Social Services and Health Services in Minority-Language Communities: Towards an Understanding of the Actors, the System, and the Levers of Action

Marie Drolet, *University of Ottawa*, Pier Bouchard, *Université de Moncton*,
Jacinthe Savard, *University of Ottawa*,
and Solange van Kemenade, *University of Ottawa*

Have you ever imagined what it would be like to communicate with a doctor or other health care or social services professional in a language you cannot speak or only speak occasionally? That is the everyday experience of many Francophones living in Francophone minority communities (FMCs) and many Anglophones living in Quebec, especially in areas outside Montréal. It is very common for people in these situations, particularly among seniors and young children, to be unable to access comparable social services and health care in both official languages even though many do not speak the language of the majority—English in FMCs and French in Quebec.

The first multidisciplinary volume of its kind, this collective work presents current research on language issues in the area of health and social services in Canadian official language minority communities. The chapters in the collection, covering major topics in the field, are anchored in the notion of active offer. From an operational perspective, "[a]ctive offer can be defined as a verbal or written invitation to users to express themselves in the official language of their choice. The active offer to speak their language must precede the request for such services" (Bouchard, Beaulieu, & Desmeules, 2012, p. 46). Moreover, the results of several studies to date reveal that the active offer of health

and social services in both official languages in minority situations is a matter of quality and safety (Drolet, Dubouloz, & Benoît, 2014; Lapierre *et al*., 2014; Roberts & Burton, 2013); humanization of care and services; professional ethics; rights and equity (Bouchard, Beaulieu, & Desmeules, 2012; Vézina & Dupuis-Blanchard, 2015); and satisfaction on the part of users and their caregivers (Drolet *et al*., 2014; Éthier & Belzile, 2012; Roberts & Burton, 2013).

It is interesting, too, that active offer practices are also part of other minority language situations, such as among Welsh speakers in Wales. Active offer is part of an approach that involves developing best practices in the planning and organization of health and social services and fostering the emergence of a social service and health care system that is linguistically appropriate (Roberts & Burton, 2013). Along the same lines the United States adopted the National Standards on Culturally and Linguistically Appropriate Services (CLAS) in 2001. The objectives of these standards are to improve the social services and health care provided to minority populations through (1) better access to services in the user's language; (2) culturally sensitive care; and (3) organizational support (U.S. Department of Health and Human Services, 2001).

All these studies and analyses suggest that efforts must continue to enhance the education offered in post-secondary institutions, thereby enabling future health and social services professionals to better understand the issues they will face in the workplace: accessibility and the active offer of services in official language minority communities. It is essential that students be equipped to become leaders who are able to intervene effectively in this regard and to support changes in the organizations for which they will work.

The Importance of Health and Social Services in the Official Language of One's Choice

Before turning to the specific content of the chapters in this volume, it would be beneficial to offer some reflections on the importance of access to health and social services in the official language of the user's choice, and the reasons that lie behind such active offer. These thoughts can be framed by international research work on the vulnerability of people with limited language and literacy skills, which introduced the concepts of health literacy and Limited English Proficiency (LEP) (Andrulis & Brach, 2007; Derose, Escarce, & Lurie, 2007).

If we examine the rates of bilingualism in Canada, it is Francophones living in minority language communities (i.e., outside Quebec) who have the highest rate: 87% speak both official languages. In Quebec, which at 42.6% has the highest overall rate of bilingualism in Canada, 61% of Anglophones and 38% of Francophones speak both languages fluently (Lepage & Corbeil, 2013). On the other hand, New Brunswick, Canada's only officially bilingual province, has an overall rate of bilingualism of 33.2%; 72% of Francophones are bilingual, representing two thirds (67.4%) of bilingual residents in the province (Pépin-Filion & Guignard Noël, 2014). Furthermore, immigrants, who constitute the primary factor of demographic growth in Canada, represent 20% of the Canadian population, and approximately 20% of these newcomers speak a language other than French or English as their mother tongue. The result is that a large proportion (82.5%) of Canadians cannot speak both official languages (Lepage & Corbeil, 2013). Finally, more than 86% of bilingual people live in Quebec, Ontario, and New Brunswick, while they make up only 63% of the overall Canadian population (ibid.).

Despite the high rate of bilingualism among Francophones in official language minority communities, they prefer to receive social services and health care in French (Gagnon-Arpin *et al*., 2014). The same is true for English-speaking Quebeckers, who prefer to receive these services in English. Indeed, language plays a fundamental role in the ability of the user and/or the user's caregiver or family members to build a relationship of trust with the health or social service professional. In terms of safety, when the professional and user share a common language, verbal communication is clearer and more efficient. As a result, the professional's treatments and interventions are better able to respond to the needs expressed by the people concerned and the experiences and conditions they describe (Snowden, Masland, Peng, Wei-Mein Lou, & Wallace, 2011).

This observation also holds true for bilingual people seeking services; they are generally more comfortable and have a higher language proficiency in one of the two languages they speak (Boudreault & Dubois, 2008). It is wrong to assume that a bilingual person who can converse in a second language can express him/herself at the same level in this language as a person for whom it is the first language. For example, in a study by Manson (1988, cited by Ferguson & Candib, 2002), Spanish-speaking people in the United States ask more questions when a physician from the same language group is present.

Furthermore, various factors can affect the language in which people who have learned several languages are best able to express themselves on a given subject. Among the factors are the order and the context in which they learned the language, and how often they use each of the languages in different contexts (Köpke & Schmid, 2011; Pavlenko, 2012). People who speak an official language in a minority context may switch regularly between the language of the minority and that of the majority. For example, they may prefer to use the language of the majority to find a specific element in their environment (Santiago-Rivera *et al*., 2009). These authors emphasize the tendency for the language of the minority, or of the majority, to adapt to the way people speak and the terms they use in their everyday speech (ibid.). An individual may rely predominantly on one language to express ideas that are work-related and another to express emotions, or share a situation in the language in which it occurred.

Finally, words spoken by an individual in their first language seem to be more emotionally charged or have a higher affective value and be more complex and spontaneous (Santiago-Rivera *et al*., 2009). This is even more apparent when the person is distressed or suffering, expressing emotions, or analyzing events in depth and interpreting their meaning (Castaño, Biever, González, & Anderson, 2007; Madoc-Jones, 2004). Understanding this is vital for helping the relationship or problem-solving when a health or social issue arises, and for empowering people to overcome their situation.

A number of studies from Canada, Wales, the U.S. and other countries also have demonstrated the consequences of not receiving care and services in the language of one's choice. In terms of access, people in official language minority communities are less likely to consult health professionals who provide examinations and primary care, and to receive preventive care. They have a weaker understanding of the care and services they receive (Bonacruz Kazzi & Cooper, 2003) and are, therefore, less likely to follow the recommendations of a health professional compared to people in the majority language group (Jacobs, Chen, Karliner, Agger-Gutpa, & Mutha, 2006; Qualité de services de santé Ontario, 2015). Mainly because of this context, people in the minority language group are at greater risk of being admitted to the hospital (Drouin & Rivet, 2003) and, once there, tend to remain there longer (Jacobs *et al*., 2006).

The safety and quality of care are also affected: users have a greater tendency to experience diagnostic errors and negative

repercussions from their treatments (Bowen, 2015; Drouin & Rivet, 2003; Ferguson & Candib, 2002; Irvine *et al*., 2006; Flores *et al*., 2003). For example, they may have an adverse reaction to their medication if they do not completely understand the instructions, at least in part because of the complexity of the medical and professional language used (Drouin & Rivet, 2003). When dialogue becomes difficult, language barriers, trust, and confidence in the health or social service professional can be diminished (Anderson *et al*., 2003), the user's confidentiality can be violated, especially if there is an interpreter or if has been hard to obtain informed consent (Flores *et al*., 2003), and the user is less satisfied with the care and services received (Bowen, 2015; Drolet *et al*., 2014; Irvine *et al*., 2006; Mead & Roland, 2009; Meyers *et al*., 2009).

For seniors, proficiency in the second language has often deteriorated because of age-related conditions such as loss of hearing or neurological damage (Alzheimer's disease, related dementia, cardiovascular accident, etc.) (Madoc-Jones, 2004). In this case, research has found that the first language learned is connected to procedural memory, as it has been learned implicitly; the second or even third languages are more often learned explicitly and draw instead on the declarative memory (Paradis, 2000; Köpke & Schmid, 2011). These different types of memory are associated with different brain structures. Thus, in the case of a brain injury, the first and second languages learned can be affected in similar or distinct ways and recovery can follow various paths: parallel, differential, selective, etc. (Paradis, 2000; Köpke & Prod'homme, 2009).

When they are in need of social service and health care procedures in which communication is of paramount importance, people in an official language minority community are less likely to consult professionals; their weak skills in the language of the majority are among the reasons (Kirmayer *et al*., 2007). Difficulties finding a general practitioner able to refer them to a specialist, long wait times, the inability to find relevant and reliable information on mental health (especially in the minority language), and the differences in perspective in this area cause additional limitations and significantly decrease the use of mental health services by immigrant, refugee, and cultural minority citizens (Fenta *et al*., 2006; Reitmanova & Gustafson, 2009; Lachance *et al*., 2014). Moreover, immigrants are often unfamiliar with the Canadian health and social service system in general (Zanchetta & Poureslami, 2006). Combined with migratory

and social integration issues, these challenges make newcomers and cultural minority citizens even more vulnerable and put them at increased risk for further health disparities compared to the overall population.

In addition to all these issues, Francophones who live in official language minority contexts face specific challenges. They are not necessarily comfortable nor confident enough to ask for services in French (Forgues & Landry, 2014) for such reasons as: (1) linguistic insecurity (Deveau, Landry, & Allard, 2009); (2) fear of not receiving services as quickly (Drolet *et al*., 2014); (3) the conviction that it is impossible to receive these services (Société santé en français, 2007); (4) internalization of the minority identity (Tajfel, 1978; Tajfel & Turner, 1986), which can lead to two consequences: difficulty asking for or insisting on services in their language, and the belief that services in French may be of inferior quality (Drolet *et al*., 2015); (5) ease of agreeing to speak English rather than listening to a service provider who has trouble speaking French (Deveau *et al*., 2009); and (6) lack of French vocabulary for medical issues or health care, which may make the person wonder if it would be harder to understand verbal or written information in French than in English (Bouchard, Vézina, & Savoie, 2010; Deveau *et al*., 2009). Likewise, some Francophones attended English schools, even though they spoke French more often at home. In some cases, this was their choice, and in others it was because of rules in the past that prevented the use of French in the schools or access to French-language schools. Francophones educated in English may find it easier to read and write in English, although they prefer to converse in French.

Towards an Understanding of Actors, the System, and Levers of Action

The idea of publishing this particular volume, a collaborative work issued in both official languages, has its roots in the research of two teams, both of which had been working for several years in the area of French-language health care and social services within Francophone minority communities throughout Canada. The *Groupe de recherche de l'innovation sur l'organisation des services de santé* (GRIOSS) at the Université de Moncton, which took the initiative for this book, and the *Groupe de recherche sur la formation professionnelle en santé et en service social en contexte francophone minoritaire* (GReFoPS) at the

University of Ottawa, collaborated closely to bring the project to fruition. In the interest of presenting a rich variety of analytical perspectives and further developing multiple collaborations in the field, members of the two groups also invited contributions from other Canadian researchers in the fields of health care, social work, political science, law, public administration, psychology, and education, all recognized for their expertise in the area.

It is useful to review the legal context. In 1969, the Parliament of Canada adopted the first *Official Languages Act*, making English and French the two official languages of Canada and guaranteeing access to federal government services in both languages. The amendments made to the *Act* in 1988 (the addition of Part VII) affirmed the Government of Canada's commitment to enhancing the vitality of the English and French linguistic minority communities (OLMCs) in Canada and supporting and assisting their development. Moreover, Parliament inserted a section protecting the rights of the English and French linguistic minority populations into the *Canadian Charter of Rights and Freedoms* in 1981 (Allaire, 2001). Although the *Canadian Constitution* gives provinces and territories the responsibility for social services and health care, Parliament adopted the *Canada Health Act* in 1984, stating: "The primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada, and to facilitate reasonable access to health services without financial or other barriers" (Bowen, 2001, p. 18).

Table 1. Timeline of Important Canadian Events

EVENTS	DATES
The first *Official Languages Act* recognizes the equal status of English and French in all institutions of the Government of Canada	1969
Amendment of the *Constitution Act* and introduction of the *Canadian Charter of Rights and Freedoms*	1982
Canadian Health Act	1984
Amendment of the *Official Languages Act* adding, among other items, Part VII: Advancement of English and French (enhancing the vitality of the English and French linguistic minority communities in Canada and supporting and assisting their development)	1988
The Government of Canada's *Action Plan for Official Languages* policy statement is released; $2 million per year is allocated for creating networks and organizing activities.	March 2003
Creation of the *Consortium national de formation en santé*, the successor of the *Centre national de formation en santé*	2003
Part X of the *Official Languages Act* (Court Remedy) makes it possible to enforce Part VII of the *Act* (Advancement of English and French)	2005
Roadmap for Canada's Linguistic Duality 2008–2013	June 2008
Roadmap for Canada's Official Languages 2013–2018	March 2013
Statement of commitment to education on the active offer of French language health services is signed by the leaders of *Consortium national de formation en santé* (CNFS) member institutions; launch of the *Tool Box for the Active Offer*	2013

In this volume, the researchers we invited to contribute have highlighted the diversity of the provinces in applying this legal framework, as well as the socio-demographic complexity of the Canadian context in the area of official languages. While certain constitutional and legal measures facilitate access to social services and health care in linguistic minority contexts (Chapter 3), the demographic weight of official language minority communities (OLMCs) and their vitality can also be a lever to establish policies and practices that have a positive impact on the active offer of services in the official language of the minority (Chapters 3, 4 and 14).

Federal and provincial jurisdiction and unwritten constitutional principles are also discussed: these authors present an illuminating and nuanced view of the complexity and diversity of the situations and issues they've encountered. In their chapters we learn, for instance, that New Brunswick has the most highly developed legal framework to govern the provision of social services and health care in the minority official language as it is the only officially bilingual Canadian province. Ontario follows, with its system for designated French-language services in designated regions. Finally, a law passed in 2016 created a legal framework that fosters French-language services in the province of Manitoba. Balancing these provisions is Quebec, with a population that is 78.9% Francophone (Verreault, Fortin, & Gravel, 2017). It is the only province that has adopted French as its official language, prompting the Anglophone minority to assert its language rights. Despite its attention to the Canadian context as a whole and in all its complexity, this volume focuses more on these four provinces and on Nova Scotia. However, research on regions with smaller concentrations of Francophone minorities and on Anglophones outside Montreal is becoming more prevalent.

In order to enhance the quality of our reflections on the subject, we decided to adopt a theoretical framework based on the strategic analysis first developed by Crozier and Friedberg (1977), and presented in Chapter 1. The sociology of organizations provided an overall framework to analyze the relationship between the actor and the system. This framework allowed us to examine the issues and challenges of access to and the active offer of social services and health care in official language minority communities in greater depth, as well as to investigate the strategies and levers of action implemented by actors in linguistic minority contexts.

Thus each contribution on the challenges of active offer contained in this book is a source of information on the *actors* (their role, their behaviours, their actions, their strategies, their interactions, etc.); on the *system* (the organization of services, measures promoting active offer, limitations, etc.); and/or the *relationship* between the actors and the system. We believe this is an original and unique contribution to research on the practices and challenges related to active offer. Indeed, when we are confronted with one of the issues raised by active offer, all of us, researchers as well as practitioners and community members, have to address the following question: Is the problem, strategy for action, or solution primarily a matter of actors (e.g., an insufficient number of health or social service professionals who are aware and equipped to actively offer services), or does it lie within the system (lack of policies, procedures, or measures favourable to active offer within organizations; inadequate networking opportunities among professionals; or a lack of directories of bilingual, Francophone, or Francophile professionals outside Quebec or Anglophone professionals in Quebec)? The fact that the two are interrelated makes the question even harder to answer.

We should specify that the authors do not use the model of strategic analysis as the only framework to guide the analysis and reflection in each of their chapters. In the interest of the wealth and diversity of expertise, the contributors to this book hope, instead, to improve our understanding of the role of the actor and the system by offering current perspectives on the principles of active offer. Each of them in their own way contributes to the study of the dynamics of the actors, system, and relationships involved in the active offer of services in the minority official language.

In the following fourteen chapters (grouped into five sections), our colleagues pursue their examination of the issues, challenges, and possible solutions related to promoting the active offer of services in the official languages in minority settings, as well as its challenges in terms of human resources (recruitment and retention) and elements to consider for education and training in this area. The authors share the results of their studies as well as their understanding of the different dimensions that come into play in an analysis of the active offer of social services and health care to linguistic minority populations across Canada.

While some authors discuss theoretical foundations, others present findings from their empirical studies. Some of them make

recommendations for improving access to services and the active offer of services in the minority language. The authors raise issues that do not appear to be insurmountable and which organizations, service providers, individuals, and communities as well as decision-makers could address.

The following paragraphs briefly outline each of the chapters.

Part I — Engaging Actors: Putting the Strategic Analysis to the Test

Chapter 1 lays the foundations for a theoretical framework designed to give a general readership interested in the subject a better idea of the active offer of social services and health care services in official language minority communities. Sylvain Vézina and Sébastien Savard explain how the sociology of organizations, and more specifically strategic analysis, can help us better understand the relationships of conflict and cooperation between actors and the system. The authors believe this is a major contribution to both research on and the practice of active offer. Strategic analysis enables us to determine how to articulate the research problem and how to develop a strategy for action. Is the answer to be found among the actors, or in the policies and procedures? The appropriate response will be found in the complexity of the interactions between and among them, which are set out in the theoretical model. These divergent and sometimes contradictory interests, as well as the power relationships founded on resources and assets (among other elements), play out in different ways in the interactions. In the chapters that follow, other researchers will explore the question of active offer in the same theoretical perspective. Some give us a better understanding of the role of the actor, and others focus on the system or the interaction between the two. All help to shed light on the subject.

Based on research on the provision of French-language services and the results of a national dialogue, Pier Bouchard *et al*. examine the education and training of health and social service professionals in **Chapter 2**, as well as the competencies these professionals need to develop to better serve Francophone minority communities. This is a line of research and reflection that threads through other chapters in the book and is of great significance. The authors offer new insights about the active offer of French-language services in relation to future graduates in post-secondary health and social service programs,

notably those that are part of the *Consortium national de formation en santé* (CNFS). Among the essential elements to be included in these professional programs, the authors stress the importance of information on language as a health determinant, on living conditions in minority language communities, and on working in minority language settings. Competencies associated with skills and attitudes for working with Francophones in minority contexts are also considered important components of education and training.

Part II — Policy Levers and Legal Measures: The Interplay of Actors

Chapter 3 is distinct from the other chapters in that the author approaches the questions of language and access to health and social services from a legal standpoint. Is the state legally required to provide free universal access to health care? The answer, according to Pierre Foucher, author of this chapter, is "no." Access to the health system in Canada is not a "fundamental right;" instead, it is a political decision. The author then studies the legal aspects of language rights, examining two components: federalism and its impact on French-language health services, and fundamental rights protected by the *Canadian Charter of Rights and Freedoms.* This chapter allows readers to grasp an extremely important issue: although the Canadian approach is geared to cooperation and coordination of federal-provincial-territorial efforts and respects the division of powers, it does not provide for firm legal guarantees of the right to receive health care in one's own official language. Instead, Foucher suggests it is in provincial legislation that linguistic minority groups can find elements that protect certain rights to access health services.

Chapter 4 provides a critical reflection on active offer in the justice sector in Ontario, with ideas that could be considered in the health and social services sector. Linda Cardinal *et al*. focus first on legislative and policy instruments and outline the evolution of French-language services (FLS) in the province. Based on a review of literature dating from the 1980s and continuing to the time the first strategic plan for developing the active offer of FLS was created, the authors consider the positive aspects of these instruments, which represent the outcome of dialogues between community actors and government actors. However, even though there is a process to co-construct the provision of FLS, and this co-construction is founded

on dialogue, the authors feel that the process often relies on the willingness of various actors. This is inadequate for ensuring FLS will continue to be offered. The authors suggest that policies, directives, planning, and accountability should become the standard instruments for ensuring the active offer of French-language services. Results from a series of interviews support the authors' findings.

Part III — Accessibility and the Active Offer of French-Language Services

In **Chapter 5**, Louise Bouchard and Martin Desmeules look at the situation of Francophone seniors (65 years and over) in the linguistic minority population and draw a socio-sanitary portrait of their living conditions. The authors point out that the rate of aging is more rapid in this population than in the overall population of Canada. Moreover, Francophone seniors who live in minority settings are comparatively less well off, with fewer financial and cultural resources. Overall, these individuals are more vulnerable to health problems. The findings are based on the authors' analysis of data from the Canadian Community Health Survey (CCHS) in three large Canadian regions (Atlantic Canada, Ontario, and the West). The authors conclude the chapter with interesting suggestions for actions that could be undertaken to improve the situation. These include, for example, strengthening literacy programs for Francophone seniors who live in minority language communities, and enhancing the active offer of the areas of preventive health, health education, and programs that empower individuals to take ownership of their health care and social services.

Chapter 6 describes the experience of Francophone users in eastern Ontario accessing French health services. Based on qualitative research and an analysis of the actors and the system, Marie Drolet *et al*. reveal the paradoxes inherent in the complex identity construction processes of users in the health and social service network. These users must navigate through English and French services and settings, and at the same time maintain the quality of their mother tongue. For staff providing services, the fear of being marginalized and sometimes their own linguistic insecurity are among the feelings that are ever-present and prevent some professionals from serving users in French and practising active offer.

The authors' analysis is informed by tools such as the Chronic Care Model and the Expanded Chronic Care Model, which outline the conditions enabling users to take charge of their chronic health problems. In particular, these models describe the roles that users, their caregivers, and service providers play in care and services. Concepts such as "productive interaction," "proactive," and "better-informed and better-equipped caregivers" are introduced by the authors, in order to explain the paradoxes facing actors in a system that is not always positive towards the active offer of social services and health care in the minority language.

In **Chapter 7**, Éric Forgues *et al*. review the legal and political context as well as achievements made by Francophone minority communities, in particular following the conflict surrounding the Ontario Conservative government's plan to close Hôpital Montfort in 1997. This event was a milestone, the authors remind us, in the struggle of Francophone minority communities for the right to access social services and health care in their own language. Inequalities in health and social services were at the centre of their protests that, in the end, brought about improvements in FLS. This chapter illustrates the complexity of the barriers that prevent access to services. The barriers cannot be attributed solely to the lack or shortage of health professionals. In fact, in an empirical study to identify the factors that foster health and social services for Francophone users in four Canadian provinces, the author focuses on factors related to the social, political, and legal environments, as well as the organization of work. Compliance with policy decisions and the vigilance of actors ready to take the political and legal action necessary for change seem to constitute the basic conditions that guarantee access to health and social services in an official language minority community.

Part IV — Bilingualism and the Active Offer of French-Language Services

In **Chapter 8**, Danielle de Moissac *et al*. explore the point of view of Francophone and bilingual professionals on access to French-language health and social services by Francophone minority populations in Manitoba and eastern Ontario. Their research combines two qualitative studies underlining the challenges that professionals face in those two environments. Some of the challenges are not unique

to Manitoba or Ontario, as other chapters show. Among the challenges identified are the shortage of bilingual, Francophone, and Francophile professionals; the difficulty of identifying bilingual clients and service providers; a lack of networks to support bilingual professionals; and often a lack of organizational support to make an active offer of services in bilingual health and social services facilities. The authors present options for improving access to services, suggesting, among other possibilities, that various organizational strategies may be adopted.

Along the same thematic lines, **Chapter 9**, by Sébastien Savard *et al*., studies factors contributing to the recruitment and retention of bilingual health and social service professionals, again in a minority language setting. The qualitative research on which this chapter is based took place in the two Canadian cities of Winnipeg and Ottawa. The results demonstrate that the most significant factor in retaining these professionals is the quality of the work environment. The quality of the connections professionals make with their co-workers and with users is one of the primary sources of job satisfaction for them, contributing to the overall satisfaction and retention of employees. The authors conclude the chapter with several recommendations that could lead to a better use of resources, especially through the education and training of service providers working in the sector.

In **Chapter 10**, the author examines active offer under the lens of organizational culture, hoping to identify, through empirical research, the predominant language-related values operating in Anglophone and Francophone hospitals in New Brunswick. These values are fundamental to organizational culture and determine the importance of the active offer of French-language services in a given setting. Informed by a perspective drawing from the sociology of organizations as a starting point, Sylvain Vézina believes that actors may interpret the idea of bilingualism as a threat to the balance of power in the system, and that such an attitude may create resistance among members of the linguistic majority. This is the reason he suggests a discourse that promotes the value of a culture of active offer by emphasizing the goals of safety and quality of care and services in both official languages.

Part V — Issues and Strategies in Educating and Training Future Professionals

Chapter 11 turns to the question of educating educators, that is, the university professors offering education and training on active offer to future graduates. The authors found that most of them had not received training on the teaching and learning strategies best suited for students in professional programs who would be working with Francophone minority communities. This realization led Claire-Jehanne Dubouloz *et al*. to explore educational theory in the area of andragogy (adult education) and to propose a conceptual framework within which an educational component on active offer could be developed. Three types of knowledge can be distinguished in this framework: knowledge, skills, and people skills or attitudes. The authors also reflect on the particular issues of teaching active offer that they discovered while conducting a pilot project on the implementation of education on active offer.

Chapter 12 by Jacinthe Savard *et al*. discusses a research program whose objective was to design and validate measurement tools for active offer behaviours. Three tools were developed: the first was intended to measure the perception of service providers regarding their own behaviours to promote active offer; the second measured the perception of service providers with respect to the actions taken by their organization to support active offer behaviours (organizational support); the third investigated factors believed to determine the provision of an active offer of French-language services (e.g., the ethnolinguistic vitality of a person's community, a person's identity and acculturation, etc.). According to the author, these factors are determinants of active offer. The tools, which are robust, reliable, and constructed according to recognized theoretical models, fill a major gap in the field since no measurement tools existed before this research began. In a series of tables, the authors synthesize the contents of the measurement tools (questionnaires) as well as the results obtained through statistical tests. The findings reveal, among other facts, that the perceived organizational support and certain individual behaviours (notably the affirmation of identity, education in

active offer, and proficiency in French) are positively associated with active offer. In this sense, the research offers concrete knowledge we can use to improve education on active offer in programs for future health and social service professionals.

In **Chapter 13**, Josée Lagacé and Pascal Lefebvre compile data from scholarly studies and present new research data. They show a gap between best practices and current practices in the use of normalized tests for audiology and speech-language pathology assessment of bilingual children. In Canada, most Francophone children who live in linguistic minority settings are bilingual. However, as the authors explain, audiologists and speech-language pathologists who assess clients for communication disorders do not have tests that have been normalized in this population. Better tests that can more accurately identify the difficulties found in official language minority communities are needed. Moreover, these tests should also account for the complexity and the value of learning two languages at the same time. For this reason, the authors make recommendations for university programs and professional development in audiology and speech-language pathology. Recommendations are also made for employers and parents.

Last but not least, **Chapter 14** is entirely dedicated to the English-speaking communities of Quebec. In it, Richard Bourhis presents a theoretical model that helps us to understand the relations between majority and minority groups. The author explains how the Interactive Acculturation Model (IAM) provides an intergroup approach to minority/majority group relations in multilingual settings. He points out the importance of the ethnolinguistic vitality as the first element of this model, which describes the relative strengths and weaknesses of linguistic communities in contact. Additionally, he examines the types of language policies that regulate the status of linguistic communities, which is the second element of the IAM. Thirdly, the acculturation orientations of minority and majority group speakers are described as they interact to yield harmonious, problematic, or conflictual intergroup relations. In the second part of his chapter, M. Bourhis analyses bilingual health care policies for official language minorities in Canada and in Quebec. Finally, the author presents in a detailed analysis the implications of the 2014 Quebec government health care Bill 10 for the vitality of the English-speaking communities of Quebec.

In the **Conclusion**, we present the contribution made by each author to a cohesive reflection on active offer, considering each of them in the light of strategic analysis. We then propose six strategies to promote active offer, locating them in an analytical framework that allows us to reconcile the largest possible number of perspectives possible and, thus, capture the object of study in its full complexity. Levers and options for action serve as different angles from which to look ahead to further explorations in the field. The framework is founded on theory and empirical data and, at the same time, oriented towards action. In this way, it encompasses the limitations of the system as well as the opportunities it offers to the various actors involved, who can then adapt their actions to their respective environment in which they operate.

References

Allaire, G. (2001). *La Francophonie canadienne: Portraits*. Québec: CIDEF-AFI, and Sudbury: Prise de parole.

Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., & Normand, J. (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine*, 24(3, Supplement), 68–79. doi:10.1016/S0749-3797(02)00657-8

Andrulis, D. P. & Brach, C. (2007). Integrating literacy, culture, and language to improve health care quality for diverse populations. *American Journal of Health Behavior*, 31(Supplement 1), S122–S133. Retrieved from http://search.proquest.com.proxy.bib.uottawa.ca/docview/211891742?accountid=14701

Bonacruz Kazzi, G., & Cooper, C. (2003). Barriers to the use of interpreters in emergency room paediatric consultations. *Journal of Paediatrics and Child Health*, 39: 259–263.

Bouchard, L., Beaulieu, M., & Desmeules, M. (2012). L'offre active de services de santé en français en Ontario: Une mesure d'équité. *Reflets: Revue d'intervention sociale et communautaire*, 18(2), 38–65. http://doi.org/10.7202/1013173ar

Bouchard, P., Vézina, S., & Savoie, M. (2010). *Rapport du Dialogue sur l'engagement des étudiants et des futurs professionnels pour de meilleurs services de santé en français dans un contexte minoritaire: Formation et outillage, Recrutement et Rétention* (pp. 43–43). Ottawa, ON: Consortium national de formation en santé (CNFS). Retrieved from http://www.weebly.com/uploads/7/4/7/3/7473881/rapport_projet_de_loutillage.nov2010.pdf

Boudreau, A., & Dubois, L. (2008). Représentations, sécurité/insécurité linguistique. In S. Roy & P. Dalley (Eds.). *Francophonie, minorités et pédagogie*. Ottawa: Presses de l'Université d'Ottawa, 145–175.

Bowen, S. (2001). *Barrières linguistiques dans l'accès aux soins de santé*. Ottawa: Santé Canada. Retrieved from http://www.offreactive.com/wp-content/uploads/2013/08/1-barrieres-linguistiques-sarah-bowen-email1.pdf

Bowen, S. (2015). *Impact des barrières linguistiques sur la sécurité des patients et la qualité des soins* (p. 62). Retrieved from http://francosantesud.ca/wp-content/uploads/SSF-Bowen-S.-%C3%89tude-Barri%C3%A8res-linguistiques.pdf

Castaño, M. T., Biever, J. L., González, C. G., & Anderson, K. B. (2007). Challenges of providing mental health services in Spanish. *Professional Psychology: Research and Practice*, 38(6), 667–673. http://doi.org/10.1037/0735-7028.38.6.667

Crozier, M., & Friedberg, E. (1977). *L'acteur et le système*. Paris: Seuil.

Derose, K. P., Escarce, J., & Lurie, N. (2007). Immigrants and health care: Sources of vulnerability. *Health Affairs*, (26) 5, 1258–1268. Retrieved from http://content.healthaffairs.org/content/26/5/1258

Deveau, K., Landry, R., & Allard, R. (2009). Utilisation des services gouvernementaux de langue française. Une étude auprès des Acadiens et francophones de la Nouvelle-Écosse sur les facteurs associés à l'utilisation des services gouvernementaux en français (p. 195). *Institut canadien de recherche sur les minorités linguistiques (ICRML)*. Retrieved from http://www.weebly.com/uploads/7/4/7/3/7473881/rapport_deveau_utilisation_services_gouv.pdf

Drolet, M., Arcand, I., Benoît, J., Savard, J., Savard, S., et Lagacé, J. (2015). Agir pour avoir accès à des services sociaux et de santé en français: Des Francophones en situation minoritaire nous enseignent quoi faire! *Revue canadienne de service social*, 32(1–2), 5–26.

Drolet, M., Dubouloz, C.-J., & Benoît, J. (2014). L'accès aux services sociaux et de santé en français et la formation des professionnelles et des professionnels en situation francophone minoritaire canadienne. *Reflets: Revue d'intervention sociale et communautaire*, 20(2), 10–19. http://doi.org/10.7202/1027584ar

Drolet, M., Savard, J., Benoît, J., Arcand, I., Savard, S., Lagacé, J., … Dubouloz, C-J. (2014). Health Services for Linguistic Minorities in a Bilingual Setting: Challenges for Bilingual Professionals. *Qualitative Health Research*, University of Ottawa, Ottawa, Ontario, Canada, 24(3), 295–305. https://doi.org/10.1177/1049732314523503

Drouin, J., & Rivet, C. (2003). Training Medical Students to Communicate with a Linguistic Minority Group. *Academic Medicine*, 78(6), 599–604. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/12805039

Éthier, S., & Belzile, L. (2012). *Améliorer l'accès des personnes âgées de Saint-Boniface et de Saint-Vital aux services de santé en français / Improving St. Boniface and St. Vital Seniors' Access to French-language Health Services*. Conseil communauté en santé du Manitoba. Université de Saint-Boniface. Retrieved from http://ustboniface.ca/file/documents-recherche/RAPPORT-Objectif-3-pratiques-exemplaires-version-finale-BILINGUE.pdf

Fenta, H., Hyman, I., & Noh, S. (2006). Mental health service utilization by Ethiopian immigrants and refugees in Toronto. *The Journal of Nervous and Mental Disease*, 194(12), 925–934.

Ferguson, W. J., & Candib, L. M. (2002). Culture, language, and the doctor-patient relationship. *Family Medicine*, 34(5), 353–361.

Flores, G., Laws, M. B., Mayo, S. J., Zuckerman, B., Abreu, M., Medina, L., & Hardt, E. J. (2003). Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters. *Pediatrics*, 111(1), 6–14. http://doi.org/10.1542/peds.111.1.6

Forgues, É., & Landry, R. (2014). L'accès aux services de santé en français et leur utilisation en contexte francophone minoritaire (p. 158–159). Moncton, Nouveau-Brunswick: *Institut canadien de recherche sur les minorités linguistiques (ICRML)*. Retrieved from http://www.icrml.ca/fr/recherches-et-publications/publications-de-l-icrml/item/8709-acces-aux-services-de-sante-en-francais-et-leur-utilisation-en-contexte-francophone-minoritaire

Gagnon-Arpin, I., Bouchard, L., Leis, A., et Bélanger, M. (2014). Accès et utilisation des services de santé en langue minoritaire. In R. Landry (Ed.), *La vie dans une langue officielle minoritaire au Canada*. Sainte-Foy, QC: Presses de l'Université Laval.

Irvine, F. E., Roberts, G. W., Jones, P., Spencer, L. H., Baker, C. R., & Williams, C. (2006). Communicative sensitivity in the bilingual healthcare setting: A qualitative study of language awareness. *Journal of Advanced Nursing*, 53(4), 422–434. http://doi.org/10.1111/j. 1365-2648.2006.03733.x

Jacobs, E., Chen, A. H., Karliner, L. S., Agger-Gupta, N. & Mutha, S. (2006). The Need for More Research on Language Barriers in Health Care: A Proposed Research Agenda. *Milbank Quarterly*, 84: 111–133.

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., & coll. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *CMAJ: Canadian Medical Association Journal*, 183(12), E959–67.

Köpke, B., & Prod'homme, K. (2009). L'évaluation de l'aphasie chez le bilingue: une étude de cas. *Glossa*, 107, 39–50. http://doi.org/http://glossa.fr/pdfs/107_2009 1204092949.pdf

Köpke, B., & Schmid, M. S. (2011). L'attrition de la première langue en tant que phénomène psycholinguistique. *Language, Interaction and Acquisition*, 2(2), 197–220. http://doi.org/10.1075/lia.2.2.02kop

Lachance, L., Martin, M., Kaduri, P., Godoy-Paiz, P., Ginieniewicz, J., Tarasuk, V., & McKenzie. K. (2014). Food insecurity, diet quality, and mental health in culturally diverse adolescents. *Ethnicity and Inequalities in Health and Social Care*, 7(1), 14–22. http://doi.org/10.1108/EIHSC-02-2013-0002

Lapierre, S., Coderre, C., Côté, I., Garceau, M-L., & Bourassa C. (2014). Quand le manque d'accès aux services en français revictimise les femmes victimes de violence conjugale et leurs enfants. *Reflets: Revue d'intervention sociale et communautaire*, 20(2), 22–51. http://dx.doi.org/10.7202/1027585ar

Lepage, J.-F., & Corbeil, J.-P. (May 2013). L'évolution du bilinguisme français-anglais au Canada de 1961 à 2011. *Regards sur la société canadienne*. Ottawa: Statistique Canada. No 75 006 X.

Madoc-Jones, I. (2004). Linguistic sensitivity, indigenous peoples and the mental health system in Wales. *International Journal of Mental Health Nursing*, 13: 216–224.

Mead, N., & Roland, M. (2009). Understanding why some ethnic minority patients evaluate medical care more negatively than white patients: A cross sectional analysis of a routine patient survey in English general practices. *BMJ*, 339, b3450–b3450. http://doi.org/10.1136/ bmj.b3450

Meyers, K., Tang, G., & Fernandez, A. (2009). Responding to the Language Challenge: Kaiser Permanente's Approach. *The Permanente Journal*, 13(3), 77.

Paradis, M. (2000). Generalizable Outcomes of Bilingual Aphasia Research. *Folia Phoniatrica et Logopaedica,* 52(1–3), 54–64. http://doi.org/10.1159/000021513

Pavlenko, A. (2012). Affective processing in bilingual speakers: Disembodied cognition? *International Journal of Psychology*, 47(6), 405–428. http://dx.doi.org/10.1080/00207594.2012.743665

Pépin-Filion, D. (in collaboration with Guignard Noël, J.). (2014). *Évolution du bilinguisme au N.-B.* Rapport rédigé pour le Commissariat aux langues officielles du N.-B. Retrieved from http://www.droitslinguistiques.ca/index.php?option=com_content&view=article&id=372%3Aevolution-du-bilinguisme-au-n-b&catid=1%3Aactualites&Itemid=1&lang=fr

Qualité de services de santé Ontario. (2015). *Les soins intégrés: point de vue des Ontariens concernant la communication et la coordination dans les soins de santé. Résultats de l'Enquête internationale de 2014 auprès des adultes âgés sur les politiques de santé du Fonds du Commonwealth.* Toronto: Qualité de services de santé Ontario.

Reitmanova, S., & Gustafson, D. L. (2009). Mental Health Needs of Visible Minority Immigrants in a Small Urban Center: Recommendations for Policy Makers and Service Providers. *Journal of Immigrant and Minority Health*, 11(1), 46–56. http://doi.org/10.1007/s10903-008-9122-x

Roberts, G. W., & Burton, C. R. (2013). Implementing the evidence for language-appropriate health care systems: The Welsh context. *Canadian Journal of Public Health*, 104(6), 88–90.

Santiago-Rivera, A. L., Altarriba, J., Poll, N., Gonzalez-Miller, N., & Cragun, C. (2009). Therapists' views on working with bilingual Spanish–English speaking clients: A qualitative investigation. *Professional Psychology: Research and Practice*, 40(5), 436–443. http://doi.org/10.1037/a0015933

Snowden, L.R, Masland, M.C, Peng, C.J, Wei-Mein Lou, C., & Wallace, N.T. (2011). Limited English proficient Asian Americans: Threshold language policy and access to mental health treatment. *Social Science & Medicine*, 72(2), 230–7.

Société santé en français. (2007). *Une offre active de services en santé pour une meilleure santé des francophones en situation minoritaire*. Ottawa, ON: Société santé en français (SSF). Retrieved from http://www.weebly.com/uploads/7/4/7/3/7473881/ssf_plans_directeurs _sommaire_2007-11-26.pdf

Tajfel, H. (1978). *The social psychology of minorities*. Sacramento: Minority Rights Group. Retrieved from http://books.google.ca/books?id=q7ULAQAAIAAJ

Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behavior. In W. G. Austin & S. Worchel (Ed.). *Psychology of Intergroup Relations*, 7–24. Chicago, IL: Nelson-Hall.

United States (US) Department of Health and Human Services, O. of M. H. (2001). *National Standards for Culturally and Linguistically Appropriate Services.* Final Report.

Verreault, B., Fortin, J.F. & Gravel, P.L. (2017). Tableau statistique Canadien. *Institut de la statistique du Québec (ISQ).* Retrieved from http://www.stat.gouv.qc.ca/statistiques/economie/comparaisons-economiques/interprovinciales/tableau-statistique-canadien.pdf

Vézina, S., Dupuis-Blanchard, S. (2015). La recherche au profit d'un meilleur accès aux services de santé en français / Research Benefiting Better Access to Health Care Services in French. *Linguistic Minorities and Society*, 6: 3–16.

Zanchetta, M. S., & Poureslami, I. M. (2006). Littératie en matière de santé dans la réalité des immigrants, sur le plan de la culture et de la langue. *Canadian Journal of Public Health / Revue Canadienne de Santé Publique*, 97, S28–S33. Retrieved from http://www.jstor.org/ stable/41995834

Page left blank intentionally