Community Needs ASSESSMENT Summary Report

2019

DETAILED REPORT OF FINDINGS: Discussion and Recommendations

Health and Social Services
Haldimand and Norfolk

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The following reports outlines results of the Haldimand Norfolk Health and Social Services (HNHSS) Community Needs Assessment (CNA) 2019. This section of the report includes detailed discussion, recommendations, and conclusions from the CNA in this community. This chapter should be read in context of the other chapters of this report.

Discussion Recommendations

Following the triangulation of the quantitative data (i.e. community profile and community survey) and the qualitative data (i.e. focus group discussions and key informant interviews), the major themes emerge as common community needs that the participants in all elements of the CNA prioritized. Seven major themes emerged from the qualitative data collected via focus group discussions and interviews: (i) Mental Health and Addictions; (ii) Physical Health; (iii) Poverty; (iv) Housing; (v) Rurality; (vi) Availability of Products and Services; and (vii) Organizational Structures. All of these discussions were had in context of the rurality of Haldimand and Norfolk counties. Further, three major exacerbating factors were described: generational poverty, rurality, and lack of available products and services.

Community members, agency staff, and HNHSS staff provided a wealth of information that should be considered when developing recommendations and actions to address the needs of the community. Recommendations and actions have been summarized into key themes.

Representativeness

The survey data and focus group data are not entirely representative of the communities in Haldimand and Norfolk counties. In particular, the respondents to the survey over-represented females and under-represented males. Additionally, the survey over-represented adults compared to seniors. Finally, the survey over-represented participants with higher levels of education compared to those with lower levels of education.

In contrast, the participants in focus group discussions typically over-represented those with difficult lived-experiences, such as those living in poverty, facing mental health and addictions issues, and experiencing precarious housing. Interviews commonly balanced this data with individuals who worked for agencies. However, the opinions of the focus group discussion and interview participants do more often reflect those experiencing more hardship in this region.

Therefore, while important and relevant, and still addressing the greatest needs in Haldimand and Norfolk, the following discussion, recommendations, and conclusions should be interpreted in context of those we heard from most.

Mental Health and Addictions Supports

Mental health and addictions supports were one of the top priorities or greatest needs described by participants in both the focus group discussions and key informant interviews. In the survey, mental health and addictions supports were ranked as a top three need for healthy families often. Further, in discussions with participants, this was often stated as one of the greatest priorities for the community.

Participants described the need for mental health and addictions supports as being very high, while describing the availability of services for mental health and addictions as being very low. Participants stated that supports often had long waitlists that delayed entry into programs, were difficult to travel to, or had costs that they could not afford.

Mental health and addictions issues were often described as exacerbated by poverty and rurality. Poverty was seen as a stressor that often initiated mental health and/or addictions issues, further compounded by a generational trauma of poverty or addictions. Additionally, rurality as a cause for loneliness or isolation, as well as boredom, was often considered a contributing factor for the high demand for mental health and addictions services.

Mental Health Provisions

According to the Ontario Public Health Standards (OPHS)1, public health units are required to either provide mental health services or to assure that the community agencies are sufficiently filling and meeting the needs of the community. However, given the data collected through both quantitative and qualitative methods for the CNA, the community feels that currently available provisions are not sufficient. Therefore, HNHSS should, by mandate1, actively consider opportunities to provide additional supports for mental health and addictions in the community or ensure that agencies increase available provisions, either through advocacy or some other way. Internal programs may take the form of the success of programs such as the Quit Clinic (i.e. provision of necessary services for addictions support and sobriety) at HNHSS or include health promotion activities for mental health. Alternatively, ensuring agencies provide services may involve advocacy to external agencies to provide additional supports by calling on the government to provide additional funding for existing agencies to fund more beds or staff, or recruitment of additional agencies to the region to fill noted gaps, such as youth mental health programming.

Additionally, HNHSS collaborations with agencies that provide supplemental services to HNHSS mandated services will help streamline service delivery for HNHSS clients. This collaboration could include information sharing about services delivered by HNHSS and supporting agencies with one another, and developing a structured referral system between HNHSS and supporting agencies. Identified supporting agencies include Centre for Mental Health and Addictions, food banks, Salvation Army, and faith-based centers, such as community churches.

Specifically listed types of mental health provisions requested by the community participants included: rehabilitation and detox facilities, psychiatry, harm reduction clinics, 24-hour emergency or urgent care facilities beyond only using the hospitals, and counselling services.

Further, a reoccurring theme within the CNA is the need for rehabilitation and detox facilities in Haldimand and Norfolk counties. A participant (KI20) explained that, there are no rehabilitation centers and the available ones in neighbouring counties have a long waitlist and very limited space:

"There is no rehab; You know, you want to go to rehab, but you don't have money for rehab. Nobody has money for that. Unless you have an affluent family who is like 'we will help you'. I mean nobody has that. And there is nowhere. And if there is, they are all waitlisted. They go for 7 weeks for detox, so you can make sure you don't die while you are getting off drugs. There is no room, they have a few beds. Some of them get into the rehab and then you get 30 days. Some of these people need intensive rehabilitation and there isn't any. It's sad, because someone wants to fix their life and they don't know how to fix their life."

Similarly, HNHSS could foster the formation of client-driven support groups for people struggling with addictions. Most

support groups focus on alcohol addictions and are often inadequate for those who have other addictions. As such, HNHSS could better serve the population struggling with other addictions by fostering the creation of diverse support groups. This could include encouraging the use of county buildings (e.g. libraries) as locations for support meetings, initial supervision of meetings, and referring clients who need these supports to relevant groups.

A separate but important recommendation for mental health and addictions supports that was heard many times in the focus group discussions and interviews was to move the needle exchange drop-boxes in Caledonia and Dunnville. The rationale for these moves was that the boxes are currently in places that make users feel vulnerable, such as beside policing or parole stations.

Physical Health

The quantitative and qualitative data collected as part of this CNA indicate that physical health is a major concern for residents in Haldimand and Norfolk counties. Survey respondents and focus group and interview participants described several key physical health concerns, including nutrition, high rates of cancer, and sexual health. Further, and perhaps most pronounced of all, respondents and participants both described a lack of available family physicians in this community.

Medical and Health Service Provisions

HNHSS is not mandated to recruit doctors or other medical service providers directly; however, without sufficient family doctors and/or specialists in Haldimand and Norfolk, some additional responsibilities may fall to HNHSS1. For example, HNHSS is not mandated to provide sexual health services, physical activity/ obesity services, or sleep services, but is required to if the services are not available locally through another provider.

In addition, a common theme among the focus groups and interview conversations was the lack of many medical services. With regards to recommendations, the OPHS mandates that HNHSS is required to provide, or ensure that others provide, healthy eating behaviours education and training. While HNHSS employs two dieticians, the community has demonstrated a desire for increased availability of these programs, particularly targeted at how to eat healthy in an affordable way. To meet the OPHS, HNHSS could be aiming toward the goal of reducing the burden of chronic disease of public health importance (i.e. including cancer). In this example, addressing the local risk factors for cancer, such as high rates of tobacco use, would meet the mandates. The responsibility of increasing the number of health care specialists does not fall within HNHU's mandate. However, limited practicing specialists (or, in some cases, complete lack thereof) creates a substantial barrier to accessing some HNHSS services. For instance, access to services such as psychiatry requires referrals from a family doctor. A participant (KI27) explained that, "Wait times are pretty high still and people that need specialists in the community can be there for a long time." HNHSS could improve access to services by collaborating with the Board of Health to advocate for the enactment of incentives that will encourage physicians as well as other health care specialists to practice within Haldimand and Norfolk. Additionally, HNHSS collaborations with supporting agencies that currently fill HNHSS service gaps will help streamline service delivery for HNHSS clients. These include advocating for information sharing about services delivered by HNHSS and supporting agencies with one another, and developing a structured referral system. Similarly, collaboration with the local hospitals and the new Ontario Health Teams may also serve to reduce this barrier over time.

Poverty

Poverty was described as both a major community issue and a major exacerbating or contributing factor to other needs in the community. Poverty was seen as a barrier to accessing many of the things that individuals needed to be healthy, such as a safe place to live and healthy food, and as a stressor that heightened the experience of other needs, such as mental and physical health.

In and of itself, poverty was described as the outcome of lack of employment opportunities in Haldimand and Norfolk counties, insufficient government funding from Ontario Works and Ontario Disability Support Programs, and limited educational attainment and opportunity in this region. Further, poverty was described as a contributing factor to the high demand for mental health and addictions services, and as a stressor in general life that lowered perceived overall health of many participants.

Poverty issues were often described as being exacerbated by a generational poverty system, by the relative rurality of the communities, and by a lack of available services. Rurality was described as an exacerbating factor for poverty because many participants suggested this was the reason for less employment and education opportunities.

Provision of Necessary Goods

Several types of recommendations related to the provision of necessary goods for community members arose in the focus group discussions and interviews. Recommendations centered on both what HNHSS and other agencies could be providing to help community members who were struggling with accessing necessary goods as a result of poverty. These types of goods were often food, family planning supplies (i.e. condoms), and cold-weather clothing. While HNHSS is not mandated to provide necessary goods1, these goods were often described as necessities that allowed staff to more meaningfully engage with clients and ultimately provide necessary services. That is to say, clients who were struggling with access to necessary goods often had too many co-morbidities and issues to address before the services were able to really assist them.

As a recommendation to HNHSS, it would be valuable to consider continuing to advocate on behalf of the community residents who are struggling with access to necessary goods. Some participants recommended that HNHSS continue to provide through donations to clients who come for services. Others recommended that HNHSS curate lists of available goods in each community, such as with the list of meal programs and food banks available by community. In addition to having these provisions available, there were several recommendations about how to most equitably provide these goods. For example, participants recommended a private space where individuals could enter and take what they needed without feeling watched or stigmatized by other clients at HNHSS.

Advocacy for Increased Incomes

The second major recommendation to alleviate poverty and reduce the chronicity of poverty in Haldimand and Norfolk was for HNHSS to consider advocating on behalf of the residents of the communities for increased government subsidies. In both the quantitative and qualitative data collected, participants recommended changes to Ontario Works and Ontario Disability Support Program. Participants explained how they could not afford to access enough food or healthy food, or could not access safe shelter when restricted by the amounts of the government subsidies. For example, the Market Based Measure for an affordable standard of living suggests that residents in rural areas, such as Haldimand and Norfolk counties, need to make more than double the current Ontario Works subsidy to achieve a basic standard of living2. As front-line workers who interact with our clients regularly, HNHSS is in a prime position to advocate for and

with clients for increased subsidy amounts and thus, an improved standard of living.

Affordable Housing

Affordable housing was the other top priority or greatest need (i.e. alongside mental health) described by participants in both the focus group discussions and key informant interviews. This need was reiterated in the community survey. Given the "Housing First" philosophy employed at HNHSS and at many other agencies, it was not surprising that this was a major need in Haldimand and Norfolk. Participants with lived-experiences also explained how the lack of affordable housing and low availability of housing stock was a major factor in maintaining their family's health.

Affordable housing was described as exacerbated by poverty and rurality. With regards to poverty, low incomes and high costs of housing were coupled to make many families feel they could barely or could not make ends meet each month. Many felt that their shelter costs were a driving factor for their experiences with poverty. Further, the lack of available housing stock was often described as being worsened by the rurality of Haldimand and Norfolk counties. Some felt that builders were uninterested in the communities for building new developments due to the rurality and relative property values while others felt that the types of homes previously needed here did not reflect the current needs of the community (i.e. dwellings for large families rather than a single adult).

Affordable Housing Ideas

As housing was a major theme of the focus group and interview discussions, recommendations for alternative affordable housing were also common. After describing the current problems with affordable housing in this region, it was often a natural progression for participants to provide ideas for solutions or recommendations to address the issue. Commonly described recommendations for increasing availability of housing were to explore creative ways to build new affordable housing such, as smaller houses (i.e. "Tiny House"), co-ops, or communal living. Tiny House communities, provide a wrap-around style housing service through organizations that maintain the affordable housing stock to support individuals who are seeking employment or addictions supports, and provide communal spaces where each client or resident has private spaces but might share a kitchen or living area. Also, a participant (KI46) explained that in Peel Region, co-occupancy/ communal living has not only reduced the cost of housing for occupants but also provided residents with the social capital needed to prevent loneliness,

"Because you figure for somebody on OW, ODSP, rents are huge and even if they're subsidized, you know, it's still [expensive]. But people don't necessarily need to live alone. And I know it could be a struggle when people share a new [place]. But down there [in Peel], they got like-minded people connected. They had an agreement and they had kind of mediator to go through all of this. And we kind of followed them, worked with them a little bit, [like] if there were problems specific to them sharing an apartment."

Many clients claimed that affordable housing was designed for families of four or more and did not account for single people or couples without children seeking smaller, more affordable spaces. In these cases, participants often recommended smaller units or communal spaces with private bedrooms. These recommendations were particularly relevant given the long wait times for a one bedroom unit in Simcoe.

Given that HNHSS oversees the non-profit housing providers for Haldimand and Norfolk counties, HNHSS could act on

the above recommendations via three main pathways: advocate for the development of affordable units or Tiny Houses by external organizations, release a call for proposals related specifically to the development of some of the affordable housing ideas mentioned above and oversee the projects, or take on the building themselves. From a feasibility perspective, the first two options are much more viable than the third. However, HNHSS could consider advocating to shift legislation to allow for Tiny Houses or could continue to explore alternative methods for providing affordable and rent geared to income housing. A participant (KI28) explained that;

"I think what we need to do is to keep bothering the province to change the rules whereby a project of 500 or a thousand homes has to include some components of social housing and/or affordable housing. If they have to work with the municipality and health and social services to do that, so be it."

A final housing-related suggestion that was mentioned by several participants was that the clustering of affordable housing on certain streets and in certain neighbourhoods produces stigma. These participants often explained how the services were not as available in these communities, or how they felt there was a general isolation from the community that prevented them from being truly included in their neighbourhoods.

Availability of Products and Services

A lack of access to products and services was frequently discussed in the qualitative data and supported by the quantitative data. Specifically, issues around transportation, childcare, food, and youth programming abounded in the data. These issues were often linked to rurality and the assumption or explanation that services were simply too difficult to provide in a vast geographical area with a relatively low population density. Further, with regards to a lack of services, the lived-experiences of poverty were often described as exacerbated because of the lack of transportation to access supportive services (e.g. food banks) or the lack of childcare to be able to seek employment opportunities. Participants of the focus groups and interviews discussed recommendations to improve the availability of services delivered by HNHSS within two broad contexts: first, reducing the gap between services provided and services needed; and second, addressing the barriers to accessing the services provided.

Recommendations on reducing the gap between services provided and service needed focused on transportation, childcare provision, food, youth programming and recreational opportunities.

For HNHSS, the major role to play in availability of products and services is to be an advocate on behalf of the community. The recommendations and ideas shared in this report are valuable beyond the walls of HNHSS, and it should be the responsibility of HNHSS to share these findings and recommendations with those who may be able to implement them across the community.

Transportation Ideas

Transportation was discussed as a subtheme of several major themes, including rurality, available products and services, and organizational structures. However, as with housing, suggestions for solutions to transportation issues were also common. While some recommended extending existing transportation services, such as RIDE Norfolk into other communities and into Haldimand, many participants recommended new and innovative ideas to address transportation needs. Two specific recommendations for transportation ideas were to mimic the Uber ™ ride-share model from Innisfil

(i.e. subsidized transportation costs in owner-operated vehicles) and to introduce a bike-share system that linked the key areas of the communities for a simple deposit cost (i.e. no user fee).

HNHSS is not mandated through the standards for public health or for social services to provide transportation systems across the region1. However, HNHSS is mandated to provide several services that require an individual to come to HN-HSS in person. For example, sexual health services and vaccines cannot be provided to a client who cannot come to the building. In social services, Ontario Works clients are required to attend in-person meetings on a regular basis to maintain their status and receive subsidy. Some social services programs are mandated to provide transportation to medical appointments1, however, the cost of these services is much higher when provided without an existing transportation system (i.e. providing taxi service rather than a bus ticket). Therefore, it is at the crux of service delivery that HNHSS consider opportunities for more affordable transportation systems to be available for their clients. HNHSS could advocate to the Haldimand and Norfolk Municipal Councils on the benefits of the ride-share and bike-share systems, encouraging the councils to provide the service themselves or seek bids from external agencies to offer the service.

Alternatively, health-buses present opportunities for limiting the impact of transportation barriers. A HNHSS health bus would allow for movement of multiple service units to large population groups. For instance, multiple units can visit farms to deliver services to seasonal agricultural workers, senior residential services, remote communities, and so on. It could also provide opportunities to move clients between service stations. For instance, to reduce transport barriers, a health bus could have a fixed schedule to move between the community center or the library to other HNHSS buildings.

Childcare

Similarly, the lack of childcare was among the most discussed barriers to access services and to seek employment opportunities. The recommendations for childcare ranged from increasing available services to providing childcare subsidies. HNHSS could aim to increase available childcare spaces by providing incentives to new centres and by encouraging existing centres to increase their capacity where space and staffing permit. One recommendation for increasing available childcare spaces was to reintroduce or to strengthen partnerships between HNHSS and other agencies that manage childcare provision locally, with the goal to increase spaces in childcare lacking areas across the county. Additionally, existing subsidies were described as helpful and participants called on HNHSS to continue to redirect funds directly to families using childcare services to make it more affordable.

Food

Further, recommendations for service availability were talked about in the context of food availability. Recommendations focused on availability and affordability of food. Regarding availability, it would be helpful to increase the amount of grocers available, particularly in communities that do not currently have one, such as Jarvis. HNHSS could play the role of advocating for more stores, advocating for subsidies to access healthier choices, and health promotion and education activities targeted at empowering people to make healthier meals. Participants recommended that HNHSS could partner with, or encourage partnerships between, grocers and food banks to create synergies for communication and prevent food wastages (i.e. re-direct foods approaching best before dates). One participant (KIX) explained,

“There are the agencies that are creating a volunteer base to create frozen meals that then go out to our emergency housing programs. And they are the ones that are orchestrating a food center in the downtown core. So I feel like if you

begin a collaboration and integration piece of informal services with formal social services, [we] would better facilitate that gap."

With regards to agencies providing food, participants recommended that foodbank users be able to make choices for their food, rather than handed things they may be unable or unwilling to eat. They highlighted the resulting wastage of food this way and the way that this process de-humanized and further stigmatized the process.
For HNHSS, the major role to play in food provisions and availability, as with other products and services, is to be an advocate on behalf of the community. These ideas and feedback opportunities should be shared broadly.

Youth Programming and Recreation

Participants in both the quantitative and qualitative elements of the CNA described one of the greatest needs locally as a lack of youth programming and a general lack of recreational opportunities for all ages. In the survey, increased access to recreational facilities was the most commonly desired service to make families healthier. Youth programming was described as the greatest need for youth in Haldimand and Norfolk in nearly every instance where youth needs were described. Participants explained how youth were bored and/or lonely and often linked this to experimentation with vaping, tobacco, alcohol, and drugs, or with negative mental health outcomes.

General recreation for all age groups was also a common desire. Participants described a need for recreational facilities in context of high rates of obesity, low physical activity, feelings of isolation in a rural community, and in context of the current barriers they faced to access recreational opportunities, such as hours, distance, and costs. Participants reiterated many times the importance of recreational opportunities that were affordable for families on limited incomes.

Recommendations for recreational facilities included parks and pools. Participants explained that, recreational centers for youths would help increase physical activity, and reduce boredom/ loneliness linked to experimentation with vaping and drug use. It would help if the recreational centers are located across multiple town centers, easily accessible and have affordable youth programs. For example, participants, especially youth participants, explained that the location of the skate park was far from the schools and services they use, and thus, did not get the use that it would in other locations.

Also, a participant (KI46) suggested that HNHSS should be collaborating with the school boards for youth programming as that is one of the easiest ways to reach that population group,

"…but also working in collaboration with the schools because kids are in school, how many hours a day and that they're a captive audience there. So when organizations can work with the School Board for programming or space. It will really make a difference. I do some work with the mental health lead for the [School] Board and the [other] School Board, and we have some programming together."

As with several other services in the area, HNHSS is not explicitly mandated to provide recreational opportunities or build facilities for individuals and families to use1. However, HNHSS is mandated to consider the local needs for physical activity and healthy behaviour, including obesity rates, and could advocate to ensure that services are being sufficiently provided locally. Among other options, HNHSS can act on this recommendation by applying for grant funds to build and expand recreational facilities in the region. Having done this recently, Norfolk County is recognizing the need of the community and responding with appropriate actions; therefore, HNHSS is meeting its mandates in this area. Further actions that

could be investigated or considered are the possibility of subsidies to allow families to access recreational programming and intentional diversification of available programming to include lower-cost activities such as swimming and baseball, beyond the commonly noted availability of hockey in Haldimand and Norfolk.

Organizational Structures

Barriers to services in Haldimand and Norfolk, and specifically at HNHSS, frequently involved organizational structures that made it difficult for clients to use or access services. This barriers may have prevented any use or may have prevented full use of a program or service. However, solutions to these problems were often the most actionable and feasible recommendations made by participants in both the quantitative and qualitative elements of the CNA. These recommendations broadly focused on improving communication (strategy and content), collaboration (both within HNHSS divisions as well as among HNHSS, supporting agencies and the community), meeting people where they are, operational changes, and anti-oppressive actions (see below for more information). All of which can be considered part of the OPHS mandates to provide supportive environments1. Supportive environments are part of the standards related to chronic disease and well-being, healthy growth and development, infectious and communicable diseases, and substance use and injury prevention.

Collaboration

The most commonly discussed idea for solutions or recommendations to improve the health and social services provided in Haldimand and Norfolk was to increase intra- and inter-agency collaboration. For instance, establishing active partnerships among HNHSS divisions will reduce administrative barriers such as wait-times and lack of data sharing. In theory, cross collaborations within HNHSS divisions will eliminate service duplication, scenarios that require clients to re-live traumatic experiences by telling their stories multiple times, and make it possible to plan service delivery around a client's availability. A consensus among most participant with regards to recommendations to foster inter agency collaboration is the use of a coordinated care plan. A participant (KI67) stated that;

"… we can be doing a better job of using coordinated care plans so that people are not filling out the same information for all agencies, because not only is that a barrier for them to fill out, but I don't know if that's providing the dignity that people deserve to have to continue to tell their story to meet every service that they need. Many times you have to tell your story to a stranger. And make yourself visible just for service. Multiple times over. So it's vulnerable and it makes it hard like. And I think it would then allow us to kind of look at how, you know, internally our systems are operating so that we can better operate to not only collaborate, but to fill in gaps."

Elaborating on the idea of a coordinated care plan, participants believed that certain strategies like the use of a single consent form for most services provided and piggybacking on appointment times are less capital intensive steps that could be easily taken towards achieving a coordinated care plan. A participant (KI37) advised that if "[We] can only achieve one thing from this, if you could get us all to have just one consent form, which would be great". The idea of a single consent form will allow for flexibility of data sharing among service delivery units within HNHSS. As such, service delivery units could piggyback on one another's appointment times to reduce transportation costs for clients. A cost intensive, but more practical route, to establishing a coordinated care system would be the use of an electronic database. This would be a centralized-access system that would offer a 'one stop-shop' opportunity for service delivery units. In other words, it would allow units access (to a limited extent) to information regarding other services that are being pro-

vided to their clients by their colleagues in other departments of the Division. A participant (KI37), explained that;

"It would speed up the ability to provide service and probably stop duplication of service. Because we all have our staff. Right. And maybe if there was just one place we could go to find out. 'Oh, yeah. This person's on other people's radar. What have you done? Oh, I won't have to do that. I won't have to recreate that piece or [I can] learn from what you've found out.' So, yeah…"

Further, collaborations with external agencies were among some of the more feasible ideas from participants. Most of these recommendations centered on HNHSS taking up more advocacy roles within the community to improve access to HNHSS' services for clients. For instance, to reduce transportation barriers, HNHSS could advocate for Ride-Norfolk's services to be more streamlined to accommodate HNHSS clients. This could be in the form of advocacy for additional bus stops (closer to HNHSS service delivery locations), bus times rescheduled to fit with HNHSS hours of service (i.e. reducing wait-times for buses during HNHSS hours of service), subsidies to commuters based on need, and additional buses.

Another opportunity for advocacy by HNHSS is the advocating for active partnerships between community agencies to bridge service delivery gaps and prevent duplication of service.
Another idea for collaborations, was for HNHSS to host a phone line that would be available to all local residents as a way to determine the appropriate programs and services that they desire or need. For example, one participant (KIX) described, "[Having] that one point of contact. Where you call through and find your way to the appropriate person [or service of interest]". Other participants referred to this as a "no wrong-number approach," which they believed would better serve the community's complex needs and lack of awareness of services.

Alongside these collaborations, participants recommended how a system map (i.e. web) of community services may allow HNHSS and other agencies to see what is currently available, identifying gaps and duplications of services. Participants recommended that this map be hosted online and updated regularly, distributed among HNHSS staff who refer clients to various services, and part of communication plans for interactions with clients and the public who may be in need of services.

Communication

The second most commonly discussed idea for solutions or recommendations to improve the health and social services provided in Haldimand and Norfolk was to increase communication. This idea was presented by both focus group and interview participants; however, it was clear that the idea of communication meant two different things across participant groups. Agency participants typically spoke of communication in conjunction with collaboration, as a response or solution to the ideas of service duplication and service gaps. In contrast, participants who were speaking from a perspective of lived-experience felt that HNHSS needed to do more to communicate their program offerings to the general public, specifically to those priority populations who required services. For instance, about one in four survey respondents do not know how to access health and social services for themselves or their families.

Tangible ideas for communication abounded in the interviews and focus groups. One of the most commonly discussed ideas for communication was to increase awareness of available programming. These recommendations ranged from more complex and high impact solutions to low cost and more feasible solutions. A recurring low-cost recommendation among participants of the focus group discussions and interviews (i.e. both HNHSS staffs and service users) was the

need for a clear description of services that HNHSS delivered. This could be in the form of a comprehensive flowchart that lists the services rendered by HNHHSS, and simplifies the processes and requirements needed to access these services. A participant (KI33) explained that a flowchart such as this will not only improve awareness of current services but also aid cross-collaborations within HNHSS and streamline service delivery.

‘[We need] a flowchart saying ‘Is your client experiencing this? Yes or no, go to this person, go to that person.’ Like, I really need a comprehensive tool that tells me [this], not an email. Like I need something on a piece of paper that I can look at that I know exactly who does what. If that exists, I don't have it. But that is even a barrier to me accessing services there are, trying to call and advocate on behalf of my clients because I don't know who to call.’

In addition, a tool like this will be more effectively utilized if it is easily accessible and easy for clients, service providers, and community members to understand. Accessibility to such tool could be improved by distributing it within HNHSS and its supporting agencies, provided to clients (translated where necessary), and hosted online (on HNHSS websites and social media). Similarly, high impact solution to addressing the problem of service awareness will be an asset map of all community resources. This would be a list of events, organizations, locations, contact information and corresponding hours of operations. A participant (KI66) gave an example of how a resource like that will help improve access.

“If you service, that although we may not be there every day of the week, that we're still offering vaccinations on Tuesday mornings. And it may be the only time we're there, but people know coming in or people calling in know that if they need a vaccination to get up to for their school age children, they know they can go in at that time or they can schedule services at that time.”

While HNHSS currently produces several print materials and maintains a media presence, the data suggests that the community did not feel this was enough to be familiar with the breadth of available programs.

Meet People Where They Are

The third most commonly discussed idea for solutions or recommendations to improve the health and social services provided in Haldimand and Norfolk was to intentionally meet clients where they are. This referred to both physical access and emotional state.

With regards to physical access, participants often described the value of a community hub. Participants believed that establishing a community hub would aid access to HNHSS services, especially if the hub allowed community members to, as one participant (FG3) said, “connect to everything [i.e all HNHSS services] at once and in one place.” Access to HNHSS services can be improved if communities have a central location where community members can walk in with the guarantee of, at best, having their needs met or at least, having reliable information they need to meet their needs in other places. To achieve this, the community hub will need to host representatives from all HNHSS Teams that provide services directly to clients. A more cost effective, but temporary alternative to the community hub will be the use of HNHSS and county buildings as ad hoc spaces for providing services. For instance, the libraries or parks could be used as sites for a one-time, “one stop shop” that allows community members to come in and interact with multiple service providers at the same time. Expanding on these recommendations, the creation of a system that allows for onsite checks for targeted population groups will improve access for hard to reach groups within the county. For instance, a participant

(KI50) recommended meeting with seasonal agricultural workers, "On farms while they are not working, such as Sundays or evenings," because this population group typically works during the hours which HNHSS services are delivered.

In addition, the lack of a county-wide public transport system and prevalence of poverty exacerbates the problem of access to services that already exists within Haldimand and Norfolk. To address the barrier of access due to transportation problems and the counties' geography, participants recommended meeting people where they are. One such recommendation involved setting up meetings with clients in places they can easily access. A key informant (KI27) explained that;

"[Because of the transportation barrier], a lot of times because I [have to] go out to people's homes, it is breaking down the barrier of always having to meet here [i.e. HNHSS building] as opposed to having to go out to meet people where they need to be met. Like a doctor's appointment, houses, or apartments. I pretty much meet clients wherever. We have met in a park. We try to use as many resources in the community to meet. Whether it is in a library or whatever."

From an emotional perspective, participants felt that HNHSS was not employing a trauma-informed lens for providing client-facing services. Several participants reiterated that HNHSS typically works with vulnerable clients who are experiencing various forms of trauma, such as generational poverty, abuse, or substance-related issues, and who should be treated in an informed way so as not to exacerbate existing traumas. For this barrier, recommendations primarily centered on providing training as to trauma-informed care for staff at HNHSS.

Further, from a health equity lens, service accessibility can be greatly improved through involvement of individuals with lived-experience in program planning and agenda setting. This could be achieved by frequent Health Equity Impact Assessments of programs delivered and strategic planning backed up by local empirical data (e.g. Community Needs Assessment reports). For instance, a key informant (KI15) recommended that programming units should,

"Consider [that] the context of these workers [i.e. Seasonal agricultural workers] is not the context of the rest of the population. These are like a mini unit. So don't pretend to address the health issues with this population the way you address them in general [population] because the duality that exists in that context makes this situation totally different. And so the health unit needs to think- 'how can we facilitate the health of these people under these conditions?'"

An example of non-contextual planning that that participants reiterated throughout the qualitative phase of the CNA was the placement of the needle-drop box for the harm-reduction program very close to a police post. Many participants recommended moving these boxes to locations that were not near police and parole stations where users feared prosecution.

Operational Changes

Another recommendation for increasing accessibility of HNHSS programs and services was to extend operating hours to serve families in the evenings and on weekends. If HNHSS considers the opportunity that staff were encouraged to flex their day to work 12PM-8PM one day per week, the client-facing programs, such as sexual health, oral health, and vaccine preventable diseases would be more accessible to working families and families whose children are in school full time. Hours could be extended to 8PM Monday to Thursday to accommodate the needs of the community.

Anti-Oppressive Actions and Empowerment

Participants in focus group discussions and interviews, as well as the community survey, described feelings of stigma related to using several HNHSS services. Stigma was commonly described in context of other clients or program users, however, some participants also described feelings of being stigmatized by staff. Typically, participants felt that HNHSS was making progress in client empowerment and anti-oppressive actions to address stigma, but often felt that HNHSS could continue to do more in this space to reduce feelings of stigma. Not only did participants feel that HNHSS could be doing more to address these issues, many participants felt that HNHSS was missing an opportunity to be a community leader in this space. Tangible recommendations for anti-oppression included initiating meetings and events with land acknowledgements, advocating on behalf of priority populations, and empowering priority populations to sit on decision-making committees to share their experiences. Relatedly, the Chief Public Health Officer of Canada's Report on the State of Public Health in Canada 2019 calls for similar actions3. Dr. Tam calls for Canadian public health programs to build on the Canadian values of multiculturalism while openly naming and recognizing issues such as racism, homophobia, transphobia, and other stigmas of social identity. Additionally, Dr. Tam describes how the elimination of stigmatizing behaviours can improve overall health and wellbeing in our communities[3].

Related to meeting people where they are emotionally and empowering individuals, a distinct subtheme of recommendations for informing practices by lived-experiences also emerged. These recommendations focused on the idea that individuals with lived-experiences of all sorts should be included in decision-making processes, program planning discussions, and in more intentional ways, such as via this CNA. Participants described the ways that informing programming by lived-experiences practically addressed the needs the community members wanted to prioritize. For HNHSS, that may include considering a regularly scheduled CNA every 5 years, inclusion of individuals with lived-experiences on program planning committees, and more.

Conclusions

The data collected as part of the CNA for HNHSS 2019 came from many sources in an attempt to triangulate the data and present the most comprehensive and representative conclusions possible. The results suggest that HNHSS is doing a good job, but that there are several key areas of recommendations to continue addressing to meet the needs of residents in Haldimand and Norfolk counties. Major needs in the community included mental health and addictions supports, affordable housing, and poverty alleviation. Further, many of the issues being experienced in Haldimand and Norfolk were exacerbated by generational poverty, rurality, and a lack of available products and services, such as transportation, child-care, and recreational opportunities. However, from a solutions-oriented perspective, the community participants shared several exciting, tangible, and important recommendations to continue to improve the services available through HNHSS. It is important that HNHSS and the counties continue to work together to implement the recommendations and serve the communities to the best of their ability. Not all of these recommendations can be met by HNHSS and the counties alone—collaboration and communication with other agencies, residents, and the Board of Health will be essential for success. Next steps for action on the findings of the CNA are to develop a new Strategic Plan in 2020 for HNHSS, build and maintain strong relationships with partners, and prioritize the recommendations presented above.

References

1. Ontario Public Health Standards (OPHS) 2018. Protecting and Promoting the Health of Ontarians. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Ontario_Public_Health_Standards_2018_en.pdf
2. Feed Ontario. (2019) Hunger Report: Ontario’s Changing Landscape and Its Impact on Foodbank Use. Available from: https://feedontario.ca/wp-content/uploads/2019/11/Hunger-Report-2019-Feed-Ontario-Digital.pdf
3. Tam, T. (2019) Addressing Stigma: Towards a More Inclusive Health System; The Chief Public Health Officer’s Report on the State of Public Health in Canada, 2019. Available from: https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-toward-more-inclusive-health-system.html?utm_medium=email&utm_source=stakeholder&utm_campaign=cpho-19.