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

To be submitted to

Health Canada

By the

Health and Social Services Priorities Committee

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Foreword

The Health and Social Services Priorities Committee (HSSPC) is established as a collective of the organizations named below 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 twenty-two sponsoring organizations of community health and social services networks across Quebec:[1]

4 Korners 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
Centre for Access to Services in English (CASE), Drummondville
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 Isanders (CAMI), Grosse-Ile
East Island Network for English Language Services (REISA), Montreal
English Community Organization of Lanaudière (ECOL), Rawdon
English Community Organization of Saguenay-Lac-Saint-Jean, (ECO-02), Jonquière
Heritage Lower Saint Lawrence, Metis-sur-Mer
Jeffery Hale Community Partners (JHCP), Quebec City
Megantic English-speaking Community Development Corp. (MCDC), Thetford Mines
Montérégie East Partnership for the English-speaking Community (MEPEC), Beloeil
Montérégie West Community Network (MWCN), Chateauguay
Neighbours Regional Association of Rouyn-Noranda, Rouyn-Noranda
North Shore Community Association (NSCA), Baie-Comeau
Townshippers' Association, Sherbrooke and Knowlton (two community networks)
Vision Gaspé Percé Now (VGPN), Gaspé

[1] Three community networks are in development: Nord-de-l'Île-de-Montréal (REISA), Ouest-de-l'Île-de-Montréal (ACDPN), Centre-Ouest-de-l'Île-de-Montréal (Eva Marsden Centre)

Introduction

In the upcoming months, the federal government will announce the renewal of the Action Plan for Official Languages for the period 2023-2028. It will affirm 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 will be invited to develop a new 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.

The collaboration developed between the CHSSN and the Quebec Ministry of Health and Social Services (MSSS) since the first Health Canada Contribution Program in 2003, has established a solid framework for integration of the federal investments into English-speaking communities and the public health and social services system. A key to this framework is an implementation agreement between the CHSSN and the MSSS. The agreement ensures that measures enhance Quebec's legislative provisions with respect to the right to services in English, and are carried out in a manner consistent with Quebec's responsibility to plan, organize and deliver health and social services.

It is expected this year the Government of Canada will announce its intention to launch a new Official Languages plan for 2023-2028. The CHSSN and its community partners are issuing this report to prepare for consultations. The report provides an updated portrait of English-speaking communities and their vulnerable populations, community perspectives on access to services in English, and measures to support access and improve health outcomes in English-speaking communities.

Prior to submitting the report to Health Canada, the CHSSN will invite the MSSS to undertake consultations on the document with the health and social services network. The objective is to ensure that a proposal to Health Canada reflects the shared commitment of Quebec and its English-speaking communities to work in partnership to improve access to health and social services in English.

1. A Socio-demographic profile of English-speaking communities

The largest Official Language community in Canada

There are more than one million English speakers comprising 13.8% of Quebec's population. According to Statistics Canada 2016 *Census of Canada*, regional English-speaking populations range from more than 600,000 on the island of Montreal, with large population counts in nearby Montérégie (156,200) and Laval (90,980), to tiny populations in regions such as Bas-Saint-Laurent (1,225) and Saguenay Lac-Saint-Jean (1,970).[2] Overall, 9 in 10 English speakers live 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 Northern Quebec (100%), Gaspésie – Îles-de-la-Madeleine (97%), Abitibi-Témiscamingue (52%), Estrie (49%) and Bas-Saint-Laurent (45%).[3] In contrast to Montreal and adjoining administrative regions, there are highly dispersed communities on the North Shore, in the Gaspé and on the Magdalen Islands. Among Official-Language minority communities in Canada, Quebec's English-speaking population is the largest, followed by the francophone populations of Ontario and New Brunswick. Quebec anglophones are second only to New Brunswick francophones with respect to their percentage of the provincial population.[4]

Socioeconomic vulnerability

Quebec's English-speaking communities are experiencing socioeconomic vulnerability which poses a risk to health, particularly for certain sub-groups within the population. Income disparities are associated with lower health status and social inequalities.[5] 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".[6] According to the INSPQ study, income disparities by region and gender were greater among anglophones, and these disparities were particularly high in the Montreal census metropolitan area. A composite socioeconomic indicator developed by the Department of Canadian Heritage also notes very high levels of socioeconomic vulnerability in Gaspésie – Îles-de-la-Madeleine, Nord-du-Québec, Abitibi-Témiscamingue, Côte-Nord and Estrie regions.[7]

The 2016 Canadian census tells us that the rate of unemployment is higher in Quebec's English-speaking population (8.9%) compared to the francophone majority (6.9%). It is also much higher in some regional communities. For example, the unemployment rate of English speakers in Côte-Nord is 25.3% compared to 11.6% for French speakers. English speakers in Gaspésie experience an unemployment rate of 24.4% while that of their French-speaking neighbours is 15.1%.[8]

Visible minorities and immigrants

With respect to population diversity, more than one-quarter of Quebec's English speakers are members of a visible minority group (29.8%). This level is much higher than that in the francophone majority (9.7%). Some regional communities have a significantly greater proportion of visible minority members. For example, 45.3% of English speakers in RTS Nord-de-l'Île-de-Montréal and 41.9% in RTS Centre-Ouest-de-l'Île-de-Montréal belong to a visible minority group.[9] English-speaking visible minority communities experience more socioeconomic vulnerability than other communities. One third (33.2%) of visible

[2] JPocock Research Consulting for the Community Health and Social Services Network (CHSSN) (2016/2017). These calculations are based on a special order drawn from the 2016 Census of Canada, Statistics Canada.
[3] Ibid., p.51.
[4] Ibid., p.51.
[5] Institut National de Santé Publique du Quebec (INSPQ) (May 2012) *The Socioeconomic Status of Anglophones in Quebec.* Gouvernement of Québec. p.24 http://www.inspq.qc.ca/pdf/publications/1494 SituationSocioEconoAngloQc .pdf
[6] Institut National de Santé Publique du Québec (INSPQ) (May 2012) *The Socioeconomic Status of Anglophones in Québec*. Gouvernement of Québec, p.24. http://www.inspq.qc.ca/pdf/publications/1494 SituationSocioEconoAngloQc .pdf
[7] Canadian Heritage (2015a). *Composite Indicators of Official- Language Minority Communities in Canada*. Gatineau: Research Team, Official Languages Branch, Department of Canadian Heritage.
[8] JPocock Research Consulting for the Community Health and Social Services Network (CHSSN) (2016/2017). These calculations are based on a special order drawn from the 2016 Census of Canada, Statistics Canada.
[9] RTS is « Réseau territorial de services », an administrative territory circumscribing service networks.

minority English speakers live below the low-income cut-off (LICO) compared to 17% of non-visible minority English speakers and 13.8% of the French-speaking non-visible minority group.[10]

According to the 2016 Canadian Census, the proportion of immigrants within Quebec's English-speaking population substantially outweighs the proportion of in the francophone population. This is the case in every region of Quebec. Immigrants that are newcomers face challenges navigating the health system and establishing crucial community support networks. The highest concentrations of immigrants aged 15 and over who use English as their first official language are located in Montreal (49.6%) and Laval (47.2%). They are followed by Montérégie (34.2%) and Capitale-Nationale (37.7%). When the place of birth of English-speakers aged 15 or more is considered, over half of them (52.8%) where born outside Canada or in another Canadian province. In some regions, such as the Outaouais and Saguenay-Lac-Saint-Jean, approximately one-third of English speakers were born outside the province.[11]

2. Vulnerable English-speaking populations

2.1 Seniors

Aging communities

Of the one million English-speaking persons in Quebec, 159,670 are 65 years or older representing 14.5% of the English-speaking population.[12] In many regions this proportion is much higher. For example, seniors represent 26.9% of the English-speaking population in RTS de la Gaspésie, 25.2% in RTS des Îles and 24.5% in RTS du Bas-Saint-Laurent. In other regions, the proportion of seniors is lower yet notably greater when compared to that of French-speaking seniors in their communities. In the Estrie region, English-speaking seniors comprise 23% of their community, while French-speaking seniors make up 18.8% theirs .[13]

Visible minority seniors

Quebec's English-speaking seniors differ notably from their francophone counterparts in their likelihood to be members of a visible minority community. Among English-speaking seniors aged 55 to 64, 21.6% report a visible minority status compared to 4.2% of French speakers the same age. Of those 65 years and over, 15.5% of English speakers belong to a visible minority community compared to 2.6% of French speakers.[14]

Socioeconomic status

Many English-speaking seniors are living on a low income and have low levels of educational attainment. Canada's *National Population Health Survey* reveals that income and education are strong predictors of health and life satisfaction among seniors.[15] Low socioeconomic status is linked to lower rates of health literacy and an increased risk of social and health-related problems. Among English-speaking seniors, 32.8% had an annual income of less than $20,000 in 2016. There were 25,445 English-speaking seniors living below the low-income cut-off representing 15.9% of all English-speaking seniors. This is a higher

[10] JPocock Research Consulting for the Community Health and Social Services Network (CHSSN) (2016/2017). These calculations are based on a special order drawn from the 2016 Census of Canada, Statistics Canada.
[11] JPocock Research Consulting for the Community Health and Social Services Network (CHSSN) (2016/2017). These calculations are based on a special order drawn from the 2016 Census of Canada, Statistics Canada.
[12] JPocock Research Consulting for Community Health and Social Services Network (CHSSN) (2019-2020). *Socio-demographic Profile of the Population Aged 65 and over.* Based on the 2016 Census of Canada. P.7. https://chssn.org/documents/socio-demographic-profile-of-the-population-aged-65-and-over-province-of-quebec/
[13] Ibid., p.7.
[14] JPocock Research Consulting for Community Health and Social Services Network (CHSSN) (2019-2020). *Socio-demographic Profile of the Population Aged 65 and over.* Based on the 2016 Census of Canada. P.17. https://chssn.org/documents/socio-demographic-profile-of-the-population-aged-65-and-over-province-of-quebec/
[15] 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

rate than that among French speaking seniors (13.2%). Among the English-speaking elderly aged 85 and over, the poverty rate was 18.2%.

With respect to educational attainment, there were 84,915 English-speakers seniors who reported they had a high school certificate or less. They represented over half of English-speaking seniors (53.2%). Among English speakers 65 to 74 years of age, 48.5% reported a low level of educational attainment, while the rate was 57.3% for those aged 75 to 84. For seniors 85 years and over, 66.8% of them reported a high school leaving certificate or less.[16]

Vulnerable seniors

The *Special Senate Committee on Aging* has identified unattached seniors and those considered frail as a vulnerable group.[17] The quality of life of the older age population living alone is strongly correlated with the level of support they are able to receive from public institutions, community organizations and any informal network still available to them. The CHSSN provincial survey (2018-2019) on access to health and social services reports the critical need expressed by both bilingual and unilingual English seniors for access to services in English across a spectrum of medical situations.[18]

Among English speakers, there were 46,165 aged 65 years and over living alone in 2016. They represented 28.9% of English-speaking seniors. For English speakers aged 85 and over, 45.5% reported living alone in 2016.[19] Many seniors cannot afford to cover the cost of private caregiving as an option to public resources. Among English-speaking seniors aged 55-64 years living alone, a substantial 42.7% were living in poverty compared to 32.3% of francophone seniors of the same age and in the same living arrangement. Within the frail elderly aged 85 years and over, 32.4% were living alone and below the low-income cut-off.[20]

Seniors may also be required to play the role of caregiver to a family member or friend, and in some cases to an adult child with special needs including mental health. A Statistics Canada survey cited by the *Special Senate Committee on Aging* noted that one in four caregivers were over the age of 65, with a disproportionate share of caregiving being borne by women.[21] The Committee's report pointed to increasing vulnerability of seniors in situations where children have left communities, leaving seniors to look after seniors.[22]

2.2 Children and youth

When the position of English-speaking children and youth is examined with respect to key determinants of health, a substantial proportion of this sub-group and their families can be considered at risk of poor health.

[16] JPocock Research Consulting for Community Health and Social Services Network (CHSSN) (2019-2020). *Socio-demographic Profile of the Population Aged 65 and over.* Based on the 2016 Census of Canada. P.33. https://chssn.org/documents/socio-demographic-profile-of-the-population-aged-65-and-over-province-of-quebec/
[17] 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
[18] Community Health and Social Services Network (CHSSN) 2019. *Baseline Data Report 2018-2019. Part 1 Telephone Survey. English- Language Health and Social Services Access in Quebec,* p. 169. https://chssn.org/pdf/CHSSN-Baseline-Data-Report-2018-2019-part-1.pdf
[19] JPocock Research Consulting for Community Health and Social Services Network (CHSSN) (2019-2020). *Socio-demographic Profile of the Population Aged 65 and over.* Based on the 2016 Census of Canada. P. 22. https://chssn.org/documents/socio-demographic-profile-of-the-population-aged-65-and-over-province-of-quebec/
[20] Ibid., p.27.
[21] 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
[22] Ibid., p.117.

Children in vulnerable families

According to the 2016 census, there were 61,400 English-speaking children aged 0 to 5 living in Quebec.[23] Their regional distribution varies widely. There were 10,900 children in RTS Ouest-de-l'Île-de-Montréal and 10,180 in RTS Centre-Ouest-de-l'Île-de-Montréal. This contrasts with the 30 children in RTS Bas-Saint-Laurent as well as in RTS des Îles. In this age group, 20,805 (33.9%) were members of a visible minority. This proportion was higher than in the French-speaking population of the same age (16.4%).[24] Parents of minors living in lone parent households were 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.[25] In 2016, there were 8,825 English-speaking children aged 0 to 5 living in lone parent families (14.4%).[26] Among English-speaking lone parents with at least one child aged 0 to 5, 35.9% belonged to a visible minority compared to 17.1% of French-speaking lone parents.[27]

With respect to socioeconomic status, 23.0% of English-speaking parents with at least one child aged 0 to 5 reported a high school diploma as their highest level of educational attainment in 2016.[28] Among English-speaking lone parents of this age group, 47.8% reported a high school diploma as their highest level of educational attainment. This rate was higher than that reported by French-speaking lone parents (38.7%).[29] There were 9,395 (15.3%) English-speaking children aged 0 to 5 living below the low-income cutoff, a higher percentage than that reported for the French-speaking population (10.6%).[30] Among English-speaking lone parents of the age group, 30.5% of them were living below the poverty line, a higher rate compared to that of French-speaking lone parents (23.6%).[31]

Developmental challenges

According to a 2017 report by the Institut de la statistique du Québec, kindergarten students whose mother tongue is English are proportionately more likely than their French mother tongue counterparts to be vulnerable in four of the five developmental areas featured in standard provincial testing.[32] In fact, 16% of English-speaking children are vulnerable in the "Physical health and well-being" area, compared to approximately 10% of French mother tongue children. The proportion of kindergarten students who are vulnerable in the "Social competence" area is 14% among English speakers and 10% among French speakers. For the "Language and cognitive development" area, 13% of English-speaking children are in a vulnerable situation, compared to 10% of French speaking children. Results also present a statistically significant difference between both linguistic groups for "Communication skills and general knowledge". In this area, the proportion of vulnerable English mother tongue children is much higher than that of French mother tongue children (21% compared to 8%).[33]

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[23] Community Health and Social Services Network (CHSSN)/Pocock), (2019). *Socio-demographic Profile of Children aged 0 to 5 and their Parents. Province of Quebec*. p.8. https://1omae22rkruy1i4j5xh07m9u-wpengine.netdna-ssl.com/wp-content/uploads/2021/08/0-to-5-Profile-Quebec.pdf

[25] For further discussion see Community Health and Social Services Network (CHSSN)/Pocock), (2008*). Baseline Data Report 2007-2008. Quebec's Social and Health Survey Information.* https://chssn.org/document-tag/2007-2008-health-and-social-survey-information-on-quebecs-english-speaking-communities/

[26] Community Health and Social Services Network (CHSSN)/Pocock), (2019). *Socio-demographic Profile of Children aged 0 to 5 and their Parents. Province of Quebec.* P.15. https://1omae22rkruy1i4j5xh07m9u-wpengine.netdna-ssl.com/wp-content/uploads/2021/08/0-to-5-Profile-Quebec.pdf

[27] Ibid., p.26.

[28] Ibid., p.31.

[29] Ibid., p.31.

[30] Ibid., p.16.

[31] Ibid., p.41.

[32] Institut de la statistique du Québec (ISQ) (2017). *Vulnerable English-speaking Children: 2017 Quebec Survey of Child Development in Kindergarten.* Data analysis. https://1omae22rkruy1i4j5xh07m9u-wpengine.netdna-ssl.com/wp-content/uploads/2021/08/ISQ-EQDEM-Report_ENG-1.pdf

[33] Ibid., p.4.

Youth

According to the 2016 Canadian census, there are 225,585 English-speaking youth (ages 15 to 29) living in Quebec forming a substantial 20.5% of their minority language population.[34] When looking at key indicators, they exhibit vulnerability as a group with respect to health.

Visible minority status

While 29.8% of all English-speaking Quebecers are members of a visible minority community, this rate is exceeded by English-speaking youth (35.1%). The proportion belonging to a visible minority group varies widely between urban and non-urban regions. For example, 53.1% of English-speaking youth in Nord-de-l'Île-de-Montréal and 49.8% in Centre-Ouest-de-l'Île-de-Montréal are visible minority members. This is the case for only 1% of youth in Côte-Nord and Gaspésie. While 35.1% of English-speaking youth are visible minority members, the rate is 12.6% for French-speaking youth.[35]

Socioeconomic vulnerability

When compared to the English-speaking population as a whole, English-speaking youth are more likely to experience socioeconomic vulnerability. Among this group, 23.6% are living below the low-income cut-off which is higher than the rate for the English-speaking population (17.8%). When comparing the two language groups, English-speaking youth are more likely to be living in poverty (23.6%) compared to their French-speaking counterparts (14.9%).[36]

In 2016, 13.3% of English-speaking youth aged 15 to 29 were unemployed compared to 8.9% of the provincial English-speaking population. The variance between this age group and the provincial average was greater in some regions. For example, in RTS de la Gaspésie, 31.4% of English-speaking youth were unemployed compared to 24.4% of the English-speaking community as a whole. When comparing English and French-speaking youth at the provincial level, 13.3% of English speakers were unemployed in contrast to 9.8% of their French-speaking counterparts.[37]

Educational attainment

When looking at educational attainment within the English-speaking population, English-speaking youth were more likely than others to report a low level of attainment. In this group, 51.6% reported high school leaving or less as their highest level of educational attainment compared to 40.7%% for the English-speaking population as a whole. With respect to the gap between English and French-speaking youth, 62.4% of English-speaking youth in RTS de Estrie reported having a high school diploma or less. This is in contrast to 53% of French-speaking youth with the same level of educational attainment. In RTS de la Gaspésie, 64.7% of English-speaking youth reported low educational attainment compared to 53.5% of their French-speaking counterparts.[38] The education milieu links the rate of student success to the socioeconomic status of youth and their families. In 2020-2021, the Quebec Ministry of Education reported that 30% of the student population at the elementary and secondary levels attended schools considered disadvantaged according to a socioeconomic indicator.[39] For the nine English boards, 36% of their schools were identified as disadvantaged.

[34] Community Health and Social Services Network (CHSSN)/Pocock, (2018). *Key Demographic and Socio-Economic Characteristics of Quebec's English-speaking Youth (15-29).* https://chssn.org/documents/key-demographic-and-socioeconomic-characteristics-of-quebecs-english-speaking-youth-15-29/
[35] Ibid., p.4.
[36] Ibid., p.4.
[37] Ibid., p.5.
[38] Ibid., p.5.
[39] MEES. Indices de défavorisation des écoles publiques 2020-2021. www.education.gouv.qc.ca.
Schools located in disadvantaged areas are schools with a socioeconomic environment determined by an indicator measuring the low level of education of the mother and the level of parental activity in the job market.

2.3 Persons with mental health problems and their caregivers

In the words of Sarah Bowen concerning mental health, “There is perhaps no other health area where diagnosis and treatment is as dependent on language and culture.”[40] Support services like counselling for anxiety and depression rest upon effective communication. Furthermore, a substantial and compelling body of international research demonstrates that the reduction of language barriers increases participation in prevention activities; encourages timely presentation for care; reduces risk of misdiagnosis; improves patient understanding and adherence to prescribed treatment; improves rate of treatment success and improves overall trust in health authorities and the health system.[41] When asked how important it was to receive mental health services in English, 81.9% of 3,133 anglophones surveyed across the province replied “very important.”[42]

Persons dealing with mental health issues are likely to be more susceptible to social isolation as they age, given the multiple dimensions of aging that increase social isolation. In a profile of social isolation in Canada, it is determined that a lack in the quantity and quality of social contacts (family, friends, neighbours), living alone, and low social participation in community life are indicators of the risk of social isolation.[43] These factors affecting older community members living with mental health issues point to the need for more support for community resources aiming to reduce social isolation and provide service in English.

Pre-COVID-19

In 2012-2013, a sample of 3,171 English-speaking respondents across Quebec, aged 12 and over, answered the Statistics Canada *Canadian Community Health Survey* (CCHS) regarding their mental and emotional health.[44] According to this survey, when English-speaking minority communities across Quebec were compared with the majority language group in their territory, they exhibited a greater risk of poor mental and emotional health with respect to a number of indicators. For example, in 7 of the 12 regions reporting, anglophone respondents reported a greater likelihood to have missed work due to chronic physical or mental health conditions compared to francophones. In 7 of 7 regions reporting, the anglophone respondents stated they were more likely to report high levels of stress as a barrier to improving their health. English-speaking respondents were less likely to have a positive attitude towards self. In 10 of 11 regions anglophones outweighed francophones when reporting a tendency to have feelings of failure. Anglophones scored lower than francophones in the CCHS attachment scale which measures the quality of close relationships and emotional bonds.[45] As well, anglophones scored less than francophones with respect to having a regular place to go for medical advice (73.7% compared to 82.1%).[46]

When considered by age, English speakers 45-64 years of age, often referred to as the caregiver generation, reported the highest rate of diagnosis of anxiety with the highest levels of anxiety found among women compared to men.[47] In the *Canadian Community Health Survey*, English-speaking youth (15-24) scored low on many mental and emotional health indicators when compared to other age groups within their language community, as well as compared to francophones of the same age. Anglophone

[40] Bowen, S. (2015) for Société Santé en Français (SSF). *Impact of Language Barriers on Quality and Safety of Healthcare*. P. 17. Http://santefrancais.ca/wp-content/uploads/SSF-Bowen-S-LanguageBarriers-Study-1.pdf
[41] Ibid., p. 35-36.
[42] Community Health and Social Services Network (CHSSN) 2019. *Baseline Data Report 2018-2019. Part 1 Telephone Survey. English- Language Health and Social Services Access in Quebec,* p. 169. https://chssn.org/pdf/CHSSN-Baseline-Data-Report-2018-2019-part-1.pdf
[43] Final Report: A Profile of Social Isolation in Canada. Federal, Provincial, Territorial Working Group on Social Isolation (2006).
[44] 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*, https://1omae22rkruy1i4j5xh07m9u-wpengine.netdna-ssl.com/wp-content/uploads/2021/12/Baseline-Data-Report-2014-2015_Canadian-Community-Health-Survey-copy.pdf
[45] Ibid., p.99.
[46] Ibid., p.71.
[47] 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. https://1omae22rkruy1i4j5xh07m9u-wpengine.netdna-ssl.com/wp-content/uploads/2021/12/Baseline-Data-Report-2014-2015_Canadian-Community-Health-Survey-copy.pdf

youth were less likely to report their mental health as excellent (31.3%) compared to francophone youth (43.5%). They were also less likely to feel they were a person of worth (44.9% compared to 53.7%) and less likely to have individuals upon whom they can depend (71.9% compared to 79.8%).[48]

IMPACT OF COVID-19

Studies of the psychosocial impact of the COVID-19 pandemic underline the decline in mental health among adults living in all regions of Quebec. Dr. Mélissa Généreux, advisor to the Direction de santé publique de l'Estrie and INSPQ, reports that there are social groups that have been more affected by the pandemic than others. These at-risk groups are Quebec's adults aged 18-24, anglophones and health care workers.[49] In the words of Dr. Généreux, "In our study, 37% of adults aged 18-24 reported symptoms of anxiety or depression in the previous two weeks. It is concerning that a significant portion of young people are not doing well. It is equally striking that anglophones are twice as likely as francophones to have anxiety or depressive symptoms."[50]

This trend is borne out by a survey of English-speaking men and fathers with respect to the impact of the pandemic.[51] This group was more likely than their French-speaking counterparts to have felt a negative impact of COVID-19 on daily life (74% compared to 66%); on financial health (27% compared to 21%); and were more likely to report high psychological distress (22% compared to 12%).[52] For the subgroup of English-speaking fathers, the rate of reported psychological distress was very significant (30% compared to 13%).

As research begins to reveal the extent of the impact of COVID-19 on English-speaking communities, addressing barriers to access to mental health programs including prevention and treatment is emerging as a key priority.

[48] 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. 11,122 and 106. https://1omae22rkruy1i4j5xh07m9u-wpengine.netdna-ssl.com/wp-content/uploads/2021/12/Baseline-Data-Report-2014-2015_Canadian-Community-Health-Survey-copy.pdf
[49] *Actualités*, Université de Sherbrooke, https://www.usherbrooke.ca/actualites/relations-medias/communiques/2020/septembre/communiques-detail/c/43547/
[50] *Actualités*, Université de Sherbrooke, https://www.usherbrooke.ca/actualites/relations-medias/communiques/2020/septembre/communiques-detail/c/43547/
[51] Jacques Roy. *Portrait of Men and Fathers in Quebec's English-speaking community and their Relationship to Service.* Pôle d'expertise et de recherche en santé et bien-être des hommes (CIUSSS de la Capitale-Nationale). January 2022.
[52] The data is drawn from a SOM survey done in 2021 of 2,740 men in Quebec of whom 392 were English-speaking.

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

The CHSSN has sponsored four CROP surveys since 2005 of English-speaking communities regarding perspectives on access to health and social services in English. The surveys reflect the importance communities give to the language of communication in the delivery of services. Understanding a broader context of access to public health and social services for both English-speaking and French-speaking populations is a helpful first step in focussing on those issues of access more related to language. As well, probing the language experience of English-speakers within the health system can give more information to communities and their public partners in efforts to target actions to improve access. Looking at the general trends of access that have emerged over fourteen years may point to new strategies to improve access to services in English.

3.1 Language and access: the importance of communication

The Quebec Ministry of Health and Social Services (MSSS) has affirmed the importance of language in the delivery of quality health and social services. In its guide for the development of government-approved access programs, effective communication is deemed necessary to ensure that English-speaking persons are able to understand the services offered. Clear communication is considered vital in order to ensure the safety and quality of the services provided.[53] Supporting effective communication with English-speaking persons "ensures the information exchanged is accurate, that informed consent is obtained and that confidentiality is maintained at all times".[54]

The guide cites scientific literature containing examples of how language barriers compromise the accessibility and quality of services. These include medication errors, misdiagnosis, less frequent and longer clinic visits, among others.[55] In addition to the safety factors associated with poor communication, language barriers engender difficulties for English-speakers navigating the health and social services network. For service providers, issues with communication may mean that services are not provided to the same standard as those applied to others; or that informed consent to treatment is not adequately ensured.

The following comments of members of English-speaking communities about experiences in the French-language health system give voice to the issues of language and effective communication. The comments are drawn from a series of focus groups conducted by the CHSSN in 2019 in the Saguenay, Abitibi-Témiscamingue, Côte-Nord, Chaudière-Appalaches, Centre-du-Québec, Îles de la Madeleine and Bas Saint-Laurent.[56]

Communication challenges

Focus group participants mention that they try their best to understand French in order to communicate with service providers. They invite health professionals to take the time to listen and understand a person's attempts to communicate in French; and ask that personnel slow down when speaking French to ensure understanding the first time.

> "Our English accent when speaking French is not understood."
>
> "They (health professionals) are rushed to say what they must say instead of taking the time to ensure that it is understood the first time and not have to go back and re-ask."

Participants reported they generally require assistance to communicate with health professionals and frequently turn to family and friends to support.

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[53] MSSS. Guide pour l'élaboration de programmes d'accès aux services de santé et aux services sociaux en langue anglaise, cadre de référence. April 2018.
[54] Ibid.
[55] Ibid.
[56] CHSSN. English-language Access to Health and Social Services in Québec, Baseline Data Report 2018-2019. Part 2 (focus groups). 2019.

> "People bring their children or friends when they go to the specialist, otherwise they sometimes feel ignored."
>
> "I speak enough to make appointments. I look up words or ask bilingual family members to assist me."
>
> "…I can't make appointments for myself, so I usually get one of my friends (bilingual) to call for me or go into my appointments with me."
>
> "It is difficult when the patient doesn't understand and the companion has to interrupt, explain in English, and then resume the dialogue."

Language and stress

Participants stated they believe there is a negative impact on their health due to the stress of interventions in their second language. This includes interpreting forms in French prior to medical procedures, trying to understand medical information such as diagnoses, or dealing with professionals in French at different points in the health system.

> "A sense of panic sets in. On the forms, if you have to fast or eat before an examination or blood work, it is not clear."
>
> "When you get called for results of your exams, it is usually given in French and this creates a sense of unease and stress as you're not sure if you have heard correctly. Usually you have to ask a friend or member of the family to come along with you or ask to be called back when you have someone with you who can speak French."
>
> "People are nervous at the health services anyway, so language makes it even worse for seniors. Knowing what's going on provides peace of mind…especially about results."
>
> "It is stressful in another language, especially for mental health issues."
>
> "I get highly stressed when needing information and not knowing where to go or who to ask."
>
> "It is stressful worrying about missing important medical information in a visit to a doctor or hospital."
>
> "When I can speak in English, it takes my anxiety down."

Reticence to use the health system

Focus group participants noted that communication challenges when obtaining services in French, along with a lack of access to services in English, can create reticence to use the health system with potential consequences for their health. Participants also noted that some people give up trying to receive services in English if they have encountered problems in the past, and then fail to seek help as a result.

> "…people are hesitant to ask (for service in English)." "I don't want to make a scene or be made to feel stupid." "You hesitate to call or go to the emergency."
>
> "We absolutely need services in English to understand and receive explanations clearly. Some residents will not go for care because of the language barrier."
>
> "I'm nervous about seeking help or information over the phone. I'll do without (if it is not in English)."
>
> "I know a senior bachelor in our community who will not seek medical attention for his loss of hearing because of not being able to communicate in French."

> "If I can't get help in English, I just avoid the system."
>
> "…because you're less likely to ask (for service in English), usually you just wait it out (a health issue) because it is too much effort."
>
> "I am hesitant to seek help because it is difficult to get English services and will only go if I really need it."

Information and consent

Focus group participants noted that not having English documentation in hospitals or clinics, especially consent and procedural forms, is a barrier to fully understanding interventions or patient requirements.

> "After consultations with the doctor, forms and documents are in French. Telephone calls from the hospital are hard to understand for what we are being called for. Correspondence is in French only."
>
> "Admissions is always tough in English… Signing paperwork that is not in English is common and making telephone appointments in English is difficult."
>
> "You are not sure what you're consenting to. You're told if you don't sign there'll be no operation. Difficult choice!"

In its provincial framework to develop access programs, the MSSS has affirmed the importance of the relationship between effective communication and successful clinical intervention. It recognizes that the user's language is an essential tool in ensuring the success of clinical interventions; that the English-speaker, like any other person, needs to be listened to and needs to communicate; and that when a person's health or well-being is at stake, being able to speak English may become a need, even a necessity.[57]

3.2 General access to health services: Attitudes of French and English-speaking users

To set the broader context of the experience in the health system of English and French-speaking users, the following portrait describes access to family doctors, specialists and medical procedures of both language groups. Drawn from a CHSSN-CROP provincial survey of over 3,000 English-speaking and 1,000 French-speaking respondents in 2019, the information reveals attitudes of both groups towards access with particular attention given to wait times for different medical interventions. The general portrait sets an important context within which to examine the specific experience of English speakers in accessing these and other health and social services in English.[58]

It is important to note that the survey information predates the pandemic, and that a new survey in the current context of the health system may produce different results. As well, the information is primarily presented at the provincial level and will require consulting the CHSSN Baseline Data Report for regional portraits.

Access to a family doctor

Survey respondents were asked if they had a family doctor. Over 80% of the two language groups answered yes, with English speakers reporting 82.6% and French speakers, 81.9%. Both language groups experienced regions where the percentage with family doctors was significantly below the provincial average. Only 54.2% of English speakers in Montérégie-Est, and 60.9% of French speakers in Nord-de-l'Île-de-Montréal stated they had a family doctor.

[57] MSSS. Guide pour l'élaboration de programmes d'accès aux services de santé et aux services sociaux en langue anglaise, cadre de référence. April 2018.
[58] CHSSN. English-language Access to Health and Social Services in Québec, Baseline Data Report 2018-2019. Part 1 (telephone survey). 2019.

For those with a family doctor the survey asked how long they waited for an appointment when requiring immediate care for a minor health problem. For an appointment on the same or next day, both language groups were in the same range with 24.5% of English speakers and 27.4 of French speakers treated within this delay. The rest of respondents reported appointment times ranging from two days to one month or more. While 54.5% of English speakers saw their doctor between two days and two weeks, 47.5% of French speakers saw theirs in the same period. Respondents were asked how they would describe the wait time for the appointment with their family doctor. For English speakers, 79.3% stated wait times were good or very good, similar to French speakers at 76.3%. There were three regions where one in five respondents waited one month or more to see their family doctor. They were Capitale-Nationale for English speakers, and Nord and Est-de-l'Île-de-Montréal for French speakers.

Referred to a medical specialist

Over 40% of both language groups were referred by a doctor to a medical specialist. Respondents were asked from the time they were told of the referral to the time they saw the medical specialist, how long they waited for an appointment. The percentage who waited up to a month was essentially the same for English and French speakers (38.9% and 37% respectively). The percentage of both groups who waited more than five months for an appointment was also similar (16.1% for English speakers, and 18% for French speakers). Respondents were asked how they would describe the wait time for their appointment. For English speakers, 65.6% described the wait as good or very good, while 66% of French speakers said the same.

Underwent a medical procedure

About one-quarter of respondents in both language groups stated they (or a person they helped) underwent a medical procedure in a hospital in the twelve months prior to the survey. From the time the person was told they needed the medical procedure to the time of the procedure, 45.8% of English speakers and 46.4% of French speakers stated they waited up to a month. For procedures occurring more than three months after referral, 22.4% of English speakers and 30.3% of French speakers stated this was their experience. Attitudes towards wait times were similar in both language groups, with 74.7% of English speakers and 72.7% of French speakers describing wait times as good or very good. Nothwithstanding attitudes toward wait times, 34.5% of English speakers and 24.9% of French speakers somewhat or strongly agreed that wait times had a negative impact on treatment and recovery.

Over 80% of respondents in both groups who underwent a medical procedure also required patient follow up. English speakers (34.5%) waited less than two weeks for follow up, while 43.5% of French speakers did so. For waits of one month or more 34.1% of English speakers had this experience, while the rate was 24.5% for French speakers. Attitudes toward wait time were within range for both groups, with 81.4% of English speakers describing their wait time as good or very good, while 88.9% of French speakers doing so.

The CHSSN-CROP survey shows that the attitudes of English and French speakers towards performance of the health system are generally in the same range. Positive attitudes to access to doctors, specialists and medical procedures represent a degree of confidence in the system that appears shared by both groups. However, the negative responses by both language groups signal certain challenges to health system performance affecting the whole population.

Within this context, language becomes an additional element in terms of access and communication. The following portrait looks at the experience of English speakers accessing the key entry points in the health and social services system.

3.3 Access to services in English: key entry points in the health and social services system

The CHSSN-CROP survey in 2019 asked over 3,000 English-speaking persons in several administrative regions about their experience accessing services in English through five entry points into the health and social

services system.[59] Respondents reported whether they received the services in English, whether they were offered or had to ask, how important was it to receive the services in English and was information available in their language.

Requesting services in English

Asking for services in English can be a key step in establishing the language of communication early on and determining the system's response. When respondents were asked if they felt comfortable requesting a service in English in a public health and social services institution, over three-quarters said they did, while one-fifth said no. Only 4.9% felt it was not important to ask. Discomfort asking for services in English was higher in certain regions including Estrie (36.2%), Lanaudière (50%), and laval (34.9%).

What are the reasons for not feeling comfortable asking for English-language services? Some were too embarassed or shy to ask (23.2%). Some feared the answer would be no (23.4%). Others thought the request would impose an extra burden on personnel (30.4%). Still others believed a delay might occur in obtaining the service (25.7%). Female respondents (28.6%) were more likely than males (17%) to feel too embarassed or shy; and more likely to feel the request would impose an extra burden on personnel (34.1% compared to 26.1%). When citing their discomfort asking for services in English, males were more likely than females to believe a delay in services might occur (31.7% compared to 20.5%).

Using assistance to communicate with personnel

Over one in ten respondents required the assistance of another person when communicating with personnel in a public health and social services setting. This rate was considerably higher in the Outaouais (22.8%) and Montérégie-Est (40.8%). Women were more likely than men to require assistance (13.1% compared to 8.6%), and unilingual persons (23.1%) were more likely than their bilingual counterparts to have another person with them (7.8%). The majority of persons assisting in communications were family members (53.5%), followed by friends (22.8%).

Used a doctor in a private office or clinic

Over 40% of respondents used the services of a doctor in a private office or clinic in the year prior to the survey, with 80.5% of them receiving services in English. There was considerable variation in the regions, with 30.4% reporting service in English in Montérégie-Est, 23.4% in lanaudière and 12.6% in Capitale-Nationale. For the almost 20% of respondents who were not served in English, 22.9% of them had asked for the services in English, and 34.9% felt service in English was important.

Using a CLSC

About one-third of respondents used the services of a CLSC for themselves or on behalf of another person in the year leading up the survey. Just over half (54.7%) were served in English, with significant variations between regions (over 75% in the centre and west of Montreal, while under 45% in eight other regions). For those served in English, 68.1% were served directly in their language, while 29.6% had to ask. Almost 80% of these two groups felt it was very important to receive services in English. For those not served in English, 76.8% of them did not ask to be served in their language. Just over one-third felt it was very important to receive services in English, while the rest felt service in French was acceptable.

Once engaged with the CLSC, respondents reported on their experience with receptionists, professionals and documents. Just under half of receptionists spoke English during initial encounters, with large variations in the regions. In Montérégie-Est and in Laval the rate was 13.9% and 13.8%, while the percentage was 30% or less in the regions of Montérégie-Centre, Nord-de-l'Île-de-Montréal and Capitale-Nationale.

[59] CHSSN. English-language Access to Health and Social Services in Québec, Baseline Data Report 2018-2019. Part 1 (telephone survey). 2019.

Overall, 66% of the health and social services professionals providing service did so in English. Over 80% of respondents felt it was somewhat or very important to receive their services in their language. With respect to information forms, or forms requiring users to provide health status information, 51.8% of respondents in twelve regions stated these documents were provided in English.

Using Info-Santé

One in five respondents used Info-Santé with 59% of them served in English. While 56% of this group were served directly in English, 39.7% of others had to ask. For those served in English, 88.4% felt is was very important to receive the service in their language. For those not served in English, 28.2% of them asked to be served in their language, and 28.3% of them felt it was very important to be served in English. The rest of this group stated that service in French was acceptable.

Hospital emergency rooms and out-patient clinics

A significant number of respondents (40%) used the services of a hospital emergency room or out-patient clinic either for themselves or to help another person in the year prior to the survey. Almost 70% were served in English, with wide variations among the regions. While the centre and west of Montreal had a high percentage of users served in English, under 40% of users in the regions of Capitale-Nationale, Lanaudière, Estrie were served in English. For those served in English, 80.1% were served directly in their language, and 82% felt this was very important for them. About one-quarter of those not served in English had asked to be served in their language. Just over 40% of them considered English-language service to be very important.

Once respondents were within the hospital emergency room or out-patient clinic, they described their language experience with admissions personnel, doctors or health professionals, and with forms. Less than 50% of users in six regions were dealt with in English by admissions personnel (Capitale-Nationale, Estrie, Nord-de-l'Île-de-Montreal, Est-de-l'Île-de-Montréal, Laval, and Lanaudière). The percentage was higher (over 80%) in the three Montreal subregions covering the centre-south, centre-west and west of the Island. The percentage of doctors or health professionals serving in English was higher than that of admissions personnel, with 78.4% of them providing service in English.

Respondents were asked if the forms they were required to fill out, or other information forms given to them were provided in English. Just over 60% said yes, with significant variations among the regions. Less than 30% of respondents in three regions were provided with forms in English (Capitale-Nationale, Estrie and Est-de-l'Île-de-Montreal).

Overnight stay in a hospital

For those requiring an overnight stay in a hospital, 67.9% of them were served in English. This was less the case in Capitale-Nationale (21.6%), Laval (38.1%) and Est-de-l'Île-de-Montréal (55.6%). Overall, 80.1% of patients were served directly in English, and 87.3% considered it was very important to be treated in their language. For the one-quarter of patients not served in English, just under half thought it was very important to be treated in English, while the rest considered it was acceptable to be served in French.

Admissions personnel responded in English to 66.2% of patients coming in, with this percentage just over 50% in Laval. Nurses provided service in English for 71.7% of those admitted in eight regions with a significantly lower percentage in Laval (38%) and Est-de-l'Île-de-Montréal (40.8%). In the nine regions for which the language of doctors was reported, 80.4% of patients were served in English, with this being the case for 45.8% of patients in Laval, and 32.3% of patients in Capitale-Nationale. Medical technicians spoke English to 71.1% of survey respondents in nine regions, with Laval and Capitale-Nationale reporting the lowest percentages (36.6% and 5.8% respectively).

Respondents in nine regions reported their experience with consent forms. In 58.5% of the cases, consent forms were provided in English. Just over 30% of unilingual respondents received consent forms in French. This was the similar situation for other information other than consent forms, with 54.4% of respondents provided written material in English. This information included pre-intervention and post-intervention

instructions (58.8% provided in English). With respect to receiving English instructions when discharged, 62.7% of respondents said this was the case.

Information about services provided by health and social services institutions

Respondents in seven regions were asked if, in the two years prior to the survey they received information about services in English provided by public health and social services institutions in their regions. About 17% said they had. With respect to the source of this information, 43.6% of this group stated they received it from a public institution, 25.9% from a community organization, 20.2% from a newspaper, and 16.2% from a school. In comparison, 63.4% of French speakers surveyed stated they received their information about health and social services from a public institution, followed by 30.5% from a newspaper.

With respect to information regarding public health promotion and prevention programs, 14.1% of respondents in fifteen regions stated they received this information in English. Almost 20% said that a community organization was the information source, while 24.6% stated it was a school.

3.4 Access to services in English over time: trends to consider

In 2020, the CHSSN published a report relaying the findings of four CHSSN-CROP surveys of English speakers conducted between 2005 and 2019.[60] The information provides a perspective on trends relating to access to services in English over fourteen years and complements the more detailed portraits available in each survey.

Key trends emerge regarding the rate of use of four entry points into the health and social services system, the importance of these services in English, and the differences between bilingual and unilingual respondents with respect to importance of being served in their language.

A downward trend appears when looking at the rate of use of CLSC services by English speakers, with 46.9% of them using the services in 2005 compared with 34.8% in 2019. It should be noted that the rate of use in 2019 is comparable to that of French speakers surveyed in that year (36.2%). The data also show a decline in the rate of services in English, with 67% served in English in 2005, and 56.5% served in their language in 2019.[61] However, when looking at the experience of unilingual English speakers compared to their bilingual counterparts, 94.2% of unilingual respondents were served in English in 2005, with a moderate drop to 87.6% in 2019. This group remained consistently high in stating they felt the service in English at the CLSC to be very important (96.2% in 2005, and 93.5% in 2019). With respect to bilingual English speakers, 56.2% of them were served in English in 2005, compared to 47.2% in 2019. As well, 58.1% in 2005 felt that service at CLSCs in English was very important, compared to 51.9% in 2019.

A consistently high proportion of unilingual respondents who have used Info-Santé were served in English (89.3% in 2005, 91% in 2019). This group strongly felt it was very important to be served in English (94.7% in 2005, 99.3% in 2019). Their bilingual counterparts who were served in English showed a slight decline from 2005 to 2019 (55.7% to 47.5%). Similarily, 64.4% of them felt the service in English to be very important, declining to 54.7% in 2019.

The percentage of respondents using the services of a hospital emergency or an out-patient clinic declined between 2005 and 2019 (49.8% to 39.9%). However, the proportion of those served in English has remained stable over the fourteen years (73.3% in 2005, 71.5% in 2019). This is also the case for unilingual English speakers served in English (92.6% in 2005, 92% in 2019). Those who felt it very important to be served in English rose slightly in this period (93% in 2005, 97.7% in 2019). For their bilingual counterparts, a very slight decline occurred with respect to being served in English (67.7% in 2005, 65% in 2019). This was also the case with respect feeling it was very important to receive the services in English (69.2% in 2005, 65% in 2019).

[60] CHSSN. Baseline Data Report 2019-2020. Time Series Report : CHSSN-CROP Surveys 2005-2019. Access to English-language Health and Social Services in Quebec, Provincial Profile. 2020.
[61] Slight variations in percentage may occur between the data presented in the 2019 Baseline Data Report and the Time Series. This is due to data treatment adjustments that were required in the Time Series in order to ensure comparability of data of the four CHSSN-CROP surveys.

The percentage of survey respondents requiring an overnight stay in a hospital declined between 2005 and 2019 (22% in 2005, 16% in 2019). The proportion of those served in English remained stable over the period (88.7% in 2005, 87.7% in 2019), while the percentage of those who felt it was very important to be served in English increased very slightly (95.7% in 2005, 97.6% in 2019). The percentage of bilingual respondents served in English declined from 75.8% to 64.9%; and the proportion of those who felt it was very important to be served in English declined from 74.5% to 66.2%.

The CHSSN Time Series shows a decline over fourteen years in the number of respondents receiving information about services in English provided by a public health and social services instiitution.[62] While 27% of respondents in 2005 reported receiving information about English-language services, this declines to 15.5% in 2019. Similarly, the proportion of respondents receiving health promotion and prevention information in English declined from 20.9% in 2005 to 12.4% in 2019.

3.5 What the surveys tell us about access

Members of English-speaking communities in the focus groups have given voice to the issues of language and communication in situations dealing with the French language. The accounts of communication challenges have affirmed the importance of language for the delivery of quality services as expressed in the MSSS guide for the development of access programs of services in English.

With regard to use of certain health services, the rate of access to doctors, specialists and medical procedures was essentially the same for English and French-speaking respondents. There were no wide differences in their attitudes toward the length of wait times for these services, expressed as more positive than negative. As well, a significant percentage of both groups agreed that wait times had a negative impact on treatment and recovery. Against this backdrop of common experience is added the dimension of language and access to services in English.

The CHSSN-CROP survey in 2019 provides us with details of linguistic access to five entry points into the health and social services system. Certain general observations can be made about this information. We gain insight into the extent to which English speakers are comfortable asking for services in English, as well as important reasons for discomfort. We see the proportion of those not served in English and their views about this circumstance. We also see an extent to which services were offered directly in English as an active offer, and how many users had to ask to be served in their language. Variations in the provision of services in English become apparent when looking at the community experience with doctors, CLSCs and hospitals. Differences in access are evident between regions and in the case of Montreal, between sub-regions. We can see there are challenges with English-language information and consent forms in hospital settings. The survey would support a review of the extent to which communities are receiving information about services in English available in their region.

A broader perspective is gained in the Time Series looking at trends of access over fourteen years. We note a declining rate of use of CLSCs and hospitals by English speakers over this period. However, we see that the proportion of those served in English when using Info-Santé, hospital emergency and out-patient clinics, or requiring an overnight stay in a hospital has remained relatively stable over time. Unilingual survey respondents consistently reported a higher rate of service in English than their bilingual counterparts. These trends encourage further inquiry into the rate of use of public institutions by English speakers. Despite a slight decline in the rate of certain services in English, there is affirmation of a relatively stable performance of the health system in serving in English, particularly unilingual English speakers.

[62] A slight variation in percentage exists between the data presented in the 2019 Baseline Data Report and the Time Series. This is due to data treatment adjustments that were required in the Time Series in order to ensure comparability of data of the four CHSSN-CROP surveys. However, the data support the same trend of a decline in the proportion of survey respondents receiving information about services in English and health promotion and prevention programs in their language.

4. Measures to support access and improve health outcomes in English-speaking communities

The collaboration between the community networks and Quebec's health and social services system has established itself as the most effective model for integrating investments into English-speaking communities and the health system in order to improve access. Since 2003, this partnership approach has built a solid foundation of interconnected measures strengthening communities, adapting the health system to better respond to needs, and creating shared strategic information supporting the range of actions aiming to improve access to services in English.[63]

To achieve the outcome of improved access and health outcomes, the CHSSN and the community networks propose that new investments be integrated into the established framework of interconnected measures. In this manner, community and public partners can sustain gains in improved access while developing the innovative measures needed to address new priorities and challenges facing communities and the public system in the period ahead.

4.1 Strengthening communities

The community network partnership model

The CHSSN and the community health networks subscribe to an evidence-based development model that has successfully mobilized English-speaking communities and created formal partnerships with Quebec's health and social services system.[64] The 22 community networks supported by a CHSSN program coordinate multiple partnerships at the local level.[65] A significant number of these partnerships are directly with the public system, supporting projects and initiatives engaging the community sector. Other partnerships are with community organizations working to strengthen community resources and collaboration between different sectors, such as education, health and justice.[66] The CHSSN and the community networks serve to link the different components in the current Health Canada Contribution Program to English-speaking communities and the public system.

While the 22 community networks promote projects and partnerships at the local level, the CHSSN provides a support program to them, and works in a formal partnership with the Quebec Ministry of Health and Social Services. This model has been successful since 2003 in coordinating the implementation of the Health Canada Contribution Program in Quebec. The CHSSN proposes this approach be affirmed by Health Canada as the delivery framework for the new Contribution Program.

Developing community networks

Many of the community networks cover territories that are enormous in size with low population densities. Others serve dense urban or suburban populations that are culturally and socio-economically diverse. Community networks can face challenges stretching resources to respond to local service needs.

[63] The model of interconnected measures was established in the 2003-2008 Health Canada Contribution Program and served as the approach in the three subsequent five-year programs.
[64] The evolution of development of the network partnership model and its impact is documented in an article by Joanne Pocock entitled "Quebec's English-speaking Community and the Partnership Approach of its Network in Health" in the journal "Minorités linguistiques et société", digital publication, June 2021, Number 15-16. https://www.erudit.org.
[65] The community networks are supported by a CHSSN program "Networking and Partnership Initiative" funded by Health Canada. For purposes of this report, "community network" refers to the community organization sponsoring a networking and partnership initiative (NPI) in an administrative health region. In the case of Townshippers Association, two NPIs are supported, one in the Estrie region and the other in the southeastern sector of Montérégie-est. Three NPIs are in development: Nord-de-l'Île-de-Montréal, Ouest-de-l'Île-de-Montréal, Centre-Ouest-de-l'Île-de-Montréal.
[66] 853 partnershps were identified in 2020-2021, with 27% in the social services sector, 21% in health, 18% in community resources, 16% in education, with the remaining 18% spread between government, economy, culture and media, sports and leisure, and justice and legal. Source: administrative survey of partnerships by sector and status. December 2021. Unpublished.

A strong majority of the 22 community networks state there are areas within their administrative health territories they feel are underserved by their community network programs.[67] In many cases, large administrative territories with isolated English-speaking populations pose challenges for onsite offering of community network programs such as outreach, wellness centre activities for seniors, and other programs offering mental health support or early childhood development activities. Examples of underserved English-speaking communities include very large municipal regional counties (MRC) in areas such as the Outaouais region (MRC Vallée-de-la-Gatineau), the Côte-Nord region (MRC Caniapiscau including Fermont, Schefferville and Kawawachikamach), and the northern part of the Laurentide region (MRC des Laurentides). Other examples include regions where English-speaking people are located in population centres separated by large distances. This is the case of the Gaspé coast, the Abitibi region (Rouyn-Noranda and Val d'Or), and central Quebec (Drummondville, Victoriaville-Arthabaska, Shawinigan).

Similarly, there are particular outreach challenges for community networks serving administrative health territories where English-speaking persons are dispersed in densely populated or highly diverse communities. Examples include the Montérégie-est region, where English-speakers are "hidden" in the highly dense area of Vieux-Longueuil, as are English-speaking immigrant and multicultural communities in the northern and central districts of Montreal (Villeray, Parc-Extension, Ahuntsic-Cartierville). There are challenges to extending community network programs to English-speaking Black communities that are "pockets" in the municipalities of Lachine and LaSalle in the western administrative health territory of Montreal.

Extending community network programs to underserved communities

Despite these challenges, the community networks have applied different approaches to stretching resources in order that an underserved community can receive a general benefit from its network program. Almost 90% of networks use communications such a website, newsletter or information campaigns to reach underserved areas.[68] Over three-quarters of the networks provide support activities such as information and referral, accompaniement or advocacy to English-speakers in these areas, while two-thirds of them host ad hoc or small meetings with community members and public partners. Half the networks carry out representation activities such as participation on advisory bodies, or meetings and events with community stakeholders.

Favoured options for community network development

In order to better serve all communities in an administrative health territory, the community networks have identified options to enhance community network programs. Over 80% of them feel a general increase in resources to support community network programs is needed to account for cost of living adjustments and other rising infrastructure costs. For half of the networks, this increase would accompany adjustments in their local network program offer. This would include measures such as reorganizing a program to improve program outcomes, strategic planning to prioritize the network program offer, reorganizing or training human resources, and rationalizing program costs such as reducing rent and other overhead costs. Ten of the networks would favour the creation of a sub network or satellite office to reach underserved communities.

Community outreach program

The current outreach component of the community network program is an innovative practice demonstrating success in reaching isolated and vulnerable English-speaking persons. 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 program was instituted in 2018 following the major reorganization of the Quebec public system. The more recent

[67] CHSSN administrative survey of the community networks on development priorities. August 2021. Unpublished. While this report selects examples of underserved communities, the administrative survey provides a more complete list of communities identified by the networks.
[68] CHSSN administrative survey of the community networks on development priorities. August 2021. Unpublished.

experience with COVID-19 reinforced the importance of the community role linking vulnerable clientele to the health and social services network. With the impending implementation of new government-approved access programs of services in English, the community networks see outreach activity as key to their contribution to supporting access to the identified service programs and installations. The networks declared as a top priority, the creation of a dedicated community liaison function in the outreach program.

The community liaison function would include the following activity components:

INFORMATION AND REFERRAL

Community networks would have a dedicated person or persons with good knowledge of access programs and complementary community resources. This knowledge would be disseminated on different platforms (web and social media) and use a variety of communication methods to inform community members of where services in English can be accessed. With this information a community liaison person can respond to community inquiries and refer the person to the appropriate institution or community resource.

NAVIGATION AND ACCOMPANIEMENT

The community liaison function can include a navigation and accompaniement component to support and guide community members accessing the public system. This function helps to mitigate the effects of language barriers on quality of care and health outcomes, supporting both community members and health professionals in optimizing the positive effect of health interventions. The accompaniement role can include assisting community members in planning medical appointments, accompanying patients within the system, ensuring patients understand medical treatment plans, and providing emotional and logistical support for community members dealing with their health issues.

CULTURAL AND LINGUISTIC BROKERING

Some community networks that have already instituted a dedicated community liaison function have added a new dimension to their interactions with health professionals when navigating and accompanying patients in the system. This emerging role recognizes that language barriers can impede effectiveness of professional interventions, affecting the quality of care and potentially health outcomes. Accounts of patients and interpreters-navigators in a recent study detail their experiences of poorer patient assessment, misdiagnosis or delayed treatment, and impaired confidence in services received.[69] The community liaison person, prepared to act as a cultural and linguistic broker, would support health and social service professionals in developing linguistic and cultural competency to better understand and serve a diverse English-speaking clientele.[70] In effect, the broker acts as a "go between" in a specific patient-professional intervention. The broker can also be instrumental in supporting professionals promoting awareness within their institutional settings of the linguistic and cultural factors that can affect the quality of care of English-speaking persons. It is anticipated that interaction between the community liaison person and a professional will be enhanced by the increased use of video platforms such Zoom and Teams by both community networks and the public system.

Community leadership development

The community network program aims to build the capacity of community members to represent their community effectively in the governance and advisory structures of the health and social services

[69] Danielle de Moissac and Sarah Bowen. "Impact of Language Barriers on Quality of Care and Patient Safety for Official Language Minority Francophones in Canada". Journal of Patient Experience 2019, Vol 6(1) 24-32.

[70] Mamata Pandey, Geoffrey Maina et al. "Impacts of English Language Proficiency on Healthcare Access, use and Outcomes among Immigrants: A Qualitative Study". Research Square. 2021. https://doi.org/10.21203/rs.3.rs-291909/v1.
This study corroborates the work of de Moissac and Bowen documenting the impact of language barriers on quality of care. It concludes that the interpreter-broker role should be more integrated within the health system.

network. This representation is playing a key role in the development of government-approved access programs of services in English. The continued impacts of major reorganization of health and social services and emerging post-pandemic needs facing communities are added challenges to the adaptation of services to better serve English-speaking people. The community networks play a key role in community leadership development and have identified priorities for building community leadership and representation capacity.

- sponsorship or co-organization of events that bring French and English-speaking leaders and representatives together;

- creation and provision of a training and support program for new community representatives on governance, advisory and planning bodies;

- promotion of representation on tables and other bodies of the French-speaking majority;

- sponsorship of community activities, events or awards that recognize the community leadership contributions of representatives;

- creation of a liaison program with representatives on governance, advisory and planning bodies to enhance regular reporting and a two-way information flow between the community network partners and representatives;

- dedication of more resources to sponsor campaigns or other initiatives to recruit and support community representatives on specific bodies such institutional boards, regional access committees, the provincial committee, planning tables and other bodies.

4.1.1. Innovative models of service delivery

Through its projects and partnerships, the CHSSN promotes development of innovative models of service delivery to support access to services in English. The goal is to apply promising practices to create new service delivery models that either complement a public program or are integrated as a standard of practice in the health and social services system. The successful piloting of community-based seniors wellness centres with the support of a Health Canada investment has resulted in transfer of the program to Quebec for an interim funding period. The impact is significant, as Quebec has committed to fund up to 70 wellness centres expected to be in operation during the period ahead.[71] This has demonstrated that a targetted investment within the Health Canada Contribution agreement with the CHSSN is an effective approach that recognizes the nature of sponsoring innovation programs, their evaluation, and the timeframe for conversion of results into adapted service delivery models.The CHSSN considers that two other innovative service delivery initiatives are candidates for a targetted investment strategy.

Patient Navigator project

The Patient Navigator project was launched as a pilot project by the Quebec Community Health and Social Services Foundation in 2018 to assist English-speaking patients in Eastern Quebec who must travel to Quebec City for specialized health care services.[72] A bilingual patient navigator provides a range of services to support patients and their families who face the challenge of receiving health care away

[71] Secretariat for relations with English-speaking Quebecers. “Government grants $2.7M to reduce social isolation for vulnerable English-speaking seniors”. June 21, 2021.
[72] Eastern Quebec regions include the Gaspésie, Magdalen Islands, the Lower North Shore, the North Shore, and Bas-St-Laurent.

from home.[73] Over a 20 month period, the patient navigator served 181 patients, with well over a third requiring multiple visits to Quebec City. The majority of patients were unilingual (78%), with almost half over 65 years of age. Commercial plane was the mode of transport for 85% of patients, 34% of whom travelled alone, and 70% of them coming from the Lower North Shore.[74]

The key activities include assistance with travel logistics, emotional support for patients, and the facilitation of communications with health care providers. As a result, patients and their caregivers have more access to information about the Quebec City health care network and travel logistics. As well, the patient navigator acts as a stand in for family members so that vulnerable and unilingual patients are not left alone. Emotional support is provided as patients deal with fear, loneliness, and being overwhelmed by their health care situations. For the health care system, the project has increased its awareness of the needs for services in English for this vulnerable out-of-region clientele.

The project has mobilized support from four community health networks operating in Eastern Quebec, along with five other community foundations, the CIUSSS Capitale-Nationale, and more recently the MSSS. As a result of the evaluation of the project, the CHSSN aims to engage community and public partners in an initiative to expand the model to other regions where English-speaking persons experience significant inter-regional travel for specialized health services. The CHSSN goal is to integrate the model into the public system in regions where inter-regional services have been identified in their access programs of services in English.

Distant community health education: the next phase

The CHSSN Community Health Education Program (CHEP) is an established program employing a video conferencing platform that has been supported by the public health system to deliver health promotion information to urban, rural and remote English-speaking communities across Quebec. As a result of a longstanding partnership with the McGill University Health Centre (MUHC), the CHSSN has had access to the RUIS (McGill) Telehealth system. Through this technology, 20 community networks have annually sponsored video conferences connecting professionals with 700-800 participants living in isolated or dispersed English-speaking communities. In addition to the video conferencing sessions, CHEP has produced DVD recordings of the events which have been used to disseminate health promotion information to a broader audience. In 2019-2020, twenty-one health topics were presented in 41 DVD sessions reaching 642 viewers.[75] These sessions have improved information in English-speaking communities and mobilized community engagement in health promotion activities that complement the public health mission of the health and social services network.

While the pandemic imposed constraints with respect to attendance at video conference sessions, the experience afforded CHSSN opportunities to reorient CHEP, adopting a new technology platform and aligning programming with public health priorities related to COVID-19. In 2020-2021, five of the six CHEP video conferences focussed on the pandemic addressing isolation and mental health issues. The sessions were:

- Coping with Arthritis during Self-Isolation
- Taking Care of Your Mental Health and Emotional Resilience
- Eating Well during the COVID-19 Pandemic
- Moving Well during the COVID-19 Pandemic

[73] The patient navigator model is similar to the one being used by a number of francophone communities outside Quebec. Francophone interpreter-health navigators provide interpreter services and assist vulnerable patients in overcoming barriers wth the health system. In a study, Danielle de Moissac and Sarah Bowen have established the link between well-documented research on language barriers and patient safety and quality care of linguistic minorities, and the experience of official language minorities in Canada. The authors documented the experiences of patients and intepreter-health navigators where language barriers contributed to poorer patient assessment, misdiagnosis or delayed treatment.
Danielle de Moissac and Sarah Bowen. "Impact of Language Barriers on Quality of Care and Patient Safety for Official Language Minority Francophones in Canada". Journal of Patient Experience 2019, Vol 6(1) 24-32.
[74] Evaluation of the Quebec Community Health and Social Services Foundation Patient Navigator Project. 2021. https://chssn.org/documents
[75] Project Report: CHSSN Community Health Education Program (CHEP) 2019-2020. https://chssn.org/documents.

- Managing Risk and Uncertainty in Life
- Straight Talk about End-of-Life Options

Over 850 participants attended the sessions, and an additional 200 individuals viewed recorded presentations of past CHEP sessions. The community networks made a successful transition from sponsoring live sessions to mobilizing participants to attend from their homes through a ZOOM platform. This technology and other similar platforms are likely to dominate delivery of CHEP in the period ahead.

The next phase of development of CHEP includes expansion of partnerships and resource-sharing to enrich programming and open up opportunities for communities to have access to health promotion resources from a range of associations and other bodies. This would include expanded contacts with speakers and written resources. The CHEP consultants would work with expert presenters to create the video conference content. Current partnership examples include the MUHC Women's Healthy Heart Initiative and the PERFORM Centre (Concordia University), a research and education program promoting health lifestyles.

CHEP will continue to integrate its programming to support community networks developing the 70 seniors wellness centres across Quebec. Organizations such as the Cummings Centre for Seniors, and the Jeffery Hale Community Wellness Centre will be invited along with public partners and other community resources to contribute material for distance community health education. As well, CHEP will expand its capability to support community networks operating programs addressing mental health issues and early childhood development.

4.1.2. Adaptation of francophone community resources to serve English-speaking persons

As a result of promoting leadership and representation, the community networks have increased their presence on tables and other bodies addressing the needs primarily of the French-speaking majority. As well, the CHSSN has increased its collaboration with francophone community resources particularly in the areas of mental health, youth and early childhood development. The pandemic and emerging post-pandemic needs have added challenges for both community resources and the health and social services system with respect to serving communities. This circumstance has encouraged dialogue between community networks and francophone community resources expressing a willingness to adapt their services to better serve English-speaking people. In the area of mental health, the CHSSN is supporting projects with francophone organizations to adapt their promotion campaigns, resources, training programs, tools kits, web sites as well as increase access to psychosocial support services.[76]

In the area of early childhood development the CHSSN is working directly with two key organizations well-established in the majority community. Supported by resources from the CHSSN program "Bright Beginnings", the Regroupement pour la valorisation de la paternité (RVP) has translated a guide and hired an outreach worker to train and accompany the CHSSN-affiliated community networks to adapt their practices to better reach and support fathers. The CHSSN is now a member of the Collectif Petite Enfance, and sits on a table sharing its perspective on early childhood needs in English-speaking communities. The result is a collaboration in the organization of the "Grande semaine des tout-petits" which has translated campaign materials and its website.

The CHSSN will continue to build partnerships with francophone community resources at the provincial and local levels to support this sector's growing commitment to adapt programs to better serve an English-speaking clientele.

[76] These projects include: (a) *REVIVRE*: adaptation of campaign materials for *Semaine de l'autogestion de la santé mentale*. (b) *Fondation Jeune en Tête* : Translation of the *Youth Mental Health Toolkit*. (c) *Association québécoise de soins palliatifs (AQSP)*: Translation of the website and print materials, outreach to English-speaking communities. (d) *Réseau avant de* craquer: translation of the website and mental health caregiver tools. (e) *Association québécoise pour les parents et amis de la personne atteinte de maladie mental* : increased access to psychosocial support services.

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

Adaptation of service programs in the health and social services system

Over the last decade, the CHSSN has actively supported the initiatives of Quebec's public system to improve access to health and social services in English. By agreement with the Ministry of Health and Social Services (MSSS), the CHSSN provides Health Canada Contribution Program resources to the public network in order to enhance its capacity to adapt service programs and support its human resources to better serve English-speaking communities. Our implementation agreement with the MSSS ensures that the Health Canada contribution fully respects Quebec's jurisdiction in the health and social services domain.

Projects generated locally and regionally by the sixteen CISSS and CI(U)SSS have laid a solid foundation for new investments to support adaptation of services in the context of revised access programs of health and services in English.[77] The projects underscore the importance of the partnerships established with the community networks, an approach considered the best strategy for achieving improved access and better health outcomes. The collaborative model was affirmed at the "Building Together" virtual conference held in February, 2021, an event co-hosted by the CHSSN and the MSSS.[78] Three other virtual conferences in the next three months brought together the CISSS and CI(U)SSS respondents along with the community network representatives to look at best practices, a key step in mapping the priorities of a new adaptation program.

The adaptation projects have demonstrated improved knowledge of communities and their needs, increased partnerships between the public system and English-speaking communities, and increased information documents and communications in English.[79] In 2020-2021, the projects tracked improvements in access to services in English in a number of service programs.[80] These included public health, youth in difficulty, support for the autonomy of seniors, mental health and dependencies, and general services (clinical activities including first line services that respond to needs of persons with acute and reversible health problems). The community networks, for their part, reported improved access to services in community resources as a result of their own projects. Community resources play an important and recognized complementary role in the public system. The adaptation projects recognize this key feature in their active partnerships with the community networks.

As the adaptation program moves into its last year, the CHSSN along with all stakeholders will focus on setting the priorities for renewal of a five-year program that would be aligned with the implementation of new access programs of services in English covering the period. The objective is to identify priority areas for improvement of access and the parameters for defining projects reflecting best practices. This planning approach aims to ensure continuity of current effective initiatives while introducing innovative approaches to address emerging needs.

The adaptation program has reinforced CHSSN's commitment to continue building partnerships between communities and the health and social services system. The adaptation projects have demonstrated this same commitment of our public partners to the shared goal of improving access to services and achieving better health outcomes in English-speaking communities.

[77] CHSSN. L'Initiative d'adaptation : Guide des projets 2018-2023. March 2021.
[78] https://chssn.org/event/building-together-02-21/
[79] Contribution Agreement administrative data for 2020-2021. Unpublished.
[80] The health and social services system is divided into 9 service programs. A service program designates the group of services and activities organized to respond to the general needs of the population as well as to the specific needs of a group of persons sharing the same problem. Access programs of services in English identify the service programs and installations where a service is accessible in English.

4.3 Strategic knowledge

The collaborative model presented in the current proposal is founded on a shared understanding that improved access to services and health outcomes is achieved by strengthening communities and adapting the health and social services system to meet the needs of English-speaking persons. Contributing to this understanding is strategic information that supports in substantial ways the range of stakeholder actions to improve access.

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

The CHSSN partners with Quebec's institutes producing epidemiological and population health studies of the Quebec population. The purpose is to identify the health and social trends that are associated with the determinants affecting the health status of English-speaking communities and their members. The CHSSN has partnered with the INSPQ and the ISQ to identify the English-speaking population as a sub-population of large surveys carried out in Quebec and Canada. Recent studies include a report of the INSPQ on the health profile of linguistic communities in Quebec; and an ISQ report on vulnerable English-speaking children in kindergarten with regard to child development.[81]

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

The CHSSN produces knowledge tailored to support community mobilization. The purpose is to ensure 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 information from direct community experience forms a strong base for engaging communities and supporting partnerships with the public system. Recent featured reports include a time series report of the CHSSN-CROP surveys between 2005 and 2019.[82] Also featured are socio-demographic profiles of English-speaking population subgroups that include men and fathers, women and mothers, children 0-5 and their parents, and seniors over age 65.[83]

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 shared commitment to advance knowledge about the many factors that influence language, access and health. A new Health Canada investment can continue to support collective efforts to produce the evidence base required to improve access and health outcomes in English-speaking communities.

[81] INSPQ. Health Profile of Linguistic Communities in Québec. 2018. https://www.inspq.qc.ca/publications/ and https://chssn.org/documents/
ISQ. Vulnerable English-speaking children: 2017 Quebec Survey of Child Development in Kindergarten data analysis. 2017. https://chssn.org/documents/
[76] CHSSN. Baseline Data Report 2019-2020. Time Series Report: CHSSN-CROP Surveys 2005-2019. "Access to English-language Health and Social Services in Quebec". Joanne Pocock. 2020. https://chssn.org/documents/
[83] These four profiles are accessible in Featured Resources of the CHSSN document centre. https://chssn.org/documents/

5. Going Forward

In September 2021, the CHSSN surveyed 41 of its member organizations on general priorities for policies and programs serving the community sector in the period ahead.[84] The survey results add an important dimension to the community context to be taken into account in proposing a new Health Canada investment.

The survey respondents serve English-speaking communities in 21 administrative health territories across Quebec. They operate community programs serving a specific target population. A majority also have programs that mobilize and represent English-speaking communities, as well as develop knowledge and provide information on communities.

Relationship with the public health and social services system

A key characteristic of many of the community organizations is their relationship with the health and social services network. Almost 60% cited a direct relationship between their community program and the public system, while almost 62% stated their program enhances or complements publicly-provided services. This same percentage said their program provides a service where there is a service gap in the health and social services system.

The experience of COVID-19

When asked if the exerience of COVID-19 changed their program, 85% of the organizations said yes, stating COVID-19 challenges their ability to serve their target population (79%). Three-quarters said the pandemic is creating new needs and priorities not previously served. They felt this new situation would affect their program over the mid or long-term (82%).

Developing knowledge and informing English-speaking communities

The community organizations play a key role informing their communities with 92% of them directing information to an English-speaking target population. Most notable is the predominance of information programs regarding access to public health and social services as well as to community resources. For those survey respondents (75%) that reported knowledge development as a specific program, two-thirds stated their knowledge products are developed from data, surveys, research and other information sources.

Mobilization and representation

Community mobilization and representation is a significant activity of survey respondents. Eighty percent of them reported that bringing together organizations serving English-speaking communities is a defined aspect of their mandate. The organizations play a key role in their sector, with almost 90% of them providing programs, resources or services supporting other organizations serving their communities Over 90% also promote community representation on bodies or structures that affect the interests of English-speaking communities. Eighty-two percent stated they advocate on behalf of English-speaking communities or individuals.

Survey respondents were asked to identify what types of support for community representation they consider important in addressing the needs of their priority population. Eighty percent identified expanding representation at the provincial level as important. This includes ministries, secretariats, government advisory bodies, non-government bodies and the political level. Two-thirds of respondents cited expanding community representation at the local level as a priority. This would include institutional advisory and governance structures and participation on community tables. This same percentage (66%) sees as important the expansion of community representation at the federal level, including federal departments, agencies, advisory bodies and the political level.

[84] Survey on priorities for CHSSN policy and program development. September 2021. Unpublished.

Priority populations and government programs

Respondents were asked to identify one priority population in English-speaking communities they consider needs support. Thirty-seven percent identified seniors and caregivers as a priority, while 34% identified persons with mental health issues. Twenty-four percent identified families including young children and youth. Community organizations often rely on government programs to support their capacity to serve their communities. When surveyed on what type of support for community resources is considered important in addressing the needs, half of the respondents cited gaining access to current government programs that support community resources, while 72% stated that expanding existing government programs for community resources is important.

With respect to existing provincial programs and services, 57% of the organizations felt it is a priority to improve access, while 67% stated that expansion of existing programs is important. Fifty-five percent identified creation of new provincial programs as a priority.

With respect to the federal government, 50% of respondents identified improvement in accessing existing federal programs as important, while 60% said expansion of existing federal programs is a priority. Half of respondents cited creation of new programs as important.

The new context

The two years of pandemic experience have impacted the community sector serving English-speaking communities, creating challenges but also inviting innovation in responding to needs. The portrait of priorities in this survey affords a fresh perspective on shaping actions of government and communities as they map the strategies needed to guide new initiatives to improve access to services and health outcomes.

6. Recommendations

This report has provided an updated sociodemographic profile of English-speaking communities that underscores their geographic and social diversity and the socioeconomic determinants affecting health status. The evidence highlights vulnerable populations that require particular measures to improve health outcomes. The community perspectives on access give voice to the challenges that face community members as well as health professionals committed to providing quality services, including to English-speaking communities.

The report has also presented the evidence-based development model that has successfully mobilized English-speaking communities and created enduring partnerships with Quebec's health and social services system. The proposed measures aim to strengthen communities, adapt the health system to better respond to needs, and create the strategic information required to address new priorities and the challenges facing communities and the public system in the period ahead.

To support English-speaking communities and their public partners in achieving the shared goal of improved access, the CHSSN and the community networks propose the following recommendations to Health Canada in the preparation of a new Contribution Program.

It is recommended:

1. That a new Health Canada Contribution Program affirms the community network partnership model promoting collaboration between the community networks and Quebec's health and social services system. This model is deemed the most effective approach for integrating investments into English-speaking communities and the public health and social services system in order to improve access.

2. That a new Health Canada Contribution Program identifies the CHSSN as the designated beneficiary to support a networking component with the resources required to strengthen English-speaking communities. Specifically, this component would provide resources to support development of community networks including extending community network programs into underserved communities. The component would support community outreach that provides information and referral, navigation and accompaniement, and linguistic and cultural brokering to connect English-speaking persons with the services programs of the public system . A key networking activity would be leadership development to enhance the representation of English-speaking communities in the governance and advisory structures of the health and social services network. Through projects and partnerships, the networking component would continue to develop innovative models of services delivery to support access to services in English.

3. That a new Health Canada Contribution Program identifies the CHSSN as the designated beneficiary to support a health projects component with the resources required to conclude an agreement between the CHSSN and the Quebec Ministry of Health and Social Services. The purpose of the agreement would be to provide resources to the public system to promote adaptation of health and social services network to meet the needs of English-speaking persons.

4. That a new Health Canada Contribution Program identifies the CHSSN as the designated beneficiary to support a strategic knowledge component with the resources required to create new knowledge of the health status of English-speaking communities, promote research, and mobilize knowledge to engage communities and support partnerships with the public system.

5. That a new Health Canada Contribution Program affirms the model in Quebec of integration of the federal investment through an implementation agreement between the Ministry of Health and Social Services and the CHSSN. The implementation agreement ensures that the investment supports measures within Quebec's legislative provisions regarding application of the right to health and social services in English. The agreement sets out the framework for integration of results in a manner consistent with Quebec's responsibility to plan, organize and deliver health and social services.