THE REGIONAL MUNICIPALITY OF NIAGARA
PUBLIC HEALTH & SOCIAL SERVICES COMMITTEE
FINAL AGENDA

PHSSC 1-2019
Tuesday, January 8, 2019
1:00 p.m.
Council Chamber
Niagara Region Headquarters, Campbell West
1815 Sir Isaac Brock Way, Thorold, ON

Pages

1. CALL TO ORDER

2. DISCLOSURES OF PECUNIARY INTEREST

3. SELECTION OF COMMITTEE CO-CHAIRS

   3.1 Call for Nominations for Committee Co-Chair aligned to Public Health

   3.2 Motion to Close the Nominations for Committee Co-Chair aligned to Public Health

   3.3 Voting for Committee Co-Chair aligned to Public Health

   3.4 Call for Nominations for Committee Co-Chair aligned to Community Services

   3.5 Motion to Close the Nominations for Committee Co-Chair aligned to Community Services

   3.6 Voting for Committee Co-Chair aligned to Community Services

4. PRESENTATIONS

5. DELEGATIONS

6. ITEMS FOR CONSIDERATION

11. NEXT MEETING

The next meeting will be held on Tuesday, February 19, 2019, at 1:00 p.m. in the Council Chamber, Regional Headquarters.

12. ADJOURNMENT

If you require any accommodations for a disability in order to attend or participate in meetings or events, please contact the Accessibility Advisory Coordinator at 905-980-6000 (office), 289-929-8376 (cellphone) or accessibility@niagararegion.ca (email).

Cannabis Legalization

Public Health and Social Services Committee

January 8, 2019

Presentation Outline

- Cannabis Legalization
- Data and Health Impacts
- Financial Considerations
- Community Impact
- Areas of Work for NRPH & ES

Legalization

- April 13, 2017 Federal Cannabis Act introduced
- October 17, 2018 cannabis became legal in Canada
- Anyone 19 or older in Ontario can now legally purchase from the on-line OCS
- Edibles are not yet available for legal purchase in Canada

Legalization – Retail Stores

- Public Health is responsible for enforcement of places of use through Smoke Free Ontario Act
- The first retail stores April 1, 2019, licensed and regulated by the AGCO, first round limited to 25 licences, due to availability
- Municipalities declare by January 22, 2019 whether they opt-out of private retail storefront sales

Data and Health Impacts

- 12.2% of individuals reported using marijuana at least once in the last 12 months (CCHS, 2015-16)
- 35% of secondary students in Niagara used cannabis in the last year (2015 data)

These rates are concerning given

- Second-hand smoke harms
- Link to mental health and impact on the developing brain
- Impaired driving risk

Financial Considerations

- Cannabis legalization has created financial pressures
- No additional funding for prevention and protection in 2018
- Unknown whether additional funds will be allocated to NRPH & ES for 2019

Community Concerns

NRPH & ES has heard concerns including

- Second-hand smoke, especially in multi-unit dwellings
- Odours from growing operations

Comprehensive Drug Strategy

Combination of Drug Strategy and Tobacco Pillars

- Prevention
- Harm Reduction
- Treatment
- Protection/Enforcement
- Denormalization

Key NRPH & ES role:
✓Education
✓Surveillance
✓Working with partners
✓Enforcement

Partnerships

- Enforcement agencies including
  - NRPS,
  - Local Area Municipalities (LAMs) by-law departments,
  - Niagara Region prosecutors
- Planners from LAMs
- School boards
- Workplaces
- Other Public Health Units
- Youth Engagement Community of Practice

Be educated.
BE RESPONSIBLE.

Niagara Region | GOOD to know NIAGARA

Thanks to Colorado Department of Public Health and Environment for use of brand materials

Them saying
"NO"
starts with you
saying something

GOOD to know NIAGARA

Niagara Region

Thanks to Colorado Department of Public Health and Environment for use of brand materials.

GOOD to know NIAGARA

Cannabis and alcohol
DON'T
MIX
at all.

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Thanks to Colorado Department of Public Health and Environment for use of brand materials

LOCK IT UP RIGHT.
OUT OF REACH & OUT OF SIGHT.

GOOD to know NIAGARA

Niagara Region

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Be educated.
BE RESPONSIBLE.

LEGAL DOES NOT MEAN SAFE

- Smoking cannabis can hurt your lungs and expose others to harmful second-hand smoke.
- Cannabis slows down your reaction time, affects your coordination and increases your risk of a car crash.
- The brain is still developing until age 25. Regular cannabis use in youth is linked to an increased risk of psychosis and schizophrenia.
- Cannabis use can increase the risk for depression and some forms of anxiety disorder.

GOOD to know NIAGARA

Thanks to Colorado Department of Public Health and Environment for use of brand materials.

Smoke Free Policy

- Under the Smoke-Free Ontario Act, Cannabis is prohibited from use in the same places that tobacco is currently restricted
- Smoking tobacco on all municipal and regional properties is restricted under *Regional By-law 112-2013.*
- By-law covers more outdoor spaces than *SFOA,* by-law only covers tobacco
- NRPH & ES working on next steps to align the by-law with *SFOA*

Subject: Cannabis Legalization

Report to: Public Health and Social Services Committee

Report date: Tuesday, January 8, 2019

Recommendations

That staff **BE DIRECTED** to report back on Niagara Region Public Health & Emergency Services' (NRPH & ES) response to cannabis legalization in 2019 Q4.

Key Facts

- Cannabis is now available for purchase and consumption to anyone 19 or older, online from the Ontario Cannabis Store (OCS). On April 1, 2019, Ontarians will be able to purchase cannabis from physical stores, licenced by the Alcohol and Gaming Commission of Ontario.
- *Smoke-Free Ontario Act, 2017 (SFOA)* now includes language around cannabis and vaping products in addition to tobacco. Public Health Units will continue to enforce *SFOA* with the added responsibility of education and laying charges for those using cannabis and vapour products in prohibited places.
- NRPH & ES continues to work with our partners, leading efforts in surveillance, education, and prevention in order to reduce the potential harms related to cannabis use.

Financial Considerations

The province has announced that it will provide $40 million over two years to help municipalities with costs related to the legalization of cannabis. Funding will be distributed to municipalities on a per household basis, adjusted to ensure that each municipal government receives no less than $10,000 (e.g., if a municipality opts out). If Ontario's portion of the federal excise taxes exceed $100 million in the first two years, the province will provide 50% of the surplus only to municipalities that decide to allow cannabis retail outlets. In areas such as Niagara where there are two-tiers, the funding will be split 50/50. The final amount will depend on how many municipalities opt out of allowing retail stores or remain in by default.

NRPH & ES has requested one-time funding from MOHLTC to support increased staff time related to cannabis enforcement and prevention work. At the time of writing this report there has been no response to the funding request.

Analysis

Legalization

On April 13, 2017 the Federal Cannabis Act was introduced. The Act regulates licensed producers, types of legal products, and potency of cannabis in each product. It also establishes a minimum age for purchase and consumption, maximum amounts for possession and rules for labelling, advertising and promotion. Under the law, provinces were able to decide on a model for retail sale and distribution, regulating public consumption (where cannabis can be used, or “places of use”) and enforcement.

On October 17, 2018, the day cannabis became legal, the Province passed the Cannabis Statute Law Amendment Act, 2018. This new legislation allows for private retail storefront sales in Ontario licensed and regulated by the Alcohol and Gaming Commission of Ontario (AGCO). It also amended prior legislation so that Public Health Units are now responsible for enforcement of acceptable places of use of cannabis.

The first retail stores are to be operational on April 1, 2019. Businesses could apply for a license starting December 17, 2018. Municipalities must declare by January 22, 2019 whether they will opt-out of private retail storefront sales in their communities. To opt-out, municipalities must provide a notice of resolution to the Registrar no later than January 22, 2019. Opting out is a one-time option for municipalities, however, those that choose to opt out may opt-in at a later date. There was recently notice from the province that the first round of licensing will be limited to 25 licences, awarded by lottery, due to low availability of legal product.

Ontario Regulation 468/18 made under the *Cannabis Licence Act, 2018* governs private cannabis retail in Ontario and requires that

- Stores may not be located within 150 metres of schools;
- Persons under 19 are not allowed in stores, and persons who appear to be under 25 must show ID to enter the store;
- Stores are only allowed to sell cannabis, cannabis accessories and shopping bags;
- Stores must be enclosed by walls separating it from any other commercial establishment.

Finally, edibles are not currently available for legal purchase in Canada. We anticipate they will be introduced by the federal government in the fall of 2019.

Data and Prevalence of Use

In Niagara, 12.2% of individuals reported using marijuana at least once in the last 12 months (CCHS, 2015-16) The Ontario Student Drug Use and Health survey from 2015 shows that 35% of secondary students in Niagara had used cannabis in the last 12 months. We look forward to newer data to see the impact of legalization on prevalence of use.

The high prevalence of use is concerning given there are many short and long-term health impacts linked to cannabis use including poisoning (young children), mental health impacts, and addiction. These harms are worse for youth and those who are frequent and regular cannabis users.

Every four years NRPH & ES purchases an over sample of the Ontario Student Drug Use and Health Survey (OSDUHS). This survey gives Niagara-specific data on youth health behaviours including cannabis use. This information assists NRPH & ES and our partners in developing youth focused programs. We will have access to new data in 2020.

In addition, the Early Intervention in Psychosis (EPI) service, a Niagara Region Mental Health program, has added a module in their Electronic Medical Records to track changes in demand for EPI service, and substance of choice for clients entering the service. This will provide more accurate data about the youth seeking this service.

Community Impact

In the 12 months prior to legalization, NRPH & ES received more than 40 calls from residents on the issue of cannabis. These calls were complaints around odour from cannabis growing operations and second-hand smoke in a multi-unit dwelling, as well as questions about the law.

NRPH & ES is not responsible for regulating cannabis production operations; this is Health Canada's responsibility. Health Canada requires operations to be equipped with an air filtration system to prevent the escape of odours. Residents with concerns have been asked to contact Health Canada. NRPH & ES has provided residents with the email and phone number to the division of Health Canada that inspect cannabis production operations. An evidence brief from Public Health Ontario regarding this issue found that there were no studies associated with exposure to cannabis odours identified in either the scientific or grey literature. Additional research is needed around the impact of cannabis odour on the health and well-being of Canadians.

One in three Ontarians resides in an apartment, condo or co-op where they may be involuntarily exposed to smoke through shared walls, hallways or ventilation systems. NRPH & ES provides consultation and support to landlords, tenants and housing providers interested in developing a smoke-free policy.

Niagara Region Public Health and Emergency Services' Areas of Work

NRPH & ES has been engaged in various initiatives that fall under the pillars of a comprehensive drug strategy: prevention, harm reduction, treatment and enforcement. These activities include policy work, working with partners, training staff, research and data, and external campaigns and presentations. Staff from all divisions are involved, as there are many complexities in this work reaching various audiences.

Partnerships

- In order to ensure a common understanding of roles and create a forum for sharing and learning, NRPH & ES has met regularly with enforcement agencies across the region (including Niagara Region Police Services, local area municipality by-law departments, Niagara Region prosecutors, Ministry of Labour, Ministry of Environment and the Ontario Ministry of Agriculture, Food and Rural Affairs). Meetings will continue into 2019 as long as they serve a need for agencies involved.
- NRPH & ES was able to consult with the planners from the Local Area Municipalities around set-backs for cannabis retail locations.
- NRPH & ES hosted a Youth Engagement Community of Practice education event around the latest research in cannabis messaging for a youth audience, generating learnings and confidence for those working directly with young people.
- Changes in *SFOA* impact where students can smoke and vape in proximity to schools. Tobacco control officers, school health nurses and school resource officers have visited all secondary schools to review the changes to *SFOA* and the new distances with school administration.
- The Workplace Health program has connected workplaces to cannabis resources and policy support through a policy-writing workshop. Over 50 employers learned about substance use and workplace policy.
- NRPH & ES is involved with a number of other Public Health Units in a Locally Driven Collaborative Project to study effective health promotion interventions around cannabis for the young adult population. The project is awaiting funding approval.

Internal Staff Training

- An e-module has been designed, created, and launched for NRPH & ES staff to gain a better understanding of cannabis and legalization.

- NRPH & ES has put a system in place to track all calls related to cannabis in order to better inform our programs of the needs and concerns of the community, this tracking has been implemented with a call directory to ensure residents are connected to the appropriate staff or resource within the department.

External Campaigns and Presentations

- Good to Know Niagara campaign is getting cannabis information to the community. Messages have been launched on social media, in bus shelters, posters, and in print media.
    - **Let's be Clear** campaign targets youth, encouraging them to wait to use cannabis and instead focus on the life goals that they may have
    - **Cannabis and Alcohol Don't Mix** targets young adults who may wish to use both cannabis and alcohol at the same time, increasing the potential harms
    - **Store it Right** reminds residents that choose to use cannabis to lock it up so that children and pets cannot gain access
    - **Legal Does Not Mean Safe** outlines potential health harms related to cannabis use
    - **Them Saying No** emphasizes the importance in talking with their kids about cannabis
- REACT (NRPH & ES youth staff) is partnering with CAA on a health promotion campaign highlighting dangers associated with cannabis impaired driving. The campaign targets teens through street marketing and social media.
- Several parent info evenings and community presentations have been hosted answering residents' questions about cannabis legislation and potential risks.
- Many resources have been created internally or by other agencies that NRPH & ES has been able to distribute at events and to community partners for unique audiences.

Smoke Free Policy

In Niagara, smoking tobacco on all municipal and regional properties is restricted under Regional By-law 112-2013. This By-law covers more outdoor spaces than the new *SFOA*. This means there are places in Niagara where individuals are permitted to use cannabis and vapour products, but could be fined for smoking tobacco. NRPH & ES is currently working on next steps to support aligning the by-law with *SFOA.*

Relationship to Council Strategic Priorities

NRPH & ES coordinates with Council's Strategic Priorities. Our comprehensive approach to cannabis supports DOING BUSINESS DIFFERENTLY and ORGANIZATIONAL EXCELLENCE.

Alternatives Reviewed

A comprehensive approach to substances is the best, evidence based approach. In addition, this is a newly legalized substance, which is a unique and very rare situation. The alternative would be to do less of this work, but it would not be recommended.

Other Pertinent Reports

- PHD 15-2018 Cannabis Legalization
- PHD 07-2018 Cannabis Legalization
- PHD 04-2017 Ontario Student Drug Use and Health Survey Results

Prepared by:
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Submitted by:
Ron Tripp, P. Eng.
Acting Chief Administrative Officer

This report was prepared in consultation with Diana Teng, Manager, Chronic Disease and Injury Prevention, David Lorenzo, Associate Director, Chronic Disease and Injury Prevention, and reviewed by Dr. Andrea Feller, Associate Medical Officer of Health.

Subject: Outdoor Second-hand Smoking By-law Amendment – ***REVISED***

Report to: Public Health and Social Services Committee

Report date: Tuesday, January 8, 2019

Recommendations

1. That By-law No. 112-2013 BE UPDATED to harmonize with the Smoke Free Ontario Act to include vaping and cannabis, as an interim measure for consistency, with an appropriate sunset clause;

~~2.~~ That staff **BE DIRECTED** to consult with the Local Area Municipalities (LAMs) ~~on revisions to By-law No. 112-~~*~~2013~~* ***and the public to build a consensus on a*** ***n updated*** regional by-law to protect children and vulnerable persons from exposure to outdoor second-hand smoke ~~as follows:~~; and

~~a) Addition of cannabis and e-cigarettes to substances prohibited from use in public outdoor spaces.~~

~~b) Addition to the list of prohibited places of use including nine metres from any public building entrance and/or exit.~~

3. That staff **BE DIRECTED** to report back to PHSSC in a timely manner on the learnings from this consultation with the recommended next steps.

Key Facts

- The Province of Ontario passed the *Smoke-Free Ontario Act, 2017 (SFOA),* which prohibits spaces where individuals can smoke or vape. Changes to this legislation expand beyond tobacco to include cannabis and all vaping products.
- Niagara's By-Law No. 112-2013 aims to protect children and vulnerable persons from exposure to outdoor second-hand tobacco smoke, which does not address the second-hand smoke exposure to cannabis or second-hand vapour exposure from ***electronic*** e-cigarettes through outdoor spaces.
- Local data suggests support in Niagara to harmonize the Regional By-law with SFOA by including vaping and cannabis, in addition to tobacco, ~~as well as support for restrictions around entrances and exits.~~ ***as an interim measure to ensure consistency and avoid confusion***
- Consultation internally, across Regional departments ~~is important, as well as consultation~~ with the LAMs ***and the public, is important*** ~~to assess support.~~ to ***develop the next version of the Regional By-law, by consensus across all municipalities*****.**

Financial Considerations

The Ministry of Health and Long Term Care (MOHLTC) provides multiple funding sources to support the Smoke-Free Ontario strategy at 100% with the approved budget of $668,600 for 2018. This funding supports five FTE Tobacco Control Officers (TCO) responsible for the promotion, education, enforcement of the *SFOA* and Niagara Region's By-law 112-2013.

The province has announced that it will provide $40 million over two years to help municipalities with costs related to the legalization of cannabis.[1] In the first phase, $15 million is to be disbursed in early January 2019, this has been allocated for each municipality. The allocation of these funds to Public Health will be determined once funding amounts have been finalized.

NRPH & ES received 281 complaints, requests and inquiries related to tobacco, cannabis and e-cigarette products in 2018. Of these calls, 82 were complaints related to use of tobacco products being used in places thought to be prohibited places. NRPH & ES has requested funding from MOHLTC to support increased staff time related to cannabis enforcement and prevention work. At the time of writing this report there has been no response to the funding request.

Analysis

SFOA, 2017 Updates

The *SFOA* restricts tobacco sale, supply and places of use; changes to the *SFOA* now include cannabis and vaping products in those restrictions.

SFOA Prohibited Place Examples

- Enclosed public places
- Enclosed work places
- Condos, apartment buildings and university/college residents
    - Application: Common areas
- Playgrounds
    - Application: Perimeter plus 20 metres
- Sports fields
    - Application: Patio plus 20 metres
- Restaurant bar patios
    - Application: Patio plus nine metres

[1] Fedeli, V. Ontario Cannabis Legalization Implementation Fund — Heads of Council Letter [Internet]. Toronto, ON: Ministry of Finance; 2018 [cited 2018 Dec 10]. Available from: https://www.fin.gov.on.ca/en/budget/oclif/

- Hospitals, psychiatric facilities, community health facilities
    - Application: Grounds of facility
- Child care Centre
    - Application: Grounds of facility

Niagara's By-Law No. 112-2013

Tobacco

In 2012, NRPH & ES conducted public consultations and found that 88% of the 1,907 Niagara residents surveyed supported a by-law restricting smoking in outdoor public settings.[2] In order to protect the public from second-hand exposure to outdoor smoke, Niagara passed By-law No. 112-2013, which prohibits smoking tobacco on the grounds of all municipal and regional properties, parks, playground, sports fields, splash pads, outdoor pools, arenas and bus shelters. The by-law has a strong focus on protecting children and youth, and this includes denormalization. Also, those who wish to quit find that fewer visual cues and denormalization of smoking is helpful.

Strengthening local by-laws to reduce second-hand exposure to tobacco in outdoor spaces, has been ranked as a highly impactful policy change to protect the public from tobacco smoke.[3] ~~*Prohibiting tobacco and cannabis smoke and vaping of any product within nine metres of public entrances and exits will be a consideration during consultations.*~~

Beyond tobacco, the *SFOA* now prohibits the use of cannabis and e-cigarettes in public spaces. The benefits of aligning the By-law No. 112-2013 with the *SFOA* by the inclusion of cannabis and e-cigarettes are:

1. Protecting individuals, especially children and vulnerable populations from second-hand smoke exposure
2. Preventing the normalization of tobacco, cannabis, e-cigarette use amongst youth
3. Creating supportive environments for individuals that are motivated to quit or cut back from use of tobacco, cannabis or e-cigarettes

Cannabis

[2] Smoke-Free Outdoor Spaces Public Consultation Report, Niagara Region Public Health [Summer 2012]
[3] Smoke-Free Ontario Scientific Advisory Committee. Evidence to Guide Action: Comprehensive tobacco control in Ontario [Internet]. Toronto, ON: Public Health Ontario [cited 2018 Dec 10]. Available from: https://www.publichealthontario.ca/en/BrowseByTopic/ChronicDiseasesAndInjuries/Pages/smoke-free-ontario.aspx

Cannabis has been criminalized in Canada since 1923, yet prior to legalization 46.4% of adults in Niagara indicated that they have used cannabis at least once in their lifetime and 12.2% used cannabis in the past 12 months.[4] Within Niagara's secondary schools 35% have used cannabis in the past 12 months and 23% have used cannabis in the past 4 weeks.[5] The Canadian Cannabis Survey (2018) included 12,958 respondents and found the most common form of consumption of cannabis was through smoking (89%), followed by edibles (42%), and e-cigarettes (26%).[6] Research has found that second-hand exposure to cannabis smoke and tobacco smoke have similar chemical composition. [7, 8] Holitzki et. al recommend an alignment in tobacco and cannabis policy by prohibiting outdoor spaces where products can be used.[9] *Including cannabis as a prohibited drug to smoke or vape into the amended by-law will be a consideration during consultations.*

E-cigarettes

Electronic Cigarettes are known as e-cigarettes, e-cigs or vapes, and typically include a rechargeable battery, a heating element, and an e-juice containing chemical ingredients, which forms a vapour when inhaled. E-cigarettes do not contain tobacco but generally contain nicotine, which may lead to addiction in those who vape but aren't smokers. E-cigarettes contain more than 80 compounds, such as particles, metals, nitrosamines, carbonyls, and flavourings.[10] While the long-term health effects from e-cigarette use are still unknown, some research indicates that use can lead to lung damage, and short-term health effects can include increased heart rate, increased blood pressure, increased airway resistance, decreased airway conductance.[11] In Niagara, 25% of secondary students have used an e-cigarette in the past 12 months.[12] The Ontario Student Drug Use and Health Survey found that 61% of secondary students believe there is no risk from regular e-cigarette use.[13] ~~*Including e-cigarettes as*~~

[4] Canadian Community Health Survey [2015-2016]
[5] Ontario Student Drug Use and Health Survey, Centre for Addiction and Mental Health [2015]
[6] Canadian Cannabis Survey 2018 Summary. Government of Canada. [cited 2018 Dec 10]. Available from: https://www.canada.ca/en/services/health/publications/drugs-health-products/canadian-cannabis-survey-2018-summary.html
[7] Maertens RM, White PA, Williams A, et al. A global toxicogenomic analysis investigating the mechanistic differences between tobacco and marijuana smoke condensates in vitro. Toxicology 2013;308:60-73.
[8] Maertens RM, White PA, Rickert W, et al. The genotoxicity of mainstream and sidestream marijuana and tobacco smoke condensates. Chem Res Toxicol 2009;22:1406-14.
[9] Holitzki, H., Dowsett, L.E., Spackman, E., Noseworthy, T., Clement, T., Health effects of exposure to second- and third-hand marijuana smoke: A systematic review [Internet] Canadian Medical Association Journal Open, 2017: Oct-Dec, 5(4): E814-E822. [cited 2018 Dec 10]. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5741419/
[10] Tobacco and Public Health: From Theory to Practice, E-Cigarettes Module [Internet], Toronto, ON, Ontario Tobacco Research Unit [cited Dec 11]. Available from: https://tobaccocourse.otru.org/course/
[11] Tobacco and Public Health: From Theory to Practice, E-Cigarettes Module [Internet], Toronto, ON, Ontario Tobacco Research Unit [cited Dec 11]. Available from: https://tobaccocourse.otru.org/course/
[12] Ontario Student Drug Use and Health Survey, Centre for Addiction and Mental Health [2015]
[13] Ontario Student Drug Use and Health Survey, Centre for Addiction and Mental Health [2015]

~~*a prohibited product into the amended by-law will be a consideration during consultations.*~~

In By-law No. 112-2013, tobacco use is more restricted than the public places outlined in the provincial *SFOA*. Outside of the established buffer zones in the *SFOA*, individuals could be fined for use of tobacco, but not for cannabis or e-cigarettes at those same locations. ***As an interim measure, harmonizing the By-law No. 112-2013 with the SFOA is important to ensure consistency and avoid confusion.*** ~~By enhancing By-law No. 112-2013, NRPH & ES is aiming to align it with the provincial legislation to include cannabis and e-cigarettes.~~

Proposed Municipal Consultation

In preparation for cannabis legislation, NRPH & ES has been meeting with the municipal partners through their by-law, park/recreation and planning staff. Area Chief Administrative Officers ~~have been notified of the proposed amendments, and meetings with each of the local area municipalities~~ ***discussed next steps and support harmonizing now, with a sunset clause, with a consensus approach moving forward. An initial meeting is*** ~~are being~~ planned for ***late January/early*** February. ~~During these meetings, NRPH & ES will learn whether the municipalities want to~~

1. ~~**Continue with the status quo**~~
   ~~By-law 112-2013 includes only tobacco within the mandate with the *SFOA* restricting use of tobacco, cannabis and e-cigarettes, despite the confusion in the application and messaging between the pieces of legislation.~~
2. ~~**Amend By-law No. 112-2013 to align products with the *SFOA***~~
   ~~Include the substances of cannabis and e-cigarettes to apply to the same places that are currently covered by the by-law.~~
3. ~~**Amend By-law No. 112-2013 to align products with the *SFOA* and add in restrictions related to public entrances and exits**~~
   ~~Include the substances of cannabis and e-cigarettes to apply to nine metres from all public entrances/exits.~~
4. ~~**Amend By-law No. 112-2013 to align products with the *SFOA* and expand the prohibited places of use**~~
   ~~Include the substances of cannabis and e-cigarettes to tobacco, and add additional places (i.e. nine metres from all public entrances, beaches, trails).~~

~~Once we have this information, we propose that we return to PHSSC to provide recommended next steps. If there is support for updating the by-law we will bring the proposed amendments to Council.~~

Alternatives Reviewed

Consideration was given to ***not harmonizing, and just embarking on the*** ~~a~~ larger public consultation process. We recommend that we first ~~assess whether there is agreement on~~ harmoniz**e**~~ing and updating~~ the by-law as outlined, as it is likely that a large public consultation ~~beyond municipal and regional meetings~~ is not warranted ~~for the two recommended changes.~~ ***for this simplification of the bylaw.***

Relationship to Council Strategic Priorities

This work supports Doing Business Differently by proposing that Niagara continue to aim for simplicity and consistency while remaining among the leaders in Ontario in its smoke-free policies.

Other Pertinent Reports

- PHD 01-2019 – Cannabis Legalization
- PHD 13-2018 – Comprehensive Tobacco Control Report
- PHD 07-2018 – Cannabis Legalization
- PHD 01-2018 – Smoke-Free Ontario Modernization
- PHD 04-2017 - Ontario Student Drug Use and Health Survey Results
- PHD 09-2016 Revised - Cannabis Regulation and Control

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Submitted by:
Ron Trip, P.Eng.
Acting, Chief Administrative Officer

This report was prepared in consultation with Renata Faber, Manager, Chronic Disease and Injury Prevention, David Lorenzo, Associate Director, Chronic Disease and Injury Prevention and reviewed by Dr. Feller, Associate Medical Office of Health.

Bill 112

THE REGIONAL MUNICIPALITY OF NIAGARA

BY-LAW NO. 112-2013

A REGIONAL BY-LAW TO PROTECT CHILDREN AND VULNERABLE PERSONS FROM EXPOSURE TO OUTDOOR SECOND-HAND SMOKE

WHEREAS subsection 115(1) of the *Municipal Act, 2001,* S.O. 2001, c.25 as amended provides that a municipality may prohibit or regulate the smoking of tobacco in public places*;*

AND WHEREAS it has been determined that smoking and second-hand tobacco smoke is a health hazard or discomfort for individuals residing in or visiting The Regional Municipality of Niagara (hereinafter, “Niagara Region”);

AND WHEREAS smoke-free policy interventions are effective mechanisms to reduce exposure to tobacco smoke, prevent initiation of smoking, encourage cessation of smoking, support recent quitters, and contribute to the denormalization of tobacco use;

AND WHEREAS Niagara Region therefore wishes to prohibit tobacco smoking in outdoor public places for the health of the public generally, and particularly for the benefit of young persons, and to improve the environmental and social conditions in public places;

AND WHEREAS Section 115(5) of the said Act provides that a by-law passed under subsection 115(1) shall not come into force unless,

(a) a majority of all votes on the Council of the upper-tier municipality are cast in its favour;

(b) a majority of the Councils of all the lower-tier municipalities forming part of the upper-tier municipality for municipal purposes have passed resolutions giving their consent to the by-law; and

(c) the total number of electors in the lower-tier municipalities that have passed resolutions under clause (b) form a majority of all the electors in the upper-tier municipality.

NOW THEREFORE BE IT RESOLVED THAT the Council of The Regional Municipality of Niagara enacts as follows:

DEFINITIONS AND INTERPRETATION

1. (1) The following definitions shall be used in interpreting and applying this by-law:

"authorized person" means an individual designated or authorized by Niagara Region or an area municipality whose duties include, without limitation, tobacco control or the monitoring of regional or municipal property for the purpose of addressing unauthorized activities;

"**area municipality**" means any one of the municipalities of the Town of Fort Erie, Town of Grimsby, Town of Lincoln, City of Niagara Falls, Town of Niagara-on-the-Lake, Town of Pelham, City of Port Colborne, City of St. Catharines, City of Thorold, Township of Wainfleet, City of Welland and the Township of West Lincoln.

"outdoor public place" means any property owned, leased or controlled by the Niagara Region or any area municipality, including without limitation parks, playgrounds, sports or playing fields, arenas, recreational centres, bus shelters, splash pads, pools and any area that is within a nine-metre radius of an entrance to or exit from a building located on any property owned, leased or controlled by the Niagara Region or any area municipality, whether or not a "No Smoking" sign is posted, but does not include the following:

a. highways;

b. road allowances abutting a regional or municipal property;

c. municipal sidewalks, save and except for that portion of any municipal sidewalk that is within a nine-metre radius of any entrance to or exit from a building located on any property owned, leased or controlled by the Niagara Region or any area municipality;

d. parking lots or any area designated for the parking of motor vehicles;

e. beaches;

f. walking or hiking trails;

g. rights-of-way; and

h. residential dwellings owned, operated or subsidized by Niagara Regional Housing or an area municipality;

"smoke" or **"smoking"** includes the holding of tobacco or other lighted smoking material or equipment while the product is alight or emitting smoke;

"tobacco" includes pipe tobacco, water-pipe tobacco, cigarettes, cigars, cigarillos or any similar product made with or containing tobacco;

PROHIBITION

2.(1) No person shall smoke tobacco upon or within an outdoor public place.

2.(2) The prohibition in section 2.(1) above applies whether or not a “No Smoking” sign of any format or content is posted.

2.(3) No person shall remove a sign posted under this section while the prohibition remains in force.

2.(4) No person shall hinder or obstruct an authorized person lawfully carrying out the enforcement of this by-law.

OFFENCE and SET FINE

3.(1) Any person who contravenes a provision of this by-law is guilty of an offence and, upon conviction, is liable to a set fine of $250.00.

ENFORCEMENT

4.(1) The provisions of this by-law respecting smoking in an outdoor public place shall be enforced by any authorized person as designated by the Niagara Region or an area municipality.

CONFLICTS

5.(1) If a provision of this by-law conflicts with an Act or a regulation or another by-law, the provision that is the most restrictive of smoking shall prevail.

SEVERABILITY

6.(1) If any section or part of this by-law are found by any Court of competent jurisdiction to be invalid, such section or part shall be deemed to be severable and all other sections of this by-law shall remain valid and enforceable.

ENACTMENT

7.(1) This by-law shall come into force on the day that it is approved in accordance with section 115(5) of the *Municipal Act, 2001,* S.O. 2001, C.25.

EFFECTIVE BY-LAW DATE

8. This by-law shall come into force on the date specified by the Regional Clerk as the date when the following have been achieved:

   a) A majority of the Councils of all of the lower-tier municipalities forming part of The Regional Municipality of Niagara have passed resolutions giving consent to this by-law: and

   b) The total number of electors in the lower-tier municipalities that have passed resolutions under clause (a) above form a majority of all the electors in The Regional Municipality of Niagara.

PASSED, a majority of the members of the Regional Council assenting hereto, this 10th day of October, 2013.

THE REGIONAL MUNICIPALITY OF NIAGARA

Original Signed By:

_____

(Gary Burroughs, Regional Chair)

Original Signed By:

_____

(Janet Pilon, Regional Clerk)

~~Bill 112~~

THE REGIONAL MUNICIPALITY OF NIAGARA

(CONSOLIDATED) BY-LAW NO. ~~112-2-13~~

A REGIONAL BY-LAW TO PROTECT CHILDREN AND VULNERABLE PERSONS FROM EXPOSURE TO OUTDOOR SECOND-HAND SMOKE **AND VAPING**

WHEREAS subsection 115(1) of the *Municipal Act, 2001,* S.O. 2001, c.25 as amended provides that a municipality may prohibit or regulate the smoking of tobacco **or cannabis** in public places;

AND WHEREAS the Smoke-Free Ontario Act, 2017, S.O. 2017, c. 26 as amended prohibits smoking tobacco or cannabis and vaping (use electronic cigarette), but Regional By-Law No. 112-2013 only prohibits smoking tobacco;

AND WHEREAS it has been determined that smoking and second-hand tobacco **and cannabis** smoke is a health hazard or discomfort for individuals residing in or visiting The Regional Municipality of Niagara (hereinafter, "Niagara Region");

AND WHEREAS smoke-free policy interventions are effective mechanisms to reduce exposure to tobacco smoke, prevent initiation of smoking, encourage cessation of smoking, support recent quitters, and contribute to the denormalization of ~~tobacco uses~~ **smoking**;

AND WHEREAS Niagara Region therefore wishes to prohibit tobacco **and cannabis** smoking **and vaping (use electronic cigarette)** in outdoor public places for the health of the public generally, and particularly for the benefit of young persons, and to improve the environmental and social conditions in public places;

AND WHEREAS Section 115(5) of the said Act provides that a by-law passed under subsection 115(1) shall not come into force unless,

(a) a majority of all votes on the Council of the upper-tier municipality are cast in its favour;

(b) a majority of the Councils of all the lower-tier municipalities forming part of the upper-tier municipality for municipal purposes have passed resolutions giving their consent to the by-law; and

(c) the total number of electors in the lower-tier municipalities that have passed resolutions under clause (b) form a majority of all the electors in the upper-tier municipality.

NOW THEREFORE BE IT RESOLVED THAT the Council of The Regional Municipality of Niagara enacts as follows:

~~Bill112~~

DEFINITIONS AND INTERPRETATION

1. (1) The following definitions shall be used **in** interpreting and applying this by-law:

"authorized person" means an individual designated or authorized by Niagara Region or an area municipality whose duties include, without limitation, tobacco, **cannabis or electronic cigarette** control or the monitoring of regional or municipal property for the purpose of addressing unauthorized activities;

"area municipality" means any one of the municipalities of the Town of Fort Erie, Town of Grimsby, Town of Lincoln, City of Niagara Falls, Town of Niagara-on-the-Lake, Town of Pelham, City of Port Colborne, City of St. Catharines, City of Thorold, Township of Wainfleet, City of Weiland and the Township of West Lincoln.

"outdoor public place" means any property owned, leased or controlled by the Niagara Region or any area municipality, including without limitation parks, playgrounds, sports or playing fields, arenas, recreational centres, bus shelters, splash pads, pools and any area that is within a nine-metre radius of an entrance to or exit from a building located on any property owned, leased or controlled by the Niagara Region or any area municipality, whether or not a "No Smoking" **or "No Vaping"** sign is posted, but does not include the following:

a. highways;

b. road allowances abutting a regional or municipal property;

c. municipal sidewalks, save and except for that portion of any municipal sidewalk that is within a nine-metre radius of any entrance to or exit from a building located on any property owned, leased or controlled by the Niagara Region or any area municipality;

d. parking lots or any area designated for the parking of motor vehicles;

e. beaches;

f. walking or hiking trails;

g. rights-of-way; and

h. residential dwellings owned, operated or subsidized by Niagara Regional Housing or an area municipality;

"smoke" or "smoking" includes the holding of tobacco **or cannabis** or other lighted smoking material or equipment while the product is alight or emitting smoke;

"tobacco" includes pipe tobacco, water-pipe tobacco, cigarettes, cigars, cigarillos or any similar product made with or containing tobacco;

"cannabis" has the same meaning as in subsection 2 (1) of the *Cannabis Act* (Canada); ("cannabis")

"electronic cigarette" has the same meaning as in subsection 1 (1) of the Smoke-Free Ontario Act, 2017

PROHIBITION

2.(1) No person shall smoke tobacco **or cannabis, or vape (use electronic cigarette)** upon or within an outdoor public place.

2.(2) The prohibition in section 2.(1) above applies whether or not a "No Smoking" or **"No Vaping"** sign of any format or content is posted.

2.(3) No person shall remove a sign posted under this section while the prohibition remains in force.

2.(4) No person shall hinder or obstruct an authorized person lawfully carrying out the enforcement of this by-law.

OFFENCE and SET FINE

3.(1) Any person who contravenes a provision of this by-law is guilty of an offence and, upon conviction, is liable to a set fine of $250.00.

ENFORCEMENT

4.(1) The provisions of this by-law respecting smoking in an outdoor public place shall be enforced by any authorized person as designated by the Niagara Region or an area municipality.

CONFLICTS

5.(1) If a provision of this by-law conflicts with an Act or a regulation or another by-law, the provision that is the most restrictive of smoking shall prevail.

SEVERABILITY

6.(1) If any section or part of this by-law are found by any Court of competent jurisdiction to be invalid, such section or part shall be deemed to be severable and all other sections of this by-law shall remain valid and enforceable.

DRAFT

~~Bill112~~
ENACTMENT

7.(1) This by-law shall come into force on the day that it is approved in accordance with section 115(5) of the *Municipal Act, 2001,* S.O. 2001, C.25 **as amended.**

EFFECTIVE BY-LAW DATE

8. This by-law shall come into force on the date specified by the Regional Clerk as the date when the following have been achieved:

a) A majority of the Councils of all of the lower-tier municipalities forming part of The Regional Municipality of Niagara have passed resolutions giving consent to this by-law: and

b) The total number of electors in the lower-tier municipalities that have passed resolutions under clause (a) above form a majority of all the electors in The Regional Municipality of Niagara.

THE REGIONAL MUNICIPALITY OF NIAGARA

:

Original Signed By:

_____

(James Bradley, Regional Chair)

Original Signed By:

_____

(, Regional Clerk)

DRAFT

Subject: Preventing Deaths by Suicide on Public Infrastructure

Report to: Public Health & Social Services Committee

Report date: Tuesday, January 8, 2019

Recommendations

1. Regional Council as the Board of Health **RESOLVES** that current public discourse around suicide has caused contagion and **REQUESTS** local media and others with a public audience to adhere to the Canadian Psychiatry Association's 2017 "Media Guidelines for Suicide Reporting" to prevent further contagion of suicide
2. Regional Council as the Board of Health **ENDORSE** the proposed framework for preventing suicides on public infrastructure
3. Within this framework, Regional Council as the Board of Health **ENDORSE** the importance of considering a barrier at the location of multiple recent deaths by suicide and **DIRECT** staff to proceed with planning for such a barrier for installation in 2019, reporting back by spring 2019 with a final recommendation, detailed cost estimates, and budget options
4. To implement this framework, Regional Council as the Board of Health **DIRECT** staff to develop and report back in spring 2019 with detailed cost-estimates and budget options for:
    a. Suicide identification/intervention training
    b. Suicide risk assessment capacity-building
    c. Support for a Mental Health Hub/Clubhouse in St. Catharines
5. To implement this framework, Regional Council **DIRECT** staff to engage with the Ministry of Transportation on opportunities for provincial funding to support a possible infrastructure barrier as in recommendation #2
6. As part of this framework, Regional Council **DIRECT** staff to include consideration of barriers on any future major infrastructure projects, and to include details of their consideration in reports to Council for approval of such projects

Key Facts

- Deaths by suicides increase in the days and weeks after widespread discourse or coverage of the details of a death by suicide. This "contagion" is usually characterized by deaths from the same or similar means, and often in the same location. To prevent contagion, many specifics have been omitted from this report.

- Niagara-wide, there are approximately 44 deaths from suicide each year. Of these, an average of 3.8 deaths from suicide each year can be attributed to a fall from a height.
- Since October 2018, there have been three deaths by suicide from a single public infrastructure element in St. Catharines, as well as at least one death from an analogous infrastructure element elsewhere. The latter three deaths all occurred within days of significant public discourse of a prior death by the same means, and were likely due to contagion.
- Historically, the infrastructure implicated has not been associated with deaths from suicide, emphasizing that public discourse fueling contagion is likely responsible. It is unknown if this location may now become a “suicide magnet” longer term or not.
- Scientific research on suicide prevention in public places points to five areas of activities that should be taken in concert:
    - Restricting or deterring access to the means of suicide
    - Increasing opportunities for individuals to seek help
    - Increasing probability of human intervention
    - Redefining the public image of a place to no longer be attractive as a place to die by suicide
    - Improving integration and access of the mental health services
- Niagara Region staff and partners have escalated activity and plans in all five of these areas since October 2018 in order to reduce deaths by suicide Niagara-wide.
- Regarding the first area, barriers on infrastructure have relatively strong scientific evidence of preventing deaths by suicide from falls from a height, without a proportional increase in deaths elsewhere.
- The two infrastructure elements most strongly associated with deaths by suicide from a fall from a height are at locations other than where recent deaths have occurred, and where in discussion with the jurisdiction owner, barriers would not be feasible.
- Addition of a barrier to the infrastructure implicated recently in St. Catharines would cost upwards of $4 million and would take until late 2019 to be completed.

Financial Considerations

The proposed framework for suicide prevention on public infrastructure identifies several opportunities for enhanced work locally. The cost of such enhancements are included the table below.

Table 1. Framework to Prevent Suicides on Public Infrastructure and Possible Budget Implications

Area of Suicide Prevention	Activities	Local Enhancement	Estimated Capital Cost	Estimated Operating Cost
Restricting & Deterring Means	Barrier on public infrastructure	Barrier at location of recent suicides in St. Catharines	Approximately $4 million	
	Lighting	Review of lighting on infrastructure	$TBD	
Increasing Opportunities for Help Seeking	Signs & crisis phones	Signs		$TBD
	Staffed sanctuary	Implement HUB model or Clubhouse model in St. Catharines	$TBD	Contribution toward $700,000 cost
Increasing Probability of Intervention	Surveillance cameras	NRPS surveillance pilot	$TBD	
	Increased patrols	Increase in patrols		$TBD
	Suicide awareness & intervention training	ASIST & safeTALK training		$300,000 over 2 years (1.5 FTE)
Redefining the Public Image	Media Portrayal	Engagement with media Digital engagement campaign		$TBD
	Memorials	Relocation of memorials		$TBD
Mental Health System	Increasing suicide risk assessment	Public Health & CAMH-led capacity building		$67,500 over 2 years (0.5 FTE)
	Integration of mental health system	LHIN System Mapping		$500,000 implementation

Public Health could increase training for suicide awareness and intervention with 150 people who regularly interact with mental health clients as well as 500 members of the public. As well, Public Health has a plan to build capacity among health care providers for increased risk assessments. Together, this would require 2 FTEs of work over 2 years, production of supplies, reimbursement of the Niagara Distress Centre for services, and hosting a community forum at a total cost of $367,500.

Operating a mental health HUB or Clubhouse in St. Catharines would cost approximately $700,000. Niagara Region could support a portion of these operating

costs. Alternately, the Region could consider support through acquiring and donating a physical facility as a capital expenditure.

The LHIN is embarking on mapping the mental health system locally to identify gaps and opportunities for improvement. Niagara Region could contribute to implementation of improvements identified, particularly as they relate to current services. A possible future budget of $500,000 to implement these has been estimated. It is not recommended that any decisions be made to fund these until possible improvements have been identified.

None of the above estimates have been included in the 2019 operating or capital budgets, and/or previously approved budgets for Regional infrastructure. The Capital Variance Project provides funding for in-year capital project adjustments, and at this time $5.8 million in capital variance project funding is available to support priority projects, including the One District Police Facility, a number of transportation related projects and the low end estimate for the barrier on public infrastructure noted above.

Once the detailed cost estimates are determined, a report to Council with those estimates will be provided as well as recommended sources of funding. Council approval is a requirement of a Capital Variance Project draw greater than $1 million, and any further Capital Levy Reserve funding and/or an operating budget funding would required Council approval and a budget amendment.

Analysis

Contagion & Use of Language

Suicide “contagion” is the phenomenon where susceptible persons are influenced towards suicidal behaviour and certain suicide methods by learning of another’s suicide. This scientific finding has been validated many times: public discourse of a death, be it on social media, public fora, political debate, or traditional media can lead to an increase in deaths in the days and weeks after.[1] Additional suicides are most likely when there is/are

- greater volume or profile of discourse (e.g. front page coverage),
- descriptions that are specific and graphic (including the means of death and/or the location of death),
- descriptions of the victim in relatable terms,
- coverage of sympathy and concern towards the victim after the death, and
- ascribing simple or singular reasons for the death (e.g. was caused by bullying)

[1] Niederkrotenthaler T, Herberth A, Sonneck G. The "Werther-effect": legend or reality? *Neuropsychiatr*. 2007;21(4):284-90.

- language that implies action, control, or solution (e.g. “committed”, “successful” or “failed” attempt, “took their life”, prominent use of “suicide”)
- portrayal as achieving a result (e.g. relieving of pain/suffering; leading to peace or a “better place”; going to “heaven”; the act was quick, easy, and/or painless)

Research shows that when language and reporting avoids the above, contagion can be minimized (elimination of contagion requires there be no reporting).[2] As well, coverage that focuses on the opposite (e.g. other people who have overcome mental illness), it can lead to the opposite of contagion—a reduction in deaths by suicide in the days and weeks after.

In order to prevent this report, quotes taken therein, debate at Committee/Council, or subsequent coverage from contributing to contagion, language used in this report will sometimes be indirect and avoid specifics.

Statistics in Niagara

Statistics Canada’s Vital Statistics database is the established standard for examining causes of death. The most recent data release showed that in the 5 year period of 2008 to 2012, there were 222 deaths by suicide (average 44.4 deaths per year). Of these, on average,

- 18.2 deaths resulting from suspension from a cable,
- 9.8 deaths from a drug overdose,
- 3.8 deaths from a fall from a height,
- 3.2 deaths from chemical overdose,
- 3.0 deaths from firearms, and
- 1.8 deaths from sharp or blunt objects.

Examination of calls received by Emergency Medical Services data from 2016 to September of 2018 shows that call volumes related to suicide attempts and self-harm were stable from 2006 to 2015 (between 550 and 600 calls per year). There was an increase in calls thereafter with closer to 800 calls per year in 2016 to 2018. Part of this increase may be attributable to revised dispatch protocols during this time. It is unknown if more severe impacts from opioid use may be a contributor to this increase.

[2] Mark Sinyor, Ayal Schaffer, Yasunori Nishikawa, Donald A. Redelmeier, Thomas Niederkrotenthaler, Jitender Sareen, Anthony J. Levitt, Alex Kiss and Jane Pirkis. *CMAJ* July 30, 2018 190 (30) E900-E907; DOI: https://doi.org/10.1503/cmaj.170698

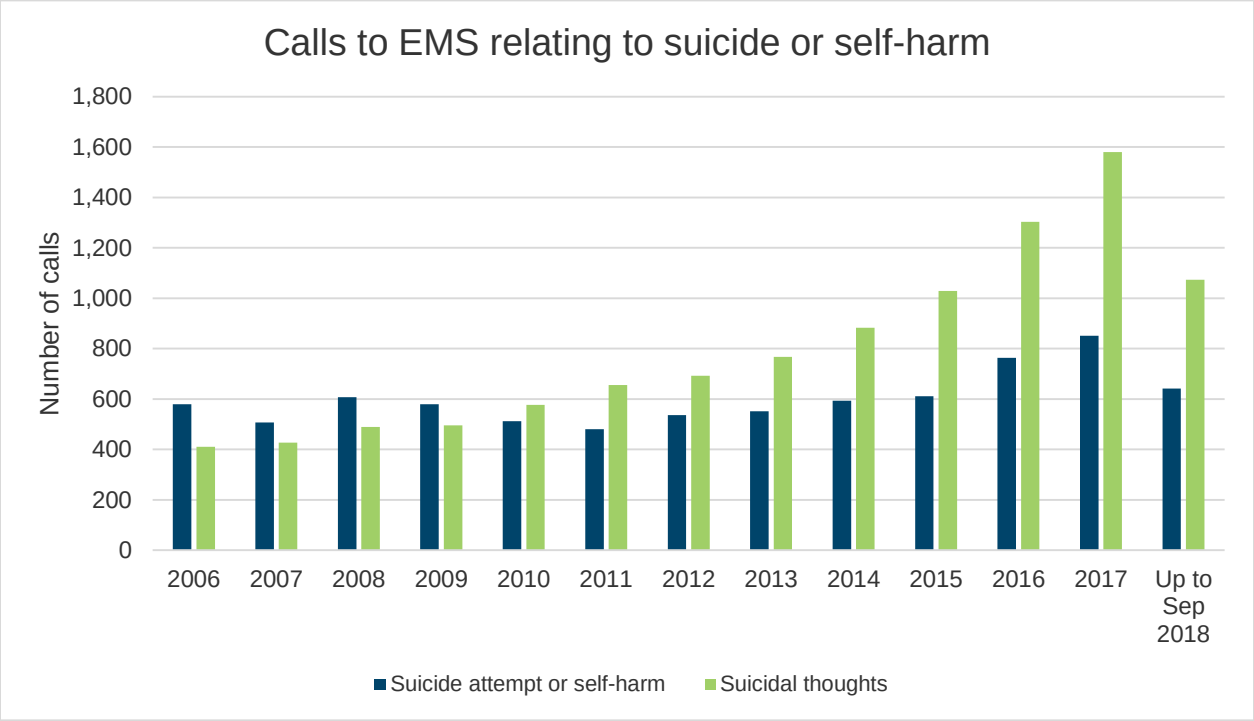

Figure 1 Calls to EMS relating to suicide or self-harm (2006 to September 2018)

Recent Events

In the three months since October 2018, there have been three deaths by suicide on an element of public infrastructure in St. Catharines, in addition to one reported attempt. As well, there has been at least 1 death at a similar infrastructure element elsewhere. Given the expected 3.8 deaths Niagara-wide per year from a fall from a height, 3 deaths in 3 months is unexpectedly high.

Under section 10 of the *Coroner's Act*, the Ontario Coroner's Office investigates every suspected death by suicide, and so has the most comprehensive and reliable data set. The coroner reported to us that they did not identify any deaths by suicide at this infrastructure between 2006 and 2017 (because the Coroner does not geocode investigations, their database query for deaths at this location was based on searching for place names, which is less accurate than geographical coordinates).

Data from Emergency Medical Services does not show any incident responses coded consistent with a death by or attempt of suicide at this infrastructure between 2010 and 2017 (EMS data is coded based on the 911 call, so if a response was not attributed to suicide or suicide attempt on the call, it would be missed by this database).

The lack of history of deaths by suicide at this location makes these recent deaths unusual. These deaths and the attempt all received significant discussion in the media, on-line, in political councils, and in public memorialization. This created significant risk of contagion. Indeed, all three of the later deaths occurred within 10 days of significant media coverage and public discourse of the earlier suicides, the highest risk period. The

reported attempt occurred within 18 days of such coverage. All of these are therefore likely attributable to a cycle of contagion, explaining the deviation from the historical norm.

In discussion with suicide experts, the three-month history is not enough to have confidence whether if this location will continue to have contagion-fuelled deaths by suicide, or if the cycle of contagion could end. However, there is certainly risk of the former.

Framework for Preventing Deaths by Suicide

Public Health England, the United Kingdom's scientific expert body on public health matters, published a guideline in November 2015 on preventing suicides in public places[3]. The guideline was based on a review of the scientific evidence, existing international guidelines, published and unpublished reports and policy documents, consultation with local governments worldwide, and interviews with survivors. The resulting guideline was pilot tested in local jurisdictions as well for revision prior to being published.

The guideline prioritizes action at the most frequently used places by individuals who die by suicide. A framework for prevention is outlined involving action in four areas of focus:

- Restricting and deterring individuals from the means of dying by suicide
- Increasing the opportunities for those in a public place who are contemplating dying by suicide to seek help
- Increasing the probability that persons can intervene with those intending to die by suicide in a public place
- Redefining the image of a public place where individuals die by suicide into one less attractive for this purpose

As suicide is complex, measures from multiple areas should be undertaken, ideally from all four, in order to be effective.

In addition, given the important role of the health care sector in diagnosing and treating mental illness before it progresses to suicidality, a fifth area of focus relating to this sector has been added to the framework

Below, the five areas are applied to publicly-accessible infrastructure in Niagara where deaths may occur from a fall from a height.

[3] Dr Christabel Owens, Rebecca Hardwick, Nigel Charles and Dr Graham Watkinson at the University of Exeter Medical School. *Preventing suicides in public places: A practice resource*. 2015.

Restricting/Deterring the Means

Restricting/deterring the means has been identified as one of the most scientifically-supported measures for suicide prevention[4]. When dealing with deaths on public infrastructure that occur from a fall from a height, the major means restriction is a barrier or netting. Additional deterrents would include lighting.

Research consistently shows that barriers (henceforth assumed to include netting) are effective at preventing deaths by suicide from falls on infrastructure, and that the majority of these deaths do not simply redistribute to other locations, but are completely prevented.[5][6]

The Ontario Coroner's Office was asked to identify the locations where deaths from suicide from a fall from a height are most common, and therefore where a barrier would be most impactful. The Coroner identified two locations (NF-1 and NF-2/NF-3 in Table 2). In addition, data was requested for the location of recent interest (StC-1). EMS responses for suicide and suicide attempts consistent with a fall from a height were also collected.

To supplement this, EMS data on responses to suicidal ideation by threatening to fall from a height was also reviewed. Data was limited to infrastructure widely used by the public (e.g. private residences, industrial buildings were excluded). Suicidal ideation rarely proceeds to death. Often it spurs individuals to treatment; other times it can be help-seeking for someone struggling to navigate the health care system. Nonetheless, suicidal ideation may highlight locations that are generally attractive for a suicide attempt.

A total of 44 locations had a suicide death, suicide attempt, or suicidal ideation associated with falling from a height from public infrastructure (Table 2).

As previously noted, location StC-1 has rarely seen deaths by suicide prior to 2018. Reviewing the EMS responses to suicidal ideation, however, StC-1 does seem to be the location with the most suicidal ideation, followed by NF-1 and NF-2.

It should be noted that after averaging less than 2 incidents per year at StC-1, in 2018 there have been 7 incidents up to December 14. This is likely due to contagion again.

With the history of the most deaths by suicides historically, NF-1 and NF-2/NF-3 are the best candidates for a barrier. Staff have informally engaged the jurisdiction owners for that infrastructure, however, barriers in those locations are deemed by them not to be feasible.

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[4] Jane Pirkis, Matthew J Spittal, Georgina Cox, Jo Robinson, Yee Tak Derek Cheung, and David Studdert. The effectiveness of structural interventions at suicide hotspots: a meta-analysis. *International Journal of Epidemiology 2013;42:541–548. doi:10.1093/ije/dyt021*

[5] Pirkis *et al*. 2013.

[6] Sinyor M, Schaffer A, Redelmeier DA, et al. Did the suicide barrier work after all? Revisiting the Bloor Viaduct natural experiment and its impact on suicide rates in Toronto. *BMJ Open* 2017;7:e015299. doi:10.1136/bmjopen-2016-015299

StC-1 has the most frequent suicidal ideation implying some greater potential for deaths from suicide to occur here, though only a 3 month history of frequent deaths.

The Region retained the original designer of the structure in St. Catharines to develop a barrier design that would be structurally and esthetically compatible. This work is ongoing. The order of magnitude cost estimate for a barrier along all exposed edges of the structure is $4 million based on conceptual design and market intelligence. The design work continues, along with the refinement of the cost estimate and will be subject to a subsequent report to Council.

Given that, after consulting with suicide experts, there is uncertainty whether deaths from suicide due to ongoing contagion can be expected to continue at this location. There is therefore also uncertainty whether a barrier would be the best mental health intervention and the best use of taxpayer dollars, since there is a possibility that contagion will dissipate and deaths will stop occurring as was the case prior to 2018. However, if a barrier is not built but contagion does not dissipate, preventable deaths will continue.

To balance these imperatives, and given that a barrier cannot be erected until late 2019 at the earliest, it is recommended that planning for a barrier to be erected in late 2019 continue as a contingency. In the next several months, other suicide prevention efforts will continue. Based on the pattern of any further deaths over those months, a final recommendation on whether to build a barrier will be brought to Council in spring 2019.

The other means deterrent to suicide, lighting, does not appear to be a concern at StC-1 or NF-1 and NF-2/NF-3. Review of lighting in other locations can be pursued as part of the larger framework.

Table 2. Suicide deaths, attempts, and ideation associated with falls from a height from public infrastructure

	Deaths & Attempts (2010-2017)		**Deaths & Attempts (2018)**		**Suicidal Ideation (EMS Responses)**	
Infrastructure Element	Coroner (To Nov. 20)	EMS Calls	Coroner (To Nov. 20)	EMS Calls	2006–2017	2018 (To Dec.14)
NF-1	11	1	1		16	2
NF-2	10		0		7	
NF-3		1			2	
NF-4					3	1
NF-5				1	3	
NF-6		1			2	
NF-7					2	
NF-8					3	
NF-9						2
NF-10					1	
NF-11					1	
StC-1	**0**		**3***	**1**	**22**	**7**
StC-2					1	
StC-3		1			4	
StC-4				1		1
StC-5					1	1
StC-6		1				1
StC-7					1	
StC-8		1			2	
StC-9		1				
StC-10					1	
StC-11		1			3	1
StC-12		1			2	4
StC-13		1			5	1
StC-14		1			1	
StC-15					2	
StC-16		1				
StC-17					1	
StC-18						1
Thorold-1					1	
Thorold-2		1				
Thorold-3						1
Thorold-4					1	
Thorold-5					1	3
Welland-1					4	1
Welland-2					2	
Welland-3					1	
Welland-4					1	
Welland-5					1	
Grimsby-1					1	
Grimsby-2					1	
Fort Erie-1					2	
NOTL-1					1	
PC-1						1

Increasing Opportunity for Help Seeking

Encouragement to seek help, even subtle ones, are often enough to help suicidal persons break from their plan. Research has shown this to be effective, though less so than means restrictions.[7]

Installing signs of where to seek help is one significant measure. In response to the deaths by suicide in October, signs were immediately put up in the area with the number to call the Niagara Distress Centre.

Crisis phones and automated messages are additional measures that have been effective in other jurisdictions.

One other opportunity for help seeking exists when there is a staffed "sanctuary" nearby to which individuals experiencing a crisis can attend. In downtown Welland, the Oak Centre has been developed according to the internationally-recognized Clubhouse Model. This model is predicated on those with mental illness helping each other, and then supplementing that with professional services to help clients build mental health and social integration skills. The International Centre for Clubhouse Development has found that admission to hospital, and hospital stays for clients are significantly reduced if someone is a Clubhouse member. Given the success of the model in Welland, there is interest by many in St. Catharines to develop a Clubhouse in this city as well. The Oak Centre is largely funded through the local LHIN and has a total budget of around $700,000.

Another model that is being discussed locally are regional mental health HUBs. HUBs of this nature accept individuals in crisis, who would normally be taken to an emergency department. Instead, in a HUB, with no competing patients needing to see a caregiver, people with acute mental health or addictions issues can get immediate help, in a setting tailored with services they need, while simultaneously relieving pressure on overcrowded emergency departments. HUBs also engage with the community and other groups to raise awareness, build the community's skills to foster social inclusion and mental wellness, and facilitate community-led responses to mental health issues.

The Suicide Prevention Coalition has recommended a HUB for St. Catharines as a top priority.

Increasing Probability of Persons to Intervene

Human interaction is very effective at deterring a person from dying by suicide. Where a location is having frequent deaths by suicide, human interaction can be increased by having additional patrols by emergency workers, as well as surveillance (e.g. by cameras) to trigger an intervention. The Niagara Regional Police Service (NRPS) has a raised level of awareness by front line patrol officers with respect to persons in crisis or experiencing suicidal thoughts, and has increased patrols in affected areas. The NRPS is piloting the use of closed circuit television (CCTV) to enhance its ability to respond to

[7] Jane Pirkis, Lay San Too, Matthew J Spittal, Karolina Krysinska, Jo Robinson, Yee Tak Derek Cheung. Interventions to reduce suicides at suicide hotspots: a systematic review and meta-analysis. *Lancet Psychiatry* 2015; 2: 994–1001

calls for service, including suicidal persons and persons in crisis in parts of St. Catharines where there have been recent deaths.

Research shows that there is no significant difference to interaction by a member of the public versus an emergency worker. However, given their greater numbers, it is usually more likely someone contemplating suicide will interact with a member of the public, rather than an emergency worker. However, people often lack the confidence to intervene, or the skill to recognize suicidal behaviour. Applied Suicide Intervention Skills Training (ASIST) is an internationally-recognized program for helping people gain the skills to recognize someone at risk of suicide, and to know how to intervene to support a suicidal person. A condensed version of this training is known as safeTALK.

Currently Public Health has staff who provide safeTALK in certain settings. As well, through the Niagara Distress Centre, Public Health has access to ASIST trainers. Public Health proposes to increase ASIST (targeting 150 of those working with mental health clients) and safeTALK training (targeting 500 members of the general public).

The Suicide Prevention Coalition currently ranks suicide identification/intervention training as one of its two key areas of focus.

Redefining the Public Image

The most important measure to decrease deaths by suicide in a public place is to end discourse that associates that location with suicide. This sentiment is reflected in how this report is written. Recognizing the disproportionate role the media play in spreading information, a half-day session was held with all local media outlets on November 16, 2018 to discuss the current public discourse and ways to shift it to better align with the Canadian Psychiatry Association's 2017 "Media Guidelines for Suicide Reporting". Public Health Communications along with Strategic Communications and the media are continuing to work on measures resulting from that meeting. The Suicide Prevention Coalition currently ranks shaping media report as its second key area of focus.

Mental health experts highlight that memorials and floral tributes after a death can associate a location's public image with suicide. This can lead to others dying by suicide in the same location. Experts recommended that memorials be removed "as quickly and sensitively as possible to prevent them building up, within two to three days at the most".[8]

In recognition of this, the memorials at the location where several recent deaths by suicide have occurred were removed in early December 2018 to reduce the risk of additional deaths by suicide. This, unfortunately, occurred much later than the "two or three days" recommended by experts. Attempts were made to remove the memorial at earlier dates. However, given public outpouring and attention prior attempts were aborted when it became clear their removal would generate controversy and more discussion of the location in association with suicide, exactly what would cause additional contagion. Going forward, staff hope to be able to adhere to the 2–3 day

[8] PHE

expert recommendation if there are any additional unfortunate deaths. As well, a permanent memorial site is being made available by Public Health at the Glenridge Naturalization Area where another memorial already exists for mental health clients who have died by suicide.

One other means of redefining the public image of a location associated with suicide is to redecorate or landscape in order to change the location's feel to be more hopeful, and to less visible sections where one may die by suicide in relative privacy. Staff plan to be mindful of opportunities to undertake such changes, though it is not anticipated that this will be a significant activity.

Improving Supports in the Mental Health System

As the mental health sector has the greatest contact with those at risk of suicide, particularly those with the greatest risk and most severe illness, deaths from suicide may be preventable through better support for these patients.

Niagara Region Mental Health has developed a Suicide Risk Assessment Strategy to strengthen health service providers' abilities to identify those at risk of suicide so that they can receive needed care earlier in their course of illness. This strategy will be delivered over the next several years, though it could be accelerated with additional investment.

The LHIN is also considering engaging a consultant to map the mental health system to address difficulties in navigating the system, to identify gaps in service, and to enable its many parts to work as a more cohesive whole. As Niagara Region serves mental health clients, there may be opportunities to implement recommendations from this exercise here. However, given that our mental health program is generally not supported through municipal levy funding, it would be a variation from past practice to do so. Until concrete proposals for change are available, staff do not recommend investing in this.

Alternatives Reviewed

As suicide affects all of Niagara and many means beyond falls from a height, the report has examined suicide holistically and Niagara-wide, rather than focused only on the location of recent interest.

Staff recommend a comprehensive approach to suicide prevention, rather than focusing on a single measure, as multi-factorial action has been shown in research to be most effective.

Recommending a barrier on the recent location of interest could have been proposed, but this was deemed to be premature given the lack of certainty that contagion will continue. However, recommending against a barrier would be imprudent given the risk that deaths by suicide might continue. The recommendation to continue working towards a barrier but deferring a final decision preserves the same opportunity to prevent suicide deaths, while also being fiscally prudent.

Relationship to Council Strategic Priorities

This report does not relate specifically to any of Council's strategic priorities. Nonetheless, it addresses a matter of current public interest.

Other Pertinent Reports

N/A

_____

Prepared & Recommended by:
M. Mustafa Hirji, MD MPH FRCPC
Medical Officer of Health & Commissioners (Acting)
Public Health & Emergency Services

_____

Submitted by:
Ron Tripp, P.Eng
Acting Chief Administrative Officer

This report was prepared in consultation with Dr. Mark Sinyor, Assistant Professor of Psychiatry (University of Toronto) and Associate Scientist (Sunnybrook Research Institute); Stacy Terry, Chair (Niagara Suicide Prevention Coalition) and Director (Niagara Distress Centre); Dr. Karen C. Schiff, Regional Supervising Coroner; Ron Tripp, Acting CAO and Commissioner (Public Works); Rachel Skellet, Epidemiologist (Organizational & Foundational Standards); Renata Faber, Manager (Chronic Disease & Injury Prevention); Michael Franklin, Commander (Quality Management & Performance Standards, Emergency Medical Services), Heather Rilkoff, Health Research Specialist (Healthy Public Policy, Toronto Public Health), Sarah Sanford (Toronto Public Health), Jan Fordham (Healthy Public Policy, Toronto Public Health) and reviewed by Brett Flynn, Deputy Chief (Niagara Regional Police Service); Shelley Chenitz, CAO (City of St. Catharines); Linda Boich, Vice-President (Niagara Health); Karen Lutz, Commander (Quality Management & Performance Standards, Emergency Medical Services); Adrienne Jugley, Commissioner (Community Services); Sean O'Brady, Acting Director (Strategic Communications & Government Relations); Meredith Maxwell, Manager (Public Health Communications & Engagement).

Appendices

Preventing Deaths by Suicide on Public Infrastructure

Public Health & Social Services Committee

January 8, 2018

M. Mustafa Hirji
Medical Officer of Health & Commissioner (Acting)

Outline

- Contagion
- Statistics on Suicide in Niagara
- Recent Events in Context
- Framework for Suicide Prevention
- Summary of Recommendations

THE INFLUENCE OF SUGGESTION ON SUICIDE: SUBSTANTIVE AND THEORETICAL IMPLICATIONS OF THE WERTHER EFFECT*

DAVID P. PHILLIPS

State University of New York at Stony Brook

American Sociological Review 1974, Vol. 39 (June): 340-54

This paper shows that suicides increase immediately after a suicide story has been publicized in the newspapers in Britain and in the United States, 1947-1968. The more publicity devoted to a suicide story, the larger the rise in suicides thereafter. The rise in suicides after a story is restricted mainly to the area in which the story was publicized. Alternative explanations of these findings are examined; the evidence indicates that the rise in suicides is due to the influence of suggestion on suicide, an influence not previously demonstrated on the national level of suicides. The substantive, theoretical, and methodological implications of these findings are examined.

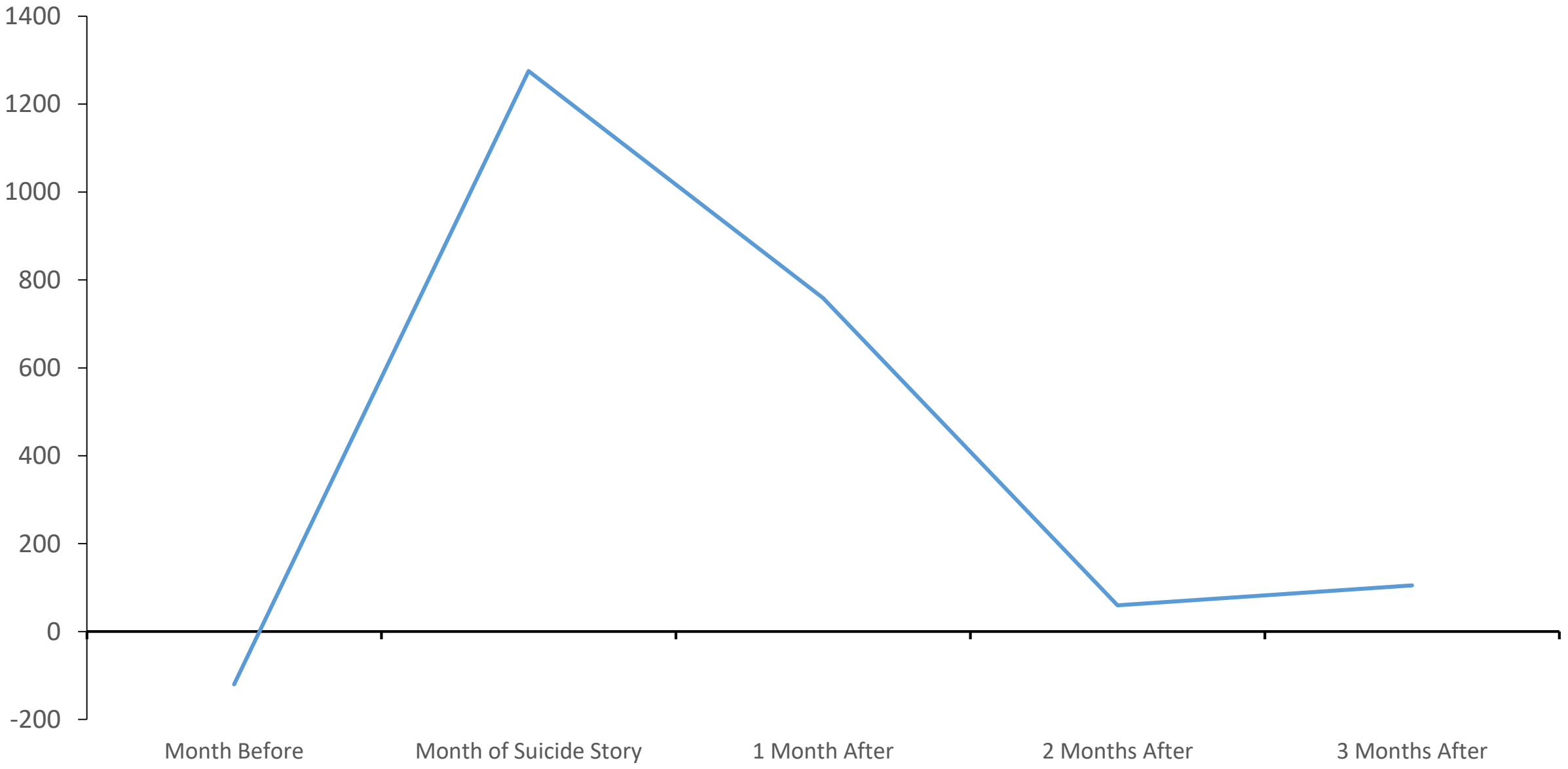
Two hundred years ago, Goethe wrote a novel called *The Sorrows of the Young Werther*, in which the hero committed suicide. Goethe's novel was read widely in Europe, and it was said that people in many countries imitated Werther's manner of death. According to Goethe, "My friends. . .thought that they must transform poetry into reality, imitate a novel like this in real life and, in any case, shoot themselves; and what occurred at first among a few took place later among the general public. . . ." (Goethe, quoted in Rose, 1929:XXIV.) Widespread imitation of Werther's suicide was never conclusively demonstrated, but authorities were sufficiently apprehensive to ban the book in several areas, including Italy (Gray, 1967), Leipzig, and Copenhagen (Rose, 1929).

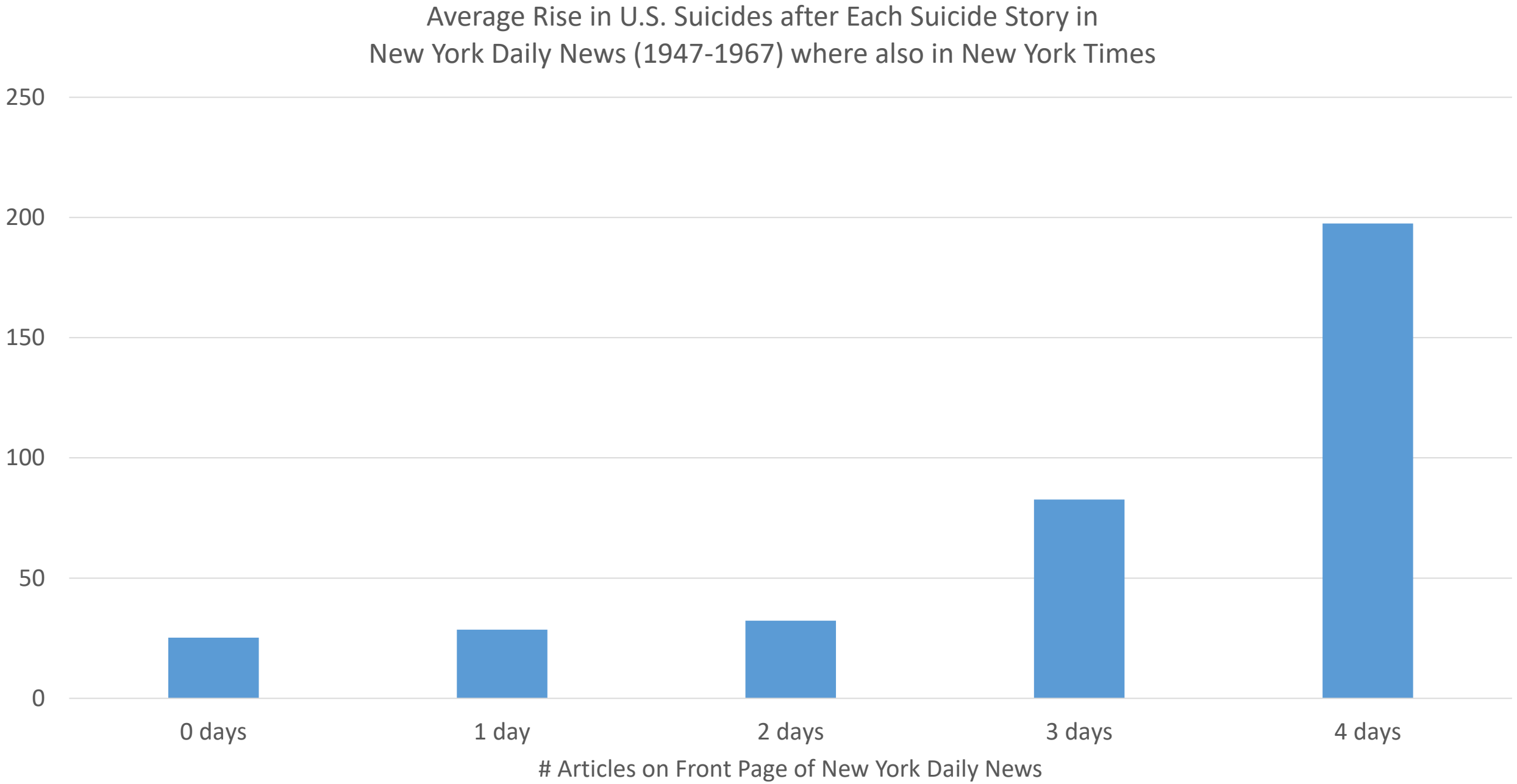
More than one hundred years after *Werther* was written, Durkheim (1897) reviewed

suggestion but he felt that these would probably have occurred eventually even in the absence of suggestion. Students of suicide have tended to follow Durkheim rather than Goethe or Tarde; and in the eighty years since *Suicide* was published, the influence of suggestion on suicide has seldom been studied. The comprehensive *Bibliography on Suicide and Suicide Prevention, 1897-1970* (Farberow, 1972) which includes several thousand items, does not list the words "suggestion," "imitation," or "contagion" in its index.

In his book reviewing the literature on suicide, Lester (1972) found seven studies on suggestion or imitation, and he devoted a chapter to describing them. Lester noted that the results of some studies were inconclusive (Motto, 1967), contradictory (Crawford and Willis, 1966; Seiden, 1968) or could be

Additional Suicides per Month for 35 Front Page Articles in the New York Times (1947-1967)




Average Rise in U.S. Suicides after Each Suicide Story in
New York Daily News (1947-1967) where also in New York Times
250
200
150
100
50
0
0 days
1 day
2 days
3 days
4 days
Articles on Front Page of New York Daily News

International Journal of Epidemiology, 2014, 623–629
doi: 10.1093/ije/dyu056
Advance Access Publication Date: 16 March 2014
Original article

Original article

The effects of media reports of suicides by well-known figures between 1989 and 2010 in Japan

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Accepted 17 February 2014

Abstract

Background: Many studies have shown that media reporting of suicide incidents can trigger suicidal behaviours in viewers and readers. Yet little is known about the exact timing and duration of the imitative effects.

Methods: We estimated the Poisson regression model using original data on 109 celebrity suicides and daily suicide counts ($n = 8035$) in Japan from 1989 through 2010. Various fixed effects were included in the model to control for the effects of seasonal variations and time-specific shocks.

Results: The media reports on celebrity suicides were associated with an immediate in-

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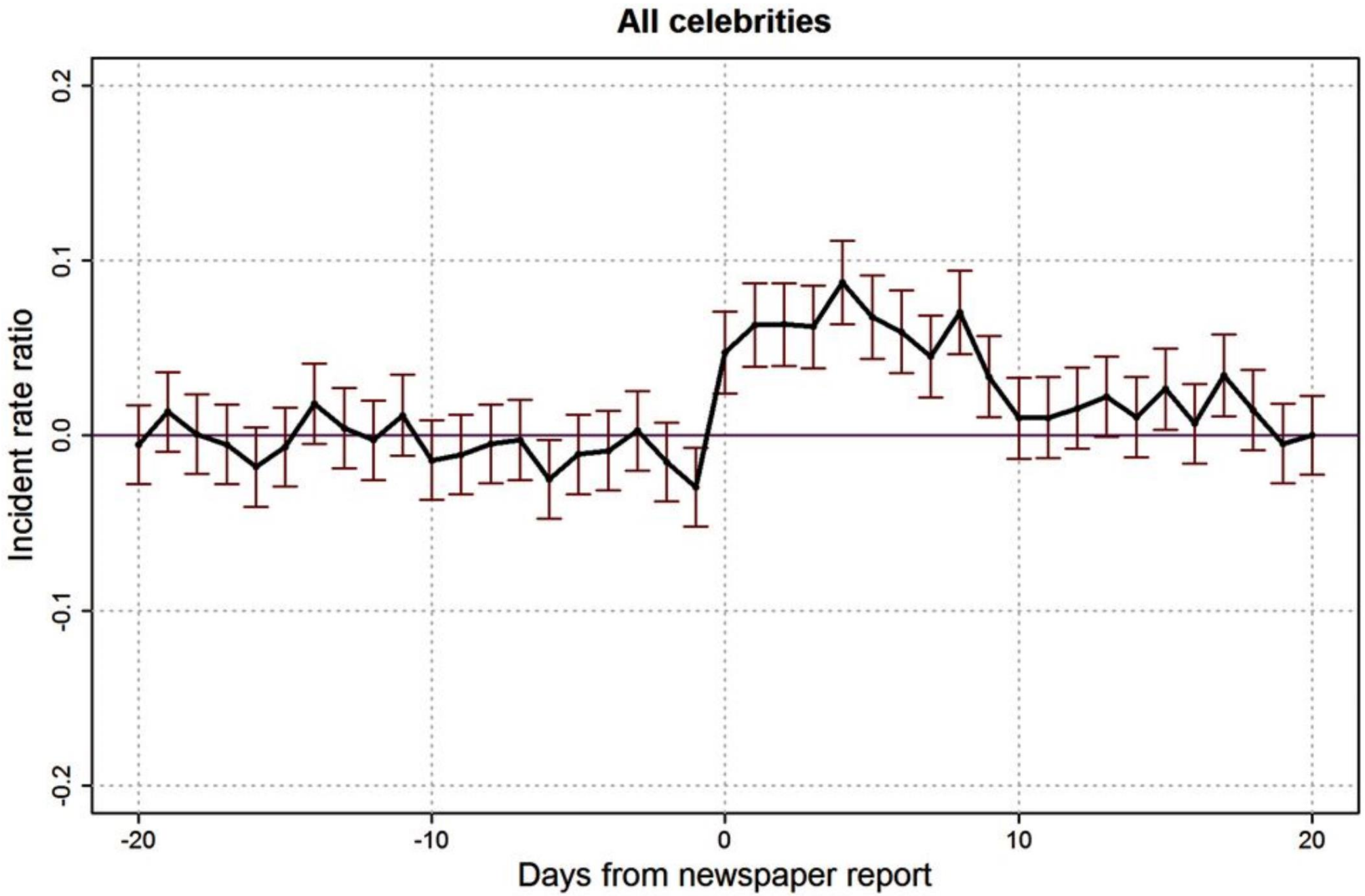
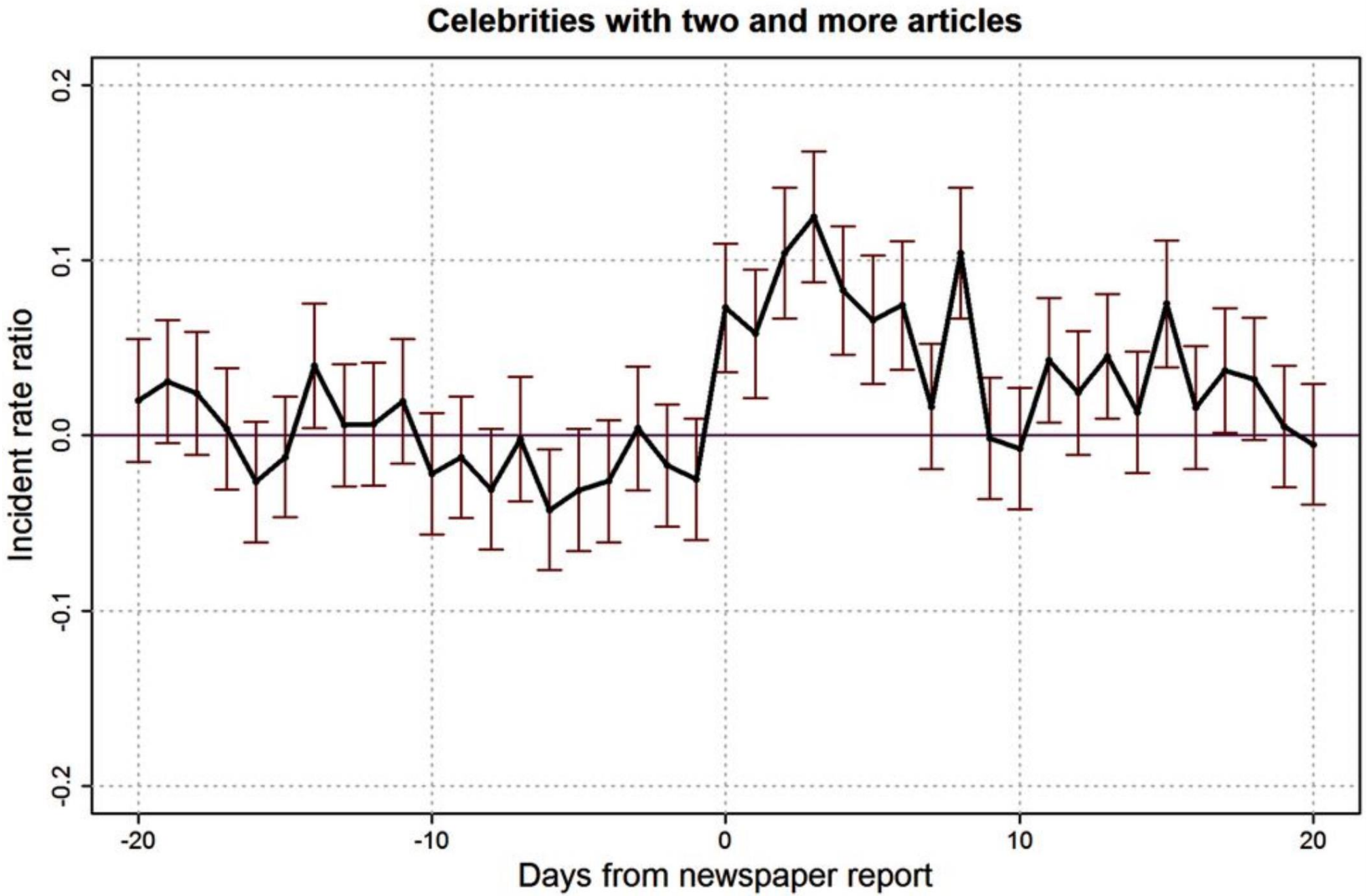
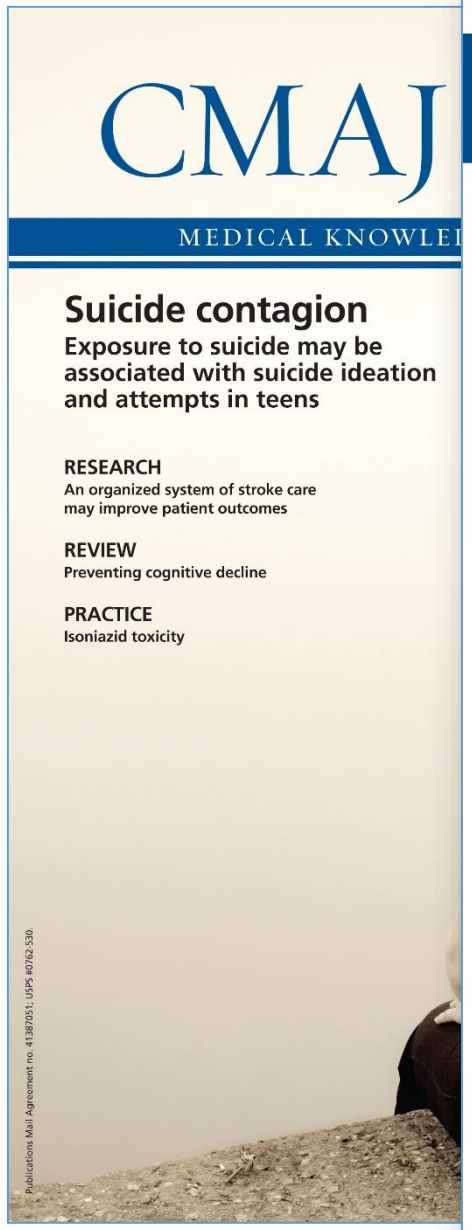
Niagara Region


All celebrities
Incident rate ratio
0.2
0.1
0.0
-0.1
-0.2
-20
-10
0
10
20
Days from newspaper report


Celebrities with two and more articles
Incident rate ratio
0.2
0.1
0.0
-0.1
-0.2
-20
-10
0
10
20
Days from newspaper report



Association between exposure to suicide and suicidality outcomes in youth

Sonja A. Swanson ScM, Ian Colman PhD

See related commentary by Bohanna on page 861 and at www.cmaj.ca/lookup/doi/10.1503/cmaj.130678

Competing interests: None declared.

This article has been peer reviewed.

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CMAJ 2013. DOI:10.1503/cmaj.121377

Abstract

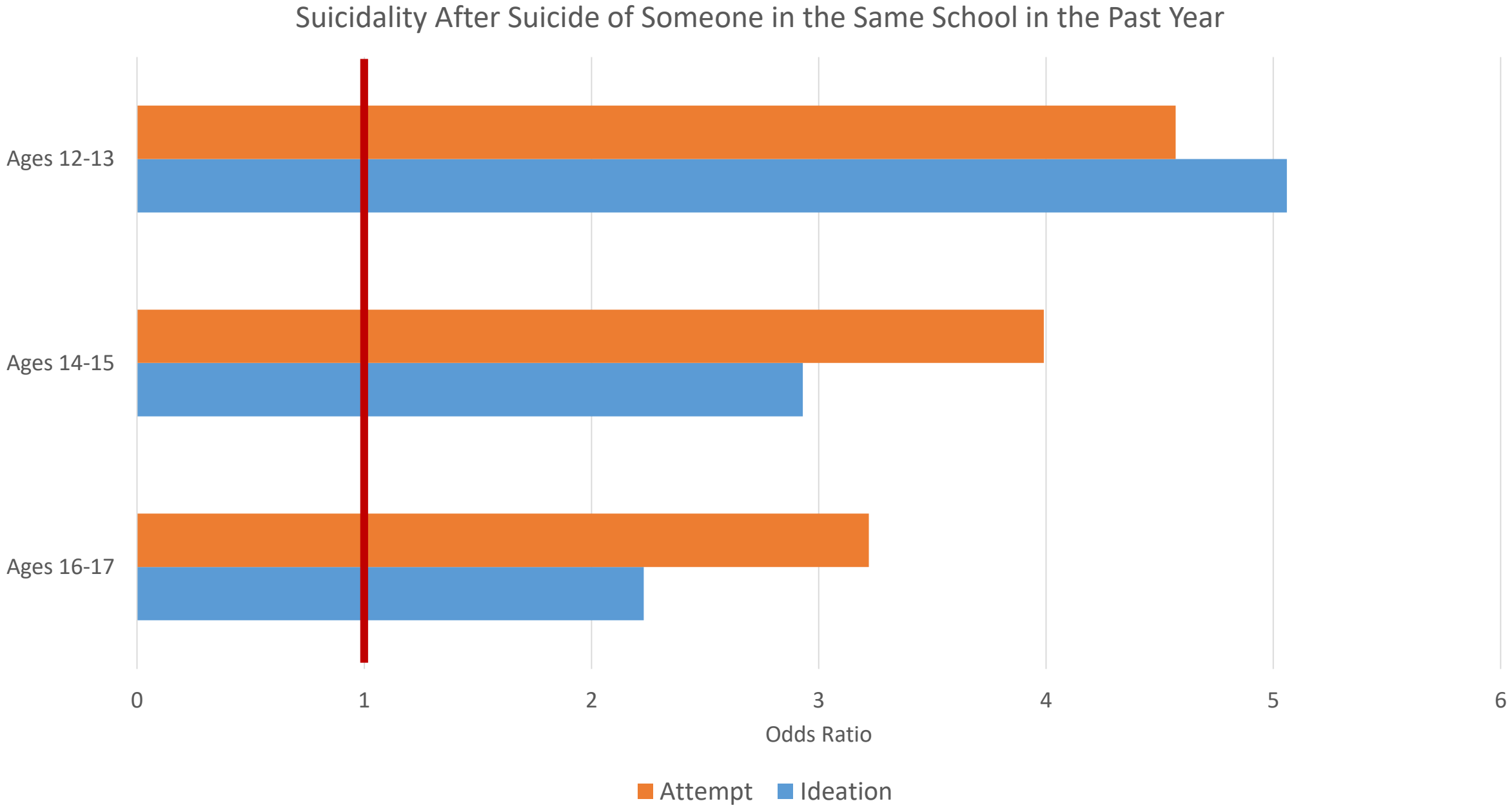
Background: Ecological studies support the hypothesis that suicide may be "contagious" (i.e., exposure to suicide may increase the risk of suicide and related outcomes). However, this association has not been adequately assessed in prospective studies. We sought to determine the association between exposure to suicide and suicidality outcomes in Canadian youth.

Methods: We used baseline information from the Canadian National Longitudinal Survey of Children and Youth between 1998/99 and 2006/07 with follow-up assessments 2 years later. We included all respondents aged 12–17 years in cycles 3–7 with reported measures of exposure to suicide.

Results: We included 8766 youth aged 12–13 years, 7802 aged 14–15 years and 5496 aged 16–17 years. Exposure to a schoolmate's sui-

4.24) and 16–17 years (OR 2.23, 95% CI 1.43–3.48). Such exposure was associated with attempts among respondents aged 12–13 years (OR 4.57, 95% CI 2.39–8.71), 14–15 years (OR 3.99, 95% CI 2.46–6.45) and 16–17 years (OR 3.22, 95% CI 1.62–6.41). Personally knowing someone who died by suicide was associated with suicidality outcomes for all age groups. We also assessed 2-year outcomes among respondents aged 12–15 years: a schoolmate's suicide predicted suicide attempts among participants aged 12–13 years (OR 3.07, 95% CI 1.05–8.96) and 14–15 years (OR 2.72, 95% CI 1.47–5.04). Among those who reported a schoolmate's suicide, personally knowing the decedent did not alter the risk of suicidality.

Interpretation: We found that exposure to sui-


Suicidality After Suicide of Someone in the Same School in the Past Year
Ages 12-13
Ages 14-15
Ages 16-17
0
1
2
3
4
5
6
Odds Ratio
Attempt
Ideation

RESEARCH MENTAL HEALTH

The association between suicide deaths and putatively harmful and protective factors in media reports

Mark Sinyor MSc MD, Ayal Schaffer MD, Yasunori Nishikawa, Donald A. Redelmeier MD, Thomas Niederkrotenthaler MD PhD, Jitender Sareen MD, Anthony J. Levitt MD, Alex Kiss PhD, Jane Pirkis PhD

Cite as: *CMAJ* 2018 July 30;190:E900-7. doi: 10.1503/cmaj.170698

See related article at www.cmaj.ca/lookup/doi/10.1503/cmaj.180900

ABSTRACT

BACKGROUND: Exposure to media reporting on suicide can lead to suicide contagion and, in some circumstances, may also lead to help-seeking behaviour. There is limited evidence for which specific characteristics of media reports mediate these phenomena.

METHODS: This observational study examined associations between putatively harmful and protective elements of media reports about suicide in 13 major publications in the Toronto media market deaths in the 7 days after publication, compared with a control window.

RESULTS: From 2011 to 2014, there were 6367 articles with suicide as the major focus and 947 suicide deaths. Elements most strongly and independently associated with increased suicides were a statement about the inevitability of suicide (odds ratio [OR] 1.97, confidence interval [CI] 1.07–3.65), about asphyxia by a method other than car exhaust (OR 1.72, CI 1.36–2.18), about suicide by independently associated with decreased suicides were unfavourable characteristics (negative judgments about the deceased; OR 1.85, CI 1.20–2.84), or mentions of railway (OR 1.61, CI 1.10–2.36) and cutting or stabbing (OR 1.59, CI 1.19–2.13) deaths, and individual murder-suicide (OR 1.50, CI 1.23–1.84).

INTERPRETATION: This large study identified significant associations between several specific elements of media reports and suicide deaths. It suggests that

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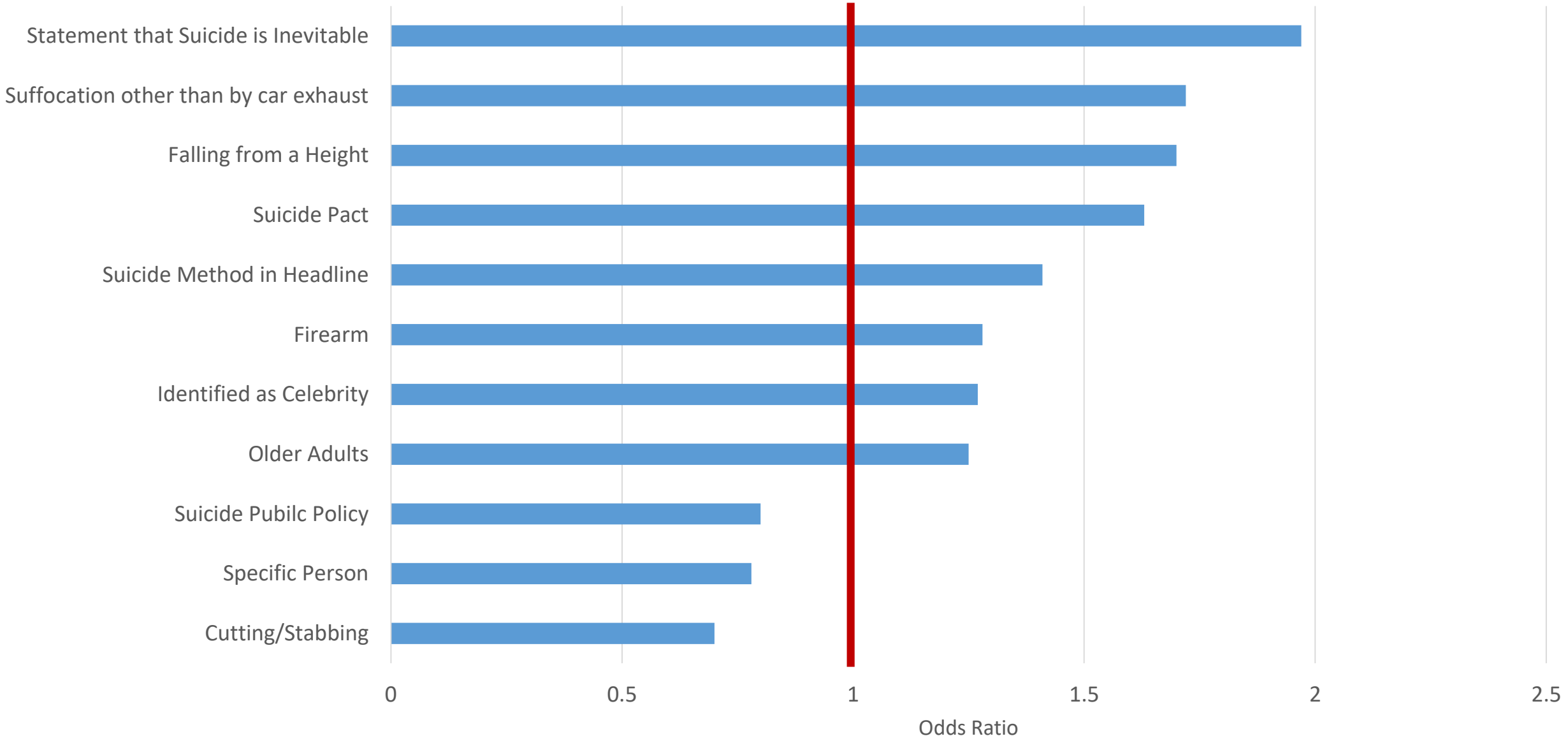

Association of Characteristics of Media Articles on Suicide Death
Statement that Suicide is Inevitable
Suffocation other than by car exhaust
Falling from a Height
Suicide Pact
Suicide Method in Headline
Firearm
Identified as Celebrity
Older Adults
Suicide Pubilc Policy
Specific Person
Cutting/Stabbing
0
0.5
1
1.5
2
2.5
Odds Ratio

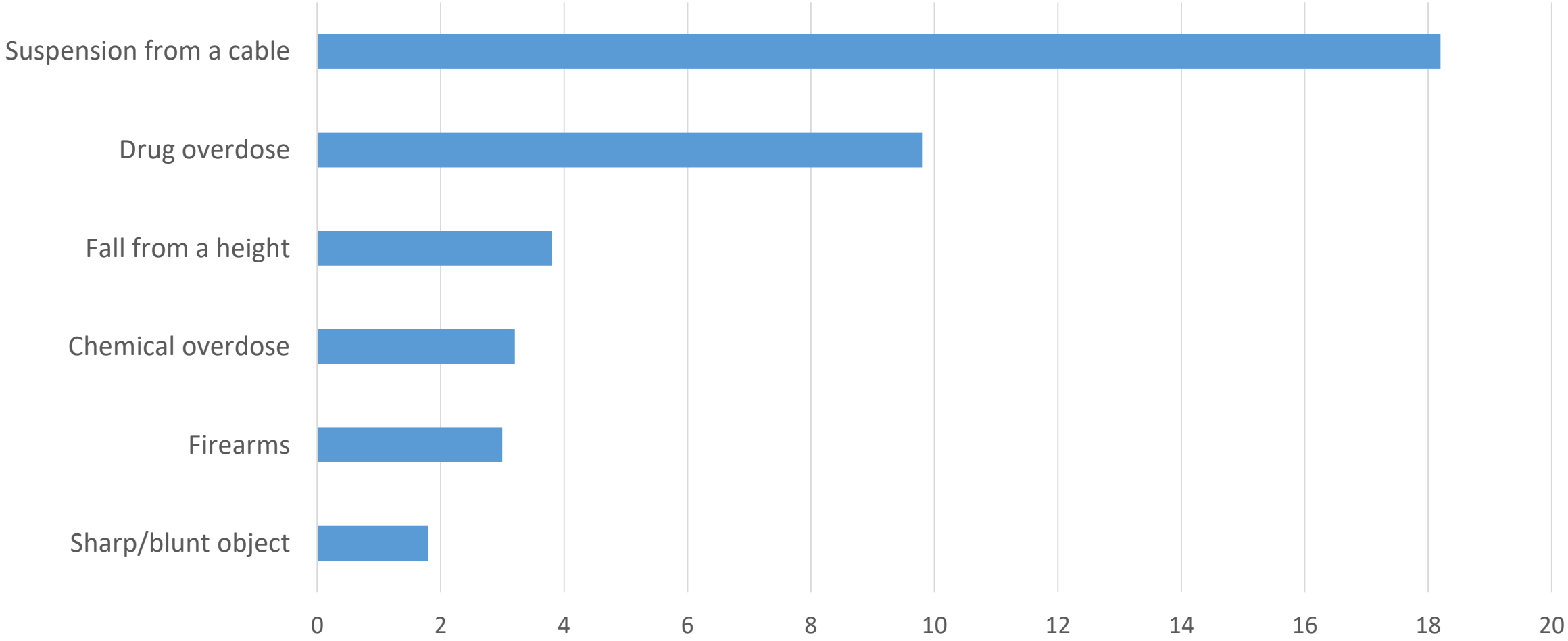
Increases Suicide

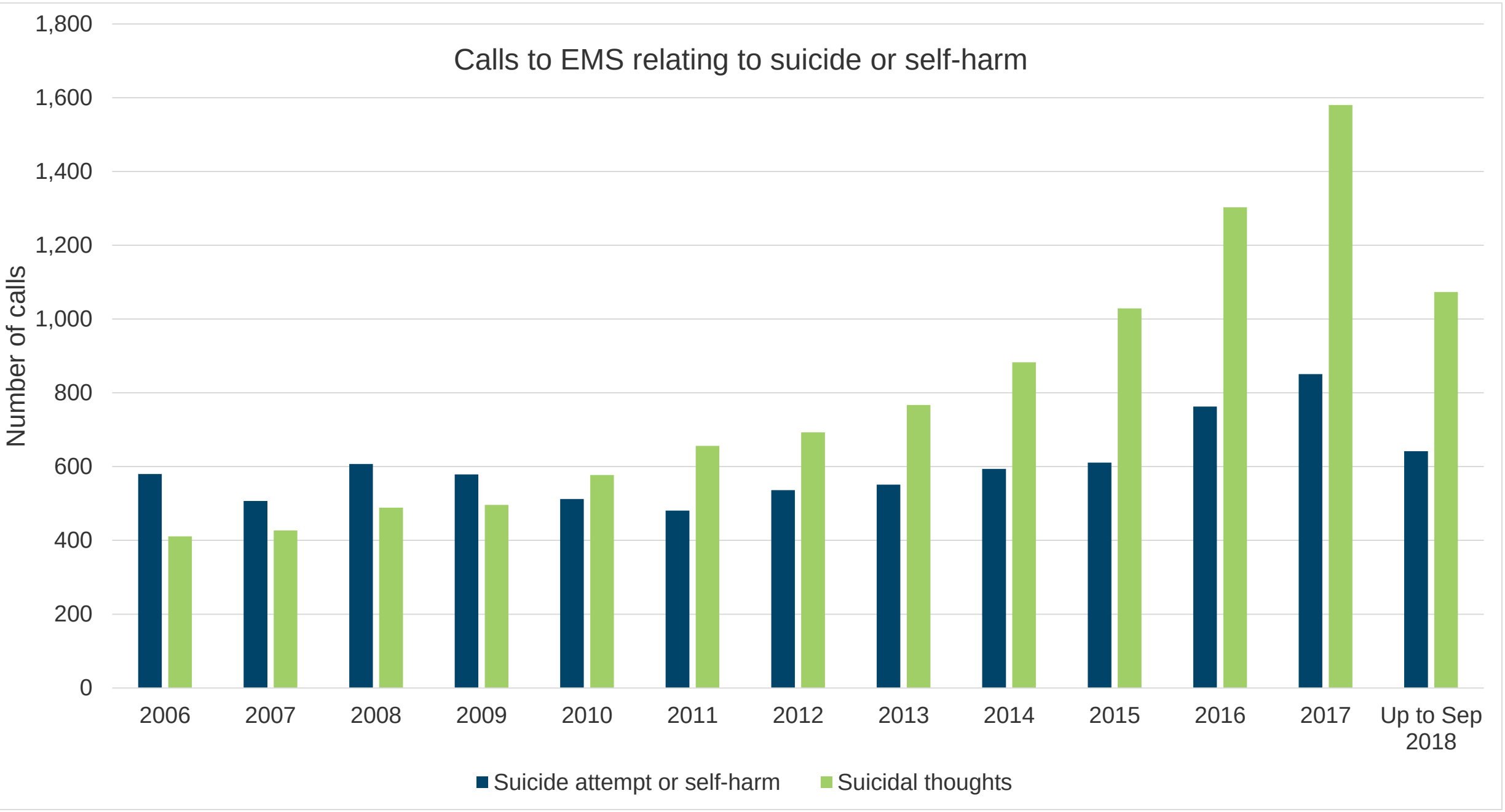
- greater volume or profile (e.g. front page)
- specific and graphic
  - including the means and/or location
- descriptions of the victim in relatable terms
- coverage of sympathy and concern towards the victim
- ascribing simple or singular reasons
  - e.g. bullying
- language that implies action, control, or solution
  - e.g. “committed”, “successful” or “failed” attempt, “took their life”, prominent use of “suicide”
- portrayal as achieving a result
  - e.g. relieving of pain/suffering; leading to peace or a “better place”; going to “heaven”; the act was quick, easy, and/or painless

Reduces Suicide

- Appropriate language
  - e.g. “died by suicide”, “suicide death”
- Reducing stigma, challenging myths
  - Linking mental disorders to suicide
  - Mental disorders are treatable
  - Death loses opportunity for someone to have received help
- Discussion of alternatives
  - Treatment
  - Community resources, hotlines
  - Reaching out to social supports
- Positive outcomes of treatment
- Information for friends/relatives to help

Average 44.4 Suicide Deaths per Year




Calls to EMS relating to suicide or self-harm
Number of calls
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
Up to Sep 2018
Suicide attempt or self-harm
Suicidal thoughts

October to December 2018

Infrastructure 1	3 deaths by suicide	Within 10 days of media coverage
	1 attempt to die by suicide	Within 18 days of media coverage
Infrastructure 2	1 death by suicide	Within 10 days of media coverage

Ontario Coroner

- Investigates every suspected death by suicide
  - Determine cause as definitively as possible
  - Make recommendations to prevent repetition

Deaths by Suicide at This Infrastructure (2010 to November 20, 2018)

2010	2011	2012	2013	2014	2015	2016	2017	2018
0	0	0	0	0	0	0	0*	3*

* preliminary figures

Recommendation

- Regional Council as the Board of Health **RESOLVES** that current public discourse around suicide has caused contagion and **REQUESTS** local media and others with a public audience to adhere to the Canadian Psychiatry Association's 2017 "Media Guidelines for Suicide Reporting" to prevent further contagion of suicide

Framework: Preventing Deaths by Suicide

- Restricting means
- Increasing opportunities for help-seeking
- Increasing probability of intervention
- Redefining image of suicide magnets
- Supports in mental health system

	Deaths & Attempts (2010-2017)		Deaths & Attempts (2018)		Suicidal Ideation (EMS Responses)	
Infrastructure Element	Coroner (To Nov. 20)	EMS Calls	Coroner (To Nov. 20)	EMS Calls	2006–2017	2018 (To Dec.14)
NF-1	11	1	1		16	2
NF-2	10		0		7	
NF-3		1			2	
StC-1	**0**		**3***	**1**	**22**	**7**
StC-2					1	
StC-3		1			4	
Thorold-5					**1**	**3**
Welland-1					4	1

Barrier at STC-1

- Engaged Parsons
- Conceptual designs completed

- Cost: Est. $4,000,000
- Timeline: Late 2019

- Ongoing
  - Detailed design work
  - Refinement of cost estimate

Recommendations

- Within this framework, Regional Council as the Board of Health **ENDORSE** the importance of considering a barrier at the location of multiple recent deaths by suicide and **DIRECT** staff to proceed with further planning for such a barrier, and report back by spring 2019 with a final recommendation, detailed cost estimates, and budget options
- To implement this framework, Regional Council **DIRECT** staff to engage with the Ministry of Transportation on opportunities for provincial funding to support a possible infrastructure barrier as in recommendation #2
- As part of this framework, Regional Council **DIRECT** staff to include consideration of barriers on any future major infrastructure projects, and to include details of their consideration in reports to Council for approval of such projects

Increasing Opportunities for Help-Seeking

- Signs to call Niagara Distress Centre
- Crisis phones
- Automated messages
- Staffed sanctuary

OAK CENTRE
CLUBHOUSE

1-905-788-3010 | oakcentre@bellnet.ca
24 Dorothy St., Welland, ON

Oak Centre | Members | Clubhouse

Access Line 1-866-550-5205

Providing confidential 24/7 telephone support for adult residents of Niagara facing addiction and mental health concerns.

Upcoming Events

Who We Are:
An Alternative Community Support

An intentional community designed to foster a restorative environment where people can grow, build self-confidence, and experience themselves as citizens in creating a world for themselves and others.

Learn more

Become a Member

Encouraging participation and empowering individuals through connecting, education, work, and activities.

Connect with someone at the Oak Centre today!

Learn More | Contact Us

Acorn Newsletter

We have a lot of interesting topics, some will make you laugh and others will make you think. We also have a puzzle and our delicious lunch menu. We work hard to bring it to you on a monthly basis.

Newsletters

Recommendation

- To implement this framework, Regional Council as the Board of Health **DIRECT** staff to develop and report back in spring 2019 with detailed cost-estimates for approval of
  - Support for a Mental Health Hub/Clubhouse in St. Catharines

Increasing Probability of Intervention

- Patrols by emergency workers
- Surveillance cameras triggering intervention
- Training to identify/intervene

Recommendation

- To implement this framework, Regional Council as the Board of Health **DIRECT** staff to develop and report back in spring 2019 with detailed cost-estimates for approval of
  - Suicide identification/intervention training

Redefining the Public Image

- Change media coverage and public discourse
- Memorials & floral tributes
- Lighting
- Redecoration/landscaping

Improving Supports in Mental Health System

- Suicide Risk Assessment Strategy
- System Mapping & Integration

Recommendations

- To implement this framework, Regional Council as the Board of Health **DIRECT** staff to develop and report back in spring 2019 with detailed cost-estimates for approval of
  - Suicide risk assessment capacity-building
- Regional Council as the Board of Health **ENDORSE** the proposed framework for preventing suicides on public infrastructure

Questions?

Canadian Psychiatric Association
Dedicated to quality care
Association des psychiatres du Canada
Dévouée aux soins de qualité

POLICY PAPER

Media Guidelines for Reporting on Suicide: 2017 Update of the Canadian Psychiatric Association Policy Paper

Mark Sinyor, MSc, MD, FRCPC[1]; Ayal Schaffer, MD, FRCPC[2]; Marnin J. Heisel, PhD, CPsych[3]; André Picard, BComm, BJourn, Hon LLD[4]; Gavin Adamson, MJ[5]; Christian P. Cheung, BSc Candidate[6]; Laurence Y. Katz, MD, FRCPC[7]; Rakesh Jetly, MD, FRCPC[8]; Jitender Sareen, MD, FRCPC[9]

This paper has been substantially revised by the Canadian Psychiatric Association's Research Committee and approved for republication by the CPA's Board of Directors on May 3, 2017. The original policy paper[1] was developed by the Scientific and Research Affairs Standing Committee and approved by the Board of Directors on November 10, 2008.

Summary

A substantial body of research suggests that media reports about people who have died by suicide, as well as the topic of suicide in general, can influence vulnerable people and is associated with higher subsequent rates of suicide. Emerging evidence also suggests that reports about people overcoming suicidal crises may lower suicide rates. The original 2009 Canadian Psychiatric Association (CPA) policy paper on media reporting of suicide[1] led to meaningful discussion between mental health professionals and journalists in Canada. This second iteration of the policy paper reviews the most up-to-date evidence relating to media reporting and suicide, and updates recommendations with more direct

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[4] Health Columnist, The Globe and Mail, Toronto, Ontario
[5] Associate Professor, School of Journalism, Ryerson University, Toronto, Ontario
[6] Research Student, Department of Psychiatry, Sunnybrook Health Sciences Centre, Toronto, Ontario.
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[8] Head, Centre of Excellence, Directorate of Mental Health, Canadian Armed Forces Health Services, Ottawa, Ontario; Chair, Military Mental Health, Royal Ottawa Hospital, Ottawa, Ontario; Assistant Professor, Department of Psychiatry, Dalhousie University, Halifax, Nova Scotia
[9] Professor and Head, Department of Psychiatry, Max Rady College of Medicine, Rady Faculty of Health Sciences, University of Manitoba, Winnipeg, Manitoba

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Note: It is the policy of the Canadian Psychiatric Association to review each position paper, policy statement and clinical practice guideline every five years after publication or last review. Any such document that has been published more than five years ago and does not explicitly state it has been reviewed and retained as an official document of the CPA, either with revisions or as originally published, should be considered as a historical reference document only.

engagement and input from the journalism community. Recommendations are meant as a guide for all relevant stakeholders, including journalists, editors, producers, journalism educators, researchers, policy makers, mental health professionals, and social media platforms. The paper suggests a framework for approaching suicide-related coverage and outlines potentially harmful and helpful aspects of reporting that should be avoided and included, respectively. Recommendations include using appropriate language, trying to reduce the stigma around mental disorders, and providing information about alternatives to suicide. Pertinent resources for people contemplating suicide, such as crisis services, should also be provided and can be directly linked to reports that appear online. Simplistic or glorified depictions of suicide should be avoided, and suicide should not be presented as a way of solving problems. Reports should avoid details of suicide methods, particularly if they are novel or unusual. Recommendations also include that, where possible, suicide should be covered by or with the input of health reporters who are best positioned to contextualize suicide within the broader topic of mental health. The paper also makes preliminary recommendations for social media and suggests collaboration with online platforms to help establish organizational standards concerning the dissemination of information about suicide.

Introduction

Scientific evidence from numerous natural experiments worldwide demonstrates that media reporting of suicide can sometimes result in contagion, with increased suicide rates across a population.[2-12] The association has satisfied the criteria of consistency, strength, temporality, specificity, and coherence required to conclude that there is a causal relationship.[13-14] The research evidence indicates that, in general, more suicide deaths occur following repetitive reporting of suicide.[5-6] This relationship is widely known as the Werther Effect, a reference to a 1774 novella published by Goethe describing the death by suicide of a young man who was rejected by the young woman he loved.[2] This suicide contagion effect is thought to be mediated by social learning, whereby a vulnerable person identifies with people depicted in the media and may be more apt to copy their suicidal behaviour and subsequently die by suicide.[5-7,15-16] The effect may be particularly pronounced for youth, a group that can be more susceptible to social learning,[17-22] and in cases where the media report relates to a celebrity, whose behaviour people may be more prone to emulate.[4,12,16,23-27] In contrast, the effect does not seem to occur if the person who died by suicide was a criminal.[16] Although the best evidence in this area comes from large, population-based, natural experiments, where it is challenging to prove exposure to media reports, findings from psychological autopsy studies, reviews of suicide notes, and interviews with people who have attempted suicide show that many have or were exposed to suicide-related media content, which influenced suicidal behaviour.[8,28-34] More recently, Niederkrotenthaler et al. postulated a corollary effect to the Werther Effect called the Papageno Effect, whereby media reporting emphasizing a positive outcome of a suicidal crisis may be associated with lower subsequent suicide rates.[5] This was based on a latent class analysis examining media and suicide reporting in Austria. The authors found that articles stressing "mastery of crisis," in which people contemplating suicide employed adaptive coping strategies rather than suicidal behaviour, were associated with a subsequent decrease in the rates of suicide.[5] The "active ingredients" of reporting that mediate contagion of suicide and adaptive behaviour are not fully understood; however, there is general consensus on putatively harmful and protective aspects of media reporting, and these form the basis for media guidelines.

Guidelines for responsible media reporting of suicide have been developed across numerous countries and jurisdictions worldwide.[35-38] Several guidelines have been produced in Canada, including those from the Canadian Psychiatric Association,[1] the Canadian Association for Suicide Prevention (CASP),[39] and the Mindset guidelines developed by journalists themselves.[40] Media guidelines have demonstrable impact on the quality of reporting on suicide[41-44] and, in some cases, have been associated with lower suicide rates.[42,45] It is estimated that guidelines can prevent more than 1% of suicide deaths; such a reduction in Canada would translate to the prevention of more than 40 deaths per year across the country.[46-47] Canadian studies examining media reporting—in general and per the guidelines above—are limited. A recent study examining adherence to Mindset's 14 specific recommendations in the aftermath of a celebrity suicide found that most recommendations were followed (range of adherence was 65% to 99% of articles), except for the recommendation to tell people considering suicide how they can get help (present in only 27% of articles).[48]

The original CPA position paper on media reporting and suicide[1] garnered controversy from some who expressed scepticism about the evidence base for suicide contagion,[49] and argued that perceived efforts to suppress suicide-related stories are counter-productive.[50] In the interim, there has been increased engagement

between mental health professionals and the media via informal dialogue surrounding specific reports, through symposia at the CPA annual meeting, and during and after Canada's first media forum for suicide prevention, held in Toronto in November, 2015.[49] In part due to a greater public desire for information about mental health, journalists are increasingly interested in covering issues related to mental health, including suicide, in a respectful and destigmatizing manner.[49] Most suicide deaths are not newsworthy and the media are sensitive to concerns about contagion; however, deciding when and how to cover suicide is a delicate balancing act.[49] Rather than telling journalists how to do their jobs, consensus is that the mental health community needs to work collaboratively with the media and provide them with the best available information to make those difficult decisions, and to provide context and help mitigate risks of contagion when the decision is to proceed with a report.[36,39,49]

One relatively new aspect to this discussion is the proliferation of social media and the implications for media guidelines on reporting suicide.[51-52] There are significant concerns about pro-suicide content, which accounts for a substantial proportion of suicide related-information online,[53-54] and that users may use social media to learn about suicide,[55-56] disseminate suicide methods,[57-58] normalize and desensitize people to self-injurious behaviour,[59] and publish suicide notes.[60-61] Social media sites also provide opportunities for prevention through learning about alternatives to suicide, resources for getting help, and for access to peers who have mastered suicidal crises.[52,62] Some platforms have developed built-in responses in which, for example, queries about suicide prompt the display of prevention resources or where users can report concerns about people who may be expressing suicidal ideation.[52,62-64] It has been suggested that, in the age of the internet, media guidelines may be impractical or irrelevant given the difficulty inherent in trying to constrain or regulate billions of comments and postings.[65] However, there is general agreement that social media sites should facilitate access to health information and resources for people contemplating suicide.[65-66] Furthermore, studies show that the traditional media commonly uses social networking sites like Facebook and Twitter to inform their coverage and, likewise, their coverage can influence social media.[51] This bidirectional relationship suggests that the approach of the traditional media to covering suicide is likely to have some impact on how it is depicted in social media.

The goals of this updated policy paper are 1) to increase engagement with the journalism community and to adjust previous recommendations collaboratively with journalists; 2) where possible, to achieve consistency between CPA recommendations and recent Canadian and international guidelines; and 3) to address the challenging issue of recommendations in the context of new online and social media. The recommendations below stem from a careful review of the available literature and of Canadian and international guidelines, as well as discussion with journalists and mental health professionals.

Recommendations for Traditional Media Coverage

Table 1 outlines in detail the recommended approach to developing a suicide-related report. Table 2 describes specific elements to be avoided and included, respectively, in media reports. We highlight 3 of these recommendations for special attention:

1. Health reporters, not crime reporters, are best positioned to cover suicides.

A key element of these recommendations is that, as much as possible, suicide be covered by health reporters rather than crime reporters or other journalists. The notion that suicide is a crime rather than the result of a mental disorder is archaic. Crime reporting often includes graphic details of the suicide to make reports more exciting and sensationalistic. Such detailed reporting for suicide coverage is inappropriate and may promote contagion. Health journalists have the greatest awareness of the complex issues surrounding suicide reporting and are therefore best positioned to cover the topic. We acknowledge that there may be situations where other journalists, such as sports, entertainment, or financial reporters, may want to cover suicide deaths in their areas; however, we recommend that they do so cautiously, paying attention to these guidelines, and we suggest they consult with their health reporter colleagues about suicide-related content.

2. Reports should generally avoid details of suicide methods, especially when unusual or novel methods are involved.

There is growing evidence that media reporting on novel methods of suicide has led to dramatic increases in suicide deaths by these methods and in overall suicide rates in various areas of the world.[67-70] Whereas media reports should generally avoid details of suicide methods, as these can lead to contagion effects, such an effect may be particularly pronounced when unusual

Table 1. Factors for Journalists and Editors/Producers to Consider Before Covering Suicide-Related Content

1. Weigh the story's newsworthiness and the public's need to be informed with potential harm related to contagion.
   - Be familiar with your organizational guidelines relating to reporting on suicide.
   - If the decision is to proceed with coverage, plan and/or discuss how harm might be minimized.
   - Seek advice from suicide prevention experts.
   - Be especially cautious when reporting on celebrity or youth suicide deaths, as these currently have the strongest evidence for contagion.
   - Consider how a vulnerable person may identify with the suicidal behaviour/people depicted, and consider steps that might minimize this.
2. Consider the impact of the report on:
   - those thinking of suicide or potentially at-risk for suicide,
   - those bereaved by suicide, including attention to respect for their privacy and grief,
   - the journalist who is reporting the story.
3. Consider the appropriate approach/format.
   - Suicide reporting should generally be done by health reporters rather than other journalists (e.g., crime reporters), as they are best positioned to contextualize the issue within the broader topic of mental health; if other journalists do report, they should at least consult with guidelines and/or health reporter colleagues.
   - Where possible, long-form reporting is recommended, as it allows journalists the opportunity for nuanced discussion and may avoid presenting the causes of suicide in an overly simplistic fashion.

Table 2. Recommendations for Potentially Harmful Elements of Media Reporting that Should Be Avoided and Potentially Helpful Elements to Include

Avoid	Include
1. Prominent coverage, including • front page/lead story coverage • prominent photos of the deceased or loved ones or people engaged in suicidal behaviour 2. Graphic or sensational depictions 3. Excessive detail, including • details or photos of the method and/or location; particularly avoid reporting novel or uncommon methods • glorifying or glamourizing either the person or the act of suicide in a way that might lead others to identify with them • the content of suicide notes 4. Repetitive or excessive coverage[a] 5. Inappropriate use of language, including • the word "suicide" in the headline • "commit" or "committed" suicide[b] • "successful/unsuccessful" or "failed" attempts 6. Simplistic or superficial reasons for the suicide (i.e., suicide as arising from a single cause or event, such as blaming social media for suicide) 7. Portraying suicide as achieving results and solving problems • do not describe suicidal behaviour as quick, easy, painless, certain to result in death, or relieving suffering/ leading to peace ("in a better place")	1. Appropriate language (e.g., "he died by suicide" or "her suicide death") 2. Reporting that reduces stigma about mental disorders/ seeking mental healthcare, and that challenges common myths about suicide • refer to research linking mental disorders with suicide • highlight that mental disorders are treatable and therefore that suicide is preventable • highlight the tragedy of suicide (i.e., describe it in terms of a lost opportunity for someone suffering to have received help) • seek advice from suicide prevention experts and consider including quotes on causes and treatments 3. Alternatives to suicide (i.e., treatment) • include community resource information, such as websites or hotlines, for those with suicidal thoughts • where possible, list or link to a list of options including reaching out to a trusted family or community member, speaking to a physician or health care provider, seeking counselling/talk therapy, calling a hotline/911, or going to a nearby emergency department • where possible, cite examples of a positive outcome of a suicidal crisis (i.e., calling a suicide hotline) • embed emergency resource links/banners (for online content) 4. Information for relatives and friends, such as • warning signs of suicidal behaviour • how to approach, support and protect a suicidal person

[a]We acknowledge that suicide death of prominent figures will invariably result in serial coverage but urge journalists to nevertheless weigh the need for additional stories.

[b]"Commit" evokes a crime, since suicide was historically criminalized; however, this terminology is not consistent with the modern understanding of suicide evolving from a treatable disorder.

or novel methods of suicide are involved. Therefore, publicizing these details should be avoided.

3. Emergency resource links should be included in all articles that deal with suicide.

Guidelines universally advise the media to provide resources, such as crisis lines, to people contemplating suicide. Online platforms afford an opportunity to go a step further. Reports themselves can be accompanied by embedded links to crisis services to facilitate access, thereby decreasing barriers to help-seeking.

Recommendations for Social Media

As described, this is largely uncharted territory in Canada and throughout the world. The recommendations below are meant to be a starting point, with the intention that future iterations of the CPA policy paper will refine and expand on them with input from social media organizations.

We recommend:

1. A novel collaboration between Canadian mental health professionals and social media organizations. Just as journalists are the experts in their area and must take a leadership role in responsible reporting of suicide, those best positioned to address suicide on social media are the designers of the social media sites themselves. In replicating efforts that have been successful with the traditional media, the CPA and mental health professionals should organize meetings, symposia, and forums to address the topic of suicide collaboratively with social media stakeholders.
2. Social media organizations consider the degree to which they might be used as a platform for suicide prevention. Specific efforts may include 1) providing information and resources to people who make suicide-related queries or posts, 2) including "panic buttons" that allow for rapid access to crisis services/hotlines, 3) providing mechanisms for users to report if they are concerned about someone with the possibility for rapid intervention, and 4) moderating forums that frequently include suicide-related postings and making sure to remove inappropriate posts.

Recommendations for Dissemination of Guidelines

Evidence from other countries suggests that media guidelines work best when there is ongoing collaboration between suicide prevention experts, journalists, journalism schools, and public health policy experts.[39]

We recommend:

1. Ongoing collaboration between journalists and mental health professionals, acknowledging scientific evidence and the autonomy of journalists.
2. All journalism schools include teaching of how to report responsibly and respectfully on the topic of suicide, including attention to issues related to ethics and social justice.
3. Media training for mental health professionals who are likely to be called on to comment on suicide in the press.
4. Education for policy-makers and other prominent figures who may be asked to comment publicly on the topic of suicide.

Conclusions & Future Directions

These recommendations mainly rely on data from large, natural experiments, which must be interpreted with a note of caution. Nevertheless, the weight of evidence suggests that certain types of media reporting, particularly those that glamourize suicide or a person who has died by suicide, can and do influence some people to die by suicide. Similarly, reporting that describes people overcoming suicidal crises and finding other solutions may encourage help seeking and more adaptive coping strategies. Further high-quality research is needed to identify which putatively harmful and protective elements of media reports mediate risk and confer benefit, respectively. More studies on the influence of media reporting in Canada and the impact of social media on suicide are also needed. The Canadian Psychiatric Association and mental health professionals across Canada are committed to helping the media make informed decisions about when and how to report on suicide. These efforts will ideally involve collaborative partnerships among all stakeholders, including mental health professionals, members of the media, individuals with lived experience, and all those touched by suicide. These ongoing collaborations, and future efforts that also include social media platforms, will provide the best opportunity to address this important issue.

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Subject: Community Homelessness Prevention Initiative Investment Plan 2019-20

Report to: Public Health and Social Services Committee

Report date: Tuesday, January 8, 2019

Recommendations

That the Ministry mandated Community Homelessness Prevention Initiative investment plan for the 2019-20 funding allotment **BE APPROVED**.

Key Facts

- The Ministry of Municipal Affairs and Housing (MMAH) provided notification on November 2, 2016 of funding allocations for the Community Homelessness Prevention Initiative (CHPI) which included the year 2019-20.
- Based on the November 2, 2016 notice Niagara will receive $7,847,786 for the term April 1, 2019 through March 31, 2020.
- Consistent with previous years, MMAH requires service managers to submit the CHPI investment plan for 2019-20 by February 15, 2019 outlining the planned spending in the directed categories of: emergency shelter solutions, housing with related supports, other services and supports, homelessness prevention and program administration.
- The proposed Investment Plan included in the report has been developed based on the CHPI program guidelines (January 2017), alignment with Niagara's Ten Year Housing and Homelessness Action Plan and consideration to existing funding allocations to support a stable homelessness system in Niagara.
- In 2017, homelessness services in Niagara assisted 351 unique households through outreach, 950 with emergency energy funds, 1,641 with emergency hostel services, 2,785 with prevention services and 444 with supported transitional housing.
- Final confirmation of funding allocations is not anticipated to be received until March 2019, as part of the Provincial budget approval process.
- Should the additional funding of $311,353 (the proposed increase over 2018-19) not be available from the Province, the Region will make adjustments within the Prevention program area to offset the emergency shelter funding pressure.

Financial Considerations

The total 100% provincial CHPI funding provided for 2019-20 is anticipated to be $7,847,786. It should also be noted that the Region allocates $1.7M of levy funding to the same priority funding categories beyond the proposed provincial amounts (Emergency shelter $586,094; Housing with related supports $50,149; Other services $0; Prevention $921,449; and Administration $145,869, assuming a consistent levy

allocation in Q1 2020). The Region also receives $714,705 of Federal funding for homelessness efforts (Housing with related supports (Housing First) $635,110 and Administration $79,595). These other funding sources are not included in the CHPI investment plan prepared for the MMAH.

Current homelessness service contracts expire March 31, 2020. Niagara Region funds and works collaboratively with 22 agencies in the region to deliver homelessness services to the residents of Niagara.

Analysis

The proposed CHPI investment plan is designed to align with the CHPI program guidelines issued in January 2017. The Ministry requires that an investment plan be submitted each year indicating how the Region plans to use the funding provided based on the categories identified by the province, and additionally, recognizing the four provincial homelessness priorities of chronic homelessness, youth, indigenous persons and homelessness following transitions from provincially-funded institutions and service systems.

The vision for CHPI is to have:
"A coordinated and holistic service delivery system that is people-centered, evidence informed and outcomes-based, and reflects a housing first approach that focuses on homelessness prevention and reduces reliance on emergency services." [1]

This vision reflects a shift towards a system that focuses on proactive and permanent housing solutions rather than reactive responses to homelessness.

The chart below shows the funding plan submitted for 2017-18, 2018-19, the proposed plan to be submitted for 2019-20 and the changes in funding allocations, over the prior year.

2019-20 CHPI INVESTMENT PLAN

	2017-18	2018-19	2019-20	Change
Emergency Shelter Solutions	$2,065,228	$2,186,223	$2,421,799	$235,576
Housing with Related Supports	$1,255,867	$1,071,155	$956,155	$(115,000)
Other Services and Supports	$141,109	$178,592	$314,016	$135,424

[1] Community Homelessness Prevention Initiative Program Guidelines, January 2017, Ministry of Housing.

	2017-18	2018-19	2019-20	Change
Homelessness Prevention	$3,530,628	$3,811,701	$3,867,054	$55,353
Program Administration	$232,512	$288,762	$288,762	$0
Total	$7,225,344	$7,536,433	$7,847,786	$311,353

The relative amounts set out in Niagara's investment plan align with provincial expectations, and also ensure funding levels in each category support stability in the Niagara homelessness system while allowing for the capacity to move the system forward achieving provincially identified priorities. Funding allocations in each service area reflect the outcome of the 2017 Expression of Interest procurement process allocating 52 contracts to 22 agencies. The types of services that will be funded under the CHPI categories, as well as some specific work, related to system improvements, are outlined below:

Emergency Shelter Solutions

- Funding would support: a safe bed, offered in a variety of settings; necessary basic needs, meals, along with support services including transportation to the shelter and assistance to secure stable housing.
- Funding increase provides dollars for Niagara Falls Out of the Cold Pilot, increased number of beds in the shelter system and additional funding for hotel rooms to address Emergency Shelter overflow, emergency situations and addressing special needs (e.g. accessibility, service animals and health and safety).
- Staff continue to monitor the impact of the implementation of best practice Housing First and Home for Good Supportive Housing programming on shelter stays with an effort to reduce demand for emergency shelters.
- There will be continued focus and effort to align with Provincial policy expectations, emphasizing prevention over emergency response.

Housing with Related Supports

- Funding will continue to support Housing First units and transitional housing programming in Niagara.
- Supports also include medical needs and other supports that are not otherwise available to ensure well-being of clients. Examples include: supports related to mental health, substance use, medical assistance and crisis intervention.

Other Services and Supports

- This category captures Niagara's outreach services, including outreach support workers who provide help to find stable housing, supplies, and connections to other services including mental health programs, healthcare, addictions services,

and legal aid. This category also includes the mobile food truck that serves all of Niagara on a rotating schedule and provides, outreach, free meals and supplies.

Homelessness Prevention

- Homelessness Prevention funding supports programs which address eviction prevention, assistance to secure and retain housing and assistance with budgeting, banking and trusteeship.
- This category also funds programs specific to vulnerable youth and young adults who are at risk of homelessness to keep them housed and avert their entry into the system.
- This category includes the Housing Stability Plan (HSP) which, as in prior years, will represent $1.8 million of the CHPI funding available in Homelessness Prevention. HSP provides financial assistance for rent arrears, and rent deposits.
- This category also includes funding towards the Niagara Emergency Energy Fund to address utility arrears, to support clients to retain housing.
- Niagara, in alignment with provincial direction, continues to emphasize prevention programs to reduce the need for emergency shelters and support people to access and retain stable housing.

Program Administration

- This includes capacity building and training funding for all 22 agencies.
- While permitted under the Administration category, Niagara does not allocate the full 10% available under the CHPI guidelines for administration, focusing as much funds as possible to direct client service delivery.

Risk Management planning for CHPI

Under the CHPI program guidelines (January 2017), there is a requirement to identify potential risks and mitigation strategies.

The risks that will be identified in this investment plan include:

RISKS	**MITIGATION**
➢ Effectively meeting the capacity, assessment and development requirements for municipal service managers and all third party agencies delivering programs on our behalf (particularly as the Province has not yet shared expectations and targets for this requirement).	➢ Continue to monitor the sector for best practice developments and evolving policy changes. ➢ Continue to allocate administration monies to this initiative and work with all agencies to identify system wide training needs, ensuring system capacity along with standard processes. Plans for 2019 include further Housing First training.
➢ An affordability risk in Niagara, as the provincial funding available remains inadequate to support local needs and	➢ Local funding allocations and contract award processes seek to ensure that selected agencies utilize outcome-

address existing demand for services. Ongoing reliance on the local not-for-profit sector contributions and levy sources is not sustainable.	based models and best practices. Niagara will continue to ensure effective monitoring of contracts and outcomes. Dialogue will continue with the MMAH related to local needs and relative funding levels.

Alternatives Reviewed

Not applicable.

Relationship to Council Strategic Priorities

N/A

Other Pertinent Reports

- COM 08-2015 Community Homelessness Prevention Initiative Funding Allocations 2015-16 and 2016-17
- COM 02-2017 Community Homelessness Prevention Initiative Investment Plan 2017-18
- COM 02-2108 Community Homelessness Prevention Initiative Investment Plan 2018-19

Prepared by:
Cathy Cousins
Director, Homelessness Services & Community Engagement
Community Services

Recommended by:
Adrienne Jugley
Commissioner
Community Services

Submitted by:
Ron Tripp, P.Eng.
Acting Chief Administrative Officer

This report was prepared in consultation with Kayla De Pauw, Program Financial Specialist.

Niagara Regional Housing

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Fax – Contractors: 905-682-8301
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November 16, 2018

Ann-Marie Norio, Regional Clerk
Niagara Region
1815 Sir Isaac Brock Way
Thorold, ON L2V 4T7

Dear Ms. Norio:

At their November 16, 2018 meeting, the Niagara Regional Housing Board of Directors, passed the following motion:

> That Niagara Regional Housing Quarterly Report July 1 to September 30, 2018 be APPROVED and FORWARDED to the Public Health and Social Services Committee and subsequently to Regional and Municipal Councils for information.

Your assistance is requested in moving the attached report, NRH 15-2018, through proper channels to Council.

Sincerely,

Henry D'Angela
Chair

Q3 (July 1 to September 30, 2018) to Board of Directors

Recommendation:

That Niagara Regional Housing Quarterly Report July 1 to September 30, 2018 be APPROVED and FORWARDED to the Public Health and Social Services Committee and subsequently to Regional and Municipal Councils for information.

Submitted by:

Donna Woiceshyn
Chief Executive Officer

Approved by:

Henry D'Angela
Chair

Directors:

Henry D'Angela, Chair
Regional Councillor
Thorold

James Hyatt, Vice-Chair
Community Director
St. Catharines

Karen Blackley, Treasurer
Community Director
Thorold

Betty Ann Baker - Secretary
Community Director
St. Catharines

Betty Lou Souter
Community Director
St. Catharines

Paul Grenier
Regional Councillor
Welland

Tim Rigby
Regional Councillor
St. Catharines

Walter Sendzik
Regional Councillor
St. Catharines

Selina Volpatti
Regional Councillor
Niagara Falls

Q3 (July 1 to September 30, 2018)

HIGHLIGHTS:

Application Activity

739 received & processed

Work Orders

3,216 issued

Capital Program

32 jobs/projects ongoing

6 public tenders closed

40 contract orders issued

Rent Arrears

= $23,378.86

or

2.01% of the monthly rent charges

Community Resources & Partnerships

offered supports to

240 new referrals

45 partners

Non-Profit Housing Programs

66% deemed HEALTHY

Rent Supplement / Housing Allowance

1,354 units

Niagara Renovates

49 homeowners were approved for funding.
Repairs/renovations are underway.

Welcome Home Niagara

14 homeowners received assistance

Housing First Project

9

Individuals / families housed

Appeals

= 15

9 upheld
5 overturned

New Development

Carlton - approx. 75% complete
Roach - in the design phase

VISION

That the Niagara community will provide affordable, accessible and quality housing for all residents

MISSION

To expand opportunities that make affordable housing an integral part of building healthy and sustainable communities in Niagara

As the administrator of social housing for Niagara Region, Niagara Regional Housing (NRH) works to fulfill our vision and mission through six main areas of responsibility:

1. Public Housing (NRH Owned Units)
2. Non-Profit Housing Programs
3. Rent Supplement Program
4. Affordable Housing Program
5. Service Manager Responsibilities
6. Housing Access Centre and Centralized Waiting List

Definitions can be found in the attached Reference Sheet.

1. Public Housing (NRH Owned Units)

DAY-TO-DAY MAINTENANCE:

In Q3, **3,216 work orders** were issued, representing $1,004,192.35. $56,698.50 of this amount was charged back to tenants who were held responsible for damages.

	2017-Q3	2017-Q4	2018-Q1	2018-Q2	2018-Q3
# of work orders issued	3,263	2,993	2,566	2,768	3,216

CAPITAL PROGRAM:

The Capital Program is responsible for maintaining the Public Housing (NRH Owned Units) asset and planning for future sustainability.

In Q3, 40 contract orders were issued, six public tenders closed and purchase orders issued $4,157,787.68. This total includes the purchase order for Roach Avenue New Build.

The Capital Program was responsible for 17 capital projects valued at $ 2,660,416.32 and 15 Social Housing Apartment Improvement Program (SHAIP) funded Capital projects valued at $1,606,976.65 including:

- Parking lot replacement – one project
- Installation of Heat Control System – eight projects
- Foundation repairs/Damproofing – three projects
- Design and preparation of tender for bathroom replacements – one project
- Balcony repair and railing replacement – two projects
- Design and Tender Domestic Hot Water replacements – five projects

As of September 30, 2018, $3,500,000 of the $7,000,000 budgeted (excluding emergency) has been committed and or actually spent (50%).

Reallocating SHAIP year two and three projects to be completed in year one funding.

TENANT MOVE OUTS:

Move Outs By Reason	
Health	7
Long Term Care Facility	8
Deceased	20
Private Rental	2
Voluntarily Left Under Notice	0
Eviction – Tribunal	8

NRH Transfer	29
Moved to Coop or Non-Profit	1
Bought a House	0
Left Without Notice	0
Other/None Given	14
Cease to Qualify	0
TOTAL	**89**

In Q3, there were **89 move outs**. Eight involved eviction orders granted under the Ontario Landlord Tenant Board (LTB) – arrears (six), impaired safety (one), harassment (one). Seven of the evictions were enforced by the Sherriff.

	2017-Q3	**2017-Q4**	**2018-Q1**	**2018-Q2**	**2018-Q3**
# of move outs	75	81	67	83	89

ARREARS:

NRH Housing Operations actively works to reduce rent arrears and saw a decrease in Q3.

	Sept 30, 2017	Dec 31, 2017	Mar 31, 2018	Jun 30, 2018	Sept 30, 2018
Rent charges for the month	$1,122,027.00	$1,150,372.27	$1,167,751.69	$1,136,607.00	$1,165,765.00
Accumulated rent arrears	$44,326.67	$49,045.27	$48,660.91	$35,055.56	$23,378.86
Arrears %	3.95%	4.26%	4.17%	3.08%	2.01%

INSURANCE:

Nothing to report in Q3.

COMMUNITY RESOURCES AND PARTNERSHIPS:

In Q3, we had partnerships with **45 community agencies** across Niagara. As a result of these partnerships, more than 200 support and enrichment activities were offered to tenants at NRH sites. Each partnership contributes to tenant lives and, in turn, the success of the Public Housing community as a whole:

- Once again this year, NRH partnered with the RAFT to provide summer camps in Manchester, Old Pine Trail and Rykert (St. Catharines) and Warden and Waters (Niagara Falls) and Faith Welland Church in McLaughlin (Welland).

  The cost and transportation required for summer camp is often out of reach for low-income families, so these camps provide workshops, sports, crafts and excursions they would not be able to access otherwise. In addition to offering constructive activities to keep youth occupied during the summer months, summer camps help youth to develop new interests, improve socialization and help partner agencies develop trusting relationships with tenants and their children.

Also during Q3, NRH Community Programs Coordinators (CPCs) offered support to **240 new referrals of tenants in need of assistance**. Of those new referrals, **54% were considered medium-high need**. In particular, as the weather got warmer, there were more requests for help resolving social issues between neighbours. There was also an increase in the number of tenants needing help with clutter and bed bugs, as well as the number of tenants declining supports.

2. Non-Profit Housing Programs

As administrator of social housing for Niagara Region, NRH provides legislative oversight for 62 Non-Profit Housing Programs (non-profit and co-operative). Operational Reviews are conducted to determine the overall health of each.

	2017-Q3	2017-Q4	2018-Q1	2018-Q2	2018-Q3
Healthy	42	43	41	41	41
Routine Monitoring	18	18	18	18	18
Intensive Monitoring	2	1	1	1	1
Pre-PID (Project in Difficulty)	1	1	1	1	1
PID (Project in Difficulty)	1	1	1	1	1
TOTAL	**64**	**64**	**62**	**62**	**62**

NRH Housing Programs staff continue to work with Federal Housing Providers as they move toward End of Operating Agreements (EOA).

3. Rent Supplement Program

In Q3, there were **1,354 Rent Supplement/Housing Allowance units** across Niagara. In the Rent Supplement program, tenants pay 30% of their gross monthly income directly to the private landlord and NRH subsidizes the difference up to the market rent for the unit. The Housing Allowance program is a short term program that provides a set allowance to help applicants on the wait list.

	2017-Q3	2017-Q4	2018-Q1	2018-Q2	2018-Q3
Fort Erie	26	26	27	28	28
Grimsby	25	26	26	26	26
Lincoln (Beamsville)	2	2	13	12	12
Niagara Falls	200	219	228	229	230
Niagara-on-the-Lake	--	-	-	-	-
Pelham	24	24	23	23	22
Port Colborne	44	47	51	53	51
St. Catharines	567	600	657	700	719
Thorold	24	29	32	37	54
Welland	189	199	202	201	197
West Lincoln	15	14	14	15	15
TOTAL	**1,116**	**1,186**	**1,273**	**1,324**	**1,354**

Variances in the number of Rent Supplement/Housing Allowance units reflects the general management of the program and required take-up/deletion of units due to End of Operating

Agreements (EOA), move out of tenants, and/or new units/landlords. Totals will be increasing in the future as some Non-Profit Housing Programs transition into a Rent Supplement agreement upon expiry of their operating agreement. It is unknown which areas will be affected.

4. Affordable Housing Program

NIAGARA RENOVATES PROGRAM:

The Niagara Renovates program provides assistance to low-to-moderate income homeowners for home repairs, accessibility modifications and the creation of secondary suites in single family homes.

Niagara Renovates inspections for 2018-2019 funding are now underway. Inspections include all areas inside and outside of the home to ensure compliance with program guidelines. Issues are identified and a detailed Inspection Report is completed for review before a decision is communicated to the homeowner.

NRH received $500,000 through the Investment in Affordable Housing - Extension (IAH-E) program for homeowner and secondary suite repairs and $626,300 for multi-unit repairs, totaling $1,006,300 for the 2018/2019 period.

49 homeowners were approved for funding in 2018. Repairs/renovations are underway.

HOMEOWNERSHIP PROGRAM – "WELCOME HOME NIAGARA":

The Homeownership program assists low-to-moderate income rental households to purchase their first home by providing a down payment loan.

In Q3, **14 homeowners** received assistance through Welcome Home Niagara.

	2017-Q3	2017-Q4	2018-Q1	2018-Q2	2018-Q3
# of homeowners assisted	11	13	5	9	14

HOUSING FIRST PROGRAM:

The Housing First program helps people move quickly from homelessness to their own home by providing supports to help difficult to house individuals find and keep housing.

In Q3, **nine individuals/families** were housed through the Housing First program. Since 2012, Housing First has helped 344 individuals/families.

	2017-Q3	2017-Q4	2018-Q1	2018-Q2	2018-Q3
# of individuals/families housed	10	22	17	14	9
# of Housing First units (at quarter end)	131	148	165	170	178

RENTAL HOUSING (NEW DEVELOPMENT):

NRH New Development

Carlton Street, St. Catharines	Amount	Units
Investment in Affordable Housing-Extension (IAH-E), Year 3	$5,806,000	45
Investment in Affordable Housing-Extension (IAH-E), Year 4	$2,888,000	23
Social Infrastructure Fund (SIF), Year 1	$2,387,817	17
Roach Avenue, Welland		
Social Infrastructure Fund (SIF), Year 3	$1,200,000	8
TOTAL	**$12,281,817**	**93**

At the end of Q3:

Carlton Street

- Envelope work – generally 70% complete. EIFS (Exterior Insulation and Finish Systems) is in progress - 50% complete. Other components of the exterior envelope – no change.
- 1st floor – boarding started, mechanical and electrical rough-in of suite rooms 90% complete
- 2nd floor – interior drywall of rooms 95% complete, painting of rooms 95% complete, mill work delivered and installation started, flooring in rooms 80% complete, wall tiles installation started, electrical devices, switches, plugs, lights installation 70% complete, doors to suites 10% complete, door hardware installation started, hallways boarding 80% complete
- 3rd floor – 80% rooms boarded, 30% rooms taped
- 4th floor – interior drywall of rooms generally 95% complete, painting of rooms 75% complete, floor preparation - sanding is in progress, hallways boarded
- 5th floor – interior drywall of rooms 95% complete, painting of rooms 90% complete, flooring installation - 90% complete, wall tile installation started, hallways boarded
- Schedule delayed approximately two months due to the number of Change Orders & lack of performance of trades. Currently we have approximately $259,430 in changes out of cash allowance of $500,000.
- Overall progress – approximately 75% complete

Roach Avenue

- Design build contract signed with T.R. Hinan Construction
- T.R. Hinan and architects Raimondo & Associates worked on the design drawings and applied for foundation permit
- Demolition to start in October

Additional New Development

Investment in Affordable Housing-Extension (IAH-E), Year 2 funding has been allocated to three non-profit organizations and will result in the creation of 40 units for seniors and mental health consumers in Niagara:

	Amount	Units
Gateway Residences of Niagara, Huron Street, Niagara Falls	$720,000	9
Thorold Municipal Non-Profit, Ormond Street, Thorold	$1,228,912	14
Stamford Kiwanis, Barker Street, Niagara Falls	$1,089,088	17
TOTAL	**$3,038,000**	**40**

At the end of Q3:

- Gateway Residence of Niagara and Thorold Municipal Non-Profit – complete and operational
- Stamford Kiwanis – approximately 60% complete. On hold pending financing. Construction to resume in 2019.

5. Service Manager Responsibilities

APPEALS:

In Q3, **15 appeals** were heard (same as in 2017-Q3).

Five related to ongoing RGI eligibility

- Two for failure to provide information
  - One failed to report change in income that resulted in receiving RGI overpayment; must repay the amount. Upheld.
  - One given more time to supply missing information so RGI could be calculated. Tenant provided some information but not all; given more time, not received. Upheld.
- One where tenant disagreed with amount of former arrears. Committee allowed extra time to provide additional information. Upheld.
- One where overhoused tenant was denied request for additions to the household. Upheld.
- One related to review of balance owing for unreported income. NRH agreed to tenant's proposal to pay NRH the difference for only two months. Overturned.

Nine for decisions made by Housing Access (e.g. requests for special priority status, urgent status, additional bedroom). Five upheld, four overturned.

One from an overhoused tenant requesting the extra bedrooms due to health issues. Not eligible. Tenant decided to stay in current unit and pay market rent.

	2017-Q3	2017-Q4	2018-Q1	2018-Q2	2018-Q3
# of appeals	15	9	19	9	15

INVESTMENTS:

See Appendix A – Investment Report

6. Housing Access Centre & Centralized Waiting List

APPLICATION ACTIVITY:

# of Applications Received & Processed	739	# of Eligible Applications	713
# of Special Provincial Priority Status Applications	98	# of Ineligible Applications	26
# of Urgent Status Applications	128	# of Cancelled Applications	345
# of Homeless Status Applications	171	# of Applicants Housed	136

In Q3, **345 households were removed** from the Centralized Waiting List because they were no longer eligible, they found alternate housing or we were unable to make contact.

Q3 (July 1 to September 30, 2018)

CENTRALIZED WAITING LIST:

		2017-Q3	2017-Q4	2018-Q1	2018-Q2	2018-Q3
		# of households				
A	**Rent-Geared-to-Income (RGI) waiting list:**					
	Niagara resident RGI waiting list	4,282	4,344	4,287	4,562	4,642
	Applicants from outside of Niagara	641	657	639	692	758
TOTAL RGI waiting list:		**4,923**	**5,001**	**4,926**	**5,254**	**5,400**
	Housing Allowance: a set allowance to help applicants on the waiting list with affordability in the private market until housed in an RGI unit	428	505	569	605	618
A1	**RGI waiting list demographics:**					
	Seniors	2,038	2,061	2,064	2,173	2,236
	Adults no dependents	1,652	1,703	1,630	1,727	1,764
	Adults with dependents	1,233	1,237	1,232	1,354	1,400
A2	**RGI list further segmented (#'s included in A & A1):**					
	SPP – Special Provincial Priority (Ministry Priority): helps victims of violence separate permanently from their abuser	114	101	122	129	129
	URG – Urgent (Local Priority): for applicants with mobility barriers and/or extreme hardship where their current accommodation puts them at extreme risk and/or causes hardship	105	99	104	120	123
	HML – Homeless (Local Priority): provides increased opportunity for placement to homeless households	821	832	842	894	947
	SUP – Supportive/Transitional: provides targeted, provisional services to assist individuals to transition beyond basic needs to more permanent housing	26	19	17	17	13
B	**In addition, NRH manages:**					
	Overhoused: households who are living in subsidized accommodation with more bedrooms than they are eligible for	111	143	152	167	171
	Transfer: households who are currently living in subsidized accommodation and have requested a transfer to another provider	499	513	518	525	547
TOTAL RGI households on waiting list managed by NRH:		**5,533**	**5,657**	**5,596**	**5,946**	**6,118**
C	**NRH maintains a waiting list for market rent units (62 Non-Profit Housing Programs):**					
	Market: applicants who have applied for a market rent unit in the Non-Profit Housing Programs portfolio	592	591	578	597	629
TOTAL households on waiting list managed by NRH:		**6,125**	**6,248**	**6,174**	**6,543**	**6,747**
TOTAL individuals on waiting list managed by NRH:		**10,217**	**10,449**	**10,380**	**11,052**	**11,496**

Note: the above chart includes only those who apply to the Centralized Waiting List and does not capture the full number of those in need of affordable housing in Niagara.

Q3 (July 1 to September 30, 2018)

ESTIMATED WAIT TIMES:

CITY	SENIORS Age 55 and older		SINGLES Age 16-54		HOUSEHOLDS WITH DEPENDENTS			
	Bachelor	1 Bed	Bachelor	1 Bed	2 Bed	3 Bed	4 Bed	5 Bed
	YEARS							
Fort Erie	-	9	2	8.5	2	1	5	-
Grimsby	-	4	-	-	-	-	-	-
Lincoln	-	4.5	-	12	9	8	-	-
Niagara Falls	4	6	-	16	5	3	7	14
Niagara-on-the-Lake	-	6.5	-	-	-	-	-	-
Pelham	-	3.5	-	-	-	-	-	-
Port Colborne	-	4.5	-	13	3	3	3	-
St. Catharines	-	6.5	9	13	3.5	3	9	12
Thorold	-	6.5	-	10	6	8	-	-
Welland	-	5	6	15	5	2.5	7	2
West Lincoln	-	4	-	-	5.5	7	-	-

- no units of this size available in this community **January 2018**

Please note:

- wait time information can fluctuate and is an approximation only
- wait times may not reflect the actual time one may wait for affordable housing

Quarterly Report on Cash / Investments / Reserves for Period Ending September 30, 2018

	This Quarter Balance	Last Quarter Balance	Variance $	Variance %	Comments
BANK ACCOUNTS					
Current Bank Account: Royal Bank account used for day-to-day operations for the owned units. Also to cash flow various short terms programs funded by Prov and Fed gov't usch as development, homeownership and capital repair programs.	**$14,961,182.38**	**9,692,265.71**	**5,268,916.67**	**54.36%**	Since the February 2016 transition to PeopleSoft, day-to-day accounts payable transactions are paid by the Region through PeopleSoft. Reconciliation of the due to the Region account will be performed on a regular basis to transfer amounts due to the Region.
Investment Bank Account: Used to hold funds "In Trust" for designated Housing Providers for capital work.					Interest earned at a rate of RBC Prime minus 1.70% on balances in bank and investment accounts.
A CMHA: Reserves held for CMHA Units.	4,592.36	4,592.36	-	0.00%	
B Ganawageh Capital Fund:	97,971.49	97,971.49	-	0.00%	Withdrawals are made in accordance with approved procedures. Current quarter interest.
C Due (From) Current Account	275,734.45	273,939.50	1,794.95	0.66%	
Total Investment Bank Accounts	**378,298.30**	**376,503.35**	**1,794.95**	**0.48%**	

NRH 15-2018
Appendix A
18-176-4.2.
Nov. 16, 2018

Quarterly Report on Cash / Investments / Reserves for Period Ending September 30, 2018

	This Quarter Balance	Last Quarter Balance	Variance $	Variance %	Comments
INVESTMENT VEHICLES - FUND ACCOUNTING					
Various investment vehicles are used to protect and optimize the cash that is held for specified purposes. Investments are both short-term and long-term in nature. These funds are intended to ensure continued growth without capital erosion by inflation.					
Current Instruments:	2 Year GIC, $521,565; due date is 05/16/2019; interest rate of 1.26% to 1.63%				
RBC Investment Savings = $4,420,647.69	2 Year GIC, $188,000; due date is 08/17/2020; interest rate of 2.65% to 2.74%				
	2 Year GIC, $376,000; due date is 08/20/2020; interest rate of 2.60% to 2.65%				
	2 Year GIC, $264,280; due date is 08/21/2020; interest rate of 2.53%				
	2 Year GIC, $497,000; due date is 08/15/2019; interest rate of 1.45% to 2.25%.				
1 PASS THROUGH FEDERAL/PROVINCIAL PROGRAM FUNDING					
A AHP - New Development	65,375.90	65,375.90	-	0.00%	
2 ADMINISTRATION FUNDING					
B Affordable Housing Prog & Housing Allowance Prog	-	-	-	0.00%	
C IAH - Admin Fee	199,517.61	(32,048.08)	231,565.69	-722.56%	
3 RECONCILIATION					
D Due (From)Current Account	6,024,337.39	6,232,416.58	(208,079.19)	-3.34%	Due to current account
Total	**6,289,230.90**	**6,265,744.40**	**23,486.50**	**0.37%**	

Quarterly Report on Reserves for Period Ending September 30, 2018

Description	Balances at December 31, 2017	Year-to-date Net Transfers from (to) Operating	Year-to-date Capital Transfers	Balances at September 30, 2018	Net Transfers Forecast from (to) Operating*	Capital Commitments *	Forecasted Balance at December 31, 2018
NRH Owned Units Public/Local Housing Corp:	$ 4,327,035	$ 292,337	$ (596,001)	$ 4,023,371	$ 97,446	$ -	$ 4,120,816
Niagara Regional Housing:							
Emergency Capital Funding for Housing Providers	1,924,871			1,924,871			1,924,871
Title Normalization for NRH Owned Units	712,381			712,381			712,381
New Initiatives, other social housing purposes and any new deposits are added to this category	4,513,047	-	(1,110,000)	3,403,047	-	-	3,403,047
Niagara Regional Housing TOTAL:	7,150,299	-	(1,110,000)	6,040,299	-	-	6,040,299
Total NRH Capital Reserves	**$ 11,477,334**	**$ 292,337**	**$ (1,706,001)**	**$ 10,063,670**	**$ 97,446**	**$ -**	**$ 10,161,115**
NRH Rent Supplement:	$ 302,301	$ (18,000)		284,301	(6,000)		278,301
Total NRH Stabilization Reserves	**$ 302,301**	**$ (18,000)**	**$ -**	**$ 284,301**	**$ (6,000)**	**$ -**	**$ 278,301**
NRH Employee Future Benefits:	$ 792,733	$ -	$ -	792,733	-	-	792,733
Total Future Liability Reserves	**$ 792,733**	**$ -**	**$ -**	**$ 792,733**	**$ -**	**$ -**	**$ 792,733**
Total	**$ 12,572,368**	**$ 274,337**	**$ (1,706,001)**	**$ 11,140,704**	**$ 91,446**	**$ -**	**$ 11,232,149**

* 2018 Budget amounts

Interest no longer applied by approval of Regional Council (CSD 02-2013).

503 NRH Owned Units Public/Local Housing Corp: This reserve was set-up by the Board of Directors as a Reserve Fund in September 2004 for capital expenses related to the NRH owned units.

502 Niagara Regional Housing
This reserve includes three major elements: (1) Emergency Capital Funding for Housing Providers - *intent to support capital repair program for housing providers; surplus from housing programs should be directed to this component of the reserve* (2) Title Normalization for NRH Owned Units (3) New Initiatives / New Development - *$2.29M is restricted to future development/intensification in Niagara Falls (see 2017 Year-End Transfer) - expected to cover $810k - 100% costs related to 2019 NF capital project; remainder unrestricted;* ***Potential acquisition / intensification effort identified by NRH SMT utilizing Provincial SIF funds currently utilizes $275k of unrestricted balance***

NRH Rent Supplement: This fund was set-up by the Board of Directors in December 2008 (year end) for a new Rent Supplement program. This Rent Supplement program is budgeted annually and withdrawal from the Reserve matches that year's expenditures.

NRH Employee Future Benefits: This fund was set-up by the Board of Directors in 2011 to fund Employee Future Benefits. (retiree benefits, sick leave, vacation. etc.).

Niagara Region

PUBLIC HEALTH
1815 Sir Isaac Brock Way, Thorold, ON L2V 4T7
905-980-6000 Toll-free: 1-800-263-7215

MEMORANDUM

CWCD 330-2018

Subject: **Opioid Work Update**

Date: **October 5, 2018**

To: **Board of Health**

From: **Dr. Andrea Feller, Associate Medical Officer of Health**

In our goal to continue to keep you updated around opioids, please see the following.

1. Positive Living Niagara (PLN) and the Overdose Prevention and Education Network of Niagara (OPENN) have learned that the Overdose Prevention Site (OPS) review by the province has been extended, we think until the end of October. The federal exemptions required for these sites have been extended another six months. A research approach that re-analyzed data and called into question the effectiveness of these sites has been retracted (in other words, the validity of the findings are questionable according to science). https://www.ijdp.org/article/S0955-3959(18)30180-4/fulltext

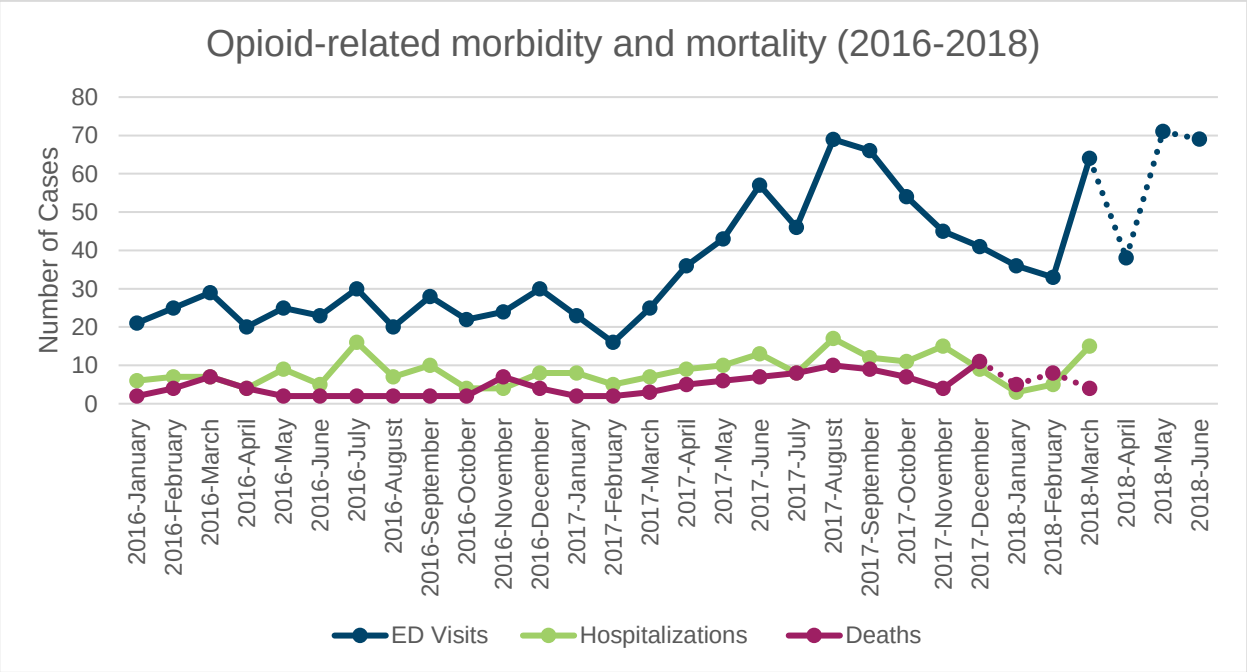
2. Naloxone has been distributed to 19 key agencies who are actively distributing within the critical social and close peer network, as well as appropriate patient provisions through St. John Ambulances, Niagara Health, and EMS. Nine other agencies are in the process of receiving naloxone (unchanged since last update). All agencies that have chosen to be a public access point are listed at: https://www.ontario.ca/page/where-get-free-naloxone-kit

3. In coordination with CASON, community presentations have been booked with libraries across the region focusing on opioids, naloxone, and promoting health and social services available.

4. The website is updated as data becomes available. These updates are available through NRPH&ES site (in addition to elsewhere on the Region's site). https://www.niagararegion.ca/living/health_wellness/alc-sub-abuse/drugs/overdose-prevention.aspx

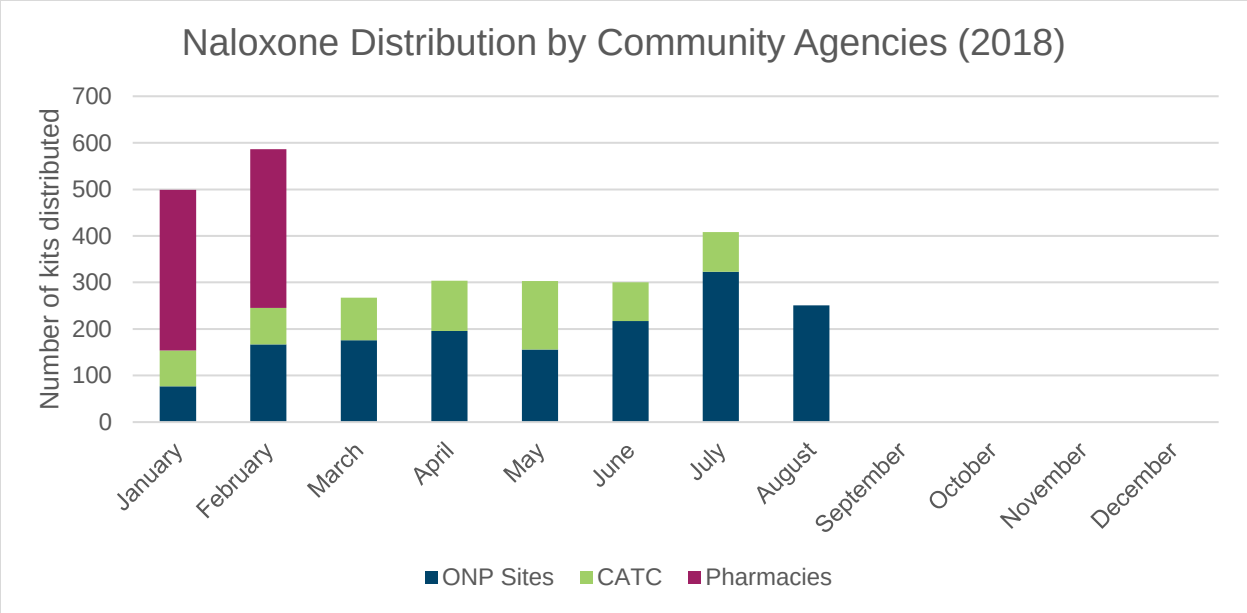
5. For this report, we have included some **preliminary** data (in broken lines) in addition to the data found on the website. A summary of opioid-related population health outcome and naloxone distribution data available to date follows. Death data have been received through March. It is possible that the increase in availability of naloxone and education have made an impact. Reports from partners indicate that deaths have unfortunately risen over the summer, similar to last year.

As of January 2018, a new data extraction process (i.e. First Watch) has been made available to track EMS responses to suspected opioid overdoses. This process is automated, faster and applies standardized inclusion and exclusion criteria to detect suspected overdoses. Currently, we are working on revising this process to align better with other health units across the province.

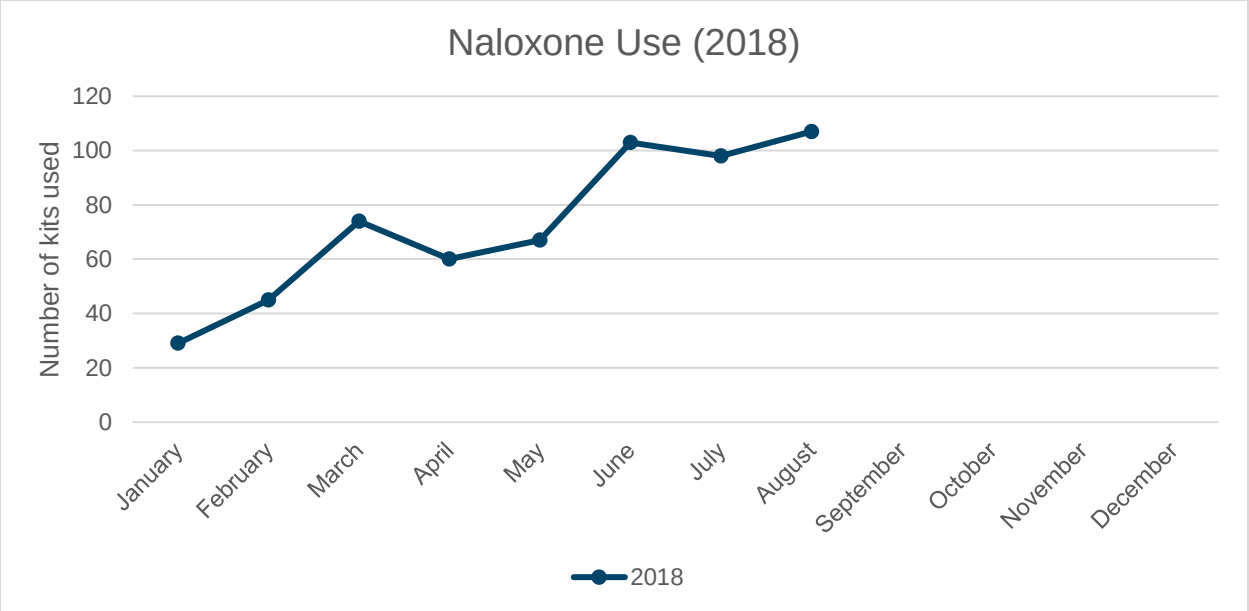


Data source: National Ambulatory Care Reporting System, 2018; Discharge Abstract Database, 2018; Office of the Chief Coroner of Ontario, 2017.

- In 2016 there were a total of 297 opioid poisoning emergency department (ED) visits, and 82 hospitalizations
- In 2017 there was a total of 521 opioid poisoning ED visits (a 75% increase from 2016) and 124 hospitalizations (a 50% increase from 2016)
- In the first quarter of 2018, there have been 133 opioid poisoning ED visits and 23 hospitalizations
- In 2017 there were 74 opioid overdose deaths, which is an 85% increase from 2016, where there were 40 deaths. In 2017, fentanyl was the most common type of opioid present at the time of death (present in 58% of deaths), followed by hydromorphone (present in 20% of deaths).



Data source: Niagara Region Naloxone Distribution and Use [2018].



Data source: Niagara Region Naloxone Distribution and Use [2018].

- Currently, naloxone can be obtained from participating Ontario pharmacies, community health centres, methadone clinics, detention centres, and addiction treatment facilities. NRPH is ordering, coordinating, and supervising naloxone inventory, distributing it to community agencies to in turn distribute to their clients, and reporting on its distribution and use to the Ministry of Health and Long-Term Care (MOHLTC).
- As of January 2018, a new data collection system has been implemented for naloxone distribution and use in the community

    - Data on naloxone use may change over time as more individuals have their kits replaced
- The graph on naloxone distribution in the community now contains data from Ontario Naloxone Program (ONP) sites, Canadian Addiction Treatment Centres (CATC), and pharmacies in an effort to show a more holistic picture of distribution within the community
    - Data from pharmacies is currently unavailable
- Public Health Units are working with the MOHLTC to obtain a more fulsome picture of data related to naloxone distribution and use

We will continue to keep you updated. Other pertinent correspondence is listed below:

CWCD 08-2018
CWCD 19-2018
CWCD 39-2018
CWCD 44-2018
CWCD 83-2018
CWCD 109-2018
CWCD 140-2018
CWCD 174-2018
CWCD 205-2018
CWCD 218-2018
CWCD 283-2018
CWCD 300-2018

Respectfully submitted and signed by

_____
Andrea Feller, MD, MS, FAAP, FACPM
Associate Medical Officer of Health

Niagara Region

PUBLIC HEALTH
1815 Sir Isaac Brock Way, Thorold, ON L2V 4T7
905-980-6000 Toll-free: 1-800-263-7215

MEMORANDUM

CWCD 353-2018

Subject: **Opioid Work Update**

Date: **October 26, 2018**

To: **Board of Health**

From: **Dr. Andrea Feller, Associate Medical Officer of Health**

In our goal to continue to keep you updated around opioids, please see the following.

1. The Overdose Prevention Site (OPS) review by the province has been completed. The St. Catharines site is now “unpaused”. There will be an application process for something called “Consumption and Treatment Services sites”. Early information is very much in line with current plans for the St. Catharines site, but any further details are pending at the time of writing this memo.

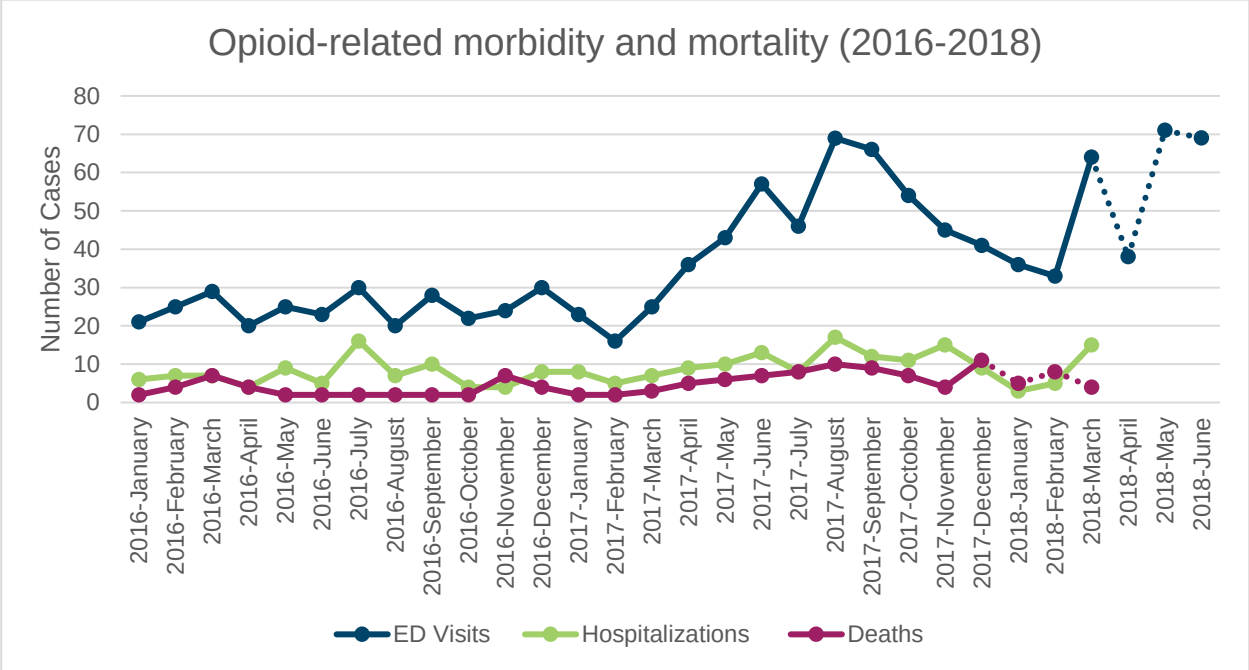
2. Naloxone has been distributed to 21 key agencies who are actively distributing within the critical social and close peer network, in addition to appropriate patient provisions through St. John Ambulances, Niagara Health sites, and EMS. Seven other agencies are in the process of receiving naloxone (unchanged since last update). All agencies that have chosen to be a public access point are listed at: https://www.ontario.ca/page/where-get-free-naloxone-kit

3. The EMS Mental Health and Addictions Response Team (MHART) is responding in real time to mental health and addictions calls including active opioid overdoses alongside the responding paramedic crews; the purpose of which is to intervene earlier especially for patients who refuse transport to the ED. In addition, this team is performing outreach to those individuals that accessed 911 for opioid overdose or addictions issues. Early results have been very promising.

4. The website is updated as data becomes available. These updates are available through PH&ES site (in addition to elsewhere on the Region’s site). https://www.niagararegion.ca/living/health_wellness/alc-sub-abuse/drugs/overdose-prevention.aspx

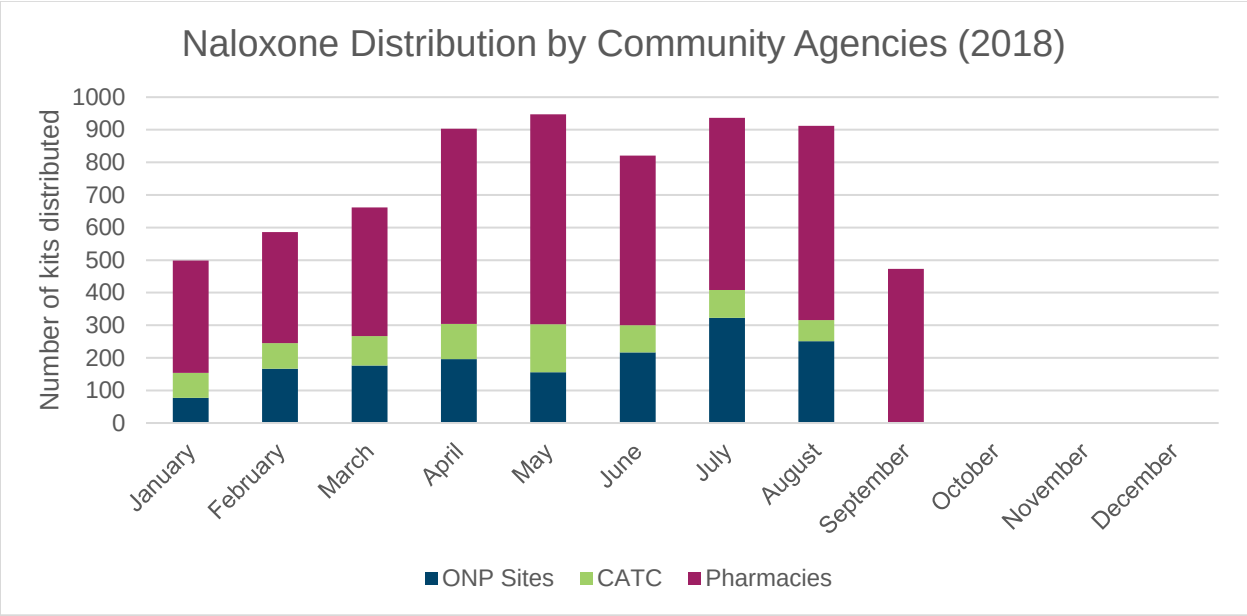
5. For this report, we have included some **preliminary** data (in broken lines) in addition to the data found on the website. A summary of opioid-related population health outcome and naloxone distribution data available to date follows. Death data have been received through March. It is possible that the increase in availability of naloxone and education have made an impact. Reports from partners indicate that deaths have unfortunately risen over the summer, similar to last year.

As of January 2018, a new data extraction process (i.e. First Watch) has been made available to track EMS responses to suspected opioid overdoses. This process is automated, faster and applies standardized inclusion and exclusion criteria to detect suspected overdoses. Currently, we are working on revising this process to align better with other health units across the province.

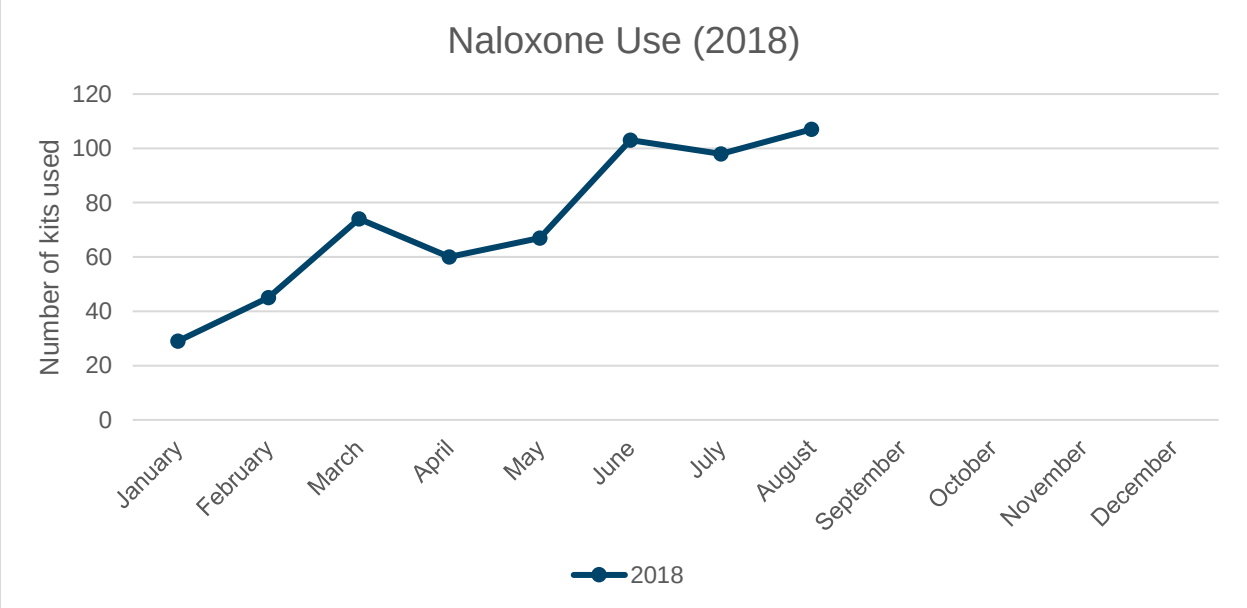


Data source: National Ambulatory Care Reporting System, 2018; Discharge Abstract Database, 2018; Office of the Chief Coroner of Ontario, 2017.

- In 2016 there were a total of 297 opioid poisoning emergency department (ED) visits, and 82 hospitalizations
- In 2017 there was a total of 521 opioid poisoning ED visits (a 75% increase from 2016) and 124 hospitalizations (a 50% increase from 2016)
- In the first quarter of 2018, there have been 133 opioid poisoning ED visits and 23 hospitalizations
- In 2017 there were 74 opioid overdose deaths, which is an 85% increase from 2016, where there were 40 deaths. In 2017, fentanyl was the most common type of opioid present at the time of death (present in 58% of deaths), followed by hydromorphone (present in 20% of deaths).



Data source: Niagara Region Naloxone Distribution and Use [2018].



Data source: Niagara Region Naloxone Distribution and Use [2018].

- Currently, naloxone can be obtained from participating Ontario pharmacies, community health centres, methadone clinics, detention centres, and addiction treatment facilities. NRPH is ordering, coordinating, and supervising naloxone inventory, distributing it to community agencies to in turn distribute to their clients, and reporting on its distribution and use to the Ministry of Health and Long-Term Care (MOHLTC).
- As of January 2018, a new data collection system has been implemented for naloxone distribution and use in the community

    - Data on naloxone use may change over time as more individuals have their kits replaced
- The graph on naloxone distribution in the community now contains data from Ontario Naloxone Program (ONP) sites, Canadian Addiction Treatment Centres (CATC), and pharmacies in an effort to show a more holistic picture of distribution within the community
    - Data from ONP sites and CATC is currently not available for September
    - Data from pharmacies is now available
- Public Health Units are working with the MOHLTC to obtain a more fulsome picture of data related to naloxone distribution and use

We will continue to keep you updated. Other pertinent correspondence is listed below:

CWCD 08-2018
CWCD 19-2018
CWCD 39-2018
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CWCD 283-2018
CWCD 300-2018
CWCD 330-2018

Respectfully submitted and signed by

_____
Andrea Feller, MD, MS, FAAP, FACPM
Associate Medical Officer of Health

Niagara Region

PUBLIC HEALTH
1815 Sir Isaac Brock Way, Thorold, ON L2V 4T7
905-980-6000 Toll-free: 1-800-263-7215

MEMORANDUM

CWCD 379-2018

Subject: **Opioid Work Update**

Date: **November 16, 2018**

To: **Board of Health**

From: **Dr. Andrea Feller, Associate Medical Officer of Health**

In our goal to continue to keep you updated around opioids, please see the following.

1. Positive Living Niagara and the community plan to be able to open the St. Catharines Overdose Prevention Site (OPS) in December. Public Health staff are supporting the community's application for the new Consumption and Treatment Services (CTS) sites, which will be permanent. Application includes a process involving both federal approval and provincial application and approval. Positive Living Niagara will be sharing information and requesting Board of Health support.

2. Naloxone has been distributed to 23 key agencies who are actively distributing within the critical social and close peer network, in addition to appropriate patient provisions through St. John Ambulances, Niagara Health sites, and EMS. Four other agencies are in the process of receiving naloxone (unchanged since last update). All agencies that have chosen to be a public access point are listed at: https://www.ontario.ca/page/where-get-free-naloxone-kit

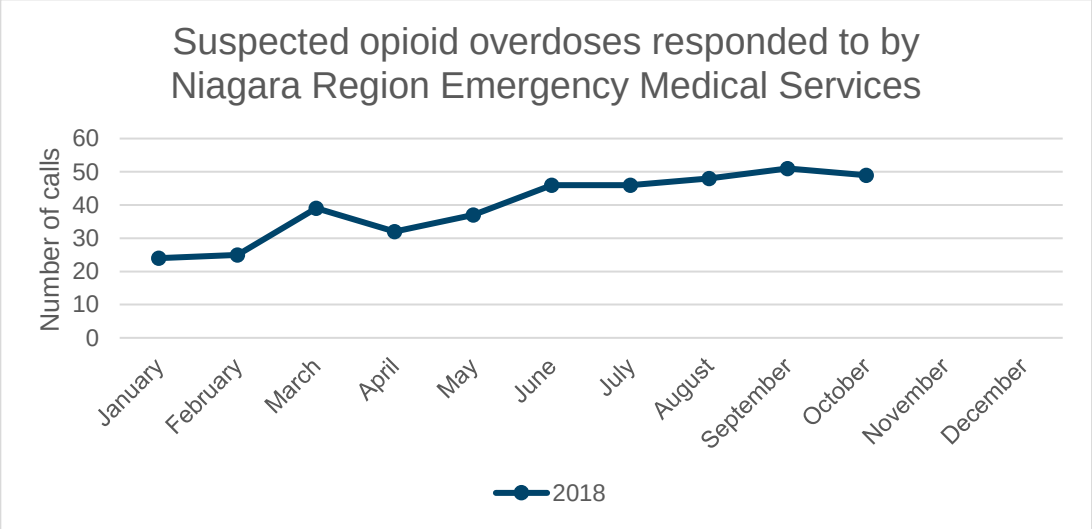
3. National Addiction Awareness Week is November 26 to December 2. The hashtag this year is #allwalksoflife. The Film House will begin showings of the highly acclaimed movie "Beautiful Boy" that week. On December 6, Community Addiction Services of Niagara (CASON) will be hosting a panel discussion following that evening's showing of the film.

   Movie "Beautiful Boy" starring Steve Carell and Timothy Chalamet
   Dec. 6, 2018
   The Film House (Inside the PAC downtown St. Catharines)
   Speakers discussion panel to follow the movie

4. The website is updated as data becomes available. These updates are available through PH&ES site (in addition to elsewhere on the Region's site). https://www.niagararegion.ca/living/health_wellness/alc-sub-abuse/drugs/overdose-prevention.aspx

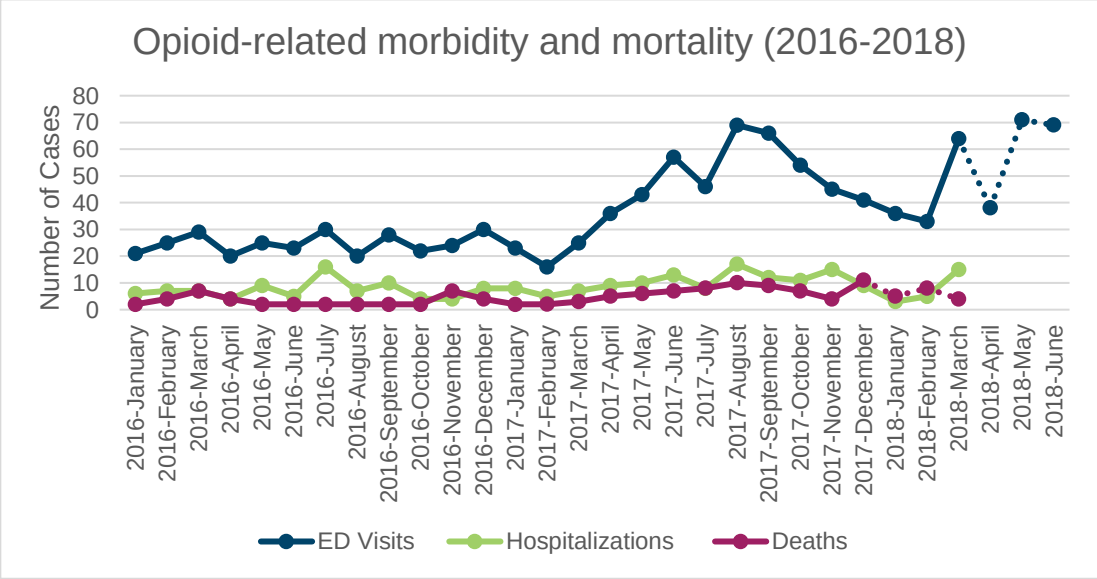
5. For this report, we have included some **preliminary** data (in broken lines) in addition to the data found on the website. A summary of opioid-related population

health outcome and naloxone distribution data available to date follows. Death data have been received through March. It is possible that the increase in availability of naloxone and education have made an impact. Reports from partners indicate that deaths have unfortunately risen over the summer, similar to last year.



Data source: EMS Edge [2018].

As of January 2018, a new data extraction process (i.e. First Watch) has been made available to track EMS responses to suspected opioid overdoses. This process is automated, faster and applies standardized inclusion and exclusion criteria to detect suspected overdoses. Currently, we are working on revising this process to align better with other health units across the province.



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- In 2016 there were a total of 297 opioid poisoning emergency department (ED) visits, and 82 hospitalizations
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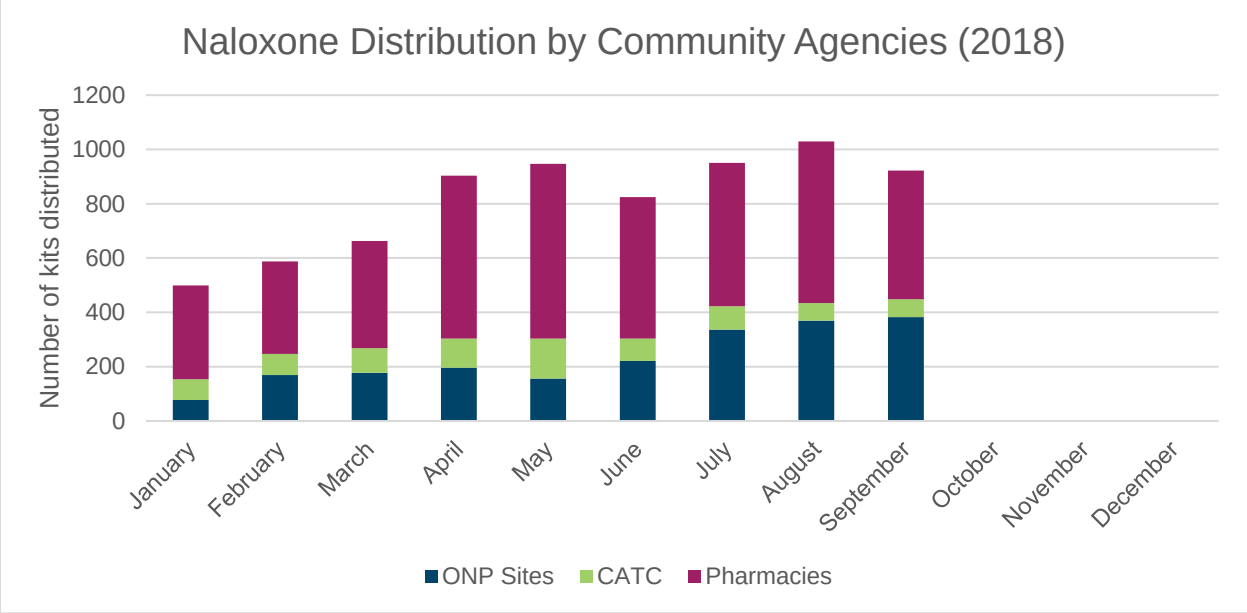
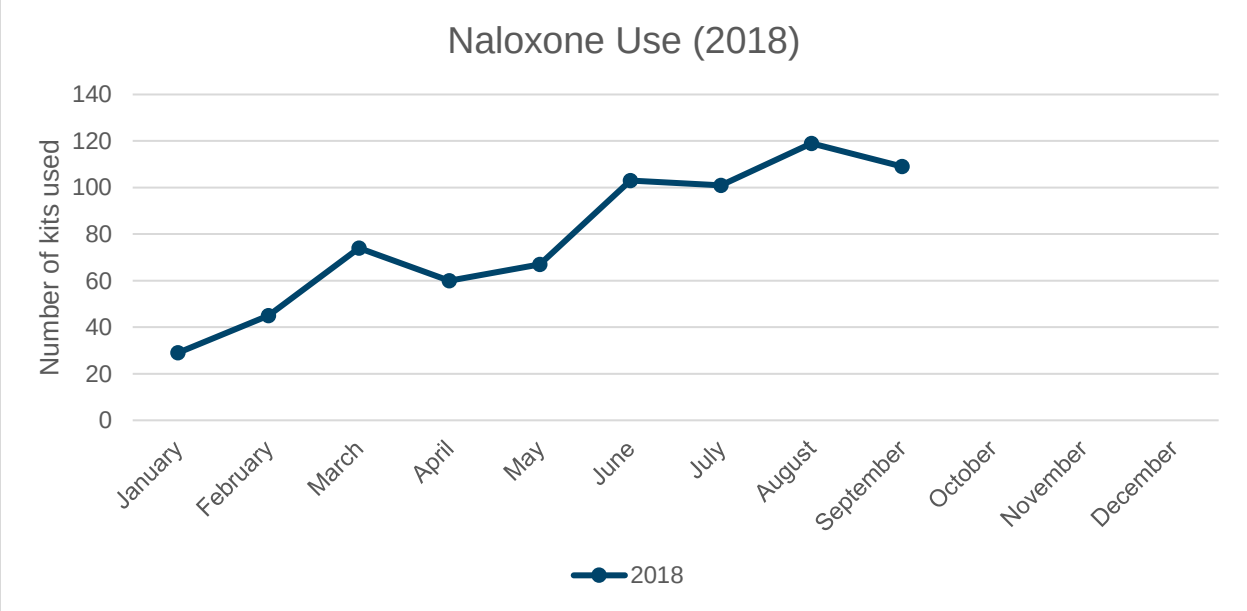


Data source: Niagara Region Naloxone Distribution and Use [2018].



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Respectfully submitted and signed by

Andrea Feller, MD, MS, FAAP, FACPM
Associate Medical Officer of Health

Niagara Region

PUBLIC HEALTH
1815 Sir Isaac Brock Way, Thorold, ON L2V 4T7
905-980-6000 Toll-free: 1-800-263-7215

MEMORANDUM

CWCD 407-2018

Subject: **Opioid Work Update**

Date: **December 7, 2018**

To: **Board of Health**

From: **Dr. Andrea Feller, Associate Medical Officer of Health**

In our goal to continue to keep you updated around opioids, please see the following.

1. Positive Living Niagara and the community were able to open the St. Catharines Overdose Prevention Site (OPS) on December 3. Public Health staff are supporting the community's application for the new Consumption and Treatment Services (CTS) site, which is due December 14. Positive Living Niagara will be sharing information and requesting Board of Health support on December 13.

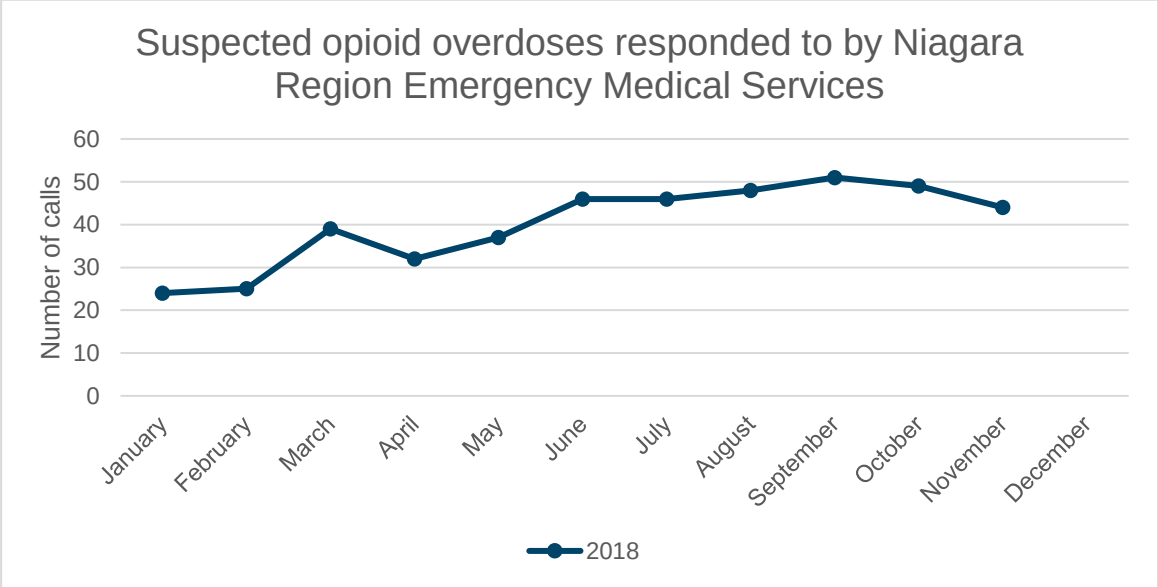
2. Naloxone has been distributed to 23 key agencies who are actively distributing within the critical social and close peer network, in addition to appropriate patient provisions through St. John Ambulances, Niagara Health sites, and EMS. Four other agencies are in the process of receiving naloxone (unchanged since last update). All agencies that have chosen to be a public access point are listed at: https://www.ontario.ca/page/where-get-free-naloxone-kit

3. As part of the EMS system transformation, data is already suggesting potential small reductions in call volume related to the Mental Health team. This will be verified.

4. The movie, "Beautiful Boy" was aired at The Film House on December 6 hosted by Community Addiction Services of Niagara (CASON). Staff participated on a speaker's panel after the movie.

5. The website is updated as data becomes available. These updates are available through PH&ES site (in addition to elsewhere on the Region's site). https://www.niagararegion.ca/living/health_wellness/alc-sub-abuse/drugs/overdose-prevention.aspx

6. For this report, we have included some **preliminary** data (in broken lines) in addition to the data found on the website. A summary of opioid-related population health outcome and naloxone distribution data available to date follows. Trends are mirroring those seen last year.



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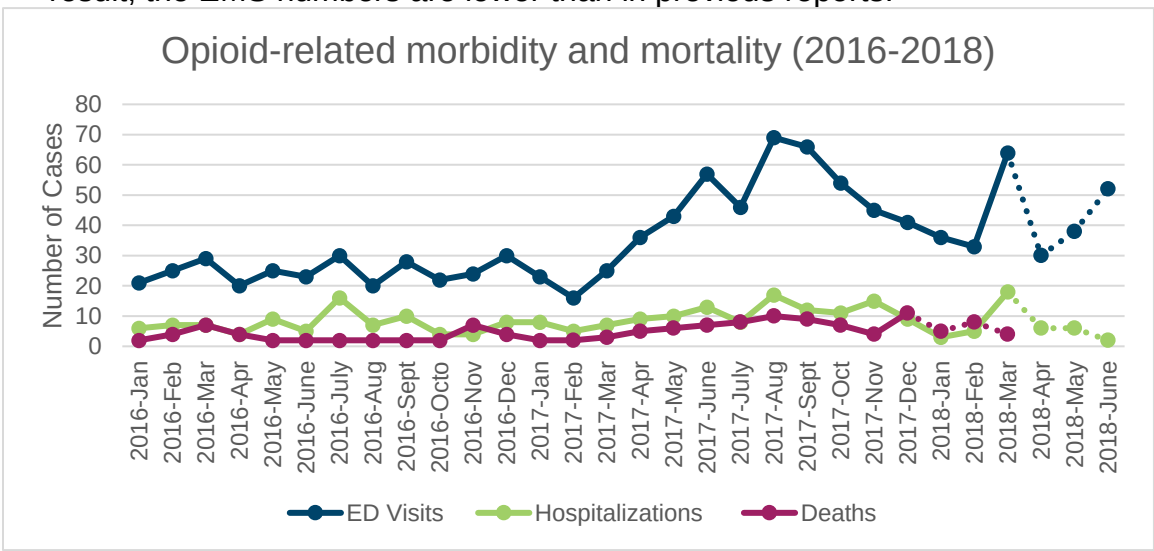
- As of November 2018, a new data extraction process has been made available to track EMS responses to suspected opioid overdoses. This process is automated, faster and applies standardized inclusion and exclusion criteria to detect suspected overdoses that is better aligned with what is being reported by other ambulatory services across the province. As a result, the EMS numbers are lower than in previous reports.



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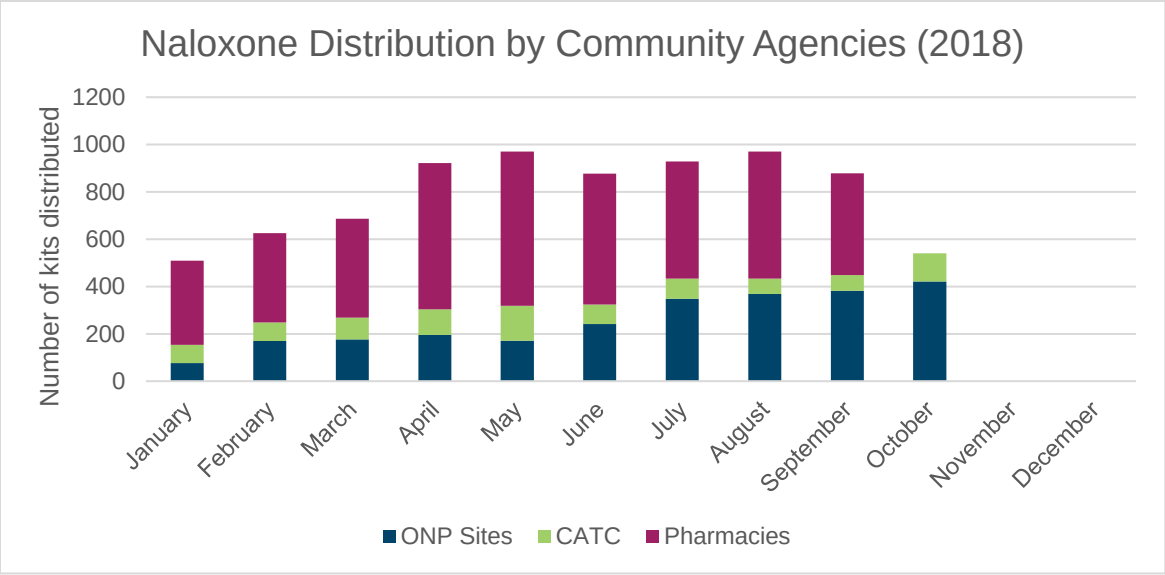

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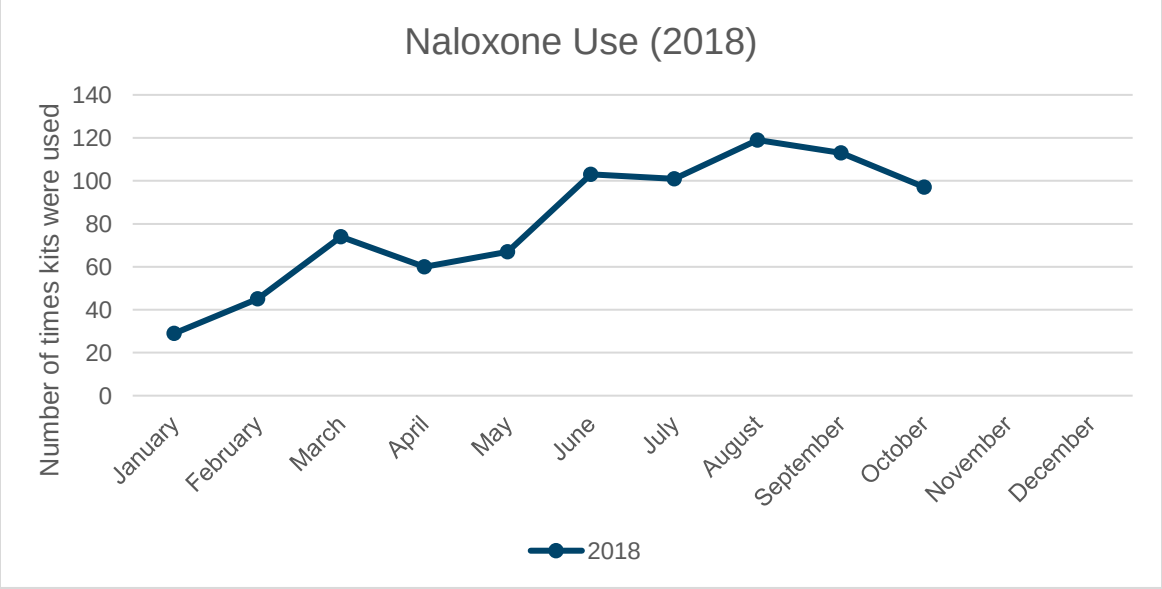

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Respectfully submitted and signed by

_____
Andrea Feller, MD, MS, FAAP, FACPM
Associate Medical Officer of Health

Niagara Region

PUBLIC HEALTH
1815 Sir Isaac Brock Way, Thorold, ON L2V 4T7
905-980-6000 Toll-free: 1-800-263-7215

MEMORANDUM

CWCD 440-2018

Subject: **Opioid Work Update**

Date: **December 28, 2018**

To: **Board of Health**

From: **Dr. Andrea Feller, Associate Medical Officer of Health**

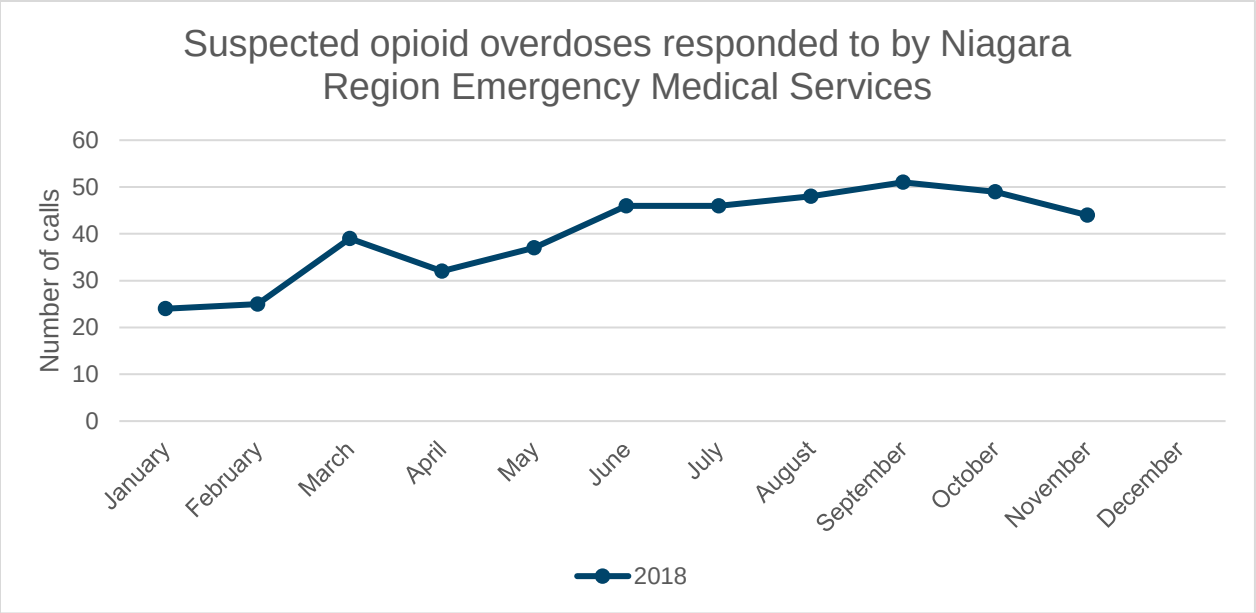
In our goal to continue to keep you updated around opioids, please see the following.

1. Positive Living Niagara and the community were able to open the St. Catharines Overdose Prevention Site (OPS) on December 3. With support from the Overdose Prevention and Education Network of Niagara (OPENN), the City of St. Catharines, and Niagara Region, the Consumption and Treatment Services (CTS) site application was submitted on time in December as well as the application for federal exemption. At the time of writing this memo, we are unsure of when responses will be received.

2. Naloxone has been distributed to 23 key agencies who are actively distributing within the critical social and close peer network, in addition to appropriate patient provisions through St. John Ambulances, Niagara Health sites, and EMS. Four other agencies are in the process of receiving naloxone (unchanged since last update). All agencies that have chosen to be a public access point are listed at: https://www.ontario.ca/page/where-get-free-naloxone-kit *(this has not changed due to the holiday time period).*

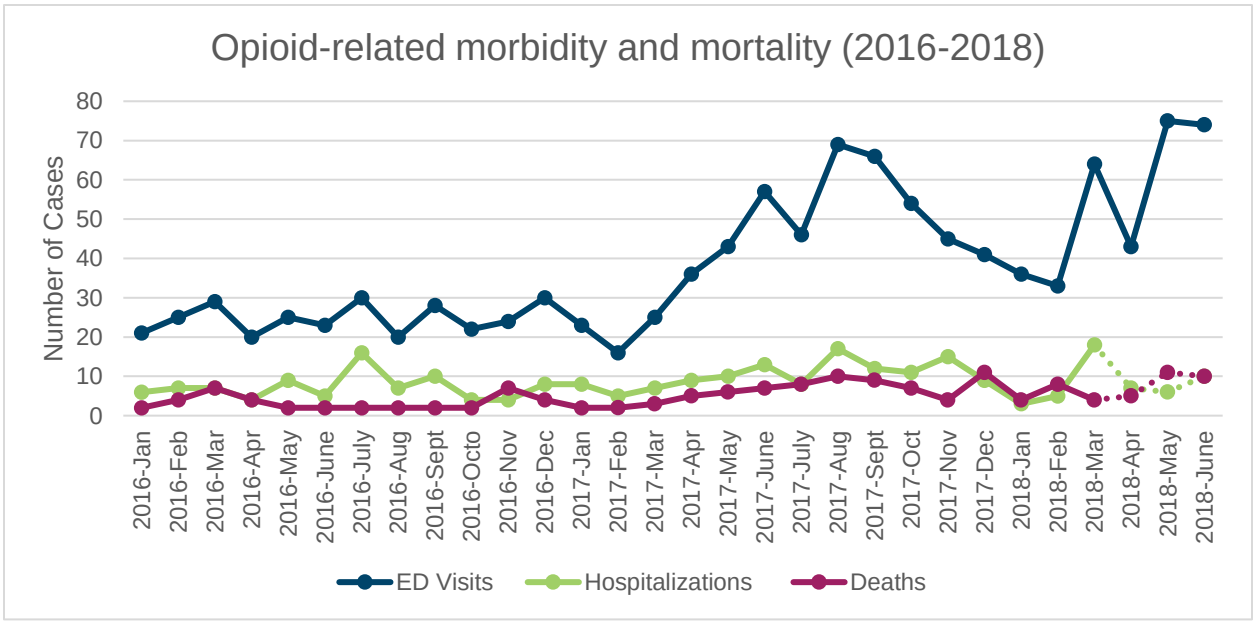
3. The website is updated as data becomes available. These updates are available through PH&ES site (in addition to elsewhere on the Region's site). https://www.niagararegion.ca/living/health_wellness/alc-sub-abuse/drugs/overdose-prevention.aspx

4. For this report, we have included some **preliminary** data (in broken lines) in addition to the data found on the website. A summary of opioid-related population health outcome and naloxone distribution data available to date follows. Trends are mirroring those seen last year.



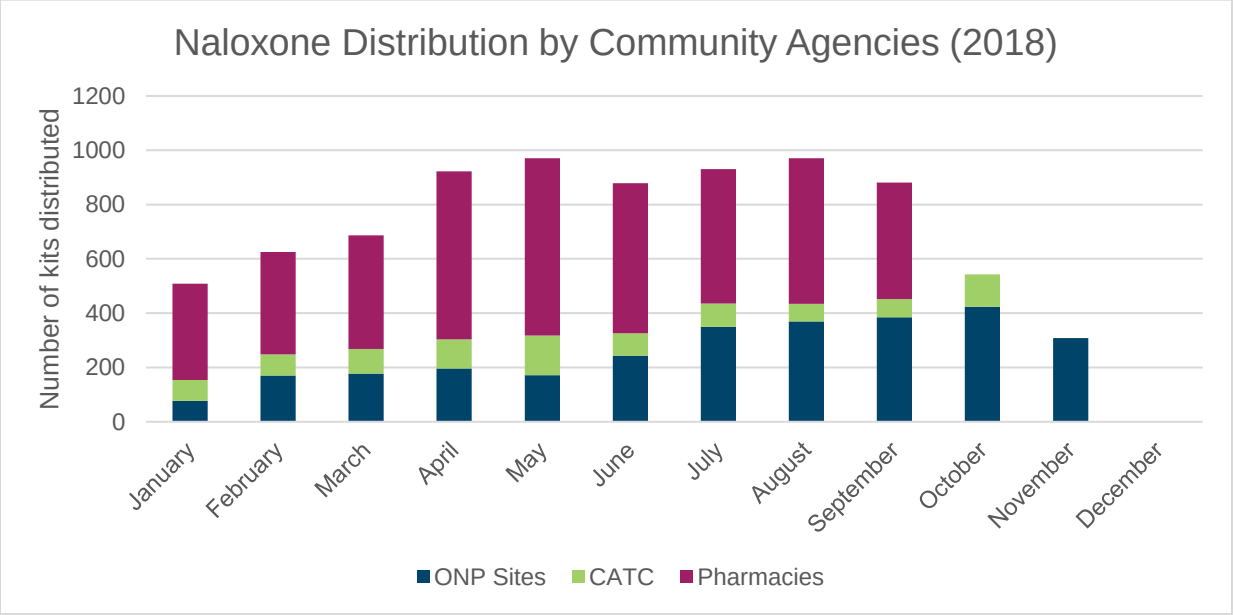
Data source: EMS Edge [2018].

- As of November 2018, a new data extraction process has been made available to track EMS responses to suspected opioid overdoses. This process is automated, faster and applies standardized inclusion and exclusion criteria to detect suspected overdoses that is better aligned with what is being reported by other ambulatory services across the province. As a result, the EMS numbers are lower than in previous reports.

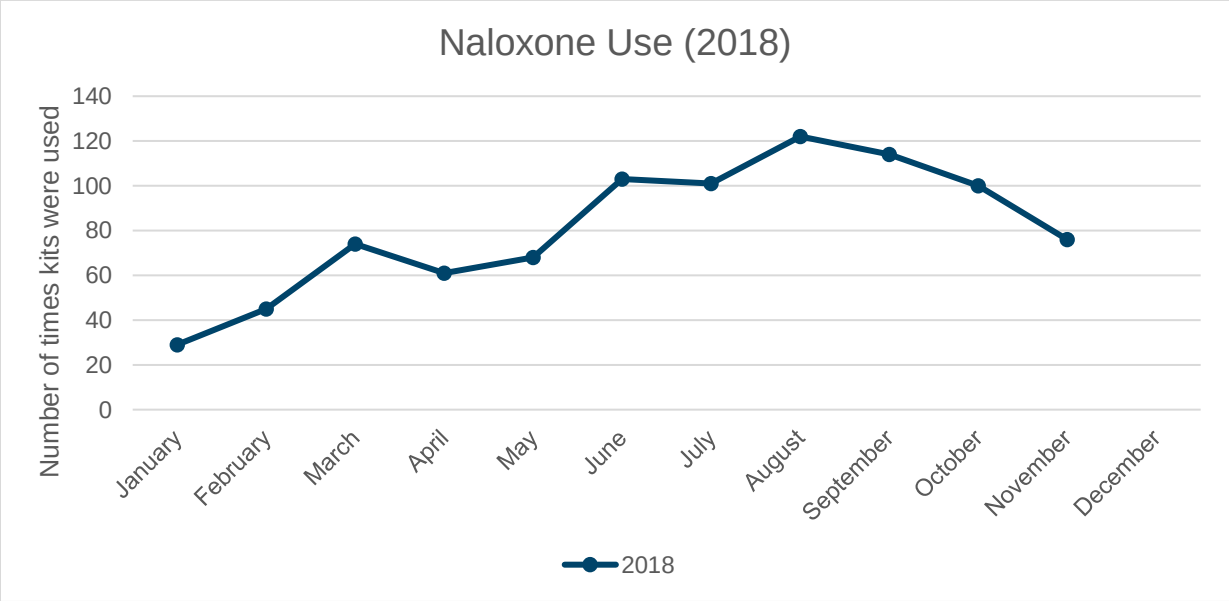


Data source: National Ambulatory Care Reporting System, 2018; Discharge Abstract Database, 2018; Office of the Chief Coroner of Ontario, 2017.

- In 2016 there were a total of 297 opioid poisoning emergency department (ED) visits, and 82 hospitalizations
- In 2017 there was a total of 521 opioid poisoning ED visits (a 75% increase from 2016) and 124 hospitalizations (a 50% increase from 2016)
- In the first half of 2018, there have been 325 opioid poisoning ED visits
- In the first quarter of 2018, there have been 23 hospitalizations related to opioid poisonings. Data from the second quarter of 2018 is still preliminary.
- In 2017 there were 74 opioid overdose deaths, which is an 85% increase from 2016, where there were 40 deaths. In 2017, fentanyl was the most common type of opioid present at the time of death (present in 58% of deaths), followed by hydromorphone (present in 20% of deaths).



Data source: Niagara Region Naloxone Distribution and Use [2018].



Data source: Niagara Region Naloxone Distribution and Use [2018].

- Currently, naloxone can be obtained from participating Ontario pharmacies, community health centres, methadone clinics, detention centres, and addiction treatment facilities. PH&ES is ordering, coordinating, and supervising naloxone inventory, distributing it to community agencies to in turn distribute to their clients, and reporting on its distribution and use to the Ministry of Health and Long-Term Care (MOHLTC).
- As of January 2018, a new data collection system has been implemented for naloxone distribution and use in the community
    - Data on naloxone use may change over time as more individuals have their kits replaced
- The graph on naloxone distribution in the community now contains data from Ontario Naloxone Program (ONP) sites, Canadian Addiction Treatment Centres (CATC), and pharmacies in an effort to show a more holistic picture of distribution within the community

We will continue to keep you updated. Other pertinent correspondence is listed below:

CWCD 08-2018
CWCD 19-2018
CWCD 39-2018
CWCD 44-2018
CWCD 83-2018
CWCD 109-2018
CWCD 140-2018
CWCD 174-2018
CWCD 205-2018
CWCD 218-2018
CWCD 283-2018
CWCD 300-2018
CWCD 330-2018
CWCD 353-2018
CWCD 379-2018
CWCD 407-2019

Respectfully submitted and signed by

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