# Disposition of Resolutions 2024

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**2024 Annual General Meeting**
**Thursday, June 6, 2024**

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**alPHa RESOLUTION A24-01**

**TITLE:** **Permitting Applications for Automatic Prohibition Orders under the *Smoke Free Ontario Act, 2017* for Vapour Product Sales Offences**

**SPONSOR:** **Middlesex-London Health Unit (MLHU)**

**WHEREAS** In Ontario, there are approximately 800 age-restricted specialty vape stores and 12,000 retail outlets that sell both commercial tobacco and vapour products; and

**WHEREAS** in Ontario, under the *Smoke-Free Ontario Act, 2017,* the sale of menthol, mint, and tobacco-flavoured e-cigarettes (vapour products) is permitted at convenience stores, gas stations, and any other retail environment where vulnerable individuals have access; and

**WHEREAS** in Ontario, the sale of menthol, mint, tobacco-flavoured, fruit, and candy-flavoured vapour products are permitted at age-restricted specialty vape stores; and

**WHEREAS** in 2023, approximately 414 charges were issued against retailers of vapour products in Ontario for selling a vapour product to a person under the age of 19 years of age; and

**WHEREAS** in 2023, approximately 182 charges were issued against retailers of vapour products in Ontario for selling flavoured e-cigarettes and/or selling vapour products with greater than 20 mg/ml nicotine, contrary to regulations under the *Smoke-Free Ontario Act, 2017*; and,

**WHEREAS** automatic prohibition orders under Section 22 of the *Smoke-Free Ontario Act, 2017* apply to tobacco product sales convictions only; and

**WHEREAS** the membership previously carried resolution A21-1 proposing provincial and federal policy measures to address youth vaping, several of which have not been implemented.

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies urge through the Ministry of Health to the Government of Ontario to include automatic prohibition order applications by public health for convictions related to vapour product retail sales to prevent unauthorized sales to the public;

**AND FURTHER** that the Association of Local Public Health Agencies advise all Ontario Boards of Health to recommend their local Members of Provincial Parliament to advocate for an amendment to Section 22 of the *Smoke Free Ontario Act, 2017* to include vapour product sales convictions for inclusion within automatic prohibition order applications.

***CARRIED***

## Statement of Sponsor Commitment

The Middlesex-London Health Unit is discouraged by the level of non-compliance by vapour product retailers despite the provisions under the *Smoke-Free Ontario Act, 2017*. Regardless of the development of regulatory measures to reduce youth access and appeal of vapour products, the number of brick-and-mortar retailers in Ontario has increased significantly. Increased youth access to vapour products threatens to reverse what has been a downward trend in smoking rates and nicotine addiction within our youth and young adult populations.

The Middlesex-London Health Unit's Tobacco Enforcement Officers have been noting an increase in the number of warnings and charges being issued against vapour product retailers for sales to persons under the age of 19 years of age. Retailers that are prohibited from offering to sell candy and fruit-flavoured vapour products and e-cigarettes with nicotine concentrations greater than 20 mg/ml continue to do so, despite the deployment of progressive enforcement measures. It has become apparent that the issuance of fines and seizures of vapour products are an insufficient deterrent.

Under the *Smoke-free Ontario Act, 2017*, routine non-compliance with tobacco sales offences results in the issuance of an automatic prohibition order under Section 22. At present, a similar enforcement tool for routine non-compliance with regulatory measures for vapour products does not exist. An amendment to Section 22 of the *Smoke-Free Ontario Act, 2017* to include vapour product sales convictions for inclusion within automatic prohibition order applications is warranted to help reduce youth access to these highly addictive products.

Dr. Alex Summers, Medical Officer of Health for the Middlesex-London Health Unit, will be present at the 2024 Annual General Meeting to provide clarification on the proposed resolution.

## Background

Under the *Smoke-Free Ontario Act, 2017* (*SFOA, 2017*), an Automatic Prohibition Order will be issued by the Ministry of Health, and served by the local public health unit, when there are two or more registered convictions within a five-year period against any owner for tobacco sales offences committed at the same location. Automatic Prohibition Orders can be based on registered convictions against multiple owners (past and present); that is, ownership of the business at that location may change but the convictions and the Automatic Prohibition Order stay with the address. The length of the prohibition on the sale and storage of tobacco at an address depends upon the number of convictions within a five-year period. Two convictions registered at the address within five years results in a six-month prohibition, three convictions registered at the address within a five-year period warrants a nine-month prohibition, and four convictions within a five-year period result in a twelve-month prohibition. While an Automatic Prohibition Order is in effect, wholesalers or distributors are prohibited from delivering tobacco products to that location.

Under Section 22 of the *SFOA, 2017*, only registered convictions for tobacco sales offences are eligible for inclusion in the application of an Automatic Prohibition Order. Examples of tobacco sales offences that can result in the issuance of an Automatic Prohibition Order include:

- The sale or supply of tobacco to someone under the age of 19 years.
- Failing to request identification from someone appearing to be less than 25 years of age.
- Selling tobacco without posting required age restriction and government identification signs.
- The sale of improperly packaged tobacco.
- The sale of tobacco in vending machines.
- The sale or storage of tobacco during an automatic prohibition.

- Selling unmarked or unstamped tobacco in violation of section 8 or 9 of the *Tobacco Tax Act.*

  Vapour products can continue to be sold at a retailer even if they are under an Automatic Prohibition Order for violating either the *Smoke-Free Ontario Act, 2017* or the *Tobacco Tax Act.* Between 2011 and 2023, Middlesex-London Health Unit has served 25 Automatic Prohibition Orders**,** with 3 Orders in effect at the present time.[1]

**The Changing Vapour Product Retail Landscape**

Since the legalization of nicotine vapour products in Canada on May 23, 2018, under Canada's *Tobacco and Vaping Products Act,* the retail market landscape has undergone significant changes in Ontario. In the Middlesex-London jurisdiction, the number of retailers that sell vapour products has grown from 186 in 2018, to 253 in 2023. Provincially, it is estimated that there are there are approximately 800 age-restricted specialty vape stores and 12,000 retail outlets that sell both commercial tobacco and vapour products. This growth in community availability of vapour products is in alignment with the growth of the global e-cigarette market. In 2021, the global e-cigarette market was valued at approximately 20.4 billion US dollars, with projections to continue its rapid growth to 30 billion US dollars by 2027 (Business Wire, 2022).

Nicotine is highly addictive, and the negative effects on youth brain development (US Surgeon General, 2016) and growing evidence regarding cardiovascular and lung health harms associated with vapour product use is a significant public health concern (Buchanan et al., 2020; Davis et al., 2022; Keith and Bhatnagar, 2021; Kennedy et al., 2019; Willis et al., 2020). To reduce youth access, it is illegal to sell or supply a vapour product to a person under the age of 19 years in Ontario under the *SFOA, 2017.* Additionally, only vapour products flavoured with mint, menthol, and tobacco can be sold in non-specialty vape stores (e.g., convenience stores, grocery stores, gas station kiosks, etc.); whereas, all flavoured vapour products, including candy- and fruit-flavoured products can be sold in age-restricted specialty vape stores. Under Canada's *Tobacco and Vaping Products Act,* the sale of vapour products with nicotine concentrations greater than 20 mg/ml is prohibited. Despite these health protective regulatory measures, public health units report significant retailer non-compliance.

[1] *The Smoke-Free Ontario Act* came into force on May 31, 2006. Although retailers were already selling tobacco products, convictions prior to this date were not applicable to APs which is why the date of 2011 is used (2006 + 5 years = 2011). Same applies for the *Smoke-Free Ontario Act, 2017* – it came into force on October 17, 2018, so any convictions prior to this date were not applicable to APs which is relative to the 3 APs that were issued in 2023 and are still active (2018 + 5 years = 2023).

**Table 1**
***Retailer Non-Compliance as Reported by Ontario Public Health Units for 2023***

| Measure | Count |
|---|---|
| **# of charges** issued to either a clerk OR an owner (e.g., sole proprietor, general limited partnership, or corporation) for the **supply or sale** of a vapour product to a **person under the age of 19 years of age**. | **414[1]** |
| **# of charges** issued to either a clerk OR an owner for the **supply or sale** of a vapour product to a person who **appears to be less than 25 years of age without requesting government ID** | **54[1]** |
| **# of charges** issued for **selling or offering to sell flavoured e-cigarettes in a prohibited place** (e.g., fruit or candy flavoured vaping products in a non-specialty vape store) and/or **selling or offering to sell** vapour products with **greater than 20 mg/ml nicotine** | **182[1]** |
| **# of vapour product seizures** | **474[2]** |

[1] These numbers are an underrepresentation of non-compliance. Many Health Units reported that due to the COVID-19 pandemic response and staff redeployments between 2020 and 2022, enforcement programs were not fully functional until 2023. In 2023, the emphasis was on education, the issuing of warnings (versus charges), and re-inspections to gain compliance.
[2]This number is an underestimation of non-compliance. Some Health Units were unable to report due to insufficient time provided to collate local tracking data. Additionally, due to capacity challenges in 2023, some public health units relied on referrals to Health Canada for seizures.

Overall, compliance with vapour product provisions under the *SFOA, 2017* is decreasing. Operators have shared with Tobacco Enforcement Officers that the total revenue from sales of vapour products far exceeds both the fine amounts and the risk of product seizures and is viewed as a cost of doing business. Public Health Units also reported that in 2023, convenience store operators began to explore how to operate an age-restricted specialty vape store in conjunction with their convenience store, to expand the inventory of vapour products that they could legally sell. This change in the retail marketplace has the potential to further increase market availability of vapour products to youth. Based on current compliance rates and reported retailer behaviours, current vapour product regulations are insufficient.

**Opportunity to Strengthen Controls to Reduce Youth Access and Increase Retailer Compliance**

Rates of youth vaping are escalating at a concerning rate. According to the 2022 Canadian Tobacco and Nicotine Survey, 30% of youth aged 15 to 19 years and 48% of young adults aged 20 to 24 years reported having tried vaping in their lifetime (Statistics Canada, 2023). Reducing youth access to vaping products through the enforcement of age restriction legislation is an important public health measure. Current test shopping and inspection practices of Ontario public health unit staff are critical to promote and monitor retailer compliance; however, opportunity exists to strengthen controls at retail. As noted in the Middlesex-London Health Unit's 2022 submission to Health Canada to help inform the legislative review of Health Canada's *Tobacco and Vaping Products Act*, there is no automatic prohibition lever that can be applied to retailers who continue to sell vapour products to persons under the age of 19 years, nor for non-specialty vape stores that continue to sell vapour products that should only be available for sale in age-restricted stores in Ontario. Retailers are not held to the same level of accountability for non-compliance with the sections of the *SFOA,* 2017 that regulate the sale of vapour products.

Based on lessons learned from the enforcement of the regulations under the *SFOA, 2017* for commercial tobacco products, the Middlesex-London Health Unit recommends that the Ontario Government implements an automatic prohibition regime for vaping products that is modelled after Section 22, which would apply to repeated convictions against retailers who:

- Sell or supply vaping products to someone under the age of 19 years.
- Fail to request identification from someone appearing to be less than 25 years of age.

- Sell or offer to sell vapour products without posting required age restriction and government identification signs.
- Sell or offer to sell vaping products that are regulated by law in a prohibited place.
- Sell or offer to sell vaping products that are prohibited by law.
- Sell or store vapour products during an automatic prohibition.

By permitting public health units to apply to the Ministry of Health for an automatic prohibition order against a retailer who has committed either tobacco product and/or vapour product violations, retailers who are providing either of these products to vulnerable individuals will be prevented from doing so for a defined period of time depending upon the number of registered convictions on file for a location. Nicotine, whether in the form of a vaping product or a commercial tobacco product, is harmful for youth and young adults. Nicotine interferes with healthy brain development, which continues until the age of 25, and young people can become heavily addicted with lower levels of exposure than adults (US Surgeon General, 2016). It is important to hold retailers of these harmful products accountable when commercial tobacco and vaping products are being sold in contravention of the *Smoke-Free Ontario Act, 2017.*

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**alPHa RESOLUTION A24-02**

**TITLE:** **Artificial Intelligence for Enhanced Public Health Outcomes**

**SPONSOR:** **Simcoe Muskoka District Health Unit, Wellington-Dufferin-Guelph Health Unit**

**WHEREAS** artificial intelligence (AI) has the potential to revolutionize public health by improving disease surveillance, health promotion, health protection, and service delivery; and

**WHEREAS** AI-driven technologies can significantly aid in the analysis of large datasets, leading to more accurate and/or rapid identification of public health trends and outbreaks; and

**WHEREAS** the integration of AI in public health can enhance health promotion and health protection interventions; and

**WHEREAS** ethical considerations, including data privacy, bias, and transparency, are paramount in the deployment of AI technologies in public health; and

**WHEREAS** there is a growing need for public health professionals to be equipped with knowledge and skills in AI to effectively utilize these technologies; and

**WHEREAS** collaboration between local public health agencies, technology experts, and policymakers is essential for the responsible and effective implementation of AI in public health; and

**WHEREAS** there is an opportunity to leverage AI for addressing health disparities and promoting health equity across different populations; and

**WHEREAS** a proactive approach would position public health agencies as beneficiaries of the technological evolution and as contributors to the ethical and impactful use of AI in improving public health and wellbeing;

**NOW THEREFORE BE IT RESOLVED** that that the Association of Local Public Health Agencies write to the Ontario Minister of Health to provide background information on the transformational possibilities of AI tools in the future delivery of Public Health programs and services;

**AND FURTHER** that alPHa call for increased academic investment in data stewardship, AI research, training, and development focused on public health applications and post-secondary educational programs through the Ontario Minister of Colleges and Universities;

**AND FURTHER** that alPHa acknowledge the transformative potential of AI and other emerging technologies as pivotal tools for the future across all sectors of industry and society, and support public health agencies in carefully leveraging these tools to enhance health outcomes, improve service delivery, and increase operational efficiency;

**AND FURTHER** that a copy of this resolution be sent to the President and Chief Executive Officer of Public Health Ontario and to the Chief Medical Officer of Health of Ontario.

***CARRIED***

**BACKGROUND**:

### Introduction

The integration of AI and emerging technologies marks a transformative shift in the landscape of public health. These innovations offer new methods for tackling complex health challenges, enhancing patient care, and improving the delivery of health services. For Ontario's Local Public Health Agencies (LPHAs), adopting AI and related technologies is crucial to meet the evolving needs of public health effectively.

### Defining AI and Emerging Technologies

AI refers to the use of technology to perform tasks that otherwise require human-level intelligence to complete[1, 2]. AI has shown effectiveness at an increasingly broad range of tasks, including pattern recognition, decision-making[3], and language understanding[1]. Emerging technologies encompass a broad range of innovative tools and systems, including blockchain, the Internet of Things (IoT), and advanced computing, which are on the cusp of becoming mainstream. These technologies offer new capabilities that can significantly impact various sectors, including public health, by enhancing data analysis, connectivity, and operational efficiency.

### AI and Emerging Technologies: Revolutionizing Public Health

AI and emerging technologies are transforming public health through applications in predictive analytics, health equity enhancement[4], and the development of digital health services[5]. These tools offer unprecedented opportunities for disease surveillance[6], optimizing health interventions[7], and providing more personalized care[3,8,9,10].

*Predictive Analytics*

AI-driven models can sift through vast datasets to predict health trends and potential outbreaks, enabling LPHAs to allocate resources more effectively and prepare for public health emergencies[11]. This predictive capability is critical for planning and emergency response, enhancing the public health system's ability to mitigate threats.

*Health Equity*

AI can play a pivotal role in identifying and addressing health disparities by analyzing patterns in health outcomes and access to care. By leveraging AI, LPHAs can design targeted interventions to meet the unique needs of underserved populations, thereby promoting equity across different communities[12].

*Digital Health Innovations*

Advancements in technology have accelerated the adoption of telehealth and digital health platforms, offering new modes of healthcare delivery. AI enhances these services by improving accuracy, enabling real-time patient monitoring, and tailoring treatment plans[3], thus making healthcare more accessible and efficient[8].

### Building Capacity for Technological Adoption

To fully benefit from AI and emerging technologies, LPHAs need to invest in digital infrastructure and upskill their workforce. This involves adopting digital tools and training healthcare professionals to use these technologies effectively, ensuring public health units are well-equipped to face future challenges[6, 13, 14, 15].

### Ethical Considerations in AI Deployment

Deploying AI in healthcare and public health must adhere to stringent ethical standards, focusing on transparency, fairness, and accountability[10, 13, 16]. It's crucial to protect privacy and ensure that health

outcomes are equitable[7]. Developing comprehensive ethical guidelines and governance frameworks is vital for maintaining public trust in public health practices[8, 10, 17, 18].

**Overcoming Challenges: Towards a Strategic Approach**

Adopting AI and emerging technologies in public health comes with its set of challenges, including data privacy concerns, potential algorithmic bias, future regulatory frameworks[19] and the digital divide[7, 16, 20]. Addressing these issues requires a strategic approach that includes policy development, stakeholder engagement, data stewardship, and continuous evaluation to ensure responsible and effective use of these technologies[7, 16, 17, 21].

**Conclusion**

Strategically utilizing AI and emerging technologies presents a significant opportunity for Ontario's LPHAs to enhance public health services and outcomes. Embracing these innovations allows public health units to improve efficiency, responsiveness, and their ability to serve the community. Moving forward, a balanced approach that tackles technological, ethical, and operational challenges will be essential for leveraging the full potential of these technologies in enhancing public health.

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Association of Local PUBLIC HEALTH Agencies

**alPHa RESOLUTION A24-03**

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|---|---|
| **TITLE** | **A Proposal for a Comprehensive Provincial Alcohol Strategy: Enhancing Public Health through Prevention, Education, Regulation and Treatment** |
| **SPONSOR** | Oxford-Elgin-St. Thomas Board of Health (Operating as Southwestern Public Health (SWPH) |
| **WHEREAS** | alcohol caused 6,202 deaths, 60,902 hospitalizations (including day surgery) and 258,676 emergency room visits in Ontario for the year 2020; and [1,2] |
| **WHEREAS** | the harms due to alcohol are disproportionally carried by individuals with low socio-economic status (SES), compared to those of high SES, even though the exact amounts of alcohol or less are consumed; described as the alcohol harm paradox; and [3,4] |
| **WHEREAS** | alcohol is classified as a group one carcinogen by the International Agency for Research on Cancer and can cause cancer of the breast, colon, rectum, mouth and throat, liver, esophagus, and larynx; and [5] |
| **WHEREAS** | between 2017-2020, 31.1% of adults age 19 and older exceeded the low-risk threshold for alcohol-related harms as per the *Canadian Guidance on Alcohol and Health*, having reported drinking more than two alcoholic drinks in the past week, with the recognition that self-reported alcohol intake usually is underreported, and the number of those drinking above this level is likely higher. [6] |
| **WHEREAS** | alcohol was the most frequently reported substance of concern among people accessing treatment services in both Ontario and Canada; and [7] |
| **WHEREAS** | research confirms that as alcohol becomes more available and affordable, the following problems increase: street and domestic violence, chronic diseases, sexually transmitted infections, road crashes, youth drinking, injury, [8] and suicide; [9,10] which is disturbing being the current government plans to increase alcohol availability with up to 8,500 new stores eligible to sell alcohol in Ontario; and [11] |
| **WHEREAS** | the current government has committed $10 million, above current funding, over five years to the Ministry of Health to support social responsibility and public health efforts; and [11] |
| **WHEREAS** | comprehensive and enforced alcohol control policies delay the age of onset and lower alcohol prevalence and frequency among young people; and [12] |
| **WHEREAS** | the World Health Organization recognizes that policies need to address the availability, acceptability, and affordability of alcohol, as these are the factors that create alcogenic environments; and [12,13] |
| **WHEREAS** | despite alcohol revenue, the substantial societal costs caused by alcohol create a deficit of $1.947 billion in Ontario and $6.196 billion each year in Canada. [1,14] |
| **WHEREAS** | the Canadian Radio-television and Telecommunications Commission (CRTC) Code For Broadcast Advertising Of Alcoholic Beverages has not been updated since 1996 and includes no provisions for new ways of advertising, such as social media and lacks concrete enforcement of the rules; and [15] |

**WHEREAS** the membership previously carried alPHa RESOLUTION A08-2, to Establish Stricter Advertising Standards for Alcohol; and

**WHEREAS** the membership previously carried alPHa RESOLUTION A08-3 requesting advocacy for an Enhanced Provincial Public Education and Promotion Campaign on the Negative Health Impacts of Alcohol Misuse; and

**WHEREAS** the membership previously carried alPHa RESOLUTION A08-4.1 to eliminate The Availability of Alcohol Except in Liquor Control Board Outlets (LCBO) (i.e. Increase Point of Sale Control); and

**WHEREAS** the membership previously carried alPHa RESOLUTION A11-1 to conduct a Formal Review and Impact Analysis of the Health and Economic Effects of Alcohol in Ontario and Thereafter Develop a Provincial Alcohol Strategy; and

**WHEREAS** the membership previously carried alPHa RESOLUTION A12-4 TITLE: Alcohol Pricing and LCBO Revenue Generation; and

**WHEREAS** all of the above resolutions on alcohol were introduced more than a decade ago, with the majority of actions taken before 2019, according to alPHa's public records, with the recognition that alPHa recently sent a letter regarding a call for an alcohol strategy dated December 14, 2023; priority for these resolutions must be re-established.

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies write to the Provincial Government recommending that a comprehensive alcohol strategy be developed, in keeping with CMOH's 2023 Annual Report on an all-of society approach, to address substance use and harms, which includes the following actions: promote comprehensive public education campaigns, strengthen regulations on advertising, increase alcohol taxes, adopt a prevention model, and improve access to addiction treatment and support services;

**AND FURTHER** that the alcohol strategy be formed and written with the support of a multidisciplinary panel of experts, including local public health and people with lived experience; Now therefore be it resolve that alPHa write to the provincial government

**AND FURTHER** that the Association of Local Public Health Agencies petitions the federal government to either ban alcohol advertising like cannabis and tobacco, or in the absence of such a ban, update the CRTC code to include alcohol restrictions on digital and social media.

**AND FURTHER** that the Association of Local Public Health Agencies recommend that health equity be foundational to the strategy;

**AND FURTHER** that the Association of Local Public Health Agencies recommends that in the development of a provincial strategy, the government implement a tax or pricing system that covers the growing deficit alcohol causes each year;

**AND FURTHER** that the government limits the influence of the Alcohol Industry on the creation of alcohol policies and education campaigns, as they have a conflict of interest being that increased consumption of alcohol provides increased industry sales and profit. [8]

**AND FURTHER** that a copy be sent to the Chief Medical Officer of Health of Ontario.

***CARRIED AS AMENDED.***

## BACKGROUND

### Effective Interventions

It is recognized in Canada and internationally that the most cost-effective strategies to reduce the harmful effects of alcohol include increasing price, restrictions on the physical availability of alcohol, restrictions on alcohol advertising and marketing, enforcing drunk driving countermeasures, and implementing screening, brief interventions, referral, and treatment. (1,4,8,13,16,17)

It cannot be disputed that tobacco control policies are highly effective in decreasing smoking rates and lung cancer deaths. (14,18,19) As tobacco regulations have slowly become stronger, alcohol regulation has eroded over the past few decades. (17,11,14) These changes began in 2014 when alcohol retail sales were permitted through farmer's markets in Ontario and continued to become more accessible through grocery stores, bookstores, movie theatres, Liquor Control Board of Ontario (LCBO) convenience outlets, extended off premise retail hours of 9 am to 11 pm, home delivery and now further expansion of privatized alcohol retail locations. (20,21) To reduce population-level harms due to alcohol, the measures used for tobacco control should be applied to alcohol.

Comprehensive Public Education Campaigns

When individuals become aware of the link between cancer and alcohol, their support of alcohol policy increases. (22,23) Education alone is known to be less effective in changing population-level behaviours than policy interventions. However, education has positive impacts when coupled with alcohol policy regulating price, availability, and marketing. (1,8,9)

Studies have shown that the public is largely unaware of the harms of alcohol. (24,25,5) The Canadian Guidance on Alcohol and Health states that even small amounts of alcohol can be harmful and that decreasing alcohol use has benefits. (5) Information on alcohol harms and the Canadian Guidance on Alcohol and Health are not promoted widely. This information must be promoted collectively on government and health organization websites, and at point of sale (by the alcohol industry retail sector) across Ontario and Canada. The lack of restrictions on alcohol marketing promotions, coupled with a population who does not fully understand the implications of their choices regarding alcohol, will likely lead to more harm. To make informed decisions using the most recent recommendations made by the Canadian Guidance on Alcohol and Health, the population needs information readily available. (5)

It is well-documented that the Alcohol Industry distorts and denies evidence of alcohol harm to the public and during government consultations regarding alcohol policy. (22,26,27) They also have a conflict of interest because the more people drink, the more profit they make. (8) Therefore, they should not have input regarding public education and alcohol policy.

Stricter regulations on advertising

Alcohol marketing accelerates the onset of drinking, increases consumption by those already drinking, and is associated with problematic alcohol use. (8) The World Health Organization recommends that alcohol advertising be banned or that comprehensive restrictions on alcohol advertising, sponsorship, and promotion be legislated and enforced. (13)

There must be restrictions on advertising and marketing in conjunction with public health campaigns. The playing field is imbalanced between the Ontario Ministry of Health and the Alcohol Industry. The financial power of the Alcohol Industry, compared to Public Health's vastly smaller budget, gives the Alcohol

Industry a clear advantage when competing in mass communication campaigns. [8,11] Marketing is an important industry strategy. Alcohol companies regularly contribute significant amounts of money towards 'investment in brands'. [8] In 2019, AB InBev, the largest alcohol corporation in 2021, was the 11th largest advertiser in the world, while another six Transnational Alcohol Companies were among the top 100 advertisers in 2019. [8]

The Canadian Radio-television and Telecommunications Commission (CRTC) Code For Broadcast Advertising Of Alcoholic Beverages has not been updated since 1996, and it includes no provisions for new ways of advertising, such as social media, and lacks concrete enforcement of the rules. [15] At a provincial level, the Alcohol and Gaming Commission of Ontario (AGCO) regulates alcohol advertising through the Liquor License Control Act, 2019, through a complaints-based system, and within the parameters set out in the regulation and the Registrar's Interim Standards and Requirements for Liquor. [28,29,30]

It is relevant to look at the experience of banning tobacco marketing when considering the likely impact of a ban on alcohol marketing. Before the global community widely adopted the World Health Organization Framework Convention on Tobacco Control (FCTC), comprehensive but not partial bans were found to reduce tobacco consumption in high-income countries. [8] Post adoption of the FCTC, and after numerous countries adopted the highest level of tobacco advertising bans on all direct and indirect advertising, it is estimated that approximately 3.7 million fewer smoking-attributable deaths occurred due to these measures. [8,31] Research from the World Health Organization currently points toward complete and comprehensive advertising and marketing bans as more effective than partial bans and industry-regulated restrictions. [8,31] The best way forward would be to enact a legislative approach, rather than a code, through a National Alcohol Act, like what exists for cannabis and tobacco. [29]

Without a complete ban, the following restrictions could be suggested as better than the status quo:

- Regulations should include all forms of media, such as the internet, social media, print, radio, and television. [29]
- Cap the quantity of alcohol advertising at all retail outlets. [29]
- Ban marketing activities in connection to young people, people with alcohol use disorders, heavy drinkers, and vulnerable populations. [29]
- Supervision should be introduced to ensure compliance with provincial and federal regulations, creating an independent organization to monitor and pre-screen alcohol advertisements and alcohol industry activities proactively rather than reactively, beyond a complaints-based system. [29]

Decrease Affordability, Increase Price

Alcohol was the substance that cost Canada the most in 2020, at $19.7 billion, due to health care, lost productivity, criminal justice, and other direct costs. In comparison, alcohol costs more than both Tobacco ($11.2 Billion) and Opioids ($7.1 Billion) combined in 2020. [14] At the very least, alcohol should cover the costs it contributes to rather than contribute to government debt each year. In contrast, AB InBev, the largest Alcohol corporation in 2021, had an annual revenue of $45.6 billion (U.S) in 2017. To provide perspective on this amount, half of the world's countries don't reach that amount in terms of their gross domestic product.

Increasing the price of alcohol has been noted as the most effective strategy to decrease harm due to alcohol. [1,8,13] Strong policies that could be used include indexed minimum unit pricing, alcohol-specific sales taxes, and markups. [1] Despite what many may think, pricing is considered an equitable policy, as it has been shown to decrease harm in those populations found to be most deprived. As recently demonstrated in Scotland, Minimum Unit Pricing (MUP) was implemented, and it was associated with a

significant 13.4% reduction in deaths and a 4.1% decrease in hospitalizations from conditions 100% attributable to alcohol consumption. [32] The greatest reductions were found in the four most socioeconomically deprived groups, demonstrating the policy is effective at improving deprivation-based inequalities in harm due to alcohol. [32]

Adoption of a Prevention Model

The factors that contribute to youth initiation of substance use, specifically alcohol, are dynamic and complex. Preventing and reducing substance use among youth should include collaborative interventions that decrease risks and harms and increase protective factors and wellness while providing a safe and inclusive environment that does not promote the use of substances. [12,33,34] Because risk and protective factors exist within every aspect of our society, a substance prevention model should consider interventions with an ecological view. This view would consider factors and interventions at the personal, interpersonal, community and policy levels and how these interact at all levels of society. [33] Participating must have a shared vision, collaboration, and agreement. [33]
The Planet Youth approach is a model that demonstrates the above vision and goals, sometimes known as "The Icelandic Model." This approach improves social environments and decreases substance use through collaborative actions based on local research that includes the whole community and partnerships across sectors. [33,35,36] While being implemented in Iceland, this model decreased youth substance use dramatically. Their rate for 30-day drunkenness decreased from 29.6% in 1997 to 3.6% in 2014, with dramatic decreases among other substances as well. [37] The Planet Youth approach has been introduced to numerous countries since 2006 and has been implemented or used in 16 countries and hundreds of municipalities since 2022. [38] Funding an approach such as the Planet Youth Model as part of an Alcohol Strategy would support goals to prevent future substance use.

Improving Access to Treatment and Support Services

Alcohol was the most common problem substance for people accessing treatment services and was reported by more than 67,000 people per year over 2016-2018. [7] Collaboration with People with Lived Experience and those using treatment services are vital, as they are the experts in this regard and their practical experience should be incorporated into the Alcohol Strategy. An alcohol strategy should consider how to improve access to treatment and support services for alcohol use disorder, such as:

- Incorporation of a Universal Screener for substance use in healthcare settings across Ontario, with compensation for healthcare staff who regularly provide screening, brief interventions, and referral to treatment for their clients.
- Improved wait times for public access to treatment and support services related to mental health care and substance-related treatment, as well as ongoing support while people wait for these services.
- Improved support and capacity for caregivers of those with substance use disorders.

The current alcohol policy environment will impact the need for treatment and support services in the future. Because the proportion of heavy drinkers is strongly associated with the total level of consumption of the general population, it is essential to consider society's overall alcohol policy within a strategy to reduce consumption in general, not just consumption by heavy drinkers. [8]

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Association of Local PUBLIC HEALTH Agencies

**alPHa RESOLUTION A24-04**

**TITLE:** **Reviewing Provincial Regulatory Needs for Supportive Living Facilities Serving Vulnerable Individuals**

**SPONSOR:** Oxford-Elgin-St. Thomas Board of Health (Operating as Southwestern Public Health (SWPH)

**WHEREAS** medical officers of health and municipal staff are required to perform inspections of residential facilities concerning public health and fire and property standards, respectively, when a complaint is received; and

**WHEREAS** unregulated and quasi-regulated residential facilities are not required to be registered or licensed with medical officers of health or municipalities on a province-wide basis; and

**WHEREAS** the human rights, safety, health and well-being of the vulnerable residents residing in unsafe and hazardous conditions of poorly managed and maintained unregulated and quasi-regulated residential facilities may be at risk; and

**WHEREAS** the state of such facilities may be in part due to the lack of registration, routine inspection, adherence to standards, and enforcement capabilities in these settings, which may lead to limited involvement with medical officers of health and municipal inspection authorities; and

**WHEREAS** the provision of care required to support activities of daily living in unregulated and quasi-regulated residential facilities is not prescribed provincially in Ontario; and

**WHEREAS** medical officers of health have no powers to inspect or resolve concerns related to the quality of care of activities supporting daily living in quasi-regulated and unregulated residential facilities; and

**WHEREAS** the patchwork regulatory nature of this sector in Ontario has contributed to a lack of adequate regulation and oversight in many jurisdictions in the province; and

**WHEREAS** the lack of regulation and oversight in Ontario has resulted in alleged reports of bad actors taking fiscal advantage of their residents; and

**WHEREAS** there needs to be more transparency and communication with the general public regarding the operation of unregulated and quasi-regulated residential facilities and the health, safety, and wellness complaints received by these facilities.

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies (alPHa) urges the Government of Ontario to review the need to regulate unregulated and quasi-regulated residential facilities on a provincial basis.

**AND FURTHER THAT** following such a review, alPHa joins voices with the 45 municipalities across Ontario that have called on the province to develop and enact provincially enforced standards for unregulated

and quasi-regulated residential facilities;

**AND FURTHER THAT** the insights of municipalities on this issue should be heard by consulting with the Association of Municipalities of Ontario and all levels of municipal government;

**AND FURTHER THAT** consideration should be taken in this review to include recommendations toward greater transparency in reporting health and safety issues in these settings to the public;

**AND FURTHER THAT** provisions should be developed in this review to prevent and penalize owners and operators who demonstrate unscrupulous practices that take advantage of vulnerable populations who reside in quasi-regulated and unregulated residential facilities;

**AND FURTHER THAT** if responsibilities in education/enforcement around updated regulatory needs for supportive living facilities serving vulnerable individuals are implemented, that sustainable funding to public health be added to ensure ongoing capacity to address needs.

**AND FURTHER THAT** that a copy be sent to the Chief Medical Officer of Health of Ontario.

***CARRIED AS AMENDED.***

**BACKGROUND**

**Reviewing Provincial Regulatory Needs for Residential Facilities**

**1. Terminology**

For a more detailed breakdown of the terminology used in this resolution, please refer to the section below:

***Provincially regulated residential facility:*** A residential facility that operates under specified standards of care and may receive provincial funding. For example, the operation and funding of long-term care homes are overseen by the Ministry of Long-Term Care and are regulated through the *Ontario Long-Term Care Homes Act*. Another example is retirement homes: the province requires retirement homes to obtain a license and comply with requirements under the *Retirement Homes Act*; however, retirement homes do not receive funding from the province.[1]

***Quasi-regulated residential facility:*** Facilities (e.g., lodging and boarding homes) that receive municipal or provincial funding, are typically registered or licensed and have associated municipal regulations (or standards imposed by community organizations). In Ontario, specific standards of care for these facilities may be prescribed at the municipal level through by-laws.

As a limitation to the operational definition above, it is essential not to disregard facilities that receive funding because there are disparities between residential facilities due to the different funding types available (for instance, Community Homes for Opportunity[2] vs. Community Homeless Prevention Initiative[3]). These funding disparities also translate to inconsistent and less frequent facility assessments, which may affect the quality of care for residents.

***Unregulated / not required to be regulated residential facility:*** Defined as a facility that operates without provincial standards of care, provincial or municipal funding or licensing for the aspects of care and accommodation that affect a resident's quality of life. This excludes other regulatory requirements prescribed by the *Ontario Building Code, Fire Code* and *Occupational Health and Safety Act* that protect tenants and workers from hazards that could lead to injury, mental and physical illness, and fatalities. Examples of this type of facility would be boarding homes, supportive living facilities, or residential care facilities operating in areas of Ontario that do not have municipal by-laws regulating these settings or the same facilities that operate without licensure in regions requiring regulations. The quality of care provided in these settings can vary quite notably, with some offering higher levels of accommodation and care and others offering notably poor standards of care. These settings' lack of regulation and standardization may contribute to this variability.

**2. Historical context**

In the 1970s and 1980s, a process known as deinstitutionalization occurred in Canada.[2] Deinstitutionalization was a practice in which the psychiatric hospitals of the day gradually released their residents into the community.[2] As a movement, deinstitutionalization was associated with increasing advocacy of human rights; this can be demonstrated by the primary goal of this movement, which was to empower people living with mental illness and enable them to integrate into communities.[3-4] However, there was a need to provide adequate community-level care to replace the institutional approach, and there has been a noted failure to provide adequate support (such as income and housing) to people living with a mental illness or substance use disorder.[3] Deinstitutionalization policies contributed to the development of residential care facilities, as new settings in the community were required to offer some degree of support for activities of daily living to individuals with severe and ongoing mental illness.[2]

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[2] Community Homes for Opportunity (CHO): This is funding from the province, and can be considered a high quality funding pot for quasi-regulated residential facilities. It includes the provision of Service Liaison personnel that regularly assess the home to ensure standards of care and quality are met.

[3] Community Homeless Prevention Initiative (CHPI): This funding is managed by municipalities and is transferred to agencies with roles in supportive housing, such as the Canadian Mental Health Association (CMHA). The funding may be tied to municipalities' standards via their bylaws, however these standards are not routinely assessed or enforced due to lack of resourcing for community agencies. As such, the condition of these facilities is variable.

Lack of effective oversight and enforcement has led to anecdotes of quasi-regulated and unregulated residential facilities being hazardous for occupants. These conditions can sometimes result in poor health outcomes or even fatalities. Notable examples include a building fire in Toronto that claimed ten lives in 1989, a housing fire in London linked to twelve fire code violations and the death of a resident, and more recently, the closure and relocation of residents living in an unregulated boarding home in St. Thomas.[5-7]

Unregulated residential facilities are often used as last-resort housing; Ontario's lack of affordable housing may be a potential contributing factor.[8] Ontario is currently experiencing an affordable housing crisis, with rent and house prices increasing faster than incomes, lack of rental supply, and unmet demand for supportive housing all playing a role in this crisis.[9] Although multiple levels of government have expressed their commitment to increasing the housing supply, this complex issue is unlikely to be resolved rapidly.[9] In the interim, populations who experience multiple inequities are left with sparse choices for housing and may have to choose between living in an unregulated housing facility or experiencing homelessness.[8]

**3. Incidents in these settings that go beyond current province-wide regulations**

Additionally, some factors not addressed by the current province-wide regulations (Fire, Building Code, and Food Safety) affect health. For instance, many unregulated and quasi-regulated residential facilities provide care in support of activities of daily living for their residents; this care can vary from requiring periodic involvement with the resident to 24/7 support and supervision.[10] The personal care provided in quasi-regulated and unregulated residential facilities is not subject to province-wide regulatory practices. As such, a regulatory gap exists in that the personal care received by the vulnerable residents who live in quasi-regulated and unregulated residential facilities can be of inferior quality if they happen to live in a municipality that does not have any by-laws that apply to these settings.

Additionally, there have been some anecdotal reports of bad actors within this sector taking advantage of the residents of these facilities. Examples of this type of behavior include operators taking the pension of residents, referring residents to pharmacies they own, and staff of these facilities attempting to bring former residents back to the facility after forced closure by authorities.[11-13]

Even in jurisdictions with bylaws for these types of settings, there has still been some degree of criticism of the regulations in place, with one of the noted concerns being the lack of public-facing transparency. This is an issue as the need for more transparency makes it harder for people looking to live in these facilities (or their relatives/loved ones) to determine a facility of high quality.[2]

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Association of Local
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Agencies

**alPHa RESOLUTION A24-05**

**TITLE:** **Early Childhood Food Insecurity: An Emerging Public Health Problem Requiring Urgent Action**

**SPONSOR:** **Ontario Dietitians in Public Health**

**WHEREAS** Provincial action is urgently needed to protect young children 0-24 months of age from the harmful effects of household food insecurity; and

**WHEREAS** alPHa's advocacy efforts have long underscored the need for income-based solutions to food insecurity and have previously resolved on the following areas: A15-04 (Basic Income Guarantee), A18-02 (Minimum Wage that is a Living Wage), A18-4 (Extending the Ontario Pregnancy and Breastfeeding Nutritional Allowance to 24 Months), A18-05 (Adequate Nutrition for Ontario Works and Ontario Disability Support Program Participants and Low Wage Earners), A23-05 (Monitoring Food Affordability); and

**WHEREAS** food insecurity is a potent social determinant of health, and infants and young children are particularly susceptible to adverse effects of household food insecurity, including associated parental stress, lower breastfeeding rates, and financial barriers to accessing adequate infant formula, when needed; and

**WHEREAS** when food insecurity results in early childhood malnutrition, infants and young children may experience growth faltering, compromised health, and cognitive impairments which may hinder their lifelong potential and result in considerable burden for the provincial health care system; and

**WHEREAS** food prices including the price of infant formula have increased over the past year; and

**WHEREAS** the Ontario Dietitians in Public Health and Food Allergy Canada has called on the Provincial government to amend the Ontario Drug Benefit program to support infants and children with a medical diagnosis*requiring strict avoidance of standard soy and milk proteins; and

**WHEREAS** the Windsor-Essex County Board of Health passed the resolution *Food Insecurity Compromises Infant Health* in March 2024 in response to a notable local increase in infant food insecurity

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies call on the Provincial government to optimize early growth and development among families most impacted by food insecurity and health inequities, by:

i. Increasing the Pregnancy and Breastfeeding Nutritional Allowance and the Special Diet Allowance to ensure families reliant on Ontario Works or the Ontario Disability Support Program can afford the products they need to adequately nourish their infants.

ii. Expanding the Ontario Drug Benefit to include specialized infant formulas for families whose children (0-24 months) have a medical diagnosis* requiring strict avoidance of standard soy and milk proteins.

**AND FURTHER THAT** alPHa continues to advocate for income-related policies to reduce household food insecurity, especially for households with children where prevalence of food insecurity is highest.

***CARRIED***

**Backgrounder: Early Childhood Food Insecurity: An Emerging Public Health Problem Requiring Urgent Action**

**SPONSOR: Ontario Dietitians in Public Health**

*We acknowledge that this document refers to breastfeeding. Breastfeeding is traditionally understood to involve an individual of the female sex and gender identity who also identifies as a woman and mother. However, it is important to recognize that there are individuals in a parenting and human milk feeding relationship with a child who may not self-identify as such and who may prefer to use the term "chestfeeding" rather than breastfeeding.*

Nutrition is fundamental for growth and development in the early years of life[1]. Early childhood malnutrition presents a considerable burden to the health care system in Ontario. The long-term effects of malnutrition during early childhood include increased risk of hypertension, dyslipidemia, insulin resistance in adulthood, poor school achievement due to impaired cognitive development and increased risk of mental illness[2]. These conditions cost millions of dollars in health care expenditures.

Food insecurity, inadequate or insecure access to food due to household financial constraints, continues to be a serious and pervasive public health problem. While the prevalence of infant-specific food insecurity has not been formally investigated, as no provincial surveillance system exists, it is likely significant considering that nearly 1 in 4 children under the age of six live in a household experiencing food insecurity[3].

In the last year, Statistics Canada data demonstrated that the price of food has increased by 10.6%, rising at a rate not seen since the early 1980s[4]. During the same time, the price of infant formula increased 35.5% in Ontario[5]. Exclusive breastfeeding is recommended for up to two years and beyond to support healthy growth and development[6], yet many families choose to offer infant formula instead of breastfeeding for a variety of reasons. Women who experience food insecurity tend to stop exclusive breastfeeding sooner than those who are food secure and they tend to struggle more often to maintain an adequate supply of breastmilk[7,8]. Medical conditions such as food allergies are another reason one may choose to offer infant formula. For those with a medical diagnosis* requiring the strict avoidance of standard soy and milk proteins, there is no substitute for breastmilk other than specialized infant formula. It is estimated that 5,125 infants and children 0-24 months of age in Ontario have a medical diagnosis requiring strict avoidance of standard soy and milk proteins and must have specialized infant formula to meet their nutrient needs[9]. When household food insecurity results in unreliable access to breast milk or formula, both infant health and parental mental health are threatened which can have significant implications for our healthcare system.

*Medical diagnosis can include an IgE mediated food allergy and/or a non-IgE mediated food allergy, such as food protein-induced enterocolitis syndrome (FPIES), food protein-induced enteropathy (FPE), allergic proctocolitis (AP), eosinophilic esophagitis (EoE) and several others. Due to the variability in clinical presentation and lack of validated diagnostic tests, a diagnosis relies on a detailed medical history, physical examination, and a trial elimination of the suspected food allergen.

Provincial interventions that reduce the prevalence of food insecurity, optimize breastfeeding, and improve access to infant formula, including expansion of the Ontario Drug and Benefit program, must be actioned.

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**alPHa RESOLUTION A24-06**

**TITLE:** **Compliance with Ontario Not-for-Profit Corporations Act (ONCA): Proposed 2024 alPHa General Operating By-Law to replace The Constitution of the Association of Local Public Health Agencies (Ontario)**

**SPONSOR:** **alPHa Board of Directors**

**WHEREAS** *The Ontario Not-for-Profit Corporations Act* (ONCA) is a significant legislative update that replaced Ontario's Corporations Act on October 19, 2021, as regards to not-for-profit corporations, including alPHa; and

**WHEREAS** ONCA represents a pivotal step forward in enhancing the governance, accountability, and overall operations of alPHa as a not-for-profit organization in Ontario; and

**WHEREAS** ONCA provides a comprehensive set of regulations tailored to meet the unique needs of non-profit corporations while promoting transparency, accountability, and effective governance; and

**WHEREAS** ONCA includes clauses that allow flexibility in organizational structure and the customization of certain provisions to the specific needs and missions of individual organizations; and

**WHEREAS** organizations that do not formally file such provisions within ONCA's compliance requirements with the government of Ontario by October 18, 2024, will be subject to the more restrictive governance provisions of the Act; and

**WHEREAS** alPHa has, in consultation with legal counsel, drafted a General Operating By-Law that retains the key elements, structures, processes and objectives of its current Constitution while ensuring compliance with ONCA provisions; and

**WHEREAS** substantial time and significant resources have been committed to this process since the Spring of 2022 with regular updates to members throughout; and

**WHEREAS** alPHa must file the General Operating By-Law with the Ontario Government no later than October 18, 2024, to ensure that alPHa's current organizational structure and objectives remain legislatively compliant; and

**WHEREAS** changes to the alPHa Constitution require ratification by the alPHa membership via resolution at a general meeting by a majority vote,

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies formally adopt and approve the formal filing of *GENERAL OPERATING BY-LAW NO. 2, A by-law relating generally to the conduct of the affairs of the ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES (ONTARIO),* which will replace *The Constitution of the Association of Local Public Health Agencies (Ontario)* effective October 18, 2024.

***CARRIED***

# Ontario's Not-for-Profit Corporations Act (ONCA)

as of March 18, 2024

Ontario's Not-for-Profit Corporations Act (ONCA) is a significant legislative update that replaced Ontario's *Corporations Act* on October 19, 2021 regarding not-for-profit corporations, including alPHa. The ONCA was introduced to enhance the legal framework governing not-for-profit organizations in the province of Ontario. It provides a comprehensive set of regulations tailored to meet the unique needs of non-profit corporations while promoting transparency, accountability, effective governance and to ensure due diligence.

The Association of Local Public Health Agencies (alPHa) has until October 18, 2024, to review, update, and file governing documents with the Ontario government or ONCA provisions will prevail. Until then, the rules in alPHa's articles and Constitution continue to be valid.

## Why the changes and what are the changes?

The main objectives of introducing the ONCA were as follows:

**Enhanced Governance:** The outdated Act did not provide comprehensive guidelines for effective governance, leading to potential issues with accountability and transparency. ONCA aims to strengthen the governance structures of not-for-profit corporations. It introduces clearer guidelines for Boards of Directors, Members, and Officers, enabling organizations to operate more efficiently and effectively.

**Improved Accountability:** The Act places a strong emphasis on financial accountability, requiring not-for-profit corporations to maintain accurate records, prepare financial statements, and undergo regular audits.

**Improved Flexibility:** The inflexibility of the previous legislation hindered the ability of not-for-profit corporations to adapt to changing circumstances and needs. ONCA streamlines the incorporation process and provides more flexibility in organizational structure. It allows for the customization of certain provisions, tailoring them to the specific needs and missions of individual organizations.

**Enhanced Member Rights:** The Act enhances the rights and protections of members of not-for-profit corporations, ensuring greater participation and representation in the decision-making processes.

**Modernization and Legislative Gaps:** The Ontario *Corporations Act*, which had been in place for decades, was outdated and unable to address the evolving needs and complexities of not-for-profit organizations. ONCA was designed to offer a modernized regulatory framework, aligning with current legal landscape and best practices. The ONCA provisions address modern challenges such as electronic communications, online governance, and virtual meetings.

**Harmonization with Federal Laws:** The ONCA aligns provincial regulations with the *Canada Not-for-profit Corporations Act* (CNCA).

Existing nonprofits are not required to pass new By-laws. However, alPHa has received legal advice to change to a By-law from the current Constitution of the Association of Local Public Health Agencies (Ontario). If alPHa does not ensure development of a By-law that aligns with, and reflects the applicable ONCA rules, the rules set out in the ONCA will prevail over alPHa's current Constitution.

Many organizations, such as the Ontario Municipal Association and others, have passed their new by-laws to come into compliance with ONCA.

## How do these changes impact alPHa and its members?

The ONCA represents a pivotal step forward in enhancing the governance, due diligence, accountability, and overall operations of alPHa as a not-for-profit organization in Ontario.

On legal advice, this By-law was targeted to address the ONCA legal compliance. Within the new By-law, the Constitution of the Association of Local Public Health Agencies (Ontario) and its objectives remain valid and have not changed substantively. The Constitution has been customized and tailored into a By-law that aligns with, and follows the ONCA rules, and supports alPHa's letters of patent and alPHa's annual requirements updating the Ontario Business Registry. This By-law is a legal necessity to allow for alPHa's unique organizational structure to remain legislatively compliant.

alPHa staff, volunteers and legal counsel have worked tirelessly on this for the better part of two years. alPHa would like to sincerely thank them for their work.

Proposed changes will come forward in a Resolution at the AGM in June for the membership to pass.

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**alPHa Resolution A24-07**

**TITLE:** **Creating a Provincial Strategy for Indigenous Opioid Epidemic Supports & Funding**

**SPONSOR:** **Grey Bruce Public Health, Board of Health**

**PREAMBLE:** The opioid crisis continues to have profound effects on all Ontarians and Canadians and has reached critical mass in many Indigenous and non-Indigenous communities. It has become apparent that Indigenous communities have been disproportionately impacted by a lack of provincial funding for mental health and addiction support, and, compounded with healthcare systems at the local level being understaffed and overwhelmed, have little capacity or resources to support in meaningful and beneficial ways. Addiction and mental health go hand in hand, with addiction problems often veiling concealed issues of past trauma. Indigenous communities in Ontario and Canada must be provided with the appropriate funding and resources needed to create impactful, positive change for present and future generations.

**WHEREAS** the lack of mental health and addictions funding awarded to Indigenous communities by different levels of government to aid in the opioid crisis, compounded by chronic homelessness and poverty, has resulted in a substantial and disproportionately negative impact on Indigenous people; and

**WHEREAS** the direct and indirect impacts of the opioid crisis are often unnoticed, dismissed, or misdiagnosed by healthcare system staff when it comes to mis-categorizing mental health struggles as unimpacted by addiction; and

**WHEREAS** Indigenous communities in Grey and Bruce counties alone have lost tens of people in the previous 5 years within an isolated population of only 750 people, meaning the opioid crisis has had a profound impact given the lack of resources and funding available to the Indigenous communities' programs; and

**WHEREAS** the provincial and federal governments have not provided the appropriate funding, resources, and supports to Indigenous communities.

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies support the petitioning of both the provincial and federal governments to invest and provide adequate and immediate funding, resources, and supports to positively impact the ability of Indigenous communities to care for their populations and provide appropriate substance use supports, programs, and community-based solutions.

***CARRIED***