

Every Child Plays

Access to Recreation for Low-Income Families in Ontario



The Health, Social and Economic Benefits of Increasing Access to Recreation for Low-Income Families

Research Summary Report

Dr. Mark Totten

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Province of Ontario
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gratefully acknowledged.



Research Summary Report



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Research Summary Report

This document was prepared for:

Ontario Task Group on Access to Recreation for Low-Income Families

This document was prepared by:

Dr. Mark Totten
Totten and Associates
32 Butternut St., Gatineau Qc.
J9H 3Z9

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Ontario Task Group on Access to Recreation For Low-Income Families**Overview:**

The Ontario Task Group on Access to Recreation for Low-Income Families is comprised of members from a broad representation of provincial, municipal, non-profit, corporate, and advocacy partners. We all share an interest in the healthy development of children, youth, families and communities and are working collaboratively to influence policy development in Ontario to increase access to recreation for low-income children, youth and families.

Vision:

Every Child Plays

Beliefs:

In Ontario we strongly support the United Nations Convention on the Rights of the Child (1989) that speaks to the rights of children to rest and leisure. Ontario's children and youth are healthier and more resilient as a result of participating in recreational pursuits.

We believe that innovative approaches should be taken to ensure that every child regardless of financial circumstances experiences play, without barriers, engages in positive and high quality leisure pursuits and enjoys physical, social and emotional health through participation in community recreation.

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1) Executive Summary

Growing up poor in Ontario is very expensive – we all pay the costs of having twenty percent of our children and youth live in poverty. Improving access to recreation is a smart way to reduce the health and social costs we all incur because our neighbours don't have enough resources. Most of us don't suffer from the profound negative health outcomes experienced by many low-income individuals in Ontario. It's about time we acted on pragmatic, achievable initiatives to improve the health of all Ontarians.

A large body of research on human development shows that health and well-being is linked to financial resources. Children and youth from low-income families are more vulnerable: they generally experience more physical, behavioural and mental health problems; they are more likely to be overweight and obese; they suffer more neglect and physical violence; they do less well at school, are more likely to drop out; and they experience less labour market success than people from more affluent family backgrounds. Low-income children and youth who have a positive family environment, positive community supports (e.g. regular involvement in structured, skill building recreational activities that develop self-esteem; an adult mentor who provides unconditional support and models healthy behaviour), access to quality health and social services, positive school experiences, or particular individual attributes create some protection against these risks. The problem is that many low-income families do not have the required resources and supports to promote the healthy development of their children.

Individual bio-physiological and psychological characteristics, combined with family, school, peer group, neighbourhood and community resources all determine the health of Canadian children and youth – they are health determinants. In addition to poverty, certain populations across socio-economic lines have inequitable access to these determinants: girls and young women, racial and ethnic minorities, and disabled people. These groups are doubly-disadvantaged if they are poor. Arguably, poverty is the greatest barrier to achieving physical and mental health. The complexity and multi-faceted nature of these barriers calls for a public health approach to improve access to recreation for low-income families. This approach identifies risk and protective factors, determines when they commonly occur and how they operate in peoples' lives, and helps to design prevention programs that reduce risk and promote protection.

Diverse outcomes are possible for children who grow up in poverty; individual, family, school and community factors can mitigate the risks to which these young people have been exposed. Improving the resiliency of low-income children, families and communities is a key method to reduce risks. Resilience is the ability of individuals living in adverse conditions to achieve positive outcomes.

Ontario has a patchwork of piecemeal policies designed to increase incomes for poor families. In comparison, countries like Sweden and France have universally subsidized childcare, family allowances, parental leaves and parenting courses. One proven strategy to buffer the negative effects of poverty in the absence of income strategies is to invest in community supports such as recreation for low-income families. A large body of scientific evidence substantiates the health, social and economic benefits of broad participation in recreation programs, such as:

- ◆ Increased appropriate access to existing social, health, and community services;
- ◆ Enhanced physical and psycho-social health of families;
- ◆ Increased attendance and achievement at school;

- ◆ Decreased number of behavioural/emotional problems among children;
- ◆ Increased self-reliance and enhanced life management;
- ◆ Decreased use of emergency services (emergency medical services, child welfare, police) and increased proactive use of health promotional services;
- ◆ Reduced future costs in emergency services;
- ◆ More efficient use of existing resources; and
- ◆ Increased ability of agencies and organizations to work together across sectors.

Taxpayers are better off with improved access to recreation for low-income families. For each dollar spent on quality programs, more than a dollar's worth of benefits are generated. Investments in the voluntary recreation sector can achieve substantial savings to the publicly funded health, social and corrections systems while at the same time improving the quality of people's lives. Yet, despite the undeniable health and social savings of providing no cost or low cost recreation activities, Canada lags at least two decades behind the policies and best practices of other countries and regions. Ontario is no exception. In order for Ontario to address this pressing situation, it is recommended that the Provincial government, local municipalities and the non-profit sector adopt the following key policies:

- ◆ Eliminate or substantially reduce user fees;
- ◆ Implement the school as hub model;
- ◆ Eliminate provincial and municipal funding silos between public health, recreation, day care, education and Ontario Works;
- ◆ Increase capacity of recreation programs to meet the unique needs of New Canadians, ethno-racial minorities, Aboriginals, girls and young women;
- ◆ Increase outreach services to low-income families to promote recruitment into and maintain participation in recreation programs;
- ◆ Maintain a single case management approach with families and actively encourage parental involvement; and
- ◆ Guarantee stable funding for the Recreation sector.
- ◆ Build capacity in the non-profit and voluntary sector to deliver more "front door" accessible programs and services.

2) Introduction

The purpose of this report is to support the work of the Access to Recreation for Low-income Families project. The working group for this project is made up of representatives from the sectors of Municipal Social Services, Public Health, Recreation, along with anti-poverty advocates and child and youth-serving agencies across Ontario. This report will inform the November 2007 provincial Access to Recreation conference in Toronto.

A number of methods have been used to review data. Relevant studies were identified through Recreation and Leisure Abstracts, Leisure Information Network (LIN), Sport Discuss, PsychLit, ERIC, Criminal Justice Abstracts, and Sociological Abstracts bibliographic databases. Recent U.S., U.K. and Australian evaluations on after-school programs, at-risk youth recreation programs, and youth development programs have been reviewed.¹ There is a paucity of comparable Canadian data. As well, evidence-based youth crime prevention strategies in community settings have been examined.²

3) The Key Determinants of Healthy Child and Adolescent Development in Canada

Roughly one in five young people in Ontario live in poverty (roughly 375,000 children and youth).³ A large body research on human development shows that health and well-being are linked to financial resources. Children and youth from low-income families are more vulnerable: they generally experience more physical, behavioural and mental health problems; they suffer more neglect and physical violence; they do less well at school, are more likely to drop out, and experience less labour market success than people from more affluent family backgrounds.⁴ The negative effects of poverty can be overcome with a positive family environment (good parenting skills, stable family unit, good mental health), positive community supports (e.g. regular involvement in structured, skill building recreational activities that develop self-esteem; an adult mentor who provides unconditional support and models healthy behaviour),⁵ access to quality health and social services, positive school experiences (e.g., high engagement, good grades, supportive teachers, development of future academic and vocational interests), or particular individual attributes (e.g., perseverance, determination) create some protection against these risks.⁶ The problem is that many low-income families do not have the required resources and supports to promote the healthy development of children and youth.

The *depth* of poverty (or how far a family falls below the low income cut-off) is important. Those families who are very poor, for a very long time, suffer profoundly negative effects. A public health approach is the best way to offset the risks faced by low-income families. It is a “practical, goal-oriented, and community-based approach to promoting and sustaining health. This approach seeks to identify risk and protective factors, determine when in the life course they typically occur and how they operate, and enable researchers to design preventive programs that are effective in reducing risk and promoting protection.”⁷ Individual bio-physiological and psychological characteristics, combined with family, school, peer group, neighbourhood and community resources all determine the health of Canadian children and youth – they are health determinants.⁸

Compared to most other countries in the world, the psycho-social health of the Canadian child and youth population is favourable. However, there are a number of key problems faced by certain groups of young people, which contribute to their poor health. Specific populations have inequitable access to these determinants of healthy child and youth development, including girls, racial and ethnic minorities, disabled people, and low-income individuals.⁹

Improving the resiliency of children, families and communities is a key method to reduce risks. Resilience is the ability of individuals living in adverse conditions to achieve positive health outcomes.¹⁰ Research has shown that a combination of societal level, institutional and individual factors contribute to resilience.¹¹ Diverse outcomes are possible for children who grow up in poverty; individual, family, school and community factors can mitigate the risks to which these young people have been exposed.

A *bio-psychosocial perspective* addresses the multiple risk factors related to child and youth development.¹² These include individual bio-physiological and psychological characteristics, family, school, peer, social, and economic factors. Below, summaries of the major determinants of healthy child and adolescent development are grouped into the three levels of the bio-psychosocial perspective: biological and genetic factors; psychological factors; and social factors. Within each category, poverty is highlighted as a significant risk factor preventing

healthy child and adolescent development. However, protective factors such as access to quality health, recreation, education and other social services and supports can improve the outcomes for children and youth who are vulnerable.

3.1 Biological and Genetic Factors:

Biological and genetic factors are key determinants of health. Children are born with different sets of abilities and potential as a result of these attributes in combination with other psychosocial factors. Factors such as resiliency, intelligence, cognitive functioning, physical ability, physical attributes and body type are important protective factors in determining healthy child and adolescent development. The presence of one or more of these attributes can go a long way in protecting a young person from the risks associated with growing up in poverty. Developmental problems, learning disabilities and intellectual limitations, fetal alcohol syndrome and effects, brain injuries, predisposition to mental health problems, and certain personality traits are important risk factors, which can lead to poor child and adolescent health in the absence of key buffers against these risks.¹³ Young people who live in poverty *and* face one or more of these risks are vulnerable to poor health – they are doubly disadvantaged.

Personality traits that influence child behaviour are complex and the product of the co-occurrence of several genes.¹⁴ Temperament (whether children are fussy or calm, upset or happy) and other characteristics such as irritability, low self-control, and irresponsibility are moderately genetic.¹⁵ Children's capacity to learn the social use of language, interact with others, and to regulate their emotions are influenced by genetic inheritance as well. These factors are directly influenced by a mother's behaviour when pregnant. For example, malnutrition, smoking, alcohol/drug consumption and victimization by violence during pregnancy all contribute to negative health outcomes on the fetus. Fetal Alcohol Spectrum Disorder, which results in infant brain damage to areas responsible for planning and self-control,¹⁶ is a particular concern in Aboriginal communities. Risky behaviours during pregnancy are more common in low-income mothers. This is primarily due to a lack of education and other behavioural risk factors.¹⁷

It has been estimated that roughly 40% of a child's antisocial behaviours may be related to genetic factors.¹⁸ However, genes interact with important environmental dynamics (nature *and* nurture). For example, so-called 'bad genes' inherited by a child (such as cognitive impairment, low intelligence) most likely will not negatively effect psychosocial functioning in the context of positive parenting, quality schooling and a pro-social peer group.

As will be shown in the following sections, healthy child and adolescent development is shaped not only by genetic and biological makeup, but also by personality traits, early interactions with parents/caregivers, socio-economic factors, and early childhood experiences in the family, school, and in the community. However, barriers to accessing these supports, such as poverty, can greatly compromise healthy outcomes when families have limited access to quality health, recreation, education and other social services.

3.2 Psychological Factors:

Certain psychological factors are key determinants of health. Intellectual and interpersonal abilities, positive self-esteem and mental health, personal responsibility, and pro-social behaviours are key protective factors, which can shelter young people from the risks of growing up in poverty.¹⁹ However, risk factors such as poor mental health status, low self-esteem and body image, learning disabilities, antisocial behaviours and attitudes, internalizing disorders

(withdrawal, anxiety, eating disorders, suicidal behaviour) and externalizing disorders (hyperactivity, concentration problems, aggression) can compromise the healthy development of children, particularly if they live in poverty and do not have protection from some of these risks. Low-income families have limited access to quality health and social services, adequate housing, educational opportunities, daycare spaces and recreation programs, all of which are key agents which buffer against the challenges of being poor.

Children and youth with emotional and behavioural disorders (EBD) are significantly more likely to live in poverty. Roughly 20% of Canadian children have symptoms of one or more EBDs; three percent are socially impaired by their problems. In the pre-school years, these high-risk children have difficulties in how they process information. Their perceptions and cognitions are not wired properly, especially how they perceive caregivers and other adult authority figures. Children who are aggressive at this early age are far more likely than non-aggressive children to attribute hostile intentions to teachers and have external loci of control. These children tend to impute threatening intentions to others, are easily slighted, and evaluate disobedience, defiance, and revenge as attributes and legitimate ways to solve problems.²⁰

During adolescence, low-income youth are also more likely to experience EBDs. Self-destructive and externalized violence are common in the lives of young people who have unequal access to the key determinants of health. Traumatized girls are most likely to engage in self-destructive youth violence. They have the highest rates of self-mutilation, eating disorders, and suicide attempts. Girls suffer higher rates of depression and other internalizing emotional disorders.²¹ Traumatized boys have higher levels of hyperactivity symptoms (impulsiveness, poor concentration, distractibility) and conduct symptoms (destroying things, threatening others, fighting, bullying and cruelty).²²

Gina Brown (1998, 2001) has demonstrated that the competencies of low-income children with EMDs can be raised substantially with the provision of no-cost, accessible recreation and daycare services. When health and social services are targeted to and delivered in neighbourhoods with high proportions of low-income families, many more families in need can access required supports. This is very important due to the fact that traditional approaches to addressing child and adolescent disorders (psychiatric and psychological treatment) only reach 20% of all young people in need. These interventions do not work well with high-risk young people: they are expensive, inaccessible and have poor outcomes.²³

3.3 Social Factors:

Social determinants of health include risk and protective factors at the family, school, peer group and community/neighbourhood levels. In addition, gender, ethnic and racial origin, and ability are all important ingredients linked to the health of Canadian children and youth.²⁴

Key protective factors at the *family level* include strong attachment to parent(s) and caregivers, bonding with other adults, effective family management practices (positive reinforcement, consistent structure and discipline, good supervision), residential stability (adequate housing, few moves), and good health of parent(s) and caregivers.²⁵ Children with strong bonds to their parents have better mental and physical health. Family demographics (education of parents, structure, income) have an indirect effect on aggression and victimization through family socialization practices.²⁶ Research shows the incidence of aggressive behavior has a higher likelihood of occurring in single-parent families where the parent has a low education.²⁷ Family stress (unemployment, poverty, being a young parent) can contribute to parent-child relations, which are hostile, punishment practices which are inconsistent and harsh,

and neglect. Parental modelling of aggression and antisocial behaviour promotes the development of hostile attitudes and orientations in their children.

Child physical abuse and neglect are more prevalent in low-income families compared to more affluent families. This is in large part due to the heightened stress of living in poverty (low socio-economic status, unemployment, being a young parent), the lack of health and social services resources to deal with these stresses, the prevalence of single-parent families, and the ill health of many parents.²⁸ Child maltreatment is a major public health epidemic. It affects many more children than cancer or AIDS. Many maltreated kids have impaired physical, emotional, cognitive and social functioning. Suffering serious and prolonged child maltreatment is strongly related to experiencing youth violence and mental health problems.²⁹

School success and bonding (high commitment and educational aspirations), attendance, participation in extra-curricular activities, and low delinquency rate of students at school are key protective factors which are related to positive health outcomes for young people. Risk factors include academic failure, low literacy, frequent school transitions, low bonding (low commitment and educational aspirations), truancy and dropping out of school, and high delinquency rate of students at school. These risks are linked to negative health outcomes in the absence of protective factors in other areas of a young person's life.

Low-income students are disproportionately excluded from participation in academics and extracurricular activities. A growing body of research outside of Canada on the long-term impact of 'zero tolerance' policies has documented the devastating consequences: huge increases in the number and duration of suspensions and expulsions; significant over-representation of visible/ethnic minorities and special needs students involved in disciplinary measures; large increases in school dropout rates; and criminalization of many behaviours which previously were addressed outside of the justice system in school settings.³⁰ Suspensions and expulsions, by excluding students from school life, contribute to problem behaviour and youth crime.³¹ Low-income students are far more likely than their more affluent counterparts to be suspended or expelled, drop out of school, have low literacy and employability skills, and have emotional and behavioural problems.³²

Key protective factors at the *peer group* level, which lead to positive health outcomes for young people, include pro-social siblings and peers and positive peer group membership. Evidence suggests that most healthy peer networks are organized around hobbies, interests, and other activities shared by friends. Positive peer relations are strong protective factors for many children and youth. Positive social support is related to lower rates of depression and anxiety.³³ These factors can protect young people from the variety of risks associated with living in poverty.

Risk factors at the peer group level include delinquent siblings and peers and membership in anti-social peer groups and gangs. Researchers who have studied violence and youth crime in the social context of peer group processes argue that peers play a significant role in enabling and sustaining these anti-social behaviours.³⁴ These problems can interact and feed off genetic, biological, family and school risk factors.

Neighbourhood and community protective factors related to healthy adolescent development include mixed socio-economic backgrounds of families, organized and accessible community and social infrastructure (recreation facilities and activities, adequate housing, high employment), bonding to institutions outside of family and school, and strong cultural identity and racial harmony.

The risk factors at this level, which can determine ill health, include community disorganization (crime, drug selling, gangs, poor housing, high unemployment, transient population), exposure to violence and racial discrimination. Social infrastructures to promote inclusion and participation in quality health, social and recreation services are minimal compared to those in more affluent neighbourhoods.³⁵ There are usually few social networks and ties, with a disproportionate number of single-parent families and individuals experiencing mental or physical health problems. Serious delinquency tends to originate in low-income, disadvantaged families in many Western countries.³⁶ In New Zealand, for example, most adolescents who exhibit several behavioural problems come from very poor and dysfunctional families. Only one out of every 400 – 500 children from economically advantaged homes becomes a multi-problem adolescent, and 80% have no problems at all.³⁷

Parents who live in high-poverty neighborhoods experience more stress.³⁸ Issues such as unemployment and being a young single parent can lead to difficulties in parenting and the supervision of children. Only 35% of low-income Canadians feel that their neighborhood is a suitable place in which to bring up children. In comparison, 63% of high earners report that their neighbourhood is a suitable place to raise children.³⁹ Immigrants, ethnic and visible minorities, and Aboriginal peoples make up a disproportionate share of the population in these communities. The poverty rate for Aboriginal children and youth who live off-reserve is 40%,⁴⁰ while immigrant families who have been in Canada for less than five years have a 50% chance of living in poverty.⁴¹

In Vancouver, Clyde Hertzman has found that, in terms of general child development, in a typical affluent community, 15% of children are vulnerable compared to 50% in low-income areas.⁴² A critical mass of affluent neighbours raises a child's chances of staying out of trouble, whereas a critical mass of low-income neighbors increases the risk for problematic behaviours and subsequent school difficulties in children as young as age five years. Low-income families often do not have adequate facilities or resource-rich schools in their neighbourhoods. The user fees charged by most municipal and school programs are out of reach.⁴³ The role of these activities in fostering civic engagement and social inclusion amongst young people is very important.

User fees in general exclude many families from participating in quality health, social and recreation services. For example, in a recent survey of recreation departments across the country, the province of Ontario had the highest proportion of municipalities which charged user fees for youth programs. Virtually all municipalities charged entrance fees for aquatics, athletics, arts, after-school, and drop-in programs. In almost every case, the amount charged was higher than what it was five years prior to the study. In the 167 municipal recreation departments in the study, user fees were a major deterrent to children and youth participation in drop-in and after-school programs. Although 85% of these departments reported that they made efforts to increase participation of low-income people, subsidies were capped at a certain level, thereby excluding access to many families and children in need.⁴⁴

4) The Psycho-social Benefits of Participation in Recreation for Low-income Families

There is a broad body of research highlighting the importance of recreation activities in developing the psychological and social competencies of low-income children and youth. Active living is a key determinant of health status. Participation in structured recreation is a key protective factor which can act as a buffer against risk factors many young people face. Engagement in structured recreational activities outside the home promotes healthy child development, attachment to a positive peer group, self-esteem and skill development, and is a critical method to prevent emotional and behavioural problems.⁴⁵ Children from low-income families face many barriers to participation in school and community-based activities. Most activities have significant user fees. There has been a sharp increase in these fees for sports, arts and musical programs in schools, forcing the exclusion of many vulnerable students. Four benefits of participation of recreation for low-income families are discussed below.

4.1 Increasing academic, social, interpersonal competence:

Children and youth who have good academic, social and interpersonal skills are less likely to engage in high-risk behaviour.⁴⁶ Participation in school-based physical activities can result in considerably healthier social and academic self-concepts, positive moods and pleasurable experiences.⁴⁷ Participation in extracurricular activities has been positively related to later educational, occupational, and status attainment.⁴⁸ Positive civic outcomes have also been linked to participation in physical recreation.⁴⁹ Studies show that participation in long-term skill-building activities promotes positive mental health, feelings of belonging, and self-worth. Structured relationships with caring adults can give these adolescents positive, alternative adult role models.⁵⁰ The best formula for school-based physical education programs is one that is inclusive of the diverse capabilities of children (many options are offered so that no child is excluded or marginalized), based on cooperation, and non-aggressive.

4.2 Reducing risky behaviours (substance abuse, school drop-out, unsafe sex):

Athletic activities can act as a deterrent to antisocial behavior for the general child and youth population. Youth participation in athletics has resulted in a decreased likelihood of engaging in risky behaviors. A number of studies have shown that individuals who participated in at least one extracurricular activity were less likely to drop out of high school and abuse substances than those who did not participate in any school-based activities.⁵¹ Female and male athletes are more likely to use birth control than non-athletes. Compared to non-athletic girls, female athletes have substantially fewer sexual partners, engage in less frequent intercourse, and begin having sex at a later age.⁵²

4.3 Reducing isolation and mental health problems:

Participation in extracurricular and community recreation activities promotes heightened self-esteem, feelings of happiness, and pro-social behaviour. Participation provides an opportunity for children and youth to gain confidence from skill development and caring relations with peers, coaches and program staff. These activities foster a sense of belonging and supportive social networks. They provide young people with routines and structure in their lives.⁵³ Low-income

children who attend structured after-school programs have more positive social and psychological development compared to poor children who participate in unstructured activities (improved grades, better conduct at school, enhanced peer relations, positive emotional adjustment).⁵⁴ Disadvantaged families require comprehensive outreach from practitioners to engage children and parents in quality services from birth onwards.

4.4 Reducing youth crime:

In community-based settings, research has shown that young people who have higher participation rates in recreational activities typically display fewer criminal behaviours. Children and youth who participate in structured sports have reduced rates of criminal arrest and antisocial behaviour.⁵⁵ Structured recreation activities can also provide safe, developmental opportunities for latch-key children. These young people have reduced opportunities for physical activities and socialization due to a lack of parental supervision. Latch-key kids who live in poverty are at heightened risk to engage in crime in the absence of participation in after-school programming. Youth crime peaks in the after-school hours, and structured play activities benefit young people in situations where supervision would be otherwise absent.⁵⁶

5) The Health and Social Cost Savings of Increasing Access to Recreation for Low-Income Families

In 1999, one study estimated that physical inactivity cost the Canadian Health Care system \$2.1 billion.⁵⁷ Low-income children and youth are much more likely to be overweight and obese compared to more affluent young people in Canada.⁵⁸ In 1998/99, one-quarter of children aged 2 to 11 living in families with incomes below the low-income cut-off (LICO) were obese; only 16% of children in families above the LICO were in this weight category. The proportion of overweight and obese children decreased as the family income increased.

The overall prevalence of overweight and obese children in Canada more than doubled between 1981 (12% of all children) and 1996 (30%).⁵⁹ In Ontario, 56% of youth aged 12-19 years are not active enough for optimal growth and development.⁶⁰ Obese children are five to seven times more likely to become obese adults than non-obese children.⁶¹ There is a significant body of research associating childhood and adolescent obesity with increased risk of adult morbidity.⁶² Research demonstrates that participation in regular physical activity is the best way to combat obesity and prevent common childhood diseases. Many longitudinal public health studies show that promotion of active lifestyles to children by caregivers, educators and mentors results in reduced spending on health care over a person's lifetime.⁶³ However, children and youth who live in poverty have limited access to the very programs aimed at combating obesity – physical activity programs. National Longitudinal Survey on Children and Youth data suggest that only 25% of children in low-income families regularly play organized sports, compared to 75% of children from more affluent families (with an annual income of \$40,000+).⁶⁴ The proportion of low-income adolescents who *almost never* participate in supervised sports, arts, and community programming is significant.

Ontario data suggest that participation in recreation by low-income families pays for itself in the reduced use of professionals and probationary services and mental health benefits for mothers. Savings have been found in the tax system, when people exit welfare and gain employment.⁶⁵ Gina Browne and her colleagues (1998, 2001) have demonstrated that proactive coordination of arts, ballet and music lessons for low-income children and youth results in increased exits from social assistance and significant cost savings to the health, youth justice, child welfare and educational sectors. Children and youth who participate in at least one 13-week skill development program per year can substantially increase their cognitive, physical and emotional competencies.

Families First (FF) programs in Peel and Edmonton have demonstrated substantial social, health and economic benefits to participating families. FF was launched in late 2000 at Ontario Works in Peel. Based on previous research by Gina Brown, the FF Program is a collaborative partnership between Ontario Works, Peel Children's Services, Peel Health, and community agencies. The program provides intensive case management supports to single parents and their children, including recreation, employment services and supports, public health nurse supports, and subsidized childcare. Families First interventions have resulted in greater self-reliance and a reduced level of reliance on income supports, health and social services. There is less reliance on public and social supports as participants gain in the areas of family health, functionality and independence. Both parents and children experience gains in social, physical and mental health as a result of recreation interventions. On average, over one-third of FF participants are actively

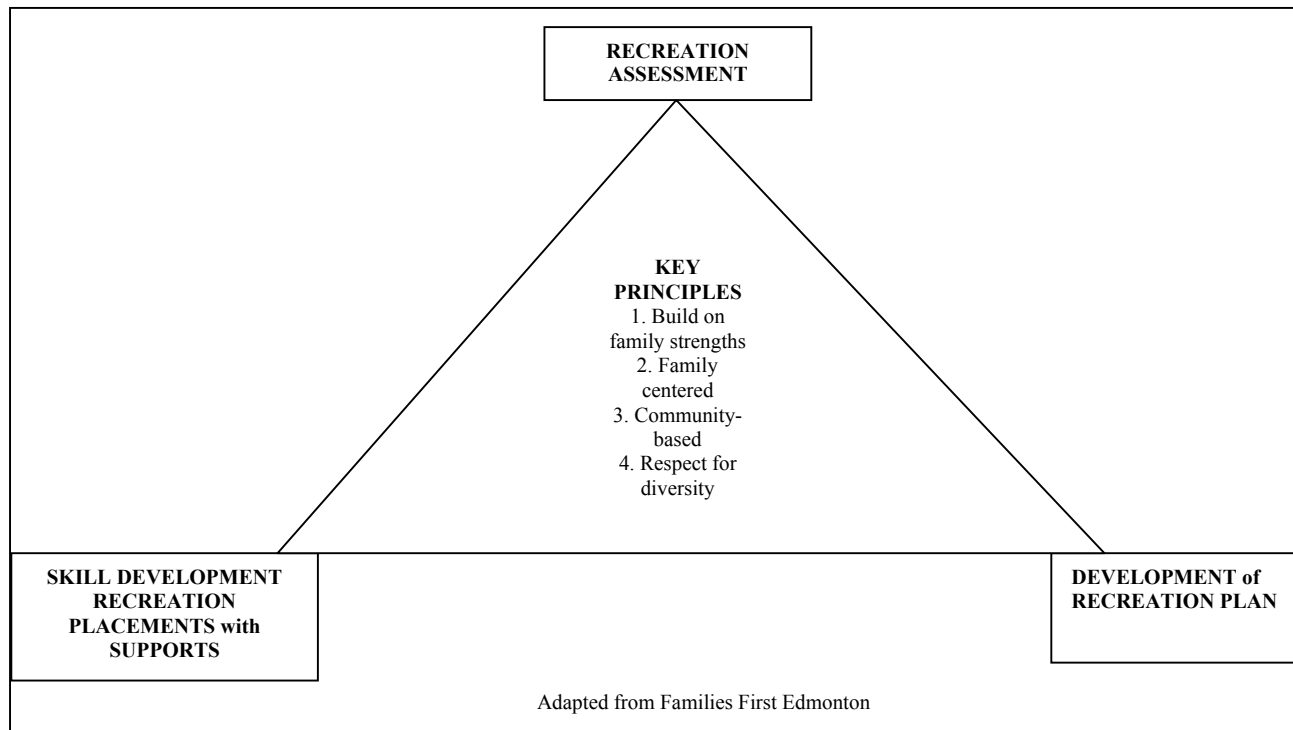
involved in the program's health supports. At May 31, 2007, over 3,000 children were involved in Peel FF.

Unfortunately, it is only a very small minority of Ontario municipalities, which are moving in this direction. If no-cost recreation was proactively arranged for a majority of Ontario Works families, significant savings would result from increased economic independence and exits from welfare rolls.⁶⁶

Edmonton is also delivering the FF program and results are comparable to the Ontario programs.⁶⁷ The greatest savings in health care have been for families who are high users of the health system. Reinvestment in the voluntary recreation sector has paid for itself through cost savings elsewhere in the system. Families First Edmonton (FFE) was initiated in 2005, when University of Alberta researchers began to follow 1,200 families during service delivery interventions and tracking outcomes for a three-year period following program completion. The goal of this \$10 million research project is to determine whether delivering health, family support and recreation services in a coordinated way can lead to better outcomes for families with low incomes. Families must be receiving Alberta Works Income Support or Child Health Benefits and are selected at random by Alberta Human Resources and Employment and are randomly placed in one of four intervention groups.⁶⁸

In FFE, recreation coordinators are responsible for conducting the initial home visit and assessment, establishing recreation placements, providing ongoing follow-up and support to families, and developing a recreation plan with each family. Recreation coordinators are also responsible for partnership development, including working with community organizations and establishing a Recreation Resource Bank.⁶⁹ A Recreation Coordination Toolkit was developed that describes how families and recreation coordinators work together in the active outreach approach. Figure One illustrates a model for an active outreach approach.

Figure One: Active Outreach Approach with Low-income Families



In another important Canadian study, Marshall Jones and Dan Offord (1989) examined a non-school skill development program called Participate and Learn Skills (PALS) for approximately 417 children living in two Ottawa social housing complexes. These researchers found that low-income children who attended structured after-school programs had more positive social and psychological development (improved grades, better conduct at school, enhanced peer relations, positive emotional adjustment) compared to young people in the control group, who received unstructured activities. The PALS study found those children who participated in structured arts had fewer problems associated with school achievement, social relationships, and emotional or behavioral difficulties. They showed statistically significant reductions in antisocial behaviours and had lower rates of criminal charges than individuals who did not participate in the program. Costs were measured for the PALS program (staffing and other costs) on the assumption that this represented the differential cost between the treatment and control sites. These costs were compared with savings resulting from the observed decreases in charges against youth, number of social housing security reports and number of fire calls to the two sites. Only immediate savings were estimated to be substantially greater than the PALS programme costs.

In other parts of the world, there is indisputable scientific evidence that quality programs can achieve significantly more benefits than costs.⁷⁰ Recreation programs give taxpayers a good return on their dollar. Scientists have developed a comparative costing of services using an inventory to track direct and indirect costs, and cost-benefit models have been constructed to assign monetary values to any observed changes in education, health,⁷¹ crime, substance abuse,

child abuse and neglect, teen pregnancy, and social assistance outcomes. Evidence points directly to the high returns on early interventions, which seek to prevent poor outcomes as compared to those that seek to rehabilitate after the event.⁷² For example, a study conducted by the New Zealand Department of Corrections (2001) highlights the economic benefits of the earliest possible intervention: “We know the earliest possible intervention works best and costs the least. Working with a five-year-old to change aggressive and defiant behaviour is estimated to cost \$5,000 and has a success rate of 70 percent; the same behaviour at age 20 costs \$20,000 and has a success rate of only 20 percent.”

In the U.S.A., a cost-benefit analysis of the High/Scope Perry Preschool Project has established that, while the program cost \$12,356 per child, when the total benefits adjusted for inflation were calculated, the net benefit to society was \$88,433 per participant.⁷³ This amounts to a savings of approximately \$16 for every \$1 spent.⁷⁴ This project examined the lives of 123 African Americans born in poverty and at high risk of failing in school. From 1962–1967, at ages three and four years, the subjects were randomly divided into a program group that received a high-quality preschool program based on High/Scope's participatory learning approach and a comparison group who received no preschool program. The study found that adults at age 40 who had the preschool program had higher earnings, were more likely to hold a job, had committed fewer crimes, and were more likely to have graduated from high school than adults who did not have preschool.

6) Policy Options to Increase Access to Recreation for Low-income Families

6.1 Eliminate or Substantially Reduce User Fees: User fees for municipal recreation and arts programs in low-income communities should be eliminated. Families receiving Ontario Works assistance and the working poor should not be required to pay any fees. This can be accomplished without stigmatizing families nor causing additional levels of bureaucracy. In Gatineau, Quebec, for example, all residents are provided with free library cards. In addition, 'Access Cards', available through all libraries, give residents free access to all municipal recreational complexes for a small yearly fee (\$10 individual; \$25 family). Residents can swim, skate, and play badminton and tennis at no cost. There are no fees for the rental of sports equipment (cross country skis, pedal boats, canoes, skates, etc.) at a community park located on a lake. Families with income under \$40,000 pay significantly less than \$25 for their access cards.⁷⁵

The Australian and New Zealand 'Concession Card' is another example of a non-stigmatizing method to provide low cost access to recreation and arts activities.⁷⁶ There are three forms of cards issued: the Centrelink Health Care Card, the Centre Pensioner Concession Card, and the Commonwealth Seniors Health Card. The three cards are issued based on income, age or both through a Centrelink office. Once a citizen has such a card, they can use it at any facility with posted concession prices. In Melbourne, this includes transportation, theatre, recreation, education, and health services. The facilities, which accept the cards vary according to the municipality and state. The card gives citizens discounts on a wide variety of recreation, health, education, housing, and transportation services. The concession price is always posted at facilities along with all the other regular prices. For example, these prices are posted at bus stops, swimming pools, zoos, museums, and theatres.⁷⁷

Another way to ensure that user fees are eliminated or substantially reduced is to tie access to funding for future provincial and or federal infrastructure programs to local municipalities having in place access to recreation policies.

6.2 Eliminate provincial and municipal funding silos between public health, recreation, day care, education and Ontario Works

Separate funding for health, social, education, recreation and corrections sectors presents a major challenge for the elimination of user fees for low-income families.⁷⁸ There are promising approaches to reducing these silos in a handful of Ontario municipalities. Hamilton, Peel, York region, and London have created historical partnerships between sectors within their municipalities, increasing the participation of low-income families. The greatest successes are achieved in smaller communities where the senior managers of municipal sectors have developed excellent working relationships. These personal ties are able to surmount the bureaucratic red tape characteristic of many cities. Typically, these services are housed in the same building, providing consumers with 'one-stop-shopping'. In the *Families First* program, for example, when parents apply for Ontario Works, they are also introduced to day care, recreation, and public health staff. Families are provided with a yearly stipend of approximately \$250 per child for recreation expenses, which parents can use in a variety of ways to access recreation services and equipment. The Peel program is being replicated in Edmonton with a \$10 million evaluation study.

It is critical that access to public health nurses is facilitated through this process. In-home visitation by nurses to high-risk families over the long-term is the best way to prevent childhood neglect and physical abuse. Nurses teach disadvantaged young mothers about healthy relationships, the impact of smoking and using drugs and alcohol on developing fetuses, infant stimulation and good baby care. This is of critical importance because children who are suffering maltreatment by caregivers are least likely to participate in recreation programs. This is because parents do not want abuse and neglect identified by adults outside their families.

Wraparound projects in Milwaukee and in other areas of the USA and the UK have demonstrated that through the elimination of funding silos, flexible ‘pots’ of money can be tailored to meet the unique needs of families living in poverty to ensure that no child or youth ‘falls through the cracks’. These projects have demonstrated incredible success in increasing protective factors to promote the healthy development of low-income children, youth and families.⁷⁹ Ontario Wraparound projects are located in 20 communities, including Toronto, Ottawa, London and Hamilton.

6.3 Implement the ‘school as hub’ model

There is a large body of research pointing to the importance of increasing school bonding as an effective way to reduce drop-out and expulsion rates of high-risk students, most of whom are low-income. Staying in school and bonding to adults in schools develops the future aspirations of high-risk students, leading to a successful transition into adulthood. For these reasons, school-based recreation programs (prior to, during and after school hours) are particularly effective in increasing access to low-income families. After-school programs are particularly important because a substantial proportion of delinquent acts are committed between 3 and 8 p.m., when children are neither in school nor with a parent present at home.⁸⁰

Given that schools have the deepest capacity to increase recreation spaces in neighbourhoods, the ‘school-as-hub’ model should be adopted. In such programs, the local municipality works with schools and the Province to recognize and capitalize on the important role of schools in getting information from the community to youth. Schools work with local service providers to help create a network between the school, the community and opportunities for recreation. In some cases school boards have signed funding agreements with the Ministry of Education regarding the community use of schools.

By turning schools into centres for human development, from birth onward, we can mitigate the many risks faced by low-income people. Empty classrooms and gyms in neighbourhood schools can be transformed into daycare centres, sites for parent training, family literacy and baby wellness programs, and food and clothing banks. Such neighbourhood services provide individual supports and develop community capacity. Indeed, some school boards are already doing precisely this – using freed-up classroom space to offer expanded early childhood development programming.⁸¹

6.4 Provide stable funding for the Recreation Sector

Programs that have unstable funding or inadequate funding are forced to charge user fees to recover costs. This is completely contrary to the research evidence on quality programs for low-income families. Many studies in various countries have demonstrated the considerable cost-savings to other sectors when no-charge, quality health, social and recreation services are provided to these families.

6.5 Increase capacity of recreation programs to meet the unique needs of New Canadians, ethno-racial minorities, and Aboriginals

Despite the fact that New Canadians and other ethno-racial minority groups make up approximately 20% of the Ontario population, the vast majority of low-income families are minorities.⁸² Aboriginals make up no more than three percent of the Ontario population, yet they are also significantly over-represented in the low-income population. The participation of these groups in traditional recreation programs is limited due to language and cultural barriers. Culturally competent programs recruit and retain diverse staff, provide cultural interpretation and translation for new Canadian families, and engage in activities where adolescents learn about their cultural heritage, backgrounds and individual differences.

6.6 Increase the capacity of recreation programs to meet the unique needs of girls and young women

There are major barriers preventing the full participation of low-income girls and young women in many Ontario recreation programs. There is sound scientific evidence supporting the importance of addressing the particular issues, problems and assets of girls and boys separately, beginning as early as age six. Programs must be responsive to gender differences (e.g., boys' programming addresses issues related to independence and separation, whereas for girls there is a focus on their sense of connection with others) and ensure that activities are safe. The gender of the supervising adult is a key determinant of success. Young females relate best to strong and assertive female role models.

6.7 Increase outreach services to low-income families to promote recruitment into and maintain participation in recreation programs.

When program staff visits the homes of families to explain programs and offer supports (transportation, equipment and supplies), the participation of children dramatically increases. Outreach efforts must be maintained, particularly when the participation of specific children decreases. In FFE, for example, the primary role of each recreation coordinator is to work closely with families to facilitate children's participation in recreational activities.

6.8 A single case management approach with families should be maintained

The benefits of recreation for low-income families are maintained over the life course of high risk children when participation is maintained throughout childhood and adolescence. These children acquire a sense of mastery and competence regarding their skills, providing them with protection against the many risks in their lives. The best way to maintain the participation of these young people throughout childhood and adolescence is by fostering long-term relationships with the same recreation worker. Programs that actively encourage parental involvement have much more success in preventing the development of negative behaviours in young people compared to those that do not engage parents.

6.9 Ensure adequate recreation infrastructure in low-income communities

Adequate infrastructure includes not only that for structured programs but also for passive activities, which are inexpensive, self-directed and responsive to need. Examples include outdoor basketball courts, gymnasiums, dance studio, art studios, and youth centres.

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8) End Notes

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- ⁶⁰ Statistics Canada, 2003a. The term physically inactive is equivalent to an energy expenditure of less than three kilocalories per kilogram of body weight per day. This level of physical activity can be achieved by playing team sports for an hour or one half an hour of running, combined with an accumulated hour of walking throughout the day
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- ⁷² Jacobsen et al., 2002; Kalil, 2003; Lynch, 2004.
- ⁷³ Welsh, 2001
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