NPI Wellness Centres for English-speaking seniors in Québec

Phase 1 Evaluation Report

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Executive summary

This document presents the results of Phase 1 of an evaluation of Wellness Centres for English-speaking seniors in Quebec, which have developed within the Networking and Partnership Initiative (NPI) led by the Community Health and Social Services Network (CHSSN). Its purpose is to contribute to a better understanding of Wellness Centres, to what extent they are achieving their intended objectives, and the impacts their existence and services have on the English-speaking seniors who use them.

Wellness Centres are part of a community model for promoting the health and well-being of English-speaking seniors in Quebec. They are an innovative response by community organizations to the challenges they face, including social isolation and language barriers in accessing public services.

Wellness Centres are a community-run program that aims to maintain and improve the health and well-being of English-speaking seniors, to improve access to and knowledge of health and social services, and to decrease social isolation through purposeful and informed programming.

Wellness Centres were originally developed specifically to address the unique needs of seniors in isolated and rural regions. They were designed based on a day centre model but did not include as strict criteria for participation and adapted their activities to local realities. The model that developed was then adopted by organizations working in other regions and types of communities. This evaluation has identified the following mission and objectives:

Mission: to contribute to the health, well-being and autonomy of English-speaking seniors and to support caregivers in their role.

Main objectives

- Reduce social isolation
- Promote health and wellness
- Facilitate improved access to health and social services

Specific Objectives

- Offer support to seniors and caregivers
- Operate as a link between the health and social service system and seniors
- Facilitate improved access to service and health information for seniors
- Support public and community partners in fulfilling their mandate to reach English-speaking seniors

Within the CHSSN network, there are a total of 42 Wellness Centre sites across ten regions of the province, organized by twelve different community organizations (see map and table).

Wellness Centres vary considerably in terms of size, number of sites, funding, and number of participants. This is a reflection of the regional and local realities, which are extremely different. Two main models can be observed, one more suited to rural and remote communities where participants all attend a session every two or three weeks and spend several hours together doing activities focused on health promotion, socializing and information sharing. The second is more suited to urban and suburban communities and involves a calendar of activities throughout the week at a central location from which participants choose.

Wellness Centres have been successful in developing a unique model that is adapted (and adaptable) to local realities. It involves outreach to vulnerable and isolated seniors, partnerships with relevant organizations (both community and public-sector) and the support of a strong network that provides funding, training and opportunities for sharing learning (CHSSN).

The challenges that remain concern funding and outreach. Outreach is needed to connect to seniors who are potentially disconnected socially or geographically from community resources. Funding challenges are related to the fact that despite funding from Health Canada, as well as some funding from other federal programs, a few provincial sources, regional health centres, local municipalities or private sources, many organizations have to constantly search for new funds, because many of these sources are single-year or non-renewable, making funding unsustainable.

Finally, there is potential for expanding the network of Wellness Centres to regions where there are none (although there may well be activities and services for English-speaking seniors) or where coverage is limited to certain communities.

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1. Context

1.1. English-speaking seniors in Quebec

Out of the estimated 1.1 million English-speaking persons living in the province of Quebec, approximately 297,740 of them are over the age of 55. (See Table 1).[i] While almost half of them are concentrated within urban centres, like the greater Montreal area, many others are dispersed in rural and remote locations throughout the province. Generally speaking, seniors or 'boomers' are the most rapidly growing demographic in Canada with the population expected to double over the next 15 years, reaching an estimated 10.4 million seniors by 2036. By 2051, one in four Canadians are expected to be 65 years or over. In certain regions of Quebec, communities are already facing this increase, with sometimes one in three English-speaking residents already a 'senior'.

As younger English-speaking individuals leave rural communities for larger urban centres, and as seniors live longer, they require increasing support to assist with health, mobility and social well-being. The 2011-2012 Canadian Community Health Survey[ii] has shown that English-speaking seniors (65+) are less likely than other age groups to feel they have a trustworthy individual they can turn to for advice or rely upon in an emergency, often because close family members have left the province. In addition, older English speakers are less likely than younger ones to be bilingual, so they often face a language barrier in accessing services. These challenges to their health and well-being can be exacerbated by low incomes: approximately 40% of English-speaking seniors are living on an annual income of $20,000 or less, and in many regions throughout Quebec English speakers have higher rates of low income than their French-speaking counterparts. As a result of these realities, English-speaking seniors become increasingly vulnerable as they age.

Table 1: Seniors in the English-speaking Population by Health Region (*Région socio-sanitaire, RSS*)

English- and French-Speaking Population by Age Group
Québec and its RTS Territories, 2016

Geography	Total Population	English Speakers					French Speakers				
		Total	55 to 64 years	65 to 74 years	75 to 84 years	85 years and over	Total	55 to 64 years	65 to 74 years	75 to 84 years	85 years and over
Québec	7,965,450	1,097,925	138,075	93,810	48,695	17,160	6,795,280	1,039,790	735,185	328,665	88,145
RTS du Bas-Saint-Laurent	189,975	1,080	175	205	50	10	188,850	35,690	26,240	11,140	2,995
RTS du Saguenay – Lac-Saint-Jean	268,870	1,975	240	225	120	25	266,835	48,080	32,680	14,930	3,655
RTS de la Capitale-Nationale	709,325	14,205	1,810	1,250	650	260	693,190	106,830	80,850	36,415	10,600
RTS de la Mauricie-et-du-Centre-du-Québec	491,370	5,800	910	740	325	85	484,485	83,265	62,360	27,005	7,625
RTS de l'Estrie – CHU de Sherbrooke	459,315	37,010	5,760	4,900	2,630	970	420,845	68,425	52,020	21,660	5,615
RTS de l'Ouest-de-l'Île-de-Montréal	349,255	194,935	27,510	18,205	9,335	3,015	148,085	22,050	14,940	7,745	2,280
RTS du Centre-Ouest-de-l'Île-de-Montréal	337,975	185,920	20,705	16,645	10,060	4,700	142,460	14,720	11,610	5,940	2,270
RTS du Centre-Sud-de-l'Île-de-Montréal	291,630	77,840	7,180	4,410	1,940	670	209,030	25,855	16,290	7,175	1,995
RTS du Nord-de-l'Île-de-Montréal	415,685	88,895	10,490	6,780	4,195	1,490	314,375	35,475	24,220	13,895	5,635
RTS de l'Est-de-l'Île-de-Montréal	500,445	74,575	9,820	4,895	2,690	990	415,110	54,365	37,855	22,005	7,115
RTS de l'Outaouais	376,905	70,575	9,795	6,115	2,640	720	304,625	46,250	29,195	11,715	2,975
RTS de l'Abitibi-Témiscamingue	143,155	5,155	930	475	145	70	137,920	23,025	14,540	6,245	1,530
RTS de la Côte-Nord	90,680	5,175	715	545	280	60	85,085	14,150	8,810	4,210	980
RTS de la Gaspésie	75,945	8,090	1,385	1,250	685	245	67,840	13,990	10,050	4,735	1,315
RTS des Îles	12,190	695	140	105	45	25	11,495	2,310	1,710	765	160
RTS de Chaudière-Appalaches	408,615	3,755	580	435	180	20	404,685	65,500	48,510	20,335	5,190
RTS de Laval	410,850	91,115	9,940	5,765	3,170	905	311,535	44,750	29,020	15,515	4,290
RTS de Lanaudière	486,285	14,215	2,160	1,380	515	150	471,020	73,295	50,235	20,395	4,275
RTS des Laurentides	577,855	37,555	5,700	4,430	2,115	620	538,755	85,450	58,440	23,385	5,125
RTS de la Montérégie-Centre	391,170	53,570	6,900	5,530	2,570	865	332,790	49,000	35,415	14,980	3,580
RTS de la Montérégie-Est	505,470	19,130	2,650	1,810	895	310	484,805	74,435	54,510	23,520	5,355
RTS de la Montérégie-Ouest	428,590	83,300	10,840	6,910	3,310	935	343,710	50,415	34,365	14,440	3,525

Source: JPocock Research Consulting, 2016 Census, Statistics Canada. Population in private households - 25% sample. The linguistic concept is First Official Language Spoken with multiple responses distributed equally.

Age Groups as a Proportion of the Total Population, Among English and French Speakers
Québec and its RTS Territories, 2016

Geography	English Speakers					French Speakers				
	55 to 64 years	65 years and over	65 to 74 years	75 to 84 years	85 years and over	55 to 64 years	65 years and over	65 to 74 years	75 to 84 years	85 years and over
Québec	12.6%	14.5%	8.5%	4.4%	1.6%	15.3%	17.0%	10.8%	4.8%	1.3%
RTS du Bas-Saint-Laurent	16.2%	24.5%	19.0%	4.6%	-	18.9%	21.4%	13.9%	5.9%	1.6%
RTS du Saguenay – Lac-Saint-Jean	12.2%	18.7%	11.4%	6.1%	1.3%	18.0%	19.2%	12.2%	5.6%	1.4%
RTS de la Capitale-Nationale	12.7%	15.2%	8.8%	4.6%	1.8%	15.4%	18.4%	11.7%	5.3%	1.5%
RTS de la Mauricie-et-du-Centre-du-Québec	15.7%	19.8%	12.8%	5.6%	1.5%	17.2%	20.0%	12.9%	5.6%	1.6%
RTS de l'Estrie – CHU de Sherbrooke	15.6%	23.0%	13.2%	7.1%	2.6%	16.3%	18.8%	12.4%	5.1%	1.3%
RTS de l'Ouest-de-l'Île-de-Montréal	14.1%	15.7%	9.3%	4.8%	1.5%	14.9%	16.9%	10.1%	5.2%	1.5%
RTS du Centre-Ouest-de-l'Île-de-Montréal	11.1%	16.9%	9.0%	5.4%	2.5%	10.3%	13.9%	8.1%	4.2%	1.6%
RTS du Centre-Sud-de-l'Île-de-Montréal	9.2%	9.0%	5.7%	2.5%	0.9%	12.4%	12.2%	7.8%	3.4%	1.0%
RTS du Nord-de-l'Île-de-Montréal	11.8%	14.0%	7.6%	4.7%	1.7%	11.3%	13.9%	7.7%	4.4%	1.8%
RTS de l'Est-de-l'Île-de-Montréal	13.2%	11.5%	6.6%	3.6%	1.3%	13.1%	16.1%	9.1%	5.3%	1.7%
RTS de l'Outaouais	13.9%	13.4%	8.7%	3.7%	1.0%	15.2%	14.4%	9.6%	3.8%	1.0%
RTS de l'Abitibi-Témiscamingue	18.0%	13.4%	9.2%	2.8%	1.4%	16.7%	16.2%	10.5%	4.5%	1.1%
RTS de la Côte-Nord	13.8%	17.1%	10.5%	5.4%	1.2%	16.6%	16.5%	10.4%	4.9%	1.2%
RTS de la Gaspésie	17.1%	26.9%	15.5%	8.5%	3.0%	20.6%	23.7%	14.8%	7.0%	1.9%
RTS des Îles	20.1%	25.2%	15.1%	6.5%	3.6%	20.1%	22.9%	14.9%	6.7%	1.4%
RTS de Chaudière-Appalaches	15.4%	16.9%	11.6%	4.8%	-	16.2%	18.3%	12.0%	5.0%	1.3%
RTS de Laval	10.9%	10.8%	6.3%	3.5%	1.0%	14.4%	15.7%	9.3%	5.0%	1.4%
RTS de Lanaudière	15.2%	14.4%	9.7%	3.6%	1.1%	15.6%	15.9%	10.7%	4.3%	0.9%
RTS des Laurentides	15.2%	19.1%	11.8%	5.6%	1.7%	15.9%	16.1%	10.8%	4.3%	1.0%
RTS de la Montérégie-Centre	12.9%	16.7%	10.3%	4.8%	1.6%	14.7%	16.2%	10.6%	4.5%	1.1%
RTS de la Montérégie-Est	13.9%	15.8%	9.5%	4.7%	1.6%	15.4%	17.2%	11.2%	4.9%	1.1%
RTS de la Montérégie-Ouest	13.0%	13.4%	8.3%	4.0%	1.1%	14.7%	15.2%	10.0%	4.2%	1.0%

Source: JPocock Research Consulting, 2016 Census, Statistics Canada. Population in private households - 25% sample. The linguistic concept is First Official Language Spoken with multiple responses distributed equally.

1.2. Wellness Centres

One community-based solution that has emerged over the last decade has been "Wellness Centres" with programming and services aimed specifically at engaging and supporting English-speaking seniors. From wellness activities to social programming and support for accessing health information, Wellness Centres exist to serve their English-speaking participants and fill a service gap that often exists between the English-speaking communities and the health and social services systems. Indeed, Wellness Centers first began as a way to reach a clientele that the public health and social services system was having difficulty reaching.

The history of Wellness Centres goes back to an earlier initiative, in 1991, when Jeffrey Hale Community Partners (JHCP, also known at the time under the name The Holland Centre) started drop-in centres for seniors. As this activity grew, JHCP began rotating between communities both in the Quebec City region and in Chaudière-Appalaches. This model drew the attention of other organizations in the Community Health and Social Services Network (CHSSN), specifically the Committee for Anglophone Social Action (CASA), an organization working with English speakers on the Gaspé Coast. In that region, a day centre pilot project for English-speaking seniors had been implemented (by the public health and social services system) in Cascapedia-St-Jules in May 2008 and continued to June 2009. The project evaluation concluded that a program was needed that would continue to support Anglophone seniors who did meet the criteria of the *Centre de santé et des services sociaux Baie-des-Chaleurs* (CSSSBC), which many English-speaking seniors did not. To do so, the health centre requested the assistance of the regional community organization, CASA, which was providing information to English-speaking seniors in the region and had a pre-established connection with them.

CASA researched alternatives to a day centre, taking inspiration from a visit to Jeffery Hale Community Partners in Quebec City and its experience with seniors. In January 2010, the first "Wellness Centre" was offered on the Gaspé Coast, and funding was secured through the Community Health and Social Services Network (CHSSN), from a health promotion program. Since 2013, Wellness Centres have been established and expanded in an effort to better cover the whole Gaspé Coast, the Magdalen Islands and eventually other regions across the province. In order to include as many seniors as wanted to participate, and to play an important role in health promotion and prevention, Wellness Centres did not apply any specific criteria for participation, such as a geriatric profile (which day centres use). Their mission is to contribute to the health, well-being and autonomy of English-speaking seniors and to support caregivers in their role.

These early versions of Wellness Centres were developed in regions of the province where populations are spread over large distances and it is therefore difficult for seniors to travel in order to participate in activities. On the Gaspé Coast, there are communities along about 500 kilometers of coastline, linked by a single road. On the Lower North Shore, there are also about 500 kilometers of coastline, but the communities have no road connecting them and in winter must travel by snowmobile. These are just two examples that highlight the challenges of providing services for seniors, which are adapted to local realities and take into account the additional barriers (to language and mobility) of remoteness and geographical isolation.

It is important to underline the fact that these Wellness Centres emerged within the context of CHSSN's Networking and Partnership Initiative (NPI) and it is therefore this

network that is the focus of the present evaluation. Other initiatives that help respond to the needs of seniors of course exist, but lie outside the scope of the present evaluation.

1.3. CHSSN's Networking and Partnership Initiative (NPI)

As this work advanced, the organizations participating in the Networking and Partnership Initiative (NPI)[iii] supported by the CHSSN developed knowledge on senior populations in their regions, built partnerships with service providers to support work with English-speaking seniors, and sometimes provided services such as Wellness Centres themselves. As part of its role in supporting the network with funding, training, networking and knowledge development, the CHSSN developed a community model for promoting the health and well-being of English-speaking seniors in Quebec, which has provided guidance for this work.[iv]

The community model developed by CHSSN emphasizes intersectoral collaboration with community and institutional partners to address five broad priorities: health and social services, health promotion and prevention, home support and living arrangements, reducing isolation and caregiver support. Collaborations aim to support service providers in the linguistic and cultural adaptation of programs and services targeting vulnerable ES seniors, in three main environments: institutions, community and home. A broad range of interconnected outcomes are the goal (see Figure 1) and are grounded in the values of equity, social inclusion and autonomy. The present evaluation is informed in part by this model.

Figure 1: Community model

Promoting the Health and Well-being of English-speaking Seniors in Quebec
A COMMUNITY MODEL

English-speaking Communities
Joint Action
Community & Public Partners
Addressing Priorities for English-speaking Seniors
Health & Social Services
Health Promotion & Prevention
Home Support & Living Arrangements
Reducing Isolation
Caregiver Support
Linguistic & Cultural Adaptation
Outcomes
Empowerment & Resiliency
Access to Health & Social Services
Healthy & Safe Living Environments
Target Population
Optimal Physical & Mental Health
Community & Family Support
Active Social Engagement
Institution
Community
Home
Targeted Environments
Values
Equity
Social Inclusion
Autonomy

Model developped by CHSSN Community Health And Social Services Network Réseau communautaire de santé et de services sociaux

Financial contribution by Health Canada Santé Canada

Wellness Centres are certainly an important part of this work promoting the health and well-being of English-speaking seniors in Quebec. However, Wellness Centres are not a defined or standardized model in the province. Various community organizations provide activities and programming to support seniors, adapting these to the needs of the local

population. In this report, we aim to present an overview of the diversity of Wellness Centres and the characteristics that they share in order to contribute to a shared understanding of this initiative.

2. Methodology

2.1. Evaluation mandate

This evaluation was requested by the *Centre of Expertise on the Adaptation for English-speaking Communities in Health and Social Services (ACESS)*, a collaborative project between Jeffery Hale – Saint Brigid's and Jeffery Hale Community Partners. Centre of Expertise ACESS was created in March 2019 and its objective is to build and share knowledge that can help improve access to health and social services for English-speaking Quebecers. It aims to connect English-speaking communities, researchers and evaluators, and the health and social services system in eastern Quebec. Centre of Expertise ACESS received funding from the *Secrétariat aux relations avec les Québécois d'expression anglaise* (SRQEA)[v] for this evaluation project. SRQEA was created to ensure that the concerns of English-Speaking Quebecers are taken into account in government orientations and decisions in collaboration with government ministries and bodies. This includes providing up-to-date information and knowledge (such as that produced through research and evaluation) to various levels of government.

Following two previous evaluations of Wellness Centres in the Gaspésie-Îles-de-la-Madeleine region carried out by the present author[vi], Centre of Expertise ACESS requested a similar and more comprehensive evaluation for all known Wellness Centres in the province that are part of the NPI network, since they are seen to be an innovative community-led program for addressing the needs of minority language seniors. This evaluation is intended to help health networks and decision makers better understand the function, programming and capacity of these Wellness Centres to support and positively impact seniors' lives across the province. It is seeking to understand to what extent these centres are achieving their intended objectives, and the impacts their existence and services have on the English-speaking seniors who use them.

2.2. Evaluation plan

The evaluation is led by Mary Richardson, PhD, and overseen by a committee comprised of key stakeholder group representatives (see Appendix). Mary Zettl, MA, provided assistance with data compilation and analysis, and with report writing, as described below.

In order to evaluate these community services for seniors, the lead evaluator and a steering committee developed an evaluation plan (see appendix) to be carried out in two phases.

- **Phase 1** – A general and organizational overview via interviews with the Wellness Centres executive directors
- **Phase 2** – A deeper exploration into the Wellness Centres to gather feedback from users and facilitators

An overarching evaluation question was formulated with additional detailed questions developed to guide data collection (see appendix). For phase 1 of the evaluation, the

focus was on the general objective of providing community-based services for English-speaking seniors:

Table 2: Phase 1 Evaluation questions

Do the wellness centres contribute to the health, well-being and autonomy of ES seniors?			
General Objectives of wellness centres	Specific Objectives of wellness centres	Actions	Evaluation Questions
Provide community-based services for ES seniors	Create and efficiently manage WC	Create WC in locations where there are enough ES seniors and sufficient need	What were the steps to put WC in place? What human, financial and material resources are required to create WC? How many WC are there per community/region?
	Service offer is adapted to the needs of local ES seniors	Identify characteristics and needs of local ES seniors	How do organizations know of the needs of the local ES seniors?
		Develop a service offer to meet the needs of ES seniors	What are the Wellness Centres' service offers (ex.: format, activities, target users)?

The CHSSN provided critical collaboration throughout these steps, connecting the evaluators to the implementing organizations and providing key documents on the program.

2.3. Process

The first step in the process was to identify existing Wellness Centres, information that had not been brought together. To do so, an email was sent to all Executive Directors of an NPI, asking them whether they ran a Wellness Centre. Follow-up phone calls were made when additional information was needed to clarify the situation, as some organizations did not consider their activities with seniors a "Wellness Centre". A preliminary list was drawn up and the organizations were contacted to schedule an on-line or telephone interview.

Participation was voluntary, and agreement to participate in an interview was taken as consent. There were no refusals. Between September and October 2019, Mary Richardson conducted semi-structured interviews with the executive directors of the 12 organizations. The interviews gathered high level information on organization history, funding, identification of participant needs, human resources, programming and activities, participants, partner organizations, perceived impacts, and challenges. More detailed written information regarding funding, participants and programming were also collected from some of the executive directors and included in the corpus along with the interviews. (See Appendix for interview outline.)

Mary Zettl (the research assistant) manually reviewed interview notes taken by Mary Richardson and any additional information forwarded by the organizations' Executive

Directors. She then coded and extracted relevant themes and data, grouping it into broad categories. Coded data was entered into an Excel workbook by category, with one categorized Excel page per organization. Each Excel sheet had columns according to the general themes (organizational information, human resources, funding, activities, participants, partners, perceived impacts, etc.). Data from each organization was then refined and reorganized within tables to display results for each respective category across all organizations. Data tables were reviewed by the lead evaluator MR. MR also had results verified by the executive directors of each organization to ensure accuracy, transparency and rigor.

2.4. Limitations

It is important to reiterate that for this phase of the evaluation we chose to focus on the CHSSN network and the model that has been emerging with its support. This evaluation therefore does not include organizations outside the CHSSN network that may be providing similar activities and services.

Phase 1 of the evaluation provides an overview of the functioning of Wellness Centres (such as funding sources or wellness activities) but not details (such as amounts or proportions of funding from different sources or specific activities). Phase 2 will provide more detail on the themes deemed important for evaluation purposes.

3. Findings

In the sections below we report on the objectives, how needs are identified, funding, human resources, perceived impacts and the challenges reported. A discussion of the findings follows.

3.1. Regions and sites

Within the CHSSN network, there are a total of 42 Wellness Centre sites across ten regions of the province, organized by twelve different community organizations.

A map can be found at the beginning of this document, along with a full table of these sites and some key information about them.

3.2. Mission and objectives

While varying in definition, capacity and organizational structure, the organizations running Wellness Centres had similar missions, programme objectives and approaches for assessing needs.

Organizational priorities reported by the interviewees included:

- reducing senior isolation and its effects
- raising awareness and informal education (health promotion)
- supporting health system and services navigation
- addressing a lack of access (due to remoteness or language barriers)
- helping empower seniors
- lending community support
- informing the organization about needs of English-speaking seniors

In line with these overarching priorities, the main programme objectives they mentioned were to reduce social isolation and improve the well-being of participants. Common themes around programming included health promotion and prevention, providing

information, facilitating access to health services, providing support (including community outreach), helping overcome the language barrier for seniors trying to access services and ultimately acting as a bridge between the public system and English-speaking seniors.

Overall, each organization cited carrying out some level of needs assessment, participant research or survey to gather input from seniors about their needs and satisfaction with activities and services. Most organizations reported continuously gathering input from participants via forums or surveys. At least half the organizations reported undertaking in-depth assessments every 1-2 years to gauge interest and applicability of services and activities offered. In a few cases, some organizations already had staff or board members directly linked to seniors within their community and, thus, had knowledge of senior needs prior to establishing the programme. One organization identified needs in consultation with the CHSSN; and one reported getting information from the CLSC.

3.3. Funding

While the budgets varied between organizations, the theme of uncertainty of funding sustainability and ineligibility for provincial or other types of government funding echoed across all but one organization. The reasons for this were not discussed at length, but eligibility criteria to apply for funding, and a lack of cohesive definition of what a Wellness Centre is or should be, were the two notable factors mentioned. While many organizations reported needing to stretch funding or requiring more to keep up with demand as participant numbers increased, ten of the twelve organizations reported having sufficient operational funding for the year.

Funders included federal and provincial sources, as well as municipalities and private sources. The main funders and funding programs are shown below.

Table 3: Sources of funding for Wellness centres (2019)

Federal sources	Provincial sources	Regional sources	Local sources	Private sources
Health Canada NPI via CHSSN (12/12)	**APPUI** pour les proches aidants (4/12)	**CISSS** (5/12) Centre intégré de santé et des services sociaux	**Local municipality** (2/12)	Private foundations (2/12)
New Horizons For Seniors (4/12) (Employment and Social Development Canada)	**ITMAV** (3/12) *Initiatives de travail de milieu auprès des aînés en situation de vulnérabilité*		**MADA** (1/12) (Municipalité amie des aînés)	Good Samaritan Fund (1/12)
PCH (4/12) Patrimoine Canadien Heritage	**QADA** (2/12) *Québec ami des aînés*			United Church (1/12)
				Alzheimer's Society (1/12)

This table shows that all Wellness Centres having federal funding from Health Canada. Some also have funding from other federal programs. Provincial sources are much less prominent. The regional health centres sometimes contribute funding to Wellness Centres, and a small number receive some money from local municipalities (or related programs such as MADA) or from private sources.

What this table does not show is what proportion and amounts of funding come from each source. It also does not shed light on contributions in kind (providing spaces for activities, professionals attending as guest speakers, materials or other). Additionally, some of these sources are available for only one year while others are multi-year, and some funders are more flexible while others are very prescriptive. Understanding these complexities will help grasp the challenges faced by these organizations in ensuring sustainability.

3.4. Human resources

All organizations reported sufficient human resources to offer services to seniors, despite also reporting that staff are operating at maximum capacity. Most organizations had at least one full-time coordinator or two or more part-time staff members. Job titles included Wellness Centre coordinator, health coordinator and outreach worker. The training required prior to hiring and the training offered varied from organization to organization with limited detail. While some required people who were personable, others required specific backgrounds to support service delivery at the Wellness Centres.
Staff responsibility at the Wellness Centre activities were generally similar across the organizations. Such responsibilities include facilitating activities, planning and coordinating events, managing snacks and lunches, helping participants access health services, providing information, providing outreach or respite care, administrative tasks and organizing information sessions with guest speakers.

3.5. Activities

Activities undertaken at the Wellness Centres included similar formats and a variety of types of activities aimed at fulfilling the organization's mandate and meeting the participants' needs and wishes. It is important to note that the numbers below refer to *reported* activities; some organizations may not have mentioned activities that they are engaged in, so some of these numbers may in fact be higher. Activity formats reported were:

Table 4: Formats

Formats	Number
Group sessions	11/12
Outreach or respite care	7/12
Individual support	6/12
Open door/walk-in times	4/12
Inter-generational programming	3/12
Referrals	2/12

Activities, themselves, were grouped into three main categories:

Table 5: Categories of activities

<table>
<tr><th>Activity category</th><th>Activity type</th><th>Number</th></tr>
<tr><td rowspan="4">Health promotion and prevention</td><td>Physical well-being (example: exercise)</td><td>7/12</td></tr>
<tr><td>Health sessions/workshops (example: information on healthy eating)</td><td>7/12</td></tr>
<tr><td>Mental health (example: dealing with grief)</td><td>4/12</td></tr>
<tr><td>Fine motor skills (example: beading, puzzles)</td><td>2/12</td></tr>
<tr><td>Social activities</td><td>Collective kitchen or meals</td><td>7/12</td></tr>
</table>

	General socializing	6/12
	Crafts	5/12
	Intergenerational activities	4/12
	Games	3/12
	Outings	1/12
	Book clubs or books on wheels	1/12
	Special events	1/12
Support	Outreach / respite care	7/12
	Helping access information	6/12
	Support groups	5/12
	Help accessing health services	5/12
	Help accessing professional services (example: legal aid)	4/12
	Transport	3/12
	Individual support appointments	2/12
	Caregiver support	2/12
	Newsletters	2/12
	Providing documentation support	1/12
	One-to-one accompaniment	1/12

Two organizations had differing needs between their locations or did not provide the same activities at both sites. One organization mentioned adding a third location due to the need in a neighbouring community, and one organization plans on adapting activities according to the changing needs of their participants as they age.

3.6. Perceived impacts

The impacts of Wellness Centres that follow are those from the perspective of the executive directors interviewed for Phase 1. Therefore, the results should be taken as legitimate but may differ from the impacts reported by participants during Phase 2 data collection. Additionally, only 10 of the 12 responded to questions about perceived impacts and it should not be assumed that they do not have any impacts to report. As such, results reported in this section are for the 10 organizations that did report in this category and are listed by most often mentioned to least.

Questions regarding the perceived impacts of the Wellness Centres on stakeholders were sub-divided into four groups: seniors, caregivers, public partners and community partners. The most common impact reported was increased social connectedness and healthier senior aging. Many of them reported that participants were excited to attend activities and felt a sense of community, belonging and even ownership of the Wellness Centres.

Benefits to participating seniors

- Reducing isolation
- Better access to information
- Feeling engaged or included in the community
- Improved quality of life
- Healthier aging
- Being more active (physically/mentally)

- Being more connected to people
- Being more empowered
- Providing feedback on a range of topics related to the Wellness Centre
- Support with transportation

These impacts are believed to support healthy ageing and result in less demand among seniors from the health care system than would be the case without Wellness Centres.

Benefits to caregivers

Benefits to caregivers were reported less frequently. Some organizations did report some participants also being caregivers or volunteers who help with activities. Thus, they would have similar impacts as participants, but additionally:

- Gaining practical knowledge (care, self-care)
- Getting time off or to self
- Feeling supported
- Not feeling alone
- Accessing respite care

Benefits to public health and social services partners

As the Wellness Centres facilitate better health access and support for seniors, they act as a bridge helping public partners to:

- Fulfill their mandate to provide services to English speakers, directly (through direct contact) or indirectly (through partnerships with community organizations)
- Gain knowledge about the needs of English-speaking seniors
- Provide information for organizations and share information with them
- Provide bilingual sessions
- Build trust in the public health care system
- Save money
- Refer participants to Wellness Centre

Benefits to community partners

Reported benefits to community partners were similar to those with public partners. Community partners, however, make up a broad range of organizations that varied between communities. Impacts reported were:

- Collaboration with the municipality
- Ability to reach the English-speaking community
- Participant referrals through seniors' associations
- Knowledge exchange with other EDs and support
- Collaborative activities with Wellness Centres, such as hosting an info booth or session
- Bridging gaps between community partners and the English-speaking community
- Help understanding the English-speaking community and its needs
- Support with unilingual clients

3.7. Challenges

Challenges identified by the organizations can be grouped into four main themes: funding, human resources, capacity and miscellaneous. While most organizations

reported uncertainty around sustainable funding, six organizations specifically reported funding being "maxed out," eligibility issues when applying for funding due to a lack of cohesive definition, and general uncertainty about funding sustainability in the future. There were only two organizations that reported human resources challenges. Such challenges were in finding and retaining qualified staff. Most often the funding only allows for a very limited number of hours, making it hard to keep staff. Additionally, one organization reported its human resources as lacking and required funding for more personnel.

Five organizations reported capacity challenges including:

- Being unable to start new initiatives or expand programming
- Being unable to provide transport or home visits
- Not having enough space for the increasing number of participants
- Needing more structure
- Needing to adapt services

Five organizations reported additional challenges including:

- Remote location
- Language barrier or low level of French among participants
- Francophone community organizations unwilling to work with English-speaking organizations
- Low level of participant education
- Unreliable internet or tech issues
- Unavailability of the nurse

4. Discussion

Communities across the province have identified the need to support English-speaking seniors and to continue building the sustainability of such support. Wellness Centres are a significant initiative that aims to meet this need. They have been developing over many years and have been expanding to adapt to changing needs.

4.1. Defining Wellness centers

Through the conversations held with the directors of the community organizations running Wellness Centres, the following definition has emerged:

A Wellness Centre is…
A community-run program that aims to maintain and improve the health and well-being of English-speaking seniors, to improve access to and knowledge of health and social services, and to decrease social isolation through purposeful and informed programming.

4.2. A clear set of objectives

Regardless of how they are named by the organization, there is consistency in the objectives of Wellness Centres. These objectives were not imposed by funders or defined by any organization in a top-down manner. Instead they have emerged through the experience of the organizations running Wellness centres, as they adapt to the senior population in their region.

Because of the NPI program and the networking model implemented by the CHSSN—which involves networking between different organizations, sharing best practices, taking inspiration from existing projects, collaborating with relevant organizations, and more—mission statement and a relatively cohesive set of objectives can be identified.

Mission: to contribute to the health, well-being and autonomy of English-speaking seniors and to support caregivers in their role.

Main objectives

- Reduce social isolation
- Promote health and wellness
- Facilitate improved access to health and social services

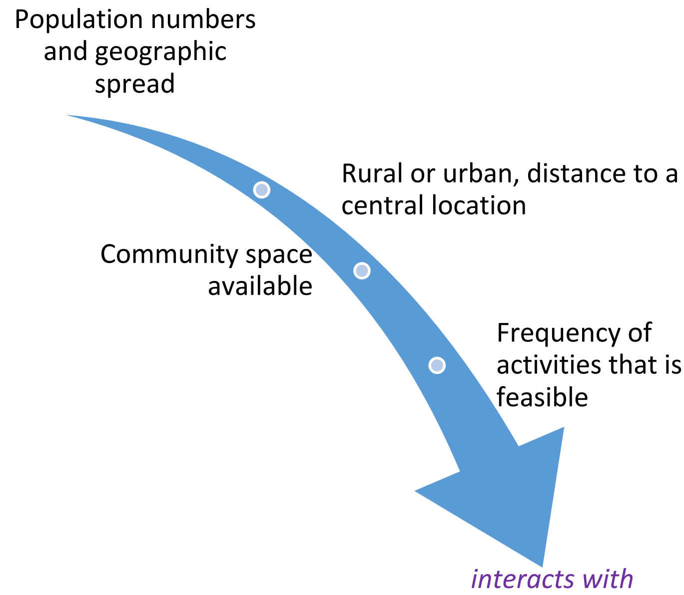
Specific Objectives

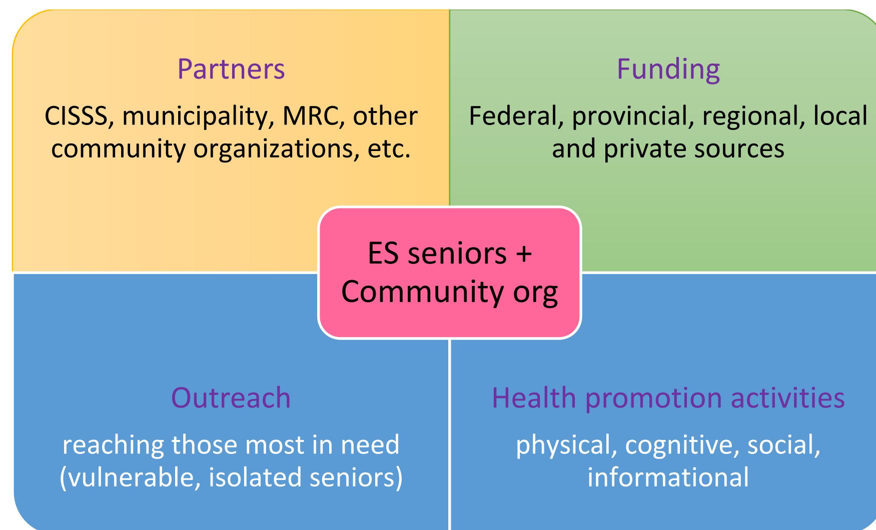
- Offer support to seniors and caregivers
- Operate as a link between the health and social service system and seniors
- Facilitate improved access to service and health information for seniors
- Support public and community partners in fulfilling their mandate to reach English-speaking seniors

These objectives are met in a variety of forms that differ depending on context. In this sense they are clearly taking into account a number of local realities. In addition, they vary depending on funding, capacity (staff, technology, facilities) and community remoteness.

4.3. An adapted approach

Generally, we found that the Wellness Centres varied considerably in terms of size, number of sites, funding, and number of participants. This is a reflection of the regional and local realities, which are extremely different. For this reason, it is not necessarily "better" to have more participants; it is most likely a reflection of local population numbers. Likewise, the formats that exist are also an adaptation to local realities: the local English-speaking population of seniors and its geographic spread; the distance to a central location where activities could reasonably be held; the availability of a community space for holding activities; and therefore the frequency of activities that is feasible all must be taken into account in designing the Wellness Centre. These social, demographic and geographic realities then interact with organizational factors such as available funding, potential partners, approaches for reaching vulnerable and isolated seniors, and the health promotion activities that will best fulfill the objectives of promoting health and wellness. At the heart of this process of developing the right fit for the context is a focus on seniors and their needs as well as the community organization serving them.





4.4. Emerging models

Generally, two main models have emerged: one best suited to rural and remote communities, and the other adapted to urban and suburban areas.

A rural and remote model

The first type is well-adapted to rural communities where populations are small and people are dispersed and therefore cannot easily attend more frequent events. Seniors may be travelling from a significant distance to attend the Wellness Centre. Staff (facilitators and coordinators) may also be travelling long distances to organize the Wellness Centre. Sessions are generally held in a local facility, often rented or loaned for the purpose. Participants come to a central location, sometimes with help for transportation, and they spend a part of the day doing various activities, including physical exercise, mental challenges, games, an information session and often a lunch.

An urban and suburban model

The second type is well suited to more urban environments where populations are larger and more concentrated, and seniors can easily attend a number of activities throughout the week. Often the community organization has its own space to hold these activities, in a central location. Activities tend to be targeted and specific, and there are many to choose from, so seniors can attend those in which they have the most interest.

MODEL	A rural and remote model	An urban and suburban model
Sessions	A single allocated time and place for all	Multiple opportunities for those interested
Organization	A series of sessions that contain a number of different activities which, together, meet the objectives of Wellness Centres in a single session	A series of activities that participants can choose from which, as a whole, meet the objectives of Wellness Centres over the course of a week (or more)
Sites	In a given region there may be many different sites because of distance and remoteness	In a given region there may be only one site, or possibly two
Frequency	Every one, two or three weeks	Activities throughout the week
Choice	Participants do not choose between activities	Participants choose between activities
Duration	Sessions last between 3-5 hours	Activities last 1-3 hours
Examples	Gaspé Coast and Magdalen islands, Lanaudière, Chaudière-Appalaches, Côte-Nord	Abitibi, Laval, Montérégie centre

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A combined community-public model

There is also a third model which to date exists in only one location: Quebec City. Jeffery Hale Community Partners, Voice of English Quebec (VEQ) and the CIUSSS Capitale-Nationale collaborate to provide a spectrum of services for seniors covering a range of needs as they age. There are both community-led Wellness Centre activities (for all age

groups) and a day centre for more vulnerable seniors (run by 2 community partners and a public partner). These target different clienteles, and enable the organization to develop and maintain a connection to their senior population as their needs evolve.

4.5. Successes

Community-led development

An overarching success of Wellness Centres in the province is that they have developed over a relatively short period of time in direct response to local needs. Community organizations have developed an innovative response to a gap they perceived in services for seniors. They have learned from each other (through the CHSSN network specifically) and have built a knowledge base on local and provincial realities, such as demographics and the needs of their population. A community model for supporting seniors has been developed and is being used to guide Wellness Centres and other initiatives.

A unique model

It is important to point out that what is offered by Wellness Centres is not the same as day centres (in the public system) or seniors clubs (such as FADOQ). The main differences are that the former have very specific criteria for participants (which many seniors might not meet) and the latter do not organize their activities with the specific goal of improving health and well-being (health promotion and prevention, health services information, etc.)—although there is some overlap.

An outreach approach

Wellness Centres are a specific response to the challenges faced by English-speaking seniors in Quebec, living in a minority language situation, often with a certain level of social and geographic isolation which the public system generally has difficulty addressing. Wellness Centres therefore include outreach to vulnerable, isolated seniors. In addition, they are offered close to where seniors live, since many of them cannot travel large distances. Some communities adapt the model to include more home visits or individual accompaniment, a legitimate adaption to local needs. This proximity is key to effective primary health care and action on health determinants, such as social inclusion and support and lifestyle factors. Because of the minority language situation, there are additional cultural and linguistic considerations that add complexity to the challenge of providing services that senior populations will access and that meet their needs.

An adapted and flexible model

There are various ways to implement a Wellness Centre depending on local realities. This model is flexible, adaptable, inclusive and adopts a broad and multifaceted approach to improving health and well-being. Partnerships are sought out and developed based on what is relevant in specific contexts. Some may be informal while others involve formal agreements.

Funding successes

Another success is that these organizations have been able to access funding from a wide variety of sources (local, provincial, regional and federal, as shown in Table 4). They are providing programming with a level of resources that, in many cases, is extremely low, particularly when compared to the cost of providing such support through the public system.

Activities and impacts

Despite some challenges, human resources have been secured for Wellness Centres and a broad range of activities are being provided. Initial evidence of positive impacts for participants, caregivers, public partners and community partners indicates that there are multiple beneficiaries and ultimately, that the Wellness Centre objectives are being reached (Phase 2 of this project will elaborate on these themes).

4.6. Challenges and Opportunities

Sustainable long-term funding

The main challenge to Wellness Centre success is sustainable, longer-term funding. This could help to resolve other challenges, such as securing human resources and being able to respond to some specific needs (such as transportation). Further defining fundable programming under the model of Wellness Centres may facilitate securing funding and aid decision-makers in understanding the principles and impacts behind such grant proposals or funding requests.

The data gathered in this phase of the evaluation shows that all Wellness Centres are funded by Health Canada and then they cobble together additional sources, as they can. While this diversity can be viewed as a positive element, it is also a source of precariousness, as many of those additional sources are short-term and sometimes even non-renewable (one-time only). Moreover, many interviewees were of the opinion that the provincial government has the mandate to provide funding for health initiatives in Quebec.

Reaching the most vulnerable

Another challenge that was not explicitly explored is knowing who is being reached and who is not. Are there vulnerable seniors who are not attending? And if so, why not? Geographic realities can make it very difficult to reach certain seniors, particularly in regions where distances between communities are significant or when there is no road access.

4.7. Gaps in weaving a strong web of Wellness Centres for seniors

In examining the map of regions and sites, it is possible to identify certain gaps in the coverage of Wellness centres. But first, it is important to point out that there can be several reasons for a lack of Wellness Centres in a given region: a) there may be other services or activities that are filling the gap, either in the public system or in the community sector; b) there may be activities for seniors that are not called a Wellness Centre or conceived of that way; c) a parallel network may exist that is not connected to the CHSSN network (as in Montreal); d) another reason.

Still, when we look at the regional populations versus the number of Wellness Centre sites, certain regions clearly are missing from the current picture. Omitting Montreal, the following regions seem to have potential for developing Wellness Centres, or expanding their coverage.

Regions that have no Wellness Centre

1. **Outaouais**: with over 70,000 English speakers (19,270 age 55 and over) spread over a relatively large area, including both urban environments and small rural communities, it would seem that there is strong potential for filling a gap.

2. **Estrie**: over 37,000 English speakers live in this region (14,265 age 55 and over). Townshippers Association is very active in the region and no doubt there are many activities for seniors, but no Wellness Centre per se. Is there potential for Wellness Centres to fill a gap in current services?
3. **Mauricie** and **Centre-du-Québec**: The population of English speakers is not very large and likely dispersed, with 2,055 age 55 and over. The regional association Centre for Access to Services in English (CASE) is working specifically with English speakers and may want to implement a Wellness Centre in its area.
4. **Saguenay-Lac-Saint-Jean** and **Bas-Saint-Laurent** both have very small populations of English speakers. Still there may be a demand for at least one Wellness Centre in each region, adapted to the needs of its senior population.

Regions with potential for growth

5. **Laurentians**: With almost 38,000 English speakers (12,860 age 55 and over), spread over a relatively large area, and only two locations with wellness centres (both in the south near Montreal), one can imagine that there are many smaller communities where seniors may want or need a Wellness Centre.
6. **Montérégie**: Between the three areas of Montérégie, there are about a million and a half Anglophones (43,525 age 55 and over), some in suburban areas on the south shore of Montreal and others throughout the more rural communities to the south. There is currently only one Wellness Centre site, and potentially a need for others.

5. Conclusion

Wellness Centres have been developed by community organizations in direct response to the needs of English-speaking seniors in Quebec and aim to address the challenges they face, including social isolation and language barriers in accessing public services. With a focus on health promotion and prevention, they are a community-run program that aims to maintain and improve the health and well-being of English-speaking seniors, to improve access to and knowledge of health and social services, and to decrease social isolation through purposeful and informed programming.

Various types of perceived impacts have been identified, including benefits to seniors, to caregivers, to public partners and to community partners. Benefits for individuals mainly concern reducing social isolation, supporting health and wellness and improving access to information and services. For partners, the benefits concern information sharing, better knowledge of the needs of English-speaking seniors and connecting service providers with potential clients.

Two main models can be observed, one more suited to rural and remote communities where participants all attend a session every two or three weeks and spend several hours together doing activities focused on health promotion, socializing and information sharing. The second is more suited to urban and suburban communities and involves a calendar of activities throughout the week at a central location from which participants choose.

Wellness Centres have been successful in developing a unique model that is adapted (and adaptable) to local realities. It involves outreach to vulnerable and isolated seniors,

partnerships with relevant organizations (both community and public-sector) and the support of a strong network that provides funding, training and opportunities for sharing learning (CHSSN).

The challenges that remain concern funding and outreach. Outreach is needed to connect to seniors who are potentially disconnected socially or geographically from community resources. Funding challenges are related to the fact that despite funding from Health Canada, as well as some funding from other federal programs, a few provincial sources, regional health centres, local municipalities or private sources, many organizations have to constantly search for new funds, because many of these sources are single-year or non-renewable, making funding unsustainable.

Finally, there is potential for expanding the network of Wellness Centres to regions where there are none (although there may well be activities and services for English-speaking seniors) or where coverage is limited to certain communities.

In phase 2 of the evaluation, we will explore the perspectives of facilitators/coordinators and participants to gain a more in-depth understanding of the range of impacts that Wellness Centres may have on the lives of English-speaking seniors.

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Appendices

Steering committee members

Consultants

- Mary Richardson, Ph.D., anthropologist
- Mary Zettl, M.A.

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- Brigitte Paquette, Adjointe du PDGA CIUSSS Capitale-Nationale chez Jeffery Hale - Saint Brigid's
- Carrie Anna McGinn, Coordonnatrice du Centre d'expertise sur l'adaptation aux communautés d'expression anglaise en santé et en services sociaux (ACESS)

Jeffery Hale Community Partners

- Louis Hanrahan, President of
- Richard Walling, Executive Director, Jeffery Hale Community Partners

Community Health and Social Services Network

- Jennifer Johnson, Executive Director

CASA

- Cathy Brown, Executive Director

Coasters Association

- Priscilla Griffin, Seniors Day Centre Coordinator

Evaluation Questions

Do the wellness centres contribute to the health, well-being and autonomy of ES seniors?			
General Objectives of wellness centres	Specific Objectives of wellness centres	Actions	Evaluation Questions
Provide community-based services for ES seniors	Create and efficiently manage WC	Create WC in locations where there are enough ES seniors and sufficient need	What were the steps to put WC in place? What human, financial and material resources are required to create WC? How many WC are there per community/region?
	Service offer is adapted to the needs of local ES seniors	Identify characteristics and needs of local ES seniors	How do organizations know of the needs of the local ES seniors?
		Develop a service offer to meet the needs of ES seniors	What are the Wellness Centres' service offers (ex.: format, activities, target users)?
	Ensure the success and sustainability of WC	Secure sufficient resources for the WC	How are the service offers currently supported (ex: funding sources and sustainability, staffing)? How well do current resources meet the needs? What gaps are there?
Contribute to health, well-being and autonomy of ES seniors	Maintain physical, mental and cognitive health and decrease isolation	Create opportunities for ES seniors to engage socially Engage seniors in physical and cognitive exercise	What activities are organized to help WC users maintain physical, mental and cognitive health? What activities are organized to help WC users decrease isolation? Were isolated WC users identified and contacted? Do WC users perceive themselves as having changed their routine as a result of WC: exercise, eating, getting out of the home, social interactions? Do WC users perceive themselves as being more socially engaged as a result of WC?
Objective	Specific Objective	Action	Evaluation Questions
Improve ES seniors' access to	Increase knowledge of and access to health and	Provide information about services	What strategies were used to inform WC users of services?

<table>
<tr><td rowspan="2">existing services and encourage their use</td><td rowspan="2">social services and home support services provided by public and community-based organizations</td><td></td><td>What kinds of information were provided?
How satisfied are WC users with this service?
Are WC users more aware of the services available to them as a result of WC?</td></tr>
<tr><td>Offer support in accessing services</td><td>What strategies were used to support WC users in accessing services?
What types of services (public, community) were targeted?
How satisfied are seniors with this service?
Were service gaps identified?
Were these service gaps communicated to service providers?
Have WC users increased their use of the services available to them as a result of WC?</td></tr>
<tr><td>Improve ES seniors' general knowledge on health and overall wellbeing</td><td>Increase general knowledge related to health and overall wellbeing</td><td>Provide education and information</td><td>What strategies were used to support WC users in improving their knowledge on health and wellbeing?
Did it meet the needs of WC users?</td></tr>
<tr><td>Lessons learned and transferability</td><td colspan="3">What are the elements that contribute to success (what strengths, what challenges)?
Do Wellness Centres meet the needs of English-speaking seniors?
How is the WC model different from other existing services?
How have they adapted to local realities?
Do they offer an innovative solution to issues faced by ES seniors?</td></tr>
<tr><td>Sustainability and future</td><td colspan="3">What lessons can be drawn from current experiences to inform future WC?
What support is needed for the future and how can it be secured?</td></tr>
</table>

Interview outline

Semi-structured interview on wellness centres in Quebec

The **purpose** of this interview is to contribute to a provincial evaluation of Wellness Centres in order to identify the factors contributing to their success, the challenges they face, and some learning areas for future Wellness Centres for English-speaking seniors in Quebec. The **results** will be used to support the development of Wellness Centres across the province and to help share the learning.

BACKGROUND

Can you tell me a bit about how you started offering Wellness Centre services for seniors?

- What year?
- Why?
- Where did you get inspiration and information?
- How did you get started?

MISSION AND SERVICE OFFER

Have you defined a mission for the Wellness Centre? If so, what is it?

What is the primary objective of the Wellness Centre?

What **issues** does the Wellness Centre aim to address for English-speaking seniors?

How do you know about the needs of the English-speaking seniors your Wellness Centre serves?

What are the main **formats** of your Wellness Centre activities?

If you hold group sessions how many people attend each group session (average)? ______

INTER-ORGANIZATIONAL COLLABORATION

What types of organizations does the Wellness Centre partner with to help meet the needs of English-speaking seniors?

Please list the groups or networks that the Wellness Centre receives support from to help meet the needs of English-speaking seniors.

Does your local health centre contact you to share information with Wellness Centre participants?

If yes, please provide an example:

FINANCIAL RESOURCES

How did you fund the Wellness Centre during the first 2 years of its existence?

- Funding organizations
- Program
- Amount/year

How are you funding the Wellness Centre for the current 2019-2020 year?

- Funding organizations
- Program
- Amount/year

What financial resources are required to maintain current Wellness Centre services? Please provide the most accurate possible total annual budget for the Wellness Centre and its activities (include salaries, rental costs, transportation costs, equipment, food, etc.)

How well do current financial resources meet the needs for this year (2019-2020)?

What are your funding perspectives for the next year for the Wellness Centre?

- Funding organizations
- Program
- Amount/year

What challenges have you encountered in securing funding for the Wellness Centre?

HUMAN RESOURCES

Please describe the human resources the Wellness Centre has this year (2019-2020).

- Number of full time positions:
- Number of part time positions:
- Types of positions:

How well do current human resources meet the needs for sustaining the Wellness Centre for this year (2019-2020)?

What are the responsibilities of the current Wellness Centre employees?

In your opinion, do staff need training to work for a Wellness Centre?

Have your staff received any training to date?

In your opinion, do staff need personal or professional support for their role (supervision, counselling, peer support, etc.)?

What forms of support are currently in place, if any?

MEETING EVOLVING NEEDS

To what extent are you able to offer services to all interested seniors?

Do you anticipate a change in number of activities the Wellness Centre offers over the next year (April 2020 to March 2021)?

What are the main factors supporting or hindering your ability to serve all seniors who might use the Wellness Centre services?

Acronyms

Organizations

ARC	Assistance and Referral Centre
CAMI	Council for Anglophone Magdalen Islanders
CASA	Committee for Anglophone Social Action
ECOL	English Community organization of Lanaudière
JHSB	Jeffrey Hale Saint Brigid's
MCDC	Megantic Community Development Corporation
NSCA	North Shore Community Association

Community/ Public Organizations

Centre of Expertise ACESS	Centre of Expertise on the Adaptation for English-speaking Communities in Health and Social Services
CHSSN	Community Health and Social Services Network (CHSSN)
CISSS	Centre intégré de santé et des services sociaux
CLSC	Centre Local de Services Communautaires
CSSSBC	Centre de santé et des services sociaux Baie-des-Chaleurs
JHCP	Jeffrey Hale Community Partners
MRC	Municipalité régionale de comté
NPI	Networking and Partnership Initiative
PCH	Patrimoine Canadien Heritage
RSS	Région socio-sanitaire
SRQEA	Secrétariat aux relations avec les Québécois d'expression anglaise Patrimoine Canadien Heritage

Funding Programs

ITMAV	Initiatives de travail de milieu auprès des aînés en situation de vulnérabilité
QADA	Québec ami des aînés
MADA	Municipalité amie des aînés

Endnotes

[i] Information extracted from CHSSN, 2019. *Promoting the Health and Well-Being of English-Speaking Seniors in Quebec. A Community Model.* https://chssn.org/document-center/chssn-publications/
[ii] https://www150.statcan.gc.ca/n1/daily-quotidien/130621/dq130621d-eng.htm
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[iv] CHSSN, 2019. *Promoting the Health and Well-Being of English-Speaking Seniors in Quebec. A Community Model*, 2019 [2016]. https://chssn.org/document-center/chssn-publications/
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[vii] Images sourced from: People vector created by photoroyalty - www.freepik.com