Oromocto and Surrounding Area

COMMUNITY HEALTH NEEDS ASSESSMENT

Fall 2018

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

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Cover photo credits:
Jason Belliveau; Town of Oromocto

List of Abbreviations

ASD-W: Anglophone School District-West
Base Gagetown: 5th Canadian Division Support Group (5 CDSG) Gagetown
CAC: Community Advisory Committee
CHA Team: Community Health Assessment Team
CHNA: Community Health Needs Assessment
Gagetown MFRC: Gagetown Military Family Resource Centre
Horizon: Horizon Health Network
LGTBQ2+: Lesbian, Gay, Transgender, Bisexual, Queer or Questioning, two-spirited (1)
NBHC: New Brunswick Health Council
OSA: Oromocto and Surrounding Area
OSI: Operational Stress Injury
PTSD: Post Traumatic Stress Disorder
RHA: Regional Health Authority

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1.0 Report Summary

Introduction to Community Health Needs Assessments

People in New Brunswick want to thrive and be healthy. Control over one's health and wellness is dependent, to a large extent, on the support provided by the people, places, and things that surround them. A Community Health Needs Assessment (CHNA) is a recognized approach to understanding health and wellness at a local, community level. Through community engagement, a CHNA can define an area's strengths and needs leading to the identification of local priorities that, when acted upon, can improve the health and wellness experienced by individuals and population groups.

Oromocto and Surrounding Area

In the spring of 2018, a CHNA was initiated by Horizon Health Network in collaboration with community representatives from Oromocto and the surrounding villages and Local Service Districts. We acknowledge that the land on which we gathered to facilitate the CHNA is the traditional unceded territory of the Wolastoqiyik (Maliseet) and Mi'kmaq Peoples covered by the "Treaties of Peace and Friendship" in 1725. Within the province, this area is in the south-central part of New Brunswick and supports a population of approximately 18,400 people. To ensure the name of the assessment reflects how community members identify with the area, members of the Community Advisory Committee chose the name Oromocto and Surrounding Area (OSA). The following communities were included in the assessment: Burton, Blissville, Fredericton Junction, Gagetown, Geary, Gladstone, Hoyt, Oromocto, Oromocto First Nation, Tracy, and Upper Gagetown. Four additional communities, resting outside the boundary of OSA, were also considered during the process as they are known to be linked to the area and many living within these communities would associate themselves with this part of the province. These outlying communities include Hamsptead, Lincoln, Rusagonis, and Wirral.

Population characteristics unique to this area include a large representation of military members and their families who are connected to Base Gagetown located in the Town of Oromocto contributing to considerable movement of citizens in and out of the area on an annual basis. In addition, the hub of programs, activities, and supports available in Oromocto often service the needs of many residents living in the surrounding rural communities. Finally, the area is home to the Oromocto First Nation. The Oromocto First Nation community sits adjacent to the Town of Oromocto and supports a Maliseet population of approximately 713 people (2).

The first CHNA for this area of the province was completed in 2011. From this work, 10 'health and wellness priority areas for action' were recommended. In response to the identified need to ensure the provision of primary health care and prevention in the local area, the Oromocto Health Centre was established. Since opening its doors, the number of residents who have access to a primary care provider has increased. In addition, the model of care provided through the health centre responds to many priority areas recommended in the 2011 CHNA report by offering outreach and supporting health services to the surrounding area through collaborations with local communities, organizations, and schools.

Current Snapshot of Oromocto and Surrounding Area's Health and Wellness

Adults and seniors living in this area of the province continue to be challenged by increasing rates of chronic health conditions that have many physical and mental health care implications. While several community members see their health as very good to excellent, the percentage of adults who see their mental health as very good to excellent has decreased. In addition, a considerable proportion of children and youth between nine and 18 years of age describe having symptoms of depression and anxiety. Finally, despite the increase in the number of residents who have access to a primary care provider since 2011, many residents still face primary care access barriers.

1.0 Report Summary continued

2018 Community Health Needs Assessment Process

Applying a population health perspective and an understanding of the social determinants of health, Horizon's Community Health Assessment Team facilitated the current CHNA with a 14-step process to meaningfully engage community members. These steps provide a level of structure that ensures a consistency between individual assessments while, at the same time, offers flexibility to shift and adjust to unique local circumstances.

We acknowledge there are limitations within this process. Our chosen timeframe to introduce and facilitate a CHNA within a given area is short and limits our ability to thoroughly inform communities and important population groups about our work. This limitation ultimately impacts who is involved and can contribute to a collaboration that does not fully represent a given area. We are learning, as a Community Health Assessment Team, ways we can share our process with communities well before beginning an assessment so we give adequate time for community representatives to understand our process and trust the purpose of our work. A second limitation, also constricted by our timeframe, is our inability to collect specific quantitative information at the local level during a CHNA. Currently, we rely on statistical data already available to support our investigation, but we recognize other information, often gathered through quantitative means, may be missed.

Health and Wellness Knowledge Gaps and Areas of Concern

OSA's CHNA Community Advisory Committee reviewed area-specific quantitative data compiled by the New Brunswick Health Council and identified knowledge gaps and areas of concern in need of further investigation. Eighteen consultations, twelve focus groups and six key-informant interviews, were facilitated. A total of 74 community members living and/or working in OSA participated. Each consultation had an intended focus, however because many identified concerns overlapped, the following is a list of the knowledge gaps/areas of concern that were purposefully discussed with community members throughout the consultation process.

- Coping as a family with young children
- Living with special needs
- Military family health and wellbeing
- Rural living
- Social supports in the community
- Youth and youth supports
- Health Promotion services
- Mental health challenges and supports
- Primary Care access
- Seniors and seniors' supports
- Women's health

2018 Health and Wellness Priorities

The following 10 Health and Wellness Priorities are the voiced needs, in order of priority, determined by OSA community representatives who joined our Community Advisory Committee or participated in a consultation (Table 1). These priorities will be shared with those responsible for health service planning as well as other stakeholders who are involved in the work of supporting the health and wellness of local citizens.

1.0 Report Summary continued

Table 1 – OSA's 2018 Health and Wellness Priorities and Recommendations[1]

Priority	Community Recommended Action
1 The need to improve access to local primary care providers and support services for all community members.	Identify and address the local barriers limiting timely, regular and confidential access to primary health care.
2 The need to better support the mental health needs of children, youth, and adults living in OSA.	Develop an understanding of mental health resources and supports available in OSA, identify service gaps, and overcome barriers to access.
3 The need to enhance public awareness of local programs and services that promote and support health and wellbeing.	Establish a community-wide public communication plan for OSA.
4 The need to address the lack of affordable, reliable transportation services in OSA.	Collectively develop a community-wide transportation plan for OSA.
5 The need to support rural communities and improve access to health services, programs, and supports in rural areas.	Identify solutions to maintain or establish community services, supports, and programs that would help sustain rural living.
6 The need to sustainably strengthen current efforts addressing community and household food security.	Support and increase the capacity of local and regional efforts already addressing food insecurity.
7 The need to better support families who are struggling with day-to-day demands and expectations.	Address local service gaps in the current system that already provides support services to families living on modest incomes and those needing extra daily support.
8 The need to improve communication and collaboration between local and regional services and programs.	Establish a community-wide service/program provider communication and collaboration plan for OSA.
9 The need to address mental resiliency in youth living in OSA and improve their coping skills.	Strengthen the collective capacity within OSA to engage youth in opportunities proven to boost mental resiliency and enhance coping skills.
10 The need to address the current understanding and belief system around cannabis use and how it impacts children and youth.	Contribute to a community-wide effort focused on educating all residents about cannabis use and the effects it has on child and youth development.

Next Steps

With the completion of this CHNA for OSA, Horizon is willing to work in innovative ways with community members and stakeholders to address the priorities identified in this report. As a Regional Health Authority (RHA), we acknowledge that good work is already underway through existing partnerships and current collaborations. We recognize opportunities exist to join in this work to contribute to impactful solutions that will address health and wellness inequities experienced in this area.

1 To support communication of OSA's Health and Wellness Priorities an Infographic can be found online: www.en.horizonnb.ca/chna

2.0 Introduction

2.1 History of Community Health Needs Assessments in New Brunswick

To be healthy is to experience "a state of complete physical, mental, and social well-being; a fundamental right of everyone without distinction of race, culture, religion, political belief, economic or social condition" (3). In New Brunswick, two RHAs support the health of its citizens by sharing in the provision of health care services (4). An important piece to providing health care is learning about the assets that support healthy living and the factors and conditions that compromise the ability of citizens to enjoy life in a healthy and well manner. A CHNA, a practice conducted in many parts of the world, is a recognized approach to understanding health and wellness at a local level (5). In 2012, the New Brunswick Department of Health released the *Primary Health Care Framework* recommending the facilitation of CHNAs as a first step to understanding and enhancing the health and wellness of communities across the province (6). Since that time, Horizon has supported the completion of 17 CHNAs, one for every community[2] within its region. Throughout this work it became evident that the practice of engaging citizens to share in the process of determining community health priorities was very valuable. It strengthened the local relationships between service providers and community members as well as the regional relationship between communities and Horizon as a health authority within the province. Also evident was the contribution CHNAs made towards fulfilling Horizon's mission of Helping People be Healthy (7). In 2017, the Government of New Brunswick committed to supporting both RHAs in the practice of facilitating CHNAs across the province on an on-going basis with the goal of completing one in each community every five years.

Figure 1 – Map of NBHC Communities

2.2 What is meant by Community?

New Brunswick is divided into seven health care zones. Each zone, on its own, canopies several communities and represents many different groups of people. To allow for a focus on local health and wellness, the New Brunswick Health Council (NBHC[3]) has divided the province into 33 communities (Figure 1). Each NBHC community is a varied collection of cities, towns, municipalities, and local service districts that fall within the catchment area of health care centres, community health centres, and hospitals. Census subdivisions within the defined NBHC community boundaries were merged together to support the collection of statistical data. To confirm a fair representation, the 33 NBHC communities were further authenticated with various community members from all areas of the province. Each NBHC community was created with no less than 5,000 people to ensure any available statistical data was usable while at the same time maintaining the privacy of citizens who provided information to inform the data (8).

2 'Community' as defined by New Brunswick Health Council. See 'What is meant by Community?' for further clarification

3 NBHC is a legislated body working at arms-length from the government with a dual mandate to report publicly on the performance of the health system and to engage New Brunswickers in the improvement of health care service quality.

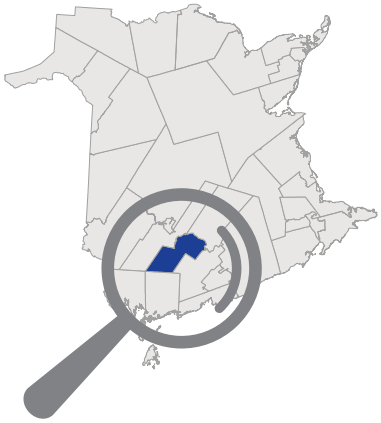
3.0 Oromocto and Surrounding Area

We acknowledge that the land on which we gathered to facilitate the CHNA for OSA and the area under assessment is the traditional unceded territory of the Wolastoqiyik (Maliseet) and Mi'kmaq Peoples covered by the "Treaties of Peace and Friendship," which Wolastoqiyik (Maliseet) and Mi'kmaq Peoples first signed with the British crown in 1725. The treaties did not deal with surrender of lands and resources but in fact recognized Mi'kmaq and Wolastoqiyik (Maliseet) title and established the rules for what was to be an ongoing relationship between nations. NBHC named this community Oromocto, Gagetown, and Fredericton Junction Area (9). During the CHNA, the name was revised to better capture how the community members identify with the area. Those involved in the CHNA as members of the Community Advisory Committee chose the name Oromocto and Surrounding Area (OSA) which includes the following municipalities and Local Service Districts: Blissville, Burton, Fredericton Junction, Gagetown, Geary, Gladstone, Hoyt, Oromocto, Oromocto First Nation, Tracy, and Upper Gagetown.

3.0 Oromocto and Surrounding Area continued

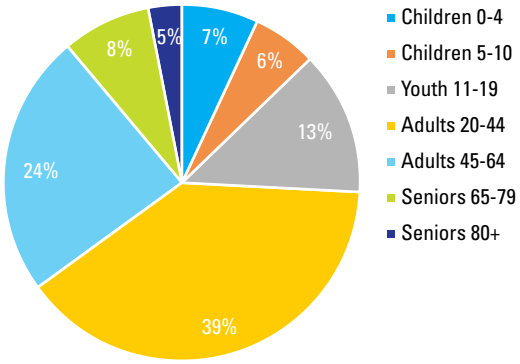
Four local communities, resting outside the mapped boundary, were identified as ones whose residents would associate with OSA: Hampstead, Lincoln, Rusagonis, and Wirral. Many residents from Hampstead, Lincoln, and Rusagonis work in and/or use the services in this area such as schools and health care. In addition, the residents from Wirral are closely attached to the tri-county area of Fredericton Junction, Tracy, and Hoyt. To acknowledge the local interpretation of NBHC community boundaries, commentary and perspectives reflecting these local areas were welcomed during our CHNA meetings and community consultations with an understanding that available quantitative data did not reflect this inclusion.

Figure 2 – Map of Oromocto and Surrounding Area



OSA is in the south-central part of the province. The Town of Oromocto is a service hub for many of the smaller surrounding villages and Local Service Districts. Many citizens that call this area of the province home live in the many smaller, more rural, communities extending along Highway 102 to Gagetown and down Highway 101 from Tracy through Fredericton Junction to Hoyt. The population of this area is approximately 18,400; 2.4% of the population of New Brunswick. Adults between the ages of 20 and 44 years represent the largest group. A unique characteristic of OSA is that many residents are connected, either through employment or through family, with Base Gagetown resulting in considerable movement of community members in and out of the area on an annual basis. Finally, this area of New Brunswick is home to the Oromocto First Nation. The Oromocto First Nation community sits adjacent to the Town of Oromocto and supports a Maliseet population of approximately 713 people (2).

Figure 3 – OSA's Age Demographics



3.1 2011 Community Health Needs Assessment

The first CHNA for OSA was completed in 2011 (10). This work was facilitated by an independent researcher supported by an active and involved Health Care Advisory Committee. From this dedicated and detailed assessment, the following 10 Health and Wellness Priority Areas for Action were recommended (Table 2):

Table 2 – OSA's 2011 Key Priorities Areas for Action

Address access to public transportation
Empower governance structures and community infrastructure
Increase access to services for mental health and addiction
Ensure appropriate and enabling housing
Provide primary care and prevention in the communities
Support sustainable income, inclusion, and health equity
Ensure ready access to recreational facilities accommodating all ages
Strengthen intersectoral collaboration
Promote a dramatic change in culture around obesity
Revive the volunteer sector

3.0 Oromocto and Surrounding Area continued

The community boundaries defining OSA in 2011 were different from our current assessment encompassing a larger population from a broader geographical area making it challenging to identify changes in community level health and wellness from then to now. This is not to diminish the work that has advanced in OSA in response to the recommended priorities over the last seven years. To address the need for the provision of primary health care and prevention in the community, the Oromocto Health Centre was established including health service support from a physician, two nurse practitioners, a registered nurse, a licenced practical nurse, a social worker, and a dietitian. The model of care provided through the health centre supports outreach to the surrounding rural area as transportation is often a challenge when health and wellness opportunities are more centrally located. Outreach service initiatives are made possible through collaborations with local communities such as the Oromocto First Nation, local organizations such as the Oromocto Clothing and Food Bank, and locally run institutions such as schools and the Gagetown Military Family Resource Centre (Gagetown MFRC).

These initiatives are strengthening community health by responding to many of the priority areas for action recommended in the 2011 CHNA report including: 1) increasing access to services for mental health and addiction, 2) strengthening intersectoral collaboration, and 3) promoting a dramatic change in the culture around obesity. In 2017, a Community Developer joined the health centre's team to forge connections, strengthen community cohesion, and facilitate action towards creating a healthier community for all. For a more detailed description of specific health promotion and disease prevention initiatives in the area, please refer to the In Your Community: Community Health Needs Assessments in Action[4], June 2016, Issue 1 (11).

4 To access In Your Community: Community Health Needs Assessments in Action, June 2016, Issue 1 click HERE or visit http://en.horizonnb.ca/home/media-centre/publications/in-your-community.aspx

4.0 Guiding Principles for Community Health Needs Assessments

CHNA Guidelines for New Brunswick, collaboratively developed by both RHAs and the New Brunswick Department of Health, recommends the application of a population health perspective informed by the social determinants of health as a guiding structure to investigating health and wellness in communities (12).

4.1 Population Health Perspective

Many groups of people live alongside one another in any given community. These groups can include seniors who live alone, immigrants new to an area, or families living on low income. The health and wellness experienced by a group of people depends on a broad range of interconnected factors and conditions often referred to as the social determinants of health (Table 3) (13,14). A population health perspective looks at different groups of people living in a given area and assesses how different social determinants impact health outcomes. Certain social determinants have a stronger influence on our health than others and can contribute to health inequities between population groups that are unfair and, with purposeful attention, can be reshaped to positively impact health and wellness (15). Using the population health perspective, a community can develop an understanding of the differences in health and wellness between groups so action taken can be focused on minimizing the factors that limit the ability to live healthy and maximizing the factors that improve health and wellness (16).

4.0 Guiding Principles for Community Health Needs Assessments continued

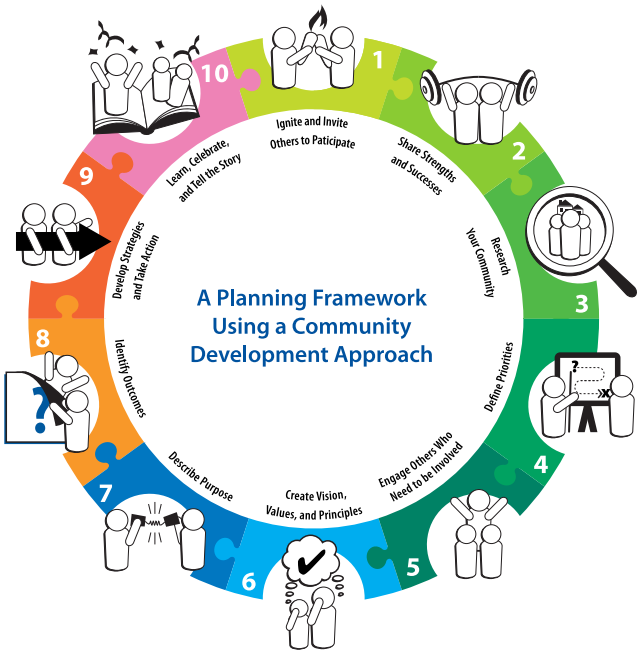
Table 3 – Social Determinants of Health, Health Canada (15)

1. Income and Social Status	**7.** Personal Health Practices and Coping Skills
2. Social Support Networks	**8.** Healthy Child Development
3. Education and Literacy	**9.** Health Services
4. Employment and Working Conditions	**10.** Gender
5. Physical Environment	**11.** Social Environment & Community Cohesion
6. Biology and Genetic Endowment	**12.** Culture

4.2 Community Development Approach

CHNAs are also guided by the Community Development Approach (17)[5]. This approach represents a belief that communities are the experts of their own needs and strengths. Engaging and consulting with communities about the lived experiences of their residents holds great value as it provides a deeper understanding of local strengths and concerns. The Community Development Approach involves 10 stages. The first four stages involve the process of inviting community representatives to come together around a focused issue to investigate and research the strengths and needs of their community. The result of this collective effort is to determine a list of priorities that need action and attention. A CHNA fulfills Stages 1 through 4 within this approach with a coordinated investigation of community health needs. Upon the completion of a CHNA, work continues by sharing results from the assessment, engaging others to create a plan on how to address the identified priorities, taking collective action, and reflecting on this work to improve and adjust efforts. The symbolism of displaying this approach in a circle is important as it shows a continuous commitment that reflects upon and responds to evolving strengths, needs, and priorities.

Figure 4 – Herchmer's Planning Framework Using a Community Development Approach



5 A Planning Framework Using a Community Development Approach by Brenda Herchmer is licensed under a Creative Commons Attribution- NonCommercial-NoDerivatives 4.0 International License.

5.0 Horizon's Community Health Needs Assessments

5.1 Our Community Health Assessment Team

Horizon's Community Health Assessment Team (CHA Team), housed within the Department of Population Health, has expanded since 2017 to not only support the completion of CHNAs but to remain in communities to be involved in and support the work of responding to identified priorities. In addition to the Research Lead and Project Coordinator whose work includes the planning and facilitation of CHNAs, there is also a Regional Facilitator who serves as a connecter across the region to ensure opportunities to learn from and collaborate with each other on related health and wellness priorities are identified and promoted. We also benefit from a network of Community Developers who are rooted in communities and work alongside community members

5.0 Horizon's Community Health Needs Assessments continued

and stakeholders. Using the Community Development Approach and the priorities identified from CHNAs, Community Developers collaborate to create healthier, stronger, more connected communities with an overall intention to improve the health and wellbeing of all community members with an emphasis on those who need it the most.

5.2 Our Process

Horizon's CHA Team follows 14 steps to meaningfully engage with communities during a CHNA (Table 4). These steps offer a backbone to the process and provide a level of structure that reassures each community of a consistency between individual assessments while, at the same time, offers flexibility to shift and adjust to distinct local circumstances. In summary, the process unfolds over approximately six to nine months whereby community representatives are engaged through CHNA meetings and/or consultations where they contribute to identifying local Health and Wellness Priorities in need of action and attention.

Table 4 – Horizon's CHA Team's 14 Step CHNA Process

Step 1: Establish a Planning Team	A Planning Team is formed with key community members who have a strong understanding of the area to be assessed. These individuals are often leaders within the community serving in a health care or community service capacity who have an established relationship with its residents.
Step 2: Identify Community Advisory Committee (CAC) members	Guided by the social determinants of health, possible CAC members are identified by the Planning Committee. The CHA Team's Project Coordinator and Planning Committee members share in inviting potential CAC members to participate in the CHNA.
Step 3: Establish CAC	During the first CHNA meeting, the CHA Team shares the goals and objectives of the CHNA. A Terms of Reference (TOR) is introduced to clarify CAC roles and responsibilities. CAC members are given opportunity to provide feedback on the TOR and a final revised version is accepted by the committee.
Step 4: Identify local health and wellness assets	Facilitated by the CHA Team, CAC members begin the process of identifying community assets. Guided by the social determinants of health, this activity supports the creation of an Asset Collection. The Asset Collection is a 'living document' to be revised throughout the CHNA process. At the end of the CHNA the document is used and updated as planned action unfolds to address the CHNA Priorities.
Step 5: Review available quantitative data	CHNAs are based on the geographic community breakdowns defined by the NBHC. Data compilations, which come from multiply surveys and administrative databases are made available by the NBHC. The CHA Research Lead explores this data looking for any indicators that reflect areas that need further investigation and/or clarification by the CAC.
Step 6: Present highlights from data review to CAC	The CHA Team shares highlights from the quantitative data with the CAC.
Step 7: Share insights and discuss 'knowledge gaps' emerging from quantitative data review	CAC members discuss issues raised through the quantitative data review and give feedback about 'knowledge gaps' and 'areas of concern' that exist and need further clarification.

5.0 Horizon's Community Health Needs Assessments continued

Step 8: Develop a qualitative data collection plan.	From discussions with the CAC, the CHA Team develops a preliminary qualitative data collection plan outlining who may be consulted, how they may be consulted, and the timeline for consultation. CAC feedback and input about the qualitative data collection plan is solicited.
Step 9: Collect qualitative data in the community	The CHA Team collects qualitative data through community consultations with identified community groups and representatives. This data complements the quantitative data compilations provided by the NBHC.
Step 10: Facilitate consultation participant health and wellness prioritization	After each consultation, participants are offered the opportunity to prioritize a broad list of health and wellness concerns generated from the quantitative data discussions with the CAC.
Step 11: Analyze qualitative data	Qualitative data, collected during consultations, is analyzed. Findings are compared alongside the reviewed quantitative data (Step 5) and contribute to the creation of a list of specific, local health and wellness issues.
Step 12: Share health and wellness concerns and facilitate ranking to establish key health and wellness priorities	The list of specific, local health and wellness issues is shared and discussed with CAC members. Each CAC member is given the opportunity to rank the top health and wellness issues they believe need action and attention.
Step 13: Finalize priorities and recommendations, and final report	The ranking results from the CAC members and consultation participants contribute to prioritization. A list of health and wellness issues, in order of voted priority, is created. Depending on the community, the top six to 10 key priorities are selected along with community voiced recommendations for action. A final report is created detailing the CHNA process and the community's priorities.
Step 14: Share final report and begin planning for action	The final report is shared with the CAC during the final CHNA meeting. Discussion regarding next steps also takes place. The CHNA results are also shared with the larger community through various avenues.

5.3 Limitations

We acknowledge there are limitations within our CHNA process. Our chosen timeframe to introduce and facilitate a CHNA within a given area is six to nine months. This limits our ability to thoroughly inform communities and important population groups, prior to initiating the process, about our intentions and what we hope to do with collected information. This limitation ultimately impacts who is involved and can contribute to a collaborative group that does not fully represent a given area. We are learning, as a CHA Team, ways that we can share our work with communities well before beginning an assessment so we give adequate time and space for community representatives to understand our process and trust the purpose of our work. A second notable limitation, also restricted by the time available to complete a CHNA, is our limited capacity to collect our own specific quantitative information from the group of communities under investigation. Currently, we rely on statistical data already available to support our investigation, but we recognize other information, often gathered through quantitative means, may be missed.

6.0 OSA's 2018 Community Advisory Committee

An initial step in Horizon's CHNA process is the formation of a Community Advisory Committee (CAC). CACs play a significant role in a CHNA as they are the link between the community and Horizon's CHA Team. Attention is placed on creating a balance of individuals who work to support the health and wellness of community members alongside individual residents who represent various population groups living in the community, so a variety of perspectives are represented throughout the CHNA. Prior to any CHNA work, a Terms of Reference is established with each CAC to clarify roles, responsibilities, and guiding engagement principles. The commitment a CAC member offers is their contribution to investigating the health and wellness of their community through attending and participating in five face-to-face meetings spread out over six to nine months.

A broad range of community representatives who live and/or work in OSA were invited to take part in the CHNA. We were very fortunate to have great interest within the community. Representation for OSA's CAC came from the following:

- 5 CDSG Gagetown; Base, Units, Supports
- Ambulance NB
- Autumn Years 50+ Club
- Burton Lions Club
- Clinic 554
- Community Residents
- Fay Tidd Public Library
- Fredericton Junction Health Centre, Horizon
- Gagetown and Area Health Services Association Inc.
- Greater Fredericton Social Innovation
- Healthy Learners Program, ASD-W
- Local Businesses
- Midwifery Program, Horizon
- New Brunswick Association of Community Living
- NB Dept. of Environment and Local Government
- Oromocto Health Centre, Horizon
- Primary Health Care Program, Horizon
- Public Health, Horizon
- Royal Canadian Legion Branch 93 Oromocto
- Sexual Assault Nurse Examiner Program, Horizon
- Transportation, ASD-W
- Town of Oromocto
- United Way of Central New Brunswick
- Village of Fredericton Junction
- Village of Tracy
- Wellness Branch, Social Development

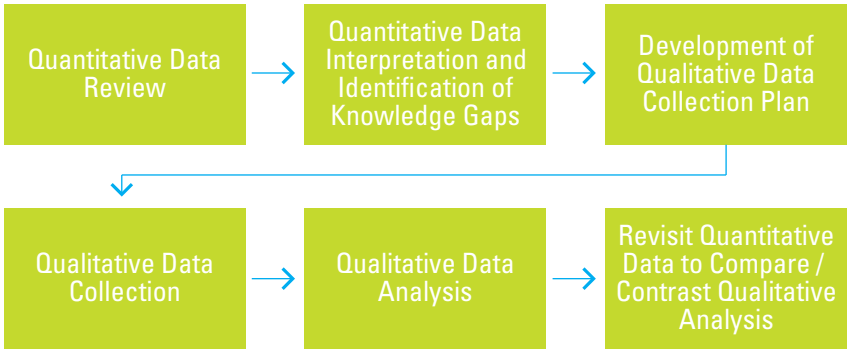
Despite a well-represented CAC, it is important to state that neither the CAC nor the CHA Team deemed our membership to be a true reflection of OSA and is a limitation of the CHNA process as described in section 5.0.

7.0 Assessing Health and Wellness

Figure 5 depicts the research process taken to ensure local information, reviewed and collected by the CHA Team, is combined and analyzed in a way that supports a deeper understanding of the factors and conditions that impact community health and wellness. Further detail of this process is described in the proceeding paragraphs[6].

6 To request more technical information on the CHNA process please email CHNA@HorizonNB.ca

Figure 5 – CHNA Research Approach used by Horizon's CHA Team



7.1 Quantitative Data Review and Interpretation

Guided by the Social Determinants of Health, the process of deepening an understanding of what impacts health and wellness within OSA began with a review of available quantitative data. The NBHC has compiled community quantitative data sets, one for each of its 33 communities within the province, and have made them publicly available through the publication of My Community at a Glance reports (8). To date, two sets of reports have been published; the first in 2014 and the second in 2017. Communities can use this information to understand their area and how it relates to provincial results as well as identify local trends in the indicators that represent the level of health and wellness experienced by their citizens. The information detailed in these data sets comes from federal, provincial, and in-house NBHC data sources as well as relevant indicators found through the review of several federal and provincial organization reports. A full description of where individual community profile indicators are sourced can be found in the NBHC My Community at a Glance 2017 Technical Document (18).

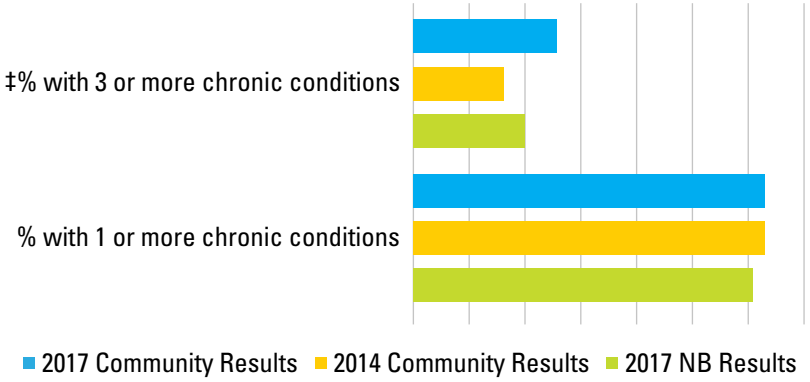
For the purpose of OSAs CHNA, the CHA Team extensively reviewed My Community at a Glance 2017 & 2014 reports and the 2017 Primary Health Care Survey results[7] (9,19,20). Using highlights from these quantitative data sources CAC members collectively identified areas of significant concern relating to health and wellness in need of more understanding and provided feedback on a summary of identified knowledge gaps.

7.2 Current Snapshot of OSA's Health and Wellness

Indicators reflecting the health outcomes of people living in OSA between 2014 and 2017 give cause for concern. While a similar percentage of community members in 2014 and 2017 see their health as very good to excellent, fewer people in 2017 see their mental health as very good to excellent when compared to previous results.

7 Data from the Primary Care Survey are included in My Community at a Glance reports; however, 2017 results were made available after the My Community at a Glance 2017 reports were published.

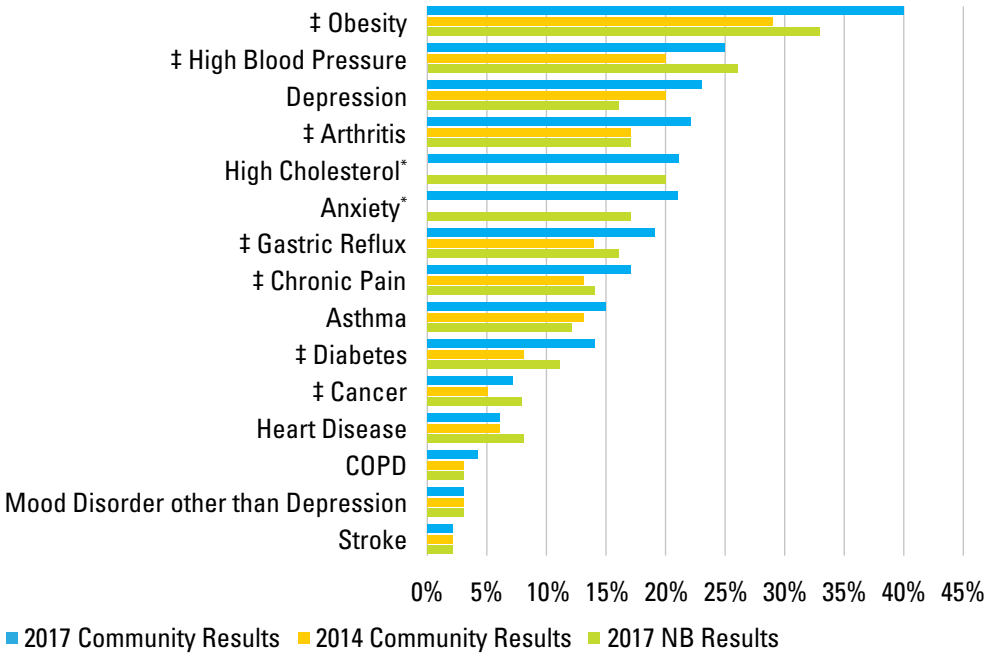
Figure 6 – Prevalence of Chronic Health Conditions in OSA



‡ significantly higher in 2017 when compared to 2014

The percentage of individuals who have one or more chronic condition has not changed since 2014, however when looking at specific chronic conditions the incidence of many has risen. The number of people who indicate that they are challenged with obesity, high blood pressure, chronic pain, and cancer has gone up significantly since 2014 (Figure 7). This may be explained by the considerable increase in the proportion of community members who have been diagnosed with three or more chronic conditions (Figure 6).

Figure 7 – Prevalence of Specific Chronic Health Conditions in OSA



‡ significantly higher in 2017 when compare to 2014
*2014 results not available

7.0 Assessing Health and Wellness continued

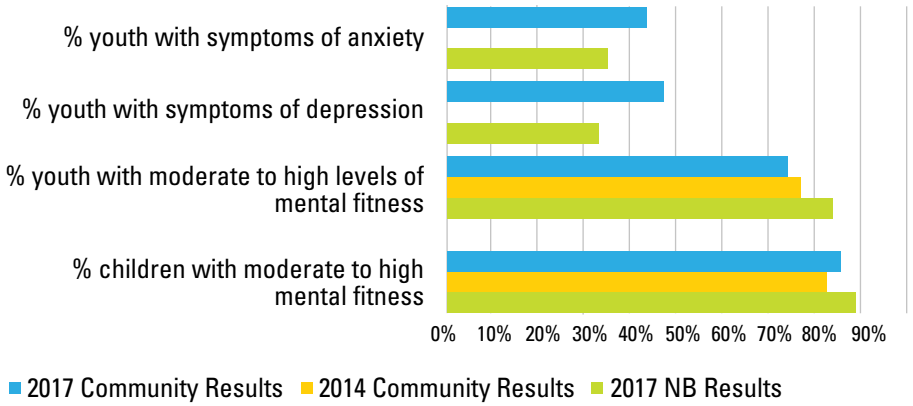
When considering changes in the health of younger generations between 2014 and 2017, roughly the same number of children, aged eight to 10, reported a moderate to high level of mental fitness[8]. However, the number of youth, aged 11 to 18, reporting a moderate to high level of mental fitness decreased (9,19). In addition, My Community at a Glance 2017 reveals that OSA has the highest percentage of youth experiencing symptoms of depression and anxiety when compared to the province (Figure 8) and to all other 32 NBHC communities.

Health and Wellness Knowledge Gaps and Areas of Concern

OSA's CHNA CAC reviewed available area-specific quantitative data compiled by the NBHC and identified knowledge gaps and areas of concern in need of further investigation. Eighteen consultations, twelve focus groups and six key-informant interviews, were facilitated. A total of 74 community members living and/or working in OSA participated. Each consultation had an intended focus, however because many identified concerns overlapped, the following is a list of the knowledge gaps/areas of concern that were purposefully discussed with community members throughout the consultation process.

- *Coping as a family with young children*
- *Health Promotion services*
- *Living with special needs*
- *Mental health challenges and supports*
- *Military family health and wellbeing*
- *Primary Care access*
- *Rural living*
- *Seniors and seniors' supports*
- *Social supports in the community*
- *Women's health*
- *Youth and youth supports*

Figure 8 – Mental Health Indicators for Children and Youth Living in OSA



At this point, it is important to reflect on the social determinants of health and the influence each determinant has on health and wellness. To promote health and prevent disease, attention needs to include but also extend beyond health care services, inequities between populations groups need to be identified and addressed, and adequate supports need to be made available to those who need them the most (13,14).

7.3 Qualitative Data Collection and Analysis

Qualitative research, often used to answer why, how, and what questions, complements quantitative data. When used in combination, unique and complex elements influencing a given community are understood more clearly (21) and can support a more meaningful use of information to inform change (22). Equipped with a summary of knowledge-gaps identified collectively by the CAC, the CHA Team applied purposive sampling principles (23) to connect with community members living and working in OSA who could contribute to a deeper understanding about the health and wellness challenges experienced in the area. Community members were invited to participate in consultations[9]. Participation was voluntary and the process of Informed Consent was reviewed with each participant.

Each consultation was audio-recorded and transcribed. Identifying information, such as the names of people and places, was removed at the time of transcription. Using a research methodology known as Interpretive Description (24), transcripts were analyzed by our CHA Research Lead. As a secondary step in the analysis process, all CHA Team members independently reviewed qualitative analysis results and, through group discussions, debated the interpretation of findings to safeguard against researcher bias (25). Qualitative findings from this analysis process resulted in the creation of a list of specific health and wellness issues for OSA. From this list, CAC members anonymously ranked their top health and wellness priorities.

8 Someone who has a moderate to high level of mental fitness has a positive sense of how they feel, think, and act

9 Consultations included KEY INFORMANT INTERVIEWS (an interview with one or two people with similar backgrounds focused on a specific topic) and FOCUS GROUPS (face-to-face interviews with five to 10 people with similar backgrounds focused on a specific topic).

8.0 OSA's Health and Wellness Priorities

The following 10 Health and Wellness Priorities for OSA were identified, in order of importance, through a prioritization process created by the CHA Team. This process combines health and wellness issue rankings provided by consultation participants and CAC members reflecting a stronger and more diverse community voice in the determination of priority issues in need of action and attention.

1. **The need to improve access to local primary care providers and support services for all community members.**
2. **The need to better support the mental health needs of children, youth, and adults living in OSA.**
3. **The need to enhance public awareness of local programs and services that promote and support health and wellbeing.**
4. **The need to address the lack of affordable, reliable transportation services in OSA.**
5. **The need to support rural communities and improve access to health services, programs, and supports in rural areas.**
6. **The need to sustainably strengthen current efforts addressing community and household food security.**
7. **The need to better support families who are struggling with day-to-day demands and expectations.**
8. **The need to improve communication and collaboration between local and regional services and programs.**
9. **The need to address mental resiliency in youth living in OSA and improve their coping skills.**
10. **The need to address the current understanding and belief system around cannabis use and how it impacts children and youth.**

In the following pages, profiles of each priority have been provided. Included in each priority profile is a Community Recommended Action and a Suggested Approach to address action intended to give Horizon, stakeholders, and other interested partners/individuals a place from which to begin or, in many cases, to join in and continue the good work already underway. Related social determinants of health and quotes from consultations are also included as well as relevant quantitative data indicators detailing how OSA compares to the rest of the province and how it compares to 2014. Finally, where possible, existing community assets aligning with a given priority are highlighted.

▲▼ Positive changes or differences in data
= No changes or differences in data
▲▼ Negative changes or differences in data

Priority 1

The need to improve access to local primary care providers and support services for all community members.

Social Determinant(s) of Health: Health Services

"I can't take [my sick child] to the emergency to sit for six hours so I'm stuck with them trying to figure out what to do because I can't find a doctor, I can't get a nurse practitioner, I can't get on the walk-in list and once again you go back to the isolation... I don't know anybody"

"It's all about access and timing for kids who need care, it's a lot more difficult for them to go to a community health centre or to the family physician. If we decrease these services we will see teen pregnancies increasing, we'll see sexually transmitted disease rates increase."

Many consultation participants and CAC members described local challenges with securing and accessing a primary care provider. Care needs for many in this community were described to be complex and time consuming. During several consultations it was voiced that Emergency Room services are often used as a last resort for health care by those who have limited or no access to regular primary care. In the community of military families, a hesitancy to use the provincial 811 Patient Connect service was described, possibly related to a mistrust in this process. In addition, during the summer months it was a perception that both local health services and military health services are seasonally strained due to a temporary influx of military members in the area. A described perception shared in several consultations was that many youth lack appropriate access to confidential primary health care and the removal of access to a nurse at the local high school was a voiced loss shared by several consultation participants. Concern was also raised about women with limited access to transportation who have women's health care needs but do not have access to a primary care provider. In addition, supporting services such as pharmaceutical services, blood collection services, and extra-mural care were perceived to be inequitably available throughout OSA. Finally, the documentation required to communicate the health status of patients who are applying for various supports was described to be an increasing burden on primary healthcare providers noticeably impacting the time available to deliver primary care.

Community Recommended Action: Identify and address the local barriers limiting timely, regular and confidential access to primary health care.

Suggested Approach: With a working group that includes Horizon Primary Health Care Services, primary care providers, military health services, ASD-W representation and citizen representation recommend, and where feasible, implement solutions to the local barriers limiting timely, regular, and confidential access to primary health care as well as the supporting services that enhance primary care. Ensure barriers facing rural communities, youth, women, released or retired military members, and military families are considered.

Who is affected? Community members who have limited or no access to a primary care provider, community members who are at risk of losing access to a primary care provider, youth who need confidential access to a primary care provider.

Primary Care Snapshot in OSA:
Currently, Horizon operates two health centres with allied health services in OSA; the Oromocto Health Centre with one fee-for-service general practitioner and two Nurse Practitioners and the Fredericton Junction Health Centre with two fee-for-service general practitioners. In addition, OSA is served by 20 general practitioners who operate private practices. Horizon also has a Public Health satellite office in Oromocto to service the local area with various health promotion programs. Primary Care needs are also supported by Horizon's Centre de Santé Noreen-Richard Health Centre, particularly the needs of French speaking military families. The primary care and occupational care needs of military members posted to Base Gagetown are supported by a walk-in clinic (four-days/week with one primary care provider) and three health service delivery units staffed by approximately three to four general practitioners of which one to two are military members subject to deployment, and five to six Nurse Practitioners who are civilian staff.

Priority 1
continued

The need to improve access to local primary care providers and support services for all community members.

Related Quantitative Data (9,19,20)

Compared to the provincial data for New Brunswick:

- ▼ Fewer citizens in OSA have a personal family doctor (76% vs. 90%)
- ▲ More citizens in OSA have a Nurse Practitioner regularly involved in their care (21% vs. 13%)
- ▼ Fewer citizens in OSA have a primary care provider regularly involved in their care (84% vs. 93%)
- ▲ More citizens in OSA use the ER when in need of care (17% vs. 11%)
- ▲ More citizens in OSA have three or more chronic health conditions (26% vs. 20%)

Compared to OSA in 2014:

- = Same number of citizens in 2017 have a personal family doctor (77% vs. 76%)
- ▲ More citizens in 2017 have three or more chronic health conditions (26% vs. 16%)
- ▼ Fewer citizens in 2017 use the ER when in need of care (17% vs. 21%)
- ▲ More citizens in 2017 reported that their family doctor has extended office hours (30% vs. 19%)

Resources that align with this priority:

- Horizon's Primary Care Practice Profile Assessment
- OpMD Gagetown MFRC
- Jordan's Principle: Ensuring First Nation children receive the public services they need when they need them

Priority 2

"I'm not sure how many other people in the community have mental health issues and what they're doing but I don't see any supports advertised about it...."

"A lot of our families are suffering from PTSD, some diagnosed, some not diagnosed and we're seeing, for the first time, secondary PTSD in our children, in our wives or husbands and there's no support."

The need to better support the mental health needs of children, youth, and adults living in OSA.

Social Determinant(s) of Health: Personal Health Practices and Coping Skills, Social Support Networks, Health Services, Social Environment and Community Cohesion

It was voiced by the CAC and in most consultations that mental health is a serious concern in OSA alongside a shared belief that the current system that manages mental health care is overwhelmed and unable to meet local needs. A few consultation participants shared that primary care providers are looking after the mental health needs of many patients with some spending an estimated 40 to 50% of their day caring for people with mental health concerns. Questions surfaced around the capacity of the local primary care system to effectively support mental illness, especially patients with early signs of mental health conditions or those classified as moderate risk. It was also shared through consultation that, due to the presence of the military, OSA has a higher prevalence of community members struggling with Operational Stress Injuries (OSI) including Post Traumatic Stress Disorder (PTSD); diagnosed and undiagnosed. Concern was for those struggling with OSIs in need of care, but also for the mental health needs of their family members. It was described that more work could focus on improving or creating opportunities to support individuals whose life circumstances put them at risk of mental and emotional stress such as during the post-partum period, when a child is diagnosed with special needs, adolescents transitioning to adulthood, when financial circumstances change, when family dynamics change, death of a loved one, and when physical health begins to decline. Several local mental health resources were described to be available in OSA to support mental health and mental resiliency. Consultation participants questioned the connection these services have with one another and if health care professionals, including primary care providers, knew the scope of these resources or how to access them.

Community Recommended Action: Develop an understanding of mental health resources and supports available in OSA, identify service gaps and overcome barriers to access.

Suggested Approach: Further consult with local and regional representatives who support mental health in OSA to collectively develop an understanding of currently available mental health resources and supports. As a working group, identify service gaps and remove barriers to access. Focus attention on supports, services, and resources for those individuals with early signs of mental health conditions or those classified as moderate risk.

Who is affected? Individuals and their families who have mental health conditions or who are at risk of developing mental health conditions.

Related Quantitative Data (9,19,20)

Compared to the provincial data for New Brunswick:

- ▲ More youth living in OSA describe symptoms of depression (44% vs. 31%) and anxiety (41% vs. 33%).
- ▼ Less adults living in OSA rate their mental health as being very good to excellent (51% vs. 60%)
- ▲ More adults living in OSA are diagnosed with depression and anxiety (23% vs. 16% and 21% vs. 17%)
- ▲ More citizens living in OSA felt that they needed to see or talk to a health professional about their mental or emotional health (27% vs. 19%)

Compared to OSA in 2014:

- ▲ More children in 2017 indicated that they had a positive sense of how they feel think and act (81% vs. 78%)
- ▲ Slightly more adults in 2017 were living with diagnosed depression (23% vs. 20%)

Resources that align with this priority:

- Canadian Mental Health Association programming
- Horizon's Mental Health and Addiction Outreach Services,
- Horizon's Mental Health and Additions Mobile Crisis Unit,
- Family Enrichment and Counselling Service
- Gagetown MFRC Prevention, Support, and Intervention programming
- Anglophone School District-West (ASD-W), Integrated Service Delivery Program
- Base Gagetown, Sentinels Program

Priority 3

"I think that a lot of the challenge is awareness and navigation. There's just so many parts and there are a lot of great resources. But people just don't know that they exist and they don't know where to find them."

The need to enhance public awareness of local programs and services that promote and support health and wellbeing.

Social Determinant(s) of Health: Social Environment and Community Cohesion, Health Services, Personal Health Practices and Coping Skills

It was often described by consultation participants that local services and programs that support health and wellness exist but public awareness around who provides them, what they are, who they are for, and where to find them is limited and ultimately impacts the use of these programs. This includes the level of awareness held by service providers from all sectors about other local service and program options. For example, the child-care service community described challenges with locating and finding local services and programs for families with young children even though such community offerings are available. This was also an experience described by families caring for individuals with special needs. Consultation participants representing rural communities described feeling very unaware that health programs and services existed in other nearby communities and felt this lack of awareness was an impediment to their own ability to manage and respond to their health needs. Consultation participants representing non-military community members vocalized a lack of connection to the community and a need for a more centralized place to gather and access information about community events, programs, services, supports, and activities.

Community Recommended Action: Collectively establish a community-wide public communication plan for OSA.

Suggested Approach: With a group of local representatives, evaluate current modes of communicating program and service information to the public. Use this information to establish an OSA community-wide communication plan to promote locally available programs and services that support health and wellness during all life stages.
Who is affected? All community members

Related Quantitative Data (9,19,20)

Compared to the provincial data for New Brunswick:

= Same number of families in Fredericton Region, including OSA, are accessing the 18-month old healthy toddler assessment (50% vs. 49%)

= Same number of citizens in OSA talked to a health professional about things they could do to improve their health (23% vs. 24%)

▲ Slightly more citizens living in OSA report having trouble finding their way around the health care system (10% vs. 8%)

Compared to OSA in 2014:

= Same number of OSA citizens in 2017 always or usually talked to a health professional about things they could do to improve their health, (24% vs. 24%)

Resources that align with this priority:

- Horizon's Oromocto Public Health
- Horizon's Oromocto Health Centre
- Horizon's Fredericton Junction Health Centre
- Local Primary Care Provider representatives
- New Brunswick Association for Community Living
- Base Gagetown, PSP Health Promotion Programs
- Gagetown MFRC

Priority 4

"There's the problem that if you can no longer drive or if you cannot afford a car, it's extremely difficult to get anywhere...other than by taxi, and if your income is low, you can't afford a taxi."

"There's an appetite [to address transportation], there's an interest, it's just that there needs to be a champion for it."

The need to address the lack of affordable, reliable transportation services in OSA.

Social Determinant(s) of Health: Physical Environment and Infrastructure, Social Environment and Community Cohesion

It was voiced in many consultations and by the CAC that a limited number of affordable, reliable transportation options exist for people to travel into Oromocto from the surrounding rural areas, within Oromocto, and between Oromocto and Fredericton. Community residents describe a reliance on family and friends for transportation needs, but this option is not always reliable and, for some, is not available. It was shared during consultation that current data sources do not accurately capture the transportation needs of the area. Other communities within New Brunswick who operate volunteer driving programs have found that transportation needs for health purposes make up almost half of all requests. This issue is believed to affect the health and wellness at the community level as it contributes to the isolation of certain population groups, it prevents people from accessing the supports and services they need, and for those with limited or low income it is a major barrier to daily life. Consultation participants voiced challenges with performing activities of daily living such as grocery shopping, banking, and picking up medication at the pharmacy; a common limitation described often by seniors. In addition, a voiced need was to make transportation options available to individuals who rely on programs and services in Oromocto and Fredericton such as the programs offered through Oromocto Training Employment Centre or those offered by Autism Connections. In terms of transportation needs specifically related to health care, several consultation participants described a need for transportation options for families whose loved ones attend regular treatment appointments (i.e.: renal dialysis). Finally, a concern voiced numerous times was for youth who live in rural areas who rely on school transportation to get to and from school and have no other available transportation options that would make it possible for them to take-part in after school programming, events, or opportunities.

Community Recommended Action: Collectively develop a community-wide transportation plan for OSA

Suggested Approach: Engage with a transportation expert to better understand the steps necessary to collect information about the transportation needs of OSA and community members. Take guidance from small-scale transportation programs operating in other areas of the province and create a transportation plan than meets the needs of those living in OSA.

Who is affected? Rural residents without private cars, those living on low income, children and youth, seniors who do not drive and/or live alone, and families who have access to one vehicle used for transportation to and from work.

Related Quantitative Data (9,19,20)

Compared to the provincial data for New Brunswick:

= Same number of citizens in OSA experienced transportation problems in getting the health care they need (5% vs. 5%)

Resources that align with this priority:

- Surfaces to Services Report
- Learning from other transportation programs operating in other areas within NB
- Orchard View Long Term Care Facility Transportation Services

Priority 5

"It's just the reality that we face, we are a rural community. We need to be able to provide for the people that live in this community and the surrounding area."

"In the winter season we are the last to receive snow removal. The road can become covered with ice which is a danger to our residents and the school bus transporting our children. Measures aimed at making our citizens safe are needed."

The need to support rural communities and improve access to health services, programs, and supports in rural areas.

Social Determinant(s) of Health: Personal Health Practices and Coping Skills, Health Services, Social Environment and Community Cohesion, Physical Environment and Infrastructure, Income and Social Status

Throughout community consultations many participants described a strong connected and cooperative spirit that exists in rural areas within OSA and a belief that this spirit enhances quality of life and strengthens the health and wellness of people living in these smaller communities. Alongside these shared sentiments was the realization that these same smaller communities are slowly eroding with the loss of important services and supports. Consultation participants described service coverage zones that do not overlap leaving some rural pockets with inequitable access. An example of this is the services that deliver meals to homes and some Extra-Mural supports. Consultation participants representing rural areas identified a number of services needed to help their communities thrive including local access to child care for families with young children, access to local schools with a voiced preference for access to both English and French Immersion, improved modes of communication between local governance structures and rural residents, regularly maintained access routes to ensure safe travel and viable transportation options for those in need, reliable internet access, affordable housing for those living with lower incomes, a space where all community members are welcome, and local access hubs to make it easier for outreach services and programs to reach rural residents who need help.

Community Recommended Action: Identify solutions to maintain or establish community services, supports, and programs that would help sustain rural living.

Suggested Approach: Establish rural working groups with community member representation to address the erosion of rural infrastructure and support the identification and establishment of services, supports, and programming that would enhance rural living and contribute to overall health and wellbeing. Working with local, regional, and provincial service providers, determine if and how these necessary community elements can be established, enhanced, or maintained.

Who is affected? Community members living in rural areas of OSA

Related Quantitative Data
No available data specific to rural communities and rural populations living in OSA.

Resources that align with this priority:
- Horizon's Community Developer
- Local recreation and leisure services and associations
- Schools operating under a Community School Model
- Rural business owners
- Community representatives

Priority 6

"A lot of kids come to school hungry, a lot of kids come to school without any lunch. The lunch seems to be more of the sore spot than breakfast because if you don't have anything in your lunch box, you have to tell somebody, right?"

The need to sustainably strengthen current efforts addressing community and household food security.

Social Determinant(s) of Health: Income and Social Status, Social Environment and Community Cohesion, Education and Literacy, Healthy Child Development

During many consultations, participants described a perception that household food insecurity is experienced by many families living in OSA. Household food insecurity can be chronic or episodic and is characterized by insecure access in socially acceptable ways to adequate nutritious food due to financial constraints. Despite the local availability of programs and services established to help those in need, stigma surrounding the acceptance of help and lack of awareness that programs were available were voiced barriers preventing some from accessing food offered by the Oromocto Food and Clothing Bank or the Community Food Smart program. In addition, it was a voiced observation that several younger families who do access such programs are limited by a lack of basic cooking skills necessary for healthy food preparation and healthy eating. Turning our focus to children and youth, it was voiced that many students, in all grade levels, come to school hungry for various reasons including lack of food at home and long bus rides early in the morning. It was a shared perception that all schools offer food programs to their students, such as breakfast and snack programs, but not all are universally available. It was recognized that summer months are particularly challenging for some children and their families when food programs accessed through the school are delayed until the start of the next school year. Finally, a perception described by some consultation participants was that school food programs rely on community donations of time and money and lack the infrastructure, human resources, and financial resources to sustainably address food insecurity experienced by their student populations.

Community Recommended Action: Support and increase the capacity of local and regional efforts already addressing food insecurity.

Suggested Approach: Through local and regional partnerships, support and increase the capacity of local and regional efforts already addressing food insecurity and the lack of food preparation skills with a focus on children, youth, and young adult generations. Find solutions that support removing the local stigma around accepting support. Collectively work towards a more sustainable universal food program available to all children and youth enrolled in the local school system.

Who is affected? Families and individuals living on lower incomes and families with limited social support networks.

Related Quantitative Data (9,19,20)

Compared to the provincial data for New Brunswick:

= Same number of children and youth living in OSA report going to school hungry often/always due to lack of food at home (6% vs. 5%)

▼ Less youth living in OSA eat breakfast daily (38% vs. 46%)

▲ More children living in OSA eat breakfast daily (73% vs. 70%)

▼ Fewer households with or without children within OSA experience moderate to severe food insecurity (6% vs. 9%)

Compared to OSA in 2014:

= The same number of youth in 2017 eat breakfast daily (38% vs. 36%)

▲ More children in 2017 eat breakfast daily (73% vs. 67%)

Resources that align with this priority:

- Local school food programs, ASD-W
- Helpline Inc., The Oromocto Clothing and Food Bank
- Community Food Smart
- Nourishing Minds, NB
- Oromocto Area Community Gardens
- Local 'Soup's On' programs
- Fredericton Area's 'Community Kitchen' model for school lunch programs

Priority 7

"Our families are struggling, our children are struggling, huge mental illness amongst children and adults. Attempted suicides. Successful suicides. Inadequate resources. Everyone is struggling."

The need to better support families who are struggling with day-to-day demands and expectations.

Social Determinant(s) of Health: Income and Social Status, Social Environment and Community Cohesion, Social Support Networks, Personal Health Practices and Coping Skills, Healthy Child Development

Consultation participants voiced that many living in OSA struggle with the daily demands and expectations of either raising children or of looking after the health and wellness of loved ones. It was a perception that those living in financially strained circumstances are even more burdened and their own resiliency and ability to cope is further compromised. It was described that those with very limited income are often located in more rural pockets where housing is more affordable but limits access to services and programs that may be of support such as parenting programs or social opportunities. In addition, a voiced concern was raised in some consultations about the prevalence of drug abuse, the impact this has on a family's ability to cope, and the lack of supports addressing this issue. It was shared that this is more of a concern in rural communities. Perceptions were shared around the hesitancy some families have with accepting available supports. An example of this was the hesitancy around accepting Integrated Service Delivery Program support offered through schools due to possible confusion around the roles of the various service providers involved and a need to better communicate what this support is and who it is for. It is important to acknowledge that there were described instances where adequate support was not available, most prominently the lack of adequate local respite services for caregivers of seniors with complex health care needs and families with family members who have special care needs.

Community Recommended Action: Address local service gaps in the current system providing support services to families living on modest incomes and those needing extra daily support.

Suggested Approach: Through a multi-sector collaboration that includes family support services, public health, school leadership, respite support, local governance, and community partners determine service gaps in the current model of providing support services to families. Ensure the rural areas extending away from Oromocto are offered equal consideration. A focused attention on drug use, respite care, community connection, and communication is needed.

Who is affected? Families in rural locations with limited income, families with family members who have behavioural challenges or mental health concerns, families living with financial strain, and families with family members who have high care needs or special needs.

Related Quantitative Data (9,19,20)

Compared to the provincial data for New Brunswick:

- ▲ OSA has higher monthly shelter costs for home owners ($834 vs. $666) and renters ($755 vs. $648).
- ▼ Fewer households within OSA exist on less than $20,000/year (11% vs. 15%)
- ▼ Fewer households within OSA exist on an income between $20,000-$59,999/year (33% vs. 41%)

Resources that align with this priority:

- Integrated Service Delivery Program, ASD-W
- LINK Program
- Community School Model, ASD-W
- St. Luke's Thrift Shop
- Oromocto Clothing and Food Bank
- Family Enrichment and Counselling Service
- The John Wood Foundation Inc.

Priority 8

"There needs to be more focus put on the building of relationships and the communication with these alternative services because even though they are not funded by the province they are the only services that are providing our families anything regardless of age."

"There's a bit of a disconnect where we're not all getting the same information. I don't feel like we're limited in what we can offer until we know what we're offering, if that makes sense?"

The need to improve communication and collaboration between local and regional services and programs.

Social Determinant(s) of Health: Social Environment and Community Cohesion, Health Services

It was voiced during most consultations that many publicly funded, private, and non-profit organizations and support systems operating locally and regionally do not connect, communicate, or collaborate regarding the care they provide within the community even if their care plans and/or focus overlaps. This was often commented on when discussion surrounded the overlap between the provincial health care system, the military health care system, and Veterans Affairs. Consultation participants who support families with young children described limited and ineffective communication between the local child care centres and the public education system specifically around transitioning young children with behavioural and learning challenges from child care into early elementary. Consultation participants representing families with children with special needs shared dissatisfaction with the lack of communication and collaboration between the publicly funded service system, the school system, and the non-profit sector. Finally, disappointment was shared around the disconnection between the health care system and the long-term care system, especially when supporting long-term care clients accessing health care services. Overall, consultation participants articulated a frustration of having to continually navigate and advocate for themselves or their family member's needs between systems and services that, in their assessment, should be working more closely together.

Community Recommended Action: Establish a community-wide service/program provider communication and collaboration plan for OSA.

Suggested Approach: Using a multi-sector approach, identify overlapping services and programs delivered in OSA. Create knowledge sharing opportunities for local service and program providers to communicate and discuss service profiles. Identify changes to communication, connection, and collaboration patterns that would positively impact the health and wellness of people living in OSA.

Who is affected? All community members

Related Quantitative Data (9,19,20)

Compared to the provincial data for New Brunswick:

= Same number of citizens living in OSA experienced a continuity of care across services (66% vs. 67%).

Compared to OSA in 2014:

▼ Fewer citizens in 2017 reported that their family doctor always helps them coordinate the care from other health care providers and places (68% vs. 76%)

Priority 9

"Those who are posted here don't have the extended family and the ones that are not military are often losing friends, even adults are losing their support people, and our children are too. I think that's unique to our community."

"Kids do not have coping skills. They don't, but sometimes what they're being asked to cope with an adult would struggle with; it's not all about coping skills and teaching coping skills, sometimes they're expected to cope with too much."

The need to address mental resiliency in youth living in OSA and improve their coping skills.

Social Determinant(s) of Health: Social Environment and Community Cohesion, Personal Health Practices and Coping Skills, Social Support Networks

It was felt that the level of mental resiliency in youth has decreased and more are challenged with social/emotional stress, anxiety, and depression. It was also a common belief voiced during consultations that youth living in OSA are more apt to present with poor coping skills than youth from other local areas increasing the risk of developing mental health issues, sexual health issues, and drug use/abuse. Consultation participants voiced a belief that this age group has an even harder time than adults accessing resources in this community as few places exist as recognized entry points to available supports. Contributing factors that need to be addressed include the effects of social media on mental resiliency, variations in the degree of family support available in the community, coping challenges faced by youth with a family member coping with an Operational Stress Disorder such as PTSD, lack of exposure to positive intimate relationships, limited community support for youth who identify as LGTBQ2+, a lack of positive role models, coping with movement in and out of the community and the limitation this puts on friendships, and the stress experienced by younger youth as they transition from smaller community schools to one large high school.

Community Recommended Action: Strengthen the collective capacity within OSA to engage youth in opportunities proven to boost mental resiliency and enhance coping skills.

Suggested Approach: Focus on further refining an understanding of the factors experienced by children and youth living in OSA that lower mental resiliency and limit their ability to cope. Guided by youth representation, take steps to investigate, create, and enhance opportunities that would strengthen mental resiliency and improve coping skills.

Who is affected? Children and Youth and their families

Related Quantitative Data (9,19,20)

Compared to the provincial data for New Brunswick:

▼ Less youth living in OSA have a moderate to high level of mental fitness. (70% vs. 79%)
▼ Less youth living in OSA feel they have people they look up to. (43% vs. 48%)
▼ Fewer youth living in OSA feel their parent or caregiver knows a lot about them. (45% vs. 56%)

Compared to OSA in 2014:

▲ More youth in 2017 could solve problems without harming themselves. (58% vs. 43%)
▼ Slightly less youth in 2017 had a moderate to high level of mental fitness. (70% vs. 73%)
= The same number of youth in 2017 felt their parent or caregiver knew a lot about them. (45% vs. 42%)

Resources that align with this priority:

- Healthy Learners Program, ASD-W
- LINK Program
- Gagetown MFRC youth programming
- Beyond the Hurt program in Schools
- Gay-Straight Alliance Youth Group at Oromocto High School
- Roots of Empathy
- Army, Air, and Navy League Cadet programs
- Chimo Helpline

Priority 10

The need to address the current understanding and belief system around cannabis use and how it impacts children and youth.

Social Determinant(s) of Health: Social Environment and Community Cohesion, Personal Health Practices and Coping Skills, Education and Literacy

"I think it's going to be a huge issue with the legalization; I think there has been issues prior to this, but I don't think [our community] is prepared to deal with it."

Consultation participants voiced the deepening challenges unfolding as communities across the country adjust to the legalization of cannabis and are particularly concerned with what this means for OSA and the current belief system around cannabis use already present. It was a voiced concern that the prevalence of community members who have access to cannabis for medical reasons has contributed to a more accepted use of this substance among youth. It was described that access has extended beyond the high school environment with more middle school students choosing to experiment with this drug. Additionally, concern was expressed around the possibility that many youth are accessing this substance in their home environments with children as young as five to nine-years-old regularly exposed to second-hand smoke. Consultation participants who support the improvement of mental health in youth commented on the popularity of drug use by youth with mental health issues, including the use of cannabis. Concern was raised around the possibility that cannabis use among youth will be treated with a disciplinary approach. Instead, participants felt children and youth need strategies on how to manage the reality that it is in this community and to create additional opportunities for high risk youth to engage and connect with peers and other community members.

Community Recommended Action: Contribute to a community-wide effort focused on educating all residents about cannabis use and the effects it has on child and youth development.

Suggested Approach: Working with community leadership, military representation, educators, mental health and addiction professionals, and public health professionals develop a community-wide strategy to address: 1) the current local beliefs held by the community about cannabis use, and 2) the use of cannabis and the factors more likely to be associated with its use by youth.

Who is affected? All Community members

Related Quantitative Data (9, 19, 20)

Compared to the provincial data for New Brunswick:

- ▲ More youth living in OSA have used cannabis in the last 12 months (37% vs. 26%)
- ▲ More youth living in OSA are current smokers (19% vs. 11%)*
- ▲ Less youth living in OSA feel connected to their school (85% vs. 92%)*

Compared to OSA in 2014:

- ▼ Slightly less youth in 2017 had used cannabis in the previous 12 months (37% vs. 39%)
- ▲ More youth in 2017 are current smokers (19% vs. 14%)*
- = The same number of youth in 2017 feel connected to their school (85% vs. 85%)*

* Top factors that are more likely to be associated with the use of cannabis (26)

Resources that align with this priority:

- Healthy Learner Programs in schools: Party Program, Teens Against Tobacco Use, ASD-W
- Gagetown MFRC youth programming
- Beyond the Hurt Program in Schools
- Gay-Straight Alliance Youth Group at Oromocto High School

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