Sooke
& Region

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FINAL REPORT

Prepared by the Community Health Initiative
on behalf of the District of Sooke

With support from the
Union of BC Municipalities Community Health Promotion Fund
and the Vancouver Island Health Authority

DECEMBER 2006

Acknowledgements

The Sooke Community Health Initiatives committee would like to acknowledge and salute the many volunteers and staff who have given so freely of their time to assist us in this project. The Sooke Region is fortunate to have such dedicated and caring individuals working on behalf of the community and the region.

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Introduction

The Sooke Region is known for its sense of community, strong volunteer base and innovative approaches to local health and social services. Local volunteers are effective advocates for their communities. We have vibrant and active neighbourhoods that are great places for families to live. We have so much to be proud of!

This time of rapid population growth inspires us to consider how to effectively plan for our future health and wellbeing. Our region has active communities that are attractive places for families to live. How do we effectively plan for the future health and wellbeing of our citizens? We live in a community that is diverse—with differences in culture, values, life stage, education, geography, and opportunities and assets. We are the experts on what it is like to live in our community but each individual's experiences and stories are unique.

Over the past year, the Sooke Community Health Initiative (CHI) through the Community Health Information Project has tried to give eyes, ears and voices to the region's health resources and needs. We intend this project to help citizens and decision makers better understand the region's current and changing health needs, its resources and the communities' health and social priorities. We offer this report on the issues, concerns and recommendations to achieve greater health in our region.

Executive Summary

CHI is a growing partnership of interested community members and health & social service providers who have been working together since 2003 to advocate for local health and social services that will maintain and improve our quality of life in the face of rapid growth in our largely rural communities. CHI includes diverse members from East Sooke to Port Renfrew. CHI has developed and sponsored the 2-year Sooke Mental Health and Addictions *Navigator Project*, in partnership with the Sooke Family Resource Society. It also serves as the Advisory Committee to Edward Milne Community School's *Wraparound Project* for youth-at-risk. The committee's Community Health Information Project (CHIP) has engaged the attention and support of the Vancouver Island Health Authority (VIHA), the Provincial Health Services Authority (PHSA), the BC Ministry of Health and the Union of BC Municipalities.

CHI's yearlong project brought together community, government, business, service providers, NGOs and other partners to engage a geographically and socially disparate region, consisting of many small communities (including three First Nations), in the pursuit of locally specific and useable population health data. We collected relevant data and community stories, and identified our communities' health priorities and concerns. We explored a variety of information acquisition, marketing, mailing, and engagement strategies. The opportunity to participate in both a targeted telephone health survey and a broader mail out health survey process allowed us to compare and contrast data acquired using different methods, requiring different inputs of time and money, and different degrees of community involvement.

Members of the CHI committee and municipal government representatives gathered information and connected with other groups by attending regional planning meetings on arts and health, food security, determinants of health, and chronic disease management. Information about the CHI project has been presented at several Vancouver Island Health Authority conferences and meetings. Our project has connected our community with other health initiatives, both on Vancouver Island and province-wide.

The Vancouver Island Health Authority funded our *Community Health Resource Mapping Project.* This supported the U.B.C.M. funded initiative and allowed us to create a base line for assessing the spectrum of services supporting health and wellness and providing illness care in our community. Once our resource questionnaire was established we then undertook the Community Resource Survey to identify needs, illuminate gaps, inform decision-making bodies, and encourage sharing rather than competition for local resources (i.e. funding, space, personnel, clients, etc.). Ultimately this resource data will be compiled to create a web-based Community Resource Map as part of the Capital Regional District's Community Health Atlas. This resource inventory is intended to be user-friendly and easily up-dated by the individual stakeholders.

The *BC Health & Wellness Survey* (BCHWS) was an initiative launched by the Provincial Health Services Authority (PHSA) with the purpose of documenting health-related lifestyle behaviours of British Columbians. BCHWS was modeled after the Ontario Rapid Risk Factor Surveillance System (RRFFSS), a randomized telephone survey conducted repeatedly in order to monitor health behaviour, risk factors, and general health. This survey process responds to an urgent need by medical health officers, epidemiologists, health planners and health administrators for current health data at a local level more frequently than is available from Statistics Canada. Phase I of BCHWS tested the survey methodology and provided an evaluation of lifestyle behaviours in 26 BC communities.

The Sooke Region is traditionally included as part of a much larger Local Health Area (LHA) in surveys and it has been difficult and expensive to extract local Sooke information from this larger data pool. By conducting our own local *Community Health Survey*, we were able to acquire local data that represents and is owned by our communities. Despite the availability of personal stories, we need accurate population data specific to our area in order to effectively plan and advocate. We also wished to see if local data supported the stories we hear. We created a survey that gave us data comparable to surveys in other regions and we developed questions to effectively reflect the rural nature of our communities since most surveys are developed for urban areas. Our information was designed to be relevant to the planning departments of the Capital Regional district (C.R.D.) and the District of Sooke but also to V.I.H.A., service clubs and similar groups in the region's communities from East Sooke to Port Renfrew. Ultimately our information acquisition process is designed to be dynamic—to grow and be renewed as our communities' needs for information change.

In addition to a survey of the overall health and wellness of our community, we specifically assessed the health of our children and youth with Resiliency Canada's *Child/Youth Resiliency: Assessing Developmental Strengths* survey. In cooperation with the Sooke School District #62, co-sponsored by the VIHA Population Health Surveillance Unit, this survey was administered in June and September 2006, and represents results from 1084 children and youth in Grades 3-12 at six Sooke schools. This '31 developmental strengths' framework measures the capability of children and youth to cope successfully in the face of stress-related, at-risk or adversarial situations, and identifies the protective factors that encourage and enhance the well-being and development of all children and youth in our communities.

Our *Community Health Forum* was held September 23rd, 2006 to report to community members and decision makers the results of the resource mapping project, two of the three health surveys, and to solicit public response and opinion. We explored all the data in the context of people's lived experience. The participation of citizens representing a broad cross section of the community gives CHI confidence that the summary recommendations we present here reflect the issues, needs and reality of the citizens of the Sooke region.

After reviewing all the priorities identified at our community forum and in all the surveys, our CHI Committee identifies three major domains for *Recommendations:*

1) Strengthen community connections and relationships for children & youth
   a) Improve access to mental health and addiction services
   b) Strengthen relationships between youth and adults including employers
   c) Create alternate learning opportunities to keep youth engaged in learning
   d) Increase support and outreach to families
   e) Create safe, youth oriented recreation and gathering spaces

2) Strengthen collaboration between community service organizations
   a) Improve resources for, build capacity in, and improve relationships between organizations, and between organizations and the community at large
   b) Develop an Active Community Plan for recreation
   c) Increase awareness and visibility of social supports and resources
   d) Re-orient primary healthcare services to improve local access

3) Create supportive physical environments for healthy lifestyles
   a) Improve, develop and encourage safe use of bike lanes, pedestrian pathways, and parks.
   b) Increase the amount of affordable and accessible housing
   c) Develop a regional food security plan with local/regional partners

The recommendations will be widely disseminated throughout the Region and to public bodies responsible for decision making that influences health in the region.

Key Learnings and Best Practices

1. A unique and flexible partnership between many levels of government and sectors beyond traditional organizational and political boundaries proved necessary to support this process: National and local NGOs + Provincial Health Services Authority + local Health Authority + Ministry of Health + school district + local government + regional government + local NGOs.

2. The survey tools were designed to reflect the unique qualities and information needs of rural communities. Many of the Canada Health Survey questions designed for urban settings were reworded to reflect the realities of life in rural communities.

3. Our project has been generated and driven by the local community from the 'bottom-up' and the community retains control and "ownership" of the data, and is responsible for further knowledge translation within the community.

4. A complex information acquisition process and analysis must return the data to the community in the form of information useable and understandable. Data (objective) and local experience (anecdotal) are equally valued.

5. The local community, 'hands-on" approach developed skills and capacity in the volunteers and municipal staff involved in the project and nurtures these resources in the community for future projects and programs.

6. We learned the detailed mechanics and pitfalls of mailing household surveys and were able to provide valuable feedback to both VIHA and BC Stats on how to increase community uptake of surveys.
7. We have developed a real understanding of the power of individual involvement, personal relationships and community contacts in effective community engagement and development.

Project Goal & Objectives

We have achieved all of the goals and objectives that we set out as follows:

1) To provide community members and decision makers with valid information on local and regional resources affecting health, health status and quality of life to support decision-making processes at many levels.
   - ✓ To measure the health of our community with carefully chosen behavioural, attitudinal and demographic indicators
   - ✓ To provide reliable, understandable and useful information to the community
   - ✓ To document our achievements
   - ✓ To identify emerging issues and challenges
   - ✓ To gauge the general adequacy of existing services, practices and strategies

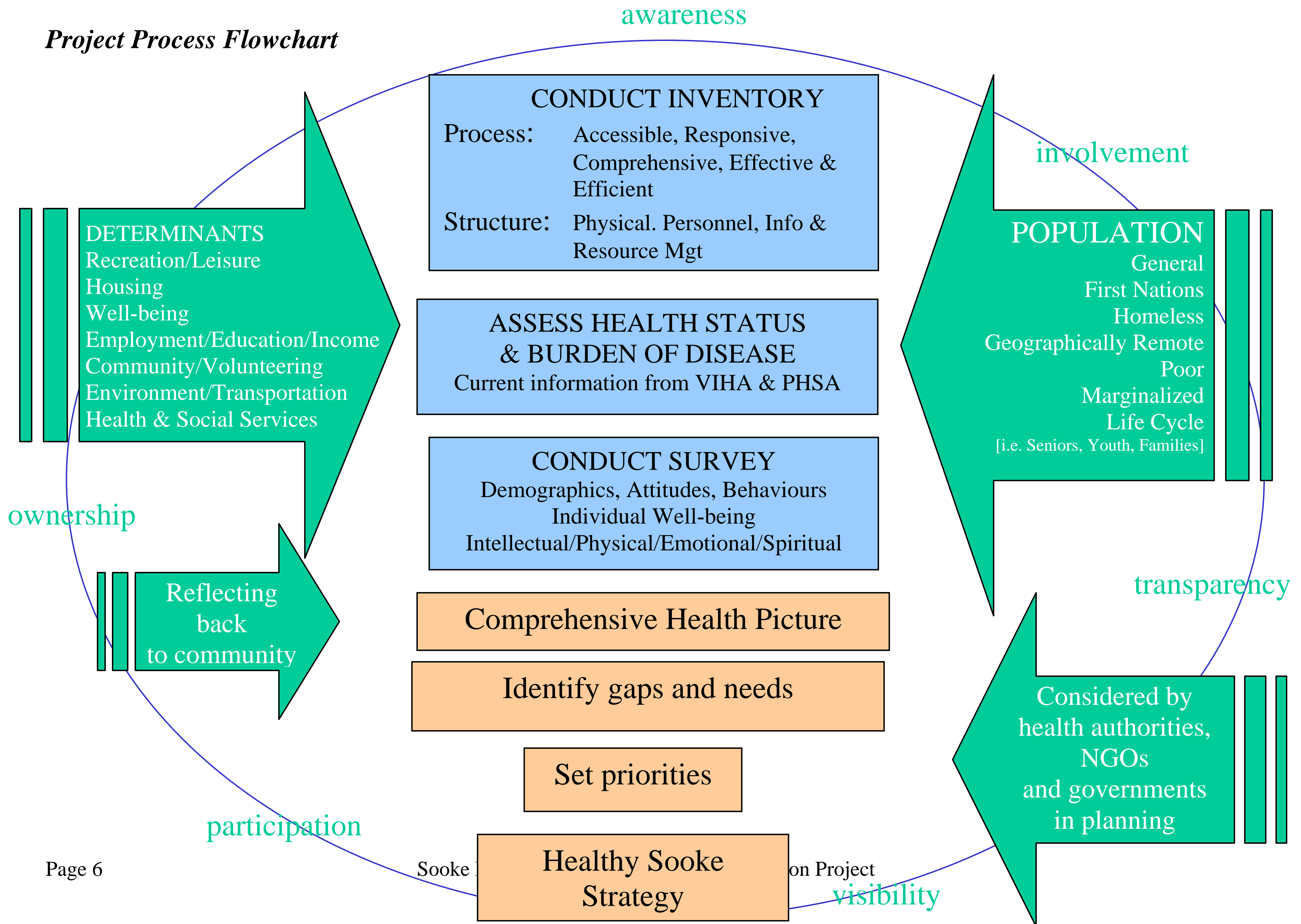
2) To create a community health plan.

- ✓ To facilitate connecting individuals with the resources they need to improve their health.
- ✓ To enable each person, business, agency and community organization to take action within their unique scope of influence.
- ✓ To build upon the challenges, character, resources and achievements of our community.

3) To build local capacity in acquiring and using data to advocate for resources.

- ✓ Create a reservoir of available and current information that describes the demographics of our rapidly changing community.
- ✓ To create a process that makes this data easily accessible to those who can use it.
- ✓ To encourage governments and agencies to use valid and current local community data to inform their decision-making and their advocacy.

Project Process Flowchart



SUMMARY OF PROCESS RECOMMENDATIONS

Overall Recommendations

- Identify principles and values of the committee before you start and rigorously adhere to them
- Build capacity by ensuring that the committee members are given the tools to understand and interpret community health data
- Set up task-groups to guide each component of the project
- Budget for resources and paid support for each component
- Track all volunteer and paid hours

Community Resource Mapping Project

- Budget for support staff to oversee process
- Develop a sub-committee of volunteers to guide the process
- Identify key health and wellness components and services
- Illuminate service gaps in community
- Engage geographically and socially outlying communities
- Seek professional assistance in developing the questionnaire
- Design questionnaire to fit end-use or distribution vehicle
- Identify key informants in community
- Use multiple resources to create contact list
- Identify and obtain contact information during initial exchange
- Run pilot of questionnaire
- Use personal follow up to increase questionnaire response rate
- Return information "borrowed" from the community and encourage revision
- Identify what information is valuable to the community
- Determine most accessible and effective method of information dissemination

Community Health Survey

- Budget for support staff to oversee process
- Develop a sub-committee of volunteers
- Create a logo and media campaign to raise awareness
- Emphasize local creation and ownership of data
- Make it easy for people to find you
- Enlist committee members with broad community networks
- Analyze the cost and coverage of survey distribution options
- Use personal follow up to increase response rate
- Take advantage of seasonal & cultural community rhythms
- Adapt other health surveys to reflect a local perspective
- Provide space for respondents' comments on survey
- Make and sustain early contact with Health Forum's speakers and key participants
- Formally acknowledge the efforts of Forum contributors

Child & Youth Resiliency Survey

- Budget for a support staff person to oversee the process
- Articulate how the survey results will be of value to the School District as a whole, to principals, teachers and parents
- Get a formal sign off on survey content and process from School Board, Principals and District Teaching Association representatives
    - Check to see if your local School District has a research protocol
    - Attend staff meetings to introduce the project to teaching staff
    - Ensure that survey results are personally presented first to the Principals and then to staff, parents and students (as appropriate).

Discussion

1. UBCM Measurements used to assess outcomes

The objectives set out by the UBCM Community Health Promotion Grant provided a framework to assess the project outcomes.

1.1. Build skills and abilities to address your community's health promotion needs.

1.1.1. A broad range of participants including service providers, citizens, volunteers and decision-makers were recruited (see Appendix 7(c))

1.1.2. Participants were informed of the broad and over-arching goals of the project, why their participation was key to the success of the project and why it should matter to them.

1.1.3. Participants were engaged by developing a process that ensured their voices were heard and identified their unique strengths and potential contribution to the project as individuals, organizations or unique constituencies.

1.1.4. Participants were involved in a range of tasks and activities that broadened their knowledge and developed their skills. These included both technical feasibility issues and values-based issues.

1.2. Collaboration was strengthened between our local government and collaborating partners despite this being a particularly challenging time for Council in terms of planning resources.

1.3. This project was innovative and a "best practice" in the region and province.

1.3.1. It used a community generated 'bottom up' approach

1.3.2. It was locally designed

1.3.3. It involved local NGOs in both the development and implementation phases

1.3.4. It paid a lot of attention to the community engagement process

1.3.5. It built capacity in individuals and groups

1.4. This project involved a high degree of information sharing and networking at community, regional and provincial levels.

1.4.1. It nurtured community networking beyond traditional boundaries

1.4.2. It encouraged broad-based membership on the steering committee

1.4.3. It reached out to constituencies which might not usually be able to participate

1.4.4. It connected volunteers, citizens, health practitioners and decision-makers

1.4.5. It provided for sustainable information sharing

2. *Community Resource Mapping Project*

The expected outcomes and subsequent by-products of developing this Community Resource Database were:

- To illuminate gaps in the services relating to health and wellness in our community;
- To inform decision-making bodies of the needs of the community;
- To create a user-friendly, representative, and dynamic Community Resource Map;
- To develop a community-based health and wellness directory on the Internet;
- To gather qualitative data to bring life to and enhance the quantitative data gathered from the other components of the CHI project;
- To enhance collaboration amongst local community groups and organizations;
- To encourage the sharing of, rather than competition for, local resources (i.e.: funding, space, personnel, clients, etc.).

Project Funding

The Vancouver Island Health Authority generously offered $5000.00 for the completion of a Community Resource Map, with measurable deliverables in the form of an electronic database and a final report.

Hiring of a Project Community Consultant

A CHI sub-committee interviewed four applicants, hiring one to develop the Community Resource Map. The work was completed over a very tight seven-week period. The successful applicant is an active member of the Sooke community, has an undergraduate degree in Anthropology from the University of Victoria and had previous experience in research, interviewing, data entry and analysis, report writing, and working with relevant computer software. Her knowledge of the community and personal connections through

her previous work experience in Sooke was an asset, as was her interest and ability in engaging local First Nations.

Development of a Community Resource Mapping Task Group

In recognition of the scope of the project and the short time frame in which to accomplish it, another CHI sub-committee was established to assist the Project Consultant. Nine volunteers made up the task group and represented various bodies in the community: Sooke Transition House Society, Vancouver Island Health Authority, Capital Regional District, Sooke District, East Sooke Community, Sooke Family Physicians, SEAPARC (CRD - Recreation Centre), Edward Milne Community School (SD62) and Rotary Club of Sooke.

The Consultant met with the group on four occasions over the seven-week period to report back and gather feedback on the project's direction, progress, and schedule. Members of the task group took an active role in editing and distributing the questionnaires.

The development of this CHI sub-committee allowed us a collaborative, rich, and community-based approach, and yielded joint and accountable decision-making on behalf of the entire CHI group.

Questionnaire Development

The first step of the process was to establish which areas of service contribute to the continued health of our community. After much discussion, CHI identified sixteen key services or "domains": recreation, leisure, housing, health care, employment, safety, transportation, social services, education, culture, arts, volunteering, natural environment, built environment, food security/farming, and general well-being.

The next step was to develop an appropriate and accessible questionnaire that would extract relevant information from the various community groups in a sensitive yet efficient manner. The project consultant conferred on a number of occasions with a BC Stats veteran to ensure the questionnaire was sound in language, structure, and user-friendliness.

The questionnaire (Appendix 4(b)) was divided into four key areas (thirty-two questions spread over five pages): General information, Client Information, Human Information, Human Resources.

Questionnaire Terminology

The following linguistic distinctions are made in the beginning of the questionnaire:

'Group' as conveyed in the questionnaire refers to any service provider, organization, business, agency, club, etc. associated with community health and wellness.

The 'Sooke Region' and the 'Community', for the purpose of this project, are defined as the area encompassing Sooke, East Sooke, Otter Point, Shirley, Jordan River, and Port Renfrew and excluding Colwood, Langford, and Metchosin.

Questionnaire Pilot

Before the questionnaire was sent out into the community, its structure, readability, validity, and suitability were tested on seven participants who represented diverse groups in the community (Sooke Family Resource Society, Goodlife Wellness Centre, Sooke Crisis Centre, Sooke Transition House Society, Ministry of Children and Family Development, and School District #62). Valuable feedback and insight were provided through this pilot, and improvements to the original questionnaire were made. A positive by-product of this small pilot process was that people in the community began thinking and talking about the project.

Formal & Informal Interviews and Consultations

During the seven-week project more than 30 formal and informal interviews were conducted with various people in the community who were identified by either the Community Resource Mapping Task Group or by the Project Consultant as "key informants" for the project's process.

Key informants are people who hold knowledge of health and wellness issues in our community, or who have contacts in the community of value to the project. The goal was to establish a varied yet comprehensive and representative contact list of the questionnaire recipients. These interviews were conducted both in-person and over the phone by the project consultant.

Contacts

After multiple meetings with the CHI sub-committee, and after conducting formal and informal interviews, a comprehensive and representative contact list was compiled with over 300 people representing over 300 groups related to health and wellness in our community in all of the sixteen previously listed domains.

The next step was determining the mailing addresses for these 300 groups. The Sooke Lion's Business Directory, the Internet, and other local community resources (see appendix 4(f).) were very helpful in this search. More than 100 phone calls were personally made in order to garner address information that wasn't located in these resources.

Questionnaire Distribution and Collection

Approximately 230 packages were delivered by mail, 20 delivered in person, and 50 delivered via e-mail.

Each mail-out package contained 4 documents:

1. Sooke News Mirror Press Release (see appendix 3(c))
2. Introductory letter (see appendix 4(a))
3. Community Resource Questionnaire (see appendix 4(b))
4. Self-addressed stamped envelope

CHI requested the questionnaire be sent back to the Project Consultant within two weeks. Within days of the first mailing, questionnaires came back completed. E-mailed

questionnaires were being completed and sent back and those that were hand-delivered were hand-collected. The response was impressive.

The Project Consultant is still receiving completed questionnaires in the mail, the result of a small resurgence of interest after the Community Health Forum in September.

Questionnaire Follow-Up

Although the initial questionnaire response rate was impressive, it paled in comparison to the effectiveness of personal follow-up. Shortly after the questionnaire completion date the project consultant, with the assistance of a few eager task group members, personally phoned those people who had not returned their questionnaires to gently remind them of the importance of their participation. In addition, reminders were made via e-mail and in person: in the grocery stores, on the streets, in the workplace and at other committee meetings.

Despite these efforts, some people still chose not to respond. Some sceptics saw no point in participating because "nothing changes anyway" and others reported that the questionnaire did not apply to them. Some confessed they had thrown it out, and others didn't phone back when a message was left. However, there was a staggering number of people who, when reminded, dug into their paper pile, filled out the questionnaire and sent it back – and often with remarkable enthusiasm about the project: "Oh excellent! Sooke really needs something like this!"

This response to the follow-up was a testament to the effectiveness of personal connections in a community. When being cold-called people generally appreciated the eager and personable voice of a community member speaking from her heart about issues that matter to everyone. It took a considerable amount of extra time and energy but it was worth its weight in gold – it reached out to many people who otherwise would not have had a voice.

Another positive consequence of the follow-up process is that it got people talking and thinking again about these issues, without which change, especially at a community level, is impossible.

Questionnaire Response

Of the 300 questionnaires sent out there was a staggering 51% response rate. 153 questionnaires were returned, and some are, to this date, still being returned. This, in large part, is due to the extensive follow-up accomplished. There has also been a small resurgence of community interest in filling out the questionnaire due to the Community Health Forum which effectively communicated the connection between filling out the questionnaire and getting one's group information on the Community Resource website.

The impressive questionnaire response-rate speaks not only to the effectiveness of personal follow-up, but to the type of community Sooke is: one that is involved, community-minded, and passionate about maintaining or changing their quality of life for the better.

Database Development

CHI wanted this resource inventory to be different from other local resources. It was essential to not simply reproduce the phone book with names and numbers of groups relating to health and wellness in our community. It was also important to identify already existing resources (hard-copy) in the community that could serve as a model to inspire and assist in the development of our own inventory[1].

After much consultation as to what software program would be most appropriate for establishing and managing the database, it was decided that Microsoft Excel© would be the best option as it is user-friendly and accessible, and graphs can be produced to serve as presentation and data analysis tools.

The Project Consultant entered the data from each questionnaire into the database essentially verbatim, being faithful to the respondent's answers. The method used to input answers to the open-ended questions, or any other elaborations/notes added, was, for the most part, to 'insert comment' rather than type paragraphs directly into the cells themselves. This eliminated unnecessary visual clutter.

The database was presented, on a number of occasions, to both CHI members and VIHA staff. Final copies on CD were given to both CHI and VIHA. The project consultant also has a copy of the database on her personal computer.

Database Analysis

Through consultation between CHI and VIHA's Population Health Analysts is was established that the data from the database would be used in two very different ways:

1. Community Resource Website: the neutral/non-confidential/public-appropriate information garnered from the questionnaire, such as group name, location address, contact details, wheelchair and bus-stop accessibility, referral and cost information would eventually be available (if the individual group so wished) on the community website.
2. Data Analysis: *all* the data would need to be analyzed in an accurate and accessible way to take back to the community to help inform their decision-making at the Community Health Forum.

There were two principal stages of this database analysis:

1. A preliminary analysis of the database, conducted by the project consultant in March (at which point there were 127 of the eventual 153 respondents), revealed highly useful community information garnered from the questionnaire, such as wheelchair accessibility, access cost, access barriers, referral information, target clientele being served, etc. This was exciting because not only did it illuminate gaps (and, as it turned out, successes) in the community (which was a projected outcome of the questionnaire), but also it offered, in a rudimentary form, tangible

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[1] The Child, Youth and Family Resource Directory published by Edward Milne Community School's Wraparound Project served as one of these models.

and accessible data to present to community members and decision-making bodies at the September Health Forum.

2. In September, a final analysis of the database was formally prepared by the Population Health Surveillance Unit, Office of the Chief Medical Health Officer, Vancouver Island Health Authority (VIHA). This data, in the form of prepared charts, was presented at the Community Health Forum.

An essential part of the database analysis, that can not be tabulated in numbers or accounted for easily in charts, are the answers to the open-ended questions from Section III on Human Resources around staff and volunteer recruitment and retention. This qualitative data, we found, was often more illuminating than the quantitative data. As insight into actual community experience these observations are highly valuable and are recorded here:

- Some observations as to why there is difficulty recruiting and retaining skilled workers:
  - Low wages
  - Location
  - Transportation
  - Burn-out

- Some observations as to why there is difficulty recruiting and retaining volunteers:
  - Burn-out
  - Small pool of volunteers to draw from, especially in smaller areas such as Port Renfrew
  - People don't have or make enough time for volunteering in their lives
  - Low interest
  - People are working outside of the community
  - People don't want to work for free

- Some observations as to why there is no difficulty recruiting and retaining volunteers:
  - People are committed/dedicated to the cause and to their community
  - Interest/passion for the cause/community
  - Rewarding work
  - A great work environment with learning/stimulating opportunities encourages recruitment and retention of volunteers
  - People want to matter
  - Newly retired folks have time to contribute
  - Sooke has a history of volunteering and caring for the greater good

First Nations And Outlying Communities Outreach

It was felt by CHI members that, in order to include, actively engage, and receive a significant questionnaire response-rate from the First Nations and outlying communities a commitment would need to be made to travel to these communities to work directly with these people in person.

Over time, the Project Consultant set up meetings in the rural communities of Port Renfrew, Pacheedaht, Beecher Bay, and T'Sou-ke to discuss the project and complete the questionnaires together in person.

Port Renfrew Community Outreach

In Port Renfrew the Project Consultant stayed overnight, and over the course of two days met, both formally and informally, with six community members who were actively involved in the community, representing the following groups that contribute to the health and wellness of the Port Renfrew community:

- Port Renfrew Preschool & Day Care
- Coastal Kitchen Café
- Lighthouse Pub & Restaurant
- Child and Youth After-school Care & Summer Care Programs
- Port Renfrew Medical Loan Cupboard
- PRHSSS: Port Renfrew Health & Social Services Society
- BC Ambulance Services

Through these meetings, 5 questionnaires were filled out in person, with the project consultant asking the questions, clarifying any questions/concerns, and engaging in personal exchange. This final point was critical in establishing a connection and again, enhancing the quantitative data with personal stories. Being open, taking the time and engaging in personal conversation about what issues were close to these community members' hearts (relating to health and wellness) was a highly valuable process. It allowed the community members to put a face to the CHI group, to engage with the larger Sooke Region, and to voice their opinions.

The BC Ambulance service staff took a questionnaire, after a discussion in person, and returned it through the mail later. A questionnaire was left for the Fire Chief, who later phoned to say that he would not complete it as he did not feel it applied to his group.

First Nations Community Outreach

In all three First Nations communities the Project Consultant contacted the Chief and/or Band Administrator directly to enquire if this was something they or their staff had time and interest to discuss. From there she followed their lead. Eventually the Community Health Representatives in all three communities were involved with the filling out of a questionnaire. It was made clear that the data from the questionnaires, once entered into the database, would be brought back to the communities for verification and further discussion.

Pacheedaht Nation

During her first visit to the Pacheedaht community the Project Consultant set up appointments with two staff members, had conversations with others, and came back later in the day. Together, with the Project Consultant, the Community Health Representative and the Treaty Councillor each filled out a questionnaire. She also met briefly with

Pacheedaht's Chief Councillor. As this was a transitional phase for Pacheedaht, there was no Band Administrator available.

The Councillor aptly noted that the word "client" used in the questionnaire to describe the people the Pacheedaht Nation serve was inappropriate terminology because "they are not clients, they are our family and friends." The Councillor decided that "Band and Community Members" would be more appropriate terminology.

The Fisheries Administrator would not fill out a questionnaire as she did not agree with the philosophy of collecting data and information on First Nations, given the fact that this data is an "interpretation" and "is often misrepresented and misused". Furthermore, she did not believe it was her place, as a Band staff member, to represent the community.

A follow-up visit was scheduled where the database was reviewed with the Chief Councillor, the Community Health Representative, and the Treaty Councillor. There was editing as well as discussion around what type of hard-copy format of the Community Resource Database the community might find useful.

Shortly after this second visit, the project consultant met with the new Pacheedaht Band Administrator in Sooke to review the larger CHI project, the Community Resource Database, and the two questionnaires that had been completed by the above Pacheedaht staff members.

The Band Administrator eventually met with Chief and Council to verify the accuracy of Pacheedaht's information in the database. The following Pacheedaht community and staff members assisted, in some way, in the community resource questionnaire process:

- Chief Councillor
- Band Administrator
- Councillor/Treaty
- Councillor/Fisheries
- Community Health Representative
- Administrative Assistant
- Fisheries Administration

Beecher Bay Nation

During the initial meeting, the Project Consultant met with the Chief Councillor and the Community Health Representative to fill out the questionnaire together. This was collaborative and involved the sharing of personal opinions and stories around health and wellness in the Beecher Bay community.

After the questionnaire's data was entered, a follow-up meeting was scheduled where the Chief Councillor and the Project Consultant reviewed the database. A few corrections were made and it was agreed that the Chief would take the database back to the rest of Council for verification. The following Beecher Bay community and staff members assisted, in some way, in the community resource questionnaire process:

- Chief Councillor
- Band Administrator

- Community Health Representative

T'Sou-ke Nation

It took some time to get connected. It was not until the end of August (long after the March 31st VIHA project completion deadline) that we met with the T'Sou-ke Nation to fill out the questionnaire and add their information to our database. This was due to communication, time and availability barriers during the busy spring and summer seasons. Once the connection was made, however, the progress was rapid.

With the collaboration of the acting Community Health Representative and with permission from the Chief Councillor and Band Administrator, the project was discussed, a questionnaire was filled out, (during which meeting Health Surveys were discussed also), and T'Sou-ke Nation was subsequently represented at the CHI meetings. To have their presence and input on the committee is invaluable and we hope this First Nations representation and perspective is expanded with the eventual presence and participation of Pacheedaht and Beecher Bay on the committee.

The following T'Sou-ke community and staff members assisted, in some way, in the community resource questionnaire process:

- Chief Councillor
- Band Administrator
- Community Health Representative (Acting)
- Home Care Nurse
- Youth Worker

Database Verification with First Nations and Outlying Communities

As agreed, the Project Consultant traveled to the rural communities of Beecher Bay and Pacheedaht First Nations, as well as to the Port Renfrew community to verify that the information gathered and presented in the database was correct, and to offer an opportunity to edit the data in person.

This was felt to be an important step in the process so as to not jeopardize the integrity of the CHI project or its members CHI knew it was essential to the integrity of the process to gather information and personal stories as well as to take the information back to the communities to give the contributors a say in the project. "The give" was felt to be as important as "the get".

The Project Consultant was able to meet with all but one of the people who were interviewed during the original outreach mission to these communities to verify, edit and discuss the next steps.

Overall, the project was received well in the above communities, except that there was, understandably, some scepticism as to what the questionnaire would bring to, or change in, these communities. "We've done this before, what's the point?" The Project Consultant felt that, in two particular situations, the interviewees were humouring her by filling out the questionnaire and that, because the process was not collaborative from the very

conception of the project, the participants (as opposed to collaborators) did not find much use in the process or the product.

This healthy scepticism highlights the need for researchers and service providers (community-based and beyond) to honour their role and responsibility to the communities they work with, to be transparent in their goals and objectives, and to follow through on the original agreement. If this follow-through is not possible, it is essential to communicate this openly with participating members.

Staff members from the three Nations: Pacheedaht, Beecher Bay, and T'Sou-ke, were personally invited, on a number of occasions, to attend the CHI monthly meetings at Sooke CASA. Despite expressed interest in attending these meetings, to date, only T'Sou-ke has been represented. Geographic barriers are probably contributing factors, but through continued outreach, relationship building, time, and patience, it is hoped that this valuable collaboration is possible. Please see Appendix 4(d), re: Community Voices.

From Database to Website

Through discussion with community members during database development, it was recognized that the most useful and accessible way the database information could be distributed to the community was via the Internet, on a community-based health and wellness directory website.

The Internet as a vehicle for knowledge dissemination is highly effective. However accessible the magic of the Internet is for the majority, though, it does exclude many – a point that needs to be acknowledged. More than a few people, including the local First Nations communities, do not have easy access to a computer or the Internet, particularly in the more remote areas. The elderly, the visually impaired, those who are not computer literate--or literate at all-- and others may also be excluded. A website, on its own, might not grant access to this information to the very people who may need access to health information the most.

To remedy this limitation, CHI brainstormed complementary methods of inventory dissemination. It was decided that during the database verification process the issue would be discussed with both Pacheedaht and Beecher Bay First Nations as to what method would be more accessible for their individual Band and Community Members. Pacheedaht suggested the production and distribution of a free hard-copy version that could be available at the Band Office, with the Community Health Representative, the Recreation Centre, etc. with posters in the Band Office publicizing its availability.

After further discussion, it was established that information provided by this method would very quickly become obsolete, wasting resources and time unless there was funding to update it at least annually, if not semi-annually. A Port Renfrew community member suggested that such a manual be available to local Real Estate Agents to distribute to new homeowners, and a Sooke community member suggested that it become part of the existing Sooke Lions Club Business Directory. These are valuable suggestions to consider after the development and eventual evaluation of the website. Despite the discussion on the

topic, there seems to be insufficient interest in these communities for non-electronic models of the Community Resource Database at this time.

The Vancouver Island Health Authority has funded this initiative so far, in partnership with the Capital Regional District.

VIHA gathers health indicators and determinant data from multiple sources to disseminate using an online interactive mapping application, the Community Health Atlas. This atlas uses a geographic information system to store spatial data. Indicator and determinant data is displayed by local health area (see http://www.viha.ca/NR/rdonlyres/677DE819-7FF9-486E-BFC6-7D10521F5744/0/vihsdalhasappvd_shea_apr05_b.gif). Local, community-collected resources pertaining to health will also be displayed on this atlas. VIHA will encourage other communities to follow in CHI's footsteps with regards to collecting information on community resources that affect health.

Please refer to Appendix 4(e) for a Community Orientation of the proposed Sooke Region Community Resource Website that was presented at the Community Health Forum on September 23rd, 2006.

Consultant's Recommendations

The Project Consultant learned much in her ten months of working with CHI on this project. Her recommendations are informed by her work in the Sooke Region's more outlying areas and with the three First Nations communities of T'Sou-ke, Pacheedaht, and Beecher Bay.

General Recommendations:

- Familiarize yourself and your project group with the Ownership, Control, Access, and Possession (OCAP) principles (and other such principles) from the outset of the project. Review Schnarch, B. (2004). Ownership, Control, Access and Possession (OCAP) or Self-determination Applied to Research: A Critical Analysis of Contemporary First Nations Research and Some Options for First Nations Communities. http://www.naho.ca/firstnations/english/pdf/OCAP5.pdf
- Encourage these principles to be used throughout the duration of the project and beyond.
- Strive for representative community engagement from the conception of the project.
- Honour your role in and the responsibility to the communities you work with.
- Be transparent with your goals and objectives – what are you and your agency wanting to get out of this project?
- Follow through on what you originally offer. If this follow-through is not possible, communicate this openly with all participating individuals.

Community Resource Mapping Process

- Pilot questionnaire in outlying communities also, particularly in First Nations communities.
- Explore the development of a separate Community Resource Questionnaire with and for the First Nation communities to better reflect their structural organization, culture, and priorities.
- Allow a substantial amount of time for this process, from pilot to database verification and beyond.

Strive for Representative Community Engagement

- Engage in collaborative discussion on strategies for respectfully engaging outlying and marginalized communities, from the very inception of the project.
- Invite and engage community members representing ALL facets of the community to be involved from the outset of the project.

Historical Consideration

- Recognize and be sensitive to a historical context: globally, nationally, provincially, and locally.
- Educate yourself about this context if you are not already aware.
- Do not let this historical context paralyse you or inhibit you from taking healthy and respectful risks and thinking outside of the box.

Cultural Considerations

- Face-to-face contact is strongly encouraged and appreciated when working with First Nations communities. Phone calls and emails may or may not be returned. "If the phone doesn't work, come by."
- When working with First Nations do so in their time frame while reflecting their priorities. It was noted by one of the Band's Cultural Liaisons that aboriginal and non-aboriginal people, generally, have a different concept of time: "our clock and our calendar are not the same". Therefore it was learned that patience and respectful perseverance over time are some of the key ingredients to making contact and establishing working relationships with First Nations communities.
- Being open and friendly is essential. Leave any judgements, assumptions, and negative feelings at the gate.
- Trust is built on respect. This takes time.
- Be flexible and open to the flow with time and schedules, with no need to rush off anywhere. Remember that the spontaneous moment is often the most valuable.
- Have a sense of humour, relax, and have fun making new connections and learning new things!

Seasonal Considerations

- Summer is a very busy time for everyone in Canada, and particularly for Coastal Peoples. Both the Coast Salish Peoples (T'Sou-ke and Beecher Bay Nations) and Nuu-chah-nulth Peoples (Pacheedaht Nation), in summertime participate in much celebrated Tribal Journeys and embrace the warm weather to travel and embark on holidays. CHI learned that summer is not typically a very effective or efficient time to work with First Nations communities as many phone calls, meeting dates, and e-mails went unanswered, sometimes for weeks at a time.
- The ideal months, generally, to engage in collaboration with the three First Nations communities were noted as May, June and September as these are, typically, the quietest months of the year for them. Of course, project and funding schedules do not often allow for such particular timing so this will not always be possible.

3. Surveys

As a result of our initiative and progress to-date, the Ministry of Health approached us to use our region as a pilot for a telephone survey they were reviewing for possible use across the province. They were also interested in comparing the results from differing processes resulting in these projects supporting each other in different ways. The first survey conducted was the Provincial Health Services Authority (PHSA) BC Health & Wellness Survey (BC HWS).

3.1. Provincial Health Services Authority BC Health & Wellness Survey

The BC Health & Wellness Survey was initiated by PHSA in an effort to better understand health-related lifestyle patterns of British Columbians. Modeled after the Ontario Rapid Risk Factors Surveillance System (RRFSS)[2], the BC-HWS was developed in response to the urgent needs of medical health officers, epidemiologists, health planners and health administrators for community-level health data. Phase I of the BC-HWS took place in 2006, and aimed to test the survey methodology and provide estimates of health-related lifestyle behaviours through the collection of information related to behavioural determinants of health and general health.

Methods:

Sooke Region was one of twenty-six communities in BC who participated in Phase I of the BC-HWS. During the selection process, five communities were chosen from each of BC's five regional health authorities (except Interior Health, which selected six communities). Health Authorities gave priority to communities with a particular interest in participating in Phase I, as well as having the capacity to disseminate the data from the BC-HWS. Because of CHIP, Sooke was one of the VIHA communities chosen. Because communities were not randomly selected, communities are not considered representative of the communities in the given Health Authority. A random sample of 400 people in each community was planned to ensure reliable estimates for most of the survey questions.

[2] RRFSS - randomized telephone survey conducted continuously throughout that year that monitors health behaviour risk factors and general health.

The BC-HWS comprised 67 questions that took on average 17 minutes to complete. Questions were based on RRFSS, and were also taken from other sources such as the Canadian Community Health Survey. The survey included questions on: socio-demographic characteristics, height and weight, general health, diabetes, blood pressure, other chronic diseases, reproductive health, physical activity level, sedentary activities, fruit and vegetable consumption, tobacco use, alcohol consumption, physical activity environment for bicycling and walking, and food access and security.

Surveys were conducted between March and July 2006 using Random Digit Dialling methodology. Random selection of respondents within a household was achieved using the next birthday method, which involves interviewing the person living in the household who is 18 years of age or older and whose birthday will be next. Male and female respondents in a household were limited to 55% of the total sample. In total, 485 interviews were completed within the 26 selected communities.

The data was weighed using the 2001 census demographic profile to ensure correct representation of the community based on age and gender.

An analysis of comparability between the results from this survey and various other BC data appears at Appendix 6(b).

3.2. Community Health Initiative Survey

Process Recommendations

- Budget for a support staff to oversee process
- Develop a sub-committee of volunteers
- Create a logo and media campaign to raise awareness
- Emphasize local creation and ownership of data
- Make it easy for people to find you
- Enlist committee members with broad community networks
- Analyze the cost and coverage of survey distribution options
- Use personal follow up to increase response rate
- Take advantage of seasonal & cultural community rhythms
- Adapt other health surveys to reflect a local perspective
- Provide space for respondents' comments on survey
- Make and sustain contact early with Health Forum's speakers and key participants
- Formally acknowledge effort of Forum contributors

As a volunteer group with the health of our communities as its focus and in the past, we have found a distinct lack of information available that was specifically relevant to our west coast area. In many surveys, the Sooke region is included in other much larger areas. It is often difficult if not impossible, as well as expensive, to extract local data from this larger pool. Although we have long known the stories, we need precise data that is specific to our area to be effective advocates. We also wanted to see if the data would support the stories. By using our own local survey, the data could reflect and be used by the community.

The CHI membership *developed a sub-committee of volunteers* to develop and implement the survey tool, and receive, analyze & consolidate data. While we did not *budget or plan for a support staff to oversee the process*, we would recommend this for future projects.

We knew that local knowledge is imperative to accurately assessing each community, making contact with key players and ensuring areas are not missed. We attempted to have members from each community on the committee and to look for long standing residents with a broad network in place. The definition of 'long standing resident' is relevant here as a resident for 16 years will have valuable input but a resident of 30, 40 or more years will offer invaluable insight and history. We also *enlisted committee members with broad community networks.*

We set out to create and conduct a survey that would answer local questions and inform planning in our communities. We wanted a survey that would give us data comparable to other surveys and to develop effective questions to assist similar rural communities. We also wanted to provide the opportunity for individual input and comment that is excluded by most surveys. Anecdotal information, though difficult to use on a large scale, is useful and relevant on a smaller, local scale. Citizens are often aware of what is needed to address problems in their community, and we knew the individual stories would be important.

We also wanted information that would be relevant not only to the planning departments of the C.R.D. and the District of Sooke but also to V.I.H.A. (e.g. as it related to our long - awaited extended care facility and primary health centre), service clubs like Rotary and Lions' Clubs, OSPRAA and similar groups in the region's communities from East Sooke to Port Renfrew, together and individually. The data collected needed to be useful to individuals looking to start new businesses or expand existing ones as well as to governing bodies. We needed to answer questions like," What are the demographics of the area?" "Where best to locate?" "What is here already and where are the gaps?" "What is viable, what is not?" "What do the majority of the people want or need?"

The more we explored the broad definition of health, the more questions we wanted to ask. What information needed to be included and what left out? It was very difficult to keep the survey to a reasonable length given the breadth and focus of the various CHI constituencies. Ultimately we wanted the process to be dynamic—to grow and be renewed regularly as our communities' needs for information change. In developing a survey relevant to our rural communities and chosen lifestyles, we reviewed many other surveys and processes of gathering information, analyzing and producing results. Ultimately the survey was the product of much review and discussion.

We began by reviewing the Sooke Area Healthy Communities report which was completed in March 1993 and utilized a written survey. Funded by the Ministry of Health Office of Health Promotion and conducted under the auspices of then regional Director Lorna Barry, the survey asked residents what they liked and disliked about Sooke and what changes they felt would make Sooke a better place to live, or a "healthier community". People liked the rural, peaceful aspects of Sooke and the community spirit. They cited fast development and crime as undesirable. They wanted to have a pool in the community, be incorporated, have a health clinic and see more recreation opportunities for youth.

Wanting a more comprehensive survey we looked at creating our own from the various interests and passions of the committee members. One of our members knew of a survey that had been conducted in Bella Coola, by Dr. Harvey Thomassen, and researched by Alex Michalos. As Bella Coola is a small, rural community as well, we decided to review that survey to see if any or all of it was relevant to our area. Each community offers unique challenges and areas of interest, and while this survey covered some of what we felt we needed to find out, it was not relevant in all areas and missed some of what interested us. With permission from Dr. Thomassen, we set out to edit and revise the survey to adapt it to our area.

At this stage we were approached by the Ministry of Health, which wished to use our region as a pilot for a telephone survey they were reviewing for possible use across the province. We were also contacted by the Vancouver Island Health Authority Population Health Surveillance Unit to use our group and region as a pilot project for community-driven survey processes. With these pilot projects came the assistance of Epidemiologist Michael Pennock as well as contact with Dr. Ron Colman from GPI Atlantic Survey, who was working with the Atlantic Provinces to develop a survey that balances health outcomes and the bottom line.

The RRFSS & GPI Atlantic Survey questionnaires were reviewed, along with Resiliency Canada and other surveys that have been used in other areas. One of the main points Mr. Pennock stressed was that the more 'comparable' any survey was, the easier it would be to verify the accuracy of the data. We noticed that the majority of existing surveys are geared to urban communities and do not represent the benefits and challenges facing rural settings. You will likely find it necessary to *adapt other health surveys to reflect a local perspective.* We did eventually choose modules and indicators that measured: neighbourhood safety, health services, food security, individual health, and physical activities. We also added a 'Sooke' module that outlined area specific questions. Following discussion of various delivery options and their pros and cons, the decision was made to have one survey prepared by each household.

When developing a new survey, even with due consideration, input and cross-checking, once the data starts coming in one finds questions that are not as effective as intended. In the case of the Community Health Initiative survey, committee members noted that the questions in the Neighbourhood module could be interpreted in any manner of ways when applied to a rural setting. It was decided that we would add a qualifying question at the beginning of the survey asking the respondent which community they lived in. This would serve two purposes:

1. If we achieved a sufficient return, data could be broken down by geography.
2. We would be able to deduce that those living in the more remote regions and responding that it was not safe to walk alone in their neighbourhood at night would be referring to bears and cougars, not people. Also, that this did not in itself indicate it was not a good neighbourhood to live in.

What we found was that all the communities covered by our survey reported similar concerns, with only small neighbourhoods directly in the core of the District of Sooke not expressing this concern. An effective rural neighbourhood survey would require a

complete reworking of this module employing anecdotal input from residents of these rural communities.

We were particularly interested in *providing space for respondents' comments on the survey* as we wanted more of the stories. This was part of the original discussion between the committee members. However, once the survey was printed there was only one spot a written response to a question. There was little blank space for additional comments. We could recommend one blank page be part of the survey or a boxed area designated for comments. Respondents who questioned this aspect were advised to write on any blank areas they could find or attach a separate page.

Data Collection and Procedures

A major concern was to keep costs down without seriously undermining the integrity of the end result. Three main methods of dissemination were considered:

- Flyer Mail: sending the surveys out via 'flyer mail' would be the least expensive option but would miss between 30% & 40% of residents according to the Sooke Post Mistress. Statistically the people who request 'no flyer or junk mail' are generally the higher educated portion of the population and the very people who are likely to fill out a survey of this type.
- Door-to-Door Delivery: hiring students to go door-to-door delivering the surveys was explored. This would have the benefit of directly involving youth, and providing employment opportunities for youth. The vast area covered by our process was a drawback as well as the number of adult volunteer hours that would be required to orchestrate this method.
- Addressed, Stamped Mail: This would be the most effective method to reach households *if* we could get addresses, but would also be the most expensive. Partially due to privacy regulations we would not be able to obtain these from any governing body nor Canada Post.

We aimed to have the surveys out in time to launch them at the Rotary Spring Fair & Auction on May 6th; well before Stats Canada started their census. We thought we could have the results in by the end of June and have a Community Forum in October. This timeline proved to be somewhat optimistic! In fact, the Community Health Survey ended up being the last of six surveys done in our region during the period March through August (Community Health Mapping, Stats Canada, PHSSA, Inter-Tribal Health Authority, Child & Youth Resiliency Survey, Juan de Fuca Electoral Director's and our Community Health Survey). Although the majority of the people we had direct contact with took it all in stride, we undoubtedly would have had an even better return rate without so much competition for people's time and attention.

Getting The Word Out

We knew that in order to increase community uptake of the survey we had to get the word out. The community needed to be fully engaged ahead of time. The Knowledge Transfer Group was formed to manage communication with the community, translate data into information, garner enthusiasm and support for the project and work with an event

coordinator to plan the Community Health Forum. The group determined that we needed to *create a logo and media campaign to raise awareness* of our project. We felt this would lend an air of professionalism and continuity to our project so that when people saw the logo they would link it with the project. We had to constantly remind ourselves that this was a regional project and it was difficult to find language that conveyed that. The initial name of the project "Healthy Sooke" did not convey that regional identity so we came up with 'Community Health Information Project' (CHIP) tying in with 'CHI'. We worked with a designer to create our logo of a paint brush with the swath of paint breaking down into binary code to represent our data collection.

The first order of business was to contact the local newspaper and make arrangements to have regular, affordable advertisements with consistent content. We also were looking for periodic coverage of the project.

We considered looking for sponsorship but were able to come to generous agreement with the publisher of the Sooke News Mirror for 2 columns by 5 inch display ads that they would match during peak points in the process, resulting in a doubling the advertisement size. We paid for approximately 28 weeks in advance with the plan to use these ads bi-weekly to pique the communities' interest, keep them informed of the process and have enough space to share the results. We ended up putting almost weekly ads, with the Publisher sponsoring a doubling of the size in several issues. We also looked towards our regional newspaper, the Victoria Times-Colonist, for coverage and support; we sent them press releases and made telephone calls to health reporters but were unable to interest them in our project.

Local knowledge is critical to successful communications strategies. It is helpful to have long standing members of each community on your committee; even if they don't directly know the person you want to contact for assistance or information, they are likely to know who to ask. It can be beneficial to involve someone born and raised locally. We were fortunate to have a member who had lived in the community for over 30 of her adult years. Knowing the stories and history behind the issues is always an asset, particularly when a community is in a time of rapid change. A wide range of local knowledge allows for a broad base of contacts and resources.

Additional Methods of Connecting with the Community

- We utilized *personal follow up to increase response rate* and continued to broaden our membership people came to see the value in our project.
- Our membership consists of many well-known and approachable residents. Wherever possible *we emphasized local creation and ownership of the data.*

- One of our members, also a member of the Sooke Fall Fair Committee, proposed a 'Healthy Community' theme to that Committee. They were eager to adopt the theme as it relates to agriculture and to support our project. The Fall Fair committee applied for and received a District of Sooke for a Grant in Aid to add 8 pages to their catalogue with information about 'Healthy Communities' & our project (see Appendix 3(f), to increase their signage and to cover the keeper trophies and prize money for categories that would be developed in each section on the 'Healthy

Communities' theme. Decorations around the fair reflected various aspects of a healthy community. A large display was created to promote "A Healthy Economic Community – Part of the Equation". A Fall Fair member went around the commercial core of the District of Sooke taking pictures of businesses with the store-owners and employees standing outside waving. This was well received by the community members and businesses alike. Having people in the pictures 'humanized' the business and made them more interesting. From this display the editor of the local paper 'The Sooke News Mirror' went on to create a business promotion display ad using similar photographs and entitled "Here for you".

- A popular annual event in Sooke is the Rotary Spring Fair & Auction at which various businesses, artists and non-profit organizations host display booths. The event is well attended by the public. Our group set up a display at which committee members connected one-on-one with community members. All members who staffed the booth felt this was a very worthwhile endeavour and contact was made with some individuals who later became CHI members.

- It was discovered late in the process that the three First Nations Bands in our region each have a newsletter that goes out monthly or bi-monthly. They advised that they would have been happy to print our information. This is a valuable resource for involving the First Nations people in future projects to ensure the survey is distributed to both reserve and non-reserve members.

- Closer to the survey being mailed, we produced posters that were placed on every notice board and distributed in many business windows and staff rooms. A member spent part of two days walking around the village core distributing the posters and talking directly to business owners and community members. We also sent a representative out to Port Renfrew for a day of putting up posters and talking to business owners, the Pacheedaht Community Health Representative, and various community members. While she attended at the Beecher Bay Band office as well, making little direct contact, the other communities in our region do not have a structured core to make this type of contact. Posters were displayed at any location we could find, i.e. rural mailboxes.

- We also received complementary space to advertise the forum in the Edward Milne Community School Program guide that was published in September. This excellent facility would be the site of the Community Health Forum.

- A week before the survey mail-out we contacted as many community groups as we had manpower to cover, to talk to their group or a representative and explain the relevance and importance of the project to their group and the community as a whole.

- One member attended the Canada Day event wearing a 6" button that said 'Go ahead – Ask me about the Community Healthy Survey'. While a few people did speak to her, mostly it drew smiles. A booth or table at this event would likely

have been more productive. The problem with this was finding enough volunteers to staff it on a major holiday weekend.

- A 'Fact Sheet' was developed giving an overview of the Community Health Initiative and the survey project including goals and planned outcomes. This information was distributed by hand and emailed to as many groups as possible.

- During the mail out process we had three volunteers staff tables from 3:00 – 6:00 p.m. in front of the 3 largest stores in the Sooke Community: Village Food Stores, Western Food Stores & Sooke Home Hardware. These people had a copy of the survey, our 'Fact Sheet' of details and a few posters. They also used a little humour by printing a sheet that said 'We are not selling nor collecting'. One volunteer ran with the humour, taped it on his chest and back, and had a lot of fun while effectively getting the message out. All three volunteers felt the effort was productive and generally considered good public relations. We have six separate communities in our region, the District of Sooke being the most densely populated and having the core facilities. With the other areas spread out, unless there was a large community event coinciding with the mail out process, it did not seem feasible to do something like this in each community, Port Renfrew being the possible exception.

We used many different methods of connecting with the community, some of which were more effective than others. In order to *make it easy for people to find us* and be as approachable as possible we rented a postal box, set up an email account and one member authorized her telephone number to be used. All three forms of contact were put in newspaper advertisements as well as press releases and posters. The postal box received nothing during the whole process. The email account CHIPCOM@shaw.ca added professionalism and continuity to information being sent out and we did receive a few requests for information. Using someone's personal and business telephone number was a risk as we did not know if this person would be inundated with calls. In fact it was manageable and most people were satisfied with being called back if it was not a convenient time for our representative. Several people (approx. 24) did use this method to request information and/or express their views. The comments below are from telephone calls, emails and general conversations on the street:

- at least two people phoned to say they felt 'disenfranchised' as their partner had the nearest birthday and they wanted to fill out a survey as well.
- At least three people phoned to say there were not enough questions directly concerning seniors on the survey (i.e. costs of health care, food, etc.).
- One woman in the Shirley Community expressed her concerns that the results may be swayed as this area has a lot of non-resident home owners, however she did not feel it was of value to us to have her fill out the survey either!
- A number of people expressed concern that there was nowhere to make comments. This was supposed to have been the case with this survey so they were advised to write on any blank spaces or attach another sheet.

- Several people complained about so many questions regarding income. Some were satisfied once we explained the relationship between health and income, others remained wary.
- A few said they would only be filling in portions of the survey
- At least two expressed concern as they were supposed to fill in the survey but their partner had a lot of health concerns and they would be missed.
- A number of people expressed concerns that the survey related only to the person filling it out, not covering the health and wellness of their household effectively.

The Mail-Out Process

Recommendations:

- ➢ When using B.C. Assessment Authority street addresses, have someone review the list to ensure the full area is covered. General descriptions such as 'the same area as the last survey' may not be accurate.
- ➢ It is important to review all mail-out methods with the Post Mistress/Master in advance, even the ones you may not be considering.
- ➢ Adjustments need to be made for P.O. Box, General Delivery and First Nations Reserve addresses.

We had no way of obtaining names and addresses to send the surveys out 'addressed mail', so our original plan was to use flyer mail to every household and obtain a Business Return Mail account from Canada Post in order to include a self-addressed, stamped return envelope with each survey. Although 'flyer mail' offered a less expensive method of mailing, it had limited reach because of the number of people who restrict its delivery. Another method we talked about was the possibility of paying students to hand deliver surveys. The vastness of our region, the amount of set up and follow up, together with questions on the reliability of the data meant this option was not viable.

The inclusion of 'self-addressed, return envelopes' with each survey would increase the likelihood of surveys being returned even when using flyer mail. We applied for and obtained a Canada Post Business Reply Account. Once the Vancouver Island Health Authority was involved with the process, they offered to arrange distribution, collection and processing through B.C. Stats. This would have been a huge undertaking for us to do on our own, both in terms of time and cost, so we enthusiastically accepted the offer. VIHA through B.C. Stats had the authority to obtain street addresses from B.C. Assessment Authority, generally eliminating businesses and vacant land, which was a major benefit over using 'flyer mail'. VIHA's handling of the mail out process included the use of a Business Reply Account, making ours redundant.

Methods Of Mail-Outs Utilized

<u>B.C. Assessment Authority Addresses</u>

There are two options when using addresses obtained through B.C. Assessment Authority. The first is utilizing the addresses used to mail assessment notices to property owners.

This option would not be effective for our purposes as property owners are not necessarily residents and this method would not connect with renters.

The second option was using the street addresses of each property that has a dwelling on it, excluding commercial properties. This method was chosen as it connected with the majority of the population. There are pros and cons to every method and we will attempt to set out the major points for and against each method as we ended up using some of each.

A major advantage of using street addresses, over mailing, was that renters would be surveyed. Also, with the street addresses on the envelopes the surveys would be considered ‘addressed mail’ by Canada Post and even people who had requested 'no flyer mail' would receive a survey. It would have been preferable to have names on the envelopes but there was no way of obtaining these under current privacy legislation.

A note for future reference: The surveys were sent out addressed to 'Occupant'. We feel that ‘Resident’ or ‘Dear Resident’ would have been preferable as many people were likely to dismiss even addressed ‘Occupant’ mail as been too generic. A disadvantage to using ‘Occupant’ or even ‘Dear Resident’ with an address is that our postal system is a rural delivery system and for concentrated areas of population all residents receive their mail via post office boxes. Surveys to any other resident that chose to use post office boxes as well as most areas of the village core were 'undeliverable'. Post Office Boxes are linked to names, not to street addresses therefore there was no way to correlate the street addresses to the correct mailing address.

We were able to overcome this with the cooperation of our Post Mistress. We were given back all 'undeliverable' envelopes and allowed to cover the address and any hand writing on the envelope (from the postal workers). We covered the same with a label that read only 'Dear Resident' then the envelopes were re-submitted to be put in each residential post office box.

A similar process was used for all Port Renfrew addresses as people there receive their mail via general delivery. The labels on approximately 140 envelopes had to be re-addressed with 'Dear Resident, General Delivery, Port Renfrew, B.C. V0S1K0’. General Delivery addresses are also linked to names and not street addresses.

Another serious problem with only using B.C. Assessment Authority street addresses, that we did not realize for some time, was that the First Nations Reserves are not included. If we had realized this in advance, we could have made arrangements with the Band Administration. We have since learned that each of the First Nations Bands in our region have a monthly newsletter in which we could have submitted information on the survey process. The Band Administration has been very helpful in problem solving and connecting with their members to complete the survey. This information will make future surveys more effective and undoubtably produce a much high uptake by First Nations peoples.

Switching to Flyer Mail

We encountered another glitch in the mail-out process on the day the surveys arrived at the Sooke Post Office. Unfortunately, the full extent of the problem was not understood for several days causing delays in mail-outs for some areas and creating new problems to handle. It was our understanding that the surveys were to be mailed to "the same research area as the PHSA telephone survey". What was received for distribution turned out to be only the District of Sooke, with the exception of a couple of roads in East Sooke (Mt. Matheson Rd. & Silver Spray Drive) & one road in Otter Point (Otter Ridge Road). However, because one of our members lives on King Road in Otter Point and her household was telephone surveyed but not on the mail-out list we received from B.C. Stats, we were alerted the problem. We would recommend for future projects that the mail-out list be reviewed by a longstanding resident on the committee, not to check accuracy but to ensure that major areas will not be missed. Despite the set backs of dealing with post office boxes, *if addresses had been obtained for the full research area, the street address method would undoubtedly have been the most efficient process to use throughout.*

The original printing of the survey was based on the number addresses obtained from B. C.Assessment Authority via B.C. Stats. We had also requested 800 surveys to be used when connecting with the disenfranchised in the region and anyone else who did not receive a mailed copy. We were advised to track all surveys that were completed by methods other than the mail out process. One reason expressed for this was that using surveys from other methods could ‘contaminate’ the data. However, there was interest from the Ministry of Health and VIHA to see how effective these methods would be.

Once the omission was noticed we felt there would be too much of a delay in obtaining addresses for the outlying areas so chose to send the remainder out by 'flyer mail', requiring another 1800 surveys to be printed. Flyer mail is fraught with problems in that the Rural Route areas overlap the District of Sooke boundaries by approximately 700 houses, thereby duplicating delivery and increasing printing costs. Also, between 30% & 40% of households have requested no flyer mail and would not receive the surveys this way. These envelopes went out with no label on the front, simply the CHIP logo.

One advantage to this method was that we 'caught' a number of the First Nations Reserve residents, mostly because they fell in the overlap area. One reserve located in the center of the District of Sooke boundaries was missed completely, and this is when we finally discovered the full extent of that omission.

In order to catch up with missed residents we advertised in the local paper about the mail-out problems, as well as putting up posters on postal boxes in the missed areas. To facilitate access, we supplied boxes of surveys, with posters on them, to 9 business locations in the survey area : 4 in the Sooke Village core and one each in East Sooke, Otter Point, Shirley, Jordan River & Port Renfrew. These were available for two weeks and then removed.

For the four First Nations Reserves we had a contact person in touch with the Band Chief and Band Administrator. Arrangements were made between those people as to what would best work with their group to obtain the most input from residents. The T'Souke Band is made up of two reservces within the District of Sooke. The Community Health Representative made one-on-one contact with as many members as she had time to connect with to complete surveys. At the Patcheedaht Band, the Community Health Representative used the same method. With out the direct contact with members of Beecher Bay Band council we did not have any surveys returned from this band.

Other Contact Methods

From the beginning we wanted to find a way to connect with those people often missed by conventional survey processes – those without mailing addresses and telephones and those with problems which prevented them from receiving or completing a survey of this type.. In addition to the surveys at various locations in each community, we attended at 'Vital Vittles' a free lunch program in the District of Sooke to talk to people about the survey and offer assistance in completing it; we completed approximately 12 surveys this way. Members of the Port Renfrew Community Association were happy to offer the same service to people in their area; they completed approximately 20 surveys.

We had phenomenal cooperation from the Post Mistress. This can be key to having the whole process work no matter which method of mail-out you use. Without the help of our Post Mistress we would have missed all residents with postal boxes, all of Port Renfrew including the Pacheedaht, and not been aware of the overlap when switching methods. She is the one who alerted us to the possibility of a problem with the mail out coverage and our source for the percentage of residents who do not accept flyer mail. It is advisable to have someone take the Post Mistress/Master out to lunch to discuss all possible options and the potential pitfalls of each method well in advance of conducting a similar survey.

Despite the difficulties we encountered, we had a 27% return rate, which is rewarding especially considering the experts predicted we would be 'lucky to get 10%'. This high return is consistent with a generally higher rate of voting in municipal elections (41% compared to a 31% provincial average) and in provincial elections (70% vs. 62 % provincial average).

Additional points that need to be considered with future mails are as follows:

- When using B.C. Assessment Authority street addresses, have someone review the list to ensure the full area is covered. General descriptions such as 'the same area as the last survey' may not be accurate.

- It is important to review all mail-out methods with the Post Mistress/Master in advance, even the ones you may not be considering.

- *Analyze the cost and coverage of survey distribution options*

- Adjustments need to be made for P.O. Box, General Delivery and First Nations Reserve addresses.

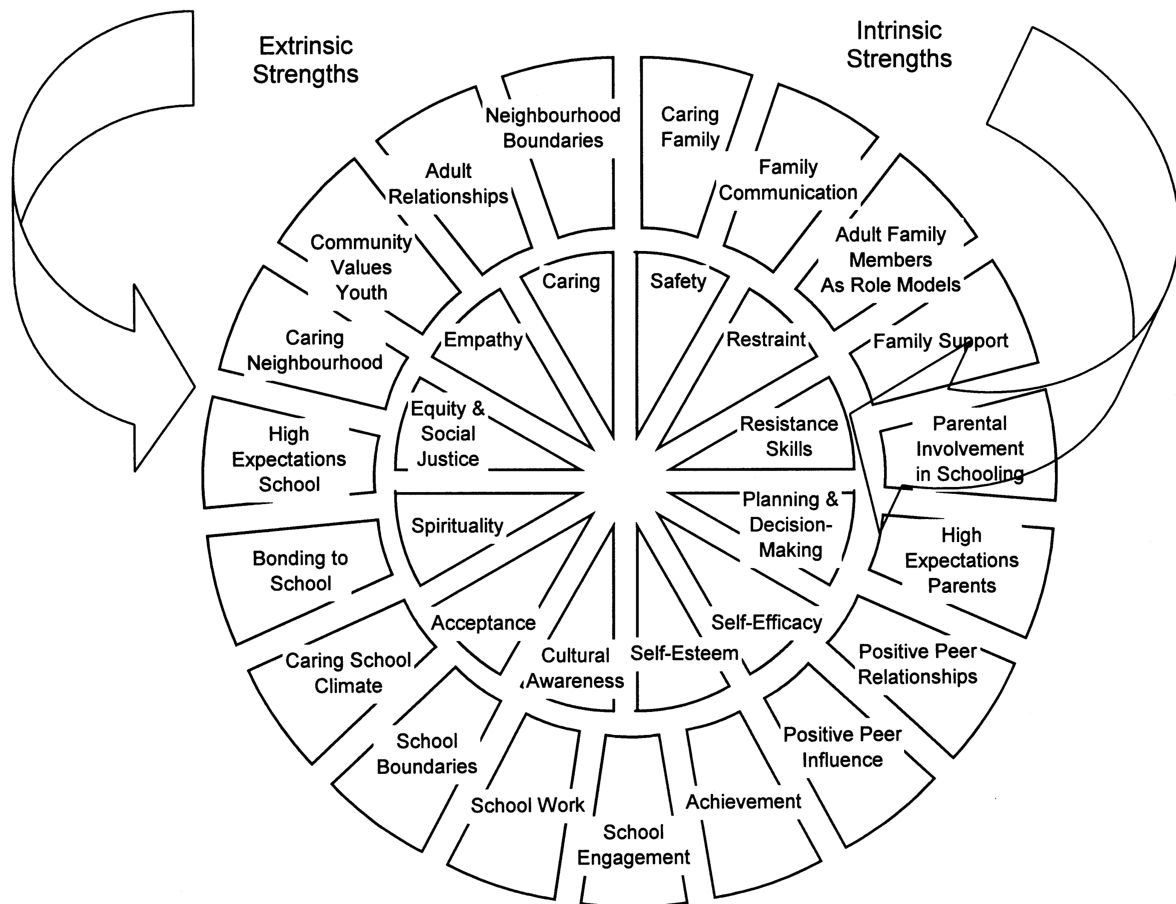
- *Budget for a support staff to oversee the process*
- *Take advantage of seasonal & cultural community rhythms*. When possible coordinate your project with community events that are well attended. When you have diverse cultural communities within your research area it can be helpful to consider their calendar of events as well.
- The mail out stage of the process is particularlya good time to have a paid person to handle any glitches which could develop. This is a crutial point in this type of project and the whole process could be stalled unless someone is ready and able to problem solve and keep things moving. At the very least the return rate would have been disappointingly low and we might never have realized we had not surveyed the intended region.
- This is also a good time to *make and sustain early contact with Health Forum's speakers and key participants.* Waiting until you start to receive responses and analyse the data can be too short of notice for Key Speakers and dignitaries.
- For tracking purposes, the survey number must be on the outside of all of the envelopes. We were asked to track each survey that was redirected in some way. Each survey has a number on the survey itself and a different number on the envelope. The first printing had the number on both envelopes. The tracking process was labour intensive when dealing with the first printing. For the second & third printings it was more so as the number was only on the return-address envelope, requiring someone to open the outer envelope and remove the return-address envelope to find the tracking number.
- Also for tracking purposes, envelopes should be in boxes in numerical order, or at the very least in numerical batches with the beginning and ending numbers recorded on the box. Mail being sent out as 'flyer mail' must be delivered to the post office in batches of 50 or 100. If using this method surveys should be received in such a way as to make this easy to record.
- Although we did track where and by what method the surveys were delivered, this information was not used. It should be confirmed in the beginning whether this is necessary, why, how and when it will be used.
- All outer envelopes should be sealed to ease delivery by postal workers. On rare occasions the inner envelope was separated from the survey due to the outer envelope not being sealed and subsequent handling. The addressed envelopes in the first printing were all sealed and it was the second and third printings that were designated for 'flyer mail' and those designated for 'other methods of delivery' which were not sealed.

Once we received an adequate number of completed surveys, the information was analyzed and the resulting data returned to CHI for presentation to the community. In addition to the forum, our intent is to have information posted on an interactive web site where interested parties can access information relevant to their concerns.

3.3. *Child & Youth Resiliency Survey*

A major undertaking in this project was the completion of Resiliency Canada's *Child/Youth Resiliency: Assessing Developmental Strengths* survey. With co-funding from the Sooke School District, and the VIHA Population Health Surveillance Unit, the survey was administered to 1084 students in Grades 3-12 in June and September 2006. These surveys have been administered to over 60,000 students in Canada. The surveys revealed what youth think about their lives, values, opportunities and relationships with peers, family, school and community. The comprehensive surveys yielded a wealth of information and identified a number of key community issues and concerns.

Child and Youth resiliency can be defined as the capability of children and adolescents to cope successfully in the face of stress-related, at-risk or adversarial situations. The 31 developmental strengths framework identifies the protective factors that encourage and enhance the wellbeing and development of all children and youth in our communities.

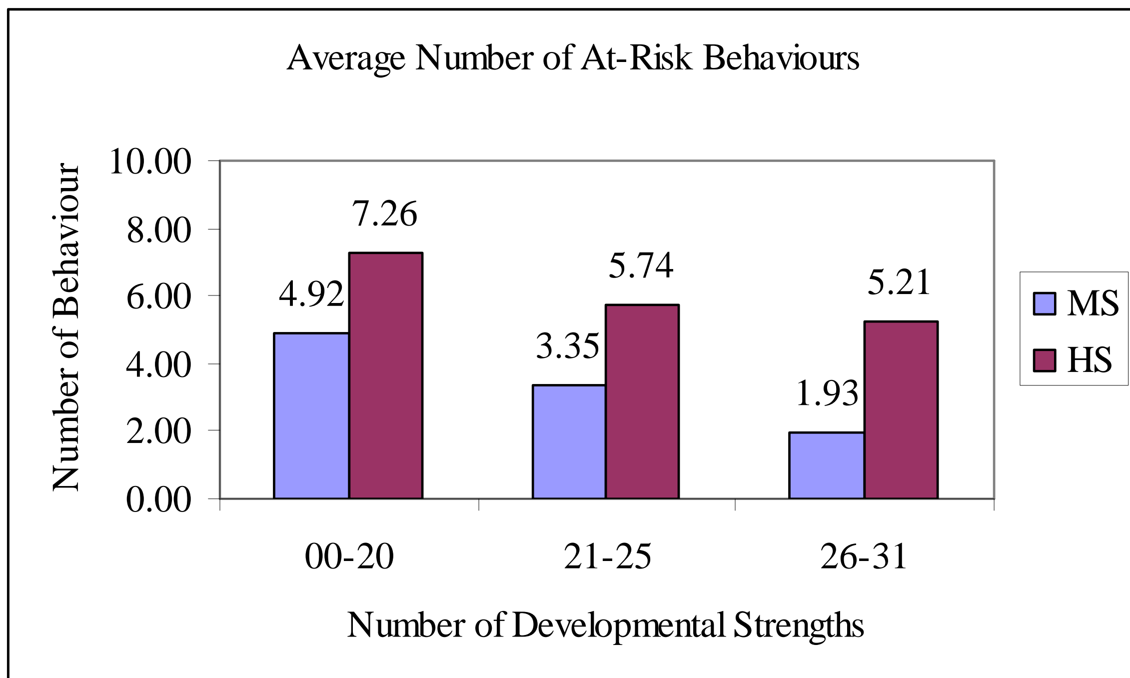


It directly links the number of assets to pro-social behaviour and risk-taking behaviours. The greater the number of assets (from 0 to a maximum of 31) a young person develops, the more likely they are to engage in pro-social behaviour and the less likely they are to engage in risky behaviour.

Dr. Wayne Hammond from Resiliency Canada met with staff, parents and community on November 14th to present the report. The results were clustered into three groups: Elementary (Grades 3-5), Middle (Grades 6-8) and High School (Grades 9-12). The children and youth surveyed have on average 26.4, 25.3 and 21.5 of the 31 developmental strengths respectfully. Resiliency Canada encourages that all children and youth have at least 21.0 strengths; 10.8% of the elementary school sample group, 14.1% of the middle school sample group and 38.8% of the high school sample group fell below this level.

Students of all ages scored highly on *intrinsic strengths* such as empowerment, self-control, self-esteem and social sensitivity. The development of these factors depends largely on *extrinsic strengths*—the degree of support and quality of relationships that children and youth have with family, peers, teachers and staff in schools and the community at large. Together these two components form a measure of resiliency.

Children and youth who have a higher number of developmental strengths are considered more resilient and less likely to engage in risky behaviours. The questions on risk were omitted from the elementary surveys to alleviate concerns by teachers and administrators about their age appropriateness so the results cannot measure against risk for that sample group. The chart below shows how important resiliency factors/strengths are to youth in helping them to restrain from risk-taking behaviours. The average number of 10 risk-taking behaviours from all children/youth surveyed are grouped by six strength categories (0 – 20, 21 – 25, and 26 – 31). There are 14 questions that measure risk-taking behaviours such as substance abuse (alcohol, tobacco, and illicit drugs), antisocial behaviour, violence, school problems, and gambling. The research consistently demonstrates that youth with higher resiliency factors and developmental strengths are less likely to be involved with a number of risk-taking activities.



This proved true for nearly all the risk behaviours except a few notable ones. Interestingly while only 34% of Grade 9-12 students had not used alcohol, only 32% had not consumed enough alcohol at once to induce a state of intoxication and only 46% had not skipped school, neither the use of alcohol nor truancy diminished in students with higher resiliency. This is unlike the results from other schools across Canada. One possible explanation is that youth do not think that these behaviours place them at risk because the excessive use of alcohol has been normalized in the community.

The other extraordinary finding was that 50% of the middle school sample and 92% of the high school sample watch television or videos more than three hours and play video games or surf the Internet more than three hours in a typical weekday. This activity correlates negatively to the degree of resiliency. In previous surveys and forums youth have lamented the lack of youth recreational and social programs in the community. This combined with the physical isolation of a geographically disparate community may account for this interesting statistic.

The table below shows that relationships with community present the greatest opportunity for action—only 53% of the high school sample described their neighbourhood as caring, only 33% felt that the community valued youth, and 42% thought the community set clear boundaries for behaviour. Meaningful relationships with adults like coaches and group leaders are lower across the board with only 26% of high school respondents citing this as a strength. The school culture provides similar opportunities. While 76% of the high school sample indicate the school's expectations of them are high, only 36% of them rated their school climate as caring. Bonding to school appears begins to drop in Grade 8 (60).

Resiliency Factors	**Strengths**	**E**	**MS**	**HS**
Community Cohesiveness	Caring Neighbourhood	79	75	53
	Community Values Children	81	70	33
	Adult Relationships	66	60	26
	Neighbourhood Boundaries	72	62	42
School Culture	School Boundaries	94	95	65
	Bonding to School	84	78	55
	Caring School Climate	86	83	36
	High Expectations School	97	96	76

From time to time, most youth experience considerable stress, hardship and misfortune as a result of various personal and/or situational experiences. While some of these youth may

develop serious and long-term problems, a greater number grow up to lead healthy and productive lives. Working from this strength-based model of understanding child development helps us understand the strengths that are related to long-term resiliency. Developing these strengths in youth requires a collaborative effort. CHI will be consulting with parents, community and youth themselves to gain a better understanding of what these results mean and how to use the opportunities they present.

Based on our experience, we would recommend that other groups who wish to conduct this process:

- Budget for a support staff to oversee the process
- Identify how the survey results will be of value to the School District and to parents
- Get a *formal* sign off on questionnaire content and process from School Board, Principals and District Teaching Association representatives
    - Check to see if your local School District has a research protocol
    - Attend staff meetings to introduce the project to teaching staff
    - Ensure that survey results are personally presented first to the Principals and then staff, parents and students (as appropriate).

OUR EYES: what we saw in our community

The communities that make up our region are varied and range from urban to very rural areas. We are loggers and fishermen, musicians and artists and bureaucrats. Some of us have been here for generations, and all of us are adapting to a surge of growth and a rapidly evolving economy, both within our community and in the region.

The Sooke Region is growing rapidly. We are demographically younger than Victoria with significant increases in school enrolment at all levels. This is one of the few areas in the province where the school enrolment has not declined! It is anticipated that this growth in population will continue as new subdivisions and homes continue to be built. Currently the estimated population is 14,993 (BC Stats 2005 data).

Based on the 2001 census:

- The median age of a citizen of the region is 38.6 years (half older / half younger)
- There are more children less than 10 years old than seniors aged 65 and over
- About 46% of people changed residence at least once in the last five years
- 40% describe their ethnic origin as 'Canadian', another 24% say they are English followed by German (8%), Scottish (7%) and 4% each for Aboriginal, Irish, and French.
- 54% of adults aged 15 and over are legally married; 9% are living common-law, 10% are divorced, 6% are widowed; the rest (21%) are single (never-married)
- among 2160 couples, 49% have children at home and about half of these couples have two children
- there are 480 lone-parent families with about 70% having one child

SOOKE POPULATION >20 YEARS BY HIGHEST LEVEL OF SCHOOLING		
% with each level	Sooke	BC
Less than high school graduation	26%	24%
High school graduate	15%	12%
Trades certificate or diploma	18%	13%
Attended college	24%	25%
Attended university	17%	27%

- 42% of those employed work in Sooke
- 14% live in poverty
- 79% own their own homes

Sooke is well serviced by local community groups and organizations and enjoys a first class recreational facility. As in all communities however, there are areas and populations who are not as well served as others. While some communities have easy access to recreational services and safe streets, other areas experience challenges. One of the bigger challenges appears to be public transportation. Transportation is also an issue in the School District, where all Sooke students are bussed to school and students from Port Renfrew spend an average of 2.5 hrs/day on the school bus. Issues such as youth access to social and recreational activities, access to local supports and services for people with mental health and addiction issues and housing for vulnerable seniors have been problems for many years.

Sooke has changed a lot in the five years since the 2001 census. We hear more stories of citizens unable to access adequate food, affordable housing, or healthy activities for their families. More and more youth seem to need community supports and interventions. It has been difficult to find current local data that could help our communities substantiate these anecdotes and plan and advocate for health.

The Population Health Surveillance Unit, Office of the Chief Medical Health Officer, of VIHA, prepared a Community Health profile for us that focused on the extent to which our Local Health Area (LHA) compared to the BC average. CHI reviewed these results in August. Some of the areas of concern were identified where we were rated as poorer than the provincial average:

- % of 18 year olds who did not graduate (38% above BC average)[3]
- % of Grade 4 and 7 students below standard in writing (41% above BC average)[4]
- % of children in care (28% above BC average)[5]
- % of potential years of life lost (PYLL) through smoking related diseases among persons <75 (32% above BC average)[6]
- % of owners spending more than 30% of income on housing (8% above BC average)[7]
- pregnancies among girls aged 15-17 per 1000 girls 15-17 (8% above BC average)[8]
- pre-term births with gestational age <37 weeks per 1000 live births (20% above BC average)[9]
- hospitalization rates for injuries / 1000 children aged 0-14 (27% above BC average)[10]

[3] 2003-2005 – BC Stats
[4] 3 year average 2002-2005 – BC Stats
[5] December 2005 – BC Stats
[6] 1998-2002 – Ministry of Health Services
[7] 2001 Census
[8] 2002-2004 average – BC Stats
[9] 4 year average 2000-2004 – BC Vital Statistics Agency
[10] 2004/05 BC Stats

- hospitalization rates for respiratory / 1000 children aged 0-14 (32% above BC average)[11]

Sooke currently has 6 family physicians (5 on-call physicians) serving a population of about 17,000 people from Port Renfrew to East Sooke. The Sooke physicians presently provide a full range of family practice services including full spectrum family practice, chronic disease management, maternity, domiciliary palliative care, hospital and nursing home care and 24/7 primary on-call coverage, in two private offices in Sooke.

The most pressing issues Sooke Family Physicians currently face[12]:

1. The high patient load per doctor challenges them to find the time and resources necessary to deal with the complex care needs of many patients; Physician burnout is a very real issue, and we have lost 3 full time physicians in the past decade due to these pressures.
2. Interdisciplinary "team care" is not available as the funding system does not support new information technology or the utilization of nurses for more comprehensive services;
3. There is limited access to specialist (both physician and non-physician) care locally and regionally, thereby limiting the ability to provide best-practice chronic disease management;
4. Limited physician access to the benefits of computerized patient healthcare information;
5. Patients are challenged by frequently having to travel to Victoria for many standard services including after hours or weekend lab or x-ray services, any ultrasound, most diagnostic imaging, most mental health services and all specialty care.
6. Specific to this community is the difficulty in the recruitment and retention of physicians due to the distance from Victoria, distance to the nearest hospital, lack of associated healthcare professionals and the demanding on-call schedule. This is reflected in the high patient to doctor ratio.

If these issues are not addressed, the community will likely experience:

- Further degradation of the primary care delivery system
- Increase in orphan patients
- Increase in health care costs due to chronic disease
- Unnecessary suffering of patients with chronic disease
- Unnecessary transfer of patients to emergency rooms to access after hours lab, ECG or X-ray
- Potential further loss of physicians from the community

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[11] 2004/05 BC Stats

[12] derived from physician and community member interviews & meetings over the past 2 years

The results of the Community Health Survey supported the difficulties of access for local citizens. 391 (29%) respondents reported not receiving care when they needed it at some point in the previous 12 months. The reasons given were:

- Not available in area (161)
- Not available at time required (194)
- Wait too long (181)
- Felt it wouldn't help (70)
- Cost (110)
- Too busy (86)
- Didn't get around to it (68)
- Didn't know where to go (44)
- Transportation problems (69)
- Personal/family responsibilities (76)
- Lack of trust/fear (72)
- Decided not to seek care (69)

OUR EARS: what the community told us

A Community Health Forum entitled: "TODAY'S INDICATORS---TOMORROW'S SOLUTIONS: HARNESSING THE POWER OF COMMUNITY TO IMPROVE OUR HEALTH" was held at Edward Milne Community School on Saturday, September 23rd, 2006 in order to report the results of the Community Resource Mapping Project, the Community Health & Resiliency surveys, and to garner public input.

We wanted to give community members the opportunity to provide some of the stories behind the data, to ask further questions of the data and to establish health priorities using the information collected in the surveys. There were speakers, presenters, and opportunities for individuals to ask questions and respond to the information provided. The information from the forum was assembled into a printed report that appears in Appendix 8.

It is always difficult to estimate public attendance at events such as this in advance, even with RSVP requests with each invitation. We contacted all of the community groups involved in the Mapping Process as well as any other businesses, groups, and individuals who might be interested in the results. Initial contacts to collect essential information were made by telephone, but invitations and updates were sent by email to control costs.

We set out to be as inclusive as possible and explored the option of paying for childcare but found costs to be prohibitive, especially since we had not budgeted for it. We contacted two facilities in the community to see if they could donate licensed daycare providers. There was some potential here but we learned that we did not need to have licensed personal on hand as the parents would be on site. We could use volunteers. Sooke Family Resource Society was able to recommend a couple of great people who were happy to help out. We were able to offer 'child minding' services through volunteers. Providing child minding, lunch and refreshments permitted people to stay at the facility for the day. Although 3 families indicated they would be attending with 3 children under the age of 3 and possibly one more child slightly older, no families attended the event. Though this was a big disappointment for those involved we still felt it was better to be prepared. Our two youth volunteers chose not to stay, but the adult volunteer joined the forum and participated in other capacities.

We are fortunate to have an excellent facility in the community of Sooke at the Edward Milne Community School. There is a theatre with seating for 350 people as well as break out rooms. The School's 'Culinary Arts Program' caters on-site so food and refreshments are not an onerous task. The theatre is equipped with a large screen and projector so the only special equipment we needed to provide was a laptop computer with enough memory to handle the Power Point presentations. A student technician ran the lighting and sound equipment. Custodial clean up is also part of rental so was not a drain on our volunteers.

Over and above the Forum Coordinator we needed volunteers:

- to run the daycare (minimum of two, full amount dependent on ages and numbers of children attending)

- two people to check in attendees and give out the forum handouts; these people also helped with refreshments at the morning break and then were free to participate in the forum and workshops.

- liaison with the Facilities Coordinator who is familiar with the building and location of any last minute equipment.

A week before the Forum we sent a press release out to every newspaper, radio station and television station in our region. We were contacted by CBC and CFAX1070 radio for interviews which were aired and Village900 radio read portions of our press release.

Just days before the forum the idea of having the event filmed was brought up. Luckily a member of our community runs a web site and does filming of community events. She was approached and offered a reasonable rate to film the morning presentations, an overview of what was going on in the focus groups, and then the final coming together and conclusion. The forum was recorded on two unedited CD's.

Our local newspaper sent a reporter to the end of the event to interview a couple of the speakers and our Project Coordinator. They ran a half page article the week after the event. However, they missed our regular paid ad the week before the event so there was nothing in that week's paper as we were unable to convince the editor there was enough community interest to run another editorial before the event.

We contacted the Chief of the T'Sou-ke First Nations Band to open the Forum and the Chiefs of the other two bands to say a few words as well. The Chief of the T'Sou-ke Nation sent her representative, though prior commitments kept the Chiefs from attending.

Altogether 89 people attended the Forum. In the morning, participants were welcomed by a representative from the T'Sou-ke Nation, the Mayor of Sooke and a representative from the Vancouver Island Health Authority. Keynote speaker Valerie Tregillus, Executive Director of Chronic Disease Management and Primary Health Care Renewal with the BC Ministry of Health Services (and Sooke resident) spoke about the power of the community to change the system through relationships and compared the burden of disease in BC to that in Sooke. She left us with the message that "The best health system cannot mend the burden of illness created by poverty, loneliness and lack of education, but a community has that power".

Dr. Ellen Anderson, a CHI member and Sooke resident, described the Community Resource Inventory and gave a demonstration on how the website will work once it's up and running. Dr. John Millar, Executive Director Population Health Surveillance & Disease Control, Provincial Health Services Authority (PHSA) provided highlights from the telephone survey with comparisons to other places in the province. Dr. Murray Fyfe, Medical Health Officer, Population Health Surveillance Unit, Vancouver Island Health Authority provided highlights from the community survey.

We offered healthy refreshments and a portable lunch so that people would be free to move around for discussions and possibly take their lunch into the rooms for the focus groups. Lunch consisted of vegetarian wraps in a Chinese food type container, with trays of local

cheese and produce like plums, apples, grapes, cherry tomatoes as well as baked squares and cookies. We also had bottled water available.

After lunch, we broke into six different focus groups with participants choosing the topic that most interested them. We did not attempt to direct people to any specific topic. We arranged to have one long-standing CHI member head each of the focus groups as facilitator and had another volunteer to record their findings. Each focus group was provided with a flip chart and markers. The topics were:

> Social Networks & Resource Inventory: For those interested in promoting a spirit of community and support. Examples included: volunteering, social and support groups, recreation
>
> Child & Youth: for those interested in options for children, youth and families in our communities. Examples included: role models, safety, play spaces
>
> Food Security: For those interested in ensuring we have high quality, fresh food available in our community. Examples included: local markets, brown box programs, community gardens
>
> Primary Health Care: For those interested in exploring ways to fill the gaps in primary health care in our region
>
> Health & Economic Determinants: For those interested in the factors in our community that affect specific and overall health and wellness. Examples include: income, environment, education
>
> Neighbourhood & Physical Activities: For those interested in developing neighbourhoods to improve safety and overall health. Examples included: sidewalks, bike lanes, playgrounds, housing.

Upon completion of the workshops, each group put their priorities on flip charts in the commons area. Some groups had so many topics of interest that they had to prioritize and present only those items with the highest rankings. All participants had the opportunity to review the work of the other groups. Each participant was given ten red dots to spend on the priorities that they felt were most important to the health of the community. They were not limited on the number of dots that could be spent on one priority.

The priorities were identified as follows (in rank order):

1. Mental health and addiction services for youth (36)
2. To improve resources for, build capacity in, and improve relationships between organizations, and between organizations and the community at large (32)
3. Increased support (outreach) to families (27)
4. Accessible housing linked to economic status (27)
5. Collaboration of individuals and interest groups (recreation) (27)

6. Increased advocacy for sidewalks, bike lanes, paths and parks (24)
7. Increased awareness and visibility of social supports and resources (23)
8. Regional food security plan including land for community gardens (21)
9. Alternative learning opportunities to address low graduation rate (20)
10. One stop shop for primary health care (17)

The detailed notes from each of the groups appear at Appendix 7(c).

Recommendations for future events:

- When you make initial contact with any group or individual get all their contact information at the first contact, whether or not they participate in other sections of the process (i.e. the mapping process).
- Make contact with your prospective speakers and area dignitaries at the time of the mail out process, giving them ample time to schedule your event in. Send monthly updates to keep them informed and your project top of mind.
- After the event, we chose to purchase blank note cards each with a regional theme. Two members worked together to write a thank you and personal note to each of the presenters, facilitators and non-committee member volunteers. The three major coordinators each signed these cards which were then mailed.

OUR VOICE: recommendations for action

1) Strengthen community connections and relationships for children & youth

a) Improve access to mental health and addiction services

Over the past 16 months, the Sooke Navigator Project has begun to quantify and qualify the population of local youth and adults who need this service. 204 distinct clients were seen, of which 56 were youth, 148 were adults and 22 families. 61% of people were successfully linked to services; of the remaining 63 clients on whom service data is completed, the major barrier experienced to service (40%) was the unavailability of necessary service locally. This points out the frequent inability of clients to travel to service in Victoria (this reflects client capacity, transport barriers, time and cost of travel, inability to miss work, etc.)

The need for child, youth and family services is the largest gap in local service. Successful advocacy with VIHA and MCFD has resulted in service being locally available 2.5 days per week since October 1. The MCFD therapist is now full with a waitlist and VIHA youth addictions clinician is getting busy quickly.

In addition, we know that improving adult mental health and services for addictions will ultimately improve child health. 57% of adults and 14% of youth required addiction service. Adult clients in our community are well served however there is no medical back up so clients needing withdrawal management, medication management and medical supervision cannot be seen locally. Integration of local mental health and addictions service within primary care would improve care.

The Resiliency Survey data suggests that the excessive use of alcohol has been normalized in our community. Even youth who have high resiliency do not see drinking to excess as risky behaviour. A 2001 youth survey also describes alcohol and drugs as being "part of Sooke's culture".

b) Strengthen relationships between youth and adults including employers

Of the protective factors that contribute to child/youth resiliency development, community-based strengths receive the least attention and, subsequently, are one of children and youth's greatest needs for action. The community-related factor is essential to the development of resiliency strengths and consists of four developmental strengths: caring neighbourhood, adult relationships, community values youth and neighbourhood boundaries.

The Youth Resiliency survey showed that only 33 % of youth felt that the community values children/youth. In addition, only 26% of youth had valued relationships with adults and only 42% felt there were clear neighbourhood boundaries. In a 2001 survey by SFRS, youth reported negative perceptions by adults as a problem they were facing in the community. These findings present a clear opportunity for community action in this regard.

c) **Create alternate learning opportunities to keep youth engaged in learning**

Sooke has a relatively low local graduation rate (66% in 04/05 compared to a BC average of 75%). Many students leave school early. There is not a lot of solid evidence that points to any one reason for this but there is a suggestion that some students find traditional classes challenging.

Participants in SookeWorks Youth Employment programs have an average Grade 10 education and describe school as "not fitting for them". This lack of relevancy is exacerbated by social factors, alcohol and drug usage, the value their parents ascribe to education, and learning disabilities. The Youth Resiliency Survey also suggests that truancy is not viewed as risky behaviour by youth regardless of their level of resiliency; this is unusual when compared to a national cohort.

Alternate learning opportunities have been tried by the school, SookeWorks and the School District in an effort to improve student success and engagement. The Environmental Science and Culinary Arts programs are frequently cited examples of success. There needs to be further exploration in this area.

d) **Increase support (outreach) to families**

Since 1997, there have been an average of about 116 births per year to teen mums in the Sooke Local Health Area [1997-2004 BC Stats]. We know that this significantly increased last year. Often the people who need it the most do not try to access help; some of these families will need extra support to raise healthy children. One in three children in school are from single parent families [MCFD].

22 families have sought assistance through the Navigator project and 16 youth and family teams are taking part in Wraparound project; some youth have been unable to participate in Wraparound because their families are unwilling or unable to participate. Last year the School Based Social Worker provided early intervention, preventative services to 167 children, youth and families and discovered many family situations where there were severe behaviour and mental health issues for the child. The reality is that most times when a youth needs support, the family also needs support.

e) **Create safe, youth oriented recreation and gathering spaces**

There have been many local surveys with and by youth that have identified trends and programming gaps. An SFRS Youth Survey in 2001 described most frequent youth pass times as hanging with friends, listening to music and surfing the Internet; indeed, the Youth Resiliency survey data showed that 92% of high school students spent more than 3 hours on the Internet and a further three hours playing video games!

One of the developmental opportunities the SFRS survey identified was pursued by a group called PLAAY (Positive Leisure Activities and Assets for Youth); PLAAY worked with SEAPARC (Sooke Electoral Area Parks & Recreation Commission) to create more appealing recreational opportunities for youth at the SEAPARC Leisure Centre. An example of community response recently cited by youth as an example of not being valued is a local business removing their benches to deter youth from gathering and thus prevent vandalism.

2) Strengthen collaboration between community service organizations

a) Improve resources for, build capacity in, and improve relationships between organizations, and between organizations and the community at large

This project proved to be a successful entrée into the community, connecting agencies in a way that has built trust, fostered collaboration and generally benefited the community. A general theme throughout the process and at the forum was how to get people from different groups thinking together. This is a stressful time of scarce resources and short-term program funding where trust issues, factions, defensiveness, turf protection and competition for funds get in the way of sharing information. Group leaders are under tremendous pressure and over-committed, have no time to meet and are seeking other ways to connect. It is hoped that the website will at least help bridge the information gap.

The survey showed that local citizens have a strong sense of community belonging[13]. We need to build on these strengths by exploring mechanisms that can serve and support the work of our local non-profit sector where 45% of our citizens volunteer. While local businesses have been very supportive, it is by nature episodic and there is a limit to what they can do. Ideas that were put forward include developing our own United Way, Volunteer Bureau, Social Planning Council or a like-minded interagency group; bringing together funders to make collaboration a funding requirement, creating a local "social tax" with its own mil rate to establish a reliable resource base, encouraging citizens to identify and donate to local charities and putting forth these recommendations as a platform for citizen involvement.

CHI has organised a Community Research 101 workshop with Dr Ruth Elwood-Martin funded by VIHA on Jan 31st to bring community leaders together to look at some of the data that the project has assembled.

b) Develop an Active Community Plan for recreation

Recreation has been traditionally programmed by individual agencies like Sooke & Area Parks & Recreation Commission (SEAPARC) and the Edward Milne Community School Society. When asked what they had done to improve their health in the past year, 40% of survey respondents said they had exercised; 73% of respondents had participated in some sports in the past three months. The Community Health Survey results form an ideal resource from which to launch an Active Community Plan that could focus efforts on building capacity in the community and in individuals for regular physical activity.

SEAPARC will be gathering a broadly representative group to lead this initiative. Resources for planning and implementation are readily available through ActNow BC. The Active Communities Initiative is a commitment to improve physical activity levels of British Columbians by 2010.

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[13] Strong/Very strong sense of community belonging: East Sooke 45.2%, Sooke 55%, Otter Point 60% and Shirley, Jordan river, Port Renfrew 73.4%.

c) Increase awareness and visibility of social supports and resources

An analysis of the Community Resource Mapping project data revealed that 58 (40%) of registered groups reported having persons who had difficulty accessing their services/programs. The most-frequently reported barrier to accessing services/programs was "unawareness of services/programs"; transportation was also frequently cited as a barrier. Once it is up and operating, the CRD website will enable individual agencies to post and maintain accurate information that will be widely accessible by Internet. Additional methods of improving local knowledge of available services should be pursued.

d) Re-orient primary healthcare services to improve local access

The Community Health Survey showed that 391 (29%) of respondents did not receive care when they needed it at some point in the previous 12 months. The top barriers to access were: not available at time required, wait too long, not available locally and cost.

A population health approach to the provision of primary healthcare in the Sooke-Port Renfrew region is needed. An inter-disciplinary, collaborative healthcare practice would connect medical services with community health and social services. The team could provide comprehensive primary health services[14] over the lifespan of all area citizens including health promotion, disease prevention, acute episodic care, chronic disease management, screening, prevention, patient education, counselling, and palliative care with practice participants working in partnership with local community, social service agencies and the community at large.

In addition to improved care and access to care, this type of model would compliment the education, support and prevention services provided by the local non-profit sector to improve health outcomes for local residents, particularly for those with chronic diseases and complex illness. It would increase patient, provider and staff satisfaction and ultimately enhance the recruitment and improve the retention of family physicians and other primary health care providers in our community.

3) Create supportive physical environments for healthy lifestyles

a) Improve, develop and encourage the safe use of bike lanes, pedestrian pathways, and parks.

The need to develop and improve the pedestrian and cycling infrastructure was evidenced by the health survey. The results reveal that 65% of the respondents felt that there is not room to safely walk in their neighbourhoods, 73% of respondents felt that there is not room to safely bike in their neighbourhoods, 35% believe that it is not safe to cross the street, and almost 50% reported that drivers do not "behave well" on the road. This data clearly demonstrates that there is a lack of

[14] including prenatal care, primary care obstetrics and paediatrics, child and adolescent medicine including primary care mental health, adult and seniors care

safe routes for pedestrians and cyclists. This not only affects people wanting to exercise outdoors for recreation and leisure purposes, but also adults and children that want to walk or cycle to work, programs and services, community events and schools. There is also a need for both pedestrians and drivers to learn how to navigate safely.

In their report Promoting Public Health through Smart Growth: Building Healthier Communities through Transportation and Land Use Policies and Practices (2005) Frank, Kavage and Litman reveal that over the long term, land use and transportation policies can provide significant health benefits[15]. Research has documented that all else being equal, residents that live in communities with well-connected street and sidewalk networks, and a supportive pedestrian environment walk and bicycle more and drive less than residents of more isolated, automobile-dependent locations. This results in measurably better physical fitness, reduced likelihood of obesity and traffic crash risk, and fewer air pollutants per capita than residents of more automobile oriented communities.

b) Increase the amount of affordable and accessible housing

It is clear from the survey results that our citizens' health is linked to income with 33.2% of those who reported fair/poor health having incomes <$30,000. Further, of the 10.8% who reported renting homes, 38.5% of them spent greater than 30% of their income on rent.

Those on income assistance and most minimum wage earners live below the poverty line. Many cannot afford safe shelter and enough nutritious food for their families. There are a number of families in our region who face these challenges. For example, this year's Christmas bureau is serving more than 350 families. The numbers of children and families who appear at the Sooke Crisis Centre and at Vital Vittles[16] are growing. Waitlists for affordable housing are such that people have stopped registering.

c) Develop a regional food security plan with local/regional partners

A recent CRD report[17] describes food security as "the condition in which all people at all times can acquire safe, nutritionally adequate, and personally acceptable foods in a manner that maintains human dignity". In our region, 3.2% of citizens who completed the health survey reported using the food bank in the past six months. Poverty is one aspect of this recommendation. 16% of citizens report getting their food from a local farm or producer, 8.4% from fishing or hunting and 14.4% from their own garden; so having sustainable local agriculture is obviously another important aspect. These two aspects are not mutually exclusive.

The gradual disappearance of agricultural land in our communities, and the chopping up of land into smaller parcels that can't accommodate home gardens was

[15] Lawrence, F., Kavage S., & Litman T. (2005). Promoting public health through Smart Growth Building healthier communities through transportation and land use policies and practices. www.vpti.ca

[16] free lunches served by a local church on Fridays at the Sooke Child, Youth & Family Centre

[17] "Final Report, Phase 1: Putting Food and Food Policy on the Table" CRD Roundtable on the Environment and the Capital Region Food & Agriculture Initiatives Roundtable (CR-FAIR), 2005-2006

worrisome to many Sooke residents. They want to preserve this life-style of raising a few chickens, having a garden and raising children in this environment. They are strong supporters of the 'grow local, eat local' promotion of organic and other local food growers within our community. Community gardens are one way of making 'home grown' available to everyone. Food security should be a consideration in all land use planning in our region. Current regional and provincial initiatives present unique opportunities for us to create a local, food security initiative to build the capacity of our community to access healthy food.

Our aspirations: sustaining the outcomes over time

Once our recommendations are disseminated to the community, the region and the province, we will be able to measure whether they are acted upon. Our plan for this long-term evaluation of the outcomes is as follows:

Outcomes	**Evaluation**	**Evidence**
Key stakeholders among local organizations & businesses have a good understanding of local determinants of health	*Feedback from organizations and individuals sought following health forum and final report.*	*In progress*
The health priorities identified in the plan are considered by local organizations and local governments in their planning.	*Direct evidence will show that participating organizations have found this data useful and have considered it in setting priorities for their organizations and in planning for the community.*	*Information is being produced for consumption by these groups*
Data informs the Official Community Plan Processes in the region.	*Usefulness of data is highly rated by municipal planning staff, politicians and citizens involved in the OCP review processes.*	*OCP review hasn't begun due to turnover of municipal planning staff*
An accessible resource of local health data.	*A health database is centrally housed and a process and procedures are in place to manage it.*	*Ultimately this resource data will be compiled to create a web-based Community Resource Map as part of the CRD Community Health Atlas. This will be user-friendly and easily up-dated by community agencies.*
Better relationships and collaboration between Project partners.	*Evaluation tool reports better relationships and there is evidence of collaborative behaviour that improves the quality of services and the health of citizens.*	*The degree of cooperation and partnership is reported as unprecedented.*

Discussion

It takes time for community members to understand what role they are being asked to play, what it is they can and need to do to help improve the quality of life for all members of their community, what assets they bring to the table, and what responsibilities they take away. So far it has also been largely volunteer time, for which we are very grateful.

This is the beginning of a larger discussion about some of the questions we need to address if we wish to reflect the differences in what it means to participate in service development, action research, or community development in our very different roles as service providers, as community members, as 'clients' or as 'care seekers'. We are approaching the completion of two very big research projects in which all of the participants have invested a lot of time and energy, and we need to plan for what comes next.

As we write this, we know that ripples from the project are spreading. The Union of B.C. Municipalities has invited a proposal from CHI representatives from the Juan de Fuca Electoral Area and the Canadian Cancer Society to develop active and alternative transportation in the area.

Within the community, members have discussed organizing a series of presentations to further the dialogue about community health. On 18 December the CHI committee met with a consultant hired by the Kingdom of Bhutan to advise on its progress towards a Genuine Happiness Index. A presentation for the community has been discussed, as has a lecture by Ron Coleman, developer of the Genuine Productivity Index. A presentation of Peter Donaldson's performance of *Salmon People*, about the interconnections of life and landscape, has also been proposed.

Members of the Chamber of Commerce have recognized that the community resource map is a baseline for economic definition and development, and data on community services continues to flow.

This exploration has, not surprisingly, raised questions as well as answered them. Different groups will choose different facets to investigate. The committee hopes that the spirit of cooperation and investigation will be sustained and strengthened. To do so, we will be holding a "Community Research 101" course for all interested community members on January 31 2007, and using community generated data to teach the concepts. While it would have been helpful to do this at the beginning, time constraints made it impossible. By doing it now, we'll bring the data to interested citizens and teach them how to use it to build initiatives.

Some of the questions and some of the barriers we've learned about are summarized here.

Some Questions:

1. How do we set priorities? How do we reconcile what the 'experts' might think our community needs to address (e.g., smoking, obesity,) versus what the community thinks they need (e.g., health care services, affordable housing, addictions services)?
2. How do we represent the diverse voices of the community? Who really 'represents' a particular part of the community, and what obligations do they have to the people they represent? What do we do to maintain the interest and commitment of community members over time?

3. How do we fund our efforts? Can we reconcile what we see as our own priorities with the funding that is available? Whose job is it to keep this going?
4. Who 'owns' the community relationship? How would we respond if an outside researcher with no community connections invited us to work with her? What expectations would we have? What do we offer? Who 'owns' the stories and data we acquire and who has the right to determine its use?
5. How do we ensure that we remain dedicated to both continuing community engagement and to continuing community dialogue?
6. Is the sense of coherence we have experienced so far in this community project a result of a selection process? Shared values? Or something else? How have we avoided 'history' and 'baggage' to date and maintained our positive relationships and energy? Is this something we can better understand and translate to other areas of community engagement?
7. How do we maintain accurate data and sustain community energy?

Some Barriers

1. Time
2. Distance and Transportation
3. Funding
4. Translating between academic and popular expression
5. Communication and 'getting the information out there'
6. A perception that funders or leaders want us to be a front for research recruitment or for their larger agendas; a community rubber stamp instead of engaged decision makers.

We do not imagine that these lists are complete, but we know that knowledge of open questions and barriers can be as helpful to future projects as the data we've collected.

Some Aspirations

A potent but unexamined part of the project is the role of 'non health care professionals' providing ideas, direction, advice and guidance in community health projects. A look at the tension between community knowledge and desires and epidemiological protocols and goals would surely inform effective health promotion and planning.

A second goal might be for every interested member of CHI, to be funded and supported to attend and present at a national conference. The appetite from government, academia and funders to hear community voices is enormous. Curious and committed Sooke citizens could be in the vanguard among activists inspired by books such as Malcolm Gladwell's "The Tipping Point".

Appendix 1: Key Project Data

(a) Key Project Dates and Events

Event	Date
Community Resource Mapping	to Mar 31st
Community Survey Development completed	April
PHSA Telephone Survey	March to July
Booth at the Sooke Rotary Auction & Spring Fair	May 6th
Youth Resiliency Surveys (Elementary & Secondary)	June 5-9th
Interim Report to Sooke Council	June 19th
Interpreting Data Workshop with Michael Pennock	Sept 6th
Youth Resiliency Surveys (Middle)	Sept 9th
Community Survey Distribution	June 25-August
Community Forum	September 23
Youth Resiliency Report Presentation	November 14th
Draft final report completed	December 22nd
Final Report to UBCM	January 15th

(b): Participants in Project and Audiences Reached

This project had broad reach in the community and the region.

- there are 31 Community Health Initiative members covering a diverse cross section of the community, of that 5 members were on the 'Knowledge Transfer" Committee, 9 members were on the 'Resource Mapping' Task group and 7 members were on the 'Survey Development' Committee
- Over 300 individuals were contacted from groups relating to health & wellness in our community regarding the Community Mapping process and 153 Community Mapping surveys were completed and returned
- 411 individuals completed telephone surveys for PHSA's B.C. Health & Wellness Survey
- Community Health Surveys were mailed out to approximately 5000 households with a 27% return rate; 14 surveys were completed in Sooke and 20 in Port Renfrew by direct contact with persons with no fixed address or other barriers; approximately 50 surveys were completed by on reserve First Nations members by direct contact with their Community Health Representative
- information was distributed in regular columns in the local newspaper and distributed weekly to 5400 households & businesses
- 1084 students in Grades 3 – 12 completed the Resiliency Survey
- 95 people attended the forum and 5 additional volunteers were utilized in the running of the Community Forum

Appendix 2: Committee Terms of Reference

Committee Composition

Collaborating Partners	Involvement	Contribution
District of Sooke (to Nov 1) Roger Lam	Committee	Planner, Financial oversight Data storage & dissemination
Juan de Fuca Electoral Area Rachelle Rondeau, Planner Jane Hutchins, Community Member	Committee	Planners Regional Director or alternate
T'Sou-ke First Nation: Kerrie Maclean, Marcella Planes, Colleen George	Committee	First Nations perspectives
Pacheedaht First Nation	Contributing	
Beecher Bay First Nation	Contributing	
Vancouver Island Health Authority Mary Dunn, Public Health Nurse Anita Dotts, Chronic Disease Michael Pennock, Epidemiologist Gillian Frosst & Brendan Mather, Population Health Analysts	Committee Contributing	Health information, data and analysis Access to target populations
Provincial Health Services Authority Dr. John Millar	Contributing	Health Status & Burden of Disease Data
School District #62 (Sooke) Lori Messer, EMCS	Committee	Staff support (Project Leader) Child & youth voices
Community Health Initiative:		Project oversight & planning
Sooke Family Resource Society Kathryn McCormick/Nina Linguanti	Committee	Information and statistics on needs of children and families
Sooke Works Employment Centre Denise Chewka	Contributing	Youth employment
Kate Kittredge	Committee	Project Consultant Community Liaison Coordinator
Ministry for Children & Families Sharon Watson, Mental Health	Committee	Youth Mental Health information
Sooke Transition House Society Sue Wright, ED	Committee	Arrange access to women and children with specific needs
Pacific Family Services Society Dalyce Dixon	Contributing	Arrange access to people with mental health and other special needs.
Good Life Wellness Centre Marlene Barry	Committee	Information and statistics on use of wellness practitioners by area residents
Sooke Physicians Dr Ellen Anderson, Family Medicine Dr. Shayna Chamitoff, Psychiatrist	Committee	Representing physicians
People Patterns Consulting Roger Sauve (to October 2006)	Committee	Environmental scan for existing local health data

Collaborating Partners	Involvement	Contribution
Sooke Evergreen Physiotherapy Suzanne Manley	Committee	Information and statistics on fitness & physiotherapy
Grant Hall, Pharmacist (retired)	Committee	Communications
Canadian Cancer Society Nancy Falconer	Committee	Community action coordination South Island Healthy Living Alliance
OPSRRA – Emma Taylor	Committee	Communication
Michelle Merier, Community	Committee	Forum Volunteer Facilitator
SEAPARC – Dan Ovington	Contributing	Recreation services

***Membership**:* Community members and representatives of health, education and social services agencies in our region.

***Region**:* East Sooke to Port Renfrew –the District of Sooke and those areas of the Juan de Fuca Electoral Area falling within the boundaries of the Sooke School District

Purpose, Values, and Principles

CHI undertook this project to identify common concerns and to foster community participation in developing innovative projects to address health service needs. The Committee began by identifying existing resources and establishing current demographic data for the community, information not available from the more general Health Region or Stats Can information. Members of the community offered insight and connections in this research, establishing networks, identifying both resources for, and barriers to, improved community health. Using its insight, energy, and connections, the community has undertaken the development of services, identified priorities in the improvement of community health and resources, explored ways to diminish health barriers and inequalities, and advocated for healthy communities in the region.

Prior to beginning the work, the Committee agreed on the values that would inform the work. They were:

1. Concern for the well being of all members of our community.
2. Respect for individual dignity, privacy, and autonomy of all people.
3. Opportunity for all people that was fair, just, unbiased, and reasonable.
4. Co-operation and collaboration encompassing community members, professionals, care providers, politicians, community agencies, and public agencies.
5. Transparency in establishing an open honest accountable process accessible to all members of the public
6. Benevolence in doing good.
7. Beneficence in preventing harm.

Finally, the Committee agreed that the ten principles listed below would govern all aspects of the project process:

1. We will use a consensus-based model to work together while respecting different points of view, incorporating compromise, sharing, collaboration and teamwork.
2. We will have voluntary and open membership..
3. We will have a clear, easily understood, democratic decision-making process
4. Roles of collaborative partners will be clearly defined and documented.
5. Mutual trust and respect among all partners will be a key priority.
6. Conflict resolution between project partners will be addressed through a mediation process.
7. We will engage representatives of the community who are not currently represented.
8. We will be as inclusive as possible, while acknowledging and respecting individual differences.
9. We will innovate and be open to change while understanding and respecting the importance of tradition.
10. People's experiences and understanding and formal statistical data will both be accorded value in explaining issues.

Appendix 3: Promotion & Publicity Media Package

Appendix 3(a) Goals & Objectives

1. Achieve Informed Public Understanding Necessary to Success
   a) Public acceptance that health needs are real and matter
   b) Greater public awareness about local determinants of health
   c) Information is provided from 1992-93 survey
   d) Public understand how survey data is to be used—what it will and won't do
   e) Media are engaged in disseminating planned messages

2. Maximum Community Participation
   ensures reliable, valid and broadly representative data and participation of marginalized and/or generally under-represented populations
   a) Design relationships with many different audiences
   b) Culturally and socially appropriate processes
   c) Broad-based communication about events and other opportunities designed to inform, listen to and engage various population groups
   d) Use of existing networks, affiliations and interest groups
   e) Reduced number of barriers to participation
   f) Input from people's actual experiences
   g) Neutral territory for forum venues

3. Pride of Community Ownership in Final Product
   a) Advice and involvement in pre-forum planning and follow-up activities
   b) Maximum use of local resource people
   c) Reporting processes reflect community culture
   d) Data is transformed into meaningful information
   e) Reporting procedures are timely and helpful to the community

4. Move from a Solution-based to Evidence-based Approach
   a) No premature solutions—necessary steps are taken to assess what needs really are
   b) Comparable information from other communities provides context
   c) Priorities are established based on the data
   d) A transparent, participative process is used to rank priorities

Appendix: 3(b) Project Accomplishments [one paragraph summary]

The Sooke Community Health Information Project (CHIP) assembled local population health data to identify community health priorities and concerns. Information on local health resources formed a baseline for assessment and will be used to create a web-based *Community Resource Map* as part of the Capital Regional District's Community Health Atlas. The region participated as a pilot in the *BC Health & Wellness Survey,* administered a *Child/Youth Resiliency Survey* and created a rural *Community Health Survey* that provides data comparable to other major surveys. The three survey processes allowed the group to compare different methods of data acquisition. The broad participation of citizens at a *Community Health Forum* gives CHI confidence that the following summary recommendations reflect the issues, needs and reality of the citizens of the Sooke region:

- Strengthen community connections and relationships for children & youth;
- Strengthen collaboration between community service organizations to improve overall community health; and
- Create supportive physical environments for healthy lifestyles.

The recommendations will be widely disseminated throughout the Region and to public bodies responsible for decision making that influences health in the region.

Appendix 3(c): Press Release - January 24, 2006

The Community Health Initiative (CHI)
The group that brought the Navigator Project to Sooke is at it again!

CHI is a growing partnership of interested community members and health & social service providers who have been working together since 2003 to advocate for and create healthy communities. It includes membership from East Sooke to Port Renfrew. CHI has a track record of developing and sponsoring the 2-year Mental Health and Addictions *Navigator Project*, through the Sooke Family Resource Society. Due to the success this committee achieved, it attracted the attention of other community groups. Subsequently Edward Milne Community School approached CHI to serve as the Advisory Committee to their *Wraparound Project* for youth.

With the Navigator & Wraparound Projects up and running, CHI continues to develop new, innovative, community-based projects, bringing together local health care providers, social service agencies, community organizations and researchers. The committee's current project has caught the attention of agencies such as VIHA, the BC Ministry of Health and the Union of BC Municipalities. The District of Sooke recently learned that it had been awarded a grant of $35,000 from UBCM to support this health promotion project.

In its current project, CHI continues to look at the needs of the community and is asking the public for their input. In order to accomplish this CHI will be using such methods as phone surveys, public forums, individual consultations and written surveys.

CHI is gathering information in order to develop an inventory of health & social determinants that affect the well being of our population. Including areas such as:

- i) Recreation and leisure
- ii) Education and employment
- iii) Housing
- iv) Health Care
- v) Social services
- vi) General well being
- vii) Environment

Once completed, they will bring this information back to the community for further development and input. The next stage will be dependent on this input.

The communities of southwestern Vancouver Island are vibrant and active communities that are attractive places for families to live. The Sooke region is currently experiencing a time of rapid growth, presenting opportunities to consider how to effectively plan for its citizens' future health and well being. This project will help citizens understand the region's current health needs and resources and its health and social priorities.
For further information contact: Lori Messer, Project Leader, 642-6371

Appendix 3(d): Press Release – June 19, 2006

Community Health Information Project (CHIP)

This week, Sooke region residents, in the communities from Port Renfrew to Beecher Bay, will have an opportunity to influence the quality of life in their region. Over 3,500 health surveys designed by local volunteers with help from BC Stats will be mailed to area households on Wednesday, June 21st. Supported by the VIHA's Population Health Surveillance Unit and the BC Ministry of Health through UBCM's Community Health Promotion Fund, Sooke is the first community to pilot this process in the health region and in the province.

The Sooke Region is an area well-known for its sense of community, strong volunteer base and innovative approaches to local health and social services. Local volunteers are strong advocates for their communities. In the face of rapid population growth and changes, their biggest challenge is finding local information to inform and support the need for services. Most health data is collected for larger areas that include the very different communities of Colwood, Langford and Metchosin. The Sooke Community Health Information Project (CHIP) was created by volunteers to collect local information and increase local understanding of health related needs and issues.

Over the past six months, the CHIP group has developed a comprehensive inventory of local health resources that will eventually be Internet accessible. This will allow all residents to readily locate services in the community. With the help of VIHA epidemiologist Dr. Michael Pennock, CHIP has developed a unique survey that explores many dimensions of health including access to health and social services, neighborhood safety, food security, individual health practices and lifestyles. The survey includes some questions that will allow the community to compare their results nationally and provincially. Sooke schools are providing youth voices through a health survey of their own. Results of both surveys and the inventory will be presented to the community in a planning forum to be held September 23rd where residents will have the opportunity to discuss gaps and priorities in health resources.

CHIP members are hoping for a high survey return. Project leader Lori Messer says, "We are told that a good return is 10% but we say just watch us! We are confident that Sooke area residents will give 20 minutes for the opportunity to improve community health and well being."

CHI CONTACTS:

Lori Messer, Project Leader 642-6371 (w) 642-4327 (h) until 10 pm Mon, June 19th

After Monday June 19th, please contact Dr. Ellen Anderson 217-9149 (cell)

VIHA CONTACT: Dr. Michael Pennock, 519-7092 (w)
Population Health Epidemiologist, Office of the Chief Medical Health Officer, VIHA

BACKGROUND: The Community Health Initiative (CHI)

Partners: Vancouver Island Health Authority (VIHA), Provincial Health Services Authority (PHSA), School District #62, BC Ministry of Health through Union of BC Municipalities, District of Sooke, Juan de Fuca Electoral Area and the Community Health Initiative (CHI)

CHI is a growing partnership of interested community members and health & social service providers who have been working together since 2003 to advocate for local health and social services and to maintain quality of life in the face of rapid growth. It includes members from East Sooke to Port Renfrew. CHI has a track record of developing and sponsoring the 2-year Mental Health and Addictions *Navigator Project*, through the Sooke Family Resource Society. It also serves as the Advisory Committee to Edward Milne Community School's *Wraparound Project* for youth-at-risk.

CHI continues to develop new, innovative, community-based projects, bringing together local health care providers, social service agencies, community organizations and researchers. The committee's Community Health Information Project (CHIP) has caught the attention of agencies such as the Vancouver Island Health Authority (VIHA), the Provincial Health Services Authority (PHSA), the BC Ministry of Health and the Union of BC Municipalities.

In January '06, the District of Sooke was awarded a grant of $35,000 from the UBCM to support this health promotion project, one of 30 different projects in the province. A list of these communities appears on the UBCM website www.civicnet.bc.ca under Programs and Services, Local Government Program Services, Health Promotion Fund. The Pilot Projects are part of the first and key phase of the Community Health Promotion Fund and are intended to contribute to best practices and innovation with respect to local government health promotion activities and collaborative partnerships

CHI has completed an inventory of health & social determinants that affect the well being of the area population. It includes areas such recreation and leisure, education and employment, housing, health care, social services, general well being, and environment. This information will form a layer of an Internet-based Community Health Atlas being hosted by the CRD in partnership with VIHA. This mapping interface will make local services data much more accessible.

The second phase of the project is the development and dissemination of a comprehensive health survey. In the third phase, community members and service providers will come together in a community forum to identify gaps and plan to address them. This information will also be used to inform the Official Community Plan which is currently in the early stages of revision.

The communities of southwestern Vancouver Island are vibrant and active communities that are attractive places for families to live. The Sooke region is currently experiencing a time of rapid growth, presenting opportunities to consider how to effectively plan for its citizens' future health and well-being. This project will help citizens understand the region's current health needs and resources and its health and social priorities.

Appendix 3(e): Press Release – September 19, 2006

Community Health Information Project (CHIP)

This summer, an unprecedented 1400 Sooke region households completed a fifteen page health survey designed by local volunteers. On Saturday, September 23rd at Edward Milne Community School, in an open forum, the committee will present its findings. The Sooke region is the first community to pilot this process in the health region and in the province. It is supported by VIHA's Population Health Surveillance Unit and the BC Ministry of Health through UBCM's Community Health Promotion Fund. The region's communities stretch from Port Renfrew to Beecher Bay.

The forum has attracted broad representation from agencies serving the Sooke region. Executive Director Valerie Tregillus from the Ministry of Health will bring data on primary care, Dr. John Millar from PHSA's (Provincial Health Services Authority) will discuss the results of their telephone survey and Dr. Murray Fyfe, from VIHA's Population Health Surveillance Unit will present local health data. Local family physician and active CHIP member, Dr. Ellen Anderson, will demonstrate the power of a local health resource map that catalogues 150 local resources. Attendees at the forum will have the opportunity to discuss gaps and priorities in health resources, ask questions of the data and begin to identify health priorities.

Project leader Lori Messer describes the survey phase of the project as the "eyes" of the project. "By sharing the data, we will showing the community what we and others have seen so far." The forum will begin the "ears" phase where we listen to stories, questions and priorities. The last phase is the written report that gives "voice" to the community's health priorities.

The Sooke Region is an area well known for its sense of community, strong volunteer base and innovative approaches to local health and social services. Local volunteers are strong advocates for their communities. In the face of rapid population growth and changes, their biggest challenge has been finding local information to inform and support the need for services. Most health data is collected for larger areas that include the very different communities of Colwood, Langford and Metchosin. The Sooke Community Health Information Project (CHIP) was created by volunteers to collect local information and increase local understanding of health related needs and issues.

Over the past nine months, the CHIP group has developed a comprehensive inventory of local health resources that will be Internet accessible. This will allow all residents to readily locate services in the community. With the help of VIHA epidemiologist Dr. Michael Pennock, CHIP developed a unique survey that explores many dimensions of health including access to health and social services, neighborhood safety, food security, individual health practices and lifestyles. The survey includes some questions that will allow the community to compare their results nationally and provincially.

CHI CONTACTS:

Dr. Ellen Anderson 217-9149 (cell)   Marlene Barry, Forum Coordinator   642-3790 or 3390
Or email: chipcom@shaw.ca

Appendix 3(f): News Clippings

BACKGROUND: The Community Health Initiative (CHI)

Partners: Vancouver Island Health Authority (VIHA), Provincial Health Services Authority (PHSA), School District #62, BC Ministry of Health through Union of BC Municipalities, District of Sooke, Juan de Fuca Electoral Area and the Community Health Initiative (CHI)

CHI is a growing partnership of interested community members and health & social service providers who have been working together since 2003 to advocate for local health and social services and to maintain quality of life in the face of rapid growth. It includes members from East Sooke to Port Renfrew. CHI has a track record of developing and sponsoring the 2-year Mental Health and Addictions *Navigator Project*, through the Sooke Family Resource Society. It also serves as the Advisory Committee to Edward Milne Community School's *Wraparound Project* for youth-at-risk.

CHI continues to develop new, innovative, community-based projects, bringing together local health care providers, social service agencies, community organizations and researchers. The committee's Community Health Information Project (CHIP) has caught the attention of agencies such as the Vancouver Island Health Authority (VIHA), the Provincial Health Services Authority (PHSA), the BC Ministry of Health and the Union of BC Municipalities.

In January '06, the District of Sooke was awarded a grant of $35,000 from the UBCM to support this health promotion project, one of 30 different projects in the province. A list of these communities appears on the UBCM website www.civicnet.bc.ca under Programs and Services, Local Government Program Services, Health Promotion Fund. The Pilot Projects are part of the first and key phase of the Community Health Promotion Fund and are intended to contribute to best practices and innovation with respect to local government health promotion activities and collaborative partnerships

CHI has completed an inventory of health & social determinants that affect the well being of the area population. It includes areas such recreation and leisure, education and employment, housing, health care, social services, general well being, and environment. This information will form a layer of an Internet-based Community Health Atlas being hosted by the CRD in partnership with VIHA. This mapping interface will make local services data much more accessible.

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The communities of southwestern Vancouver Island are vibrant and active communities that are attractive places for families to live. The Sooke region is currently experiencing a time of rapid growth, presenting opportunities to consider how to effectively plan for its citizens' future health and well-being. This project will help citizens understand the region's current health needs and resources and its health and social priorities.

Appendix 4: Community Resource Mapping

Appendix 4(a): Cover Letter – Resource Mapping

March 1, 2006

Dear fellow community member:

We are a group of volunteers* who have come together to help build a healthier community. We are the Community Health Initiative (CHI) and we need your help!

The Sooke Region (from East Sooke to Port Renfrew) is growing rapidly. We wish to ensure that as we grow we will all have the local resources we need to be healthy. We need complete and current information in order to ensure we can get those resources. We need to convince service providers of our local needs. We need to identify what resources we have and where the gaps are. We need to bring local providers together to address those gaps. We need to tell our story with reliable and authentic data.

CHI has secured funding from the local health authority to produce an inventory of resources and services provided in our community that contribute to the well-being of our population. We have hired Kate Kittredge to gather information about area recreation, leisure, employment, education, housing, health care, social services, environment (natural and built), transportation, safety, general well-being, arts, culture, food security/farming, and volunteering. Once completed, we will bring this information back to the community.

Please take some time to fill out the attached *Community Resource Questionnaire*.

The inventory needs to be completed by the end of March so please **complete and return the attached questionnaire before March 15th** either by email to Kate at womens_wellness@hotmail.com or in the enclosed stamped envelope (return address: Kate Kittredge, RR6 Glinz Lake Road, c/o Camp Thunderbird, Sooke, BC V0S 1N0.

If you have questions or concerns about the questionnaire or the project or wish to help in some way please do not hesitate to contact me at 642-6371 or lmesser@sd62.bc.ca.

Thank you for your time! We know it's precious!

Sincerely,

Lori Messer
Project Leader

Appendix 4(b): Community Resource Questionnaire

PLEASE fill out the following questionnaire to provide the Community Health Initiative (CHI) with information on your organization, business, agency, club, etc. (from hereon, referred to as '**GROUP**'). **Please return completed questionnaire as soon as possible** either by email to Kate Kittredge at womens_wellness@hotmail.com or by mail to Kate Kittredge, RR6 Glinz Lake Road, c/o Camp Thunderbird, Sooke, BC V0S 1N0.

> **PLEASE NOTE:** Our '**community',** for the purpose of this project, is defined as the area encompassing Sooke, East Sooke, Otter Point, Shirley, Jordan River, and Port Renfrew (this area excludes Colwood, Langford and Metchosin).

SECTION I:
GENERAL INFORMATION

1. Please check the **main service(s)** your Group provides or contributes to in our community:

☐Recreation	☐Leisure	☐Culture	☐Natural Environment
☐Housing	☐Transportation	☐Arts	☐Built Environment
☐Health Care	☐Social Services	☐Volunteering	☐Food Security/Farming
☐Employment	☐Education	☐General Well-Being	
☐Safety	☐Other(s): ____________________		

2. Please list the specific **Services/Programs** provided by your Group:

____

____

____

____

3. **Name** of Group you represent: ______________________________

4. a) **Location Address** of Group you represent: ______________________

____

____

b) **Mailing Address** of Group you represent,
(if different from above): ______________________

____

____

5. **Contact Details** of Group you represent:

6. **Hours of Operation** of Group you represent:________________________________

7. Is there a **cost** for someone to access your Group's services/programs?
☐ NO ☐ YES, for ALL services/programs ☐ YES, for SOME services/programs

8. Is a **referral** necessary for someone to access your Group's services/programs?
☐ NO ☐ YES, for ALL services/programs ☐ YES, for SOME services/programs

If yes, from whom? ☐ Self ☐ Professional ☐ Parent/Guardian
☐ Other(s): ____________________________________

9. At what **location(s)** does your Group provide services/programs?
Please check all that apply:
☐ Your own establishment/office ☐ Client homes ☐ Outdoors
☐ Community Meeting Place(s) ☐ School ☐ Recreation Centre
☐ Satellite offices in other communities ☐ Other(s):________________________

10. What is the **physical infrastructure** of your Group's main facility? ☐ N/A
Please check all that apply:
☐ Public waiting room(s) ☐ Open office(s) ☐ Private office(s)
☐ Play space(s) ☐ Washroom(s) ☐ Recreational area(s)
☐ Outdoor Area(s) ☐ Meeting room(s) ☐ Kitchen/Eating Space(s)
☐ Single-Storey Building ☐ Multi-Storey Building ☐ Emergency Exit(s)
☐ Handicapped Access ☐ Other(s): ______________________________

11. Is your Group's facility wheelchair accessible? ☐ YES ☐NO ☐N/A

12. Is your Group's facility located within easy walking distance of a public bus-stop?
☐ YES ☐NO ☐N/A

13. a) What best describes your Group's **organizational structure**?
☐ Local Government ☐ Provincial Government ☐ Federal Government
☐ Other Government (please specify):______________________________
☐ Non-Profit ☐Commercial/For-Profit ☐Other __________

b) Please indicate your source(s) of **funding**. *Please check all that apply:*

	Approximate % of Total Revenue
☐ Government	______%
☐ Charitable Organizations	______%
☐ Private Donations	______%
☐ Revenue from Clients	______%
☐ Other (please specify):__________________________	______%

SECTION II:
CLIENT INFORMATION

14. Who is your Group's **Target Clientele**? *Please check all that apply:*

☐ General Population ☐ Seniors ☐ Women ☐ Men
☐ Families ☐ Youth ☐ Children ☐ Students
☐ First Nations/Metis ☐ Unemployed ☐ Immigrants/Refugees ☐ Homeless
☐ Persons living in Poverty ☐ Persons c/o Mental Health & Addictions
☐ Persons with Disabilities/Special Needs ☐ Persons involved in the Justice System
☐ Other(s): ____________________

15. a) Approximate # of **clients accessing your services/programs** in a **typical busy month** in 2005. *If you served the same client more than once per month please count them as only one client for this question*: ______ ☐ N/A

b) Approximate # of **client contacts** in a **typical busy month** in 2005. *If you served the same client more than once per month please count each contact with that individual as one 'client contact' for this question:* ______ ☐ N/A

16. Does your Group provide services/programs for only part of the year?

☐ YES ☐ NO ☐ N/A

If yes, how many months of the year does your Group provide services/programs?______

17. a) Approximately what percent of your Group's clients **live INSIDE the local areas** of:

Sooke ______% East Sooke ______% Otter Point ______%
Shirley______% Jordan River ______% Port Renfrew ______%

b) Approximately what percent of your Group's clients **live OUTSIDE the local area**: _____%

18. Is there **currently** a wait list for any of your Group's services/programs?

☐ YES ☐ NO ☐ N/A

If yes, please fill out the following table:

NAME OF SERVICE/PROGRAM WITH A WAIT LIST	# OF PERSONS ON THE WAIT LIST	# OF DAYS A PERSON MUST WAIT TO RECEIVE SERVICE
1.		
2.		
3.		
4.		
5.		

19. Do any persons have difficulty accessing your Group's services/programs?

☐ YES ☐ NO ☐ N/A

If yes, what are the barriers?

☐ Wait List ☐ Referral ☐ Unaware of our services/programs
☐ Transportation ☐ Financial ☐ Other(s): ____________________

SECTION III:
HUMAN RESOURCES

20. In a **typical busy month** in 2005 how many **paid staff** did your Group employ?

# of Full Time Staff	_______
# of Part Time Staff	_______
# of Contract Workers	_______

21. In 2005 approximately how many **volunteers** served your Group? _______

22. In 2005 approximately how many **volunteer hours** were donated to your Group? _______

23. Does your Group have any difficulty **recruiting** skilled workers? ☐YES ☐NO ☐N/A

If yes, in what occupation(s)? ____
____
____

24. Does your Group have any difficulty **retaining** skilled workers? ☐YES ☐NO ☐N/A

If yes, what might be the reason(s)? ____
____
____

If no, what might be the reasons(s)? ____
____
____

25. Does your Group have any difficulty **recruiting** volunteers? ☐YES ☐NO ☐N/A

If yes, what might be the reason(s)? ____
____
____

If no, what might be the reasons(s)? ____
____
____

26. Does your Group have any difficulty **retaining** volunteers? ☐YES ☐NO ☐N/A

If yes, what might be the reason(s)? ____
____
____

If no, what might be the reasons(s)? ____
____
____

SECTION IV:
ADDITIONAL QUESTIONS

27. Does your Group refer/recommend its clients to other services/programs?

☐ YES ☐ NO ☐ N/A

If yes, approximately what percent of clients does your Group refer/recommend to other services/programs: **inside** the community? ______%

outside the community? ______%

***Please Note:** *'Community' includes the area encompassing Sooke, East Sooke, Otter Point, Shirley, Jordan River, and Port Renfrew.*

28. Do other service providers refer/recommend **their** clients to your Group's programs/services?

☐ YES ☐ NO ☐ N/A

29. Does your Group invite feedback from clients as to their satisfaction with its services/programs?

☐ YES ☐ NO ☐ N/A

If yes:

What method(s) does your Group use?

☐ Survey/Questionnaire ☐ Public Meetings ☐ Suggestion Box
☐ Focus Groups ☐ Other(s): ______________________________

How often?

☐ Upon completion of service/program ☐ More than once per year
☐ Approximately once per year ☐ Every two years or more
☐ Other(s):____

30. Does your Group collect confidential information on its clients?

☐ YES ☐ NO ☐ N/A

If yes, what method(s) does your Group use to store this confidential information?

☐ Filing Cabinet(s) ☐ Electronically ☐ Other: ________________

31. Does your Group enforce a policy to protect the privacy of its clients?

☐ YES ☐ NO ☐ N/A

32. An objective of the Community Health Initiative (CHI) is to track the health of our community by frequently updating the Community Resource Inventory following its development. We plan to make appropriate information available to the public. Would your Group be willing to assist this process by providing updated information?

☐ YES ☐ NO

The Community Health Initiative (CHI) thanks you for the time and energy you have invested in filling out this Questionnaire. Your input is essential to this project.

Questionnaire Terminology

The following linguistic distinctions are made in the beginning of the questionnaire:

- 'Group' as conveyed in the questionnaire refers to any service provider, organization, business, agency, club, etc. associated with community health and wellness.
- The 'Sooke Region' and the 'community', for the purpose of this project, is defined as the area encompassing Sooke, East Sooke, Otter Point, Shirley, Jordan River, and Port Renfrew and excluding Colwood, Langford, and Metchosin.

Appendix 4(c) Community Resources and Key Informants

Sooke/East Sooke:
Sooke District
CRD
VIHA – Home & Community Care; Chronic Disease Management
SEAPARC Recreation
Non-SEAPARC related Recreation & Volunteering
Volunteering/Well-Being/Spiritual
Health & Social Services
Sooke Works Employment Centre
Arts & Culture – First Nations & Non-First Nations
Sooke Family Resource Society – re: Databases
East Sooke Community Members
Goodlife Wellness Centre
Edward Milne Community School's Wraparound Project
Vancouver Island Regional Library: Sooke Branch
Sooke Cycle

Port Renfrew:
Preschool & Day Care
Coastal Kitchen Café
Lighthouse Pub & Restaurant
After-School Care & Summer Care
Medical Loan Cupboard
PRHSSS: Port Renfrew Health & Social Services Society

Pacheedaht First Nation:
Chief Councillor
Band Administrator
Councillor/Treaty
Councillor/Fisheries
Community Health Representative
Administrative Assistant
Fisheries Administration

Beecher Bay First Nation:
Chief Councillor
Band Administrator
Community Health Representative

T'Sou-ke Nation:
Chief Councillor
Band Administrator
Community Health Representative (Acting)
Youth Worker
Administrative Assistant

Appendix 4(d): Community Voices – Port Renfrew/Pacheedaht

COMMUNITY VOICES:
SOME IDENTIFIED BARRIERS IN THE PORT RENFREW AND PACHEEDAHT COMMUNITIES*
(A QUALITATIVE REPORT)

TRANSPORTATION AND ROADS (WITHIN AND WITHOUT PORT RENFREW):

Transportation: was voiced as the number one need for Pacheedaht by a Band Office staff member and a major concern by other interviewees. There is no public (bus or shuttle) or private transport (taxi services) offered in Port Renfrew. There is little to no way for residents to commute into Sooke and beyond for amenities and services, etc. if they have no access to a vehicle. This can increase resident's sense of isolation, leave them to go without things they may need, and/or force them to resort to unsafe choices such as hitchhiking or driving under the influence.
Another voiced concern was that with one school-bus leaving the community in the morning with only one returning to the community in the afternoon, some high school students attending EMCS in Sooke miss the morning bus (or catch the bus only to get off in Sooke and hang around the town unsupervised instead of attending classes), or can't participate in extracurricular activities after school because they will miss the afternoon bus home.

Roads: there was voiced concern that the roads are not safe, particularly at night. Within the community the roads are unlit and there are no sidewalks or walking/biking paths on the side of the road. One young woman said if she were a parent she wouldn't let her children out on the road (walking or on bikes) even to go to the store. People drive dangerously and there is a lot of drunk driving (which goes unmonitored as the RCMP presence is limited). For the Pacheedaht children and youth walking along the road to and from Port Renfrew School is of particular concern because the road is completely unlit. Also, the highway linking the community to Sooke is terribly unsafe: narrow, winding, not maintained and with little signage warning of the potholes/caving sides, etc.
The road linking the Red Creek Fir to the main highway is in need of major repair. The Red Creek Fir could be another popular tourist attraction for the town (like Botanical Beach) if this road was repaired.

HOUSING/RENTAL ACCOMODATION:

Rental accommodations are particularly sparse. This is particularly problematic in the summer months as housing the influx of seasonal staff becomes nearly impossible. Available properties and housing are being bought up by wealthy seasonal residents who are driving up the market price, in which local Port Renfrew residents can't compete.

STEADY EMPLOYMENT:

This was identified as the number one need in the Pacheedaht Community by a current Band Councillor. Employment opportunities increase in the summer months as Port Renfrew is such a seasonal town dependent on the tourism industry. However, this does not keep the town afloat during the off-season.

HEALTH CARE:

Many interviewees stated they were uncomfortable with the lack of health care services in the community for themselves and their children. Some complained the ambulance services were not reliable.

Dental Care for Children (identified as a problem by the Pre-school and daycare manager): a Dentist with the Health Team does a pre-check of the children's teeth and then refers them to a Dentist in Victoria. As there are no dentists in Port Renfrew, and apparently, at this time, no Dentists in Sooke that will see these children without a pay-up-front scheme, they need to travel to Victoria for this service leaving many children without dental care.

ALCOHOL AND DRUG ABUSE/MISUSE:

This was identified as a huge problem in the community, both on and off Reserve. Unemployment, boredom, poverty, and isolation, amongst other social factors all contribute to this problem.

Although people identify this as a major issue in the community there is still no AA or other substance misuse/abuse support groups. It was noted that there was an AA group years ago but it was discontinued. Because it is such a small community the support group was never anonymous leaving people to feel uncomfortable in their seeking of help.

EXTRA-CURRICULAR ACTIVITIES:

The owner and operator of The Coastal Kitchen Café, identified a lack of community interest in extra-curricular activities and noted that when she or others have, in the past, initiated various activities for the community to get involved in, there is very little interest or commitment. Interestingly, she hypothesized that this is because many in the community are drawn to Port Renfrew as a place to "be off the map". She said that most don't get involved and those who do are juggling many responsibilities and get burnt out, thus sucking dry the already small pool of volunteers to draw from in such a tiny community.

One of her suggestions was the inclusion of an indoor fitness space such as a gym or work-out facility. She noted that there is a need for this, especially in the winter months.

* As identified by local Port Renfrew and Pacheedaht residents in Winter/Spring 2006.

Appendix 4(e): Community Resource Website

SOOKE REGION[18] COMMUNITY RESOURCE WEBSITE: A COMMUNITY ORIENTATION

WHAT IS THE COMMUNITY RESOURCE WEBSITE?

The Community Health Initiative (CHI) in collaboration with the Vancouver Island Health Authority (VIHA) is creating a Community Resource Website, an online map and description of the services that might impact any aspect of health and wellness in our community. Intended for those who reside both inside and outside the Sooke Region, the data is locally generated and locally owned.

The website will feature an aerial map of the Region with each group or organization's location pinpointed on the map. The website will show each group's contact information, hours of operation, the service(s) it provides, if there is a cost to access those services, if a referral is necessary, accessibility to public transportation, wheelchair accessibility, the target clientele, volunteer opportunities, etc.

WHY ARE WE BUILDING A WEB SITE?

CHI hopes to fill a need in the community for a central bank of easily updated and useful information that provides any community member with essential information on all of the local resources that contribute to health and wellness. Community members have identified 16 key services that contribute to the continued health of our community: recreation, leisure, housing, health care, employment, safety, transportation, social services, education, culture, arts, volunteering, natural environment, built environment, food security/farming, and general well-being. CHI anticipates the website will become a useful resource for community service providers and individuals.

HOW HAVE WE ARRIVED HERE?

CHI, with funding from VIHA and the support of the community, invited service providers who contribute to the health and wellness of our community through the service(s) they provide to participate in the project. So far, 150 providers have completed the questionnaire. The data received to date has been translated into a web format with publicly available information excerpted from the questionnaires. We seek questionnaires from any organizations that haven't yet responded. Questionnaires will be available at the Forum, and on the website.

~~The 'Sooke Region', for the purpose of this project, is defined as the area encompassing Sooke, East Sooke, Otter Point, Shirley, Jordan River, and Port Renfrew and excluding Colwood, Langford, and Metchosin.~~

WHO SUPPORTED THE PROJECT?
The Vancouver Island Health Authority has funded this initiative, in partnership with the Capital Regional District.

PROJECTED BENEFITS:

Benefits to Community Members:

- Easier access to current information
- Searchable database with appropriate links
- Educational resource

Benefits to Service Providers:

- Communication with potential clients
- Able to easily update own information
- Publicity and marketing
- Encourages enhanced collaboration between service providers
- Information for planning

VERIFICATION & UPDATE PROCESS:
CHI requests that all groups verify their information before it is posted on the website. CHI will attempt to ensure that each group understands the website initiative (including how they can verify and regularly update their information) and will provide a closed-date opportunity to verify and alter their information prior to the website launch.

OPEN QUESTIONS:

- Is this a project the Community will use and benefit from?
- Is this a project local Service Providers will use and benefit from?
- Does this resource inventory allow us to better understand gaps in services and programs in our community?
- Are there potential risks or harms from such information being made more readily available?
- Will the benefits outweigh the investment of capital, time and energy?
- Is this project sustainable?

ACKNOWLEDGEMENTS:
CHI would like to thank the following:

- Vancouver Island Health Authority
- The Capital Regional District
- All the community organizations and groups who completed their Community Resource Questionnaire

*Appendix 4(f) **Additional Resources Used for Community Resource Mapping Project***

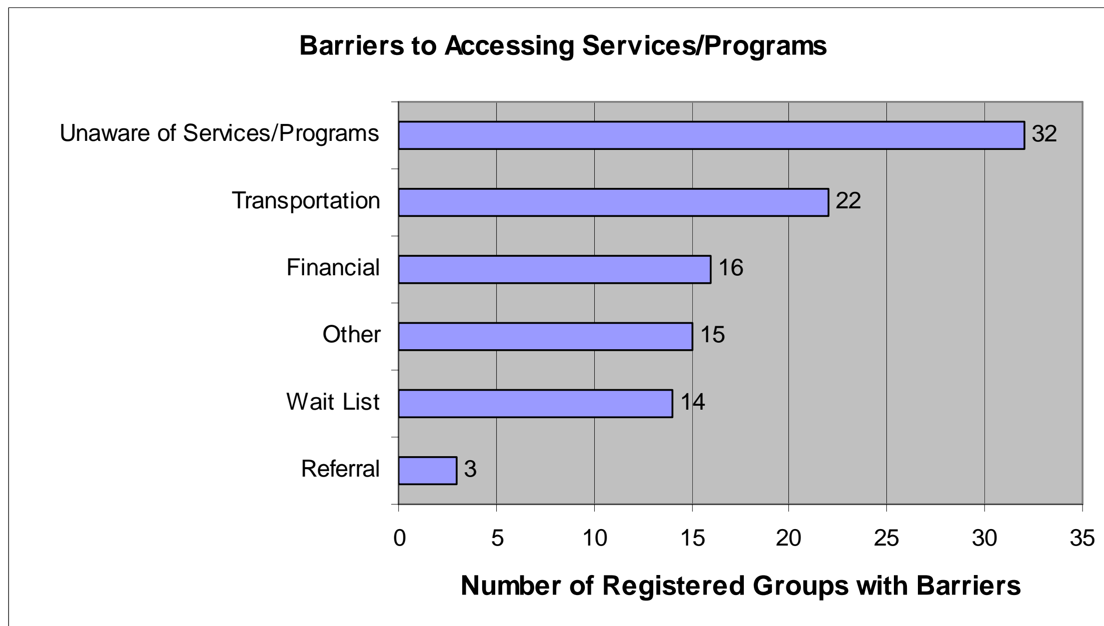
Although the Task Group and the people in the communities of Sooke, T'Sou-ke First Nation, East Sooke, Beecher Bay Nation, Port Renfrew, Pacheedaht Nation, Shirley, Otter Point and Jordan River proved to be the most valuable of resources during this project, there were many printed resources that proved useful as well:

- Schnarch, B. (2004). Ownership, Control, Access and Possession (OCAP) or Self-determination Applied to Research: A Critical Analysis of Contemporary First Nations Research and Some Options for First Nations Communities.
  http://www.naho.ca/firstnations/english/pdf/OCAP5.pdf
- Sooke Lions Club Business Directory: 2006
- Stein, K. (2005). Sooke and Area, Child, Youth and Family Resource Directory
  Wraparound Project
- Bridges Victoria Community Handbook: Sixth Edition, August 2004
  Bridges for Women Society
- Port Renfrew Community Visions Report: "A Jewel in the Wilderness"
  Queen Alexandra Foundation for Children & the Community of Port Renfrew
- Welcome Wagon: Array of promotional/informational material for various Groups throughout Region
- Promotional/informational pamphlets collected over the 7 week project – mostly from Sooke and Port Renfrew (many from the Visitor Info Centres in both areas)
- Sooke to Port Renfrew: 2005 Visitors Guide
- The Rural Observer
- The Sooke News Mirror
- Internet – an invaluable resource for research and validation of current Group contact information
  Various supporting documentation supplied by CHI members such as formal articles, academic papers and reports.

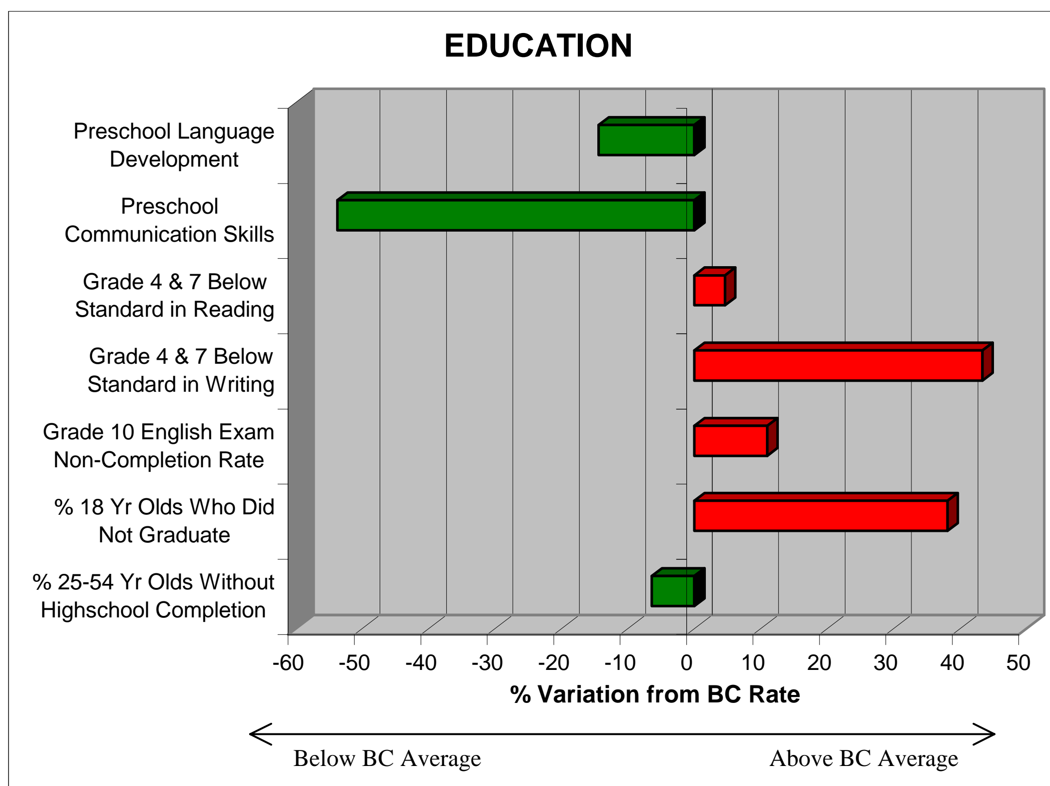
Appendix 4(g) Data Analysis from Community Resource Mapping Project

- 58 (40%) of registered groups reported having persons who had difficulty accessing their services/programs.

- The most-frequently reported barrier to accessing services/programs was 'unaware of services/programs'.

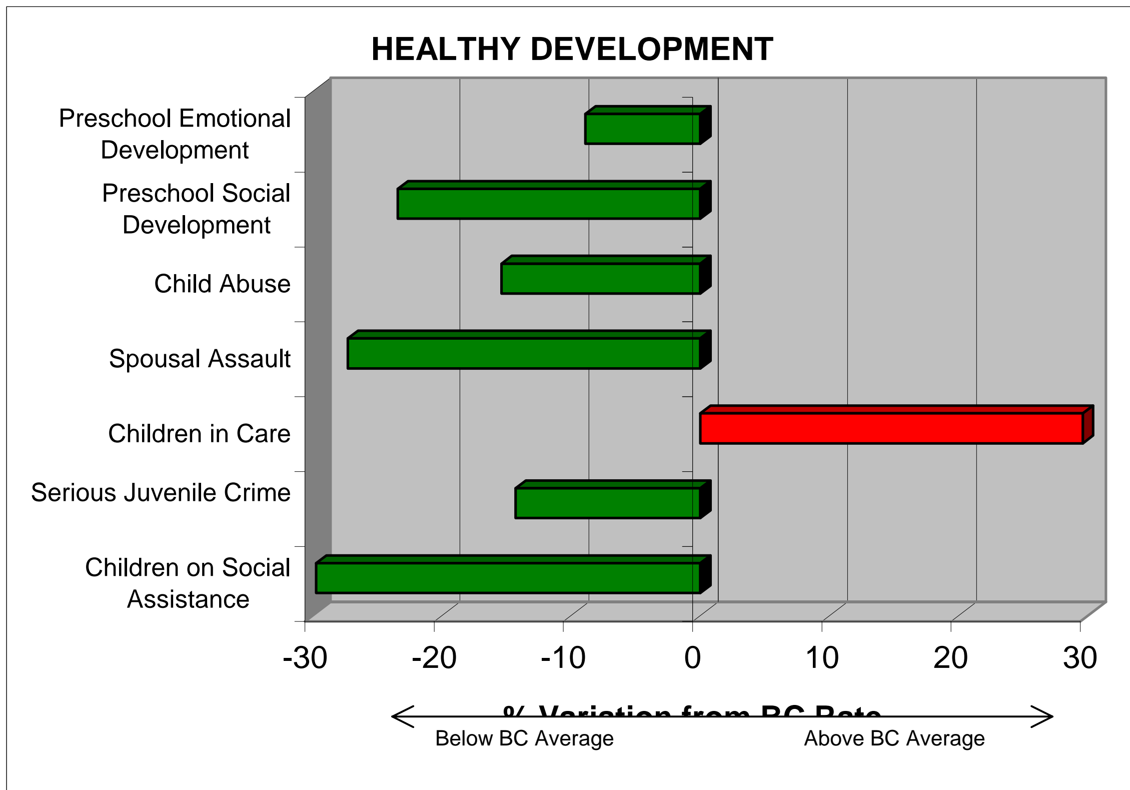


Appendix 5: Sooke Community Health Profile[19]

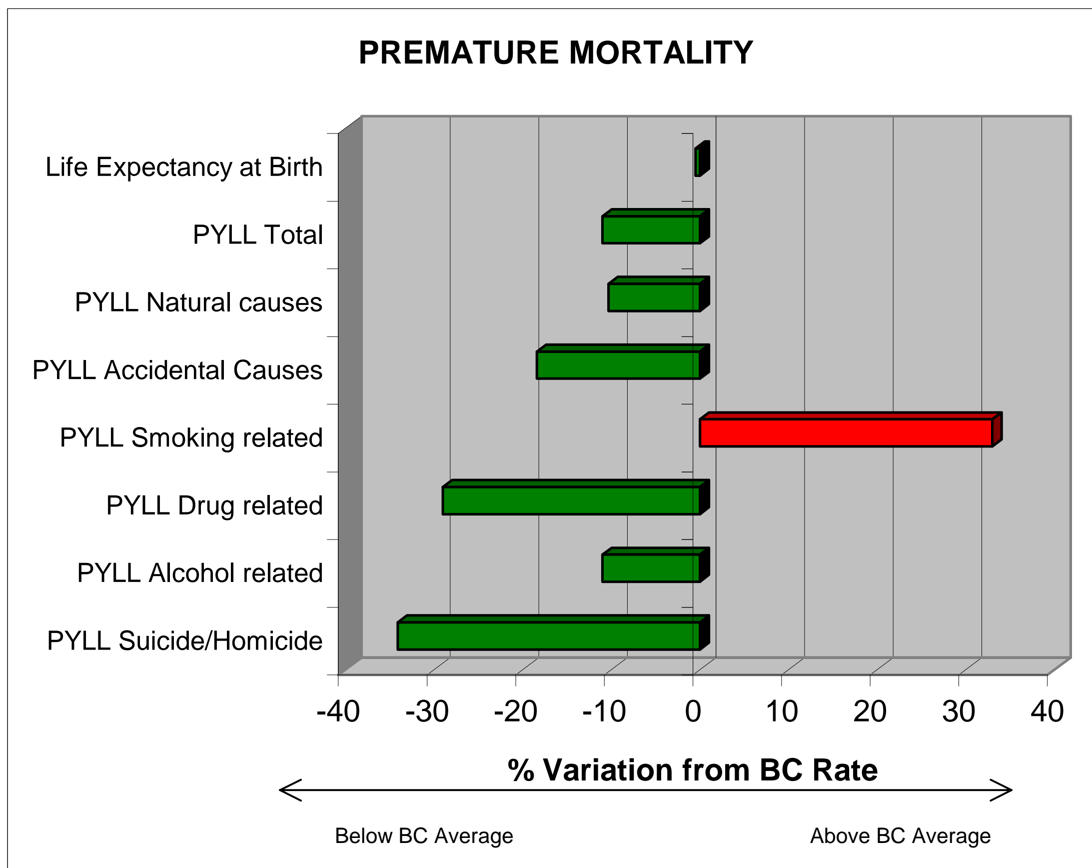


Indicator	Description	Year(s)	Source	Sooke	BC
Preschool Language Development	% of kindergarten children rated as vulnerable for language and cognitive development (problems in reading, writing and numeracy)	2000-2004	British Columbia Atlas of Child Development, 2005	8.56	10
Preschool Communication Skills	% of kindergarten children rated as vulnerable in communication and general knowledge skills	2000-2004	British Columbia Atlas of Child Development, 2005	4.63	10
Grade 4 & 7 below Standard in Reading and Writing	% of students scoring below standards on standardized test	2002/03-2004/05	BC Stats	22.6	21.6
Grade 10 provincial English Exam Non-completion rate	% of students who did not write or pass English 10	2004/05	BC Stats	15.2	10.6
Educational status of 18 year olds	% of 18 years olds who did not graduate	2003-2005	BC Stats	26.2	23.6
Adults who did not graduate	% of population aged 25 to 54 without high-school completion	2001	BC Stats from Census	33.7	24.4

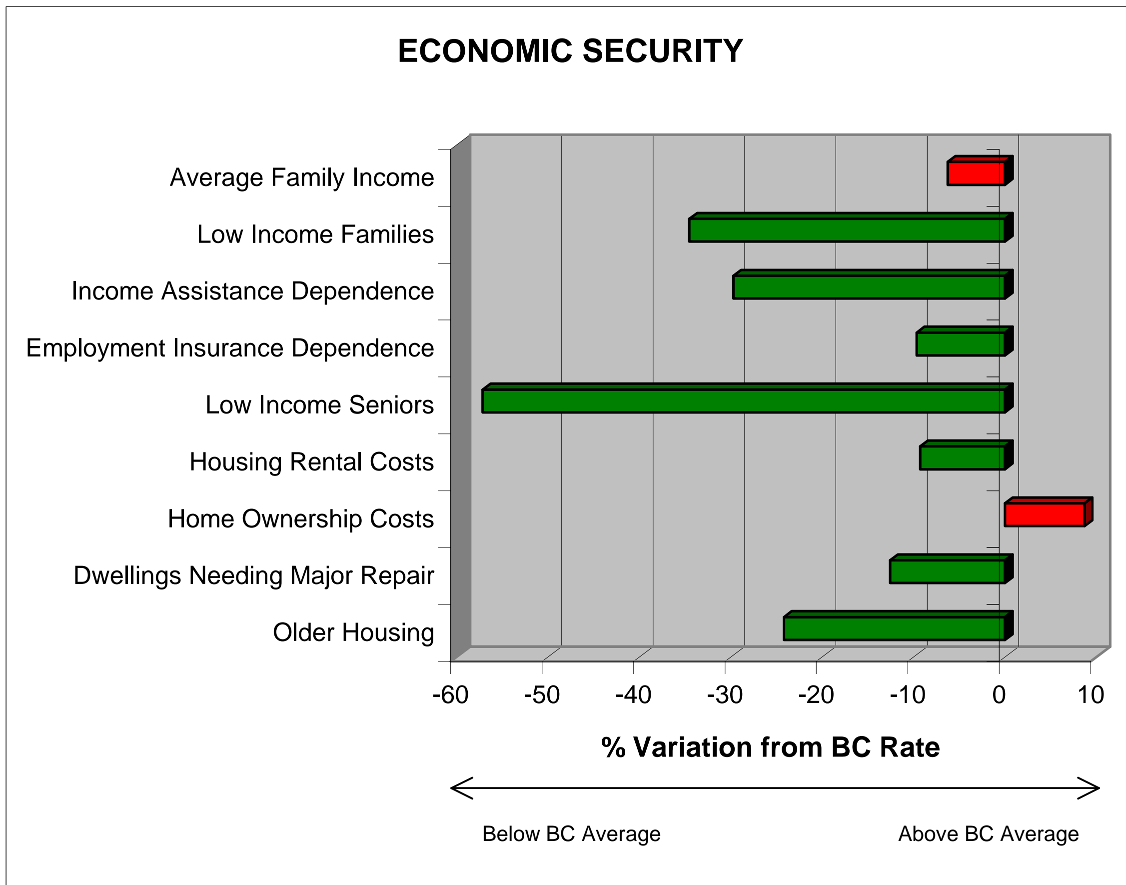
[19] **Prepared by Population Health Surveillance Unit, Office of the Chief Medical Health Officer, Vancouver island health Authority, August 2006**



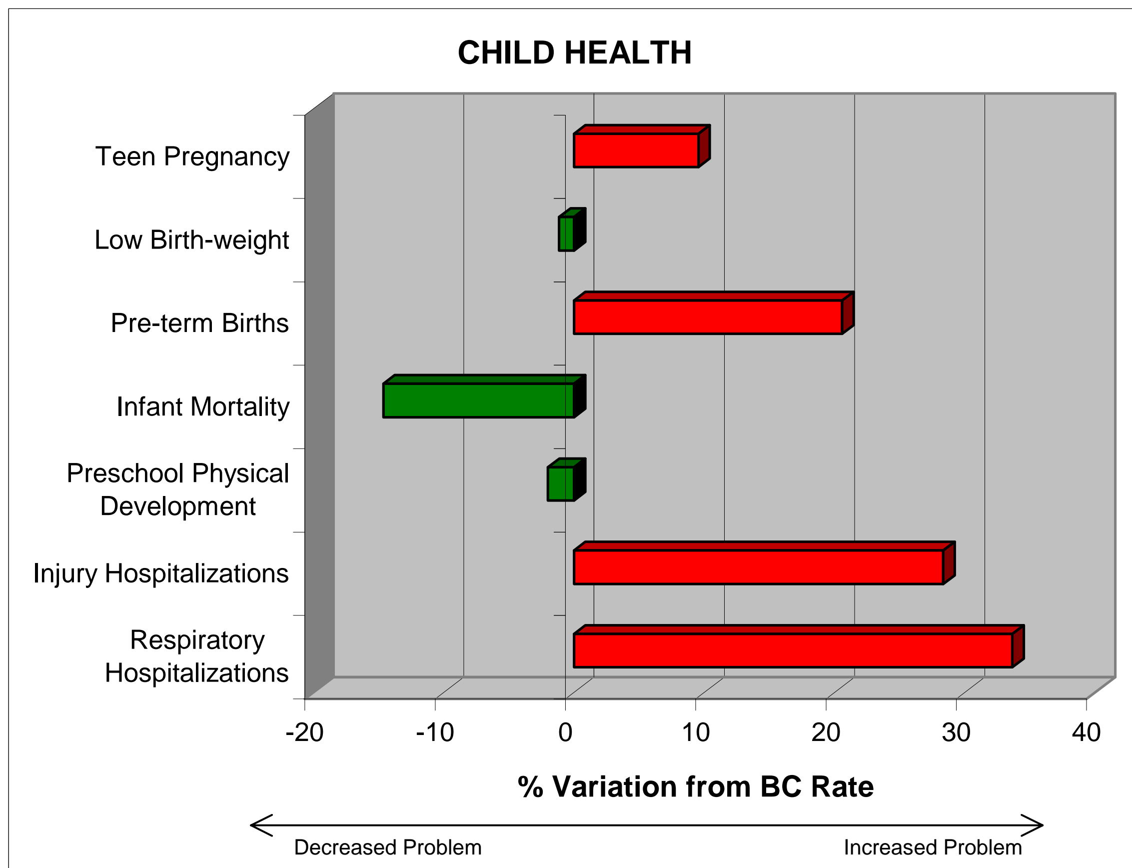
Indicator	Description	Year(s)	Source	Sooke	BC
Pre-school Emotional Development	% of kindergarten children rated as having problems with aggressive behaviour, impulsivity, disobedience and inattentiveness	2003-2004	British Columbia Atlas of Child Development, 2005	9.11	10
Pre-school Social Development	% of kindergarten children rated as having problems forming friendships, accepting rules and showing respect for adults	2003-2004	British Columbia Atlas of Child Development, 2005	7.66	10
Child Abuse	Reported child abuse cases per 1,000 children 0 to 18	2003	BC Stats	6.6	7.8
Spousal Assault	Spousal assault crimes per 1,000 population	2002-2004	BC Stats	1.6	2.2
Children in care	% of children in care per 1,000 children 0-18	Dec 2005	BC Stats	12.7	9.8
Serious juvenile crime	Juvenile crime rate per 1000 pop aged 12-17 (B&E, crimes with weapons and assaults with serious injury)	3 yr average 2002 to 2004	BC Stats	4.8	5.6
Children on Social Assistance	% of children under 19 living on social assistance	Sept 2005	BC Stats	2.6	3.7



Indicator	Description	Year(s)	Source	Sooke	BC
Life expectancy	Number of years a resident can expect to live, given current mortality patterns	Average 2001 - 2005	BC Stats	80.4	80.8
Premature Mortality	Potential years of life lost (PYLL) through mortality among persons younger than 75	2000-2004	Vital Statistics	0.9*	1.0
PYLL Natural Causes	Potential years of life lost (PYLL) through disease-mortality among persons younger than 75	2000-2004	BC Stats	29.6	33
PYLL Accidental Causes	Potential years of life lost (PYLL) through accidental and external causes among persons younger than 75	2000-2004	BC Stats	7.1	8.7
PYLL Smoking related	Potential years of life lost (PYLL) through smoking-related diseases among persons younger than 75	1998-2002	Ministry of Health Services	1.3*	1.0
PYLL Drug related	Potential years of life lost (PYLL) through drug related causes among persons younger than 75	1998-2002	Ministry of Health Services	0.7	1.0
PYLL Alcohol related	Potential years of life lost (PYLL) through alcohol related disease among persons younger than 75	1998-2002	Ministry of Health Services	0.9*	1.0
PYLL Suicide/Homicide	Potential years of life lost (PYLL) through suicide and homicide among persons younger than 75	2000-2004	BC Stats	2.9	4.4
* Values created using a PYLL Index where Provincial Rate = 1.0					

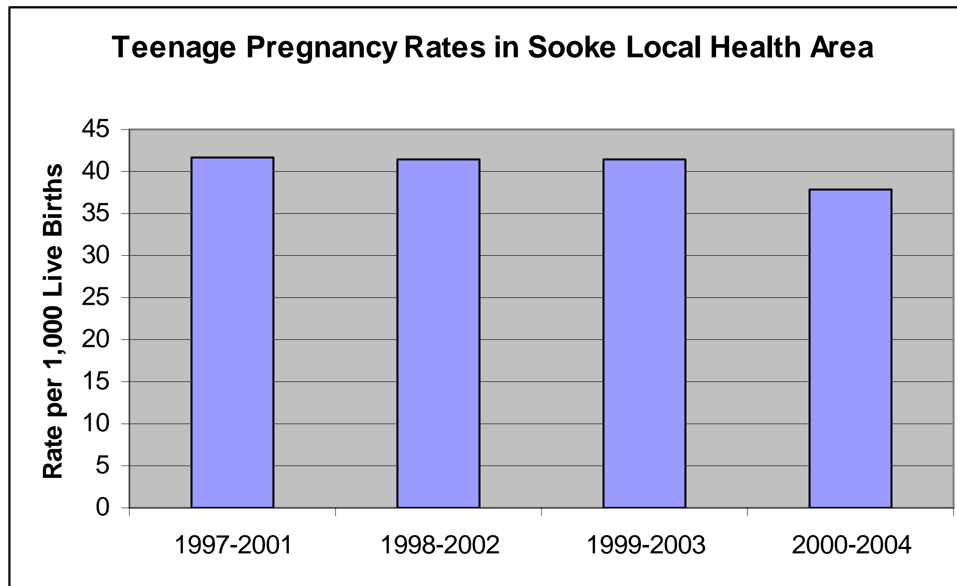


Indicator	Description	Year(s)	Source	Sooke	BC
Average Family Income	Average income from all sources of families in Sooke	2000	Census	$60,755	$64,821
Low Income Families	% of families below the Statistics Canada Low Income Cut-off Point	2000	Census	9.1	13.9
Income Assistance Dependency	% of population aged 0 to 64 receiving income assistance from provincial program	Sept 2005	BC Stats	2.6	3.7
Employment Insurance Dependency	% of population 19 to 64 receiving employment insurance payments Sept 04 to 05	Sept 2004 to Sept 2005	BC Stats	2.8	3.1
Low Income Seniors	% of seniors receiving maximum GIS Income Supplement	2005	BC Stats	1.5	3.5
Housing Rental Costs	% of renters spending more than 30% of income on rent	2001	Census	40	44.1
Home Ownership Costs	% of owners spending more than 30% of income on housing	2001	Census	22.5	20.7
Dwellings Needing Major Repair	% of dwellings rated as needing major repairs by renter or owner	2001	Census	7.3	8.4
Older Housing	% of dwellings built prior to 1960	2001	Census	15.6	20.6



Indicator	Description	Year(s)	Source	Sooke	BC
Teen Pregnancy	Pregnancies among girls aged 15 to 17 per 1,000 girls	3-Yr Average 2002-2004	BC Stats	19.5	17.8
Low Birth-weight	Births weighing less than 2500 g per 1,000 births	4-Yr Average 2000-2004	Vital Statistics	52	52.6
Preterm Births	Newborns with a gestational age < 37 weeks per 1,000 live births	4-Yr Average 2000-2004	Vital Statistics	86.1	71.4
Infant Mortality	Deaths of children under 1 year of age per 1,000 children under 1	4-Yr Average 2000-2004	BC Stats	3.5	4.1
Preschool Physical Development	% of kindergarten children rated as having problems with fine and gross motor skills, daily preparedness for school , washroom skills and handedness.	2003/2004	British Columbia Atlas of Child Development, 2005	9.8	10
Injury Hospitalizations	Hospitalization rates per 1,000 children aged 0 to 14	2004/2005	BC Stats	7.7	6
Respiratory Hospitalizations	Hospitalization rates per 1,000 children aged 0 to 14	2004/2005	BC Stats	14.7	11

Teenage Pregnancy (Births to Teen Mums) in Sooke Local Health Area		
Year	**Rate per 1,000 live births**	**No. of births**
1997-2001	41.65	122
1998-2002	41.42	118
1999-2003	41.31	116
2000-2004	37.97	108
Source: BC Vital Statistics Agency.		



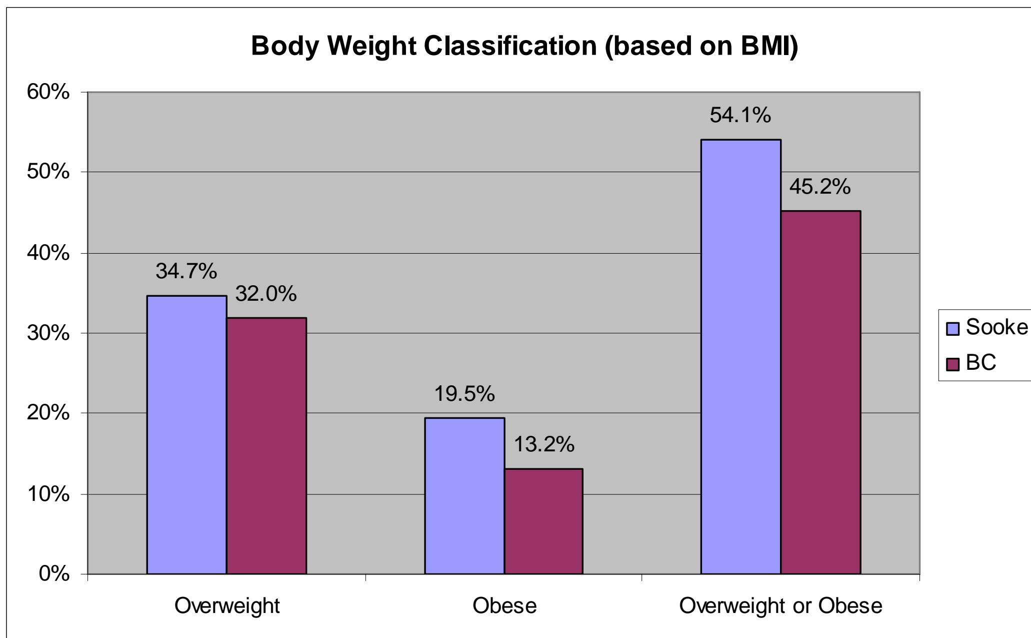
Appendix 6 Surveys

Appendix 6(a) Sooke Community Health Survey (tool)

Appendix 6 (b) Comparing the BC Health and Wellness Survey (Sooke Region) to BC as a whole)[20]

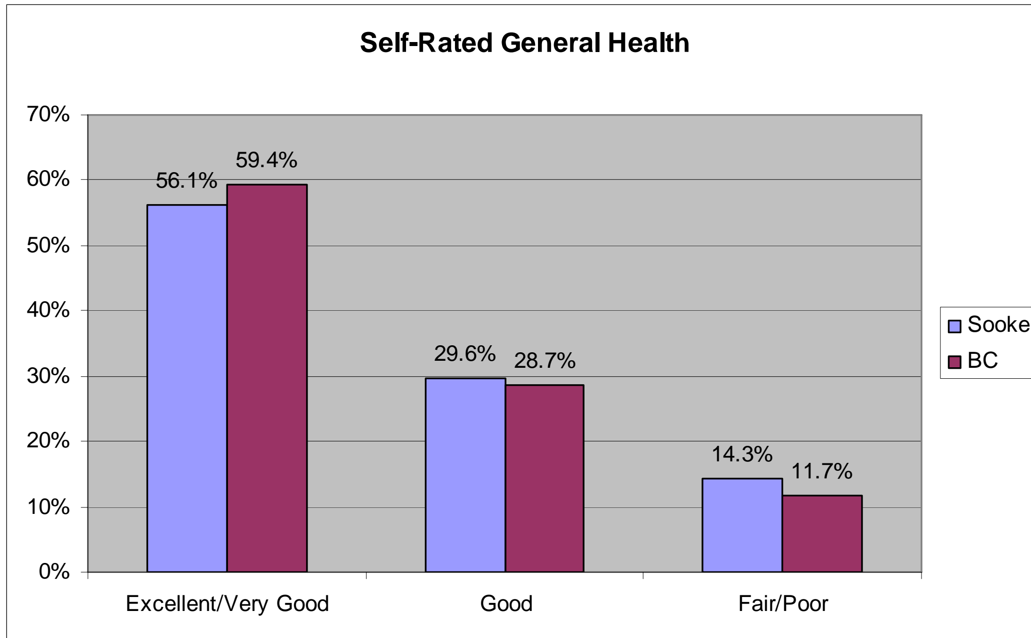
PLEASE NOTE: Data from Phase I were collected primarily to test the methodology and capacity in BC for collecting local level data and to learn from communities how useful the data are for decision-making and community-level resources towards addressing health-related lifestyle behaviours. Data were collected over a 3-month period, and so data may be biased because many of the lifestyle behaviours assessed are known to be affected by seasonality.

Since any change in data collection methods has a great impact on data, differences between BC data sources should be noted, and data should be compared with caution. The data collection methods for CCHS are quite difference from the BC-HWS and in itself could explain any differences observed with the BC-HWS data. Please refer to 'Note on Comparability' under each figure.

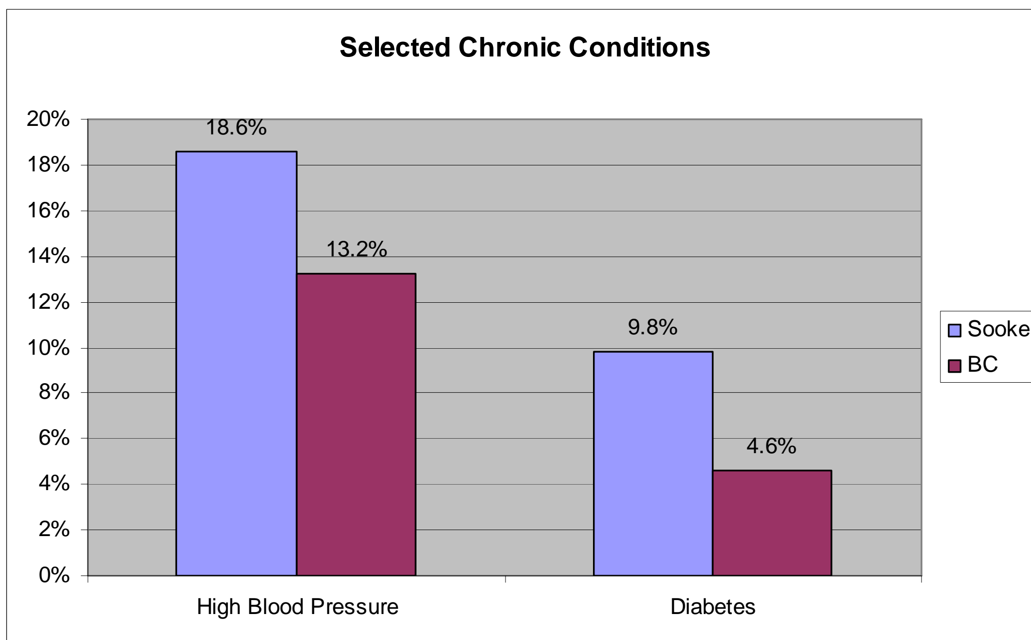


(Source of BC data: CCHS 3.1 (2005) via CIHI e-publications. Note on Comparability: Comparable.)

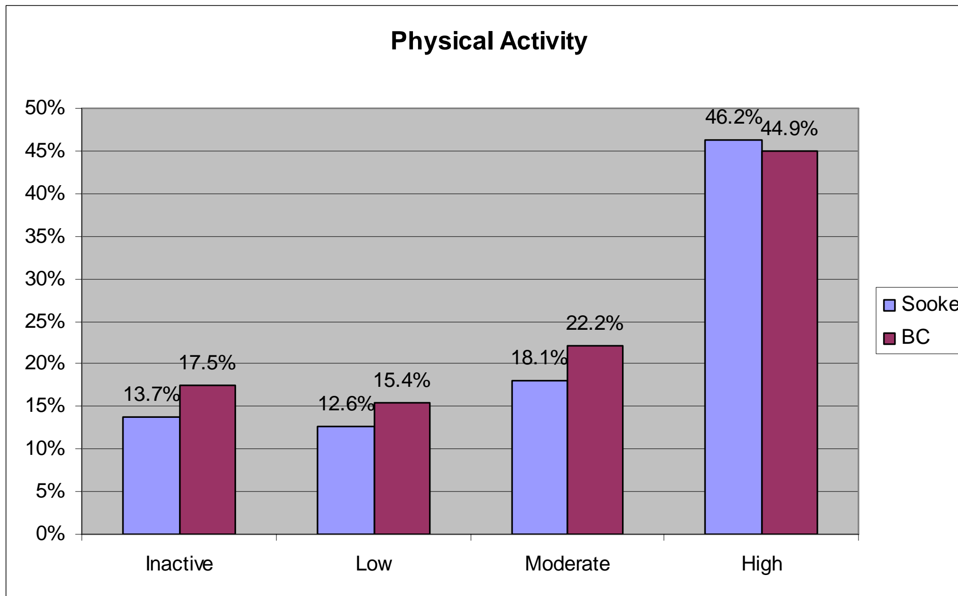
[20] Prepared by Population Health Surveillance Unit, Office of the Chief Medical Health Officer, Vancouver Island Health Authority, November 17, 2006



(Source of BC data: CCHS 3.1 (2005) via CIHI e-publications. Note on Comparability: Comparable.)

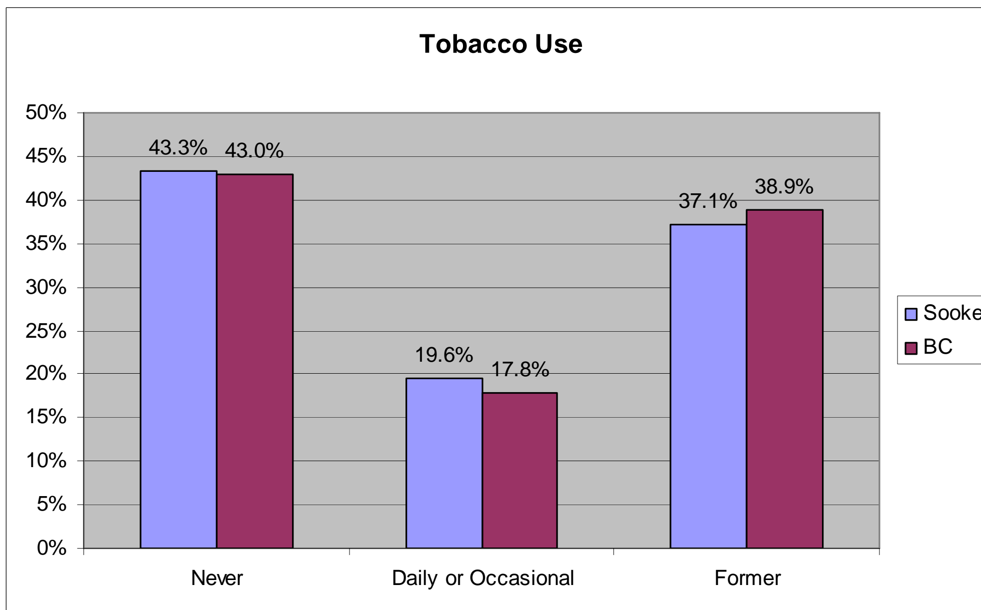


(Source of BC data: CCHS 3.1 (2005) via CIHI e-publications. Note on Comparability: Comparable.)



(Source of BC data: CFLRI (Canadian Fitness and Lifestyle Research Institute). Note on Comparability: Not comparable to CCHS but can potentially compare with CFLRI unpublished data for BC - Cora Lynn Craig of CFLRI.)

Fruit and Vegetable Consumption		
	Sooke (HWS)	**BC (CCHS 3.1)**
Less than 5 times per day	59.7%	53.7%
Source of BC data: CCHS 3.1 (2005) via CIHI e-publications.		
Note on Comparability: Slightly different but comparable.		



(Source of BC data: CCHS 3.1 (2005) via CIHI e-publications. Note on Comparability: Slightly different, but comparable.)

Appendix 7: Community Forum

Appendix 7(a): Agenda

TODAY'S INDICATORS---TOMORROW'S SOLUTIONS
"harnessing the power of community to improve our health"

September 23rd, 2006 9:00 a.m. to 3 p.m.
@ Edward Milne Community School

0800	Registration & coffee
0900	Welcome/overview Marlene Barry, Forum Coordinator T'Sou-ke Nation Councillor, Rodney George Sooke District Mayor, Janet Evans Victoria Power-Pollitt, Vancouver Island Health Authority
0945	Keynote: Valerie Tregillus, Executive Director Chronic Disease Management and Primary Health Care Renewal British Columbia Ministry of Health Services
1015	BREAK
1045	Community Resource Inventory – Dr. Ellen Anderson Family Practice Physician & CHI member
1100	RRFSS data – Dr. John Millar, Executive Director Population Health Surveillance & Disease Control Provincial Health Services Authority (PHSA)
1130	Survey Data – Dr. Murray Fyfe, Medical Health Officer Population Health Surveillance Unit Vancouver Island Health Authority
1200	LUNCH
1230	FOCUS GROUPS: *Identify further questions of the data, recommend priority area, identify potential partners interested in addressing priority* Food Security; Social Networks &Resource Inventory Children & Youth; Primary Health Care Health & Economic Determinants; Neighbourhood & Physical Activity
1400	Results are posted in main commons for everyone to see - informal
1430	Closing comments – Lori Messer, CHI Coordinator

Appendix 7(b): CHI Forum Community Participants

	Registration		
	NAME		**E Mail**
1	Abernathy, Gail	Citizen	
2	Anderson, Ellen	CHI	jeanderson@telus.net;
3	Barry, Marlene	CHI	barryfambarry@netscape.net;
4	Barwis, Joyce	Citizen	
5	Beech, Sheila	Sooke Councillor	sbeach@district.sooke.bc.ca;
6	Benson, Barb	Citizen	
7	Bernard, Diane	Citizen	
8	Brehn, Nelly	Citizen	
9	Bryant, Chris	Citizen/Dentist	
10	Byers, Robert	Citizen	jkhutch@allstream.net;
11	Campbell, Arnie	OP/Shirley Rate Pay	d.acampbell@shaw.ca;
12	Childers, Milly	Citizen	
13	Clark, Bob	Citizen	
14	Corsiglia, John	Citazen	john_corsiglia@hotmail.com;
15	de Groot, Ursula	Citizen	
16	Dixon, Dalyce	Pacific Centre Family Services Assoc	ddixon@pcfsa.org;
17	Dotts, Anita	CHI	Anita.Dotts@viha.ca;
18	Dotts, Steven	Citizen	
19	Dowhy, Laura	Citizen	ldowhy@shaw.ca;
20	Dunn, Mary	CHI	Mary.Dunn@viha.ca;
21	Evans, Janet	Dist. Of Sooke Mayor	
22	Falconer, Nancy	CHI	nfalconer@bc.cancer.ca;
23	Fritz, Wayne	Citizen	wlfritz@shaw.ca;
24	Frosst, Gillian	VIHA	
25	Fryer, Michele	VIHA	Michele.Fryer@viha.ca;
26	Fyfe, Murray	VIHA	Murray.Fyfe@viha.ca ;
27	Gagnier, Janine	Pacheedaht Health Rep	counsellor@pacheedaht.ca;
28	George, Charlene	Citizen	selenii@go.com;
29	George, Colleen	T'Souke Nation	
30	George, Rheanna	T'Souke Nation	
31	George, Rodney	T'Souke Band Councillor	treaty2@tsoukenation.com;
32	Gilligan, J.	Longboating Group	gilligansisle@shaw.ca;
33	Gordon, Linda	Citizen – film maker	
34	Gruno, Mrs.	citizen	
35	Hall, Gail	Citizen	gandghall@shaw.ca;
36	Hall, Grant	CHI	grantlorahall@shaw.ca;
37	Hanneson, Bill	Citizen	blueotterfarm@shaw.ca;

38	Harper, Caryl	VIHA	Caryl.harper@viha.ca;
39	Heenan, Coleen	CHI	cheenan@uvic.ca;
40	Howe, Sandy	Citizen	
41	Hutchings, Larry	Seaparc Rep	lhutchings@crd.bc.ca;
42	Hutchins, Jane	CHI	jkhutch@allstream.net;
43	Ina		cooperscove@shaw.ca;
44	Irving, Robin	VIHA	Robin.Irving@viha.ca
45	Jorna, Rosemary	Juan de Fuca Trails Soc.	
46	Kadiri, Gillian	Sooke/Westshore Community Response Network	gilly@pacificcoast.net;
47	Klein, Kerri	BC Healthy Comm.	kerri@bchealthycommunities.ca;
48	Kumar, Ron	CHI	pdm180@shaw.ca;
49	Kusyzyn, Kathryn	Citizen	
50	Lambert, Sonia	Citizen	ricknsonia@yahoo.com
51	LaPage, Mary	Citizen	
52	Larke, Sue	Citizen	
53	LeComte, Dana	Citizen	Dana-l@shaw.ca;
54	Lewers, Ellen	Citizen	Mrslewersfarmhouse@shaw.ca;
55	Liguanti, Nina	Sooke Fam Res Cntr	**nlinguanti@sfrs.ca**;
56	Livingstone, May	Citizen	
57	Longstaff, Stephanie	SPEAC	sookepac@shaw.ca;
58	Mallett, Carol	Sooke Garden Club	info@snuggerybnb.com;
59	Manley, Suzanne	CHI	suzanne-manley@shaw.ca;
60	Mather, Brendan	VIHA	
61	Merier, Michelle	CHI	hah35@shaw.ca;
62	Messer, Lori	CHI	lmesser@sd62.bc.ca;
63	Millar, John	PHSA	jmillar@phsa.ca;
64	Moore, Warren	Citizen	
65	Nabata, Lynne	VIHA	lynn.nabata@viha.ca;
66	Parkinson, Brenda	Sooke Councillor	bparkinson@district.sooke.bc.ca;
67	Parsons, David	Citizen	
68	Peters, Carrie	Dunworkn Industries	carrieis@shaw.ca;
69	Phillips, Heather	JDF Trails	bphill1046@aol.com;
70	Plamondon, Angela	Citizen	Roger.Plamondon@rcmp-grc.gc.ca
71	Plamondon, Roger	RCMP Staff Sargent	Roger.Plamondon@rcmp-grc.gc.ca;
72	Planes, Marcella	T'Sou-ke Band Rep Community Health	health@tsoukenation.com;
73	Pocock, Jeff	Sooke Doctor	jeff.pocock@shaw.ca;
74	Pocock, Sallie	Citizen	jeff.pocock@shaw.ca;
75	Power-Pollitt, Victoria	VIHA	Victoria.Power-Pollitt@viha.ca;
76	Priest, Sharon	Citizen	suzanne-manley@shaw.ca;

77	Sannerz, Robin	Citizen	
78	Sprinkling, Bonnie	Sooke District Management	bsprinkling@district.sooke.bc.ca;
79	Stafford, Krista	School based Social Worker	Krista.Stafford@gov.bc.ca;
80	Stirling, Bridey	Citizen	
81	Swinburson, Margot	Sooke School Board	margot_bc@shaw.ca;
82	Szadkowski, Laurie	SD62 Teacher	szads@shaw.ca;
83	Taggart, Tara	Canadian Cancer Assoc	ttaggart@bc.cancer.ca;
84	Tata, Tony	Sooke Family Resource Centre	
85	Taylor, Emma	CHI	emtaylor@uvic.ca;
86	Thonney, Claudine	St Vincent DePaul Soc	cthonney@svdpvictoria.com;
87	Traver, Margaret	Citizen	
88	Tregillus, Valerie	BC Ministry of Health	
89	Valley, Tomas	Sooke Doctor	

Appendix 7(c): CHI Forum Community Input

CHILD AND YOUTH:
NOTES

WHAT PROBLEMS OR ISSUES DID THE SURVEY EMPHASIZE?

- Those who said Sooke "is not a good place to raise children":
  - WHY?
  - What needs are not being met for them? (20%)
- Why did the respondents feel Sooke "is a good place to raise children"?
- How do we get the adults more involved in a positive way that encourages youth/children to look up to?
- Trust
  - Allowing children to be with other adults
  - How do we deal with this issue?
- How do we promote community role models or 'champions' for the youth?
- Need for cross-generational connection
- Absence of opportunities to learn 'life skills'
- Less opportunity for Safe Parks, playgrounds, and play spaces – not enough
- More information is needed on how Injury Hospitalization/Respiratory Hospitalization was measured
  - Do people become 'chronic' before seeking intervention?
- How was "preschool development" measured?
- Breakdown between 'children' and 'youth' needs to be defined more in-depth
- Increased need for transitioning from 'school' to 'life':
  - Practical essentials i.e.: ID, passports, services, etc.
- High school Graduation (low)
- Not enough organized group activities that bring families together
- Need for apprenticeship and/or trades programs for youth
- Very little support for mental health and addictions issues
- Non-sufficient support for families
  - Re: intervention of individual supports
  - Creative outreach for families
- No affordable access to counselling

COMMUNITY PRIORITY	
36	➢ **Services for mental health and addictions are needed**
27	➢ **More support (outreach) to families:** - **ie.: individual supports, parenting, etc.**
20	➢ **Need alternative learning opportunities:** - **ie.: apprenticeship programs, trades, experiential learning programs (because of low graduation rate)**
11	➢ **Positive mentorship needed in the community:** - **Identify and advertise who the 'champions' are**
10	➢ **Need increased Life-skills:** - **Organized team/group activities that prepare youth for the 'real world'**
4	➢ **Low school and/or community spirit**

CHILD AND YOUTH: PRIORITY SUMMARY

CHI FORUM
COMMUNITY INPUT
SEPTEMBER 23, 2006

FOOD SECURITY:
NOTES
Caryl Harper
Room 1100

- EDUCATION:
  - Accessing and promotion of existing local knowledge/resources
  - How to garden
  - Preparation/Preservation
  - Map of current community garden locations
  - Increase awareness of available resources
  - Benefits of backyard garden

- ECONOMICAL FACTORS:
  - Short-term food relief
    - Barriers to access
    - Remote community challenges
  - Gleaming Programs (sharing)
  - Bartering (trade food for labour)

- LAND AVAILABILITY:
  - Density of housing
  - Losing more and more land from ALR
  - Is there land available for more community gardens?

- LIFESTYLE CHOICE:
  - Community Service
  - Motivation
  - Slow Food Movement
  - Therapeutic Benefits
  - More fairs/competitions to promote faming/gardening

COMMUNITY PRIORITY

FOOD SECURITY PRIORITY SUMMARY:
Caryl Harper

Community Health Survey Result:
A high % of respondents ate less than they should have

21

- LAND AVAILABILITY:
  - Retain affordable land for the lifestyle choice or feasible options for community gardens

16

- LIFESTYLE CHOICE:
  - Promoting Slow Food Movement/Bartering
  - Promoting “backyard gardens”
  - Grow Local, Buy Local

15

- EDUCATION:
  - Accessing and promoting existing local knowledge and resources
  - Linking “those in need” with those with knowledge and resources
  - Develop Regional Food Security Plan

9

- ECONOMIC FACTORS:
  - Gleaning Programs (sharing)
  - Address barriers:
    - Short-term food relief (i.e.: transportation, knowledge)

CHI FORUM
COMMUNITY INPUT
SEPTEMBER 23, 2006

HEALTH & ECONOMIC DEVELOPMENT: NOTES

Jane Hutchins, Room 1103

- Health – local level
- Current Sooke inventory and statistics
- Environmental/Economic Science
- Children – health, nutrition, actions
- Local business resources and support
- System support to keep people healthy
- Holistic resolutions/collaboration
- Economic Status = Health Status
- Health promotion tool development
- Dementia/delirium research results
- Social infrastructure must keep up with growth?
- Chicken or the egg?
- Low Income = Low Health
- Transportation improvement
  - Community Bus (new)
- Rapid Growth: Housing
- Houses/condos/trailers, etc.
- Environment
- No place left to go
- Constraints
- Self-image related to income
- Starting with children
- Early teen self-esteem support workshops
- Subsequent action following information
- Volunteer system as actual resource
- New resident influx
- Culture shock for new residents
- Part of Official Community Plan
- Population changes?
  - Schooling
  - Health
- More use of local resources
- Produce
- Books
- Buildings
- Transportation
- Advocacy role
- Education (re: options)
- Isolation (re: issues)
- Priorities: inventory of what we already have
- Factual information
  Access to this information
- Directory of Services ("Blue Book")
- Facts free of political views
- Information is key
- Trust is HUGE issue
- Relationship networking
- New "normal"?
- HOUSING ISSUES
- Rapid Growth: Housing
  - Houses/condos/trailers, etc.
  - Environment
  - No place left to go
  - Constraints

Courtyard neighbourhood concept

3. Socialization issues
   - Economic
   - Proximity
   - Generation interaction
   - UNTIEING QUALITY OF LIFE FROM ECONOMIC STATUS
   - Self-image related to income
     - Starting with children
   - Chicken or the egg?
     - Low Income = Low Health
   - EDUCATION
     - Re: Resources and life-skills

- (RAPID) POPULATION GROWTH
  - Newcomers
  - Social Infrastructure
  - Perceptions (the challenges they pose)

- ➢ TYPE OF AND AMOUNT OF EMPLOYMENT OPPORTUNITIES
- ➢ Community support of local business who support the community
- ➢ Chamber of Commerce
- ➢ Community support of local business who support the community
- ➢ More use of local resources
  - Produce
  - Books
  - Buildings
  - Transportation
- ➢ INFORMATION AND TRUST/RELATIONSHIP
  - Subsequent action following information
- ➢ Information is key
  - Trust is HUGE issue
- ➢ Relationship networking
  - Factual information
  - Access to this information
- ➢ Directory of Services ("Blue Book")
  - Facts free of political views

- ➢ LEVELS OF ISOLATION (perceived)
  - Need to be addressed
- ➢ Socialization issues
  - Economic
  - Proximity
  - Generation interaction
  - Isolation (re: issues)

- RECIPROCAL RELATIONSHIP WITH BUSINESS COMMUNITY

- HEALTH
- ➢

CHI FORUM COMMUNITY INPUT – SEPT 23, 2006
HEALTH & ECONOMIC DEVELOPMENT
PRIORITY SUMMARY:
Jane Hutchins

COMMUNITY PRIORITY	
27	- HOUSING ISSUES
14	➢ UNTIEING QUALITY OF LIFE FROM ECONOMIC STATUS
8	➢ EDUCATION - Re: Resources and life-skills
7	- (RAPID) POPULATION GROWTH - Newcomers - Social Infrastructure - Perceptions (the challenges they pose)
5	➢ TYPE OF AND AMOUNT OF EMPLOYMENT OPPORTUNITIES
4	- INFORMATION AND TRUST/RELATIONSHIP
4	➢ LEVELS OF ISOLATION (perceived) - Need to be addressed
2	- RECIPROCAL RELATIONSHIP WITH BUSINESS COMMUNITY

CHI FORUM
COMMUNITY INPUT
SEPTEMBER 23, 2006

NEIGHBOURHOODS & PHYSICAL ACTIVITY: NOTES

Nancy Falconer
Room 1086

- WHOSE RESPONSIBILITY??
- Assets:
  - Existing parks, trails
- Protection
- Safety:
  - Biking
  - Walking
- Access:
  - Public vs. Private
  - Signage/Awareness
  - Waterfront
- Tourism:
  - Economic Development
- Political and Legal Issues
- Existing Information:
  - Collaboration (VIHA – Community Resource Inventory)
  - District Newsletter
  - JDF Recreation

NEIGHBOURHOODS & PHYSICAL ACTIVITY: PRIORITY SUMMARY

Nancy Falconer

COMMUNITY PRIORITY	
27	➢ Collaboration of individuals and interest groups: - SEAPARC, JDF Recreation, etc.
24	➢ Advocacy: - For improved sidewalks, bike lanes, paths, wheelchair access, parks, beach access, etc.
15	➢ Add to Community Resource Inventory Map: - Trails, beach access, bike lanes, parks, etc.
10	➢ Safety, traffic calming, lighting, signage
4	➢ Economic Barriers (to recreation): - Cost of bikes, programs, transportation, etc.
2	➢ Children and Youth and School: - Location of bus stops, traffic, routes, etc.
2	➢ Private Land and Trail Access
1	➢ Work Parties (Volunteer): - Maintenance of trails
0	➢ Getting to Bus Stops

COMMUNITY PRIORITY	CHI FORUM COMMUNITY INPUT SEPTEMBER 23, 2006

PRIMARY HEALTH CARE:
NOTES
Dr. Ellen Anderson
Room 1094

Public Perception of Public Health Care: Primary = $ MSP

Secondary = Everything Else

COMMUNITY PRIORITY	
2	❖ PRIMARY HEALTH CARE ➢ 1st Contact ➢ VIHA: regular on-going care (multi/inter-disciplinary): 1. Increased Chronic Disease 2. To get better 3. End of life
2	❖ COMPLEMENTARY HEALTH CARE ➢ Integration of Complementary Health Care and other services to decrease economic barriers
2	❖ IS PUBLIC HEALTH CARE ACCESSIBLE? ➢ NO ➢ Often problem-focused: - People disempowered - Decreased accessibility

➢ Prevention/early intervention has not been funded (this is changing)

➢ Larger perspective needed:
- Complementary Care
- Prevention

➢ VIHA/Interdisciplinary Communication:
- Need systemic support
- Need good communication and system knowledge

COMMUNITY PRIORITY	
	➢ Geography: - Remote locations - Housebound - Transportation
	➢ First Nations access is limited - Face-to-face relationships needed first - Being present/outreach - This needs to be system-wide
14	➢ ONE-STOP SHOPPING: - Need a range of services working together in one place, or within a network. This increases accessibility (e.g.: Navigator Project) - Each member needs to reach out with questions/ knowledge - RESPONSIBILITY
7	➢ SUSTAINABLE funding for volunteer organizations (e.g.: driving services, Crisis Centre) for what community prioritizes.
	➢ Need "hubs" of knowledge and relationships
2	➢ "Bridging" clients is effective in increased accessibility of service
6	➢ Need information to flow 2 ways, in a timely manner, between Primary Health Care and referred services.
11	➢ A Personal Health Record (ownership is client's): - Empowers people - Pilot Project coming through VIHA (Ladysmith, Port Renfrew & Sooke?) - Need capacity to keep updated - Providers must commit to this
	➢ Port Renfrew/Pacheedaht: - Decision tree for service access - Key local people who know services and access protocols.
1	➢ VIHA and MOH are creating on-line resources: - Networks are making these resources more accurate and viable over time
	➢ Agency access: - We need to look at the threshold of access

COMMUNITY PRIORITY	
2	➢ Economic barriers affect service access
9	➢ Most services are aimed at the 50% who might benefit - No options for others
	➢ NGO funding for high-needs services is tenuous, inconsistent and hard to find
	➢ We need to support alternative ways of delivering care
2	➢ ? A community network to support… - e.g.: Caregivers Support Networks
9	➢ ? Increase in local taxes for sustainable "Healthy Communities" - We need commitment locally
5	➢ Healthy Community Policy at a Municipal level - With 'teeth' to support bylaws and initiatives
8	➢ Need to advocate with Provincial and Federal Governments for sustainable funds for services in our community

PRIMARY HEALTH CARE: PRIORITY SUMMARY

COMMUNITY PRIORITY	
17	➢ One-stop shopping for service access
9	➢ Personal Health Record (and other ways to empower people and share information)
7	➢ Need services for the people who need them the most and access them the least
7	➢ Sustainable funding for volunteer and NGO services
3	➢ Need local advocacy for needed services
3	➢ Two-way information flow: i.e.: Clients ← → Primary Health Care Primary Health Care ← → Other Services
1	➢ Small increase in local taxes for a "Healthy Community Plan" with community-determined priorities

COMMUNITY PRIORITY	CHI FORUM COMMUNITY INPUT SEPTEMBER 23, 2006
	SOCIAL NETWORKS/RESOURCES: NOTES AND PRIORITY SUMMARY Michelle Marier Room 1177
32	➢ To improve resources for, build capacity in, and improve relationships between organizations, and between organizations and the community-at-large.
23	➢ To increase awareness and visibility of social support and resources in our community.

Appendix 8: Community Survey Results

Appendix 8 (a) CHI Community Health Survey Results

Appendix 8 (b) CHI Community Health Survey Cross Tabulations

Prepared by Population Health Surveillance Unit, Office of the Chief Medical Health Officer
Vancouver Island Health Authority, November 17, 2006

Economic Determinants

Table 1. Economic Determinants

	<$30,000	$30,000-$49,999	$50,000-$79,999	$80,000+
Self-Reported Fair/Poor Health	33.2%	15.5%	11.6%	8.4%
Self-Reported Fair/Poor Mental Health	21.9%	11.8%	8.6%	7.6%
Dissatisfaction with Life	13.4%	6.8%	5.9%	2.4%
Fair/Poor Ability to Cope with Unexpected Situations	30.2%	12.4%	9.9%	9.3%
Fair/Poor Ability to Cope with Day-to-Day demands	22.3%	9.3%	5.7%	1.7%

Social Networks

Table 2a. Social Networks

	<$30,000	$30,000-$49,999	$50,000-$79,999	$80,000+
Strong/Very Strong Sense of Community Belonging	52.8%	56.5%	55.9%	55.1%

Table 2b. Social Networks

	Single Parent with Kids	Spouse/Partner with Kids	Spouse/Partner without Kids	Unattached Living Alone or with Others
Strong/Very Strong Sense of Community Belonging	52.0%	57.3%	56.5%	53.9%

Table 2c. Social Networks

	East Sooke	Sooke	Otter Point	Other
Strong/Very Strong Sense of Community Belonging	45.2%	55.0%	60.0%	73.4%

Neighbourhoods

Table 3. Neighbourhoods				
	East Sooke	**Sooke**	**Otter Point**	**Other**
Room to Walk Safely	29.4%	28.6%	26.3%	23.5%
Room to Bike Safely	15.2%	20.5%	13.0%	13.0%

Food Security

Table 4a. Food Security				
	Single Parent with Kids	**Spouse/Partner with Kids**	**Spouse/Partner without Kids**	**Unattached Living Alone or with Others**
Ate Less than Should Have	42.3%	8.0%	2.7%	9.1%

Table 4b. Food Security				
	<$30,000	**$30,000-$49,999**	**$50,000-$79,999**	**$80,000+**
Used Food Bank	12.5%	2.3%	0.3%	0.0%
Ate Less Than Should Have	19.5%	6.5%	4.3%	1.6%

Table 4c. Food Security		
	16-64 years	**65+ years**
Used Food Bank	3.8%	8.6%
Ate Less Than Should Have	0.7%	2.3%

Children & Youth

Table 5a. Children & Youth				
	East Sooke	**Sooke**	**Otter Point**	**Other**
Good/Very Good Place to Bring Up Children	79.6%	76.4%	80.7%	69.6%
Agree/Strongly Agree Safe Parks and Play Spaces	53.1%	52.7%	27.5%	55.1%
Agree/Strongly Agree Neighbourhood has Adults that Children Look Up To	75.3%	61.8%	69%	73.4%

Table 5b. Children & Youth				
	<$30,000	**$30,000-$49,999**	**$50,000-$79,999**	**$80,000+**
Good/Very Good Place to Bring Up Children	71.3%	72.7%	82%	86.1%