Revelstoke Child and Youth Substance Use and Mental Health Report

Research, Community Voice, Recommendations

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Appreciation

This report has been prepared under the guidance of a steering committee and direct feedback from residents. The project lead thanks the committee members and community stakeholders for their many contributions and Business and Visitor Information Centre staff for their support.

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Executive Summary

"Children's connections to their parents, peers, and the people in their schools and communities play a central role in their development. These connections promote mental health and can act as protective factors to children's well-being. Research shows that a single caring adult, be it a family member, a teacher, or a neighbour, can make a very powerful difference in a child's life" (HELP, 2015a, p. 13)

This report was created through a Masters of Social Work practicum project with the City of Revelstoke Social Development department. The scope of research and literature reviewed included topics addressing community development, social programming and policy, best-practices with children and families, resilience and relational contexts of working in the area of child and youth substance use and mental health. A review of local statistical information from a variety of reports is also included in this report. Through the project interviews and focus groups were conducted with community stakeholders and individuals, families, and groups of residents to gain an understanding of local culture on the topic areas and the areas where there is a desire for change or improvement. A survey with 174 respondents at Revelstoke Secondary School was conducted in May which asked youth about their worries, how they manage, and what supports them. The survey responses and interviews were conducted from a lens of resilience and privileged respondent knowledge and experiences as the context for recommendations in this report.

Research indicates best-practice to be constructed as a focus on prevention and building resilience in children, families, and communities (Miller-Day & Hecht, 2013; Ungar, 2015). This is consistent with local findings and local indications for direction.

Based on high reporting of importance of the relational context in all levels of engagement, it is essential as we go forward to include this frame in all planning and service and community development.

"Local results also highlighted the importance of supportive relationships with peers and adults including family, teachers, and other professionals" (Poon et al., 2014, p. 4).

Recommendations:

- Parent engagement and developing further supports for children aged 6-12 has been highlighted as a priority for our families, schools, and community.
- Seeking to encourage language and dialogue that supports the learning in the community, at home, from a foundation of family culture, values and beliefs.
- Accessibility must be a paramount consideration in community development and addressing social supports and issues. In determining what is accessible we need to

privilege local knowledge and culture to create meaningful and supportive experiences that build resilience.

SharedCare Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative, Local Action Team (LAT)

In terms of setting and meeting objectives that fit well in our community context, there has been discussion in interviews and meetings suggesting the following action areas for consideration (guided from The Charter (2015)).

2. Increase referrals to existing local and provincial resources to enhance wraparound care (Support sustainable models of collaborative care)

- Joint consultation; ICAT Model for consideration
- Building partnerships and trust and communication in relationships between service providers

4. Increase school and community participation to enhance support and protective factors for children and youth (Support 'Caring Adults' in community)

- Further develop and support services for ages 6-12
  - Extend wellness fair in to elementary schools and offer an after school time for parents
  - Deliver relationships program to target grades
  - Extend school mentorship program
- Continue service delivery and evolution with ages 12-18
  - Extend wellness fair to offer after school time for parents
- Establish and build on transition services 18-25
- Support committee and working group involvement

8. Test and implement system-level prototypes, guidelines and protocols as recommended by the system Working Groups

- ICAT Model to be considered
- Collective Impact Outcome Measurement and Evaluation?
- Tests of Change
- Crisis Response-Referral Line/Texting
- Resilience inventory

Connections From Existing Plans and Strategies: OCP, ICSP, SUS, YAP

This report draws from existing community plans to provide local relevance and context on the strategies and direction of the City of Revelstoke. Below are the areas of the plans that are connected to a focus on children and family, community and resident health and well-being, and the strategies pertaining to youth and substance use in Revelstoke.

The Official Community Plan 2009

Community Vision

Community Vision Statement

Revelstoke will be a leader in achieving a sustainable community by balancing environmental, social and economic values within a local, regional and global context.

Building on its rich heritage and natural beauty this historic mountain community will pursue quality and excellence. Revelstoke is seen as vibrant, healthy, clean, hospitable, resilient and forward thinking. It will be committed to exercising its rights with respect to decisions affecting the North Columbia Mountain region.

Community priorities include: Opportunities for youth; economic growth and stability; environmental citizenship; personal safety and security; a responsible and caring social support system; a first-class education system and local access to lifelong learning; spiritual and cultural values, and diverse forms of recreation.

All residents and visitors shall have access to the opportunities afforded by this community.

Part 3: Charting Our Future (relevant goals and policies noted)

3.1 The People

Community Character

Community Goals

A distinct, diverse community where all residents, families and visitors feel welcome and respected.

Foster a sense of place consistent with historical and cultural values, and collaborate with agency and public partners especially Parks Canada.

Policies

Retain Revelstoke's friendly small town character.

Foster a sense of place consistent with historical and cultural values, through mutual planning efforts with agency and public partners, especially Parks Canada.

Support the high quality of life that individuals and families enjoy by fulfilling their lifelong health, cultural, educational, spiritual, recreational and economic needs.

Health and Wellness

Community Goals

A healthy community with adequate health and wellness facilities and services including outreach and emergency supports.

Policies

Meet the needs of a growing population with appropriate outreach and emergency supports and health and wellness facilities and services, including access to out-of-town health care.

Promote and encourage healthy lifestyle choices for all residents

Citizens must have equal access to resources, employment, services, low income rental housing and opportunities they need to meet their basic needs.

Work with all levels of government to ensure all citizens (including our seniors) maintain incomes about the Poverty Line.

Promote programs that limit the negative impacts of substance use on the social and economic wellbeing of individuals, families, and the community.

Identify shortcomings and address issues of accessibility and inclusiveness for residents and visitors with disabilities.

Integrate strategies of 'age-friendly' planning through the Social Plan.

Integrated Community Sustainability Plan 2013

- Part 3 of 3 Documents
- Integrating Strategies and Goals

3.2 Strong Community Capacity: Integrating Goal

3.2.1 Healthy Living

Support individuals who are challenged to meet their basic needs, and promote and encourage healthy lifestyles choices for all residents

3.5 Responsive, Caring Social Systems: Integrating Goals

3.5.2 Health Services

Meet the needs of a growing and changing population with appropriate outreach and emergency supports and health and wellness facilities and services, including access to out-of-town health care

3.5.3 Recreation

Maintain, develop and manage a well- integrated and linked system of parks, trails, and recreational facilities serving the needs of residents and visitors that is accessible for all citizens

3.5.4 Families and Children

Continue to demonstrate that our community is 'family friendly' and actively supports our children, youth, and families.

3.5.5 Youth

Meet the physical and psychological needs of youth associated with a positive transition to adulthood and as guardians of Revelstoke's future, including the needs for belonging, independence, mastery and generosity.

Revelstoke Community Substance Use Strategy 2010 (Zacharias, 2010)

- Part Two: Understanding the Challenges
- Part Three: The Way Forward
- Revelstoke Youth Drug Survey Final Report 2014 (Zacharias, 2014)

Table 1: 2.1 Children (0-12 years): Protective and Risk Factors (Zacharias, 2010, p. 12)

	Protective Factors	Risk Factors
Individual	- Acceptance of & respect for parents' positive values - Favourable attitude towards restricting use - Strong personal social skills - Self-esteem, sense of optimism - Good literacy & capacity for problem- solving	- Genetic predisposition to mental illness - Favourable attitude towards use - Early initiation of substance use - Use perceived as low risk - Low self-esteem - Limited social skills - Temperament (aggression, poor impulse control, sensation seeking)
Family	- Warm & affectionate parent-child relationships – Family nurturance - Shared family activities - Parents encouraging positive social activities - Parents providing appropriate supervision/discipline - Children having responsibilities at home - High level of participation (being and interacting) with adults	- Parents' substance misuse - Parents providing/condoning substance use - Substance use problems or mental illness in family - Positive family attitudes towards antisocial behaviour and/or substance use - Neglectful parenting - Family conflict - Unstructured home environment - General low parental expectations
Peer	- Positive peer affiliations and role models - Pro-social peer group	- Substance using friends and/or role models - Antisocial friends or member of deviant peer group - Peer rejection and bullying
School	- Positive school climate - Caring relationships within school community - High but achievable expectations - Opportunities for meaningful participation and contribution - School connectedness	- Poor attachment to school - Academic failure - Difficulty at transition points (e.g. entering school, transition to high school)
Community	- Substance-free community events (family friendly) - Laws/norms discouraging use - Substances unavailable - Opportunities for positive social involvement & meaningful participation in community groups/activities - Involvement with adult mentors and role models - High community cohesion	- Substances readily available and high tolerance for use - Substances at community events (beer gardens etc) - Economic disadvantage - Social/cultural discrimination/isolation - Positive media portrayals of substance use

2.1 Children (0-12 years): What we could be doing better (Zacharias, 2010, p. 15)

In Revelstoke, there is an opportunity to move forward with a school-family-community partnership and the development of a comprehensive effort. A key factor for success is to promote the formation of a partnership between the School District, Interior Health and other organizations to implement the following:

1. Assess whether best practices for substance use prevention are being used in – individual, peer, family/cultural, school, community, societal.
2. Critically review the range of services offered for children, youth and families in Revelstoke, identify where gaps might exist (e.g. that left by the loss of Interior Health's School Based Prevention Program), and how to support existing services (e.g. Community Connections programs, DARE program).
3. Investigate partnering with regional organizations to better enhance services.
4. Investigate the feasibility of enhancing local services (see Implementation Summary).

Table 2: 2.2 Youth (12-19 years): Protective and Risk Factors (Zacharias, 2010, p. 17)

	Protective Factors	Risk Factors
Individual	- Girls – positive body image, ability to always contact mother/parent - Healthy self esteem - Religiosity or spirituality - Favourable attitude towards restricting use	- Lack of knowledge of (or not caring about) consequences, harms of substance use or what is in whatever he/she is using - Poly-substance use - Persistent antisocial behaviour - Use perceived as low risk - Girls – early menstruation, anxiety, depression, eating disorders, teen pregnancy - Low self-esteem - History of trauma, physical or sexual abuse
Family	- Going home after school - Mother's/parent's knowledge of whereabouts & companions - Family rules against substance use/encouraging youth to abstain - Continued parental involvement	- Tolerant parental attitudes towards teen alcohol/drug use - Parents providing substances - Lack of after school supervision - Not enough family time
Peer	- Peer pressure (anti-substance use)	- Friends or older siblings using substances - Exposure to older youth/adults at bush parties - Peer pressure (pro-substance use) - Gang involvement
School	- See previous table	- See previous table
Community	- Active after school involvement/options - Minimizing cost of pro-social activities - Active enforcement of consequences for under age drinking and marijuana use	- Lack of pro-social, affordable activities for youth - Marketing/Media influences - Lack of privacy/confidentiality (small town) can act as a barrier to seeking help - Lack of enforcement (under age drinking) - Community norms favouring use

2.2 Youth (12-19 years): What we could be doing better (Zacharias, 2010, p. 19)

Also pertaining to youth is the recommendation to coordinate and develop partnerships and collaboration to create a comprehensive prevention framework to strengthen protective factors and address risk factors for children and youth involved in problem substance use. The following are examples of best practices:

- Mentorship programs have been found to have a positive influence, especially where youth are matched with mentors who have similar issues and a genuine respect for youth. Mentors can provide social support and friendship.
- Targeted skill building and education programs for parents. Utilizing school transition points for universal parenting education.
- Targeted skill-building programs for students (e.g. gender-specific programs).
- FASD prevention education for youth.
- Additional teacher training and professional development around substance use.
- Additional training for counsellors and staff facilitating support groups for students who are substance users on brief interventions and motivational interviewing - youth can be more open to interventions in a group setting.
- Implement high school DARE program.
- Questions about substance use could be incorporated into health and rehabilitation protocols (medical check-ups).
- Best practice counselling for problem substance use.
- Brief interventions for secondary school students with mild to moderate substance use problems (a brief intervention takes place through motivational interviewing in which the goal is simply to see their substance use in a different way and begin to think about changing it; the next step is to provide the person with skills to help them change).
- Extra training for organizations (Community Connections, Employment Centre) in early/brief interventions.
- Specific services for high-risk youth.
- Working together with stakeholders to implement community mobilization programs that aim to reduce perceived norms and restrict access; education/awareness campaign targeting underage alcohol use.
- Education/awareness campaign targeting use of caffeinated energy drinks.

Community consultation indicates that one of the most critical challenges has been to engage parents. Some school districts have implemented mandatory education sessions for families of youth suspended from school for substance use issues. Education also needs to extend to the community at large.

Youth Action Plan 2014

3. Home, Health and Safety Priority Actions

Objective 3: Encourage healthy choices, harm reduction and injury prevention
Relevant Priority Actions:

3. Support the work of the Youth Mental Health and Substance Use Committee

4. Develop opportunities that teach youth how to assess and manage risk

5. Implement priority actions, particularly around community and parent educations, prevention supports for youth, and reducing alcohol-related harms in the community.

6. Critically review the range of services offered for youth and families in Revelstoke and look where gaps might exist (e.g. school based prevention program) and how to support existing services (e.g. Community Connections Youth Program, DARE program).

7. Assess whether best practices for substance use prevention are being used – individual, peer, family/cultural, school, community, societal.

8. Enhance community partnerships to restore a high level of school-based substance use prevention in all schools.

11. Provide information and support for parents to communicate with their children

Connecting Local and Provincial

The local plans, strategies and reports are included to provide a base understanding of the work that has been done and of the priorities and direction of the work going forward in the area of children, youth, and families. The provincial initiative being implemented in Revelstoke is the SharedCare Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative. Bringing together community consultation, direction, and planning with the objectives and intent of the Collaborative will set the foundation for the Local Action Team (LAT) coming together in the fall of 2015.

CYMHSU Collaborative, LAT

The CYMHSU Collaborative is a provincial initiative brought forward by a partnership between the Doctors of BC and the Ministry of Health under the umbrella of SharedCare. The intention is to improve and increase timely access to and through health services; to integrate child and youth mental health and substance use services locally and throughout the province (CYMHSU Collaborative, 2015).

The LATs "are key components in the structure of the Collaborative and provide the foundation for approaching improvements at the local level. The long-term goal is to establish multi-sector partnerships for a sustainable infrastructure to support local children, youth and families experiencing mental health and substance use challenges." (CYMHSU Collaborative, 2015, p. 9)

There is intentional collaboration with the F.O.R.C.E. Society for Kids' Mental Health (Families Organized for Recognition and Care Equality) that helps inform and direct the process of the provincial initiative and the work of LATs. It "is a provincial organization that supports and empowers families and works collaboratively with professionals and systems in understanding and meeting the mental health needs of children, youth and their families" (CYMHSU Collaborative, 2015, p. 4).

In moving forward in Revelstoke, taking the existing planning and prior consultation (outlined above) in to consideration will be essential along with local and provincial leadership. Leadership in the context of local involvement, experience, interest and commitment matched a with child, youth and family focus is paramount. "Leadership is key: Physicians, MCFD, Health Authorities, parents, schools, RCMP, school boards and the Ministries of Health and Education, as well as local government have been key to success" (CYMHSU Collaborative, 2015, p. 6).

In establishing a LAT for Revelstoke, there will be an extension of the previously existing work and commitment from the Child and Youth Mental Health and Substance Use Committee for continued commitment and engagement of a diverse cross-section of partners in child, youth and family services, other stakeholders, and individual youth and families from the community. In moving forward the LAT will identify one or more of the following objectives to achieve and will implement means of measurement that is meaningful in the local context.

Table 3: Key Objectives

	Key Objectives (Child and Youth Mental Health and Substance Use Collaborative, 2015, p. 10)	**Local Context**
1.	**"Identify and communicate to service providers and community members how to access local and provincial mental health and substance use services and supports for children, youth, youth in transition, and their families in their local communities, to move towards FamilySmart Practice."**	Youth Survival Guide Could be added
2.	**"Establish multi-sector, sustainable practices of care that are effective for children, youth and their families. These practices can include any areas of care that align with community priorities, for example: i.e. crisis intervention, suicide and self-harm prevention, early intervention care for mild to moderate."**	Joint consultation? ICAT Model Building partnerships and trust and communication in relationships between service providers
3.	**"Integrate new provincially developed system-level information sharing guidelines into existing local practices**."	ICAT Model
4.	**"Increase participation of schools and communities in fostering "caring adults" to provide support and protective factors for children and youth."**	Further develop and support services for ages 6-12 - Extend wellness fair in to elementary schools and offer an after school time for parents - Deliver relationships program to target grades - Extend school mentorship program Continue service delivery and evolution with ages 12-18 - Extend wellness fair to

		offer after school time for parents Establish and build on transition services 18-25 Support committee and working group involvement
5.	**"Partner with schools to provide mental health and substance use literacy for teachers, students, school personnel and families through initiatives targeted to address specific and community needs."**	Mental Health First Aid September 2015
6.	**"In consultation with PSP Regional Support Teams, increase participation in the Practice Support Program's (PSP) Child and Youth Mental Health Module by family and specialist physicians, as well as CYMHSU partners and service providers, such as MCFD, CYMH, school counsellors, psychologists and community agencies. Targets for improvement will be locally determined in conjunction with the PSP program and should be robust and significant."**	September 2015
7.	**"Promote uptake of the PHSA Indigenous Cultural Competency (ICC) Training and/or other education and practices to address and enhance cultural safety and competency in child and youth mental health and substance use for Aboriginals."**	Could partner with the newly established Friendship Centre
8.	**"Test and implement system-level guidelines and protocols in the local community, as recommended by the Collaborative Working Groups."**	ICAT Model Collective Impact Outcome Measurement and Evaluation? Small-Tests of Change Crisis Response-Referral Line/Texting Resilience inventory

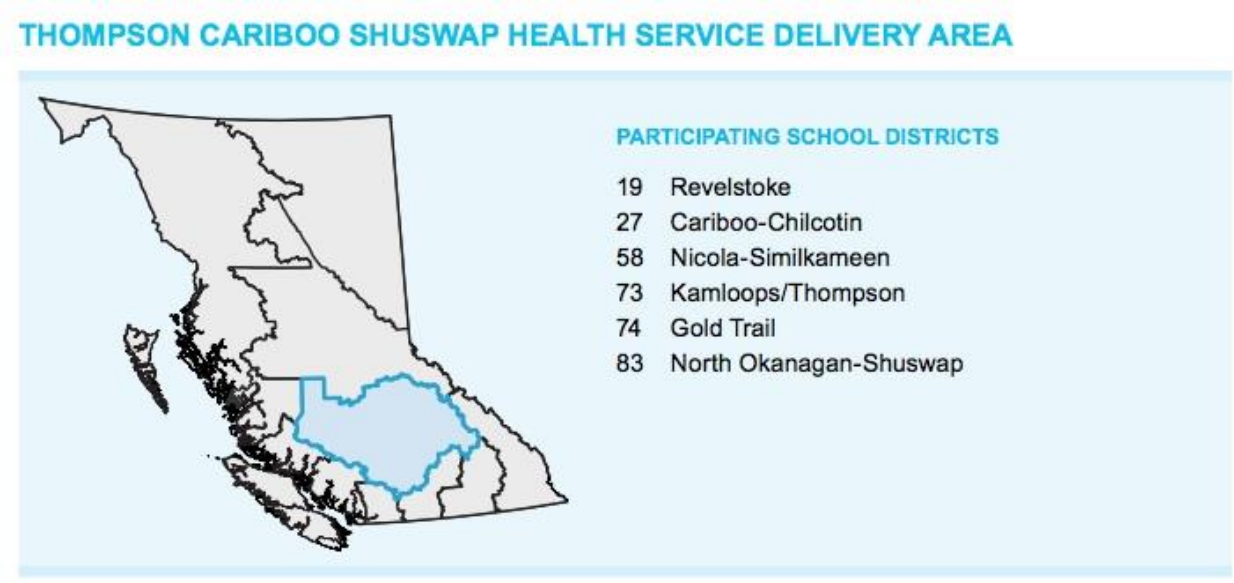
Research and Relevant Literature

This section summarizes the results of previous research and data that is relevant to our community, the interior region, and the province of British Columbia. The focus areas of the following data and analyses are health, mental health, substance use, relational aspects and connection, and protective factors. Generally the data shows that Revelstoke scores better than provincial averages and highlights some areas of concern with regards to substance use and mental health; specifically the incidence of young people experiencing feels of despair. There is also a review of best practices on the target areas of this report indicating suggestions for direction in service delivery and development and considerations for community focus in supporting local social efforts and sustainability. It is interesting to note that for comparable community size, geography (rural) and demographics, there was little to no available research, or available practice literature or strategies, to compare Revelstoke with. It leads to the thought that our community is progressive in it's social efforts and that it would greatly contribute to available research to document what is being done in our local context; what we are doing and why, what are the outcomes, and how will we sustain it.

Statistics

McCreary Centre Adolescent Health Survey (Poon et al., 2014, p. 6)

Local results highlighted the importance of supportive relationships with peers and adults including family, teachers, and other professionals.



Key Findings (Poon et al., 2014, p. 16-19)

Students were asked about specific mental health conditions. Females were more likely than males to have at least one condition (27% vs. 19%). They were also more likely to have multiple conditions (11% vs. 5% of males).

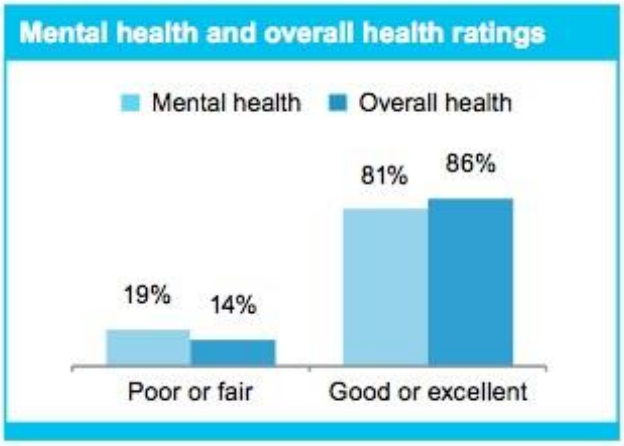
Youth most commonly reported having Depression (11%), Anxiety Disorder (10%), and/or Attention Deficit/Hyperactivity Disorder (ADHD; 8%). Other conditions included an addiction to alcohol or other drugs (3%), Post-Traumatic Stress Disorder (PTSD; 1%), Autism or Asperger's (1%), and Fetal Alcohol Spectrum Disorder (FASD; 1%).

Females were more likely than males to report Depression (16% vs. 6%), Anxiety Disorder (15% vs. 4%), and PTSD. Males were more likely to have ADHD (10% vs. 6% of females) and Autism or Asperger's.

Local female students were more likely than females across the province to report having any condition (27% vs. 22%), and specifically an addiction to alcohol or other drugs (3% vs. 2% provincially). Local males were comparable to those of males across BC.

Poon et al., 2014, p. 16

Students were also asked the extent to which they felt so sad, discouraged, or hopeless that they wondered if anything was worthwhile. Thirty-eight percent of males reported feeling some level of despair in the past month, which was similar to the local rate among males in 2008 and 2003. Fifty- six percent of females felt some level of despair, which was similar to the rate in 2008 but a decrease from 2003 (62% among local females).

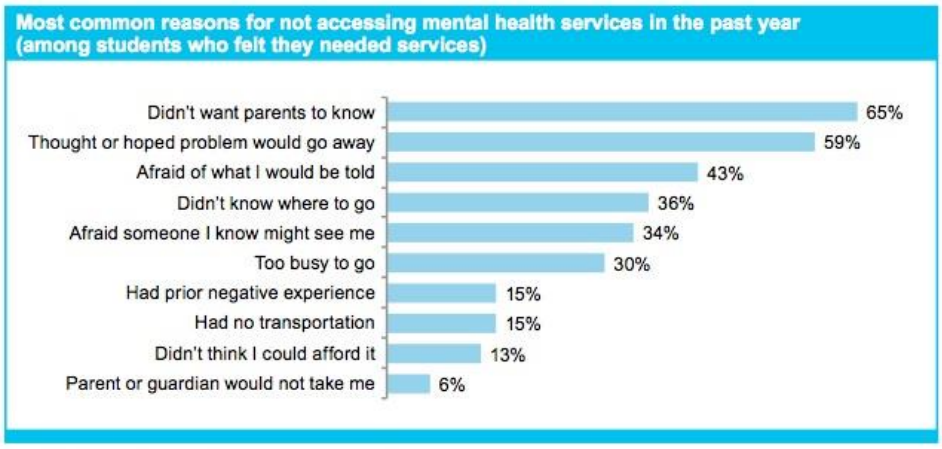


- Most students (80%) reported feeling stressed in the past month. Females were more likely than males to experience extreme stress that prevented them from functioning properly.
- Extreme levels of stress and despair were higher among students aged 14 or older than among younger ones.
- Although youth in this area reported higher rates of some health risk behaviours than seen provincially, there were many local improvements. For example, **there were decreases in the percentage of youth trying alcohol, marijuana, or tobacco;** and

decreases in the percentage of youth who reported engaging in oral sex or having a sexually transmitted infection.

- Compared to the provincial picture, youth in this area were more likely to be engaged in physical activity and exercise, including weekly informal sports (such as road hockey, hiking and skateboarding; 63% vs. 58% provincially).

Poon et al., 2014, p. 19

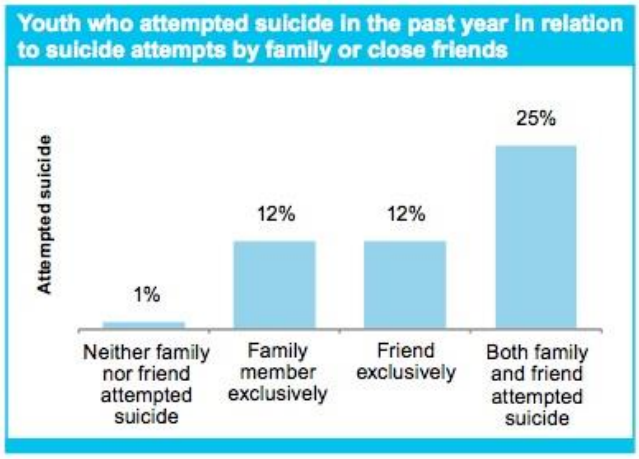


Note: Youth could choose more than one response.

The survey showed that local students were less likely to miss out on needed medical care than their peers in 2008. However, there was no such improvement in missing out on mental health care. Also, as was seen provincially, there was a local increase in the percentage of youth who did not seek necessary mental health care because they did not want their parents to know.

Poon et al., 2014, p. 18

Mental health, particularly for female youth, was an area of concern highlighted by the survey findings. Females were more likely than males to report a mental health condition (such as depression or anxiety). They were also more likely than males to report extreme stress, extreme despair, self-harm, suicidal ideation, and suicide attempts.



- **Results also showed the link between sleep and mental health, and highlighted that most local students (77% of males and 83% of females) were doing something such as homework or using their cellphone after the time they were expected to be asleep.**

- Sixty-eight percent of students (65% of males vs. 72% of females) in this region reported having an adult in their neighbourhood or community (beyond their school or family) who cared about them. This was higher than the provincial rate of 61% (59% of males vs. 63% of females).

Protective Factors

- The survey identified protective factors that appear to be linked to better outcomes for even the most vulnerable youth. These included physical activity, nutrition, and sleep.

- More than three quarters of youth had an adult in their family they could turn to if faced with a serious problem, which was also above the provincial rate.

- Youth with a caring adult in their life were more likely to report positive mental health, as well as positive aspirations for the future.

- School connectedness appeared to have positive associations for all youth. For example, youth who had been teased, excluded, and/or assaulted in the past year were more likely to have only positive aspirations for the future if they felt more connected to their school. In addition, youth with a mental or emotional health condition were more likely to feel good about themselves if they felt more connected to their school.

Analysis

In this survey the included areas are relatively broad and Revelstoke may not be completely representative of the findings. Used as general data the themes noted are that females are more likely to report struggles with mental health conditions and experiences and that students aged 14 or older reporting extreme levels of stress and despair is higher than for younger students. This may indicate that support for kids earlier on will help them manage as they reach middle teenage years. It was noted that there were decreases in the percentage of youth trying alcohol and substances and that youth in this area were more likely to be engaged in physical activity and exercise than the provincial picture. More than three quarters of youth had an adult they could turn to for support when facing a serious problem and it was also noted that those indicating they have a caring adult in the life were more likely to report positive mental health. Further, school connectedness appeared to have positive associations for all respondents and that those experiencing this connection were

more likely to feel good about themselves even when reporting a mental or emotional health condition.

Revelstoke Youth Drug Survey (Zacharias, 2014)

(This report compares the 2009 and 2013 results of the Youth Drug Survey)

"In October 2009, as part of a community-wide Substance Use Strategy first local Youth Drug Survey was administered at Revelstoke Secondary School. The survey was developed by Jill Zacharias, Social Development Coordinator for the City of Revelstoke, in partnership with Lory Borges, who at the time was the Interior Health School-based Prevention Worker.

The survey covers a wide range of topics from personal substance use to how much RSS students know or have experienced about harms related to drugs and alcohol. The survey was administered again in November 2013, during National Drug Awareness Week. In both 2009 and 2013, the survey was done on-site and in partnership with Revelstoke Secondary School, with over 85% of students completing the survey. In 2009, there were 399 valid responses (out of 450 students), while in 2013 there were 340 valid responses (out of 397 students). Surveys that were obviously 'spoiled' were discarded. The goals of the survey were to:

- Better inform those who work with youth on the scope and patterns of use.
- Use the survey as a tool to increase awareness of use that may lead to a variety of harms.
- Measure the impact of preventative and supportive strategies over time." (p. 3)

Table 4: Youth who reported having ever tried different substances (Zacharias, 2014, p. 9)

Substance	BC (2013 Adolescent Health Survey)	Revelstoke (Youth Drug Survey)
Alcohol	45%	77%
Marijuana	26%	36%
Tobacco	21%	22%

The above result, combined with the perception of parents' lack of concern (specifically for use of alcohol and marijuana), is a 'red flag'. It speaks to a culture of acceptance of substance use as 'the norm' not only for youth, but for parents as well.

The Revelstoke Community Substance Use Strategy (2010) was based on a comprehensive community health-based approach. For children and youth, the overarching community goal was to "Develop partnerships and collaboration to create a comprehensive prevention framework to strengthen protective factors and address risk factors (see Appendix One) for children and youth involved in problem substance use." (Zacharias, 2014, p. 9)

Alcohol (Zacharias, 2014, p. 3-4)

- The survey asked, 'have you ever had alcohol to drink'? In both 2009 and 2013, about 23% students said **NO** & 77% said **YES.** Of those who said **YES,**
    - In both 2009 and 2013, about 33% reported that they have never been drunk.
    - Between 2009 and 2013, the average age of first use increased slightly, as did the average age of 'first time drunk' (from age 13 to age 14).

- The percentage of students who reported having alcohol occasionally increased while those who reported using daily or every weekend decreased by 5%.
- Finally, the percentage of students who reported drinking "until you get really drunk" decreased by 3.5%, from 16.7% in 2009 to 13.2% in 2013. This shows a slight decrease in reported binge drinking.

Marijuana (Zacharias, 2014, p. 4-5)

- Ever tried smoking marijuana? In both 2009 and 2013, about 64% students said **NO** & 36% said **YES.**
- Of those who said **YES**, between 2009 and 2013, again the average age of first use increased a little.

Tobacco (Zacharias, 2014, p. 5)

- The number of students who reported having tried smoking cigarettes decreased 16% between 2009 (38%) & 2013 (22%). Again, the average age of first use increased slightly.
- Of those who said, **YES**, in 2013, only 18.6% of students reported smoking cigarettes daily, compared to 32.6% in 2009.
- We also asked about other forms of tobacco. Between 2009 and 2013, the percentage of students who reported having tried cigars or little (flavoured) cigars decreased by nearly 17%, with a significant decrease in the number of students who reported regular use.
- There was also a 2% decrease in those who reported using smokeless tobacco – in 2009, 17 students reported using smokeless tobacco regularly compared to 13 students in 2013.

Other Drugs (Zacharias, 2014, p. 6)

The survey asked about a number of other drugs, from caffeinated energy drinks and prescription drug *misuse* to ecstasy, magic mushrooms, LSD and the like. Between 2009 and 2013, reported use of other drugs dropped considerably.

- In both 2009 and 2013, caffeinated energy drinks held the top spot for reported 'other' drug use, followed misuse of a variety of prescription drugs, magic mushrooms and ecstasy.

- In 2009, 259 respondents reported having tried caffeinated energy drinks compared to 140 in 2013, and in 2009, 71 students reported that they had tried magic mushrooms, compared to 25 in 2013.
- In 2013, reported regular use of other drugs was relatively minimal and again, dropped considerably. Of all substances in the 'other' category, reported regular use of caffeinated energy drinks was most commonplace but still decreased considerably. In 2009, 60 students reported using caffeinated energy drinks 'daily or every weekend', whereas in 2013, only 12 students reported using at this level.

  Students' perception of how easy it is to acquire alcohol was constant between 2009 and 2013, with over 80% of respondents reporting that it was 'easy' to get alcohol. However, between 2009 and 2013, there was a 13% increase in the percent of students who thought it was 'easy' to acquire marijuana. (Zacharias, 2014, p. 7)

Analysis

This survey has been conducted twice (2009 and 2013) and has created an opportunity to take a snap shot of substance use for youth in Revelstoke. It was noted that across alcohol, marijuana and tobacco, local youth are reporting higher instances of having tried substances compared to provincial data. From the analysis of the findings it seems that there is a culture of 'lack of concern' over youth substance use and that it is commonly seen as the norm for youth and parents to use marijuana and alcohol. Further it is noted that students reported that their perception of access and acquiring alcohol or drugs is that it's easy available to get.

RCMP (Grabinsky, K., personal communication, August 5, 2015)

Youth Intoxicated in public, Prisoners held in custody and or released to parents:

- 2012 there were 5 youth, plus 3 files where youths were released directly to parents
- 2013 there were 9 youths lodged in cells plus 2 released to parents and
- 2014 there was 1 youth lodged into cells plus 5 released to parents

Analysis

In personal communication it was noted that these numbers to not show the incidences of youth who have been taken home or interactions and support being provided by members where files are not opened. Further, access to mental health data was not available possibly due to the nature of the problem (confidentiality, not opened files, service as a support to medical services).

Early Development Instrument (EDI) (Human Early Learning Partnership, 2014)

Wave 5 Results

The Revelstoke School District (19) has participated in all 5 waves of EDI data collection. Wave 5 results were collected in 2011/12-2012/13 from 7 schools in 1 neighbourhood(s). A total of 165 kindergarten children participated in Revelstoke in Wave 5. EDI results are mapped based on children's neighbourhood of residence, not where they go to school (HELP, 2014, p. 1).

The Early Development Instrument (EDI) is HELP's longest running and most well-known population-level research project. Both the EDI and MDI measure trends in populations of children at different ages (5, 9 and 12 years). The EDI is a questionnaire completed by Kindergarten teachers, while the MDI is a self-report questionnaire that gathers data directly from children in grades 4 and 7. These tools illustrate the variations in children's well-being across time and place. Understanding how populations of children are doing, during Kindergarten and again during grade 4 and 7, allows program delivery organizations and policy makers to make informed decisions that better support children and families (HELP, 2015a, p. 5).

Key Findings (HELP, 2014, p. 1)

Overall, Revelstoke had a vulnerability rate of 11% compared to the provincial vulnerability rate of 32.5%.

District wide, vulnerability was highest on the Physical Health & Well-Being scale at: 5%. Child vulnerability was lowest on the Social Competence and Language & Cognitive Development scales at: 2%.

12 years of community ECD action using EDI and other data have shown that effectiveness can be enhanced by paying attention to the following (HELP, 2014, p. 5):

- Strong intersectoral leadership
- A focus on local research, including EDI outcomes
- Alignment between the school system and the early care, learning and development sectors
- A plan to increase access to service by decreasing barriers for families; and
- A commitment to advocacy

Analysis

Revelstoke's vulnerability rate is much lower than provincial averages, indicating as a community support for young children and families is having effective impact on the well-being of children.

Middle Years Development Instrument (MDI) (Human Early Learning Partnership, 2015a; Human Early Learning Partnership, 2015b)

2015 School District and Community Report

Grade 4 (HELP, 2015a,p.)

DEMOGRAPHICS

District total sample: 73
Participation rate: 96%

Gender: Boys 38, Girls 35

Languages spoken at home:

Aboriginal	1%
English	97%
Cantonese	0%
Filipino/Tagalog	0%
French	6%
Hindi	0%
Japanese	0%
Korean	0%
Mandarin	1%
Punjabi	0%
Spanish	0%
Vietnamese	0%
Other	6%

Grade 7 (HELP, 2015b, p.)

DEMOGRAPHICS

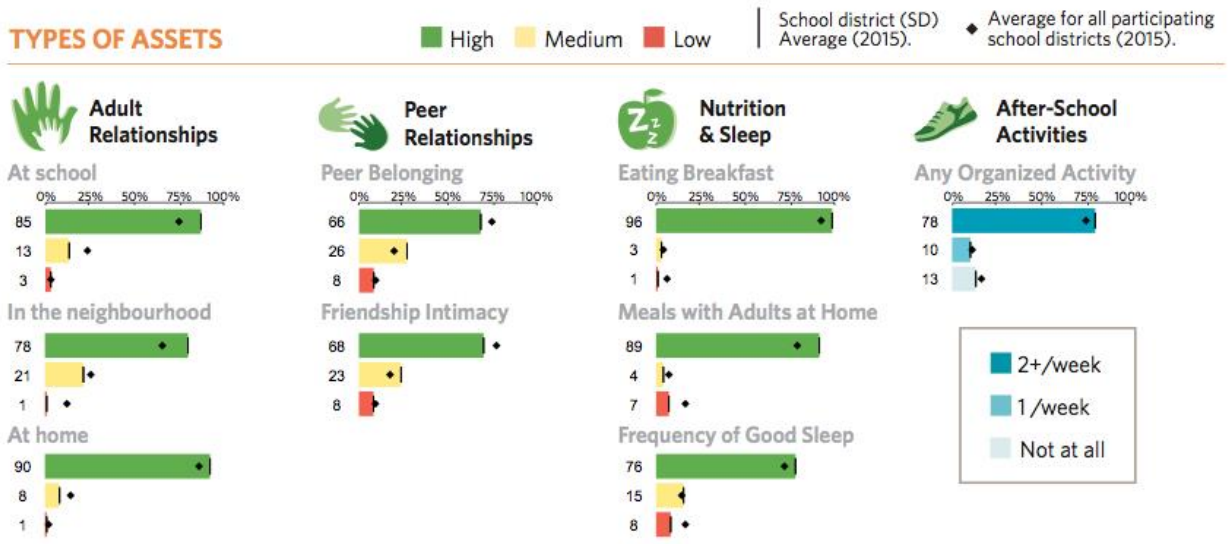
District total sample: 61
Participation rate: 95%

Gender: Boys 34, Girls 27

Languages spoken at home:

Aboriginal	0%
English	96%
Cantonese	0%
Filipino/Tagalog	0%
French	2%
Hindi	0%
Japanese	0%
Korean	0%
Mandarin	0%
Punjabi	0%
Spanish	2%
Vietnamese	0%
Other	5%

Key Findings (HELP, 2015a, p. 26)



Children's connections to their parents, peers, and the people in their schools and communities play a central role in their development. These connections promote mental health and can act as protective factors to children's well-being. Research shows that a single caring adult, be it a family member, a teacher, or a neighbour, can make a very powerful difference in a child's life (HELP, 2015a).

Table 5: MDI 4&7 Local Comparison (compiled from HELP 2015a & HELP 2015b)

Well-Being	
Grade 4	**Grade 7**
57% of children (73) are shown to be experiencing high well-being (thriving)	61% of children (61) are shown to be experiencing high well-being (thriving)
19% of children (73) are shown to be experiencing medium to high well-being	21% of children (61) are shown to be experiencing medium to high well-being
25% of children (73) are shown to be experiencing low well-being	18% of children (61) are shown to be experiencing low well-being
Connectedness	
94% of children reporting the presence of adult relationship assets at school	90% of children reporting the presence of adult relationship assets at school
90% of children reporting the presence of peer relationship assets	90% of children reporting the presence of peer relationship assets
85% of children reporting the presence of nutrition and sleep assets	80% of children reporting the presence of nutrition and sleep assets
88% of children reporting the presence of after-school activity assets	86% of children reporting the presence of after-school activity assets

Social and Emotional Development						
	% High Well-being		% Medium Well-being		% Low Well-being	
	Grade 4	Grade 7	Grade 4	Grade 7	Grade 4	Grade 7
Optimism: the mindset of having positive expectations for the future	78	64	19	33	3	3
Empathy: the experience of understanding and sharing the feelings of others	90	84	8	15	1	2
Pro-social behavior: refers to actions that benefit others	42	43	40	43	18	15
Self-esteem: refers to a person's sense of self-worth	86	84	12	10	1	7
Happiness: refers to how content or satisfied children are with their lives	73	70	19	23	8	7
Absence of sadness: sadness measures the beginning symptoms of depression	71	68	17	22	13	10
Absence of worries: worries measure the beginning symptoms of anxiety	42	53	38	27	20	20
Long-term self-regulation: requires adapting present behaviour to achieve a goal in the future	71	65	27	28	1	7

Short-term self-regulation: is about impulse control. It requires adapting behaviour or emotions to meet an immediate goal	58	63	31	25	11	12
Responsible decision-making: is about understanding the consequences of one's actions and making good choices about personal behaviour.	N/A	77	N/A	18	N/A	5
Self-awareness: is the ability to recognize one's emotions and thoughts while understanding their influence on behaviour	N/A	54	N/A	36	N/A	10
Perseverance: refers to determination. It means putting in persistent effort to achieve goals, even in the face of setbacks	N/A	52	N/A	30	N/A	18
Assertiveness: means communicating a personal point of view. It includes the ability to stand up for oneself	N/A	69	N/A	23	N/A	8

Analysis

This survey indicates that the children in grades 4 and 7 experience a high level of connectedness at school, with adults, and with peer relationships. This connectedness plays a central role in their development and has been highlighted as a local priority in how services are made accessible and how they are delivered. These connections promote mental health and it is believed locally that support for this relational context of how kids experience their world is essential in prevention and resilience.

Best Practices

Ultimately best-practice research and literature indicate a shift to meaningful evaluation and outcome measurement for all levels of work in communities and the social sector (Morino, 2011; Phillips, 2014). There are many articles and studies demonstrating that modality for interventions in mental health services are not the most important factor, and that 'local knowledge' and relationships are the critical aspects in change.

In community development literature it is being suggested that policies and initiatives build in aspects of measurement as opportunities for learning and accountability to funders and stakeholders. At the governance level it is being recommended that to support healthy and vibrant communities, municipal policies and practices adopt a triple bottom line approach to supporting residents and promoting a sustainable community (Siu, 2014; Tamarack Institute). The equal support and focus on economic, environmental, and social efforts will benefit all aspects of a community (Kline, 1997).

Funders, service leaders, and clients are seeking ways to understand change and to improve on outcomes. Meta-analyses have been conducted that show support for meaningful outcome measurement as a way to evolve the nature of services (Tilsen & Nylund, 2010; Wampold & Bhati, 2004). Best-practice approaches on the issues of child and youth services and mental health and substance use are to embrace harm reduction principles and programs; to look at accessibility and client preference, local knowledge, and to take a resilience focus to addressing problems (Ministry of Health, 2005; Poulin, 2006; Wampold & Imel, 2015). There are many studies indicating a lack of desirable outcomes in D.A.R.E. programs and there are suggestions in the literature of programs that far better support the delivery of information and support of children, youth and families addressing substance use issues (Gregg, 2012; Krieger et al., 2013; Lynam et al., 1999; Shin, Miller-Day, Pettigrew, Hecht & Krieger, 2014). With regard to mental health services and treatment, the evidence suggests that the type of treatment only accounts for a small percentage of the impact on client outcome and that client factors, preference, and alliance in the relationship account for up to 80% of client outcomes (Tilsen & Nylund, 2010).

It is important to note that the concept of resilience has the potential to further marginalize populations by implying that by working harder to bounce back they can overcome poverty and social injustice. For the context of this research and report resilience is meant as a frame by which we look at how people experience problems and the innate qualities individuals, groups, and communities possess (Resilience Research Centre). Resilience is meant to uphold the belief that local knowledge should be privileged and that no matter what the response may look like on the outside, a response to oppression, subjugation, and obstacles is occurring (Ungar, 2015).

It is our responsibility to be curious about what is getting in the way of peoples preferred lives. In community development and social sector work, meaningful change can be achieved by allowing local, relational context to drive the process of addressing issues (Miller-Day & Hecht, 2013).

Interviews and Focus Groups

At the onset of the project I attended the RSS Mental Health and Wellness Fair to engage students in a brief survey about their experiences of worry, what they believe supports them, and what might get in the way of them accessing services in a meaningful way.

From the data we can see that students who responded felt connected to family and friends predominantly. They reported experiencing worry around many different aspects of their lives. They also reported that 'services' play a small role in their lives with regard to the nature and amount of their worries and their preferred support systems (relationships). If we are to move past delivering services that are designed to respond to specific problems, then perhaps we should be making a different kind of list, or inventory. Perhaps we should be inventorying and quantifying the relational engagement of youth and families in our community, as they support each other through challenges and obstacles to their desires.

Through the process of researching this project, local stories, and best practices, I met with a continuum of stakeholders. There were two separate formal interview tools developed from the Resilience Research Centre and the questions were adapted from The Child and Youth Resilience Measure. One set of questions for service providers (in individual or group sessions) and one set for children/youth and families. Beyond these more structured interviews I also engaged in many discussions with residents from our community on how they see the issues and how they relate to the culture, health, and wellbeing of individuals, groups, families, and the community.

Stakeholders:

School District: Administration, Teachers, Counsellors, Support Staff (Arrow Heights Elementary, Columbia Park Elementary, Begbie View Elementary, Revelstoke Secondary School)

Ministry for Children and Family Development: Child and Youth Mental Health, Child Protection, Resource Support, Children and Youth with Special Needs

City of Revelstoke: Economic and Social Development

Organizations: Community Connections (Revelstoke) Society (Family Services – Counselling, Supported Child Development, Infant Development, Children and Youth with Special Needs; Outreach Services - Food Bank, Social Justice Advocate), SAFE Spaces, Revelstoke Women's Shelter, Work BC, Early Childhood Development Committee

Health Services: Chinese Medicine Practitioner, Adult Mental Health, Drug and Alcohol Counsellor, Paramedics, Nurses

Emergency Services: RCMP, Victim Services

Children, youth, families, and interested residents: Focus groups, families and extended families, individual youth interviews and surveys at RSS, and individual sessions with residents

Local Findings: Data and Themes

Survey:

174 respondents

Grade: 8 (51 respondents); 9 (19); 10 (41); 11 (32); 12 (31)

55% Female; 45% Male

Themes from the questions:

Biggest worries: majority said school, and many indicated family, health, and money

How do worries affect them: can't sleep, grumpy all the time, losing interest

What stops them from getting help: fear of judgment, feeling others won't understand, not sure who to seek for support

What helps them manage worries: majority responded friends, family, and sports; many also indicated sleep music and internet

8% responded with drinking

6% responded with drug/substance use

Who do they talk to for support: mainly friends and family; many mentions of coaches and pets as well as Community Connections Counselling/Services and teachers

What helps in the school: Community Connections (Sheena) and presentations/guest speakers (Rob Nash)

What will they take away from the fair: learning about all aspects of health; when and where to get help

Relationships are essential and should be held with high respect and consideration in the context of the work

Supporting and building family resilience and engagement from early years in to elementary years and beyond

Building relationships between organizations/groups and services

Trust, respect, and understanding what is being done by whom

Building and supporting relationships between services and children and families is essential to facilitate a meaningful process

Accessibility is more than knowing which door to go through

Possibilities for supporting child/youth and family engagement as a priority

Seeing the issues (mental health and substance use) as a symptom or behavior that indicates struggle in peoples preferred lives

It is not seen to be effective to solely be responsive to the issues, but to strengthen response collaboration processes while working to build resilience in preventative support and engagement

Relatable and empowering experiences of seeking support

Having choice and avoiding labeling is a struggle for our community

Engaging parents is seen to be a critical piece that is universally desired to be built on

Participating in opportunities to pass forward learning and knowledge; to engage in the service being accessed and create opportunities to for others to connect and to feel heard and understood from the sharing of someone who has gone before

Interviews and Focus Groups:

Q1: What do children/youth need to know to grow up well here?

- they are cared about; they are respected
- they are important and a part of the community
  - they have a sense of capacity and contribute

        - school connectedness
    - there are supports available; they aren't alone
    - a sense of community; that they are visible and connected and that they belong
    - how to negotiate relationships
    - a sense of self and self-awareness; to be reflective; understand vulnerabilities; understand how they are seen and how their choices impact the context of their identity
    - there are happy people despite struggles; getting out and seeing the world - perspective
    - beliefs and values about being busy and active
    - okay to make mistakes

Q2: What roles do families play in supporting children/youth to grow up well here?

- stay connected to their children; role shifts as they age, the importance does not
- make time amongst business for emotional/social/spiritual needs
    - engaging and interacting, practicing and teaching communication and expression
- looking out for one another, advocating for their children
    - meeting other parents and supporting each other
    - advocating for their children
- provide the structure/context (values, beliefs, opportunities) and safety for growing up
    - consistency and expectations
    - role-modelling and learning, education, learning how to manage stress
    - families are children's connections to the community; participating with them
        - activities, sports, social, spiritual, learning and perspective
        - relational aspects
- services need to support families to create the space they need to be the best they can for their children
        - families are the experts in their lives
        - acknowledging poverty as an issue - locating the problem outside of parents or the family

Q3: What other factors contribute to children and youth growing up well here?

- active/outdoor/lifestyle
- connection and closeness in the community; visibility, working together, multiple connection
    - openness and a variety of learning opportunities
    - connected to an older someone they trust, that they can go to
    - teaching children and youth to create and contribute to a safe environment
- being well-rounded
    - exposure to many different experiences
    - schools, friends, activities
    - perspective and dynamic identity
    - accessibility
    - healthy friendships and relationships with adults

- network of collaboration and community connectedness around them
- encouraging families and finding ways to support them to be involved with their children in activities
- getting parents to embrace and believe that getting support is a positive thing

Q4: How do you describe people who grow up well here despite the many problems they face?

- resilient, leadership, confidence
  - they are curious about the world
  - well developed consideration of other
- have an appreciation for connection
  - being a part of a team or club
  - relationships
  - they have a healthy respect for adults in the community
- dedicated and connected/supported
  - have had exposure to adversity and perspective
- community limitations can challenge people further to be resourceful and dynamic as they adapt
  - having learned from mistakes, they can share their learning
- children see the kid first, not the struggle first
  - more compassionate
  - they know how important having friends and connection is
- vulnerability fosters a sense of family importance
  - see themselves and each other as strong
  - they think it sucks that they don't have family to look after them?

Q5: What does it mean to youth, their family and their community when bad things happen?

- deeply felt
  - failure, collapse, devastating - far reaching effects
  - difficulties, loss, etc., can have a legacy
- learning opportunity, many who struggle regularly respond with leadership
  - children and youth need to go through adversity to move beyond and grow, comes back to understanding self and a dynamic identity
- how it is responded to matters, regardless of how big or small the incident
  - little ones are more insidious and big ones can bring people together
  - little ones can make people less trusting, big can create more trust
- lack of anonymity can be hard
  - there is lots of support, but little privacy

Q6: What kinds of things are most challenging for youth growing up here?

- MH concerns begin early and aren't supported effectively - unhelpful patterns become long standing and hard to break - bullying can be life-long, hard to break labels or reputations, and everyone knows your story
- Limited peer groups or diversity; difficult to develop an appreciation for difference

        - limited number of children and youth in town, different age cohorts with very different personalities or identities (hard to stray or branch out)
    - Conservative standard and judgement; legacy of reputation can be hard to shift
        - high and narrow expectations of success
    - isolation, not having opportunities for perspective
    - access to higher or alternate education; related to employment struggles
    - lack of activities or a place for youth to go without making a declaration, for unstructured experiences
        - transitions to adulthood when remaining in the community
    - social media issues, adding to the complexity of growing up
        - because everyone is known, adds to stress and exposure, lack of anonymity or opportunities to branch out and try on different identities
        - creates a false sense of connection
        - increased exposure and vulnerability, limited visibility from adults
    - culture of weekend partying/recreational lifestyle seeps in to local residents
        - binge appeal given licence and momentum
    - poverty and making ends meet; pressure to 'be involved' or participate in activities
        - significant socioeconomic class divide in Revelstoke
        - housing
        - getting around
    - disconnection from community fosters a sense of resentment and wanting to get out

Q7: What do youth do when they face difficulties in their life?

- talk to friends and family, vent online, motivation to become stronger and help others (pass it on)
- express it - anger, with-draw, sub use - there is always a response; high adrenaline activities
- some kind of action whether in or out
    - the trick is to see the behaviour and to try and understand where it's coming from; to listen, deconstruct the problem, deal with the behaviour AND the issue

Q8: What does being healthy mean to youth, their family and their community?

- active/physical health is the dominant discourse in the community
    - the picture is still incomplete
    - youth are better at including holistic view of health compared to older generations; youth open to talking where parents may not be
- having enough food/healthy food
    - thinking of being healthy is a privilege of those not in poverty or under extreme stress
- to be 'normal' or free from an issue (depression, etc)

- connected to each other
    - children/youth are an active part of the family, and family is a part of the community
- well-rounded and access to all aspects of self; interests and engagement, relationships
    - balance
    - being able to participate in their community, sense of connection (giving and receiving)
    - freedom to be unique; a healthy community has the ability to accept, foster, and encourage children and youth to become their best, creative, compassionate selves

Q9: What do youth do to keep healthy?

- doing things - skateboarding, biking, participating, accessing services (doctor, OPT, CC, etc.), educational achievement
    - awards given to reward children and youth that fit
- friends and relationships (receiving mentorship or learning passed on, coaches, teachers, etc.)
- unless parents facilitate there is little accessibility for children and youth to go out and engage
- spiritual expression is a commonly identified gap here

Q10: How would you describe the culture of substance use in our community?

- visible and accepted for adults and not unaccepted for youth (grade 9-12+)
- nonchalance or even support for drinking for youth
- normalcy to drinking and medicating (not exclusive to Revelstoke), an escape and unwind culture
- seen that parents facilitate for teens (in the name of safety and preparedness)
- accepted use of marijuana and recreational drug use
- binge drinking culture is historical in this community (bush parties)
- the culture that nothing bad is going to happen; acceptance is inconsistent with the response when there is a problem or something bad happens
- easily accessed
    - use is visible and openly discussed, perhaps a protective factor
- room for dialogue - open to conversation about it
- worry that it's a culture of coping

Q11: How would you describe the culture of mental health in our community?

- invisible, fear, not wanting to talk about it or let people know
    - vulnerabilities are masked by a 'fun and active lifestyle'
    - when there is mental illness we aren't sure what to do about it, an assumption that the community and residents are generally well - *struggle to understand that aspects of wellness and struggle can co-exist*
- demographic variations - 'serious' or not

        - trend of increased self-referral as preventative or seeking to improve mental health (less diagnosed or 'serious' referrals), and gain perspective
        - seems to be community acceptance and compassion for the few 'obvious' residents that struggle visibly
    - lots of judgement, shame is prevalent for families and individuals who feel they aren't meeting expectations, fear stops people from sharing or asking
    - getting to a culture of openness around stress and anxiety (many parents will talk about stress in their lives), hopefully will continue to include openness around depression and other struggles
    - stigma replaced by empathy once it is known or shared
    - not associated with crime, mostly connected to a personal failure or deficit
    - higher levels of service or care NOT accessible in this community (psychiatric supports)

Q12: What has been done? What has worked well? What could we be doing better?

- look to ECD to continue the pattern of parent/family engagement beyond early years
- be more visible - as a committee and a strategy - open up dialogue, education, engagement of children and youth earlier
    - making the ISSUES visible, not blaming or shaming the individuals or families that are struggling with the issues
    - community education/service provider professional development opportunities
        - to develop a shared, relational and contextual, language to engage with and about children, youth and families
- earlier prevention rather than intervention
    - integrated services and partnerships/sharing information in a safe and respectful context
    - co-locating services; in a location that is accessible
- maybe specific or separate support for vulnerable or marginalized families
- a need to support diversity; reflecting on how we develop and offer support
- program suggestions:
    - youth centre!
    - crisis texting line
    - cross-generational engagement (ex. taking youth to Monashee court for lunch)
        - extend and grow mentoring opportunities
    - parent engagement
        - parent component to presentations, guest speakers, health and wellness fair in all schools
- ICAT model for 'serious'/high risk mental health cases and transition planning
    - follow-up after connection or service established
    - re-invigorate the community wide intervention agreements (after staff/leadership turn-over)

        - tracking children from early years to adulthood, continuation of service or connection gives context
        - ASSESSMENT OF EFFECTIVENESS AND OUTCOMES OF COLLABORATIVE, and committee work
- RCMP building relationships with service providers AND youth
    - more than just an enforcement job
- project based learning - engaging children and youth in their learning and passing it on
- gaps:
    - doctors engaged in community collaboration
    - access to psychiatric services
    - administrative support at BVE; seems to be lots of struggles there
- LISTENING TO PEOPLE STORIES AND NOT SHAMING!
- seeing the behaviour as an expression of a struggle, problems are separate from people

Services, Gaps, Recommendations for Action

Table 6: Services Existing

Service	Age	Location	Provider
Health education and support		RSS	Interior Health
RCMP School Liaison	Grade 8-12	RSS	RCMP
D.A.R.E. Program	Grade 5	CPE/AHE/BVE	RCMP/SD 19
CYMH Counselling	to 19	MCFD/Schools?	MCFD CYMH
Youth Liaison: Stoke Youth Network	12-18	RSS	City of Revelstoke
School Mentoring	Grades 1-7/10-12	All schools at BVE	Community Connections
Mentoring	Ages 8-18	Community	Community Connections
Youth Nights (Sangha Bean)	Ages 12-18	Sangha Bean	Community Connections
Health and Career Education (HACE) 8: Drug/Alcohol Presentations	Grade 8	RSS	Community Connections
Individual Counselling	Ages 6-18	All schools, or Community Connections	Community Connections
Family Counselling	All	Schools or Community Connections	Community Connections
Group counselling/support	Grades K-12	Schools, community, outdoor, Community Connections	Community Connections
FASD Support	All	Community	Shuswap Children's Association (Salmon Arm)
Alcohol/Drug Counsellor	12 +	QVH	Interior Health
School Assessment	Grades K-12	Schools	SD 19 – Psychologist
School Counselling	Grades K-12	Schools	SD 19
Alternate School Program (YELL)	Grades 8-12	RSS/Community	SD 19 (Community Connections participation)
Health and Career Education (HACE)	Grades 8-12	RSS	SD 19
Presentations	Grades K-12	All schools	SD 19
SAFE Spaces	All	Schools/Community	Safe Spaces Committee
Medical Services	All	Clinic/Hospital	Selkirk Medical Group
Canadian Mental Health Association	Community	Community	Denise Butler (Salmon Arm)

Gaps

There are a number of obstacles to seeking out services for children, youth and families. Some are value based, often there is fear of uncertainty and judgment, not knowing where to go or what it will be like, community and societal stigma, and what has been identified as most significant is a lack of trust or relationship.

The community has identified that we are missing a physical, safe, accessible space to 'hang-out', talk, not do substances, connect with adults who care and support them.

Direct, local, and timely access to psychiatric services is a noted gap for children, youth and families who are looking for mental health support. The model in place from government does not meet the needs of our residents.

Partnerships and collaboration with local medical practitioners has been identified as a need and that has been some movement on this issue with some doctors participating in planning and case consultation.

Resources and funding to support existing services and programs and to expand and take on new areas identified as a need.

Recommendation Areas

1. Psychiatric services expanded and more timely: it has been suggested that an alternative way to access a local child/youth psychiatric consultation be established and that it be available more often (perhaps once per month).

2. Parent/ family engagement (children aged 6-12): responses indicate a gap in services supporting mental health and well-being of children ages 6-12 and that these services and supports should engage families and friends as those are the natural support systems children go to.

3. Volunteer/mentor opportunities: there were many responses indicating the value of mentorship experiences, providing opportunities for connection and relational learning and support.

4. Measure effectiveness and outcome of collaborative/committees: there is a strong desire to implement outcome measurement and to know if the work and time going in to committees is having a desired impact.

    - Ensure that the LAT 'small tests of change' is indicative of the desired measurement process or if a larger effort would be preferred or welcomed to go along side.

- See appendix for possible context of measurement of effectiveness
- Determine effect size
- Determine Social Return on Investment (SROI)

5. Funding / creation of crisis intervention services / volunteer coordination: across the board of service provider interviews it was noted that funding is extremely tight and that actual money to support actual service delivery is a high priority.
   - Some programming suggestions (it does not seem like there is the capacity for any one program to expand or that there is enough resources to create new programs to address the issues or gaps raised):
     - Youth Centre!
     - Crisis response 'text' line
     - Deliver the friends program in elementary schools
     - Expand counseling and transition support at RSS
     - Youth Drug/Alcohol support and prevention group
     - MH Fair to elementary schools and a parent component

6. Intentional integration and partnerships of services responding to needs of children, youth, and families:
   - Not about model, all clients and families are unique and desire different things from services
   - It's not about us, it's about the work – the work is contextual and relational
   - Integrated case support
     - Identifying who is involved and how to best support children/youth and families based on their identified knowledge, preference, values
     - Follow up from nursing and hospital/medical discharge

Implementation: Moving towards a Local Action Team

A sense of caution to commit and participate in further committee/bureaucratic processes

- There is a worry about committee burn out, dissatisfaction, and holding back of full participation; that being said, there is significant interest and belief in the importance of this work in supporting the health and wellbeing of our children, families, organizations and community
- Struggle to see the 'effectiveness' and 'meaningfulness' of further administrative engagement
- There are hopes that engagement of families and youth in the collaborative will increase opportunities for accessibility and greater impact – reconnecting why we do the work

Commitment

- project plan, roles, timelines, outcome measurement
- interest and opportunities to build in local context and culture
- engaging children/youth and families
- build and repair relationships – focus is on the work and the process is determined by the people we see in our work

Interest and time

- what are people interested in
- what do families want

Hard issues

- psychiatrist
- school services
- systemic differences
- poverty
- seeing the whole picture, the context of families, children/youth who are struggling
- youth space!

What we do well

- compassion from understanding
    - those who are 'clearly struggling' have a place and are seen to be important and to be protected
    - can we leverage compassion to extend to less visible struggles
        - language
        - education

        - more than one thing at the cause
- we are the local experts – local knowledge and need for service is unique
        - using local context, culture and values to inform direction, NOT political agendas and funding direction

Conclusion

In summary, this report is intended to help support the moving forward to the Local Action Team in addressing local issues and supporting the children, youth, and families around issues of mental health and substance use. The background information gathered to inform the analysis and recommendations consisted of local plans, strategies, and documents; local, regional, and provincial statistical information relevant to the focus of this project; and research and literature pertaining to community development, social services programing, research and data on the issues. Through the project, a survey was conducted at Revelstoke Secondary School, and stakeholder interviews and focus groups were conducted to gather information about individual, family, and community resilience and desired and valued direction in supports and services for children and families.

Engagement from local residents, service providers and families has been central in the analysis of data and literature. Significant findings have come from local voices and patterns outlining the cultures of Revelstoke. The identified struggles for children/youth and families are access to meaningful experiences or activities; barriers have been indicated as poverty, stress and not having the time, limited service options for child and youth mental health and psychiatric consultation, and integrated responses by service providers (not having to go from place to place and re-tell their story).

The data demonstrates that the community of Revelstoke is doing well when compared to provincial averages in the areas of early year's vulnerability, middle years health and well-being and connectedness, and that the relational culture of our community is a strong protective factor that supports the lives of residents. Some of the areas of concern were the higher local numbers of use of alcohol, marijuana and tobacco and the culture of acceptance and access to those substances that young people and adults are aware of.

From the analysis data and local findings and the literature review, this report has highlighted gaps in services and recommendations for moving forward in supporting children, families, and the community sustainability. The areas of recommendations are expanded psychiatric services that are more timely, parent and family engagement and expanded services for children aged 6-12, support for and expansion of mentorship opportunities, measurement of outcomes and effect of committees and the collaborative, increased funding and resources for expansion and creation of programs, and intentional integration and partnerships of services responding to needs of children, youth, and families.

Overall this community is very responsive to the needs brought forward of individuals, groups, and families. It is encouraging to have found that there is such deep and expansive belief in the resilience of the people who live here and a commitment to individual and collective well-being.

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