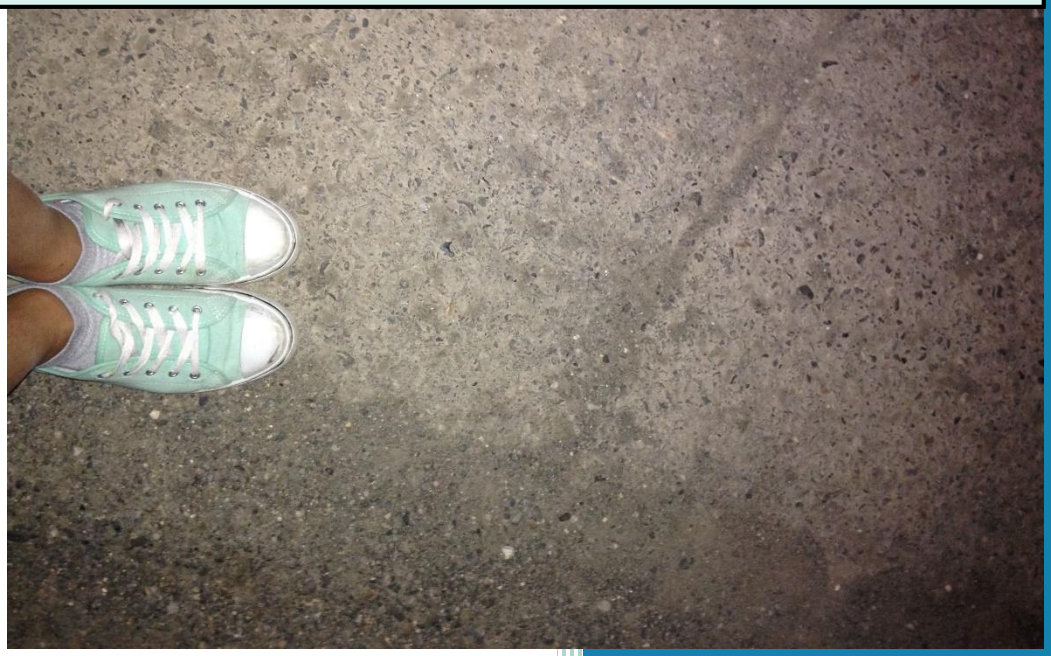
2017

South Cariboo Community Profile



Communities That Care

Acknowledgements

Community That Cares is a cross-sector community initiative that brings together multiple organizations to work collaboratively for prevention related to social issues that affect children, youth and their families. Completion of this report is due to the significant contributions of both individuals and organizations. We are very appreciative of the time, expertise and funds that our many community partners brought to this process. A particular thanks to those who reviewed drafts of the report and provided feedback and input.

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School District #27
Division of Family Practice Cariboo Action Team – CYMHSU
United Way – Thompson-Cariboo-Shuswap
Central Interior Community Services Co-op
Cariboo Regional District
City of Williams Lake
Axis Family Resources

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Executive Summary

Communities That Care (CTC) is a collaborative community effort to improve the health and well-being of children and youth. CTC was established in Williams Lake and Anahim Lake in 2009. While there is not a specific CTC initiative in the South Cariboo, School District 27 undertook a district wide approach to addressing the school domain risk and protective factors during the implementation of programs. Although there is not comparative data available, the data contained in this report provides information that is relevant and informative for the community and can be used to provide concrete evidence of the issues, concerns, and priorities for children, youth and their families. More information about the Communities That Care model itself is available in the Williams Lake Community Profile.

The Prevention Needs Assessment survey is the cornerstone of the Communities That Care process. It is a standardized instrument for measuring the existence of risk and protective factors, as well as involvement of youth in six specific problem behaviours. In November 2015, we did a survey of all children and youth attending grades six through twelve in South Cariboo schools.

A total of 638 students (78% of all students) completed the survey. The following are highlights of the results:

- *62% of youth have a high number of protective factors*
- *56% of youth have a high number of risk factors in their lives*
- *Grade 8 students reported more risk and have the lowest percentage of students with high protective factors.*
- *In the family domain, 60% of students reported strong family attachment*
- *In the school domain, risk factors are significantly higher among Grade 8 students than either Grade 7 or Grade 9 students, and protective factors are correspondingly lower.*
- *50% of students said they participate in pro-social activities with peers.*
- *59% of students in Grade 10 reported experiencing depressive symptoms.*

The survey data in this report represents an opportunity to better understand the particular strengths and challenges facing children and youth in the South Cariboo. It is important to hear and honor the information youth have shared. It tells an important part of their story, and presents an opportunity and invitation for the community to respond to that story, to support their strengths and address their needs.

Introduction

Communities That Care is a collaborative community effort to improve the health and well-being of children and youth. It was established in Williams Lake in 2009 through a community initiative led by the City of Williams Lake, Ministry for Children and Families, Social Planning Council and several inter-agency network tables. Over the past eight years, many organizations and individuals have worked collaboratively to respond to the data in the first community profile, the priorities set by the community, and the challenge of learning how to do collaboration differently. As we moved into the phase of a second round of data collection, several of our funders asked that we include the entire school district in this process and supported the development of separate community profile documents for the South Cariboo and Chilcotin, as a resource for those communities. Information about the implementation of the CTC model, and the activities of the CTC initiative in Williams Lake can be found in the Williams Lake Community Profile.[1] Even though CTC as a model does not extend into the South Cariboo, the data is relevant and informative for a range of community initiatives, and provides information that can be utilized to identify the issues, concerns and priorities for work with children, youth and their families.

What is Communities That Care?

Communities That Care[2] (CTC) is a community based approach to preventing problem youth behaviours, including substance abuse, delinquency (crime), violence, teen pregnancy, school drop-out, depression and anxiety. It focuses on promoting positive and healthy youth behaviour, while understanding the root causes of negative behaviour.

Several decades of research have demonstrated that there are particular risk factors which increase the likelihood that youth will engage in problem behaviours, and that many risk factors are predictive of multiple problem behaviours. Therefore, the principle is that if you address the risk factors, rather than the presenting behaviours, you not only reduce the likelihood of the problem behaviour, but you can impact more than one problem behaviour. It shifts the focus of prevention activities from the behaviour itself to the root causes of that behaviour. CTC defines prevention in terms of delivering programs focused on reducing the existence and prevalence of risk factors rather than intervention with individuals who are already involved in one (or more) of the problem behaviours.

One of the cornerstones of the CTC model is data driven decision making. Research in prevention science over the past 30 years, across a variety of disciplines, has identified 20 risk factors that can reliably predict problem behaviours in adolescents. The more risk factors present, the greater the chance of problem behaviours, and the more protective factors, the less chance. Because some risk factors are predictive of multiple problem behaviours, implementing programs focused on key risk and protective factors can be expected to produce long term results.

CTC uses a population level survey of youth, the Prevention Needs Assessment Survey, to identify the existence of risk and protective factors among youth in our community, along with contextual data from all sectors. This data is paired with the knowledge of those working directly with children, youth and their families, to give us a picture of how well youth in our community are doing.

[1] Available online at http://www.sd27.bc.ca/healthy-schools-healthy-students/communities-that-care/
[2] Additional information about the CTC model can be found at: http://www.communitiesthatcare.net/

Risk Factors	Substance Use	Delinquency / Crime	Teen Pregnancy	School Dropout	Violence	Depression & Anxiety
Community						
Availability of Drugs	√				√	
Availability of Firearms		√			√	
Community laws & norms favourable toward drug use, firearms and crime	√	√			√	
Media portrayals of violence					√	
Transitions and mobility	√	√		√		
Low neighbourhood attachment and community disorganization	√	√			√	
Extreme economic deprivation	√	√	√	√	√	
Family						
Family history of the problem behaviour	√	√	√	√	√	√
Family management problems	√	√	√	√	√	√
Family conflict	√	√	√	√	√	√
Favourable parental attitudes to, and involvement in the problem behaviour	√	√			√	
School						
Academic failure beginning in late elementary school	√	√	√	√	√	√
Lack of commitment to school	√	√	√	√	√	
Peer & Individual						
Early and persistent antisocial behaviour	√	√	√	√	√	√
Rebelliousness	√	√		√		
Friends who engage in the problem behaviour	√	√	√	√	√	
Gang involvement	√	√			√	
Favourable attitudes toward the problem behaviour	√	√	√	√		
Early initiation of the problem behaviour	√	√	√	√	√	
Constitutional factors	√	√			√	√

Figure 1*: Research connections between risk factors and problem behaviours*[3]

The CTC model provides a guided process that uses research based decision making and integrated approaches to prevention, as well as the importance of mobilizing the community to take action. The CTC process is organized into five phases, which each have specific benchmarks and milestones.

[3] http://www.communitiesthatcare.net/research-results/

Figure 2*: CTC Process*

The *Communities That Care* system has been designed to guide communities through the most critical and challenging steps in this process, from community mobilization through outcomes evaluation. The *Communities That Care* system helps communities:

1. Identify and address readiness issues — such as targeting and resolving potential obstacles to a successful community-wide prevention effort.
2. Organize and involve all community members who have a stake in healthy futures for young people by bringing together representation from all of those stakeholders
3. Bring together diverse community efforts that address youth and family issues, by establishing a shared vision, a common language and a collaborative approach to planning and implementing needed changes.
4. Set priorities for action based on a data-based profile of community strengths and challenges.
5. Strengthen funding applications, using a community profile that pinpoints the community's specific needs.
6. Define clear, measurable outcomes that can be tracked over time to show progress and ensure accountability.
7. Identify gaps in how priorities are currently addressed.
8. Select tested, effective (evidence-based) programs, policies and practices to fill community-identified gaps.
9. Evaluate progress toward desired outcomes

Social Development Model

The Social Development Model is a strength based approach to healthy youth development which is the foundation for CTC. It focuses on all aspects of children/youth lives (individual characteristics, families, peer relationships, schools, and communities). It is based on nurturing the individual characteristics of

each child, giving them the opportunity to build their skills, and recognizing positive behaviours. This builds bonds, attachment and commitment to their families, positive peers, schools and communities. In order to do this, we need to provide children and youth with a whole set of healthy beliefs and clear expectation about what positive characteristics and behaviours we expect from them. This requires strong and healthy adult role models in all domains of a child's life who can reinforce these healthy beliefs. The strategy must be woven into all areas of youth development in the community including: individual relationships, youth serving organizations and programs, and all segments of the community.

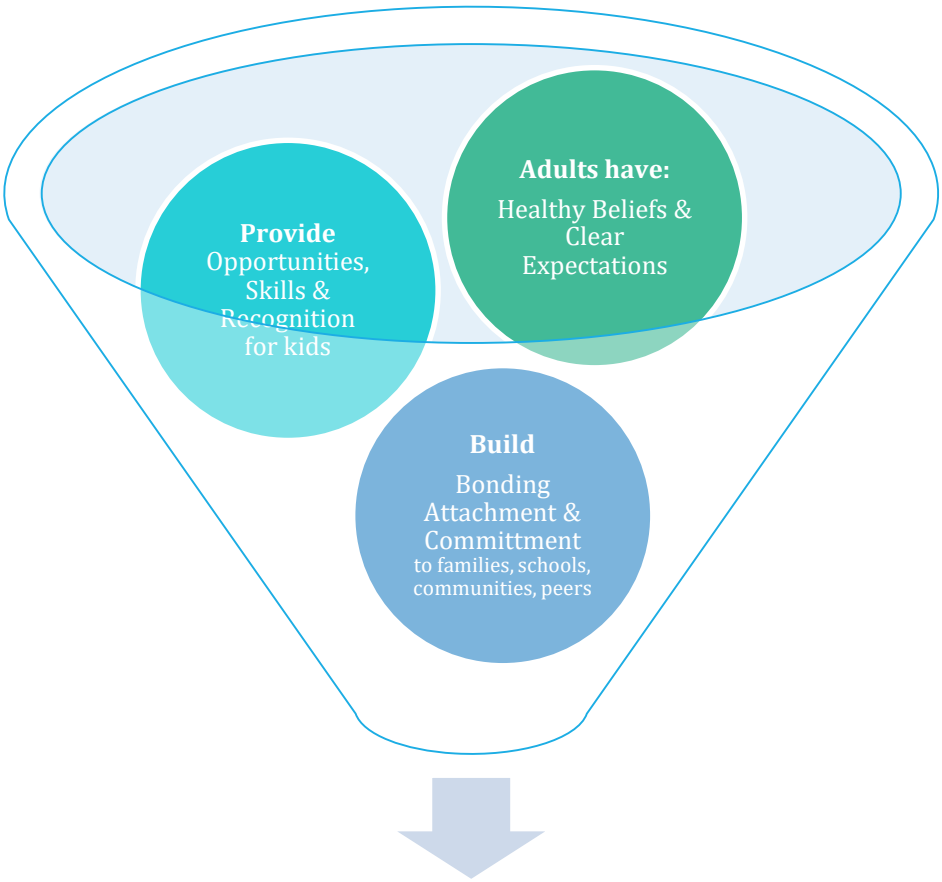


Figure 3*: Social Development Model*

Prevention Needs Assessment Youth Survey

About the PNA Survey

The cornerstone of the Communities That Care process is the Youth Prevention Needs Assessment Survey. This is a survey of all children and youth from grades six through twelve. It is completed in classrooms, facilitated by a survey implementation team, with support from classroom teachers.

The Prevention Needs Assessment Survey is a standardized instrument for measuring the existence of risk and protective factors, or strengths and needs of students in a given area or community. The survey is designed to assess students' involvement in a specific set of problem behaviours as well as their exposure to a set of risk and protective factors that have been shown to influence the likelihood of youth being involved in or experiencing one or more of the following six behaviours:

- **school dropout**
- **substance abuse**
- **violence**
- **delinquency/crime**
- **depression/anxiety**
- **teen pregnancy**

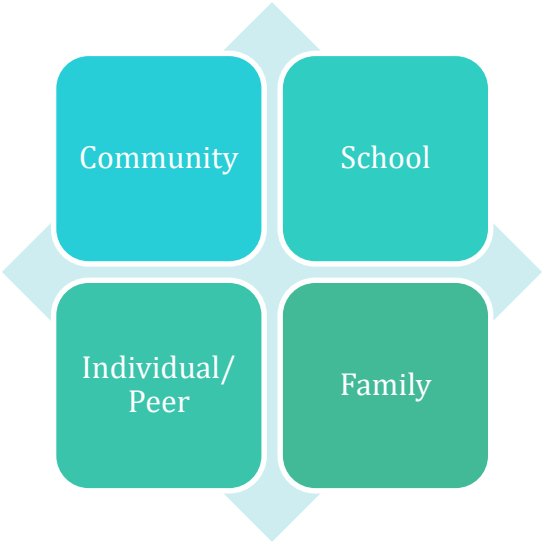
A NOTE ABOUT HONESTY

The PNA survey is completed anonymously and confidentiality is stressed throughout the survey process. This removes most of the reasons for students to exaggerate or deny behaviours on the survey. There are also a number of checks built in to the data analysis to minimize the impact of dishonest responses or students who do not take the survey seriously.

The survey was completed in November 2015. A total of **638** students grades 6-12 in South Cariboo schools completed the survey, representing 78% of the sample population[4]. This response rate gives us confidence that the data reflects, with reasonable accuracy, the experiences of the population being surveyed.

Risk and Protective Factors

Risk and Protective Factors are scientifically validated characteristics of a child and his or her environment that can be used as indicators of how well the children and youth in our community are doing. Risk factors are known to increase the likelihood of negative outcomes for children. Protective Factors exert a positive influence and shield children from the negative influence of risk, thus reducing the likelihood that children and youth will experience negative outcomes. Risk and protective factors are grouped in four domains - community, family, school, and individual/peer - because they represent the key areas where youth live, develop and interact. However, a factor from one domain can also be addressed in another. For example, school-based programs can affect peer influences and parenting programs can affect children's academic performance. Research has demonstrated that many of the same risk and



[4] 100 Mile Elementary, Horse Lake, Forest Grove, 108 Mile, and Peter Skene Ogden

protective factors predict multiple youth well-being outcomes. Addressing these root causes of youth well-being is a proven method for improving children's health and development.

Survey Results

The survey results report provides us with a substantial amount of data that can help us understand not only the risk and protective factor profile of the population surveyed, but a range of other indicators that contribute to those factors. We have chosen to present data here that is most helpful in understanding what the strengths and needs of our youth are, and what professionals might take notice of when planning programs, services and activities aimed at children and youth.

Risk and Protective Factor Profile

The PNA Survey provides a profile of the percentage of children and youth who have each risk and protective factor in their life across the four domains of community, school, family and individual/peer. Students considered high risk are those who have five or more risk factors in Grade 6, six or more in Grades 7-9 and seven or more in Grades 10-12. Those with high levels of protection, which buffers against risk, are those who have three or more protective factors in Grade 6-7, and four or more in Grades 8-12. In the South Cariboo, 62% of students have enough protective factors to have a high level of protection, while 56% have enough risk factors to put them at high risk for engagement/involvement in one or more of the six problem behaviours identified.

62% High Protection

56% High Risk

Exploring the levels of risk and protection by grade gives a broader view of how students across the grades are reporting their risk and protective factors. This data represents a snapshot of students at a particular point in time, so it is important to consider contextual factors. For example, low protection in the Grade 8 students may represent a drop in protective factors at Grade 8 in the community, or it may be that this particular cohort of Grade 8 students has few protective factors. Tracking data over time will help the community to understand the subtleties of the data. In addition, the survey is designed to help communities identify prevention needs in their community. For example, if a community wants to address low levels of protective factors in Grade 8 students, it is important to address those from a prevention focus. This requires the community to implement activities targeted at students much earlier than Grade 8.

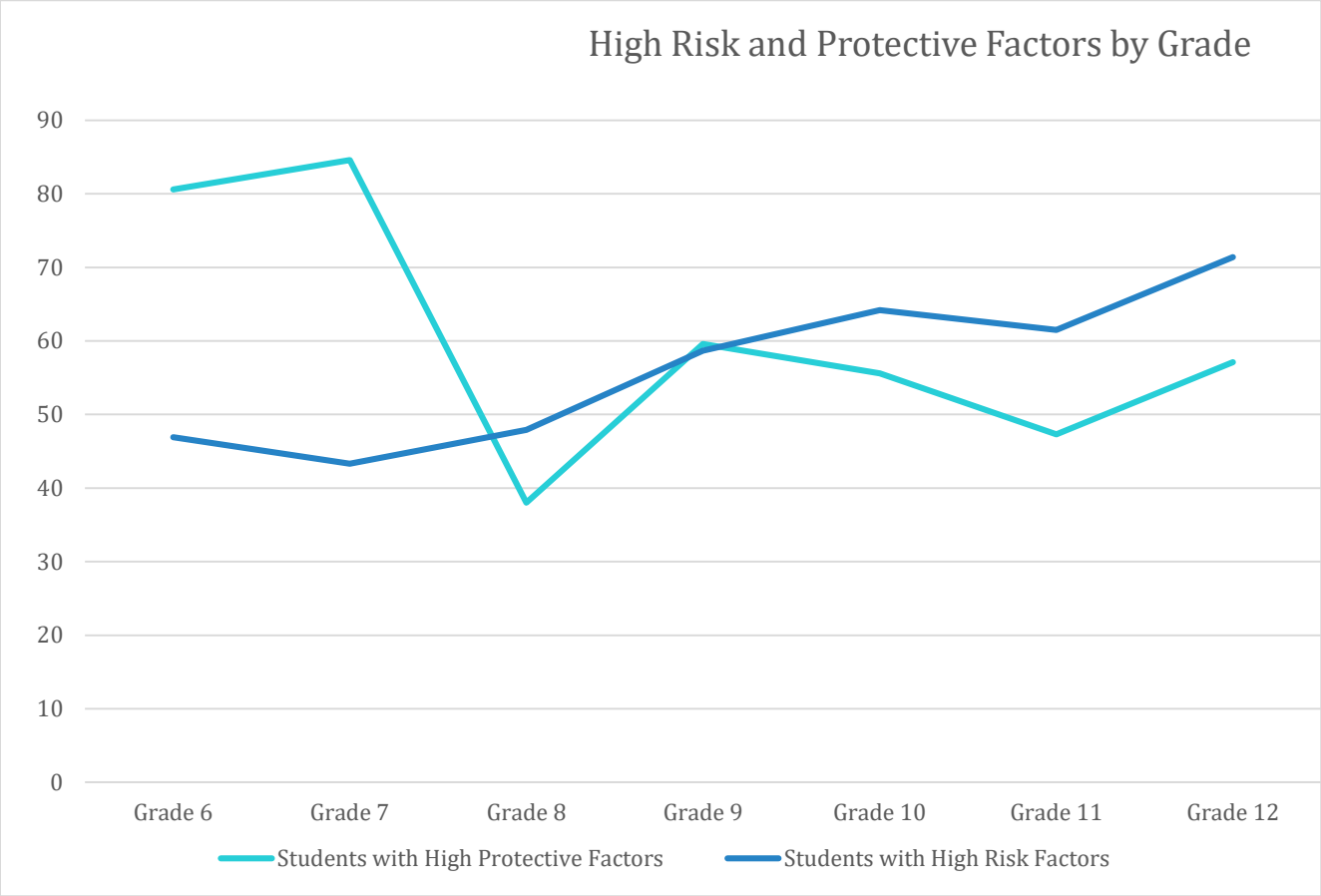
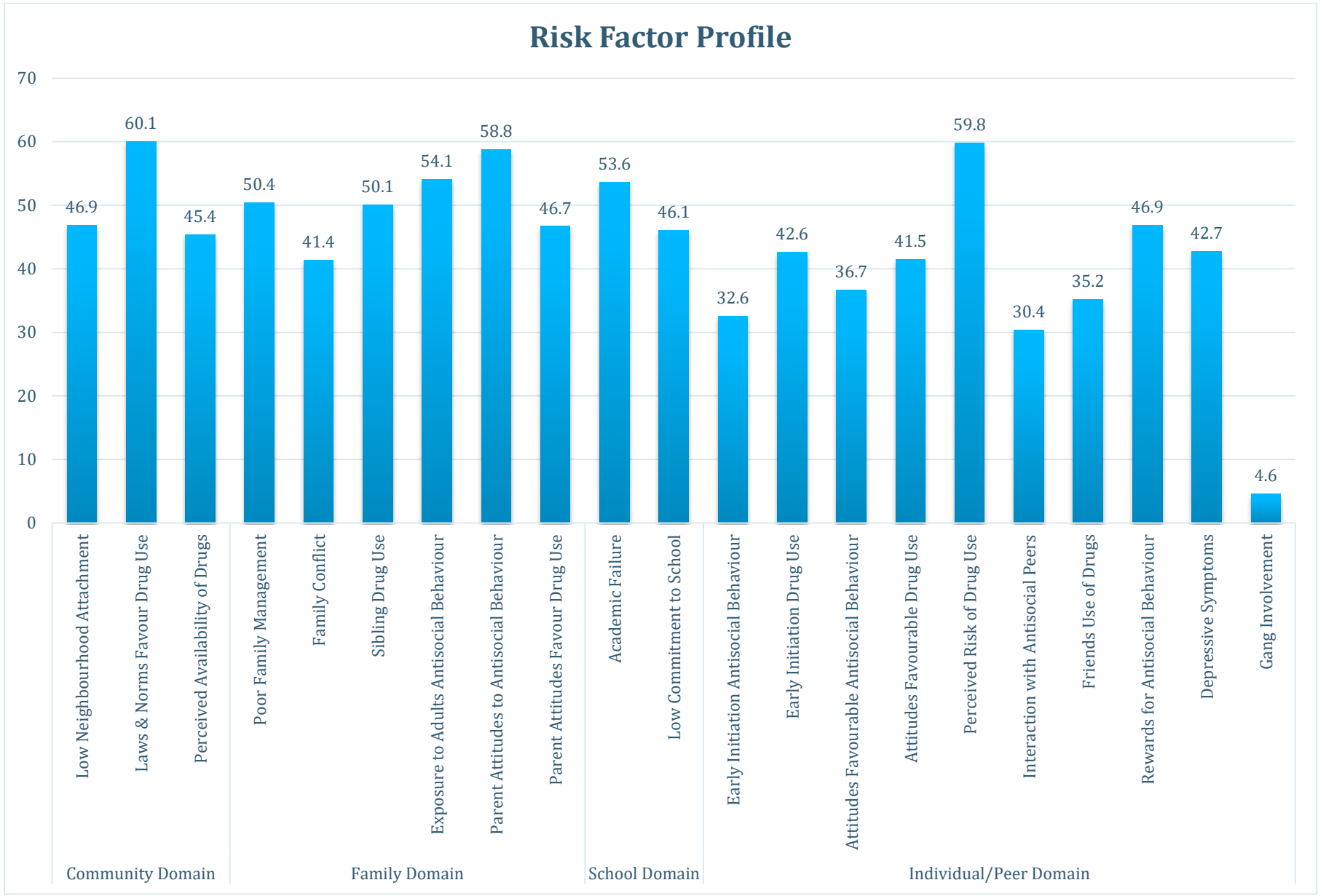
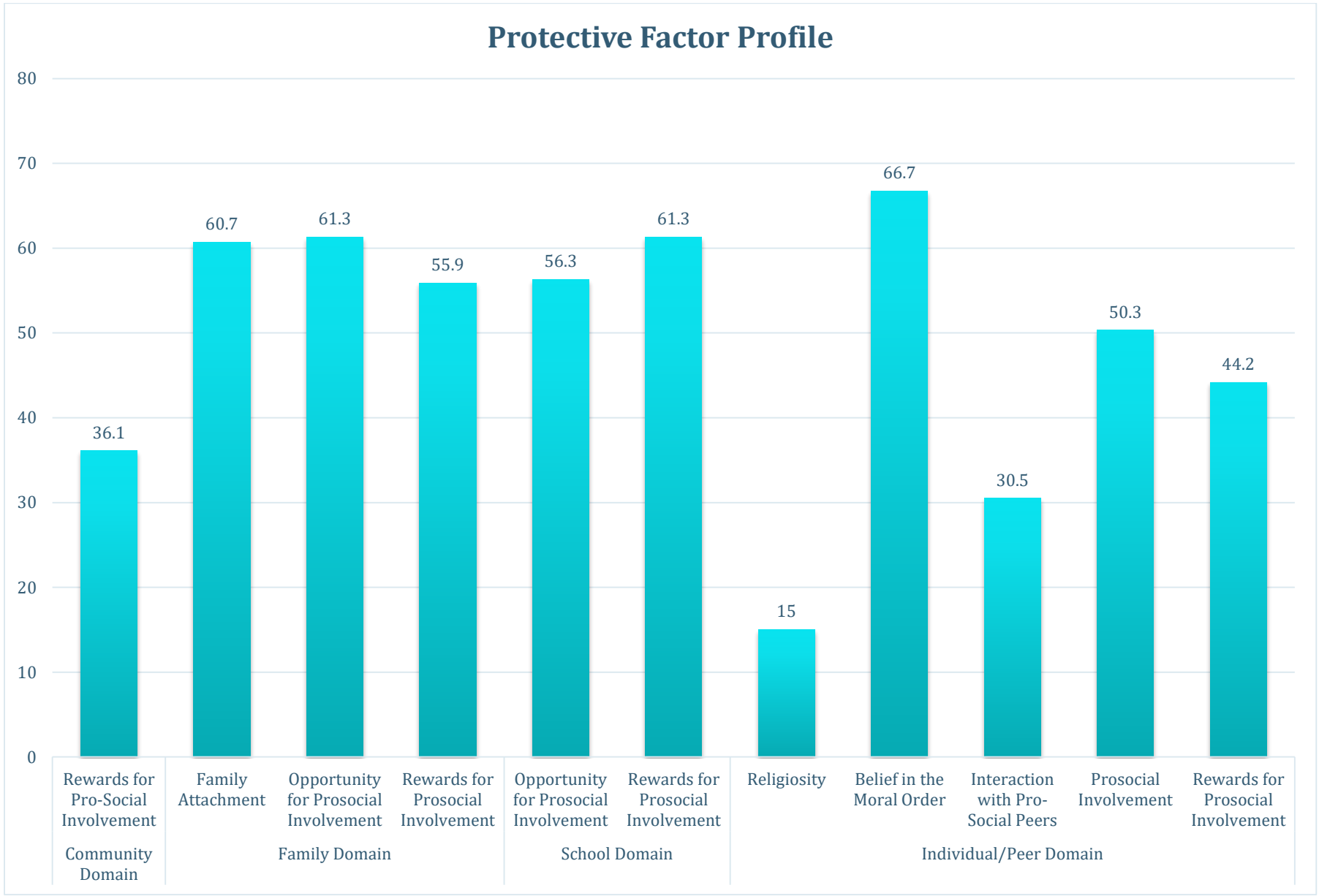


Figure 4: Percentage of Students with High Risk and Protection

Although results are corrected for the reality that the number of risk factors in a youth's life increases as they get older, the percentage of students with high risk[5] does tend to rise from younger to older students. Again, the importance of considering the community and cohort context is important, and prevention initiatives need to be focused earlier rather than at the grade level where increased risk levels are observed in the data. Also, the domain in which risk is increasing and the specific risk factors themselves are also important to understand.

[5] five or more risk factors in Grade 6, six or more in Grades 7-9 and seven or more in Grades 10-12


Risk Factor Profile
70
60
50
40
30
20
10
0
46.9
60.1
45.4
50.4
41.4
50.1
54.1
58.8
46.7
53.6
46.1
32.6
42.6
36.7
41.5
59.8
30.4
35.2
46.9
42.7
4.6
Low Neighbourhood Attachment
Laws & Norms Favour Drug Use
Perceived Availability of Drugs
Poor Family Management
Family Conflict
Sibling Drug Use
Exposure to Adults Antisocial Behaviour
Parent Attitudes to Antisocial Behaviour
Parent Attitudes Favour Drug Use
Academic Failure
Low Commitment to School
Early Initiation Antisocial Behaviour
Early Initiation Drug Use
Attitudes Favourable Antisocial Behaviour
Attitudes Favourable Drug Use
Perceived Risk of Drug Use
Interaction with Antisocial Peers
Friends Use of Drugs
Rewards for Antisocial Behaviour
Depressive Symptoms
Gang Involvement
Community Domain
Family Domain
School Domain
Individual/Peer Domain


Protective Factor Profile
80
70
60
50
40
30
20
10
0
36.1
60.7
61.3
55.9
56.3
61.3
15
66.7
30.5
50.3
44.2
Rewards for Pro-Social Involvement
Family Attachment
Opportunity for Prosocial Involvement
Rewards for Prosocial Involvement
Opportunity for Prosocial Involvement
Rewards for Prosocial Involvement
Religiosity
Belief in the Moral Order
Interaction with Pro-Social Peers
Prosocial Involvement
Rewards for Prosocial Involvement
Community Domain
Family Domain
School Domain
Individual/Peer Domain

Community Domain

The community domain focuses on the neighbourhood and broader community where children and youth live. Research shows that a low level of bonding to the neighbourhood, neighbourhood attitudes that favour drug use, and easy access to tobacco, alcohol, and other drugs increases the risk that children and youth will be involved in problem behaviours. The community can increase protection for children and youth by providing opportunities for pro-social involvement, and particularly by recognizing and acknowledging positive behaviour by youth in their neighbourhoods and communities. While this domain may seem as though it is the most challenging domain to address, it is also an important domain, and opportunities for discussion about community values and standards, as well as the role modelling of adults in a broad range of community settings is useful in understanding how communities can tackle factors in this domain.

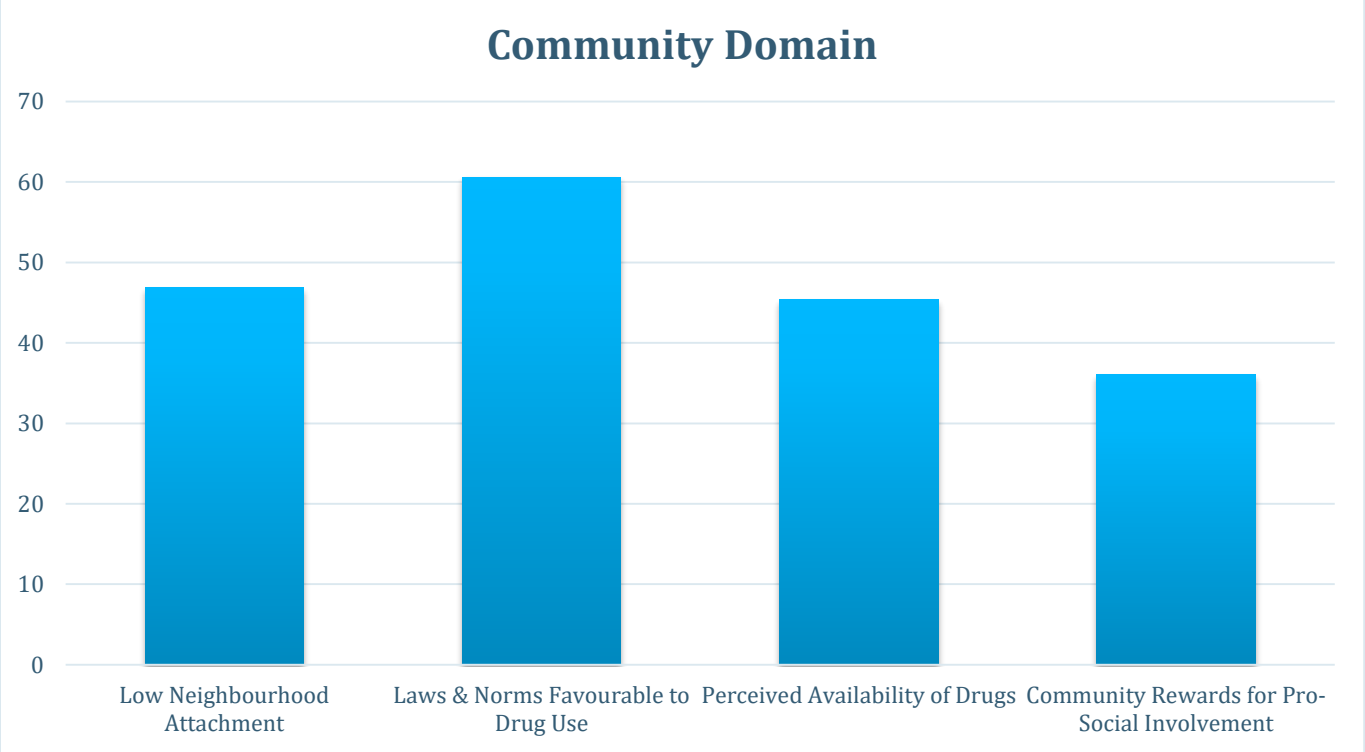


Figure 5: Community domain risk and protective factors with school district wide comparison

Family Domain

The family domain is where children and youth are most strongly influenced in their early years. Early attachment and modelling of family values and norms sets the stage for other experiences and influences in their lives. When children have strong family attachment, are valued, have opportunities to participate in a meaningful way and are recognized for positive behaviour, they are less likely to engage in alcohol and drug use and other problem behaviour. Families where discipline is inconsistent or unusually harsh or where parents don't provide clear expectations and monitor their children's behaviour (Family Management), are more likely to have children who engage in problem behaviour. Also, children raised in families with high levels of conflict, or with a history of problem behaviours (including children being exposed to adult or sibling anti-social behaviour) are at higher risk. The risk is further increased where

parents involve their children in their drug or alcohol using behaviour (such as asking a child to light their cigarette, or get them another drink). Interestingly, in this domain, the risk factor *Parent Attitudes Favourable to Drug/Alcohol Use* has a significant increase from 32% of Grade 8 students to nearly 58% in the Grade 9 students. This data also correlates with a significant increase in binge drinking from Grade 8 (13%) to Grade 9 (28%) students.

Students do have strong protective factors in the family domain. Over 60% of students reported strong family attachment, as well as opportunities for pro-social involvement/activities with their family. While this is often seen as important in the early years, there is increasing evidence that maintaining family attachment throughout adolescence is critical.

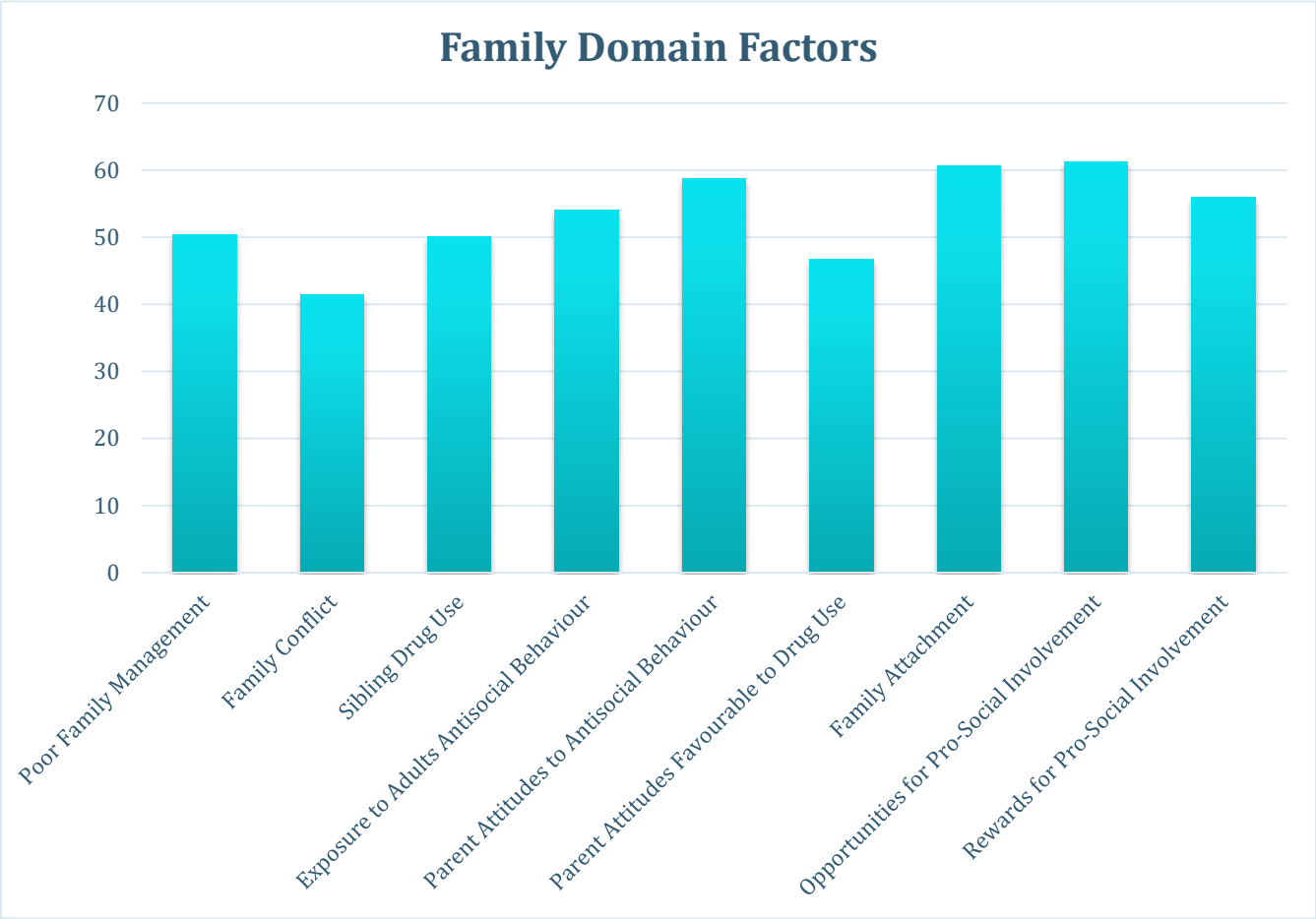


Figure 6: Family domain risk and protective factors with school district wide comparison

School Domain

Children and youth spend a significant amount of time in schools, so this is where we have an opportunity to have a substantial influence on them, both in terms of the specific school risk and protective factors, but also on individual and peer factors as well. It is important to highlight that research shows that it is the experience of academic failure that elevates risk, rather than actual failure according to grading schema. *Low Commitment to School* is a measure of how much students like school, spend time on their studies, and see their coursework as relevant.

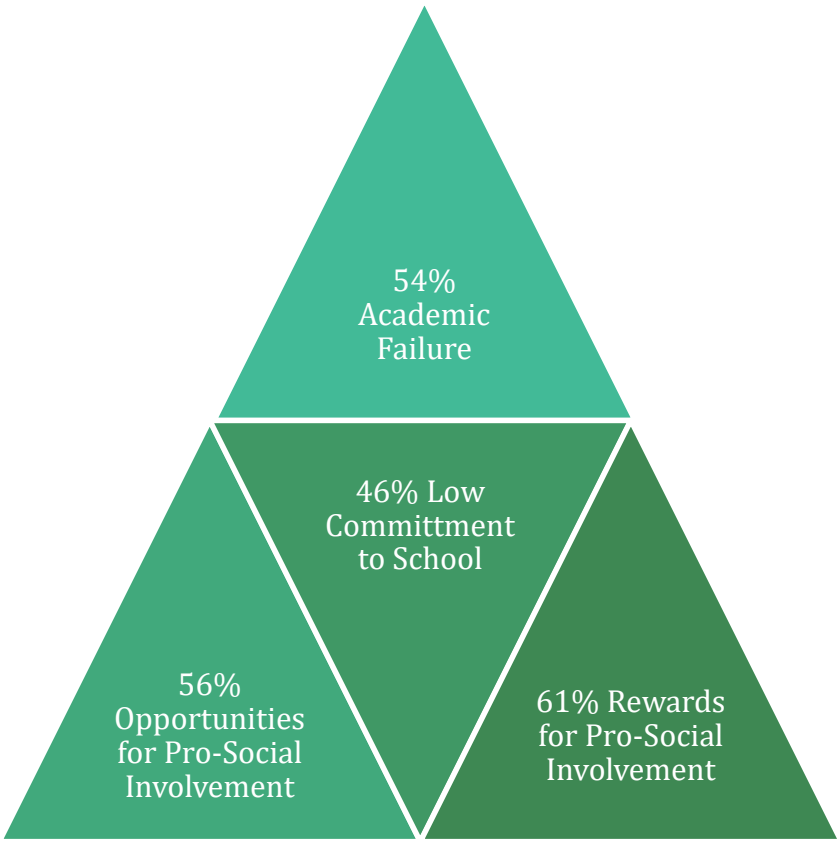


Figure 7: School domain risk and protective factors - all grades

In the school domain, we see a significant shift from Grade 7 to Grade 8 in both risk and protective factors. It is uncertain whether these are shifts related to transitions from elementary to secondary school settings; however, it is notable that this shift is not observed consistently across the district at the Grade 7-8 transition, nor at the elementary-secondary transition. This suggests there may be some other elements implicated, either for this particular cohort, or as a result of the secondary school environment.

	Risk Factors		Protective Factors	
	Low Commitment to School	Academic Failure	Opportunities for Pro-Social Involvement	Rewards for Pro-Social Involvement
Grade 7	29	37	78	79
Grade 8	54	55	54	37
Grade 9	44	62	54	67

Table 1: Change in school domain factors over transition from elementary to secondary school

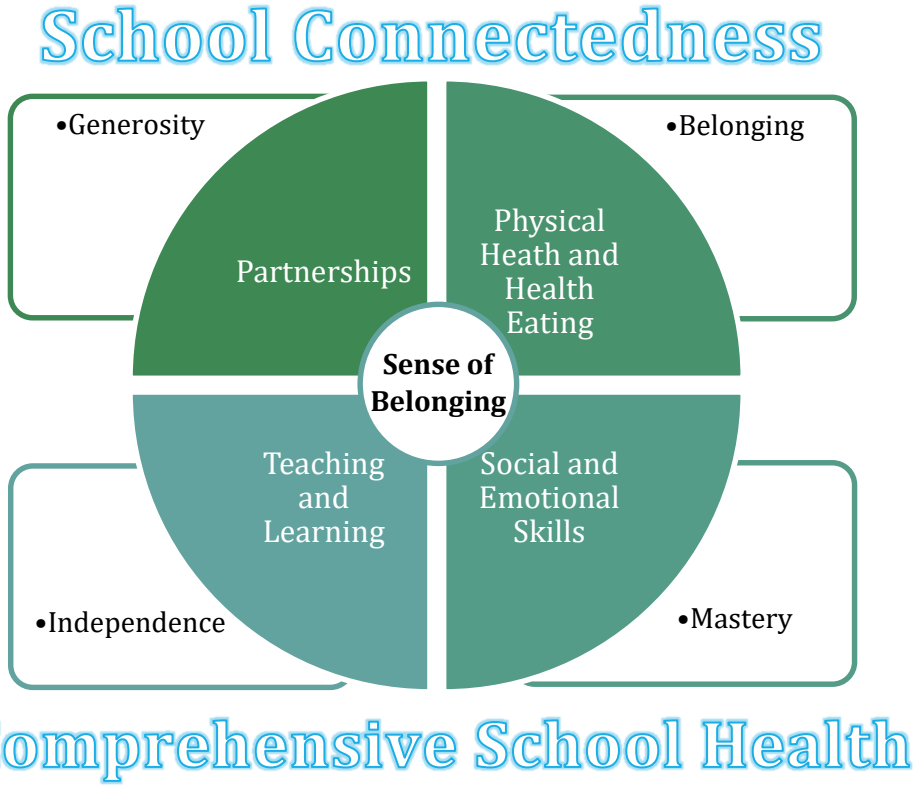
In 2010, the leadership at the School District viewed *Low Commitment to School* as a root cause associated with poor academic achievement. The rationale for this decision is that if we can increase students' commitment to school, they are more likely to engage in pro-social activities, and academic success is also likely to increase when commitment to school increases. As a result, the School District took a broad view

that in addition to offering the Positive Action® program to individual teachers for implementation, there would be a district wide approach to this issue. The Circle of Courage, developed by Dr. Martin Brokenleg, was identified as a culturally appropriate framework consistent with building the principles of the Social Development Strategy within the school system. It also fit well with the Comprehensive School Health framework which was the focus for the District's Healthy Schools initiative. With so many components, the district made a strategic decision to align their approach.

Multiple workshops to share this framework with district leadership, school principals, teachers and other staff set the stage for schools to develop a Sense of Belonging strategy as a foundation to their school based planning process and Building Resilient Learner plans, which are now required for each school. In recognition of their work on this, in 2015 School District 27 was awarded a School Connectedness grant to produce a video outlining their approach.[6] [7]

Just One Thing… A Sense of Belonging

School District 27 developed a comprehensive school health program around the Circle of Courage and Communities That Care priorities. They established Sense of Belonging and School Connectedness as pillars of their Healthy Schools initiative. This focus on building support, relationships and connections among staff, students and community partners focused activities into a single document – the Building Resilient Learners School plan, which each school developed to suit their strengths and needs. This focused all initiatives on one foundation goal rather than insisting that schools do more and more programming to address a wide range of issues. They committed funds to ensure schools had the resources to implement their plans.



[6] http://www.sd27.bc.ca/healthy-schools-healthy-students/
[7] http://healthyschoolsbc.ca/key-focus-areas/school-connectedness/

Individual/Peer Domain

This domain speaks to the individual characteristics and experiences of children and youth and to the influence of their peers on their attitudes, beliefs, and behaviours. Research shows that early onset of alcohol and other drug use (prior to age 15), in addition to having implications for brain development, is a consistent predictor of future drug abuse.

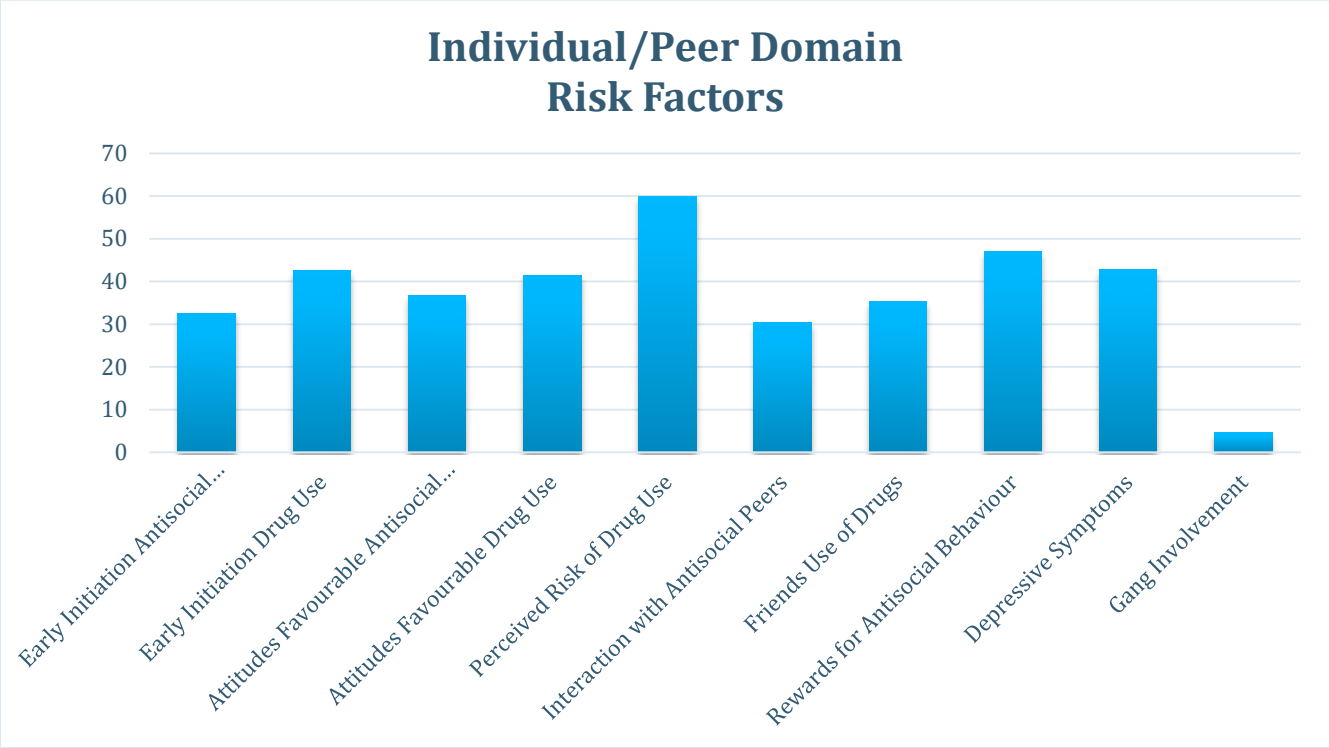


Figure 8: Individual/Peer domain risk factor profile

The risk factor *Perceived Risk of Drug Use* has increased across the school district since 2009. There has been some suggestion that this may be due to the public discourse about legalization of marijuana, since the increase contradicts a decrease in the *Community Laws and Norms Favourable to Drug Use* risk factor.

There is a spike at Grade 7 in *Early Initiation of Anti-Social Behaviour* from 33% in Grade 6 to 44% in Grade 7, dropping back to below 25% in Grade 8 students. Anti-social behaviour is a measure of the percentage of students who report any involvement during the past year with the following eight behaviours:

- Been suspended from school
- Been drunk or high at school
- Sold illegal drugs
- Stolen or tried to steal a vehicle
- Been arrested
- Attacked someone with the intent to seriously harm them
- Carried a weapon
- Carried a weapon to school

The *Depressive Symptoms* risk factor represents students who report experiencing depressive symptoms, not those who have been diagnosed, or accessed services or treatment for depression. Grade level data shows that the percentage of students experiencing depressive symptoms jumps significantly between Grade 9 and Grade 10, and peaks at 59% of Grade 10 students reporting this risk factor, with a slight drop to an average of 53% of Grade 11 and 12 students.

In the South Cariboo 25% of students reported one or more incidents of self-harming, without suicidal intentions. Over 42% of Grade 10 students reported at least one incident of self-harming.

We also asked students whether they had an adult in their life that they could share their thoughts with or ask for help with a problem. Across all grades, 20% of students said they did not. The highest percentages were in Grade 8 (35%) and in Grade 10 (32%). Over 17% of Grade 10 students reported being suspended from school, which is 5% higher than the rest of the district.

59% of **Grade 10** students report experiencing **Depressive Symptoms**

In terms of protective factors, *Belief in the Moral Order* can be described as having an understanding of right and wrong. Students in the South Cariboo have a high level of protection in this area. Students also report *Pro-Social Involvement with Peers* as a strong protective factor.

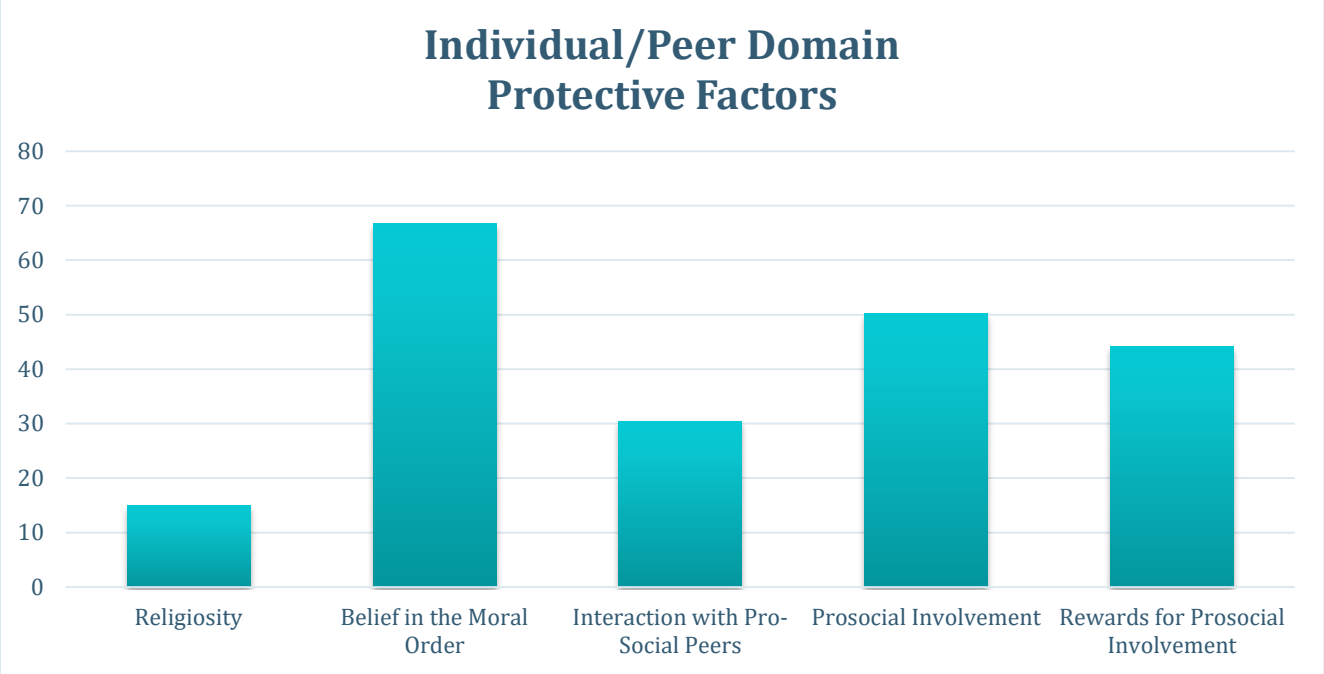
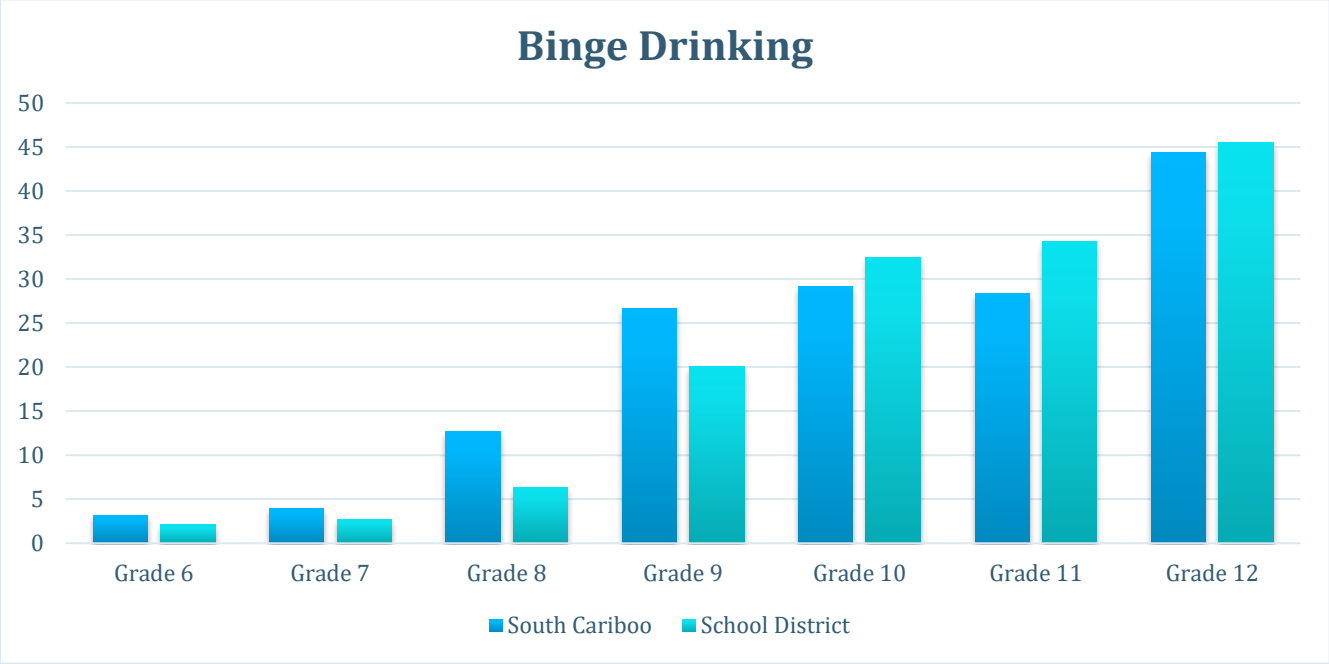


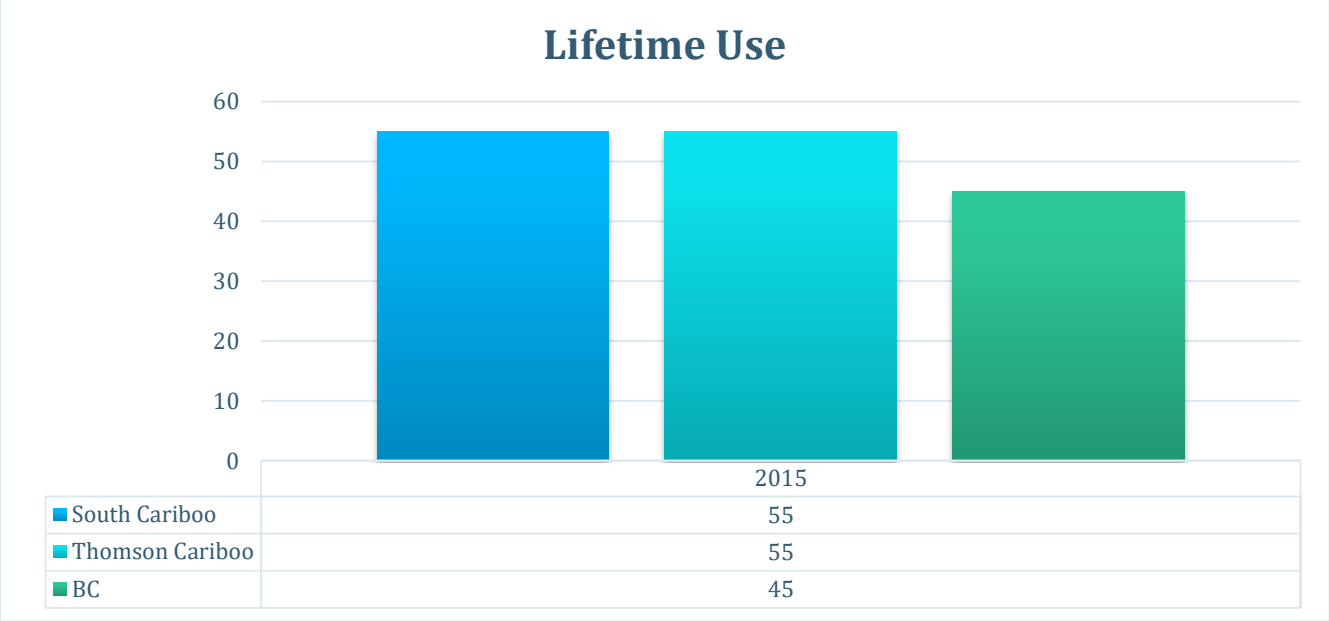
Figure 9: Individual/Peer domain protective factor profile

Alcohol and Other Drug Use

Particularly among students in Grades 7 through 9, as well as Grade 12, *Early Initiation of Drug Use* is significantly higher than the average across the district. Youth who engage in alcohol and drug use prior to age 15 risk negative impacts on brain development, and research shows this is a consistent predictor of

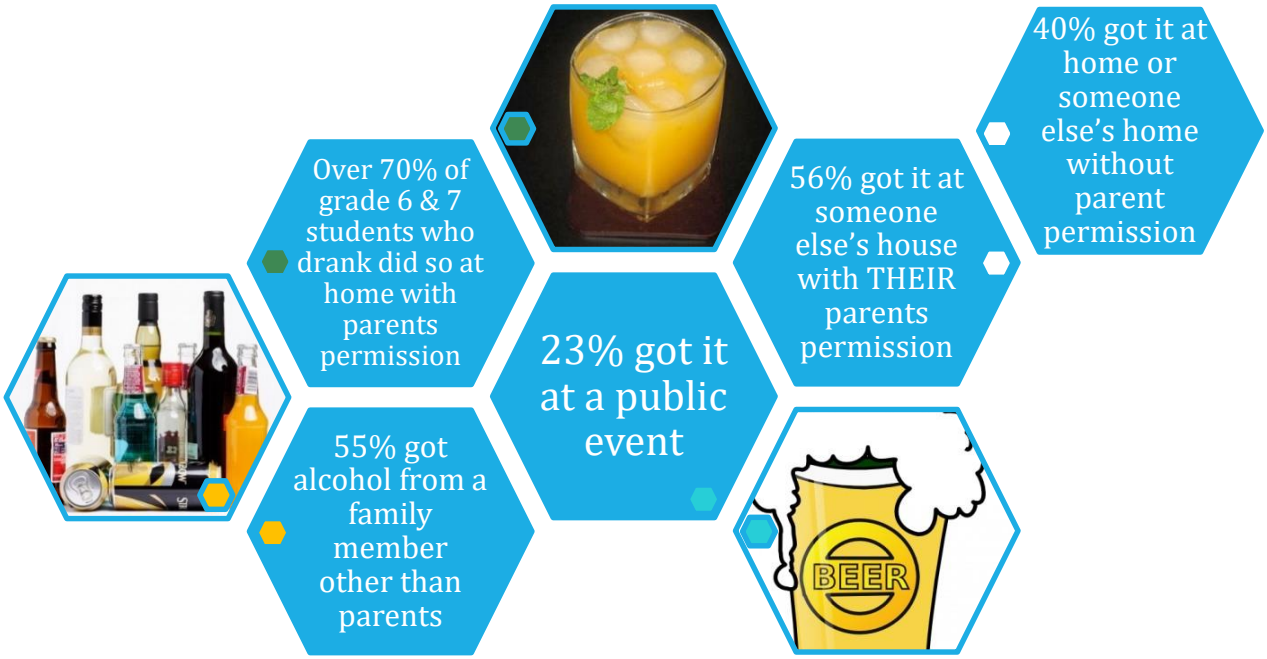
drug abuse. In addition, binge drinking rates among students in those grades are also significantly higher. Binge drinking is defined as five or more drinks over a short period of time, and the survey measures this over the two weeks prior to the date students take the survey. Lifetime use measures students who have ever used alcohol, which means more than just a few sips.





Students shared a substantial amount of information about their access to and use of alcohol and other drugs. There is elevated use of amphetamines across several grades, with 2.6% of South Cariboo students reporting use in the past 30 days compared to 1.7% of students across the district. Grade 10 students show higher rates of use of inhalant use with just under 4% reporting use in the past 30 days.

Young people are not legally permitted to buy alcohol, so those who are consuming it must find other ways to access it. This is one of the ways communities can influence young people's understanding of the values and standards of their family and community around alcohol and other drug use.



Community Context – About the community/region

In examining the results from the survey, it is important to locate the data in the context of the broader community. We also need to understand the connections between data collected from youth and data collected more broadly from the general population as indicators of socio-economic well-being. Increasingly, that type of data is difficult to access as governments reduce data analysis and reporting to the public. An additional challenge is that data collection regions differ depending on the system or level of government collecting them. Census data in rural areas is reported primarily according to regional district area boundaries, while health data is generally reported by Local Health Area (LHA). This makes comparisons challenging. The elimination of the mandatory long form census had a significant effect on the quality of data available, but the provincial government has also substantially reduced the amount of data they provide access to, particularly at a regional or community level. For example, the most recent socio-economic profile available is from 2012. Despite these challenges, we feel it is important to provide as much data context as possible in order to broaden our understanding of our community context and challenges.

Demographic data

The most recent demographic data available is from the 2011 Census and National Household Survey (Long-form Census). While it is slightly dated, it is generally representative of the population of our community. The population of the 100 Mile House Local Health Area was 13,618 (2014). According to Census data, in 2016 there were 13,124 people living in the South Cariboo, comprising the District of 100 Mile House and Regional District Areas G, H, and L. Of those, 2,180 were children nineteen years and younger, and 455 were children under age 5.[8] In 2011 (most recent data available) there were over 330 single parent families and 70% of them were headed by the female parent.

Total population		**10,700**
0 to 4 years		455
5 to 9 years		550
10 to 14 years		560
15 to 19 years		610
20 to 24 years		445
25 to 29 years		475
30 to 34 years		475
35 to 39 years		525
40 to 44 years		595
45 to 49 years		729
50 to 54 years		1125
55 to 59 years		1355
60 to 64 years		1440
65 to 69 years		1420
70 to 74 years		1080
75 to 79 years		620
80 to 84 years		375
85 years and over		285
Average age of the population		49.2

Figure 10: Census population of Cariboo Regional District Regions G, H and L

[8] Statistics Canada Census 2011 and 2016 data

Total lone-parent families by sex of parent and number of children		**330**
Female parent	230	
1 child	150	
2 children	55	
3 or more children	20	
Male parent	100	
1 child	80	
2 children	10	
3 or more children	5	
Total children in census families in private households		2275
Under six years of age	455	
6 to 14 years	875	
15 to 17 years	350	
18 to 24 years	370	
25 years and over	220	
Average number of children at home per census family		1.9

Figure 11: Census data regarding family structure, 2011

Socio-economic data

Socio-economic data available is primarily based on 2011 and 2012 Census and National Household Survey (NHS), so is somewhat dated. In addition, the 2011 NHS was voluntary and non-response rates in the South Cariboo were between 42-49% so the data should be viewed with some caution. However, it does provide some context in terms of the challenges and constraints for families in the community. In general, 100 Mile House and the surrounding neighbourhoods fall within the averages for rural communities in central British Columbia and the Thompson Cariboo Health Region. Overall it rates somewhat better than surrounding communities such as Williams Lake, the Chilcotin and the South Cariboo. The Composite Index of Human and Economic Hardship ranks communities based on a number of indicators, and 100 Mile Health Area is ranked at 35 out of 77 areas[9]. 2.1% of the total population were on Income Assistance as of September 2012, with 5.3% of children 14 years and younger and 2.9% of children 15-19 who are on Income Assistance. In 2015, there were between 260-280 individuals on Income Assistance on any given month, including between 48 and 67 dependent children. In the Cariboo, Regional District Electoral Areas that surround 100 Mile, the 2010 median family income was $55,980, while 3855 individuals (age 15 and over) had incomes less than $20,000. Lone parent family income was significantly lower at $33,300.

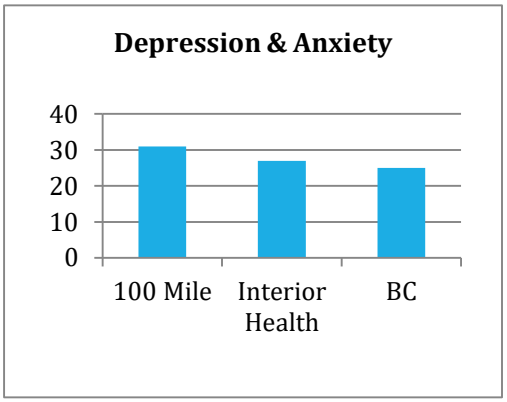
Child poverty rates in the Cariboo Regional District: 25.2% of children 0-17 live in low income families (based on after tax LIM)[10]

[9] BC Stats (2012). Indicators of Human and Economic Hardship. http://www.bcstats.gov.bc.ca/StatisticsBySubject/SocialStatistics/SocioEconomicProfilesIndices/SocioEconomicIndices/LHAReports.aspx

[10] First Call Coalition to End Child Poverty (2015). Child Poverty BC Report Card. http://still1in5.ca

Health Data[11]

Population health data from BC Stats and Interior Health show that 100 Mile House has an older population with a median age of 54. Population trends are toward an aging population, with a decline in the population under age 18 over the next 5-7 years and only slight increases over the longer term. Major causes of mortality in the 100 Mile House LHA (based on standardized mortality rates) are motor vehicle accidents, chronic lung disease, and heart and stroke diseases. Chronic disease rates are similar to Interior Health as a whole, with the exception of depression and anxiety, which at 31% is higher than the Interior Health and BC prevalence rates. Life expectancy in 100 Mile House and the South Cariboo is 80.2 years, slightly lower than the BC average of 82.3 years.



Alcohol consumption in 100 Mile House in 2012 was 138 litres per person (age 19+) and in the South Cariboo 147, compared to the BC average of 103 litres. Alcohol spending was an average of $892/person on alcohol.

From 2007-2011 the potential years of life lost per 1000 population were as follows:

	100 Mile House	British Columbia
Suicide or Homicide	0.5 (lowest rate in BC)	4
Natural Causes	44.8	29.7
Accidental Causes	17.3	7.0

Hospitalization rates for children 0-14 years:

	Respiratory Diseases	Injury and Poisoning
100 Mile House	10.3	8.2
South Cariboo	7.6	9.5
British Columbia	9.0	4.4

Hospitalization rates for youth 15-24 for Motor Vehicle Accidents (2011-12) per 1,000 population

		Motor Vehicle Accident Hospitalizations
100 Mile House		2.3
South Cariboo		5.4
British Columbia		1.1

[11] Local Health Area Profile: 100 Mile House (2014). Interior Health

Children and Youth in the South Cariboo

Early Development Index

The Early Development Instrument (EDI) is a population level measure of the developmental vulnerability of children as they enter kindergarten. Kindergarten teachers complete a 104-item questionnaire in February, once they have had time to get to know their students, so they can answer the questions knowledgeably. The EDI measures five core areas of development that are known to be good predictors of adult health, education, and social outcomes.[12] We know that the early years (0-6) are a critical period in children's development, and the EDI helps us to understand population level trends in children's early vulnerabilities. Data from the EDI is used to inform planning processes related to community based early child development initiatives.

School District 27 has participated in the EDI questionnaire since its inception, and consequently we have many years of data. While we have seen shifts over time, it is important to place this data within the context of our community as well as shifts in provincial averages, and to understand which differences are meaningful. EDI data is collected in 'waves' of several consecutive school years to ensure that data is statistically significant and accurate. Data is currently available from Wave's one through six, which span the 2001/02 school year through the 2015/16 school year. Wave six reports data from 2013-2016.

The EDI measures children's development in five areas, or domains:

Physical Health and Well-being: Assesses children's gross and fine motor skills, physical independence and readiness for the school day. E.g. *Can the child hold a pencil? Is the child able to manipulate objects? Is the child on time for school?*

Social Competence: Assesses children's overall social competencies, capacity for respect and responsibility, approaches to learning, and readiness to explore new things. E.g. *Is the child able to follow class routines? Is the child self-confident? Is the child eager to read a new book?*

Emotional Maturity: Assesses children's prosocial and helping behaviours, as well as hyperactivity and inattention, and aggressive, anxious and fearful behaviours. E.g. *Does the child comfort a child who is crying or upset? Does the child help clean up a mess?*

Language and Cognitive: Assesses children's basic and advanced literacy skills, numeracy skills, interest in math and reading, and memory. E.g. *Is the child interested in reading and writing? Can the child count and recognize numbers? Is the child able to read simple sentences?*

Communication Skills: Assesses children's English language skills and general knowledge. E.g. *Can the child tell a story? Can the child communicate with adults and children? Can the child take part in imaginative play?*

The vulnerability threshold or cut-off is the EDI score that distinguished the bottom 10% of children in the province from the other 90%. Children who fall below that score are said to be vulnerable on that domain of development. The appropriate interpretation of vulnerability is that the child is, on average, more likely to be limited in his or her development than a child who scores above the cut-off. Results in this summary show the proportion of children who are vulnerable in each domain of development, as well as the proportion that are vulnerable on one or more domain.

[12] Human Early Learning Partnership, University of British Columbia (2017). http://earlylearning.ubc.ca/edi/

It is also important to know that the EDI reports data at a neighbourhood and School District level. Children's scores are recorded for the neighbourhood in which they live, not the neighbourhood in which they go to school.

	Total Number of Children screened		Vulnerable (one or more domains)		Physical		Social		Emotional		Language		Communication	
	W5	W6	W5	W6	W5	W6	W5	W6	W5	W6	W5	W6	W5	W6
South Cariboo	89	202	37	37	29	21	11	11	18	22	11	7	9	11

Figure 12: Percentage of Children Vulnerable by neighbourhood of residence and domain

Vulnerability rates vary over time and the number of children screened in each neighbourhood can affect whether changes over time are due to real change, or to change in measurement. *Critical difference* is a method used by EDI researchers to determine whether a change reflects a real, statistically significant change in vulnerability rather than a minor change associated with measurement variations. In the South Cariboo, between Wave 5 and Wave 6, there was no *critical difference* in vulnerability over the period studied. Vulnerability rates in the South Cariboo are similar to the district wide vulnerability, with the highest number of children vulnerable in the Physical Health and Well-Being domain.

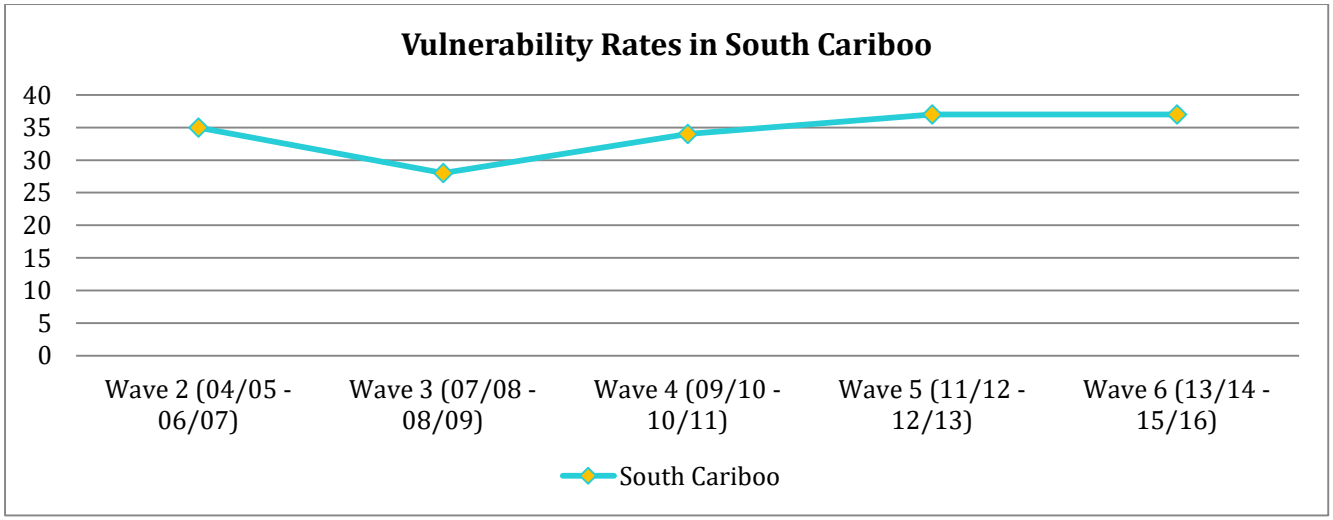


Figure 13: Percentage of children vulnerable in one or more domains over time

Foundation Skills Assessment

Foundation Skills Assessment (FSA) tests are completed by all students in grades four and seven and measure how well students are achieving basic skills in relation to provincial curriculum performance standards. Grade 4 reading rates are particularly important because up until grade four students are learning to read while beyond Grade 4 they are using those reading skills to learn content related to curriculum. Research shows that students who do not have basic reading skills achieved by Grade 4 are at a disadvantage for further academic success[13]. While there is some controversy over the use of FSA result, the data is useful in understanding shifts over a period of time. There are a number of background factors that contribute to students' academic success, and there is some complexity in terms of factors such as how poverty, learning disabilities, and other issues affect a particular student's score, or the average scores in a particular school. However, at a broader population level they are useful to understand whether there are changes over time in the basic academic skills of that population, such as across the school district. The charts below capture this data in reading, writing, and numeracy across the entire school district (including the Chilcotin and South Cariboo). [14]

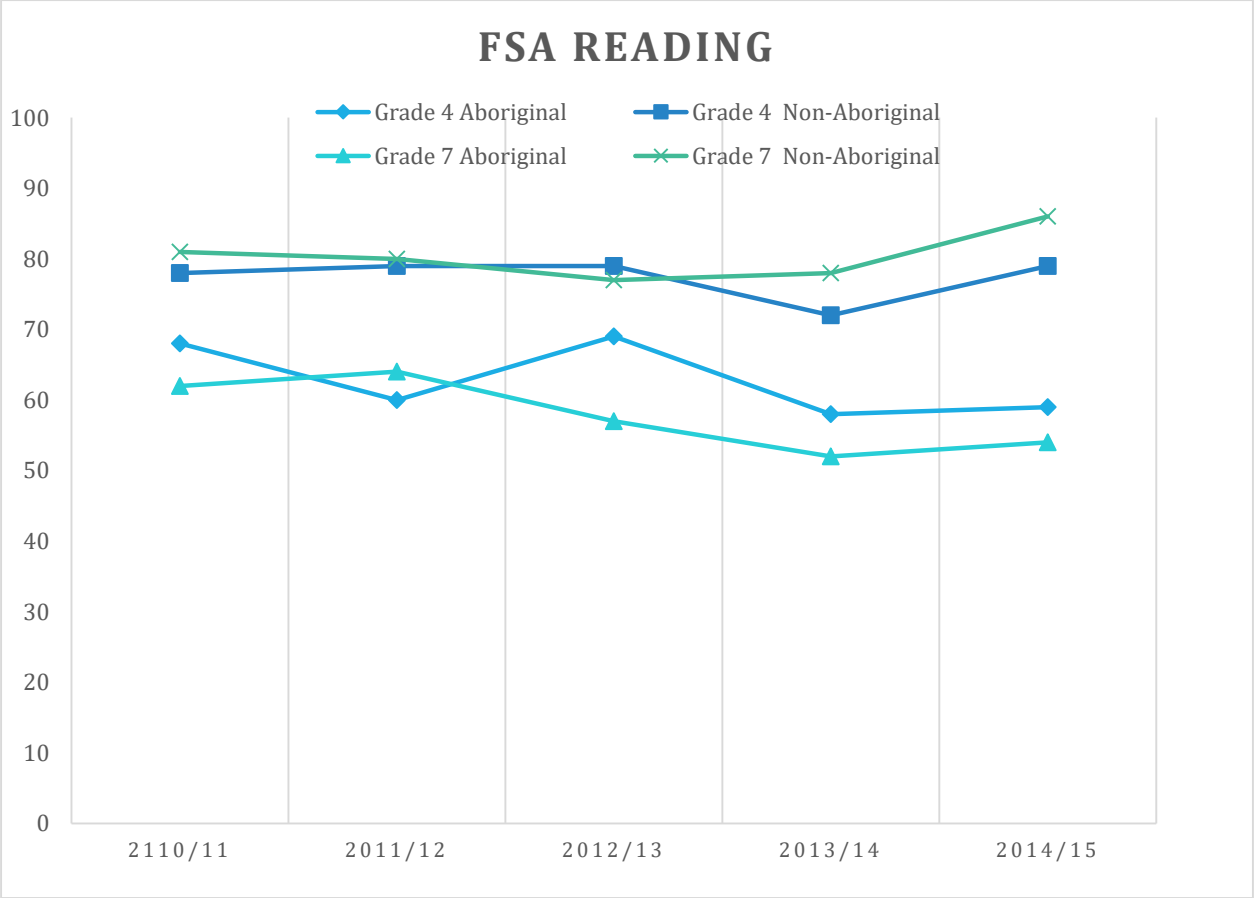


Figure 14: Percentage of students meeting or exceeding grade level standards in Reading

[13]Annie E. Casey Foundation (2010). http://www.aecf.org/resources/early-warning-why-reading-by-the-end-of-third-grade-matters

[14] https://www.bced.gov.bc.ca/reporting/district.php

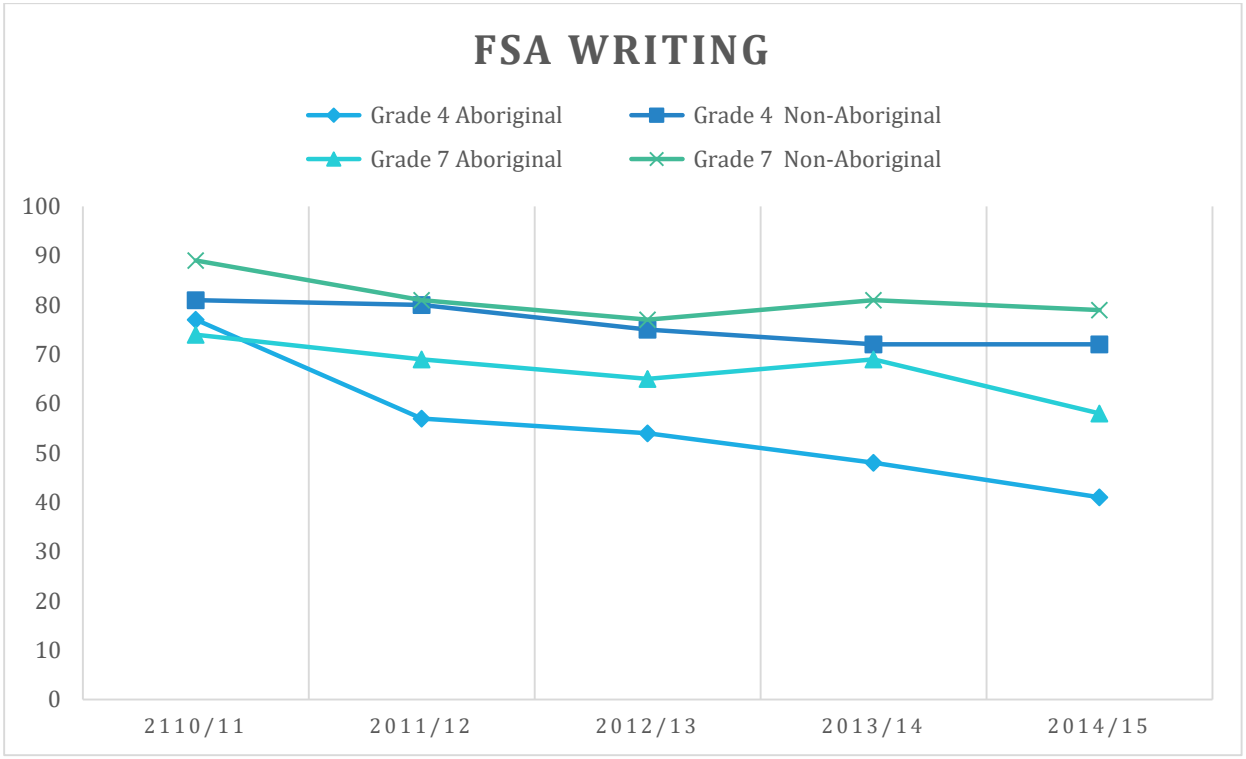


Figure 15: Percentage of students meeting or exceeding grade level standards in writing

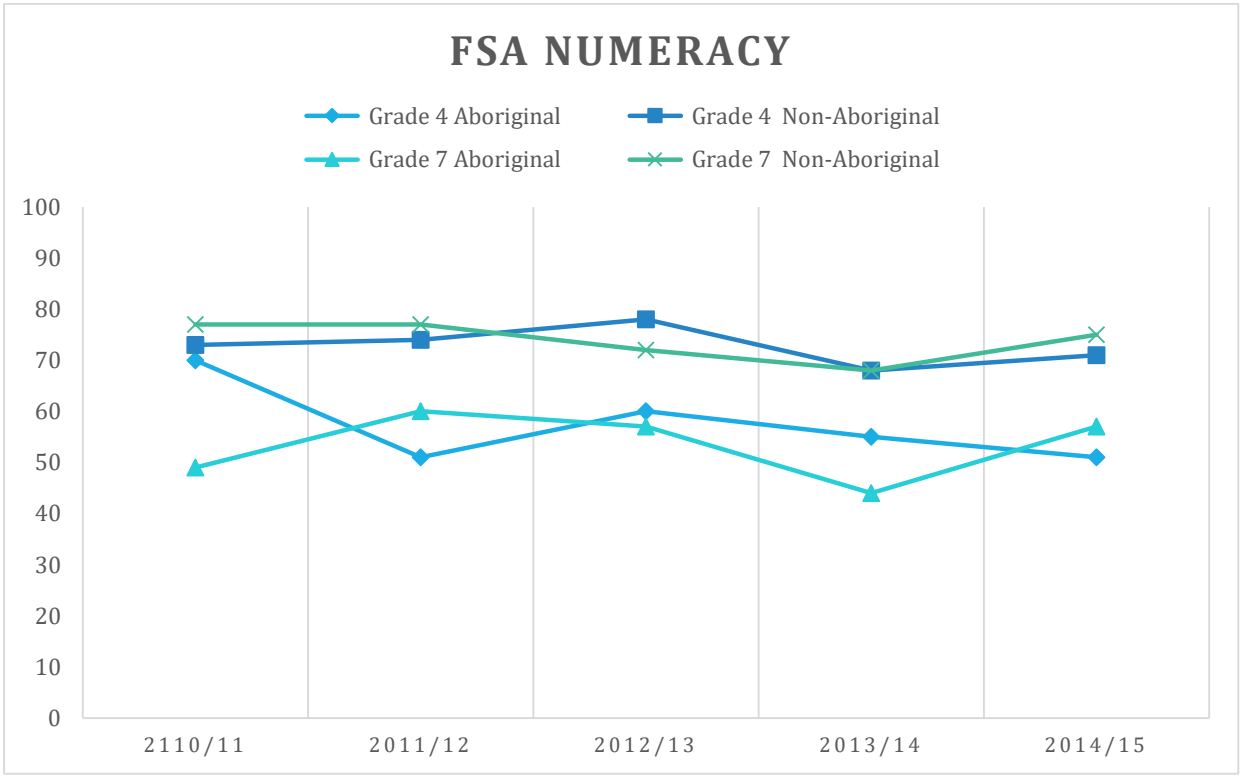


Figure 16: Percentage of students meeting or exceeding grade level standards in numeracy

Grade to Grade Transitions and Completion

Grade transition data provides us with a picture of the number of students successfully moving from one grade to the next. This data also includes those who leave the district for a variety of reasons: students who move to another jurisdiction or to an independent school would be shown as not successfully transitioning. The number of students leaving the school district in grades 8-12 is generally small. Six-year completion rates are generally considered the most accurate data on graduation. It includes all students who complete a dogwood graduation certificate within six years of entering Grade 8.

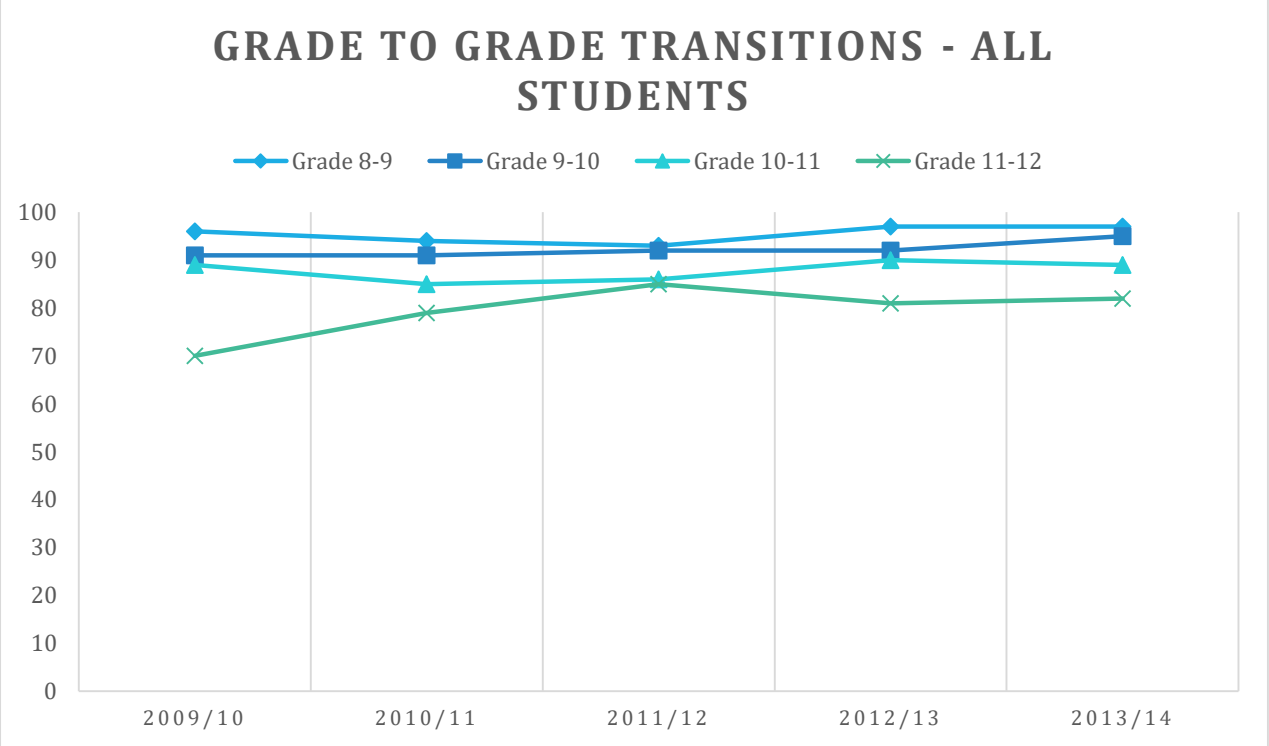


Figure 17: Percentage of students successfully moving to next grade – district wide[15]

Measuring high school graduation rates is slightly tricky business. We are utilizing six-year completion rates as the best measure. This is because education data that shows the number of students enrolled in Grade 12 who actually graduate is skewed by at least two elements. The first is that it includes students enrolled in modified programs who complete high school with an "Evergreen Certificate". These students will leave the high school system, but have not completed the requirements for full graduation (BC Dogwood Certificate). High school completion rates are also significantly skewed because once a student enrolls in a single Grade 12 level course, they are 'counted' as a Grade 12 student. If that student is a Grade 11 student, they would not graduate that year and would be counted as 'not completing'. As a result, six-year completion rates are the best measure of high school completion. It provides a picture of the percentage of students who graduate within six years of entering Grade 8.

[15] https://www.bced.gov.bc.ca/reporting/district.php

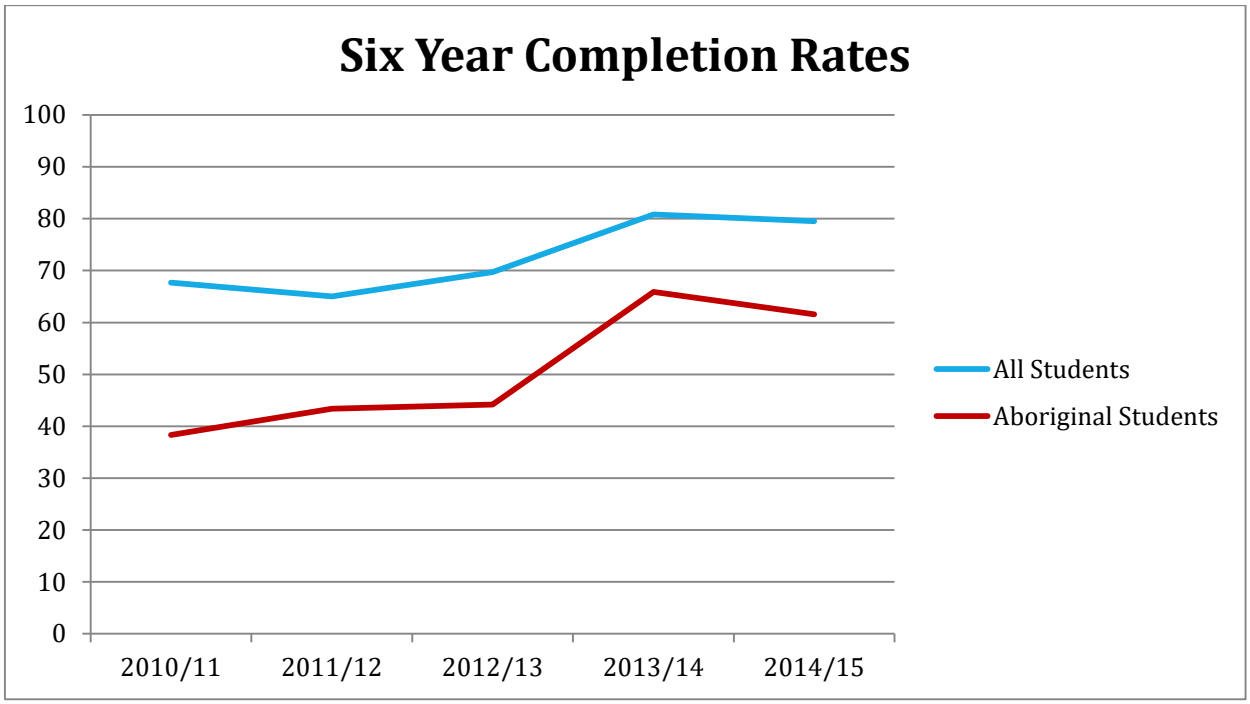


Figure 18: Percentage of students completing grade 12 within six years of entering grade 8[16]

Children and Youth at Risk

The BC Composite Index (2012) of Youth at Risk placed the 100 Mile Local Health Area (LHA 27) 26th worst in the province (out of 77 LHA's) based on the following indicators: youth 15-24 on income assistance, youth on EI, number of 18 year olds who didn't graduate high school, serious crime and non-cannabis drug offences (youth), and hospitalizations due to motor vehicle accidents.

Indicator	LHA 25 Rate	BC Rate	Ranking vs. other LHA's in BC (1 is worst)
% youth 15-24 on income assistance (Sept. 2012)	2.9	2.1	23
% youth 15-24 on EI (Sept. 2012)	1.0	0.7	31
% 18-year old's who didn't graduate high school (2009/10 - 2011/12)	30	26.2	28
serious crime per 1000 population (avg. 2009-2011)	7.6	11.1	52
non-cannabis drug offences (per 100,000 pop.)	101.4	193.6	55
hospitalizations due to motor vehicle accidents age 15-24 (per 1000 pop.)	2.3	1.1	24

Table 2*: Youth at risk indicators*

[16] https://www.bced.gov.bc.ca/reporting/district.php

Ministry for Children and Families data

The number of children in foster care varies widely from month to month and the way those numbers are captured is influenced by the staffing/team structure at MCFD. In some years, all staff teams are managing caseloads with children in care, while during other periods one team may have responsibility for managing 'guardianship' (children in care) files. Averages are difficult to calculate as a result. From 2010 to 2015 the number of children in care of the 100 Mile House MCFD office in any given month ranged from approximately 37 in May 2010 to 30 in January 2013 to approximately 25 in October 2014.

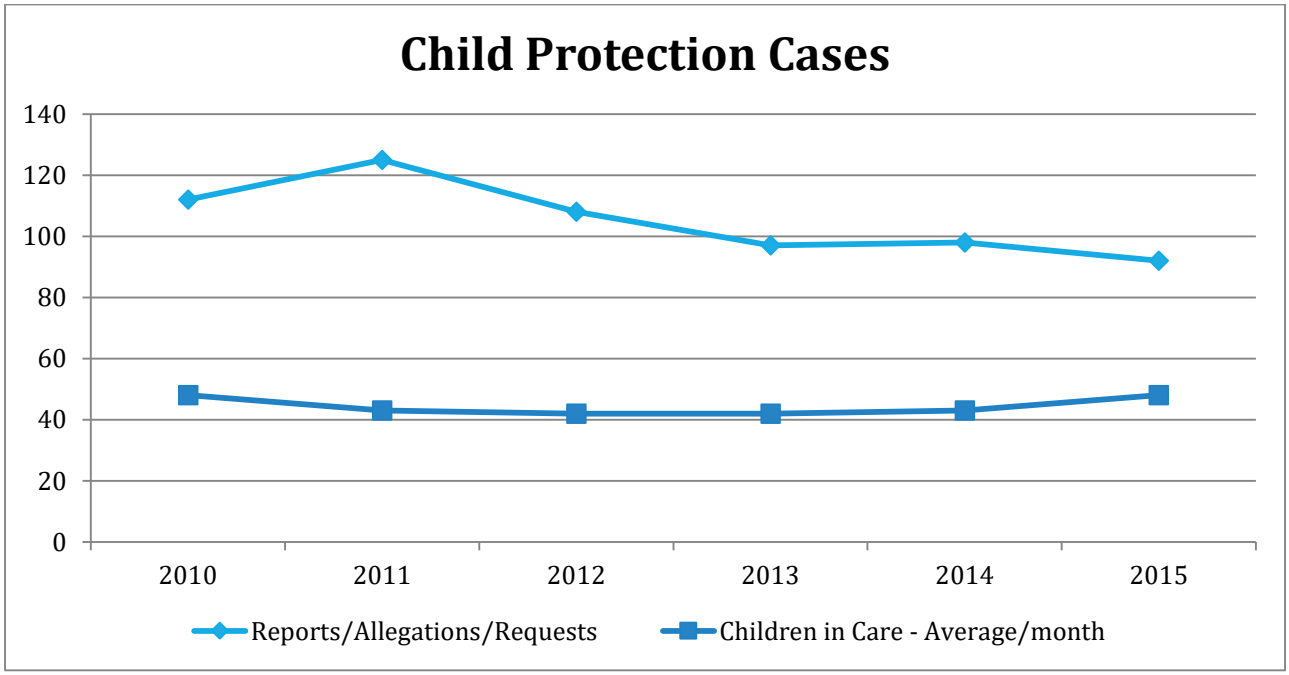


Figure 19: Intake requests and number of children 'in care' (includes extended family care under an MCFD order)

Responding to the Survey Results

Even though the Communities That Care initiative has not extended to the South Cariboo, this survey data represents an opportunity to better understand the particular challenges facing children and youth in their community. It is important to honor the information youth have shared with the community, and to recognize that the data is a tool that can be used to explore these challenges more deeply, and to engage youth in an exploration of the issues that are presented. It tells a story of the strengths and challenges faced by youth in the South Cariboo, and is an invitation for the community to respond and focus on what their needs are in order to reduce risk and increase protective factors that will help young people to move into healthy adulthood.

It is up to the communities of the South Cariboo to decide how the data in this report will be used. It provides a baseline of information about the state of children and youth in the community. It can provide 'hard data' to support the development of programs and services, and in particular to help advocate and build a case for prevention. It can also be used to engage the community in a conversation about strengths, challenges, and priorities for responding to the messages this information sends about what children and youth in the community need.

Appendix A – Risk and Protective Factor Definitions

Community Risk and Protective Factors	
Laws and Norms Favorable Toward Drug Use	Research has shown that legal restrictions on alcohol and tobacco use, such as raising the legal drinking age, restricting smoking in public places, and increased taxation have been followed by decreases in consumption. Moreover, national surveys of high school seniors have shown that shifts in normative attitudes toward drug use have preceded changes in prevalence of use.
Perceived Availability of Drugs	The availability of cigarettes, alcohol, marijuana, and other illegal drugs has been related to the use of these substances by adolescents.
Rewards for Prosocial Involvement	Rewards for positive participation in activities helps youth bond to the community, thus lowering their risk for substance use.
Family Risk and Protective Factors	
Poor Family Management	1 Parents' use of inconsistent and/or unusually harsh or severe punishment with their children places them at higher risk for substance use and other problem behaviors. Also, parents' failure to provide clear expectations and to monitor their children's behavior makes it more likely that they will engage in drug abuse whether or not there are family drug problems.
Family Conflict	Children raised in families high in conflict, whether or not the child is directly involved in the conflict, appear at risk for both delinquency and drug use.
Sibling Drug Use and Exposure to Adult Antisocial Behavior	When children are raised in a family with a history of problem behaviors (e.g., violence or ATOD use), the children are more likely to engage in these behaviors.
Parental Attitudes Favorable Toward Antisocial Behavior and Parental Attitudes Favorable Toward Drugs	In families where parents use illegal drugs, are heavy users of alcohol, or are tolerant of children's use, children are more likely to become drug abusers during adolescence. The risk is further increased if parents involve children in their own drug (or alcohol) using behavior, for example, asking the child to light the parent's cigarette or get the parent a beer from the refrigerator.
Family Attachment	Young people who feel that they are a valued part of their family are less likely to engage in substance use and other problem behaviors
Opportunities for Prosocial Involvement	Young people who are exposed to more opportunities to participate meaningfully in the responsibilities and activities of the family are less likely to engage in drug use and other problem behaviors.
Rewards for Prosocial Involvement	When parents, siblings, and other family members praise, encourage, and attend to things done well by their child, children are less likely to engage in substance use and problem behaviors.
School Risk and Protective Factors	
Academic Failure	Beginning in the late elementary grades (grades 4-6) academic failure increases the risk of both drug abuse and delinquency. It appears that the experience of failure itself, for whatever reasons, increases the risk of problem behaviors.
Low Commitment to School	Surveys of high school seniors have shown that the use of drugs is significantly lower among students who expect to attend college than among those who do not. Factors such as liking school, spending time on homework, and perceiving the coursework as relevant are also negatively related to drug use.

Individual & Peer Risk and Protective Factors	
Early Initiation of Antisocial Behavior and Early Initiation of Drug Use	Early onset of drug use predicts misuse of drugs. The earlier the onset of any drug use, the greater the involvement in other drug use and the greater frequency of use. Onset of drug use prior to the age of 15 is a consistent predictor of drug abuse, and a later age of onset of drug use has been shown to predict lower drug involvement and a greater probability of discontinuation of use.
Attitudes Favorable Toward Antisocial Behavior and Attitudes Favorable Toward Drug Use	During the elementary school years, most children express anti-drug, anti-crime, and pro-social attitudes and have difficulty imagining why people use drugs or engage in antisocial behaviors. However, in middle school, as more youth are exposed to others who use drugs and engage in antisocial behavior, their attitudes often shift toward greater acceptance of these behaviors. Youth who express positive attitudes toward drug use and antisocial behavior are more likely to engage in a variety of problem behaviors, including drug use.
Perceived Risk of Drug Use	Young people who do not perceive drug use to be risky are far more likely to engage in drug use.
Interaction with Antisocial Peers	Young people who associate with peers who engage in problem behaviors are at higher risk for engaging in antisocial behavior themselves.
Friends' Use of Drugs	Young people who associate with peers who engage in alcohol or substance abuse are much more likely to engage in the same behavior. Peer drug use has consistently been found to be among the strongest predictors of substance use among youth. Even when young people come from well-managed families and do not experience other risk factors, spending time with friends who use drugs greatly increases the risk of that problem developing.
Rewards for Antisocial Behavior	Young people who receive rewards for their antisocial behavior are at higher risk for engaging further in antisocial behavior and substance use.
Depressive Symptoms	Young people who are depressed are overrepresented in the criminal justice system and are more likely to use drugs. Survey research and other studies have shown a link between depression and youth problem behaviors.
Gang Involvement	Youth who belong to gangs are more at risk for antisocial behavior and drug use
Religiosity	Young people who regularly attend religious services are less likely to engage in problem behaviors.
Belief in the Moral Order	Young people who have a belief in what is “right” or “wrong” are less likely to use drugs.
Interaction with Prosocial Peers	Young people who associate with peers who engage in prosocial behavior are more protected from engaging in antisocial behavior and substance use.
Prosocial Involvement	Participation in positive school and community activities helps provide protection for youth.
Rewards for Prosocial Involvement	Young people who are rewarded for working hard in school and the community are less likely to engage in problem behavior.

Electronic copies are available online at the following location:

Communities That Care
http://www.sd27.bc.ca/healthy-schools-healthy-students/communities-that-care/