Fredericton and Surrounding Area

COMMUNITY HEALTH NEEDS ASSESSMENT

SPRING 2021

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

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Acknowledgments:

We acknowledge that the land on which we gathered to facilitate Fredericton and Surrounding Area's Community Health Needs Assessment (CHNA) is the traditional unceded and unsurrendered Wolastoqey Peoples territory. We thank them for allowing us to gather and hold gratitude and appreciation to the Indigenous people who have been living and working on the land from time immemorial.

This report is produced by Horizon Health Network's Community Health Assessment Team for Fredericton and Surrounding Area. The Community Health Assessment Team would like to extend gratitude to all the organizations, groups, and community members who took part in the CHNA process.

List of Abbreviations

ASD-W: Anglophone School District-West
CAC: Community Advisory Committee
CHNA: Community Health Needs Assessment
DECRH: Dr. Everett Chalmers Regional Hospital
FSA: Fredericton and Surrounding Area
Horizon: Horizon Health Network
2SLGBTQIA+: Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex & Asexual
LSD: Local Service District
NBHC: New Brunswick Health Council
PCP: Primary Care Providers including General Practitioners and Nurse Practitioners
RHA: Regional Health Authority
Vitalité: Vitalité Health Network

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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 wellbeing experienced by individuals and population groups.

Fredericton and Surrounding Area

In the Spring of 2019, a CHNA for Fredericton and Surrounding Area (FSA) begun encompassing the geography of the City of Fredericton, the Village of New Maryland, the First Nation communities of Pilick (Kingsclear) and Sitansisk (Saint Mary's), the rural community of Hanwell, and the local service districts of Kingsclear, Lincoln, Maugerville, New Maryland, and Saint Mary's. Collectively, this assessment reflects the health and wellness needs of approximately 92,646 residents. The last CHNA for this area of New Brunswick, was completed in 2012 and resulted in the recommendation of 10 priority areas in need of action to improve the health and wellness of the local population (Table 2).

Community Health Needs Assessment Process

Applying a population health perspective with a health equity lens and an understanding of the Social Determinants of Health, Horizon's Community Health Needs Assessment (CHNA) 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 community assessments while, at the same time, offers flexibility to shift and adjust to unique local circumstances.

Health and Wellness Knowledge Gaps and Areas of Concern

FSA's CHNA Community Advisory Committee (CAC) reviewed available area-specific quantitative data compiled by the New Brunswick Health Council (NBHC)[1] and identified knowledge gaps and areas of concern in need of further investigation. Nineteen engagement opportunities, ten focus groups and nine key-informant interviews, were facilitated. A total of 101 community members living and/or working in FSA participated. Each consultation had an intended focus, however because many of the identified concerns overlapped, the following is a list of the concerns that were purposefully discussed with community members throughout the consultation process:

- Basic income
- Access to local supports and services
- Housing
- Mental health and wellbeing
- Affordable and reliable transportation
- Food security
- Navigation and advocacy within the system
- Community support and cohesion
- Jurisdictional barriers / siloed services
- Employment and education
- Cultural safety

[1] 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.

1.0 Report Summary continued

Fredericton and Surrounding Area's Health and Wellness Priorities

The following six Health and Wellness Priorities are the community needs ranked by FSA's CAC (Table 1). These priorities will be shared with those responsible for health service planning as well as other community stakeholders who are involved in the work of supporting the health and wellness of FSA residents.

Table 1: FSA's 2021 Health and Wellness Priorities

Priorities specific to Horizon's local responsibility as a Regional Health Authority	Priorities that require collective action
1 Ensure timely access to local primary health care and Horizon services	**1** Ensure safe and supportive housing for all
2 Ensure mental health care services are accessible to those living with health inequities	**2** Work within our systems to minimize the impact low-income has on health and advocate for everyone to access a basic income
3 Address structural and interpersonal stigma and discrimination in service settings	**3** Invest in early child development, youth-at-risk, and families who live with inequities

Next Steps

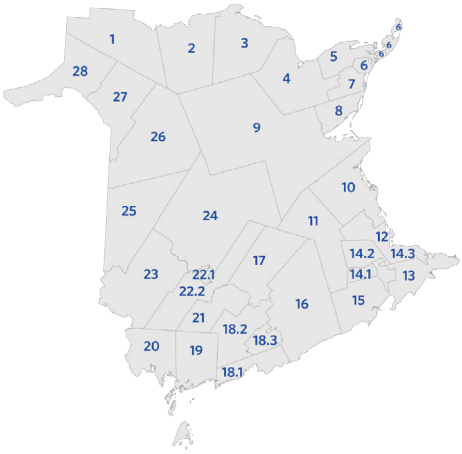
With the completion of this CHNA for FSA, Horizon is committed to working in innovative ways with community members and stakeholders to address the priorities identified in this report. As a Regional Health Authority (RHA), we acknowledge that good work is already underway through existing partnerships 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. We also acknowledge the need to be accountable to these priorities. Through our Department of Population Health, we have established and are strengthening mechanisms that will allow us to monitor action and initiatives, both within Horizon and through our collaborative partnerships, which are addressing the priorities identified in this report.

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 Regional Health Authorities (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 recommended 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 a CHNA for every community 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[8]. 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 NBHC has divided the province into 33 communities (Figure 1). Each NBHC community is a varied collection of cities, towns, municipalities, and LSDs 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[2].

3.0 Fredericton and Surrounding Area

The geographical area under assessment was a combination of two NBHC community boundaries; NBHC Community 22.1 (Fredericton) and NBHC 22.2 (New Maryland, Kingsclear, and Lincoln Area). During CHNA facilitation, this area was referred to as FSA encompassing the following municipalities and communities:

The City of Fredericton, the Village of New Maryland, the First Nation Communities of Kingsclear and Saint Mary's, the rural community of Hanwell, and the local service districts of Kingsclear, Lincoln, Kingsclear, New Maryland, and Saint Mary's.

Figure 2: Map of NBHC communities, Fredericton

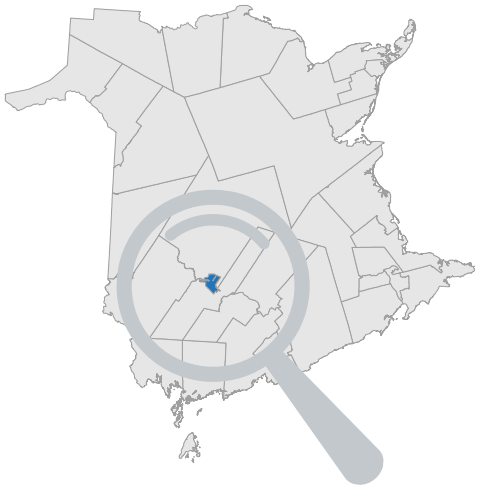


Figure 2: Map of NBHC Communities, New Maryland, Kingsclear, and Lincoln Area

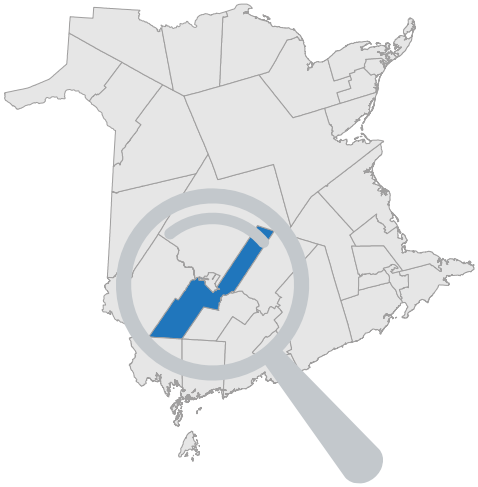
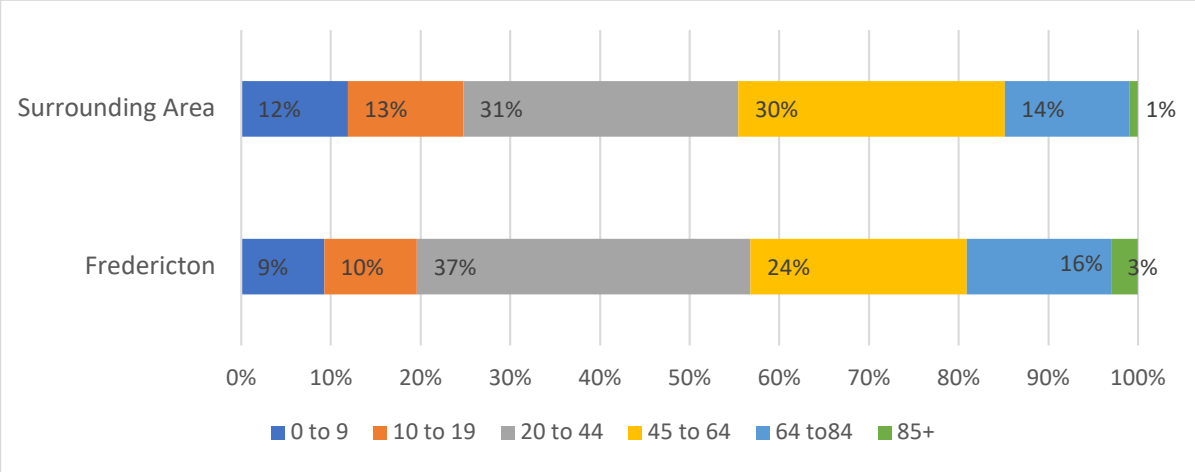


Figure 4: FSA's Age Demographic, 2021 Census



To acknowledge the local interpretation of the area, health, and wellness considerations for the local service district of St. Mary's was also included in the FSA CHNA as per the recommendation of FSA's CHNA CAC.

Encapsulating the second largest city in New Brunswick, Fredericton and the surrounding area is home to many different population groups, including those who live with health inequities. National Census data, published in 2021, indicates that this area of the province supports a population of 92,646 people[8]. Two-thirds of the residents live in the City of Fredericton with the remaining 28,466 citizens living in the smaller, surrounding communities. Together, the surrounding community has a higher proportion of children and youth and adults between the ages of 45-64 years while a higher proportion of adults between the ages of 20-44 years and over the age of 65+ reside in the City of Fredericton.

It is important to acknowledge that most residents speak English most often at home[8] and most children and youth, over the age of five, are enrolled in Anglophone School District-West (ASD-W), however approximately 1,700 children and youth are in enrolled in the Francophone school district and attend one of three Francophone schools in the local area[10].

It is also important to highlight that the cultural make-up of the City of Fredericton is shifting as it becomes home to more immigrants including refugees. Ninety-seven per cent of the 2656 recent immigrants who relocated to FSA between 2011 and 2016 live in the City of Fredericton[8]. Since 2016, it is known that many more immigrants have moved into the province with high probability that the majority re-located to one of the three largest urban areas of Moncton, Saint John, and Fredericton.

3.0 Fredericton and Surrounding Area continued

At the time of this assessment, Horizon supported the health care needs of the area through the following facilities and services:

- Dr. Everett Chalmers Regional Hospital (DERCH)
- Diabetes Education Centre
- Fredericton Addiction and Mental Health Services
- Fredericton Detoxification Unit
- Fredericton Downtown Community Health Centre
- Fredericton Northside Community Health Centre (previously the Gibson Health Centre)
- Fredericton Midwifery Centre
- Fredericton Mobile Crisis Service
- Fredericton Operational Stress Injury Clinic
- Public Health Fredericton
- Hemodialysis Unit
- Primary Health Care Network
- Veterans Health Unit Fredericton
- Community Health and Wellness programs at the Woodbridge Centre

In addition to Horizon's health care services, health care needs are also supported by paramedic services operated by Ambulance New Brunswick and home care services operated by the Extra Mural Program; both administered by Medavie Health Services NB. Primary health care needs are also serviced through the network of primary care practitioners (PCP) operating office-based practices.

National census data published in 2021 suggest the area is divided in terms of wealth with affluent households and communities existing alongside those living with greater financial constraints:

- The median household income ranges between $116,000 (Village of New Maryland) and $48,000 (Kingsclear First Nation)[2]. Well above and well below the provincial median household income of $70,000/year[7].

- The local poverty rate for adults ranges between 3 per cent (Village of New Maryland) and 25 per cent (Kingsclear First Nation)[3]. The local poverty rate for older adults over the age of 65 ranges between 4 per cent (Village of New Maryland) and 30 per cent (Kingsclear First Nation). Comparable provincial poverty rates for adults and older adults are 11 per cent and 21 per cent respectively[8].

- 31 % of households rent their dwelling, most of whom live in the City of Fredericton. Almost 12 % of tenants living in the City of Fredericton live in subsidized housing, while 24 % of tenants and 8 % of owners living in the area spend greater than 30 % of their income on shelter. The provincial rate is 14 % and 10 % respectively.

[2] Median Household Annual Income, Before Tax, 2020 Census

[3] Low-Income Measure, After Tax (LIM-AT), 2020 Census.

3.0

3.1 2012 Community Health Needs Assessment

In 2012, a CHNA for FSA was completed. From this work, 10 prioritized health needs were identified (see Table 2).

Table 2: FSA's 2012 Health and Wellness Priorities

1	Centre primary health care on prevention and health	**6**	Campaign for a more systematic approach to healthy eating and active living in FSA
2	Establish a CAC in downtown Fredericton	**7**	Provide access to a full spectrum of health services in both official languages
3	Take health services out into the communities to the people who need them the most	**8**	Update the public and health professionals on recent changes to how mental health and addictions services are being delivered; and engage the public around mental resiliency
4	Improve access to information on available community-based and systems-based health and well-being services and programs	**9**	Identify and collect local data that illuminate disparities
5	Leverage Under One Sky Head Start into an urban (off-reserve) Aboriginal Family Resource Centre.	**10**	Better connect tertiary and community-based care to facilitate hospital admissions and discharges

Since 2012, several investments have been made by Horizon informed by the CHNA. Below are a few examples that demonstrate how Horizon responded to the identified priorities:

- Through a partnership between Horizon and the University of New Brunswick's Community Health Clinic, the Fredericton Downtown Community Health Centre was established and officially opened in March 2017. As a teaching and research facility that uses a population health approach, it delivers integrated services including illness and injury prevention, chronic disease management, community development and outreach services. Its team of health providers work together under a collaborative practice model with community participation and focus on patient-centred care serving several population groups seeking equity including those who are without stable housing, those managing substance use-disorders, and the refugee population new to Fredericton.

- Primary care, mental health, and public health outreach services and programs were enhanced throughout the local area through partnerships with AIDS NB, local shelters, within local schools.

- Primary care capacity for local Indigenous community members was strengthened with the allocation of a full-time nurse practitioner from the Fredericton Downtown Community Health Centre to provide primary care services in both Kingsclear and Saint Mary's First Nation communities and at the Under One Sky Friendship Centre.

- Two community development roles were created. One was specifically designed to help facilitate action for the local Francophone community to help address conditions within the community that greatly impact population health and wellbeing.

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 investigate health and wellness in communities[12].

4.1 Population Health Perspective and a Health Equity Lens

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 and can contribute to inequitable differences in health outcomes (Table 3)[13,14]. A population health perspective, viewed through a health equity lens, looks at different groups of people living in an 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. With purposeful attention, these inequities can be addressed to positively impact health and wellness. Using the population health perspective with a health equity lens during CHNAs, a community can develop an understanding of the differences in health and wellness between groups allowing action to be focused on minimizing the factors that limit the ability to live healthy and maximizing the factors that improve health and wellness for all[16].

Table 3: Social Determinants of Health, Health Canada[15]

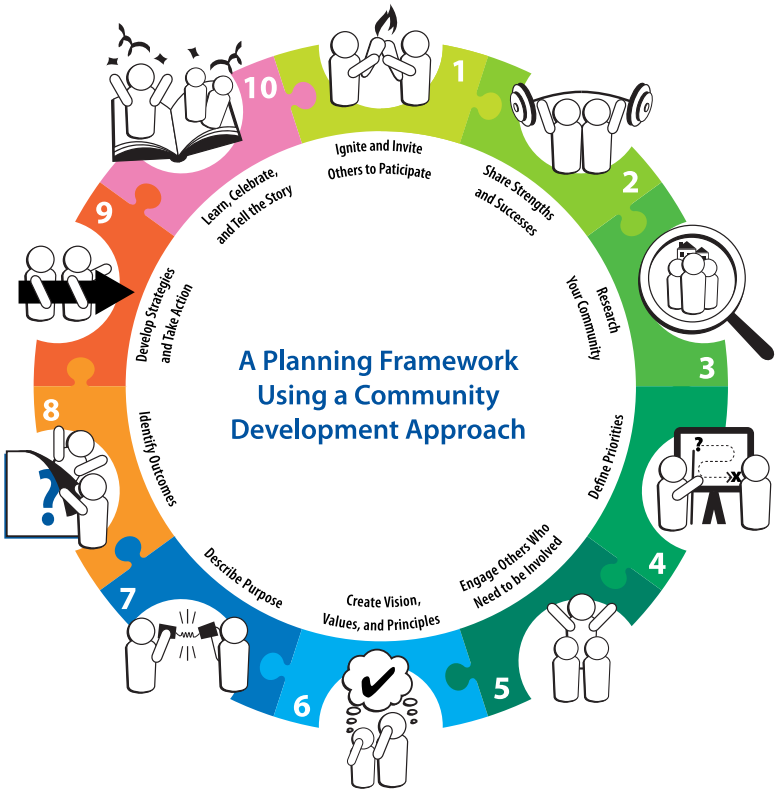
1. Income and Social Status	7. Personal Health Practices and Coping Skills
2. Social Support Networks	8. Healthy Child Development
3. Education and Literacy	9. Health Services
4. Employment and Working Conditions	10. Gender
5. Physical Environment	11. Social Environment and Community Cohesion
6. Biology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

4.0 Guiding Principles for Community Health Needs Assessments continued

4.2 Community Development Approach

CHNAs are also guided by the *Community Development Approach*[17]. 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* used by Horizon 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 one through four 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 learn with the intention to improve and adjust efforts. The symbolism of displaying this approach in a circle is important as it shows the continuous commitment of community development that reflects upon and responds to evolving strengths, needs, and priorities and aligns with the intention to complete CHNAs every five years.

Figure 5: Herchmer's Planning Framework Using a Community Development Approach



5.0 Horizon's Community Health Needs Assessments

5.1 Our Community Health Needs Assessment Team

Horizon's CHNA Team, housed within the Department of Population Health, has expanded since 2017 to not only support the completion of CHNAs but to also 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. The Regional Facilitator ensures CHNA priorities are promoted and monitored, and action is tracked and documented. We also benefit from a network of Community Developers who are rooted in communities and work alongside community members and stakeholders. Using a 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 well-being of all community members with an emphasis on those who need it the most.

5.2 Our Process

Horizon's CHNA 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 offering 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 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 team. The CHNA 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 CHNA 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	Throughout the health needs assessment process, assets and resources mentioned during CAC discussions and community consultations are recorded. Informed by the Social Determinants of Health, this activity supports the creation of an asset list. The asset list is a 'living document' and is used and updated as planned action unfolds to address the CHNA Priorities.

5.0 Horizon's Community Health Needs Assessments continued

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 CHNA 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 CHNA 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 that exist and need further clarification.
Step 8: Develop a qualitative data collection plan	From knowledge gap discussions with the CAC, the CHNA 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 CHNA 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 input to inform CAC priority ranking	To contribute to community voice, participants are offered the opportunity to prioritize a broad list of health and wellness issues generated from the quantitative data discussions held by the CAC. This helps to inform the CAC during Step 12.
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 issues and facilitate ranking to establish health and wellness priorities	The list of specific, local health and wellness issues is shared and discussed with CAC members. Through a formalized ranking process, each CAC member is given the opportunity to rank the top health and wellness issues they believe need action and attention.
Step 13: Finalize health and wellness priorities and recommendations	As a committee, the CAC reviews and confirms the final ranked order of issues. Depending on the community, the top four to eight issues are chosen by the CAC as Key Health and Wellness Priorities. A final report is created detailing the CHNA process and the community's priorities along with community voiced recommendations for action. This report is shared with Horizon's Board of Directors for endorsement.
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.

5.0 Horizon's Community Health Needs Assessments continued

5.3 Limitations

We acknowledge there are limitations within our CHNA process. Our time-frame to introduce and facilitate a CHNA within a given area is between six months to one year. Some community organizations and important population groups would benefit from a longer time frame to learn about the CHNA process, how it could support their own efforts, and how action addressing identified priorities can support those living with health and wellness inequities. This limitation ultimately impacts who chooses to be involved in our CHNA process. We are learning, as a CHNA 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 limitation, also constricted by our time frame, is our inability to collect specific quantitative information at the local level during a CHNA such as creating and circulating a community-wide survey. 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 FSA's 2021 Community Advisory Committee

An initial step in Horizon's CHNA process is the formation of a CAC. CACs play a significant role in a CHNA as they are the link between the community and Horizon's CHNA 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. A variety of perspectives are represented throughout the CHNA process. Prior to any CHNA work, a Terms of Reference (TOR) 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.

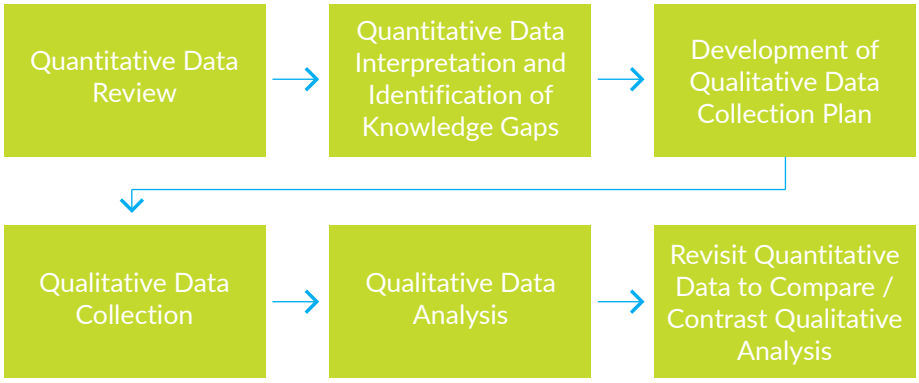
A broad range of community representatives who live in, work in, or support residents from the FSA area were invited to take part in the CHNA. Horizon's CHNA Team was fortunate to be supported by the following representation throughout the course of FSA's CHNA:

- Addictions and Mental Health - Director
- Primary Health Care - Director, Sexual Health, Access Coordinator, Dietitian
- Midwifery Program - Manager
- Public Health- Director, Baby-Friendly Initiative Coordinator, Healthy Learners
- Dr. Everett Chalmers Regional Hospital - Executive Director
- Population Health - Regional Director
- Fredericton Downtown Community Health Centre
- Ambulance New Brunswick
- Extra Mural, Manager of Fredericton Unit
- Department of Health, Primary Care Branch, Regional Medical Officer of Health
- Department of Environment and Local Government
- City of Fredericton Councillor
- Under one Sky Friendship Centre
- Saint Mary's First Nation
- Kingsclear First Nation
- Centre communautaire Sainte-Anne
- Francophone schools - Parent Committee Rep.
- Village of Maryland - Recreation Coordinator
- Social Innovation Fredericton
- Economic and Social Inclusion Council
- Anglican Diocese of Fredericton
- Opal Family Services
- Fredericton Sexual Assault Centre
- Meals on Wheels
- NB Community Harvest Gardens
- Fredericton Police Force
- Fredericton Family Resource Centre
- Unité du troisième âge pour l'apprentissage de la Capitale (UTAAC)
- John Howard Society
- NB Association of Community Living
- United Way of Central NB
- Capital Region Mental Health and Addictions

7.0 Assessing Health and Wellness

Below is a figure depicting the research process taken to ensure local information, reviewed and collected by the CHNA 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.

Figure 6: Approach used by Horizon's CHNA 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 FSA 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[2] reports. 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 residents. 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].

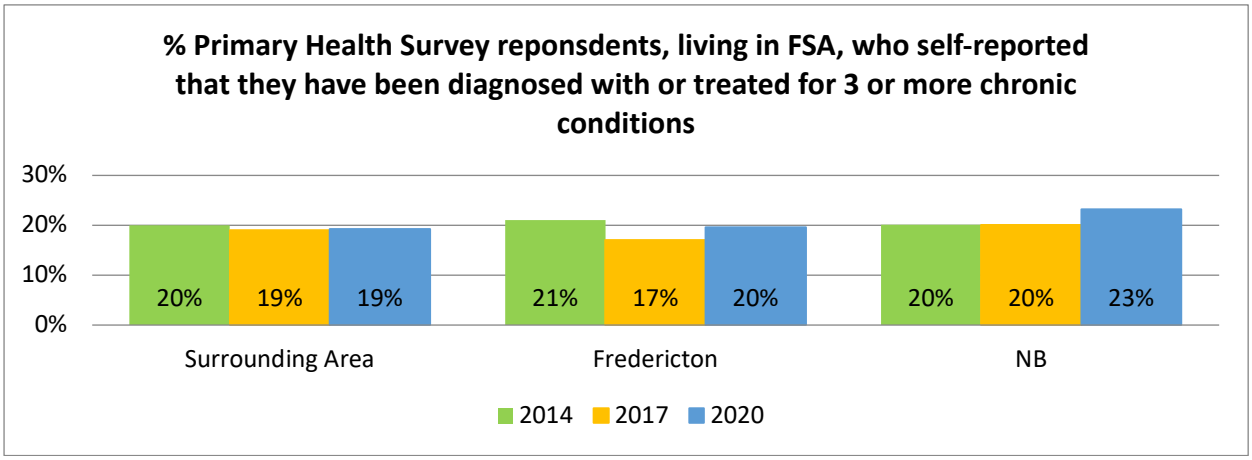
For FSA's CHNA, the CHNA Team extensively reviewed NBHC community profiles, Primary Health Survey results[5], and Census data[1,8,9]. Using highlights from these quantitative data sources, CAC members collectively identified areas of significant concern relating to health and wellness in need of more understanding and provided feedback on a summary of identified knowledge gaps.

7.2 Current Snapshot of FSA Health and Wellness

Statistical data, from NBHC's Primary Health Survey, detailing self-reported health outcomes of people living in FSA in 2014, 2017, and 2020 show that the percentage of adults 18 years and older who self-report that they manage three or more chronic health conditions has not changed (Figure 7).

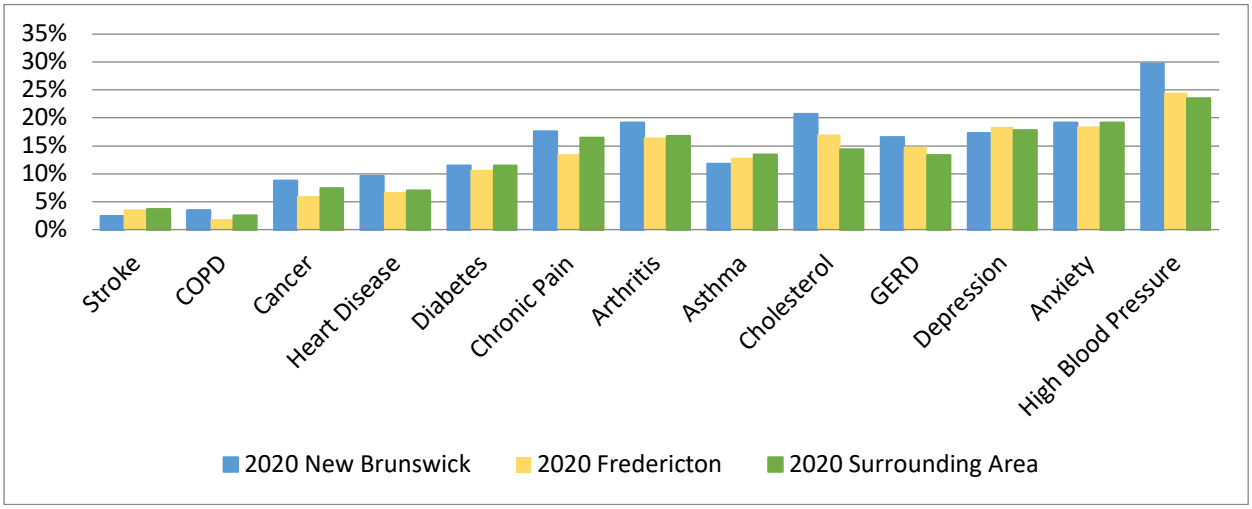
[5] Data from the Primary Health Survey are included in My Community at a Glance reports; however, 2017 results were made available after the My Community at a Glance 2017 reports were published.

Figure 7: Self-reported prevalence of Chronic Health Conditions in FSA, Primary Health Survey, NBHC[1]



The self-reported incidence of specific chronic conditions in the FSA changed for some conditions between 2017 and 2020. In Fredericton, the self-reported incidence increased for chronic pain[1]. In the surrounding area, the self-reported incidence increased for stroke, diabetes, and depression and decreased for gastro-esophageal reflux[1]. When compared to the province, the prevalence of most conditions was lower for adults living in FSA except for depression. The prevalence of stroke was higher in the surrounding area only (Figure 8). NBHC users are advised to use the 2020 data with caution, especially when creating estimates for small sub-populations or when comparing it to other Primary Health Survey editions.

Figure 8: Self-reported prevalence of Specific Chronic Health Conditions in FSA, Primary Health Survey, NBHC[1]

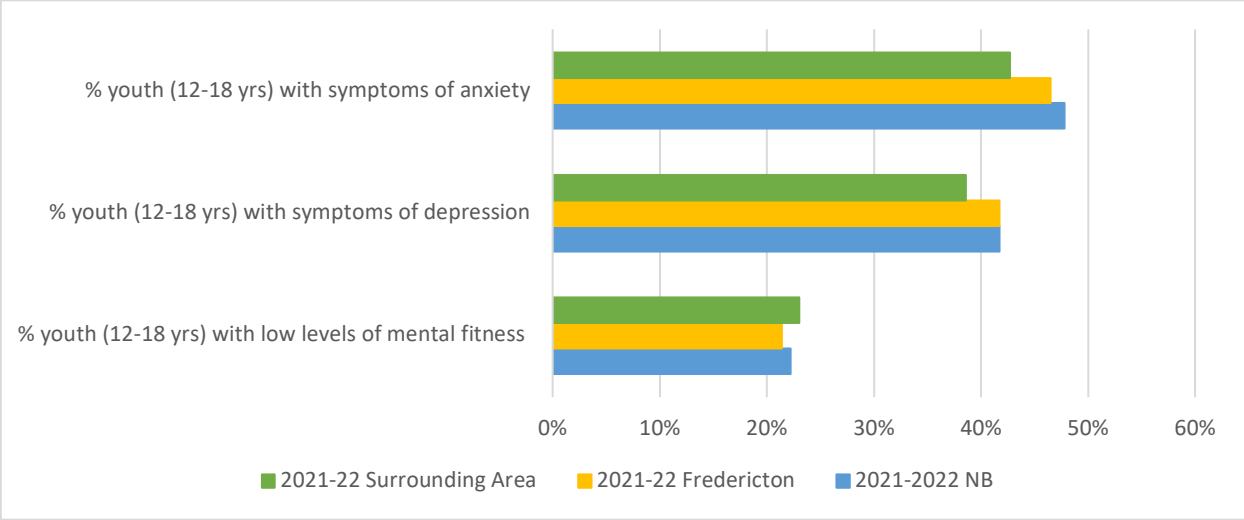


∗ 2014 results not available

When considering the health of younger generations, the prevalence of youth from FSA who reported a low-level of mental fitness[7] in 2021-2022 was similar to provincial rates[9]. In addition, when compared to provincial rates, fewer youth in the surronding area experienced symptoms of depression while fewer youth, living in both Fredericton and the surrounding area, experienced symptoms of anxiety during the 2021-22 school year (Figure 9).

[7] mental fitness related to how a person feels, thinks, and acts.

Figure 9: Mental Health Indicators for Children and Youth Living in FSA, Student Wellness Survey, NBHC[3]



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]. To better understand the inequities that exist, it is important to look beyond the quantitative data and speak directly to the population groups in FSA and those who support them to learn about the impacts of the social determinants of health.

7.0 Assessing Health and Wellness continued

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 and can support a more meaningful use of information to inform change[19]. Equipped with a summary of knowledge gaps identified collectively by the CAC, the CHNA Team applied purposive sampling principles[20] to connect with community members living and working in FSA who could contribute to a deeper understanding about the health and wellness challenges experienced in the area. Community members were invited to participate in engagement sessions. Participation was voluntary, and the process of Informed Consent was reviewed with each participant. Whenever possible, 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[21], transcripts were analyzed by our CHNA Research Lead. As a secondary step in the analysis process, all CHNA Team members independently reviewed qualitative analysis results and, through group discussions, debated the interpretation of findings to safeguard against researcher bias[22]. Qualitative findings from this analysis process resulted in the creation of a list of specific health and wellness issues for FSA.

Health and Wellness Knowledge Gaps and Areas of Concern

FSA'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. Nineteen engagement opportunities, three focus groups and four key-informant interviews, were facilitated. A total of 101 community members living and/or working in FSA participated. Each consultation had an intended focus, however because many identified concerns overlapped, the following is a list of the areas of concern that were purposefully discussed with community members throughout the consultation process.

Basic income
Access to local supports and services Housing
Mental health and wellbeing
Affordable and reliable transportation
Food security
Navigation and advocacy within the system
Community support and cohesion
Jurisdictional barriers / siloed services
Employment and education
Cultural safety
Healthy child development
Social supports
Availability of local data
Exposure to risky behaviours
Impact of climate change on health and wellbeing

8.0 FSA's Health and Wellness Priorities

The following six Health and Wellness Priorities for FSA were identified through a priority ranking process.

Priorities specific to Horizon's local responsibility as a Regional Health Authority

1. **Ensure timely access to local primary care and Horizon health services**
2. **Ensure mental health care services are accessible to those living with health inequities**
3. **Address structural and interpersonal stigma and discrimination in service settings**

Priorities that require collective action

1. **Ensure safe and supportive housing for all**
2. **Work within our systems to minimize the impact low-income has on health and advocate for everyone to access a basic income**
3. **Invest in early child development, youth-at-risk, and families who live with inequities**

While reflecting on the needs of the local area, CHNA engagement participants also identified the local strengths and assets. Beyond the many services, non-profit organizations, and programs regionally and locally administered, FSA was recognized by many to benefit from several collaborative partnerships and working groups that have driven change in the local area including the following:

- Partnership supporting youth-in-transition between Chrysalis House and Social Development's Youth Enhancement Service Social Workers
- Collaboration between the Flexible Assertive Community Treatment (FACT) Team and the local shelter system supporting those in the community with serious and persistent mental illnesses.
- Collective support for those who are homeless or vulnerably housed from Fredericton's Community Action Group on Homelessness (CAGH)
- Health care system support for First Nation community members through Horizon's First Nation Liaison Committee with membership from First Nation health centres and organizations within the Horizon region
- Collective action to relieve poverty and make Greater Fredericton a better place to live, work and play through the Greater Fredericton Social Innovation network of concerned organizations, agencies and individuals

Included in each priority profile are specific details of each need and suggested recommendations, that were voiced during the assessment process, to give Horizon, stakeholders, rightsholders 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. Quotes from consultations are also included as well as relevant quantitative data.

Priorities specific to Horizon's local responsibility as a regional health authority

Priority 1

Ensure timely access to local primary care and Horizon services

"The diabetic screen is done at the hospital. I would say probably one half to one third of my patients who are very high risk for gestational diabetes cannot make it to the hospital."

The [health care] system is not as equipped to even manage people who don't speak either English or French. For instance, primary care doctor offices, after hours clinics; they don't even have access to the language line."

What we heard from community: Throughout community engagement sessions, feedback about the frustrations related to not being able to access health care in a timely manner was shared. Of most concern was the timely access to primary care providers and the primary care system, but some concern was also shared around how this limitation affects timely access to care and services beyond the primary care system. Many factors limit access to care including having no assigned primary care provider, poor communication options for patients, low-literacy levels, language barriers, hours of operation, and transportation barriers.

Why is this important? To achieve optimal health and wellbeing people need regular access to timely health care.

Specific concerns and suggested recommendations:

- Throughout engagement, many voiced the current challenge of accessing a regular primary care provider in a timely manner for their health concerns. ***Work with health care system partners to build a more robust and accessible primary care system across Fredericton and surrounding area. Communicate more openly to the public about the process and mechanisms used to recruit primary care providers to support the primary care needs of the local area.***

- Through engagement it was voiced that our current local primary care system is not meeting the primary care needs of refugees new to the area and First Nation community members living in and outside First Nation communities. ***Work with community partners who represent refugees and First Nation community members both living in and living outside First Nation communities to proactively assess and forecast primary care needs including the need to ensure access to primary care is provided in a culturally competent manner in culturally safe places. Find mechanisms that identify and support primary care providers aiming to build their practice around these population groups.***

- Francophone community members shared that care provision in French is limited and directly affecting the health and wellbeing of community members who do not easily connect and communicate using English. ***Identify and address local operational barriers that limit Horizon's ability to provide care in French to our Francophone population and consider innovative approaches to supporting those who need health care service in French.***

- Health care service providers voiced the challenges they faced when supporting patients without a primary care provider. In such instances they have no way of passing on important individual health plan recommendations to a provider who would be able to consistently support an individual with specific health care needs. ***Audit Horizon services that are self-referral to gain a deeper understanding of this concern. If this is a common challenge, consider developing a temporary care pathway that could be offered to those without a primary care provider to ensure individual health care plans can continue in the absence of a primary care provider. The Upstream COPD program would be a good starting point to learn more about this challenge.***

- Community voiced concern about the perception of long waitlists for health care services and wondered why access to such services cannot be made available outside the typical work week of Monday to Friday, 8:30 a.m. to 4:30 p.m. ***Review service waitlists of offered services to understand if community concern aligns with current service demand. Horizon is encouraged to find mechanisms that allow for greater transparency with the local community about waitlist data.***

Related NBHC 2020 Primary Health Survey Data[1]

Survey Indicator	Fredericton	Surrounding Area	NB
% of citizens who report being able to get an appointment with their family doctor within 5 days	53%	51%	51%
% of citizens who have a family doctor who has extended office hours	39%	n/a	17%
% citizens who most often go to an after-hours clinic or walk-in when sick or in need of care	28%	16%	21%
% citizens who most often go to an emergency room when sick or in need of care	7%	9%	11%

Priority 2

"There seems to be a complete lack of services and supports for individuals with cognitive impairments.."

"Even if you do refer somebody,...you recommend psychiatry, they will actually do their own triaging and decision making and say 'no a social worker is fine'."

Ensure mental health care services are accessible to those living with health inequities

What we heard from community: Through engagement with those from FSA we heard the following two prominent concerns.

1. Barriers exist within our system that make it difficult for populations living with inequities to access needed mental health care and;

2. The coordination and connection between our mental health care service and our primary care system needs to be strengthened to meet the mental health care needs of the local area;

Why is this important? Inaccessibility of high-quality mental health care is a factor that impacts health, especially the health outcomes of population groups who are marginalized and who are seeking health equity[23]. In addition, a coordinated and integrated mental health care approach that ensures continuity between and within services is an aspect of person-centered care[24].

Specific concerns and suggested recommendations:

- Primary care providers describe feeling unsupported by Horizon's mental health services when they refer patients who must wait for mental health care. Some psychiatric services, available through direct referral from a primary care provider were described to be underutilized by the local primary care community. ***Create mechanisms that give those waiting for mental health support from Mental Health and Addiction Services and their providers an ability to connect with Horizon's Mental Health and Addiction services.***

- During several engagement sessions, questions were raised about the possibility of building mental health service capacity within the primary care service system so that more mental health care can be offered in the primary care setting. ***Collectively define a mental health care pathway for primary care including necessary supports and required resources. Ensure this plan includes elements that strengthen relationships between the primary care services, primary care providers, and the Mental Health and Addiction services to ensure continuity in mental health support from one service to another.***

- It was shared during consultation that families with individuals who have cognitive or developmental disabilities have been told that there is limited mental health care expertise available to support them with their mental health care needs. ***Identify and address the system barriers that prevent the local mental health service system from being able to support those with cognitive or development disabilities.***

- Indigenous communities need access to robust mental health care services that use culturally safe and supportive practices and are provided in culturally supportive spaces. ***Work with Indigenous partners to identify mental health care process, practices, and pathways that will meet the mental health care needs of their communities.***

- In many cultures represented by Fredericton's immigrant and refugee population, mental health is a subject that is not discussed openly. Some newcomers need effective mental health care that is offered using culturally respectful and sensitive approaches. ***Assess the mental health care capacity and training needs of service providers who care for patients from these population groups to ensure the effectiveness of our mental health care system.***

Priority 2
continued

Ensure mental health care services are accessible to those living with health inequities

- 2SLGBTQIA+ community members, who live with a limited income, are limited in terms of accessing mental health care and support that is LGBTQ2+ sensitive and free of stigma and discrimination. ***Engage with 2SLGBTQIA+ community partners to better understand the mental health care needs of the 2SLGBTQIA+ community.***

- The Francophone community shared that few Francophone mental health care options exist for community members who require service provision in French. For mental health care to be most effective it should be provided in the language that one feels most comfortable using to communicate. ***Learn from mental health care providers currently supporting the local Francophone populations to better understand mental health care access concerns, barriers, and solutions.***

- Consultation participants often linked the common relationship between substance-use disorder and mental health challenges. Those working to support substance use disorders shared that we need to support their mental health if we are intent on supporting their substance-use recovery. ***Consider the provision of addiction and mental health counselling services out of the Downtown Fredericton Community Health Centre, a location whereby many suffering from both substance abuse and mental illness access primary care support. It was also suggested that we re-examine the current DETOX model used by Horizon to ensure that its delivery supports those who are struggling with long term use of crystal methamphetamine and other substances.***

Related NBHC 2020 Primary Health Survey Data[1]

Citizens who felt that they needed to see or talk to a health professional about their mental or emotional health, or their use of alcohol or drugs [in the last 12 months] categorized by population group:

Target Population Group: >$60,000/year = 15%

Living with a disability	25%	Income <$25,000/yr	19%	Fredericton	16%
Self-identify as Indigenous	22%	Sexual minority	38%	Surrounding area	18%

Priority 3

"Racism has no place in a health-care provider's world, but it's there. It's time to move forward."

"There is a fear among [those with substance-use disorders] of 'how am I going to be treated up at emerge?' "

Address structural and interpersonal stigma and discrimination in service setting

What we heard from community: Throughout our engagement sessions we heard from community members about experiences they or their family members or friends have had with the health care system and with the social care system. Such experiences were not only interpersonal in nature, meaning the treatment they experienced when interacting with a service provider left them with feelings of being discriminated against, but were also structural in nature. This means that the processes and mechanisms that help marginalized populations within the health care system are set up in a manner that may be reinforcing how we negatively stereotype and label population groups.

Why is this important? Stigma is the social process of labeling, stereotyping, and rejecting human difference as a form of social control. It influences the health of a population group by worsening, undermining, or impeding several processes including social relationships, resource availability, stress, and psychological and behavioral responses that exacerbate poor health[25].

Specific concerns and suggested recommendations:

- Population groups that shared stigmatizing and discriminatory experiences included those living on low-income or social assistance, Indigenous people, those with substance-use disorders, 2SLGBTQIA+ community members, newcomers, and those who are living without shelter. ***Identify service areas that are at a high risk of delivering structural or interpersonal 'stigmatized' care to populations living with inequities (those living on low-income or social assistance, Indigenous people, those with substance-use disorders, 2SLGBTQIA+ community members, newcomers, and those who are living without shelter) and put in place structural process within Horizon that safe guard against discrimination. Plan an approach that explicitly addresses stigma and discrimination in the workplace.***

- Consultation participants from community organizations and within our service settings expressed a need to be more aware and appreciative of the impact of trauma and how it affects a person's engagement with the health care system. ***Invest in trauma-informed care training so that we become an organization that can explicitly offer a trauma-informed approach to care and build collaborations with other organizations who apply trauma-informed care to strengthen the trust patients/clients have in the system of supports available to them.***

- There is a limited understanding among front-line service providers about the health care jurisdictions that support the health needs of some Indigenous (First Nation, Metis and Inuit) people. This lack of understanding about who funds what services and how to access them has contributed to stigma and discrimination experienced by Indigenous people living in the local area. ***Educate front-line service providers about the jurisdictional barriers that exist within the health care systems that are available to Indigenous community members.***

Priority 3
continued

Address structural and interpersonal stigma and discrimination in service setting

- Local collaboration across service systems is lacking which reinforces structural stigmatizing practices that affect those living with disabilities. Build partnerships between service providers and government agencies who support those living with disabilities to ensure stigmatizing processes across systems do not exist. Service delivery planning needs to integrate supports for those living with disabilities and to assess how we engage and support them during service delivery (e.g.: consider how we treat individual who lives with a disability when they access emergency services).

Related NBHC 2020 Primary Health Survey Data[1]

Percentage of Citizens living in NB who reported that discrimination contributed a lot to feelings of stress [in the last 12 months], categorized by population group

Target Population group: Income is >$60,000/year = 3%

Living with a disability	9%	New Immigrant	11%
Self-identify as Indigenous	16%	Income <$25,000/yr	9%
Sexual minority people	14%	Surrounding Area	7%
Fredericton	5%		

Priorities that require collective action

Priority 1

"What we have now is all of the people that are more easily housed are already housed so what we're getting is a condensing of the most challenging to house not because they aren't worth it but because of the profound issues that is in the constellation of their lives."

Ensure safe and affordable housing for all

What we heard from community: Throughout our engagement sessions we heard from community members about the lack of affordable housing, the growing number of people who are precariously housed, the lack of supports available to those with more complex health and social needs, and the anticipated challenges that will come with an aging population and a growing number of households who are existing on a limited income.

Why is this important? Decent, affordable housing fulfills a basic human need for shelter and contributes to the wellbeing of all family members. Decent, affordable housing reduces stress, toxins, and infectious disease, which leads to improvement in both physical and mental health. It frees up household funds to spend on health care and food. Affordable housing also means reduced stress due to a lessening of concerns that high housing costs will lead to foreclosure and eviction; this in turn leads to fewer physical and mental health problems and reduced absenteeism on the job[26].

Specific concerns and suggested recommendations:

- Recognition that current affordable housing options will not meet the needs of older adults in years to come and immigrants and refugees with large families. ***Collectively, join in the work of evaluating housing needs of older adults and of newcomers to create affordable housing options for these population groups in the coming years.***

- Individuals who are street involved who have complex needs need more than housing. The local area is lacking a more collaborative, wrap-around approach that includes access to mental health support, harm-reduction initiatives and substance-use disorder support, employment support, advocacy support, social work support to help navigate debts, and support from Department Public Safety to navigate socially unsafe situations. ***Collectively, become more involved in work that is aiming to create a comprehensive wrap-around service approach for those who are street involve who also live with complex health and social needs.***

- There are no supportive processes to help those living in subsidized housing to advocate for improvement in their housing quality. ***Collectively, create advocacy channels for those living in subsidized housing to address housing quality concerns.***

- There are no avenues within our service system for families with family members who live with a disability to advocate for their housing needs. ***Collectively, create channels for families with differently abled family members to advocate for affordable housing.***

Priority 1
continued

Ensure safe and affordable housing for all

- It was shared through consultation that housing conditions for many First Nations people are unacceptable and that too many family members are often living in one dwelling which contributes to physical and mental health challenges. ***Collectively, acknowledge the unacceptable living conditions in First Nation communities and support efforts that aim to address this issue.***

- The supportive housing spaces for youth-at-risk who no longer feel safe at home is limited and not matching need. ***Collectively, develop a more robust and supportive housing plan for at-risk-youth who no longer feel safe at home.***

Related Quantitative Data[8]

% of Owner and Tenant households spending 30% or more on housing by Census Subdivision
Provincial prevalence 13%

*data not available for First Nation communities

City of Fredericton	**20%**	New Maryland LSD	6 %	St Mary's LSD	8 %
Lincoln LSD	7 %	Kingsclear LSD	5 %	Hanwell RCR	6 %
Maugerville LSD	7 %	Village of New Maryland	4 %		

% of Tenant households in core housing need by Census Subdivision
Provincial Prevalence 14%

*data not available for First Nation communities

City of Fredericton	**17%**	New Maryland LSD	0 %	St Mary's LSD	**26 %**
Lincoln LSD	**17%**	Kingsclear LSD	0 %	Hanwell RCR	0 %
Maugerville LSD	0 %	Village of New Maryland	**20 %**		

Priority 2

" I think they don't want people to be comfortable enough on income assistance to stay on it and that may be the case in an old school approach, but the reality is, there's a certain percentage of people on income assistance who will never not be on it. So, it just makes for a much more expensive health care system."

Work within our systems to minimize the impact low-income has on health and advocate for everyone to access a basic income

What we heard from community: Alongside a lack of affordable housing, one of the biggest challenges voiced during CAC meetings and community engagement sessions, was the lack of income that allows people to afford the necessities of life and live with dignity.

Why is this important? The fewer goods and services provided publicly by the community, the more important individual income is for health and wellbeing. At the low end of the scale, individual incomes matter for health because of their link with both material deprivation and restriction on social participation and opportunity to exercise control over one's life[27]. Despite having a publicly funded health care system, many costs associated with maintaining or achieving health are passed onto the patient and their family. For those living on low-income, these costs are unmanageable and can lead to poorer health outcomes.

Specific concerns and suggested recommendations:

- It was a described need throughout engagement that more advocacy work needs to occur to encourage provincial government decision makers to entertain the provision of a basic income for all. Frustration was shared by those working in health care and social service roles about the limited power they have, within their workplaces, to advocate for better financial support and fairer income distribution. ***Collectively, build advocacy mechanisms that create communication channels from front line health care and social service stakeholders to advocate for changes to our provincial practices to include a basic income.***

- Consultation participants representing front-line service providers described feeling ill-equipped to identify issues related to income and to support individuals in the betterment of the factors determining income. ***Collectively, consider how to equip service providers with mechanisms that help them support their clients living on low incomes. (e.g.: use of a poverty screening tool and capacity to respond to issues related to poverty).***

- Throughout engagement discussions, examples of how our system mechanisms pass on hidden costs to individuals were often shared. For example, hidden costs in the form of medication use, equipment costs, transportation costs, and the cost of continually needing to advocate for disability supports. ***Across services and systems, evaluate how hidden costs are passed onto the clients so that we can adjust the system mechanisms that contribute to inequity.***

- Throughout engagement, we heard from those with experience living on low income about the lack of understanding and compassion people in service roles have for those living on limited incomes. ***Collectively, make use of available learning opportunities, or find new opportunities, that educate about income-bias and stigma.***

- Throughout engagement, many voiced the need to enhance our local capacity to support those living on low income. ***Collectively:***

    - ***Collaborate locally to connect newcomers with meaningful employment that matches their skills or is related to their field of expertise.***

    - ***Strengthen the availability of English-Language supports available to newcomers to better their chances of getting meaningful employment that pays a living wage.***

    - ***Strengthen current efforts to secure opportunities for those who are homeless to earn money.***

- ***Build infrastructure that supports the local employment of differently abled youth and adults. This includes finding employment opportunities and supporting businesses through the process of training and supervising employees that are differently abled. This also needs to include training so a culturally safe work environment for differently abled employees is created.***

- Throughout engagement we heard about the high cost of food and transportation. ***Collectively, we need to reduce food and transportation costs with attention directed towards ensuring access to affordable food during summer months when school food programs are not available.***

Related NBHC 2020 Primary Health Survey Data[28]

Percentage of New Brunswick citizens who have no insurance for prescription medications, categorized by population group

Target population groups: Income >$60,000/year = 5 % New Brunswick = 15%

Living with a disability	16%	New Immigrant	17%	>75 years	15%
Self-identify as Indigenous	24%	Sexual Minority People	23%	People who prefer to receive their services in French	19%
Education high school or less	20%	Income <$25,000	30%	18-64 years	15%

Percentage of New Brunswick citizens who reported that "their financial situation" contributed a lot to feelings of stress [in the last 12 months], categorized by population group

Target population group: Income >$60,000/year = 24 % New Brunswick = 23%

Living with a disability	42%	New Immigrant	35%	>75 years	12%
Self-identify as Indigenous	40%	Sexual Minority people	49%	People who prefer to receive their services in French	27%
Education high school or less	31%	Income <$25,000	44%	18-64 years	37%

Priority 3

"I think what we have to do, as a society, is to go right back to what is the root cause of a lot of issues and that is adverse childhood events. So there needs to be some attention paid to that... and this is not Horizon's problem, it's all of our problem."

Invest in early child development, youth-at-risk, and families who live with inequities

What we heard from community: Throughout consultations support was expressed around the importance of investing in our children, youth, and their families. Many shared a belief that such an investment will have a long-term impact on the health and wellbeing of Fredericton and Surrounding area by building the capacity of our younger generations.

Why is this important? The health and social problems in many communities are highly complex. They are interrelated and intergenerational. Reducing and preventing the root cause of these problems, often reflected in adverse childhood experiences (ACEs), involves investing in those most at-risk and in approaches that aim to shift cultural norms and build community capacity and resiliency[29]. In addition, failing to invest in children and youth triggers substantial economic, social, and political costs resulting from negative outcomes such as early school drop-out, poor labour market entry, risky sexual behaviours, substance abuse, and crime and violence[30].

Specific concerns and suggested recommendations:

- Through engagement, questions surfaced about the local area's investment in supporting families with children and youth who live with inequities. ***Collectively, identify the support needs of families with young children who live with inequities to ensure they are supported in the process of raising children who are healthy and resilient. We also need to establish a model that supports families with youth to help them navigate the challenges of adolescents and provide access routes to mental health support.***

- Some engagement sessions recognized the impact of adverse childhood experiences on health and wellbeing and the need to incorporate it into our practice and service settings. ***Collectively, invest in training front-line staff about Adverse Childhood Experiences and Trauma Informed Care. It was also suggested that we invest in support for parents who are living with multiple adverse childhood experiences of their own, recognizing that supports for such families could come in the form of mental health and parenting guidance.***

- Concern was raised around the lack of life-skills training offered to today's youth. ***Collectively, ensure that the local infrastructure offering life-skills training for youth is meeting the needs of local youth. Life-skills training may include understanding and managing household finances, food skills, resume writing and job application, community and service navigation, and self-care practices. Topics need to be determined by engaging with youth directly.***

- It was voiced during engagement that some families with children who are differently abled are under-supported. ***Collectively, invest in the childcare supports/respite care for families with differently abled children.***

- Concern was raised about the existence and influence of youth gangs in the local area. It was shared during consultation that we do not have data that captures the challenge of youth-at-risk in the local area. ***Collectively, investigate and build understanding about the existence and influence of youth gangs in the local area which includes collecting data pertaining to at-risk-youth in FSA.***

- It was suggested that other models exist that could inform our work. ***Collectively, learn from the Youth Impact Model in Moncton as an approach that provides a safe refuge for at-risk-youth where they can seek support, access condoms, needles, a shower, programs, and to build a trusting relationship with support workers to help them move through the challenges they are facing.***

Related Quantitative Data[28]

- 2018 Point-in-Time Count, "Everyone Counts" Homelessness survey, one of the top three reasons for homelessness in Fredericton was conflict with a parent of guardian.

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