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Promoting Healthy Early Childhood Language Development in Migrant Families at La Maison Bleue, in Montreal, Quebec

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Ce mémoire intitulé :

Promoting Healthy Early Childhood Language Development in Migrant Families at La Maison Bleue, in Montreal, Quebec

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Abstract

Objective: To explore care-providers' perspectives on the needs of migrant families regarding early language development and the strategies that are used, or that could be used, to promote language development in a culturally safe manner among this population.

Methods: This was a qualitative descriptive study conducted at La Maison Bleue (LMB). Data were collected via semi-structured interviews from eight LMB care providers and support/administrative staff and thematically analyzed.

Results: Language development problems among children in migrant families are of concern at LMB, and factors related to the migration context (isolation, mental health, lack of access to resources) are believed to contribute to these problems. Parents' understanding about children's language development sometimes add to this challenging context. Targeted interventions as well as more global strategies that focus on building trust and increasing the family's overall receptivity to care, are used to promote language development. Participants recommended more individual time with families to enhance understanding of child development, and to further promote parents' engagement in language stimulating activities. On site access to specialists and more resources in the community were also suggested to further support early language development among migrant families.

Conclusion: At LMB, an interdisciplinary, holistic approach, that considers the migration/vulnerability context, is used to promote early-language development in migrant families in a culturally safe manner. Broader application of this approach across different primary care settings may be beneficial for helping more migrant families in need of early-language development support.

Keywords:

Early language development; migrant populations; culturally safe strategies/interventions

Résumé

Objectif: Explorer les perspectives des fournisseurs de soins sur les besoins des familles migrantes en matière de développement du langage et les stratégies qui sont utilisées ou qui pourraient être utilisées pour promouvoir le développement du langage d'une manière culturellement sécuritaire.

Méthodes : L'étude s'est déroulée à La Maison Bleue (LMB), un centre offrant des services sociaux et de périnatalité aux familles vulnérables à Montréal pendant la grossesse et jusqu'à l'âge de cinq ans de l'enfant. Les données ont été recueillies par le biais d'entretiens semi-structurés avec 8 membres du personnel et analysées thématiquement.

Résultats: Les problèmes de langage sont une préoccupation à LMB, et les facteurs liés à la migration (l'isolement, la santé mentale, le manque d'accès aux ressources) sont considérés comme pouvant contribuer à ces problèmes. La compréhension qu'ont les parents du développement du langage de l'enfant ajoute parfois à ce contexte difficile. Des interventions ciblées ainsi que des stratégies plus globales axées sur le renforcement de la confiance et de la réceptivité des familles aux soins en général, sont utilisées pour favoriser le développement du langage. Les participants ont recommandé d'accorder plus de temps individuel aux familles pour améliorer leur compréhension du développement de l'enfant et pour favoriser leur implication dans des activités visant à stimuler le développement langagier. Ils ont également suggéré d'avoir accès à des spécialistes sur place et plus de ressources communautaires pour mieux soutenir le développement précoce du langage dans les familles migrantes.

Conclusion: À LMB, une approche interdisciplinaire et holistique, qui tient compte du contexte de migration/vulnérabilité, est utilisée pour promouvoir le développement du langage d'une manière culturellement sécuritaire. Une mise en œuvre plus large de cette approche dans différents contextes de soins primaires pourrait être bénéfique pour aider davantage des familles migrantes ayant besoin d'un soutien au développement précoce du langage.

Mots clés: Développement précoce du langage ; les populations migrantes ; stratégies/interventions culturellement sécuritaires

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List of abbreviations

CALD: Culturally and linguistically diverse
CERSES : Comité d'éthique de la recherche en sciences et en santé
CINAHL: Cumulative Index to Nursing and Allied Health Literature
CISSS: Centres Intégrés de Santé et de Services Sociaux (Integrated Health and Social Services Centers)
CIUSSS: Centre Intégré Universitaire en Santé et Services Sociaux (Integrated University Health and Social Services Centres)
LMB: La Maison Bleue
MECSH: Maternal Early Childhood Sustained Home Visiting
QD : Qualitative Desciptive
SES: Social Economic Status

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Chapter 1- Context and Problem Statement

Context

La Maison Bleue (LMB) is a non-profit community-based social, perinatal health organization in Montreal, Quebec. This organisation seeks to help women and their families who live in vulnerable situations, including immigrants, refugees, and those living in socio-economically disadvantaged conditions (La Maison Bleue, 2016). The families they follow include those with economic insecurity, low educational levels, an undesired pregnancy, isolation, mental health concerns, a fragile migratory status as well as marital issues. Migrants make up a large component of LMB's clientele. More specifically, between April 1, 2020, and March 31, 2021, 47% of LMB clients had a precarious migration status and/or had just immigrated (La Maison Bleue, 2021). The interdisciplinary team of nurses, specialized nurse practitioners, midwives, family physicians, psychoeducators and social workers working at LMB provide health care and social assistance to these women and families from the beginning of pregnancy, until the child reaches the age of 5 years old (Aubé et al., 2019; La Maison Bleue, 2016). Through implementing a preventive and a collaboration-based and culturally-safe approach (i.e., respectful of identity/context, collaborative and empowering), the team aims to facilitate access to health and social services, promote a smooth pregnancy, delivery, and parenting experience, while supporting and strengthening parenting skills and encouraging the child's and family's optimum development (La Maison Bleue, 2016).

LMB personnel have expressed a concern about language developmental issues among the children they follow, especially children in migrant families. Therefore, in response to this concern, a master's nursing student (UdeM) conducted a project that aimed to estimate the prevalence of language delays and to identify its determinants (migration, socio-economic, and family factors) among children attending LMB. The study reported here was conducted concurrently and is complementary to the prevalence study. Both studies were conducted as part of a larger research endeavour by LMB, which aims to evaluate their services and impacts on the population receiving their care. The current study contributed to this process by providing knowledge on LMB's health promotion interventions and strategies used regarding children's early language and communication development and by providing recommendations on how interventions

may be further strengthened or improved. More broadly the study contributes to the body of knowledge regarding culturally safe approaches for early-language development.

Problem Statement

According to *Regroupement Langage Québec* (2020), 9.4% of 5-year-old children living in Quebec have a language development disorder, defined as a situation when a child is not at the level of language development corresponding to their age. A language disorder differs from a language delay, which is when a child's language develops, but at a slower pace compared to other children (Law et al., 2017). Language developmental issues can be associated with many factors such as the socio-economic situation of the family, the level of education of the parents, accessibility to health and community resources (e.g., daycare), the mental health status of parents, especially mothers, or even due to having a mother tongue other than English or French (in the context of Quebec) (Sultana et al., 2020; Tantut, 2008).

Disparities in the prevalence of language development problems by socioeconomic status have been observed in several studies conducted in various high-income countries (Fernald et al., 2013; Rowe, 2008; Schwab & Lew-Williams, 2016). According to a research study conducted in the UK by Law et al. (2017), for example, preschool aged children of families living in more vulnerable contexts (low SES, low parental education, living in at risk neighborhoods, socially isolated) were significantly more likely to have a difficulty in language development (language disorders or delays) compared to children living in more privileged conditions.

Parents' education level and understanding regarding child development can also influence the frequency and type of interactions they have with young children, which in turn affects language development (Hoff et al., 2018, Huang et al., 2005; Schady, 2011). In this regard, higher levels of maternal education are generally associated with more engagement and language development promoting activities (e.g., reading to children). In addition to education, caregivers' knowledge and views about child development and consequently their conduct with children, are also shaped by culture (Weber et al., 2017). For instance, in certain cultures caregivers are more inclined to engage in discussions and communicate with their young children since they are perceived to understand, whereas in other cultures children are not viewed in this way (Foster et al., 2005). Cultural

differences have also been observed to influence the frequency of other language development promoting activities, such as reading books to infants, which has been shown to be positively associated with the early language development of infants and vocabulary outcomes (Foster et al., 2005; Hindman et al., 2016).

The economic, social, and cultural background of individuals can also create a social stratification which can result in an uneven distribution of power and access to resources, including services that could be used to prevent problems and/or to promote growth and development (Mason et al., 2015). Not all children receive the healthcare and other services that they require, and the families who are most in need of assistance are frequently the ones who receive the least (Moore et al., 2015). Cost, insufficient availability in certain neighborhoods, and accessibility issues, including transportation, lack of awareness of services offered, no time off work, as well as language barriers, are recognised as limits to accessing services by vulnerable families (Ou et al., 2011). Not only do these families face hurdles to access, but more socially advantaged parents are more likely to have the financial means for acquiring resources, thus further widening the disparities (Woolfenden et al., 2013). For language development, this may result in delays in identifying children at risk or those with early signs of delays and consequently missed opportunities for early intervention. It could also lead to children having reduced access to resources (e.g., daycare, community activities) that would stimulate and promote communication skills and language development.

In addition, mental health challenges such as maternal depression, characterized by symptoms such as anxiety, sadness, and irritability, can make it challenging for parents to respond to their children's needs and emotions in a caring and supportive manner. This in turn can make it more difficult for infants to acquire some important emotional and cognitive skills, including language skills (Sohr-Preston & Scaramella 2006).

Lastly, language barriers can also have an impact. For example, it may prevent parents' involvement and participation as partners with early health care and education programs towards promoting their children's growth and development as parents may feel discouraged from engaging in events, such as preschool parent orientation or parent-teacher meetings (Park & McHugh, 2014; Trainor, 2010). Moreover, numerous studies have found that these parents, particularly those with very limited English language

abilities (or the dominant language), feel uncomfortable and unwelcomed in educational settings (Park & McHugh, 2014; Turney & Kao, 2009). Parents may therefore feel excluded and may withdraw and not participate. Insufficient awareness of the living conditions and parenting practises of linguistically diverse families may also lead to misunderstandings among professionals. Non-attendance at preschool parent-teacher conferences, for example, may be misinterpreted by teachers as a lack of interest and support for their infant's development and education without considering the need for translation services.

Migrant families with young children, and especially refugee and asylum-seeking families often experience several of the risk factors that are associated with language development problems, including low socio-economic status, maternal (postpartum) depression, low maternal educational levels, minority language household, and isolation (Bowie et al., 2017; Hrabok et al., 2020). The province of Quebec has long been a main destination for migrants arriving in Canada (Government of Quebec, 2017). The city of Montreal is one of the three Canadian cities with the most migrants after Toronto and Vancouver (Statistics Canada, 2017), with 34% of its population being born outside of Canada, (Montréal en statistiques, 2020). In addition, migrant births account for more than 50% of all births in Montreal (Institut de la Statistique Quebec, 2012). The percentage of children aged 0 to 5 who were born outside of Canada and live in Montreal, according to the Early Childhood Observatory (2019a; 2019b), is 5.8 percent (7,570 children). Given the growing number of migrant children in Canada and the importance of the early developmental years, as well as the mounting evidence that immigration status has a significant impact on welfare, knowledge about migrant children's health and development, is critical to ensuring their long-term well-being.

Many migrant parents describe feeling overwhelmed and worried while raising and caring for their children in the setting of relocation (Busch Nsonwu et al., 2013). According to Merry et al. (2017), difficulties tend to be magnified for migrants from low and middle-income countries, as well as those with more vulnerable or insecure statuses (e.g., refugees, asylum seekers). This includes certain migrant families being excluded from certain services and resources which are offered to the general population (Vaghri et al., 2019) and/or facing access barriers to healthcare and social services. For example, a

study conducted by Gagnon et al. (2013) discovered that migrants had a higher number of post-partum health and psycho-social issues and were less likely than Canadian-born women to have those concerns treated by the health care system. The study also showed that migrants were more likely to have low incomes, to report having limited support and to have language barriers, compared to Canadian-born individuals. Moreover, according to the same study, refugees and asylum seekers were also more likely to have lower levels of education. Therefore, this stressful context can negatively affect the mental well-being of the parents and hence influence early child development, including language development (Zhang et al., 2018).

Many migrant families also have problems accessing community resources (Tantut, 2018), including childcare that can have an impact on children's development and early learning (Karoly & Gonzalez, 2011). This could be related to several reasons, such as language barriers, bureaucratic/eligibility difficulties or due to cultural differences (Karoly & Gonzalez, 2011). For example, asylum seekers are not eligible for government-subsidized childcare in Quebec; although the Supreme Court of Quebec deemed this discriminatory and recently granted access, the government appealed the decision and as such asylum seekers remain ineligible for the time being. As a result, these families have to pay for the childcare services, which is often not feasible given their financial situation (Préfontaine et al. 2021). In a study conducted in the city of Montreal by Laurin et al. (2016), the children of low-income families who had not attended any childcare centers were more likely to demonstrate problems in their development, compared to other children who were enrolled in centers. Therefore, children in migrant families who do not have access to childcare may be more disadvantaged and at increased risk of experiencing long-term learning issues.

Another factor that puts children of migrants at risk for language development difficulties is post-partum depression (O'Hara & McCabe, 2013). Lower social economic status (SES), reduced social support (due to family separation), high levels of stress associated with migration and resettlement, and difficulties in accessing health and social services are all factors that may render migrants more prone to postpartum depression (Dennis et al., 2017). Research has shown that migrant women are 1.5–2 times more likely than native-born women to experience postpartum depression symptoms (Falah-

Hassani et al., 2015). Moreover, refugees and asylum seekers are among the most vulnerable groups. This is considered as a risk factor and could jeopardize the cognitive development of the child, through impeding the normal functioning of the mother, as well as the mother-child relationship and interactions (Maternal depression and child development, 2004; Vernon-Feagans et al., 2013).

Furthermore, the COVID-19 pandemic has further exacerbated the situation for children living in vulnerable conditions. The implementation of social-distancing and confinement measures as well as the limitations on gatherings and closing of services to prevent the spread of the virus, have resulted in families being more isolated (Charney et al., 2021). This social isolation has thus further reduced children's exposure to language stimulating activities, including playing and socializing with others, (Iqbal & Tayyab, 2021; Snyder et al., 2022). Low-income families in particular were disadvantaged, given their already limited access to resources before the pandemic, and because activities, such as play groups, offered in community organizations were closed (Araújo et al., 2021; Synder, 2022). According to a research study done at LMB between November and December 2020, by Lim et al. (2022), the COVID-19 pandemic, worsened pre-existing feelings of social isolation and loneliness among migrant women having young children (0-5 years old). Mothers' experiences impacted their emotional and mental health, while children's social possibilities outside the house were limited, particularly if they did not attend daycare. In sum, the confinement imposed caused many children, including children in migrant families, to live in conditions that are not optimal for their development, including less human interaction, longer screen times, irregular sleep schedules etc. (Wang et al., 2020).

Language development problems in early childhood can have long lasting effects on the health and well-being of children, which may persist into adulthood (Short et al., 2019). These long-term impacts include mental health and emotional disturbances (Baker & Cantwell, 1987). Studies indicate that 40%–60% of children with untreated speech and language problems have a greater risk of experiencing social, emotional, behavioral, and cognitive difficulties during adulthood (Gilkerson et al., 2018; Morgan et al., 2017). Early language development is also an important determinant of children's later educational success (Fernald & Weisleder, 2011; Pagani & Fitzpatrick, 2014). For example,

vocabulary developed at young age, as early as 19 months of age, could have an influence on the academic performance of the child in the following ten years (Suggate et al., 2018). Moreover, children who are deficient in their language development throughout their early years are at risk of having difficulty learning to read and write, as well as scholastic underachievement (Law et al., 2017; Roulstone et al., 2011). In addition, deficits in language development hinder child health and can have negative impacts on their well-being during adulthood in a variety of ways, such as behavior, learning, mental health, employment, parenting issues etc. (Schoon et al., 2010). Overall language development difficulties are linked to health and social inequities later in life, since they have a long-term influence on the literacy of these children, their social relationships, mental health, and their quality of life (Johnson et al., 2010). Given these long-lasting effects, promotion of early language development and early detection and intervention when problems are identified, are essential, especially for those most vulnerable, such as immigrants, refugees, and asylum seekers.

There are many studies that discuss the interventions that have been implemented on many levels. However, these studies and interventions have their limitations. There is a gap in the literature regarding whether or how these interventions and strategies consider cultural differences or the context in which migrants and vulnerable families live (SES, education levels, mental health, language barriers). Despite their unique traits and their increased exposure to language development risk factors associated with their migration context, little study has been done on the promotion of healthy language development of children from migrant or refugee families (Prevoo et al., 2014). For instance, many strategies that are often implemented do not target children whose parents do not understand or read English or French (in the context of Quebec) (Hammer et al., 2012; Paradis, 2011; Sorenson Duncan & Paradis, 2020). So, it is not known if or how these parents participate in such activities that promote language development. Moreover, some research focuses on families with low SES or those who are bilingual, but it does not adequately concentrate on migrant families' and some of the specifics to this population, such as the cultural differences that may be more pronounced due to recent arrival, stresses and mental health issues, isolation due to access barriers to care, services and benefits, as well as language barriers (MacLeod et al, 2020; Prevoo et al., 2014).

Therefore, more inquiry is needed to learn about the needs of migrant families regarding the promotion of early-childhood language development and whether and how interventions and strategies respond and meet these needs in a culturally safe manner (i.e., consideration of the cultural, socio-political context and the resulting power-imbalances). Research to identify culturally safe approaches for promoting language development, is also warranted.

Nurses can play a key role in detecting language delays, and in ensuring primary prevention through the implementation of appropriate interventions to promote early language development (Tantut, 2018). So, as nurses, and as promoters of health and patients' advocates, it is important to shed light on this topic and to encourage the implementation of effective, culturally safe strategies to help prevent language problems that are detrimental for migrant families, their children, and their healthy development. A scoping review done by Wightman et al. (2021) affirms that public health nurses or child and family health nurses play an important role in promoting healthy development for infants and children, in partnership with their parents/caregivers. These nurses can support and assist parents to better understand and respond to the needs of their children and thus make it easier for them to care for their children, through patient education and health promotion. Nurses are also well equipped to identify the health needs of the child and the family and to intervene to promote health directly and/or in collaboration with other health care professionals.

Moreover, from the standpoint of the Canadian Public Health Association (CPHA, 2010), public health nurses, who work in family medicine settings or in primary health care centers (in Quebec CLSCs, where families go for vaccinations and other health and social services), are often in contact with families and children. Therefore, public health nurses can be the first healthcare professionals to detect and identify potential language problems among children, and if necessary, to refer these children to a primary care provider for further assessment and ultimately additional follow-up with a specialized health care professional (audiologist, the speech therapist, the psychologist etc.) if deemed necessary. Nurses are also often involved in early intervention programs that promote healthy development among children coming from vulnerable contexts. For instance, in Quebec, there is the "system of integrated perinatal and early childhood

services" (SIPPE) program, which aims to assist families living in vulnerable conditions during pregnancy, as well as during the post-partum period, until the child enters school. Based on the parents' education, living situation, and/or social support network, services are designed to each family's needs and aim to support parents' well-being and healthy child growth and development. Nurses, social workers, family support workers, dietitians, and psychoeducators are among those who provide care (Government of Quebec, 2020). Similarly, at LMB, where health and social care professionals intervene with young families in vulnerable contexts with the goal of promoting health and preventing long term issues, nurses, as key members of the inter-disciplinary team have an important role to play. Some of the nursing roles are family and child assessments, as well as active involvement in health promotion during the regular follow-up wellness visits or during the appointments for vaccination. The nurse is therefore well-positioned to detect children with potentially early language development delays and to intervene to promote language development.

Study Objectives and Research Questions

As a first step towards learning more about the needs of migrant families in vulnerable contexts regarding early childhood language development, the responsiveness of interventions and strategies to meet these needs, and also culturally safe approaches that can be implemented, the objective of this project was to explore health care providers' perspectives on the topic. The choice to focus on healthcare providers in this study was to avoid overburdening the LMB clientele as they are often solicited for research. While culturally safe care can only be determined by the recipients of care, the perspectives of healthcare providers was deemed to still be an important source of information, since they can share their own experiences of care interactions as well as offer some insight on families' views based on their observations and what families share with them. The specific objectives of this project were to explore from the perspective of health care providers (nurses, social workers, family doctors, midwives, administrators) at LMB, the needs of the families that they care for regarding early language development, and the strategies and approaches that can be used to promote communication and language development in a culturally safe manner among this

population. The study also sought to identify from the point of view of health care professionals additional culturally safe interventions and approaches that could be useful to further promote healthy language development. The research questions of this study were the following: What are the perspectives of health care providers working at LMB regarding families' needs in terms of language development promotion language? For example, is this a particular concern for the families at LMB? What do families express as challenges? What do families identify as important for healthy language development? How do healthcare providers at LMB promote healthy language development and prevent language problems in a culturally safe manner (their role and strategies used to respond to families' needs; and families' preferences and dislikes regarding strategies)? What are some additional culturally safe interventions or approaches that could be used to further promote healthy language development among children at LMB?

Chapter 2 – Research Framework and Literature Review

Research Framework

The guiding lens that was used in this project is the concept of cultural safety. In the late 1980s, in response to the Maori people's dissatisfaction with nursing care and health system in New Zealand, a group of Maori nurses established the concept of cultural safety (Papps & Ramsden, 1996; Ramsden, 1993; Wepa, 2015). This approach emerged due to the colonial history and oppression of Indigenous communities in New Zealand, and has subsequently been embraced in Australia, Canada and elsewhere, and applied to other marginalized communities (Lokugamage et al., 2021). Irahepti Ramsden, a Maori registered nurse and woman of culture and inventor who worked in the cross-cultural setting of Western nursing, established the cultural safety paradigm. Her original issue was how to effectively manage power differentials between Western health care providers and Indigenous communities who used their service (Papps & Ramsden, 1996), and the negative effects this imbalance had on Maori health and well-being. This vision aligns with a postcolonial perspective, which aims to draw attention to and address the imbalances and inequalities from colonial oppression that continue to exist today. "Cultural safety" as a concept is useful in that it allows one to assess their social position in relation to those who are most vulnerable and marginalized in society. The focus of cultural safety is thus not on culture, but rather on how the different parts of society, such as social aspects, economics, politics, and historical events, as well as personal factors, influence health outcomes (Richardson et al., 2017). Cultural safety addresses power dynamics and focuses on power imbalances between healthcare practitioners and the patients they care for, who include individuals who are oppressed due to their ethnic background or class (Harrowing et al., 2010). Shifting power relations entails first admitting that power comes via the social position of care providers, and then ensuring that this power does not further oppress individuals who rely on care-providers for healthcare, but rather that it is channeled towards empowering patients and creating an environment where they feel safe and not discriminated against.

Indigenous communities around the world have a long history of disparities in their exposure to health determinants, access to and use of healthcare, as well as receipt of quality healthcare (Anderson et al., 2016). Health care practitioners have a moral and ethical commitment to give equitable treatment to everyone, regardless of their

socioeconomic situation, class, colour, sexual orientation, religion, and other factors. So, the role of health care providers and institutions in establishing and perpetuating these injustices is becoming more well recognised (Nelson, 2002). Recognizing the place of minority communities within a society, such as immigrants and refugees, and the importance for nurses and health care professionals to be able to respond effectively to increasing and diverse populations, cultural safety also has relevance more broadly in the delivery of healthcare. For migrants, it is not only their beliefs and cultural practices that need to be considered in care interactions, but it is also imperative to consider how they are seen and treated by society (Coup, 1996).

Recognizing the impediments to clinical efficacy originating from the inherent power imbalance between care-provider and patient is what cultural safety is all about (Papps & Ramsden, 1996). This concept opposes the idea that health care practitioners should focus on only learning about diverse ethnic groups and their cultural norms. Instead, the objective is to improve treatment by recognising differences, addressing power dynamics, and applying reflective practice (Curtis et al., 2019; Laverty et al., 2017; Papps & Ramsden, 1996). One of the related concepts of this approach include cultural competence, which entails being aware of and sensitive to one's own beliefs and prejudices, as well as engaging with individuals who are different from oneself in a respectful manner (Green et al., 2002; Larson & Bradshaw, 2017; Verdon et al, 2015). Also related concepts are cultural sensitivity and cultural awareness. The latter is defined as a person's comprehension of the distinctions that exist between oneself and others from various nations or backgrounds, particularly in terms of attitudes and values (Kaihlanen et al., 2019). Cultural sensitivity refers to the acknowledgement of cultural variations and the need of respecting these differences in health care (Tucker et al., 2015). Culturally sensitive health care has also been defined as care in which health care personnel give services that are tailored to the requirements and expectations of their patients (Majumdar et al., 2004). Going beyond these concepts, culturally safe interactions are respectful of culture but also aim to rectify power inequities inherent at the individual and system levels (Green et al., 2002; Larson & Bradshaw, 2017; Verdon et al, 2015). Similar, to the concept of ‘emancipatory knowing’, a nursing concept conceived and put forth by Chinn and Kramer (Chinn & Falk-Rafael, 2015), healthcare and interventions are viewed

through a social justice lens, where the sociopolitical processes that contribute to inequities are considered and challenged. The objective here is to produce an environment that is devoid of prejudice and discrimination, and where individuals feel comfortable. In this approach practitioners are self-aware of their position of power and the influence of that role on patients in this setting and considers how the broader social and historical settings, as well as structural and interpersonal power inequalities, influence health and health-care outcomes (Laverty et al., 2017; Shah & Reeves, 2015). Empowerment is a key underpinning principle, which emphasizes that everyone's knowledge and reality are relevant and worthy of consideration. The care receiver is involved in decision-making and becomes part of a collaborative effort towards optimising their care and health. Open communication is fostered, and patients are encouraged to express their concerns about care that they believe is unsafe (Ramsden, 1996). Establishing trust with the patient is evidently an important part of culturally safe practice as well (Curis et al., 2019; Laverty et al., 2017; Ramsden,1996). In the approach of cultural safety, "safety" of the care is determined by the people to whom the care administered, not by those who offer it (Laverty et al., 2017; Shah & Reeves, 2015).

For migrants, the broader socioeconomic and political contexts, including the immigration process itself can have an impact on immigrants' well-being and contribute to disparities in health and care (Castañeda et al., 2015; Mkandawire-Valhmu, 2018). For example, a precarious migration status can contribute to power imbalances, where the person feels afraid to access care and/or to openly express themselves to care providers. A traumatic refugee history can also create issues of distrust, wariness, and fear of discrimination and the broader anti-migrant rhetoric can also contribute to fears of discrimination, and unfair treatment. In Quebec, the current social and political context, including initiatives that are being implemented to preserve the Quebec cultural and linguistic identity, may also be a factor affecting migrants' feelings of safety. For example, bill 96, also known as the language law reform and the province's revision of the Charter of the French language that was passed into law on May 24, 2022, has caused divisiveness within Quebec society and feelings of marginalization among minority-language groups. Therefore, cultural safety when applied in the context of migrants, must not only consider the individual preferences and needs, which may be shaped by country

of origin, culture, age, sex, and religious convictions, but also must consider migration status, and the broader political and social context which may affect health and care.

In this study cultural safety is relevant since the health care professionals working at LMB interact with families from various migration, cultural and ethnic backgrounds. In this context health professionals need to consider the culture-related factors as well as the social, and political environment that may prevent or promote the implementation of interventions that affect the health of families. This is equally true in terms of language development strategies. Families for example, may believe that their parenting abilities are being criticized. They may also be especially sensitive to language, as it is a critical method for them to preserve their connection and identity with their native country, especially for their children. As a result, interventions must consider the families' unique circumstances and ensure that they feel valued and empowered throughout the process. These families should feel "safe" and any interventions applied need to be culturally acceptable. Families should also feel empowered to express their views and to actively collaborate with the healthcare professionals, so that their needs and preferences are incorporated into the interventions. In this research project this conceptual lens of cultural safety was used to guide the interview and during the analysis phase (described below).

Literature Review

The literature review is divided into two sections, the first body of literature is about the social, emotional, and other migration-related factors that may increase migrant children's risk to develop language problems; the second body of literature is about the interventions that are in place at different levels (family homes, daycare centers, clinics etc..) and help promote early language development among children. The first section examines all the different aspects including culture and knowledge systems, health literacy, social and emotional support, as well as access to healthcare which may influence migrant families' experiences and consequently their risks related to language developmental issues. The second section presents and discusses the various strategies used to promote language development in young children including whether and how they consider and address various risk factors.

To identify relevant literature, searches were conducted in online databases, including CINAHL, Medline and PubMed. Three central concepts were combined and used to guide the searches, including “Language development”, “Infants/early childhood”, and “vulnerability context”. Language development terms included “Language Acquisition", "Speech development", "Language Evaluation". Infants/early childhood terms included “Preschoolers”, "Kindergartners”, “Toddlers”; and Vulnerability context terms included “Vulnerable Populations”, “Underserved Population”, “Disadvantaged Populations”, and “Immigrants". Articles that focused on early childhood language development, the risk factors, and migrant communities and/or strategies and interventions for promoting language development and/or preventing language problems, were considered for inclusion. The selection of literature on interventions also included articles that focused on early childhood language development promotion strategies more broadly. For feasibility (time constraints), literature published in the past 10 years was prioritized for inclusion. After examination of the recent literature, it was found that most studies discussing early language development fail to consider or overlook the importance of environmental /vulnerability factors and cultural diversity of families, especially among migrants (Cote, 2020; Janus et al., 2018). Therefore, this study is beneficial in the sense that it adds to the body of literature by providing some information about culturally safe interventions to implement among populations in more vulnerable contexts, particularly migrant families.

Language development disparities and social and migration factors

Despite the fact that infants learn languages quickly, there still remains a lot of variances in how each child develops language and communication abilities (Schwab & Lew-Williams, 2016). Disparities in language development may be associated with the socioeconomic status of the family, parental education levels, maternal mental health, social interactions, the quantity and quality of language stimulation, and access to healthcare and other services (Smith et al. 2018, Baydar et al. 2014). It is widely known that children who experience social and environmental hardships are more susceptible to have poorer development than children who do not, and language development is particularly sensitive to these influences (Bornstein et al. 2016b, Hoff 2013, Nicholson et al. 2012). Thus, in several studies conducted in various countries, many of these factors

have been observed as contributing to disparities (Fernald et al., 2013; Rowe, 2008; Schwab & Lew-Williams, 2016).

Child development is often influenced by family income, and this impact is important for performance in the educational system (Cheung & Wong, 2021). For example, research conducted by Hart and Risley (2003) in the USA, studied 42 families with children aged 10 months to four years old, and had their speech exchanges recorded. The researchers found that young children in low-income households heard around 30 million fewer words by the time they attended kindergarten compared to their high-income peers. Parents who were professionals employed more conversational language compared to less privileged families, which was dominated by more commanding type language and interactions. Similarly, a research study conducted by Fernald et al. (2013) in the USA, also had as one of its research goals to examine the variations in early language development in relation to family socioeconomic status. Participants were 48 children who were learning English from various socioeconomic backgrounds. Using different measures of spoken language processing, these kids were monitored longitudinally for 18 to 24 months. The study concluded that there was a 6-month delay in the development of cognitive capabilities crucial to language development among low SES groups, compared to high SES families, by the age of 24 months. It was also concluded that family income had a deleterious influence on children's language development as early as 18 months, and that the difference between lower and higher-SES children became more prominent by 24 months of age. However, this study did not include the migrant population or indicate the linguistic background of the participants, it only mentions the SES of the families and the parental educational levels.

Parents' education level and understanding regarding child development can also influence the frequency and quality of interactions that they have with young children, which in turn affects language development (Hoff et al., 2018, Huang et al., 2005; Schady, 2011). The development of language abilities in early and middle childhood was examined in a longitudinal study carried out in the US (Bruce et al., 2022). The aim of this study was to assess the effects of maternal education on language development. Both the mothers and the fathers of the children in this study came from a variety of educational backgrounds. The sample was made up of 313 children. Receptive

vocabulary (words that are understood) was assessed using a vocabulary exam at 3, 4, 6, and 9 years of age. The findings of this study showed that at age 3, receptive vocabulary outcomes and maternal education were indeed associated. In this regard, low maternal educational levels were associated with less developed receptive vocabulary among children. Therefore, the results of this study suggest that when parents have a low education level and hence understanding regarding child development, this often leads to a less stimulating environment for children's language development. Another research study, by Hirsh-Pasek et al. (2015), looked at the relationship between children's language development and the quality of parent-child communication in 60 low-income homes in the United States. The purpose of this longitudinal research was to investigate the impact of the quality of early childhood care on children's cognitive, linguistic, and social-emotional development, as well as their physical and mental health. Their specific criteria for determining the level of quality included shared routines and rituals between the parent and child (e.g., reading books before sleep time), play routine, mother-child interactions etc. It was found that variations in the quality of these interactions at 24 months accounted for a significant difference in the development of children's expressive language (words spoken) at 36 months. Therefore, fewer quality interactions were associated with lower levels of expressive language among children and more quality interactions were associated with better and faster expressive language development.

Parental mental well-being can also influence interactions between parents and children which can significantly contribute or hinder language development (Baydar & Akcinar 2015). For instance, maternal depression, characterized by symptoms such as anxiety, sadness, and irritability, can make it challenging for parents to respond to their children's needs and emotions in a caring and supportive manner, thus making it more difficult for infants to acquire some important emotional and cognitive skills, including language skills (Sohr-Preston & Scaramella 2006). Research conducted by Peterson and Albers (2001) in the USA expands on previous research with low SES families and child developmental outcomes by examining maternal depression. The sample included 7,677 mother-child pairs. The researchers used information from the National Maternal and Infant Health Survey and discovered that maternal depression and poverty were harmful for early childhood development, particularly in early cognitive development (language

development etc.). Moreover, children in families with depressed mothers had worse verbal, cognitive, and social–emotional outcomes compared to children with non-depressed mothers, and the effects were even more pronounced if the depressed mothers were also low-income. The study concluded that depressed women's parental conduct was less responsive and active, and more aggressive, critical, disorganised, and overall, less competent, when compared to non-depressed women's behaviour.

A study done in the USA by Kaplan et al. (2014) also investigated the link between maternal depression symptoms and infant's cognitive and communicative developmental milestones throughout the first year of life. Ninety-one mothers and their babies were recruited. The updated Bayley Scales of Infant and Toddler Development was used to evaluate 1-year-olds with the purpose of exploring the effects of maternal depression on infant cognitive and linguistic development. The researchers discovered a statistically significant link between maternal depressive symptoms and reduced infant expressive language at the age of 12 months. The researchers therefore concluded that among depressed mothers the sorts of activities that are supposed to enhance language development among infants, were deficient, and thus led to subsequent vocabulary and speech delays. However, this article does not mention the reason why the mothers were depressed and therefore, it's not known whether stressful life events such as migration, were potential contributors to the depression for some women.

Bilingualism, although very common, especially in immigrant families, has often been viewed as "bad" and leading to problems in early language acquisition (Petito, 2001). Byers-Heinlein & Lew-Williams (2013) claim that early bilingualism is typically seen as unhelpful for the language development of children, mainly because of misconceptions and myths rather than actual scientific data. There is currently a number of studies demonstrating that learning more than one language does not hinder childhood language development (Hay et al., 2022). A longitudinal population study was conducted by McLeod et al. (2016) in Australia to explore the link between multilingualism and language competence, as well as academic and social-emotional development of children. In this study an analysis of the academic and social-emotional outcomes for 4983 kids who were followed from 4-5 years old to 8-9 years old was done. At three distinct stages, groups of children who were monolingual or bilingual had their academic and

socioemotional outcomes compared (by ages 4–5, 6–7, and 8–9). Face-to-face interviews with parents, self-administered questionnaires, observations, direct child assessments, and questionnaires addressed to teachers were all used to gather data. The results of the study indicate that at ages 4-5, multilingual children with speech and language concerns did worse on English vocabulary and behavioural adjustment, but by ages 6-7 and 8-9, they had caught up to the monolingual children in terms of language and literacy skills and social-emotional outcomes. Therefore, this study refuted the idea that multilingualism causes worse educational and social-emotional outcomes among children at school. However, there is also the publication of Hillmert (2013), a paper that expands on previous research findings, and that aimed to obtain a better understanding of the educational performance of migrant children in some western countries (Germany, France, UK, Sweden, Netherlands). The article examined the link between immigration, educational policy, as well as the performance of migrant children in those countries. According to the paper, children from immigrant families were more prone to face social, cultural and health related inequalities due to many factors, including language barriers that prevented this population from accessing different services. In this context, speaking a minority language may contribute to language development problems by reducing access to stimulating activities and services, including education and healthcare, where early identification and prevention of problems take place.

In addition to limited official language abilities, lack of sufficient pre-arrival health care, health literacy issues, insufficient knowledge about the health care system and resources, and difficult financial circumstances are also barriers to health and care that newcomers to Canada typically face (Bogenschutz, 2014; Hui & Barozzino, 2013). Most refugees and asylum seekers particularly arrive to the host country after many sufferings and trauma, and many come from conflict-ridden regions where there is little access to quality healthcare. When they arrive in the host country, they unfortunately face additional disadvantages such as language difficulties, prejudice, trouble navigating the social and medical systems, which make them vulnerable to isolation and mental health problems (Sheath et al., 2020). Children of migrants, including refugees and asylum seekers may therefore be at greater risk for developing language developmental problems due to the accumulation and exposure to many risk factors.

This notion is supported by a recent case-control study conducted by Valade et al. (2022) who investigated the individual and familial risk factors associated with language development issues among children living in Montreal; factors studied included child's gender, prenatal circumstances (such as gestational age etc..), child's age at which developmental milestones were achieved, maternal education level, maternal age, mother's birth country, the use of a foreign language in the household, parental marital status, a family history of language delays, and the child's birth order. Data were taken from the medical records of children who visited a clinic for early childhood psychiatry. This clinic provides services to children experiencing developmental, emotional, and behavioral issued. The research team evaluated the clinical records of 795 children referred and treated at the clinic during the period 2000 to 2016. The participants' average age was 4.11 years and there were three boys for every one girl. The researchers discovered that children of immigrant mothers were three times more likely to suffer a developmental language problem compared to children of mothers born in Canada. Children with a family history of language delays was also associated with twice the risk of having language developmental problems compared to children with no family history. The study underscores the necessity for healthcare providers to improve early detection of language development problems among children by being aware of the specific risk factors leading to this problem in their identification procedures and evaluation algorithms. In addition, the study suggests that rather than waiting for a potential improvement in the challenges faced by children with language development problems, children with an immigrant mother and a family history of language delay should be directed immediately for further screening and assessment, so that intervention may be applied without delay. To increase migrant families' access and care, strategies may include targeted social programs and mental health services, supportive community-based groups, and culturally competent interventions. Hence the relevance of this project, which focuses on culturally safe interventions to be implemented on children coming from migrant families, to help promote language development and ensure that referrals to professionals are provided without delay in order to offer better access to healthcare and avoid further complications.

Early language development promotion strategies

Children's brains are growing quickly throughout the first few years of life, creating the groundwork for learning. Hence, early childhood is a key period in language development and therefore, it is a crucial and important time for stimulation, detection and intervention, including the implementation of strategies to prevent language problems (Weiland, 2017). In addition, early prevention, detection and intervention can positively influence social behavior of the child as well as their general health and well-being, both in the short and the longer term (Janus et al., 2018). Smith et al. (2018) affirm that to enhance health outcomes among children, it is critical to identify young children who are at risk of developing language development problems and to implement timely interventions. The researchers also purport that early diagnosis may be helpful for kids who are at risk for developing this developmental problem because environmental modifications can be implemented to promote early language acquisition among these children (Smith et al., 2018). For children in very vulnerable contexts, such as refugees who have experienced several challenges both before and after their migration, early assessment and taking appropriate and culturally safe actions can ensure that these children receive equitable results while also enhancing their health and well-being (Bhayana & Bhayana, 2018).

According to the literature, interventions to stimulate a healthy language development can be implemented at many levels and in different settings. These include, at home through educating parents during home visits or by providing support and the distribution of educational material through nurses, early childhood educators, or speech therapists; at childcare centers; in primary care clinics; and in public spaces through posters or charts which promote the importance of early language development. The Canadian pediatric society encourages parents to include literacy promotion in their routine activities with their kids (Shaw, 2021). For instance, reading aloud to them, singing, chatting, and telling them tales. They also highlight the crucial role that health care professionals can play in encouraging and supporting families to access books and other resources, through connecting families with neighbourhood services. They may also provide a language-stimulating environment in waiting and examination rooms (books,

toys that foster speaking), to further help families with young children develop literacy-promoting habits (Shaw, 2021).

The literature also highlights the importance of actions being implemented in various settings. At the community/population level this includes public education campaigns; for example, the "Talking is Teaching: Talk, Read, Sing," is a parent directed education initiative targeting the promotion of early brain and language development in the United States. This initiative is implemented through public messaging such as handouts or other training material distributed in various community settings, such as in libraries, and other public spaces where families frequent, and via direct promotion from trusted caregivers, for example through the pediatrician or other health care provider of a child. This has been introduced in cities and communities across the country to raise awareness among parents/caregivers of the value of talking to children, and to help enhance the development of children and to create a healthy child-caregiver bond by encouraging parents/caregivers to engage with their children, by reading, singing, and playing with them from the moment of birth (Too Small to Fail, 2016). Although the campaign is diffused broadly in English and Spanish via different forums and using various mechanisms, it has some limitations. For example, it appears that no specific strategies are used to reach more isolated families in vulnerable situations (low SES, limited access to internet, etc.) who may be more prone to having poor child health outcomes. Similarly, families who speak minority languages and do not understand English or Spanish wouldn't be able to understand the information being diffused, and thus are likely to not benefit from this campaign.

Daycare centres are considered important community milieus as well for the promotion of early language development. This includes promoting child-parent relationships through role modeling and coaching and via the distribution of movies, games, and books to families to further encourage family friendly activities that promote language development. They also directly promote speech and communication among children through play in play groups and activities such as story circles (Cates et al., 2016; Dickinson et al., 2012; Zuckerman, 2009). Daycare-workers further promote language and communication by observing and actively engaging with children; i.e., responding to the child's interests, through asking questions, and making remarks that

help promote language reception and expression (Greenwood et al., 2017; Pianta et al., 2009). However, none of these papers mention whether the interventions implemented are culturally safe, i.e., whether they consider the diversity and socio-political and migration context, so that the children and families receiving these interventions feel they are appropriate, helpful and relevant. In this sense, Torres and Arrastia-Chisholm (2019) conducted a research study in the USA that aims to understand the process of English language development among migrant Spanish speaking children in a daycare facility, through activities and interactions. Twenty-five children participated in the study, and data were collected through observation at two different periods of time. This article suggests that daycare educators should implement interventions such as small group reading activities and vocabulary teaching to help migrant children develop academic English skills as this would help enhance interactions and decrease distractions. However, this study did not mention any other strategies that could be implemented to address barriers and ensure migrant families feel implicated and welcomed in language promoting activities.

In terms of the home environment, several studies have emphasised the importance of interactions and shared activities in which children and their parents/caregivers actively interact with one another (Crow & O'Leary, 2015; Ford et al., 2020; Rowe & Zuckerman, 2016; Suskind, 2016). These studies provide evidence that frequent and active adult-child interactions including discussions between the adults and children are linked with greater observed language skills in young children (Cartmill, 2016; Crow & O'Leary, 2015). For example, Weisleder & Fernald (2013) conducted a study in the United States, where 29 infants in Spanish speaking families who had low-incomes were assessed at 19 and 24 months to determine the relationship between caregiver/parent-child speech interactions and the children's Spanish language development. The researchers recorded interactions between family members and their children during an average day at home when the child was 19 months and then at 24 months old. The findings reveal that during the course of a 10-hour day, the overall amount of adult speech that was available to children varied dramatically, ranging from approximately 29,000 adult words to fewer than 2,000 words. The results of this study indicate that at 24 months, children's vocabularies were greater if they had heard and

were exposed to more speech at 19 months. However, this study does not comment on what factors contributed to families not interacting with their children (for example stress or mental health issues, cultural differences regarding childrearing), which can be highlighted as a limitation. Therefore, this further shows that more knowledge is needed regarding needs of families in vulnerable contexts in order to develop more tailored and responsive interventions that best meet their needs.

Home visits by care-providers have been noted in the literature as important interventions to promote language development activities among families. Research done by Christakis (2019) suggests that children's language skills can be improved through a mix of feedback, parental coaching, and provision of links/resources about age-appropriate parent-child activities by first-line health care providers during home visits. Healthcare professionals can also raise awareness among parents/caregivers about developmentally suitable back-and-forth communication that can enhance children's enthusiasm in learning new vocabulary and help them better their school preparedness (Rowe & Zuckermam, 2016). Also, nurse home visiting in particular, is a way to have an early prevention of problems, while also addressing the issues that prevent families living in vulnerable contexts, such as migrants, from accessing services. This intervention aims to narrow the socioeconomic gap between the richest and the poorest by halting the patterns set in early infancy that result in unfavourable health related results in adulthood (Fifolt et al., 2017). For example, according to a study conducted in the USA by Olds et al. (2014), nurse home visits were beneficial to children and toddlers in terms of linguistic and behavioral outcomes. These visits enhanced the verbal responsiveness and expressiveness of children and decreased parental stress as well. This study included some information regarding the vulnerability status of the families visited, the team mentions that they were low SES families and migrant Latinos in living the United States. However, the research team does not mention whether or not the interventions that were implemented considered the social and cultural background of the participants, which highlights how research provides little insight on whether and how interventions are adapted based on the cultural background of the individuals receiving care.

Another study conducted in Sydney, Australia, also examined how 'maternal early childhood sustained home visiting' (MECSH), conducted by nurses, affects the language

development of the children (Short et al., 2020). This study demonstrates the value of early intervention in assisting in the prevention of developmental issues, including language problems. The purpose of this study was to investigate, through a qualitative comparative analysis, the combination of various factors that result in good and poor language outcomes, following home nurse visits. The research project examined 24 families from disadvantaged backgrounds, living in poor socio-economic contexts and that had at least one psychosocial risk factor that could contribute to poor child language development, such as major life stressors, antenatal or postpartum depression etc. The intervention program had five main goals, one of which was to promote child language development. The intervention started during prenatal care and the MECSH intervention continued for 2.5 years after the birth of the child; children were monitored until they entered school around the age of 5. The first year of the intervention included the "Learning to Communicate Programme", which entailed a strong emphasis on communication development and parent-child interactions. Over the 2.5 years, the nurses visited the mothers regularly (at least once a month), and strengthening parent-child interactions that promote language development was a priority in every home visit (there were 17 home visits in total). Over the course of the investigation data were gathered through questionnaires and direct measurement. More specifically, the score on a standardised language test (Wechsler Preschool and Primary Scale of Intelligence, WPPSI) measuring three subtests of language skills (vocabulary, information, and word reasoning), and the teacher's assessment of the child's language ability, were the two criteria used to determine the language outcome at school entry. To meet the criteria of a good language development, the child had to score 85 or above on the WPPSI, and score at least 5 on the teacher's assessment. This study concluded that when a number of favourable circumstances came together, such as strong prenatal mother psychological health and at least 2 years of early childhood schooling for the child (daycare), language development at age of 5 was good. This was true even when the mother had a low education level. Poor mother responsiveness and prenatal distress were the two main modifiable risk factors that most frequently led to poor language results. However, this study did not mention whether the interventions considered the cultural background of participants, neither did it mention about the migration status of participants. Moreover,

the project did not include any information about addressing mental health and poor mother responsiveness as part of the interventions, which is an important limitation for this study.

A study conducted in Australia by Goldfeld et al. (2019) also investigated the usefulness of nurse home visits provided to expectant mothers facing hardship through a randomised control experiment. The sample included 596 women who had psychological and social risk factors of having poorer child outcomes such as alcohol and drug abuse, and anxiety. The intervention consisted of nurse home visits that began during pregnancy and continued up until the child was 2 years old. The program is known as right@home, and aims to help women and children who at risk for developmental problems. Nurses provided the mothers with information and support on infant sleep, nutrition, safety, parent-child relationship and communication, as well as the delivery process. Up to 25 nurse visits (60-90 minutes each) were made available to women participating in the intervention. Women in the control group did not receive the intervention and were provided with the usual services that consisted of one nurse home visit after birth and the regular follow-ups at the local centers. The results of this study show that women in the intervention group reported more consistent child bedtimes, increased safety, less hostile parenting, and increased parental interaction with children as compared to women in the control group. As a result, it was determined that these programs enhanced factors that influence parenting and the home environment that affect children's health and development, which in turn affects language development. Although the study recruited women who were identified as having various risk factors for poor child development outcomes, it did not take into consideration the migratory background of the participants. However, the research team in this study mentions that the interventions that were implemented took into consideration the risk factors the participating families were facing. They also mention that they worked collaboratively with the Victorian and Tasmanian state governments and philanthropic organisations to create and assess the interventions so that they consider the cultural contexts of the families. However, they do not mention or specify how the interventions were sensitive to these factors.

Visits to primary health care centers in the early childhood period have been shown to have a positive effect on language development as well. For example, well-

child visits in primary care settings, which are currently implemented in Canada, USA, Germany, Switzerland, and other countries are also contexts where language development is promoted (Wakai, 2018). These visits, conducted by a health care professional (family physicians and nurses), aim to assess the development of the child and to detect potential health problems. It's also an opportunity to promote activities that enhance development, such as pretend play, joint reading, and routines that foster parent-child exchanges, many of which positively influence the language development of children (Mendelsohn et al., 2011). This study is a randomized controlled trial in the United States, which aimed to understand how parent-child relations in households with low socioeconomic level are affected by paediatric primary care interventions. Overall, 40 families participated in this study, and it was concluded that primary care health care centers increase parent-child interactions, hence they represent a crucial resource for improving the development of at-risk children. However, this study does not provide any information regarding how these strategies are promoted and adapted in different populations with different social and cultural backgrounds.

In the province of Quebec in Canada, there is the *Agir Tôt* (act early) program (Government of Quebec, 2022) which is offered to families with children aged 0 to 5. This program is offered by nurses through the Integrated Health and Social Services Centers (CISSS) and Integrated University Health and Social Services Centres (CIUSSS) across the province of Quebec for children at risk of having developmental issues (Government of Quebec, 2022). During the 18-month vaccination appointment, the nurse at the clinic administers vaccines and assesses the development of the child using the *ABCdaire 18months+* monitoring tool. If any developmental issues or delays are identified, the parents and the child will be referred (with the permission of the parents), to the *Agir Tôt* screening service or to the necessary services to stimulate the development of the child and prepare them to start school. The program seeks to identify signs of developmental issues in young children so that they can be directed into the appropriate assistance as quickly as possible. It also strives to help support children to reach their greatest potential developmentally and ease the transition into kindergarten. To assist the child's growth and engagement in everyday activities, this program provides interventions and services to the family and the child according to needs. The services are

provided for free, and participation is voluntary. Parents are also encouraged to ask any questions or share their concerns regarding the development of their child. However, the description of this program does not mention anything about cultural appropriateness, or addressing social factors of children and their families, such as low SES, mental health problems, new arrival to the country etc.

Another Quebec example is an intervention implemented in Parc Extension, Montreal. This neighborhood, according to *Montréal en statistiques* (2016), is one of the poorest communities across Canada and is the poorest on the island of Montreal, with 38% of its inhabitants living in low-income households (i.e., 1 out of 5 families, have a yearly income of less than 20,000 CAD). The neighborhood also has a high percentage of migrant families, especially newcomers and represents a diversity of cultures. Therefore, as part of the initiative named "Parc-Extension invests in its children", a guide was developed to respond to the specific needs of the population. The overall goal of this initiative is to encourage, educate, and help community workers and educators in their work with families in stimulating children's language. Various early childhood health care professionals collaborated to create the guidance package, which was informed by the literature and their experience. The guide consists of 12 tips (one tip a month) to promote early childhood language development, along with accompanying and explanatory images. In addition, considering the cultural and migration context of the population, the sheet was translated into 8 languages. The information guide is shared directly with families through different venues, for example during parents' meetings at childcare centers, or during caregiver-child workshops at CLSCs. As part of this initiative, each month, childcare facilities (healthcare or daycare) in the area also receive a "tip of the month". For example, the tip for one particular month was to encourage parents to verbally describe to children the actions they do, as well as the ones performed by the children. This aims to help children acquire new words related to their routine everyday lives, such as action verbs like washing, cutting, reading watching etc. Another tip encouraged caregivers /parents to wait for their child to tell them verbally what they wanted rather than the child using signs and gestures to indicate their wants, followed by the caregiver/parent saying the words. The intention is to motivate children to verbally express themselves with the support of the guardian. For the parent/caregiver it's a tool

that provides direct guidance on simple methods that can be used to promote language. For instance, the language development promoting package mentions the example of water. That is, when the child wants some water but cannot really express themselves, they would say water (or anything that signifies it). Then, the person taking care of the child would add "'Water? So you want water!" and would give some water to the child. Therefore, this is a great and effective resource for supporting allophone parents.

In terms of other interventions in the literature that consider the diversity of families, a systematic review conducted by Larson et al. (2020) synthesised and evaluated 40 research publications on therapies and interventions aimed at enhancing language development in culturally and linguistically diverse (CALD) children during early-childhood (from birth to the age of 5). More specifically, the goals of this review were to describe and discuss how cultural and linguistic factors are addressed in present interventions, as well as to determine the effectiveness of these interventions on language skills in English and in the language used in the child's home.

The participants in the studies included in the review by Larson et al. (2020) were generally children, parents, and educators at daycare centers in the USA; most of the children were pre-school age between 3 and 5 years old. Most of the studies (37 out of 41 studies) included participants having low socio-economic status or even living in poverty. More than half of the studies included participants who were from migrant families and from a minority racialized/ethnic background, although exact migration status was not indicated. Some studies also took into consideration the racial and ethnic background of participants. Many of the studies included participants with diverse linguistic backgrounds, having limited English proficiency. The most common language spoken by kids and/or parents across studies was Spanish. Some other languages were Haitian Creole, Portuguese, and Korean.

In terms of the types of interventions, two main categories were identified including 'linguistically-responsive' and 'culturally-responsive' interventions. Some of the studies were about one type or the other, and some focused on interventions that fell into both categories. Overall, there were four types of interventions: explicit instruction on targeted skills, interactive book reading, classroom curriculum and naturalistic based interventions. In total, 41 research articles were included in this review. Many of the

articles (n= 14) described ‘the explicit instruction on targeted skills’ intervention, while 13 described ‘interactive book reading’, 2 focused on ‘naturalistic, routine-based interventions’, and 12 studies reported on ‘classroom curriculum’ interventions. The most common outcome examined was vocabulary, and all types of strategies were deemed successful in promoting language development, except for the last intervention, naturalistic routine-based interventions, for which the effect was not evaluated in the review.

‘Explicit instruction on targeted skills’ involves small education groups with children that aims at promoting the acquisition of new vocabulary by language. This intervention is often conducted by educators in preschools with groups of one to five children and involves presenting in-depth descriptions of selected language (English) terms to children, while reading books. The 14 studies examining this intervention, which included children or grandchildren of migrants, showed that this intervention promotes complex word learning and language acquisition along with rich explanation of vocabulary. Overall, Larson et al. (2020) concluded that explicit instruction of teaching vocabulary is very important and beneficial for the vital objective to close the word gap and enhance language development for young children from various backgrounds. Moreover, this intervention had better outcomes when the chosen books and strategies were language and culture sensitive, while taking into consideration the home language and beliefs of the families.

‘Interactive book reading’ involves an adult reading a book to a child or to a group of children while interacting with the children. The results of this review show that this intervention was most effective when the chosen books represent diversity and are in the child’s first language. ‘Naturalistic routine-based’ interventions emphasise oral language exchanges between parents and children during typical daily routines and activities. The main goal of these interventions is to promote language development and word acquisition via parent-child/ child-educator connections. For example, one of the studies described strategies to enhance parent-child interactions during mealtime. However, no specific information was mentioned regarding how this intervention was adapted to be more appropriate for CALD families. Lastly, ‘preschool curriculum’ interventions were shown to be beneficial when preschool educators adapted the interventions to the home

language (e.g., bilingual classrooms) and culture of the children for example by reflecting the home culture in the curricula at school, such as in academic texts, prompts and other activities.

Overall, the systematic review done by Larson et al. (2020) shows that linguistically and culturally responsive interventions result in better language development outcomes among children. These interventions are the ones in which the home language, values, experiences, and anything pertinent to the cultural backgrounds of the children and their families receiving the intervention are taken into account. In contrast, when the intervention implemented is not coherent with a family's parenting style and knowledge system, it may be ineffective since there is less openness and receptivity from parents. The authors also conclude that attention to children's home language and culture does not hinder bilingualism or host-country language development among children (especially migrants), but in fact promotes effective and healthy early language acquisition and retention of the family's language. In other words, as interventions better match with the values and knowledge systems of the children and their families, this increases meaning of the intervention for children and their parents. The authors add that the implementation of such strategies increase the possibility that children and their families will have meaningful connections to the intervention's objectives, methods, and results (i.e., perceive the interventions as acceptable and valid). However, the authors report that gaps remain regarding strategies to promote language development and the implementation of these for children from CALD (culturally and linguistically diverse) populations. Cultural adaptations remain limited and many interventions that are implemented do not adequately take into consideration the linguistic and cultural backgrounds of the care recipients. The review also had its limitations. The articles chosen were limited to studies that have taken place in the USA and that were published in English. Additional research and data are therefore required to identify and further inform the development of interventions and techniques that will be most successful in closing the word gap between children from CALD and non-CALD backgrounds.

In summary, through this literature review, it is evident that a number of social factors can increase the risk of children having language development issues and children

in migrant families are more likely to experience these vulnerabilities. The literature highlights several strategies for promoting early language development. However, further inquiry is needed to learn more about the needs of migrant families regarding early language development, and how, or if interventions, address and consider the cultural and linguistic diversity and/or vulnerable circumstances in which some migrant families are exposed to. The objective of the current study was to contribute to the body of literature on culturally safe approaches for promoting early-language development among migrant families in vulnerable contexts.

Chapter 3- Research Methodology

This chapter presents details regarding the research methods used, the steps taken such as recruitment, consent, data collection, analysis, and the methods employed to ensure rigor. It also outlines the ethical considerations and confidentiality as well as the strategies implemented to handle them effectively.

Method

A qualitative descriptive design (QD) was used. The purpose of qualitative descriptive research is to describe experiences or occurrences to learn more about the "who, what, where, and how" (Bradshaw et al., 2017). In this methodology the results keep close to the data and there is restricted interpretation (Neergaard et al., 2009). This design was chosen for its simplicity, since this is a master's project, with limited time and resources. This research design aims to discover and comprehend phenomena, as well as the viewpoints and worldviews of those involved in it (Caelli et al., 2003). This strategy is also utilised, according to Neergaard et al. (2009) and Sullivan-Bolyai et al. (2005), when a straightforward explanation of a phenomena is necessary or when data are required to inform clinical care and build and enhance interventions, as is the case in this master's project. This methodology was therefore deemed appropriate for this study since the student's project aimed to gather data on healthcare professionals' perceptions about language development issues and interventions to promote healthy language development in children.

Participants and Recruitment

Participants

This research project used purposive sampling and the study sample included health care providers of the inter-disciplinary team working in La Maison Bleue (nurses, midwives, family physicians, psycho-educators, social workers, administrators); emphasis was put on recruiting nurses since this project was for master's degree in nursing. There were no criteria for exclusion; all care-providers were invited to participate. The number of participants we aimed for this study was 10-12. This range is frequently regarded as adequate for achieving data sufficiency (Polit & Beck, 2017).

Moreover, based on the time provided for performing the study and having in mind the timeline for completing a master's study, this sample size was also judged viable and acceptable.

Recruitment

LMB has four locations, each of which has a dynamic multidisciplinary work environment (approximately 50 health care employees across all sites), and which are located in neighbourhoods with a large proportion of low-income and migrant families (Côte-des-Neiges, Parc Extension, St. Michel, Verdun). The student recruited participants and gathered data in two locations, chosen because the supervisor has research privileges there, and because each delivers care to many migrant families.

La Maison Bleue's purpose is to alleviate social inequities by assisting pregnant women and families who are in disadvantaged situations. LMB takes a proactive, culturally safe approach and provides programmes aimed at breaking isolation, assisting parents in raising their children, advocating for families, and promoting physical and mental health. Each LMB has access to an interdisciplinary team that welcomes, supports, treats, refers, and, most importantly, focuses on strengths and aims to empower families. Family doctors, midwives, nurses, social workers, psycho-educators, and educators make up the team.

Ms. Jennifer Hille, who held the position of director of development and strategic positioning at LMB during the time of the study, facilitated and coordinated recruitment. Ms. Hille introduced the study to staff by email and/or in person at staff meetings; she utilised her CIUSSS institutional email to disseminate information about the research. Ms. Hille was only responsible for informing the staff about the study and letting them know that a student was looking to recruit participants, she did not recruit any participants. To avoid undue pressure, when sharing information Ms. Hille emphasized that participation or non-participation would not impact the staff's employment status or their work at LMB. Participation details were not disclosed to LMB managers or other colleagues.

Those who expressed interest in participating in the study were asked to communicate directly with the student. The student communicated using her University

of Montreal email account, but also provided a phone number in case anyone preferred to communicate by phone or texting. All those interested were given the opportunity to ask questions and to receive more information about the study. The student was the one responsible for explaining the study, answering questions, and obtaining consent.

Consent

To facilitate the process, the consent was obtained virtually via zoom just before the interviews (in accordance with the *The Psychosocial Research Ethics Committee (REC) of CIUSSS West-Central Montreal Research Ethics Board (REB*) guidelines). The student sent a Zoom link dedicated to the consent process. Participants were instructed to disable their cameras and read aloud the "Participant Statement" found in the Declaration of Consent part of the consent form (Appendix A). This statement contained their complete name, the date, and an expression of their agreement to participate in the study. The audio recording of the consent was captured (no video was retained) and stored on the University of Montreal OneDrive (password protected and separate from any data files).

Data collection

The student was responsible for data collection. Individual interviews were conducted via Zoom. Participants were also given the option to complete the interviews in person at a location convenient to them (e.g., coffee shop, University of Montreal). Participants were advised to choose a quiet environment to minimize distractions and ensure confidentiality during zoom calls. The interviews were scheduled at a mutually convenient time and typically lasted from 20 to 45 minutes. Participants could choose to conduct the interviews in either English or French. To ensure the accuracy of the collected data, the interviews were audio-recorded with the consent of the participants (no videos were kept). The participants were notified before the recording commenced.

Interview

The interviews began with a brief sociodemographic questionnaire (e.g., professional role, years of working experience at LMB) (Appendix B). Afterwards, a

semi-structured interview was conducted This type of interview is frequently used in healthcare research because it provides structure and allows the researcher to ask pre-set questions in order to ensure that the participant addresses topics that are significant to the research questions, but also remains flexible so that new topics may be covered and the participant may focus on what they deem most important to share, and in an order that suits them (Stanley, 2014) (Bradshaw et al., 2017; Polit & Beck, 2017). As recommended by Sandelowski (2000), an interview guide with open-ended questions was used (Appendix C). The interview guide was developed by the student (with support of the supervisor); a collaborator from La Maison Bleue was also asked to review the guide and adjustments were made accordingly before its implementation.

The interview approach and the content of the questions both considered the concept of cultural safety. Firstly, interview questions were formulated and asked in a way to not incur feelings of being judged and aimed to establish an environment where participants felt encouraged to share and openly express their views. Secondly, interview questions aimed to tap into the views/experiences of families and/or how care and interventions respond to families' needs and provide an environment where families feel empowered. The interviews commenced with participants being asked to speak generally about their work at LMB and their experiences working with migrant families. Subsequent questions focused on their perceptions of language development and problems among pre-school aged children followed at LMB. Participants were asked whether families expressed language development as a problem, as well as about families' views on challenges and their knowledge and practices concerning healthy language development. Following these introductory questions, inquiries shifted toward interventions and strategies employed at LMB to foster healthy language development and to prevent problems, and their role, as well as the role of others on the team, towards this effort. They were asked about strategies used to respond to the specific needs, contexts, cultural traditions and values of migrant/vulnerable families, especially those who are most disadvantaged (e.g., significant language barriers, mental health issues, minimal support network and more isolated), and their perceptions regarding families' preferences and dislikes for certain approaches. Additionally, participants were prompted to discuss, based on observations and interactions with families, potential actions that could be done to further promote

healthy language development in a culturally safe manner. The final questions explored more generally on how healthcare providers deliver culturally safe care with families at LMB. Following each interview, the student assessed the appropriateness of the methods used and made necessary adjustments in following interviews to improve criticality and enhance rigor (Polit & Beck, 2017).

During the interviews, the student also took observational notes, which were promptly reviewed afterward to ensure that the data were comprehensive and complete (Polit & Beck, 2017). Throughout the research, the student took general field notes to keep an audit trail of all remarks made during the interviews, as well as her comments and perceptions of data, increasing the reliability and trustworthiness of the results (Nowell et al., 2017; Polit & Beck, 2017).

Data Analysis

The student transcribed verbatim the audio recordings of the interviews and generated transcripts in Word documents shortly after each interview. Thematic analysis was used. This method is relatively simple and adaptable while being rigorous, and is therefore useful for a less experienced, novice qualitative researcher (Braun & Clarke, 2006; Nowell et al., 2017). This approach is a great strategy for exploring diverse participants' viewpoints, showing parallels and contrasts (Braun & Clarke, 2006). The sample was described using data from the socio-demographic questionnaire, which enabled the research team to gain a more comprehensive understanding the study's findings.

In a QD approach the data collection and analysis processes are done concurrently (Patterson & Morin, 2012). The thematic analysis was predominantly the responsibility of the student. There are six phases to thematic analysis. First is the phase of becoming familiarized with the data. The student immersed herself in the various data by listening to the audio recordings and by thoroughly reviewing the transcripts, field notes, and observational notes, to generate first impressions (Braun & Clarke, 2006). Second, she coded the observation notes and transcripts using line-by-line analysis and applying initial codes (words and brief sentences that captured key ideas in the text). Manual coding was done with Microsoft Word. The analysis was done both inductively (open

coding) and deductively (selective coding) from the conceptual framework and based on the research questions. The supervisor independently analyzed and coded a sample of the interviews to validate the initial coding. Third, the codes were grouped together into broader categories. The student then examined the codes and categories and saw how they related to each other in order to begin to identify the major themes, while keeping the research questions in mind; codes and categories were merged together and/or refined as needed (Braun & Clarke, 2006). The various elements of cultural safety were considered during this process (e.g., power dynamics and relationships, cultural competence, empowerment, collaboration/partnership). Excel was used to organize the codes and categories; each participant had a sheet that summarized the codes and categories, with extracted excerpts from interviews to support the codes and categories. A master sheet was also created and served as a working document for organizing the categories and codes into themes. Fourth, the student evaluated whether the themes adequately reflected the meanings in the data set as a whole, to construct a cohesive pattern (Braun & Clarke, 2006). There are two degrees of examining and refining topics in this step. The first stage entails an evaluation of the coded data extracts. This means all the extracted data were reviewed to verify whether they fit well together; all themes were examined in connection to the data at the individual level, and also as a whole to ensure they accurately reflected the meanings of the data overall (Braun & Clarke, 2006). This involved examining the master sheet in relation to the individual sheets and iteratively going back and forth in order to refine the themes on the master sheet. In the fifth phase, the themes were further refined, this included removing redundancy, and verifying that the themes aligned and addressed the research questions; the names of the themes were also confirmed (Braun & Clarke, 2006). For each individual theme, a detailed description was written. The sixth and final phase, was the production of the report (Braun & Clarke, 2006). This phase was conducted concurrently as the thematic analysis evolved through steps three to five; the findings with detailed descriptions and supporting quotes were developed over time. The student and supervisor worked closely together throughout this process to convey their thoughts and understandings of the data and to validate the interpretations (Nowell et al., 2017; Polit & Beck, 2017). The pre-final draft of the findings was reviewed by a La Maison Bleue colleague and their feedback was

incorporated. Braun and Clarke's (2017) "15-point Checklist of Criteria for Good Thematic Analysis" was utilized to improve the overall rigor of the data analysis process (see Appendix D).

Trustworthiness

The four criteria of trustworthiness that were considered in this study were credibility, transferability, dependability, and confirmability.

Credibility

One of the most significant components in building rigour according to Lincoln and Guba (1985) is assuring credibility, which refers to the coherence between the respondents' views and the researcher's depiction of them (Tobin & Begley, 2004). In this study, the student employed rigorous research methods to enhance credibility. These methods included iterative questioning during the interviews to elicit detailed responses; ensuring a private and comfortable space so that participants feel comfortable sharing information; usage of audio recording to ensure accuracy of data; usage of an iterative analysis process; having the supervisor independently analyze some of the transcripts; usage of detailed and descriptions and quotes to support the themes; and validation of the results with LMB personnel. Additionally, before the initial data collecting discussions, the student developed an early acquaintance with LMB to better understand the context and to establish a relation of trust, as suggested by Erlandson et al. (1993). This was accomplished by consulting relevant papers and meeting with staff members via Zoom to present the study. Moreover, to further ensure the credibility of the results, the student researcher and her supervisor had periodic debriefing meetings to discuss the data collection process, the analysis, and the interpretation of the findings. These dialogues helped the student have a deeper analysis and understanding of the research process.

Transferability

Another important notion in assuring the rigor of the study is transferability (Shenton, 2004). Transferability is the extent to which the findings of qualitative research may be applied to other settings or situations with different respondents (Korstjens &

Moser, 2018). The findings of this research project were interpreted and reported with consideration of LMB's unique qualities, as well as its geographic location (Quebec), so that others may determine whether the findings are applicable and pertinent to their settings or organizations.

Dependability

The third element is dependability. In qualitative research, dependability is the consistency of data throughout time and across situations (Tobin & Begley, 2004). To address the issue of dependability, the study's methods were followed carefully; all steps are described in detail in this document (Shenton, 2004).

Confirmability

The last element is confirmability. This notion is concerned with ensuring that the researcher's interpretations are clearly drawn from the data, and it necessitates that the researcher demonstrate how they arrived at their interpretations and conclusions (Tobin & Begley, 2004). Again, this document includes all details on the methods, including the analysis process. The description of the results is detailed and supported with quotes. The student maintained a record of the rationale for methodological, and analytical approaches used throughout the study. All analysis documents and files (coded Word documents and the Excel file) were also kept. As suggested by Koch (1994), these records (with personal identifiers removed) may be available for verification upon request so that others may understand how and why decisions were taken as well as how the findings were derived from the data.

Ethical Considerations

The study was approved by the *The Psychosocial REC of the CIUSSS West-Central Montreal REB* (Appendix E) as well as from the CERSES (*Comité d'éthique de la recherche en sciences et en santé)* at the Université de Montréal (Appendix F). Multiple steps were implemented to honor participants' autonomy, ensure their well-being, and mitigate potential adverse effects. All participants gave consent before participating in an interview. Participants received a $15 Starbucks gift card as

compensation for their time. A list of resources was provided on the consent form in case any participant felt negative emotions and wished to discuss their feelings with someone. All dissemination of the findings are being done in collaboration with LMB.

Confidentiality

All information collected during the research project remained, and will remain confidential to the extent provided by law. Confidentiality was preserved by conducting interviews in a quiet, private area; participants were requested to ensure that they were in a place where they could retain privacy during interviews. For interview recordings, only the audio recordings, not the videos, were retained.

A random identification code was used to identify each participant, and except for the consent and the master participants' list (which links the participants' names to their identification numbers), names are not recorded anywhere. The master participant list is saved on the University of Montreal's secure OneDrive, password protected, and in a file separate from the data and the consents; this list will be destroyed once it is no longer needed (a maximum of 10 years). All data are also saved on the OneDrive and are password protected and only the student and supervisor have access; the supervisor will be responsible for destroying all data once they are no longer needed. No information that could identify a participant or LMB site are included in the research results; any information that could potentially identify participants or sites were omitted, changed or masked from the quotes (e.g., identifiers like "nurse" or "her/him"; or any distinctive detail that could identify a LMB site).

Chapter 4- Results

Description of the study participants

In total 8 professionals from LMB provided data for the study. Five participants participated through interviews, while three shared responses to the interview questions via email. Participants were all females and their ages ranged from 20-59 years old. All interviews were conducted in French. One participant had an administrator/support role, while seven were healthcare professionals. Six of the participants had been working at LMB for less than 5 years, and one had been working at the organization for more than 10 years; one participant did not specify how long they had been working with LMB. At the time of data collection all participants were working at LMB more than 25 hours/week. Four participants had graduate degrees, three had an undergraduate degree and one the education is unknown. Four participants had at least 10 years of experience in their respective professions, while three had less than 7 years of experience; one the experience was not recorded. Two participants had a migration background, but both had been living in Canada for more than 10 years. All participants were bilingual (French/English), and two also spoke other languages. Four themes were identified, these are presented in the next section.

Themes

The participants discussed what they had heard or observed through direct care and interactions with families, but also what they had heard from colleagues and their experiences with families. Although participants were asked to respond based on what they thought families would say about their knowledge, practices and concerns regarding early language development, the responses mainly included the participants' perspectives. The first theme therefore largely reflects the participants' concerns about language development problems among migrant families at LMB and their interpretations about the contributing factors to these problems. The views of migrant families, through the lens of the participants, however, are also incorporated within this theme. The second theme highlights the strategies and approaches used at LMB to promote language development and to prevent problems, as well as the responses of families to these interventions. This theme also provides a more global view of care provision at LMB and sheds light on how cultural differences are addressed, and how professionals build trust

and non-judgemental relationships with the families. Finally, the third theme focuses on strategies proposed and that could be implemented to further promote healthy language development among children being followed at LMB.

1. **“It's related to different factors like precarious migratory status…"**

When participants were asked to discuss language development problems among children being followed at LMB, almost all expressed that this was an important and common issue among their population. P1 mentioned the following: “According to our observations, at LMB we have a good proportion of children who encounter language difficulties. Of course, it's still a small sample, but the proportion is still high.”

Many of the participants shared that they believed the multilingual context of migrant families was an important contributing factor to language development challenges. For example, when at home, the mother and the father may each respectively speak in their mother tongues, and then the child may go to daycare, where they are exposed to French and/or English. One participant said that they felt that the exposure to multiple languages caused confusion and overwhelmed the child. P2 explained it as follows:

> Sometimes the dad and the mom each speak in their mother tongue with the child. In addition, sometimes there are also siblings at home, who go to school and speak to the child in French. There is also the screen and the videos, which would also expose the child to other foreign languages, such as English. So, the little one is exposed to many languages at home, which can make him feel lost and mix the languages, in a way that he cannot be understood.

Another important factor that was discussed and believed to create language challenges for migrant children is not having access to daycare- this lack of access is often due to the parents’ asylum-seeking status. Because the children are not able to attend daycare, this results in them spending lots of time at home, where they may not have much stimulation. P5 shared the following:

> In fact, what I particularly noticed here at LMB, there are many children who have a late language development, and it's not necessarily related to difficulties with early diagnosis and intervention. But, in some families with precarious migratory status, the children do not attend daycare and are often at home alone with their mother or both parents.

The participant then added:

> When possible, we encourage these families to enroll the children in childcare facilities, however this is not possible when they are asylum seekers, as they do not have access to subsidized childcare. So sometimes we look at other alternatives, like for the mother to enroll in francization courses which also offers a drop-in daycare, so we can find this kind of possibilities too.

The lack of stimulation for these children was also discussed; many of these children are living in homes with parents who are experiencing very challenging situations, and due to competing demands, they may lack time and energy to play and interact with the child. P5 said:

> I talk and teach about the importance of stimulating the language development of the child, but sometimes parents lack the energy to apply them. A father once told me that his wife works all day and then he works all night and then during the day takes care of the child, while the mother is at work. They sometimes work 7 days a week, so they are not really able and do not have the energy to apply the recommendations.

In addition to a lack of interaction with parents, another major issue that was raised by most participants, was the overexposure of children to screens. For many, screens were considered a way to entertain their children, especially when parents are tired.

Some participants had the impression that certain parents also viewed screen time as a method to help promote language development. The participants explained that for some families' "screens" were a way for their child to be exposed to the mainstream (English) language, which could help their children acquire new vocabulary. Overall, participants expressed significant concern about the amount of time children are exposed to screens.

P6 expressed her concern: “Families unfortunately believe a lot in screens and think that the child will absorb language by listening to videos.”

P3 also added:

> When we talk about the impact of screens, I would say that some families don't like it. The subject of screens is difficult, because in some families the TV is on all day. Also, in some cases, babies who are 7-8-9-10 months or 1 year old, have a phone in their hands when they come here.

Also, some participants had a particular concern about children’s French language development since children will be required to function in French once they begin school. The combination of parents not speaking French, and being shy to speak it, and the child not going to daycare, and mostly being exposed to English online, were all described as contributing to children not learning the language. It was therefore felt that children in migrant families have more difficulties in French than the average child given their lack of exposure to the language and their added challenges in general. This concern was also shared by families, and the following was mentioned by P2:

> Many children do not necessarily speak French, so this is a common concern for families because they know that they are going to have to send their children to French school or daycare centers that are French speaking. So, this worries parents knowing that their child cannot express himself.

The participants shared that they thought cultural and social norms might also have an indirect effect on language development by influencing family dynamics. For example, views about parent/child roles may influence how parent and children interact. One of the participants mentioned that in some families, parents do not consider that they should play with the child, as they do not consider this is as part of their role. In this sense, P1 said:

> We face different cultural and social norms. Sometimes families mention that even if they play with the child, others will comment on their behavior. A parent once commented: “Why do you play with your child?

> It's not your role to do that, as the child will eventually develop language and other skills when he goes to daycare. Let the child play, and you do your chores at home".

The social context in which children are growing up is also very different from the home countries of many migrant families; back home the families have big family networks and so children have more opportunity for socialization. One of the participants discussed how migrant families and their children experience a lot of social isolation, and thus this contributes to children having fewer social interactions. P6 said the following:

> Sometimes, we can realize that children coming from migrant families are often much more isolated here than they would be in their country of origin. Here, they have no support network as in their home countries, and sometimes don't even have access to subsidized childcare services. This leads to less socialization, and hence children have less opportunities to help them develop language.

When participants were asked about families' perceptions on language development, they reported that language development doesn't seem to be a particular preoccupation for most families. They explained that it isn't a concern commonly expressed and some parents, who had children with delays, explicitly stated that they thought their children would eventually "just grow out of it". P3 said: "Many immigrant parents do not see the relevance of talking to their child/working on language, they say: "In my country, children do not speak before the age of 3, language develops on its own."

P1 also added:

> A lot of parents do not necessarily know the normal development of children's language, and don't notice the language delay, thinking that it will unblock over time, and that the child has not reached this developmental milestone yet.

In contrast, the participants said that some parents do become concerned once a language problem has been pointed out to them by a healthcare professional. In other instances, it's actually the families who notice the problem and they actively seek out

advice and help. In many of these cases, the parents become worried when they notice that their child isn't speaking as much as other children around them, for example at daycare, or at school once they begin attending (pre)-kindergarten. P2 said the following:

> If they see that the child does not speak or speaks incorrectly, after a while it worries the parents. They go visit other families, but their child does not speak. So, they will compare their children to others, and in general they come to LMB quite easily to talk about their concerns.

Parents who have older children, and who have experienced how their first-born child developed language, are also more likely to notice, for example if their child speaks in a way that is not very clear, or when they don't say a word, and this is different from how their older children developed. These families will express their worries and concerns regarding the language development of their child. P5 shared: "There are some families who are worried, sometimes when they have an older child or when they compare with children of the same age, the language delays will be very very pronounced."

In sum, language development problems among children in migrant families are of concern at LMB, and factors related to the migration context (lack of access to subsidized daycare, socio-cultural differences, difficult/stressful home environment, isolation) are believed to contribute to these problems. Due to their migration status, children in these families have less exposure to language stimulating activities and interactions. They also have less exposure to the French language, which is needed for school readiness. A lack of knowledge about children's language development also sometimes adds to this challenging context.

2. "We are a very interdisciplinary team, but we all have the same goal and the same message"

In speaking with the participants, it became evident that they generally viewed each professional as having a different role when it comes to supporting language development. The psychoeducators were viewed as having the most direct and involved role, including monitoring language development, and implementing interventions to

prevent problems and to promote healthy language development throughout the time children are followed at LMB. This includes screening evaluations at different ages according to a pre-established schedule to detect if there are any developmental delays, assess if the parents have concerns, and to refer them to a specialist if needed. The following was mentioned regarding the role of the psychoeducators at LMB:

During their journey at LMB, all children have appointments with the psychoeducator to do the developmental screening, to evaluate how things are going at home, what the routine is, and if the parents have any special needs for their children. If a developmental delay is detected or if the parents express certain needs, the team is not just available at 8 months, 2 years, and 4 years, but in the meantime too, to offer support and follow up with the children.

The nurses also play an important and complementary role in assessing for language development issues. During vaccination visits, nurses generally have the task of conducting developmental assessments, which comprises language/communication development. This includes a general screening for developmental delays using the ASQ at 8 months old, which is a tool that helps guide the assessment of a child's overall development, including communication skills. As part of the *Agir Tôt* program, recently implemented by the government of Quebec to screen for developmental deficiencies, to ensure early detection and to prevent complications, the nurse also conducts a comprehensive developmental assessment at the 18-month vaccination visit. This examination includes an evaluation of language development using the ABCdaire (developmental assessment tool), which has a dedicated section that targets the language of the child. Children are then referred for additional support and assessment as needed. If the nurse has concerns, she refers the child to the psychoeducator, who may then carry out a more in-depth screening of the child's difficulties. It was also mentioned that if deemed necessary, families and their children are referred to a specialist such as a speech therapist, to help the child develop language. The role of the nurse was described as follows:

> Nurses evaluate the development of the child. At 12 months, our team expects the child to say a few words, and at 18 months 14 words. If that's not the case, nurses refer the child to the psychoeducator who will provide them with educational tools, such a visual support, pictograms, and books. Therefore, the nurses are often the professionals who detect language problems.

It was mentioned that assessments and concerns about language include delays in any language, not only French and English: "I am not even speaking about French or English. If we see that the child has not acquired the language, even their language, then we consult the psychoeducators to provide us with possible solutions."

Overall, nurses at LMB play an important role in health promotion through education about various topics related to the development of children. Moreover, the nurse role was described mostly as promoting women's health, and mental health generally, both during pregnancy and post-partum; though they play a key role in identifying language development promotion it was mentioned that once these issues are identified, families are then referred to the psychoeducators, who are the ones primarily responsible for addressing language development problems. Nurses' responsibility is more in regards to supporting the parents, particularly the mother, so that they may have more capacity to tend to their children and create a healthy environment in which their children may thrive.

Social workers at LMB were described as having a more indirect role in early childhood language promotion. Their primary role is to assess for social issues (housing, food, migration, mental health), including emotional well-being of the family, and to provide support and referrals accordingly. During interactions with families, however, they may reinforce language development via role modelling (i.e., interacting and speaking with children), speaking French in order to expose children to the language, encouraging and supporting access to daycare, and urging parents to learn French and supporting their access to language programs. The following was mentioned regarding the role of the social worker at LMB:

> It is certain that the implication of the social worker is more indirect than the psychoeducator in the promotion of language development. However, social workers still play an informal role in the prevention of language problems during their meetings with families, where they conduct assessments to find out where the family comes from, their status in Canada, the income, the problems they are facing etc. In this sense, the social workers try to speak in French during these meetings so that children and families start to get used to it before school, they also encourage parents to read, to have the child repeat words/ phrases etc.

The support personnel were generally viewed as not having an active role in promoting language development of children. However, they did talk about how they often interact with families more informally. This indirectly supports language development by encouraging French/English communication among the parents and children. It also contributes to creating a welcoming and friendly environment, which creates a sense of community and fosters trusting relationships between the families and the LMB personnel. This in turn has a positive effect for the success of other interventions (see below in theme 2.2). They also provide practical support to the care-providers' which can support their interventions. P2 gave the following example:

> The support personnel don't have appointments with families, but they certainly give a helping hand to professionals. For example, if a family needs to enroll the child in daycare, and if the psychoeducator has no room in their schedule, the support personnel will do the registration with the mom etc.

Overall, despite each having a particular role with regards to language development, the participants emphasized how the professionals at LMB collaborate and apply an interdisciplinary approach, as all of them have the same goal, which is the well-being of the children and the families. Health and social issues as well as interventions being implemented to address these are discussed at team meetings to ensure everyone reinforces the same message and approach. This was described by P2 in the following quote:

> We are different professionals, but all have the same message. We're very interdisciplinary, we meet every Tuesday, we talk to each other as a team,

> so we have the same message and the same goal. I think that's the beauty of LMB, because everyone is on the same wavelength.

2.2 "I know you love your child, and you want the best for them. I am also here, because I have the well-being of your child at heart"

When asked about how language development is promoted at LMB, participants described a few different approaches. One that was commonly mentioned, was parenting groups, these are animated by a psychoeducator and aim to enhance parenting skills and promote parent-child attachment. The participants shared that mothers in particular seem to really enjoy participating in these group activities. The following was reported by P3: "There are several groups at LMB, there are some related to language, parenting, etc. I think families really like it when we do things in groups. They participate well in these activities."

During these group activities the psychoeducators engage parents in play and in other educational activities, promoting communication between parents and children and providing strategies to develop language are a particular focus of these activities. One participant explained:

> We try to work with parents who we call precursors of communication. We teach them about the importance of eye contact, attention, the repetition of words and phrases to the child etc. We provide parents with strategies that help stimulate language the child's language, and things to practice at home. We try to target interventions that are both beneficial for the developmental stage of the child, and that are accessible to parents.

An emphasis is also put on reading with children. Some participants commented that they also encourage reading books in the maternal language. P2 said:

> We even succeed during our groups to encourage and teach the importance of reading to children, and other strategies that stimulate the development of language. We have many parents who are very interested in the subject.

Reading was also further promoted by referring families to organizations, which hold activities that encourage reading to children and allow families to borrow books and educational toys. This is particularly helpful for families who cannot afford to buy books and toys for their children.

Care interactions with families were also described as opportune moments for supporting language development. LMB professionals will often use these interactions to provide general information on healthy child development and to encourage parents to speak with their children in their own language. The maternal language is really valued among professionals at LMB and is viewed as a natural way to encourage the child to speak and develop their language skills; through the use of their own language parents can effortlessly engage with their child and serve as role model. This was explained by P1:

> We encourage families to express themselves with their children with their mother tongue even if they are in Canada or Quebec where people speak French or English. Even in our interventions, in groups, we encourage them to express themselves in their mother tongue to interact with the children, and the other parents, even if we don't understand anything. Sometimes they translate for us, sometimes not, but it doesn't matter.

P4 gave the following example:

> Sometimes for example when we see a child pointing at something we say to the parents: oh, he pointed that out, tell him, tell him in your language. For instance, if the child is pointing at an apple, we encourage the parent to verbalize and say apple in their home language. This way, parents are also encouraged to speak in their mother tongue with their child.

The value of the maternal language was further emphasized by one of the participants who spoke about using a translated tool (developed by a community speech therapist in Montreal), which is available in 9 languages (English, French, Arabic,

Bengali, Spanish, Punjabi, Mandarin, Hindi and Tamil) to provide tips to families for encouraging language development. This document outlines 12 tips, one for each month of the year, with corresponding images, to promote language development during daily routines. For example: “I sing children’s songs and encourage the child to imitate my gestures”. This translated document was described as an excellent tool for supporting allophone parents at LMB, as explained by P5:

> It is very interesting, because we can find information in different languages (referring to the translated tool). Here at LMB we have a lot of families who come from India or Pakistan, so it is very helpful to find such information in their language.

Another strategy described for supporting language development, was role-modelling. A participant discussed how health professionals at LMB directly interact and speak with children and name objects out loud when children point to them, as a form of normalizing this behavior. As mentioned above, direct interactions with children are also used specifically to reinforce the use of French. This is a way for families to observe, and naturally integrate what they see rather than being told what to do, which may lead to families feeling judged in their parenting skills.

To further promote French, LMB personnel also strongly encourage parents to enroll their children in daycare or to use “halte-garderies” (drop-in daycares offered by community organizations) where children will be exposed to the language. Participants also spoke about encouraging parents to learn and speak French, as an indirect strategy to improve children’s French speaking skills. LMB motivates parents to enroll in ‘francisation’ courses.

Overall, bringing families to LMB was considered a way to encourage children as well as their parents to be off their screens and to interact more. The environment at LMB is home-like, small, and warm, where children can play, and parents can talk and interact. Therefore, this promotes interaction, gets children and their parents off screens,

encourages communication, increases exposure to French, and allows children to have access to educational toys and books. P3 explained:

> Here at LMB children are exposed to many toys, a lot of books and educational crafts. Therefore, at least when they are at LMB, they can take a break from cell phones and screens and get exposed to French and these educational resources offered to them.

The friendly, warm milieu also encourages families to spend more time at LMB, which in turn can lead to greater participation in group activities and hence have a positive effect for early language development. The welcoming environment was described by P3 as follows:

> LMB is really like a little house. A very warm and cozy environment and professionals. It's like a house with a living room with toys everywhere, a dining room, and a small kitchen. I think that already helps our families a lot. We are a small team, we really work together, and the families feel it. We also have food, if the children are hungry, there are healthy snacks and many educational toys. Families often tell us that LMB is like their second home.

2.3 "Our mission at LMB is to have a bond of trust from the start"

More general approaches and strategies that are used when intervening with families were also discussed. The participants described how LMB professionals try to focus on families' strengths. They also spoke about how they tend to take their time to understand the context, in order to find solutions that families feel most comfortable with.

P1 expressed the following:

> We get there by using the basic strengths of the parents at first, respecting their beliefs and visions without any judgments, to inform them afterwards about what is recommended for the child to develop language, then leave them with this information, and to decide whether they would like to implement them or not.

Another participant also described how they use positive reinforcement, to build from what parents are already doing with their children, but also to support new behaviours that parents engage in. This promotes confidence and helps parents feel valued in their role. They said: “When they try new things, we congratulate them for taking the step to help the development of their child and encourage them to try and add on that. This already gives parents confidence.”

The participant then added: “We try to strengthen the families in what they already do well to promote a healthy language development, because I believe that there are no families who just do harm for the development of their children.”

In addition to being strengths focused, participants commented on how they are careful to not overstep, and to let families decide which advice they would like to follow, and when; they really try to go at the family’s pace. This includes allowing parents to warm up to referrals and seeing specialists. It also includes being responsive and providing assistance, and referrals whenever it’s the parents who come to them seeking support and advice. P1 shared an example of how they respond when parents express concern about language problems:

> Sometimes parents at LMB ask us questions like: why does my child mix languages? Why is he speaking more like a baby language? Why doesn't my child make a request with words instead of gestures? They bring us examples from the child’s behavior they observe at home. So, in these cases, they are the ones who tell us all these information. So, we then tell them about normal language development of children, and they will see the difference compared to what they have told us and try to take additional steps to help the child.

Furthermore, a lot of effort is made to ensure good communication with families. For families who have language barriers, LMB uses interpreters to help understand the concerns and the wishes of the families, as well as to give advice and guidelines. One of the participants also mentioned the usage of Google Translate, images and pictograms, to help the families understand when the language barrier is evident. The usage of these

tools and resources at LMB are key for ensuring interventions are appropriate, whatever the issue may be. It also helps with building a rapport.

Creating a rapport is a key element to LMB's success with families. All participants discussed how creating a relationship contributed to building trust with families. As described above, the warm, welcoming atmosphere at LMB fosters many informal exchanges with families and the fact that LMB professionals follow children until age 5, provides an opportunity to build a relationship over time and to get to know the families well. This trusting relationship then allows care-providers to successfully intervene with families, especially on topics that may be more sensitive, such as language development problems. The development of this trusting bond was explained by P2 as follows:

> Our mission at LMB is to have a bond of trust from the start. We meet the mother when she is pregnant and follow up all the way till the child turns 5. However, sometimes there is mistrust at the beginning, but generally it settles quite quickly at LMB, because we are very interdisciplinary team with a very warm environment.

At the core of all interventions and strategies, is the child's health and well-being. As one participant so eloquently explained, what helps most while working with families to achieve objectives, is by making the child the focus; this was considered a way to find common ground with parents and to effectively intervene. P1 mentioned the following:

> We are there, living the situation with the families, and our goal, just like theirs, is the well-being of the child. Therefore, we put the child at the heart of our interventions then we add: "I know that you love your child and that you want the best for them. I am also here because I have the well-being of your child at heart.

Overall, many different approaches and strategies, by different professionals, are used to promote early childhood language development, these include more targeted interventions as well as more global strategies that focus on building confidence and trust and increasing the family's receptivity to care. Support is given towards developing the maternal language and/or English, but emphasis is put on learning French, so that

children may be better prepared for school. Finally, to achieve success with families and to find a common ground, the well-being of the child is always considered as a priority and is put at the center of all care interventions and strategies.

2.4 **"We try to build together a solution that will work for them"**

The participants discussed several challenges related to promoting early language development. Participants shared that sometimes families don't follow recommendations. Thoughts were that this might simply be due to parents' context and competing demands (their migratory status, financial reality, etc.), which may lead to a situation leaving them with little mental energy or time. It was also mentioned that sometimes it was difficult to know parents' views, and whether or not they agreed with a recommendation. Parents will often say yes and agree on everything the professionals say, but then they would not follow through. Participants thought social desirability or cultural factors may therefore explain this behavior; i.e., it may be that recommendations are not followed because the families do not agree with them but do not feel comfortable expressing their perspective.

P4 gave the following example of how a family asked if they were required to say yes to everything:

> I remember a family once asked to me: "do we always have to say yes?" I was very happy to hear that and assured them that no, they do not always have to agree. So, I have that cultural sensitivity, but it's hard for us to get there, due to different barriers. Sometimes we don't understand each other well, sometimes they say yes, even if they are not fully convinced if what we are saying makes sense or not. They sometimes have the idea that they must always agree with the health professionals, as they are part of the team that does the follow-up with their child.

The participant also explained how they try to make an effort to know what parents think and feel, but this can be very challenging:

> It's not easy, but we try a lot to understand their points of view. We ask parents if they know why we are intervening and try to make sense of it. We also take into consideration that in their country of origin it is not common for a healthcare professional to ask parents a series of questions

> to see if the child is doing well or not. Also, there are certain families to which we say if you don't understand, tell us or if you don't agree with what ask you to do, let us know. Therefore, it is not easy to take into account their particularities and their values.

In some instances, families do express their thoughts and preferences regarding interventions. For example, some families shared that they found certain behaviours or recommendations odd; it was mentioned that some found it peculiar to speak to children who are not yet verbal. Also, being told to read to children is not always well received and adopted by parents at home, because it's a more challenging activity to implement with their children, who seem to prefer playing, particularly with toys that have sounds and lots of colors, which can be more entertaining than listening to a story. P1 gave the following example:

> If we compare a fire truck that makes sounds and has lights to a book, it's sure that the child will be less interested in books and will prefer the toy. So, the parents will see that the child is less interested in books and won't invest their time in reading to/with the child.

Participants shared that the different educational levels among parents also pose challenges in understanding and applying information. In this sense P1 explained:

> There are parents who are ready to work, who want to get involved in the promotion of the early language development of their child, and who put in place the means to do so. However, there are also parents, who have a little knowledge limitation, so in such cases we have to work with that before we can intervene to promote the language development of children.

Working across languages and finding materials and resources in a family's language is also difficult. Although at LMB a lot of value is placed on promoting and preserving the maternal language, finding books and toys, even online, isn't always feasible. Therefore, this unavailability of educational resources in different languages adds to the challenges in promoting early language development among allophone families, many of whom struggle significantly to understand or read in English or French.

Language barriers in general are challenging and working with interpreters further adds complexity. Participants discussed that it is not always easy to understand the concerns of families, especially the way they feel. Communicating information back in an effective manner, through a third person, particularly when there are different understandings and perspectives on childrearing, is equally difficult. Moreover, working with interpreters is not only challenging in terms of communication, but it can also contribute to hindering language development. In this regard, working with interpreters is a double-edged sword because while it facilitates communication, it can also slow the learning of French among parents. P5 said:

> Working with interpreters requires us to simplify our thinking a lot, so that they can easily explain it to the families. Also, it could sometimes be challenging to have an interpreter, as I think that families sometimes feel a little limited in the way they want to tell us things, especially when it's related to their concerns and feelings. So sometimes having an interpreter is also a barrier, even if they help the families to be understood.

Also, P3 shared the following:

> Sometimes I find that even though we want to help families through requesting the help of the interpreters, sometimes this could hinder the learning of French. It's not a question of nationalism, but I try to speak in French in my office, so that families start to get used to it. I know that we must be careful, and that there's a whole debate about this. There are people who say we should always have the option of speaking in other languages, I think yes, but up to a certain limit. At the beginning of the follow-up, for example for the first appointment with the nurse of the physician, it's important. However, for appointments such as vaccination, I don’t think having an interpreter would be essential.

Participants shared that sometimes it can also be quite emotional for families to learn that their child has a developmental delay, and their reactions may be negative. One participant reported an incident where she had told a mother that she had observed her child seemed to have a language delay and the mother seemed angry about this evaluation. The participant thought that this reaction may be due to the overall stress

experienced by the family or could be related to certain factors such as the understanding of parents or different views about what was observed.

As described above, LMB professionals are sensitive to families' needs and try to adjust their approach accordingly. They take into consideration the various challenges families are facing, and if the approaches they are recommending are not working for the families, they try to figure out why and find ways so that interventions will be more acceptable and applicable to the realities of the parents. This involves asking questions to find out which intervention best suits them and to discover their preferences; actively listening to their concerns so they may adapt the interventions; and being open to different ways of doing. In other words, LMB professionals work to find a solution that will work for the family and that will respond to their needs and challenges. P1 explained this in the following:

> ... if we give advice and the person does not apply it, then we will ask ourselves the question, what went wrong? Sometimes we're really going to ask the question, we discussed it, but you didn't do it, can I know why? I think that also helps, we don't position ourselves as great experts, but we try to build together a solution that will work for them.

3. "I think it would be accommodating to have intervention strategies close and adapted to needs of the families"

When asked about additional interventions, participants made a few different suggestions on strategies that could be implemented to better help and promote language development among migrant children being followed at LMB. One suggestion made was to have more time dedicated to directly working with families to help them learn and understand more about language development and to engage them in language stimulating activities with their children. One participant suggested one-on-one sessions to help them better understand the importance of early intervention in the promotion of language development, and to recognize signs that might indicate problems, and hence a need to consult a health professional. This was explained by P5 in the following way:

> For some families language promotion does not make sense. They will say that it is not important for them, but we do not really understand why. Therefore, I am thinking of organizing more meetings on why these interventions are important... It is crucial to help them understand that as their child is closer to school, they need language skills to be functional. I am linking it to school, because I know that education is important for families who attend LMB and for all families in general. So, I have the impression that such meetings would mobilize families a little more to act.

P1 had a similar idea, but emphasized the importance of repetition and proposed that parents do 'homework' so that LMB professionals could then build their interventions in response to parents/families' needs:

> Ideally, I think it would be beneficial to have more meetings about language stimulation with families, but on a regular basis. For instance, to meet with parents regularly, and give them some homework to complete, so that when they come back with feedback, we could work on that together to see where the problem is and to intervene accordingly. I think it would really be a great asset.

Another suggestion raised was to have more educational resources available in a range of languages, so that they would be better adapted to migrant families and could facilitate communication with families on the topic. It was also deemed as a way to promote more confidence in parents and to encourage them to apply their recommendations. P1 explained:

> In terms of prevention of language difficulties, I think it could be interesting to put in place some resources that are in different languages, so that parents understand the development of language, watch out for warning signs and seek help as soon as possible.

The participant then added:

> I think it would be really helpful for parents to have access to translated tools, and more educational resources about language development in different languages, especially that we encourage the use of the mother tongue. I think this also gives parents more confidence to apply the

> recommended interventions. So, I would say having books, tools and more information in different languages, could help our families.

Participants also recommended having direct access to specialists on site. For example, it was suggested to have an audiologist and a speech therapist specifically for LMB families, especially given the long waiting lists that currently exist for consulting a professional. They also explained that sometimes some families avoid these appointments due to the unfamiliarity with the environment and difficulty navigating the healthcare system. Therefore, it was felt that having these professionals at LMB would increase adherence to appointments and would encourage parents to follow up on the child's case, as families are used to LMB and are comfortable with the professionals working there. P2 mentioned the following:

> I think it would be very helpful to have audiology and speech therapy clinics on site at LMB, because as soon as it's outside LMB, it would be difficult for families to go there. They feel confused, don't know where to go, and how to navigate in the system. However, when it's at LMB, it would be easier for our families as they already know LMB, they trust us, they know where we are and who we are, and it is easy for them to come here.

In the same vein, a participant suggested to have an audiologist and a speech therapist present during less formal activities (e.g., parties, parental groups) that are organized for families. They explained that the specialist being present in this context would help demystify the concept of language difficulties and the importance of following up with the professional. Hence, this would reduce the stress of families. The following was explained by P5:

> This way families meet the professional at less formal activities, in a slightly more playful way. Therefore, if the child needs to be followed by the professional afterwards, the family would have already built the trust relationship with them, because they have already encountered them in another facet, which is less threatening. I think that would help a lot in reducing their stress.

Finally, two participants emphasized the need for more community resources and more support for orientating migrant families towards these resources. One of the participants suggested, that soon after arrival in Canada, families should be helped to become familiarized with the public educational resources in their area, such as libraries, and community organizations that are open and free for everyone. They explained that many migrants do not know about these resources. It was explained that these organizations are important entities in communities, as they can play an important role in promoting language development, especially for migrant families. These organizations provide books, toys, movies, and other basic materials that address the families' broader social needs, which in turn can reduce stress and promote well-being in families. In addition, these community organizations are also key venues that help both children and parents socialize with other people, which can reduce social isolation. The following was mentioned by P2:

> It is important to orient migrant families and their children towards their local libraries, and to show them how to navigate. Our families don't know that we have such resources available and open to them, where they can consult and borrow books and other educational resources. This idea is usually new for them. Therefore, it would be helpful to introduce them to the library, encourage them to read etc.

One participant also suggested having community educational workshops about various topics in neighborhoods where many migrants and asylum seekers live. Topics would range from language difficulties, how to prevent them, how to detect them, when to seek help etc. The participant explained that this could be helpful in reducing commutes, especially with public transportation, which tends to be complicated and difficult for parents with very young children. Thus, this would encourage mothers to attend these workshops. P4 said:

> I think it would be beneficial to have workshops in neighborhoods where migrant families are brought together. This way, it would be much easier for a mother to directly attend these workshops that are near to her, instead of using subway and buses with her young children, and instead of waiting for her spouse to come back home from work, because he is the one who has the car. Therefore, I think it would be accommodating

to have intervention strategies close and adapted to the needs of the families.

In summary, LMB professionals raised different suggestions to help and better promote language development among migrant children. These ranged from targeted interventions such as one-on-one sessions with parents, to more general approaches like community workshops that would serve as a primary or sometimes secondary prevention for language problems. Inherent to all recommendations was that interventions and strategies be adapted to the diverse needs of families and be in proximity, i.e., close and easily accessible within LMB or the communities where families live.

Chapter 5- Discussion

The participants in this study described how factors related to the migration context of the families being followed at LMB, such as difficult access to daycare, a stressful home environment and isolation, and socio-cultural differences, contribute to problems in early language development. This context results in children having less exposure to language stimulating activities and interactions, particularly in French, which is especially important for school readiness in the province of Quebec. It was also believed that being exposed to multiple languages causes confusion and further adds to challenges for early-language development among children of migrant families.

The results of this project shed light on the various approaches and strategies implemented at LMB that are helpful to promote language development among migrant families. The team at LMB has an interdisciplinary approach, wherein each member plays a different but complementary role. The interventions implemented include more global strategies that aim to build confidence and trust and increase the family's overall receptivity to care. There were also more targeted interventions, such as parenting and play groups, which focus directly on stimulating social interactions between parents and children and providing education to families on healthy language development. The environment itself at LMB is also warm and welcoming and conducive to stimulating lots of communication among and between care-providers and families. Some unique challenges related to working specifically with migrant families were raised by participants, these included: how to overcome cultural norms that lead to families not voicing their preferences; how to balance working with interpreters but also promoting the use of French; and finding resources in the families' maternal language, which was deemed to be especially helpful when there are significant language barriers combined with low education levels. Overall, respect for families, including valuing the maternal language, going at their pace, and respecting their decisions and having a non-judgmental tone, emerged as key to effectively working with families at LMB. To achieve success with families and to find a common ground, the well-being of the child is also emphasized as a priority and put at the center of care. Lastly, to further promote language development, participants recommended more individual time with families to enhance understanding of child development, and to further promote parents' engagement in

language stimulating activities with their children. On-site access to specialists and more resources in the community were also suggested.

1. Migration context creating vulnerability to language development problems

Results suggest that migration related factors contribute to the underlying conditions that make children more susceptible to develop language problems. One of the major issues discussed was accessibility to daycare, which can play an important role in the promotion of early childhood language development. Asylum-seeking families in particular are affected since they are not eligible to send their children to subsidized daycare centres (Government of Quebec, 2023). The financial circumstances of these families, who often depend on social aid, are unable to afford to pay the fees up front for the unsubsidized care; access to daycare for asylum-seeking families in Quebec is a known issue (Desharnais-Préfontaine et al., 2021; Morantz et al., 2013). Studies have highlighted the deleterious effects when children, who are living in vulnerable contexts, including migrant families, do not attend daycare such as increased isolation and reduced access to educational resources, which can have an accumulated negative effect on language development (Araújo et al., 2021; Synder, 2022; Wang et al., 2020; Woolfenden et al., 2013). Several studies have highlighted the importance of daycare, including the educator-child relationships and interactions and the educational activities and toys, in stimulating language development and enhancing school readiness among children, particularly for children in more vulnerable contexts (Cabell et al., 2013; Cates et al., 2016; Gialamas et al., 2015; Greenwood et al., 2017; Laurin et al., 2016; Y ang et al., 2021). In the Québec study conducted by Laurin et al. (2016), results showed that children from low-income families who attended early childhood care centers (i.e., subsidized daycare centers), compared to their counterparts who did not attend daycare, were less likely to be vulnerable in two or more domains of development in kindergarten, as measured using the early development instrument (EDI) which assesses five domains of child development, including language development.

The participants also discussed the effects of isolation and exposure to a stressful home environment, which are issues in part due to the parents' having competing demands. Many of the families followed at LMB are recently-arrived and thus are

focused on resettlement, including finding employment and processing their immigration/asylum claim documents, which leaves families with little time and energy. A number of studies have shown that the initial resettlement period can be very isolating, stressful and draining, especially when there is a lack family support, unfamiliarity with the new environment, insufficient knowledge about the available resources, and language barriers (Bogenschutz, 2014; Hillmert; 2013, Hui & Barozzino, 2013). Furthermore, although the participants did not explicitly identify a lack of access to educational toys in the home as a concern, living in poverty, may also have added to a lack of a stimulating home environment for these children. Research shows that families with lower SES levels are more likely to have worse outcomes in terms of language development in children, due to factors such as increased parental stress and having less time to stimulate child's language (Cheung & Wong, 2021; Fernald et al., 2013) as well as reduced access to educational resources (Fernald, 2013; Perkins et al., 2013; Schwab & Lew-Williams, 2016). For example, in the longitudinal study by Cheung & Wong (2021), where 139 children living in Hong Kong were followed from kindergarten to their second year in primary school, results showed that children's learning outcomes were negatively influenced by parental stress and low socioeconomic status (SES). More specifically, low family income increased parental stress which in turn resulted in less positive parenting approaches and ultimately had detrimental impacts on children's cognitive abilities and English language proficiency. Additionally, the study revealed that parental stress heightened the likelihood of behavioral issues in children, which, also impeded children's cognitive growth.

A lack of interaction and not spending enough time playing and speaking with children on the part of parents, was also believed to be due to socio-cultural differences regarding child-rearing and family dynamics. It was also mentioned that in some families they believe children will eventually develop language over time once they begin school, and that intentional engagement with children, particularly in the pre-verbal stage, is not necessary. In Western culture, one-on-one interaction and direct communication with children tend to be common whereas, in many other cultures, the norm is for children to be exposed to communication and interactions which involve multiple people in their environment, in a more natural, non-contrived manner (Foster et al., 2005; Weber et al.,

2017). There are also variations in knowledge systems and attitudes across cultures, regarding who interacts with children and how, when, and to extent, children are engaged in interactions. Culture can therefore play a significant role in shaping how children perceive and understand their environment and achievement of specific milestones may vary based on the cultural practices and communication patterns prevalent in a particular society (Kuo & Lai, 2006). However, despite cultural differences, children across countries still learn and acquire language, and thus it is not the socio-cultural differences per se that contribute to language problems for migrant families, but rather it may be more the change in the social and cultural environment in which families are living that create vulnerabilities. As noted by the study participants, many of the families followed at LMB are from countries that are more collective-oriented, where families are in frequent contact with the extended family and their community, and where children are naturally exposed to other children and adults and have many interactions (Allport et al., 2019). In a study conducted by Allport et al. (2019), in which Somalian refugee women living in UK participated, the results highlight how the environment in Somalia and the community in general foster social interaction that allows children to engage freely and learn. Conversely, in the UK, factors such as lack of knowledge of available resources, a change in the physical environment, weak host language abilities, as well as restricted financial resources that families face, hinder children's play and interactions with peers, potentially leading to social isolation and developmental problems. Therefore, it may be that living in a more isolated environment, and a society that is more individualistic, in addition to dealing with multiple demands and stressors, is what leads to limited language-stimulating activities in the home, and ultimately language problems among children in migrant families. It is also crucial to note that in general many families regardless of having an immigrant background, are not fully aware of how language develops and require coaching to promote parents to engage in language-stimulating activities (Ferjan Ramírez et al., 2020; Vernon-Feagans, 2012). However, the effects of this lack of knowledge may be more harmful for isolated, stressed migrant families, who have limited access to daycare and other resources.

For many of the LMB families, who are exhausted and stressed, and have little resources, screens were considered an easy method for entertaining their children. Some

of the families also viewed screens as a means for ‘educating’ their children and to help them learn languages while watching videos. The amount of screen time that children are exposed to was very concerning to LMB care-providers; it was also noted that this further hindered children from learning French, since many of the videos children were watching were in English. Findings of numerous studies confirm that there is a negative link between screen time and child development and that more screen time is linked to poorer language development (Duch et al., 2017; Dynia et al., 2021; Madigan et al., 2019; Martinot et al., 2021). For example, in a research study conducted in Argentina, Medawar et al. (2022) showed that screen exposure had a negative impact on vocabulary and sentence use in children who were 18-36 months old. However, the authors add that shared reading with an adult and interactive screen experiences can offer language stimulation, especially when accompanied by active dialogue and joint engagement with the child. Nonetheless, passive screen exposure and inadequate content can be detrimental to toddlers' language development. According to the Canadian Pediatric Society statement (2017), heavy screen exposure among children under the age of five can lead to significant language delays, while exposure to background TV can result in poor levels of attention and language use and acquisition, as well as poorer cognitive development. High exposure to background TV can also negatively impact parent-child interactions and children’s play time. Again, for migrant families living in more vulnerable contexts, the effects may be more devastating.

Lastly, the participants felt that exposure to multiple languages was causing confusion and creating more vulnerability to language difficulties for children in migrant families. Exposure to many languages does not in and of itself inhibit language development, however, it may take a longer for a child to develop each language and if they don’t receive support and/or are not exposed to the host country language sufficiently, French in the Quebec context, then these delays may lead to significant problems once children start school (Hay et al., 2022; Paradis et al., 2011). In fact, research suggests that exposure to multiple languages actually enhances a child's communication skills. Additionally, bilingualism is linked to a number of positive cognitive outcomes, such as improved attention, control and working memory, and that it does not delay language development (Adesope et al., 2010; Barac et al., 2014; Fibla et al., 2022; Hambly et al.,

2013). The systematic review conducted by Larson et al (2020) further confirms this and showed that bilingualism /learning the host-country language among migrant children does not hinder language development, but in fact promotes effective and healthy early language acquisition and retention of the family's language. The findings therefore highlight the importance of ensuring young children in migrant families have ample opportunity to be exposed to and learn the host country language and for parents to receive support and access to resources towards achieving this goal, including support and encouragement for them to learn the language as well.

2. Cultural safety and the promotion of healthy language development

Participants in the study spoke about specific interventions towards promoting language development, including play groups, parenting support, and education to families regarding child development and encouragement to read and interact with their children, referrals to resources, including daycare. These findings are consistent with the existing literature which also shows developing parenting skills, engagement of parents in activities with their children, education, referrals, and the provision of educational materials to be key strategies for promoting early language development (Cartmill, 2016; Christakis, 2019; Hammer & Sawyer, 2016; Rowe & Zuckerman, 2016). Furthermore, similar to what was reported by Larson et al. (2020), a review synthesizing language development promoting interventions for CALD children, LMB care-providers used small groups and focused on play to make activities more accessible to parents, and used more 'naturalistic' engagement when interacting with children, and considered the cultural and language backgrounds, including encouraging parents to speak and access resources in their mother tongue, in order to be more effective in their strategies. The results of this project also further highlight how a culturally safe environment is created at LMB through careful attention to families' contexts and backgrounds (i.e., recognizing and respecting differences; understanding individuals' personal experiences and barriers; engaging in two-way dialogue and sharing knowledge and developing trust) (Richardson et al., 2017). This includes using role modeling- i.e., directly interacting and speaking French with children, so that families do not feel judged or stigmatized with respect to their parenting skills; using translated tools, pictures and interpreters to overcome

language barriers to ensure that parents understand all the information and recommendations provided to help their child develop language; encouraging parents to learn and practice their French through facilitating their access to francization programs, as a means to further overcome language barriers and as an indirect strategy to increase children's exposure to the language; emphasizing the child as the center of care as a means of creating feelings of solidarity; providing direct support to families in registering for services and resources so that they are not limited due to language or lack of familiarity with the system, and referring families to community organizations that are easily accessible and that offer free access to resources, to overcome economic barriers. LMB care-providers are also reflexive in their practice and spoke about the importance of reflecting on their actions, continuously asking questions and allowing families to go at their pace, and not imposing interventions.

In addition to the above, LMB uses a strengths-based approach and aims to empower families by offering positive feedback on families' efforts, reinforcing what families are doing well and respecting their preferences. Research shows that positive reinforcement, and empowerment enhance parental confidence, increase their perceived sense control in decision- making, and increase their involvement in their child's care; this in turn may translate to application of recommendations from care-providers towards promoting language development in their children (Ashcraft et al., 2019; Hsiao et al., 2018; Pellecchia et al., 2020). Empowerment is a key underlying concept to cultural safety by addressing power dynamics and placing the responsibility and power in the hands of the patient, and turning them into an active and influential participant rather than a passive recipient in the care process (Brascoupé & Waters, 2009).

The findings show that the role and involvement in interventions varied by profession. Psychoeducators were identified to be the most actively involved in language promotion activities and ongoing monitoring of children's language development whereas nurses are involved in more formal developmental evaluations at set time points, and social workers seem to play a more supportive role by facilitating access to resources; all care-providers contribute through role-modelling and by creating a social environment that fosters socialization among and between families and care-providers. Psychoeducators are known to have an involved role in language promotion via direct

engagement with families in activities (reading, play, circle groups etc.) (Order of Psychoeducators in Quebec, 2023). Also, previous research has highlighted the crucial role that nurses can play in identifying language delays and in providing education and parenting support for early language development when doing home visits and during regular medical check-ups with physicians, thus contributing to prevention and early detection (Tantut, 2018; Wightman et al., 2021). Although not explicitly discussed in the interviews in the current study (perhaps due to the small sample size or because of who participated in the interview), family physicians in primary care settings are also known to participate in promoting early-language development by encouraging parents to read and play with their children (Moharir et al. 2014).

Overall, the findings emphasize and bring to the forefront the interdisciplinary aspect to early-language promotion at LMB, including the involvement of social workers and support personnel and highlight how the team, all located in one location, works together over the long term to reinforce interventions. LMB is also unique in that while it is a primary care setting, it is also a milieu where families can come together and feel like they are part of a community. In contrast to interventions delivered in formal healthcare settings, or during nurse home visits, LMB provides a welcoming and friendly safe space where families can create relationships. In another recent study at LMB (Lim et al., 2022), conducted with mothers, women shared that one of the aspects they really enjoyed about LMB was the open-door policy wherein they could drop-by at any time; they described LMB as an extended family. The participants here (care-providers) also said that families view LMB as their second home. It appears that through the LMB care model a number of the migration-related factors, which are thought to be contributing to be language problems, including isolation, a change in the social/cultural environment, and children having less exposure to developmental stimulating activities, are being addressed. In this sense, it seems that LMB actually simulates the collective-oriented environment that many families had, or would have had back home, and provides a more 'natural' environment where children have an opportunity to play and socialize. For parents, it promotes social connectedness, mutual support, and sense of belonging by allowing them to connect with others who are in the same situation, as well as engage in

discussions about their children and childcare, all of which can lead to better well-being and more positive parenting (Morris et al., 2021).

The LMB model of care is holistic, and aims to not only address medical concerns, but also psycho-social issues (Aubé et al., 2019). During the interviews, participants spoke extensively about LMB's role in providing social and emotional support, which is done by building relationships and rapport over the long-term by taking the time to hear from families, including their trajectory, and learn about their needs, and concerns; helping parents develop their parental sense of competence by fostering positive parenting skills; and by tending to families' broader concerns (e.g., helping families with migration documents, finding housing and employment, etc.), underlying vulnerability factors that are known to contribute to migrants' stress and which in turn can distract parents from their children. Nurses at LMB, in particular were also described in playing a crucial role in health promotion and education about various topics such as child development, women's health, particularly during pregnancy and post-partum, and mental health aspects. A scoping review conducted by Hamari et al. (2021), which synthesized what is known regarding parent support programs for migrant families, found several benefits and positive effects for families. Programs had diverse objectives, including improving parenting skills, preventing behavioral problems in children, enhancing parent-child interactions, and increasing parents' involvement in their children's education; none specified language development as a primary goal. Outcomes included more positive parenting, reduced immigration-related stress, better parental mental health, and better parental-child interactions. Similarly, a systematic review conducted by Silva and Pereira (2023), which aimed to provide an overview of interventions to promote psychosocial well-being and/or empowerment of migrant women also showed positive outcomes. Interventions varied and included counseling, health education, mental health promotion and other more targeted therapies, delivered in person individually or in a group setting, or via remote contact by telephone; length of follow-up ranged from a few days up to twenty-six weeks. Positive outcomes for women included reduced stress, anxiety, and symptoms of depression, as well as increased self-esteem, self-efficacy, and active coping. Taken together, the findings from the current study and the two reviews, suggest that broader strategies towards improving the overall health and

well-being of the family can contribute to creating conditions that will be optimal for migrant children's growth and development. It can also provide a foundation for being more effective in their more targeted interventions with migrant families, through the establishment of trust. In fact, this notion aligns with the theory "Building Early Relationships Model of Change", put forward by Morris et al. (2021) that stipulates that enhancing nurturing relationships, achieved through promoting positive interactions between parents and children as well as by boosting social support for parents, this helps parents facing economic disadvantage and results in more favorable cognitive and socio-emotional outcomes for young children.

In sum, the overall approach at LMB aligns with research that suggests that care providers should customise their strategies and approaches and should take into consideration the linguistic, social, and cultural contexts of the family rather than adopting a "one size fits all" philosophy while intervening to promote early language development (Cycyk et al., 2021). Additionally Vo (2014) emphasizes that health care professionals should be aware of the context of the family, the immigration history, any experienced trauma, sociocultural beliefs of health, and risk of prejudice or racism for the clientele they serve. Further research suggests that to manage stressors, to empower and to capitalise on strengths of families, professionals working with migrant families need to be culturally competent and knowledgeable of their own biases, by putting their own beliefs and values aside and concentrating on the context and the needs of the client (Campinha-Bacote & Kardong-Edgren, 2008). In short, having self-awareness, adopting a collaborative power dynamic, where each person/family is esteemed and valued and their unique context and concerns are recognized and addressed, are the essence to promoting healthy early-language development in a culturally safe manner (Anderson et al., 2003; Yeung, 2016).

3. Challenges of intervening among migrant families and recommendations

A few key challenges were mentioned by participants with regards to intervening and promoting language development among migrant families. Firstly, they found it sometimes difficult to assess and know parents' perspectives on care due in part to cultural norms where parents don't voice their preferences and/or they feel they must

agree and accept what is proposed to them by care-providers. Cultural safety involves recognizing the obstacles to clinical effectiveness stemming from the inherent power inequality existing between healthcare provider and patient; Curtis et al. (2019) and Laverty al. (2017) underscore the importance of considering the power differentials between care-providers and patients, especially when they may be in more vulnerable situations in order to avoid the implementation of interventions that are not wanted or that do not align with their values and choices. As described above, LMB professionals are attentive to families' cultural communication patterns and make significant effort to assess what families want. The participants also recommended that families receive more one-on-one support; this was thought to be helpful to overcome some of the cultural barriers and to optimize communication and enhance understanding of information, especially for those with lower literacy and education levels. In a similar vein, they also recommended to have on site access to specialists (speech therapists, audiologists) and more workshops (on language development) within the community to help families feel more comfortable since the milieu is familiar, which instills more trust. Working more individually and in proximity with families aligns with a cultural safety approach, in that it allows for more opportunity to build rapport and for families to feel they have a 'safe space' where they can openly express themselves (Curtis et al., 2019). Moreover, it may also be helpful for those who are experiencing very difficult circumstances (financial problems, language barriers, unfamiliarity with the new system etc.), which result in parents feeling overwhelmed and stressed, and thus unable to implement the strategies being proposed to them by LMB professionals or to follow-through on referrals (Taheri, 2016). As noted by participants, direct access to specialists would also help families overcome barriers and improve access to care (Chiarenza et al., 2019).

The second challenge raised by participants was finding a balance between promoting the use of French and ensuring good and effective communication with families. While the use of translated tools and interpreters are helpful for overcoming language barriers, participants also felt that they can also be problematic by slowing the uptake of the host country language. MacFarlane et al. (2020) mentions that using an interpreter can also have the opposite effect and create difficulties in healthcare-provider-patient communication and interactions and hinder the objectives of primary care consultations,

as it could reduce confidence and confidentiality and lead to misunderstandings and communication errors. LMB care-providers shared that using French during consultations was a way to expose both children and parents to the language and also as an opportunity to encourage families to practice their French and build confidence in a safe-space. The five-year plus relationship and follow-up with families at LMB also allows for families to develop and acquire the language over time, and thus may reduce the need and dependence on interpreters over the long-term. To counterbalance, care-providers at LMB also value the maternal language, and strongly encourage families to speak their language and to access books and materials in their own language; the psychoeducators also use a translated tool (available in multiple languages) which provides tips on language development promotion for families. Participants also recommended there be more translated tools and resources available to families, as well as greater orientation to existing resources (libraries, community centers) to further increase access to language stimulating activities (including those in French). As noted in the review by Larson et al. (2020) interactions and reading to children in their maternal language as well as direct exposure and explicit instruction in the host language environment are beneficial for promoting language development among CALD children. On the whole, in a context like LMB, the optimal approach appears to be to promote the maternal language and use interpreters and translated tools when communication is complicated and difficult, but also to combine this with regular exposure to the host-country language, especially as relationships develop and families become more accustomed to the language with time (Heath et al., 2023). A lack of availability of educational resources in minority languages, however, was the third challenge noted by participants. Therefore, to minimize disparities in language development, especially for families where parents have very limited host-country language abilities, greater access to educational resources in a variety of languages is needed (Greenwood et al.,2017; Hart & Risley, 2003).

Implications

Practice

The results taken together highlight several points that need to be taken into consideration while intervening to promote early language development among migrant populations in a culturally safe manner. Specifically, they shed light on the significance of understanding and addressing the underlying migration related factors (isolation, stressful home, change is social/cultural environment) that create conditions that may contribute or exacerbate children's vulnerability to language problems. They highlight the importance of an interdisciplinary approach that supports parents' overall mental-health and well-being and that assists families with resettlement challenges, and facilitates access to resources, including daycare, community activities, and host-country language courses (francization) for parents. Moreover, building a trust relationship, emphasizing strengths, respecting the pace of families, and focusing on the child's well-being are suggested to enhance receptivity to interventions.

With regards to direct interventions, including parenting support, group activities, and promoting reading, these can be made more accessible to families and reduce feelings of judgement or stigmatization by considering language, culture and literacy/education levels and the families' socio-economic circumstances (Browne et al., 2015). This may be achieved via spending more one-on-one time with families to relay information directly and to assess knowledge systems, values and preferences; having a reflexive stance; using translated tools; role-modelling behaviour; encouraging the use of the maternal language; promoting parent-child interactions that are associated with routine activities; offering or referring to low-cost educational activities/materials for children; and creating social opportunities that are more 'natural' and enjoyable for parents and children (Andermann, & CLEAR Collaboration, 2016). The findings suggest that interpreters and translated tools are essential for overcoming language barriers but should be used judiciously and balanced with communication in the host language (English/French) with families; striking a balance between these linguistic influences acknowledges the richness of linguistic diversity while also promoting effective language acquisition. The results also draw attention to the importance of encouraging families to

engage with their children while using screens; this can play a pivotal role in mitigating potential negative impacts, while emphasizing the value of interactive experiences with children (Medawar et al., 2023). Lastly, while the interdisciplinary team approach is beneficial for reinforcing interventions, it also highlights the complementary role that each profession can play. For nurses, the results indicate that they have a fundamental role via the standard developmental evaluations they conduct, and also through ongoing health promotion and education/parenting support at vaccination and check-up visits. Given they are in regular contact with families they are also pivotal for communicating and referring to other team members (psychoeducators, physicians, social workers) for follow-up, including referrals to specialists.

Education

This project also shows the importance of raising awareness among care-provides (and more broadly as well) regarding language development of children growing up in multi-language contexts and to address misconceptions, i.e., understanding the value of bilingualism and the promotion of learning more than one language. Overall, the project findings also emphasize that cultural safety should be incorporated into all levels of nursing education and training, including continuing professional development (workshops, conferences), as it can help nurses grasp the importance of a holistic, reflexive approach, and minimize stereotyping and biases that result in effective interventions and care (Červený et al., 2022; Kaihlanen et al., 2019).

Policy

The project has a number of policy implications. Firstly, as previously recommended, all migrant children, regardless of whether or not they are asylum seekers, should have fair access to subsidized early childhood education and childcare programs, as these centers play an important role in the promotion of a healthy language development (Desharnais-Préfontaine et al., 2021; Morantz et al., 2013). It would also facilitate parents' participation in language courses and access to employment (and/or allows for time to deal with other resettlement issues), which can help families better integrate into their new society and reduce stress. Secondly, the study results highlight the

important role of community organizations, particularly in close proximity to where families live, in providing low-cost access to resources, activities and parenting support. The results also highlight the importance of providing educational tools and resources in minority languages to accommodate the linguistic diversity of the migrant population and to establish learning environments that best meet the needs of immigrant children and their families (Bus et al., 2023); community organizations are accessible and well-positioned to do this. However, community organizations are often stretched and operate over capacity, for sustainability, it's imperative to ensure they are adequately funded and resourced. Thirdly, the participants also suggested that upon arrival migrant families should receive more orientation to their communities to improve their awareness of and utilization of local organizations, libraries, etc., additional efforts at various levels could therefore be made in this regard as well. Lastly, the results show that the LMB care model has many benefits for migrant families and their children, as it's interdisciplinary, holistic, based within the community and addresses resettlement challenges (La Maison Bleue, 2021). LMB also breaks isolation, creates opportunities for families to have social interactions and feel like they belong to a community, promotes parental (particularly mothers) mental health, and offers activities to promote child development, including language development. The extended follow-up fosters trust, rapport, and a deeper understanding of families' needs and wants. Their interventions consider the cultural, and linguistic diversity, and aim to empower families. All services are provided in one location, and the organization is well-connected to other healthcare and community services for referrals. Expansion of this care-model (additional human resources and/or sites) may be worthwhile to further promote the health, well-being, and child development among migrant families in vulnerable contexts in Quebec (and beyond). On-site access to specialists in these settings would also be ideal for ensuring timely access to interventions.

Research

It would be informative to do studies in other similar care settings, both within and outside of Quebec, to assess the generalizability of the findings. Given that LMB is an organization with expertise in caring for children in migrant families, it would also be

worthwhile to do studies in primary care settings that provide care to a broader general population for additional comparisons. Further research about the role of nurses and nursing interventions in promoting language development of children in migrant families is warranted as well.

Strengths and limitations of the study

This project has certain limitations, the first being the very small sample size, as there were only 8 participants in the study. While this number was suitable for a master's project, and qualitative descriptive research typically involves a relatively small and focused sample, a larger sample could have allowed for a more thorough exploration of the topic. A larger sample also could have permitted more contrasts in the analysis by profession; with the current sample it is difficult to know to what degree differences are due to profession vs. the individuals themselves who are in the respective roles. Including more nurses in the study would have been beneficial to gain more insights on how nurses specifically support healthy early childhood language development. The project also had time constraints (as it is a master's project), and thus data collection was limited to one zoom interview per participant and a few exchanges via email; conducting more interviews and observations on site could have yielded richer or different data. Lastly, although it was beyond the scope of this master's project, a critical analysis of cultural safety as a framework for exploring the promotion of early language development, including its strengths and limitations, and contrasts with other frameworks, would have been worthwhile to yield greater insights for practice implications.

The study also has strengths. Firstly, the theoretical framework (cultural safety) provided a holistic understanding of how professionals respond to and promote healthy early language development in migrant families. Secondly, despite the small sample size, our interviews produced a significant amount of data, enabling us to identify patterns and themes related to the promotion of language development; the participants are experienced and very knowledgeable health care professionals from different domains, who have worked extensively with migrant families and their children and thus provided credible findings. Thirdly, the methods used in the study were also rigorous; interviews were audio-recorded and transcribed verbatim to ensure accuracy and complete data were

analyzed; the transcripts were reviewed thoroughly and multiple times and the analysis process was iterative and systematic (all data excerpts were extracted and organized into an Excel file); the student and the research supervisor worked closely together to minimize the influence of personal biases, and there were several iterations of the results section, with careful selection of quotes to support the text, and the final version of the results were reviewed by a LMB collaborator.

Conclusion

This study helped gain a better understanding of interventions that promote early childhood language development in the context of immigration and cultural diversity. It also helped further identify culturally safe approaches for promoting early-language development, that consider not only the diversity of families, but also the various vulnerability factors (isolation, mental health, access to resources) that are commonly experienced by refugee and asylum-seeking families, and that are known to put children at risk of developing language delays. The findings can be used to stimulate further reflection and raise greater awareness among nurses and the interprofessional team working at LMB, and also more broadly in Quebec and beyond, regarding the needs, challenges, families' preferences, and language development interventions that best meet and respond to migrant families' contexts, and that could be implemented to prevent long-term complications and further promote healthy early-language development in this population.

References

Adesope, O., Lavin, T., Thompson, T., & Ungerleider, C. (2010). A systematic review and meta-analysis of the cognitive correlates of bilingualism. Review of Educational Research, 80(2), 207–245.

Allport, T., Mace, J., Farah, F., Yusuf, F., Mahdjoubi, L., & Redwood, S. (2019). 'Like a life in a cage': Understanding child play and social interaction in Somali refugee families in the UK. *Health & place*, *56*, 191–201. https://doi.org/10.1016/j.healthplace.2019.01.019

Andermann, A., & CLEAR Collaboration. (2016). Taking action on the social determinants of health in clinical practice: a framework for health professionals. Cmaj : Canadian Medical Association Journal = Journal De L'association Medicale Canadienne, 188(17-18), 483. https://doi.org/10.1503/cmaj.160177

Anderson, I., Robson, B., Connolly, M., Al-Yaman, F., Bjertness, E., King, A., Tynan, M., Madden, R., Bang, A., Coimbra, C. E., Jr, Pesantes, M. A., Amigo, H., Andronov, S., Armien, B., Obando, D. A., Axelsson, P., Bhatti, Z. S., Bhutta, Z. A., Bjerregaard, P., Bjertness, M. B., … Yap, L. (2016). Indigenous and tribal peoples' health (The Lancet-Lowitja Institute Global Collaboration): a population study. *Lancet (London, England)*, *388*(10040), 131–157. https://doi.org/10.1016/S0140-6736(16)00345-7

Anderson, J., Perry, J. A., Blue, C., Browne, A., Henderson, A., Khan, K. B., Kirkham, S. R., Lynam, J., Semeniuk, P., & Smye, V. (2003). “rewriting” cultural safety within the postcolonial and postnational feminist project: toward new epistemologies of healing. Advances in Nursing Science, 26(3), 196–214.

Araújo, L. A., Veloso, C. F., Souza, M. C., Azevedo, J., & Tarro, G. (2021). The potential impact of the COVID-19 pandemic on child growth and development: a systematic review. *Jornal de pediatria*, *97*(4), 369–377. https://doi.org/10.1016/j.jped.2020.08.008

Asgary, R., & Segar, N. (2011). Barriers to health care access among refugee asylum seekers. *Journal of health care for the poor and underserved*, *22*(2), 506–522. https://doi.org/10.1353/hpu.2011.0047

Ashcraft, L. E., Asato, M., Houtrow, A. J., Kavalieratos, D., Miller, E., & Ray, K. N. (2019). Parent Empowerment in Pediatric Healthcare Settings: A Systematic Review of Observational Studies. *The patient*, *12*(2), 199–212. https://doi.org/10.1007/s40271-018-0336-2

Association Canadienne de Santé Publique. (2010). *La pratique infirmière en santé publique ~ en santé communautaire au Canada* (4e édition). Association canadienne de santé publique. https://www.cpha.ca/sites/default/files/assets/pubs/3-2bk04214.pdf

Aubé, T., Pisanu, S. et Merry, L. (2019). La Maison Bleue: Strengthening resilience among migrant mothers living in Montreal, Canada. *PLoSONE, 14*(7). https://doi.org/10.1371/journal.pone.0220107

Baker, L., & Cantwell, D. P. (1987). A prospective psychiatric follow-up of children with speech/language disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*, *26*(4), 546-553.

Bandura, A. (1992). Bandura's social learning theory. *Theories of Development: Concepts and Applications*, 175-192.

Barac, R., Bialystok, E., Castro, D. C., & Sanchez, M. (2014). The cognitive development of young dual language learners: a critical review. Early Childhood Research Quarterly, 29(4), 699–714. https://doi.org/10.1016/j.ecresq.2014.02.003

Baydar, N., & Akcinar, B. (2015). Ramifications of socioeconomic differences for three year old children and their families in turkey. *Early Childhood Research Quarterly*, *33*, 33–48. https://doi.org/10.1016/j.ecresq.2015.05.002

Baydar, N., Küntay, A. C., Yagmurlu, B., Aydemir, N., Cankaya, D., Göksen, F., & Cemalcilar, Z. (2014). "It takes a village" to support the vocabulary development of children with multiple risk factors. *Developmental Psychology*, *50*(4), 1014–25.

Bhayana, A., & Bhayana, B. (2018). Approach to developmental disabilities in newcomer families. *Canadian Family Physician Medecin De Famille Canadien*, *64*(8), 567–573.

Bogenschutz M. (2014). "We find a way": challenges and facilitators for health care access among immigrants and refugees with intellectual and developmental

disabilities. *Medical care*, *52*(10 Suppl 3), S64–S70. https://doi.org/10.1097/MLR.0000000000000140

Bowie, B. H., Wojnar, D., & Isaak, A. (2017). Somali Families' Experiences of Parenting in the United States. Western Journal of Nursing Research, 39(2), 273–289. https://doi.org/10.1177/0193945916656147

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a Qualitative Description Approach in Health Care Research. Global Qualitative Nursing Research. https://doi.org/10.1177/2333393617742282

Brascoupé, S., & Waters, C. (2009). Cultural safety exploring the applicability of the concept of cultural safety to aboriginal health and community wellness. *International Journal of Indigenous Health*, *5*(2), 6-41.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Brookman, R., Kalashnikova, M., Conti, J., Xu Rattanasone, N., Grant, K. A., Demuth, K., & Burnham, D. (2020). Maternal Depression Affects Infants' Lexical Processing Abilities in the Second Year of Life. *Brain sciences*, *10*(12), 977. https://doi.org/10.3390/brainsci10120977

Browne, A. J., Varcoe, C., Ford-Gilboe, M., Wathen, C. N., & EQUIP Research Team (2015). EQUIP Healthcare: An overview of a multi-component intervention to enhance equity-oriented care in primary health care settings. *International journal for equity in health*, *14*, 152. https://doi.org/10.1186/s12939-015-0271-y

Brownell, R. (Ed.). (2000). *Expressive one-word picture vocabulary test: Manual*. Academic Therapy Publications.

Bruce, M., Miyazaki, Y., & Bell, M. A. (2022). Infant attention and maternal education are associated with childhood receptive vocabulary development. *Developmental Psychology*, *58*(7), 1207–1220. https://doi.org/10.1037/dev0001365

Bus, A. G., Broekhof, K., & Vaessen, K. (2023, June). Free access to multilingual digital books: a tool to increase book reading?. In *Frontiers in Education* (Vol. 8, p. 1120204). Frontiers.

Busch Nsonwu, M., Busch-Armendariz NoËL, Cook Heffron, L., Mahapatra, N., & Fong, R. (2013). Marital and familial strengths and needs: refugees speak

out. *Journal of Ethnic and Cultural Diversity in Social Work*, *22*(2), 129–144. https://doi.org/10.1080/15313204.2013.785350

Byers-Heinlein, K., & Lew-Williams, C. (2013). Bilingualism in the Early Years: What the Science Says. *LEARNing landscapes*, *7*(1), 95–112.

Cabell, S. Q., DeCoster, J., LoCasale-Crouch, J., Hamre, B. K., & Pianta, R. C. (2013). Variation in the effectiveness of instructional interactions across preschool classroom settings and learning activities. Early Childhood Research Quarterly, 28(4), 820–830. https://doi.org/10.1016/j.ecresq.2013.07.007

Caelli, K., Ray, L., & Mill, J. (2003). 'Clear as Mud': Toward Greater Clarity in Generic Qualitative Research. International Journal of Qualitative Methods, 1–13. https://doi.org/10.1177/160940690300200201

Campinha-Bacote, J., & Kardong-Edgren, S. (2008). Cultural competency of graduating us bachelor of science nursing students. Contemporary Nurse: A Journal for the Australian Nursing Profession, 28(1-2), 37–44.

Canadian Paediatric Society, Digital Health Task Force, Ottawa, Ontario (2017). Screen time and young children: Promoting health and development in a digital world. *Paediatrics & child health*, *22*(8), 461–477. https://doi.org/10.1093/pch/pxx123

Cartmill, E. A. (2016). Mind the Gap: Assessing and Addressing the Word Gap in Early Education. Policy Insights from the Behavioral and Brain Sciences, 3(2), 185–193. https://doi.org/10.1177/2372732216657565

Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M. E., Beyeler, N., & Quesada, J. (2015). Immigration as a social determinant of health. *Annual review of public health*, *36*, 375–392. https://doi.org/10.1146/annurev-publhealth-032013-182419

Cates, C. B., Weisleder, A., & Mendelsohn, A. L. (2016). Mitigating the effects of family poverty on early child development through parenting interventions in primary care. *Academic Pediatrics*, *16*, 120.

Cates, C. B., Weisleder, A., Dreyer, B. P., Berkule Johnson, S., Vlahovicova, K., Ledesma, J., & Mendelsohn, A. L. (2016). Leveraging healthcare to promote responsive parenting: impacts of the video interaction project on parenting

stress. *Journal of Child and Family Studies*, *25*(3), 827–835. https://doi.org/10.1007/s10826-015-0267-7

Červený, M., Kratochvílová, I., Hellerová, V., & Tóthová, V. (2022). Methods of increasing cultural competence in nurses working in clinical practice: A scoping review of literature 2011-2021. *Frontiers in psychology*, *13*, 936181. https://doi.org/10.3389/fpsyg.2022.936181

Charney, S. A., Camarata, S. M., & Chern, A. (2021). Potential Impact of the COVID-19 Pandemic on Communication and Language Skills in Children. Otolaryngology–Head and Neck Surgery, 165(1), 1–2. https://doi.org/10.1177/0194599820978247

Cheung, K. C.-K., & Wong, R. K.-S. (2021). Income effects on the intellectual development of children from low-income families in hong kong: the mediating role of parental investment and parental stress. *Child and Adolescent Social Work Journal*, *38*(3), 337–346. https://doi.org/10.1007/s10560-020-00681-5

Chiarenza, A., Dauvrin, M., Chiesa, V., Baatout, S., & Verrept, H. (2019). Supporting access to healthcare for refugees and migrants in european countries under particular migratory pressure. Bmc Health Services Research, 19(1), 1–14. https://doi.org/10.1186/s12913-019-4353-1

Chinn, P. L., & Falk-Rafael, A. (2015). Peace and power: a theory of emancipatory group process. Journal of Nursing Scholarship, 47(1), 62–69. https://doi.org/10.1111/jnu.12101

Christakis, D. A., Lowry, S. J., Goldberg, G., Violette, H., & Garrison, M. M. (2019). Assessment of a Parent-Child Interaction Intervention for Language Development in Children. *JAMA network open*, *2*(6), e195738. https://doi.org/10.1001/jamanetworkopen.2019.5738

Clancy M. (2013). Is reflexivity the key to minimising problems of interpretation in phenomenological research?. *Nurse researcher*, *20*(6), 12–16. https://doi.org/10.7748/nr2013.07.20.6.12.e1209

Collins, M. F. (2010). Ell preschoolers' english vocabulary acquisition from storybook reading. *Early Childhood Research Quarterly*, *25*(1), 84–97. https://doi.org/10.1016/j.ecresq.2009.07.009

Connor, D. J., & Cavendish, W. (2018). Sharing Power With Parents: Improving Educational Decision Making for Students With Learning Disabilities. *Learning Disability Quarterly*, *41*(2), 79–84. https://doi.org/10.1177/0731948717698828

Cote, L. R. (2020). Immigration et acculturation pendant l'enfance. *Encyclopédie sur le développement des jeunes enfants*. http://www.enfantencyclopedie.com/immigration/selon-experts/immigration-et-acculturation-pendantlenfance.

Coup A. (1996). Cultural safety and culturally congruent care: a comparative analysis of Irihapeti Ramsden's and Madeleine Leininger's educational projects for practice. *Nursing praxis in New Zealand inc*, *11*(1), 4–11.

Crow, S., & O'Leary, A. (2015). Word health: Addressing the word gap as a public health crisis. *Next Generation*

Cunningham, B. J., & Rosenbaum, P. L. (2015). A Bioecological framework to evaluate communicative participation outcomes for preschoolers receiving speech-language therapy interventions in Ontario, Canada. *International journal of language & communication disorders*, *50*(4), 405–415. https://doi.org/10.1111/1460-6984.12145

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity in Health*, *18*(1). https://doi.org/10.1186/s12939-019-1082-3

Cycyk, L. M., De Anda, S., Moore, H., & Huerta, L. (2021). Cultural and linguistic adaptations of early language interventions: recommendations for advancing research and practice. *American Journal of Speech-Language Pathology*, *30*(3), 1224–1246. https://doi.org/10.1044/2020_AJSLP-20-00101

Dennis, C.-L., Merry, L., & Gagnon, A. J. (2017). Postpartum depression risk factors among recent refugee, asylum-seeking, non-refugee immigrant, and canadian-born women: results from a prospective cohort study. *Social Psychiatry and Psychiatric Epidemiology : The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services*, *52*(4), 411–422. https://doi.org/10.1007/s00127-017-1353-5

Desharnais-Préfontaine, N., Pisanu, S., Bellemare, A. M., & Merry, L. (2021). Les politiques publiques affectant négativement les familles demandeuses d'asile avec des jeunes de 0 à 5 ans au Québec. *Canadian journal of public health = Revue canadienne de sante publique*, *112*(1), 128–131. https://doi.org/10.17269/s41997-020-00392-5

DiCarlo, C. F., Onwujuba, C., & Baumgartner, J. I. (2014, April). Infant communicative behaviors and maternal responsiveness. In *Child & Youth Care Forum* (Vol. 43, No. 2, pp. 195-209). Springer US.

Dickinson, D. K., Griffith, J. A., Golinkoff, R. M., & Hirsh-Pasek, K. (2012). How reading books fosters language development around the world. *Child development research*, *2012*.

Doyle, L., McCabe, C., Keogh, B., Brady, A., & McCann, M. (2020). An overview of the qualitative descriptive design within nursing research. *Journal of research in nursing : JRN*, *25*(5), 443–455. https://doi.org/10.1177/1744987119880234

Duch, H., Fisher, E. M., Ensari, I., & Harrington, A. (2013). Screen time use in children under 3 years old: a systematic review of correlates. *The international journal of behavioral nutrition and physical activity*, *10*, 102. https://doi.org/10.1186/1479-5868-10-102

Dunlap, G., Fox, L., Lee, J. K., Strain, P. S., Vatland, C., Joseph, J. D., & Turnbull, A. (2016). *Prevent-teach-reinforce for families : a model of individualized positive behavior support for home and community*. Brookes Publishing. Retrieved 2022, from https://public.ebookcentral.proquest.com/choice/publicfullrecord.aspx?p=4778933.

Dunn, L., Padilla, I., Lugo, D., & Dunn, L. (1986). Test de Vocabulario en Imágenes Peabody.(TVIP) Adaptación Hispanoamericana del Peabody Pictures Vocabulary Test. *Minenesota: American Guidance Service, Publisher's Building*.

Dynia, J. M., Dore, R. A., Bates, R. A., & Justice, L. M. (2021) Media exposure and language for toddlers from low-income homes. Infant Behavior and Development, 63, , 101542. https://doi.org/10.1016/j.infbeh.2021.101542

Early Childhood Observatory (2019b). *What kind of environments are Québec's youngest children growing up in? 2019 Portrait. Montréal.* Retrieved from https://tout-petits.org/img/rapports/2019/region/D-5200_fascicule-region06-Montreal_AN_V01a.pdf

Early Childhood Observatory. (2019a). What kind of environments are Québec's youngest children growing up in? 2019 Portrait. Retrieved from https://tout-petits.org/publications/portraits-annuels/2019/

Engebretson, J., Mahoney, J., & Carlson, E. D. (2008). Cultural competence in the era of evidence-based practice. *Journal of professional nursing : official journal of the American Association of Colleges of Nursing*, *24*(3), 172–178. https://doi.org/10.1016/j.profnurs.2007.10.012

Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). *Doing naturalistic inquiry: A guide to methods*. Sage.

Falah-Hassani, K., Shiri, R., Vigod, S., & Dennis, C. L. (2015). Prevalence of postpartum depression among immigrant women: A systematic review and meta-analysis. *Journal of psychiatric research*, *70*, 67–82. https://doi.org/10.1016/j.jpsychires.2015.08.010

Farkas, G., & Beron, K. (2004). The detailed age trajectory of oral vocabulary knowledge: differences by class and race. *Social Science Research*, *33*(3), 464–497. https://doi.org/10.1016/j.ssresearch.2003.08.001

Ferjan Ramírez, N., Lytle, S. R., & Kuhl, P. K. (2020). Parent coaching increases conversational turns and advances infant language development. Proceedings of the National Academy of Sciences of the United States of America, 117(7), 3484–3491. https://doi.org/10.1073/pnas.1921653117

Fernald, A., & Weisleder, A. (2011). Early language experience is vital to developing fluency in understanding. *Handbook of early literacy research*, *3*, 3-19.

Fernald, A., Marchman, V. A., & Weisleder, A. (2013). SES differences in language processing skill and vocabulary are evident at 18 months. *Developmental science*, *16*(2), 234–248. https://doi.org/10.1111/desc.12019

Fibla, L., Kosie, J. E., Kircher, R., Lew-Williams, C., & Byers-Heinlein, K. (2022). Bilingual Language Development in Infancy: What Can We Do to Support

Bilingual Families? *Policy Insights from the Behavioral and Brain Sciences*, *9*(1), 35–43. https://doi.org/10.1177/23727322211069312

Fifolt, M., Lanzi, R. G., Johns, E., Strichik, T., & Preskitt, J. (2017). Retention and attrition in a home visiting programme: looking back and moving forward. *Early Child Development and Care*, *187*(11), 1782–1794. https://doi.org/10.1080/03004430.2016.1189420

Ford, A. L. B., Elmquist, M., Merbler, A. M., Kriese, A., Will, K. K., & McConnell, S. R. (2020). Toward an ecobehavioral model of early language development. *Early Childhood Research Quarterly*, *50*, 246–258. https://doi.org/10.1016/j.ecresq.2018.11.004

Foster, M. A., Lambert, R., Abbott-Shim, M., McCarty, F., & Franze, S. (2005). A model of home learning environment and social risk factors in relation to children's emergent literacy and social outcomes. *Early Childhood Research Quarterly*, *20*(1), 13–36. https://doi.org/10.1016/j.ecresq.2005.01.006

Gagnon, A. J., Dougherty, G., Wahoush, O., Saucier, J.-F., Dennis, C.-L., Stanger, E., Palmer, B., Merry, L., & Stewart, D. E. (2013). International migration to canada: the post-birth health of mothers and infants by immigration class. *Social Science & Medicine (1982)*, *76*(1), 197–207. https://doi.org/10.1016/j.socscimed.2012.11.001

Gialamas, A., Mittinty, M. N., Sawyer, M. G., Zubrick, S. R., & Lynch, J. (2015). Social inequalities in childcare quality and their effects on children's development at school entry: findings from the Longitudinal Study of Australian Children. *Journal of epidemiology and community health*, *69*(9), 841–848. https://doi.org/10.1136/jech-2014-205031

Gibson, E., Sutherland, D., & Newbury, J. (2022). New zealand parents/caregivers' knowledge and beliefs about child language development. *Speech, Language and Hearing*, *25*(2), 153–165.

Gilkerson, J., Richards, J. A., Warren, S. F., Oller, D. K., Russo, R., & Vohr, B. (2018). Language Experience in the Second Year of Life and Language Outcomes in Late Childhood. *Pediatrics*, *142*(4), e20174276. https://doi.org/10.1542/peds.2017-4276

Goldfeld, S., Price, A., Smith, C., Bruce, T., Bryson, H., Mensah, F., Orsini, F., Gold, L., Hiscock, H., Bishop, L., Smith, A., Perlen, S., & Kemp, L. (2019). Nurse home visiting for families experiencing adversity: a randomized trial. *Pediatrics*, *143*(1). https://doi.org/10.1542/peds.2018-1206

Government of Quebec. (2017). *Immigration et démographie au Québec*. http://www.mifi.gouv.qc.ca/publications/fr/recherches-statistiques/Pub_Immigration_et_demo_2015.pdf

Government of Quebec. (2021). *The Services intégrés en périnatalité et pour la petite enfance (SIPPE) program.* https://www.quebec.ca/en/family-and-support-for-individuals/pregnancy-and-parenthood/services-integres-en-perinatalite-et-pour-la-petite-enfance-the-sippe-program

Government of Quebec. (2022). *Agir tôt program.* https://www.quebec.ca/en/family-and-support-for-individuals/childhood/child-development/the-agir-tot-program-early-screening-to-better-address-childrens-needs#c48943

Government of Quebec. (2023). *Asylum seekers.* https://www.quebec.ca/en/immigration/refugees-asylum-seekers/asylum-seekers

Green, A. R., Betancourt, J. R., & Carrillo, J. E. (2002). Integrating social factors into cross-cultural medical education. *Academic Medicine : Journal of the Association of American Medical Colleges*, *77*(3), 193–7.

Greenwood, C. R., Carta, J. J., Walker, D., Watson-Thompson, J., Gilkerson, J., Larson, A. L., & Schnitz, A. (2017). Conceptualizing a Public Health Prevention Intervention for Bridging the 30 Million Word Gap. *Clinical child and family psychology review*, *20*(1), 3–24. https://doi.org/10.1007/s10567-017-0223-8

Hamari, L., Konttila, J., Merikukka, M., Tuomikoski, A.-M., Kouvonen, P., & Kurki, M. (2021). Parent support programmes for families who are immigrants: a scoping review. Journal of Immigrant and Minority Health, 24(2), 506–525. https://doi.org/10.1007/s10903-021-01181-z

Hambly, H., Wren, Y., McLeod, S., & Roulstone, S. (2013). The influence of bilingualism on speech production: a systematic review. International Journal of Language &

Communication Disorders, 48(1), 1–24. https://doi.org/10.1111/j.1460-6984.2012.00178.x

Hammer, C. S., & Sawyer, B. (2016). Effects of a culturally responsive interactive book-reading intervention on the language abilities of preschool dual language learners: A pilot study. HS Dialog: The Research to Practice Journal for the Early Childhood Field, 19(2).

Hammer, C. S., Komaroff, E., Rodriguez, B. L., Lopez, L. M., Scarpino, S. E., & Goldstein, B. (2012). Predicting Spanish-English bilingual children's language abilities. *Journal of speech, language, and hearing research : JSLHR*, *55*(5), 1251–1264. https://doi.org/10.1044/1092-4388(2012/11-0016)

Hampton, S., Rabagliati, H., Sorace, A., & Fletcher-Watson, S. (2017). Autism and Bilingualism: A Qualitative Interview Study of Parents' Perspectives and Experiences. *Journal of speech, language, and hearing research : JSLHR*, *60*(2), 435–446. https://doi.org/10.1044/2016_JSLHR-L-15-0348

Harrowing, J. N., Mill, J., Spiers, J., Kulig, J., & Kipp, W. (2010). Critical Ethnography, Cultural Safety, and International Nursing Research. International Journal of Qualitative Methods, 240–251. https://doi.org/10.1177/160940691000900301

Hart, B., & Risley, T. R. (1995). *Meaningful differences in the everyday experience of young american children*. P.H. Brookes.

Hart, B., & Risley, T. R. (2003). The early catastrophe: The 30 million word gap by age 3. *American educator*, *27*(1), 4-9

Hay, I., Tsourtos, G., & Bickford, J. (2021). A qualitative inquiry of professionals' perceptions of bilingualism for children with language delay. International Journal of Speech-Language Pathology, 23(5), 497–507. https://doi.org/10.1080/17549507.2020.1869306

Heath, M., Hvass, A. M. F., & Wejse, C. M. (2023). Interpreter services and effect on healthcare - a systematic review of the impact of different types of interpreters on patient outcome. *Journal of migration and health*, *7*, 100162. https://doi.org/10.1016/j.jmh.2023.100162

Hillmert, S. (2013). Links between immigration and social inequality in education: a comparison among five european countries. Research in Social Stratification and Mobility, 32, 7–23. https://doi.org/10.1016/j.rssm.2013.02.002

Hindman, A. H., Wasik, B. A., & Snell, E. K. (2016). Closing the 30 million word gap: next steps in designing research to inform practice. *Child Development Perspectives*, *10*(2), 134–139. https://doi.org/10.1111/cdep.12177

Hirsh-Pasek, K., Adamson, L. B., Bakeman, R., Owen, M. T., Golinkoff, R. M., Pace, A., Yust, P. K. S., & Suma, K. (2015). The contribution of early communication quality to low-income children's language success. *Psychological Science*, *26*(7), 1071–83. https://doi.org/10.1177/0956797615581493

Hoff, E. (2013). Interpreting the early language trajectories of children from low-SES and language minority homes: implications for closing achievement gaps. Developmental Psychology, 49(1), 4- 14. https://doi.org/10.1037/a0027238

Hoff, E., Burridge, A., Ribot, K. M., & Giguere, D. (2018). Language specificity in the relation of maternal education to bilingual children's vocabulary growth. *Developmental Psychology*, *54*(6), 1011–1019. https://doi.org/10.1037/dev0000492

Holmes, J., & Kiernan, K. (2013). Persistent poverty and children's development in the early years of childhood. Policy and Politics, 41(1), 19–42. https://doi.org/10.1332/030557312X645810

Hrabok, M., Watterson, R., DeVetten, G., & Wagner, A. (2020). Canadian Refugee Women Are at Increased Risk of Postpartum Depression: How Can We Help?. *Journal of obstetrics and gynaecology Canada : JOGC = Journal d'obstetrique et gynecologie du Canada : JOGC*, *42*(11), 1391–1393. https://doi.org/10.1016/j.jogc.2020.03.023

Hsiao, Y.-J., Higgins, K., & Diamond, L. (2018). Parent empowerment: respecting their voices. Teaching Exceptional Children, 51(1), 43–53.

Hsieh, E., & Kramer, E. M. (2012). Medical interpreters as tools: dangers and challenges in the utilitarian approach to interpreters' roles and functions. *Patient education and counseling*, *89*(1), 158–162. https://doi.org/10.1016/j.pec.2012.07.001

https://doi.org/10.1037/a003478

Huang, K.-Y., O'Brien Caughy, M., Genevro, J. L., & Miller, T. L. (2005). Maternal knowledge of child development and quality of parenting among white, african-american and hispanic mothers. *Journal of Applied Developmental Psychology*, *26*(2), 149–170. https://doi.org/10.1016/j.appdev.2004.12.001

Hui, C. P. S., & Barozzino, T. (2013). Caring for kids new to canada. *Paediatrics & Child Health*, *18*(4), 179–179. https://doi.org/10.1093/pch/18.4.179

Institut de la Statistique Québec. Naissances selon Le lieu de naissance de la mère, PAR région administrative, Québec, 2010-2012. *Available:* http://www.stat.gouv.qc.ca/docs-hmi/statistiques/population-demographie/naissance-fecondite/428ra.htm

Iqbal, S. A. et Tayyab, N. (2021). COVID-19 and children: The mental and physical reverberations of the pandemic. *Child: Care, Health and Development, 47*(1), 136-139. https://doi.org/https://doi.org/10.1111/cch.12822

Jacobs, E. A., Shepard, D. S., Suaya, J. A., & Stone, E. L. (2004). Overcoming language barriers in health care: costs and benefits of interpreter services. *American journal of public health*, *94*(5), 866–869. https://doi.org/10.2105/ajph.94.5.866

Janus, M., Enns, J., Forer, B., Raos, R., Gaskin, A., Webb, S., Duku, E., Brownell, M., Muhajarine, N. et Guhn, M. (2018). A Pan-Canadian Data Resource for Monitoring Child Developmental Health: the Canadian Neighbourhoods Early Child Development (CanNECD) Database. *International Journal of Population Data Science, 3*(3). https://doi.org/10.23889/ijpds.v3i3.431

Johnson, C. J., Beitchman, J. H., & Brownlie, E. B. (2010). Twenty-year follow-up of children with and without speech-language impairments: family, educational, occupational, and quality of life outcomes. *American journal of speech-language pathology*, *19*(1), 51–65. https://doi.org/10.1044/1058-0360(2009/08-0083)

Kaihlanen, A.-M., Hietapakka, L., & Heponiemi, T. (2019). Increasing cultural awareness: qualitative study of nurses' perceptions about cultural competence training. *Bmc Nursing*, *18*(1), 1–9. https://doi.org/10.1186/s12912-019-0363-x

Kaplan, P. S., Danko, C. M., Everhart, K. D., Diaz, A., Asherin, R. M., Vogeli, J. M., & Fekri, S. M. (2014). Maternal depression and expressive communication in one-year-old infants. *Infant behavior & development*, *37*(3), 398–405. https://doi.org/10.1016/j.infbeh.2014.05.008

Karoly, L. A. et Gonzalez, G. C. (2011). Early Care and Education for Children in Immigrant Families. *The Future of Children, 21* (1). 71-101. https://www.jstor.org/stable/41229012

Keys, T. D., Farkas, G., Burchinal, M. R., Duncan, G. J., Vandell, D. L., Li, W., Ruzek, E. A., & Howes, C. (2013). Preschool center quality and school readiness: quality effects and variation by demographic and child characteristics. Child Development, 84(4), 1171–1190.

Koch, T. (1994). Establishing rigour in qualitative research: The decision trail. Journal of Advanced Nursing, 19, 976–986. doi:10.1111/ j.1365-2648.1994.tb01177.x

Kohnert, K., Ebert, K. D., & Pham, G. T. (2020). *Language disorders in bilingual children and adults*. Plural Publishing.

Korstjens, I., & Moser, A. (2018). Series: practical guidance to qualitative research. part 4: trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120–124.

Krupic, F., Hellström Mikael, Biscevic, M., Sadic, S., & Fatahi, N. (2016). Difficulties in using interpreters in clinical encounters as experienced by immigrants living in sweden. Journal of Clinical Nursing, 25(11-12), 1721–1728. https://doi.org/10.1111/jocn.13226

Kuo, M. M., & Lai, C. C. (2006). Linguistics across cultures: The impact of culture on second language learning. *Online Submission*, *1*(1).

La Maison Bleue. (2016). *L'empreinte de La Maison Bleue : Fondements et guide de pratiques 2016*. La Maison Bleue. https://maisonbleue.info/wp-content/uploads/2018/11/La_Maison_Bleue_GuideEmpreinte_Chapitres1-2-3-WEB.pdf

La Maison Bleue. (2021). *Rapport d'activités 2020-2021*. La Maison Bleue. https://maisonbleue.info/wp-content/uploads/2021/05/LMB_RapportActivites2021_FR.pdf

Lancellotti K. (2008). Culture care theory: a framework for expanding awareness of diversity and racism in nursing education. *Journal of professional nursing : official journal of the American Association of Colleges of Nursing*, *24*(3), 179–183. https://doi.org/10.1016/j.profnurs.2007.10.007

Larson, A. L., Cycyk, L. M., Carta, J. J., Hammer, C. S., Baralt, M., Uchikoshi, Y., An, Z. G., & Wood, C. (2020). A systematic review of language-focused interventions for young children from culturally and linguistically diverse backgrounds. *Early Childhood Research Quarterly: Part 1*, *50*, 157–178. https://doi.org/10.1016/j.ecresq.2019.06.001

Larson, K. E., & Bradshaw, C. P. (2017). Cultural competence and social desirability among practitioners: a systematic review of the literature. *Children and Youth Services Review*, *76*, 100–111. https://doi.org/10.1016/j.childyouth.2017.02.034

Laurin, I., Guay, D., Fournier, M., Bigras, N., & Solis, A. (2016). Attendance in educational preschool services: a protective factor in the development of children from low-income families? Canadian Journal of Public Health : A Publication of the Canadian Public Health Association, 106(7), 20. https://doi.org/10.17269/CJPH.106.4825

Laverty, M., McDermott, D. R., & Calma, T. (2017). Embedding cultural safety in Australia's main health care standards. *The Medical journal of Australia*, *207*(1), 15–16. https://doi.org/10.5694/mja17.00328

Law, J., Charlton, J., Dockrell, J., Gascoigne, M., McKean, C., & Theakston, A. (2017). Early language development: needs, provision and intervention for pre-school children from socio-economically disadvantaged backgrounds. London Education Endowment Foundation.

Law, J., Reilly, S., & Snow, P. C. (2013). Child speech, language and communication need re-examined in a public health context: a new direction for the speech and language therapy profession. *International Journal of Language &*

Communication Disorders, *48*(5), 486–496. https://doi.org/10.1111/1460-6984.12027

Lim, M., Van Hulst, A., Pisanu, S., & Merry, L. (2022). Social Isolation, Loneliness and Health: A Descriptive Study of the Experiences of Migrant Mothers With Young Children (0-5 Years Old) at La Maison Bleue. *Frontiers in global women's health*, *3*, 823632. https://doi.org/10.3389/fgwh.2022.823632

Lim, Y. S., & Cole, K. N. (2002). Facilitating first language development in young korean children through parent training in picture book interactions. Bilingual Research Journal, 26(2), 367–381.

Lincoln, Y.S. and Guba, E.G. (1985) Naturalistic Inquiry. SAGE, Thousand Oaks, 289-331. http://dx.doi.org/10.1016/0147-1767(85)90062-8

Lokugamage, A. U., Rix, E. L., Fleming, T., Khetan, T., Meredith, A., & Hastie, C. R. (2021). Translating Cultural Safety to the UK. *Journal of medical ethics*, medethics-2020-107017. Advance online publication. https://doi.org/10.1136/medethics-2020-107017

MacFarlane, A., Huschke, S., Pottie, K., Hauck, F. R., Griswold, K., & Harris, M. F. (2020). Barriers to the use of trained interpreters in consultations with refugees in four resettlement countries: a qualitative analysis using normalisation process theory. Bmc Family Practice, 21(1). https://doi.org/10.1186/s12875-020-01314-7

MacLeod, A., Meziane, R., & Pesco, D. (2020). Language abilities of children with refugee backgrounds: Insights from case studies. *Applied Psycholinguistics, 41*(6), 1329-1349. doi:10.1017/S0142716420000405

Madigan, S., Browne, D., Racine, N., Mori, C., & Tough, S. (2019). Association Between Screen Time and Children's Performance on a Developmental Screening Test. *JAMA pediatrics*, *173*(3), 244–250. https://doi.org/10.1001/jamapediatrics.2018.5056

Majumdar, B., Browne, G., Roberts, J., & Carpio, B. (2004). Effects of cultural sensitivity training on health care provider attitudes and patient outcomes. *Journal of Nursing Scholarship*, *36*(2), 161–166. https://doi.org/10.1111/j.1547-5069.2004.04029.x

Marjanovič Umek Ljubica, Podlesek, A., & Fekonja Urška. (2005). Assessing the home literacy environment. *European Journal of Psychological Assessment*, *21*(4), 271–281. https://doi.org/10.1027/1015-5759.21.4.271

Martinot, P., Bernard, J. Y., Peyre, H., De Agostini, M., Forhan, A., Charles, M. A., Plancoulaine, S., & Heude, B. (2021). Exposure to screens and children's language development in the EDEN mother-child cohort. *Scientific reports*, *11*(1), 11863. https://doi.org/10.1038/s41598-021-90867-3

Mason, C., Barraket, J., Friel, S., O'Rourke, K., & Stenta, C.-P. (2015). Social innovation for the promotion of health equity. Health Promotion International, 30 Suppl 2, 116–25. https://doi.org/10.1093/heapro/dav076

Maternal depression and child development. (2004). *Paediatrics & child health*, *9*(8), 575–598. https://doi.org/10.1093/pch/9.8.575

McLeod, S., Harrison, L. J., Whiteford, C., & Walker, S. (2016). Multilingualism and speech-language competence in early childhood: impact on academic and social-emotional outcomes at school. Early Childhood Research Quarterly, 34, 53–66. https://doi.org/10.1016/j.ecresq.2015.08.005

Medawar, J., Tabullo, Á. J., & Gago-Galvagno, L. G. (2023). Early language outcomes in Argentinean toddlers: Associations with home literacy, screen exposure and joint media engagement. *British Journal of Developmental Psychology*, *41*(1), 13-30.

Mendelsohn, A. L., Huberman, H. S., Berkule, S. B., Brockmeyer, C. A., Morrow, L. M., & Dreyer, B. P. (2011). Primary care strategies for promoting parent-child interactions and school readiness in at-risk families: the Bellevue Project for Early Language, Literacy, and Education Success. *Archives of pediatrics & adolescent medicine*, *165*(1), 33–41. https://doi.org/10.1001/archpediatrics.2010.254

Méndez Lucía I, Crais, E. R., Castro, D. C., & Kainz, K. (2015). A culturally and linguistically responsive vocabulary approach for young latino dual language learners. Journal of Speech, Language, and Hearing Research : Jslhr, 58(1), 93–106. https://doi.org/10.1044/2014_JSLHR-L-12-0221

Merriam, S. B. (1998). Qualitative research and case study applications in education. San Francisco: Jossey-Bass Publishers. Oxford: Routledge.

Merry, L., Pelaez, S., & Edwards, N. C. (2017). Refugees, asylum-seekers and undocumented migrants and the experience of parenthood: a synthesis of the qualitative literature. *Globalization and Health*, *13*(1). https://doi.org/10.1186/s12992-017-0299-4

Mkandawire-Valhmu, L. (2018). *Cultural safety, healthcare and vulnerable populations : a critical theoretical perspective*. Routledge, Taylor and Francis Group. https://doi.org/10.4324/9781315708706

Modabbernia, A., Velthorst, E., & Reichenberg, A. (2017). Environmental risk factors for autism: An evidence-based review of systematic reviews and meta-analyses. *Molecular Autism, 8*, 13. https://doi.org/10.1186/s13229-017-0121-4.

Moharir, M., Barnett, N., Taras, J., Cole, M., Ford-Jones, E. L., & Levin, L. (2014). Speech and language support: How physicians can identify and treat speech and language delays in the office setting. *Paediatrics & child health*, *19*(1), 13–18

Montréal en statistiques. (2016). *Arrondissement de Villeray–Saint-Michel–Parc-Extension*.https://ville.montreal.qc.ca/pls/portal/docs/PAGE/MTL_STATS_FR/MEDIA/DOCUMENTS/PROFIL_SOCIOD%C9MO_VILLERAY%20ST-MICHEL%20PARC-EX%202016.PDF

Montréal en statistiques. (2020). *Coup d'oeil sur la population immigrante*. http://ville.montreal.qc.ca/pls/portal/docs/PAGE/MTL_STATS_FR/MEDIA/DOCUMENTS/POPULATION%20IMMIGRANTE%202020.PDF

Moore, T. G., McDonald, M., Carlon, L., & O'Rourke, K. (2015). Early childhood development and the social determinants of health inequities. Health Promotion International, 30, 115.

Morantz, G., Rousseau Cécile, Banerji, A., Martin, C., & Heymann, J. (2013). Resettlement challenges faced by refugee claimant families in montreal: lack of access to child care. Child & Family Social Work, 18(3), 318–328. https://doi.org/10.1111/j.1365-2206.2012.00848.x

Morgan, A., Ttofari Eecen, K., Pezic, A., Brommeyer, K., Mei, C., Eadie, P., Reilly, S., & Dodd, B. (2017). Who to Refer for Speech Therapy at 4 Years of Age Versus Who to "Watch and Wait"?. *The Journal of pediatrics*, *185*, 200–204.e1. https://doi.org/10.1016/j.jpeds.2017.02.059

Morris, A. S., Hays-Grudo, J., Kerr, K. L., & Beasley, L. O. (2021). The heart of the matter: Developing the whole child through community resources and caregiver relationships. *Development and psychopathology*, *33*(2), 533–544. https://doi.org/10.1017/S0954579420001595

Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description - the poor cousin of health research?. *BMC medical research methodology*, *9*, 52. https://doi.org/10.1186/1471-2288-9-52

Nelson, A. (2002). Unequal treatment: confronting racial and ethnic disparities in health care. *Journal of the national medical association*, *94*(8), 666

Nguyen, N. H., Subhan, F. B., Williams, K., & Chan, C. B. (2020). Barriers and Mitigating Strategies to Healthcare Access in Indigenous Communities of Canada: A Narrative Review. *Healthcare (Basel, Switzerland)*, *8*(2), 112. https://doi.org/10.3390/healthcare8020112

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. International Journal of Qualitative Methods. https://doi.org/10.1177/1609406917733847

O'Hara, M. W., & McCabe, J. E. (2013). Postpartum depression: current status and future directions. *Annual review of clinical psychology*, *9*, 379–407. https://doi.org/10.1146/annurev-clinpsy-050212-185612

Olds, D. L., Holmberg, J. R., Donelan-McCall, N., Luckey, D. W., Knudtson, M. D., & Robinson, J. A. (2014). Effects of home visits by paraprofessionals and by nurses on children: age-six and nine follow-up of a randomized trial. *Jama Pediatrics*, *168*(2), 114–121. https://doi.org/10.1001/jamapediatrics.2013.3817

Order of psychoeducators in Québec. (2023). *Who are the psychoeducators?.* https://ordrepsed.qc.ca/les-psychoeducateurs-et-psychoeducatrices/qui-sont-les-ps-ed/

Ou, L., Chen, J., Garrett, P., & Hillman, K. (2011). Ethnic and indigenous access to early childhood healthcare services in australia: parents' perceived unmet needs and related barriers. Australian and New Zealand Journal of Public Health, 35(1).

Pagani, L. S. et Fitzpatrick, C. (2014). Children'sschool readiness: implicationsfor eliminating future disparities in health and education. Health Education & Behavior, 41(1), 25-33. https://doi.org/10.1177/1090198113478818

Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: the new zealand experience. *International Journal for Quality in Health Care : Journal of the International Society for Quality in Health Care*, *8*(5), 491–7.

Paradis, J. (2011). Individual differences in child English second language acquisition: Comparing child-internal and child-external factors. *Linguistic approaches to bilingualism*, *1*(3), 213-237.

Paradis, J., Genesee, F., Crago, M. B., & Leonard, L. B. (2011). *Dual language development and disorders : a handbook on bilingualism and second language learning* (Second, Ser. Communication and language intervention series). Paul H. Brookes, Publishing.

Park, M., & McHugh, M. (2014). Immigrant parents and early childhood programs. *Washington, DC: Migration Policy Institute*.

Patterson, B., & Morin, K. (2012). Methodological considerations for studying social processes. *Nurse researcher*, *20*(1), 33–38. https://doi.org/10.7748/nr2012.09.20.1.33.c9306

Pellecchia, M., Beidas, R. S., Mandell, D. S., Cannuscio, C. C., Dunst, C. J., & Stahmer, A. C. (2020). Parent empowerment and coaching in early intervention: study protocol for a feasibility study. Pilot and Feasibility Studies, 6(1). https://doi.org/10.1186/s40814-020-00568-3

Perkins, S. C., Finegood, E. D., & Swain, J. E. (2013). Poverty and language development: roles of parenting and stress. *Innovations in clinical neuroscience*, *10*(4), 10–19.

Petitto, L. A., Katerelos, M., Levy, B. G., Gauna, K., Tétreault, K., & Ferraro, V. (2001). Bilingual signed and spoken language acquisition from birth: implications for the mechanisms underlying early bilingual language acquisition. *Journal of child language*, *28*(2), 453–496. https://doi.org/10.1017/s0305000901004718

Petterson, S. M., & Albers, A. B. (2001). Effects of poverty and maternal depression on early child development. Child Development, 72(6), 1794–1813.

Pianta, R. C., Barnett, W. S., Burchinal, M., & Thornburg, K. R. (2009). The Effects of Preschool Education: What We Know, How Public Policy Is or Is Not Aligned With the Evidence Base, and What We Need to Know. Psychological Science in the Public Interest, 10(2), 49–88. https://doi.org/10.1177/1529100610381908

Polit, D., & Beck, C. (2017). *Nursing research: Generating and assessing evidence for nursing practice* (Tenth ed.). Philadelphia: Wolters Kluwer Health.

Prevoo, M. J., Malda, M., Mesman, J., Emmen, R. A., Yeniad, N., Van Ijzendoorn, M. H., & Linting, M. (2014). Predicting ethnic minority children's vocabulary from socioeconomic status, maternal language and home reading input: different pathways for host and ethnic language. *Journal of child language*, *41*(5), 963–984. https://doi.org/10.1017/S0305000913000299

Raikes, H., Green, B. L., Atwater, J., Kisker, E., Constantine, J., & Chazan-Cohen, R. (2006). Involvement in early head start home visiting services: demographic predictors and relations to child and parent outcomes. *Early Childhood Research Quarterly*, *21*(1), 2–24. https://doi.org/10.1016/j.ecresq.2006.01.006

Ramsden I. (1993). Cultural safety in nursing education in Aotearoa (New Zealand). *Nursing praxis in New Zealand inc*, *8*(3), 4–10.

Ramsden, I. (1996). The Treaty of Waitangi and cultural safety: The role of the treaty in nursing and midwifery education in Aotearoa. *Guidelines for cultural safety in nursing and midwifery education*, 21-35.

Regroupement Langage Québec. (2020). *Le trouble développemental du langage. Portrait du TDL*. https://www.ooaq.qc.ca/media/cxflj0la/guide-tdl_v3.pdf

Richardson, A., Yarwood, J., & Richardson, S. (2017). Expressions of cultural safety in public health nursing practice. *Nursing inquiry*, *24*(1), 10.1111/nin.12171. https://doi.org/10.1111/nin.12171

Roulstone, S., Law, J., Rush, R., Clegg, J., & Peters, T. (2011). Investigating the role of language in children's early educational outcomes.

Rowe M. L. (2008). Child-directed speech: relation to socioeconomic status, knowledge of child development and child vocabulary skill. *Journal of child language*, *35*(1), 185–205. https://doi.org/10.1017/s0305000907008343

Rowe, M. L., & Zuckerman, B. (2016). Word Gap Redux: Developmental Sequence and Quality. *JAMA pediatrics*, *170*(9), 827–828. https://doi.org/10.1001/jamapediatrics.2016.1360

Sandelowski M. (2000). Whatever happened to qualitative description?. *Research in nursing & health*, *23*(4), 334–340. https://doi.org/10.1002/1098-240x(200008)23:4<334::aid-nur9>3.0.co;2-g

Saracho, O. N. (2021). Theories of child development and their impact on early childhood education and care. Early Childhood Education Journal, 51(1), 15–30. https://doi.org/10.1007/s10643-021-01271-5

Schady, N. (2011). Parents' education, mothers' vocabulary, and cognitive development in early childhood: longitudinal evidence from ecuador. *American Journal of Public Health*, *101*(12), 2299–307. https://doi.org/10.2105/AJPH.2011.300253

Schoon, I., Parsons, S., Rush, R., & Law, J. (2010). Children's language ability and psychosocial development: a 29-year follow-up study. *Pediatrics*, *126*(1), e73–e80. https://doi.org/10.1542/peds.2009-3282

Schwab, J. F., & Lew-Williams, C. (2016). Language learning, socioeconomic status, and child-directed speech. *Wiley interdisciplinary reviews. Cognitive science*, *7*(4), 264–275. https://doi.org/10.1002/wcs.1393

Shah, C. P., & Reeves, A. (2015). The aboriginal cultural safety initiative: an innovative health sciences curriculum in ontario colleges and universities. *International Journal of Indigenous Health*, *10*(2), 117–131. https://doi.org/10.18357/ijih.102201514388

Shaw, A. (2021). Read, speak, sing: promoting early literacy in the health care setting. *Paediatrics & Child Health*, *26*(3), 182–188. https://doi.org/10.1093/pch/pxab005

Sheath, D., Flahault, A., Seybold, J., & Saso, L. (2020). Diverse and complex challenges to migrant and refugee mental health: reflections of the m8 alliance expert group on migrant health. International Journal of Environmental Research and Public Health, 17(10). https://doi.org/10.3390/ijerph17103530

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63–75.

Short, K., Eadie, P., & Kemp, L. (2019). Paths to language development in at risk children: a qualitative comparative analysis (QCA). *BMC pediatrics*, *19*(1), 94. https://doi.org/10.1186/s12887-019-1449-z

Short, K., Eadie, P., & Kemp, L. (2020). Influential factor combinations leading to language outcomes following a home visiting intervention: a qualitative comparative analysis (qca). *International Journal of Language & Communication Disorders*, *55*(6), 936–954. https://doi.org/10.1111/1460-6984.12573

Silva, P., & Pereira, H. (2023). Promoting Psychosocial Well-Being and Empowerment of Immigrant Women: A Systematic Review of Interventions. *Behavioral sciences (Basel, Switzerland)*, *13*(7), 579. https://doi.org/10.3390/bs13070579

Smith, J., Eadie, T., Levickis, P., Bretherton, L., & Goldfeld, S. (2018). Predictive validity of verbal and non-verbal communication and mother-child turn-taking at 12 months on language outcomes at 24 and 36 months in a cohort of infants experiencing adversity: a preliminary study. *International Journal of Language & Communication Disorders*, *53*(5), 969–980. https://doi.org/10.1111/1460-6984.12408

Snyder, K., Chaudhary, P., Pereira, A., Masuda, K., Niski, J., & Dinkel, D. (2022). Early impact of the covid-19 pandemic on promotion of infant activity, strength and communication: a qualitative exploration. Acta Psychologica, 222. https://doi.org/10.1016/j.actpsy.2021.103480

Sorenson Duncan, T., & Paradis, J. (2020). How does maternal education influence the linguistic environment supporting bilingual language development in child second language learners of English? International Journal of Bilingualism, 24(1), 46–61. https://doi.org/10.1177/1367006918768366

Stanley, M. (2014). Qualitative descriptive: A very good place to start. In *Qualitative research methodologies for occupational science and therapy* (pp. 37-52). Routledge.

Statistics Canada. (2017*). Immigration and ethnocultural diversity: Key results from the 2016 Census. https://www150.statcan.gc.ca/n1/daily-quotidien/171025/dq171025b-eng.htm*

Suggate, S., Schaughency, E., McAnally, H. et Reese, E. (2018). From infancy to adolescence: The longitudinal links between vocabulary, early literacy skills, oral narrative, and reading comprehension. *Cognitive Development, 47*, 82-95. https://doi.org/10.1016/j.cogdev.2018.04.005

Sullivan-Bolyai, S., Bova, C., & Harper, D. (2005). Developing and refining interventions in persons with health disparities: the use of qualitative description. *Nursing outlook*, *53*(3), 127–133. https://doi.org/10.1016/j.outlook.2005.03.005

Sultana, N., Wong, L. L. N. et Purdy, S. C. (2020). Natural language input: maternal education, socioeconomic deprivation, and language outcomes in typically developing children. *Lang Speech Hear Serv Sch, 51*(4), 1049-1070. https://doi.org/10.1044/2020_LSHSS-19-00095

Suskind, D. L., Leffel, K. R., Graf, E., Hernandez, M. W., Gunderson, E. A., Sapolich, S. G., Suskind, E., Leininger, L., Goldin-Meadow, S., & Levine, S. C. (2016). A parent-directed language intervention for children of low socioeconomic status: a randomized controlled pilot study. *Journal of Child Language*, *43*(2), 366–406.

Sylvestre, A. et Mérette, C. (2012). Language delay in severely neglected children: A cumulative or specific effect of risk factors? Child Abuse & Neglect 24, 414-428. https://doi.org/10.1016/j.chiabu.2009.10.003

Table de Concertation Petite Enfance de Parc Extension (2018). *Projet parents agents multiplicateurs.* https://agirtot.org/media/489559/fiche_pam_v9nov-1-copie.pdf

Taheri, B. (2016). Caring for Syrian Refugee Children Welcoming Young Children & Their Families.

Tantut, S. (2018). Public health nurse services for maternal-child immigrant healthcare: a literature review. *Central European Journal of Nursing & Midwifery, 9*(3), 873-879. https://doi.org/10.15452/CEJNM.2018.09.0018

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. Journal of Advanced Nursing, 48, 388–396. doi:10.1111/j.1365-2648.2004.03207.x

Torres, K. M., & Arrastia-Chisholm, M. C. (2019). Second-language-acquisition developmental differences: exploring migrant children's language production in a daycare setting. *Early Child Development and Care*, *189*(11), 1827–1841.

Trainor, A. (2010). Diverse approaches to parent advocacy during special education home--school interactions. *Remedial and Special Education*, *31*(1), 34–47.

Tucker, C. M., Arthur, T. M., Roncoroni, J., Wall, W., & Sanchez, J. (2015). Patient-centered, culturally sensitive health care. *American Journal of Lifestyle Medicine*, *9*(1), 63–77. https://doi.org/10.1177/1559827613498065

Turney, K., & Kao, G. (2009). Barriers to school involvement: are immigrant parents disadvantaged? *Journal of Educational Research*, *102*(4), 257–271. https://doi.org/10.3200/JOER.102.4.257-271

Vaghri, Z., Tessier, Z., & Whalen, C. (2019). Refugee and Asylum-Seeking Children: Interrupted Child Development and Unfulfilled Child Rights. *Children (Basel, Switzerland)*, *6*(11), 120. https://doi.org/10.3390/children6110120

Valade, F., Béliveau, M. J., Breault, C., Chabot, B., & Labelle, F. (2022). Individual and cumulative risk factors in developmental language disorder: A case-control study. *Clinical child psychology and psychiatry*, 13591045221113389. Advance online publication.

Verdon, S., McLeod, S., & Wong, S. (2015). Supporting culturally and linguistically diverse children with speech, language and communication needs: Overarching principles, individual approaches. *Journal of communication disorders*, *58*, 74–90. https://doi.org/10.1016/j.jcomdis.2015.10.002

Vernon-Feagans, L., Bratsch-Hines, M. E., & The Family Life Project Key Investigators. (2013). Caregiver-child verbal interactions in child care: a buffer against poor language outcomes when maternal language input is less. *Early Childhood Research Quarterly*, *28*(4), 858–873.

Vernon-Feagans, L., Garrett-Peters, P., Willoughby, M., Mills-Koonce, R., & The Family Life Project Key Investigators (2012). Chaos, Poverty, and Parenting: Predictors of Early Language Development. *Early childhood research quarterly*, *27*(3), 339–351. https://doi.org/10.1016/j.ecresq.2011.11.001

Vo, D. (2014). Taking a history with newcomer children and adolescents. *Paediatrics & Child Health*, *19*(2), 87–88. https://doi.org/10.1093/pch/19.2.87

Wakai, T., Simasek, M., Nakagawa, U., Saijo, M., & Fetters, M. D. (2018). Screenings during Well-Child Visits in Primary Care: A Quality Improvement Study. *Journal of the American Board of Family Medicine : JABFM*, *31*(4), 558–569. https://doi.org/10.3122/jabfm.2018.04.170222

Wang, G., Zhang, Y., Zhao, J., Zhang, J., & Jiang, F. (2020). Mitigate the effects of home confinement on children during the COVID-19 outbreak. *Lancet (London, England)*, *395*(10228), 945–947. https://doi.org/10.1016/S0140-6736(20)30547-X

Weber, A., Fernald, A., & Diop, Y. (2017). When cultural norms discourage talking to babies: effectiveness of a parenting program in rural senegal. *Child Development*, *88*(5), 1513–1526. https://doi.org/10.1111/cdev.12882

Weiland, C. (2017). *Puzzling it out: The current state of scientific knowledge on pre-kindergarten effects-a consensus statement*. Brookings Institution.

Weisleder, A., & Fernald, A. (2013). Talking to children matters: early language experience strengthens processing and builds vocabulary. Psychological Science, 24(11), 2143–52. https://doi.org/10.1177/0956797613488145

Wepa, D. (Ed.). (2015). Cultural safety in Aotearoa New Zealand (Second). City:Cambridge University Press.

Wieber, W. B., & Sumner, L. Q. (2016). Promoting immigrant parents' engagement in early intervention through culturally and linguistically responsive service delivery. *Journal of Early Hearing Detection and Intervention*, *1*(1), 78-86.

Wightman, L., Hutton, A., & Grant, J. (2021). Child and family health nurses' roles in the care of infants and children: A scoping review. Journal of Child Health Care. https://doi.org/10.1177/13674935211026123

Woolfenden, S., Goldfeld, S., Raman, S., Eapen, V., Kemp, L., & Williams, K. (2013). Inequity in child health: the importance of early childhood development. *Journal of Paediatrics and Child Health*, *49*(9), 365–9. https://doi.org/10.1111/jpc.12171

Y Garcia, E. F., Breslau, J., Hansen, R., & Miller, E. (2012). Unintended consequences: An ethnographic narrative case series exploring language recommendations for

bilingual families of children with autistic spectrum disorders. *Journal of Medical Speech-Language Pathology*, *20*(2), 10-17.

Yang, N., Shi, J., Lu, J., & Huang, Y. (2021). Language development in early childhood: quality of teacher-child interaction and children's receptive vocabulary competency. Frontiers in Psychology, 12, 649680–649680. https://doi.org/10.3389/fpsyg.2021.649680

Yeung, S. (2016). Conceptualizing cultural safety: Definitions and applications of safety in health care for Indigenous mothers in Canada. *Journal for Social Thought*, *1*.

Zhang, S., Dang, R., Yang, N., Bai, Y., Wang, L., Abbey, C., & Rozelle, S. (2018). Effect of caregiver's mental health on early childhood development across different rural communities in China. *International Journal of Environmental Research and Public Health*, *15*(11). https://doi.org/10.3390/ijerph15112341

Zuckerman, B. (2009). Promoting early literacy in pediatric practice: twenty years of reach out and read. *Pediatrics -Springfield-*, *124*(6), 1660–1665.

Appendix A: Information and Consent Form

INFORMATION AND CONSENT FORM

Title: Promoting Healthy Early Childhood Language Development in Families at La Maison Bleue (LMB)

Researchers: Meghry Kevork, Master's student, Faculty of Nursing, University of Montreal; Lisa Merry, Research supervisor, Associate professor, Faculty of Nursing, University of Montreal and Regular researcher, SHERPA.

Collaborator: Jennifer Hille, Director of Development and Strategic Positioning, La Maison Bleue

You are being invited to participate in this study. Before accepting to participate, please take the time to carefully read this document. It provides information about the study purpose and what participation would involve. Do not hesitate to ask the person who presents you this document any questions that you feel are important to be answered before accepting to participate. If you choose to take part in this research study, you will be asked to sign this consent form or provide verbal consent.

INFORMATION FOR PARTICIPANTS

1. **Research Objectives**

The overall objective of this project is to learn about strategies for promoting early childhood language development in families in vulnerable contexts, including migrant families. The specific objectives of this project are to explore from the perspective of health care providers (nurses, social workers, family doctors, midwives), the needs of LMB families regarding early language development and to discuss which early-childhood language development strategies and interventions best respond to these needs. The study will also seek to identify the healthcare providers' perspectives on additional interventions and approaches that may be useful to further promote healthy language development in this population, based on observations and interactions with these families.
To achieve this objective, interviews will be conducted with approximately 8-12 health and social care providers working at La Maison Bleue.

2. **Participation**

Your participation would consist of participating in one interview. The interview will take about 20 to 45 minutes. The interview would be done either in person, or by Zoom, at a moment that is convenient for you. If the interview is done in person, it will be done at a place convenient to you (e.g., coffee shop, university of Montreal). The interview may be done in French or English.

At the beginning of the interview, you will be asked to respond to a brief sociodemographic questionnaire. This will include a few background questions (e.g., your profession, the number of years you have been working at La Maison Bleue).

During the interview you will be asked about your work with families at La Maison Bleue. More specifically, you will be asked to discuss your experiences and observations regarding language/ communication development and challenges among children followed at LMB. You will also be asked about the strategies and approaches that are used by yourself and others at LMB to promote healthy language development and prevent problems.

If you agree, the interviews will be audio-recorded in order to facilitate data analysis. If you do not agree to have the interview audio recorded, only handwritten notes will be taken.

3. **Audio-recording**

Audio-recording of the interview is optional.

If the interview is done using Zoom, the camera can be turned off if this is preferred. Please note that if the camera is kept on, only the audio will be saved, the video will not be kept.

The audio-recording will not be shared with anyone outside of the research team.

4. **Risks and inconveniences**

There are no known physical risks in participating in this study. It is possible that certain questions asked during the interview or socio-demographic questionnaire may elicit some negative emotions given the study focuses on care with families in vulnerable contexts, some of whom have had traumatic experiences (i.e. refugees and asylum seekers). You may refuse to answer any question, or you may end the interview or your participation, at any time.

In addition, as any other research project, there is always the risk of confidentiality breach. Therefore, if ever there was a breach, it is potentially possible that colleagues or clients may respond negatively. However, it is not expected that the data collected for this research would elicit reprisals.

The only foreseen inconvenience is the time to participate in the interview. You may also be contacted a second time if we need to clarify or verify information. To minimize this inconvenience, and limit the impact participation may have on your activities, including work, the interview will be scheduled at a time that is convenient for you.

If you are feeling any negative emotions following the interview, and would like to talk to someone, the services listed below may be helpful:

1. **Employee Assistance Program (EAP): mental health and well-being support services for the personnel of t**he CIUSSS West-Central Montreal:

1-800-361-2433 anytime (24 hours a day).

https://www.travailsantevie.com/?explicitSoftLogin=true

2. **Centre d'écoute Le Havre** : « A place that is welcoming and where someone will listen; doors are open to anyone who needs a listening ear without judgement ». (Service in French and sometimes in English)

514-982-0333 (Monday to Friday, 9 am to 5 pm)

http://le-havre.qc.ca/

3. **Écoute Entraide** : telephone help-line. (Service only in French)

514-278-2130 from 8 am to 10 pm, 7 days a week

https://www.ecoute-entraide.org/

4. **Tel-Aide** : telephone help-line

514-935-1101, 7 days a week, 24 hours a day

http://www.telaide.org/ / http://www.telaide.org/en/

5. **Vent over tea**: Active listening service, "We provide you undivided attention without any judgement or reaction, we are here simply to listen to you".

https://ventovertea.com/ (online booking) /

5. **Benefits**

There are no direct benefits to participating in this study. Your participation will help improve our understanding of early childhood language development problems and strategies to prevent and/or address these in the context of care of families living in vulnerable contexts.

6. **Compensation**

Each participant will be given a $15 Starbucks gift card as compensation for their time. The gift card will be sent by email within one week following the interview.

7. **Confidentiality**

The interview will be conducted in a quiet, private location. If the interview is done by Zoom, you will be asked to ensure that you are in a place where you can maintain privacy.

All of the information collected during the research project will remain confidential to the extent provided by law. You will only be identified by a random identification code. Your name will not appear on any documents other than the consent form and the master list that links the participants' names to their identification codes. Your name may be audio-recorded if you give consent by zoom.

All audio-recordings (consents and interviews done via Zoom) and electronic documents (consent forms, sociodemographic questionnaire, research notes and transcriptions) will be saved on the University of Montreal's secure OneDrive; consent forms/audio-recordings of consent will be kept in a separate folder from the data and will be password protected using a different password. The master list of participants will also be saved in a separate folder and will be password protected. All paper documents (consent forms and notes) will be kept in the principal researcher's University of Montreal office in a locked filing cabinet. Only the researchers working on this project will have access to the data.

All documents and data will be kept for 10 years. Only data with no identifying information will be kept beyond that date; all personal information will be deleted and destroyed. The principal researcher will be responsible for the data.

When the study results are shared in publications, reports, or at conferences or meetings, no information that can identify you or the LMB location where you work will be included. We will change quotes and mask any unique or sensitive information that could possibly identify you or your location of work.

For monitoring, control, protection and security purposes, your research study file could be checked by persons authorized by the Research Ethics Committee of the CIUSSS du Centre-Ouest-de-l'Île-de-Montréal, as well as by the Ethics Committee of health research at the University of Montreal. These persons are also bound by a confidentiality agreement.

In this sense, participation or non-participation will have no effect on the employment of participants and participation will be completely anonymous. Therefore, managers (including Ms. Hille) and colleagues will not be informed about your participation in this study. Thus, they will not have access to the individual information shared during the interview.

8. **Volunteer participation and the right to withdraw**

Participation in this study is completely voluntary. You are free to accept or to refuse to participate. You are free to withdraw from the study at any time without giving any reason, and without any consequences. You just need to notify the researchers. If you withdraw, you can ask that your information be destroyed and not used, unless the data have already been coded and analyzed, in which case it will not be possible to separate your information from the analysis. Once the publication process has begun, it also will not be possible to destroy your data or the results that stem from your interview. Refusal to participate or withdrawal from the study will in no way impact your employment at La Maison Bleue.

9. **Communication of results**

You will be invited to a presentation of the main findings, either in person or by Zoom in order to validate the findings with you and others at LMB.

The results of this study may be published in a scientific journal and presented in academic conferences or meetings. Your name, or any personal information that may identify you, will not be shared in any publication, report or presentation resulting from this study. The specific La Maison Bleue sites involved in the study, will also not be named.

10. Responsibility of the research team

In no way does accepting to participate in this study waive you of your legal rights, nor does it relieve the researchers, or involved institutions from their legal and professional responsibilities.

11. Resource Persons

If you have any questions regarding the project or if you wish to withdraw your participation, you may contact: Lisa Merry, Associate professor, Faculty of Nursing, University of Montreal, at the following number: [redacted] or email address: lisa.merry@umontreal.ca or with Meghry Kevork at the following email address: meghry.kevork@umontreal.ca

For any questions concerning your rights as a research participant taking part in this study, or if you have comments, or wish to file a complaint regarding your experience in taking part in this study, you may communicate with:
The Local Commissioner of Complaints and Quality of Service of the CIUSSS Centre-Ouest-de-L'Île-de-Montréal or the ombudsman at the following number: (514) 340-8222, ex. 24222, or by email address: ombudsman.ccomtl@ssss.gouv.qc.ca
You may also contact the ethics committee for health research at the University of Montreal:

Email: cerses@umontreal.ca
Phone : (514) 343-6111 poste 2604

If you have any complaints about this research project you may also contact the ombudsman of the University of Montreal by phone at +1 (514) 343-2100 or by email at ombudsman@umontreal.ca . The ombudsman will accept collect calls and can speak in English and French. Calls may be made anytime during 9 am and 5 pm.

Title: Promoting Healthy Early Childhood Language Development in Families at La Maison Bleue (LMB)

Researchers: Meghry Kevork, Master's student, Faculty of Nursing, University of Montreal; Lisa Merry, Research supervisor, Associate professor, Faculty of Nursing, University of Montreal and Regular researcher, SHERPA.

Collaborators: Jennifer Hille, Director of Development and Strategic Positioning, La Maison Bleue

DECLARATION OF CONSENT

PARTICIPANT STATEMENT

I understand the information that was explained to me as contained in this consent form. All my questions were answered to my satisfaction. I will receive a copy of this signed consent form or an email confirming my verbal consent will be sent to me. My participation is voluntary, and I can withdraw from the research study at any time without any consequences and without having to give a reason. Withdrawing from this study, at any time, will not affect my employment at La Maison Bleue. By giving my consent, I do not give up any of my legal rights.

I agree to participate in this study: Yes ☐ No ☐

I accept to have my interview audio-recorded: Yes ☐ No ☐

I agree to receive a summary of the research results when they become available: Yes ☐ No ☐

Email, phone or mailing address to receive the summary: _____

Name of the participant: _____

Signature: _____

Date: _____

Contact information, date & time for interview: _____

RESEARCHER STATEMENT

I, as the person obtaining consent, certify that I have explained to the participant the research study information contained in this consent form and have answered all questions. I have clearly explained to the participant that they are free to withdraw at any time without providing a reason, and without any consequences. I commit, together with the members of the research team to respect all conditions described in this consent form.

Name and signature of the researcher / person delegated to obtain consent:

_____

Signature: _____ Date: _____

Appendix B: Socio-demographic Questionnaire

ID#_____

SOCIO-DEMOGRAPHIC QUESTIONNAIRE

Please remember that you may interrupt the interview at any time if you are not comfortable answering a question or for any other reason. You are not obligated to answer any questions you do not wish to answer. All information collected will remain confidential.

1. **What is your gender?** : Specify : _____

2. **Profession** : ☐ Nurse, Auxiliary nurse ☐ Social worker
   ☐ Family physician, Resident ☐ Midwife
   ☐ Psycho-educator ☐ Specialised educator
   ☐ Other: _____

3. **Number of years of experience at La Maison Bleue** : _____ years

4. **Average number of work hours per week at La Maison Bleue** : _____ hours

5. **Level of education**: ☐ High School
   ☐ College
   ☐ Undergraduate level (certificate, bachelor's degree, other diploma)
   ☐ Graduate level (master's degree, PhD, medical degree, other)

☐ Other: _____

6. **Number of years of professional practice (see question 2)** : _____ years

7. **Country of origin**: _____

8. **Number of years in Canada** (if the country of origin is not Canada): _____ years

9. **What are your cultural and ethnic origins**?

_____

10. **Age** :

☐ < 20 years

☐ 20-29 years

☐ 30-39 years

☐ 40-49 years

☐ 50-59 years

☐ 60+ years

11. **Language (s) spoken** : _____, _____, _____, _____

Appendix C: Interview Guide

INTERVIEW GUIDE

Hello,

Firstly, thank you for accepting to participate in this interview.

The interview will begin with questions about your role and work at La Maison Bleue (LMB). Afterwards, we will discuss the families, in particular I will ask questions about your experiences and observations regarding language/ communication development and challenges among children followed at LMB. I will then ask about the strategies and approaches that you and others at LMB use to promote language development and prevent problems.

You are always free to interrupt or to stop the interview at any time, if you are not comfortable with a question, or for any other reason. You are not obligated to respond to any question that you do not wish to answer. All of the information that you share will be kept confidential.

Do you have any questions before we begin?

I would like to start with a brief socio-demographic questionnaire...

We will now begin the interview questions. I will start the audio-recording.

1. Please describe in general your role at LMB and the kind of work you do on a day-to-day basis with families…

2. Can you please describe what you have observed and heard from families at LMB regarding language development?

    a. What are some of the beliefs and values of families regarding their young children and language development?

b. How do families promote language development? What are some of the different strategies that families use?

c. What have families expressed in terms of challenges? Can you provide examples?

3. Can you tell me a bit about the strategies and approaches that are used to promote language development and prevent problems in children at LMB?

a. What is your role, as well as the role of the other members of the team towards this effort?

b. What strategies are used to promote early-language development among families with language barriers (i.e., who do not speak English and French or have limited ability in these languages)?

c. How do cultural beliefs, values and preferences regarding child-rearing get considered and addressed when implementing strategies to promote language development?

d. Are there any other particular approaches that are used to promote language development among families coping with multiple challenges (isolation, mental health issues, immigration etc.), if so what strategies are used?

e. Overall, which strategies do families favor and respond positively to? What is it about these strategies that families like?

f. Which strategies and approaches do families seem less open to? What is it about these strategies and approaches that families don't like?

g. Based on what you have observed and heard from families, are there other strategies or approaches that you think could be implemented to further promote healthy language development among the families at LMB? If so, can you elaborate on these?

4. Thinking more broadly now about your care interactions with families,...

    a. How do you build trust and try to create an environment where families don't feel judged or stigmatized, especially with respect to their parenting capacities?
    b. What indicators help you to know whether your interventions are acceptable to families? How do you know what you're doing is ok with families?
    c. How do you cope and react when confronted with cultural values and practices and/or worldviews that are different from your own?

Do you have any other comments or questions that you would like to share? I will stop recording now.
If I need to clarify anything, may I contact you again?

Thank you very much for taking the time to meet with me and for answering my questions.

Appendix D: 15-Point Checklist of Criteria for Good Thematic Analysis Process (Braun and Clarke, 2006)

Transcription	1.	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2.	Each data item has been given equal attention in the coding process.
	3.	Themes have not been generated from a few vivid examples (an anecdotal approach) but, instead, the coding process has been thorough, inclusive and comprehensive.
	4.	All relevant extracts for all each theme have been collated.
	5.	Themes have been checked against each other and back to the original data set.
	6.	Themes are internally coherent, consistent, and distinctive.
Analysis	7.	Data have been analyzed rather than just paraphrased or described.
	8.	Analysis and data match each other – the extracts illustrate the analytic claims.
	9.	Analysis tells a convincing and well-organized story about the data and topics.
	10.	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11.	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over lightly.
Written report	12.	The assumptions about Thematic Analysis are clearly explicated.

	13.	There is a good fit between what you claim you do, and what you show you have done – i.e. described method and reported analysis are consistent.
	14.	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15.	The researcher is positioned as active in the research process; themes do not just ‘emerge’.

Appendix E: CIUSSS Ethical Committee Approval

Centre intégré universitaire de santé et de services sociaux du Centre-Ouest-de-l'Île-de-Montréal

Québec

2022-12-01

Dr. Lisa Merry
c/o: Lisa Merry
email: lisa.merry@umontreal.ca

Object: Project 2023-3494 - Final Research ethics committee Approval of the Project Following Conditional Approval
Promoting Healthy Early Childhood Language Development in Families at La Maison Bleue

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Dear Dr. Merry,

The Psychosocial Research Ethics Committee (REC) of CIUSSS West-Central Montreal Research Ethics Board (REB), is pleased to inform you that the above-mentioned study received ethics approval.

A delegated review of the research project was provided by member(s) of the Psychosocial REC. The responses and revisions submitted via an F20 form were reviewed and approved by the Chair on 2022-12-01.

The following documents are granted final ethics approval by the Psychosocial REC:

- Initial Submission Form (F11P-31783)
- REC Conditions & PI Responses Form(s) (F20-33070)
- - External science review (Meghry Kevork_Formulaire_Approb_Scient_Proj_CIUSSS.pdf)
  - ICF approved by the REC (Formulaire de consentement_CleanCopy_5 Nov.docx)
  - ICF approved by the REC (Meghry Kevork_Consent Form_Eng_3 NOV.docx)
  - Document(s) approved by the REC (Meghry_Protocol_CleanCopy_3 Nov.docx)
  - Document(s) approved by the REC (Meghry_Kevork_ Guide d'entretien_FR_CIUSSS.docx)
  - Document(s) approved by the REC (Meghry_Kevork_Interview guide_EN_CIUSSS.docx)
  - Document(s) approved by the REC (Meghry_Questionnaire SD_french_CIUSSS.docx)
  - Document(s) approved by the REC (Meghry_Recruitment_Message_CleanCopy_Nov 3.docx)
  - Document(s) approved by the REC (Meghry_Sociodemographic questionnaire_CIUSSS.docx)

The responses and revisions will be reported to the Psychosocial REC and will be entered accordingly into the minutes of the next meeting, to be held on 2022-12-16.

The Psychosocial REC of CIUSSS West-Central Montreal REB recognizes peer review from the Nursing Department at Université de Montréal as a scientific approval.

The ethics approval is valid until 2023-12-01.

The Research Ethics Board of the CIUSSS West-Central Montreal Board (Federalwide Assurance Number: 0796) is designated by the province (MSSS) and follows the published guidelines of the TCPS 2 - Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (2018), in compliance with the "Cadre de référence ministériel pour la recherche avec des participants humains" (MSSS, 2020), and the membership requirements for Research Ethics Board defined in Part C Division 5 of the Food and Drugs Regulations; and acts in conformity with standards outlined in the United States Code of Federal Regulations governing human subjects research, and functions in a manner consistent with internationally accepted principles of good clinical practice.

Duties of Researchers

Ethics approval may be withdrawn if the following stipulations are not met:

- To obtain prior written approval from the REB for any substantive modification to the research, including changes to the study procedures, financial arrangements, and/or resource utilization, before initiating the change; except where urgent action is required to eliminate an immediate hazard to a study participant;
- To maintain confidentially, the updated Research Participants Registry is to be retained for the length of time required by regulations, and institutional policy;
- To comply with all relevant regulations and guidelines governing the conduct of research involving human subjects and the requirements of the REB;
- To comply with all REB requests to report study information, including prompt reporting of unexpected or serious adverse events (SAEs) or alarming trends in expected SAEs, according to the policies and procedures of each institution where the study is conducted;
- To advise the REB and all study subjects of new significant findings emerging during the study;
- To comply with quality assurance assessment as defined by each institution's policy;
- To maintain study records according to regulatory requirements.

Expiry and renewal – All research involving human participants requires review at recurring intervals. To comply with the regulation for continuing review at least once per year, it is the responsibility of the investigator to submit an Annual Renewal Submission Form (F9H) to the REB before expiry. **The annual renewal form**, which will be available to you approximately 60 days before the expiry date of this letter, **is expected to be completed and submitted 30 days before expiry**. Please note that if the protocol approval expires before its renewal is granted, the ethics approval will be suspended and the data collected after the expiration date may not be considered valid. However, should the research conclude for any reason before approval expiry, you are required to submit a Completion (End of a Study) Report (F10H) to the REB once the data analysis is complete to give an account of the study findings and publication status.

Furthermore, should any revision to the project or other developments occur before the next continuing review, you must advise the REB without delay, by submitting an amendment form to the committee. The regulation does not permit the initiation of a proposed study modification before its approval by the REB.

Please note that the CIUSSS WCM *Quality Assurance Program* aims to support 10% of active research in our institution. To promote best practices in research ethics, our team may contact you to schedule an on-site visit during the study.

In closing, please note that you can only start your project after having obtained all the required approvals: scientific, ethical, and feasibility, as well as the letter of authorization to carry out the research within the CIUSSS West-Central-Montreal, signed by the mandated person of the Institution.

Respectfully,

Signé le 2022-12-01 à 14:51

Appendix F: Université de Montréal Ethical Committee Approval

Comité d'éthique de la recherche
en sciences et en santé (CERSES)

Bureau de la conduite
responsable en recherche

Université de Montréal

22 décembre 2022

Lisa Merry
Professeure agrégée
Faculté des sciences infirmières

Meghry Kevork
Candidate à la maîtrise

OBJET :	Projet # 2022-1742 - Approbation éthique du projet tel que soumis Promouvoir le développement sain du langage pendant la petite enfance dans les familles à La Maison Bleue Financement : FRQS- Suvention d'établissement de jeune chercheur

Bonjour,

Le Comité d'éthique de la recherche en sciences et en santé (CERSES) de l'Université de Montréal a évalué votre projet de recherche, jugé à risque minimal, en comité restreint. Les documents suivants ont été examinés :

- Formulaire de demande d'évaluation d'un projet de recherche dûment complété signé et daté (formulaire F11)
- Documents
  - Approbation scientifique - PJ (Eval_scien_2022-08-29.pdf)
  - Approbation éthique (autre CER) - PJ (Appro_finale_CER_CIUSSS_2022-10-09.pdf)
  - Approbation éthique (autre CER) - PJ (Appro_finale_CER_CIUSSS_2022-12-01.pdf)
  - Autorisation - PJ (Auto_LMB_2022-09-09 .pdf)
  - Autorisation - PJ (Auto_CIUSSS_2022-10-24.pdf)
  - Protocole de recherche - PJ (Protocole_2022-11-03.docx)
  - Recrutement - PJ (Courriel_recrutement_2022-11-03.docx)
  - Collecte - PJ (Guide_entrevue_2022-08-30.docx)
  - Collecte - PJ (Interview_Guide_2022-08-30.docx)
  - Collecte - PJ (Questionnaire_sociodemographic_ 2022-08-30.docx)
  - Collecte - PJ (Questionnaire_sociodemographique_2022-08-30.docx)
  - Consentement - PJ (ICF_adult participant_2022-11-03.docx)
  - Consentement - PJ (FIC_majeur apte_2022-11-03.docx)
  - Entente - PJ (Meghry Kevork_lettre d'appui - 2022-09-09 .pdf)
  - Fichier (Annexe_COVID-19_2022-12-13.pdf)

J'ai le plaisir de vous informer que votre projet de recherche a été approuvé tel que soumis, à l'unanimité par le Comité.

Toutefois, nous vous demandons d'effectuer les modifications mineures suivantes avant d'utiliser les documents visés:

- Dans le courriel de recrutement, remplacer le mot *anonyme* par le mot *confidentielle,* la collecte de

données ne se faisant pas de manière anonyme, vous connaitrez l'identité des participants.
- Dans le formulaire d'information et de consentement, merci de retirer l'adresse du site web du CERSES, elle n'est plus valide.

Cette approbation éthique est valide pour un an, à compter du 22 décembre 2022 jusqu'au 22 décembre 2023. Il est de votre responsabilité de compléter le formulaire de renouvellement (formulaire F9) que nous vous ferons parvenir annuellement via Nagano 1 mois avant l'échéance de votre approbation, à défaut de quoi l'approbation éthique délivrée par le CERSES sera suspendue.

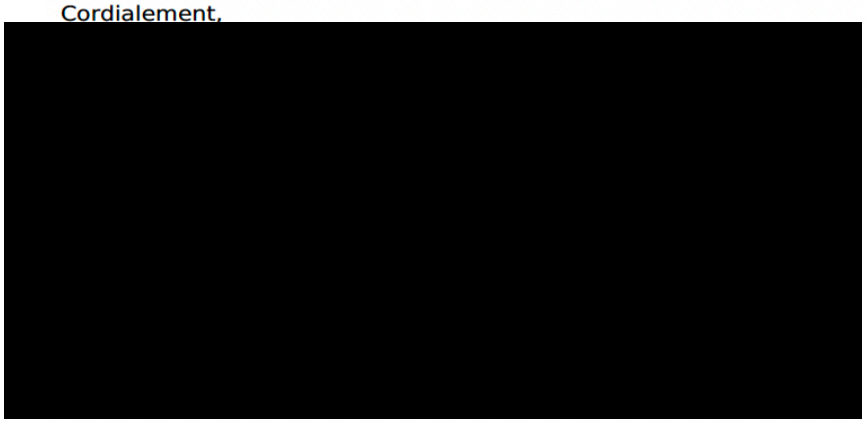
Dans le cadre du suivi éthique continu, le Comité vous demande de vous conformer aux exigences suivantes en utilisant les formulaires Nagano prévus à cet effet :

- Soumettre, pour approbation préalable, toute demande de **modification** au projet de recherche ou à tout autre document approuvé par le Comité pour la réalisation du projet (formulaire F1).
- Soumettre, dès que cela est porté à votre connaissance, toutes **informations supplémentaires, nouveau renseignement et/ou correspondances diverses** (formulaire F2).
- Soumettre, dès que cela est porté à votre connaissance, tout **incident ou accident** lié à la réalisation du projet de recherche (formulaire F5).
- Soumettre, dès que cela est porté à votre connaissance, l'**interruption prématurée** du projet de recherche, qu'elle soit temporaire ou permanente (formulaire F6).
- Soumettre, dès que cela est porté à votre connaissance, toute **déviation** au projet de recherche susceptible de remettre en cause le caractère éthique du projet (formulaire F8).
- Soumettre une demande de **renouvellement** un mois avant l'échéance de la date d'approbation afin de renouveler l'approbation éthique (formulaire F9).
- Soumettre le rapport de la **fin du projet de recherche** (formulaire F10).

Nous vous rappelons que la présente décision vaut pour une année et peut être suspendue ou révoquée en cas de non-respect de ces exigences.

Le CERSES de l'Université de Montréal est désigné par le ministre de la Santé et des Services Sociaux aux fins de l'application de l'article 21 du Code civil du Québec. Il exerce ses activités en conformité avec la *Politique sur la recherche avec des êtres humains* (60.1) de l'Université de Montréal ainsi que l'Énoncé de politique des trois conseils (EPTC). Il suit également les normes et règlements applicables au Québec et au Canada.

Cordialement,



Signé le 2022-12-22 à 11:36