MEDIA RELEASE: Friday, September 7, 2012, 4:30 p.m.

REGIONAL MUNICIPALITY OF WATERLOO
COMMUNITY SERVICES COMMITTEE
AGENDA

Tuesday, September 11, 2012
9:00 a.m.
Regional Council Chamber
150 Frederick Street, Kitchener

1. DECLARATIONS OF PECUNIARY INTEREST UNDER THE MUNICIPAL CONFLICT OF INTEREST ACT

2. PRESENTATIONS
   a) Mary MacKeigan, Executive Director, and Christine Seaver, Opportunities Waterloo Region, Re: Free Tax Clinics and the Canada Learning Bond

3. REPORTS – Social Services
   a) SS-12-041, Immigration Partnership Update (Staff presentation with John Haddock, CEO of YMCA of Cambridge & Kitchener Waterloo YMCA)
   b) SS-12-042, Community Fit For Children – Interim Update (Staff presentation with Amy Romagnoli, Data Analysis Coordinator at the YMCA Ontario Early Years Centre, Waterloo)
   c) SS-12-037, Region of Waterloo Response to Modernization of Child Care in Ontario (Staff presentation)
   d) SS-12-039, Provincial Funding Update for Sunnyside Home
   e) SS-12-040, Homemaking and Nursing Services Budget Update
   f) SS-12-034/CR-FM-12-012, Update Redevelopment – Elmira Children’s Centre & Edith MacIntosh Children’s Centre

4. INFORMATION/CORRESPONDENCE
   a) Memo: Online Application for Ontario Works Evaluation
   b) Memo: Municipal Delivery of Long Term Care Services Brief Update (Attachment distributed separately to Councillors and Senior Staff only)
   c) Memo: Provincial Consolidated Homelessness Prevention Initiative (CHPI)
   e) Memo: Region of Waterloo Tax Clinics 2012 Experience
   f) Memo: Waterloo Region Integrated Drugs Strategy (WRIDS)

1239894
(Full report distributed separately to Councillors and Senior Staff only)

5. OTHER BUSINESS

a) Council Enquiries and Requests for Information Tracking List

6. NEXT MEETING – September 25, 2012

7. ADJOURN
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: September 11, 2012

FILE CODE: A34-01

SUBJECT: IMMIGRATION PARTNERSHIP UPDATE

RECOMMENDATION:

Information only

SUMMARY:

The Immigration Partnership is comprised of a broad range of stakeholders including employers, service providers, immigrants, municipal government representatives, healthcare providers, and other representative groups. The mandate of the Immigration Partnership is to help facilitate successful settlement and integration of immigrants and refugees in Waterloo Region. This is accomplished by creating and enhancing partnerships in a comprehensive local Immigration Partnership and by implementing collaborative strategies through coordination, information sharing, problem-solving and by implementing strategies for change. To this end, the work of the Immigration Partnership is organized under three pillars: Settle, Work, and Belong.

REPORT:

Planning for the Immigration Partnership began in 2009 and was supported by funding from Citizenship and Immigration Canada (CIC). Numerous key stakeholders worked with the community to develop a strategy and action plan for the implementation of the Immigration Partnership. The purpose of the Immigration Partnership is to facilitate:

1. Improvements in accessing and coordinating services that facilitate immigrants’ settlement and integration. (SETTLE)
2. Build a strong workforce in Waterloo Region through attracting and hiring job ready immigrants. (WORK)
3. Strengthened local and regional awareness and capacity to integrate immigrants. (BELONG)

Beginning in April 2011, an additional two years of funding was provided by CIC to support the implementation of the action plan developed during the consultation and planning phase of the Immigration Partnership. The Region of Waterloo also provided one-time funding in 2011 in the amount of $50,000 to support start up and development of the Immigration Partnership.

As part of the community planning process for the Immigration Partnership, it was identified that the Waterloo Region Immigrant Employment Network be fully integrated within the Immigration Partnership. This integration occurred on August 1, 2011. As a result of the integration of WRIEN, additional funding was received from the Ministry of Citizenship and Immigration (MCI) and Kitchener Waterloo United Way.

Much has been accomplished since the implementation of the Immigration Partnership action plan in 2011. A Partnership Council has provided oversight to the process and Action Groups have been
struck to address issues specific to settlement, employment and integration. There have also been Ad Hoc Task Groups struck in each pillar to address specific priorities as they emerge. Additionally, three sub-committees of Partnership Council have been developed: Data and Evaluation, Communications Committee and “Future Possibilities”, which is focused on creating sustainability for the Partnership. Each of the above groups has members who represent the broad and diverse groups who have a stake in the Immigration Partnership achieving its goals. In total, over 100 stakeholders are involved in working to achieve the goals of the Immigration Partnership through active participation on the above committees and task groups. (See attached diagram of the Structure of the Immigration Partnership).

1.0 Settling Pillar
Since the inception of the Settling Action Group in June 2011 a number of community collaborations have been created in order to address current priorities related to the successful settlement of immigrants within Waterloo region.

The Systems Mapping Ad Hoc Task Group has completed a systems map that identifies all of the current settlement services available to immigrants and refugees. All of the settlement service providers were surveyed in order to obtain data pertaining to service delivery. As a result of this project a number of recommendations have been made to transform the delivery of settlement services in Waterloo region. These recommendations include:

- creation of a one-stop access centre for settlement services
- consistent data collection and shared evaluation activities,
- establishment of a systems level planning table that includes all of the Executive Directors or Senior Managers of settlement and language service providers
- coordination of information provided to newcomers about how to access services.

These recommendations are currently being implemented over the course of the next two years will result in a system of settlement services that are integrated, seamless and easy to navigate for newcomers.

Additionally, three Ad Hoc Task Groups have been struck that address priorities related to health care for immigrants and refugees. These task groups are focused on hospital-based interpretation, access to mental health, and access to primary care. Each of these task groups has brought together all of the relevant stakeholders and each task group has developed an action plan to address the current gaps within the system. Initial feedback from stakeholders has identified that the Immigration Partnership has created new opportunities for community members to increase their awareness of the issues that impact newcomers and work collaboratively to create solutions. Most recently, these new groups have demonstrated that collaboration can also enhance community response to emergent issues. When CIC announced changes to the Interim Federal Health Program (IFHP) for refugees, the Immigration Partnership was able to facilitate development of a collaborative community response to the proposed changes.

2.0 Working Pillar
The Working Action Group has continued to build on the activities and partnerships created by WRIEN. One of the primary goals of the working pillar is to engage employers and to increase their awareness of the value of hiring newcomers. The Immigration Partnership team works collaboratively with the YMCA (who deliver the Mentorship Program) and Conestoga College (who deliver the Internship program) to create a continuum of employer and immigrant supports aimed at helping immigrants to obtain employment that matches their skills and training. Since May 2011 approximately 400 interactions have occurred between the partners identified above and employers. There have been 38 mentorships created during the last year and 20 internships since January 2012.
In addition to creating awareness among employers, the Immigration Partnership is also working to increase the capacity of employers to hire and integrate newcomers. This has occurred primarily through seminars such as “What’s your Diversity Intelligence” which focused on cross-cultural communication. 44 employers attended this sold out event and plans are underway to host similar seminars.

Networking events are another key activity within the working pillar. Two networking events have been held to connect international job seekers with employers. As a result, 250 newcomers and 38 employers have had an opportunity to increase their connection to each other.

Another primary function of the working action group is to ensure that employers’ access to job ready immigrants is easy and seamless. The Immigration Partnership is working with all of the local employment service providers to assist them to increase their capacity to meet the needs of newcomers who are seeking employment. This included hosting events to increase their knowledge about available programs that are targeted specifically towards helping immigrants obtain Canadian Credentials.

3.0 Belonging Pillar
The Belonging Action Group is focused on strengthening the capacity of the local community to integrate newcomers. One of the primary activities that has been used to achieve this goal has been through co-hosting events that increase awareness and promote dialogue. Examples of these events include two Dialogue on Diversity sessions co-hosted with the Region of Waterloo and two Conversation Café’s co-hosted with Leadership Waterloo. Approximately 1,000 community members have participated in events hosted or co-hosted by the Immigration Partnership over the last year. These conversations have acted as springboards for further action among various partners within the Immigration Partnership.

The goal of the Immigration Partnership has been to identify all of the informal supports that are available to newcomers in Waterloo region. The Belonging Action Group has created a list of all of the ethno, cultural and faith-based supports within the region and are beginning to actively engage with these groups in order to ensure that they are included actively as important members of the Immigration Partnership.

Increasing immigrant civic participation has also been a priority for the Belonging Action Group and they have initiated a project whereby the diversity of boards of directors in Waterloo region will be assessed and organizations engaged to assist them to increase the diversity of their board membership. Concurrently, a number of partners are working to create access for newcomers to curriculums and mentoring opportunities that will support their participation on Boards and in other civic arenas.

4.0 Additional Initiatives
The Immigration Partnership has worked with the Region of Waterloo and Waterloo Public Library to create an integrated web-site focused on immigration. This will simplify access information for newcomers who have already arrived in Waterloo region and also work to attract potential newcomers to this area. The Immigration Partnership was successful in obtaining additional funding to further enhance this web-site and this project will be completed by March 2013.

It is recognized that it is critical that the Immigration Partnership be able to understand the outcomes created by the activities described above and to this end an evaluation framework has been developed. An evaluation of the first year of the Immigration Partnership is currently being completed and this will provide direction for the upcoming year.

The Immigration Partnership has engaged a wide variety of stakeholders during its first year and, through its activities, continues to generate a community-wide commitment to support and integrate
newcomers into Waterloo region. The Immigration Partnership is dependent on the commitment and participation of many community members and, without this participation, would not be able to enhance the strengths that exist or address the gaps and needs that are identified. The Partnership has been fortunate that community participation has been enthusiastic and committed over this first year of implementation and looks forward to increasing engagement and outcomes over the next year.

CORPORATE STRATEGIC PLAN:

The Immigration Partnership supports the Region’s Corporate Strategic Plan Focus Area 4: Healthy and Inclusive Communities and Strategic objective 4.8 (to) Partner with the community to improve programs and services for immigrants and refugees. The Immigration Partnership also supports the Region’s Corporate Strategic Plan Focus Areas 2: Growth Management and Prosperity: Manage growth to foster thriving and productive urban and rural communities, specifically through a diverse, innovative and globally competitive economy. Talent attraction and retention is a key component of this strategic objective and immigration is seen as a key driver in this process.

FINANCIAL IMPLICATIONS:

NIL

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

NIL

ATTACHMENTS

A- Structure of Immigration Partnership

PREPARED BY: Lynn Randall, Director, Social Planning, Policy and Program Administration
Arran Rowles, Manager, Immigration Partnership

APPROVED BY: Michael Schuster, Commissioner, Social Services
ATTACHMENT A

Immigration Partnership Organizational Structure

Region of Waterloo (host)

Communications

Data Evaluation

Future Possibilities

Council

Executive Committee

Settling Action Group

Belonging Action Group

Working Action Group

Working Advisory Group

Systems Map Ad Hoc Task Group

Access to Primary Care Ad Hoc Task Group

Access to Mental Health Ad Hoc Task Group

Access to Hospital-Based Interpretation Ad Hoc Task Group

Ethnocultural Communities Ad Hoc Task Group

Civic Participation Ad Hoc Task Group

Employer Connections

Outreach Plan

Awareness Building Plan
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: September 11, 2012

FILE CODE: S04-20

SUBJECT: COMMUNITY FIT FOR CHILDREN – INTERIM UPDATE

RECOMMENDATION:

For Information only

SUMMARY:

NIL

REPORT:

The Community Fit for Children report is prepared using data gathered from the Early Development Instrument (EDI) and the Kindergarten Parent Survey (KPS). The Community Fit for Children Interim Update report provides an update on data that was published in 2004, 2007, 2010. The purpose of the report is to give an overview on how senior kindergarten children are doing to guide planning that supports outcomes for children. The report provides a summary of the 45 predefined neighbourhoods in Waterloo Region. A summary of the most recent report findings is being presented for the Committee’s information by Amy Romagnoli, Data Analysis Coordinator, YMCA Ontario Early Years Centre today.

The EDI is a ‘population-level’ tool that is completed by teachers that monitors healthy child development at school entry. The EDI report describes senior kindergarten children’s ‘readiness to learn’ in Waterloo Region. The EDI focuses on five domains of child development: physical health and well being, social competence, emotional maturity, language and cognitive development, and communication skills and general knowledge. The EDI is completed every three years in Waterloo Region.

The KPS is completed by parents and caregivers and provides contextual information to help interpret EDI results. This portion of the report summarizes what parent said about their children, before their entry into Senior Kindergarten.

General findings of the interim report indicate that in comparison to other communities in Ontario, Waterloo Region’s Children fare well in some of the domain categories and that there is room for improvement in other domains. A summary of the findings and greater detail on the domains can be found in the interim report that will be distributed during the presentation.
CORPORATE STRATEGIC PLAN:

This initiative aligns with the Region’s Corporate Strategic Focus Area 4: Healthy and Inclusive Communities; Corporate Strategic Objective 4.5: (to) work collaboratively with the community to support the development of services for children.

FINANCIAL IMPLICATIONS:

NIL

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

NIL

ATTACHMENTS:

NIL

PREPARED BY:  Nancy Dickieson, Director, Children’s Services

APPROVED BY:  Michael Schuster, Commissioner, Social Services
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: September 11, 2012

FILE CODE: S04-20

SUBJECT: REGION OF WATERLOO RESPONSE TO MODERNIZATION OF CHILD CARE IN ONTARIO

RECOMMENDATION:

THAT the Regional Municipality of Waterloo endorse the document entitled; ‘Region of Waterloo Response to the Modernization of Child Care in Ontario’ to be forwarded to the Province and copies to AMO and OMSSA as outlined in report SS-12-037, dated September 11, 2012.

SUMMARY:

NIL

REPORT:

On June 27th, 2012 the Province released a discussion paper, Modernizing Child Care in Ontario. In the paper the Province is inviting Ontarians to provide input into proposed changes to licensed early learning and child care. The goal is to create a more integrated early learning and child care system. The Province describes a long term vision, guiding principles and some proposed medium term actions for comment. A copy of the paper was provided to Committee members at the August 14th meeting.

The attached response to the discussion paper has been prepared on behalf of the Region of Waterloo. It focuses on to the important role that Consolidated Municipal Service Managers (CMSM) play in implementing such a large vision. Input into the response was provided by staff and members of the Early Learning and Child Care Advisory Committee for Children’s Services. Comments to the discussion paper will be accepted by the Province until September 24, 2012.

CORPORATE STRATEGIC PLAN:

The provision of licensed early learning and care services aligns with the Region’s Corporate Strategic Focus Area 4: Healthy and Inclusive Communities; Corporate Strategic Objective 4.5 to work collaboratively with the community to support the development of services for children.
FINANCIAL IMPLICATIONS:

The impact of this paper on the Children’s Services operating budget is unknown at this time until Provincial direction is determined.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

NIL

ATTACHMENTS

A- Response to Modernization of Child Care Paper

PREPARED BY: Nancy Dickieson, Director, Children’s Services

APPROVED BY: Michael Schuster, Commissioner, Social Services
This document was prepared in response to the Provincial discussion paper titled, ‘Modernizing Child Care in Ontario’. This response was prepared by the Region of Waterloo, as the Consolidated Municipal Service Manager and involved consultation with the Children’s Services staff and the, Early Learning and Child Care Community Advisory Committee of Waterloo Region.

The Province is to be acknowledged for moving forward with changes to the licensed Early Learning and Child Care sector (ELCC) and soliciting input of stakeholders. The Region of Waterloo supports in principle the five key areas of focus discussed in the paper. As the Consolidated Municipal Service Manager (CMSM), the Region of Waterloo has a long standing history of supporting licensed early learning and care. A top priority moving forward is to ensure that families have access to high quality early learning and care when and where they need it.

Using the key areas for action identified by the Province this document has been prepared to share the perspective of the Region of Waterloo.

1. Operating funding formula

As the CMSM, the Region of Waterloo, acknowledges the need to review current funding allocations and begin to streamline. A more flexible, streamlined funding approach is required to improve the ability to distribute funding in alignment with service plans. Increased flexibility would allow for local planning and a responsive approach to community needs that ultimately supports timely access to ELCC services for families.

Current Provincial funding allocations are provided from over twenty different funding envelopes, each, with a variety of service targets and cost sharing arrangements and data reporting elements. A short term strategy to support CMSM’s in reporting data elements and support operational and administrative efficiencies would involve merging like funding envelopes which would significantly reduce data reporting elements.

Working towards a more long term funding model requires significant work between the Province and Municipalities to determine an approach that meets the needs for all communities. The current Provincial data management system, Ontario Child Care Management System (OCCMS) requires modifications to allow CMSM’s to use it more effectively as a business management tool and support planning for the system at Provincial and local levels. When determining allocations to CMSM’s, the Region of Waterloo encourages the Province to give greater consideration to factors such as; urban and rural/remote populations, demographics, current population & future growth projections, income levels, employment rates, immigration patterns, birth rates, school enrolment, unique populations, number of existing child care spaces and utilization of services.

2. Capital Funding Priorities

The Provincial ‘Schools First’ directive helps to ensure licensed ELCC is co-located in elementary schools when space exists is a good first step in supporting long range financial viability for licensed ELCC operators. The Region supports the vision of aligning licensed ELCC with elementary schools as part of an important continuum of early learning and care options for families. This
approach will require investment of capital funding. In Waterloo Region strong working relationships exist between the CMSM and local Boards of Education which support this level of joint planning. However, to build a system of Early Learning and Care which links child care and education together as a continuum of integrated services, clear Provincial direction and development of memorandums of understanding at local levels need to be developed to ensure continuation of these relationships. A more formalized process will help to ensure that a multi-year planned approach to capital is in place and that licensed ELCC is located in areas of greatest need.

In addition to the ‘Schools First” capital retrofit funding greater flexibility is required for joint projects in newly constructed schools. The Region of Waterloo is a growth community which currently meets only 11% of ELCC needs, since new schools are built in areas of substantial growth and development it makes sense to look at co-location options in areas where families with young children live.

3. Quality Programs

In Waterloo Region the Raising the Bar on Quality (RTB) initiative has been in place since 2004. As of 2010 the program has 100% participation from all licensed ELCC programs. RTB is built upon a strong history of collaboration and capacity building. High quality programs are not achieved over night and require a more developmental approach by building upon strengths and wins. In order for quality to be sustainable it must be embedded in all aspects of the program delivery such as; pedagogy, physical environments, staff and program philosophy. CMSM’s require the flexibility within funding envelopes to support and grow quality in partnership with post secondary institutions.

To support the ongoing development of a high, quality early learning and care system, CMSM’s must work in partnership with Provincial Quality Assurance & Licensing staff. Through a strong working partnership, operational compliance, ongoing development and fiscal accountability can be supported at the local level.

4. Modernized Legislative & Regulatory Framework

The Region of Waterloo is in support of changes to the current legislation & regulations in the Day Nurseries Act (DNA). The DNA, standards need to move beyond basic health and safety and increase the focus on elements that support program quality. Standards of practice and legislation should be grounded in research and best practice that supports developmental health of children. Inconsistencies between; summer camps, after school programs, homework clubs, kindergarten classes, child care centres, home child care programs create great confusion for parents and imply a level of monitoring that does not exist in all cases. Programs that bring children together in group settings should be required to operate under similar standards that are grounded in evidence based practice. These practices should include a combination of evaluative and monitoring tools related to all aspects of program delivery, outcomes for children and child development.

5. Support for Accountability and Capacity-Building

In addition research indicates that best practices are supported through ongoing professional development. Experienced practitioners need to stay informed and challenged in their work with children. Standards of practice established by the College of Early Childhood Educators of Ontario, should be expanded to include a minimum annual requirement for professional development. The CMSM, in partnership with post secondary education institutions and professional resource centres can support this at a local level to ensure training is geared to community need and evidence based practice.
Common evaluative tools endorsed by the Province should be based on ‘gold’ standard selection criteria and should be linked to other tools that are used for older children. As the CMSM, the role of collecting data and summary reports should be supported at the local level. **Municipalities need to be engaged in discussion with the Province to determine the best information to collect and report that reflects community needs, services and programs.** Municipalities cannot plan effectively with communities if data is being collected outside of the service system manager role.
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: September 11, 2012

FILE CODE: S07-80

SUBJECT: PROVINCIAL FUNDING UPDATE FOR SUNNYSIDE HOME

RECOMMENDATION:

For information only

SUMMARY:

This report provides an update with respect to the potential 2012 provincial revenue shortfall for Sunnyside Home which was discussed in report SS-12-009 on February 28, 2012. While the historical acuity adjustment remains frozen until April 1, 2013, confirmed additional provincial funding for 2012 of $202,560 has reduced the projected revenue shortfall to $112,525. The Home, however, is forecasting a balanced year-end budget due to the Implementation of the expenditure reductions identified in the February report. One cost-saving measure was a delay in the hiring of the new supervisor approved during the 2012 budget process. In order to meet quality care standards and effectively manage risk, it is important to now proceed with the recruitment of this supervisory position.

REPORT:

Since 2010, the Ministry of Health and Long-Term Care (MOHLTC) has been transitioning the long-term care sector to a new funding system. Long-term care homes continue to receive revenue based on a funding system consisting of four discrete funding envelopes: Nursing and Personal Care (NPC); Programs and Services; Food; and Other Accommodation. Only the NPC funding envelope is affected in the new system, but it is the largest envelope providing funding for both registered and unregulated care staff as well as nursing supplies.

The amount received in the NPC envelope is based upon the care level of individual residents, as determined through a complex assessment and data collection process. The Province assesses this data to calculate a case-mix index or CMI, which is adjusted relative to all homes in Ontario. Each home is notified annually of its CMI and corresponding funding based on historical data submissions.

In developing the Sunnyside Home annual budget, staff project the provincial subsidy based on anticipated provincial annual acuity and cost of living adjustments. In February 2012 (subsequent to the Region’s 2012 budget approval), the Province announced an unprecedented capping of acuity adjustments for all Homes whose CMIs increased, at the 2011/2012 funding level. This cap is in effect until April 1, 2013.

On February 28, 2011, report SS-12-009, advised that the unanticipated cap in the CMI was projected to result in a revenue shortfall of $271,000 compared to the approved 2012 operating budget. To mitigate the impact of the potential shortfall, new initiatives approved in the 2012 budget including the addition of a new supervisor and the cost of benefits to enable the combining of part-time staffing lines to create full-time positions were delayed. Gapping of non-direct care vacancies also took place, where possible.
Total provincial revenue announcements year to date total $158,475, resulting in a projected revenue shortfall of $112,525 (relative to the 2012 approved budget). This shortfall has been offset by the aforementioned expenditure reductions and a balanced year-end budget for Sunnyside Home is projected. Provincial revenue announcements include increases to the Nursing and Personal Care (NPC), Programs and Services, Food, and Other Accommodation funding envelopes. In addition, new funding was allocated to the 10 convalescent care beds operated by Sunnyside Home.

In order to meet quality care standards and effectively manage risk, it is important to now proceed with the recruitment of the supervisory position approved in the 2012 budget process. This non-union position will support and supervise front line staff; complete scheduling, time and attendance and payroll data; and provide new staff orientation and ongoing training and supervision for care staff on the safe use of resident equipment, care practices, protocols and documentation. The position will also provide additional supervisory presence on evenings and weekends. At the current time, managers in the resident care department directly supervise, with the support of Registered Nurses, over 90 staff members each. This span of control does not provide adequate staff support and supervision. Additional support and education for front line staff are essential to address the publicly reported quality indicators including restraint use, falls, pressure ulcers and bladder continence.

The conversion of part-time hours to full-time positions, which results in additional benefit expenses, will be delayed until the 2013 budget process is completed.

CORPORATE STRATEGIC PLAN:

This report addresses the Region’s Corporate Strategic Plan Focus Area 5: Service Excellence, specifically strategic objective 5.3: Ensuring that Regional programs and services are efficient and effective and demonstrate accountability to the public.

FINANCIAL IMPLICATIONS:

To date, additional provincial revenues of $158,475 have been announced, leaving a revenue shortfall relative to the approved budget of $112,525. This shortfall has been offset by delaying both the hiring of a supervisor and the conversion of part-time hours to full-time positions. Due to the expenditure reductions, Sunnyside Home is projecting a balanced year-end budget position. The historical annual acuity adjustment remains frozen until April 1, 2013 as previously reported, despite a significant increase in the acuity level of residents at Sunnyside Home. It is unclear as to whether further funding announcements will be made for 2012.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Finance has been consulted in the development of this report.

ATTACHMENTS

NIL

PREPARED BY: Gail Kaufman Carlin, Director, Seniors' Services

APPROVED BY: Michael Schuster, Commissioner, Social Services
TO: Chair Sean Strickland and Members of the Community Services Committee
DATE: September 11, 2012
FILE CODE: S07-80

SUBJECT: HOMEMAKING AND NURSING SERVICES BUDGET UPDATE

RECOMMENDATION:

THAT the Regional Municipality of Waterloo approve an increase of $25,650 for the Homemakers and Nurses Services program for 2012, subject to the approval of provincial subsidy from the Ministry of Health and Long Term Care in the amount of $20,520 and a Regional contribution of $5,130, to be funded within the Seniors’ Services Budget as outlined in Report SS-12-040, dated September 11, 2012.

SUMMARY:

The Homemaking and Nursing Services program serves vulnerable individuals and families and is an instrumental support in sustainable housing for this client group. The program is claims-based and is cost-shared with the Province on an 80/20 basis. The program currently serves 193 clients and has a lengthy and growing wait list. The province adjusts its annual allocation based on actual claims experience. For the fiscal year April 1, 2011 to March 31, 2012, the Province increased the Region's purchase of service budget based on its claims submission. Given the urgent need in the community for this service, it is proposed that the caseload be increased, exceeding the approved budget by $25,650. Exceeding the allocated budget to serve more individuals will substantiate the Region’s proposal to the Province to increase to its base allocation for 2012/2013. Any 2012 over expenditure will be accommodated within the Seniors’ Services budget.

REPORT:

The Homemakers and Nurses Services Program (HNSA) is legislated under the Homemakers and Nurses Act R.R.O. 1990, Regulation 634 Amended to O. Regulation 174/95. The purpose of the program is to provide support to low income clients so they can maintain their health and live independently in the community. Service is provided on a short-term basis in a crisis situation, or over a long period in a chronic situation. This program currently provides service to 193 vulnerable individuals/families and is an instrumental support in sustainable housing for this client group. The majority of clients are in receipt of Ontario Disability Support Program (ODSP), live alone, and have chronic physical and mental health issues that inhibit their ability to complete homemaking tasks. Many clients are also receiving services from the Community Care Access Centre and/or support from agencies such as Community Support Connections, Canadian Mental Health Association, and Waterloo Regional Homes for Mental Health or adult day programs.

Under this program, the Province, through the Ministry of Health and Long-Term Care, contributes to the cost of homemakers or nurses services to eligible clients. It is a claims based discretionary program that is capped and cost-shared on an 80/20 basis with municipalities. Administrative costs for the delivery of the program are not eligible for provincial subsidy. The program is currently supported by a Coordinator (0.7FTE) and clerical staff (0.4 FTE). In the 2012 budget, the program
received approval to add 0.2FTE to the Coordinator position to assist with completing wait list assessments, to support clients who were transitioning to new homemakers as a result of new contractual service agreements, and to enable the completion of annual re-assessment of clients.

Since the 2011/12 funding was confirmed by the Province in June 2012, 15 new clients have been admitted to the program from the waitlist. The waitlist, however, has increased from 73 to 109 in the past six months. The increase is due to increased referrals by Community Care Access Centre, enhanced awareness of the program throughout the Region, and the overall trend in the healthcare system to support people in their own homes, while avoiding hospital and long term care home admissions. Currently individuals are waiting about 17 months for service.

Historically, the Province has capped the service budget based on actual expenditures. Last year, the program exceeded its service budget by $31,250 gross expenditures ($25,000 provincial subsidy), which was subsequently approved by the Province. With a goal to bring an additional 30 waitlist clients on service by March 31, 2013, it is recommended that the Region exceed budgeted service levels again this year by up to $25,650. It is anticipated that this demonstrated need will result in an annualized budget increase next year. Any over expenditure, including the Region’s 20% cost-sharing, will be accommodated in the 2012 divisional budget. 2013 service levels will be adjusted accordingly if the Province does not approve the funding request.

CORPORATE STRATEGIC PLAN:

This report addresses the Region’s Corporate Strategic Plan Focus Area 5: Service Excellence, specifically strategic objective 5.3: Ensuring that Regional programs and services are efficient and effective and demonstrate accountability to the public.

FINANCIAL IMPLICATIONS:

The Region’s 2012 budget for HNSA is as follows:

<table>
<thead>
<tr>
<th>Staffing</th>
<th>$ 99,587</th>
</tr>
</thead>
<tbody>
<tr>
<td>HNSA Services</td>
<td>475,800</td>
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<tr>
<td>Total Expenditures</td>
<td>$575,387</td>
</tr>
<tr>
<td>Provincial Subsidy</td>
<td>$380,000</td>
</tr>
<tr>
<td>Net Regional Cost</td>
<td>$195,387</td>
</tr>
</tbody>
</table>

Costs related to the administration of the program are not eligible for cost sharing.

The Ministry approval for fiscal 2011/12 gross service expenditures was $437,500 ($350,000 provincial funding) as this program is cost-shared 80/20. This approval was increased to $468,750 gross and $375,000 net funding to reflect actual expenditures incurred in the program. This final approval is the base funding for the 2012/13 year.

A request was made in March 2012 to the Ministry to further increase the funding to $510,000 gross or $408,000 in subsidy for the fiscal year 2012/13 to reflect the anticipated costs of direct client service. This request represents an increase over the Region’s approved 2012 budget of $25,650 ($20,520 subsidy and $5130 Regional cost).

The Ministry has responded that monthly claims need to substantiate the need for the increased funding request. As such, it is proposed that service levels be increased by admitting approximately 30 clients from the waitlist. Any over expenditures in 2012 will be accommodated in the Seniors’ Services approved budget. If approved, the incremental expense will form part of the 2013 base budget. If not funded by the Province, the caseload will be adjusted downward in 2013 to reflect actual expenditure approvals.
OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Finance was consulted in the preparation of this report.

ATTACHMENTS

NIL

PREPARED BY: Helen Eby, Administrator, Resident Care

APPROVED BY: Michael Schuster, Commissioner, Social Services
TO: Chair Sean Strickland and Members of the Community Services Committee  
DATE: September 11, 2012  
FILE CODE: S04-20  
SUBJECT: UPDATE REDEVELOPMENT – ELMIRA CHILDREN’S CENTRE & EDITH MACINTOSH CHILDREN’S CENTRE

RECOMMENDATION:
For information only

SUMMARY:
This report provides an update on the planning process to date for two pending capital projects; the redevelopment of the Elmira Children’s Centre and the Edith MacIntosh Children’s Centre. Several options have been explored for redevelopment. Staff are recommending proceeding with replacement of these Centres by co-location with an elementary school for both projects. Staff will report back with recommendations for Committee’s consideration for both projects.

REPORT:

1.0 Background
The ten year capital forecast calls for the replacement/redevelopment of Elmira Children’s Centre starting in 2012 and the redevelopment of Edith MacIntosh Children’s Centre starting in 2014. These projects will replace the last two aging child care facilities directly operated by the Region of Waterloo. In preparation for both capital projects staff from Children’s Services and Facilities Management have been reviewing possible options.

2.0 Project Scope
Both capital projects provide for the construction of a new building which can accommodate enrolment of infants, toddlers and preschoolers. The buildings should be approximately 9,000 square feet and may incorporate space for a community hub to align with the Early Learning Framework. To make the best use of staff time and expertise options have been explored for both projects.

Elmira Children’s Centre is currently a stand alone facility constructed in 1976. Council approved the reconstruction of the centre starting in 2012. The start of this project has been delayed to allow further investigation around potential options.

Edith MacIntosh was originally constructed in 1971 by the City of Kitchener and was later transferred to the Region of Waterloo. Currently replacement of this building is not slated until 2014.
3.0 Options

Prior to entering into consultant selection and further defining project scope, staff have reviewed possible options for the reconstruction of the two facilities. The following options were explored to determine the most viable approach to sustain future growth and to establish the facility within a continuum of early learning and care.

<table>
<thead>
<tr>
<th>Option</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
</table>
| Renovate/Expand existing building | May be less costly  
Remain in same location                                                   | Does not address space and operational challenges of current building  
May not meet requirements for future development of Child & Family Centre (Service Hub)  
Would require period of closure  
Insufficient land to allow for expansion |
| Demolish & Reconstruct on the same site | Remain in same location  
No land acquisition costs                                                 | Requires period of closure  
May not meet requirements for future development of Child & Family Centre (Service Hub)  
Site space inadequate                                                       |
| Relocate to New Site          | Continued operation in old site until new completed                  | Cost of land acquisition  
May not meet requirements for future development of Child & Family Centre (Service Hub) |
| Co-locate with an elementary School | Fit with continuum of early learning & child care and full day kindergarten  
Establishes partnership with school board  
Better positioned to meet requirements for Child & Family Centre (Service Hub)  
Longer term sustainability  
May reduce land acquisition costs                                           | Physical fit on site may require some compromises |

4.0 Co-location Approach

The ‘Schools First’ policy established in 2005 requires a call for expressions of interest for co-location of a child care operator each time a new elementary school is constructed. In Waterloo Region all new schools have had a child care program co-locate since this time. This practice has allowed new growth as well as relocation of some existing child care programs. Over the next three years significant capital activity is taking place at both local Boards of Education to accommodate space needs for the final phases of full day kindergarten. Provincial Capital funding announced in July 2012 may be available to local boards for such projects. Further details are pending from the Province.

In addition Provincial direction in the ‘Modernization of Child Care’ document identifies co-location of child care and schools as a vital element in supporting a continuum of early learning and care for children and their families. This approach supports the long term viability of a child care centre which relies on a steady enrollment of young children to meet operating costs. It firmly establishes the
strong connection between child care and education and access to services for families.

From a staff perspective co-location also provides some advantages in terms of ongoing partnerships with Boards of Education and opportunities to establish community hubs/services into the new facilities. The long term Provincial vision is to establish a broad continuum of services for children and families in one location. These community hubs or Child & Family Centres are part of the broader Best Start strategy and will involve co-location with elementary schools as well as other service providers. Staff will explore the co-location options for both facilities and bring a report back for committee’s consideration.

CORPORATE STRATEGIC PLAN:

This initiative aligns with the Region’s Corporate Strategic Focus Area 4: Healthy and Inclusive Communities; Corporate Strategic Objective 4.5 (to) work collaboratively with the community to support the development of services for children as well as Focus Area 2: Develop, optimize and maintain infrastructure to meet current and projected needs.

FINANCIAL IMPLICATIONS:

The capital budget provides for an allocation of $9.051M for the redevelopment of Elmira Children’s Centre ($4.671M) starting in 2012 and Edith MacIntosh Children’s Centre ($4.380M) starting in 2014. The cost of property acquisition has been factored into the capital budget. These projects are to be funded by the issuance of debentures for a term of ten years and the associated debt costs will be included in the Children’s Services budget once the projects are completed. A preliminary estimate of the timing and costs of the financing are presented in the following table. Financing for construction costs are not eligible for provincial subsidy and will be borne entirely by the property tax levy.

<table>
<thead>
<tr>
<th>Project</th>
<th>Capital Cost</th>
<th>Estimated Annual Financing Cost</th>
<th>Projected Budget Year for Financing Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elmira Children’s Centre</td>
<td>$4,671,000</td>
<td>$574,533</td>
<td>2014</td>
</tr>
<tr>
<td>Edith MacIntosh Children’s Centre</td>
<td>$4,380,000</td>
<td>$538,740</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$9,051,000</td>
<td>$1,113,273</td>
<td></td>
</tr>
</tbody>
</table>

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

The assistance of Legal Services and Finance will be required to support this project.

ATTACHMENTS

NIL

PREPARED BY:  
Nancy Dickieson, Director, Children’s Services  
Ellen McGaghey, Director, Facilities Management and Fleet Services

APPROVED BY:  
Michael Schuster, Commissioner, Social Services  
Gary Sosnoski, Commissioner, Corporate Resources
MEMORANDUM

To: Chair Sean Strickland and Members of the Community Services Committee

From: Heather Callum, Social Planning Associate
David Dirks, Director, Employment and Income Support

Copies: Michael Schuster, Commissioner, Social Services

File No: S14-80

Subject: ONLINE APPLICATION FOR ONTARIO WORKS EVALUATION

Background: Online Application for Ontario Works

As part of the Social Services Solutions Modernization Project (SSSMP), the Ministry of Community and Social Services (MCSS) implemented an Online Application for Social Assistance. Although the online application may not be accessible for all potential applicants, it provides an additional method for many individuals to apply for social assistance. The online application was implemented by the Region of Waterloo’s Employment and Income Support (EIS) division in May 2011 and is managed through the EIS Intake Services Unit. Approximately 6% of initial applications for Ontario Works are received online.

An evaluation was conducted in 2012 to assess the effectiveness of the online application model developed for Waterloo Region, and to determine any changes that could enhance service to the community. The Online Application for Ontario Works Evaluation Report summarizes the findings of this evaluation.

Key Findings
Overall, the evaluation determined that the online application model is functioning well in many regards.

Respondents noted a variety of benefits that the online application offers to individuals wishing to apply for social assistance. For the most part, applicants said that they appreciate the convenience of being able to apply for assistance online at any time of day or night, the ease with which the online application form can be filled out, and the quick and friendly service received from Intake Services. The most common suggestions for improvement to the online application model included making it easier for potential applicants to find the online application form and improving some of the content and functionality of the form. The online application form was implemented by the Ministry of Community and Social Services (MCSS) and is outside the scope of Regional service; therefore, this feedback has been forwarded to the MCSS for their consideration.
EIS staff indicated that the online application model is working effectively overall. It appears that the model provides sufficient resources, communication is effective, the role of staff is clear, and staff feel they are able to provide good service. The most common staff suggestion for improvement to the online application model involves changing the way applicants are able to contact the EIS office to continue their application for assistance over the telephone, and providing more consistent coverage for incoming telephone calls from online applicants.

Some specific changes to the model are being recommended to improve service delivery; most of these recommendations are related to improved methods of communication with online applicants. The full list of recommendations can be found on pages 8 and 9 of the evaluation report. It is also recommended that EIS gather feedback from the approximately 20% of online applicants whose applications remain incomplete each month, and who could not be included in this evaluation, to determine whether any specific enhancements to service could improve the accessibility of this social assistance application method.

**Next Steps**

The Online Application Evaluation Report and recommendations were endorsed by the Employment & Income Support Management Team in June 2012. The Manager of Program Development and Intake will follow-up on the changes recommended in the report. These recommendations are being reviewed with the Intake Staff who were part of the initial planning and implementation of the online application model. This will allow staff to comment on these recommendations and identify any implications or unintended consequences that could arise from the proposed changes, before any enhancements are initiated. Staff will consider gradually enhanced marketing of the online application, based upon the results of the evaluation.

The evaluation report and a summary of the feedback received from applicants will be shared back with stakeholders through targeted mailings and by posting these documents to the Region of Waterloo website.

This work supports the Region’s Corporate Strategic Focus Area 5: Service Excellence: (to) deliver excellent and responsive services that inspire public trust; Strategic Objective 3: (to) ensure Regional programs and services are efficient and effective and demonstrate accountability to the public.

A copy of the Online Application for Ontario Works Evaluation Report will be placed in the Councillors’ library. For further information please contact Heather Callum, Social Planning Associate at (519) 883-2040 or hcallum@regionofwaterloo.ca; or David Dirks, Director, Employment & Income Support at 519-883-2179 or ddirks@regionofwaterloo.ca.
MEMORANDUM

To: Chair Sean Strickland and Members of the Community Services Committee

From: Gail Kaufman Carlin, Director, Seniors’ Services

Copies: Michael Schuster, Commissioner, Social Services

File No.: S07-01

Subject: MUNICIPAL DELIVERY OF LONG TERM CARE SERVICES BRIEF UPDATE

Please find attached an updated version of the brief, Municipal Delivery of Long Term Care Services: Understanding the Context and the Challenges, published by the Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS). (Distributed to Councillors and Senior Staff separately.)

This document articulates the distinct and important role of municipal long term care (LTC) homes and the environment in which they operate. The 2010 version was reviewed by an advisory group of members and updated to incorporate recent data and additional information related to the current municipal LTC home context.

For further information please contact Gail Kaufman Carlin, Director, Seniors’ Services at 519-893-8494 Ext. 6310 or gkaufmancarlin@regionofwaterloo.ca
Municipal Mandate in Long Term Care

The value of municipal involvement in long term care to the provincial health system was formally reconfirmed when the Long-Term Care Homes Act (LTCHA) was passed in June 2007. While there are some distinctions made between northern and southern municipalities in the Act, what stands out is that municipalities remain the only long term care providers in Ontario mandated to deliver this service. This legislative requirement has been in place since 1949 when the Homes for the Aged and Rest Homes Act was passed. Specifically, under the LTCHA, every upper or single-tier southern municipality is mandated to maintain at least one municipal home (either individually or jointly), and, in fact, many municipalities have the decision to operate more than one in response to local needs. Northern municipalities are treated slightly differently in that they are not required to operate a home but may do so individually or jointly. There is also a provision in the Act allowing for territorial district homes in the north, which are to be operated by a single board of management jointly established by the participating municipalities.

Municipalities have long played an essential role in the province’s long term care system with the first homes having roots dating back over 130 years. This history of caring, collaboration and connection with their communities has established municipal homes as a valued and respected player in Ontario’s long term care home system. Ensuring that municipal homes continue to thrive as an integral component of the range of services delivered locally by municipalities requires recognition of the environment in which these homes operate and their distinct role within the broader long term care system.

The Municipal Mandate in Long Term Care

The value of municipal involvement in long term care to the provincial health system was formally reconfirmed when the Long-Term Care Homes Act (LTCHA) was passed in June 2007. While there are some distinctions made between northern and southern municipalities in the Act, what stands out is that municipalities remain the only long term care providers in Ontario mandated to deliver this service. This legislative requirement has been in place since 1949 when the Homes for the Aged and Rest Homes Act was passed. Specifically, under the LTCHA, every upper or single-tier southern municipality is mandated to maintain at least one municipal home (either individually or jointly), and, in fact, many municipalities have the decision to operate more than one in response to local needs. Northern municipalities are treated slightly differently in that they are not required to operate a home but may do so individually or jointly. There is also a provision in the Act allowing for territorial district homes in the north, which are to be operated by a single board of management jointly established by the participating municipalities.

Long Term Care in Ontario

In Ontario, long term care home services are funded and regulated by the provincial government and delivered in municipal homes, charitable homes and nursing homes (not-for profit and for-profit). All long term care homes are regulated under the same legislation, the Long-Term Care Homes Act (LTCHA).

There are currently 633 long term care homes that operate 77,747 beds. Of those, municipalities operate 103 homes representing 16,473 beds, non-profits and charities operate 158 homes representing 19,535 beds and for-profits operate 360 homes representing 41,475 beds. Eldcap (Elderly Capital Assistance Program) beds – which are long-term beds in acute care hospitals – make up the balance.
Community Builders

Communities have general expectations about the range of municipal services that should be available to meet local needs. These expectations extend well beyond infrastructure such as bridges, roads and sewers. Citizens also look to their local governments to respond to their social, health and human service needs. In this way, services such as those for the elderly, the needy and the disadvantaged have become a cornerstone of the municipal mandate.

Long term care is one such service that communities expect to be available. In many areas of the province, the municipality is recognized as the primary provider of long term care. With the acknowledgement that the municipality is the owner and operator of the long term care home comes the recognition that the home is an integral part of the community. Municipal long term care home services are established based on an understanding of local needs and managed and delivered with local involvement, giving residents in the community assurance that appropriate and accessible services are available.

Municipal homes are anchored in their communities. They make a significant contribution to the local economy and in many parts of the province the home is a major employer. As such, these homes are a very visible symbol of the active role municipalities play as service providers.

Experience has shown that if municipalities try to withdraw from their long term care role, the citizens will object. It is the community’s understanding that this is an area of responsibility to which municipalities should be committed.

In a new health care environment that has seen the establishment of Local Health Integration Networks (LHIWs) and an emphasis on efficiency in health service delivery, municipalities and municipal homes in particular are models of integration and collaboration. Many homes have expanded their operations to offer a continuum of integrated services to local seniors. They are also reaching out and supporting their communities through effective partnerships with other health care providers, community service agencies, schools and universities, churches, service clubs and other groups.

Accountability to the Community

Municipal homes are publicly owned and operated. They serve local people, with and through local people. In fact, all municipally-operated long term care homes are required by legislation to be governed by a committee of management, the membership of which consists of members of council (or councils for jointly operated homes).

The involvement of elected officials in overseeing the homes is a key element in the accountability process that ensures the appropriateness and effectiveness of the program. This accountability is strengthened by a degree of transparency that includes open council meetings, community advisory committees and opportunities for public input.

As well, residents or their family members have the option of raising any issues of concern with respect to care and services in the home with their elected municipal representative.

Recent surveys have indicated over approximately 735,000 hours in volunteer time have been provided to municipal homes, equating to 377 full-time equivalents. At the County of Frontenac’s Fairmount Home for the Aged, in 2011, there were 130 registered volunteers providing over 7,000 hours of volunteer activities.
Responsive to the Local Community

Many municipal homes offer services geared toward specific populations common in their communities, such as the South Asian community in Peel Region and programs to serve younger adults with support from community-based partners, such as those found in the City of Toronto’s homes.

Similarly with the increase in Alzheimer Disease and other age-related dementias, municipal homes have been concentrating on providing care and services to serve this high risk population. For example, the Niagara Region’s T. Roy Adams Regional Centre for Dementia Care specializes in enhancing the lives of older adults living with dementia and behavioural challenges.¹¹

Strong Community Support

In one way or another, long term care homes across the province rely on the contribution and dedication of countless volunteers. Volunteering time and services can take many forms from assisting with recreation and programs (such as art therapy and horticulture therapy programs), to operating the cafes and gift shops, to assisting with meals.

Municipal Contributions Enhance Care

Many municipalities provide their own voluntary financial contribution to the operation of their homes, raising both the quality of care and the quality of the home as a workplace.

Current estimates suggest that in 2008, OANHSS member municipalities contributed well over $225M to home operations over and above provincial long term care funding. This averages out to $37.28 per resident in a municipal home per day.⁶ In addition to direct care, this enhanced funding goes toward restorative care and other support services such as social work and volunteer coordination. These contributions are reflected in higher levels of care in municipal long term care homes (see table below).

On top of this is the funding that municipalities contribute to capital projects, which in some cases is well over provincial funding.

In 2009, the Ministry of Health and Long-Term Care reported that municipal home contributions alone resulted in 48 additional minutes of care per resident day, equating to almost 11.5 minutes more direct care per resident per day than the provincial average across the long term care sector.⁹

**Average Direct Care Hours per Resident Day (2009)**

<table>
<thead>
<tr>
<th>Care Type</th>
<th>Hours Per Resident Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Care Sector</td>
<td>3.408</td>
</tr>
<tr>
<td>Municipal Homes</td>
<td>3.599</td>
</tr>
<tr>
<td>Charitable Homes (non-profit)</td>
<td>3.037</td>
</tr>
<tr>
<td>Nursing Homes (non-profit)</td>
<td>3.296</td>
</tr>
<tr>
<td>Nursing Homes (for-profit)</td>
<td>2.996</td>
</tr>
</tbody>
</table>

Demand for Services

While wait lists are high across the long term care sector, the number of people on the wait list for municipal homes is disproportionately greater than the municipal share of beds in the system. Specifically, municipal homes operate 21% of the long term care beds in Ontario but 27% of individuals on the wait list for long term care indicated a preference for a municipal bed¹⁰. This demand is a reflection of the quality of care provided and the sector’s commitment to respond to local needs.
Added Costs and Challenges of Delivering Care in the Municipal Sector

Municipal homes have different operating circumstances from other players in the long term care home sector. Many of these differences exist due to provincially controlled factors such as the arbitration process and pay equity legislation.

Municipal salary and benefit costs tend to be at the higher end of the scale and as a result put municipal homes at a disadvantage when comparing their costs to other sectors. Pay equity is an example of a significant cost obligation for municipal homes, which are bound by ongoing maintenance requirements.

Municipalities also tend to experience higher arbitration settlement decisions due to their perceived ability to pay. To illustrate, an analysis among care staff in municipal homes versus other provider type homes shows that in 2009, on average, municipal homes paid between 7.5 and 9% more per hour in salary for registered nurses (RNs), registered practical nurses (RPNs), and personal support workers (PSWs). Higher wages are exaggerated even more in municipal homes in small, rural and northern municipalities. For example, at Pioneer Manor in Sudbury the hourly salary for PSWs is 20-30% greater than in other homes in the City. Analysis also illustrates higher benefits, leaves and premiums for municipal homes as compared to other provider types – almost 37% more.

While all long term care homes receive the same operating funding from the province and are required to charge residents the same fees, the cost of providing the “same” level of service to residents will vary between municipal homes and other providers due to the additional costs imposed on homes that are outside of their control.

Most municipalities cannot rely solely on provincial funding and are forced to contribute municipal funds over and above what the province provides in order to operate without a deficit. In fact some have suggested that without this additional revenue stream, some municipal homes would be in crisis.

Pay Equity and Long Term Care

In 1990, the provincial government passed the Pay Equity Act. It was intended to eliminate gender discrimination in compensation for employees employed in female job classes in Ontario. However, the Act and certain of its provisions unintentionally created unfairness in the long term care home sector.

The methods of comparison contained within the Act resulted in an imbalance in the salary levels between job-to-job and proxy employers. Although the Act applies to all long term care providers, its provisions affect homes differently. Nursing homes were generally able to use the proxy method of comparison because they typically had an insufficient number of male comparators in their workplace. The proxy method allowed employers to select another organization of their choosing to compare wages and benefits. Also, under the Act, proxy employers have no enforceable obligation to maintain their pay equity plans, resulting in a smaller, one-time increase in salary and benefit costs for these employers. Municipal homes, on the other hand, typically had a sufficient number of male comparators within the municipality to complete the job-to-job method. Invariably, the internal job-to-job method resulted in higher salary levels than those faced by proxy employers.

The Act not only resulted in wage or cost difference between long term care homes but the province’s funding provisions affected municipal homes differently as well. Proxy employers received 100% of their proxy obligations up to 1998 and additional funding has been provided in recent years following litigation, whereas job-to-job employers receive funding only for a fraction of their pay equity obligations. The proxy method has tended to result in lower salary costs and offered those operators higher subsidy levels than provided to municipalities. Municipalities pay the difference in pay equity related cost increases.

Municipal Homes and Beds: No Monetary Value

Unlike other long term care providers that must obtain a license to operate and maintain a home, municipalities are mandated to provide long term care services under the authority of ministerial approval, which never expires. Municipalities cannot sell or transfer a home or its beds, unlike charitable, not-for-profit homes, and for-profit nursing homes which can, but with certain conditions. As such, there is no monetary value associated with a municipal home and/or its beds.
Seniors’ Demographics
Numerous reports cite that wait lists for long term care are long and will likely continue to increase in the coming years. By 2015, for the first time in history, Canadians over the age of 65 will outnumber children. By 2056, the proportion of seniors aged 80 years and over will triple to 1 in 10 compared to 1 in 30 in 2005.

Resident Acuity
Most seniors in Ontario do not go into a long term care home. If they do, it is usually their final option when their needs can no longer be met through home care, supportive housing or other community-based services. As a result, seniors entering long term care are older than ever before, have more chronic disabilities, and have more complex care needs. In fact, nearly 82% of residents are at least 75 years of age or older, over 13% of residents require total assistance with activities of daily living, such as dressing and bathing, and over half of residents require assistance with toileting (with 70% reporting at least some bladder incontinence). As well, over 76% of residents are reported to have some form of neurological disease, with Alzheimer's and other age-related dementia making up the larger number. A growing number of residents require special treatments such as chest drainage, feeding tubes and oxygen.

In an attempt to reduce the strain on long term care, governments across the country, Ontario included, are shifting their attention to developing programs and services to help keep seniors in their homes for as long as possible.

When Miramichi Lodge was rebuilt in 2004/2005, the County of Renfrew’s funding contribution was three and half times more than the province’s contribution. This reflects the value that the community and the County’s elected officials place on municipal long term care.

Long Term Care Home Funding
Long term care homes, regardless of the type of provider, receive funding from three primary sources: level of care funding, supplemental funding, and revenue from preferred accommodation fees. All homes receive the same amount of level of care funding on a per diem basis. This funding is earmarked for four separate areas, known as “envelopes”, for such things as food, programs and services, and nursing and personal care. Currently, on a per resident day basis all long term care homes receive $152.94 as of the 2011 provincial budget, which is adjusted based on a home’s case mix index.

The Ministry pays directly for the costs of nursing and personal care as well as for activation through a funding formula determined by the province. Residents pay for their room and food. Often the governing bodies of not-for-profit homes (including municipalities) augment funding to enhance services.

Costs to be paid by residents (not by their families) are set by the province and are subject to change. The province expects that charges are affordable to any applicant. The basic fee paid by residents in homes is $55.04 per day or $1,674.13 per month for standard accommodation (may be less for residents who are unable to pay).

The Ministry of Health and Long-Term Care also funds homes based on a number of supplementary funds. These supplementary funds (or “pots”) vary from home to home and across the types of long term care provider.
End Notes

1. The Long-Term Care Homes Act was passed in 2007. In addition to setting out a number of new requirements and regulations for long term care home providers, the legislation amalgamated three separate Acts that have previously governed the different long term care sectors, specifically, the Homes for the Aged and Rest Homes Act, the Charitable Institutions Act, and the Nursing Homes Act.


3. Long-Term Care Homes Act (LTCHA), Section 119 and 121.

4. LTCHA, Section 122 and 123(1).

5. LTCHA, Section 125-128.


7. LTCHA, Section 132.


11. “Niagara Region’s Role in Seniors Services” Report to the Co-Chairs and Members of the Public Health and Social Services Committee, September 6, 2011.

12. OANHSS Benchmarking Reports, Municipal Homes and Charitable/Not-for-Profit Homes, 2011.

13. Preamble to the Pay Equity Act.


18. LTCHA, Section 95.

19. LTCHA, Section 130(1).

20. LTCHA, Section 105.


22. Data obtained from the Canadian Institute of Health Information 2010-2011.

23. People living in a long term care home pay a fee for accommodation that is based on the type or style of accommodation. A home may offer “preferred” accommodation, which is a private or semi-private room, as well as “basic” or “standard” accommodation.

24. A case mix index provides a measure of health resources required within a particular home depending on resident needs and requirements.

July 2012

About OANHSS

The Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) is the provincial association representing not-for-profit providers of long term care, services and housing for seniors. Members include municipal and charitable long term care homes, non-profit nursing homes, seniors’ housing projects and community service agencies. Member organizations operate over 27,000 long term care beds and over 5,000 seniors’ housing units across the province.
To: Chair Sean Strickland and Members of the Community Services Committee

From: Marie Morrison, Manager, Social Planning
Lynn Randall, Director, Social Planning, Policy & Program Administration

Copies: Michael Schuster, Commissioner, Social Services

File No: S13-20

Subject: PROVINCIAL CONSOLIDATED HOMELESSNESS PREVENTION INITIATIVE (CHPI)

Over the summer, the Province announced the new Consolidated Homelessness Prevention Initiative (CHPI). Effective January 1, 2013 CHPI will consolidate the following five homelessness programs into one funding envelope under new program guidelines:

- Consolidated Homelessness Prevention Program;
- Provincial Rent Bank;
- Emergency Energy Fund;
- Emergency Hostel Service; and
- Domiciliary Hostel Program.

The Region, as Service Manager for Homelessness, currently administers funding for these programs and will continue to do so under CHPI. Staff is awaiting the Province’s final dollar allocation to the Region and is planning to bring a full report to Community Services Committee for September 25, 2012.

In order to begin planning for anticipated program requirements, Staff needs to begin communicating about CHPI with affected agencies/programs. A template letter is included as Attachment A. This letter will provide context to agencies as to why annual budget submissions are being required earlier than usual and within a compressed timeframe.

For further information please contact Marie Morrison, Manager, Social Planning (519-883-2238) or Lynn Randall, Director, Social Planning, Policy and Program Administration (519-883-2190).
September __, 2012

TO: Provincially Funded Homelessness to Housing Stability Program Provider

Dear Program Provider:

The Province previously announced through the 2012 budget, and has now confirmed, that effective January 1, 2013, the following five homelessness prevention programs, administered by the Regional Municipality of Waterloo (the Region), will be consolidated:

- Consolidated Homelessness Prevention Program;
- Provincial Rent Bank;
- Emergency Energy Fund;
- Emergency Hostel Service; and
- Domiciliary Hostel Program.

The new program entitled, the “Community Homelessness Prevention Initiative” (CHPI) will be administered/funded through the Ministry of Municipal Affairs and Housing (MMAH). Included in the funding for CHPI is 50% of provincial expenditures from the former Community Start-Up and Maintenance Benefit (CSUMB).

Beginning January 1, 2013, MMAH will provide the CHPI as a single funding envelope to the Region, who continues to serve as the Consolidated Service Manager for Homelessness. The Region’s dollar allocation from the Province for the CHPI is in the process of being finalized. The Region will have flexibility to determine how best to utilize this funding to deliver and administer homelessness to housing stability services at the local level.

Anticipating these changes, the Region has identified the following planning approach:

<table>
<thead>
<tr>
<th>Goal</th>
<th>Activities</th>
<th>Timeframe</th>
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| Pre-planning and preparing for immediate requirements | • Gathering data  
• Identifying an interim approach for 2013  
• Creating a “Plan to Plan” for 2013 | 2012               |
| Planning                            | • Stakeholder consultation  
• Creating an “Implementation Plan” | 2013               |
| Beginning Implementation           | • Begin to make changes as identified in the Implementation Plan            | 2014 and beyond    |
The principles driving this planning approach include:

- Meet funding and program requirements of CHPI as set by the Province
- Involve all stakeholders who will/may be effected by any changes
- Communicate effectively with all stakeholders who will/may be effected by any changes
- Minimize system destabilization as much as possible
- Set realistic timeframes
- Identify clear roles and direction
- Explore a wide range of options
- Utilize promising practices and identified community needs to inform any changes

For 2013, in keeping with the principles to minimize system destabilization and to allow realistic timeframes for planning, input and communication, Social Services will generally be seeking to provide the same programs, level of funding, and funding administration approach as 2012. It is anticipated that MMAH will require the Region to submit an investment plan indicating use of funding for 2013. In preparing for the MMAH investment plan, Social Services staff will be asking you, in a follow up e-mail, to submit your 2013 budget by **September 21, 2012**.

It is our intention, wherever possible, to consult with stakeholders regarding both the MMAH investment plan and the Region’s Plan to Plan for 2013. The degree to which we will be able to consult will depend on when MMAH provides further program details and when plans are due. It is anticipated that all plans will be presented to Regional Council sometime between October and December 2013 for approval.

We thank you in advance for your patience and commitment, as we take this opportunity to engage together, in what may be a significant change process, towards further alignment with the housing stability system’s goal to end homelessness. Staff will keep you informed as processes move forward. Please note a report for Regional Community Services Committee on this topic is planned for September 25, 2012. We will forward the report to you once it is publicly available. If you have further questions at this point, please contact me directly.

Sincerely,

Marie Morrison
Manager, Social Planning
519-883-2238
mmorrison@regionofwaterloo.ca
To: Chair Sean Strickland and Members of the Community Services Committee

From: Nicole Francoeur, Social Planning Associate
      Marie Morrison, Manager, Social Planning
      Lynn Randall, Director, Social Planning, Policy & Program Administration

Copies: Michael Schuster, Commissioner, Social Services
        Rob Horne, Commissioner, Planning, Housing, and Community Services
        Deborah Schlichter, Director, Housing

File No: S13-40

Subject: STEP HOME ANNUAL REPORT 2011-2012

The first STEP Home Annual Report (2011-2012) has been released. Region Social Services, Social Planning, Policy and Program Administration (SPPPA) serves as facilitator to the STEP Home initiative and worked with members of the STEP Home Collaborative to complete the Report.

The Report includes information related to activities/achievements from January 2011 to April 2012 (program data is based on 12 month timeframe while program activities span January 2011 to April 2012). The Report also identifies STEP Home priorities for 2012 to 2014. The Report will serve to inform STEP Home, the Homelessness to Housing Stability Strategy, and other interested stakeholders.

2011 Data Highlights (please refer to the Annual Report for additional information)

People Served:
- 209 people (of whom approximately 54 people were new) were supported intensively (e.g., several times per day to several times per week).
- 62% participants were male and 38% were female.
- Most common challenges identified for participants included concurrent disorders, mental health issues, substance use issues and physical health issues.

Housing Outcomes:
- 144 people (69%) who were supported intensively moved to and/or retained more conventional housing.
- 83% of participants have retained their housing for at least 3 months.
- There were a total of 102 moves to more or less conventional housing in the Shelters to Housing Stability program (one of the 12 programs included under the umbrella of STEP Home). Of the moves in this program, 57% were to market rent accommodations, 32% were to supportive housing, 11% were to “other” accommodations (including time-limited...
housing, respite program, couch surfing, motel stay and less conventional spaces such as park benches and bus terminals).

These results exceeded anticipated program outcomes for 2011. STEP Home has been recognized as an Ontario Municipal Social Services Association (OMSSA) Municipal Champion in 2011 and as the winner of the Canadian Urban Institute (CUI) Leadership Award for Innovation in 2012.

Partners involved with STEP Home Include:
- Argus Residence for Young People
- Cambridge Self-Help Food Bank
- Cambridge Shelter Corporation
- House of Friendship
- Kitchener Downtown Community Health Centre
- Lutherwood
- Mennonite Central Committee
- Region – Housing Division
- Region – Social Planning, Policy and Program Administration Division
- ROOF
- SHOW
- Working Centre
- YWCA

The Report is now available on the Region’s website and the Homeless Hub. For further information please contact Marie Morrison, Manager, Social Planning (519-883-2238) or Nicole Francoeur, Social Planning Associate (519-575-4757 ext. 5372).
MEMORANDUM

To: Chair Sean Strickland and Members of the Community Services Committee

From: Bob Theisz, Supervisor, Finance
Lee Parent, Manager, Financial Services
David Dirks, Director, Employment and Income Support

Copies: Michael Schuster, Commissioner, Social Services
Craig Dyer, Chief Financial Officer

File No.: S09-01

Subject: REGION OF WATERLOO TAX CLINICS 2012 EXPERIENCE

Dates and Locations for 2012

As in the past five years Employment and Income Support (E&IS) sponsored three free community tax clinics at its sites in Kitchener (235 King Street East), Waterloo (99 Regina Street South) and Cambridge (150 Main Street) throughout March and April 2012 for persons with low income including social assistance recipients. The Cambridge and Waterloo clinics ran Mondays, Wednesdays and Thursdays. The Kitchener clinic operated Tuesdays and Thursdays. The clinics were coordinated by staff from Finance and support was provided on-site by staff from Employment and Income Support. The returns were completed by three volunteers from the Community Volunteer Income Tax Program.

For the first time the Region hosted a drop-off “tax clinic” open to any member of the community with low income. People were able to drop off their tax information at the Waterloo and Cambridge offices of Employment and Income Support. Staff from Finance volunteered their time after hours to prepare the tax return, which would be picked up once completed.

2012 Highlights

This year marked the first year of Regional employees volunteering their time. In total 1,413 tax returns were completed and $1,597,812 in benefits accrued to persons with low income (eg.: GST and Trillium benefits). Specifically, by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Returns</th>
<th>Benefits to Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waterloo</td>
<td>470</td>
<td>$513,226</td>
</tr>
<tr>
<td>Kitchener</td>
<td>500</td>
<td>$550,418</td>
</tr>
<tr>
<td>Cambridge</td>
<td>258</td>
<td>$319,449</td>
</tr>
<tr>
<td>Finance volunteer/drop-off</td>
<td>185</td>
<td>$214,719</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,413</strong></td>
<td><strong>$1,597,812</strong></td>
</tr>
</tbody>
</table>

Date: September 11, 2012

Social Services
Employment and Income Support
This success would not have been possible without the generous donation of time by the volunteers from the Community Volunteer Income Tax Program and staff from the Finance Department. The Community Volunteers have provided exceptional service over the years. However, they will not be able to continue indefinitely. Other options would need to be explored such as recruiting new Community Volunteers, and/or expanding the drop-off model. Given the success of the past year both E&IS and Finance will review hosting tax clinics again in 2013.

This work demonstrates the Region’s Corporate Strategic Focus Area 4: Healthy and Inclusive Communities; Strategic Objective 4.1: (to) work collaboratively to reduce poverty.

For further information please contact Bob Theisz at 519-883-2020 or btheisz@regionofwaterloo.ca
MEMORANDUM

To: Chair Sean Strickland and Members of the Community Services Committee
From: Christiane Sadeler, Executive Director
Date: September 11, 2012
Subject: Waterloo Region Integrated Drugs Strategy (WRIDS)
File No.: C06-60

Please find attached the final report of the Waterloo Region Integrated Drugs Strategy Task Force, an ad hoc committee of the Waterloo Region Crime Prevention Council (WRCPC). The 26-member Task Force was created in June 2009, and met for 2.5 years, concluding with the submission of the Final Report to WRCPC. The WRIDS final report was approved in principle by the WRCPC in December 2011.

The development of an Integrated Drugs Strategy is identified in the Corporate Strategic Plan (4.4.1) under Fostering Healthy, Safe, Inclusive and Caring Communities: Enhance Community Safety and Crime Prevention.

The WRIDS provides 99 recommendations that seek to make Waterloo Region safer and healthier by “preventing, reducing and/or eliminating problematic substance use and its consequences”. The substances of interest in the WRIDS are alcohol, prescription medications and substances subject to provisions contained within the Controlled Substances Act.

The recommendations are framed within a 5-pillar strategic framework that includes: prevention, harm reduction, recovery and rehabilitation, criminal justice and finally, integration and collaboration. Approximately 20 municipalities in Ontario have or are developing drug strategies that incorporate a similar framework.

The WRIDS final report is based on the best available research. Additionally, the final report is grounded in the experience and wisdom of the community and institutions of Waterloo Region, gathered through an extensive public consultation process that included professional practitioners, policy makers, researchers as well as affected individuals (i.e. youth and adults who have or currently do use substances, parents and youth who live in homes where substance use is present, people who do not use substances etc.). In addition to Focus Groups, a series of 4 forums created by the task force focused on prevention, harm reduction, recovery and rehabilitation, and criminal justice systems and were attended by close to 300 people. These consultations provided the recommendations for the WRIDS final report.
Next Steps

The task force recommended that the Crime Prevention Council facilitate and lead the implementation of the WRIDS. Terms of reference to establish an Integrated Drugs Strategy Implementation Steering Committee were approved by WRCPC at its regular meeting in July 2012. A copy of these terms of reference is attached.

Efforts to implement recommendations are already underway. For example, research to determine if there are barriers to calling 9-1-1 during an accidental overdose incident is near completion after surveying 450 participants (recommendation 76). Recommendations concerning education and training are in development as part of WRCPC’s fall series called “In the Mind’s Eye: Issues of Substance Use in Film + Forum”.

As part of the Strategic plan (4.2.1) Public Health will work with community partners to implement prioritized harm reduction and prevention recommendations.

The Waterloo Region Integrated Drugs Strategy provides a roadmap to make Waterloo Region safer and healthier for everyone. The final report is informed both by the available evidence and the community.

Special thanks are due to members of the Task Force who met to create, for the first time locally, an integrated and multi-disciplinary approach of where to go and how to get there in addressing the full range of issues related to substance use. Specifically Waterloo Region Public Health was instrumental in the research phase, consultation process and final crafting of the report.

The Waterloo Region Integrated Drugs Strategy Final Report is available on the WRCPC website at: www.preventingcrime.net
Background

In November 2006, the Waterloo Region Crime Prevention Council unanimously passed a resolution to begin developing an Integrated Drugs Strategy.

In June 2009, the Waterloo Region Crime Prevention Council established the Waterloo Region Integrated Drugs Strategy Task Force, comprised of 26 people representing a variety of sectors in Prevention, Harm Reduction, Recovery and Rehabilitation, and Criminal Justice.

In December 2011, the Final Report of the Task Force was approved in principle by the Waterloo Region Crime Prevention Council.

The Final Report provides context and 99 recommendations for implementation in Waterloo Region that address issues of alcohol, prescription medications, and illicit substances.

The recommendations aim to make Waterloo Region healthier and safer by preventing, reducing and/or eliminating problematic substance use and its consequences.

The Waterloo Region Integrated Drugs Strategy Task Force recommended that WRCPC facilitate the implementation of the Strategy and noted that the success of the Strategy is dependent on the participation and support of community, strong leadership, planning and coordination. Dedicated resources, including staff support and funding, are essential to bringing the recommendations in this report to action.

Specifically, the Waterloo Region Integrated Drugs Strategy Task Force recommended that:

1. The Waterloo Region Crime Prevention Council facilitate the initiation of a Steering Committee to oversee implementation of the Waterloo Region Integrated Drugs Strategy.

1a. The Steering Committee work to appropriately resource strategy Steering.

2. The Waterloo Region Integrated Drugs Strategy Steering Committee facilitate the initiation of Coordinating Committees (i.e. working groups based on area of expertise) to address and support implementation of initiatives of the Waterloo Region Integrated Drugs Strategy.

3. Develop an implementation plan for the Waterloo Region Integrated Drugs Strategy that directly addresses funding of strategy initiatives.

3a. Request that the Waterloo Wellington Local Health Integration Network fund strategy initiatives that align with the Integrated Health Service Plan.
3b. Request that local funders and organizations increase emphasis on prevention, including incorporation of prevention efforts via organizational policies, and dedication of a portion of organizational budgets and resources toward the prevention of substance use amongst clientele, and/or employees, and/or volunteers.

3c. Develop a strategy to engage the private sector in assisting with Steering of the Waterloo Region Integrated Drugs Strategy, both as a resource to support implementation efforts and to address issues of substance use within the sector.

3d. Identify and implement opportunities to better leverage existing resources.

The following Objectives, Activities and Membership components provide guidance for members appointed to the Waterloo Region Integrated Drugs Strategy Implementation Steering Committee.

**Objective**

To facilitate the implementation of recommendations contained within the Waterloo Region Integrated Drugs Strategy. (WRIDS)

**Activities**

The purpose of the Implementation Steering Committee is:

- To develop a process for identifying recommendations that will be key priorities for implementation
- To identify implementation and integration pathways as they arise
- To establish working groups for the purpose of implementing specific recommendations
- To identify budget requirements and potential resources including dedicated staff time, in-kind staff support, financial assistance and other supports necessary for the implementation of the WRIDS.
- To ensure that the directions and activities of the implementation process are congruent with the values of the WRCPC
- To report back to the WRCPC on progress twice yearly or as requested by the WRCPC

**Membership**

Members will:

- be familiar with and display a strong commitment to crime prevention through social and community development
• be supportive of the foundation on which the WRIDS is built: prevention, harm reduction, recovery and rehabilitation, criminal justice and integration-collaboration

• be able to provide strong linkages to community and service systems

• be available to attend at least 80% of monthly meetings up to 10 times per year (no August or December meetings)

• be available to devote time to Implementation Steering Committee tasks between meetings

• be able to make decisions on behalf of their host organization

• bring supports and resources to assist the Implementation Steering Committee and working groups in implementation efforts

• maintain a long-term Region-wide strategic focus.

• to be an ambassador for the prevention-reduction-elimination of problematic substance use

The WRIDS Implementation Steering Committee will be comprised of no more than 10 members. At least two members will be members of the CPC.

The Chair will be a member of WRCPC. A co-chair will be chosen by the Committee.

Membership will be for a two year term up to a maximum of 3 terms or 6 years.

Each of the pillars will have 2 representatives on the Steering Committee:

- Prevention
- Harm Reduction
- Recovery and Rehabilitation
- Criminal Justice
- Integration

**Ex-officio**

The Chair of WRCPC is an ex officio member of all subcommittees of the WRCPC.

**Role of the Chair**

- To facilitate Implementation Steering Committee dialogue that balances outcome with process, builds consensus where possible, and monitors committee alignment with the governance policies of the CPC

- To assist staff and the Implementation Steering Committee in accomplishing the Objectives as set out in these Terms of Reference

- To report back to WRCPC on behalf of the Implementation Steering Committee

- To represent the Steering Committee at public meetings when necessary
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Published by Waterloo Region Crime Prevention Council (WRCPC) December 2011.
Accessible formats available upon request.
For more information please contact 519-883-2304
www.preventingcrime.ca
Greetings,

On behalf of the Waterloo Region Crime Prevention Council, it is my pleasure to invite you to read and consider the recommendations contained within the Waterloo Region Integrated Drugs Strategy. The recommendations are just that—for now. Implementing them will require continued efforts from within and beyond the Waterloo Region community.

The Crime Prevention Council aims to bring together the wisdom of community and the research base in an effort to prevent and reduce crime, victimization and fear of crime. We are confident that the Integrated Drugs Strategy Task Force—comprised of 26 volunteers who met over the course of 2.5 years—has done both. We deeply appreciate their contribution towards a healthy and safe community for all citizens of Waterloo Region.

What will become of these recommendations? That is the challenge before us now. The success of this plan is dependent on the commitment of community members and service providers to move the plan into action; funders to provide the necessary resources to facilitate the movement towards health and safety; and government and others to consider policy changes that will enable a smart approach to issues of substance use and addiction.

On our part, the Crime Prevention Council is committed to facilitating the implementation of the Drugs Strategy. But we cannot do it alone. If it takes a community to raise a child—and it most certainly does—it will surely take a community of concerned and committed people to realize the recommendations before you now.

We hope you will join us in a smart approach to issues of substance use and to issues of crime and victimization. Together, we can make a difference for our community, in our community.

Sincerely,

John Shewchuk
Chair, Waterloo Region Crime Prevention Council
Shortly after I joined the Waterloo Region Crime Prevention Council (WRCPC) in 2003, a police officer mentioned that it was his opinion that the vast majority of non-violent “simple crime”—break and enters, thefts, etc.—were the result of an addiction. It is no secret that when it comes to violence in the home or after the bars closed, substance use—in particular—alcohol—is a significant contributor. Survey after survey highlighted the role of problematic substance use as a factor leading to residence in one of Canada’s prisons. As an addictions counsellor and pastor, I knew that approximately 80% of Canadians have a neighbour, family member, co-worker, or friend with a profound addiction issue but often remained silent and co-dependent. I was more than interested in a fresh approach to an old problem.

A lot has happened since then. A WRCPC committee was formed to tackle issues of stigma and discrimination, among others. We established the film + forum series “In The Mind’s Eye.” Networks were started. And so much more. And now, in 2011, another committee of WRCPC—the Waterloo Region Integrated Drugs Strategy Task Force—is submitting this, our final report, after more than two years of intense collaboration.

The Integrated Drugs Strategy Task Force is diverse and includes 26 representatives from the prevention sector, the criminal justice system, the recovery and rehabilitation sector, and finally, harm reduction services. They are urban and rural residents, senior citizens, mental health and addiction professionals, police officers, attorneys, child protection staff, public health staff, social work staff and more. Collectively, they have brought the wisdom of their experience, their knowledge of the evidence base and a passion for resolving issues of substance use in creating this final report. I am grateful for their efforts to improve the health and safety of all citizens of Waterloo Region.

But this is not a report for someone else—there are recommendations for everyone. How can you personally reduce stigma faced by those who struggle with an addiction? How can we find funding for additional rehabilitation and recovery programs? When will we provide adequate addictions training for staff in our schools, counselling agencies and human resources offices? How do we nurture all our children so they feel loved? Can we prevent trauma and shame, so our children and youth will not resort to addictive substances to alleviate emotional pain? Can we improve pain management so that older persons—and others—do not become addicted to and/or overdose from opioid prescriptions?

To have a safer and healthier community, we must work together to address the plethora of issues that occur in a society in which many use, if not celebrate and encourage the use of, psychoactive substances. We are all affected, directly or otherwise.

As the work of this Task Force nears completion, I know each member of the Task Force is looking to you and others to get involved in implementation and to be part of the solution. Let’s take ownership, provide the resources, and work together so that all people can live healthier.

Sincerely,

Brice H. Balmer,
Chair, Waterloo Region Integrated Drugs Strategy Task Force
The Waterloo Region Integrated Drugs Strategy was informed and guided by the Waterloo Region Crime Prevention Council, the Waterloo Region Integrated Drugs Strategy Task Force, and consultation with more than 300 citizens and service providers.

This report was a collaborative community effort and presents primary recommendations from that effort. The views and content contained herein do not necessarily reflect the views of the contributing agencies of the Waterloo Region Crime Prevention Council or the Regional Municipality of Waterloo.

The Waterloo Region Crime Prevention Council (WRCPC) acknowledges the hard work and dedication of the members of the Waterloo Region Integrated Drugs Strategy Task Force and so many others who contributed to the development of the strategy.

The Task Force, a subcommittee of the WRCPC, was established in June 2009. Members of the Task Force at some point in the development process include:

- **Pat Allan**
  Centre for Addiction and Mental Health
- **Craig Ambrose**
  Waterloo Regional Police Service
- **Brice Balmer (Chair)**
  Wilfrid Laurier University – Waterloo Lutheran Seminary
- **Dr. Michael Beazely**
  University of Waterloo School of Pharmacy
- **Stephen Beckett**
  Waterloo Regional Police Service
- **Marian Best**
  Cambridge Shelter Corporation
- **Catrina Braid**
  Public Prosecution Service of Canada
- **Scott Buchanan**
  Waterloo Regional Police Service
- **Susan Collison**
  Formerly with Waterloo Regional Withdrawal Management Centre
- **Lesley DeYoung**
  Formerly with Grand River Hospital Mental Health and Addictions Program
- **Sandy Dietrich Bell**
  Reaching Our Outdoor Friends
- **Chris Harold**
  Region of Waterloo Public Health
- **Brenda Julian**
  University of Waterloo Counseling Services
- **Amanda Kroger**
  Region of Waterloo Public Health
- **Henny Laurin**
  Family and Children’s Services of Waterloo Region
- **Colby Marcellus**
  AIDS Committee of Cambridge, Kitchener, Waterloo and Area (ACCKWA)
- **George Mastrapa**
  Mosaic Counselling and Family Services
- **Pam McIntosh**
  House of Friendship, Addiction Services
- **Irene O’Toole**
  Community member
- **Katherine Pigott**
  Region of Waterloo Public Health
- **Andre Rajna**
  Ministry of the Attorney General, Government of Ontario
- **Shirley Redekop**
  Mosaic Counselling and Family Services, Rural Outreach
- **Chris Reitzel**
  Family and Children’s Services of Waterloo Region
- **Lesley Rintche**
  Region of Waterloo Public Health
- **Don Roth**
  Canadian Mental Health Association, Grand River Branch
- **Holt Sivak**
  John Howard Society of Waterloo-Wellington
- **Karen Verhoeve**
  Region of Waterloo Public Health
- **Harry Whyte**
  Ray of Hope

*Also indicates Steering Committee member at some time in the process

** Resigned from WRIDS Task Force in June 2011

*** Resigned from WRIDS Task Force in September 2011

† Did not participate in formulating recommendations

A special thank you is due to a number of individuals for their contributions to project management, research and writing support in the development of the strategy. In particular we wish to acknowledge Michael Parkinson and Jacinda Clouthier of the Waterloo Region Crime Prevention Council and David Siladi, Meghan Randall and James Lane of Region of Waterloo Public Health. Additional thanks to Theresa Pero (forum coordination), and Aimee White (graphic design) of Region of Waterloo Public Health. Many thanks are also due to the Ontario Network of Municipal Drug Strategy Coordinators.

The recommendations included in this report were generated from participation in a series of surveys, focus groups and community forums by a variety of community members who volunteered their experience and expertise to inform this Strategy. The Waterloo Region Crime Prevention Council offers a sincere thank you to everyone.
Some years ago, the Centre for Addiction and Mental Health estimated that most people with an addiction never seek assistance because of the stigma, stereotypes and discrimination associated with addiction. Issues of stigma, stereotyping and discrimination were strong themes throughout our work. Inherent in resolving these issues is our use of language. Is dignity and respect present in the language we use? Are we making assumptions and passing judgement? Is the language we use more a reflection of our personal bias than is actually the case? Does our language help or hinder those we purport to serve?

In this report we have made an effort to use language that is respectful, non-pejorative and accurate. You won’t see “crack addict” for the same reason most people don’t use “paranoid schizophrenic”: such terms are negative labels that ignore the totality of a person — and are very much barriers to health and well-being. People are very sensitive to labels, and for those who have been through human services over months or years, the sting of pejorative labels is not helpful. Included in the following table is a list of suggested language; it is not intended to be exhaustive or prescriptive.

<table>
<thead>
<tr>
<th>Commonly Used Language</th>
<th>Suggested Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse</td>
<td>Substance Use</td>
</tr>
<tr>
<td>Drug addict, alcoholic, junkie</td>
<td>People who use drugs</td>
</tr>
<tr>
<td>Homeless, vagrant</td>
<td>Street-involved</td>
</tr>
<tr>
<td>Prostitutes, sex trade worker</td>
<td>Sex worker</td>
</tr>
<tr>
<td>Front-line worker</td>
<td>Direct Support Worker</td>
</tr>
</tbody>
</table>

The title of this project is the Integrated Drugs Strategy. For our purpose, drugs refer to alcohol, prescription medication and illicit substances. That some drugs are legal and others are not seems to have little bearing on their burden to society. Note also that we have pluralized drugs to indicate that many people use multiple substances. We want to be sure that poly-drug use is captured in efforts to prevent and/or address issues of problematic substance use.

**Spectrum of Psychoactive Substance Use**

Substance use occurs along a spectrum from beneficial, to non-problematic or casual use, through to problematic or harmful use. Problematic substance use includes episodic or binge use that can have acute, negative health consequences and chronic use that can lead to dependence and related disorders.1

The primary focus of this strategy is on problematic substance use, on those individuals or population groups that are vulnerable to problematic substance use, or use substances in ways that cause harm to themselves and/or others.

The figure to the right illustrates the spectrum of psychoactive substance.

Source: Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use, 2004. Adapted with permission from the British Columbia Ministry of Health.

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*Spectrum of Psychoactive Substance Use*

**Non-problematic**
- recreational, casual or other use that has negligible health or social impact

**Beneficial**
- use that has positive health, spiritual or social impact: e.g. pharmaceuticals; coffee/tea to increase alertness; moderate consumption of red wine; ceremonial use of tobacco

**Problematic**
- use that begins to have negative health consequences for individual, friends/family, or society: e.g. impaired driving; binge consumption; routes of administration that increase harm

**Substance Use Disorders**
- Clinical disorders as per DSM IV criteria

*At Substance Use Disorders stage, use is actually harmful.*
executive summary

We are not the first community in Canada to initiate the development of a comprehensive plan to manage drug-related issues, but this plan is a first for Waterloo Region (Appendix D). The Waterloo Region Integrated Drugs Strategy represents a road map of where we want to go and how we plan to get there. It is a strategy whose success is dependent on the involvement and support of the full breadth of our community citizens, service providers, all orders of government and funders.

This strategy is concerned with three kinds of substances: alcohol, prescription medication and illicit drugs. While alcohol, after tobacco, is the drug with the most severe burden on society, the rise in opioid prescribing has presented a whole new set of issues in recent years.

Our vision of the Waterloo Region Integrated Drugs Strategy is to make Waterloo Region safer and healthier. Our mission is to prevent, reduce or eliminate problematic substance use and its consequences.

Citizens, neighbourhoods, businesses and a wide variety of service providers are among those who grapple with the problematic aspects of substance use. There is a clear need for structural and policy change to address issues at individual, neighbourhood and systems levels. Local research supports this need, providing a snapshot of substance use in Waterloo Region.

Everyone is affected by issues of substance use, sometimes positively, sometimes negatively and sometimes both. Where negative financial, health and/or social impacts are experienced, potential solutions go beyond the capacity of any one organization or system. The Waterloo Region Integrated Drugs Strategy presents an opportunity to address crucial issues of substance use across multiple sectors, amongst various populations and locales, throughout Waterloo Region.

The strategy draws on a framework that incorporates five approaches:

- prevention at multiple layers, throughout the lifespan
- harm reduction
- recovery and rehabilitation
- the criminal justice system
- integration and collaboration

Ten guiding principles are presented on page 14, representing the core values that will shape and direct the actions of the Waterloo Region Integrated Drugs Strategy. These guiding principles are common to all recommendations and will be considered, to the extent possible, in the development and implementation of all initiatives related to the strategy.

The strategy outlines 99 recommendations, primarily calling for action at the local levels in the areas of:

- leadership
- coordination and implementation
- collaboration
- programs and services
- awareness, education and training
- monitoring, research and evaluation

Additional recommendations call for attention at the provincial and federal levels.

Collectively, these recommendations address the broad range of opportunities to prevent, reduce and eliminate problematic substance use in Waterloo Region.

The strategy is a locally designed approach to working through issues of problematic substance use, providing a plan for improving the health and safety of our community.

It is rooted in expertise and experience. We hope that you will join us on the road ahead.
what is the waterloo region integrated drugs strategy?

For thousands of years, humans have used a wide variety of psychoactive substances for a variety of reasons including pleasure, health, pain management, religion, dependency and more. Sometimes this use is beneficial, sometimes problematic, sometimes both and sometimes somewhere in between.

In the 100 years since Canada and other nations criminalized certain substances, a multi-trillion dollar global marketplace has evolved. Annually, the global drug trade is estimated in excess of $300 billion, with less than 1% of this value seized and frozen. The socio-economic costs related to illegal substance use are reputed to be twice as high as the illicit income generated by trafficking. A variety of mechanisms adopted by governments and regulatory agencies around the world have sought to reduce the negative impacts of psychoactive substance use, and in some cases, the use of certain substances completely. Despite best efforts locally and beyond, both supply and demand remain robust.

The negative impacts from supply markets, demand, unsafe use and intoxication from substance use are far-reaching, whether you are a person with an addiction or you live with someone addicted to substances; whether you are a police officer patrolling the bar district on a Saturday night or a family affected by someone charged with impaired driving; whether you are a victim of break and enter or you find yourself living in a neighbourhood with a large number of individuals who use substances.

The Waterloo Region Integrated Drugs Strategy aims to prevent, reduce or eliminate problematic substance use and its consequences by applying the rich, local experience and expertise available, and encouraging governments, service providers and others to identify and remedy systems weaknesses in an effort to improve the quality of life for all citizens and service providers in Waterloo Region.

Root causes of, and responses to, the problematic use of licit and illicit psychoactive substances are often complex, counter-intuitive and cross multiple jurisdictions, borders, sectors, locales and service systems. Effective responses start with dialogue. The Waterloo Region Integrated Drugs Strategy offers a shared vision of where we want to go and how we plan to get there.

The Waterloo Region Integrated Drugs Strategy is the first local attempt at creating and implementing a strategy that includes prevention, harm reduction, recovery and criminal justice initiatives. The strategy addresses the broad range of concerns related to substance use in Waterloo Region through recommendations calling for:

- Actions to prevent and/or delay the onset of substance use;
- Actions to reduce harm to individuals and communities;
- Increased availability and accessibility of treatment and supports for people affected by substance use; and,
- Actions to improve the application of criminal justice initiatives including enforcement of the law related to the illegal use, trafficking, cultivation and production of substances.

**Vision:** To make Waterloo Region safer and healthier.

**Mission:** To prevent, reduce or eliminate problematic substance use and its consequences.

The strategy is in alignment with related initiatives, including Waterloo Region Crime Prevention Council Violence Prevention Plan and the Region of Waterloo Social Services Homelessness to Housing Stability Strategy.

The strategy also addresses the human element of problematic substance use. It paints the picture of substance use in Waterloo Region and how each and every citizen is affected. It presents a rationale for why we need an integrated drugs strategy, and offers 99 recommendations that aim to prevent, reduce or eliminate problematic substance use and its consequences.
Adverse Effects of Problematic Substance Use

Primary Health Effects

Problematic substance use is associated with a number of adverse health effects that extend beyond the individual to their families and to the community-at-large. Accidental overdoses often cause significant harm, including death, to people who use substances. Between 2004 and 2007, Waterloo Region experienced an annual average of 26 overdose deaths and almost two overdose incidents reported to health or coroner staff each day.

Data from a 2011 Coroner’s Inquest revealed that in Ontario in 2006, opioid-related deaths were equivalent to the number of drivers killed in car collisions. Furthermore, unsafe substance use practices such as sharing needles and other drug materials place people who use substances at a higher risk for contracting and transmitting infectious diseases such as HIV/AIDS, hepatitis B and C viruses, and sexually transmitted infections (STIs).

Fortunately, awareness of the dangers of sharing needles is well known among persons who use injection drugs in Waterloo Region; however, sharing of non-injection drug materials (e.g., pipes) continues to occur frequently. The 2008 Baseline Study of Substance Use, Excluding Alcohol, in Waterloo Region also revealed other health care issues (e.g., mental illness, poor dental health, inadequate nutrition) and barriers to accessing services in general among individuals who use illicit drugs.

Profile of Substance Use in Waterloo Region

In 2008, crack, cocaine and marijuana, as well as prescription opioids, were the most commonly used illicit drugs in Waterloo Region.

Excluding marijuana, crack cocaine is sometimes described as one of the most accessible illicit drugs in Waterloo Region. Frequent use of crack does not seem to be limited to any one demographic group.

Adults in Waterloo Wellington have significantly higher averages of hazardous drinking and alcohol-related problems compared to the province.

In 2009, 52.1% of students in grades 7–12 in Waterloo Region reported consuming alcohol in the past year, while 23.3% of students reported binge drinking. In 2009, 72.1% of high school students report consuming alcohol in the past year.

Misuse of prescription drugs is said to be particularly prevalent amongst seniors, with high usage rates of benzodiazepines (e.g., psychoactive drugs used to treat anxiety and insomnia) and opiate analgesics (e.g., painkillers) among this population.
why does waterloo region need an integrated drugs strategy?

Social Effects
In addition to the health effects associated with problematic substance use, there are numerous social effects. Often, there are stigmas associated with individuals who use substances and many are from already stigmatized populations (e.g. previously incarcerated, street-involved, mentally ill, low income). Local data revealed there is often reluctance among people who use substances to access services because of fear that they will face criminal or other sanctions or be labelled a drug user and/or face stigmatization and discrimination. Additional social effects include, but are not limited to: issues related to isolation, victimization, difficulty accessing services, and housing.

Financial Effects
There are also significant financial impacts associated with problematic substance use. Problematic substance use represents a significant drain on Canada’s economy in terms of both its direct impact on the health care and criminal justice systems, and its indirect impact on labour productivity as a result of premature death and ill health. A globally renowned study by the Canadian Centre on Substance Use estimated that the overall social cost of substance abuse (including alcohol, illegal drugs, and tobacco) in Canada in 2002 was estimated to be $39.8 billion. Excluding tobacco (the drug with highest burden), alcohol and illegal drugs accounted for $14.6 billion; 64 per cent of which was attributable to alcohol, while illegal drugs made up the remaining 36 per cent. (Note: prescription drugs were not included in this calculation). The impact on publicly funded services can be seen, for example, in the criminal justice system, where half of costs of police, courts, and corrections are related to licit and illicit drugs.

Both substance use and drug trafficking occur throughout Waterloo Region, and are not limited to any one demographic sub-group.

“Addiction is a health issue, not a moral issue. If we as a community spend our time judging those with addictions as being unworthy of quality health care, the substance use problems of our youth, spouses and parents will continue to get worse and the health of our families and community will decline.”
—Pam McIntosh, House of Friendship, Addiction Services

Service providers have noted that prescription opioids are the primary reason people seek assistance from local methadone clinics.

Misuse of prescription pills is often overlooked by those who use them and other community members as they are not commonly recognized as addictive substances.

Notwithstanding some benefits, many individuals, families, neighbourhoods and communities in Waterloo Region are negatively affected by substance use. The profile of substance use in Waterloo Region is clear. The time to act is now.
how was the strategy developed?

Strategy Development

The recommendations that make up the strategy were developed through a three phase process. The strategy synthesizes findings from several sources, including:

- Research reports
- A system assessment survey
- Public consultations.

Research

In the first phase of the project international and national evidence and local research reports were reviewed, including A First Portrait of Drug-Related Overdoses in Waterloo Region (2008); Baseline Study of Substance Use, Excluding Alcohol, in Waterloo Region (2008); and Hepatitis C Services in Waterloo Region: A Situational Assessment (2010). The reports provided background information on the local context related to substance use and insight into the issues, gaps and barriers in our community and opportunities for the Waterloo Region Integrated Drugs Strategy.

System Assessment Survey

In the second phase, a system assessment survey was conducted in the winter of 2010 to identify key issues and system needs related to substance use in Waterloo Region. A survey was completed by 42 representatives from local agencies and the community. The information captured from this survey served as a starting point to identify key issues and priorities to address through the drugs strategy. For a brief synopsis of survey findings, see appendix B. A web link to the final report, Waterloo Region Integrated Drugs Strategy: System Assessment Survey Report is provided in Appendix B.

Public Consultations

The final phase of the project served to validate and further explore the issues identified through the system assessment survey via key informant consultations, including focus groups and forums in the spring of 2011. Nine focus groups, involving 62 people, were completed with individuals who currently use or formerly used substances, individuals who have been affected by a friend or family member’s substance use, and youth who do not use substances. For a full report on the focus groups, including methodology, ethics, discussion guide and participant demographics, refer to the Waterloo Region Integrated Drugs Strategy: Focus Group Summary.

In consulting with key informants, four forums were held, representing four pillars of the strategy development framework. The forums represented an opportunity to discuss issues related to substance use and make recommendations. In total, more than 250 participants attended the forums, including people who use/used substances, youth, health and social service providers, police, criminal justice personnel, school board representatives, hospital administrators, and government officials. At each forum, participants heard presentations on a variety of topics related to substance use and the pillar of focus. Speakers shared their experience and expertise and generated discussion to engage participants through their presentations. Following presentations, participants broke into smaller groups and were guided through a facilitated discussion to generate recommendations for the strategy. For more information on the forums, including areas of focus and speakers, refer to Appendix C.

The input of survey, focus groups and forum participants were significant to the development of the Waterloo Region Integrated Drugs Strategy. Participants brought a diverse range of perspectives, opinions and expertise, and offered thoughtful and constructive input, which is reflected throughout the strategy.
how was the strategy developed?

In developing the Waterloo Region Integrated Drugs Strategy, the Task Force worked to build on the expertise and experience that exists in our community, and incorporated current and emerging evidence and practice to develop a strategy that meets its mission of reducing the consequences associated with problematic substance use. The Task Force initially adopted the widely accepted four pillar approach for its planning framework; however, it discovered a much more integrated approach was necessary as there is significant overlap between the four pillars.

Framework: A (modified) Four Pillar Approach

There are four essential pillars (or components) to drug strategies: prevention; harm reduction; recovery and rehabilitation; and enforcement and justice.

Prevention refers to interventions throughout the lifecycle that seek to prevent or delay the onset of substance use and that address root causes of underlying problems. Prevention is grounded in the notion that addressing substance use before problems begin is more favourable than waiting until problems are present. Effectively addressing substance use requires getting to the root of the problems by taking into account broader social forces. Thus, goals of prevention include addressing underlying causes of substance use (e.g. unresolved trauma) along with individual and social determinants of health such as life skills, social support and networks (e.g. family support), housing, education and employment.

Levels of Prevention:

Primary: Occurs before a person begins to use substances. The goal is to prevent or delay the onset of substance use.

Secondary: Occurs after a person has experimented with substances. The goal is to prevent more frequent or habitual substance use.

Tertiary: Occurs after substance use has become problematic. The goal is to reduce harm associated with substance use or complete recovery.

“No mass disease or disorder afflicting humankind has ever been eliminated by attempts at treating individuals… Primary prevention is an approach to reducing the future incidence of a condition through proactive efforts aimed at groups, or even a whole society.”

—George Albee’s Prevention Mantra (1990)

Harm reduction in everyday life.

Consider the risks involved in driving a car, an inherently dangerous activity. Harm reduction measures reduce the risks to all members of society through speed limits, traffic signals, and drinking and driving laws. Other techniques to reduce harm at the individual level include a plethora of safety features in cars, from seat belts and engine design to airbags and windshields.

Harm Reduction refers to interventions, including programs and policies, that aim to reduce the potentially adverse health, social and economic consequences of problematic substance use, and can include (but does not require) abstinence from substances. Harm reduction is much more than a set of materials and policies. Inherent in the approach is a way of working with people that “meets people where they are” in a client-centred, non-judgemental, pragmatic way, regardless of whether they are using substances or not. The approach in philosophy, policies and programs is about building a trusting relationship, a bridge to an improved quality of life for all.

Recovery and Rehabilitation refers to interventions that seek to improve the physical and emotional well-being of people who use or have used substances. Treatment is one part of recovery and rehabilitation.

The goal of treatment is to improve quality of life and individual functioning and to optimize health, while addressing substance use. For individuals with addiction issues, other supports such as housing, vocational rehabilitation, trauma-informed counselling, leisure opportunities, ongoing support, and other social determinants of health, are paramount in helping the individual maintain the lifestyle changes they have made.
Enforcement and Justice refers to interventions that seek to strengthen community safety by responding to crime and community disorder caused by substance use, including (but not limited to) police, courts, and corrections. Enforcement and justice interventions address criminal behaviour associated with substance use, while facilitating coordination with health and social service agencies to connect people who use substances with appropriate programs and services.

Integration (the fifth pillar)
No one pillar can independently address the issues associated with problematic substance use. Further, many of substance use-related issues cross-over between pillars. All four components are necessary, as each has its own characteristics and responses to address substance use; however, the solution to problematic substance use involves collaborative action by all pillars. As a result, the Task Force adopted a fifth pillar to ensure the final strategy is integrated, comprehensive and coordinated. Integration is an essential addition to the four pillar approach as a means to move beyond silos and sectors associated with each discipline towards a cohesive strategy where all community members can create change. An integrated plan balances all areas and involves a collaborative, multi-system response.

Success Story: One KCI

In response to numerous calls for police service, issues with youth in the local neighbourhood, gang related activities, and provincial testing results among the lowest in the region, Kitchener-Waterloo Collegiate and Vocational School (KCI) embarked on a journey to make community partners a part of the school community in an effort to create change by addressing the social determinants of health. Over five years, the program saw dramatic improvements to the school climate, including:

<table>
<thead>
<tr>
<th>Measure of School Climate</th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per cent of students that feel safe at school</td>
<td>54%</td>
<td>90%</td>
</tr>
<tr>
<td>Per cent of students that feel safe in their community</td>
<td>37%</td>
<td>89%</td>
</tr>
<tr>
<td>Per cent of students participating in intramural activities</td>
<td>39%</td>
<td>58%</td>
</tr>
<tr>
<td>Number of suspensions</td>
<td>302</td>
<td>171</td>
</tr>
<tr>
<td>Number of expulsions</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Number of violent incidents reported</td>
<td>82</td>
<td>12</td>
</tr>
</tbody>
</table>

Rick Osbourne, former resident of several Canadian Penitentiaries, speaks with youth at an “In The Mind’s Eye” event hosted by Waterloo Region Crime Prevention Council.
The vision of the Waterloo Region Integrated Drugs Strategy is to make Waterloo Region safer and healthier. The strategy’s mission is to prevent, reduce or eliminate problematic substance use and its consequences.

To help steer the strategy towards this vision, guiding principles have been developed, based on feedback gathered in the public consultation process. Guiding principles represent the core values that will shape and direct the actions of the Waterloo Region Integrated Drugs Strategy.

The following guiding principles are common to all recommendations contained in the strategy and will be considered, to the extent possible, in the development and implementation of all initiatives pertaining to the strategy.

<table>
<thead>
<tr>
<th>Guiding Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessible</td>
<td>The strategy will ensure that programs and services are accessible and appropriate to meet the diverse needs of our community. This includes addressing inequities by reducing service and system level barriers, including transportation, child care, and cost.</td>
</tr>
<tr>
<td>Collaborative</td>
<td>A collaborative, community approach is needed to address issues related to substance use in Waterloo Region. The strategy will encourage intersectoral collaboration and foster partnerships between citizens, community groups, service providers and all orders of government.</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Actions of the strategy will take into consideration the uniqueness of various forms of psychoactive substance use, including illicit drugs, alcohol, prescription medications, and poly-substance use.</td>
</tr>
<tr>
<td>Determinants of health</td>
<td>The strategy recognizes and will address the range of personal, social, economic and environmental factors that influence the health of individuals and our community, including early childhood development, education, employment, income, housing, and social supports.</td>
</tr>
<tr>
<td>Evidence-informed</td>
<td>Sound decision-making incorporates evidence from multiple sources, including scientific research, community-based practice and experience of persons who use substances. Actions of the strategy will be informed by various forms of evidence of best and promising practices.</td>
</tr>
<tr>
<td>Inclusive</td>
<td>The strategy will be inclusive of all populations across Waterloo Region regardless of age, gender, culture, income, and mental, cognitive or physical ability. Where necessary, actions will be tailored to meet the unique needs and circumstances of distinct populations.</td>
</tr>
<tr>
<td>Innovative</td>
<td>Innovation encourages an environment of leadership, excellence, and creativity. Implementation will remain open to new and creative ideas to achieve the goals of the strategy.</td>
</tr>
<tr>
<td>Locally relevant</td>
<td>The Waterloo Region Integrated Drugs Strategy is a community strategy. Actions will take into consideration the uniqueness of, and the local context found within all municipalities in Waterloo Region.</td>
</tr>
<tr>
<td>Participatory</td>
<td>The strategy will employ a participatory approach, involving people with lived experience in a meaningful way in all aspects of implementation of the strategy.</td>
</tr>
<tr>
<td>Socially just</td>
<td>We strive towards equality and solidarity in Waterloo region, and place a high value on the rights and dignity of all community members. All actions of the strategy will be free from stigmatization and discrimination of individuals who use substances or are affected by substance use.</td>
</tr>
</tbody>
</table>
Leadership, Coordination and Implementation

Successful implementation of the Waterloo Region Integrated Drugs Strategy is dependent on strong leadership, planning and coordination. Dedicated resources, including staff support and funding, are essential to bringing the recommendations in this report to action.

Recommendations:

1. The Waterloo Region Crime Prevention Council facilitate the initiation of a Steering Committee to oversee implementation of the Waterloo Region Integrated Drugs Strategy.
   a. The Steering Committee work to appropriately resource strategy implementation.
2. The Waterloo Region Integrated Drugs Strategy Steering Committee facilitate the initiation of Coordinating Committees (i.e. working groups based on area of expertise) to address and support implementation of initiatives of the Waterloo Region Integrated Drugs Strategy.
3. Develop an implementation plan for the Waterloo Region Integrated Drugs Strategy that directly addresses funding of strategy initiatives.
   a. Request the Waterloo Wellington Local Health Integration Network fund strategy initiatives that align with the Integrated Health Service Plan.
   b. Request that local funders and organizations increase emphasis on prevention, including incorporation of prevention efforts via organizational policies, and dedication of a portion of organizational budgets and resources toward the prevention of substance use amongst clientele, and/or employees, and/or volunteers.
   c. Develop a strategy to engage the private sector in assisting with implementation of the Waterloo Region Integrated Drugs Strategy, both as a resource to support implementation efforts and to address issues of substance use within the sector.
   d. Identify and implement opportunities to better leverage existing resources.
Collaboration

Collaboration is a fundamental element of an integrated strategy. There is a role for citizens, community groups, service providers and government. By enhancing access to, and effectiveness of, programs and services for clients, collaboration within and across sectors can result in greater impacts than might be achieved by one agency or sector acting alone. Feedback gathered throughout the consultation process highlighted various opportunities for increased collaboration, listed in the recommendations below.

Recommendations:

4. Improve referral systems for existing programs, services, supports, resources, and research related to substance use.

5. Increase collaboration between primary care providers and organizations to enhance services and improve treatment for persons with infectious diseases associated with substance use (e.g. HIV, hepatitis C).

6. Include the Waterloo Regional Police Service in work groups to address misuse of psychoactive substances without interfering with the care of individuals requiring treatment. This may include collaboration with the Ontario College of Pharmacists, Ontario Pharmacists’ Association, College of Physicians and Surgeons of Ontario, Ontario Medical Association, and the Ministry of Health and Long-Term Care.

7. Enhance collaboration between the mental health and addiction treatment and support sectors.

8. Enhance partnerships with local universities and colleges to collaborate on the design and implementation of research and evaluation activities related to strategy initiatives.

9. Promote greater collaboration between Waterloo Regional Police Service and community organizations in order to more effectively provide health and social services to individuals who use substances.
   a. Recognize the unique training and mandates inherent to health, social services and police.

10. Expand integration of Waterloo Regional Police Service activities with health and social service agencies to create an appropriate circle of care to support the process of developing long-term solutions that improve the health and safety of individuals, and surrounding neighbours.

11. Increase the number of schools with substance use prevention programs that involve family-school-community partnerships.

12. Enhance partnerships between the community, elementary, secondary and post-secondary education institutions in order to provide substance use prevention-related programs and policies directed at students transitioning between different stages of education (e.g. primary to secondary, secondary to post-secondary).
Programs and Services

The bulk of recommendations in WRIDS relate to programs and services to be maintained, improved, or created. Themes drawn from consultations include issues of access and capacity, collaboration between service providers and others, support services and more. Housing was a very significant theme throughout the WRIDS process.

Access and Capacity

Barriers to accessing programs and services can be the result of a number of factors, including reduced availability or capacity of services to meet demand, lack of awareness of services, the type and way existing services are delivered, as well as personal barriers (e.g. transportation, child care, cost).

Enhancing access to and capacity of programs and services related to substance use means that people who engage in problematic substance use receive the help they need when they are ready to receive it and without delay.

<table>
<thead>
<tr>
<th>LHIN</th>
<th>Average Wait Time (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial Average</td>
<td>41</td>
</tr>
<tr>
<td>Central East</td>
<td>42</td>
</tr>
<tr>
<td>Champlain</td>
<td>24</td>
</tr>
<tr>
<td>Hamilton Niagara Halldemand Brant</td>
<td>32</td>
</tr>
<tr>
<td>Mississauga Halton</td>
<td>60</td>
</tr>
<tr>
<td>North East</td>
<td>4</td>
</tr>
<tr>
<td>North West</td>
<td>54</td>
</tr>
<tr>
<td>South East</td>
<td>41</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>41</td>
</tr>
<tr>
<td>Waterloo Wellington</td>
<td>96</td>
</tr>
</tbody>
</table>


Success Story: Strengthening Families

The Strengthening Families Program (SFP) is a nationally and internationally recognized parenting and family strengthening program. SFP is an evidence-informed family skills training program found to significantly reduce problem behaviours, delinquency, and substance use in children while improving social competencies and school performance.

Family and Children’s Services Waterloo Region (FACS) runs the SFP in partnership with various neighbourhood groups across the region. Data collected 12 months after successful completion of the program shows zero per cent of children being admitted to care and only ten per cent who have had subsequent referrals to FACS.

Feedback from participating parents is very positive:

“The program went above and beyond my expectations”
“l enjoyed getting more knowledge on coping with pressures of life on the road of journey with children”
“Everything that we learned helped me, but strategies on how to deal with issues was most helpful”

In the more than two decades since its development, SFP has been reviewed by researchers and rated as an exemplary, evidence-based program.
Recommendations:

13. Create a one-stop-shop for programs and services related to substance use in a variety of community locations (e.g. schools, community centres).

14. Ensure timely access to primary care.
   a. Expand personal identification registration programs.

15. Increase the capacity of the treatment sector to ensure timely access to recovery and rehabilitation services.
   a. Increase staffing in treatment services to levels that ensure quality, safety and flexibility to meet client needs.
   b. Establish additional day treatment programs for men and youth.
   c. Increase the number of residential treatment spaces.
   d. Increase capacity of withdrawal management services, including community-based services.
   e. Increase the number of psychiatrists that provide assessment and treatment to persons who use substances and/or provide street outreach in Waterloo Region.
   f. Provide timely and low or no cost mental health assessment and treatment services.
   g. Explore the use of technology and innovative approaches in recovery and rehabilitation (e.g. online treatment programs, text messaging support services).
   h. Offer rehabilitation options to youth who use substances and who are in conflict with the law.
   i. Facilitate the transportation of individuals to treatment upon release from custody.

16. Establish holistic pain management services and resources (e.g. psycho-social and physical supports).

17. Promote and expand prescription drug management programs for persons who require trusteeship of prescribed medications. For example, establish programs where prescription medications can be distributed to clients on a daily basis.

18. Increase accessibility and affordability of counselling for substance use.
   a. Enhance counselling and other support programs for family members of persons who engage in problematic substance use.
   b. Increase counselling and other harm reduction services for individuals and families involved in the child welfare system.
   c. Expand counselling services that are available on a drop-in basis.

19. Expand the availability of long-term trauma-informed counselling and residential programs in Waterloo Region, including education and support for affected family and friends.

20. Enhance treatment services to provide access for individuals on methadone maintenance therapy and individuals using antipsychotic or other medications.

21. Expand services for older adults to include addiction treatment.

22. Expand peer-based support groups to a variety of settings across Waterloo Region.

23. Explore options that allow people to more easily meet bail conditions (e.g. tracking devices, urine screens).

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You have to grab them exactly when they ask for help because if you wait even an hour you might lose them.

—Focus group participant
Housing Stability

Housing is a necessity for healthy living, and more than a roof over your head. Housing must be accessible, safe, adequately maintained, of suitable size, affordable, continuous, and considered acceptable by the individual. Citizens also need the opportunity to access the supports when required, to help them live as independently as possible and connect to others in meaningful and healthy ways.

Ending homelessness is a shared responsibility – all orders of government, businesses, not-for-profits, groups, landlords and residents of Waterloo Region have a role to play. In the absence of central governance in the area of housing stability, All Roads Lead to Home: The Homelessness to Housing Stability Strategy was developed by the local housing stability system as one response to the need for a collective voice, calling for a shift in thinking and doing to end homelessness by ensuring that everyone can experience housing stability over the long term, fully participate in the community and create a home for themselves.

Housing stability refers to ideal living circumstances where people with a fixed address are able to retain adequate housing over the long term. To have housing stability, people must have three key resources: adequate housing, income and support. Each resource is defined further below:

Adequate housing provides security of tenure and is desirable, affordable, safe, adequately maintained, accessible and a suitable size.

Adequate income provides enough financial resources to meet and sustain minimum standards for housing (rent or mortgage expenses and utilities) and other basic needs (e.g., food, clothing, child care, transportation, personal hygiene, health/medical expenses, recreation, communication and education).

Adequate support (informal and/or formal) provides enough personal support for living as independently as desired and connecting to others in meaningful ways.

Housing stability for everyone, in a community that is designed to be inclusive, creates the conditions necessary to ensure Waterloo Region remains resilient over the long term.

Success Story: SHOW

Supportive Housing of Waterloo (SHOW) is a non-profit organization with a mandate to build and operate permanent, affordable, supportive housing for people experiencing persistent homelessness in Waterloo Region. SHOW was founded by a compassionate community concerned about the number of people using the “Out of the Cold” program in Kitchener and Waterloo. After seven years, their first project was completed in June 2010 and is included under the umbrella of STEP Home (support to end persistent homelessness). It includes a five story apartment complex with 30 self-contained units.

The Housing First and harm reduction approach offered at SHOW provides an opportunity to maintain stable housing, regardless of any issues that people are dealing with. Tenants have experienced a number of positive outcomes including reconnection with family members, completion of their education, and a reduction or end to problematic substance use issues.

One SHOW tenant shares: “My body has been addicted to opiates for 25 years, and it doesn’t want to give it up. Yet, now that I live here, I feel like I can try. SHOW provides me with a safe, secure, and affordable place to call home, and a support team to help when I need it.”

Overall, tenants have indicated they are more positive about their current life circumstances and are hopeful for the future.

The Substance Use Services Continuum in the Context of Housing (refer to Appendix E) includes six levels of housing options, from dry and damp housing where no substance use occurs on site, to wet housing where substance use is permitted on site. The Medical Services Continuum in the Context of Housing (refer to Appendix E) provides options for medical services provided through a range of housing options. The form of support and services offered varies along both continuums to meet the housing and medical needs of individuals at all stages of substance use.
**Recommendations 24–28**

*Need suitable housing out of jail and rehab because it is hard to find. It is a big issue. If you put them out on their own again they will gravitate back to individuals that are the same, they don’t know how to make connections with non-addicts. To have someone check in on them, make sure they are eating. This should be available post treatment and [post incarceration].*

—Focus group participant

**Recommendations:**

24. Increase availability and variety of longer-term housing stability program options that offer Level 1–4 support on the Substance Use Services Continuum in the Context of Housing (Appendix D) and also consider options along the Medical Services Continuum in the Context of Housing (Appendix D).

25. Establish a local managed alcohol program (Level 5 on the Substance Use Services Continuum in the Context of Housing) (Appendix E) and also consider options along the Medical Services Continuum in the Context of Housing (Appendix E).

26. Explore options for improved and coordinated community response for residences where people are engaged in problematic substance use.

27. Explore the capacity within the existing service system (e.g., police services, withdrawal management, fixed street outreach/drop-ins, emergency shelter) to offer a safe temporary space where people under the influence of alcohol and/or drugs who have encountered service restrictions from all other agencies can stay and/or become sober.

28. Refer the following housing stability recommendations to be considered within the update of the local Homelessness to Housing Stability Strategy:

   a. Increase availability and variety of longer-term housing stability program options for people experiencing persistent homelessness with complex issues (e.g., mental health, substance use, physical health.).

   b. Increase availability and variety of longer-term housing stability program options for youth.

   c. Further explore and expand harm reduction services within the existing emergency shelter programs.

   d. Ensure consistent approach and messaging related to length of stay based on individualized plans within emergency shelters.

   e. Further explore the need for time-limited housing options that incorporate a harm reduction approach.

**Just Us**

Several years ago, a single address with a large number of people using alcohol, illicit substances and/or mental health concerns was becoming a hotspot in calls for service for enforcement, health and social services. Using a harm reduction approach, and with the cooperation of the property owner, health and social agencies brought their services into the building, selective enforcement was undertaken and a church group, among others, assisted with basic needs provisions for residents.

Rather than disperse people throughout the region without addressing root issues, this approach enabled residents to access services directly, build community and take an active role in the quality of life of their building, their neighbours and the surrounding neighbourhood.

The Ontario Association of Chiefs of Police recognized the Just Us project that included the Waterloo Regional Police Service in partnership with the Regional Concurrent Disorder Committee Waterloo Wellington with a 2010 Crime Prevention award for an innovative approach that offered the promise of improved health and safety for all, and which forms the basis for recommendation number 26.
Supports

Supports refer to a range of benefits, programs and services that play a role in prevention, harm reduction, and treatment of substance use. Many supports may not appear to be directly related to problematic substance use, yet they provide protective factors to prevent an individual from engaging in risk taking behaviours, including starting or continuing to use substances. Once substance use has been established, supports are continuously needed at all stages, including pre, during, and post treatment, to ensure that individuals receive the appropriate care and assistance they require.

Recommendations:

29. Develop a management system (e.g. focus on individual plans of care) for people with addictions (including those participating in drug treatment court), both pre and post treatment, to ensure they are formally supported throughout the recovery process.

30. Implement a comprehensive set of before and aftercare supports for individuals seeking, receiving and transitioning between treatments.
   a. Increase availability of post-treatment support groups.
   b. Establish appropriate housing options for people after a treatment program has been completed.
   c. Ensure income assistance programs provide funding and support for individuals with post-treatment plans.

31. Encourage local school boards to consider alternatives to expulsion and suspension to ensure that youth are not excluded from education and supports.

For certain priority populations a universal approach to preventing and addressing issues related to problematic substance use is not effective, and specialized support programs and services are required. This may include individuals who have a high risk of engaging in problematic substance use as a result of their life experiences and/or circumstances, whose substance use is already problematic, and/or who face social, economic or environmental barriers to accessing support services.

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Substance-related call volume for emergency medical services can be dramatically skewed by a small number of individuals. In 2010, one patient was transported by ambulance 119 times. The same individual’s call volume dropped to nil when a dedicated case worker was assigned to daily visits, but returned to high use once the case worker was reassigned.

—John Prno, Region of Waterloo Emergency Medical Services
Recommendations:

32. Identify and increase supports for pregnant women or women planning a pregnancy who use substances.
   a. Explore the need for the establishment of, or increased capacity within, residential facilities for pregnant and post-partum women.
   b. Include a harm reduction alternative for this population.

33. Provide opportunities that increase safety and support for women and men involved in the street-level sex trade (e.g. 24 hour access to a safe place, bad date lines, victim supports).

34. Enhance discharge planning and programming to ensure individuals leaving custody have proper identification, housing, referrals and other supports where required.

35. Enhance support services for victims of physical, sexual, and emotional abuse to include specialized services for males.

Beyond a pay cheque, meaningful employment provides income, a sense of identity and self worth, and helps to structure day-to-day life. For youth, it can reduce the likelihood of engaging in substance use. Similarly, employment can assist individuals in the recovery process and can help to maintain a lifestyle free from problematic substance use. Conversely, unemployment can lead to material and social deprivation, psychological stress, and the adoption of health-threatening coping behaviours, including substance use.

As children grow, family connectedness is rated in the literature as the highest protective factor for later substance use. The early years are critical!
—Carol Perkins, RN, Region of Waterloo Public Health

Recommendations:

36. Expand employment opportunities for marginalized populations, including street-involved and at-risk youth.

Early childhood and parental supports offer early intervention to prevent problems associated with substance use before they occur or intervene as quickly as possible when problems arise. Parents and children who are connected with each other and their communities, and who possess resiliency and coping skills, are less likely to engage in risk taking behaviours, including substance use.

Recommendations:

37. Expand early childhood services and parental supports including programs for home visiting and early childhood education in the community and through schools.

38. Expand positive parenting programs along with supports and resources to build skills and resilience of parents in order to prevent or delay onset of substance use among their children.
   a. Encourage workplaces to institute flexible working hours for parents.

29,225 High School Students in Waterloo Region:

- 21,071 students have drank illegally
- 14,759 students have used illicit drugs
- 9,907 students were a passenger in a car whose driver was under the influence of alcohol
- 11,047 students have used cannabis
- 6,137 students have used opioid pain relievers for recreational use

Sources: Centre for Addiction and Mental Health. (2009). Ontario Student Drug Use and Health Survey and enrollment data from Waterloo Region District School Board and Waterloo Region Catholic District School Board.
Harm Reduction Programming

Harm reduction refers to specific programs and policies that seek to reduce the harms associated with substance use. Effective harm reduction programs and services are proactive, user friendly, client-centred, flexible, supportive, non-judgmental and offer a comprehensive range of coordinated services. Abstinence may be an end goal of harm reduction, but it is not a requirement. Harm reduction offers individuals who use substances options for safer use of substances to reduce disease transmission and minimize the risk of overdose and death. Programs link individuals with other services that offer the opportunity for improved health and safety for both individuals and the broader community.

Recommendations:

39. Expand harm reduction programs and services.
   a. Ensure existing harm reduction programs include a range of comprehensive services such as referral, vein care, immunization, addressing the social determinants of health, promotion of safer use of substances, and overdose prevention strategies.
   b. Engage local agencies to increase the number of organizations and mechanisms in Waterloo Region that distribute harm reduction materials.
   c. Increase availability of drop boxes for used substance use materials in the community.
   d. Research and subsequently initiate a range of harm reduction initiatives that support individuals who inject and/or inhale substances.

40. Encourage organizations to develop organizational policies in support of harm reduction.

41. Develop and implement a unified regional outreach plan including mobile outreach services.
   a. Ensure mobile services offer harm reduction education, materials, access to primary health care services, and referral to all related services.
   b. Encourage the Waterloo Wellington Local Health Integration Network to fund mobile health services for the Waterloo Region community.

42. Expand Safer Bar programming and related policies in Waterloo Region.

43. Explore alternatives to non-palatable alcohol (e.g. hand sanitizer, mouthwash) for persons engaging in this form of drug use.

Recreation and Leisure Programming

Participation in meaningful recreation and leisure activities provides more than just health benefits, including, for example, a sense of engagement and belonging. At any age, participation in extracurricular activities and the resulting effects of social inclusion can prevent or delay substance use, while there are also benefits during recovery from substance use. In order to reach all members of our community, it is important that a diverse range of activities be made available that are of interest and that these programs are accessible by all.

Recommendations:

44. Expand recreation and leisure programming in a variety of community locations in Waterloo Region.
   a. Offer diverse recreation and leisure programs at low or no cost.
   b. Provide resources to, or establish, youth drop-in centres that are age appropriate.
   c. Ensure citizens, especially youth, are involved in the design and delivery of recreational programs.
   d. Provide supports and resources to neighbourhoods and neighbourhood associations to enhance neighbourhood capacity.

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Extracurricular activities would have taken my mind off of being bored, might have prevented me from starting [to use drugs].

—Focus group participant
recommendation 45

Awareness, Education and Training

The need for awareness, education and training related to substance use was a common theme that emerged through public consultations. Efforts need to be made to reduce stigmatization and discrimination of persons who use substances and increase acceptance of innovative initiatives to address substance use issues. Education and training related to substance use is lacking, both for students and for service providers, among others, working in health, social service, education, and criminal justice systems.

Non-interactive programs that focus on increasing knowledge and attitudes about alcohol, drugs, and smoking inspired by Nancy Reagan’s ‘Just Say No’ initiative and Project DARE (Drug Abuse Resistance Education) do not work. Programs that are interactive and incorporate refusal skills training are far more effective than those that focus on knowledge and attitudes.

—Dr. Geoff Nelson, Wilfrid Laurier University, quoting West and O’Neal, 2004; Tobler et al., 2000.

Recommendations:

45. Increase public awareness of:
   a. Substance use, misuse, and addiction
   b. Harm reduction, including its role as a public health and community safety strategy
   c. Low-Risk Drinking Guidelines
   d. Factors that increase risks associated with using substances
   e. Available programs, supports, services and resources related to substance use through media, information fairs and health care providers
   f. Stigmatization and discrimination associated with substance use
   g. Evidence-informed practices across the four pillars

Low-Risk Drinking Guidelines: Maximize Life, Minimize Risk

0 – 2 – 9 – 14

0 drinks = lowest risk of an alcohol-related problem
No more than 2 standard drinks on any one day
Women: up to 9 standard drinks a week
Men: up to 14 standard drinks a week
(One Standard Drink = 13.6 g of alcohol)

Source: Centre for Addiction and Mental Health (CAMH). Revised guidelines from CAMH are pending.
recommendations 46–52

They [certain health care providers] see the track marks and they are very judgmental. They should be taught as nurses to be non-judgmental and not form opinions and they definitely do there. I ended up going to a [different location to receive care] because the [first location] called the police and said I was only there for pain pills. They treat you like you are just there for drugs even though you have a legitimate reason to be there. I have told them before I am not looking for pain medication. I am looking to have the problem fixed. I was there 5 times in one week.

—Person who uses drugs, Baseline Study

46. Develop or adapt a campaign aimed at shifting social norms and perceptions regarding social acceptability of substance use, including (over)drinking.
   a. Promote action for change and alternatives to using substances.
   b. Engage youth in campaign development and implementation.

47. Increase awareness, knowledge, competency and skills related to harm reduction throughout organizations, including at the Board of Director level.
   a. Include information on insurance, risk and liability for organizations that engage in harm reduction practices.

48. Educate funding agencies regarding harm reduction and what to consider in funding applications with substance use components.

49. Expand addictions awareness and wellness programs in the workplace to provide employers with skills and resources to create supportive environments for employees experiencing substance use issues.
   a. Encourage workplaces to include policies that support employees with substance use issues as part of their occupational health frameworks.

50. Develop and implement a prevention-specific strategy for the health care sector that:
   a. Increases health care practitioner knowledge and skills related to substance use prevention, including brief intervention and alternative approaches to pain management
   b. Increases health care practitioner knowledge of prevention-related resources, services and supports in the community

51. Develop and implement a harm reduction-specific strategy for the health care sector that:
   a. Increases health care practitioner knowledge and skills related to harm reduction
   b. Increases health care practitioner client referrals to harm reduction services
   c. Improves health care service provision for persons who use substances
   d. Reduces stigmatization and discrimination for persons who use substances seeking health care services

52. Develop and implement a treatment-specific strategy for the health care sector that:
   a. Increases health care practitioner knowledge and skills related to substance use, stages of change, and motivational interviewing
   b. Increases health care practitioner awareness of local availability of treatment services
   c. Improves health care service provision for persons who use substances
   d. Reduces stigmatization and discrimination for persons who use substances seeking health care services

There certainly is a reluctance to access medical care, [...] because of the attitude that they are likely to get. Some will say ‘I would have to be half dead’. Last week I saw someone who had [a serious injury]. And there was no way he was going to the hospital. No way.

—Health care provider, Baseline Study
Fetal Alcohol Spectrum Disorder

Drinking alcohol in pregnancy can cause permanent brain damage and birth defects. In fact, prenatal exposure to alcohol is the leading known cause of preventable brain damage in Canada. Children with brain damage may have serious difficulties with learning and remembering, understanding cause and effect, and getting along with others. While there are interventions to help children with Fetal Alcohol Spectrum Disorder (FASD), it is a life-long problem. Teens or adults with FASD often experience depression, trouble with the law, substance use issues, difficulty living on their own, difficulty keeping a job, and difficulty understanding how their behaviour affects others.

The Public Health Agency of Canada estimates the incidence of FASD in Canada is 1–2 per cent. However, experts working in the field feel suggest rate is much higher as most people affected by FASD are never diagnosed, due to a lack of diagnostic services and a lack of awareness in health and social service providers.

Due to a lack of funding, the Waterloo Region FASD Diagnostic Team is only able to see 10 children and youth per year.
Several of the recommendations that resulted from the strategy development process are exploratory in nature. That is, further information is required to determine the feasibility or necessity of making changes to existing systemic structures, policies or programs, or of investing in new initiatives. Ongoing monitoring, research and evaluation is essential to keeping informed on our local context, measuring the progress and effectiveness of the strategy and what works in substance use prevention, harm reduction, treatment, enforcement, courts and corrections.

**Recommendations:**

70. Develop a comprehensive local drug and drug use data/surveillance system to:
   a. Enhance local evidence on substance use, including meaningful crime statistics and drug-overdose related incidents, injuries and fatalities
   b. Inform substance use-related program planning and development
   c. Issue alerts about dangerous and/or new substances
   d. Evaluate the effectiveness of local interventions in prevention, harm reduction, treatment, enforcement and justice services

**Quick Stats:**

- Sixteen per cent of the general population will experience problematic substance use or substance dependence during their lifetime. This rate is higher among individuals with mental illness.\(^{13}\)
- The rate of marijuana use among 15–64 year olds in Canada is among the highest in the world at 16.8 per cent. This compares to 6.1 per cent in the Netherlands.\(^{14}\)
- Eighty-eight per cent of Waterloo Region residents believe substance use and addiction are better managed through a combination of health and criminal justice approaches over one sector acting alone.\(^{15}\)
- Funding for Canada’s National Anti-Drug Strategy, 2007–08: enforcement (70%), treatment (17%), coordination and research (7%), prevention (4%), harm reduction (2%).\(^{13}\)
- *One week in hospital for an overdose victim can cost upwards of $100,000.* —Dr. Mark Tyndall, Chief and Chair of the Infectious Diseases Division, Ottawa Hospital.\(^{16}\)
71. Expand research and evaluation (including longitudinal studies) on effectiveness of existing programs and services.

72. Utilize research and evaluation findings/evidence to promote existing programs, policies, and services with demonstrated success.

73. Evaluate the effectiveness of the Waterloo Region Drug Treatment Court and provide resources and supports to enhance effectiveness where appropriate.

74. Explore the appropriateness and capacity to increase availability of Waterloo Regional Police Service School Resource Officers.

75. Review the regional emergency response tiered protocol in overdose incidences.

76. Explore the feasibility of using Proceeds of Crime to help support funding of community organizations and projects as well as supporting victims of crime and treatment of offenders who use substances.

77. Explore the use of alternatives to court, including restorative justice approaches.

78. Explore and consider using trained workers with addiction and mental health specialities to provide supportive options to persons charged with crimes related to drug dependency.

79. Explore strategies to prevent and reduce domestic violence and expand support services for affected individuals. Ensure these strategies are in alignment with the Waterloo Region Crime Prevention Council Violence Prevention Plan.

80. Explore the feasibility of a 24-hour crisis response for individuals experiencing trauma and/or persons who use substances.
   a. Ensure trauma-informed services are offered to families in crisis.
   b. Ensure trauma-informed services are available to families after the crisis has passed.

**Community Profile: Waterloo Region Drug Treatment Court**

The Waterloo Region Drug Treatment Court was established in February 2011 with a mission to eliminate criminal activity for a non-violent offender who is committing crime to support an addiction to an illicit drug. The 12–18 month program is limited to approximately eight clients at a time. It is an important step to addressing addiction as a key root cause of crime.

The court is a collaborative initiative between a number of community agencies who provide assistance with housing, mental health and addiction treatment, among other supports. To graduate from the court, a participant must be test free of drugs, including alcohol, for 3–4 consecutive months, be involved in paid and/or volunteer work, have found stable housing, ceased committing crimes and disengaged from criminal associates. Support for transitioning to a new life path such as resolving past trauma, family issues, and other stressors is available through the court.

Supporters of the local court maintain that increasing the number of participants who complete the program will help reduce the cost of incarceration, health care and other social costs. Given the history of innovative and collaborative initiatives in Waterloo Region, this is an opportunity to improve upon drug court success rates found elsewhere.
Beyond a Regional Perspective

Throughout the public consultations, a number of opportunities were identified that extend beyond Waterloo Region and the sphere of influence of the Waterloo Region Integrated Drugs Strategy. While there is a local role in implementing these recommendations, there is also a need for encouragement of, and action by, the federal and provincial governments and other organizations to create change that will have an impact in Waterloo Region and beyond.

Similar to other recommendations in the strategy, several of the recommendations that call for advocacy at the federal and provincial level have the potential to influence many areas related to problematic substance use, including prevention, harm reduction, treatment, and criminal justice. These recommendations may be referred to by other orders of government as they work to implement provincial and national strategies, including the National Anti-Drug Strategy and Ontario’s Mental Health and Addiction Strategy.

All citizens, regulatory bodies, community organizations and orders of government need to be aware of these barriers and the importance of working to reduce them if we are to truly achieve the mission to prevent, reduce or eliminate problematic substance use and its consequences.

Addiction treatment and/or custody are not appropriate responses to FASD.
—Glynis Burkhalter, Ray of Hope

Recommendations:

81. Request the Government of Canada, the Government of Ontario, and local governments increase funding and support for local communities to undertake evidence-informed programming in prevention, harm reduction, and treatment services.

82. Request the Government of Canada and the Government of Ontario provide funding and support for local communities to develop and implement comprehensive local plans or strategies to address issues of substance use.

83. Request that the Government of Canada and Government of Ontario provide funding and support to school boards to provide dedicated resources to ensure that early intervention, counselling, and other supports are in place to assist students who use substances (or at risk for using substances), students affected by problematic substance use by family members, friends and/or students with mental health issues.

84. Request the Government of Ontario develop and fund a strategic plan/framework to guide provincial, regional, and community efforts to address Fetal Alcohol Spectrum Disorder (FASD) specifically planning for prevention, assessment and support for both persons with FASD and their caregivers.

85. Request the Government of Canada evaluate the effectiveness of Canadian drug policies.

86. Request the Government of Ontario increase social assistance rates for Ontario Works and Ontario Disability Support Program (ODSP) recipients.

Two recommendations call for advocacy to the Ontario government and have the potential to prevent or delay the use of substances.

87. Request the Government of Ontario strengthen the regulatory framework related to access, distribution and sale of alcohol. For example, pricing and taxation, decreasing marketing, physical availability and hours of sale.

The following recommendation recognizes the effectiveness of substance use therapies and calls for increased access to current and future agents used in recovery, treatment and emergencies related to problematic substance use.

89. Request the Government of Ontario expand the Ontario Drug Benefit Program to include agents used in recovery, treatment, and emergencies (e.g. Campral, Ibogaine, Naloxone, Naltrexone and Suboxone).
   a. Encourage the use of current and relevant literature for future decision-making surrounding substance use substitution and related addition therapies.
   b. Ensure access to substance use substitution and related addiction therapies for those not covered under the Ontario Drug Benefit Program.

As the criminal justice sector is largely directed by federal and provincial mandates, several of the recommendations related to this area lie outside of the realm of influence of the Waterloo Region Integrated Drugs Strategy and have the potential to impact communities far beyond Waterloo Region. Many of these recommendations call for programs and services to be offered within provincial and federal correctional facilities to provide necessary supports to individuals serving jail sentences to reduce harm and access treatment services for problematic substance use.

90. Request the Government of Canada and the Government of Ontario provide funding and support to undertake innovative evidence-informed programming within the criminal justice sector—police, courts, and corrections—that reduces or eliminates drug-related crime and recidivism.

91. Request the Government of Canada review research surrounding the efficacy of mandatory minimum sentences for drug offences.

92. Request the Government of Canada and the Government of Ontario provide funding for diversion programs that address drug related issues.

93. Request the Government of Canada and Government of Ontario designate and train judges specifically for young offenders.

94. Request the Government of Ontario provide training to probation and parole workers on identification and referral of individuals with problematic substance use and/or trauma related issues.


96. Request the Government of Ontario and Government of Canada provide peer-based support services for individuals serving jail sentences.

97. Request the Government of Ontario and the Government of Canada expand rehabilitation opportunities within provincial and federal prison systems, with appropriate treatment and supports for individuals with mental health and/or substance use issues (concurrent disorders).

98. Request the Government of Ontario and the Government of Canada implement and/or improve harm reduction and other services in prisons in an effort to remove incarceration as a significant risk factor for infectious diseases.

99. Request the Government of Ontario provide access to addiction and related services while in custody, regardless of sentence length.
next steps

The recommendations in this document are the initial step to completing a comprehensive drug strategy for Waterloo Region. They were created by a Task Force of community representatives based on feedback provided through an extensive consultation process. These recommendations are meant to be directional rather than prescriptive in nature and serve as a road map about where we want to go and how we plan to get there.

Upon approval of this document, the next planning stage (implementation) will be initiated. This will include the establishment of a steering committee to guide the implementation of the strategy and working groups to address and support the implementation of the various initiatives. These groups, which will be comprised of representatives from various sectors and pillars, will determine if and how each recommendation can be implemented based on available resources, their feasibility and having appropriate approvals. The groups will also set priorities. Some recommendations may not be implemented. In line with the guiding principles, the strategy will be participatory in nature and include persons with lived experience in all stages of the process. Strategy implementation will commence in 2012.
Abstinence: The act of refraining from the use of substances, including alcohol, licit, and illicit drugs.

Addiction: Repeated use of a psychoactive substance or substances, to the extent that the person shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means. Typically, tolerance is prominent and a withdrawal syndrome frequently occurs when substance use is interrupted. Daily living may be dominated by substance use to the virtual exclusion of all other activities and responsibilities.

Addiction is any behaviour that has negative consequences but a person continues to crave it and relapse into it, despite those negative consequences.

—Dr. Gabor Maté, Physician and author

AIDS (Acquired Immunodeficiency Syndrome): The final stage of the HIV disease. Once HIV infects and destroys blood cells, your immune system can no longer defend your body from infections, diseases or cancers that can kill you.

Antipsychotic drugs: A class of medicines used to treat psychosis and other mental and emotional conditions. Examples include: clozapine, haloperidol, risperidone. Psychosis is a symptom or feature of mental illness typically characterized by radical changes in personality, impaired functioning, and a distorted or nonexistent sense of objective reality.

Bad Date Line: An anonymous telephone reporting system for individuals in the sex trade who are victimized.

Best practice: On the evidence available, the best intervention to produce improved outcomes for an identified issue. See also Promising practice.

Collaboration: Collaboration is a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to mutual relationships and goals, a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards.

Community Inclusion: An inclusive community ensures that everyone can participate in community life. Community inclusion does not mean that everyone must assimilate or conform. It means that participation in community life is accessible to everyone and the community is designed to support people in their efforts to be included — regardless of their level of personal resources or their economic status relative to other community members. Inclusive communities intentionally support people to feel “at home” by providing opportunities for creating a sense of belonging to a shared space.

Concurrent disorder: a condition in which a person has both a mental illness and a substance use problem.

Damp housing: No alcohol and/or drugs are permitted on-site. However, residents are generally allowed to return to the program under the influence of alcohol and/or drugs.

Determinants of health: The spectrum of personal, social, economic and environmental factors that influence the health of individuals and communities. Examples include healthy early childhood development, education, employment, income, housing, and social supports.

Diversion program: A component of the criminal justice system designed to enable alleged criminal offenders to avoid charges and a criminal record. Successful completion of diversion program requirements often will lead to a dropping or reduction of the charges while failure may bring back or heighten the penalties involved.

Drug: In the context of the Waterloo Region Integrated Drugs Strategy, ‘drug’ refers to a substance that produces psychoactive effects, including alcohol, prescription drugs and illicit drugs.

Dry housing: No alcohol and/or drug use is permitted on-site and residents are not permitted to enter the building if under the influence of alcohol and/or drugs.

Emergency shelter: Shorter term residential programs designed for people with no fixed address. Locally, programs meet the immediate needs of three groups of people: adults, families and unaccompanied youth living without a fixed address; unaccompanied children 12–15 years of age who are not living at home and not currently under the guardianship of Family and Children’s Services; and women fleeing abuse, with or without dependents. Unlike Time-Limited Residence programs, people who access Emergency Shelter programs do not require a planned intake. Unlike Affordable Housing and Supportive Housing, Emergency Shelter programs do not offer permanent housing and their programs are not covered under the Residential Tenancies Act, 2006.

Evidence-informed practice: The application of the best available knowledge gained from scientific research and professional expertise towards decision making.

Fetal Alcohol Spectrum Disorder (FASD): A range of disabilities that result from consumption of alcohol by pregnant women. The brain and the central nervous system of the unborn child are particularly sensitive to prenatal alcohol exposure. Damage to the fetus varies with the volume of alcohol ingested, timing during pregnancy, peak blood alcohol levels, and genetic and environmental factors.

Harm reduction: Interventions (including programs and policies) that aim to reduce the potentially adverse health, social and economic consequences of substance use without requiring abstinence.
Hepatitis C: A chronic liver disease caused by the hepatitis C virus (HCV). HCV causes inflammation of the liver, which can progress to cirrhosis (extensive scarring that can affect the normal function of the liver). HCV is spread through contact with infected blood.

HIV (Human Immunodeficiency Virus): A virus that is primarily sexually transmitted. It can also be transmitted by blood to blood contact with contaminated drug paraphernalia. HIV is a chronic infection for which there is currently no cure. If left untreated, HIV can eventually lead to AIDS.

Holistic: A comprehensive view of health that includes not only individual physical wellness, but also the social, emotional and cultural well-being of a whole community. In order to achieve whole-of-life, culturally appropriate and relevant health outcomes, holistic health care may include traditional cultural practices alongside curative or treatment services.

Housing First*: An approach that recognizes community programs in general are more effective when provided to people who have adequate housing. That is, adequate housing comes first, regardless of what is happening in the person’s life. Housing is not a “reward” for programmatic success, adherence to treatment or advancement through a continuum of support. Rather, the focus is on increasing access to adequate housing. Once housed, people may need to have access to additional income and support, or other community resources, where needed and desired to support them to maintain housing stability over the long term.

Housing Retention and Re-Housing*: Programs that provide people with support and/or financial assistance to retain their current adequate housing and find and/or establish more adequate housing. Support is designated to the person (if a person moves, the support will follow). Depending on the nature of the program, support can take a variety of forms on three main continuums: from less intensive to crisis intervention, from shorter to longer term and/or from less to more frequent. In addition, support may be provided either directly and/or be coordinated among various formal community programs, informal connections and/or privately funded sources. Financial assistance includes grants, loans and other financial benefits as well as housing subsidies designated to a person.

Ibogaine: A hallucinogenic substance used to treat addiction to opiates, methamphetamines and other drugs.

Illicit drug: A drug whose production, sale or possession is prohibited. ‘Illegal drug’ is an alternative term.

Infectious diseases: Disease caused by a pathogen which enters the body and triggers the development of an infection. Infectious diseases have a range of causes and are considered contagious, meaning that they can be passed from person to person. Examples include hepatitis B, HIV, influenza.

Integrated Health Service Plan: A three-year plan of the Waterloo Wellington Local Health Integration Network that includes priorities, strategic directions and local strategies.

Intersectoral collaboration: A recognized relationship between different sectors of society which has been formed to take action on an issue to achieve health outcomes in a way that is more effective, efficient or sustainable than might be achieved by one sector acting alone.

Local Health Integration Network (LHIN): The province of Ontario is divided into 14 regions or Local Health Integration Networks whose main roles are to plan, fund and integrate health care services locally. The LHIN representing Waterloo Region is the Waterloo Wellington Local Health Integration Network.

Low-Risk Drinking Guidelines: Developed by a team of medical and social researchers from the University of Toronto and the Centre for Addiction and Mental Health, the Low-Risk Drinking Guidelines indicate the maximum recommended number of alcoholic beverages to consume per day and per week for men and women of legal drinking age and who do not have a pre-existing condition as defined in the guidelines (http://www.lrdg.net/guidelines.html).

Mental health: A crucial component of overall health and an essential resource for living, influencing how we feel, perceive, think, communicate and understand. Without good mental health, people can be unable to reach their full potential or actively participate in everyday life.Traditionally, a person was considered to have good mental health simply if they showed no signs or symptoms of a mental illness. In recent years, however, there has been a shift towards a more holistic approach to mental health, and today we recognize that good mental health is not just the absence of mental illness.

Mental health assessment: Provides an overall picture of how well an individual feels emotionally and how well they are able to think, reason and remember in order to diagnose mental health illness and plan for an individual’s treatment and care.

Methadone: An opioid used medically as a maintenance or replacement therapy for use in patients with an opioid addiction.

Naloxone: A drug used in the emergency treatment of opiate overdose. It is distributed under the trademarks Narcan, Nalone and Narcanti.
Overdose: The use of a drug or drugs in an amount that causes acute adverse physical or mental effects. Overdose may produce transient or lasting effects, and can sometimes be fatal.

Regional emergency response (also referred to as tiered protocol): A plan of action for the efficient deployment and coordination of services, agencies and personnel, including ambulance, fire and police, to provide the earliest possible response to an emergency.

Residential treatment: Refers to live-in treatment programs that provide recovery and rehabilitation for problematic substance use.

Restorative justice: An alternative to the traditional court system that engages both the offender and victim in post-offence mediation.

School Resource Officers: A dedicated position within the Waterloo Regional Police Service with the primary goal of facilitating crime prevention and fostering positive relationships between the police and youth within schools.

Street Involved: People who are street involved spend a significant amount of their time on the street, in public spaces or outdoors for a variety of reasons. For example, they may: be experiencing homelessness or at-risk of housing loss; be involved in street-based work; and/or have an informal support network that is largely street-involved.

Street Outreach: Programs designed to serve people who are street-involved. There are two main types of programs: general (serve everyone who is street-involved and provide a variety of resources to meet people’s basic needs and specialized (serve a particular population or provide a specific resource). There are also two main delivery models: fixed (programs located at physical sites in the community at certain times) and mobile (programs that are not tied to a particular location or time frame; initial contact with people often takes place in the community and where there is flexibility to respond to people’s emerging needs).

Participatory approach: An approach that involves active participation of stakeholders and those whose lives are affected by the issue, in all phases for the purpose of producing useful results.

Poly-substance use: The use of two or more psychoactive substances simultaneously or at different times.

Post-traumatic stress disorder (PTSD): A condition that is classified as an anxiety disorder and usually develops as a result of a terribly frightening, life-threatening, or otherwise highly unsafe experience.

Prevention: Interventions throughout the life cycle that seek to avoid or delay the onset of substance use and that address root causes of problems.

Primary health care: The health services offered by providers who act as a principal point of contact for patients within the health system. Such providers include primary care physicians, a general practitioner or family physicians, or a nurse practitioner.

Problematic substance use: Problematic substance use refers to use which could either be dependent (e.g. addiction) or recreational (e.g. binge drinking) with negative consequences. It is not necessarily the frequency of drug use which is the primary ‘problem’ but the effects that substance use have on a person’s life (i.e. experience of social, financial, psychological, physical or legal problems as a result of substance use.

Proceeds of Crime: Any property, benefit or advantage that is obtained or derived directly or indirectly as a result of criminal activity.

Promising practice: Interventions that have not been evaluated as rigorously as “best practices”, but that still offer ideas about what works best in a given situation.

Psychoactive substances: Chemicals that alter mental functioning with effects on mood and/or altered states of subjective reality. This includes illicit drugs, some prescription drugs, and alcohol.

Recovery: The stage where individuals are no longer using substances. Recovery can result from treatment or a decision to quit.

Naltrexone: A drug used primarily in the management of alcohol and opiate dependence.

Non-palatable alcohol: Toxic substances that contain alcohol but are not intended for human consumption (e.g. hand sanitizer, mouthwash, rubbing alcohol).

Ontario Disability Support Program (ODSP): A social assistance program provided by the Government of Ontario which provides income and employment supports to people with disabilities who are in financial need.

Ontario Drug Benefit (ODB) Program: A program of the Ministry of Health and Long-Term Care that covers most of the cost of prescription drug products listed in the ODB Formulary, as well as some exceptional cases. Ontario residents belonging to one of the following groups are eligible for drug coverage under the ODB Program:

- people 65 years of age and older;
- residents of long-term care homes;
- residents of Homes for Special Care;
- people receiving professional services under the Home Care program;
- Trillium Drug Program registrants.
- individuals receiving social assistance (Ontario Works or Ontario Disability Support Program assistance).

Opiate: The generic term applied to alkaloids (naturally occurring chemicals) obtained from the opium poppy (Papaver somniferum). Technically, the term opiate applies only to those chemicals from the opium poppy such as morphine and codeine, however the term is often used interchangeably with “opioid” (see below).

Opioid: An opioid is a chemical that activates opioid receptors in the brain and has “morphine-like” effects. Opioids may be naturally-occurring compounds such as morphine or codeine, they may be semi-synthetic compounds such as heroin or oxycodone, or synthetic compounds such as meperidine (Demerol). Opioids such as endorphins are also produced naturally in the brain.

Overdose: The use of a drug or drugs in an amount that causes acute adverse physical or mental effects. Overdose may produce transient or lasting effects, and can sometimes be fatal.
**Stigmatization:** The assignment of negative attitudes and perceptions towards individuals on the basis of perceived difference from the population at large which often results in stigmatized individuals becoming alienated and disconnected from society.

**Suboxone:** A trade-name for buprenorphine, a semi-synthetic opioid used to treat opioid addiction in higher dose preparations.

**Supportive housing**[^1]: Permanent housing complemented with a support program designated to a unit, building or neighbourhood (may also include subsidy). Supportive Housing programs are designed to meet the needs of people who require support to maintain housing stability over a longer period of time (e.g., people who are unable to live independently because they have a disability, they are recovering from serious trauma, they need specialized medical support and/or they have limited skills oriented to housing stability).

**Time-Limited Residence**[^1]: Shorter term residential programs designed for people in transitional situations. These programs offer support that is tailored to specific transitional circumstances in order to increase capacity to maintain housing stability over the long term. Unlike Emergency Shelter programs, Time-Limited Residence programs require a planned intake. Unlike Supportive Housing programs, Time-Limited Residence programs generally expect people to transition from the program within a certain time frame and the programs are typically not covered under the Residential Tenancies Act, 2006.

**Tracking devices:** Ankle bracelets that make use of global positioning system (GPS) technology to allow criminal offenders to be tracked around the clock to make sure that the rules set down for the probation period are consistently followed.

**Waterloo Region Crime Prevention Council:** An advisory committee to Waterloo Regional Council that works with community partners to reduce and prevent crime, victimization and fear of crime.

**Waterloo Region Harm Reduction Network:** A community-based network of service providers and community members who work to reduce the harms associated with substance use; facilitate improvements to, or creation of, services serving people who use substances; and create awareness and education around issues pertaining to harm reduction and substance use.

**Wet housing:** Housing of this type is often targeted to specific groups (e.g., people experiencing persistent homelessness) with the goal to provide a safe and secure environment for people who are not ready or able to stop using substances and who are likely to have other complex needs (e.g., mental or physical health issues). Substance use services are offered unconditionally in the same way that all other services are provided (e.g., medical care). In their efforts to help tenants maintain housing stability, providers focus their efforts on assisting with the management of problems that interfere with meeting tenancy obligations (e.g., nonpayment of rent, disruptive behaviour, use of illegal substances on the premises). Providers also use harm reduction strategies to reduce the negative impacts and consequence of substance use. In so doing, they provide ongoing opportunities for people to address their substance use issues through abstinence, reduced or even managed use.

**Withdrawal management:** A collective of medical and psychosocial interventions directed at controlling the symptoms that occur after stopping or dramatically reducing consumption of psychoactive substances after heavy and prolonged use.
References

18. Social Planning, Policy and Program Administration. (2011). We’ll leave the lights on for you: Housing options for people experiencing persistent homelessness who use substances (alcohol and/or drugs). Waterloo, ON: Regional Municipality of Waterloo.

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Appendix A: Waterloo Region Integrated Drugs Strategy Development Timeline

The Waterloo Region Crime Prevention Council (WRCPC) has been a model for crime prevention throughout Canada since its inception in 1994. The WRCPC is an advisory committee to Regional Council that works with community partners to reduce and prevent crime, victimization and fear of crime by addressing the root causes via a social development approach.

Responding to concerns, interest and requests at community and system levels, several initiatives began to emerge and were facilitated by the WRCPC, among them:

- The establishment of a committee of Council to provide education and training opportunities, develop systems approaches, address myths, stereotypes, stigma and discrimination surrounding issues of addiction, develop potential solutions, address gaps in services, ineffective or non-existent services, and pursue strategic planning options.

- The establishment of the Waterloo Region Harm Reduction Network, comprised of almost 20 members with a practical interest in reducing drug (including alcohol) related harms, in evidence based research and in sharing approaches to promote health and safety.

- The establishment of "In The Mind’s Eye: Issues of Substance Use in Film + Forum", a unique and inclusive series that seeks to engage, inform and inspire citizens and service providers in issues of substance use.

- WRCPC membership engaged in a focussed discussion on substance use in December 2005 that identified several issues related to problematic substance use, including:
  - The significant link between (problematic) substance use, crime and victimization
  - The use of a punitive approach to address health and social issues
  - The limits of the criminal justice system to affect the supply (black market) and demand for illicit substances
  - Systems-wide inertia, integration and/or indifference to achieve a reduction in the economic, health and social burden
  - Lack of horizontal and vertical systems integration
  - Lack of evidence based prevention efforts
  - Issues of stereotypes, stigma and discrimination for those affected by addiction
  - The establishment of the "Drug Users" group in 2006, a safe forum for people who use drugs to engage with others in dialogue about issues and solutions to improve health and safety.

- In May 2006, WRCPC hosted a forum for more than 30 (addiction) service providers to inform the Waterloo Wellington Local Health Integration Network (WWLHIN), providing important information about service gaps, challenges and opportunities.

- In October 2006, WRCPC facilitated a forum on Substance Use, Crime and Municipal Integrated Drug Strategies with experts from Ottawa and Toronto.

- In November 2006, an invitation from WRCPC was extended to area township, municipal and regional leaders to meet with Senator Larry Campbell – former police officer, B.C. Coroner and Vancouver mayor – to discuss municipal drug strategies.

- Later that month the Substance Abuse Committee recommended: “That the WRCPC consider undertaking a Waterloo Region Integrated Drug Strategy”. This motion was approved by WRCPC unanimously.

Since that time, WRCPC and community partners have been completing background work in preparation for the development of an Integrated Drugs Strategy. Among the key milestones:

- The release of WRCPC’s Violence Prevention Plan, based on input from 60 service providers, which identified problematic substance use as a component of preventing violence, and named the Integrated Drugs Strategy as a key component to preventing violence in Waterloo Region.

- A one day forum for 70 service providers and community members on elements of drug strategies and recommendations to inform development locally.

- In June 2008, Region of Waterloo Public Health completed a study initiated by the WRHRN called “Baseline Study of Substance Use, Excluding Alcohol” that attempted, for the first time, to gather baseline data on aspects of local illicit drug use.

- In September 2008 the WRCPC published two reports on drug-related overdoses, the first providing a look at the extent and typology of overdoses locally via secondary data. The second report identified North American overdose prevention and intervention programs.

- In November 2008, WRCPC facilitated and hosted the first meeting of drug strategy specialists from across Ontario, with more than 15 municipalities and counties represented. The Network continues to this day with 19 members.

- In December 2008, a draft Terms of Reference for an Integrated Drugs Strategy Task Force were approved by WRCPC and recruitment of task force members began.

- In June 2009, a Task Force of 26 members met for the first time, and did so once a month for the next 2.5 years. Their mission was to create an Integrated Drugs Strategy. Members were selected based on their commitment to crime prevention through social development, familiarity with the elements of a Municipal Drug Strategy, their ability to provide strong linkages to community and service systems with a long-term region-wide strategic focus.

It is expected the Waterloo Region Integrated Drugs Strategy Task Force will be disbanded at the end of 2011, to be replaced by a Steering Committee responsible for implementation of the recommendations.
Appendix B:
WRIDS System Assessment Survey Findings In Brief

The survey was conducted to identify key issues and needs with respect to substance-use related system (i.e. services, programs, activities, resources and supports) in Waterloo Region.

- The most prominent themes in the survey referred to the following:
  - limited system capacity and the need for funding and resources;
  - the issue of stigma and the need for increased substance use-related education and awareness; as well as
  - the importance of environmental supports (e.g. housing) and system integration and planning.
- The social network map constructed from participants’ responses on their partnerships appeared to suggest that links between substance use-related organizations and services in Waterloo Region are relatively well-established. In addition,
  - organizations involved in multiple pillars, found to be prominent due to their range of connections and central location in the network, may serve as key partners in implementation of WRIDS, and
  - further network development could be achieved by increasing the number of links at higher levels of integration (especially between harm reduction and other pillars).
  - Lack of time, funding and resources as well as differing mandates, priorities and philosophies were identified as main barriers to linking and interaction between organizations.
- A common theme observed with respect to the Four Pillars related to effectiveness of substance-use interventions and the nature of approach taken.
  - The stated need for effective and evidence-informed approaches to prevention may warrant addressing broader social forces and health factors as well as adopting a comprehensive, long-term approach to prevention of substance use issues.
  - Lack of acceptance of harm reduction despite demonstrated effectiveness underscores the tension between ideology, values and evidence.
  - Capacity and access issues of recovery and rehabilitation pillar may warrant an approach that involves a combination of improved system effectiveness, responsiveness and coordination as well as funding for expansion and creation of services and resources.
  - A more balanced approach and range of interventions to substance use issue could be employed within the enforcement and justice pillar while also ensuring a balanced approach across the pillars overall.
- Overall, the survey findings pointed towards a need for integration of substance use-related services, programs, activities, resources and supports in Waterloo Region.

Contact Waterloo Region Crime Prevention Council for more information about this survey.
Appendix C:

Waterloo Region Integrated Drugs Strategy: Key Informant Forum Summary

As a component of the public consultation phase of the Waterloo Region Integrated Drugs Strategy development, four key informant forums were held, representing four of the pillars of the strategy. The purpose of the forums was to bring together community stakeholders with experience or interest in the field of substance use to develop recommendations that will make Waterloo Region safer and healthier for everyone by preventing, reducing and/or eliminating problematic substance use and its consequences.

In total, more than 250 participants attended the forums, including people who use/used substances, youth, health and social service providers, enforcement and criminal justice representatives, school board representatives, hospital administrators, and government officials. At each forum, participants heard presentations on a variety of topics related to substance use and the pillar of focus. Speakers shared their experience and expertise and generated discussion to engaged participants through their presentations. Following presentations, participants broke into smaller groups and were guided through a facilitated discussion to generate recommendations for the strategy.

Forum Details:

<table>
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<tr>
<th>Pillar</th>
<th>Date</th>
<th>Number of Participants</th>
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<tbody>
<tr>
<td>Harm Reduction</td>
<td>Thursday, April 21, 2011</td>
<td>65</td>
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<tr>
<td>Enforcement and Justice</td>
<td>Wednesday, April 27, 2011</td>
<td>65</td>
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<tr>
<td>Prevention and Education</td>
<td>Monday, May 2, 2011</td>
<td>65</td>
</tr>
<tr>
<td>Recovery and Rehabilitation</td>
<td>Monday, May 9, 2011</td>
<td>60</td>
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Areas of Focus:

| Harm Reduction | • Improve our collective understanding of harm reduction  
|                | • Discuss access to harm reduction services (scope, strengths, challenges, barriers)  
|                | • Address values-based issues  
|                | • State of harm reduction in Waterloo Region  
| Enforcement and Justice | • Effects of drug addiction/use on the community  
|                          | • Pre-trial issues (includes bail, diversion, and drug treatment court)  
|                          | • Court stage issues  
|                          | • Post-sentence issues  
| Prevention and Education | • Scope and complexity of prevention  
|                          | • Evidence-informed effectiveness of prevention and education approaches/methods  
|                          | • Root causes/risk factors for substance use  
|                          | • Role of supports and social determinants of health (e.g. income, education, housing)  
|                          | • Access to prevention-related services and supports  
| Recovery and Rehabilitation | • Current services (capacity, local context, gaps)  
|                          | • Barriers to getting to treatment  
|                          | • Appropriateness and effectiveness of services  
|                          | • Continuum of care  

### appendix C

#### Speakers:

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<tr>
<th>Forum</th>
<th>Speaker</th>
<th>Affiliation</th>
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<tr>
<td><strong>Harm Reduction</strong></td>
<td>Susan Shepherd</td>
<td>Toronto Public Health</td>
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<td></td>
<td>Dr. Liana Nolan</td>
<td>Region of Waterloo Public Health</td>
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<tr>
<td></td>
<td>John Prno</td>
<td>Region of Waterloo Emergency Medical Services</td>
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<td></td>
<td>Sandra Ball</td>
<td>Waterloo Region Bail Program</td>
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<tr>
<td></td>
<td>Cathy Middleton</td>
<td>YWCA Kitchener-Waterloo</td>
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<tr>
<td></td>
<td>Natalie Basaraba</td>
<td>AIDS Committee of Cambridge, Kitchener, Waterloo and Area</td>
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<td></td>
<td>Mike Vanderstoep</td>
<td>Speaker with lived experience</td>
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<tr>
<td><strong>Enforcement and Justice</strong></td>
<td>Chief Matt Torigian</td>
<td>Waterloo Regional Police Service</td>
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<td></td>
<td>Ross Swainson</td>
<td>Waterloo Regional Police Service</td>
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<tr>
<td></td>
<td>Conny Muhic</td>
<td>John Howard Society of Waterloo-Wellington</td>
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<td></td>
<td>Sandra Ball</td>
<td>Waterloo Region Bail Program</td>
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<td></td>
<td>Lynette Fritzley</td>
<td>Waterloo Region Drug Treatment Court</td>
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<td></td>
<td>Justice Paddy Hardman</td>
<td>Ontario Court of Justice</td>
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<td></td>
<td>Stephanie Krug</td>
<td>Defense Counsel</td>
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<td></td>
<td>Catrina Braid</td>
<td>Public Prosecution Service of Canada</td>
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<td></td>
<td>Kevin McIntyre</td>
<td>Probation &amp; Parole Offices, Ontario Ministry of Community Safety and Correctional Services</td>
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<td></td>
<td>Doug Dalgleish</td>
<td>Maplehurst Correctional Complex</td>
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<td></td>
<td>Scott Brush</td>
<td>Ray of Hope</td>
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<td></td>
<td>Heather Kerr</td>
<td>Stonehenge Therapeutic Community</td>
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<tr>
<td><strong>Prevention and Education</strong></td>
<td>Dr. Geoff Nelson</td>
<td>Wilfrid Laurier University</td>
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<td></td>
<td>Carol Perkins</td>
<td>Region of Waterloo Public Health</td>
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<td></td>
<td>Jay Fewkes</td>
<td>Public speaker with lived experience</td>
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<td></td>
<td>Chris Sadeler</td>
<td>Waterloo Region Crime Prevention Council</td>
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<td></td>
<td>Cath Done</td>
<td>Families and Schools Together (FAST) program</td>
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<td></td>
<td>Darcy Edwards</td>
<td>High On Life program</td>
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<td></td>
<td>Viola Fodor</td>
<td>Life Process Counselling*, The Wellness Centre</td>
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<td></td>
<td>Katie</td>
<td>Speaker with lived experience</td>
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<tr>
<td><strong>Recovery and Rehabilitation</strong></td>
<td>Ione Clapham</td>
<td>Family and Children’s Services Niagara</td>
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<td></td>
<td>Glynis Burkhalter</td>
<td>Ray of Hope</td>
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<td></td>
<td>Lila Read</td>
<td>Kitchener-Waterloo Collegiate and Vocational School, Waterloo Region District School Board</td>
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<td></td>
<td>Penny MacLean</td>
<td>Vanier Centre for Women</td>
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<td></td>
<td>Stephen Gross</td>
<td>Kitchener Downtown Community Health Centre</td>
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<tr>
<td></td>
<td>Pam McIntosh</td>
<td>House of Friendship, Addiction Services</td>
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Breakout Session Discussion Guide:
To facilitate consistency across the four forums and lead discussion towards the development of recommendations, breakout groups for each pillar followed a similar structure and questions based on the focused conversation method.

Facilitated Discussion Questions
1. Based on what we heard today, what stood out for you the most?
2. What didn't you hear? What's missing?
3. Is this issue significant? Are certain issues more significant than others (i.e. priorities)?
4. Is this an issue that we can impact at the local level? If not, at what level can we act?
5. What action is needed to address these issues in our community?
6. What does this mean for collaborating with other pillars?

Facilitation
Breakout groups were facilitated by Region of Waterloo Public Health Planners whose role was to guide the group through the process of reviewing issues discussed during speaker and panel discussions and the development of recommendations for the Waterloo Region Integrated Drugs Strategy. Facilitators were briefed on the WRIDS background and pillar-related information and were present and took notes during keynote speaker and panel discussions. Facilitators were responsible for guiding participants through the discussion questions, ensuring discussions were focused and geared towards recommendations, and making sure that they had a clear understanding of the points that group members made so that the information provided could be used in the development of the strategy.

The input of forum participants contributed greatly to the development of the Waterloo Region Integrated Drugs Strategy. Participants brought a diverse range of perspectives, opinions, and expertise and offered thoughtful and constructive input, which is reflected throughout the strategy.

Appendix D: Drug Strategies in Ontario

Appendix E: Continuums of Support for People Experiencing Persistent Homelessness with Active Substance Use Issues in the Context of Housing

Substance Use Continuum in the Context of Housing

**LEVEL 1: DRY**
- No substance use on site (i.e., “dry”)
- Typically not allowed access if under the influence

**LEVEL 2: DAMP**
- No substance use on site
- Allowed access if under the influence

**LEVEL 3: ACKNOWLEDGMENT**
Acknowledge (formally or informally) use on site

**LEVEL 4: SUPPORT**
Various forms of support to reduce harm

**LEVEL 5: MANAGED ALCOHOL USE**
Providing and administering safe beverage alcohol on site

**LEVEL 6: MANAGED DRUG USE**
Offering supervised injection and/or direct support for non-injection substance use (e.g., inhalants)

Medical Services Continuum in the Context of Housing

**NON-MEDICAL**
- No on-site or visiting medical services available to the program
- May or may not support adherence to prescribed medication

**PARTIAL MEDICAL**
- Some on-site and/or visiting medical services available to the program
- Support adherence to prescribed medication

**COMPREHENSIVE MEDICAL**
- Some level of 24/7 medical services (e.g., physicians, psychiatrists, nurses) on-site and/or visiting
- Regular visits from other healthcare professionals
- May or may not provide palliative care

Social Planning, Policy and Program Administration. (2011). We’ll leave the lights on for you: Housing options for people experiencing persistent homelessness who use substances (alcohol and/or drugs). Waterloo, ON: Regional Municipality of Waterloo.
More and more, municipalities are adopting innovative, prevention based approaches to complex issues such as crime, victimization and fear of crime. In Waterloo Region, we have a history of innovation and collaboration.

The Waterloo Region Crime Prevention Council brings a wide range of services and citizens together to build healthier and safer communities. Our multi-disciplinary and multi-sectoral community-based council includes representatives from the social, health, and education sectors, as well as, enforcement, urban and rural centres, planning, child and family well-being, youth and more. Together, these members act as a resource and an advisory body for local communities and the Region of Waterloo.

In our experience so far, we have come to learn that the role of a crime prevention council is not to ‘do for’ the community, but to ‘do with’ the community.

The role of a crime prevention council is to be a catalyst for action, an educator, a connector, a researcher, a resource and support. WRCPC is actively engaged in social change oriented crime prevention through:

• Education
• Outreach
• Capacity Building
• Community Dialogue
• Research
• Communication
• Community Engagement
• Partnership Building

Since 1994, WRCPC has worked collaboratively on smart approaches that prevent crime and victimization by getting to the root causes of crime. From neighbourhood engagement, training and education, to research and developments that improve services for citizens, the work of WRCPC is rooted in the best available evidence and promising innovative practice.

WRCPC works to close the gaps between service silos and to identify new directions for reducing and preventing crime, victimization and fear of crime by bringing together individuals, neighbourhoods, organizations, agencies and all levels of governments. This multi-disciplinary approach is at the heart of prevention efforts in Waterloo Region and has been upheld across Canada as an effective model for municipally-based crime prevention.

To learn more about our approaches and work, visit www.preventingcrime.ca
www.smartoncrime.ca
www.preventingcrime.ca
www.smartoncrime.ca
MEMORANDUM

To: Chair Sean Strickland and Members of the Community Services Committee
From: Brenda Miller, Manager, Infection Control, Rabies, Vector-Borne Diseases, Tobacco Enforcement and Kitchener and Area Team
File Code: P03-20
Subject: WEST NILE VIRUS ACTIVITY UPDATE

Summary
There has been a significant increase in West Nile virus activity across Ontario in 2012. Provincially, Public Health Ontario reports 82 confirmed and probable human cases as of August 28, 2012. Waterloo Region has one probable human case of West Nile virus as of August 31, 2012.

Another indicator of risk of West Nile activity is the number of positive mosquito pools detected in a region. Mirroring provincial trends, there has been an increase in the number of positive mosquito detected in Waterloo Region in 2012 as compared to recent years.

Given that the West Nile Virus season will continue for the month of September, there could be more cases in Waterloo Region reported in the next few weeks.

While most people infected with West Nile Virus will show no symptoms or mild symptoms, serious health outcomes can occur in a small minority of people. Region of Waterloo Public Health has been urging residents to take personal protective measures and reminding them of ways they can reduce their risk.

Human Case
The first probable human case of West Nile virus for 2012 in Waterloo Region has been identified. This was expected given the increased number of human cases across the Province this year. As of August 28, 2012, there are 82 confirmed and probable human cases across Ontario. While this is Waterloo Region's first probable case, we would not be surprised to have other cases in the coming weeks. In 2011, Waterloo Region had one confirmed and one probable human cases of West Nile virus and before then, the last case occurred in 2005.

The majority of people infected with West Nile virus show no symptoms. However, 1 in 5 infected individuals develop mild flu-like symptoms and 1 in 150 can develop serious neurological symptoms. While serious symptoms can occur at any age, persons over the age of 50 and
persons with compromised immune systems are at highest risk. The usual time from infection with West Nile virus to onset of disease symptoms ranges from 2 – 15 days.

Vector Surveillance
Six positive mosquito pools for West Nile virus have been found across the region as of August 25, 2012. This is the highest number of pools which have tested positive in Waterloo Region since 2002 (when 12 pools tested positive). Public Health Ontario reported 375 pools of mosquito have tested positive for West Nile virus across Ontario as of August 25, 2012. The last time the number of positive mosquito pools across Ontario exceeded 375 pools was in 2002 when 408 positive mosquito pools were reported.

Warm temperatures are known to accelerate mosquito development and the extrinsic incubation period (i.e. the developmental stage within the mosquito required for the mosquito to be capable of transmitting the virus), thereby improving the probability of viral transmission to humans. This year many parts of southern Ontario including Waterloo Region have had more than 300 accumulated degree days (i.e. temperatures above 18.3°C for more than 24 hours). More than 200 accumulated degree days is associated with increased risk of human infection.

Active West Nile virus vector surveillance will continue across the region until Sept 26, 2012. Mosquito’s are expected to enter into their overwintering period once the temperatures drop and the daylight hours decrease, typically by mid to late September.

Control Efforts
For the 2012 season, Region of Waterloo Public Health continued to perform a preventative larviciding program. The scope of the larviciding program is informed each year by the abundance of West Nile virus vector species observed during larval surveillance and by the historical incidence of positive pools and human cases. A total of three rounds of catch basin larviciding (150,523 catch basins), 25.4 hectares of standing water and two sewage lagoons have been treated so far this season to suppress mosquito populations and ultimately reduce the risk of human exposure to West Nile virus.

Reduction of standing water throughout the region to suppress mosquito populations is promoted to the residents through the Region’s, “fight the bite “ public education program and is also promoted to program stakeholders (e.g. Grand River Conservation Authority, Cities and Municipalities and educational institutions). Standing water complaints regarding privately owned properties are investigated by Public Health Staff and property owners are provided with information on remediation. Standing water on public sites is investigated for the presence of mosquito larvae and control measures applied as needed.

Public Messaging
Region of Waterloo Public Health will continue to promote West Nile virus public awareness and protection messaging to the residents of Waterloo Region. The most recent media release issued was on August 31, 2012.
<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Requestor</th>
<th>Request</th>
<th>Assigned Department</th>
<th>Anticipated Response Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-May-12</td>
<td>Council</td>
<td>Staff were directed to provide Council with a prioritized list of discretionary benefits and financial impacts prior to or as part of the 2013 Budget process, as required.</td>
<td>Social Services</td>
<td>Fall 2012</td>
</tr>
</tbody>
</table>