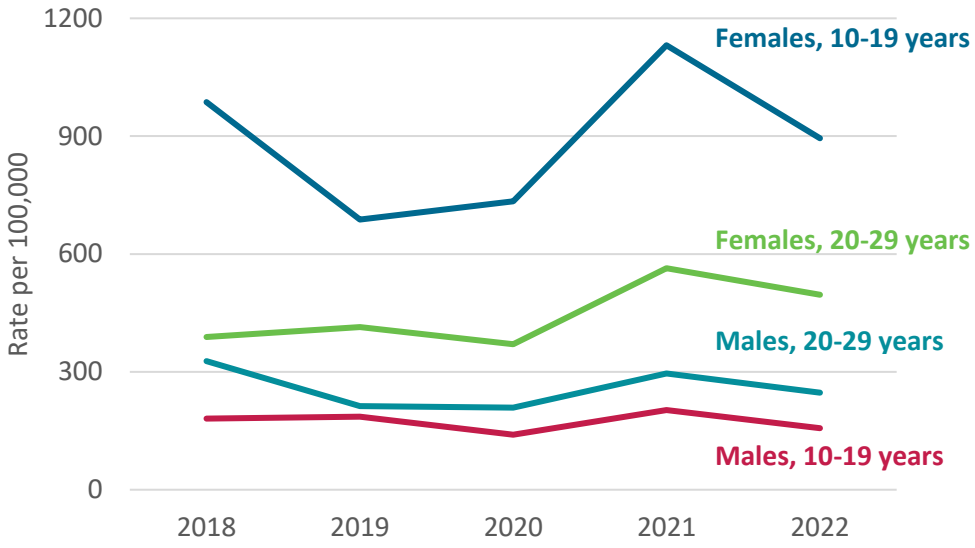


	2018	2019	2020	2021	2022
Female	247.6	212.2	210.6	314.4	257.3
Male	149.7	130.1	111.3	116.5	99.4

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Locally, females aged 10-19 had the highest rates of ED visits for intentional self-harm, followed by females aged 20-29 (Figure 39).

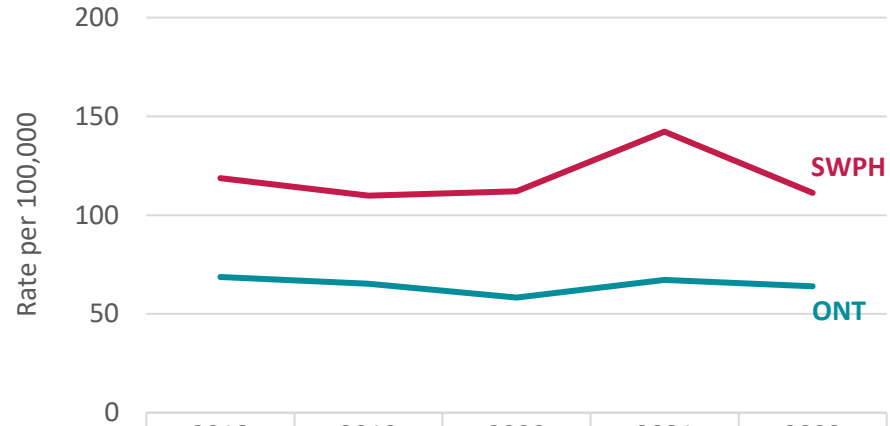
Figure 39. Intentional Self-Harm Emergency Department Visit Rates by Sex and Age Group, SWPH Region, 2018-2022



Intentional Self-Harm Hospitalizations

The local rate of hospitalizations for intentional self-harm has been consistently higher than the province over time, peaking in 2021 (Figure 40).

Figure 40. Intentional Self-Harm Hospitalization Rates, SWPH Region and ONT, 2018-2022

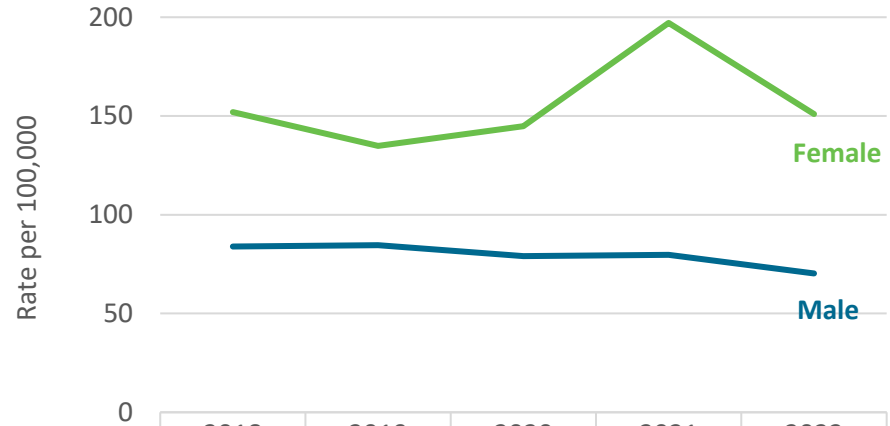


	2018	2019	2020	2021	2022
SWPH	118.7	109.9	112.1	142.3	111.4
ONT	68.7	65.2	58.3	67.2	64.1

*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Similar to the province, the rate of hospitalizations for intentional self-harm in the SWPH region was lower among males compared to females (Figure 41). The rate increased among females in 2021, which did not occur among males.

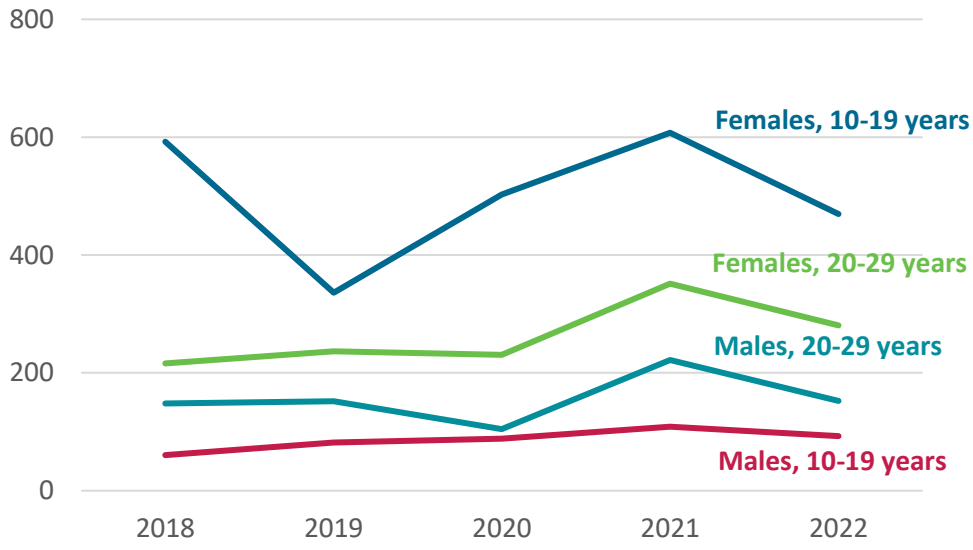
Figure 41. Intentional Self-Harm Hospitalization Rates Among Males and Females, SWPH Region, 2018-2022



	2018	2019	2020	2021	2022
Female	152.0	134.9	144.8	197.1	151.0
Male	84.0	84.6	79.0	79.7	70.3

Locally, females aged 10-19 have the highest rates of hospitalizations for self-harm, followed by females aged 20-29.

Figure 42. Intentional Self-Harm Hospitalization Rates by Sex and Age Group, SWPH Region, 2018-2022



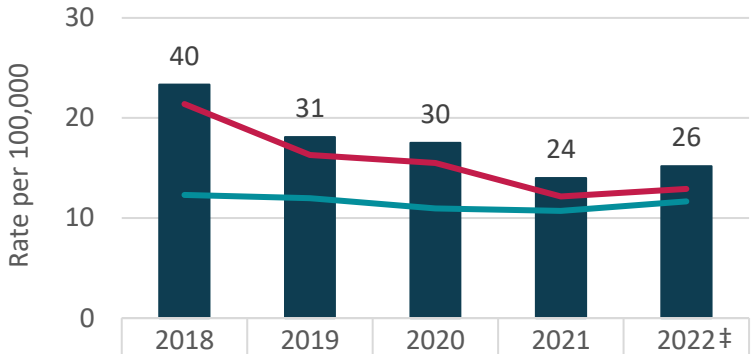
*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

Suicide Deaths

Overall, the local suicide rate decreased during the time period examined. While the local rate was 1.7x higher than the province in 2018, more recent rates are only slightly higher than the province (Figure 43).

Data Source:
Suicide data is from the Office of the Chief Coroner for Ontario.

Figure 43. Suicide Rates, SWPH Region and ONT, 2018-2022

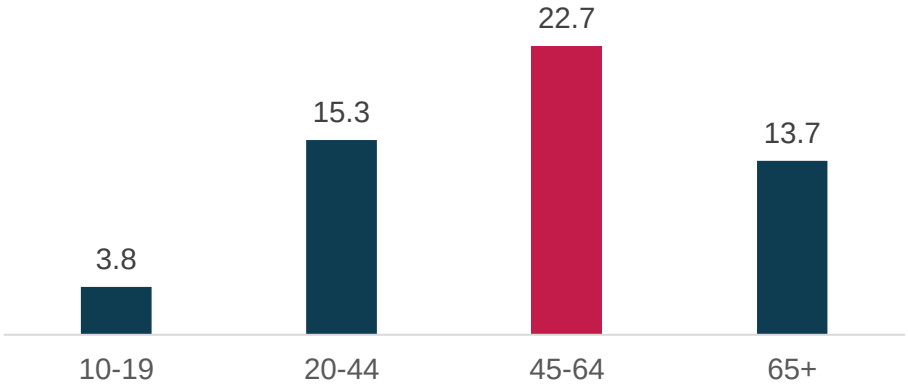


	2018	2019	2020	2021	2022‡
SWPH Count	40	31	30	24	26
SWPH Rate	21.4	16.3	15.5	12.2	12.9
ONT Rate	12.3	12.0	11.0	10.7	11.7

‡2022 data is preliminary and subject to change

Locally, the 5-year average rate (2018-2022) of suicide deaths was 4x higher among males compared to females (25.2 vs. 6.2 per 100,000). The 5-year average rate was highest among those aged 45-64 (Figure 44).

Figure 44. 5-year Average Rate of Suicide Deaths per 100,000 by Age Group, SWPH Region, 2018-2022



*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

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*Marginal co-efficient of variation: Data is reportable but has high sampling variability and should be interpreted with caution

The Value of PUBLIC HEALTH

February 2025

Historical Notations

1990

1997: 75% provincial maximum; 25% municipal minimum

1998: 100% municipal as per Local Services Realignment initiative

1999: 50% provincial maximum; 50% municipal minimum

2000

2005: 55% provincial maximum

2006: 65% provincial maximum

2007: 75% provincial maximum

2020

2020: 70% provincial maximum (incl. programs previously 100% funded); 30% municipal minimum

2020-23: Provincial mitigation funding in cost share change for municipal readiness

2024: Mitigation funding rolled into provincial base funding

2025

Ongoing: Advocacy by alPHa to restore adequate provincial funding

Investing in a Healthier Ontario

Ontario's focus on improving existing health models is evident in its Strengthening Public Health strategy and Roadmap to Wellness, and it is clear that Ontario has a firm commitment to health investment.

However, the individualized approach to health care – or, illness care – would benefit from innovation investments in upstream health – at the system and population level, and towards gathering data that identifies health impacts that prove to be barriers to communities in achieving overall health.

This begs the question: What if we could prevent or reduce some of the harms and illnesses that push a patient into the illness care funnel? This is where public health comes into focus.

Public health protects communities against infectious diseases, promotes healthy behaviours that support our most vulnerable, and prevents health issues through vaccination, dental supports, and other services, reducing the human and financial burden on primary and hospital care.

To be effective, local public health requires a sufficient – and sustainable – base funding model from our provincial partner.

Local public health requires a sufficient and sustainable base funding model from the province.

Our local municipalities shoulder the increased burden of less provincial funding and they can't keep that going.

Inflation averaged over 4% per year since 2020, meaning the 1% provincial increases to our base funding, while appreciated, are insufficient and amount to de facto year-over-year funding cuts.

Let's be clear. Ongoing funding freezes or increases of only 1% is a funding decrease.

Ontario's health sector and Ontarians are worth the investment.

The Value of PUBLIC HEALTH

Southwestern Public Health
Oxford · Elgin · St.Thomas

February 2025

The ROI of $1

- Spent on immunizing children with MMR vaccine saves $16 in health care costs
- Spent on mental health and addictions saves $7 in health care costs, and $30 in lost productivity and social costs
- Invested in tobacco prevention programs saves up to $20 in future health care costs
- Spent on early childhood development and health care saves up to $9 in future spending on health, social, and justice services

$60.7 Billion Amount of all health care costs contributed by health inequities due to socioeconomic position

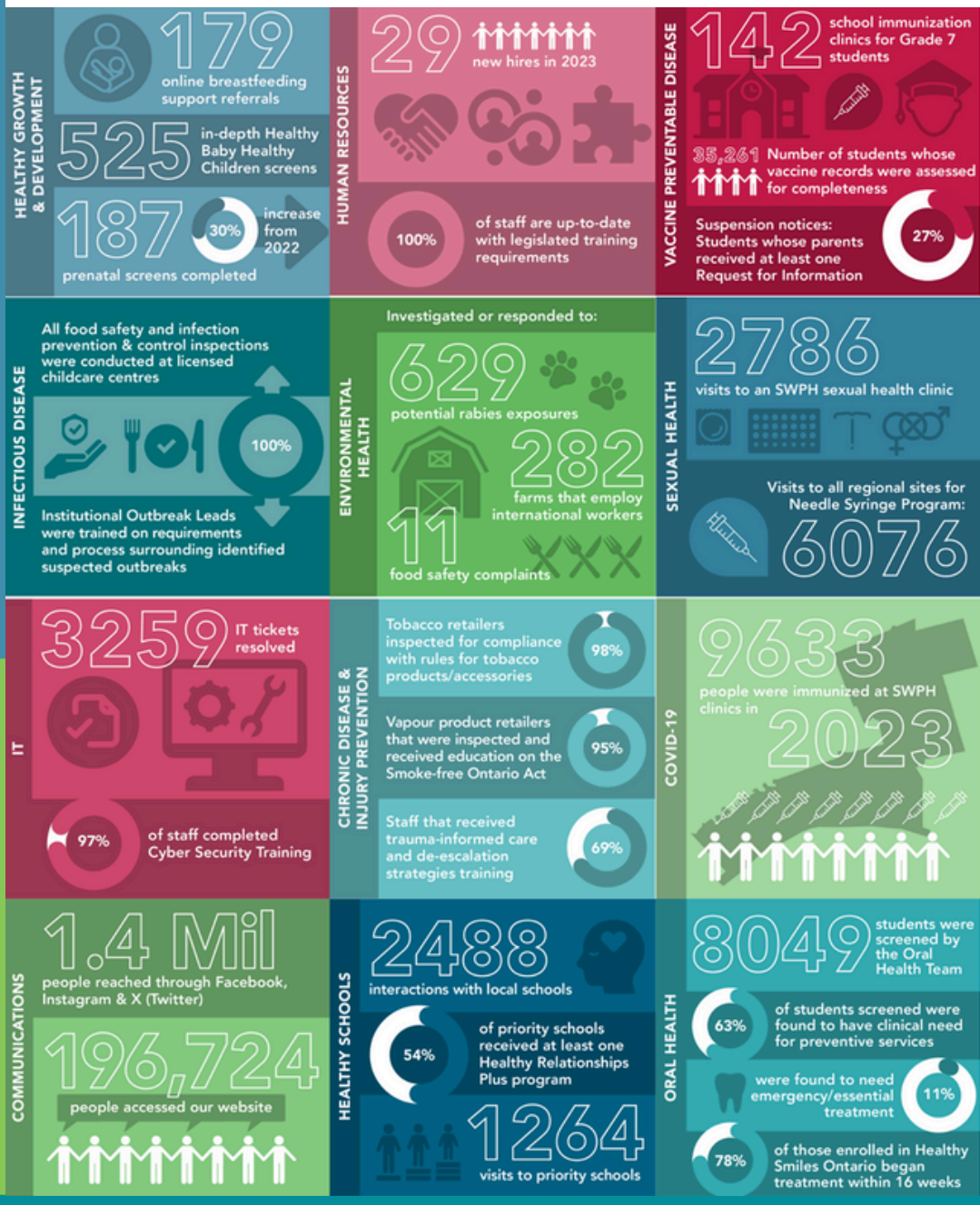
$89 Billion Amount in health care costs that could be prevented by improvements in alcohol, diet, smoking, and physical activity

$4.2 Billion Savings to health care over 10 years through the promotion of tobacco cessation and control

Source: The Association of Local Public Health Agencies (2025)

Your Investments Matter

More than ever, a commitment to – and investment in – public health matters. We respectfully call on Ontario for a full and firm commitment of 75% provincial base funding for the road ahead. The below demonstrates funding achievements within one year at Southwestern Public Health.



www.swpublichealth.ca

PUBLIC HEALTH MATTERS

Providing Leadership in Public Health Management

alPHa

Association of Local PUBLIC HEALTH Agencies

www.alphaweb.org

KEEPING ONTARIANS HEALTHY AND SAFE

Public health is essential for a healthy, thriving society, enabling individuals to live and work in optimal health. Investment in local public health enables healthy communities, which are foundational to a strong, vibrant, and economically prosperous Ontario. Public health promotes and protects communities and ensures everyone has a safe place to live, learn, work, and play.

OUR ASK

Local public health supports the Ontario government in its goals to be efficient, effective, and provide value for money.

We are asking decision-makers for their support for the goals and objectives of public health, with sustained and sufficient resources to ensure stability for Ontario's locally-based network of public health agencies.

DISEASE PREVENTION

Public health focuses on disease prevention through immunization and case management, to protect the entire community.

- 804,000+ doses of human papillomavirus, meningococcal, and hepatitis B vaccines administered (2023).
- 4,988,000+ doses of influenza vaccines distributed to public health units (PHUs) and pharmacies (2023/24 respiratory season).
- 2,349,500+ doses of COVID-19 vaccine administered (2023/24 respiratory season).
- An estimated 73% of long-term care home residents received an RSV vaccine (2023/24 respiratory season).
- Track diseases of public health significance, such as measles and pertussis, to strategically respond to rises in threats.

HEALTH PROTECTION

Public health helps to ensure the air we breathe, the water we drink, the food we eat, and the places we gather are safe.

- 39,200+ moderate and high risk food premises inspected (2023).
- 7,000+ pools and spa facilities inspected (2023).
- 2,000+ risk assessments completed for small drinking water systems (2024).
- 44,000+ total tobacco inspections completed, helping to limit youth access to cigarettes while protecting communities from the impacts of second-hand smoke (2023).
- 91% of confirmed syphilis cases where treatment and follow-up were completed (2023).
- 85 active tuberculosis cases investigated by PHUs (2023).

Population Health Assessment

Health Equity

Effective Public Health Practice

Emergency Management

Chronic Disease Prevention and Well-Being

Food Safety

Healthy Environments

PUBLIC HEALTH MATTERS

alPHa
Association of Local PUBLIC HEALTH Agencies

HEALTHY COMMUNITIES

Public health encourages healthy lifestyles and reduces health inequities by providing health support to the most vulnerable in the community.

- 510,000+ enrolled clients in *Healthy Smiles Ontario* (Apr. 2023-Mar. 2024).
- 115,650+ enrolled clients in the *Ontario Seniors Dental Care Program* (Apr. 2023-Mar. 2024).
- 97,900+ postpartum *Healthy Babies Healthy Children* screens completed (Apr. 2023-Mar. 2024).
- 8,780+ families received at least two home visits as interventions through *Healthy Babies Healthy Children* (Apr. 2023-Mar. 2024).

OUTBREAK MANAGEMENT

Track the spread, educate the public, support institutions to manage outbreaks ,and coordinate with the healthcare system to minimize institutional and community risk.

- 3,000+ services delivered by Infection Prevention and Control (IPAC) Hubs each month (2023).
- 1,250+ IPAC complaints investigated (2023).
- 5,350+ respiratory outbreaks supported (2024).
- Track diseases of public health significance, such as measles and pertussis, to strategically respond.

EMERGENCY PREPAREDNESS

Public health ensures continuity and resilience of the healthcare system during disruptions and emergencies that may put the health of Ontarians at risk.

- Continued preparedness for future public health surge responses for infectious disease and environmental health risks, including supporting the healthcare system with preparedness and response for suspect high-risk pathogen cases.
- Support municipalities and First Nations communities with planning, preparedness, response, and recovery for municipal emergencies, such as extreme weather events (e.g. heat or cold, forest fire smoke or air quality incidents, and floods).

Healthy Growth and Development | Immunization | Infectious and Communicable Diseases Prevention and Control | Oral Health | Safe Water | School Health | Substance Use and Injury Prevention