MEDIA RELEASE: Friday, November 2, 2012, 4:30 p.m.

REGIONAL MUNICIPALITY OF WATERLOO
COMMUNITY SERVICES COMMITTEE
AGENDA

Tuesday, November 6, 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. DELEGATIONS
a) Wanda Wagler-Martin, Executive Director, Shalom Counselling Services, Re: SS-12-047, Counselling Collaborative Program

3. PRESENTATIONS
a) Mary MacKeigian, Executive Director, Opportunities Waterloo Region, Re: Update on Shifting Societal Attitudes and Community-University Partnerships

4. REPORTS – Social Services
a) SS-12-047, Counselling Collaborative Program (Brochure Attachment distributed separately to Councillors and Senior Staff only.)
   b) SS-12-048, Sunnyside Community Alzheimer Day Program (Cambridge) Service Expansion
   c) SS-12-049, Update on Ontario Works Discretionary Benefits Program

REPORTS – Public Health
d) CPC-12-003, inREACH Comprehensive and Integrated Youth Gang Prevention Strategy of Waterloo Region Update (Attachments distributed separately to Councillors and Senior Staff only - Staff Presentation)
e) PH-12-048, Infectious Diseases in Waterloo Region — Surveillance Report 2006-2011

5. INFORMATION/CORRESPONDENCE
a) Ontario Municipal Social Services Association (OMSSA) Quick Connect

6. OTHER BUSINESS
a) Council Enquiries and Requests for Information Tracking List
7. **NEXT MEETING – November 27, 2012**

8. **MOTION TO GO INTO CLOSED SESSION**

   THAT a closed meeting of the Community Services, Administration and Finance and Planning and Works Committees be held on Tuesday, November 6, 2012 immediately following the Community Services Committee meeting in the Waterloo County Room, in accordance with Section 239 of the *Municipal Act*, 2001, for the purposes of considering the following subject matters:

   a) receiving of legal advice and opinion that is subject to solicitor-client privilege related to an agreement
   b) litigation or potential litigation and receiving of legal advice and opinion that is subject to solicitor-client privilege related to a contract
   c) proposed or pending acquisition of land in the City of Kitchener
   d) proposed or pending acquisition of land in the City of Kitchener

9. **ADJOURN**
REPORT:

1.0 Background
The Region of Waterloo has supported community counselling agencies to provide services to people in receipt of Ontario Works (OW) and Ontario Disability Support Program (ODSP) since 1978. Originally, the Ministry of Community and Social Services cost shared with the Region through Provincial Programs. In January 1996, the Ministry withdrew its cost share contribution and the Region agreed to continue municipally funded grants totalling $130,000 to support the community counselling agencies’ ability to serve recipients of social assistance. In 1999, the counselling agencies approached the Region requesting funding for up to 50 per cent of the cost of providing service to eligible social assistance recipients. An allocation of $308,777 was approved through the budget process. Efforts were made to match the 50 per cent cost of service delivered for the next couple of years. Beginning 2003, the Counselling Grants program was included in the base budget and has received annual economic adjustments for cost of living increases, amounting to $469,932 in 2012.

In 2008, Regional staff together with the counselling agencies initiated a Counselling Grants Review (Review). With the help of a consultant, the Review included interviews with key stakeholders (counselling agencies and others), focus groups with program participants and a literature review. The review resulted in the identification of a number of strengths of the Counselling Grants program including: collaborative relationships, networking and communication; and service delivery flexibility. A number of challenges were also identified and these included: multiple and complex client needs; barriers to participation, lack of awareness and knowledge of the service, wait lists and no shows. The physical environment, accessibility, agency culture and funding rates were also raised as areas of concern.

SUMMARY:
This report provides an update on the development of the Counselling Collaborative Program (CCP), previously named the Region’s Counselling Grant program. In this time of financial restraint, funding cutbacks and a local burgeoning Ontario Works caseload, the CCP addresses a growing need to strengthen and enhance therapeutic supports for some of Waterloo Region’s most vulnerable community members. This report communicates the CCP’s development, accomplishments to date and describes program focus areas for 2012 and beyond.

RECOMMENDATION:
For information only
After completing the Review in November 2009, it was determined that the community counselling agencies would work together to transition the counselling grant to a collaborative program. Representing all major non-profit community counselling agencies, the partners recognized the benefit of working together to develop programmatic features including: a funding formula, eligibility criteria, service parameters, shared data and evaluation, and communication activities.

The knowledge gained during the Review assisted in the redevelopment of a service agreement which aligns with current Region and community counselling agencies’ strategic focus areas and assures accountability, equity and access. In January 2011, the CCP was officially launched and the collaborative has since continued to strengthen therapeutic supports for OW/ODSP recipients.

2.0 Overview of the Service Description

The CCP is a community-based partnership between the Region of Waterloo (Region) and seven non-profit community counselling agencies in Waterloo Region (see Appendix A for a list of members). Staff from the Social Planning, Policy and Program Administration division administer funding, and offer support for convening and coordinating functions.

The CCP is designed to provide people receiving OW and ODSP with free, responsive, quality counselling services that promote health and wellbeing, enhance quality of life, and create opportunities for people to develop to their full potential.

The CCP has identified the following six service objectives:

- Identify and remove barriers that prevent OW/ODSP recipients from accessing counselling services;
- Address the diverse needs of the OW/ODSP population with particular attention to the effects of living in poverty;
- Deliver services in a flexible manner whenever possible to facilitate engagement and participation in counselling services;
- Deliver service in a timely way through the monitoring of non-attendance, and average wait times to appointment and by developing strategies for improving access;
- Address the inclusivity and accessibility of services throughout all geographic areas of the region; and
- Work from a client-centred and strength-based approach.

Using a No Wrong Door model of service delivery, each agency processes requests for service explaining treatment options and alternatives. Client needs are assessed through the intake process and triage occurs for cases that require immediate clinical/medical intervention or other treatment resources. Further, agencies will strive to accommodate a seamless referral to another partner agency whenever they are unable to accommodate a client due to wait times, availability of suitable programs or services and/or language accommodation.

The CCP has introduced an eight session cap for individual counselling sessions per calendar year, per client unless otherwise approved by a clinical supervisor. Partner agencies are now funded at a standardized rate that continues to reflect the Council approved 50 per cent of the cost of a unit of service1.

In 2011, the CCP delivered 8,923 units of service to 2609 people. Fifty-eight per cent of people

---

1 One unit equals one session scheduled for no less than fifty (50) minutes of a clinician’s time in a face-to-face counselling session. This differs from a unit of service delivered in a group setting which is determined by the number of clinicians facilitating the group and the number of OW/ODSP participants.
served were in receipt of OW and 42 per cent of people were in receipt of ODSP. Sixty-nine per cent of people received support through individual, couple or family counseling and 31 per cent of people received support through a therapeutic group.

3.0 Accomplishments to Date
Representatives from each of the partner counselling agencies have worked together to address collective goals and share innovative practices. To date they have achieved the following:
- Completed a service description including guiding principles, program objectives, service parameters, definition of terms and a funding formula;
- Developed of a promotional brochure;
- Designed a common Client Information Form;
- Developed a shared data collection/measurement tool; and
- Completed a program-wide client satisfaction survey.

Most notably, the CCP was recently awarded a Local Municipal Champion award through the Ontario Municipal Social Services Association (OMSSA) in recognition of best practices and peer-recognized outstanding contributions to human services.

4.0 Action Plan/Next Steps
The CCP is currently working on the development of a detailed inventory of programs and services delivered through the CCP. The inventory will include areas of specialization and capacity to address linguistic and ethno-cultural diversity. The inventory will serve two purposes: as a planning tool to identify gaps and opportunities for development; and to inform a CCP Information Guide to be used by CCP agency staff, Regional staff and other community organizations to enhance effective CCP referrals.

Additional activities include continued data collection and analysis to better understand program outcomes (e.g., Social Return on Investment). The CCP will continue to build knowledge and training to better understand the shifting challenges and changing needs experienced by people living in low income.

It is important for service providers as well as policy-makers to be aware of the potential barriers faced by people living in low income and the many factors that influence their decision to seek professional help. The CCP is committed to continuing to develop models of practice and service delivery that take into account these factors, mitigate potential barriers and result in efficient service and successful outcomes for those seeking help. The CCP has demonstrated substantial and consistent progress toward these goals.

CORPORATE STRATEGIC PLAN:

This initiative aligns with the Region’s Corporate Strategic Focus Area 4: Healthy and Inclusive Communities; Corporate Strategic Action 4.1.2 to “Continue to collaborate with community partners in broad based efforts to reduce poverty”.

FINANCIAL IMPLICATIONS:

NIL

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

NIL
ATTACHMENTS

Appendix A: Members of the Counselling Collaborative Coordinating Committee
NOTE: Brochure to be distributed separately.

PREPARED BY: Heather Froome, Administrator, Social Development Programs
               Lynn Randall, Director, Social Planning, Policy and Program Administration

APPROVED BY: Gail Kaufman Carlin, Acting Commissioner, Social Services
Appendix A: Membership

Counselling Collaborative Coordinating Committee

Lisa Akey  Acting Executive Director
           Interfaith Community Counselling Centre

Michele Braniff  Program Manager, Mental Health Services
                 Lutherwood Family Counselling Centre

Sue Gillespie  Executive Director
              Mosaic Counselling and Family Services

Bobbye Goldenberg  Executive Director
                    Family Counselling Centre of Cambridge and
                    North Dumfries

Leslie Josling  Executive Director
                K-W Counselling Services

Wanda Wagler-Martin  Executive Director
                      Shalom Counselling Services

Mary Wilhelm  Executive Director
              Woolwich Counselling Centre

Heather Froome  Administrator, Social Development Programs,
                Social Planning, Policy and Program Administration
                Region of Waterloo

Pam Mank  Supervisor, Counselling Services
           Employment and Income Support
           Region of Waterloo

Lynn Randall (chair)  Director, Social Planning, Policy and Program
                      Administration
                      Region of Waterloo
Why Counselling?

Counselling is helpful in many ways:

- It gives you the time and space to work through your personal or relationship issues in a way that is safe and non-judgmental.
- It reduces stress and helps you feel better about yourself.
- It teaches you new behaviours, techniques or ways to respond to issues which can help you reach your goals.
- It helps you understand and make sense of your own thoughts, feelings, and responses.
- It helps you better understand your loved ones.
- It gives you the chance to speak with a skilled professional about things that are important to you.
- It helps you to feel that you are not alone and that there is hope!
What is offered?

The Counselling Collaborative Program is a community-based partnership between the Regional Municipality of Waterloo and seven United Way member agencies to ensure that you have access to the counselling services you need.

Our goal is to:
• provide up to 8 counselling sessions
• assist you to feel better about yourself
• improve your quality of life, and
• create opportunities to be all that you can be.

Services offered include: Individual, Group, Couple and Family Counselling.

Who is eligible?

If you are receiving support through Ontario Works or Ontario Disability Support Program you are eligible to participate.

How do I get connected to the program?

You can receive counselling service through the Counselling Collaborative Program. Simply call any of the agencies listed below and speak with an Intake Worker to determine the right program or service for you. Whenever possible, counselling appointments are offered at flexible times.

<table>
<thead>
<tr>
<th>Family Counselling Centre of Cambridge &amp; North Dumfries</th>
<th>519-621-5090</th>
<th><a href="http://www.fcccnd.com">www.fcccnd.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Walnut Street, Cambridge (walk-in available Thursdays 1 p.m. - 9 p.m.)</td>
<td>519-621-5090</td>
<td><a href="http://www.fcccnd.com">www.fcccnd.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interfaith Community Counselling Centre</th>
<th>519-662-3092</th>
<th><a href="http://www.interfaithcounselling.ca">www.interfaithcounselling.ca</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>23 B Church Street, New Hamburg</td>
<td>519-662-3092</td>
<td><a href="http://www.interfaithcounselling.ca">www.interfaithcounselling.ca</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>K-W Counselling Services</th>
<th>519-884-0000</th>
<th><a href="http://www.kwcounselling.com">www.kwcounselling.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>480 Charles Street East, Kitchener (walk-in available Thursdays noon – 6 p.m.)</td>
<td>519-884-0000</td>
<td><a href="http://www.kwcounselling.com">www.kwcounselling.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lutherwood Family Counselling Centre</th>
<th>519-622-1670</th>
<th><a href="http://www.lutherwood.ca">www.lutherwood.ca</a> (go to mental health, click on family counselling)</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 Dickson Street, Cambridge</td>
<td>519-622-1670</td>
<td><a href="http://www.lutherwood.ca">www.lutherwood.ca</a> (go to mental health, click on family counselling)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mosaic Counselling and Family Services</th>
<th>519-743-6333</th>
<th><a href="http://www.mosaiconline.ca">www.mosaiconline.ca</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>400 Queen Street South, Kitchener</td>
<td>519-743-6333</td>
<td><a href="http://www.mosaiconline.ca">www.mosaiconline.ca</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shalom Counselling Services</th>
<th>519-886-9690</th>
<th><a href="http://www.shalomcounselling.org">www.shalomcounselling.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>9 Avondale Avenue South, Waterloo</td>
<td>519-886-9690</td>
<td><a href="http://www.shalomcounselling.org">www.shalomcounselling.org</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Woolwich Counselling Centre</th>
<th>519-669-8651</th>
<th><a href="http://www.woolwichcounselling.org">www.woolwichcounselling.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>65 Memorial Avenue, Elmira</td>
<td>519-669-8651</td>
<td><a href="http://www.woolwichcounselling.org">www.woolwichcounselling.org</a></td>
</tr>
</tbody>
</table>
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: November 6, 2012

FILE CODE: S07-20

SUBJECT: SUNNYSIDE COMMUNITY ALZHEIMER DAY PROGRAM (CAMBRIDGE) SERVICE EXPANSION

RECOMMENDATION:

THAT the Regional Municipality of Waterloo approve the expansion of the Community Alzheimer Day Program (Cambridge site) operations from three to five days a week, conditional upon approval and 100% funding by the Waterloo Wellington Local Health Integration Network (WWLHIN), effective January 2, 2013;

AND THAT an increase of 1.92 full time equivalents (FTE) be approved for the Seniors’ Services Division as of January 1, 2013 for Cambridge Alzheimer Day Program;

AND THAT the 2013 Operating Budget for the Seniors’ Services Division be increased by $227,000 gross and $0 net;

AND FURTHER THAT this matter be forwarded to the Budget Committee of the Whole for consideration, as outlined in report SS-12-048, dated November 6, 2012.

SUMMARY:

This report seeks approval for Seniors’ Services (Sunnyside Community Alzheimer Program) to expand the operation of the Alzheimer Day Program in the City of Cambridge from three to five days per week, subject to 100% funding approval by the Waterloo Wellington Health Integration Network (WWLHIN). This program provides therapeutic programming and personal care to enhance the quality of life for people with a dementia, while providing caregiver respite services. It is anticipated that this program will help to address the key WWLHIN priorities of reducing Alternate Level of Care beds in local hospitals, as well as reducing unnecessary visits to the Emergency department by older adults.

REPORT:

1.0 History of Community Alzheimer Program

Sunnyside Community Alzheimer Programs provide a range of services for people with mid to late stage Alzheimer’s disease or a related dementia and their families. Services currently include day programming in Kitchener and Cambridge, an overnight stay respite program in Kitchener and an in-home therapeutic recreational program. Over 250 clients and their families are served annually through these programs.
2.0 Cambridge Alzheimer Day Program

In March 2011, the Adult Day Program Network, a provider-based committee supported by the WWLHIN, requested that the Region give consideration to opening an Alzheimer Day Program in Cambridge. At the request of the WWLHIN, the Network undertook an extensive needs assessment for adult day services for the WWLHIN catchment area. This report confirmed the provision of day programs as a systems solution in supporting the reduction of Alternative Level of Care (ALC) bed days in acute care hospitals (beds occupied by those no longer requiring acute care, but unable to be safely discharged to the community) and in reducing avoidable emergency department visits by seniors.

The report also indicated that the City of Cambridge was significantly under serviced in adult day program spaces as compared to the urban areas of Kitchener, Waterloo and Guelph/Fergus. Day program spaces are noted below and include all adult day programs currently operated by the municipalities and other community agencies. With the exception of Sunnyside, these programs serve seniors with less complex needs and refer clients to the Sunnyside programs, if they can no longer be accommodated due to their physical support needs, and/or challenging behaviours, related to their advanced stage of dementia.

<table>
<thead>
<tr>
<th>City</th>
<th>Population</th>
<th>Spaces per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kitchener-Waterloo</td>
<td>302,143</td>
<td>665</td>
</tr>
<tr>
<td>Cambridge</td>
<td>120,371</td>
<td>205</td>
</tr>
<tr>
<td>Guelph-Fergus</td>
<td>140,943</td>
<td>531</td>
</tr>
</tbody>
</table>

At its July 2011 Board meeting, the WWLHIN approved a total allocation of $662,687 for Adult Day Program expansion for the Waterloo-Wellington area. At that time, the Region of Waterloo received an allocation of $283,553 as part of this investment to open the Sunnyside Alzheimer Day Program in Cambridge. Upon approval from Council (SS-11-056, December 2011), the Community Alzheimer Program opened its doors for the first time on May 2, 2012, operating Monday, Wednesday and Friday from 9:00 am to 2:30 pm, serving up to 16 clients per day.

Due to caregivers’ requests for a daily service and an ongoing community need, it is proposed that the program be expanded to five days a week (Monday to Friday), serving up to 16 clients per day. Eligible clients include those living in the community with mid to advanced stages of dementia, who are unable to be accommodated in a regular seniors’ day program environment. Providing five days of weekday service also supports those caregivers who require supervision and care for their family member while they are working.

The Sunnyside Community Alzheimer Programs are 100% funded by the WWLHIN and client fees. Clients currently pay $15.00 per day in the Cambridge program, which will increase to $16.50 in 2013. The additional two days of service will be provided at a 2013 cost of $227,000. The funding will support the addition of 1.92 FTE of supervisory and program staff and other operating expenses.

CORPORATE STRATEGIC PLAN:

The proposed program expansion presented in this report is consistent with the Corporate Strategic Plan, Focus Areas 4 and 5 – Healthy and Inclusive Communities and Service Excellence. Specifically, approval of this program expansion will improve access to services for individuals living in the community with mid to late stage dementia and their families.
FINANCIAL IMPLICATIONS:

The proposed expansion of the program to five days a week represents an increase to the operating base budget of $227,000 gross, $0 net, being fully funded by the WWLHIN ($203,000) and client fees of approximately $24,000. Operating funds will fund an increase of 1.92 FTE staff and other operating expenses. A budget issue paper will be presented to Budget Committee for consideration.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Finance department has been consulted in preparation for this report.

ATTACHMENTS

NIL

PREPARED BY:  Julie Wheeler, Manager, Community Programs

APPROVED BY:  Gail Kaufman Carlin, Acting Commissioner, Social Services
REPORT:

1. Background

1.1 Provincial Budget

As summarized in Report SS-12-019 (May 8, 2012) the 2012-2013 Provincial Budget contained several items that impact the delivery of social assistance (both Ontario Works and Ontario Disability Support Program). Two items in particular were identified: the removal of Community Start-up and Maintenance Benefit (CSUMB) as a mandatory benefit from social assistance effective January 1, 2013 and the revision of the cost sharing formula for discretionary benefits.

1.2 Community Start-Up

The Community Start-Up and Maintenance Benefit is currently a mandatory benefit under social assistance to assist in establishing a new principal residence and prevent eviction or the discontinuance of utilities or heating in an existing residence. CSUMB may also be issued where there is a threat to the health and welfare of a recipient or a member of the family in a non start-up situation. In 2011 the Region issued $2.3M in CSUMB for Ontario Works (OW) participants and their families. This was cost shared with the Province (81.2/18.8) with the Regional share being $0.43M. The Province through the Ontario Disability Support Program (ODSP) issued $2.1M in CSUMB to ODSP participants in the Region of Waterloo in 2011. This was funded 100% by the Province.

The Provincial budget eliminated CSUMB as a mandatory benefit for OW and ODSP participants effective January 1, 2013. As described in Report SS-12-044 (September 25, 2012) 50% of the total Provincial expenditures on CSUMB (both Ontario Works and Ontario Disability) have been invested in the new Community Homelessness Prevention Initiative (CHPI). Funds have been allocated to individual municipalities based on a needs formula. The Region’s allocation is estimated to be less than half of the 2011 expenditures. This is an important consideration as staff has used the CSUMB and discretionary benefits to address the needs of both OW and ODSP participants and so affects
decision making on the Discretionary Benefits program. Social Planning, Policy and Program Administration will present a report to Council on the CHPI once further program details are available from the Province.

### 1.3 Ontario Works Discretionary Benefits

Under the Ontario Works Act, municipalities can provide certain discretionary benefits as approved by the Ontario Works Director to OW and ODSP participants. There are two types: health related and non-health related. In 2011 the Region provided $6.0M in discretionary benefits. Non-health related benefits were cost shared by the Province up to a maximum of $8.75 per case (based on the average monthly OW and ODSP caseload). Total non-health related expenditures for 2011 were $1.8M (2011 Region share $0.34M). Health related discretionary benefits were not capped. Total health related expenditures were $4.2M (2011 Region share $0.79M).

Effective July 1, 2012 discretionary benefits (both health related and non-health related) are cost shared (82.8 Province/17.2 Region) to a maximum of $10 per case per month for the combined average monthly OW, Temporary Care Assistance, ODSP and Assistance for Children with Severe Disabilities caseload. Based on this change the Region expects to receive $3.6M in Provincial subsidy for its 2012 discretionary benefits expenditures, $1.7M less than if no change was made to the cost sharing formula. Any expenditure above the capped amount is the responsibility of the Region. Based upon the 2011 caseload and experience, staff estimated in Report SS-12-019 a shortfall for the remainder of 2012 and a potential annual shortfall of $3.8M in 2013 without any changes to the program. Council approved continuation of the program without change through 2012 with the fiscal shortfall (estimated now at $1.7M) to be funded from year-end surplus. Staff was to return with options for consideration as part of the 2013 Budget process.

### 1.4 Discretionary Benefits Experience

Discretionary Benefits cover a range of services and supports for OW and ODSP participants. They are issued on a case-by-case basis. For the majority of expenditures health and non-health related benefits can be grouped in such broad categories (with 2011 gross expenditures) as:

#### Health Related
- Dental care for adults $1.7M
- Vision care for adults $410,723
- Funerals $368,111
- Orthotics $330,111
- Prescription drugs $186,183
- Heat/hydro/gas/utility connections $165,724
- Mobility aids $76,743
- Emergency response $55,454
- Layettes/baby supplies $18,510
- Other Health* $350,471

*Includes items such as one time mobility aids not captured in other categories, heat/hydro connections, last month’s rent

#### Non-health Related
- Food hampers $770,000
- Travel/transportation $345,489
- Interpreter fees $167,891
- Appliance repair/moving costs $41,936
- Other non-health* $639,309

*Furniture, appliances, mattresses, replacement costs
In reviewing the 2010-2011 Provincial summary of Discretionary Benefit expenditures, the Region of Waterloo has the second highest average monthly cost per case ($26.36) behind Hamilton ($26.60). In looking at the usual comparators, the Region has invested significantly in its Discretionary Benefits Program. Staff has also provided the average among all 47 municipalities delivering Ontario Works.

### 2010-2011 Discretionary Benefits Expenditures

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Average Monthly Cost Per Case ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hamilton</td>
<td>26.60</td>
</tr>
<tr>
<td>Waterloo</td>
<td>26.36</td>
</tr>
<tr>
<td>York</td>
<td>18.07</td>
</tr>
<tr>
<td>Durham</td>
<td>14.32</td>
</tr>
<tr>
<td>London</td>
<td>11.68</td>
</tr>
<tr>
<td>Halton</td>
<td>11.55</td>
</tr>
<tr>
<td>Peel</td>
<td>10.98</td>
</tr>
<tr>
<td>Niagara</td>
<td>5.24</td>
</tr>
<tr>
<td><strong>Average Among Comparators</strong></td>
<td><strong>15.97</strong></td>
</tr>
<tr>
<td><strong>Provincial Average</strong></td>
<td><strong>12.41</strong></td>
</tr>
</tbody>
</table>

In reviewing the information staff do not know whether an individual municipality has used another funding source (such as the CSUMB) as an alternative to discretionary benefits, which would impact the level of support available to a community and provide a more complete picture.

### 2. Community Consultation

#### 2.1 Process

Given the importance and complexity of the program staff established an Advisory Group of community partners, front-line staff and OW and ODSP participants to advise on principles for decision making and a consultation process to assist and inform work on options for future direction. The community partners included the House of Friendship, the Kitchener-Waterloo Multicultural Centre, Woolwich Community Services, the Cambridge Self-Help Food Bank and The Working Centre. The Group met during July and August. A survey of community agencies, front-line staff (both Ontario Works and Ontario Disability Support Program) and social assistance recipients was held during the period of August 27 to September 14, 2012.

The response rate was very positive given the compressed time frame:

- 112 staff from Employment and Income Support
- 151 community agency staff representing such service sectors as housing and shelter programs and services; mental health; food assistance; advocacy; supportive counselling; education; training and employment; health services; immigrant and settlement services
- 388 current and former OW and ODSP participants

In the survey respondents were asked:

- What are the most important benefits?
- What would happen without the benefits?
- Do you agree with the decision making principles?
- If benefits are reduced/eliminated what is the effect on your organization and the health/social services system?

A detailed report of the community consultation and findings is being prepared and will be provided to Council once available.
2.2 Summary of Findings

A consistent theme throughout the responses was to not reduce or eliminate benefits. There was remarkable agreement among the three stakeholder groups as to the top five benefits.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Participants</th>
<th>Community Partners</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Costs</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Last Month’s Rent</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Vision Care</td>
<td>3</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Food Hampers</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Late Payments/Connection Fees</td>
<td>5</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

In reviewing the findings with the community consultation Advisory Group and then the Employment and Income Support Community Advisory Committee, there are several things to bear in mind:

- These represent some of the more costly expenditures (e.g. Dental; Food Hampers; Vision). Conversely when asked what benefits could be eliminated, the least costly were identified by staff and community partners.
- In completing the survey, participants may not have been aware of the elimination of the Community Start-Up Benefit which may have affected their responses.
- Staff identified interpreter services as their sixth priority, a higher ranking than the other respondents. This may reflect the value staff sees in this support in terms of access to service in determining an applicant’s eligibility and explaining a person’s rights and responsibilities. As interpreters are routinely arranged for an interview, participants and community partners may not have seen the need to prioritize.
- The Region has a responsibility to ensure the burial at a minimum of unclaimed bodies and so there will always be a need to consider the funding of funerals in some form. Contracting and funding of funeral services remain unresolved.
- A benefit such as the cost of identification (i.e. replacement of Health Card, Social Insurance) may be very small but critical as a first step in stabilizing the situation of a person.
- Finally, the ability to respond to a special circumstance is important.

2.3 Potential Impact

Participants were very eloquent in describing the impact upon their situation if benefits are reduced or eliminated. Of community partners 90% anticipated an impact upon their organization and 96% anticipated an impact upon the health and social services system if benefits were reduced or eliminated. Participants, for example spoke of the low social assistance rates and so the reliance on such benefits as a necessary supplement for basic needs and health and welfare as well as the assurance of some quality of life. From a broader service system perspective if adult dental costs are reduced it would affect the dental community broadly (and in particular, the two providers who have contracted to offer denture services at Regional rates); the low-income dental clinics provided by Public Health may see increased demand. If food hampers are reduced, this cost would be passed to community partners, who may need to reduce their programs accordingly. Recognizing the elimination of the current Community Start-Up and Maintenance Benefit landlords (including the Region’s Social Housing program) will need to rethink their approach to last month’s rent and the management of arrears. Similarly, utility companies will need to revisit their approach to arrears and cut-offs. Otherwise in these instances vulnerable persons with limited resources may find their housing situation further destabilized.
3. Next Steps

3.1 Principles

The Advisory Group for the community consultation assisted staff in developing a framework for decision making. It included basic principles for setting priorities:

- Basic needs (food and shelter) should be given priority
- An individual’s safety and health should be maintained
- The stabilization of an individual’s circumstances is important
- Discretionary Benefits should allow individuals to move forward with their life
- Discretionary Benefits should promote being part of the community
- Social assistance participants should have easy access to Discretionary Benefits.

As well the Group suggested guidelines for administration such as:

- Use other sources of funding before issuing Discretionary Benefits
- Individuals must meet specific criteria for a benefit
- There must be an ability to meet unique circumstances
- Staff must be accountable to ensure the approval is appropriate and within budget.

3.2 Options

Staff will incorporate the above principles in the administration of the program going forward, which will ensure further integrity in the delivery of Ontario Works Discretionary Benefits. However the general principles do not assist as much in the challenge of prioritizing benefits given the size of the shortfall. Staff has begun to model a number of options. These are by no means recommendations. An important consideration will be the Community Homelessness Prevention Initiative. Staff must align Discretionary Benefits with this program to ensure the reduced funds in both areas are used most effectively to support the vulnerable citizens of the Region given the priorities identified in the survey. Detailed financial implications are provided below.

Option One (Status Quo)
This is the status quo. The Region would continue the current Discretionary Benefits program. The potential annual impact to the property tax levy would be $3.53M. This would be reduced somewhat by applying the suggestions provided by the consultation Advisory Group and the Community Advisory Committee (e.g. development of a more robust database to track expenditures; setting clearer criteria for funding; and changing business practices).

Option Two (Provincial Cap)
The Region would adhere to the cap established by the Province’s cost sharing formula of $10 per case. There would be no impact ($0) upon the levy. To achieve the reduction of $3.5M in total expenditures would require a reduction in the benefits available. Staff would consider a severe reduction or the elimination of significant expenditures such as dental care, food hampers, purchase of furniture and so on. The issuance for travel would be on an emergency basis only. This would also require a capping of items and/or costs in other categories such as funerals, orthotics and a potential requirement for contribution by the recipient. There would be little capacity to address unanticipated pressures as a result of the elimination of the CSUMB (eg., to address hydro cut-off, evictions). With option two staff is considering some form of mitigation strategy which will require one time funds to ease the transition from the current program to its future state.
Option Three (Regional Commitment of Levy)
The Region would approve expenditures beyond the cap at 100% Regional cost. The intent is to balance the principles of basic needs/health and welfare against the feedback to continue all benefits. Option three would see gross expenditures of $3.25M with an impact upon the levy of $0.78M. In both options three and four below, staff is considering no longer funding furniture and mattresses, repairs to appliances and baby supplies. The intent would be to work with community partners to identify alternatives. Dental care for adults would be reduced to pain relief only and the food hamper program would also be impacted. All other areas as in option two would be reviewed to establish caps to bring expenditures within the approved budget.

Option Four (Further Regional Commitment of Levy)
The Region would approve expenditures beyond the cap with an impact upon the levy of $1.5M. Staff is considering no longer funding similar categories as in Option Three (furniture, appliances, baby supplies). Dental care would be reduced as in option three and food hampers could be increased. Travel would be supported on an emergency basis. All other areas would be reviewed to establish caps or ceilings. However, there would be greater flexibility to support participants. The goal would be to identify funds in 2013 to mitigate implementation and also anticipate the impact of the elimination of the CSUMB. This would ensure an enhanced ability to respond to individuals in need and allow adjustments of the program in 2014 on the basis of experience.

3.3 Implementation
Staff has only begun the modelling of options. The above is only preliminary thinking and are not recommendations. Further additional information and detail will be provided during the 2013 Budget process as an issues paper. It is anticipated that staff will need to be flexible as the Discretionary Benefits program transitions to its future state within a compressed timeframe. This will also require a review of such complementary programs as the Waterloo Region Energy Assistance Program. Staff will work with community partners to identify alternatives to support citizens. Whatever option is decided further adjustments are anticipated both in year and certainly for 2014 based upon the 2013 experience.

CORPORATE STRATEGIC PLAN:
The provision of Discretionary Benefits supports the Region’s Corporate 2011-2014 Strategic Plan, Focus Area 4: Healthy and Inclusive Communities; Strategic Objective 4.1 (to) work collaboratively to reduce poverty.

FINANCIAL IMPLICATIONS:
Ontario Works Discretionary Benefits (OWDB) is cost shared with the Province of Ontario. Since July 2012, the Province has capped the amount it will cost share at $10.00 per case per month. As reported in the most recent Periodic Financial Report, it is projected that the Region will contribute an additional $1.7 million for the OWDB program in 2012. Council, at its meeting of May 16, 2012, authorized this additional municipal contribution to be funded by the 2012 Regional Surplus. The OWDB program is part of the Provincial upload and the capped level of expenditures will be fully funded by the Province by 2018. The resulting savings to the Property Tax Levy from the upload have been dedicated by Regional Council to the Region’s Transportation Master Plan (RTMP). Accordingly, these savings have been accounted for and cannot be used as a sustainable funding source to fund an enhanced Regional contribution to the OWDB program. That is, any additional OWDB funding approved by Regional Council will result in an increase in the Regional Property Tax Levy. The 2013 Operating Budget currently before Budget Committee includes a net
levy of $256,898 for the Ontario Works Discretionary Benefits program. In addition to the levy amount, an allocation from the Tax Stabilization Reserve Fund (TSRF) is provided to offset additional Regional costs related to increased caseload resulting from the current economic downturn.

Based on caseload projection provided by the Province of Ontario, the 2013 total spending that the Province will cost share is $2.47M which results in Provincial funding of $2.117M. Should actual caseload vary from the Provincial estimate, the amount that the Province will cost share will change.

The following table summarizes the financial implications of the options presented above on the 2013 Regional Levy as well as the impact if the average cost per case among Regional Comparators were used as the basis for expenditures.

<table>
<thead>
<tr>
<th>Option</th>
<th>$ In 000's</th>
<th>Average Among Comparators</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One</td>
<td>Two</td>
</tr>
<tr>
<td>Expenditures</td>
<td>$ 6,000</td>
<td>$ 2,467</td>
</tr>
<tr>
<td>Provincial Subsidy</td>
<td>2,117</td>
<td>2,117</td>
</tr>
<tr>
<td>Region Share</td>
<td>$3,883</td>
<td>$ 350</td>
</tr>
<tr>
<td>TSRF Funding</td>
<td>93</td>
<td>93</td>
</tr>
<tr>
<td>Regional Property Tax Levy</td>
<td>$3,790</td>
<td>$ 257</td>
</tr>
<tr>
<td>2013 Base Budget Levy</td>
<td>257</td>
<td>257</td>
</tr>
<tr>
<td>Change to 2013 Property Tax Levy</td>
<td>$3,533</td>
<td>$ 0</td>
</tr>
<tr>
<td>% Additional tax levy impact</td>
<td>0.89%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Cost per Case per month</td>
<td>$24.32</td>
<td>$10.00</td>
</tr>
</tbody>
</table>

Option One (Status Quo) would increase the Region’s Property Tax Levy by $3.53M. Option Two (Provincial Cap) would have no impact ($0) on the Region’s 2013 property tax levy. Option Three (Regional Commitment) would increase the property tax levy by $0.78M; Option 4 (Further Regional Commitment) by $1.53M. If the average among comparators is used this would have a $1.47M impact upon the levy.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Staff from Finance and Social Planning, Policy and Program Administration, Social Services has been consulted.

ATTACHMENTS

NIL

PREPARED BY:  David Dirks, Director, Employment and Income Support

APPROVED BY:  Gail Kaufman Carlin, Acting Commissioner, Social Services
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: November 6, 2012    FILE CODE: C06-60

SUBJECT: inREACH COMPREHENSIVE AND INTEGRATED YOUTH GANG PREVENTION STRATEGY OF WATERLOO REGION UPDATE

RECOMMENDATION:

For information

SUMMARY:

This report provides a third update on the inREACH project since receiving funding in September 2009. The purpose of this report is provide a status update on the project. The project has been at full implementation for 13 months and the report will provide an update of project activities and preliminary evaluation findings. The report will also outline the steps being taken to achieve long term sustainability of the project.

REPORT:

1.0 Background

In September 2009, The Waterloo Region Crime Prevention Council (WRCPC) received $3.8 million from the National Crime Prevention Centre (NCPC), a branch of Public Safety Canada, to implement a multi sector, community-based street gang prevention and intervention project. The overall goals of the project are twofold, to assist youth in effectively exiting gangs and to prevent youth from entering gangs. Since the last report to Committee in February, 2012 (CPC-12-001) inREACH continues to make inroads in the community by working with the target youth population and by collaborating with neighborhood identified through research. The project has grown in terms of the increased number of youth participants as well as the number of initiatives throughout the community that are facilitated by inREACH.

inREACH is a collaborative, multi-sector initiative. Current project partners include:

- John Howard Society of Waterloo Wellington
- Lutherwood
- Reaching Our Outdoor Friends (ROOF)
- St. Mary’s Counselling
- Waterloo Regional Police Service
- Mosaic Counselling and Family Services
- House of Friendship
- Kinbridge Community Association
- Preston Heights Community Group


In addition, inREACH has Memorandums of Understanding with the Waterloo Catholic District School Board and the Waterloo Region District School Board.

2.0 The Project

The project is comprised of three phases: community needs assessment; community treatment; and community mobilization. The Community Assessment was completed in the spring of 2010 and informed the next two phases of the project, Community Treatment and Community Mobilization. Below is brief summary of the Community Treatment and Community Mobilization phases and some of the activities/initiatives that have been implemented.

Community Treatment:

Community treatment began upon approval of a detailed work plan by NCPC in November 2010 and involves providing support to 60 youth per year, ages 13-24, and their families in Waterloo Region who are actively involved in, associated with or at risk of joining a gang. To participate in this phase, a thorough screening, intake and assessment is completed for each youth to ensure the project is working with the youth most at risk of gang involvement. inREACH staff develop individual case plans to best meet youth’s needs and provide one-on-one counselling, group therapeutic interventions, housing and employment support, addictions counselling and recreation activities. inREACH main office is located at 450 Frederick Street. Group programming and individual counseling sessions occur at the office. However, the staff are also mobile and meet with youth in various community settings. Referrals can be made by parents, service agencies, schools and the youth themselves.

In addition to the supports provided to youth program participants, the Community Treatment Team also provides supports to parents/caregivers in the form of community referrals and information groups. Areas of discussion typically are around issues relating to substance use, mental health and the cognitive development of the adolescent brain. The purpose of these groups is to increase the knowledge and capacity of the parents/caregivers to support and work with their children.

The following statistics describe some of the activities of inREACH for the program year 2012/2013:

- 35 Program Participants
- 19 referrals currently being processed to determine eligibility for inREACH
- Average age of participant is 18 years
- Average length of stay in program 42 weeks
- 60% of program participants have addictions issues
- 40% of program participants are known to the police
- 20% are confirmed youth gang members

Since November 2010, the Community Treatment Phase has received over 200 referrals, which demonstrates that there is a need for a program such as inREACH and there is community buy-in for the supports that inREACH provides. The two main referral sources are from the school boards and self referrals. Because of the high intensity and complex needs presented by youth in the program, the best way to support this youth population is with 1-on-1 intensive case management. 85% of Community Treatment program participants are receiving individualized counseling and support. Additionally, inREACH staff engage in significant advocacy efforts to affect system and policy changes, which long term, lead to the community being better equipped to deal with the complex task of youth gang prevention.
The treatment team has 5 staff dedicated to it and these include: a concurrent disorder clinician from St. Mary’s Counselling Services, an employment consultant and a mental health clinician from Lutherwood, a Case Manager from John Howard Society, one full-time Street Outreach Worker from ROOF.

**Phase 3: Community Mobilization**

Using the results from the community assessment phase along with a community consultation, five neighbourhoods in the Region were selected to receive a Youth Outreach Worker (YOW). In addition to the primary research, “A Community Fit for Children” (2009) report, indicates that each of these neighbourhoods ranked in the bottom one-third of the 45 neighbourhoods in Waterloo Region on the following indicators:

- Low-income families;
- Single-parent families;
- Adults without high school education;
- Recent immigrants;
- English as a second language.

As this phase is about community capacity building, inREACH chose to partner with community organizations that already have strong connections in these communities. The YOWs are located directly in the neighbourhoods, in community centres, so they can become familiar to the community and so the youth know where they can be reached. Below is a list of the neighbourhoods and corresponding organizations:

**Kitchener**
- Paulander (Mosaic Counselling and Family Services)
- Greenfield (House of Friendship)
- Courtland-Shelley (House of Friendship)

**Cambridge**
- Preston Heights/Preston (Preston Heights Community Group)
- Southwood/Christopher-Champlain (Kinbridge Community Association)

Since the last report, inREACH has stopped working directly in the Greenfield community for a host of reasons, such as, some youth having access to recreational opportunities already provided in the community and a low number of youth program participants.

The purpose of the Community Mobilization phase is to engage youth in positive relationships and to provide opportunities, such as mentoring and recreation, in their community. This is a strengths-based approach which seeks to identify youths’ interests, abilities and talents that help prevent them from trending towards joining a gang.

This phase of the project began in October 2011 and since that time the YOWs have been building relationships with and engaging youth in their communities. There were no predetermined programs or activities to be implemented in the neighbourhoods; instead, the ideas for programs and opportunities come from the youth.

This engagement approach is a key strategic method for reaching high risk populations.
The core programming that has been developed with the youth in the various neighbourhoods include:

- Girls’ Group (this is for young females aged 12-17 and focuses on topics such as healthy body image, mental health/well being, stress reduction, safety 101, etc)
- Boys’ Group (this is for young males aged 12-17 and provides the youth with the opportunity to develop and implement short-term projects that meet the youths' interests and helps to build leadership capacity e.g., graffiti mural, cooking class, etc)
- Boxing
- Art Studio
- Homework Club
- Drop ins
- Basketball

At each of the four Community Mobilization program sites, there are on average 17 program participants at each site, which equals 68 program participants in total for the Community Mobilization Phase at any one time.

In addition to the regular programs, below is a list of youth led initiatives that happened thus far as a direct result of their regular participation in their neighbourhood-based programs:

- A week long Art Exhibit at the Cambridge Galleries which showcased the art the youth had created during their weekly Art Studio at the Allen Reuter Centre
- A meeting with the Mayor of Kitchener to share their experiences in their neighbourhood and with the inREACH project
- Working with City of Kitchener staff to get a local basketball court refurbished

**Project Advisory Committee (PAC)**

An advisory committee supports the work of inREACH with the purpose of providing a consultative forum to effectively address issues arising as a result of the delivery of inREACH as well as exploring opportunities for sustainability, through community and systems changes that go beyond the time period for which funding has been secured. The PAC provides recommendations for policy changes to increase the capacity of the community and its organizations to reduce and prevent street gang related crimes during and after the project. The PAC is comprised of representatives from numerous sectors including: Family and Children’s Services; Waterloo Region District School Board; Waterloo Catholic District School Board; Probation; Community Arts; Crown Attorney’s Office; Waterloo Regional Police Service; Neighbourhoods; the Working Centre.

**Evaluation**

Two evaluations are associated with inREACH: an impact evaluation and a process and monitoring evaluation. The impact evaluation which was provided through a consultant was discontinued by NCPC in January 2012 because the evaluation framework was not deemed to be feasible. The contract for the process and monitoring evaluation rests with the WRCPC and more recently has been awarded to a locally-based evaluator. Results from this evaluation are expected to inform the knowledge base for how to work with gang involved youth through the Office of the Juvenile Justice and Delinquency Prevention (OJJDP) model, in the Canadian context. Results will also be used to inform sustainability efforts within the local community.
A robust and comprehensive Process and Monitoring Evaluation report will be completed in June 2013. The bulk of the data collection through case file reviews and key informant interviews with project partners, staff and youth program participants will begin in January of 2013. The Evaluation team has provided some preliminary data results from both phases of the project. All of the data collected to date would suggest that inREACH is working with the target youth population, in the correct neighborhoods and using the correct supports and youth engagement strategies to intervene in and prevent youth gang involvement.

Preliminary Evaluation Results

Community Treatment Phase:

Based on case review, the characteristics of the client group served to date appear consistent with inREACH’s target group:

- The average age of our participants is 18.3, well within the program parameters of 13 to 24. As more than one-half (54.3%) of the participants are under the age 18, it suggests that there are substantial crime prevention benefits associated with the program, because of reaching youth before they enter the adult criminal justice system.
- Of the 35 current youth, 7 are confirmed as currently or formerly gang involved (20.0%) with another 2 being suspected of being gang involved (5.7%). Further, 14 of the 35 youth are known to police.
- More than one-half (60.0%) have addictions, and of those, more than 75% have severe addiction issues. These addictions place youth at higher risk of criminal behaviour and gang involvement, since participation in gangs and the illicit drug trade is one way in which personal consumption habits can be maintained.
- Consistent with previous reports, many clients are from challenging home circumstances characterized by one or several risk factors including poverty, single parenthood, absence of positive male role model, residency in a high risk community where gangs are active/drugs are available, etc.
- Many have significant personal risk factors including but not limited to challenges with behavioral regulation (easily frustrated, anger management challenges), poor self-esteem, previous emotional or physical trauma, lack of connection to school, etc. Several youth are dealing with issues related to addictions and concurrent disorders featuring a combination of addictions and mental health considerations including FASD, PTSD, anxiety disorders, attachment disorders and depression.
- Consistent with the research, many clients have negative peer relationships including those with criminally or gang-involved youth, which increase risks accordingly.
- Many clients are disengaged from most if not all pro-social institutions including school and work.

Community Mobilization Phase

- **Relationship Building is central in this approach. There is a need to “meet them where they’re at”.** The success of the mobilization phase was not just about providing programs, but about building trust and engaging those who are hard to engage.
- **A collaborative approach is critical because it produces collective impact.** Collaboration occurred between inREACH and its program partners, as well as between the mobilization team and the treatment team of inREACH. Key informants recognized that the program would not have worked without all the partners.
• **Flexibility is essential all levels.** Flexibility was considered essential by staff and was cited as one of the challenges as well as one of the strengths of the project. Flexibility in approach was evident in the work of the YOWs, as all neighborhoods took a different path. Community centre and agency partners also affirmed the need to be flexible in policy and practice and a willingness to try something new.

• Key informants noted that youth were spending more time in the community centre (many had never been there previously), more young people going to rehab, keeping youth off the streets, giving them “something to look forward to”, providing a “safe space”, and “… people to talk to”.

• Programs and beyond: Many highly successful and well attended programs were developed in partnership with youth. However, beyond the program activities themselves, youth development activities and supports occurred within and outside of programs including:
  • Connecting to resources / opportunities in community (e.g., using YMCA facilities)
  • Expanding horizons – facilitating experiences and exposure outside the neighbourhood such as attending a diversity event at City Hall
  • Mentoring
  • Getting help (with a job, a dream, overcoming an addiction, school work)
  • Civic engagement (such as organizing a community clean-ups)

3.0 Challenges

The most immediate issue that inREACH is facing is developing a long term sustainability strategy for the project. There are a number of reasons why this is a challenge. The biggest issue is that there is no level of government or funding body that provides long term core funding for comprehensive youth gang prevention.

Many of the funding opportunities that are available in the community will fund singular activities such as, youth drop in, a substance use group, employment support or access to recreational programs. The evaluation however shows that comprehensive and integrated community collaboration are ideally placed to meet and address the complex needs of this youth population and are the most effective means to youth gang intervention/prevention. However most funding tends to be short term and pilot project based.

4.0 Future Directions

As of March 31st 2013, the Contribution Agreement with NCPC will expire. NCPC has made it clear that they will not be able to provide a project extension for two main reasons: (1) NCPC has experienced a significant cut to their budget; (2) NCPC funding is committed to future approved projects, including funds lapsed by current projects.

inREACH is currently developing a strategic approach to creating a long term sustainability plan. Which includes:

• Mobilizing the local funding community to support inREACH
• Looking to transition inREACH to a community partner
• Meeting with local area MP’s to put the issue of youth gangs and youth gang prevention on their ‘radar’
• Leveraging inkind and financial resources from current project partners to keep inREACH going.
Without a significant commitment from several sources the project has created successful opportunity for prevention that will cease to exist in March 2013. Staff in the project are thus involved with three conflicting directions at the present time:

1. Engaging in project closure
2. Seeking sustainability options
3. Considering whether minimal funding opportunities merit any consideration.

CORPORATE STRATEGIC PLAN:

Healthy and Inclusive Communities: Enhance community safety and crime prevention.

FINANCIAL IMPLICATIONS:

inREACH is 100% funded through a federal Contribution Agreement with Public Safety Canada. This agreement ends March 31st 2013. One time funding for 2013 is the subject of a budget issue paper that will be part of the 2013 budget package. The ask comprises a significantly reduced annual budget pro-rated to 9 months. At $450,000 the budget can both sustain as close to current service levels as possible while finalizing the evaluation and seeking out other resources for the future. Efforts to find funding and resources through opportunities outside the Region of Waterloo budget continue at time of report and might lead to the ask being significantly reduced by time of budget deliberations.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

inREACH has benefitted greatly from support from IT, Facilities Management, Legal Services, Finance and Waterloo Region Housing. In-kind contributions generated through the WRCPC staff and volunteers compensated at 12.6% of actual resources provided, as much as possible have been used to offset costs to these departments over and above the 12.6% administration support through the contribution agreement from NCPC.

ATTACHMENTS: (4)

1. Street Gangs and Crime, Research and Planning (RAP) factsheet
2. Booklet: inREACH…Our Story So Far
3. DVD
4. Letter from an inREACH youth

* The above-noted attachments are distributed separately from the report.

PREPARED BY: Rohan Thompson, Project Manager, inREACH

APPROVED BY: Christiane Sadeler, Executive Director, WRCPC
Why Do Youth Join Gangs?

A Waterloo Region Crime Prevention Council survey of people who were at one time involved in a gang suggests that boredom is the number one reason youth first engage in gang activity. Youth join gangs for a variety of reasons. Some seek excitement; others are looking for prestige, protection, a chance to make money or a sense of belonging (Public Safety Canada, 2007).

What is a Street Gang?

A street gang is a group of three or more persons, formally or informally organized, that have a common name or identifying sign or symbol and form an alliance for a common criminal purpose. These members individually or collectively engage in, or have engaged in patterns of criminal behaviour, creating an atmosphere of fear and intimidation within the community. These groups may constitute a criminal organization as defined in the criminal code of Canada.

A survey of Canadian police officers suggests that the majority of gang members are male (94%) and almost half are under the age of 18 (48%).

Street gangs are most likely to commit crimes of assault, drug trafficking, or vandalism.

How Many Gangs Exist?

There is an estimated 434 youth gangs in Canada, made up of more than 7,000 members. The highest number of youth gang members is found in Ontario, where more than 3,300 youth are suspected of engaging in gang activity. According to Waterloo Regional Police Services, there are currently 25 gangs in Waterloo Region with a combined membership of about 340 (Waterloo Region Record, July 2012).

Why Do Youth Join Gangs?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boredom</td>
<td>91.3%</td>
</tr>
<tr>
<td>Family dysfunction</td>
<td>87%</td>
</tr>
<tr>
<td>Family/friends in gangs</td>
<td>87%</td>
</tr>
<tr>
<td>Lack of a sense of belonging</td>
<td>87%</td>
</tr>
<tr>
<td>Poverty</td>
<td>78.3%</td>
</tr>
<tr>
<td>Power seeking</td>
<td>73.9%</td>
</tr>
<tr>
<td>Addictions</td>
<td>73.9%</td>
</tr>
<tr>
<td>Lack of job opportunities</td>
<td>69.6%</td>
</tr>
<tr>
<td>Educational challenges</td>
<td>65.2%</td>
</tr>
<tr>
<td>Labelling</td>
<td>65.2%</td>
</tr>
</tbody>
</table>

A Waterloo Region Crime Prevention Council survey of people who were at one time involved in a gang suggests that boredom is the number one reason youth first engage in gang activity.

Youth join gangs for a variety of reasons. Some seek excitement; others are looking for prestige, protection, a chance to make money or a sense of belonging (Public Safety Canada, 2007).
The most prevalent risk factors for youth gang involvement include:
- Limited attachment to community
- A mostly unmet need for belonging & recognition
- Poor parental supervision
- Over-reliance on anti-social peers
- Problematic alcohol & drug use
- Poor educational or employment opportunities or potential

Research suggests that youth are 2 to 4 times more likely to join gangs if they are affected by these factors. The more risk factors a youth faces, the more likely they are to join a gang.

“Several studies indicate that risk factors associated with gang involvement are present long before a youth joins a gang.”

(Public Safety Canada, 2007)

Just the Facts

FACT: Youth crime is not on the rise.
The youth crime rate has been generally declining over the past decade. The 2010 youth crime rate fell 7% from the year before and was 11% lower than a decade ago (Statistics Canada, Police reported crime statistics in Canada, 2010).

FACT: A small percentage of young people are responsible for a high percentage of criminal incidents.
A Canadian study found that 16% of alleged young offenders who were classified as chronic offenders were responsible for 58% of all alleged criminal incidents (Public Safety Canada, 2007).

FACT: One positive relationship with an adult can make a difference.
According to the Department of Justice (2008), having positive relationships such as mentors, positive social environments through community and family, and having social and economic policies that support positive youth development will prevent many youth from becoming involved in gangs.
REGION OF WATERLOO
PUBLIC HEALTH
Epidemiology & Health Analytics

TO: Chair Sean Strickland and Members of the Community Services Committee
DATE: November 6, 2012
FILE CODE: P20-80
SUBJECT: INFECTIOUS DISEASES IN WATERLOO REGION — SURVEILLANCE REPORT 2006-2011

RECOMMENDATION:
For information

SUMMARY:
Infectious diseases are illnesses caused by microorganisms, such as bacteria, viruses and parasites, which may cause serious illness or be transmitted to large numbers of individuals. As per Ontario’s Health Protection and Promotion Act (HPPA), a number of diseases must be reported to local public health units. This CSC Report presents highlights from the monitoring of reportable infectious diseases from 2006 to 2011.

Between 2006 and 2011, there were a total of 13,448 cases of reportable infectious diseases in Waterloo Region. The top five diseases reported were chlamydia, influenza, campylobacteriosis, gonorrhea, and hepatitis C, which accounted for 78.5 per cent of all cases (refer to Appendix A for a list of the number and proportion of all reportable diseases in Waterloo Region). Overall, rates of most reportable diseases in Waterloo Region were consistent with or lower than the provincial rates, while some disease rates were higher than the provincial average. Some variation occurs naturally, as disease rates are not expected to be uniform across populations; however, some of the variation could be due to differences in modifiable risk factors or risk behaviours, and it would be important to focus interventions on these where possible.

Public Health undertakes a number of activities to prevent or minimize the occurrence and spread of infectious diseases. This is in keeping with the Ontario Public Health Standards which establish requirements for fundamental public health programs and services in the Province.

The following are some examples of initiatives undertaken in the past year in response to infectious disease trends:

- Working with community partners to implement Waterloo Region’s Sexual Health Youth Strategy (refer to Report PH-12-017). This newly developed strategy (summer 2012) is a coordinated effort that will work to reduce the incidence of sexually transmitted infections such as chlamydia, which accounts for the largest proportion (47.7 per cent) of all reportable diseases. The increase in Waterloo Region mirrors that which is occurring across Ontario as well as Canada, affecting in particular those 15-24 years of age. The continuing rise in chlamydia rates is a challenge experienced by jurisdictions across Canada. Given the contributing factors behind acquisition (e.g. personal skill development, sexual health education, parenting) there is no single or easily implemented intervention that authorities can use to reduce incidence rates. As a result, the youth strategy is multi-faceted and seeks to engage other orders of government. The local strategy will be evaluated and results will be reported to the Board of Health.
Developing a strategy, in collaboration with community partners, focused on harm reduction programming (as per action item 4.2.1 in the Corporate Strategic Plan). Harm reduction strategies are the most effective interventions available for reducing the burden of blood borne infections, including hepatitis B, hepatitis C and HIV.

Partnering with the Well Aware Program offered by Green Communities Canada in 2012 to educate well owners on how to keep their water safe. Region of Waterloo Public in partnership with The Public Health Agency of Canada through the C-Enternet initiative examined risk factors for cryptosporidiosis, giardiasis and verotoxin producing E. coli (VTEC) in Waterloo Region. Findings suggest that, in addition to established risk factors such as consuming undercooked ground beef for verotoxin producing E. coli (VTEC) and swimming in an untreated water source (e.g. river, lake or stream) for cryptosporidiosis and giardiasis, those living on a farm or rural property can also be at increased risk for these illnesses. The literature suggests that this would be due to their proximity to agricultural processes and livestock operations (e.g. land where manure has recently been applied). By extension, if their primary water source is groundwater from a private well, it may also be at increased risk from run-off or surface water contamination if it is not at an appropriate depth, was not properly constructed or has degraded over time. This underscores the importance of regular testing of private wells by their owners to ensure safe drinking water.

Increasing efforts to improve uptake of immunizations. As an example, an analysis of local cases of invasive pneumococcal disease revealed many cases who would have qualified for publicly-funded vaccine were not immunized. This was raised with community physicians in an effort to decrease lost opportunities for prevention.

REPORT:

Background
Infectious diseases are illnesses caused by microorganisms, such as bacteria, viruses and parasites, which may cause serious illness or be transmitted to large numbers of individuals. Under provincial law, certain cases of communicable diseases, as designated in Ontario’s Health Protection and Promotion Act (HPPA), must be reported to local public health units.

The full technical report, Infectious Diseases in Waterloo Region — Surveillance Report 2006-2011 (electronic link available in the Attachments section) presents Waterloo Region’s rates of reportable diseases between 2006 and 2011 and provides a provincial comparison of rates. The report is organized into a series of summaries for diseases which had five or more reported cases during the six year study period.

Key Findings
Between 2006 and 2011, there were a total of 13,448 cases of infectious disease and the top five diseases - chlamydia, influenza, campylobacteriosis, gonorrhea, and hepatitis C - accounted for 78.5 per cent of all cases, with chlamydia accounting for the largest proportion of the cases at 47.7 per cent. Overall, rates of most reportable diseases in Waterloo Region were consistent with or lower than the provincial rates, while some disease rates were higher than the provincial average. Some variation occurs naturally, as disease rates are not expected to be uniform across populations; however some of the variation could be due to differences in modifiable risk factors or risk behaviours, and it would be important to focus interventions on these where possible.
For all **sexually transmitted and blood-borne infections**, chlamydia, gonorrhea, and hepatitis C accounted for 95.9 per cent of cases. This is similar to the ranking and proportion (92.6 per cent) of these diseases provincially. Known risk factors for chlamydia (2009-2011) included lack of condom use (63.3 per cent of risk factors) and having more than one sexual contact in the last six months (13.4 per cent of risk factors). Females account for the majority of chlamydia cases.

Among **enteric diseases** (diseases that give rise to intestinal symptoms), campylobacteriosis, salmonellosis, and giardiasis accounted for 77.9 per cent of cases. This is also similar to the ranking and proportion (78.3 per cent) of these diseases provincially. Travel represents a significant risk factor for enteric illnesses, as 28.9 per cent of all reported enteric diseases were associated with travel outside of Canada.

For **vaccine preventable diseases**, influenza, invasive pneumococcal disease (IPD), and pertussis (whooping cough) accounted for almost all reported cases both locally and provincially. Of these, influenza accounted for 77.4 per cent. Most reported cases in this disease category, especially influenza, occurred in very young children under four years of age or in adults 65 years of age and older; however, greater detection in these age groups may be the result of being tested more often. In 2011, among cases of invasive pneumococcal disease in Waterloo Region whose immunization history was collected, 65 per cent of high risk cases eligible for publicly-funded vaccine were not immunized, representing lost opportunities for prevention.

Of the **vector-borne and zoonotic disease cases**, there were 34 cases of malaria, 15 cases of Lyme disease (14 of which were acquired outside the Region), and one case of West Nile Virus. Locally and provincially, there were no human cases of rabies during the study period.

In terms of **other infectious diseases**, the most significant risk factor for tuberculosis in Waterloo Region was having lived in an endemic area. Similar to Canadian data, the incidence rates of tuberculosis were highest among younger adults (20-29 years). A full report on Region of Waterloo Public Health’s tuberculosis programming and local disease rates was recently presented to Community Services Committee (see Report PH-12-045). Invasive Group A streptococcal disease can sometimes lead to severe complications such as necrotizing faciitis. It was most common in adults over the age of 30, and the most frequently reported risk factors were chronic illness, being immunocompromised, and illicit drug use.

There were a total of 515 **outbreaks** in Waterloo Region between 2006 and 2011: 378 were enteric (mostly occurring in child care centres) and 137 were respiratory (mostly occurring in long-term care and retirement homes). Of the respiratory outbreaks, 44 were influenza-related. All types of outbreaks peaked in the winter months between December and March.

**Region of Waterloo Public Health Disease Prevention Programming**

As communicable diseases may cause serious illness and can have community wide implications, Public Health undertakes a number of activities to prevent or minimize their occurrence and spread. This is in keeping with the Ontario Public Health Standards which establish requirements for fundamental public health programs and services in the Province. Specifically, the Infectious Diseases Program Standards and Environmental Health Program Standards require the Board of Health, through its programs, to prevent or reduce the burden of infectious diseases of public health importance.

---

2 The Infectious Diseases Program Standards include requirements for: Infectious Diseases and Prevention Control, Rabies Prevention and Control, Sexual Health, Sexually Transmitted Infections, and Blood-borne Infections, Tuberculosis Prevention and Control, and Vaccine Preventable Diseases.
3 The Environmental Health Program Standards include requirements for: Food Safety and Safe Water.
To meet its mandate under the Ontario Public Health Standards, the health unit undertakes a number of activities. Examples of initiatives or programs that work to prevent or reduce the burden of communicable diseases include, but are not limited to:

- Partnering with seven community stakeholders to develop and implement a Sexual Health Youth Strategy for Waterloo Region (refer to Report PH-12-027). One of the main objectives of the strategy is to encourage healthy sexual practices among youth in Waterloo Region, including a reduction in the number of sexually transmitted infections. The continuing rise in chlamydia rates is a challenge experienced by jurisdictions across Canada. Given the contributing factors behind acquisition (e.g. personal skill development, sexual health education, parenting) there is no single or easily implemented intervention that authorities can use to reduce incidence rates. As a result, this newly developed youth strategy is multi-faceted and seeks to engage other orders of government. The local strategy will be evaluated and results will be reported to the Board of Health.

- Developing a strategy, in collaboration with community partners, focused on harm reduction programming (as per action item 4.2.1 in the Corporate Strategic Plan). Harm reduction strategies are the most effective interventions available for reducing the burden of blood borne infections, including hepatitis B, hepatitis C and HIV.

- Partnering with the Well Aware Program offered by Green Communities Canada in 2012 to educate well owners on how to keep their water safe. Region of Waterloo Public in partnership with The Public Health Agency of Canada through the C-Enternet initiative examined risk factors for cryptosporidiosis, giardiasis and verotoxin producing E. coli (VTEC) in Waterloo Region. Findings suggest that, in addition to established risk factors such as consuming undercooked ground beef for verotoxin producing E. coli (VTEC) and swimming in an untreated water source (e.g. river, lake or stream) for cryptosporidiosis and giardiasis, those living on a farm or rural property can also be at increased to these illnesses. The literature suggests that this would be due to their proximity to agricultural processes and livestock operations (e.g. land where manure has recently been applied). By extension, if their primary water source is groundwater from a private well, it may also be at increased risk from run-off or surface water contamination if it is not at an appropriate depth, was not properly constructed or has degraded over time. This underscores the importance of regular testing of private wells by their owners to ensure safe drinking water. Public Health supports private well owners by providing access to well-water testing through water sample bottle pick-up and drop-off, and assistance in the interpretation of results.

- Increasing efforts to improve uptake of immunizations. As an example, an analysis of local cases of invasive pneumococcal disease revealed many cases who would have qualified for publicly-funded vaccine were not immunized. This was raised with community physicians in an effort to decrease lost opportunities for prevention. In addition, Public Health regularly distributes vaccine to primary care providers and also offers community flu clinics to increase the public’s access to influenza vaccine (refer to Report PH-12-046 for an update on the 2012-2013 influenza season preparations)

- Implementing annual activities to prevent or reduce the number of West Nile virus and Lyme cases. This includes:
  - Routine monitoring and surveillance (adult mosquito trapping and testing for West Nile virus and active tick dragging for Lyme at a variety of locations throughout the region)
  - Implementing vector control measures where appropriate (e.g. larviciding for West Nile virus)
Raising awareness on ways the public can reduce their risk of West Nile virus and Lyme disease

- Investigating all reported cases of animal bites to determine the appropriate action to reduce the human risk of acquiring rabies. Public Health also enforces the requirement to immunize dogs and cats over the age of three months.

- Offering both case management and clinical activities to prevent or reduce infectious diseases such as tuberculosis.

- Performing routine food premise, recreational water and personal service setting (e.g. tattoo parlour) inspections to prevent the occurrence or transmission of infectious diseases.

- Investigating all enteric and respiratory outbreaks reported by child care centres, hospitals, long-term care homes and retirement homes. The health unit supports these providers in investigating the source of the outbreak and implementing appropriate infection prevention and control practices to minimize the spread of illness. In addition, a number of health promotion activities, including our bi-annual Long-Term Care forum and annual Child Care Forum, are targeted to these partners to enhance/maintain their infection prevention and control knowledge and skills.

Conclusion
As communicable diseases may cause serious illness and can have community wide implications, Public Health undertakes a number of activities to prevent or reduce the burden of infectious diseases in the community. These include follow-up of all reportable cases, their contacts and/or outbreaks of infectious diseases; prevention activities such as food premise, recreational water and personal service setting (e.g. tattoo parlour) inspections; immunization programs; health promotion activities targeting the general public as well as more vulnerable group settings (long-term care homes, hospitals, daycares); West Nile virus, Lyme disease and Rabies prevention and control programs; surveillance (monitoring) of disease rates and reporting on disease incidence in the community.

The Infectious Diseases in Waterloo Region - Surveillance Report 2006-2011 helps to fulfill Region of Waterloo Public Health’s mandate for disease surveillance and reporting in accordance with the Ontario Public Health Standards. This report builds on previous reports and will be part of an ongoing series of annual reports which will monitor infectious disease activity in Waterloo Region. This series of annual reports will contribute to ongoing and enhanced disease surveillance as well as updates to the community on the local status of infectious diseases of public health importance. As illustrated in this report, the findings and trends from these reports also help to inform and improve public health programming.

ONTARIO PUBLIC HEALTH STANDARDS:

Infectious Diseases Program Standards, Environmental Health Program Standards, Foundational Standards of Surveillance and Population Health Assessment.

CORPORATE STRATEGIC PLAN:

This report relates to Focus Area 4: Healthy and Inclusive Communities: Foster healthy, safe, inclusive and caring communities in the 2011-2014 Corporate Strategic Plan.
FINANCIAL IMPLICATIONS:

NIL

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

NIL

ATTACHMENTS:

Attachment A: Number and proportion of all reportable diseases (with one or more cases reported), Waterloo Region, 2006-2011


PREPARED BY: Asma Razzaq, Epidemiologist
Janelle Witzel, Public Health Planner, Health Protection and Investigation
Chris Harold, Manager, Information and Planning, Infectious Diseases, Dental & Sexual Health
Dr. Hsiu-Li Wang, Associate Medical Officer of Health

APPROVED BY: Dr. Liana Nolan, Commissioner/Medical Officer of Health
Attachment A
Number and proportion of all reportable diseases, Waterloo Region, 2006-2011 combined

<table>
<thead>
<tr>
<th>Rank</th>
<th>Disease</th>
<th>Number</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chlamydia</td>
<td>6,414</td>
<td>47.7</td>
</tr>
<tr>
<td>2</td>
<td>Influenza*</td>
<td>1,685</td>
<td>12.5</td>
</tr>
<tr>
<td>3</td>
<td>Campylobacteriosis</td>
<td>923</td>
<td>6.9</td>
</tr>
<tr>
<td>4</td>
<td>Gonorrhea</td>
<td>762</td>
<td>5.7</td>
</tr>
<tr>
<td>5</td>
<td>Hepatitis C</td>
<td>760</td>
<td>5.7</td>
</tr>
<tr>
<td>6</td>
<td>Salmonellosis</td>
<td>680</td>
<td>5.1</td>
</tr>
<tr>
<td>7</td>
<td>Giardiasis</td>
<td>412</td>
<td>3.1</td>
</tr>
<tr>
<td>8</td>
<td>Invasive Pneumococcal Disease (IPD)</td>
<td>345</td>
<td>2.6</td>
</tr>
<tr>
<td>9</td>
<td>Syphilis^</td>
<td>201</td>
<td>1.5</td>
</tr>
<tr>
<td>10</td>
<td>Amebiasis</td>
<td>151</td>
<td>1.1</td>
</tr>
<tr>
<td>11</td>
<td>Group A Streptococcal disease (iGAS)</td>
<td>142</td>
<td>1.1</td>
</tr>
<tr>
<td>12</td>
<td>Cryptosporidiosis</td>
<td>123</td>
<td>0.9</td>
</tr>
<tr>
<td>13</td>
<td>Pertussis</td>
<td>101</td>
<td>0.8</td>
</tr>
<tr>
<td>14</td>
<td>Verotoxin producing <em>Escherichia coli</em> (VTEC)</td>
<td>101</td>
<td>0.8</td>
</tr>
<tr>
<td>15</td>
<td>Human Immunodeficiency Virus (HIV)</td>
<td>97</td>
<td>0.7</td>
</tr>
<tr>
<td>16</td>
<td>Encephalitis/Meningitis</td>
<td>92</td>
<td>0.7</td>
</tr>
<tr>
<td>17</td>
<td>Tuberculosis (TB)</td>
<td>85</td>
<td>0.6</td>
</tr>
<tr>
<td>18</td>
<td>Yersinia</td>
<td>71</td>
<td>0.5</td>
</tr>
<tr>
<td>19</td>
<td>Hepatitis A</td>
<td>36</td>
<td>0.3</td>
</tr>
<tr>
<td>20</td>
<td>Malaria</td>
<td>34</td>
<td>0.3</td>
</tr>
<tr>
<td>21</td>
<td>Hepatitis B</td>
<td>32</td>
<td>0.2</td>
</tr>
<tr>
<td>22</td>
<td>Typhoid/Paratyphoid fever</td>
<td>24</td>
<td>0.2</td>
</tr>
<tr>
<td>23</td>
<td>Invasive Meningococcal Disease (IMD)</td>
<td>22</td>
<td>0.2</td>
</tr>
<tr>
<td>24</td>
<td>Legionellosis</td>
<td>22</td>
<td>0.2</td>
</tr>
<tr>
<td>25</td>
<td>Mumps</td>
<td>19</td>
<td>0.1</td>
</tr>
<tr>
<td>26</td>
<td>Lyme disease</td>
<td>15</td>
<td>0.1</td>
</tr>
<tr>
<td>27</td>
<td>Cyclosporidiosis</td>
<td>13</td>
<td>0.1</td>
</tr>
<tr>
<td>28</td>
<td>Group B streptococcal disease (neonatal)</td>
<td>10</td>
<td>0.1</td>
</tr>
<tr>
<td>29</td>
<td>Acquired Immunodeficiency Syndrome</td>
<td>6</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>30</td>
<td>Cytomegalovirus, congenital</td>
<td>&lt;5</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>31</td>
<td>Neurosyphilis</td>
<td>&lt;5</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>32</td>
<td>Brucellosis</td>
<td>&lt;5</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>33</td>
<td>Herpes, neonatal</td>
<td>&lt;5</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>34</td>
<td>Haemophilus influenza B (HiB)</td>
<td>&lt;5</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>35</td>
<td>Ophthalmia neonatorum</td>
<td>&lt;5</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>36</td>
<td>Q fever</td>
<td>&lt;5</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>37</td>
<td>West Nile Virus</td>
<td>&lt;5</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>13,448</strong></td>
<td>100</td>
</tr>
</tbody>
</table>

*Influenza data is from the 2004-05 season to the 2011-12 season (September 1, 2004 to May 31, 2012)
^ Includes infectious, non-infectious and unspecified cases of syphilis
Source: iPHIS 2006-2011, MOHLTC, extracted May 22nd and June 5th, 2012
October 24, 2012

Commissioners Vision for Social Assistance Reform includes key role for CMSMs and DSSABS

After almost two years, Commissioners Francis Lankin and Munir Sheikh, delivered today their best advice to the Government of Ontario on how to reform Ontario’s social assistance system. Brighter Prospects: Transforming Social Assistance in Ontario, is a far reaching report containing 108 recommendations that provide the framework to transform Ontario’s social assistance system.

Important to OMSSA members, the report lands squarely on local integrated service system management as a foundation to support and drive the new system envisioned by the Commissioners.

High level points of interest to OMSSA members are outlined below with further comment and analysis and include:

- the integration of Ontario Works and the Ontario Disability Support Program into a single social assistance program managed by CMSMs and DSSABs;
- The coordination and integration of employment programs and services;
- A new rate structure; and
- Cost considerations and implications of moving forward with transformation.

Background:

In 2010, Premier Dalton McGuinty appointed Francis Lankin and Munir Sheikh to undertake a review of Ontario’s social assistance program and to make recommendations for improvement. As a part of the government’s Poverty Reduction Strategy, the undertaking was intended to move away from an overly complex, regulatory burdened system that fell far short from meeting recipient’s basic needs and moving them out of poverty and into the labour market. The Commissioners were tasked with developing a vision and approach for a new system that would efficiently and effectively meet the twin objectives of providing employment supports and financial supports.

released for public comment and discussions with key stakeholders and communities of interest across the province over the two year period of the review.

The work of the Commission was informed by five specific outcomes upon which to make recommendations that will enable government to:

- Place reasonable expectations on, and provide supports for, people who rely on social assistance with respect to active engagement in the labour market and participation in treatment and rehabilitation;
- Establish an appropriate benefit structure that reduces barrier and supports people’s transition into, and attachment within, the labour market;
- Simplify income and asset rules to improve equity and make it easier to understand and administer social assistance;
- Ensure the long-term viability of the social assistance system; and
- Define Ontario’s position vis-à-vis the federal and municipal governments as it relates to income security for Ontarians.

Social assistance in Ontario is a $8.3 billion dollar program, cost shared by the provincial and municipal governments. The direction to find efficiencies and to improve not only the program but the outcomes for those in receipt of assistance has been welcomed by all communities of interest and Ontarians.

Some very significant events have occurred throughout the review process, most notably the economic down turn and the continuing impact on Ontario’s economic and labour market prospects. The ongoing economic challenges have caused the government to reprioritize its objectives. This, along with the recent prorogation of the provincial legislature, it can be expected, will have a strong influence on how the recommendations may or may not be implemented.

The report we have before us today addresses the above five outcomes. It also, importantly, recognizes that social assistance reform is only one element of addressing poverty and growing inequality. And that a more robust and coordinated approach across government is required.

OMSSA’s initial assessment of the report indicates that the recommendations would amount to a significant change, in many cases increases, in the service delivery and service system management role. However, given the breadth and complexity of the recommendations, including understanding how they work together, it is not immediately clear how the recommendations to streamline services and benefits, maximize the use of technology, the new approach to labour market entry and attachment and moving to block funding, will, in the long term impact program outcomes and outcomes for recipients.

As well, it is not clear how the recommendations, within the current and foreseeable economic context, would impact both the service delivery and funding obligations of CMSMs and DSSABs.
What is clear, is that transformation, as supported and recommended by the Commissioners in today’s report must be done in partnership with OMSSA, municipalities and CMSMs and DSSABs.

Overview of Key Recommendations of interest to OMSSA members:

A key theme that emerges in the recommendations that supports OMSSA’s advocacy and members’ interests to deliver high quality and effective services is that of service integration. It is important to note that both OW - ODSP and employment services integration have been identified by the Commissioners as “early implementation priorities”.

OMSSA assumes, given the current fiscal context of the provincial government as described above, that the “early implementation priorities” are seen to not include significant upfront provincial investments. The assumptions within the report appear to be that changes such as program/service integration, simplified benefits and better services and supports, could occur within existing funding envelopes and structures, and in fact, may result in “savings”.

OMSSA strongly believes that these assumptions must be tested and modeled.

Service Integration:

OMSSA has long advocated the benefits of an integrated approach to service delivery and administration and we are pleased the Commissioners have supported this, quite significantly, throughout its recommendations including:

- Streamlined and integrated program and delivery: integration of Ontario Works and the Ontario Disability Support Program (ODSP), to be delivered by CMSMs and DSSABs (recommendation 17).
- Improved employment outcomes and employer engagement through coordinated and integrated program delivery: with municipalities as full partners with the province in managing and planning employment services in their communities (recommendation 23).

Integration of Ontario Works and ODSP:

The Report has a strong emphasis on supporting ODSP recipients both in terms of appropriate benefits and supports to employment. In the envisioned fully transformed system, people with disabilities requiring support will be eligible for supplementary benefits outside of the social assistance system.

A new streamlined and effective social assistance program, in the Commissioners’ vision, would include a one door approach for all individuals, those with and without disabilities, seeking financial and employment assistance.
The Commissioners concluded that CMSMs and DSSABs and First Nations “are best positioned to manage and deliver the new social assistance program” because of the understanding of local labour markets and role in the delivery of other relevant, human services.

Implications:

From a programmatic and service delivery perspective, this recommendation makes sense. However it will be critical that this not result in the transfer of costs to municipalities. Lessons learned during Local Service Realignment (LSR) when the transfer of labour saw the costs and implications of salaries, benefits and union negotiations, office space, IT and liability fall to the tax payer and municipal budgets must be remembered.

An understanding of the level and intensity of case management will also be an important implication to measure.

In addition to this, a number of recommendations and assumptions require close analysis as to understanding the impact of the integration of OW and ODSP. This includes the recommendation (105) that the province, as an early implementation priority, set a target for administrative savings that “should” be achieved through the integration of OW and ODSP and implementing the new rate structure. The recommendation includes the vigorous undertaking of medical reviews with administrative and program savings to be reinvested in employment services and supports.

OMSSA believes that it will take time to get “transformation” right. And, that the implementation of “early priorities” will likely not yield “savings” in the short term. This is particularly true given full transformation is identified as a longer term undertaking. Meaning, implications of system reform, and how they play out on all aspects of CMSM and DSSAB program obligations, delivery and funding will take time to understand.

Financing OW-ODSP Integration:

The report remains largely silent on cost considerations related to the integration of OW and ODSP. There are clear recommendations however that all changes be planned in collaboration with key stakeholders such as municipalities and labour groups.

In other areas of change, the Commissioners recommend the province establish frameworks to assess impacts such as, on health, of the system changes on different groups (as examples, poor, people of colour, people with disabilities). OMSSA argues that a similar framework be established between the province and municipalities to identify and understand the scope and impact of all changes against municipal capacity through the initial phase to full transformation.
Employment Planning and Services: Collaboration and Integration:

In an effort to better support all recipients of social assistance to gain employment, it is recommended that the current participation agreements be replaced by a more collaborative and responsive approach through Pathways to Employment Plans. Premised on identifying people’s “distance from the labour market” and individual’s goals that would be supported through activities, services and supports is an approach that makes sense.

CMSMs and DSSABs will continue to be responsible for local employment services.

Other recommendations to improve employment outcomes include:

- Increased eligibility for employment services (outside of Canada-Ontario Labour Market Development Agreement protocols) (21);
- Expanding the number of service managers, where there is interest and capacity, to be designated Employment Ontario deliverers (22);
- That CMSMs and DSSABs be full partners with the Province in managing and planning employment services in their communities (23); and
- Develop provincial standards for the provision of employment services (13);

Implications:

OMSSA has strongly advocated that employment services and planning belongs at the local level, administered and delivered by CMSMs and DSSABs. We are pleased to see this will continue and that the Commissioners have recommended a coordinated and partnership based approach, between municipalities and the province, to better coordinate and align services in the interest of clients and employers.

While OMSSA supports high standards in service provision, it will be important, while keeping in mind the very likely expansion of those seeking employment services as a result of social assistance program integration, that standards reflect local capacity and realities and are flexible and responsive to changing circumstances including demands on human resources. Important to this, will be that during early implementation and through transformation that municipalities are appropriately resourced and supported. It would make sense that service agreements based on phases of implementation be developed to support system and program changes.

We note that under the Provincial Municipal Fiscal and Service Delivery Review implementation working groups, provincial and municipal partners developed an approach to local planning through the Employment Working Group. In an effort to avoid duplication, this work lead by the Association of Municipalities of Ontario and the City of Toronto and the province, should be considered in discussions on moving forward with employment services coordination and integration.
Financing employment services and support recommendations:

The commissioners expect that enhancing employment supports and services could primarily be funded from within the existing budget allocation for social assistance by better “targeting” existing resources and reinvesting administrative savings resulting from the integration of OW and ODSP into a single program.

The assumption that existing resources can be better targeted, again, must be tested. And, while reduction in regulations and directives, the harmonization of benefits, greater use of technology in reporting and the application processes, may in time, yield savings and efficiencies, this assumption should not be built in to the up front development of new program and service delivery approaches and funding.

Rate and Benefit Changes:

The vision for a transformed social assistance program includes simplifying and harmonizing benefits. This two phased approach would see a standard rate that would be supplemented (a building block approach) dependent on disabilities, sole support parentage and number of children. The final and second phase, where the system is “fully transformed”, disability supplements and children’s supplements would be available to both social assistance recipients and low income earners.

A priority for the Commissioners was to create a rate that would be: adequate, fair (to low income Ontarians and recipients alike) and support people into employment (eliminating disincentives to work).

Some features of the new rate:

- A new standard rate at $100.00 more per month than the OW rate for single adults;
- A modified rate of 86 percent of the standard rate for adults who share accommodation;
- A disability and children’s supplement on top of the standard rate (building blocks);
- Earnings exemptions of $200.00 per month;
- Harmonization of health benefits so that all recipients receive the same benefit;
- Eliminate the ODSP Work Related Benefit
- Pilot the consolidation of employment related special benefits and other special benefits into a block fund to be used at the discretion of local service system administrators;
- Eliminate the Special Diet Allowance (SDA) and transfer responsibility to the Ministry of Health and Long Term Care ($30 million). Reinvest the remaining SDA ($200 million) into the standard rate; and
- Replace the rent scales for Rent-gear to Income (RGI) housing with rent based on 30 percent of household income, including from social assistance net of the “clawbacks” for social assistance recipients residing in RGI units.
The above recommendations are identified as early implementation priorities. Understanding the implication of the suite of recommendations will take time. This includes the implications for both recipients of social assistance and CMSMs and DSSABs.

Two items of immediate interest to OMSSA and its members however are:

1. moving to block funding for employment related supports; and
2. the elimination of the rent scales.

Block funding has long been of interest to service managers and seen as a tool to respond to the people we serve in the communities we live. Specifically, that service managers unrestricted by a “one size fits all” approach to funding and service requirements can respond to individual needs within local circumstances and capacity. OMSSA supports this approach but, it will be imperative that this recommended approach not result in “winners and losers” as we have often seen when new funding formulas are developed within existing funding envelopes. Moving to a reduced envelop when implications related to the potential for increased case management and caseloads is unclear, may undermine a key objective of social assistance reform: getting people into work.

The Social Reform Housing Act, 2000 included a provision that resulted in differing subsidy rates paid to social assistance recipients depending if they resided in social housing or private housing. The Ontario Works rent scales required municipalities to pay a significantly higher subsidy to recipients living in social housing rather than private housing thereby reducing the provincial cost share portion. The Commissioners have identified this amount to be approximately $200 million annually.

Long a bone of contention for municipalities, the elimination of the rent scales is a welcome recommendation and potentially, depending if the recommendation is implemented and how, could see a savings to municipalities in the amount of $200 million annually. The Commissioners have recommended the province and municipalities negotiate this issue. However, they are calculating the $200 million against the cost of implementing their recommendations.

It will be critical that this issue be fairly negotiated with municipal leaders. It is estimated, that since devolution, through the rent scales, municipalities have subsidized social assistance by almost $2 billion beyond their required cost-share arrangements.

Financing Rate and Benefit Changes:

The Commissioners acknowledge that transformation on the scale they have recommended will require new funding but that a large portion of the anticipated costs could come from reallocation of existing costs to implement the early priorities. Long term transformation, it is indicated, would come through reduced caseloads, particularly related to those with disabilities. As well, fiscal savings, tax revenues and economic
returns from slower caseload growth could be used to finance the disability supplement that in the fully transformed system will be available beyond recipients of social assistance.

The Commissioners have calculated that the cost to implement phase one of the benefit structure reform (the standard rate with a $100.00 per month increase, $200.00 per month earnings exemptions, and disability and parent supplements) will be a gross cost of $770 million.

The Commission indicates that over half of the gross cost can be financed through existing funding. Once the $200 million from the elimination of the SDA, the $30 million from the elimination of the ODSP Work – Related Benefit and the $200 million in municipal revenue from the reduction of the rent scales are considered, the net cost to implement the benefit structure reform is $340 million.

It is assumed that the fiscal circumstances of the provincial government will be one of a number of key factors in the government’s decision to act on and implement the recommendations delivered to them in the Commissioners report.

It is important to note, that municipalities-CMSMs and DSSABs-like the province, are experiencing the same fiscal constraints and economic challenges. Recognizing, that only few of the many recommendations within the report will not implicate municipalities in one form or another, we argue that implementation of recommendations require an understanding and analysis of municipal capacity to move forward on the government’s implementation priorities.

Municipal governments will be free of the cost share funding obligations for the social assistance benefit by 2018. It is important, however to understand the implications of rate and benefit changes through to that period.

**Sweeping and Complex Recommendations:**

The above highlights a number of the key and immediate areas of interest and concern to OMSSA and its members. Recognizing the complexity of the recommendations, taken in their entirety and within recommended implementation timeframes, further analysis and discussion is required and will be forthcoming.

It is important to note that the full scope of the areas comprising the 108 recommendations have not been touched on in this analysis. More time and consultation with members and subject matter experts will be required to understand the implications across the range of recommendations on CMSMs and DSSABs.

In time, OMSSA members can expect a closer examination and understanding of the recommendations related to:

- simplifying and harmonizing rules and benefits;
- strengthening accountability and new approaches to compliance;
• the role of technology; and
• our changing economic environment and labour market.

In Ontario, outcomes for recipients of social assistance are inextricably linked to CMSMs and DSSABs. While our initial analysis and feedback has been focused on the implications of the recommendations on municipalities and service managers, our responses are also driven by the role and obligations CMSMs and DSSABs have in building stronger and healthier lives and communities. The ability and capacity for service managers to implement any or all of the recommendations will be directly tied to the outcomes of the clients we serve.

The vision for reform of Ontario's social assistance program and the lives of social assistance recipients and low-income individuals and families will be dependent on a realistic plan, appropriate resources and time to implement the recommendations government chooses to move forward on. The Commissioners rightly acknowledge that the complexity of poverty requires a new way forward and the efforts of all orders of government, the private and public sectors and citizens alike.

But it is CMSMs and DSSABs who link directly with their clients in the communities where they live. Using the person-centred, human services integration approach as our starting point allows us to understand all the complicating factors at play in a person's life and the tools at hand to address these. It will be critical that all of the aspects of the recommendations are implemented in a reasonable and sustainable way and in partnership with OMSSA and service managers to ensure the outcomes envisioned in this ambitious transformation can and will be realized.

**Social Assistance Reform and Prorogation:**

The recent resignation of Dalton McGuinty and prorogation of parliament raises some important questions on what it means for moving forward on social assistance reform.

While there is uncertainty, proroguing only stops activities in the legislature, specifically all activity of Bills. Government Ministries can still develop Cabinet Submissions and Treasury Board can continue to make decisions on programs and activities that do not require legislation. Government can enact regulations and launch new programs or make program changes.

In short, any of the recommendations that do not require legislative changes can be put in to motion. OMSSA will work to identify what can or cannot be implemented in this current environment.

It is important to keep in mind, *Brighter Prospects: Transforming Social Assistance in Ontario* is a report to government. Government will decide which, if any of the recommendations it will implement.
OMSSA’s Next Steps:

We will be working with our membership, including the Employment and Income Issues Network to analyze the implications of the report recommendations and what advocacy work OMSSA will undertake to support its membership and ensure the best interest of our members and those in receipt of social assistance are best served in the new system. This includes working with Association of Municipalities of Ontario to analyze and respond to the report recommendations.

Links:

Commission for the Review of Social Assistance in Ontario’s website includes the full report, as well as a full composition of additional resources including SARAC recommendations, videos of the Commissioners commenting on both the final report and the process, fast facts, charts and other documents that OMSSA members may find useful.

OMSSA’s submission to the Commission’s first discussion paper

OMSSA’s response to Discussion Paper 2: Approaches for Reform

For more information please contact:

Dave Landers
President, OMSSA
705.266.1216
landersd@cdssab.on.ca

Petra Wolfbeiss
Director, Policy and Public Affairs OMSSA
416.479.8254
pwolfbeiss@omssa.com
<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>