

# Report on the Health and Social Services Priorities of English-speaking Communities in Quebec

Submitted to

Health Canada

By the

Health and Social Services Priorities Committee

Prepared by

James Carter  
Program and Policy Advisor  
Community Health and Social Services Network

In collaboration with

Joanne Pocock  
Researcher

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## Foreword

The Health and Social Services Priorities Committee (HSSPC) is established as a cooperative effort of community organizations to determine and represent the English-speaking communities' health and social services priorities to Health Canada. The HSSPC mandate is to provide advice to Health Canada on the health and social services priorities of Quebec's English-speaking communities, and the implementation of multi-year Contribution Programs under Canada's commitment to linguistic duality and enhancing the vitality of English-speaking communities.

HSSPC members are the Community Health and Social Services Network (CHSSN) and the sponsoring organizations of the twenty community health and social services networks across Quebec:

4 Korner's Family Resource Centre, Deux-Montagnes  
African Canadian Development and Prevention Network (ACDPN), Montreal  
AGAPE- The Youth and Parents AGAPE Association Inc., Laval  
Assistance and Referral Centre (ARC), Brossard  
Collective Community Services (CCS), Montreal  
Coasters Association, Saint-Paul's River  
Committee for Anglophone Social Action (CASA), New Carlisle  
Community Health and Social Services Network (CHSSN), Quebec City  
Connexions Resource Centre, Gatineau  
Council for Anglophone Magdalen Islanders (CAMI), Grosse-Ile  
East Island Network for English Language Services (REISA), Montreal  
English-Community Organization of Lanaudière (ECOL), Rawdon  
Heritage Lower Saint Lawrence, Metis-sur-Mer  
Jeffery Hale Community Partners (JHCP), Quebec City  
Megantic English-speaking Community Development Corp. (MCDC), Thetford Mines  
Neighbours Regional Association of Rouyn-Noranda, Rouyn-Noranda  
North Shore Community Association (NSCA), Baie-Comeau  
Réseau emploi entrepreneurship (REE), Vaudreuil-Dorion  
Townshippers' Association, Lennoxville (two community networks)  
Vision Gaspé Percé Now, Gaspé

This report reflects the continuity of results and emergence of new priorities stemming from multi-year initiatives carried out by the community and public partner stakeholders in the Health Canada Contribution Program. It incorporates a dynamic evidence base established through an HSSPC monitoring program of current priorities of access, CHSSN-CROP surveys, a series of portraits to highlight the situation of vulnerable English-speaking populations, and other information from census data and reports on population health.

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## 1. Introduction

In March 2013, the federal government announced the Roadmap for Canada's Linguistic Duality 2013-2018. It affirmed Canada's commitment to promote linguistic duality and the vitality of official language minority communities including Quebec's English-speaking communities. As part of the federal commitment, Health Canada developed its Official Languages Health Contribution Program to improve access to health and social services for English-speaking communities in Quebec, and French-speaking communities in the rest of Canada.

In Quebec, the Health Canada Contribution Program has supported a range of projects through implementation agreements between the principal designated Program beneficiaries and the Ministry of Health and Social Services. The agreements ensure that the investments support measures within Quebec's legislative provisions with respect to the right to health and social services in English. They set the framework for integration of results into English-speaking communities and the health and social services system in a manner consistent with Quebec's responsibility to plan, organize and deliver health and social services. The projects funded in 2013-2018 supported partnership initiatives with communities and institutions in the health and social services and education sectors. As the designated beneficiaries, McGill University and the Community and Health and Social Services Network (CHSSN) received 41.06 million dollars to coordinate initiatives in training and retention of health professionals, support and development of community networks, health promotion, adaptation of the health and social services system, and knowledge development.

In June 2016, the Government of Canada announced a series of consultations in anticipation of developing a new federal Official Languages plan. The multi-year action plan, among other objectives, will aim to enhance the vitality of English-speaking and French-speaking minority communities. For Quebec, the action plan will add momentum to current federal investments strengthening English-speaking communities and contributing to Quebec's initiatives to improve access to health and social services in English.

In July 2017, the CHSSN submitted the present report to the Quebec Ministry of Health and Social Services inviting it to undertake consultations with key public institutions and community representatives with respect to the recommendations. The objective was to ensure that a proposal to Health Canada reflected the shared commitment of Quebec and its English-speaking communities to work in partnership to improve access to health and social services in English. In its reply to the CHSSN in October 2017 (Appendix), the Ministry supported the recommendations in accordance with comments reflecting the results of its consultations with the public institutions.

To support Health Canada in its mandate to prepare a new Contribution Program, the sponsoring organizations of the twenty recognized community health and social services networks along with the CHSSN are submitting the present report and recommendations reflecting the continuity of results of the last federal contribution and emergence of new priorities for the period ahead.

## 2. A socio-demographic profile of English-speaking Communities

There are more than one million English speakers comprising 13.5% of Quebec's population. According to Statistics Canada 2011 *Census of Canada*, regional English-speaking communities range from more than 600,000 on the island of Montreal, and large population counts in nearby Montérégie (159,515) and Laval (82,078), to tiny populations in areas such as Bas-Saint-Laurent (1,135), Saguenay Lac-Saint-Jean (1,798) and Centre-du-Québec (2,635).<sup>1</sup> Overall, 9 in 10 of Quebec's English speakers are living in cities. Yet despite this urban character, a number of regional English-speaking communities show significant proportions of community members living in rural situations. This is the case in Gaspésie – Îles-de-la-Madeleine (97%), Abitibi-Témiscamingue (52%), Estrie (49%) and Bas-Saint-Laurent (45%).<sup>2</sup> In contrast to the concentration of English-speakers in Montréal and adjoining regions, there are highly dispersed communities on the North Shore, the Gaspé and Magdalen Islands. Among Official-Language minority communities in Canada, Quebec's English-speaking population is the largest followed by Ontario and New Brunswick's Francophone populations, and second only to New Brunswick Francophones in terms of its share of the provincial population.<sup>3</sup>

Quebec's English-speaking communities are experiencing socioeconomic vulnerability which poses a risk to their health, particularly for certain sub-groups within the population. Income disparities within a population are associated with lower health status and social inequalities.<sup>4</sup> A 2012 study produced by the INSPQ shows "income inequalities are greater in the Anglophone population of Quebec at every level when compared with Francophones"<sup>5</sup>. According to the INSPQ study, income disparities by region and gender were also greater among Anglophones and disparities were particularly high in the Montreal census metropolitan area. A composite socio-economic indicator developed by the Department of Canadian Heritage also notes very high levels of socio-economic vulnerability in Gaspésie – Îles-de-la-Madeleine, Nord-du-Québec, Abitibi-Témiscamingue, Côte-Nord and Estrie regions.<sup>6</sup>

In terms of population diversity, one-third (33.6%) of Quebec's English speakers are immigrants. These levels are much higher than the levels found among Quebec's French-speaking majority where immigrants represent 8.8% of the population.<sup>7</sup> Immigrants can face particular linguistic and cultural barriers in accessing the health and

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<sup>1</sup> Canadian Heritage (2015b). *Socio-cultural Profile of Quebec, 1996 -2011*. Gatineau: Research Team, Official Languages Branch, Department of Canadian Heritage.p.51

<sup>2</sup> Ibid., p.51.

<sup>3</sup> Ibid., p.51.

<sup>4</sup> Institut National de Santé Publique du Québec (INSPQ) (May 2012) *The Socioeconomic Status of Anglophones in Quebec*. Gouvernement of Quebec. p.24 [http://www.inspq.qc.ca/pdf/publications/1494\\_SituationSocioEconoAngloQc .pdf](http://www.inspq.qc.ca/pdf/publications/1494_SituationSocioEconoAngloQc .pdf)

<sup>5</sup> Institut National de Santé Publique du Québec (INSPQ) (May 2012) *The Socioeconomic Status of Anglophones in Quebec*. Gouvernement of Quebec, p.24. [http://www.inspq.qc.ca/pdf/publications/1494\\_SituationSocioEconoAngloQc .pdf](http://www.inspq.qc.ca/pdf/publications/1494_SituationSocioEconoAngloQc .pdf)

<sup>6</sup> Canadian Heritage (2015a). *Composite Indicators of Official- Language Minority Communities in Canada*. Gatineau: Research Team, Official Languages Branch, Department of Canadian Heritage.

<sup>7</sup> Pocock and CHSSN Team. (2016). Meeting the Challenge of Diversity in Health: The Networking and Partnership Approach of Quebec's English-speaking Minority. *Journal of Eastern Townships Studies* (JETS), p.5, forthcoming.

social service system. In English-speaking communities, this group tends to be less bilingual (English and French) than their non-immigrant counterparts (54% compared to 73.9%). This adds an additional challenge to ensuring services are adapted to their needs. When place of birth of English-speakers is considered, it is noted that nearly half (45%) of English speakers were incomers to the province with their place of birth located either outside Canada or in another Canadian province. In some regions, such as the Outaouais at 67% and Saguenay Lac-Saint-Jean at 56%, more than half of English speakers were born outside of Quebec.<sup>8</sup> The highest concentrations of immigrants who use English as their first official language are located in the urban regions of Montreal (40.4%) and Laval (38.2%) followed closely by Montérégie (27.4%) and Capitale-Nationale (26.7%).<sup>9</sup>

Other diverse members of English-speaking communities are visible minorities who make up more than one-quarter (27.9%) of the English-speaking population. In comparison, this group comprises 7.8% of the French-speaking population. English-speaking visible minorities experience significant vulnerability with respect to their socioeconomic status. One-third (33.2%) live below the low-income cut-off (LICO) compared to 17% of the English-speaking non-visible minority population and 13.8 % of the French-speaking non-visible minority group. In the Montreal region, noted for high levels of ethno-cultural diversity, visible minority English speakers living below the low-income cut-off represent a substantial 37.7% of the English-speaking visible minority group. Another factor of diversity in English-speaking communities is the presence of an English-speaking aboriginal population. In four of Quebec's regions, individuals who claim an aboriginal identity comprise 25% or more of the English-speaking population.<sup>10</sup>

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<sup>8</sup> Canadian Heritage (2015b). *Socio-cultural Profile of Quebec, 1996 -2011*. Gatineau: Research Team, Official Languages Branch, Department of Canadian Heritage., p.51.

<sup>9</sup> Pocock and CHSSN Team. (2016). Meeting the Challenge of Diversity in Health: The Networking and Partnership Approach of Quebec's English-speaking Minority. *Journal of Eastern Townships Studies* (JETS), pp.9,10 Forthcoming.

<sup>10</sup> Ibid, pp.9,10.

## 3. Vulnerable English-speaking populations

### 3.1 Seniors and their caregivers

Of the one million English-speaking persons in Quebec, 268,696 of them are 55 years of age or older. This group represents over one-quarter (25.4%) of the English-speaking population and 29.6% of the French-speaking population. Projections state that by 2051, about one in four Canadians is expected to be 65 years and over. By comparison, in Quebec there are English-speaking communities like those in the rural Estrie and Gaspésie-Iles-de-la-Madeleine regions that are ahead of these projections and are already living in a situation where one in three English speakers is a senior.<sup>11</sup>

The proportion of Quebec seniors 85 years of age and over is greater among English-speaking communities compared to the French-speaking majority, and at the regional level this is most pronounced in the Estrie and Laurentides regions followed by Abitibi-Témiscamingue, Lanaudière, Bas-Saint-Laurent, Cote-Nord, Montérégie and Gaspésie-Iles-de-la-Madeleine and Montreal. In the majority of regions, the proportion of English-speaking females who are 85 years and over is substantially greater than the proportion of English-speaking males.

Many of English-speaking seniors have low education levels and are living on a low income. Canada's *National Population Health Survey* reveals that education and income are strong predictors of health and life satisfaction among seniors.<sup>12</sup> Low socio-economic status is linked to lower rates of health literacy and an increased risk of social and health-related problems. Among English-speaking Quebecers who are 65 years of age and over, 41.5% have an annual income of less than \$20,000.<sup>13</sup> This compares to 47.9% of older French-speakers with an annual income less than \$20,000. Overall, Quebec's English-speaking seniors tend to have higher levels of education when compared to French-speaking seniors but this varies widely by region. The proportion of English-speaking seniors with low educational attainment (without high school certificate) is very high in some regions such as Cote-Nord (68.9%), Gaspésie-Iles-de-la-Madeleine (52%), Laval (45.6%) and Abitibi-Témiscamingue (43.2%).<sup>14</sup>

The *Special Senate Committee on Aging* has identified unattached seniors and those considered frail as a vulnerable group.<sup>15</sup> Among English speakers 65 years of age and over, 30% are living alone. This compares to 31% of French speakers living alone. The older age segment of the senior population identified as frail elderly are likely the most dependent on support from public institutions, community organizations and family for the quality of their experience in all areas of their life. In the case of Quebec's English-speaking seniors, low levels of bilingualism and a lower likelihood to have children living

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<sup>11</sup> Community Health and Social Services Network (CHSSN) (2016) submitted to the Health and Social Services Priorities Committee (HSSPC). *Final Report on the Community Monitoring of Progress related to the Health and Social Services Priorities of Quebec's English-speaking Minority* (unpublished), p.6.

<sup>12</sup> Roberts and Fawcett, (2001). *At Risk: A Socio-economic Analysis of Health and Literacy among Seniors*. Statistics Canada: Ottawa. <http://www.statcan.gc.ca/pub/89f0104x/4151175-eng.htm>

<sup>13</sup> Quebec Community Groups Network(QCGN), (2013). *Socio-demographic Profile of Quebec's English-speaking Seniors Section1*, p.11, <http://www.qcgn-seniors.org/statistical-profile.html>

<sup>14</sup> Ibid; p.11

<sup>15</sup> Senate Special Committee on Aging (2009), *Canada's Aging Population: Seizing the Opportunity*, <http://www.parl.gc.ca/Content/SEN/Committee/402/agei/rep/AgingFinalReport-e.pdf>

in proximity compared to the French-speaking majority combine to elevate challenges for this group with respect to the response of the public system to their needs.<sup>16</sup>

With respect to social isolation, English-speaking seniors are less likely to have a regular place to go when sick or in need of medical advice, and less likely to feel they have someone to rely upon in an emergency, when compared to French-speaking seniors of the same age.<sup>17</sup> As well, English-speaking seniors are less likely to be proficient in the French language compared to English speakers of the younger generation; and those that are bilingual tend to experience the second language attrition that is normally associated with aging and a decline in health.<sup>18</sup>

Family and friends of English-speaking seniors are an important support system and provide high levels of unpaid care. According to a Statistics Canada study, the high intensity level of caregiving for parents and spouses observed within English-speaking communities is associated with negative health effects on the caregivers such as increased depression and stress, work-related problems (reduction of work hours) and decrease in social participation.<sup>19</sup> Given that seniors are living longer and with chronic illnesses and mobility issues on the rise, the demands on family caregivers are very likely to continue to increase.<sup>20</sup> This translates into a high demand for public homecare services to meet the needs of seniors and for caregiver support for their families.

Along with improving information on services for seniors and improving access to health and social services in English, increasing public home support available in English emerged as one of the priority needs of this vulnerable population when a community organization conducted consultations with English speakers 55 years and over.<sup>21</sup> In addition, the high proportion of seniors living on low income pointed to risk of more health problems and a lack of means to obtain private services.<sup>22</sup>

With respect to community support, community organizations serving the English-language population are acting as a protective factor with respect to the health and well-being of seniors. Community participants in two consultations have underlined the reliance of older English-speaking adults on their regional community organizations for an array of needs. These include social participation and emergency contact, information

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<sup>16</sup> CHSSN (2016d). *Promoting the Health and Well-being of English-speaking Seniors in Quebec. A Community Model*. <http://chssn.org/pdf/Community-Booklet-Seniors-2016-En.pdf>

<sup>17</sup> Community Health and Social Services Network (CHSSN)/Pocock, (2015a). *Canadian Community Health Survey (2011-2012). Findings related to the Mental and Emotional Health of Quebec's English-speaking Communities*. P.79, [www.chssn.org](http://www.chssn.org).

<sup>18</sup> Community Health and Social Services Network (CHSSN) (2016) submitted to the Health and Social Services Priorities Committee (HSSPC). *Final Report on the Community Monitoring of Progress related to the Health and Social Services Priorities of Quebec's English-speaking Minority* (unpublished), p. 36; Goral, M. (2004). "First-language decline in healthy aging: implications for attrition in bilingualism". *Journal of Neurolinguistics* 17 (2004) pp.31-52.

<sup>19</sup> Williams, (2004). "The Sandwich Generation", *Perspectives*, Vol.5, No.9, pp.5-12. Statistics Canada Catalogue No. 75-001-XIE; p.5,6 Statistics Canada, 2013.

<sup>20</sup> Statistics Canada, (2013). Turcotte (researcher). "Family Caregiving: What are the consequences?" *Insights on Canadian Society*, p.,1,2. Catalogue no.75-006-X ISSN 2291-0840.

<sup>21</sup> Seniors Action Quebec (SAQ), (2016). *Building Community Capacity: From Evidence to Action (2015-2016)* power point presentation, slide 13 <http://seniorsactionquebec.ca/images/Research-Canadian-Heritage-Project-PDF/SAQ-Press-Conference-Presentation.pdf>

<sup>22</sup> Community Health and Social Services Network (CHSSN) (2016) submitted to the Health and Social Services Priorities Committee (HSSPC). *Final Report on the Community Monitoring of Progress related to the Health and Social Services Priorities of Quebec's English-speaking Minority* (unpublished) p.36.

regarding health and social services and health conditions, and support resources for unpaid caregivers.<sup>23</sup>

### 3.2 Children, youth and families at risk

A substantial proportion of English-speaking children and youth experience vulnerability according to a measure of key social determinants of health. With respect to socio-economic status, these children and youth tend to live in communities with high levels of low income and unemployment. The proportion of children 0-5 living below LICO is greater among English speakers (19.2%) when compared to French speakers (14.4%). In the Montreal region, 26% of minority language children 0-5 are living below LICO.<sup>24</sup>

When the situation of the parent age cohort (25-44) is examined, English speakers are more likely to be living below the low income cut-off (LICO) compared to French-speakers of the same age (23.2% compared to 14.7%).<sup>25</sup> When language communities are compared, English speakers aged 15-24 are more likely than their French-speaking counterparts to be unemployed (16.9% compared to 12.8%), and more likely to be living below the low income cut-off (23% of English-speaking youth compared to 14.3% of French-speaking youth).<sup>26</sup> English-speaking youth may also be members of visible minority communities, many of whom experience an even more challenging socio-economic situation than their non-visible minority counterpart.

For certain English-speaking communities, the income gap with respect to the majority community is substantial. For example, in the Gaspésie-Iles-de-la-Madeleine region, 36.3% of pre-school English-speaking children live in lone-parent families compared to 15.3% of French-speaking children the same age.<sup>27</sup> For Quebec's English-speaking Black community, 34.2% of community members live below the low income cut-off compared to 17% of the English-speaking non-visible minority, and 13.8% of the French-speaking non-visible minority group.<sup>28</sup> Because visible minorities experience greater

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<sup>23</sup> Community Health and Social Services Network (CHSSN) (2016) submitted to the Health and Social Services Priorities Committee (HSSPC). *Final Report on the Community Monitoring of Progress related to the Health and Social Services Priorities of Quebec's English-speaking Minority* (unpublished); Community Health and Social Services Network (CHSSN)/Pocock. (2016a). *Baseline Data Report 2015-2016 English-language Health and Social Service Access in Quebec. Based on CHSSN-CROP (2015) Survey on Community Vitality.* [www.chssn.org](http://www.chssn.org); Seniors Action Quebec (SAQ), (2016). *Building Community Capacity: From Evidence to Action (2015-2016)* power point presentation <http://seniorsactionquebec.ca/images/Research-Canadian-Heritage-Project-PDF/SAQ-Press-Conference-Presentation.pdf>

<sup>24</sup> Community Health and Social Services Network (CHSSN)/Pocock (2016e). *Key Socio-demographic Characteristics of English-speaking Children (0-5) based on 2011 Statistics Canada National Household Survey.* Submitted to CHSSN as a power point presentation, October 26, 2016.

<sup>25</sup> Community Health and Social Services (CHSSN)/Pocock, (2016c). *Key Socio-demographic Characteristics of English-speaking Children, 2011, Gaspésie-Iles-de-la-Madeleine and its Census Divisions.* PowerPoint presentation, January 2016, slide 14, <http://chssn.org/wp-content/uploads/2014/11/Gaspe-overview-of-youth.pdf>

<sup>26</sup> Community Health and Social Services Network (CHSSN), (2015c). *Partnering for the Well-being of Minority English-language Youth, Schools and Communities* p.6, <http://chssn.org/pdf/En/CHSSN-LEARN-Booklet-2015-EN.pdf>

<sup>27</sup> Community Health and Social Services (CHSSN)/Pocock, (2016c). *Key Socio-demographic Characteristics of English-speaking Children, 2011, Gaspésie-Iles-de-la-Madeleine and its Census Divisions.* PowerPoint presentation, January 2016, slide 10, <http://chssn.org/wp-content/uploads/2014/11/Gaspe-overview-of-youth.pdf>

<sup>28</sup> Community Health and Social Services Network (CHSSN)/Pocock, (2015b). *Socio-demographic Characteristics of Visible Minorities in Quebec's English-speaking Communities.* [www.chssn.org](http://www.chssn.org)

income inequality than the non-visible minority population, the children in the former group are also at greater risk. In 2011, 31.2% of English-speaking children (0-5) also belonged to a visible minority group compared to 13.5% of French-speaking children of the same age.<sup>29</sup>

Household arrangements are a key social determinant of health. The findings of the *Quebec Social and Health Survey* (1998) continue to be valid. Parents of minors living in lone parent households are more likely to report food insecurity, display high levels of psychological distress and have more than one health problem compared to parents with other household arrangements.<sup>30</sup> According to the Statistics Canada 2011 *National Household Survey*, there are 127,535 English-speaking Quebecers living in a lone parent family representing 12.2% of the English-speaking population. The proportion of this group in the French-speaking population is 11.5%. Among the 0-14 age group, 22.1% live in a lone parent household and among those 15-24, 19% live in this family arrangement.<sup>31</sup>

### 3.3 Persons with mental health problems and their caregivers

In 2012-2013, some 3,171 English-speaking persons in Quebec aged 12 and over, responded to the Statistics Canada *Canadian Community Health Survey* (2012-2013) regarding their mental and emotional health.<sup>32</sup> According to survey findings, English-speaking respondents are less likely to frequently feel satisfied with their life compared to French-speaking respondents. There are notable gaps between English and French respondents in regions such as Capitale-Nationale (34.7% English-speakers feeling satisfied compared to 51.4% of French-speakers), Gaspésie-Iles-de-la-Madeleine (53.8% compared to 63.4%) and, Laval (40.2% compared to 49.7%).<sup>33</sup> The *Canadian Community Health Survey* also tells us that when age groups are compared, English speakers 45-64 years of age, often referred to as the caregiver generation, exhibit the highest rate of diagnosis of anxiety with the highest levels of anxiety found among women compared to men.<sup>34</sup>

When English-speaking regional communities are compared to the majority group, findings reveal that they exhibit a greater likelihood to have missed work due to chronic

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<sup>29</sup> Community Health and Social Services Network (CHSSN)/Pocock (2016e). *Key Socio-demographic Characteristics of English-speaking Children (0-5) based on 2011 Statistics Canada National Household Survey*. Submitted to CHSSN as a power point presentation, October 26, 2016. Slide 10.

<sup>30</sup> For discussion of the survey, see Community Health and Social Services Network (CHSSN)/Pocock, (2008). *Baseline Data Report 2007-2008. Quebec's Social and Health Survey Information*. [www.chssn.org](http://www.chssn.org)

<sup>31</sup> Statistics Canada (2011). *National Household Survey* (NHS), special tables ordered by the Community Health and Social Services Network (CHSSN).

<sup>32</sup> Community Health and Social Services Network (CHSSN)/Richardson, (2015.) *Inter-regional Access to Specialized Health and Social Services for English-speakers from Eastern Quebec*.p.14. <http://chssn.org/wp-content/uploads/2014/11/Interregional-Report-Nov-2015.pdf>

<sup>33</sup> Community Health and Social Services Network (CHSSN)/Pocock, (2015a). *Canadian Community Health Survey (2011-2012). Findings related to the Mental and Emotional Health of Quebec's English-speaking Communities*, p.55 [www.chssn.org](http://www.chssn.org)

<sup>34</sup> Community Health and Social Services Network (CHSSN)/Pocock, (2015a). *Canadian Community Health Survey (2011-2012). Findings related to the Mental and Emotional Health of Quebec's English-speaking Communities*, p.12 [www.chssn.org](http://www.chssn.org)

physical or mental health conditions.<sup>35</sup> As well, these communities are more than twice as likely to report high levels of stress as a barrier to improving their health.<sup>36</sup> Overall, Quebec's English-speaking respondents scored lower than their French-speaking counterparts on the attachment scale that measures the quality of close relationships, emotional bonds and access to dependable help.<sup>37</sup>

Quebec's English speakers are somewhat less likely than French speakers to have a regular place to go for medical advice (73.7% compared to 82.1%).<sup>38</sup> When queried regarding their use of mental health professionals and the type of mental health professional consulted, 11.7% of English-speaking survey respondents stated they had consulted a mental health professional in the year prior to the survey. The rate of use ranged from 17.2% in the Mauricie-Centre-du-Quebec region to 3.8% in Laval. Findings indicate that English speakers were much more likely to have consulted a social worker than French speakers (21% compared to 13.6%) and French speakers were more likely to have consulted a psychologist compared to English speakers (47.7% compared to 39.1%).<sup>39</sup>

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<sup>35</sup> Community Health and Social Services Network (CHSSN)/Pocock, (2015a). *Canadian Community Health Survey (2011-2012). Findings related to the Mental and Emotional Health of Quebec's English-speaking Communities*, p.21,22 [www.chssn.org](http://www.chssn.org)

<sup>36</sup> CHSSN Community Health and Social Services Network (CHSSN)/Pocock, (2015a). *Canadian Community Health Survey (2011-2012). Findings related to the Mental and Emotional Health of Quebec's English-speaking Communities*, p.43,44 [www.chssn.org](http://www.chssn.org)

<sup>37</sup> Community Health and Social Services Network (CHSSN)/Pocock, (2015a). *Canadian Community Health Survey (2011-2012). Findings related to the Mental and Emotional Health of Quebec's English-speaking Communities*, p.107,108 [www.chssn.org](http://www.chssn.org)

<sup>38</sup> Community Health and Social Services Network (CHSSN)/Pocock, (2015a). *Canadian Community Health Survey (2011-2012). Findings related to the Mental and Emotional Health of Quebec's English-speaking Communities*, p.78,79 [www.chssn.org](http://www.chssn.org)

<sup>39</sup> Community Health and Social Services Network (CHSSN)/Pocock, (2015a). *Canadian Community Health Survey (2011-2012). Findings related to the Mental and Emotional Health of Quebec's English-speaking Communities*, p.71-78 [www.chssn.org](http://www.chssn.org)

## 4. Community perspectives on access to health and social services in English

Through an initiative carried out by the CHSSN in collaboration with the twenty community health and social services networks, a monitoring program was undertaken to capture the experience of community members with the health and social services network. The resulting perspectives add an important dimension to efforts of communities and the public system to improve access and the quality of services provided to English-speaking persons. The information was gathered over the last four years through surveys, research reports, a monitoring panel, focus groups and community consultations. The following section presents selections of this community experience.

### *The community monitoring framework*

The framework for monitoring community experience in the health and social service system included a strategy for gathering community feedback on an annual basis for three years (2013-2016). The community feedback approach entailed creating a “panel” by extending by three years the participation of approximately 30 of the 222 focus group members of a 2011 survey. The panel members answered a series of questions through yearly interviews. They remained anonymous to the CHSSN and the community networks. There were 26 panel members who participated in 2013-2014, 20 in 2014-2015 and 17 in 2015-2016 with a total of 63 over the three years. The monitoring framework also used research conducted through large studies primarily national and provincial in scope. These studies either randomly targeted the provincial English-speaking group as their sample or organized their data collection such that Quebec’s English speakers could be selected out as a random sub-sample. Some research, like the evidence gathered for CHSSN Baseline Data Reports, is conducted annually with its target sample varying from a provincial sample of 3,000 English-speaking individuals (CHSSN-CROP surveys) to smaller sub-samples emanating from the 20 community networks. Part of the monitoring report includes selected responses to the QCGN *Survey of Quebec’s English-speaking seniors* conducted in 2013. The study captured the perceptions and experience of 820 English speakers 55 and older residing in eight administrative regions of Quebec.

The following statements of the community members who participated in the community feedback approach reflect their personal experiences accessing health and social services, or in other cases, the experiences of family members or others close to them. The focus of their statements is the challenge of obtaining services in English. Their accounts do not address situations where delays in accessing services, such as specialized social services or homecare for seniors, are due to factors other than language. These factors may include constraints on resources that affect the availability of services for the entire population of a region or territory, and not just English-speakers.

### *Information on services in English*

Among English-speaking respondents to the provincial *Survey on Community Vitality* (2015), 74.1% reported they had not received information about services in English that

are provided by public health and social services institutions in the previous two years.<sup>40</sup> When considered by region, the proportion of those who had not received information ranges from 87.1% in Lanaudière and 85.5% in Laval to 36.5% in the Cote-Nord region. When findings from the same survey conducted in 2005, 2010 and 2015 are compared, the percentage of English speakers receiving information from the public health and social services system had decreased in the most recent period; 2005 (32%), 2010 (38.4%) and 2015 (25.9%).<sup>41</sup>

According to the monitoring panel, when information was accessed, it was most frequently drawn from flyers in a public location with less availability of material in English compared to that available to the majority population. A disparity was also evident when accessing information through telephone calls, face-to-face visits and use of websites. When panel members were queried concerning their preferred mode for accessing health information, the top three listed were web-based communication, information sessions primarily through English language community organizations and telephone calls.<sup>42</sup>

According to the 2015 *Survey on Community Vitality*, the most frequent source of information regarding public health promotion or prevention programs in English was schools (31.8%) and community organizations (29.1%) followed by the public health system (19.3%).<sup>43</sup> Among age groups, those aged 18-24 years (14.5%) and 25-44 years (15.5%) were the least likely to receive health promotion or prevention program information from the public health system.<sup>44</sup> The majority of panel members reported that they did not have access to the internal documents (consent forms, medical information etc.) of public health and social services organizations in English. Among those who did have access, it was typically gained by special request, which in some cases resulted in a treatment delay or was perceived by the person requesting as a threat to good relations with the medical staff. Respondents in the 2013 QCGN *Survey of Quebec's English-speaking Seniors* reported that the websites of public institutions and agencies often do not translate from French into English, are not kept up-to-date or designed for older adults, and use technical or specialized language.<sup>45</sup>

### *Primary level services*

When queried by a 2015 provincial survey with respect to their satisfaction with health and social service offerings in their region in English, 42.6% of English-speaking respondents reported being satisfied. The highest level of dissatisfaction was among

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<sup>40</sup> Community Health and Social Services Network (CHSSN)/Pocock. (2016a). *Baseline Data Report 2015-2016 English-language Health and Social Service Access in Quebec. Based on CHSSN-CROP (2015) Survey on Community Vitality*, p.67 [www.chssn.org](http://www.chssn.org)

<sup>41</sup> Community Health and Social Services Network (CHSSN) (2016) submitted to the Health and Social Services Priorities Committee (HSSPC). *Final Report on the Community Monitoring of Progress related to the Health and Social Services Priorities of Quebec's English-speaking Minority* (unpublished); p.12

<sup>42</sup> Community Health and Social Services Network (CHSSN) (2016) submitted to the Health and Social Services Priorities Committee (HSSPC). *Final Report on the Community Monitoring of Progress related to the Health and Social Services Priorities of Quebec's English-speaking Minority* (unpublished); p.12,13

<sup>43</sup> Community Health and Social Services Network (CHSSN)/Pocock. (2016a). *Baseline Data Report 2015-2016 English-language Health and Social Service Access in Quebec. Based on CHSSN-CROP (2015) Survey on Community Vitality*, p.69. [www.chssn.org](http://www.chssn.org)

<sup>44</sup> Ibid; p.71

<sup>45</sup> Community Health and Social Services Network (CHSSN) (2016) submitted to the Health and Social Services Priorities Committee (HSSPC). *Final Report on the Community Monitoring of Progress related to the Health and Social Services Priorities of Quebec's English-speaking Minority* (unpublished); p.17

English speakers who reported the poorest health status.<sup>46</sup> The health and social services used most frequently by English speakers are doctors in a private office, CLSC and walk-in clinics and hospital emergency and out-patient clinics.<sup>47</sup> When language of service is considered across types of medical situation, English is most likely to be used with a doctor in a private clinic or office (82.1%) and least likely to be used at a CLSC (57.9%). These different situations vary substantially by region. Another example where the regional proportion of English speakers being served in English can drop below the overall provincial average is in the case of hospital emergency rooms or out-patient clinics. Only 48.5% of survey respondents residing in the Estrie region and 52.6% of those in Laval were served in English in a hospital emergency room or out-patient clinic while the provincial average was 74%.<sup>48</sup>

Members of the monitoring panel cited difficulties accessing specialized social services. They reported long waiting times for services such as psychological counseling, speech therapy, diagnosis and treatment of children with intellectual challenges and family crisis intervention. They believed prolonged delays could be due to requiring English as the language of communication. For example, “For children with special needs the wait is always longer for service in English. Unlike French-speaking children in the same situation, a request has to be made for a CLSC worker or educator who speaks English. Instead of days, it can take many weeks for an evaluation.”<sup>49</sup> In Baie-Comeau-Port Cartier area, students at the English language school can be on the waiting list for a year or two to have access to a speech therapist or psychologist.

Many of Quebec’s English speakers report needing assistance to communicate with the providers of public health and social services. Among survey respondents in this position, 58.3% depend upon family members and 24.3% on a friend.<sup>50</sup> A CHSSN focus group participant recounts needing translation assistance at the local CLSC, “Medical staff were approached first but could not help. Eventually they located a janitor who could speak English”.<sup>51</sup> For survey respondents with the lowest health status, 45.5% reported they could have benefited from communication assistance in their use of public health and social services if it had been available. The reliance on family and friends for translation is observed to have an impact upon English-speakers in several ways. CHSSN focus group participants report increased anxiety and stress surrounding their engagement of the system and in response to their medical concerns, “You don’t feel

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<sup>46</sup> Community Health and Social Services Network (CHSSN)/Pocock. (2016a). *Baseline Data Report 2015-2016 English-language Health and Social Service Access in Quebec. Based on CHSSN-CROP (2015) Survey on Community Vitality*, p.16,17 [www.chssn.org](http://www.chssn.org)

<sup>47</sup> Community Health and Social Services Network (CHSSN)/Pocock. (2016a). *Baseline Data Report 2015-2016 English-language Health and Social Service Access in Quebec. Based on CHSSN-CROP (2015) Survey on Community Vitality*, p.13 [www.chssn.org](http://www.chssn.org); Community Health and Social Services Network (CHSSN) (2016) submitted to the Health and Social Services Priorities Committee (HSSPC). *Final Report on the Community Monitoring of Progress related to the Health and Social Services Priorities of Quebec’s English-speaking Minority* (unpublished); p.25

<sup>48</sup> Community Health and Social Services Network (CHSSN)/Pocock. (2016a). *Baseline Data Report 2015-2016 English-language Health and Social Service Access in Quebec. Based on CHSSN-CROP (2015) Survey on Community Vitality*, p.28-44 [www.chssn.org](http://www.chssn.org)

<sup>49</sup> Community Health and Social Services Network (CHSSN) (2016) submitted to the Health and Social Services Priorities Committee (HSSPC). *Final Report on the Community Monitoring of Progress related to the Health and Social Services Priorities of Quebec’s English-speaking Minority* (unpublished); p. 26

<sup>50</sup> Community Health and Social Services Network (CHSSN)/Pocock. (2016a). *Baseline Data Report 2015-2016 English-language Health and Social Service Access in Quebec. Based on CHSSN-CROP (2015) Survey on Community Vitality*, p.64 [www.chssn.org](http://www.chssn.org)

<sup>51</sup> Ibid; p.95

confident that the information passed is clearly understood”.<sup>52</sup> “A night or two in a hospital without someone to speak to in English...can interfere with the sense of comfort needed to heal”.<sup>53</sup> Also, “it is uncomfortable to feel like an inconvenience to people” and difficult to organize appointments and hospitalization around their schedule. This results in delaying diagnosis and treatment and a sense of exclusion from the public programs and level of care enjoyed by the majority.<sup>54</sup>

### *Medical services out of region*

In some regions, a high proportion of English speakers report using health services outside their region. For example, 43.6% of respondents residing in the Outaouais region, 36.4% in Laurentides and 36.3% in Abitibi-Témiscamingue use services outside their home region.<sup>55</sup> When respondents were asked to give their reasons for going out of region the following emerged as the two main motivations: the services are not available in their region, or the services are unavailable in English.<sup>56</sup> In the words of monitoring panel members, “We go out of the region quite regularly to reduce our waiting times and avoid communication issues...there is a cost but...I don’t want to come away from an appointment feeling anxious that I may have misunderstood information or didn’t ask the questions I really needed to”. Similarly, “I go out of region for my father because there is less waiting time and no interpretation issues”.<sup>57</sup>

For most of the monitoring panel members, going out of their region for services represents time and money. A few report being reimbursed for transportation but not for overnight hotel stays. Time lost at work or cost of care for dependents left at home were not reimbursed. All agreed when it comes to seeing their specialist, often about matters extremely important to their quality of life, communication is of utmost concern.

There is a particular challenge for English-speaking communities in rural and remote areas of eastern Quebec. Community members in the Gaspé, Îles-de-la-Madeleine, Lower Saint-Lawrence, North Shore and Lower North Shore must travel to larger urban centres for specialized medical or social services. In a survey of 847 community members, including 13 focus groups with 85 participants, many challenges accessing services in English were identified.<sup>58</sup> English-speaking patients from eastern Quebec were likely to be referred to hospitals in Sept-Îles, Rimouski and Quebec City. The main challenges related to language barriers, written information, family or caregiver support, unfamiliarity with cities and hospitals, costs and transfer protocols. About 85% of the survey respondents stated they were most comfortable working with a health care provider in English, with 75% stating they did not have the proficiency to understand medical or technical terminology. With a variable capacity in the hospital centres to

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<sup>52</sup> Ibid; p.93

<sup>53</sup> Ibid; p.91

<sup>54</sup> Community Health and Social Services Network (CHSSN)/Pocock. (2016a). *Baseline Data Report 2015-2016 English-language Health and Social Service Access in Quebec. Based on CHSSN-CROP (2015) Survey on Community Vitality*, p.95 [www.chssn.org](http://www.chssn.org)

<sup>55</sup> Ibid; p.13

<sup>56</sup> Ibid; p.59

<sup>57</sup> Community Health and Social Services Network (CHSSN) (2016) submitted to the Health and Social Services Priorities Committee (HSSPC). *Final Report on the Community Monitoring of Progress related to the Health and Social Services Priorities of Quebec’s English-speaking Minority* (unpublished); p.31

<sup>58</sup> Community Health and Social Services Network (CHSSN)(2015) *Inter-regional access to specialized health and social services for English-speakers from eastern Quebec*.

communicate in English, concerns were voiced regarding miscommunication or misunderstanding, less than optimal health outcomes and loneliness during longer stays.

There are issues with an inconsistent availability of written information in English, particularly with consent forms and after care information. Because of language barriers and need for support, particularly for children and seniors, patients may bring someone with them usually at a high cost. Accompaniment can be a critical support, as patients may be unfamiliar or anxious about the urban environment, their accommodations and the strangeness of a hospital setting. However, the person accompanying may not be able to stay for the full treatment, have trouble interpreting or understanding medical terminology, and be uncomfortable dealing with confidential matters or an emotionally charged situation. The situation can be very stressful for families that cannot accompany a vulnerable patient in the transfer process. “The only thing that was truly traumatic regarding this situation was having to place our under 2 year old on the ambulance plane totally alone knowing we couldn’t be at the CHUL (Quebec City) to receive him and that he would be alone the many hours it took for me to join him in Quebec City”.<sup>59</sup>

### *Seniors*

Restructuring in the health sector has resulted in fewer days spent in recovery at a treatment center and an increase in the medical and personal aid needed at home during this vulnerable period. Also, provincial policy concerning seniors is organized around the priority of supporting the elderly to live independently in their homes for as long as they are able. Often this is only feasible if seniors have access to homecare services and reside in an age-friendly environment. The challenges cited by the members of the monitoring panel included a long waiting period for homecare services, lack of services in English for government homecare services and insufficient service offerings once access was achieved (on the average once or twice a week for two hours). Government homecare services very rarely replaced the need to have the contribution of the family, volunteers and, if available and affordable, paid services. Aside from the cost associated with non-governmental services, panel members pointed to the fact that for-profit services cater to the market and frequently services in English are not offered especially where the English-speaking population is small. Language barriers in accessing homecare services may result in English-speakers paying for services in order to receive them in English and to avoid dependency on family members and volunteers for translation.<sup>60</sup> In the words of one panel member, “As caregiver for my husband, I struggle to keep things going. I have to push all the time and I have withdrawn from volunteering and participation in the community. There is just too much on my plate. The specialists in Montreal are great but follow-up services in English in our region are poor”.<sup>61</sup>

The 2015 *Survey on Community Vitality* queried English-speaking respondents with respect to the services they anticipated requiring within the next five years. Among the services listed, English speakers were most likely to anticipate needing public homecare services (35.3%) in the next five years for themselves or a person they know. When regional realities are considered, the proportion anticipating the need for public

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<sup>59</sup> Ibid. p. 32.

<sup>60</sup> Community Health and Social Services Network (CHSSN) (2016) submitted to the Health and Social Services Priorities Committee (HSSPC). *Final Report on the Community Monitoring of Progress related to the Health and Social Services Priorities of Quebec’s English-speaking Minority* (unpublished); p.32-34

<sup>61</sup> Ibid; p.33

homecare services ranges from 50.7% in Cote-Nord and 46.8% in Estrie to 27.5% in Lanaudière and 28.6% in the Mauricie et Centre-du-Quebec region.<sup>62</sup>

### *Children, youth and families*

According to the monitoring panel, English-speaking youth and families in crisis face many challenges when it comes to accessing the public health and social service system.<sup>63</sup> A crisis often includes trauma and other poor health symptoms, which make communication a challenge. This challenge is compounded when second language use is required of those in critical need. Panel members report that places for English-speaking youth to turn to when they are in crisis such as drug rehabilitation programs, centers for pregnant youth or shelter for victims of family violence are insufficient and those that exist tend to be located in urban centers. Accessing public services in English often entails going out of the region. This can represent a prohibitive cost and an emotionally difficult separation from family members and friends. It was considered that these challenges could delay assistance, increase stress and isolation and ultimately place English-speaking youth and their families in crisis at even greater risk.<sup>64</sup> In the words of a panel member: “It is important to understand that a youth in crisis may not have an advocate. If you are fourteen years old and pregnant you may be seeking help without a parent. In many ways, they are like a newcomer to the system and seeking help is difficult for them. It is huge for them to even admit they have a problem like an addiction. The school and the health system have to be as open as they can to encourage the request for help. Anything like not being able to speak their language is a reason for them not to turn to the system at all”.<sup>65</sup> “A crisis by definition means you are dealing with something out of the ordinary – something that you aren’t used to dealing with. Usually it means something must happen quickly and that there are lives at risk. It is not the time to be dealing with language barriers or the logistics of distant relocation. You need information, you need to provide the health professional with information and all as quickly as possible. It is a matter of safety first”.<sup>66</sup>

English-speaking youth of school age are at risk as the result of not gaining access to the timely attention they need for an array of issues such as learning disabilities, speech impediments and autism. Monitoring panel members and CHSSN focus group participants report problems of access for children with specialized needs. “There is a long waiting list for the initial assessment of need; two, sometimes two and a half years. While you are waiting you may be dealing with some very challenging symptoms and all the anxiety of not knowing what the problem is or how it should be approached or by whom. When you’re dealing with a child, and a child with special needs, you have to realize they cannot always communicate what is going on in their bodies and minds”.<sup>67</sup> An observation of panel members is that once an assessment has been made and the child is a patient in the system the reporting by therapeutic professionals, occupational therapists and speech therapists is often available in French only. This creates challenges in transferring knowledge among all those involved in an intervention

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<sup>62</sup> Ibid; p.24-25

<sup>63</sup> Ibid; p.41

<sup>64</sup> Ibid; p.41-42

<sup>65</sup> Ibid; p.41

<sup>66</sup> Community Health and Social Services Network (CHSSN) (2016) submitted to the Health and Social Services Priorities Committee (HSSPC). *Final Report on the Community Monitoring of Progress related to the Health and Social Services Priorities of Quebec’s English-speaking Minority* (unpublished); p.41

<sup>67</sup> Ibid; p.39,40

strategy. It is noted that families of children with specialized needs must bring together the professionals in English-language schools and the health and social system to organize an intervention for their child. The process can be delayed or blocked by a lack of communication in English.<sup>68</sup>

### *Mental health*

According to the *Canadian Community Health Survey (2011-2012)*, when English speakers consult a mental health professional they are more likely than French speakers to consult a social worker (21.0% compared to 13.6%) and less likely to consult a psychologist (39.1% compared to 47.7%) for their concerns.<sup>69</sup> The higher use of social workers for mental and emotional health concerns is consistent with the overall tendency to be frequent users of the services offered by CLSC's, hospital emergency and out-patient clinics and schools. Social workers are also noted for the longest waiting times especially if there is a request for service in English.<sup>70</sup>

Members of the monitoring panel affirmed the view that when it comes to mental and emotional health services, receiving assistance in English is essential. English-speaking persons in the 18-30 age range are identified as a particularly vulnerable group as they are at a stage of life where they are expected to transition from their parent's home to independent or group living. "I am supporting a young woman (29 years of age) seeking help in English. She understands French but it is important that she receives assessment and treatment in English. She feels that understanding her condition, choosing among medications and making recommended lifestyle changes, both for her and her family, requires making communication as easy as possible."<sup>71</sup> As youth become young adults, they may no longer be connected to mental and emotional health services geared to younger people, and new service options are not clear. At this stage, they and their family caregivers can be vulnerable. A monitoring panel member notes there seems to be insufficient support available in English for these caregivers, and support from the public health system can be lacking when they can no longer do the job by themselves. "I am aware of many English-speaking mothers, family members in general, who are exhausted and depressed from their caregiving demand. They have no place to turn and can be uncomfortable admitting it. Access to information and services in English would result in an improvement to their situation and to their health".<sup>72</sup>

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<sup>68</sup> Ibid; p.39,40

<sup>69</sup> Community Health and Social Services Network (CHSSN)/Richardson, (2015) *Inter-regional Access to Specialized Health and Social Services for English-speakers from Eastern Quebec*. P.71 <http://chssn.org/wp-content/uploads/2014/11/Interregional-Report-Nov-2015.pdf>

<sup>70</sup> Community Health and Social Services Network (CHSSN) (2016) submitted to the Health and Social Services Priorities Committee (HSSPC). *Final Report on the Community Monitoring of Progress related to the Health and Social Services Priorities of Quebec's English-speaking Minority* (unpublished); p.28 and 33

<sup>71</sup> Community Health and Social Services Network (CHSSN)/Pocock. (2016a). *Baseline Data Report 2015-2016 English-language Health and Social Service Access in Quebec. Based on CHSSN-CROP (2015) Survey on Community Vitality*,p.43 [www.chssn.org](http://www.chssn.org)

<sup>72</sup> Community Health and Social Services Network (CHSSN) (2016) submitted to the Health and Social Services Priorities Committee (HSSPC). *Final Report on the Community Monitoring of Progress related to the Health and Social Services Priorities of Quebec's English-speaking Minority* (unpublished, p.39.

## 5. The special context of reorganization of Quebec's health and social services system

In February 2015, legislation was adopted introducing a major reform of Quebec's health and social services network.<sup>73</sup> The reorganization is transforming the organization and governance of the network through regional integration of health and social services, creation of institutions with enlarged missions and reduction of administrative levels. The consolidation process has reduced the number of institutions from 182 to 34. At the heart of the reform is the creation of 22 integrated health and social services centres (CISSS) including nine with university affiliation (CIUSSS). The aim is to harmonize practices and improve user access to a continuum of services by means of merging or regrouping various institutions in a territorial network of services.

The reform has posed challenges for English-speaking communities and their historical institutions. With the abolition of agency boards and reduction of institutional boards from 182 to 33, the participation and representation of English-speaking communities in the network's administrative structures is reduced. The challenge ahead is to ensure effective representation of communities in the new governance system. The governance of over twenty institutions historically affiliated with English-speaking communities was affected, as these institutions were merged or regrouped into new institutional entities<sup>74</sup>. While legislative provisions protect the designated bilingual status of these institutions as they transform into new administrative entities, major changes lie ahead in their governance and management practices, as they transition into a new identity as an installation or regrouped entity in a larger service structure.

The network reorganization builds on a previous reform in 2004-2005, which established local service networks in each health and social service region. The creation of the health and social services centre (CSSS) with a populational responsibility, provided impetus for English-speaking communities to establish community health and social services networks in a number of regions. The community networks have been successful in promoting access and community engagement through a model of collaboration and partnership with the public system. Community mobilization in this earlier phase of reform has positioned the community networks and their public partners to build on this relationship and take advantage of the opportunities for positive change presented in the latest reform.

Each CISSS and CIUSSS will be at the core of its territorial network of services in assuming responsibility for the delivery of services, including public health, to the population of its health and social service territory. Each is required to organize the core and complementary services in its territory as part of its multiple missions, which include hospitals, CLSCs, long-term care centres, youth protection centres, and readaptation centres. This integration of public services is based on the needs of its population and its territorial realities, and will require agreements with a whole range of other institutions and partner organizations in the territory including community organizations. For English-speaking communities, populational responsibility is an affirmation that their needs must

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<sup>73</sup> *An Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies*

<sup>74</sup> These are institutions recognized under section 29.1 of the Charter of the French language, and designated by virtue of section 508 of the *Act respecting health services and social services* (Chapter S-4.2) to render all their services accessible for English-speaking persons in the English language.

be taken into account in the reorientation of the system. Given the scope of the reform, the community health and social services networks are ready to offer collaboration to assist the CISSS and the CIUSSS in carrying out its populational role.

## 6. Measures to improve access and health outcomes in English-speaking communities

The demographic and health determinant portrait of English-speaking communities indicates areas of vulnerability in English-speaking communities and disparities in health status with respect to the majority population. Coupled with new information on the diversity of English-speaking communities and their geographic realities, the community networks have identified vulnerable populations within their regions that are deemed a priority for intervention. As well, the articulation of the different challenges community members face in accessing health and social services in English provides a key information base for collaborative action of community networks and the public system to improve access. To achieve an outcome of improved access to services and health outcomes the community networks propose interconnected measures that strengthen communities, adapt the health and social services system to the needs of English-speaking communities, and create shared strategic information that informs the public system and empowers communities to be full partners in the health and social services network.

### 6.1 Strengthening communities

#### *The community network partnership model*

The community health and social services networks supported by the Official Languages Health Contribution Program Health promote strategies for English-speaking communities in Quebec to mobilize communities to create partnerships with Quebec's health and social services network. The purpose is to undertake collaborative action to improve access to services and health outcomes in English-speaking communities. Support is provided to 20 community networks across the province.

The CHSSN and the affiliated community health networks have established an effective evidence-based development model that has successfully mobilized English-speaking communities and created formal partnerships with Quebec's health and social services system. In 2014-2015, the 20 community networks coordinated over 500 partnerships at the local level. Over 40% of the partnerships were with the public system, supporting projects and initiatives engaging the community sector. The other partnerships were with community organizations in the health and other sectors, strengthening community resources and links between different sectors, such as education, health and justice. The CHSSN and affiliated networks serve to link the different components in the current Health Canada Contribution Program to English-speaking communities and the public system.

While the 20 community health networks promote the projects and partnerships at the local level, the CHSSN provides a support program to them, and works in a dynamic partnership with the Quebec Ministry of the Health and Social Services and McGill University. This model has been successful in establishing a collaborative or partnership approach to coordinating the implementation of the Health Canada Contribution Program in Quebec. The CHSSN proposes this approach be affirmed by Health Canada as the delivery model for the new Contribution Program.

### *Creating new networks*

There are administrative health regions in the province currently not supported by community health networks. Open call resources in the previous Health Canada Contribution Program have supported development efforts in some of these areas. Community and public partners have been mobilized and are ready to launch new community health networks in at least three regions.

### *Satellite sites for existing community health networks*

Many of the community networks cover territories that are enormous in size with population densities ranging from high to low. Although the English-speaking residents in outlying areas of large territories achieve a general benefit from a community health network, it is often difficult for the network to stretch resources to mobilize around a local service delivery need. The creation of sub networks or satellites within an existing community network would be an efficient way to reach these populations.

### *Community outreach program*

Health and social service professionals and community health networks acknowledge the challenges in reaching isolated and vulnerable English-speaking persons. To address this, Health Canada-funded pilot projects are testing community liaison and outreach approaches. These are joint initiatives of community health networks and the public system. Results demonstrate that outreach activities sponsored by community health networks are successful and cost-effective in reaching an isolated and vulnerable English-speaking clientele. The outreach model links this clientele to appropriate health and social service professionals. It also supports professionals in efforts to better adapt services to an English-speaking clientele. The CHSSN proposes that a Community Outreach Program be added to the community network component of a new Health Canada Contribution Program.

### *Community volunteer action*

Community health networks are effective in the recruitment, referral and placement of bilingual volunteers in community and institution-based health and social service programs and services. Expanded efforts would improve on the use of English-speaking volunteers in the delivery of health and social services in the English-language.

### *Information and referral*

Informal and ad hoc community-based information and referral services are very successful in helping English-speaking people become aware of the health and social services available to them in English. The community approach builds confidence in community members to access the public system to receive services in their language. Community networks wish to expand the information and referral function to meet increasing demand.

### *Community leadership development*

This addresses the major reorganization of the system and the need to support community representation in new governance structures. Community health networks

have identified leadership capacity as a critical aspect of community efforts to improve access and participate as full partners in the health and social services system. This includes supporting the capacity of community members to represent their community effectively in governance and planning situations. It also recognizes the need to support historical institutions serving English-speaking communities as they transition into new administrative structures.

Supporting the capacity of community members to represent their community requires a dedication of resources for this purpose. This has become a priority in order to meet new leadership challenges as a result of a major restructuring of the health and social service system.

The network partnership model has attracted the interest of a range of other organizations that are engaged in community development activities to support English-speaking communities. This has become a major dissemination activity for CHSSN and community networks requiring a dedication of new resources to respond to invitations to present, and in some cases, develop the network model with other organizations.

#### *Community-based health promotion*

This priority supports the community role in carrying out health promotion activities that complement the public health mandate of the public system. All community networks have implemented health promotion projects aligned with local public health priorities. These projects have improved information in English-speaking communities, mobilized community engagement in health promotion initiatives, and connected professionals in the public system with isolated or dispersed English-speaking communities.

#### *Early childhood development*

Community networks serving disadvantaged English-speaking communities have established an evidence base that links a number of determinants such as income and family status with the development of young children prior to school age. These networks are active in promoting a community environment that supports schools and their education mission. The community networks have identified pilot initiatives to promote health outcomes in target vulnerable communities that support early childhood development and better prepare children for school success.

#### *Mental Health*

A strong evidence base describing the mental health status of English-speaking communities has mobilized community and institutional stakeholders to identify strategies to promote resiliency and mitigate the effects of psychological distress for vulnerable populations. Health Canada Contribution Program resources have played a central role in supporting community efforts to increase access to mental health information for English-speaking communities. This has been achieved through partnerships with community health networks, community resources serving youth and seniors and institutional stakeholders such as school boards. Mental health has been identified as a priority for new health promotion investments in the coming period.

### *Distant health education technologies*

The CHSSN Community Health Education Program is very successful in delivering distance health education information to hundreds of English-speaking Quebecers every year. English-speaking seniors have been identified as a priority for a Health Canada investment. With new resources, the CHSSN will develop web based health promotion modules to reach isolated and homebound seniors. The CHSSN will partner with an established community centre for seniors to extend the centre's Virtual Learning Program to the community health networks, and adapt information to meet the needs of English-speaking seniors across Quebec.

### *A new community partnership to improve access*

Filling out complaints is an important strategy for English-speaking communities to ensure improvements are made in the delivery of health and social services in the English-language. La Fédération des centres d'assistance et d'accompagnement aux plaintes (FCAAP) is a not-for profit organisation that supports users in the health and social services system filing complaints and educates them on their rights. The CHSSN will partner with the FCAAP to support the 16 regional offices in their efforts to adapt their programs to serve English-speaking communities.

### *A partnership with the Quebec Ministry of Health and Social Services*

The Quebec Ministry of Health and Social Services plans to adopt new access programs of services in English in the wake of a major reorganization of the health system. The current Health Canada Contribution Program has supported collaboration between the CHSSN and the Ministry to assist the Ministry's preparation of new guidelines for the implementation of updated access programs. New resources would support CHSSN collaboration with the Ministry to support Ministry initiatives to develop evaluation tools to cover a five-year period of implementation and monitoring consistent with the lifespan of an access program.

### *Retention of professionals in communities and promotion of youth engagement in professional degree programs in the health and social services sector*

Community networks are well placed to work with degree programs to support internships that can lead to employment and retention of professionals in their regions. Community-sponsored bursary programs encourage local youth to obtain degrees and return to home regions to pursue a career serving an English-speaking community.

The McGill University Training and Retention of Health Professionals Project has provided funding for community networks to carry out activities to support interns in their regions. Activities include production and distribution of welcome kits and partnering with host institutions and community organizations to welcome them, facilitate their integration into the community and promote the benefits of employment in the region. A new orientation aims to support community networks as facilitators between educational institutions and the health and social service network for the development of new internship and employment opportunities. An additional priority is to create tools to assist community networks to effectively share and economically produce promotional and information materials. The McGill Project has also supported community networks through its Community Leadership Bursary Program with outstanding results. The purpose of the program is to

address the need for professionals with both English and French language skills in health and social services in selected Quebec regions by encouraging students to return to or stay within their regions to work. The program is coordinated at the regional level by the community networks. A new orientation aims to extend the program to all remote regions in Quebec.

In this regard, the projects and partnerships that have been the hallmark of collaboration between the public system and the community health and social services networks since 2003 have set the foundation for a new phase of collaboration in the current reform.

## 6.2 Adaptation of the health and social services system in partnership with communities

### *Adaptation of service programs in the health and social services system*

By agreement with the Quebec Ministry of Health and Social Services, the CHSSN provides Health Canada Contribution Program resources to the public network to improve access to services in English. Promoting adaptation of the health and social services system in partnership with communities is considered the best strategy for achieving improved access and better health outcomes. These resources have enhanced the capacity of the public system to adapt its programs and support its human resources to better serve English-speaking communities. Projects generated locally and regionally by institutions in partnership with the community networks have laid a solid foundation for new investments to support adaptation of new service programs in light of major network reorganization. The next generation of adaptation projects would respond to new strategic orientations of the public system as result of reorganization.

The CHSSN and the community networks are working with the Ministry of Health and Social Services and institutions in the last year of the current Contribution Program to align new investments with the adoption of new access programs. The objective is to move seamlessly into the first year of a new Contribution Program with identified priority areas for improvement of access. As well, parameters for defining projects will have been established with an emphasis on best practices emanating from several years of project activity. This planning approach will ensure continuity of effective initiatives supported by the last Health Canada investment into the first year of a new Contribution Program.

The following five examples of community investment in Quebec's public system illustrate the quality of the partnerships that have been established with service providers, and impacts on English-speaking communities.<sup>75</sup>

#### “Stand Up!” for Healthy Independence

A study by CSSS-Gatineau (Outaouais) revealed that approximately 2,880 seniors who are living at home sustained injuries due to a fall in 2008. One in five of those accidents resulted in hospitalization. The community network, Connexions Resource Centre, in collaboration with CSSS-Gatineau sought to reduce falls among seniors, helping to promote their autonomy. The CSSS offered a series of workshops to English-speaking seniors to increase body balance and muscle strength, as well as secure a safe home environment. The CSSS Coordinator for Rehabilitation stated that the partnership with Connexions Resource Centre was indispensable in recruiting seniors and extending the CSSS's reach deep into the community.

#### “Helping Outaouais Seniors Manage Diabetes”

When 50 English-speaking seniors showed up at an information session on diabetes at the CSSS installation in Buckingham, Connexions Resources Centre worked with CSSS Papineau to respond to seniors coping with diabetes and their need for information and support. The CSSS ran a successful information program in English on healthy eating and

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<sup>75</sup> Community Health and Social Services Network (CHSSN), (2014a). *Partners for Better Care* [http://chssn.org/pdf/En/Partners-for-Better-Care\\_EN.pdf](http://chssn.org/pdf/En/Partners-for-Better-Care_EN.pdf)

stress management provided by doctors, nutritionists and physiotherapists. The response from English-speaking seniors was overwhelmingly positive, and the CSSS organizer attributed the success to a partnership with the community resulting in real change.

“Just being present is the most important thing” – A Liaison Agent in Sept-Îsle

The Centre hospitalier régional de Sept-Îsles worked with the community network, the North Shore Community Association, to establish a welcoming and accompaniment program in the hospital to orient and support English-speaking patients arriving for treatment. The hospital hired a community person who facilitated access, having an impact on the hospital personnel and English-speaking patients. The liaison person put people at ease and helped them through stressful situations. There are language barriers for people coming from places ranging from Alymer Sound, Tête-à-la-Baleine and communities along the Lower North Shore to Schefferville and Fermont. The accompaniment program encouraged hospital personnel to organize appointments to ensure the liaison agent could support English-speaking patients and reduce the language barrier to service.

“Identifying Language Skills for Better Care” – Chaudières-Appalaches

In the CSSS in Chaudière-Appalaches region, a simple system identifying French-speaking personnel who can speak English as well as community volunteers working with them has had great success. The “system” is a simple pictogram, a yellow conversation bubble that hospital and other health and social services staff and volunteers who are willing to speak English have affixed to their identification cards. Patients and staff can turn to any of these individuals when they need some translation help. This was a best practice coming out of experience in the Gaspé involving the community health network (Vision Gaspé Percé Now) and public partners. Over time, the little yellow pictogram has become the first thing many English-speaking patients look for when they seek help from the health system.

“Feeding a Hunger for Information” – Estrie

There is a tradition in the Estrie of public partners supporting better access to services in English. A program director at the Centre hospitalier universitaire de Sherbrooke (CHUS) stated that the innovative online video to prepare patients for various procedures is just a continuation of that tradition. Maternity services is an area of high demand, so a web page was created called “I’m having a baby” that included a video-based visit to the CHUS maternity unit. For some English-speaking mothers at a distance from the hospital, the video is the only contact they have with the maternity unit before they arrive. The hospital program director identified the close partnership with community partners such as Townshippers’ Association and the Women’s Centre as the key to success, allowing health information resources in English to go further and faster than would otherwise be possible.

## *Adaptation of human resources through language training, recruitment and retention*

### *Language training*

McGill University is a key educational partner in the initiatives supporting the adaption of human resources in the health and social services system to meet needs of English-speaking communities. It is a leading post-secondary institution that provides a range of professional degree programs in the health and social services sector; has a renown research capacity; is linked through its medical faculty to an extensive network of health institutions; and has the expertise and technology to develop and deliver professionally geared language training programs. A tripartite partnership involving McGill, the CHSSN and the 20 affiliated community health networks, and the Quebec Ministry of Health and Social Services has ensured that its language-training, retention initiatives and research development activities are integrated into English-speaking communities and the Quebec health and social services system. This formal partnership model is endorsed as the best approach to achieving positive results of the new Health Canada Contribution Program in Quebec.

The human resources of Quebec's health and social services are the key to the effective delivery of services in English. Studies have shown that language barriers can impede access and compromise the quality of care. The McGill University Training and Retention of Health Professionals Project has provided measures to contribute to Quebec's initiatives to build and maintain a sufficient complement of personnel capable of providing services in English. The McGill Project has offered training to over 11,000 health and social services professionals since 2003. A new program will aim to increase the number of professionals who can offer services in English; transfer knowledge, skills and competence acquired in language training to daily working practice; and evaluate the impact of the program on patient-provider communication in English. The Ministry of Health and Social Services will play a pivotal leadership role in these orientations.

To complement this action, the CHSSN and the 20 community health networks are proposing a community role in reinforcing the language acquisition of French-speaking professionals in the program. For example, networks can offer conversation groups or other community activities to provide professionals with opportunities to use English and get to know the communities they serve. A new Health Canada investment in the language-training measure can identify and support this complementary community role.

### *Recruitment and retention of new health professionals*

#### *Support for educational institutions*

The McGill Project will continue to support educational institutions to provide French-language training to English-speaking students; increase access to support material for language learners; promote peer-mentoring; and expand contact with CEGEPs and universities. A new orientation aims to engage CEGEPs, universities and school boards in programs to support internships, interns and supervisors.

### *Support for internships, interns and supervisors*

The McGill Project's Student Support program offsets the cost of travel and accommodation for students who choose to intern in an institution in a region of Quebec located far away from their place of study. The Project also provides resources to enable health institutions or related organizations to hire clinical supervisors when they would otherwise be unable to do so. McGill professional schools are the main partners for these projects. Partnership projects with a number of educational institutions and a youth placement organization have promoted the bursary program in the regions; supported a clinical equivalency program for internationally-trained physical therapists; developed online materials to support nursing internship teachers; and coordinated public health activities with students in related programs.

With a new Health Canada investment this component will prioritize support to students in health and social service fields who come from the regions, enabling them to complete internships in their home region with the goal of facilitating employment. Universities, CEGEPs and school boards will be solicited to participate in this renewed component and the community networks will be invited to provide a contribution at the regional and local level.

### *Targeted bursaries*

Targeted bursaries are directed towards students in fields identified as problem areas for access to services in English. Students who participate in this component must commit to working in public health institutions or related organizations in Quebec for one year for each year that they are funded. The goal of targeted bursaries is to strategically respond to existing gaps in services. As the Ministry of Health and Social Services has an initiative underway to identify and address vulnerable service areas throughout Quebec, it will be a key collaborator in these targeted bursaries.

### *The Community Leadership Bursary Program*

The purpose of the Community Health and Social Services Leadership Bursary Program is to address the need for professionals with English and French language skills in health and social services in selected Quebec regions by encouraging students to return to or stay within their regions to work. For each bursary awarded, recipients commit to staying or returning to a selected Quebec region following the successful completion of their studies to work for a minimum of one year in a public health and social service institution or related organization. The program is coordinated at the regional level by the community networks.

The program is reaping positive results as students from different communities receive financial support and demonstrate commitment to return to their regions upon graduation. The established community partnership model with the public system increases the chances for post-graduation employment opportunities. This is as critical in Montreal and adjacent regions as it is with the other regions working to retain their youth. A challenge in the urban and suburban milieus is the encouragement of youth from diverse minority communities to enter professional degree programs and stay in Quebec to pursue their careers. The Bursary Program would be extended to four regions that are not currently represented by a community network through an outreach approach where existing networks will be encouraged to sponsor students from a second region.

### *Promotional activities of community networks*

The community networks have participated in grass roots promotional activities aimed at both health and social services institutions and the education sector. Activities targeting health sector partners are intended to educate and sensitize them to the specific needs of the local English-speaking community and to inform them of the opportunities through the McGill Project to address these needs through the development of internships and the allocation of bursaries. These community network activities include production and distribution of welcome kits and partnering with host institutions and community organizations to welcome them. This approach facilitates their integration into the community and promotes the benefits of employment in the region. A number of community networks are supporting employment of graduates in their regions in partnership projects with regional employment organizations.

This community network role has paved the way for future initiatives aimed at increasing the presence of English-speaking professionals in the health and social services network. The community networks are keen promoters of partnerships with secondary-level schools and CEGEPs, targeting students at various levels of study to promote careers in health. To support this objective, the McGill Project proposes to fund community networks to act as facilitators between educational institutions and the health and social service network for the development of new internship and employment opportunities. McGill will also develop tools to assist community networks in becoming successful facilitators.

McGill is proposing new orientations that include building on the momentum of current results through the creation and maintenance of a regional database that tracks students studying in health and social services related fields at the CEGEPs and university level. This will provide valuable information for the creation of local internships for these students and contribute to the goal of facilitating their employment in the regions. Furthermore, the Project plans to provide an online platform to assist community networks to effectively share and economically produce promotional and informational materials adapted to their needs in an effort to optimize available resources and capitalize on successful initiatives.

### 6.3 Strategic knowledge

The collaborative model reflected in the current proposal is founded on a shared understanding that improved access to services and health outcomes is achieved through the interconnected actions of strengthening communities and adapting the health and social services system to the needs of English-speaking persons. Strategic information on the many dimensions connected to this collective undertaking is a key to its success. Creating new knowledge of the health status of English-speaking communities, promoting an emerging field of research, and mobilizing knowledge to empower communities are priorities that link communities, researchers and the public system in a common effort to advance knowledge about the many factors that influence language, access and health.

#### *Creating new knowledge of the health status of English-speaking communities*

A new Health Canada investment can continue to support the research that informs authorities on the population health profiles of Quebecers including health inequalities that affect its sub-populations. Epidemiological studies are identifying long-term health trends and are supporting English-speaking communities engaged in Quebec policy initiatives (for example, multi-year plans in the areas of youth, mental health, public health). This strategic knowledge also supports service providers in adapting service programs for minority communities.

#### *Developing a field of research in language and health*

The McGill research initiative has made a significant contribution to developing a field of research in language and health. A network of researchers is now producing new knowledge that will support community and institutional initiatives to develop and tailor programs that are better adapted to the linguistic and sociocultural needs of English-speaking and other communities. The research program is starting to establish a global reach, as connections are being made with researchers in other countries addressing issues of language and access to health services. This will have the benefit of enriching research in Canada and advancing the cause of French-speaking and English-speaking minority communities internationally. In the Quebec context, the body of research is contributing to an evidence base supporting community efforts to influence public policy in order to improve the health and well being of English-speaking communities. One objective community networks propose for a new program is aligning more of the research with the specific interests of the health and social services network and English-speaking communities.

The McGill Project Research Development Program in the next phase will be oriented towards creating an international network to allow researchers to share work and break down research silos. The student research program will continue to promote research in health care and social services and language among Quebec-based graduate students. A new priority is knowledge transfer and an implementation phase to ensure that what is generated through research projects is applied and produced.

*Mobilizing knowledge to empower communities and inform the health and social services system*

Knowledge tailored to support community mobilization ensures that community networks and their public partners always work with an updated and relevant base of information on English-speaking communities and their needs. A blend of use of statistical data along with interactive data from community experience forms a strong base for engaging communities and supporting partnerships with the public system.

## 7. Enhancing legislative guarantees of services in English

### *Integrating investments into English-speaking communities and the public system*

Since the approval of the first access programs in 1989, the Quebec government has concluded agreements with the Government of Canada, providing financial contributions to Quebec's initiatives to improve access to services for English-speaking communities. These inter-governmental actions, with the engagement of English-speaking communities, continue to support measures enhancing the capacity of the public system to provide services in English. With the launch of the first federal action plan in 2003, major new resources were available to support the vitality of Canada's Official Language communities including Quebec's English-speaking communities. Health Canada recognized the CHSSN and McGill University as the primary beneficiaries of its Contribution Program. In carrying the responsibility for this investment for the last fifteen years, the CHSSN and McGill University have been committed to a model of collaboration and partnership with the Quebec Ministry of Health and Social Services and the public system. This is still deemed to be the best approach to working with the province to integrate new federal investments within the framework of legislative guarantees of services in English.

The current proposal to Health Canada for a new Contribution Program outlines measures aimed at improving access to services in English, strengthening communities, adapting public health and social services to meet community needs and building a strategic knowledge base to support common action. With an affirmation of the CHSSN and McGill University as the primary beneficiaries, all measures in a new Health Canada Contribution Program would be identified in an implementation agreement between the Ministry of Health and Social Services and the CHSSN, and a similar one between the Ministry and McGill University. These agreements have guided a decade of Health Canada programs supporting Quebec's English-speaking communities. As health and social services is a provincial jurisdiction, the implementation agreement with McGill set out the roles and responsibilities of the different institutional partners in activities related to training and retention of professionals, as well research. The Ministry agreement with the CHSSN guided development of the community health and social services networks, health promotion projects in English-speaking communities, innovative projects in the public system to adapt services, and creation of new knowledge on the health status of English-speaking communities. Implementation of these measures was carried out in a direct relationship with the Ministry, which ensured the necessary links with the Provincial Committee advising the Minister of Health and Social Services, and with the health and social services network. In this manner, the implementation agreements have ensured that results of the Health Canada Contribution Program are integrated into English-speaking communities and the public system in manner that enhances legislative guarantees of services in English in conformity with the policies and orientations of Quebec.

### *New access programs of health and social services in English*

English-speaking persons are entitled to receive health services and social services in English in keeping with the resources of institutions providing these services and to the extent provided by an access program. For the community networks, the access program is a focal point for connecting the measures in the current proposal to improve

access, strengthen communities, adapt the public system and apply shared knowledge of the needs of English-speaking communities. In the recent legislation reorganizing the health and social services system, the provision for access programs was updated to reflect the new organizational structure of the network. Each public institution must, in the centres it specifies, develop an access program for the English-speaking population it serves or, if applicable, develop such a program jointly with other public institutions in specified centres operated by those institutions. It will also address the language dimension with respect to the personnel needed to provide such services. The program must take into account the institution's human, physical and financial resources. It must also be approved by the Government and revised at least once every five years.

The goal of the access program is to make accessible to English-speaking persons a range of health and social services in English that is appropriate, as complete and as close as possible to their milieu. Specifically, the access program aims to identify community needs; identify the services required to respond to specified needs; identify the gaps to be filled to meet the objectives of access, continuity and quality of services; identify the service providers, specifying the locations where the obligation applies to provide services in English; and identify the modalities of access to services in the English language for English-speaking persons.

The access program is developed in conformity with orientations reflecting the basic principles underpinning the health and social services network.<sup>76</sup> The measures in the current proposal are aimed at supporting these orientations in order to mobilize the public system and communities around a common objective of ensuring effective and efficient application of right to services in English. The following are examples of the complementarity between the proposed measures and key orientations that are expected to guide the development of new access programs.

“Populational responsibility” orients service providers to offering services to a territorial population with a view to rendering accessible the most complete gamut of services possible. It means ensuring the system takes responsibility for services and accompanies persons in the system while promoting a convergence of efforts to improve the health and well-being of the population and the communities that comprise it. The proposed measures to strengthen formal community network partnerships with the system; provide resources to strengthen the human resource capacity of the system to meet community needs; provide resources to service providers to carry out innovative projects to adapt the system; and build strategic information on the health status and needs of English-speaking communities, will enhance the capacity of institutions to carry out population responsibility for the English-speaking communities they serve.

Ensuring the complementarity of services is key to facilitating the referral of persons to the different levels of services. Referral mechanisms imply referrals between the general and specific services of the “first line” and specialized and ultra specialized services. To ensure access to services in English, the institution undertakes to guide English-speaking persons to the required services where there is an adequate response to their need for services in English. The proposal that community health and social services

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<sup>76</sup> The objectives and orientations of the access program are set out in a Ministry administrative guide for the development of access programs, *Cadre de référence pour l'élaboration des programmes d'accès aux services de santé et aux services sociaux en langue anglaise pour les personnes d'expression anglaise*, MSSS, 2006.

networks undertake outreach and carry out information and referral activities to connect English-speaking persons with an institution's service programs would enhance the referral mechanisms and ensure an appropriate access. Also, institutions carrying out projects to adapt the system to better serve English-speaking person can identify referral mechanisms as a priority.

Another access program orientation addresses "navigation", or direction of English-speaking persons within the health and social services system. The access program aims to support professionals so that an English-speaking person is oriented to the appropriate service at the right time. The successful orienting of English-speaking persons is dependent on the transversal presence of the access program within the institution, ensuring the engagement and coordination of different service and administrative structures that support orientation of an English-speaking clientele. The formal community network partnerships with the public system have been instrumental in assisting institutions in better serving an English-language clientele. The proposals to enhance the capacity and number of community health and social services networks, as well as bolster their representation capacity in the system, will have a positive impact on institutions in their efforts to develop effective access programs within the new structures of the health and social services system. Adaptation projects under the leadership of the institutions can be a support to the development and integration of access programs within the new organizational structures.

The administrative guide for developing an access program recognizes that the client's language is an essential tool to ensuring the success of a clinical intervention. To receive adequate services, English-speaking persons, like others, need to understand and communicate. When health is at stake, to express in English can be important if not essential. It is this recognition of need, and by an adapted personalized response, that a successful clinical intervention is defined. To improve the communication and response to needs in a clinical intervention, information contained in the access program must be known and easy to use by the professional who must respond and guide the client. The professional must be able to inform the client of the location and way in which the services in English will be provided. For this, the modalities of access to services must be public and easily accessible to professionals and to others who wish to consult them.

A number of measures in the current proposal support the access program orientation citing language as the key communication tool. The McGill Language Training Program, in collaboration with the Ministry of Health and Social Services, offers institutions opportunities for their professionals and other personnel to improve English-language skills tailored to support successful interventions. The community health and social services networks through their partnerships with the institutions can ensure that the modalities of access to the services identified in the access program are known to community members through network outreach, liaison, and information and referral activities. The CHSSN proposes to continue to support the Ministry in its initiatives aiming to align the process of renewal of the access programs with Ministry objectives related to evaluation of the quality of performance of institutions.

The access program guidelines affirm that in the health and social services domain, the participation of individuals in their intervention or service plan, as well as the decisions affecting their state of health and well being, is essential for a successful intervention. On the collective level, the participation of people from English-speaking communities is indispensable in the development of an effective access plan. In each region or territory,

the access program must emanate from an initiative that ensures the participation of persons from English-speaking communities and allows them to express their needs with respect to the provision of services in the English language. It is incumbent on the institution to undertake the necessary means to take into account these needs in the organization and provision of services.

The measures of the current proposal that aim to strengthen community networks, support outreach, liaison and volunteer capacity, as well enhance community representation within institutional structures can complement and support the institution's commitment to enhancing the participation of English-speaking clients in their intervention plans, as well as the engagement of community representatives in the development of the access program. By partnering with and supporting access program respondents in public sector establishments in facilitating community awareness and engagement, the community networks can play an important role in the deployment of measures designed to support the success of the access programs.

## 8. Community Partnerships with the health and social services network: Priority areas for action

A key factor in the successful implementation of measures over the last decade to improve access to services in English has been the model of partnership established between the community networks and the public system. This pivotal relationship will play an essential role in determining the priorities for collaboration in the period ahead. Taking into account the needs of English-speaking communities, and the development of new access programs of services in English, four priority areas for collaborative action between the community networks and the public system have been identified.

### *Information in English*

In light of the major reorganization of the health and social services system and the development of new access programs, the need to provide information on access to services in English will be prominent. As well, information requirements within the institutions such as consent forms, medication instructions, and patient information on medical procedures will continue to pose challenges with respect to availability of material in English. Community networks and their public partners can collaborate to ensure availability of information in English, as well as effective orientation of English-speaking persons to the services accessible in English.

### *Reinforcement of models of organization of services in English*

Adaptation of service programs in the public system to ensure access for English-speaking persons will be an important activity in light of major network reorganization and the implementation of new access programs. Institutional partnerships with the community networks have already laid the foundation for new initiatives to support adaptation of services. Collaboration with the community networks can ensure new models of service organization are reaching vulnerable English-speaking populations. For example, community networks can promote information, outreach and volunteer activities to complement a range of measures that service programs can implement to improve access and ensure the quality of communication that is essential for successful intervention with an English-speaking clientele.

### *Adaptation of human resources*

The human resources of the health and social services system are at the heart of the delivery of quality services in English. Measures to recruit and retain professionals and provide language training for those already in the system are aimed at building and maintaining a sufficient complement of personnel capable of providing services in English. A community network can collaborate with the public system to align its community-based promotional activities of recruiting new professionals, developing internships and supporting students with its institutional partner's human resource plan. Community networks can also reinforce the language acquisition of French-speaking professionals participating in the McGill language training program through community activities to provide professionals with opportunities to use English.

*Community participation in the health and social services network*

The major reorganization of the public system and the development of new access programs have underscored the importance of effective representation from English-speaking communities in the network's governance and consultative mechanisms. The institutional commitment to ensure participation of persons from English-speaking communities in consultative mechanisms can work hand in hand with the community networks' efforts to support the capacity of community members to represent community needs. For institutional partners, having effective community representation within its consultative and administrative structures can strengthen community support of the institution's commitment to the development and successful implementation its access program.

## 9. Recommendations

The community health and social services networks and the CHSSN propose the following recommendations to Health Canada in preparation of a new Contribution Program in Quebec. The recommendations reflect the continuity of results and emergence of new priorities stemming from activities carried out by the community and public partner stakeholders in the last Health Canada Contribution Program. Strengthening of communities and adapting Quebec's health and social services system is affirmed as the best approach to ensuring that the new investments improve access to services in English and promote positive health outcomes in English-speaking communities.

It is recommended:

1. That a new Health Canada Contribution Program provide the required resources to the designated Program beneficiaries in order to support initiatives addressing the general priorities of access to health and social services in English and needs of vulnerable populations, as determined by English-speaking communities in collaboration with the Quebec Ministry of Health and Social Services, its advisory bodies representing English-speaking communities and its institutional network.
2. That a new Health Canada Contribution Program identify a networking component with the resources required to strengthen English-speaking communities. Specifically, this component would provide the resources required to support creating new community health and social services networks and expand existing network capacity, as well as support outreach and liaison, volunteer action, information and referral, and community leadership development. The networking component would include the resources required to support community-based health promotion initiatives, address new priorities, expand distant education capacity, and provide resources to expand partnership initiatives with complementary non-government organizations serving the health and social services network. The network component would continue to support direct collaboration between the CHSSN and the Quebec Ministry of Health and Social Services.
3. That a new Health Canada Contribution Program identify a community network health projects component with the resources required to support an agreement between the CHSSN and the Quebec Ministry of Health and Social Services to provide resources to the public system to promote adaptation of services to the needs of English-speaking persons.
4. That a new Health Canada Contribution Program identify a training and retention of professionals component with the resources required to continue an agreement between McGill University and the Quebec Ministry of Health and Social Services to support Quebec's initiatives to build and maintain a complement of personnel in the health and social services system capable of providing services in English. Specifically, the training and retention of professionals component would contribute to the initiatives to increase the number of professionals who can offer services in English; transfer knowledge, skills and competence acquired through language training to practice; support a complementary community role reinforcing language acquisition; and evaluate the impact of these initiatives on access to services in English.

The training and retention of professionals component would also support a range of initiatives aimed at recruitment and retention of new health and social service professionals. These measures would include support for educational institutions providing French-language training to English-speaking students; support for internships, interns and their supervisors; targeted bursaries, as well as a community leadership bursary program and complementary promotional activities supporting recruitment and retention to be carried out by the community networks.

5. That a new Health Canada Contribution Program provide the required resources through the networking component and the training and retention of professionals component to support creation of new knowledge of the health status of English-speaking communities, promote research including a student research program and an international network of researchers, and mobilize knowledge to engage communities and support partnerships with the public system.

6. That a new Health Canada Contribution Program affirm the model in Quebec of implementation of federal investments through implementation agreements between the Ministry of Health and Social Services and the principal designated Program beneficiaries. The implementation agreements ensure that the investments support measures within Quebec's legislative provisions with respect to the right to health and social services in English. The agreements set the framework for integration of results into English-speaking communities and the health and social services system in a manner consistent with Quebec's responsibility to plan, organize and deliver health and social services.

## Notes on Methodology of Key Data Sources

### 1. Community Health and Social Services Network (CHSSN) Baseline Data Reports

1.1 Baseline Data Report 2007-2008. Quebec's social and health survey information. Compendium of tables including mother tongue information derived from the 1998 *Quebec Social and Health Survey (Enquête Sociale et de Santé)*.

While the 2007-2008 Baseline Data Report (BDR) is intended to build upon the extensive demographic, survey and interview data analyzed in previous volumes of the series, it is primarily focused on presenting the findings of the 1998 Quebec Social and Health Survey (Enquête Sociale et de Santé) conducted by the Institut de la statistique du Québec. Approximately 20,000 Quebec citizens participated in the survey with some 18,000 French mother tongue and 1,000 English mother tongue respondents. Throughout the study previous surveys from 1978 and 1992-1993 are included to provide a point of comparison with the 1998 findings and lend insight into changes occurring over time in the Quebec population.

The first section of this report presents tables with some key characteristics of the survey sample population (mother tongue) including age, gender, civil status, income level and education. In recognition of income as a key health determinant this section also includes tables that draw on the 2001 Census, therefore the larger Quebec population, to inform us of the percentage of persons in families and unattached individuals living below the Statistics Canada low-income cut-offs (LICO). These are organized by first official language spoken (FOLS) and administrative region.

The remainder of the report is organized in terms of a selection health determinants considered by the Quebec survey and organized in terms of five levels: the individual, the immediate milieu, social networks, social conditions and the physical and normative environment. The tables and commentary present findings for both Francophone and Anglophone survey respondents.

1.2 Baseline Data Report 2010-2011. *English-Language Health and Social Services in Quebec*. Based on data from the *CHSSN-CROP Survey on Community Vitality 2010*.

The 2010-2011 Baseline Data Report (BDR) draws on the 2010 CHSSN *Survey on Community Vitality* conducted by the CROP polling company. For the purpose of comparison, this report reproduces the design of the 2005-2006 BDR that uses the 2005 CHSSN *Survey on Community Vitality* to explore access to health and social services as a primary health determinant. Survey questions include types of services used, language of service, active offer, information on services and health promotion as well as unpaid care.

For the 2010 English study, a total of 3,195 English-speaking Quebecers aged 18 and over were interviewed over the telephone between February 9th, 2010 and March 31st, 2010. For the French study, a total of 1,001 French-speaking Quebecers aged 18 and over were interviewed over the telephone between March 15th and 31st, 2010. Data was weighted according to region, age and gender using data from the 2006 census.

The study of the English-speaking community was divided into a) a panel study, which was comprised of 1,001 respondents who had also participated in the 2005 study, and b) the main study of 2,194 randomly selected respondents from across Quebec. The panel study was used to validate the trends that emerged from the comparison of 2005 and 2010 findings. The regions in the report tables are the 16 health regions acknowledged by Quebec in 2011.

### 1.3 Baseline Data Report 2013-2014. *Demographic Profile of the English-speaking Communities.*

This report is based on a series of tables developed by CHSSN based on data from the 2011 National Household Survey (NHS). A series of demographic profiles are produced for the provincial territory as well as CSSS (72) and CLSC (83) territories in Quebec where there are at least 250 English-speaking residents. The demographic and socio-economic variables addressed in the 2013-2014 BDR are: population size, age structure, household living arrangements, educational attainment, labour force activity, income and low-income cut-off (LICO).

This report uses the First Official Language Spoken (FOLS) definition with multiple responses proportionally distributed since it best reflects the total English-speaking health service users in the province. First Official Language Spoken is derived from three census questions: knowledge of official languages, mother tongue and home language. Dual responses are divided equally among English-speaking and French-speaking groups.

### 1.4 Baseline Data Report 2015-2016. *English-Language Health and Social Services Access in Quebec. Based on Data from the 2015 CHSSN-CROP Survey on Community Vitality.*

The CHSSN provincial Survey on Community Vitality was conducted in 2005, 2010 and 2015. For the purpose of comparison, the 2015-2016 BDR reproduces the design of reports in the BDR series that present findings from previous implementations of the survey. Survey questions include types of services used, language of service, active offer, information on services and health promotion as well as unpaid care.

For the 2015 English study, a total of 3,014 English-speaking Quebecers aged 18 and over were randomly selected for interviews over the telephone between February 27th and April 15th, 2015. Data was weighted according to region, age and gender using data from the 2011 census. Four health regions resulted in a low response rate to the telephone interviews. This imbalance was addressed through focus groups that were conducted to gather responses from the English-speaking communities residing within these regions. The four regions are Chaudière Appalaches, Côte-Nord (middle and upper parts), Abitibi-Témiscamingue and Bas-Saint-Laurent. The focus groups were held in September and October 2015. The methodology and findings from this data collection technique are presented in the final section of this Baseline Data Report.

The regions in the report tables are the 16 health regions across Quebec. Due to small sample size the findings from the Bas Saint-Laurent, Saguenay-Lac-Saint-Jean, Chaudière Appalaches and Nord-du-Québec regions are not generally included in tables that list regional level percentages. To reflect the important differences in the composition and experiences of the Montreal English-speaking population which

accounts for 60% of the province’s English speakers, the Montreal region has been divided into three sub-regions: Montreal (west), Montreal (centre) and Montreal (east).

## 2. Other Sources

### 2.1 Health and Social Services Priorities Committee 2013-2016. *Annual Reports on Community Monitoring of Progress Related to the Health and Social Service Priorities of Quebec’s English-speaking Minority*

The Health and Social Services Priorities Committee (HSSPC) 2013-2016 designed and implemented a framework for monitoring progress with respect to the health priorities and community vitality of Quebec’s English-speaking communities. The framework served as a systematic vehicle to capture and convey the experience of members of the English-speaking community and their organizations and networks in the health and social service sector. The initiative built upon the priorities nominated in the QCGN report on *Health and Social Services Priorities of Quebec’s English-speaking Population 2013-2018* (QCGN, May 2012) and the *Companion Document* (CHSSN, January 2013) that resulted from a broad provincial consultation of the community.

The strategy for monitoring progress related to health and social service priorities included (1) research conducted by agencies external to the HSSPC as well as (2) community feedback gathered on an annual basis for three years (2013-2016) by a research consultant reporting to the HSSPC.

**External:** Research conducted through external agencies includes large studies that are primarily national and provincial in scope and collected according to a two or five-year cycle. These studies either randomly target the provincial English-speaking group as their sample or organize their data collection such that Quebec’s English speakers may be selected out as a random sub-sample. Some research, like the evidence gathered for CHSSN Baseline Data Reports, is conducted annually with its target sample varying from a provincial sample of 3,000 English-speaking individuals to a smaller sub-sample such as the 20 CHSSN NPI networks. As an example, feedback for the first year of monitoring included selected responses to the QCGN *Survey of Quebec’s English-speaking Seniors* conducted in 2013. This includes the perceptions and experience of 820 English speakers 55+ residing in 8 administrative regions of Quebec. See <http://www.qcgn-seniors.org/surveys.html> for further information on the survey.

**Internal:** The main lines of evidence that informed the QCGN report on the *Health and Social Services Priorities of Quebec’s English-speaking Population 2013-2018* (2012) consisted of findings from focus groups (2011), key informant interviews (2011) and the CHSSN/CROP *Survey of Community Vitality* (2005,2010). The focus group participants were selected to represent a range of circumstances (urban, semi-urban, and rural/remote) and participant types (younger adults with children living at home, older adults, people with chronic or debilitating conditions or their caregivers and users of social services). The community feedback strategy of the HSSPC framework entailed extending the participation of some 30 of the 222 QCGN focus group members through the

Region of Panel Members	
Abitibi-Rouyn-Noranda	2
Gaspé	4
Îles de la Madeleine	2
Laurentians	4
Laval	2
Monteregie Granby/Cowansville	2
Monteregie South Shore	4
Montreal Centre	2
Montreal East Island	3
Outaouais Gatineau/Pontiac	6
Vaudreuil-Soulanges	4

organization of a panel to be consulted over the three years. Participant types are consistent with those of the QCGN focus groups and the regional distribution of HSSPC panel members is shown in the accompanying table. Aside from the panel, 20 CHSSN NPI were monitored across the three years and assessed for their progress with respect to community network partnerships and intersectoral action. For their locations go to <http://chssn.org/chssn-programs-and-projects/networking-and-partnership-initiative/>

2.2 Community Health and Social Services Network. 2015. *Canadian Community Health Survey (2011-2012). Findings related to the Mental and Emotional Health of Quebec's English-speaking Communities.*

This report consists of 131 statistical tables and descriptive commentary that provide information from the 2011-2012 *Canadian Community Health Survey (CCHS)*. The *Canadian Community Health Survey (CCHS)* is a cross-sectional survey that collects information related to health status, health care utilization and health determinants for the Canadian population. It surveys a large sample of respondents – approximately 98% of the Canadian population – aged 12 and over living in private dwellings in ten provinces and three territories. Individuals living on Indian Reserves and on Crown Lands, institutional residents, full-time members of the Canadian Forces and residents of certain remote regions (altogether less than 3% of the population) are excluded from the sampling frame. Further details on the *Canadian Community Health Survey* may be found at: <http://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=3226>

The report provides information organized by region, age and gender for an estimated 3,171 English-speaking respondents and 19,101 French-speaking respondents distributed across 15 of Quebec's 16 health regions. Nord-du Quebec was not included as a region in the Statistics Canada distribution of CCHS findings. The language definition used is First Official Language Spoken (FOLS) with multiple responses proportionally distributed since it best reflects the total English-speaking health service users in the province. First Official Language Spoken is derived from three census questions: knowledge of official languages, mother tongue and home language. Dual responses are divided equally among English-speaking and French-speaking groups.

Three indices are used in the report analysis which allow for a comparison of the percentages for selected population characteristics.

- The **Minority-Majority Index (MMI)** compares the value for the English-speaking population of a given region with that of the French-speaking population which shares the territory.
- The **Relative to the Provincial Average (RGI)** for English speakers compares the value for the English-speaking population of a given region compared to the total English-speaking population across the province.
- The **Generation and Gender Index (GGI)** compares the values for main generational and gender groups compared to the total English-speaking population.

### 2.3 Community Health and Social Services Network. 2015. *Socio-demographic Characteristics of Visible Minorities in Quebec's English-speaking Communities.*

This document draws upon the Statistics Canada 2011 National Household Survey to present a series of tables illustrating key socio-demographic variables of visible minority populations within language groups for 8 of Quebec's 16 health regions. (There is only sufficient data for 8 regions, the remaining regions are grouped into a "rest of Quebec" category). The variables covered are:

- Gender
- Age structure
- Household living arrangements
- Recent mobility
- Educational attainment
- Labour force activity Income
- Low-income cut-off

The language concept used in this series of tables is First Official Language Spoken (FOLS) which is derived from three census questions (knowledge of official languages, mother tongue and home language). Multiple responses are assigned equally among declared languages.

The concept of visible minorities in the Canadian context is provided by the Employment Equity Act which refers to, "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour." Under this definition, regulations specify the following groups as visible minorities: Chinese, South Asians, Blacks, Arabs, West Asians, Filipinos, Southeast Asians, Latin Americans, Japanese, Koreans and other visible minority groups, such as Pacific Islanders". <http://www12.statcan.gc.ca/nhs-enm/2011/ref/guides/99-010-x/99-010-x2011009-eng.cfm>

### 2.4 Canadian Heritage. 2015. *Socio-cultural Profile of Quebec, 1996-2011*

The Canadian Heritage *Official Language Communities in Context* initiative provides information based on the Statistics Canada Census of Canada 1996, 2001, 2006, 2011 and the National Household Survey 2011. The linguistic definition used is First Official Language Spoken (FOLS) and geographic levels include National (Canada, Canada less Quebec, Quebec), provinces/territories, economic regions, Census Divisions and Census Metropolitan Areas (CMA). Community profiles are organized around four types of characteristics:

- Demolinguistic (Language concepts, linguistic continuity, bilingualism)
- Demographic (size, proportion, growth, urbanization, youth/seniors)
- Sociocultural (immigrants, interprovincial migrants, place of birth, visible minorities)
- Socio-economic (education, labour force, income)

For the purpose of this report, only the Quebec based profile was accessed.

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## Appendix: Avis du Ministère de la Santé et des Services sociaux du Québec

Le 12 juillet 2017

Monsieur Pierre Lafleur  
Sous-ministre adjoint  
Direction générale de la coordination réseau et ministérielle  
Ministère de la Santé et des Services sociaux  
Édifice Catherine-de-Longpré  
1075, chemin Sainte-Foy  
4<sup>ième</sup> étage  
Québec (Québec)  
G1S 2M1

Monsieur,

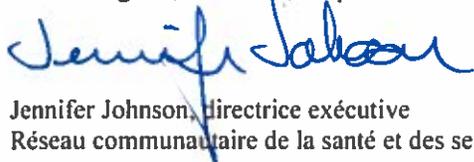
Le 11 avril 2017, nous vous avons transmis un document intitulé « Rapport sur les priorités des communautés d'expression anglaise du Québec en matière de santé et de services sociaux » en vous invitant à consulter le réseau public sur les recommandations des réseaux communautaires formulées à Santé Canada à propos du renouvellement du programme de contribution 2018-2023.

À la suite des consultations entre notre personnel et le MSSS, nous avons modifié le document afin de définir les champs d'action prioritaires de collaboration entre les réseaux communautaires et le système public. Le modèle de partenariat s'est avéré un facteur déterminant du succès de la mise en œuvre de mesures au cours des dernières années pour améliorer l'accès aux services en langue anglaise. Nous croyons que cette relation fondamentale jouera un rôle crucial pour définir les priorités de collaboration au cours de la période à venir.

Les réseaux communautaires invitent le ministère de la Santé et des Services sociaux à consulter le système public et la collectivité sur le document ci-joint. Notre objectif vise à présenter officiellement le rapport à Santé Canada d'ici à la fin de septembre 2017.

Nous sommes à votre disposition pour vous fournir tout renseignement supplémentaire qui pourrait vous être utile.

Veuillez agréer, Monsieur, l'expression de mes sentiments distingués.



Jennifer Johnson, directrice exécutive  
Réseau communautaire de la santé et des services sociaux

P.J. : Rapport sur les priorités des communautés d'expression anglaise du Québec en matière de santé et de services sociaux

Direction générale de la coordination  
réseau et ministérielle

PAR COURRIER ÉLECTRONIQUE

Québec, le 16 octobre 2017

Madame Jennifer Johnson  
Directrice exécutive  
Réseau communautaire de santé et de services sociaux  
Jeffrey Hale Pavillon  
1270, chemin Ste-Foy, bureau 2106  
Québec (Québec) G1S 2M4

Madame Johnson,

Le présent avis fait suite à la demande que vous nous avez adressée le 12 juillet 2017 concernant l'avis du Ministère de la santé et des services sociaux (MSSS) sur le document « Rapport sur les priorités des communautés d'expression anglaise du Québec en matière de soins de santé et de services sociaux, document de travail ». Afin de pouvoir répondre à votre requête, nous avons demandé l'avis des responsables du dossier langue anglaise de chaque établissement, mais également, le cas échéant, l'avis du membre représentatif de la communauté d'expression anglaise au sein des conseils d'administration de chaque établissement.

Nous vous transmettons, en annexe de cette correspondance, l'avis du MSSS. Cet avis est le fruit de l'ensemble de nos consultations.

Nous tenons à vous remercier de votre engagement dans le domaine de la santé et des services sociaux auprès de la population d'expression anglaise.

Nous demeurons à votre disposition pour tout renseignement additionnel. Veuillez agréer, Madame Johnson, l'expression de nos sentiments distingués.

Le sous-ministre adjoint,



Pierre Lafleur

p. j. (1)

N/Réf. : 17-CM-00256

## Annexe

### Avis du Ministère de la Santé et des Services sociaux

#### Rapport sur les priorités des communautés d'expression anglaise du Québec en matière de soins de santé et de services sociaux, document de travail

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#### Structure du document

Nous souhaitons souligner l'absence de distinction au sein du document entre les problèmes liés à l'accès aux services en général et les problèmes d'accès aux services en langue anglaise. Afin de pouvoir analyser les problèmes d'accès de la population d'expression anglaise, il est essentiel de pouvoir établir une comparaison avec ceux de la population d'expression française. Lorsque ceux-ci sont similaires, ces problèmes découlent généralement de défis autres que celui de la langue. Par exemple, les difficultés d'accès aux services spécialisés sont un problème mentionné autant par les populations d'expression française que par les populations d'expression anglaise.

Également, le document aurait eu avantage à rappeler l'importance de recevoir des services en langue anglaise, particulièrement du point de vue de la sécurité et de la qualité des soins.

#### Méthode de consultation

Considérant le nombre restreint de participants (un total de 63 personnes sur 3 ans), la validité des commentaires soumis par votre « Groupe de discussion », dans le cadre de l'initiative « Cadre de suivi auprès des communautés » pourrait être remise en question.

#### Contexte linguistique du Québec

Comme vous le savez depuis plus de trente ans, le Québec s'est doté d'une Charte de la langue française. Aujourd'hui cette Charte régit les affaires linguistiques du Québec. Toute activité menée au niveau linguistique devrait tenir compte de cette importante législation. Le contexte linguistique du Québec a autant d'impact sur la prestation des services de santé et des services sociaux en langue anglaise que le contexte démographique des communautés d'expression anglaise. Le texte de votre document d'étude devrait refléter cette réalité. À titre d'exemple, le manque de brochure d'information en anglais accessible dans les lieux publics, ce qui est strictement réglementé dans les établissements qui ne sont pas reconnus en vertu de l'article 29.1 de la Charte.

### **Mesures pour améliorer l'accès**

Nous tenons à souligner les diverses mesures mises de l'avant par le Réseau communautaire de santé et de services sociaux (RCSSS) et ses organismes locaux. Les partenariats communautaires avec le réseau de la santé et des services sociaux sont essentiels et peuvent soutenir les efforts des Centres intégrés de santé et de services sociaux à mieux répondre à leur responsabilité populationnelle. Par contre, le document met fortement l'accent sur l'apport que peuvent avoir les acteurs des réseaux communautaires et peu sur celui des établissements, entre autres le rôle joué par les responsables/répondants du dossier langue anglaise. Nous croyons que la contribution des établissements est un élément incontournable à la réussite des projets Adaptation. Il serait souhaitable que le document reflète davantage l'apport et les besoins du réseau de la santé et des services sociaux.

Aussi, les rôles et responsabilités respectifs des Centres intégrés et des organismes communautaires devraient être mieux définis, afin d'optimiser la collaboration. Les responsabilités des organismes communautaires (mobilisation de la communauté, accompagnement) ne peuvent être substituées à celles des établissements, qui sont responsable de l'offre et de la dispensation des soins et services. Par exemple, à la page 25, il serait approprié de préciser que le recours aux bénévoles permet de *soutenir* la prestation de services de santé et de services sociaux en langue anglaise.

Les initiatives du RCSSS sont vues par le réseau comme des exemples prometteurs de la contribution des réseaux communautaires. Plusieurs établissements ont exprimé le souhait que la prochaine période de financement favorise l'élargissement et la consolidation des réseaux existants plutôt que la création de nouveaux réseaux. Nous suggérons également une collaboration accrue avec des partenaires intersectoriels tels les réseaux de l'éducation et municipaux.

### **Champs d'action prioritaire**

L'analyse effectuée dans le cadre de notre propre démarche a permis de constater que les champs d'action prioritaires qui sont énoncés dans votre document sont en concordance avec ceux du MSSS et des établissements du réseau de la santé et des services sociaux. D'ailleurs, plusieurs programmes d'accès ont identifié un ou plusieurs de ces champs d'action comme étant des priorités locales.

L'adaptation des ressources humaines est perçue comme étant le défi le plus important des établissements, particulièrement ceux situés dans des régions avec une faible population d'expression anglaise. En ce sens, nous jugeons essentiel le maintien du volet de formation et de maintien en poste des intervenants afin de soutenir le recrutement et la rétention de la main d'œuvre d'expression anglaise.

En lien avec le champ d'action prioritaire « Information en langue anglaise », il serait intéressant d'examiner la possibilité de créer un partenariat avec le MSSS et le réseau de la santé et des services sociaux afin de mettre sur pied une bibliothèque virtuelle provinciale.

Finalement, nous tenons à insister sur l'importance de prioriser les mesures d'aide aux clientèles vulnérables. Les personnes âgées, peu scolarisées, itinérantes ou encore ayant un problème de santé mentale ou de dépendances ont déjà un accès difficile aux soins et aux services; elles sont d'autant plus marginalisées du fait qu'elles s'expriment en anglais. Soutenir les établissements pour qu'ils desservent, et rejoignent mieux ces clientèles devrait être une priorité du RCSSS.

### **Recommandations**

En résumé, nous appuyons les recommandations soumises par votre organisation au gouvernement fédéral conformément à nos précédents commentaires. Nous souhaitons particulièrement que Santé Canada réaffirme et tienne compte de la spécificité du modèle québécois de mise en œuvre des investissements afférents à ce programme, et ce, en respect de la compétence exclusive du Québec quant à la gestion, la planification, l'organisation et l'évaluation des services de santé et de services sociaux sur son territoire. Le renouvellement de ses investissements devrait concorder avec le processus de renouvellement des programmes d'accès aux services de santé et aux services sociaux en langue anglaise 2018-2023, permettant ainsi de poursuivre les efforts d'adaptation déployés par les établissements du réseau de la santé et des services sociaux du Québec.