COMMUNITIES THAT CARE

Community Profile

Williams Lake

2016

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.

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City of Williams Lake
Axis Family Resources

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Executive Summary

Communities That Care is a collaborative community effort to improve the health and well-being of children and youth in our community. This report provides an overview of the work we have done together as a community between 2009 when the initiative was launched, and 2016 when we completed our second youth survey and data scan. The results presented here are attributable to a myriad of community activities and initiatives that have resulted from increased collaboration and a collective approach to addressing key priorities for the well-being of children and youth. In addition to the data results, we also are able to say that we work together in a different way now than we did in 2009. We have new language, new relationships and a new understanding of how to align our efforts toward a common goal.

The work of the CTC initiative is based on data from the Prevention Needs Assessment survey, a standardized survey instrument that measures risk and protective factors of all youth from grades six through twelve. We surveyed Williams Lake youth in 2009 and again in 2015. Data from the 2009 survey was used to inform priorities for action. The 2016 survey results provide comparative data that allowed us to measure our progress.

Following the completion of our community profile 'A Place to Start' in 2010, our community initiated a number of evidence based programs focused on addressing the key priorities outlined in that document. Positive Action® was our flagship program, implemented in school classrooms, preschools, after-school programs and throughout the community via our 'Word of the Week' initiative. We also supported Roots of Empathy, the Circle of Courage initiative, school Sense of Belong initiatives, and a wide range of collaborative approaches to youth services.

HIGHLIGHTS OF 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. While we cannot claim that the programs of Communities That Care has focused on have been the sole contributor to changes in the risk and protective factors, we are confident that our collaborative work has made a substantial contribution to the shifts we see. We are very pleased to report that things ARE changing for the better for youth in our community.

- Protective Factors: More kids have high levels of protection: from 60% in 2009 to 67% in 2015 (7% improvement)
- Risk Factors: Fewer kids are 'high risk': from 60% in 2009 to 55% in 2015 (5% improvement)
- Aboriginal Students: 9% more Aboriginal students have a high level of protection, and 9% fewer are 'high risk'
- Community Domain: 5% fewer students perceive that our *Community Laws and Norms* are favourable to alcohol and drug use
- Family Domain: There has been no significant change in the priority risk factor (*Parent Attitudes to Drug and Alcohol use and Anti-Social Behaviour*); however, *Family Attachment* and *Opportunity for Family Pro-Social* activities have both improved

- School Domain: *Low Commitment to School* has improved by 9% and *Academic Failure* has improved by 6%. This is corroborated by improved grade to grade transition rates.
- Individual/Peer Domain: *Early Initiation of Anti-Social Behaviour* and *Early Initiation of Alcohol and Drug Use* have both improved by 10%.
- Depressive symptoms continue to be a concern at 38% with 50% of Grade 10 students showing this as a risk factor
- 20% of students don't have an adult in their life that they trust and can ask for help
- Grade 8 alcohol consumption indicators are down, and Grade 8 binge drinking has dropped from 21% of students in 2009 to only 4% in 2015.
- Gang involvement has dropped from 7.5% of students in 2009 to 3.5% in 2015

This report also provides a substantial amount of contextual data from a variety of systems and sources. Regional data has been increasingly difficult to access, as both provincial and federal governments have reduced their public data access over the past eight years. We provide this data as a resource for our community, and to set out the broader context in which the youth survey data can be nested. Issues such as family make-up (ie. number of single parent families), poverty and community economic conditions, housing costs, health statistics, and crime rates are important for consideration in understanding the larger picture of influences in children and youth's lives. The Early Development Index also gives us clues to the early years of children's development, which are critical to their future well-being and how risk and protective factors play out in their lives individually and as a cohort population. Some data is intended to be corroborative – education data that links academic testing results, grade to grade transitions, and high school completion rates give us a broader picture of how students are doing in our schools beyond the indicators from the youth survey.

MOVING FORWARD

Our community has spent several months exploring and discussing the data contained in this document. As a result of those dialogues, we have established our priorities in each domain, to continue the improvements we have seen in the past six years, to focus on some new areas, and to continue the collaborative work that has moved our community forward.

Community Domain

- Community Rewards for Pro-social Behaviour
- Laws and Norms Favourable to Anti-Social Behaviour

School Domain

- Opportunities for Pro-Social Behaviour
- Low Commitment to School

Family Domain

- Family Attachment
- Parent Attitudes to Anti-Social Behaviour

Individual/Peer Domain

- Interaction with Pro-Social Peers
- Depressive Symptoms

Introduction

This Community Profile offers a picture of the work of the Communities That Care initiative in Williams Lake. It highlights the work of the initiative and its impact over the past seven years, reports on the data indicators by which we measure that impact, and provides corroborating contextual data.

Communities That Care is a collaborative community effort to improve the health and well-being of children and youth in our community. It was established in 2009 in response to the reality that our youth were struggling with a variety of issues that we could no longer respond to using the traditional siloed interventions that focused on treating the problem behaviour. With the support of community leaders, pilot funding from the Youth Justice Secretariat, and the support of the City of Williams Lake, Ministry for Children and Families, Social Planning Council, and many other organizations, we embarked on a new way of working.

Since then, hundreds of people in dozens of organizations have spent thousands of hours working collaboratively to figure out how to do things differently. In 2011, School District 27 agreed to sponsor the facilitation of the initiative, and made a commitment to ensure the work continued to be community led. We are grateful for their ongoing commitment and in-kind contributions to ensuring support for the coordination and facilitation of this work over the past five years.

"Back in 2009 when we started, some of us were skeptics around the table… but the results really speak for themselves…"

Participant from Key Leader table

We work differently now. We have new language, new relationships and a new understanding of how to align our efforts toward a common goal. The collaborative work of CTC has spread to many tables in the community, and the results speak for themselves. When we began learning about CTC as an approach, we were told to expect direct, program level results in 2-3 years, results at the risk and protective factor level in 7-10 years, and reduction in problem behaviour results in 10-15 years. We are delighted to be reporting significant shifts at the population level in many areas, both in our risk and protective factors and in our problem behaviour indicators. Communities that Care isn't a magic wand. We continue to have work to do, and we continue to have challenges. There continue to be youth with problem behaviours and the percentage of youth with risk factors is still too high. We continue to have conversations about how to move our work forward. This report is a celebration of our success and a call to action for our next steps.

What is Communities That Care

Communities That Care[1] (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 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

[1] Additional information about the CTC model can be found at: http://www.communitiesthatcare.net/

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 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.

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*[2]

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

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. We have moved through these phases over the past seven years. This community profile represents the evaluation stage of our first cycle through the process, as well as the community assessment for our second cycle. We will now be looking to determine our community's readiness to mobilize around a new set of community priorities based on the information presented here.

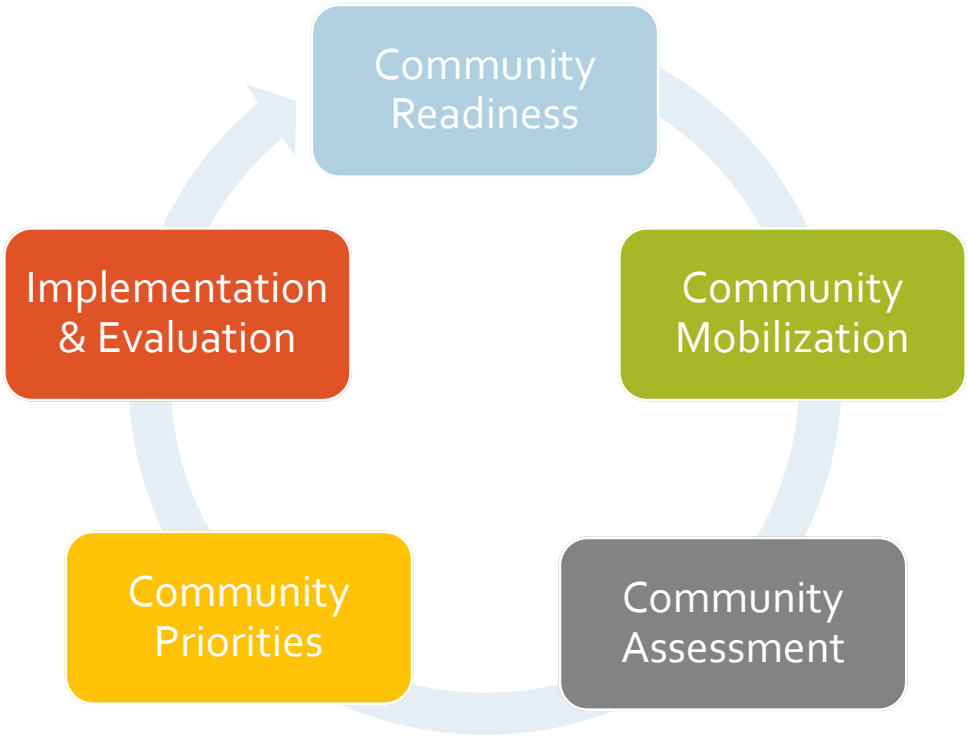

Figure 2*: CTC Process*

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 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.

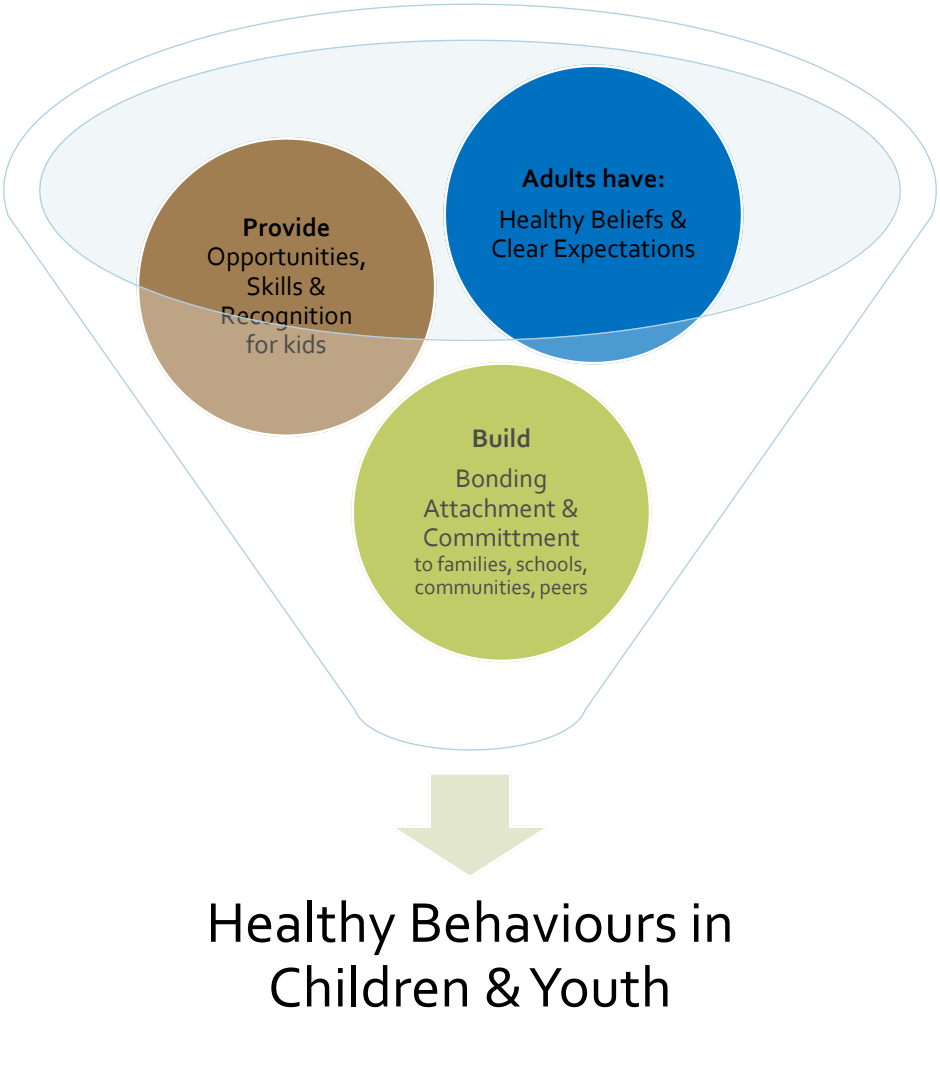

Figure 3: ***Social Development Model***

Communities That Care in Williams Lake

How and why we got started – the 2008 story…

In 2008-09 our community was experiencing a crisis. In addition to a major economic downturn driven by significant job loss in the forestry and mining sectors, youth crime and violence were at a high point. The RCMP, school officials and community leaders acknowledged a youth gang problem for the first time; violent crimes were of increasing upset to the community; and general concern about the level of violence among youth was high. In attempting to respond to these issues it became apparent that many service providers, both community and government, were unaware of the full extent of these youth issues or of the range of initiatives and services being implemented to address them. A lack of understanding on all levels existed as to what risk and protective factors are present in the community and in the youth population, was coupled with a lack of knowledge on how to identify those factors. Most of the work to address the issues was focused on the problem behaviour rather than being prevention focused. Led by the City of Williams Lake and the Ministry for Children and Families, and in partnership with the Social Planning Council, the Communities That Care initiative was launched in January 2009 with three-year pilot funding from the provincial Youth Justice Secretariat. The CTC model was chosen following extensive consultation with community and government agencies engaged in the response to these serious community issues. It was chosen particularly because of its community collaboration approach and its focus on prevention.

Our first Prevention Needs Assessment survey and community assessment in 2009 were eye-opening. Youth told us a lot about the messages that they were getting about what unhealthy behaviours they saw in their peers, families, schools and community. Youth violence and alcohol use among young teens were of particular concern, and we were surprised at how many of our youth were considered 'at risk'. One of the things that stood out in every domain was that youth indicated that adult behaviours and values around alcohol and drug use and violence were sending the message that these behaviours were acceptable among youth.

It is important to note that although the survey is completed by students in Grade 6 and older, successful risk prevention and strengthening protective factors begin much earlier, and often see the greatest impact when implemented in the early years and in the primary grades.

How we approached this challenge…

The Communities That Care process is community owned and is structured around two collaborative groups. The Key Leader Board is made up of community leaders and decision makers and provides strategic direction to the initiative. They meet quarterly, based on the needs of the initiative. The Community Board meets monthly to collaborate on initiatives that align with our goals, which are focused on reducing risk factors chosen by the collective group in 2010.

Using the results from our 2010 Community Profile, members of our Community and Key Leader boards identified the risk and protective factors that were priorities for action. They were chosen based on the principles of CTC that working across domains is a key strategic approach to effective prevention. The following priorities were chosen:

- *Community Domain*
  - *Laws & Norms Favourable Toward Drug Use*
  - *Rewards for Positive Involvement*
- *Family Domain*
  - *Parental Attitudes Favourable Toward Antisocial Behaviour and Drugs*
- *School Domain*
  - *Low Commitment to School*

- *Individual/Peer Domain*
    - *Early Initiation of Antisocial Behaviour and Drug Use*

Based on these priorities, small working committees researched the best evidence based programs available to target each individual priority. The groups brought their recommendations together and identified two programs that met the criteria for addressing all of the priority risk and protective factors. Positive Action® was the priority program chosen for implementation. In addition, a one-time investment was made to the Roots of Empathy program which had been running in our community for a number of years, but had recently had a funding disruption. In addition, the Community Board continued to meet monthly to facilitate implementation of the programs, but also to collaborate on other children and youth initiatives that aligned with the priorities. This collective approach has yielded a significant number of additional activities focused on providing children and youth with the building blocks of the Social Development Approach. Some activities have been short term or one-off events (such as Youth Week), others have informed broad approaches (such as the Circle of Courage) but all have been consistent with our focus.

Roots of Empathy

Roots of Empathy[3] is an evidence based program that brings infants and their parents, along with a facilitator, into primary age classrooms to build emotional literacy, raise social/emotional competency and reduce aggression. The focus is on creating a culture of caring, social inclusion and attachment through observing parent/infant interactions and learning about understanding your own and other's feelings. This program has operated in Williams Lake for many years, facilitated by School District #27, and in 2010 funding was withdrawn. Communities That Care provided bridge funding until ongoing funding for the program was reinstated.

Positive Action

Positive Action[4] is an evidence based program that promotes intrinsic interest in learning and encourages cooperation and positive behaviour among students. There is substantial evidence that use of the program results in significant reduction of substance use, violence, bullying and absenteeism, along with increased pro-social interaction and academic achievement. The program provides age/grade appropriate curriculum kits that are easily implemented in a classroom or other group setting. School District #27 piloted the program in four schools in 2010, and expanded the program to an additional ten schools in the 2010-11 school year. Additionally, in 2012 several after school programs, preschools and parenting programs began using the Positive Action program. The program foundation is based on the principle that when you do positive things, you feel good about yourself. Activities are built around concepts about self-concept, doing positive things, managing yourself responsibly, and how you treat others. A 'Word of the Week' guides each lesson, and we have utilized this approach to expand the program out into the community. The Community That Cares Facilitator distributes the Word of the Week, along with a brief description of the concept, by email each Monday morning. It is posted around the community on staff bulletin boards, in public locations, in program settings, and re-shared to various networks. Many programs now incorporate the basic philosophy of the program and use the Word of the Week in their programming. Parents have the opportunity to reinforce it with their children as well.

[3] http://www.rootsofempathy.org/roots-of-empathy/
[4] https://www.positiveaction.net/overview/philosophy

Circle of Courage

Developed by Dr. Martin Brokenleg, the Circle of Courage® is a model of positive youth development based on the universal principle that to be emotionally healthy all youth need a sense of belonging, mastery, independence and generosity.[5] This framework integrates Indigenous knowledge and traditional wisdom with contemporary youth development work. In 2012, Dr. Brokenleg came to Williams Lake and spent several days working with our community to help us understand the model and how we could use it to frame our work with youth. Specific work with School District staff led to a comprehensive framework for building a sense of belonging in schools as a foundation to improving academic achievement. The broader community also took part in a workshop and community planning process that identified current and future initiatives related to each stage of development identified in the Circle of Courage model. This community level work was captured by a graphic artist and resulted in the following depiction of how our collective work aligns with this framework.

Figure 4: *Circle of Courage: Cariboo Chilcotin Style*[6]

[5] https://www.starr.org/training/youth/aboutcircleofcourage

[6] Drawing created by Sam Bradd based on written notes from the workshop session.

Collaboration – A Collective Impact Approach

One of the most important elements of Communities That Care is that it has provided a framework for increasing collaboration regarding many social issues in our community. No single agency, policy or government department can tackle the complexity of the challenges we face. Collective Impact approaches focus multiple sectors on creating a common agenda, developing shared measurement, aligning mutually reinforcing activities, communicating regularly, and providing for facilitated support for the activities of an initiative tackling complex social issues.

Communities That Care provides a roadmap that guides the development of a systematic approach to collaboration across multiple agencies and sectors. The result over time has been that we work differently together now – we increasingly collaborate both on our prevention initiatives and in our front-line intervention by aligning our efforts toward a shared goal. We have better relationships and a new shared language to talk about what we are doing. We have a commitment to measuring our impact and using the data to inform our decisions. We share information more frequently and more fluently, for the purpose of achieving our goals. At the same time, it is a framework that allows for the development of unique responses based on the context of our community at any point, while maintaining a focus on our shared longer term goals. There are many examples of this in action:

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 of 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 plans.

Integrated Youth Services

Front line youth service providers meet regularly to coordinate intervention services for youth, to identify youth at high risk, and to do integrated case planning to provide wrap-around services for high risk youth.

Cariboo Action Team - Child and Youth Mental Health Collaborative

Mental health professionals working collaboratively with families to provide timely access to mental health and substance use response services for children, youth and their families.

BC Youth Week

Williams Lake has had the largest Youth Week event in the province, with the most events offered for youth. This event is organized collaboratively by multiple organizations who serve youth.

Youth Drop-In at the Library

The Community Librarian requested help responding to a group of youth in the library who were disruptive but clearly needed somewhere to be. Within two weeks a drop-in program for 'high risk' youth not otherwise connected to services was created with support from several agencies. The library provided free space, and youth organizations provided their outreach staff.

Graduation Parade

Graduates participate in a parade through the downtown, which is attended by the whole community cheering on their success. Thousands of spectators turn out for this event annually.

Glass Slipper Project

A community effort to provide gowns, suits, footwear, make-up and hair, and all the supports to graduates without the financial resources to participate in the graduation ceremony, graduation parade, and dry grad celebration.

Early Childhood Development Network

Multi-organization table focused on creating opportunites for early learning activities across the community.

Figure 5: ***Collaboration examples in our community***

Prevention Needs Assessment Youth Survey Results

About the PNA Survey

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 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.*

The cornerstone of the Communities That Care process is the 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 Williams Lake. 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 **academic success, school dropout, substance abuse, violence, delinquency/crime, depression/anxiety,** and **teen pregnancy** among youth.

The survey was first completed in 2009 and this second survey was completed in November 2015 in most schools. Due to a delay in receiving the surveys from the printer, surveys at Lake City Secondary School (both campuses) were completed in the second week of January. November is considered the ideal time for a student survey as students have had time to settle into school, and things are generally fairly stable. There is some possibility that results from the January survey time-frame may result in the survey population showing elevated risk factors as Christmas break is sometimes a period of increased stress, as well as increased use of alcohol and other risk behaviours in some families.

In 2015, **1217** students in Williams Lake schools completed the survey, representing 70% of the sample population. This response rate gives us confidence that the data reflects, with reasonable accuracy, the experiences of the population being surveyed. Generally, response rates are higher at the lower grades and lower in Grade 12. For this reason, Grade 12 specific rates results should be viewed with some caution, though they are comparative with the 2009 response rates. The survey results provide us with the opportunity to compare the risk and protective factors for Williams Lake youth in 2015 with those in 2009, when we began the CTC process.

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. We are excited to share the impacts and changes over time since our first survey in 2009. While we cannot claim that the programs of Communities That Care has focused on have been the sole contribution to changes in the risk and protective factors, we are confident that our collaborative work has made a substantial contribution to the shifts we see. We are very pleased to report that things ARE changing for the better for youth in our community. In addition, rates of improvement for Aboriginal students are even higher in many cases: **9% more Aboriginal kids** have 'high protection' and **9% fewer** have high levels of risk.

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.

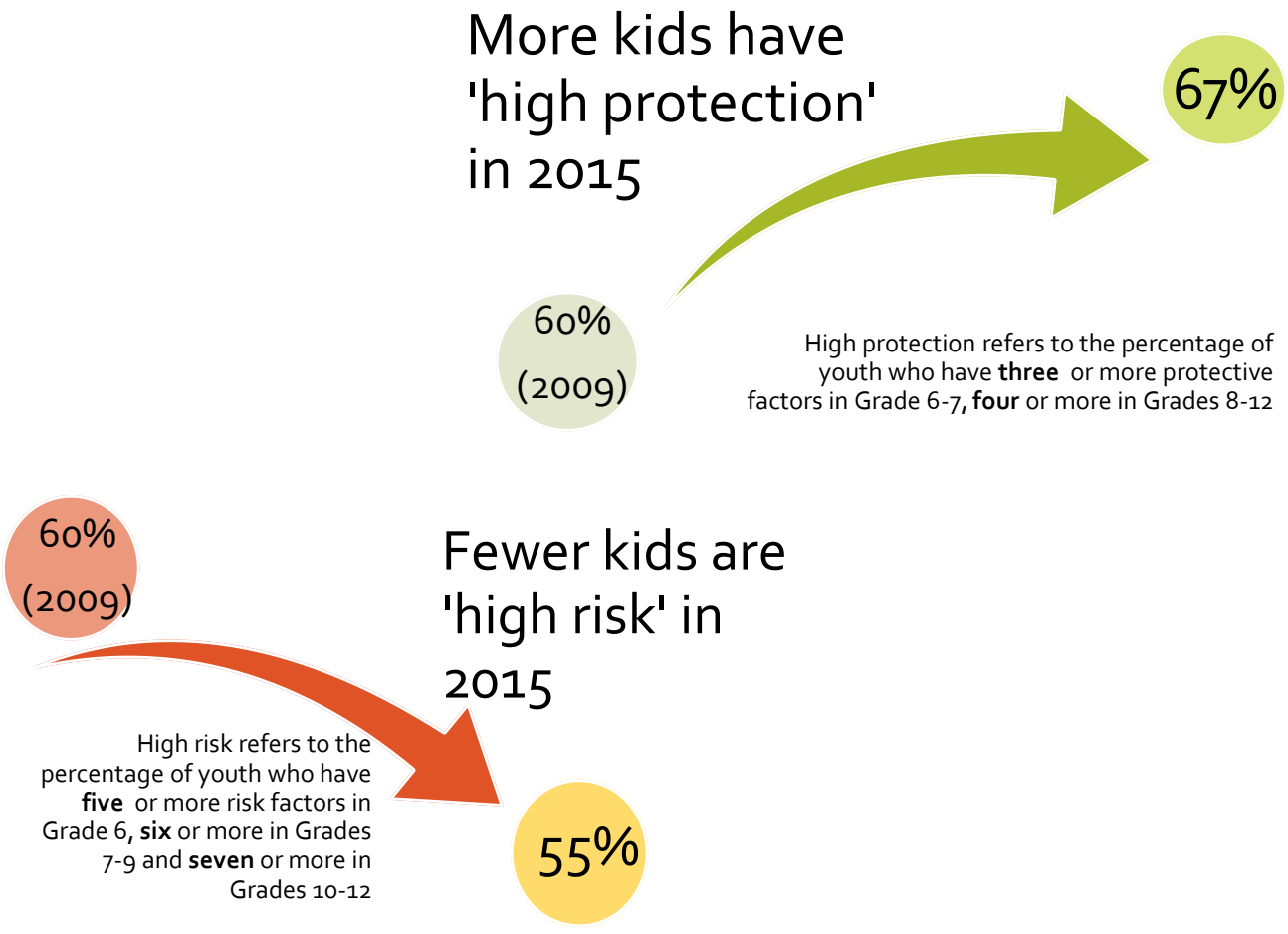

Figure 6*: Risk and Protective Factor changes*

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 these 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. This is particularly important for Aboriginal student as in 2015 8% fewer students said they experienced *Community Rewards for Pro-Social Behaviour*.

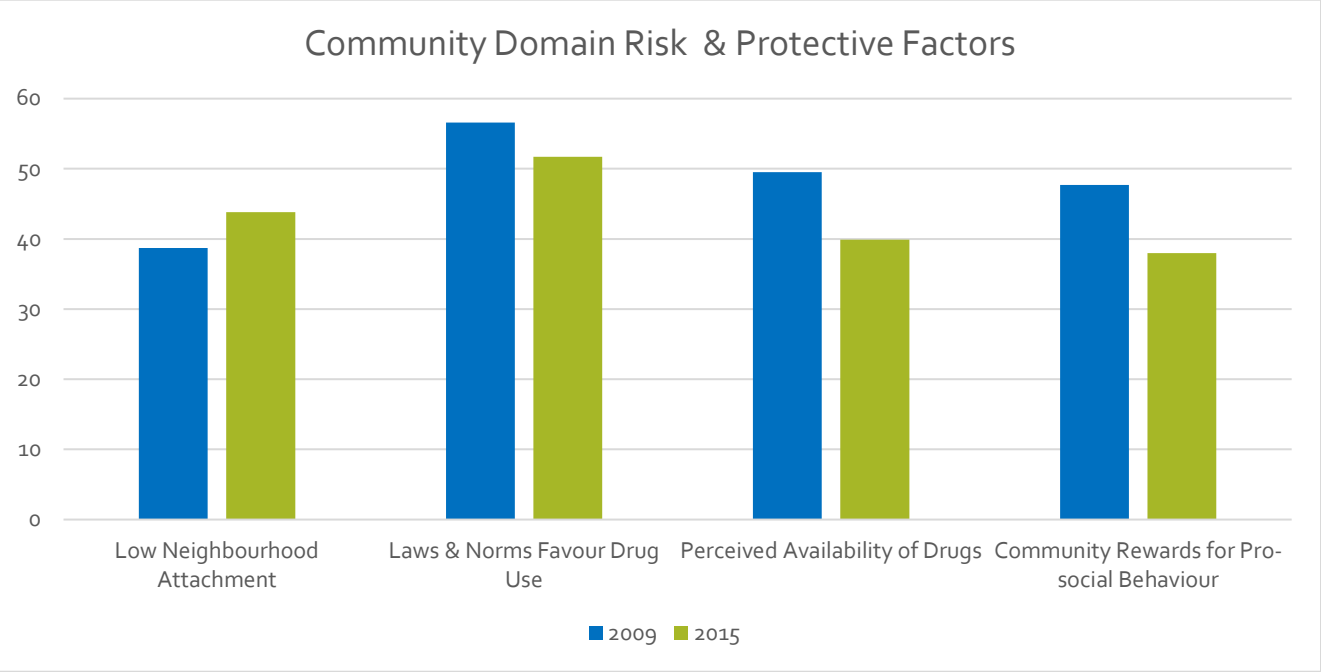

Figure 7: ***Change in Community Domain Risk and Protective Factors 2009-2015.***

In 2010, we set a goal to reduce the risk factor *Community Laws and Norms Favourable toward Drug Use*[7] by 1% each year. Although we knew this was a very challenging goal, we felt strongly that our community's attitudes toward drug and alcohol use was contributing to the choices children and youth were making. The graphic below represents the change we have seen over the past five years. We are also pleased to see that fewer young people perceive that there is easy availability of drugs and alcohol.

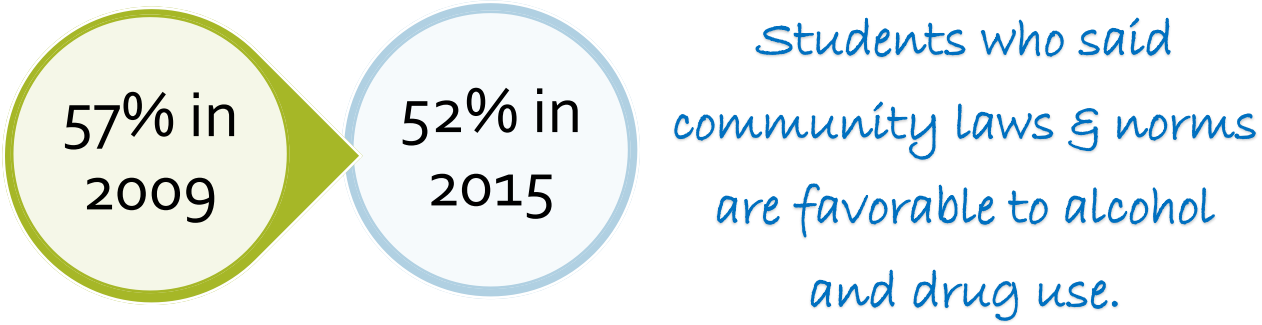

Figure 8: Community Domain priority risk factor change 2009-2015

[7] Definitions of each risk and protective factor can be found in Appendix A

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).

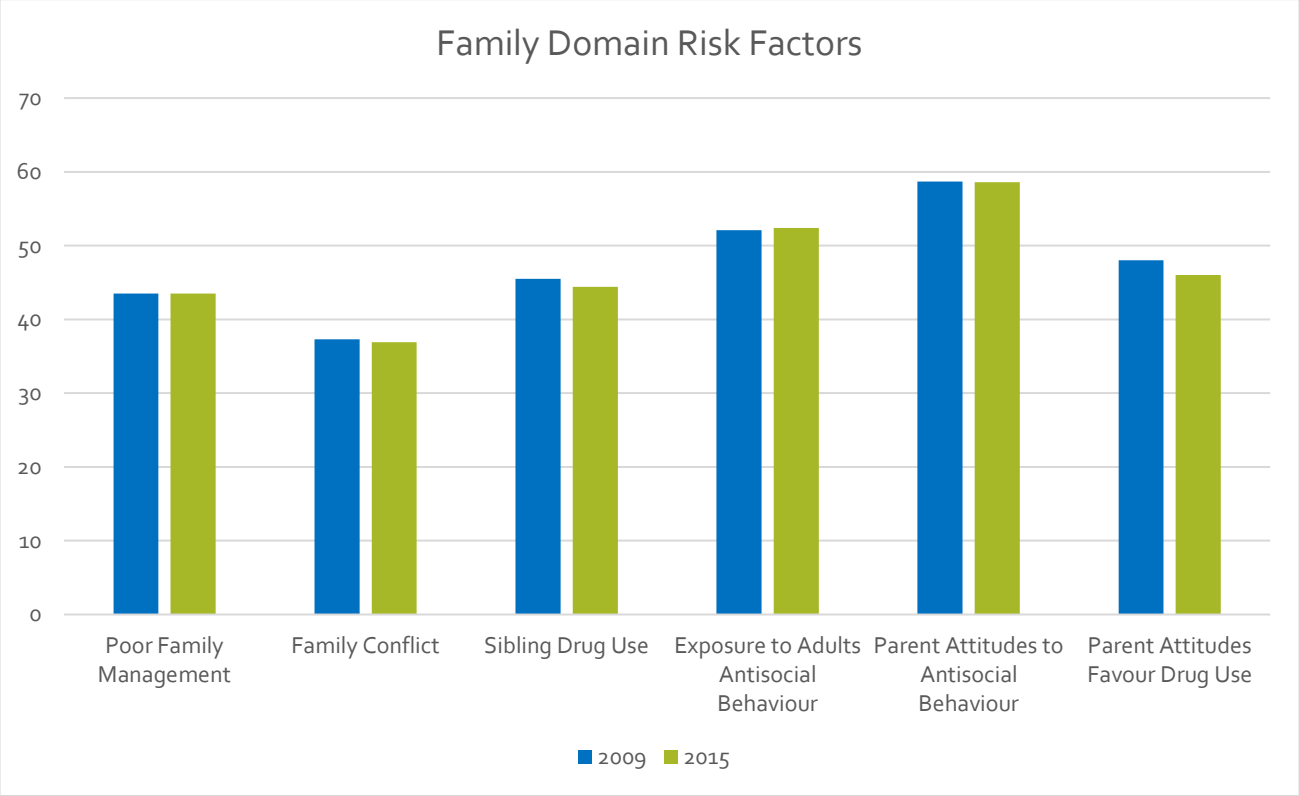

Figure 9: ***Risk factors in the Family domain***

This domain has been the subject of considerable discussion at various community tables over the past five years. We have not identified any specific program intended to address the risk and protective factors in this domain at a population level. Many programs exist that are targeted at families who have been identified as high risk, primarily through the child protection system and associated services. However, in order to shift these indicators at a population level, programming needs to be focused at that level of intervention. We feel the lack of change in the risk factors for this domain reflect the challenges discussed here. These risk factors are also the subject of considerable discussion around family values and norms, which are sensitive and personal for everyone. Beliefs about when or if it is appropriate for parents to introduce young people to alcohol, and what constitutes healthy use are value laden and sometimes culturally influenced. For example, in many European cultures young people are allowed to drink socially with their family at an earlier age than is permitted legally in Canada. For others, abstinence is considered the most acceptable/healthy approach.

While we have not seen shifts across the population in the family domain, for aboriginal students the picture is slightly different. Aboriginal student data shows small improvements in four of the six family domain risk factors, with significant positive change in the *Family Management* risk factor.

Where we have also seen positive shifts is in the family domain protective factors and the percentage of children with family protective factors is high. This may well be the most effective way to address family domain influences, to strengthen the foundation of family attachment, along with opportunities and recognition of pro-social behaviour. We also asked some additional questions about family relationships in the 2015 survey that reveal some of the issues that interfere with these and may be opportunities for discussion about possible ways to impact them.

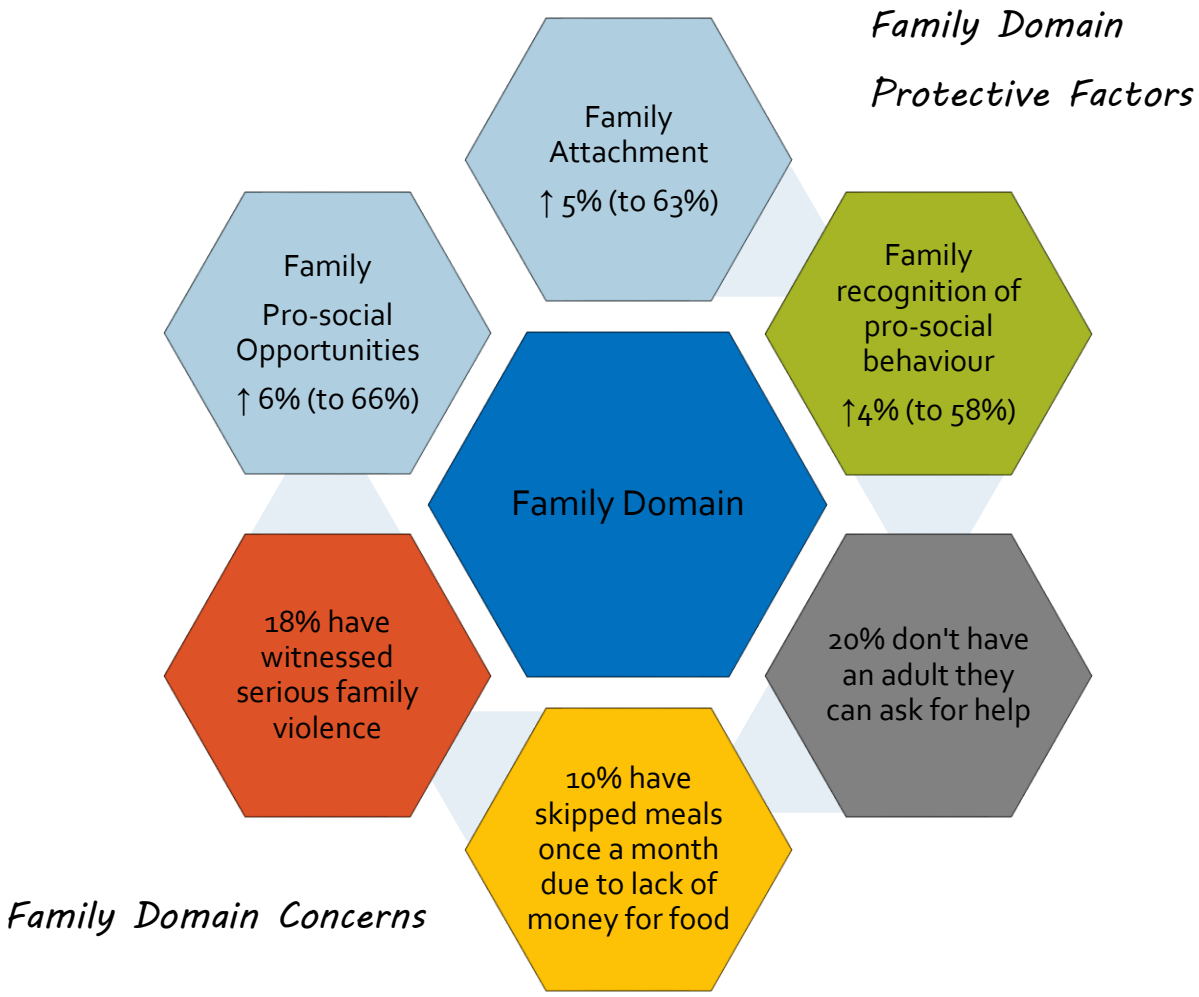

Figure 10*: Family domain protective factors and associated issues*

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. Schools in Williams Lake (and across the school district) have embraced positive behaviour support programs as a strategy for improving student behaviour. *Low Commitment to School* was a priority risk factor identified in our 2009 data. We have seen significant positive improvements in both of the school domain risk factors. Aboriginal students show a 14% improvement in the Academic Failure risk factor.

In Williams Lake, we had a substantial restructuring of our schools in 2012. In particular, we closed several elementary schools, and moved from two 8-12 high schools to a single school, two campus model with grades 7-9 on one campus and 10-12 at the other. This resulted in students changing schools, loss of school history and identity, and new administration structures. While we feel that the new structure has now stabilized, students currently in grades 10-12 were significantly affected by this restructure as some students moved schools three times over a three-year period.

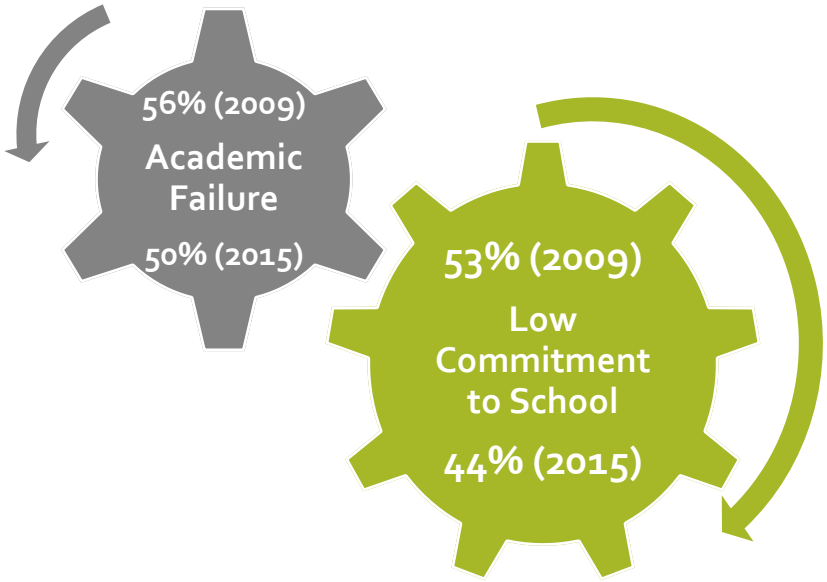

Figure 11*: School domain risk factor changes*

Low Commitment to School is a measure of how much students like school, spend time on their studies, and see their coursework as relevant. When viewed across the grade spectrum, we can see that the most significant improvement over 2009 results is in grades 6-8, with less improvement in the higher grades and Grade 9 students showing an increase in this risk factor.

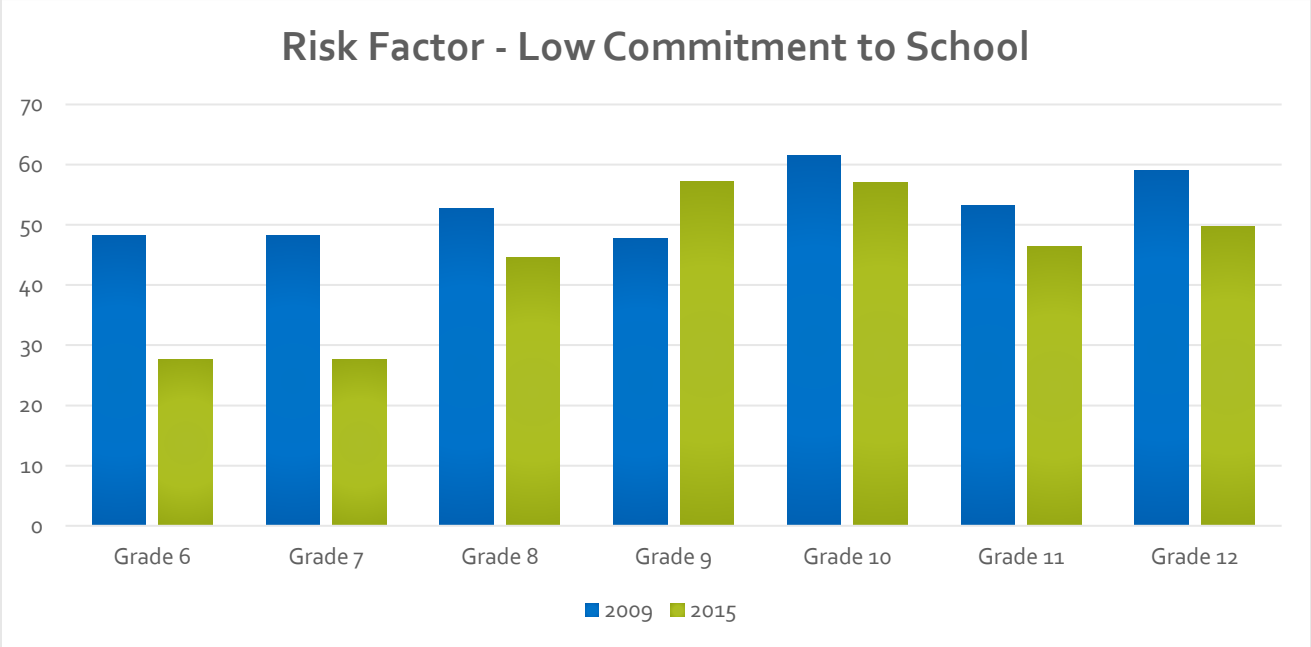

Figure 12*: Low Commitment to School Risk Factor changes by grade*

Protective factors in this domain have not fared as well. These indicators show that students feel they have significantly fewer opportunities to participate in pro-social activities in their schools in 2015. Research demonstrates that when young people have opportunities to participate meaningfully in important activities at school, and are recognized for doing so, they are less likely to engage in substance use and other problem behaviours.

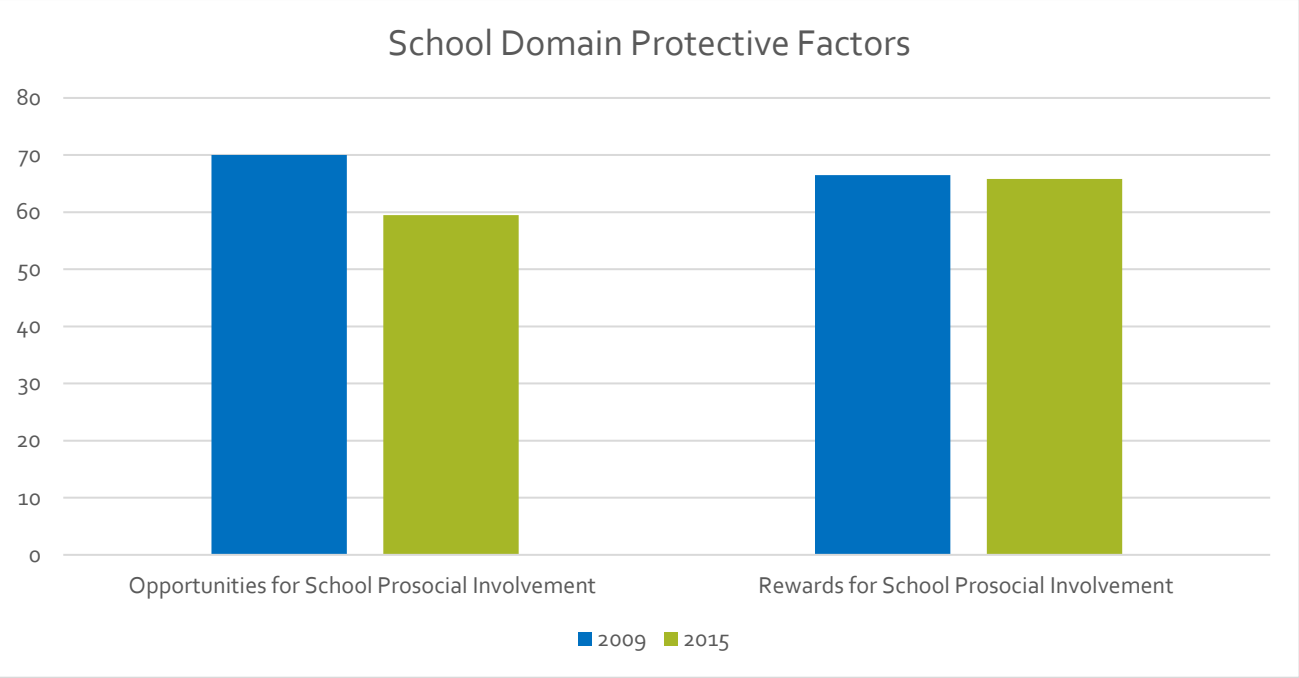

Figure 13: ***Change in School domain protective factors 2009-2015***

In 2010 the leadership at the School District viewed *Low Commitment to School* as a root cause associated with poor academic achievement. As a result, the School District took a broad view that in addition to offering the Positive Action® 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.[8] [9]

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

This district-wide approach has helped to align a variety of approaches and initiatives to focus on one strategy. The results show that this approach has paid off. In addition to improvement in the risk factor *Low Commitment to School* across virtually every grade, we have seen significant improvement in students' perception of their academic performance, as measured by the Prevention Needs Assessment survey. We have also started to see some improvement in grade-to-grade transitions and six-year completion/graduation rates, particularly for Aboriginal students.[10] We are also pleased to see substantial improvement in the *Low Commitment to School* indicator for grades six through eight. These are the students who have had the most exposure to Positive Action and Sense of Belonging initiatives.

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 of 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.

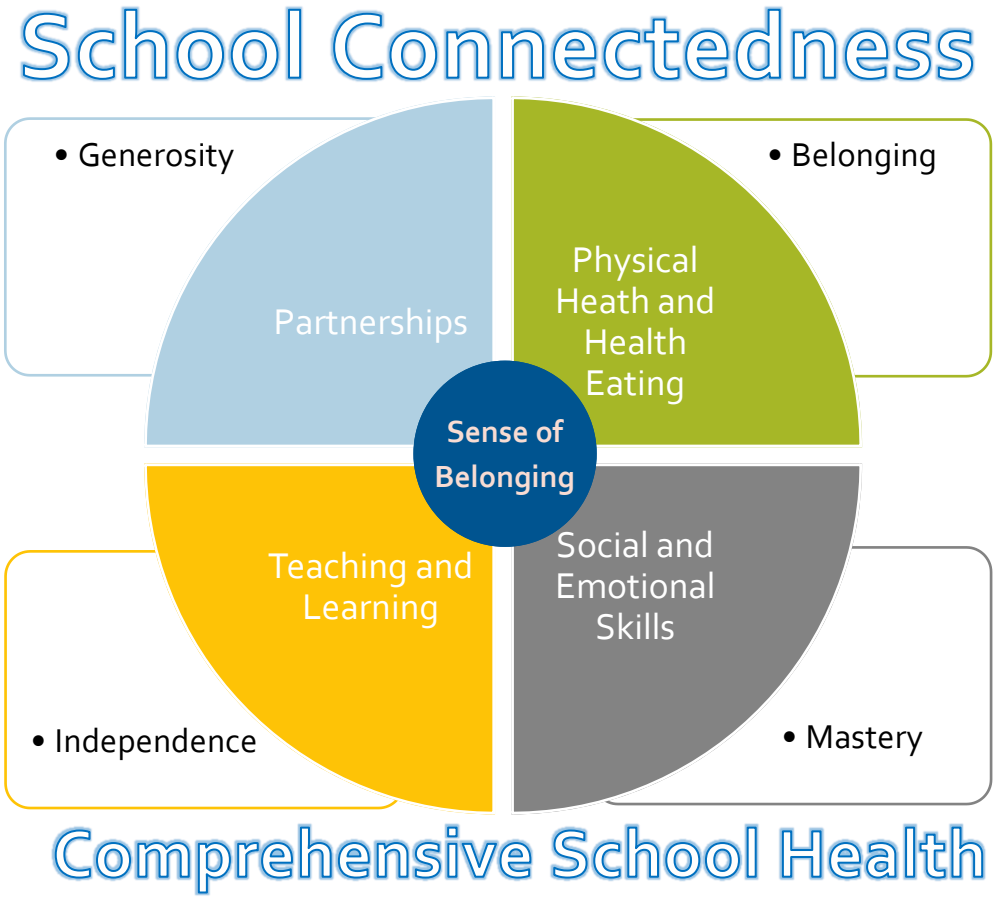

Figure 14*: Healthy Schools Model*

[10] See pages 14 &15 in this document.

Individual/Peer Domain

This domain speaks to the individual characteristics of children and youth and to the influence of their peers on their attitudes, beliefs, and behaviours. The priority risk factors for this domain were *Early Initiation of Anti-Social Behaviour* and *Early Initiation of Drug Use*. Research shows that early onset of alcohol and other drug use (prior to age 15) is a consistent predictor of future drug abuse. 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

These risk factors were chosen because even though they were not the highest risk factors in the domain, our community felt they were key risks that underlie some of the serious issues with youth behaviour that our community was experiencing. We have seen significant shifts in both of these indicators. In addition, we've seen a 15% improvement *in Early Initiation of Drugs and Alcohol*, and a 17% improvement in *Early Initiation of Anti-Social Behaviour* among Aboriginal students.

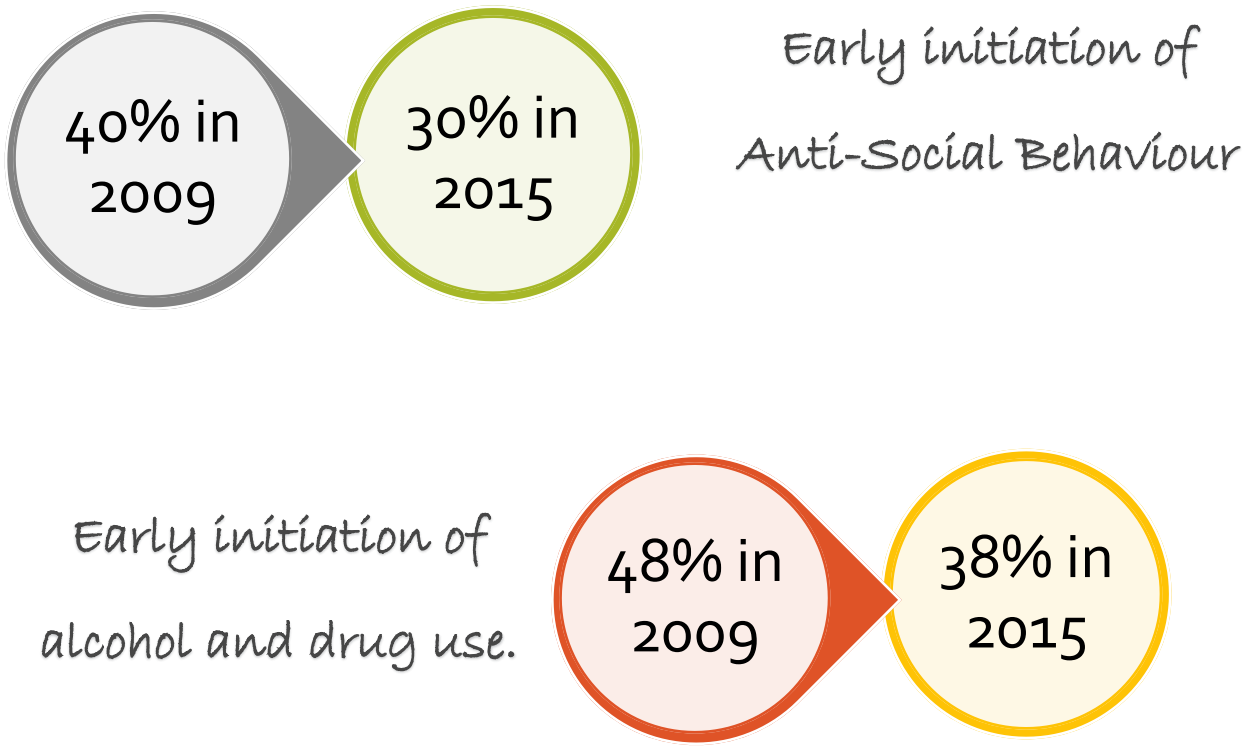

Figure 15*: **Change to Individual/Peer Domain priority indicators***

Use of Alcohol and Other Drugs

We noted in the 2009 survey results that youth in our community began experimenting with alcohol at a much earlier age and in greater numbers than other youth in BC; binge drinking was high starting in Grade 8; and rates for gang involvement and violence were much higher than expected. While we have not seen improvements across all the risk factors in this domain, a closer inspection show areas of significant improvement in some key areas.

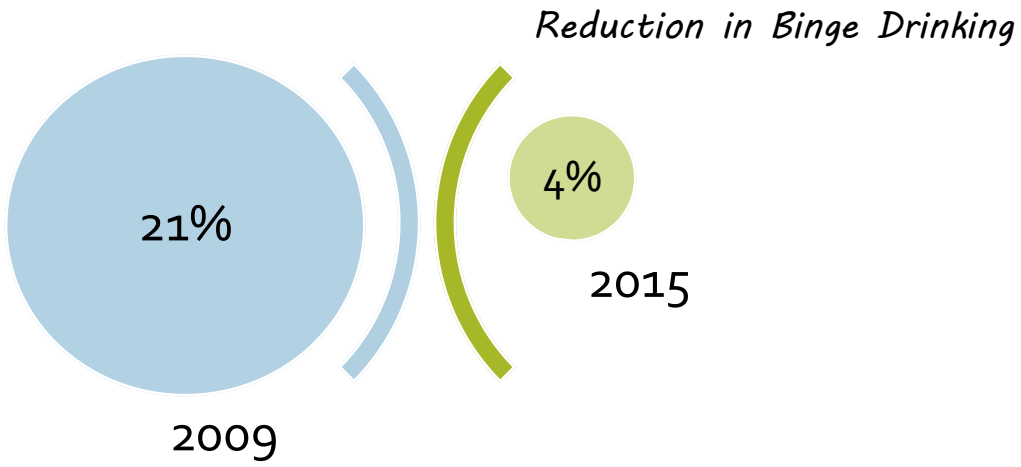

Figure 16*: Grade 8 binge drinking in the past two weeks*[11]

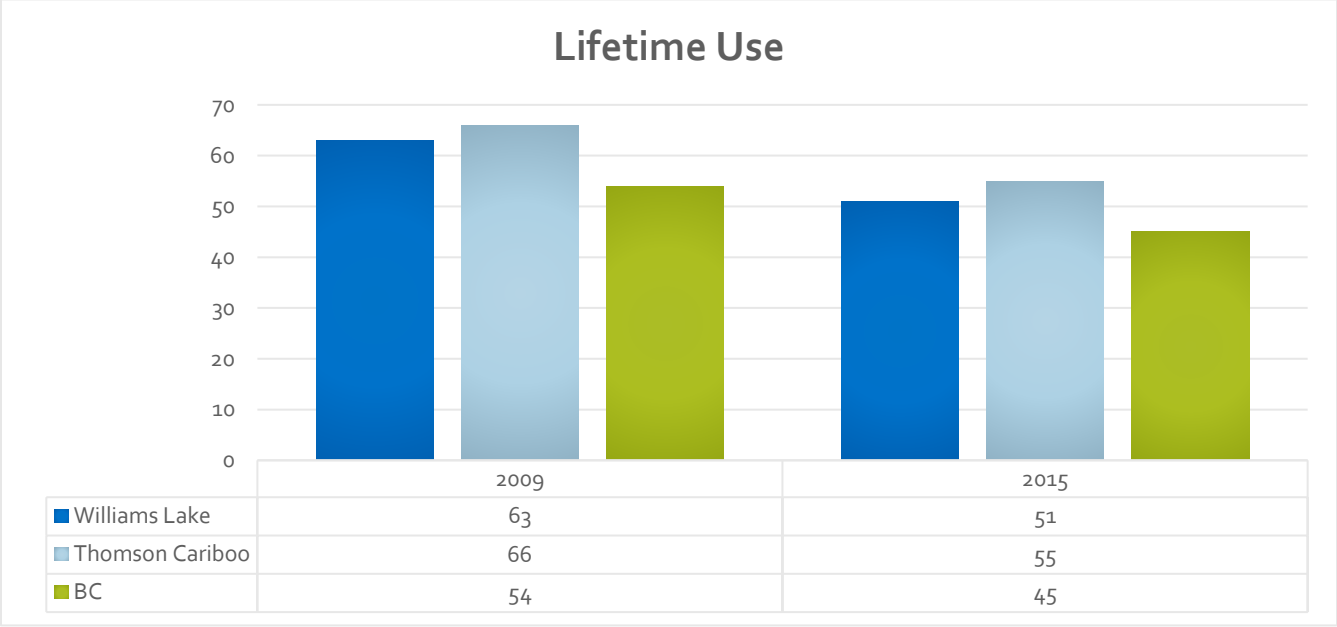

Figure 17*: Percentage of students who have ever used alcohol in their lifetime*

We have also seen some significant shifts in this area for Aboriginal students. Usage rates (reported past 30 day use) for tobacco use and marijuana are both down 8% for Aboriginal students, a significant shift that brings usage rates to a similar range as all other students. Rates of riding with a drinking driver are also down 10% from 2009 in the Aboriginal student population.

[11] Binge drinking is defined as having five or more drinks in a short period of time, once or more in the past two weeks.

Anti-social Behaviour

Anti-social behaviour among youth was of significant concern in 2009, and was one of the motivating factors for the development of the Communities That Care initiative. In particular, reports of violence and gang involvement were very present in schools, the media, and the wider community. The 2009 survey validated this concern as a significant percentage of youth reported involvement in this activity. We are very pleased to see that the survey results in 2015 show decreases in youth reporting this behaviour.

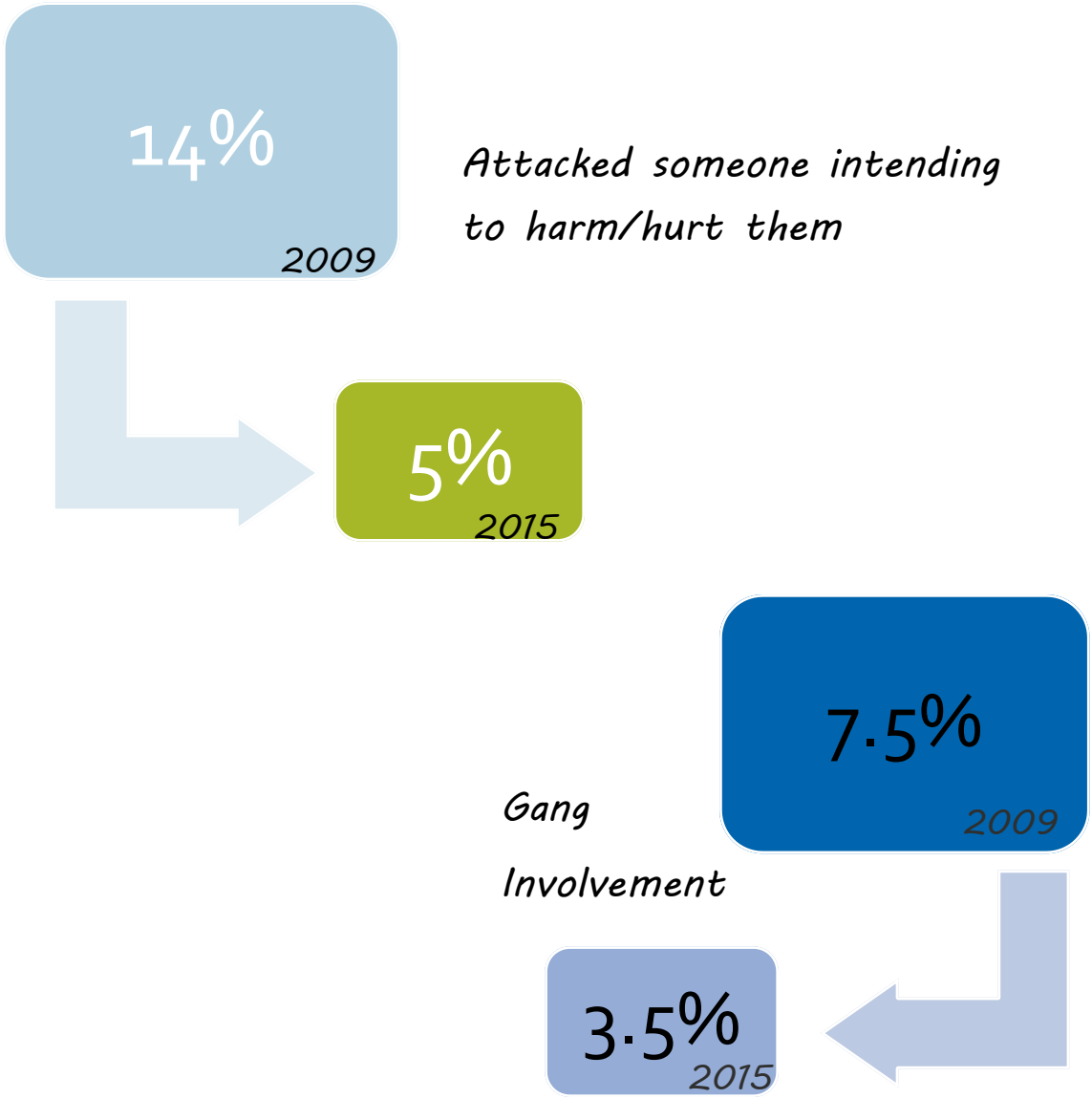

Figure 18: ***Change in indicators flagged for concern in 2010***

This is another area where we have seen significant positive shifts for Aboriginal students. There are significant decreases in all indicators for anti-social behaviour. Twenty percent fewer Aboriginal students reported being suspended from school in the past year (a 2/3 reduction, from 32% in 2009 to 12% in 2015). Violence (attacking with intent to harm) has gone down from 25% to 6%. Stealing a motor vehicle has dropped from 7% to less than 2% in 2015, and gang involvement has dropped from 21% to under 5%.

Mental Health Concerns

50% OF GRADE TEN STUDENTS REPORTED DEPRESSIVE SYMPTOMS

An area of concern in our community is the sense that increasing numbers of children and youth are presenting with mental health concerns. School counsellors and other clinical professionals have seen increases in the number of children and youth struggling with anxiety and depression. The Child and Youth Mental Health and Substance Use Collaborative's Cariboo Action Team, a cross-sector working group led by Shared Care and Doctors of BC and in conjunction with the Central Interior Rural Division of Family Practice, has been working toward an improved system of care for children and youth with mental health and substance use issues in need of clinical and acute services. While there are no reliable measures for comparing the incidence of depression across large populations, the Prevention Needs Assessment survey offers a reliable report of the indication of the presence of depressive symptoms among survey respondents.[12] Young people who are depressed are overrepresented in the criminal justice system and research shows links between depression and other problem behaviours, including drug and alcohol use. The percentage of youth reporting depressive symptoms[13] has not changed significantly overall; however, the number of students reporting depressive symptoms in grades ten through twelve are of particular concern.

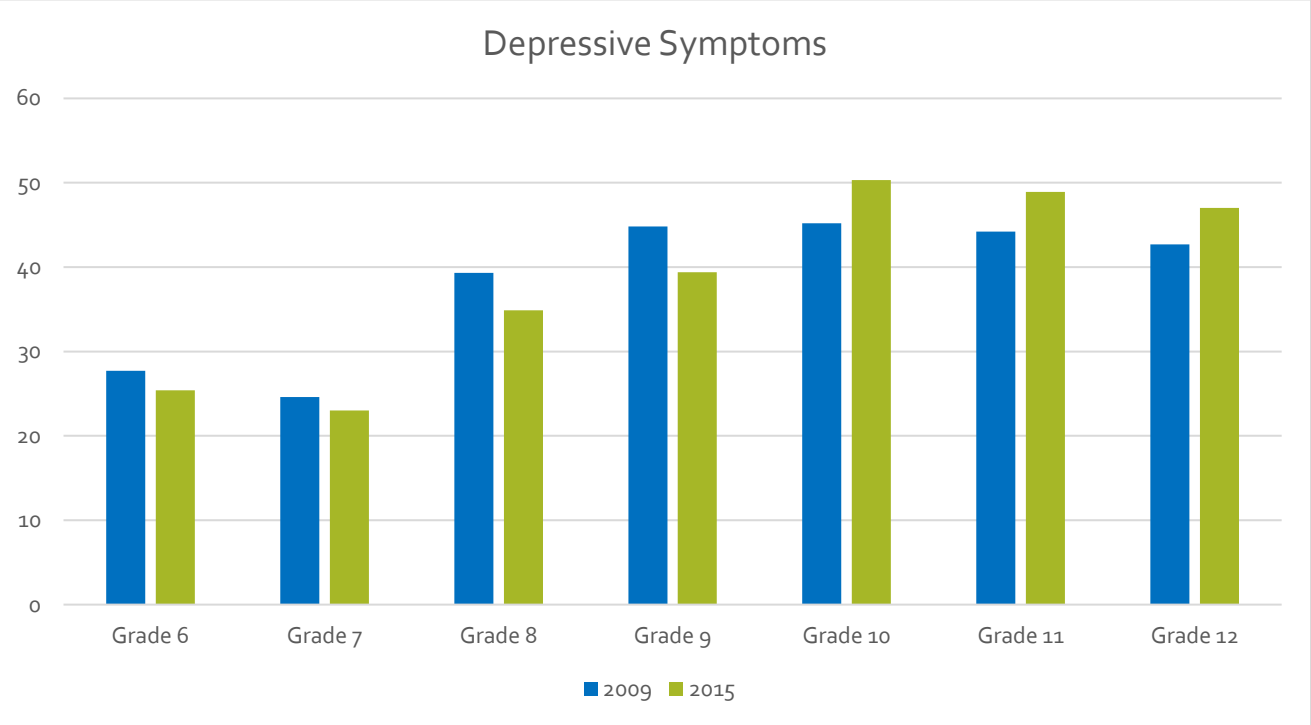

Figure 19: ***Percentage of students who have ever used alcohol in their lifetime***

We also asked students about self-harming behaviours. Just over 20% of students reported that they had purposefully hurt themselves in the past year, without suicidal intention. Over 6% had done so six or more times. In comparison, the McCreary Adolescent Health survey reported that 8% of males and 23% of females reported self-

[12] Rhew, Isaac C., Monahan, Kathryn C., Oesterle, Sabrina, Hawkins, J. David (2016). The Communities That Care Brief Depression Scale: Psychometric properties and criterion validity. Journal of Community Psychology, 44(3), 391-398.
[13] Depressive symptoms in the PNA survey are a measure of youth reporting their experience of depressive symptoms only, not a reflection of a diagnosis or increased awareness of mental health issues.

harming. Behaviours reported most frequently were self scratching, hitting, cutting and burning, which were reported by 30% of students who indicated they had done self-harming behaviours.

How are we making a difference?

One of the key questions that arises when reviewing the data from the youth survey alongside the list of programs, initiatives, and activities that our community has engaged in over the past six years, is 'how do we know what made a difference'? More specifically, how do we know whether the changes we see can be attributed to the activities of the Communities That Care initiative? This is a legitimate question, albeit a challenging one to answer. It would be impossible to design an experimental study that could isolate the effects of our initiatives on the population of children and youth in our community. Outcome measurement is messy business, and proof that our actions directly result in a particular outcome is elusive. When we look at what specific changes we want to achieve in large complex social issues over a long period of time, it is impossible to find direct attribution, even identifying contribution can be tricky. However, trials comparing communities where CTC has been implemented with those where it has not, show that CTC was a factor in increased levels of protection among youth in the school, community and individual domains.[14] Our results are consistent with this finding.

Tamarack Institute, which has worked in the fields of collaboration and community level change for many years, suggests that focusing on finding proof of attribution is folly. They propose that a better approach is to consider utilizing the idea of outcomes for strategic intent and focussing of resources. The concept of identifying 'Game Changer' outcomes focuses the work and identifies "aspirations with strategic imperatives that are used for planning, organizing, innovating, and allocating resources". Tamarack identifies Game Changers as "*a priority area or strategy that not only aims to deliver on its own specific goals or outcomes, but also elicits an array of other significant, positive outcomes that cascade both within and outside of its area of emphasis."*[15]

"The good news is we have seen positive and encouraging shifts in our Prevention Needs Assessment Survey Results! Prevention work is a very hard sell. It is not as concrete as intervention and results can only be measured over a longer period of time. Many funders want to see outcomes that can be measured in intervals of 6 months, and a change in leadership/champions at a government, institutional, or agency level can have tremendous impact on the momentum, effectiveness and sustainability of prevention work. We are fortunate to have consistent and strong champions of Communities that Care even when key leaders have changed. This has enabled the work to complete its first iteration and for us to measure these results."

This still requires a set of indicators to measure impact, and the struggle to identify the extent to which the activities of the initiative contribute to the outcome. For the Williams Lake Community That Cares initiative, there are challenges to this, but also some clues. Firstly, a review of the data shows that the greatest improvement in risk and protective factors shows in the Grades 6-8 data. These are students who were in Kindergarten through Grade 3 when the initiative began, and have therefore had the greatest exposure to the variety of program specific activities implemented. Secondly, a very specific and intentional focused approach

[14] Kim, B. K. Elizabeth, Gloppen, Kari M., Rhew, Isaac C., Oesterle, Sabrina, Hawkins, J. David (2015). Effects of the Communities That Care prevention system on youth reports of protective factors. Prevention Science, 16(5), 652-662.
[15] A Game Changer Approach to Poverty Reduction Strategy and Evaluation. Tamarack Institute (2016).

was undertaken by the school district to improve low commitment to school, as they felt this was a pivotal (or game changer) indicator, which would lead to an impact on other indicators. This indicator shows substantial positive change, particularly for students in grades 6-7, where that risk factor has dropped by over 20% (nearly in half), and has positively impacted on academic success as well. Thirdly, in the domain where no programs or initiatives were implemented (family domain), little if any change took place. We recognize that additional work is required to better track how our activities contribute to these outcomes and the learning is as important as the results. But we are also confident that the results indicate that we are getting it 'roughly right' in terms of contributing to the improved well-being of children, youth and their families.

Monitoring Results

The Communities That Care initiative is concerned with prevention and root causes related to six problem youth behaviours. The focus on prevention targets risk factors that are shown to predict an increase in the likelihood that youth will be involved in those six problem behaviours. The Risk and Protective Factors measured with the Prevention Needs Assessment are indicators of the health and well-being of our youth population. Monitoring these indicators, along with indicators directly measuring youth involvement in the behaviours we are trying to impact, gives information to guide decisions about strategic direction for prevention efforts in our community. By setting strategic priorities, and aligning our prevention efforts, we have seen a significant impact on those indicators.

	Indicators	2009 Benchmark	2015 Benchmark
PRIORITY RISK AND PROTECTIVE FACTORS	**Community Laws and Norms Favorable to Drug Use** **Community Rewards for Pro-Social Involvement**	57% 48%	52% 38%
	Parental Attitudes Favorable Toward Anti-Social Behaviour **Parental Attitudes Favorable Drug Use**	59% 48%	59% 46%
	Low Commitment to School	53%	44%
	Early Initiation of Anti-Social Behaviour **Early Initiation of Alcohol and Drug Use**	40% 48%	30% 38%
PROBLEM BEHAVIOUR INDICATORS	**Substance Use:** Grade 8 Students – Used alcohol in past 30 days Grade 8 Students – Binge drinking	 31.5% 21%	 15.5% 4%
	Violence: Attacked a person with intent to harm (all grades)	14.5%	5.4%
	School Completion: Completion of grade 12 within 6 years (all students) Completion of grade 12 within 6 years (Aboriginal)	 81% 54%	 84% 63%
	Depression & Anxiety: Depressive Symptoms (all grades)	38%	38%
	Youth Crime: Number of incidents Gang Involvement	335 7.5%	245 3.5%
	Teen Pregnancy: Per thousand population	23.9	No longer reported

Figure 20: ***Benchmark indicators comparison 2009-2015***

Community Context

In examining the results from the survey, it is important to locate the data in the context of the broader community. For example, since 2009 we have seen significant transitions in terms of families moving in and out of the community due to employment shifts related primarily to industry contraction and expansion. 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. 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. In 2011 there were 18,490 people living in 7310 households in Williams Lake and the surrounding residential neighbourhoods. Of those, 4400 are children nineteen years and younger, and 1265 are children under 6.[16] We have over 900 single parent families and 76% of them are headed by the female parent. Williams Lake also is a service region for many outlying rural communities, including ten Aboriginal communities. 20% of the Williams Lake population identifies as Aboriginal.

Socio-economic data

In 2012 (the most recent data available), the Cariboo Chilcotin LHA was ranked 6th worst in the province (out of 78) on the Human Economic Hardship Composite Index. This is an improvement from the position of 3rd worst in 2006. The index is based on a number of factors including the percentage of people on income assistance, seniors receiving the low income supplement, and average household incomes.

	Williams Lake	BC
Median After Tax Family Income		
All families	$65,278	$67,915
Couple families	$71,213	$73,063
Lone-parent families	$35,891	$40,646

Table 1: Family Income

Housing costs in Williams Lake are often assumed to be 'affordable' since we have lower market prices for home ownership. However, for many people home ownership is not financially accessible and the rental market is less affordable than is often assumed. The Canadian Mortgage and Housing Corporation sets affordability at a maximum of 33% of before-tax income going toward shelter costs (including rent or mortgage, electricity, heating and other utilities). The following data provides a snapshot of the variability of housing affordability at a population level, but there are additional subtleties for single parent families and families living in poverty. The adequacy (quality) and suitability (size relative to number of people) aspects of housing are more challenging to capture on a population scale, however Census data identifies that 11.6% of renters and 8.5% of owners indicate that their dwelling was in

[16] Statistics Canada Census 2011 data

major need of repairs in 2010. Additionally, 8.8% of renter households indicated they lived in households that were overcrowded based on the National Occupancy Standard[1]. The cost of rent has also been rising substantially over the period of the report.

Housing indicator	Housing tenure	Williams Lake (Census Area)	British Columbia
Percentage of households spending **30% or more** of 2010 total income on shelter costs	**Total**	19.3	30.3
	Owner	13.0	23.8
	Renter	36.9	45.3
Average monthly shelter cost (2010)	**Total**	$806	$1,156
	Owner	$830	$1,228
	Renter	$737	$989
Average rent (does not include other shelter costs) across all multi-family units (October 2016)[17] *Rent has increased by nearly 10% since October 2015		$757	$1099

Table 2: Housing Costs

Poverty/Economic Deprivation

Poverty has a significant impact on children and family's vulnerability, and it is a significant risk factor for five of the six problem behaviours CTC is focused on addressing (the exception is depression/anxiety). In Williams Lake, poverty is an issue for almost 15% of households, which includes a significant number of families with children. Poverty is an issue not only for those who are not in the workforce, but also for those who have low-wage jobs that are below a living wage. The cost of poverty in BC was calculated at over $9 billion annually,[18] which represents the costs related to health care, poverty related crime, and lost income.

The Salvation Army operates the official Food Bank in Williams Lake, although several other faith organizations also provide food to vulnerable people. The Salvation Army sees an average of 1300 adults visiting the food share shelf (bread, veggies, fruit) each month. On average 140 families, including approximately 100 children, utilize the food bank monthly. The Salvation Army meal program also serves breakfast and lunch five days a week to between 80-110 people, for a total of nearly 2400 meals per month. In addition, two churches provide lunch to vulnerable people on weekends.

	Williams Lake		BC	
	2010	**2014**	**2010**	**2014**
Under age 18	18.7	22	19.1	19.8
Under age 6	22.7	28	18.5	20.1

Table 3: ***Child poverty rates – percentage of population***[19]

Approximately 4% of the households in Williams Lake are recipients of income assistance (excluding First Nations on reserve), and this is relatively unchanged from 2010. Unemployment rates have high seasonable variability but have dropped from 8.4% in 2010 to a low of 5.9 in 2013 and up to 7% in 2015. Poverty among families with children has increased significantly since 2010, putting many more young children at risk. While the number of children in families

[17] CMHC Rental Market Report October 2016
[18] Canadian Centre for Policy Alternatives, 2011
[19] BC Child Poverty Report Card 2016: http://still1in5.ca/report-card/

on income assistance has dropped, the number of children in poverty has not. This points to the increased number of children with working parents who are living below the poverty line.

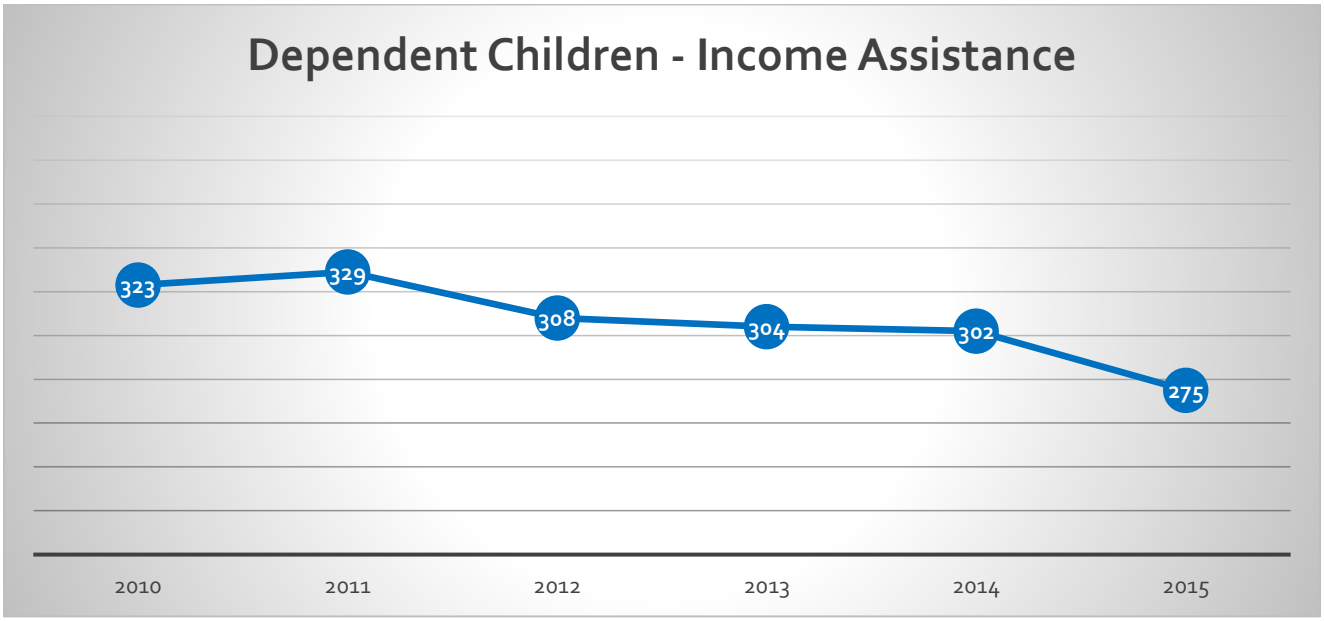

Figure 21*: average number of dependent children receiving income assistance[20] (excludes Aboriginal population receiving federal income assistance on reserve)*

Health Data

Health data for this report is based on the Cariboo Chilcotin Local Health area, which has a population of 25,727.[21] The median age across the LHA is 43, younger than most other LHA's in the Thompson Cariboo Health Service Area, with a life expectancy of 81.7 for women and 75.5 for men.

Rates of death are measured based on the Standardized Mortality Rate (SMR) where 1 is the expected rate for deaths based on provincial age specific mortality rates. The Cariboo Chilcotin LHA has higher rates of death due to many causes that are preventable. These coordinate with many of the behaviours that the Communities That Care initiative targets for prevention.

Cause of Death	SMR for LHA 27
Motor Vehicle Accidents	3.7
Alcohol related deaths	2.35
Suicide	1.87
Drug induced deaths	1.58

Table 4*: Standardized mortality rate represents the number of deaths relative to provincial averages*

Depression and anxiety rates are equal to the BC rate at 25% which is slightly lower than the Interior Health wide rate of 27%.

[20] BC Ministry of Social Development and Social Innovation, Employment and Assistance
[21] Interior Health Authority (2014). Local Health Area Profile for Cariboo Chilcotin

Crime

Crime is a significant concern in Williams Lake. We have been at the top of the Crime Severity Index for Canada in both 2008 (the year preceding the initiation of CTC) and in 2015. At the same time, we recognize that much of our violent crime is targeted, and that crime rates overall, while variable from year to year, have been gradually declining at about the same rate as the BC crime rate[22]. The one area where we are seeing a significant increase is in drug related crime. It is important to note that Williams Lake is a catchment community for a large rural region, and as a result, calculations of crime based on population reflect the disproportionate number of crimes committed outside city limits, or by those who live outside city limits, but commit a crime with the city's police jurisdiction.

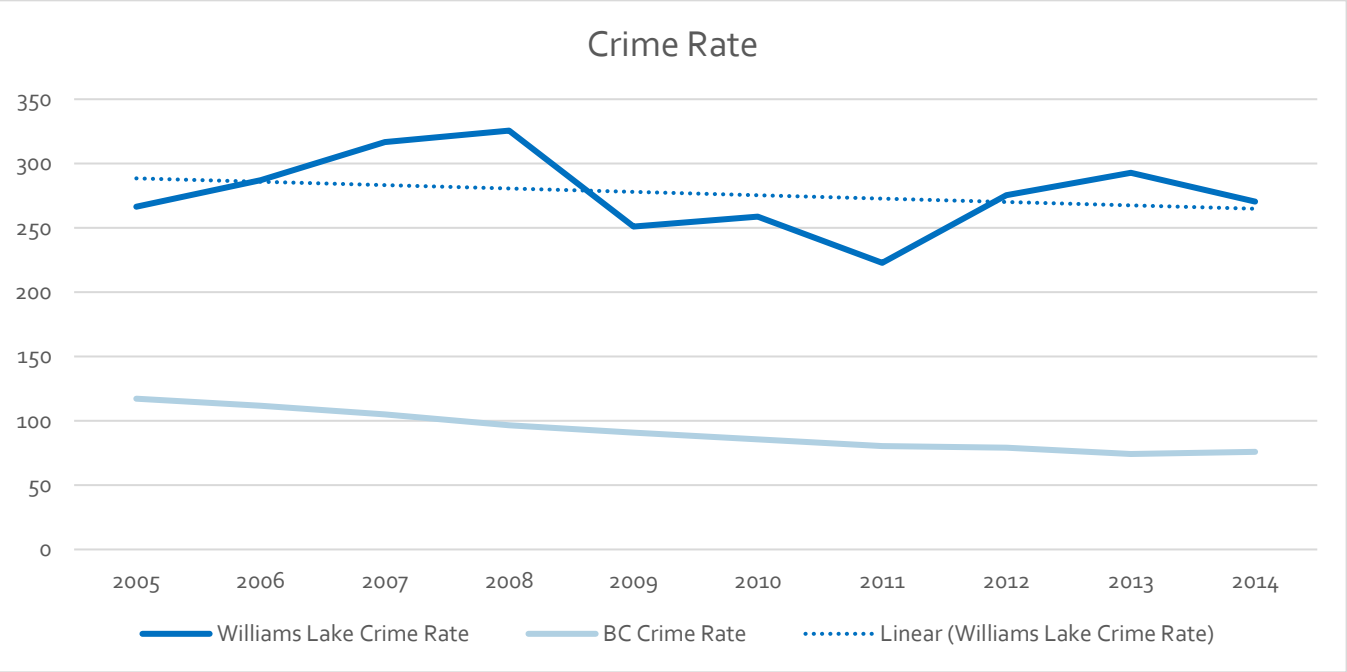

Figure 22*: total criminal offenses per 1000 population*

[22] Ministry of Justice, Police Services Division. BC Policing Jurisdiction Crime Trends 2005-2014

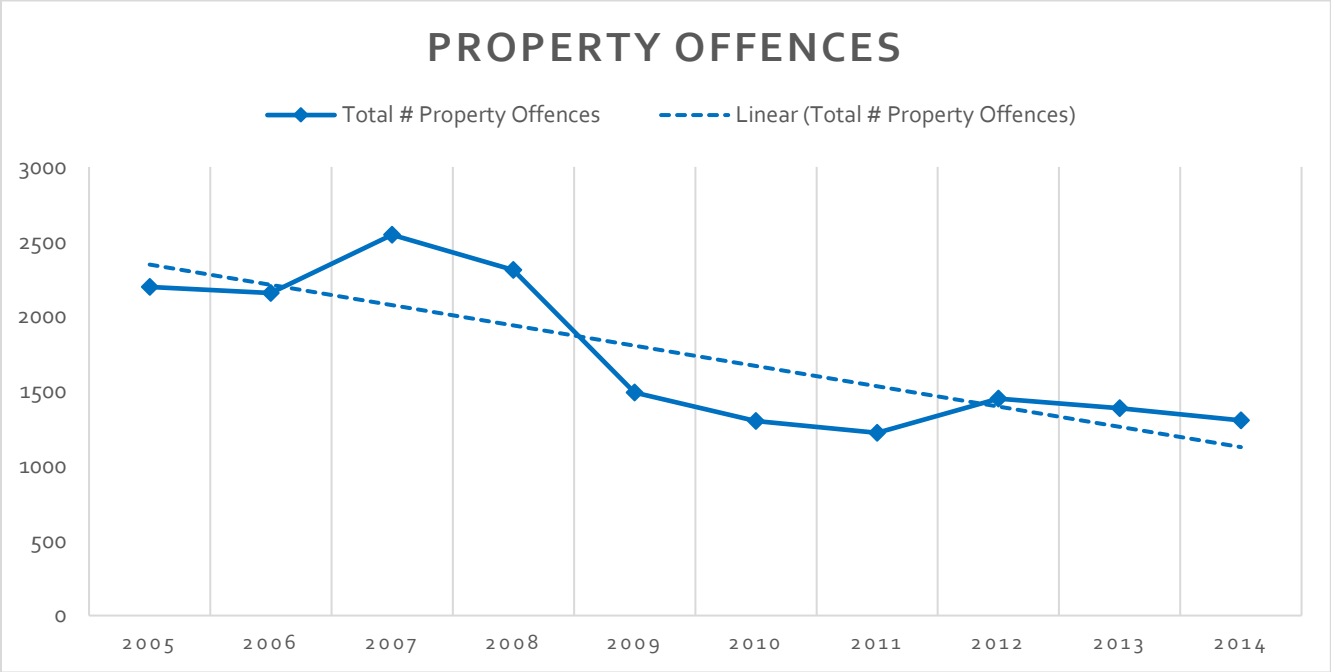

Figure 23*: total number of property offences per year*

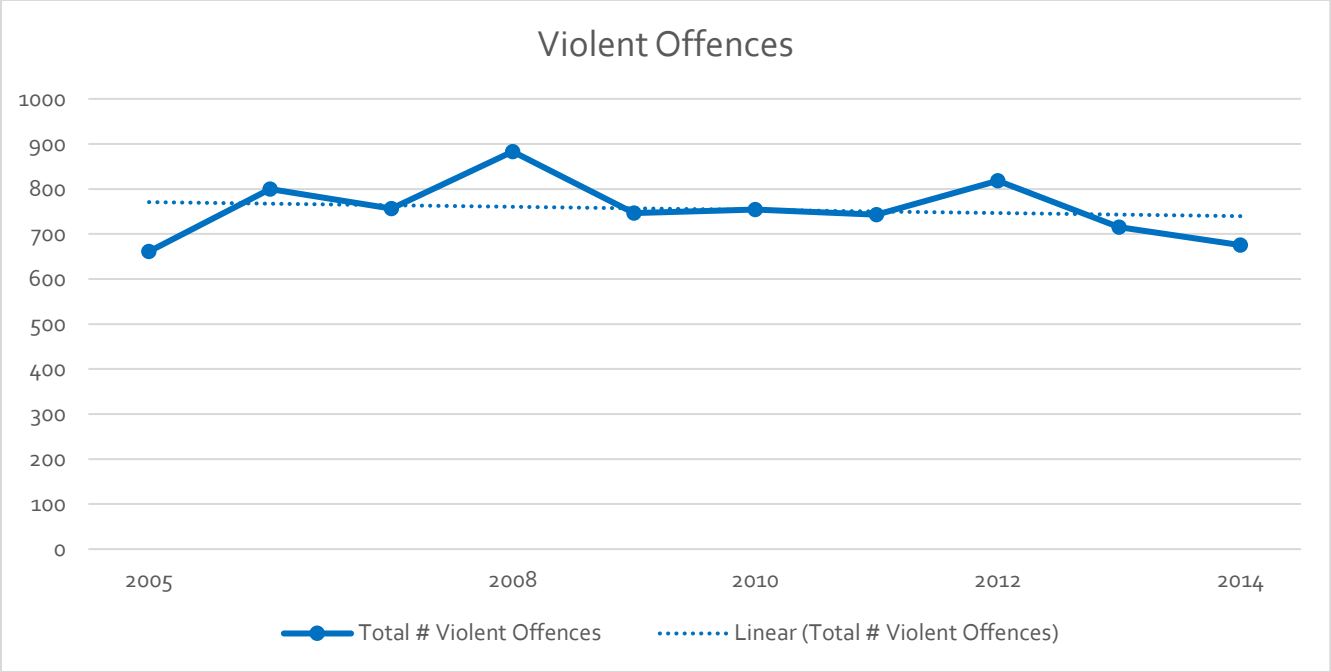

Figure 24*: total number of violent offences per year*

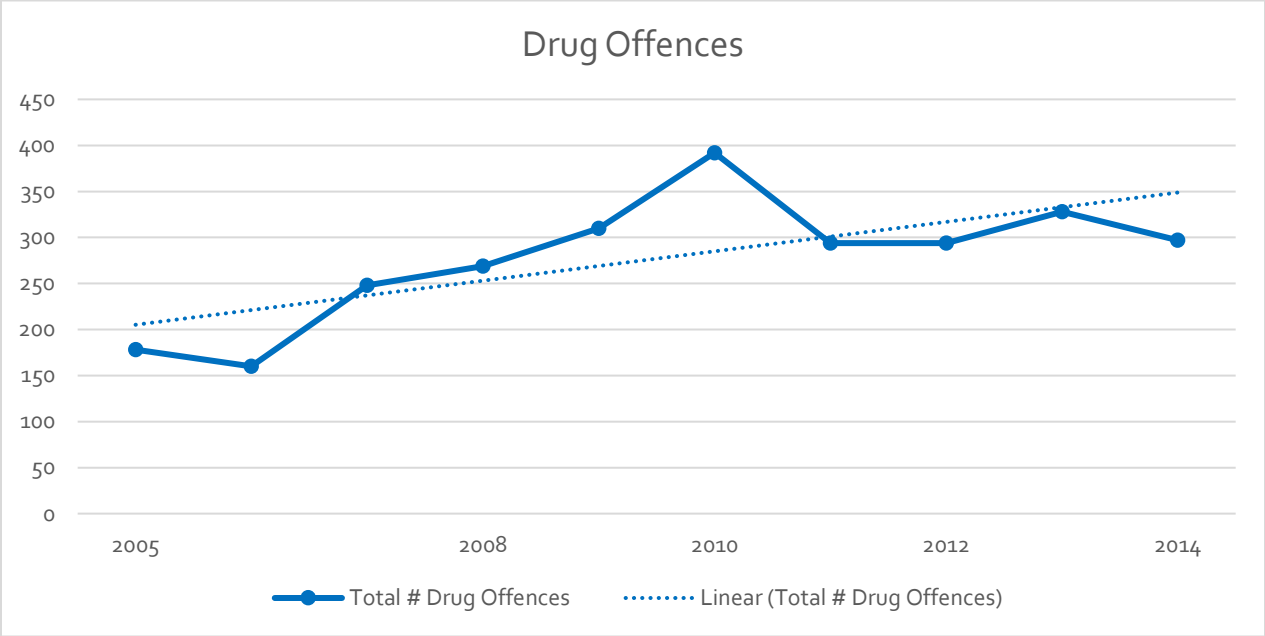

Figure 25: ***Total # of drug offences by year (includes all drug offences except simple possession of marijuana)***

Domestic assault and violence in intimate relationships is a significant concern in our community. A number of initiatives are in place to address this issue, both from a public education perspective and to respond to individual victims. The Inter-Agency Case Assessment Team is a multi-agency group who meet to respond to high risk cases of domestic violence to coordinate a service response and develop a safety plan for victims who are at high risk. Increases and decreases in the data on domestic assaults are sometimes a reflection of changes in awareness of the need to report, as well as how changes in how service delivery systems respond. As such, an increase in domestic assault cases recorded by police may be a result of increased reporting rather than increased incidents, and therefore may be a positive indicator.

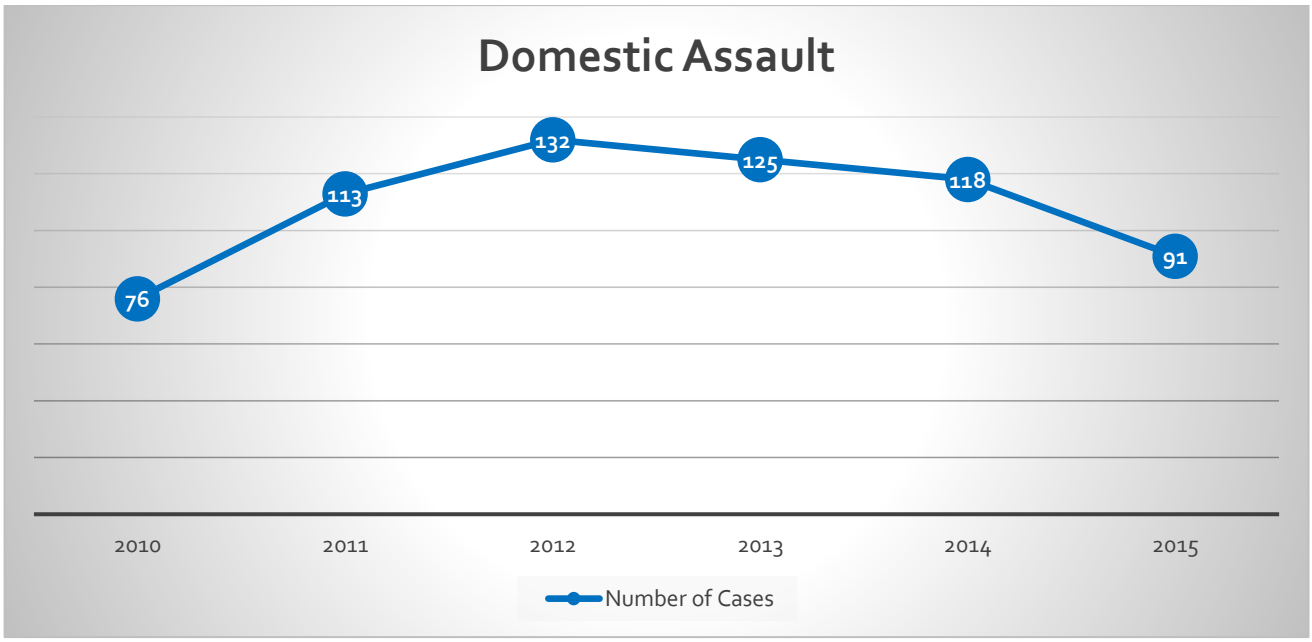

Figure 26: ***Total number of domestic violence calls to Williams Lake police by year***[23]

[23] Williams Lake RCMP Detachment data

Children and Youth

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.[24] 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 a number of 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.

Additional information and discussion of the EDI data for Williams Lake can be found in the companion document: **State of the Child**. State of the Child is a companion document to the Community Profile which looks specifically at the data and community context for children 0-6. More information is available at: www.wlchild.ca

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

Physical Health and Well-being: Measures things such as motor development, energy level, daily preparedness for school, washroom independence and established handedness.

Social Competence: Measures behavior in structured environments including cooperation and respect for others socially appropriate behavior, self-control and self-confidence.

Emotional Maturity: Measures things such as behavior in less formal environments, focusing on helping, tolerance and ability to demonstrate empathy for others.

Language and Cognitive: Measures things such as interest in books, reading, language-related activities, literacy and interest in simple math-related activities.

Communication Skills: Measures things such as the ability to communicate one's needs, understand others in English, actively participate in storytelling and general interest in the world.

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. 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.

[24] Human Early Learning Partnership, University of British Columbia (2015). http://earlylearning.ubc.ca/edi/

	Total Number of Children Screened		% Vulnerable (one or more domains)		% Vulnerable Physical		% Vulnerable Social		% Vulnerable Emotional		% Vulnerable Language		% Vulnerable Communication	
	W4	W6	W4	W6	W4	W6	W4	W6	W4	W6	W4	W6	W4	W6
Westside	99	91	27	34	14	22	12	21	14	21	11	12	8	13
Downtown	111	101	43	60	26	37	21	39	26	34	23	28	19	29
North	113	103	26	40	10	21	8	25	8	19	15	19	15	18

Figure 27*: **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 Williams Lake, between Wave 4 and Wave 6, the neighbourhoods of Williams Lake Downtown (17% increase in vulnerability) and North (14% increase in vulnerability) showed a *critical difference* in vulnerability over the period between 2009 and 2016. This change is primarily driven by increases in the Physical and Social domains. There has been an increase in physical, emotional and social vulnerability rates provincially.

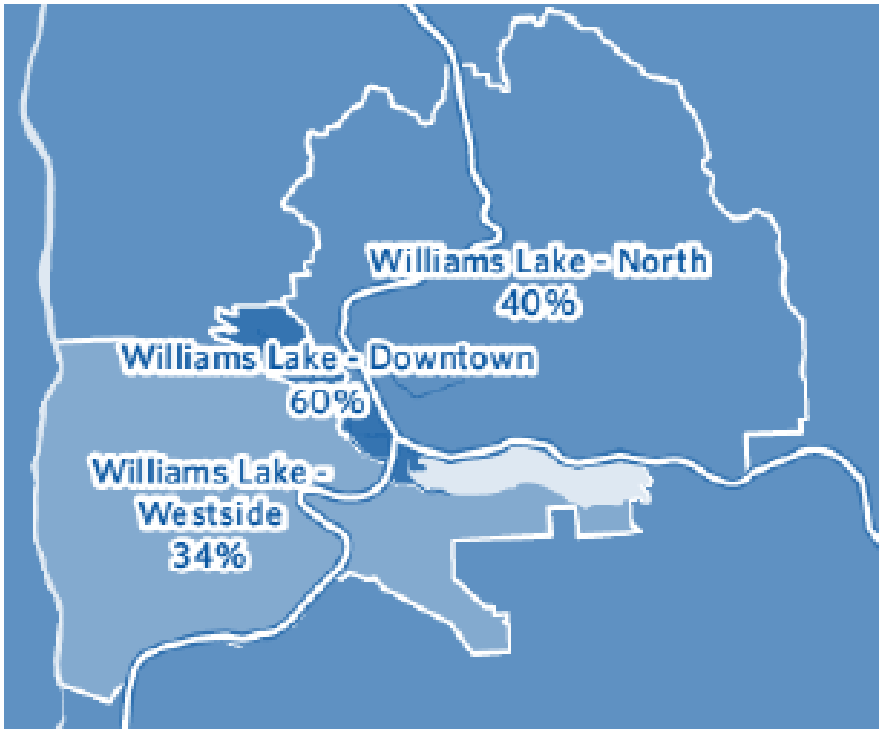

Figure 28*: Neighbourhood EDI vulnerability rates - % of children with vulnerability in one or more domains*

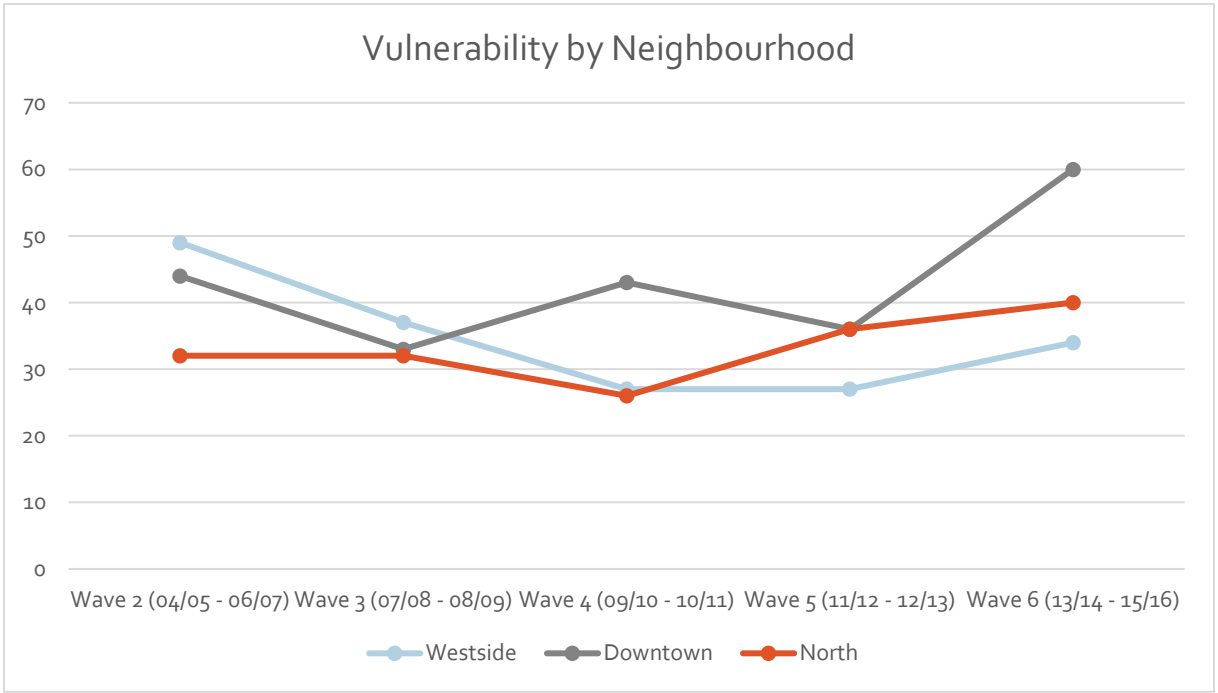

Figure 29*: Percentage of children vulnerable in one or more domains over time*

Education Data

Education and basic literacy skills are fundamental to not just academic success, but to achieving a better quality of life. With 40% of adults in BC unable to read a newspaper, fill out a job application or understand a tenancy agreement, 39% of offenders in the justice system who have not completed grade nine, and almost 4 in 10 youth without basic reading skills at age 15, literacy is a critical issue.

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[25]. 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 that data across the entire school district (including the Chilcotin and South Cariboo).

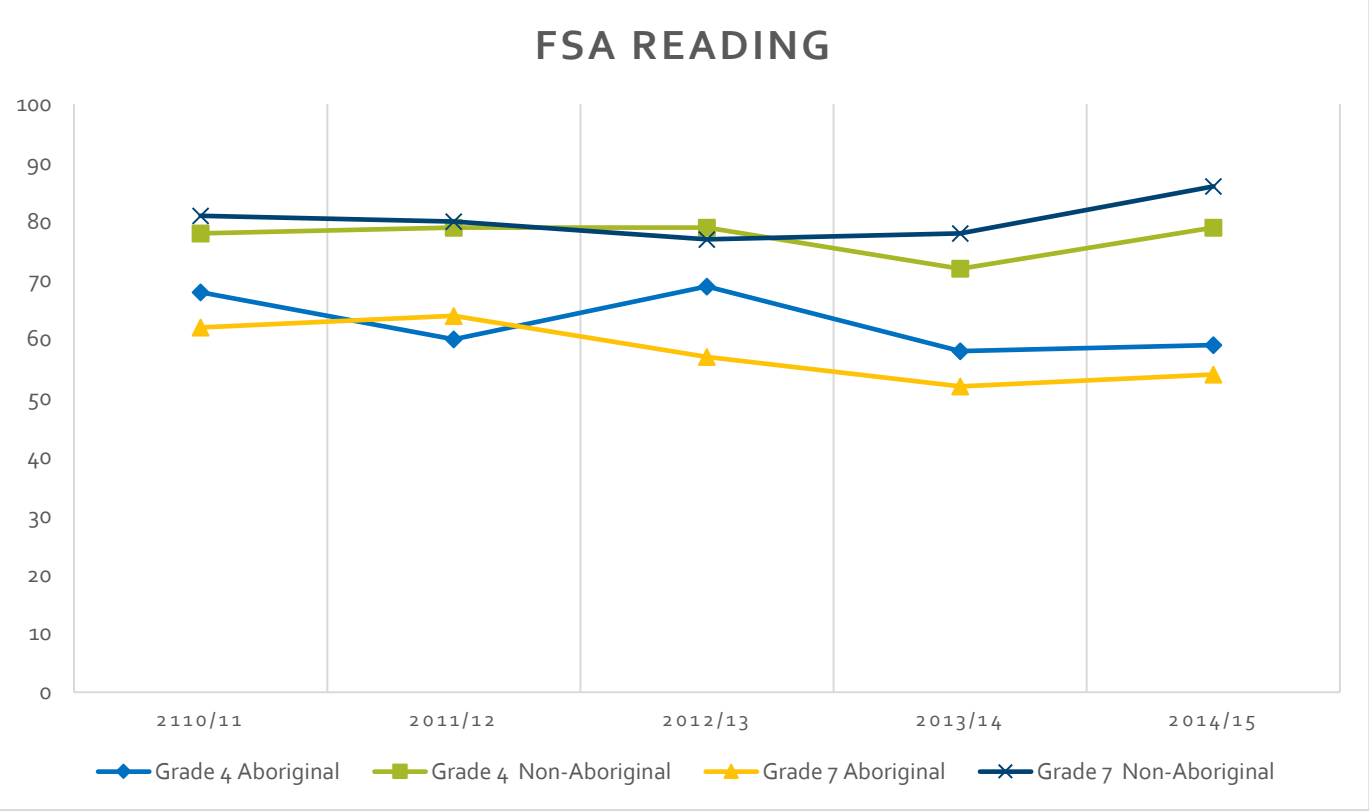

Figure 30: ***Percentage of students meeting or exceeding grade level standards in*** *Reading*

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

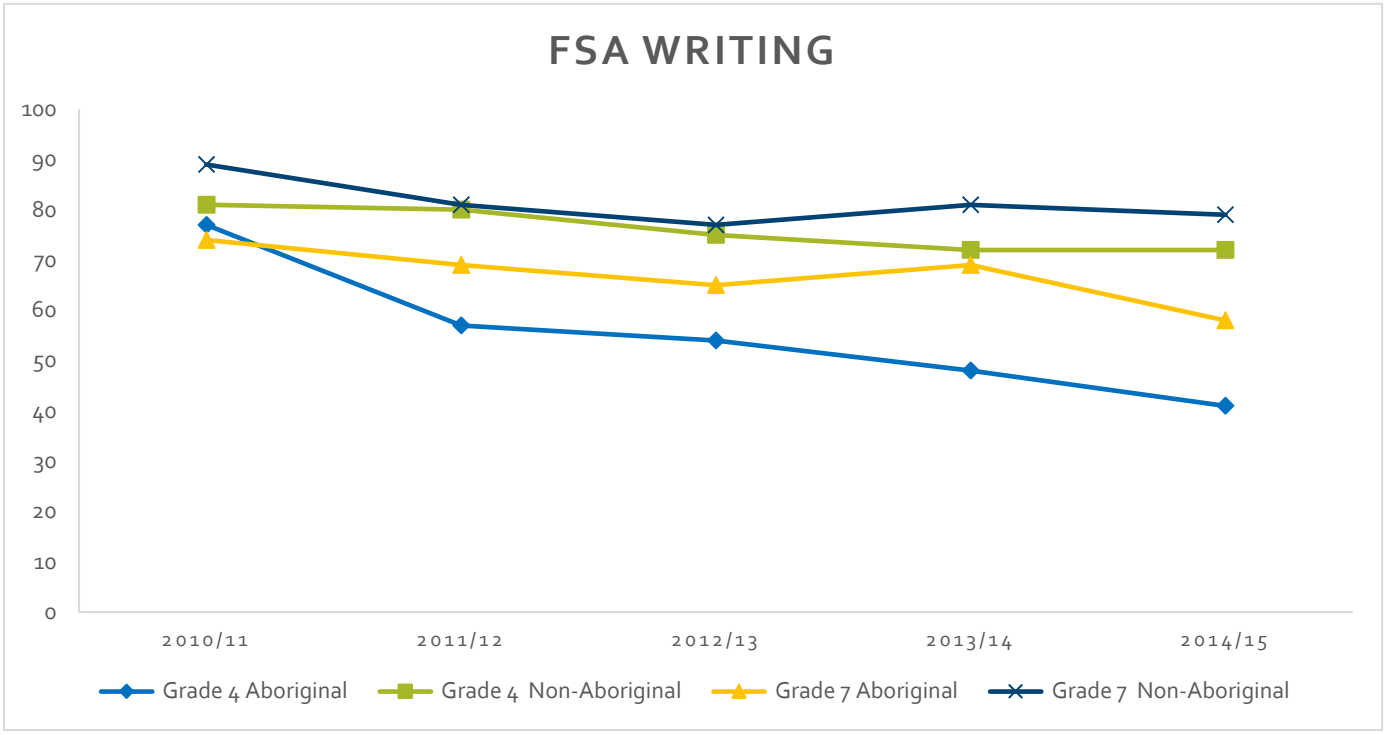

Figure 31*: **Percentage of students meeting or exceeding grade level standards in W**riting*

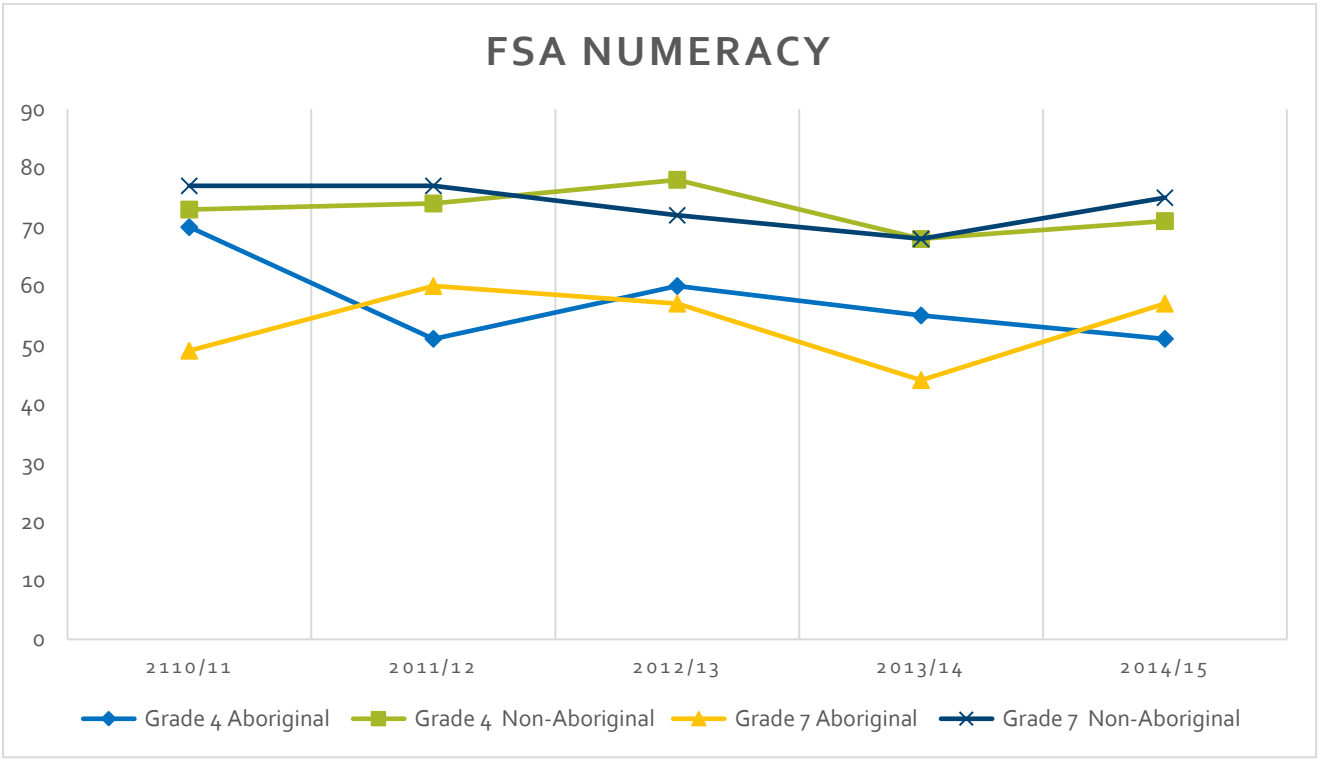

Figure 32*: **Percentage of students meeting or exceeding grade level standards in** Numeracy*

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 – move to another jurisdiction, move to an independent school and those students 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 with six years of entering Grade 8.

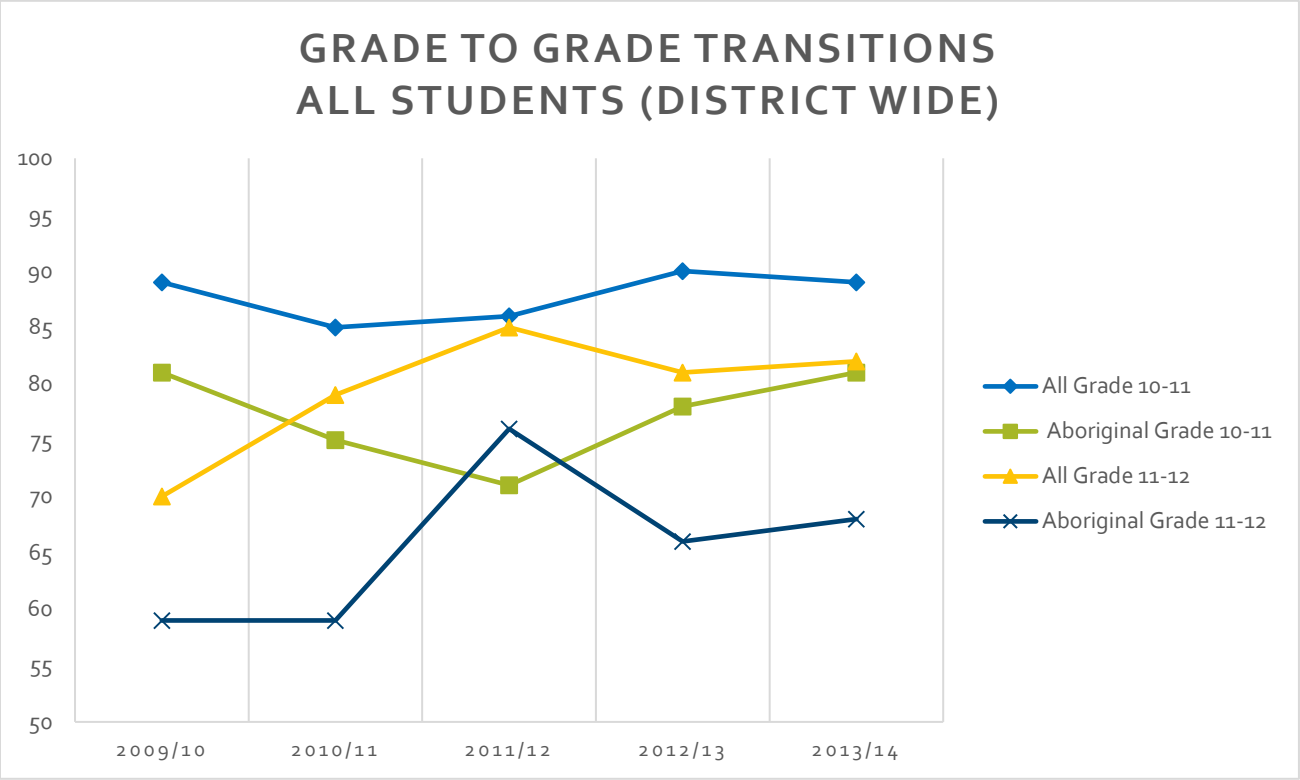

Figure 33: ***Percentage of students successfully moving from one grade to the next***

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 a '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 with six years of entering Grade 8.

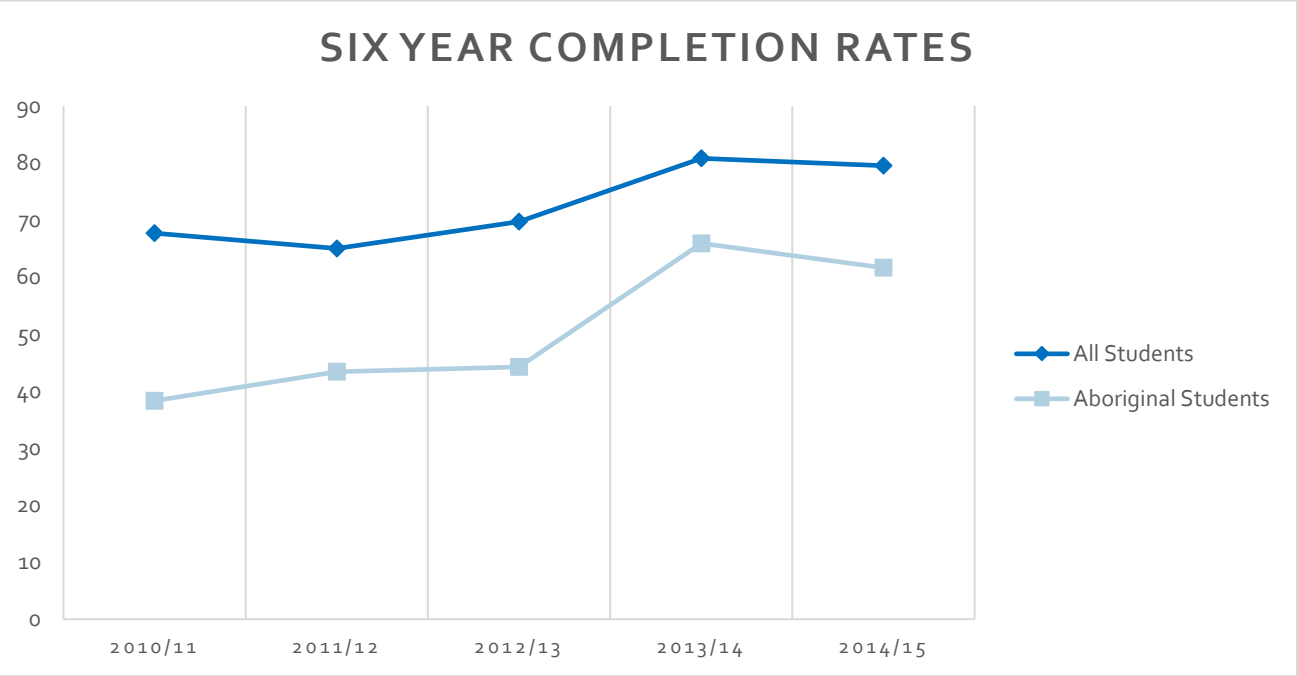

Figure 34*: Percentage of students completing Grade 12 (Dogwood) within six years of entering Grade 8*

Children at Risk

The BC Composite Index (2012) of Youth at Risk placed the Cariboo Chilcotin Local Health Area (LHA 27) sixth worst in the province (out of all 89 LHA's) based on the following indicators: youth 15-24 on income assistance, youth on EI, number of 18 year old's who didn't graduate high school, serious crime and non-cannabis drug offences (youth), and hospitalizations due to motor vehicle accidents.

Indicator	LHA 27 Rate	BC Rate	Ranking vs. other LHA's in BC (1 is worst)
% youth 15-24 on income assistance (Sept. 2012)	4.4	2.1	8
% youth 15-24 on EI (Sept. 2012)	1.3	0.7	17
% 18 year old's who didn't graduate high school (2009/10 - 2011/12)	40	26.2	9
serious crime per 1000 population (avg. 2009-2011)	11.7	11.1	24
non-cannabis drug offences (per 100,000 pop.)	192.7	193.6	25
hospitalizations due to motor vehicle accidents (per 1000 pop.)	4.1	1.1	9

Table 5*: Youth at risk indicators*

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 in any given month ranged from approximately 50 in May 2010 to 75 in July 2012 to approximately 78 in September 2015.

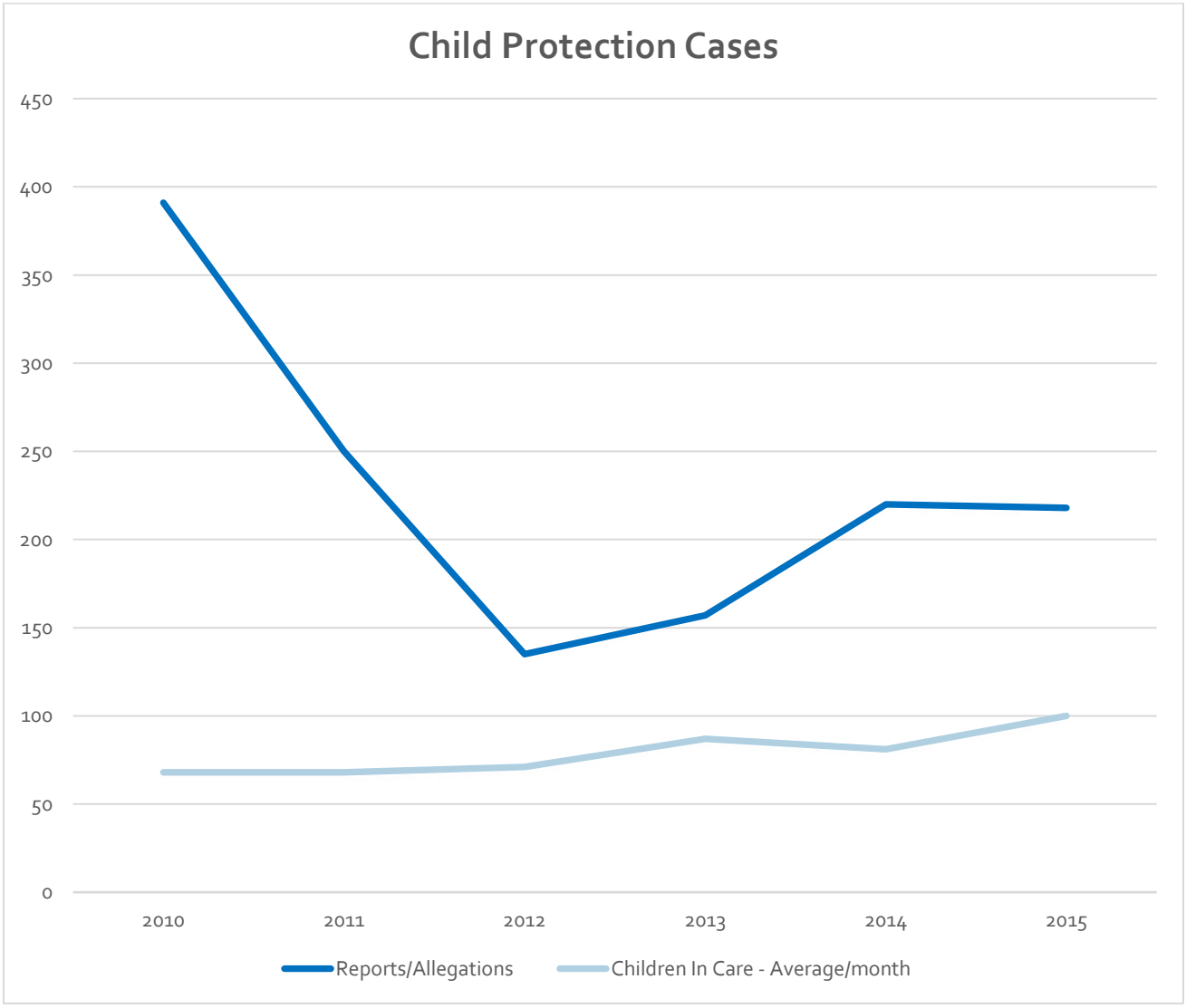

Figure 35: ***Intake requests and number of children 'in care' (includes extended family care under an MCFD order)***

Youth Crime - Criminal Involvement

Youth crime rates in Canada have been declining steadily since the mid-1990's, and in BC the Youth Crime Severity index is considerably less than the Canadian rate. The rate of serious youth crime in the Cariboo-Chilcotin region (LHA 27) is similar to the BC average. In Williams Lake, we have seen a similar pattern of reductions in youth crime overall, though a spike of youth crime by males in 2014 is notable.

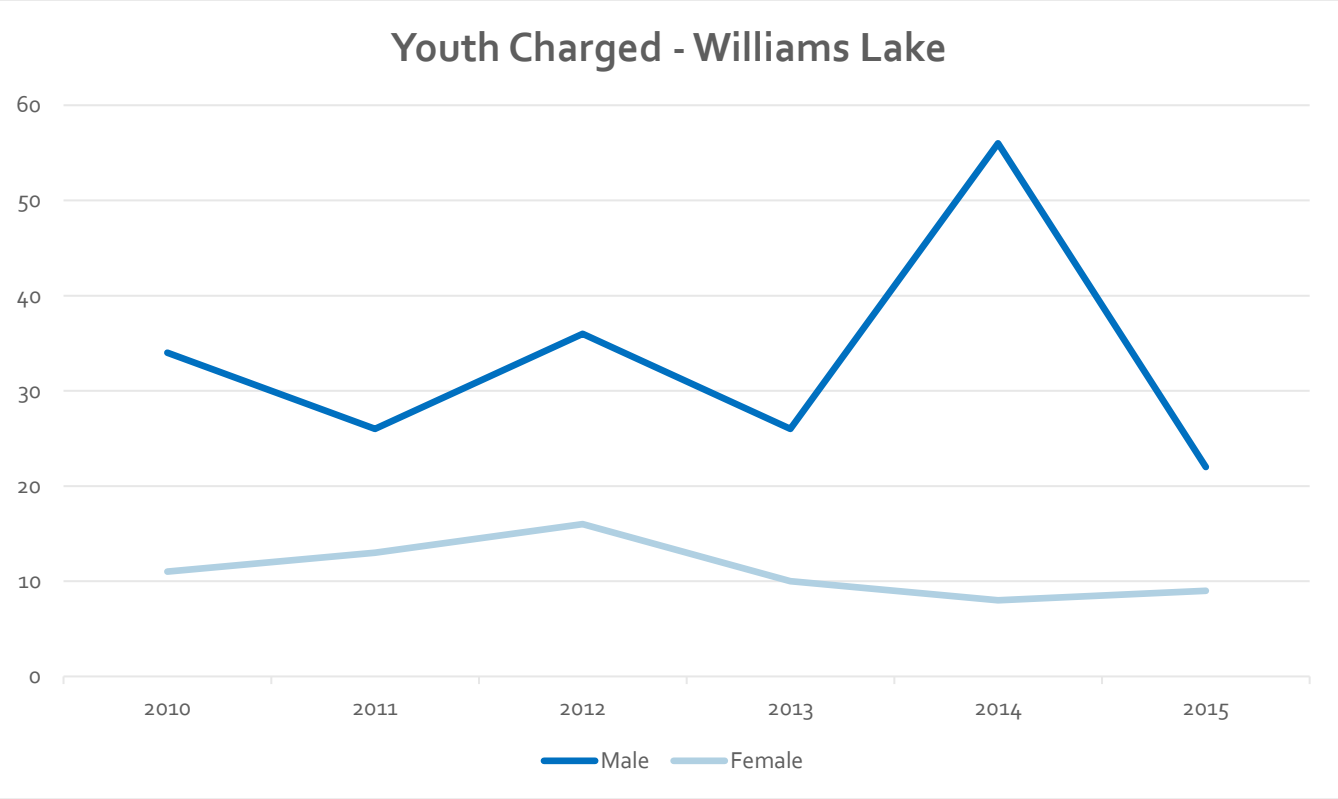

Figure 36*: Number of youth charged with an offence, by year, segregated by gender*

Next Steps

Over the past several months, our community has taken time to explore all of the data contained in the report, to have many discussions about what the data means for our community, where we have had success, and where more work needs to be done. This process is critical to setting new priorities for moving forward. We have presented the results to a variety of organizations, networks, and community tables. The result is a set of priorities to focus on over the next five years of our work together.

Strategic Priorities

We have chosen to focus on all four domains as this has the greatest chance for making change. In addition, we've decided to include both a risk factor AND a protective factor in each domain. While this increases the number of priorities, we feel there is alignment across the domains based on our choices, and this will allow us to leverage our work across multiple domains. The theme of these priorities is attachment and belonging, and this theme will guide our implementation decisions as we move forward, within the context of the foundation of the social development strategy.[26]

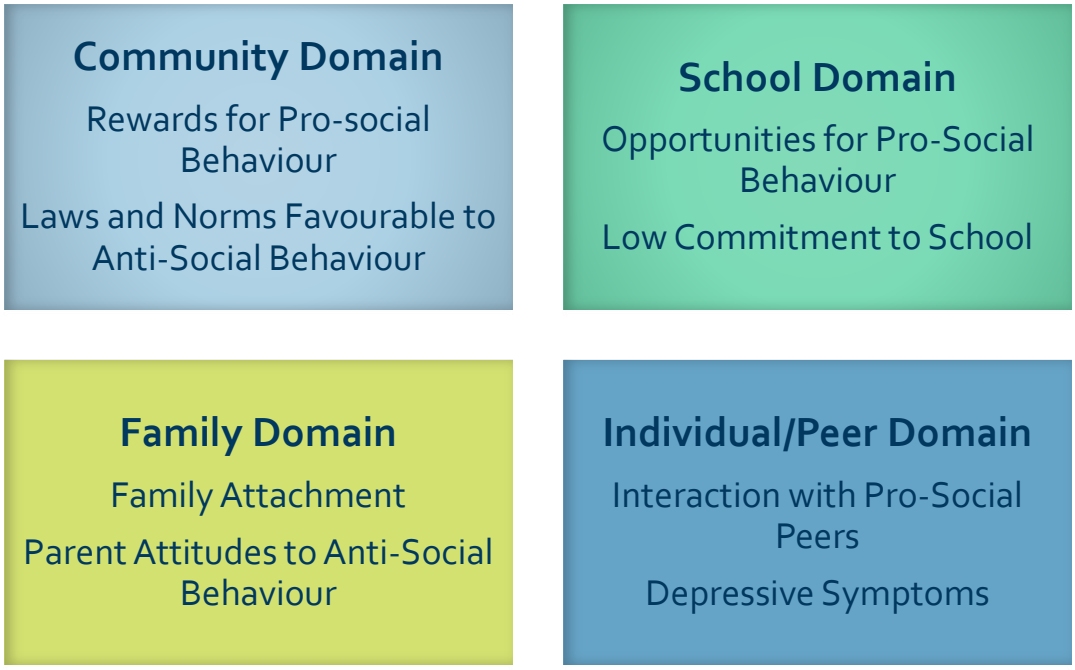

Figure 37: Strategic priorities by domain

[26] The Social Development Strategy and Circle of Courage approaches are consistent with the priorities chosen and could be used to weave together all areas of youth development in the community:

- Individual relationships, where adults can serve as healthy role models for youth and provide them with opportunities and recognition for positive social involvement.
- Youth-serving organizations and programs, which can provide youth with *opportunities* to interact with adults and peers who have positive social values, *skills* to successfully take part in those opportunities and *recognition* for their involvement.
- All segments of the community, which can establish healthy adult attachments, beliefs and clear standards through clear and consistent laws, values, policies and practices—for adult and youth behavior.

Discussion and Rationale for Priorities

Community Domain

We have decided to continue with our previous priorities in this domain. We have made significant progress in the risk factor *Community Laws and Norms* over the past six years, however shifting the culture of a community is a long-term effort. This risk factor speaks to both the explicit rules around access to alcohol and drugs, as well as to the enforcement of those standards. It also speaks to the conversations we have about our values and standards in terms of what behaviours are tolerated or acceptable in our community, and how we respond to them. In terms of our collaboration work, this risk factor also provides a clear role for the important work of those who are primarily focused on intervention or enforcement roles, which align with the work of prevention that is at the heart of Communities That Care.

There has been significant attention to the risk factor of *Neighbourhood Attachment* and while we think that is important to pay note to, the complications and subtleties of that risk factor suggest that although it may seem on the surface straightforward and practical to address, there are deeper issues in place that make neighbourhood attachment more challenging. Particularly over the past year when we have had a number of high visibility incidents of crime and violence, people have expressed increased fear about their safety in neighbourhoods across many parts of the community. Anecdotally, youth have expressed a much higher level of concern about the safety of being out in the community during both daylight and dark hours. This affects the sense of community and neighbourhood attachment. For children and youth in neighbourhoods where these incidents have occurred, their perception of the safety and connection they feel to that neighbourhood may be quite damaged.

The survey data for the protective factor *Rewards for Pro-Social Involvement* is focused on questions about whether people in your neighbourhood notice, encourage, and praise positive behaviour and accomplishments. We feel this will be the work that builds a foundation for stronger neighbourhood attachment. We encourage the community to continue to address the importance of neighbourhood safety and relationships to build community and neighbourhood connections, and we feel that focusing on the protective factor *Rewards for Pro-Social Involvement* will have that effect.

School Domain

In the school domain, we will continue to focus on *Low Commitment to School* as our priority risk factor for many of the same reasons we chose it in 2010. Students who are not connected and committed to the school community are much less likely to be academically successful, including attending post-secondary training. They are also more likely to struggle with other connections, and to have greater probability for the use of drugs and alcohol. In addition, we have seen a significant commitment by the school system to addressing this risk factor, and corresponding success. We want to recognize and strongly encourage this continued focus and direction, as we believe the results will show continued improvement.

On the protective factor side, *Opportunities for Pro-Social Involvement* is an area where we have seen a substantial drop in the percentage of youth reporting this protective factor. In particular, grades eight through eleven show a drop of 13-20% (depending on the grade) in opportunities for positive social involvement in their schools. This is an area that we feel has high potential for action, but also is an opportunity to engage youth themselves in conversations about how this might be addressed.

Family Domain

In the family domain, our focus on *Parent Attitudes Favourable to Anti-Social Behaviour* will continue. The many discussions we have had suggest that providing families with resources, information and support is key to

empowering families regarding their role in setting clear standards and boundaries for healthy behaviour in children and youth. We also feel this risk factor pairs well with the protective factor, *Family Attachment* as there are many ways to create and support family activities that build healthy bonds in families. In particular, we see a need to both continue the work of supporting early attachment, but also to support families to maintain attachment as children reach adolescence and the influence of their peers becomes stronger. We see opportunities to engage families in conversations about the data from the survey as a tool for raising awareness and encouraging and supporting parents in their role.

Individual/Peer Domain

In this domain, we will focus on *Depressive Symptoms* as the key risk factor. There is significant concern about the rates of depressive symptoms, particularly for students in grades ten through twelve. There is a lot of work already underway to address the treatment needs for children and youth with mental health and substance use, but early intervention and prevention efforts are a critical piece. The survey provides the best population level data we have to measure the incidence of depressive symptoms in youth in our community. The depression scale used in the CTC Prevention Needs Assessment Survey has been established as a reliable and valid assessment.[27]

We will also focus on the protective factor *Interaction with Pro-Social Peers*. Research shows that participation in positive activities at school and in the community with peers helps provide protection for youth whether they are at risk or not. There are a number of programs and activities underway already that provide these opportunities, but there are also gaps in access that we have identified and have been working on over the past five years. We will focus on continuing to improve access points for additional youth to participate in peer activities that support pro-social behaviour.

[27] Rhew, Isaac C., Monahan, Kathryn C., Oesterle, Sabrina, Hawkins, J. David (2016). The Communities That Care Brief Depression Scale: Psychometric properties and criterion validity. Journal of Community Psychology, 44(3), 391-398.

Benchmarks

Tracking our progress on the above priorities, as well as the incidence of the problem behaviours we are trying to affect, provides us with concrete, tangible, measurable impacts. The CTC Prevention Needs Assessment survey provides the data for measuring these indicators. Setting goals for each priority helps us to maintain focus on the alignment of our many activities that move us forward in each area. Because prevention work requires a long-term commitment, and often requires years to see results, we will be tracking the results of all priorities and goals from 2009 forward into the 2020 survey.

In determining goals for 2020, we looked to balance achievable targets with ambitious aims. For some indicators where we have had less success, we want to return to or improve on our 2009 benchmark. For indicators where we are already moving in a positive direction, we hope our momentum and continued action will result in reaching more ambitious goals.

	INDICATORS	2009 Benchmark	2015 Benchmark	2020 GOAL
PRIORITY RISK AND PROTECTIVE FACTORS	**Community Laws and Norms Favourable to Drug Use**	57%	52%	45%
	Community Rewards for Pro-Social Involvement	48%	38%	50%
	Parental Attitudes Favourable to Anti-Social	59%	59%	55%
	Behaviour Parental Attitudes Favorable to Drug Use	48%	46%	
	Family Attachment		63%	70%
	Low Commitment to School	53%	44%	35%
	School Opportunities for Pro-Social Involvement		60%	70%
	Early Initiation of Anti-Social Behaviour	40%	30%	
	Early Initiation of Alcohol and Drug Use	48%	38%	
	Depressive Symptoms		38%	33%
	Interaction with Pro-Social Peers	46%	34%	50%
PROBLEM BEHAVIOUR INDICATORS	**Substance Use:**			
	Grade 8 Students – Used alcohol in past 30 days	31.5%	15.5%	10%
	Grade 8 Students – Binge drinking	21%	4%	2%
	Violence:			
	Attacked a person with intent to harm (all grades)	14.5%	5.4%	2%
	School Completion:			
	Completion of Grade 12 within 6 years (all students)	81%	84%	85%
	Completion of Grade 12 within 6 years (Aboriginal)	54%	63%	75%
	Depression & Anxiety:			
	Depressive Symptoms (all grades)	38%	38%	30%
	Depressive Symptoms (Grade 10)		50%	40%
	Youth Crime:			
	Number of incidents	335	245	<200
	Gang Involvement	7.5%	3.5%	2%

Figure 38*: Benchmark indicators for tracking progress*

Index of Figures and Tables

Appendix A

Risk and Protective Factor Definitions

COMMUNITY DOMAIN

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 DOMAIN

Poor Family Management

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 DOMAIN

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.

Opportunities for Prosocial Involvement
When young people are given more opportunities to participate meaningfully in important activities at school, they are less likely to engage in drug use and other problem behaviors.
Rewards for Prosocial Involvement
When young people are recognized and rewarded for their contributions at school, they are less likely to be involved in substance use and other problem behaviors.

INDIVIDUAL/PEER DOMAIN
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.