

Community Needs **ASSESSMENT** Summary Report

2019

Report of Findings

Haldimand Norfolk Health and
Social Services (HNSHSS)

Report prepared by Quality, Planning,
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Introduction

Introduction

A Community Needs Assessment (CNA) aims to identify and understand the needs of the population within a region and identify factors that must be addressed to meet the population's needs^{1,2}. When used to understand health and social service needs, a CNA should be designed to understand the needs of the population as well as to understand the factors that individuals need to feel healthy, safe, and protected in their community. A CNA typically involves three key steps: (i) assessment; (ii) dissemination; and (iii) implementation^{1,3}.

The assessment phase of the Haldimand Norfolk Health and Social Services (HNHSS) Department CNA involved four elements: (i) a community profile; (ii) a community survey; (iii) focus groups with priority population groups; and (iv) key informant interviews. This report provides a summary of findings of the CNA 2019.

The HNHSS CNA will contribute to future planning and actions of the Division and will be used by Senior Leadership, Program Managers and Program Staff to inform program offerings and implementation strategies. The information gleaned through the CNA process is as representative of the diverse populations of Haldimand and Norfolk counties as possible. The multi-faceted approach helped to ensure this diversity and representativeness.

Rationale for HNHSS CNA 2019

This is the first time that a CNA has been formally conducted across the Division of HNHSS. The HNHSS CNA 2019 process is intended to inform actions and next steps for the Division. The HNHSS CNA will inform key community priorities for action and advocacy. Data collected in a CNA can be used to guide agency planning, inform resource allocation, and improve service offerings for the public¹. Further, community engagement throughout the CNA can improve relationships with community members, local agencies, and other groups. Finally, targeting interventions according to the mandate of the Ministry of Health (MOH) will also increase the effectiveness and cost efficiency of programming in both health and social services^{1,4}.

Objectives

The specific objectives of this CNA were to:

- i. Describe current health, social status and needs of all residents in Haldimand and Norfolk counties;
- ii. Identify needs and gaps for extended health and social programming in Haldimand and Norfolk counties;
- iii. Support evidence-informed decision-making and program planning for health and social services in the region.

Methods

Methods

Approach

Overall, the HNHSS CNA employed a community-based participatory mixed-methods approach (i.e. we used quantitative and qualitative research methods together). Ethical protocols for this study were evaluated by the Research Advisory Council (RAC) at HNHSS.

Community Profile

The purpose of the community profile element of the CNA was to describe the general residents and priority populations within Haldimand and Norfolk counties. To generate the community profiles, a list of indicators (i.e. variables) for demographics, health, and social services was developed. The indicators were identified from a variety of sources, including the HNHSS Program Operational Plans, the CNA for Windsor-Essex County Health Unit¹, and in discussion amongst HNHSS staff.

Data to provide evidence for each of the identified indicators was collected by Quality, Planning, Accountability, and Performance (QPAP) staff from available sources. Sources varied depending on the indicator (please see citations in results for more information). When available, data were collected for Haldimand County, Norfolk County, Haldimand and Norfolk counties combined, and for Ontario. Data were aggregated and analyzed to provide relevant measures for the region and to generate summary measures of the data (e.g. rates, means, medians, modes, ranges). Data were investigated for emerging trends that may differentiate the Haldimand and Norfolk region from other parts of Ontario (i.e. higher, lower, or different distributions).

Community Survey

The purpose of the community survey was to collect data from members of the general population and to investigate demographics, perspectives, and health and social behaviours. The community survey collected quantitative (i.e. numerical) information via closed-ended (i.e. yes/no) questions. The survey tool was adapted from an existing validated tool¹. The adaptations to the tool included updating of terms to reflect the most culturally appropriate language of the time, inclusion of questions specific to rural communities, the inclusion of a section related to the environment and climate change, and the addition of questions for social services needs and program utilization (Full report: Appendix A).

The survey was distributed via online platforms on HNHSS social media, and across social media accounts for Haldimand and Norfolk counties. The survey was also distributed via paper versions that were available at several locations across the two counties, including libraries, churches, hospitals, county fairs, and community agencies. Participants had to be ≥18 years of age to consent to participate in the community survey. Participants who completed the survey were eligible for inclusion in a draw for one of three grocery store gift cards.

Data were analyzed via descriptive statistics, which included frequencies and proportions. Descriptive statistics were further interrogated by stratification by gender (male, female, prefer not to answer), age (18-25 years, 26-40 years, 41-60 years, 61-75 years and >75 years), income bracket (<\$30,000, \$30,000-<\$50,000, \$50,000-<\$70,000, \$70,000-<\$100,000, ≥\$100,000), and county (Haldimand, Norfolk). Data were analyzed via Select Survey (Norfolk County) and Microsoft Excel ©.

Focus Groups with Priority Population Groups and Key Informant Interviews

The purpose of the focus groups with priority population groups and the key informant interviews was to intentionally elicit and incorporate lived-experiences that might not otherwise be included in the CNA. Focus groups were conducted with community members with lived-experiences from a variety of different backgrounds and knowledge in groups of 3-8 participants. Key informant interviews were primarily conducted with agency representatives for health and social services-related organizations. Where appropriate or desired by participants for a variety of reasons (e.g. anonymity), lived-experiences were documented via key informant interviews rather than via focus groups. A purposive (i.e. targeted) snow-ball (i.e. stepwise) sampling strategy was employed for both focus groups and key informant interviews.

Both focus groups and interviews were conducted using a semi-structured (i.e. conversational), participatory (i.e. engaging) interviewing techniques⁵. Focus group and interview guides were developed a priori (i.e. before the study began) and modified conversationally as needed to collect the most relevant and useful information from each participant. Conversations were recorded with consent from participants.

Recordings of focus groups and interviews were transcribed by members of the QPAP team. Transcripts from focus groups and interviews were analyzed via thematic

analyses (i.e. working through data to identify themes or similarities across discussions) according to a codebook (i.e. guide for analysis) generated by members of the research team⁶. The codebook included data-driven (i.e. emergent, found in the transcripts of the discussions) and theory-driven (i.e. determined a priori from the literature) codes. Thematic analyses were conducted in the software Dedoose vs. 8.2.14 ©.

Triangulation

The data collected from the four elements described above were not analyzed in isolation. Triangulation (i.e. cross-data comparison) was used to synthesize the findings from the various data collection strategies to identify areas of agreement and disagreement in the data⁷. The synthesis process results in stronger support for the conclusions drawn from the data.

Community Profile Results

Community Profile Results

Demographics

- Haldimand and Norfolk counties are defined as rural regions because over 50% of the population in each county live in rural communities (i.e. <150 persons per square kilometer)⁸.
- 109,787 residents live in Haldimand and Norfolk counties combined (41.5% in Haldimand County and 58.3% in Norfolk County)⁸.
- There are a higher proportion of residents over 65 years in Norfolk County (22.5%) than in Haldimand County (18.1%) or Ontario (16.7%)⁸.
- There are approximately 4,100 seasonal agricultural workers in Haldimand and Norfolk counties⁹.
- Approximately 3.9% of the population of Haldimand and Norfolk counties speak German as a first language⁹. There are an estimated 5,000 Low-German speaking Mennonites in Haldimand and Norfolk counties. This population is sometimes migrant between Ontario and Mexico⁹.
- Approximately 3.2% of the population identify as Indigenous, which is higher than the proportion of Indigenous peoples in Ontario (2.8%)⁸.

Social Services

Income and Poverty

- Median income in Haldimand County is \$76,117 and \$67,338 in Norfolk County compared to the province (\$74,287)⁸.
- The variability of Haldimand and Norfolk residents living in low-income households is quite substantial across the region; this percentage ranges widely from 5.5% in Caledonia to 21.1% in Dunnville (based on the Low-income Measure, After Tax)⁸. Overall, 11.7% of residents in Haldimand and Norfolk are living in low-income

households compared to Ontario's rate of 14.4%.

- There are approximately 1,192 individuals accessing Ontario Works in Haldimand and Norfolk, which includes 2,043 beneficiaries⁹. The average percent of caseloads exiting to employment was 16.5% per month in Haldimand and Norfolk in 2018, compared to 18.0% in Ontario; however, proportions of caseloads exiting to employment were higher in Haldimand and Norfolk from September to December 2018 (28.55%) than Ontario (18.32%)¹⁰.
- Residents in rural areas need to make a monthly income of at least \$1,639 to afford a basic standard of living. Clients on Ontario Works receive \$733 per month, leaving a shortfall of \$906 per month. Clients on Ontario Disability Support Program receive \$1,169 per month, a shortfall of \$470 per month¹¹.
- Food costs were estimated to have increased 5.8% from 2014 to 2019¹².

Employment and Education

- Employment rates across the counties vary: Haldimand employment rate is 61.2% and Norfolk employment rate is 55.2%, compared to the Ontario employment rate of 59.9%⁸.
- The most common employment industries in Haldimand and Norfolk counties are manufacturing (14.3%) and health care and social services (11.5%)⁸.
- The proportion of residents in Haldimand and Norfolk who have not completed a high school diploma is 20.9% and 24.1%, respectively, compared to Ontario at 17.5%⁸.

Housing and Homelessness

- There are 826 rent geared to income or affordable housing units in Haldimand and Norfolk counties (65%

in Norfolk County and 35% in Haldimand County). The average waitlist for rent geared to income housing is 343 people, which equates to approximately 1-3 years for priority cases, 3-4 years for the majority population and seniors, and up to 8 years for a one bedroom unit in Simcoe⁹.

- There are 25 rooms available for emergency housing supports in Haldimand and Norfolk. The average length of stay in these rooms ranged from 0-136 nights. The vacancy rates for these rooms are variable but typically quite low⁹.
- The 2018 homeless persons enumeration identified 79 homeless residents in Haldimand and Norfolk, with more residents experiencing homelessness in Norfolk compared to Haldimand (68% compared to 32% of the total homeless population)¹³.

Social Networks

- Nationally, about 62% of Canadians reported a somewhat strong or very strong sense of belonging to their local community. In Ontario, about 70% of the population reported a somewhat strong or very strong sense of belonging to their local community. Local data are not available for Haldimand and Norfolk counties⁸.
- Nationally, about 86% of Canadians reported being satisfied or very satisfied with their life. In Ontario, about 93% of the population reported being satisfied or very satisfied with their life. Locally, 93% of residents in Haldimand and Norfolk reported being satisfied or very satisfied with their life¹⁴.

Safety

- In 2019, Norfolk County was ranked one of the safest communities to live in Ontario, based on the Statistics Canada Uniform Crime Reporting Survey¹⁵.
- The crime severity index in Norfolk County decreased by 5% from 2014 to 2019. Data were not available for Haldimand County¹⁵.
- In 2016, 673 motor vehicle collisions were reported in Haldimand County, a decrease of 9.9%, of which, 5 included one or more fatalities. In the same year, 872 motor vehicle collisions were reported in Norfolk County, a decrease of 12.2%, of which, 9 included one or more fatalities^{16,17}.

Over 95% of residents in Haldimand and Norfolk counties report feeling 'safe' or 'very safe' in their community⁸.

Childcare

- Data from the Early Development Instrument¹⁸ (a tool that considers the health at school entry) demonstrate that 25% of children in Haldimand and Norfolk are vulnerable on at least one EDI domain compared to 30% of Ontario kindergartens. Approximately 10% of children were identified as having one or more special concerns as part of the Early Development Instrument Study in 2017-2018.
- Following an engagement session with the Child Care Operator groups in February 2019, the key priorities identified for the priorities of licensed childcare systems for the next five years were: affordability, access, quality, and responsiveness⁹.
- There are 45 registered (i.e. licensed) childcare providers in the region; 19 in Haldimand and 26 in Norfolk⁹.

Health and Wellness

General Health and Wellbeing

- 36% of Haldimand and Norfolk residents reported being active during leisure time compared to 30% of all Ontario residents¹⁴.
- Self-reported adult obesity rates in Haldimand and Norfolk counties were similar to Ontario (20.5% compared to 20.3%)¹⁴.
- Significantly fewer residents of Haldimand and Norfolk counties reported brushing their teeth at least twice a day (76.5%) than all Ontario residents (81.4%)¹⁴.
- There are 57.8 physicians per 100,000 people in Haldimand and Norfolk, compared to national rates of 241 doctors per 100,000 people across Canada⁹.

Chronic Disease and Injury

- Haldimand and Norfolk counties has significantly higher rates of hospitalizations for all injuries combined compared to Ontario (927.2 vs. 552.8 per 100,000)¹⁴.

- Haldimand and Norfolk Counties has similar incidence of all cancers compared to Ontario (534.8 compared to 531.2 per 100,000)¹⁴.
- Haldimand and Norfolk Counties has significantly higher rates for both hospitalization (1104 (1048-1159) admissions per 100,000 population) and mortality (236 (211-261) deaths per 100,000 population) for chronic cardiovascular disease compared to Ontario (hospitalization: 903 (898-907) admissions per 100,000 population; deaths: 170 (168-172) deaths per 100,000 population)¹⁴.

Mental Health and Addictions

- Rates of hospitalization for intentional self-harm are significantly higher in Haldimand and Norfolk counties compared to Ontario (91.3 vs. 71.1 per 100,000)¹⁴.
- Annual counts of death by suicide in Haldimand and Norfolk Counties ranged from 10-20 individuals per year (Mental Health Promotion and Resilience Program 2018).
- The self-reported rate of exceeding the Low-Risk Drinking Guidelines is 52% for residents of Haldimand and Norfolk counties compared to Ontario (44.4%)¹⁹.
- The self-reported current smoking rates for adults were similar in Haldimand and Norfolk counties (19.5%) to the provincial rates (18.1%)¹⁴.
- Opioid related emergency department visits were 67.9/100,000 in Haldimand and Norfolk counties compared to 63.4/100,000 in Ontario¹⁴.
- Opioid related general hospitalizations in Haldimand and Norfolk counties were 23.2/100,000 compared to 14.6/100,000 in Ontario¹⁴.

Maternal and Child Health

- Approximately 20% of mothers in Haldimand and Norfolk counties exclusively breastfeed up to 6 months, according to the Infant Feeding survey, which defines exclusively breastfeeding as feeding breastmilk only to a baby, and have not introduced any other formula, solids or liquids²⁰.
- 30% of mothers in Haldimand and Norfolk counties reported using folic acid supplements prior to and during pregnancy compared to 31.5% across Ontario²⁰.
- Significantly more mothers in Haldimand and Norfolk

counties reported smoking during pregnancy compared to Ontario (12.4% vs. 7.1%)¹⁴.

- Approximately 25% of children in senior kindergarten in Haldimand and Norfolk Counties were identified as vulnerable on at least one developmental domain, compared to approximately 30% across Ontario¹⁸.
- Approximately 10% of children in senior kindergarten in Haldimand and Norfolk counties were identified as having one or more special needs¹⁸.
- Haldimand and Norfolk counties have a significantly higher pregnancy rate compared to Ontario (62.3 vs. 53.1 per 1,000 females of reproductive age)¹⁴.

Infectious and Vector-borne Diseases

- Immunization coverages for infectious diseases mandated under the Immunization of School Pupils Act in Haldimand and Norfolk counties among 7-year old students were: Measles 91%; Mumps 91%; Rubella 91%; Diphtheria 95%; Pertussis 95%; Tetanus 95%; and Polio 95%. These proportions were comparable to Ontario^{9,21}.
- Confirmed enteric infections of public health significance were reported in approximately 1.8 per 100,000 people in Haldimand and Norfolk counties in 2018, compared to 4.15 per 100,000 people in Ontario^{9,22}.
- Sexually transmitted infections of public health significance were reported in approximately 305 per 100,000 people in Haldimand and Norfolk counties in 2018, compared to 467 per 100,000 people in Ontario^{9,22}.
- There were 2.7 confirmed cases of Lyme disease per 100,000 people in Haldimand and Norfolk counties in 2018, compared to 4.0 cases per 100,000 people in Ontario^{9,22}.
- There were 5.4 cases of West Nile Virus per 100,000 people in Haldimand and Norfolk counties in 2018, compared to 0.85 cases per 100,000 people in^{9,22}.

Environment

- Population density in Haldimand County is 35.97 people/km², and 39.25 people/km² in Norfolk County⁸.
- Haldimand and Norfolk counties combined cover 2,859km². Of this land, approximately 1.9% is park lands and 68.3% is agricultural land⁸.

Community Survey Results

Community Survey Results

Survey Respondents

- A total of 492 individuals responded to the survey.
- In total, 57 responses were excluded for empty responses (i.e. no data), 4 responses were excluded for not living in Haldimand or Norfolk counties (i.e. did not meet inclusion criteria), and 4 responses were excluded for not providing consent to participate.
- Therefore, 427 responses were included in the final analyses. Participants were able to skip questions if they chose, thus n-values are provided for context throughout the survey results.

Demographics

- Survey respondents over-represented females (80%, n=336), and adults aged 26-60 years (76%, n=314).
- The majority of survey respondents had a college certificate or diploma (35%, n=142) or a high-school diploma or equivalent (24%, n=99).
- The majority of survey respondents were employed for wage or salary (48%, n=215) or retired (21%, n=61).

Self-Identification

- 25% (n=95) of survey respondents identified as a person with a disability and 10% (n=38) identified as a caregiver of a person with a disability.
- 14% (n=56) of survey respondents identified as a single parent.
- 5% (n=19) of survey respondents identified as a visible minority and 4% (n=18) of survey respondents identified as a religious minority.
- 3% (n=11) of survey respondents identified as LGBTQ2S+ or gender non-conforming.
- 2% (n=8) of survey respondents identified as Indigenous.

Social Services

Income and Poverty

- The majority of survey respondents reported an annual household income of less than \$30,000 (32%, n=118) or of more than \$100,000 (22%, n=82).
- In the past 12 months, 16% (n=59) of survey respondents reported using food bank services.

Employment and Education

- In the past 12 months, 10% (n=39) of survey respondents reported they were unemployed, not by choice.
- In the past 12 months, 15% (n=58) of survey respondents used Ontario Works or Ontario Disability supports.
- 11% (n=45) of survey respondents felt they were qualified for a better job than they could get and 26% (n=103) of survey respondents felt there were not enough job opportunities in Haldimand and Norfolk.

Housing and Homelessness

- In the past 12 months, 5% (n=21) of survey respondents reported requiring affordable or social housing but being waitlisted.
- Of the 20 survey respondents who reported accessing affordable or social housing, 55% identified as a person with a disability, 15% as a visible minority, 10% as a religious minority, 5% as an Indigenous person, and none identified as LGBTQ2S+.
- Nearly half of participants (48%, n=151) ranked more housing supports as one of the top three services needed to improve the social health of their family.
- In the past 12 months, 3% (n=10) of survey respondents reported being homeless or forced to couch surf, and 5% (n=21) of survey respondents reported being forced to live with family or friends because they had nowhere else to go.

- 72% (n=207) of survey respondents agreed or strongly agreed that Haldimand and Norfolk needs more social housing shelter spaces.

Social Networks

- 12% (n=47) of survey respondents reported feeling socially isolated where they live. Further, 12% (n=50) of survey respondents reported that they felt they had no or little social support network.
- The most commonly identified social supports were family (81%, n=241), friends (77%, n=217), and doctors or healthcare providers (52%, n=154).
- 11% (n=26) of survey respondents reported that there were social support providers that they would like to be able to access but have not been able to.

Safety

- 1% of survey respondents reported being arrested with cause in the past 12 months.
- 2% (n=8) of survey respondents identified their romantic relationship as dangerous.
- 22% (n=89) of survey respondents reported experiencing sexual or domestic violence.

Childcare

- 8% (n=31) of survey respondents reported struggling to find childcare for work.
- 71% (n=203) of survey respondents agreed or strongly agreed that Haldimand and Norfolk counties need more childcare services.
- 36% (n=114) of survey respondents ranked more youth-focused healthy activities, such as fitness, as a top three need for health of their family.

Services

- 72% (n=231) of survey respondents agreed or strongly agreed that they knew how to find the social services that they needed for themselves and their family.
- The most commonly reported sources of information for social services were doctor or health care provider (46%, n=144), websites (43%, n=134), and family or friends (41%, n=128).

- The most commonly faced barriers for accessing social services were waitlists (29%, n=81), costs (23%, n=64), and being unsure where to go (19%, n=55).

Health and Wellness

General Health and Wellbeing

- Many survey respondents (43%, n=131) reported that they had very good or excellent personal physical health.
- Survey respondents reported an average consumption of 2.9 servings of fruits and vegetables per day. Further, 24% (n=57) of survey respondents reported an average consumption of 0-1 servings per day.
- When asked to list the top three services that they needed to make or keep their family healthy, survey respondents listed more recreational opportunities as a top-three need most often. Specifically, 53% (n=167) of survey respondents reported wanting or needing more recreational opportunities to improve their physical health.
- Oral health was a commonly listed top-three education need for survey respondents. 18% (n=56) of survey respondents wanted more education about dental services for adults, compared to 10% (n=32) for children, and 10% (n=31) for seniors.
- 33% (n=103) of survey respondents reported that they would like to be able to access a healthcare provider that they have not been able to see.
- 76% (n=231) of survey respondents agreed or strongly agreed that they knew how to find the health services that they need for themselves and their family in Haldimand and Norfolk.

Chronic Disease and Injury

- When listing the top three health supports or services needed to make their family healthy, cancer screening was listed 26% of the time, making it the third most commonly listed support or service needed for healthy families in Haldimand and Norfolk.
- When listing the top three health supports or services needed to make their family healthy, falls prevention for older adults was listed 7% (n=22) of the time, and falls prevention for children was listed 2% (n=6) of the time.

Mental Health and Addictions

- 4% (n=14) of survey respondents self-identified as addicted to alcohol; 2% (n=12) self-identified as addicted to drugs, and 13% (n=53) identified as addicted to tobacco.
- Nearly half of all respondents reported experiencing depression and/or anxiety (46%, n=183) and 18% (n=72) reported experiencing non-depression mental health difficulties.

Maternal and Child Health

- 15% (n=45) of survey respondents reported that post-partum supports after a new baby as a top three mental health support needed to keep their family safe.
- Services related to maternal and child health that were reported as a top three need for a healthy family by survey respondents included: 9% for breastfeeding supports; 7% for family planning or sexual health supports; and 7% for prenatal care.

Infectious and Vector-borne Diseases

- The most commonly requested infectious disease topics that survey respondents wanted more information about were vector-borne diseases (14%, n=43) and vaccination and immunizations (11%, n=35).

Environmental Health

- 55% (n=164) of survey respondents felt that climate change was impacting their family's health.
- 37% (n=116) of survey respondents ranked more safe places to walk and/or play as one of the top three services needed to help them improve their own health.
- 71% (n=211) of survey respondents agreed or strongly agreed that Haldimand and Norfolk counties need more access to active transportation opportunities, such as bike lanes.
- In this Lyme endemic area, 75% (n=224) of survey respondents reported that they check their bodies for ticks after outdoor activities.

Community Experiences

- 72% (n=231) of survey respondents agreed that Haldimand and Norfolk is a good place to raise a family.
- 79% (n=250) of survey respondents agreed that Haldimand and Norfolk is a good place to grow old.
- 78% (n=249) of survey respondents agreed that Haldimand and Norfolk is a safe place to live.
- 78% (n=248) of survey respondents agreed that Haldimand and Norfolk is a safe place to be true to myself.

Service Experiences

- 78% (n=248) of survey respondents agreed that they knew where to find the health services that they needed for themselves or their family in Haldimand and Norfolk.
- 72% (n=231) of survey respondents agreed that they were able to find the social services that they needed for themselves or their family in Haldimand and Norfolk.
- Only 19% (n=56) of survey respondents considered themselves very familiar with the programs offered by HNHSS.
- The most commonly reported services used at HNHSS in the past year were printed materials (40%), spoken to a nurse (18%), and used HNHSS websites or social media (15% each).
- 41% (n=111) of survey respondents agreed or strongly agreed that it is easy to seek assistance from HNHSS.
- 42% (n=114) of survey respondents agreed or strongly agreed that they have always received good service from HNHSS.
- 48% (n=131) of survey respondents agreed or strongly agreed that HNHSS shows they care.
- 50% (n=135) of survey respondents agreed or strongly agreed that they trust HNHSS to have accurate, up to date information.

Focus Group & Interview Themes

Focus Group and Interview Themes

Participation in Qualitative Research

- 78 people participated in interviews as part of the data collection processes. Another 46 people participated in seven focus groups. In total, the qualitative components of this research included 124 participants.
- Participants included HNHSS staff, partner organization representatives, and individuals with various lived-experiences.

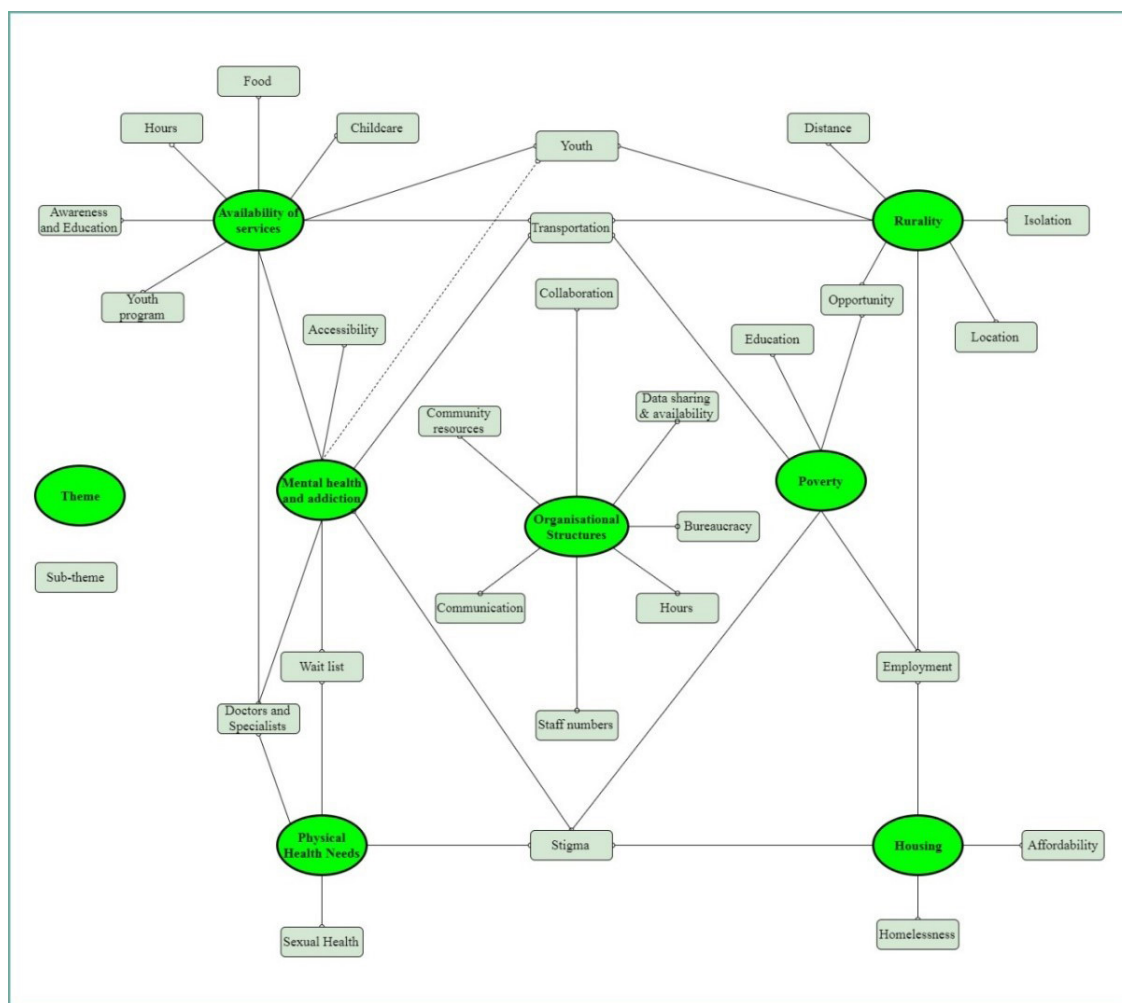


Figure 1. Web of major themes and sub-themes for focus group and interview discussions. The green circles indicate the 7 major themes identified in the data. The light green rectangles indicate sub-themes that emerged from one or more major themes. The lines linking a major theme to a sub-theme indicate areas where the sub-theme was relevant to a major theme(s).

Mental Health and Addictions

- Mental health and addictions was one of the most commonly discussed ideas or themes in all interviews and focus groups. It was commonly discussed in conjunction with the ideas for greatest need in the community.
- There was a general consensus among participants that having a mental health condition or an addiction was associated with substantial experiences of stigma.
- Participants in both focus groups and interviews reported that major barriers to accessing services for mental health and addictions were the long waitlists for treatment, lack of local professionals offering services, and the distance required to get to a treatment facility. This contributed to the overall opinion of participants that mental health and addictions services were not accessible in Haldimand and Norfolk.

Physical Health

- Several different physical health needs were mentioned in interviews and focus groups, including sexual health, aging populations, and the impacts of substance use on physical health.
- One of the most commonly discussed needs of the communities in Haldimand and Norfolk was the lack of family physicians and specialists in the region. This contributed to long wait times with the available providers or long distances to travel to see specialists.
- Participants also noted that several types of physical health needs that they may visit the health unit for, such as sexual health services, were stigmatized and made people feel vulnerable in the waiting areas of the health unit buildings.

Poverty

- Poverty was discussed as both a prominent theme and an underlying cause of many issues in the focus groups and interviews. Participants felt that the rates of poverty in the community were very high and that poverty impacted many of the other needs locally.
- Participants commonly described how the cost of living was simply too high to survive on the government funding provided by Ontario Works or Ontario Disability

Support Programs. Further, many participants described how wages were not enough to provide a good standard of living.

- Participants commonly discussed issues of generational poverty (i.e. poverty from one family generation to the next) as a major barrier. Some conversations reflected how parents who experienced poverty could not provide alternatives to their children while others reflected the trauma associated with experiences of poverty and the difficulty to overcome that.
- Again, participants discussed a stigma around poverty and accessing services such as Ontario Works, Ontario Disability Support Programs, food banks, and more. The judgements felt for accessing services were often enough to discourage participants from utilizing services that they felt that they needed.
- Transportation was a major barrier to accessing health and social services that was reported to drastically impact those living in poverty. Participants who had lived-experience of poverty or who worked with individuals experiencing poverty felt that this was exacerbated by the rurality of the region and the distance to get to various services.
- Many individuals with lived-experiences of poverty also discussed how lack of education and employment opportunities in Haldimand and Norfolk exacerbated issues with poverty.

Housing

- Like mental health and addictions, housing was one of the most commonly discussed ideas or themes in all interviews and focus groups. It was commonly discussed in conjunction with the ideas for greatest need in the community.
- Affordable housing was a major concern for participants in both Haldimand and Norfolk. Participants were concerned about the rising prices of rented and owned homes in the communities, as well as the decreasing available stock of housing. Many participants linked these changes to the expansion of the Greater Toronto and Hamilton areas and cost of housing there.
- Homeless prevention services were also mentioned regularly as an increasingly visible homeless population

are noticed in the Haldimand and Norfolk communities. Those with lived-experience typically described this as a long-ongoing issue that requires resolution while those from some agency and government positions saw this as a new issue that required resolution for other reasons (i.e. impacts on businesses).

- As with several other issues noted in the focus groups and interviews, participants felt that individuals experiencing homelessness were experiencing substantial stigma, driven in part by their visibility in parks and near businesses.

Rurality

- The rurality of the Haldimand and Norfolk communities was a theme that underlay several of the needs and barriers described by participants.
- The rurality of the communities and of peoples' homes was a common factor in feelings of loneliness or isolation in their home towns.
- The communities were commonly described as being very far apart and taking a long time to travel between. As a result, location was a commonly listed barrier for accessing services from HNHSS and other agencies. In particular, distance between communities was often cited by key informants from agencies as the barrier to providing transportation services. In contrast, distance between communities was often cited by those with lived-experience and the individuals serving them as the main reason for requiring transportation services.
- Additionally, the rurality of Haldimand and Norfolk was often cited as a reason for why participants felt there were limited employment opportunities in the region.

Availability of Products and Services

- Participants often explained that various necessities were not available in their communities or in the counties more broadly.
- Again, transportation was a major concern for participants who felt the currently available services were not enough and who noted how many communities were entirely excluded from the services.
- Despite Norfolk County being considered "Ontario's Garden" participants commonly stated that food was

inaccessible due to distance (i.e. no grocery stores in many communities) or due to cost (i.e. all food or healthy food was too expensive).

- The lack of available family physicians and specialists was also noted in context of availability of essential services.
- Several participants noted a lack of youth programming and a lack of youth and general recreation opportunities that were linked to mental health and substance abuse changes among the local youth population.
- Childcare was commonly cited as a necessary service that was not available for families that needed it. Specifically, many participants cited this as a barrier to employment.
- Waitlists and hours of operation both at HNHSS and other agencies were other common barriers to accessing necessary services in the communities.
- Further, a general lack of awareness of available services at HNHSS and other agencies impacted the familiarity with and use of services. At times, programs currently available within HNHSS were cited as needs in the community, demonstrating a lack of awareness of service provisions.

Organizational Structure

- Participants identified several factors that influenced utilization of and quality of available services at HNHSS.
- Both staff and agency participants reported insufficient availability of local data. Further, what was reported often included Haldimand and Norfolk with other counties that shifted the data to be less representative of these communities. Data that was available was reportedly not well shared between agencies.
- A lack of available financial resources to run or expand programs was a commonly discussed structural issue for both health and social services.
- There was a general consensus from key informants that there was insufficient staff to provide some services. HNHSS staff reported feeling overwhelmed by the workload while agency participants reported that HNHSS staff sometimes seemed unavailable due to workloads.
- Other structural issues that presented barriers for participants to use services were the location of the

HNHSS buildings, a relative lack of presence in the communities, and the hours that services were available (i.e. 8:30-4:30, Monday-Friday).

- The most commonly described area for growth and further improvement to address the needs of the community was stronger collaborations between HNHSS and other agencies.

- Similarly, communication, both internally and externally, were cited as both a strength and an area for growth. Some participants felt communication was very smooth and open while others felt that communication should be improved to address community needs.

Discussion & Recommendations

Discussion and 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. 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. However, 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 address-

ing 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 Standards⁴ (OPHS), 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. HNHSS should, consider opportunities to increase supports for mental health and addictions in the community such as health promotion activities for mental health. Alternatively, advocating to external agencies to provide additional supports such as youth mental health programming.

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 HNHSS⁴.

As such, HNHSS could improve access to services by advocating⁵ to council for the enactment of incentives that will encourage physicians as well as other health care specialists to practice within Haldimand and Norfolk. Further, 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 goods⁴, these goods were often described as necessities that allowed staff to more meaningfully engage with clients. 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 that a private space where individuals could enter and take what they needed without feeling watched or stigmatized by other clients at HNHSS would help.

Advocacy for Increased Incomes

The second major recommendation for poverty alleviation and to 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 call for 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 living. 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 considered 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 as well. 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.

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 were to shift legislation to allow for the development of “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.

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.

It was recommended that HNHSS could act on this 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.

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.

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 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.

Childcare

Another service that was frequently discussed as being unavailable or insufficiently available in Haldimand and Norfolk counties was childcare. Childcare was often described as being entirely full (i.e. no available spaces) or too costly for families to access. With regards to solutions, participants recommended that more spaces were needed

for full-day childcare for children 0-4 years and for before and after school care. Further, participants discussed existing subsidies for childcare that are currently managed by HNHSS from government bodies. These subsidies were described as very helpful and successful and participants called on HNHSS to continue to redirect funds directly to families using childcare services to make it more affordable whenever possible.

Food

A lack of available products and services was described in context of food in two key ways: a lack of available grocery stores in some areas (i.e. food deserts) and an inability to afford the foods that were available in their area. While it would be helpful to increase the number of grocers available, particularly in communities like Jarvis without such stores currently, HNHSS has a role to play in considering advocating for increased government subsidies or wages so that families can access healthy food or advocating for subsidies to access healthier choices. Other actions that HNHSS could implement included: training to make healthy meals for one, training to make healthy meals on a limited budget, and advocating for additional subsidies to access healthy foods.

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 recreation 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.

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.

HNHSS can act on this recommendation by applying for grant funds to build and expand recreational facilities in the region. Having done this recently, the County is recognizing the need of the community and responding with appropriate actions, 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. For example, organizational structures referred to collaboration, communication, meeting people where they are, operational changes, and anti-oppressive actions (see below for more information). However, these were often the most actionable and feasible recommendations made by participants in both the quantitative and qualitative elements of the CNA. There were many recommendations related to organizational structures.

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. Both focus group discussion participants and key informant interview participants recommended that collaboration would strengthen and improve the available services at HNHSS and other health and social services in the communities. When discussing intra-agency collaboration, participants referred to sometimes having a lack of awareness of services provided by

other departments in their own organizations, including within HNHSS. Inter-agency collaboration was discussed in the context of reducing the duplication of some services and the gaps in other services that were not well addressed due to a lack of collaboration.

One tangible idea for addressing these collaboration issues arose frequently; this idea reflected a stance of coordinated care, as has been initiated in some of the communities within Haldimand and Norfolk more recently. The idea of coordinated care models was that HNHSS and other agencies in the region would be more aware of each other and their priorities, and that duplication could be reduced to address current service gaps. A second tangible item related to collaboration was communication.

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 discussion participants and key informant 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.

Tangible ideas for communication abounded in the interviews and focus groups. One of the most commonly discussed ideas for communication was to increase staff awareness of available programming. Some recommended methods or processes to consider for increasing staff awareness of programming included information sessions with HNHSS staff in other departments, to learn how to best refer their current clients to other services. It was also suggested that HNHSS provide these types of sessions to other agencies. Additionally, updated and regularly revised

print communications was another recommendation. Ideas for communicating with the public also included regularly updated print communications about available programs, and included ideas for increased or different media presences, related more to day-to-day services. 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 location and emotional state.

From a physical perspective, participants in both focus group discussions and key informant interviews felt that HNHSS had a lower than optimal presence in many of the communities. HNHSS provides services at the offices in Simcoe, Dunnville, and Caledonia, and a few drop-in style clinic services in locations like Langton. However, it was often stated that this excluded many of the communities in Haldimand and Norfolk making it difficult to access services. Further, many participants also noted that the current locations of the three HNHSS offices were also difficult to get to as they were not downtown (e.g. Simcoe), or they were near other services that clients may be avoiding (e.g. parole or police stations in Dunnville and Caledonia). Participant recommendations primarily focused on more satellite locations and the introduction of a health bus to provide services in communities where an office was not a feasible solution. HNHSS could investigate and consider the opportunity to “hotel” (i.e. use existing spaces for short periods of time) in non-HNHSS county buildings in Haldimand and Norfolk counties. By working out agreements to use spaces in other county-owned buildings, HNHSS could feasibly provide services in many of the communities not currently feeling a community presence.

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 trauma-informed care training to staff at HNHSS.

Operational Changes

Another recommendation for increasing accessibility of HNHSS 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 12p.m.-8p.m. 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 8p.m. Monday to Thursday to accommodate the needs of the community.

Anti-Oppressive Actions and Empowerment

Participants in both focus group discussions and key informant 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. Relatedly, the Chief Public Health Officer of Canada’s Report on the State of Public Health in Canada 2019 calls for similar actions²³. 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 identity²³. Additionally, Dr. Tam describes how the elimination of stigmatizing behaviours can improve overall health and wellbeing in our communities²³.

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

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 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, childcare, 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.

Additional Information

A full version of the CNA report is available by request from the Director, QPAP, HNHSS.

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