KIT
Community speech language pathology and the collaborative continuum of services

2nd edition

Volume 3

Implementation guide

Toolbox

Theoretical and experimental framework

Groupe de Travail Montérégien
Orthophonie et développement du langage

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It is important to note that this document was created by the GTM-ODL in a French-speaking context. Some information may therefore not be fully adapted to the situation of English speaking children and their families.

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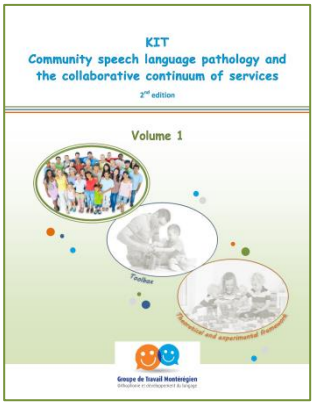
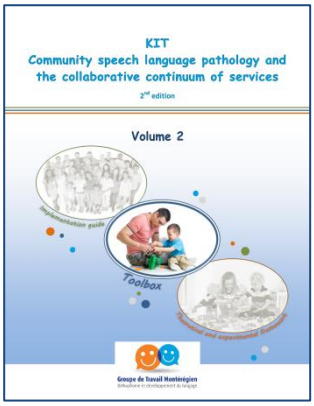
Contents of the three volumes of the Kit

The ***Kit - Community speech-language pathology and the continuum of collaborative services*** consists of three separate but complementary volumes.



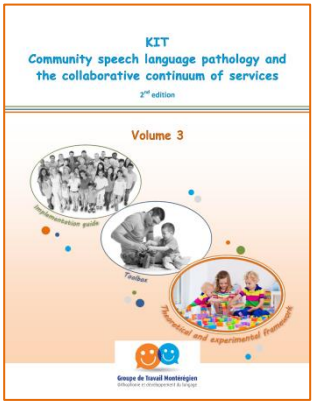
Implementation guide

Volume 1 of the Kit is an introduction to the overall approach to implementing the continuum of collaborative community speech-language pathology services. It provides the bases for understanding the concept and its various elements. It also outlines the conditions for successfully implementing the continuum in a new environment, including a proposed set of steps to follow.



Toolbox

Volume 2 outlines the useful information for the effective implementation of the continuum of collaborative community speech-language pathology services. It contains the tools needed to identify the service offering and to position it relative to the cross-cutting principles of the continuum. It also includes tools needed to design and propose the activities identified as essential to the optimal development of communication and language in young children.



Theoretical and experimental framework

Volume 3 covers the theoretical and experimental aspects of the continuum of collaborative community speech-language pathology services. It presents the data and information used to develop the concept of community speech-language pathology, which is applied through the proposed continuum of collaborative services. It also provides a broad description of the test period itself, namely the methodology surrounding the three showcase projects, and the general results of the assessment.

Editorial notes

- The images and drawings used represent all types of families and individuals, without discrimination.
- The terms *referral* and *refer* are used in the health and social services sector to mean the action of a healthcare professional requesting specialized services.

List of acronyms

AI	Appreciative inquiry
AQOA	Association québécoise des orthophonistes et audiologistes
ASD	Autism spectrum disorder
ASHA	American Speech-Language-Hearing Association
CISSS	Centre intégré de santé et de services sociaux (integrated health and social services centre)
CLSC	Centre local de services communautaires (local community services centre)
CPE	Centre de la petite enfance (childcare centre)
DLD	Developmental Language Disorder
GTM-ODL	Groupe de travail montérégien – Orthophonie et développement du langage
ID	Intellectual disability
IP	Intervention plan
MC	Montérégie-Centre
ME	Montérégie-Est
MEES	Ministère de l'Éducation et de l'Enseignement supérieur
MFA	Ministère de la Famille
MO	Montérégie-Ouest
MSSS	Ministère de la Santé et des Services sociaux
OOAQ	Ordre des orthophonistes et audiologistes du Québec
RCM	Regional county municipality
SGE	Services de garde éducatifs à la petite enfance (educational childcare services)
SIPPE	Services intégrés en périnatalité et pour la petite enfance (integrated prenatal and early childhood services)
TCPE	Table de concertation en petite enfance (early childhood advisory panel)

N.B.: This list is common to all three volumes of the Kit.

List of symbols

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References

N.B.: This list is common to all three volumes of the Kit.

Acknowledgements and contributors

The GTM-ODL wishes to thank everyone who participated, directly or indirectly, in the discussions leading to the creation of this document, in particular the representatives and members of the various early childhood advisory panels in the Montérégie region, as well as the representatives of the panels that are no longer located in the Montérégie, namely the Table petite enfance de la Haute-Yamaska and the Table périnatalité, enfance, famille de Brome-Missisquoi.

Member advisory panels of the GTM-ODL

- Table de concertation 0-5 ans du territoire du CLSC du Richelieu
- Table de concertation CONPARLE FAMILLE du territoire Samuel-de-Champlain
- Table de concertation de la petite enfance et des personnes démunies de la Vallée des Patriotes
- Comité intersectoriel de la petite enfance de la MRC des Maskoutains
- Table de concertation en périnatalité et petite enfance du Haut-Richelieu
- Table d'Actions Concertées 0-5 Beauharnois-Salaberry (TAC 0-5)
- Table enfance famille des Seigneuries
- Table de concertation intersectorielle Petite Enfance – Famille 0-5 ans de la MRC d'Acton
- Table petite enfance Kateri
- Table de concertation petite enfance de la région de Châteauguay
- Réseau 0-5 Haut-Saint-Laurent
- Table de concertation Petite Enfance Périnatalité Jardin du Québec
- Table des Partenaires Petite Enfance de Saint-Hubert
- Table intersectorielle enfance-famille de la MRC de Pierre-De Saurel – Voir Grand pour nos petits
- Table de concertation Petite Enfance Vaudreuil-Soulanges

Foreword

The Groupe de travail montérégien – Orthophonie et développement du langage (GTM-ODL) is the product of the mobilization of most of the early childhood advisory panels in the Montérégie region. Their representatives come from community organizations working in field of early childhood, childcare centres, and integrated health and social services centres (CISSS). Other partners have joined the GTM-ODL over time, including municipalities, school service centres, etc.

In 2011, the GTM-ODL set its initial objectives:

- **Promote the development of prevention and early intervention services** in the area of language development, namely speech-language pathology services in CLSCs, for children aged 0-5;
- **Build a network** of multiple partners;
- **Raise awareness for the difficulties** experienced by young children in Montérégie region in terms of communication and language development;
- **Document the issue of communication and language development** in children aged 0-5, **the service organization modalities**, and the **relevant tools** and **initiatives in the community**;
- **Ensure the delivery and sustainability** of communication and language development services.

Phase I – Establishing theoretical and practical knowledge

In 2011, the GTM-ODL produced a summary portrait, per local community service centre (CLSC) territory, of prevention, promotion, and intervention services available for children aged 0-5. This portrait highlighted the shortage of public communication and language stimulation resources available. This was especially the case with access to early childhood speech-language pathology services. At the same time, the members of the GTM-ODL began identifying the prevention and early intervention tools already available in the Montérégie and elsewhere in Québec.

In 2015, in order to continue its work and analysis process, the GTM-ODL decided to submit an action research project to *Avenir d'enfants*. The main and ultimate objective of this project is to **improve access to language development services** throughout the Montérégie region. This project is intended to be a catalyst for the GTM-ODL and for all stakeholders in the Montérégie region. It will help to develop an understanding of and common language surrounding a preventive, early, and adapted approach to communication and language development in children aged 0-5 and their parents.

The Kit 1.0 has never been translated into English.

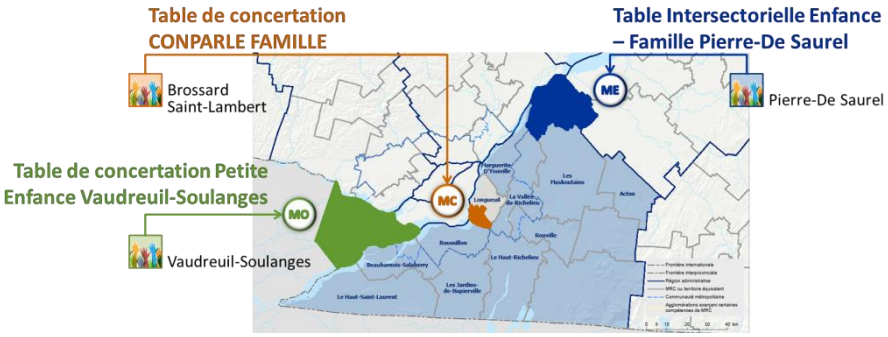
The GTM-ODL has defined the key elements of a continuum of collaborative community speech-language pathology services for communication and language development in young children. It also proposes tools for implementing this continuum on a given territory, as well as activities that can be developed or enhanced in

relation to the continuum. The ***Kit 1.0 – Community speech-language pathology and the continuum of collaborative services*** was published in 2017 as five modules:

- User guide;
- Continuum of collaborative community speech-language pathology services;
- Cross-cutting principles;
- Implementation tools;
- Concept of community speech-language pathology – theoretical and practical framework.

Phase II– Testing and implementing the continuum

Three showcase projects were begun in September 2017, to test the continuum of collaborative community speech-language pathology services developed by the GTM-ODL. These showcase projects are being carried out on separate territories covered by each of the three CISSS de la Montérégie and are being overseen by an early childhood advisory panel that serves a community on a given territory.



The continuum will be tested and its implementation evaluated over a period of two years. This will help to better mobilize early childhood stakeholders on the territories concerned and to produce the improved, enriched, and more hands-on version of the Kit. The **Kit 2.0 – *Community speech-language pathology and the continuum of collaborative service*** is now available in three separate, but complementary volumes.

What is it?

In concrete terms, the **continuum of collaborative community speech-language pathology services** is a preventive, early, and adapted approach to ensuring optimal communication and language development in children aged 0-5. This innovative approach is centred on children and their parents. It requires the participation of a large number of stakeholders with influence in the field of early childhood: the health and social services network (managers, early childhood intervention workers, speech-language pathologists, community organizers, etc.), community organizations, childcare services, municipalities (libraries and other municipal public services), early childhood advisory panels, and schools and service centres.

Theoretical and practical framework

Introduction

Language development is an extremely broad topic that concerns anyone who interacts with children. The way in which children express themselves often raises questions, whether in parents, daycare educators, speech-language pathologists in the public sector, or organizers of community activities at a family home, for example.

The objective of the **Groupe de travail montérégien – Orthophonie et développement du langage (GTM-ODL)**[1] was to achieve a common understanding on the topic of speech-language pathology and language development, formalized in a theoretical framework. Initially, this document took the form of a glossary of common terms in the area of communication and language development and speech-language pathology (see the Glossary section of this document).

Once the glossary was developed (which was added to throughout the drafting of this document), several questions were raised by the members of the GTM-ODL committees on the topic of communication and language development and speech-language pathology. On the one hand, they expressed an interest in knowing the most recent scientific data on the various aspects of this topic. In response to these questions, a graph was created to illustrate the spheres of child development and the interactions between them (Section 2.1.1), and literature reviews were done on the following topics: communication and language development in young children (Chapter 2) and evidence-based practices associated with communication and language development (Chapter 3), including the teaching of language stimulation techniques (Section 3.2), stimulation tools and techniques (Section 3.3), and best practices associated with speech-language pathology assessment and intervention (Section 3.4).

On the other hand, the members of the GTM-ODL committees examined the actions taken to promote adequate language development and to prevent language difficulties and disorders. It was important to identify effective practices in this field so as to contribute to the development of language and communication and to the prevention of communication difficulties. To that end, reports on Québec-based and international initiatives, as well as scientific studies, were consulted to identify the most effective promotion and prevention methods. These methods were then improved with input from the members of the GTM-ODL committee of experts, ultimately taking the shape of evidence-based recommendations available on several topics. These recommendations touch on the aspects of the literature considered to be the most important. The recommendations were formulated according to an evidence-based approach, based on the clinical and practical experience of the committee members, data from the scientific literature, and the needs of the families concerned (Chapter 3).

In tandem with these approaches, the GTM-ODL focused on developing a multi-network continuum of communication and language development and speech-language pathology services. This work was done in conjunction with the various committees of the GTM-ODL, based on a desire for cohesion between the service networks on the same territory (Foreword). The committee members felt it was essential that certain practices and attitudes be present and reflected throughout the continuum. Essential and cross-cutting principles applicable to all initiatives related to communication and language development and speech-language pathology were therefore identified, and recommendations for applying these principles, drawn mainly from the members' experience, were made (Section 1.2).

The completion of this lengthy project has resulted in the development of the concept of community speech-language pathology, which reflects the GTM-

[1] The **GTM-ODL** encompasses the vast majority of the early childhood advisory panels in the Montérégie region. The representatives of these advisory panels come from community organizations working in the field of early childhood, childcare centres, and integrated health and social services centres (CISSS), and are mainly community organizers.

ODL's objective of promoting language development for all children and the prevention of language difficulties and disorders. The concept of community speech-language pathology was developed in collaboration, based on an evidence-based approach (Section 1.1). As such, it takes the form of a definition, but also a theoretical and practical framework. In reality, it is manifested as a continuum of collaborative community speech-language pathology services.

In summary, this section, entitled "The concept of community speech-language pathology: Theoretical and practical framework – Toward a continuum of collaborative early childhood communication and language development services," is divided into three chapters. The first chapter presents the concept of community speech-language pathology and the cross-cutting principles essential to the establishment of a continuum of collaborative community speech-language pathology services. The second chapter presents the information obtained from a literature review on communication and language development in early childhood and the associated risk and protection factors. The third chapter outlines the best practices related to communication and language development. This theoretical and practical framework contains evidence-based recommendations for intervention workers, stakeholders, and partners involved in child development who wish to implement a continuum of collaborative community speech-language pathology services. Finally, a glossary of common terms in communication and language development and speech-language pathology appears at the end of this volume.

This section is intended primarily for educators, intervention workers, managers, speech-language pathologists, and other partners who wish to embark on a process of establishing a continuum of community speech-language pathology services, not only in the Montérégie region, but throughout Québec. It is based on all of the research work described above, as well as the expertise of the members of the GTM-ODL. It is intended to meet the needs of young children in the Montérégie region in terms of support for communication and language development and access to speech-language pathology services.

It is important to consider this theoretical and practical framework as the first version. More specifically, the limited time frame explains why certain aspects of both the theoretical foundations and the expert consultations could not be explored in more detail. However, this second version is based on sound, recognized principles, on the experience of early childhood workers, and on recent scientific data (bibliography and references), making it both reliable and practical. Nevertheless, it is important to know that certain aspects of the theoretical and practical framework associated with the concept of community speech-language pathology could be explored and explained in more detail, as needed. Moreover, the implementation of the continuum of collaborative community speech-language pathology services will reveal both its strengths and its weaknesses. Once the early childhood stakeholders on a given territory begin using the continuum, the improvements they make will result in a better, more useful version. As such, the objective of this section is to provide all intervention workers and early childhood professionals with a concrete way of channelling their actions into an evidence-based practice.

1. Concept of community speech-language pathology

1.1. Integrated, foundational concept of community speech-language pathology

The desire to promote good communication and language development in young children, to prevent the appearance of communication and language difficulties, and to improve access to public speech-language pathology services raised a central question about the complementary roles of speech-language pathologists, early childhood intervention workers, and early childhood stakeholders.

In fact, prevention in this area is largely assured by early childhood intervention workers and stakeholders, who play a complementary role to the speech-language pathologist, whether through raising parents' awareness by using language stimulation tools, organizing and leading parent meetings about language development, or leading parent-child dyad workshops. Like the speech-language pathologist, their main focus is to prevent language development difficulties. There was a need to combine the acts restricted to the speech-language pathologist with the work done by the early childhood stakeholders.

A second reflection was required on the role of the public-sector speech-language pathologist in promotion and prevention activities. Currently, it is clear that speech-language pathology services have developed differently in the Montérégie region. Several territories have limited or no access to speech-language pathology services, and few speech-language pathologists in the public sector are involved in the development and implementation of promotion and prevention activities.

DEFINITION OF THE CONCEPT

The **concept of community speech-language pathology**, defined by the Groupe de travail montérégien – Orthophonie et développement du langage (GTM-ODL), is based on the establishment of a continuum of promotion, prevention, and intervention services, which is based on concrete evidence obtained from the public-sector speech-language pathologist's expert knowledge and the experience of all intervention workers and stakeholders on a given territory. The purpose of this continuum is to support the development of communication and language in young children. It requires the ongoing mobilization of territory stakeholders and the reduction of access barriers to the activities and interventions in the continuum. Children and parents are the main focus of the actions in the continuum of collaborative community speech-language pathology services.

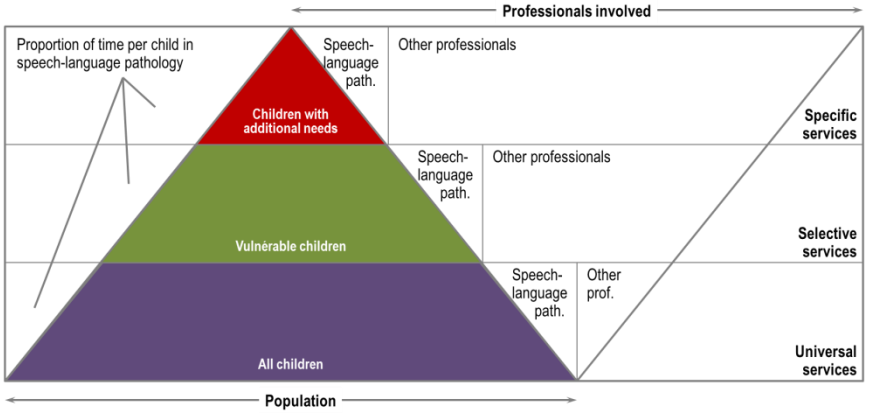
As such, any intervention worker, educator, or manager in the community, childcare, and public (health, education, municipal) sectors who channels their actions and structures their services in collaboration with the public-sector speech-language pathologists, based on the best practices recommended by the continuum of collaborative community speech-language pathology services, participates in the continuum and supports communication and language development. According to the definition of their reserved acts, the speech-language pathologist is responsible for all speech-language pathology services described in this continuum.

This definition of the concept of community speech-language pathology was ratified by the Ordre des orthophonistes et audiologistes du Québec (OOAQ) in 2017.

The GTM-ODL therefore developed and defined the concept of community speech-language pathology by integrating and combining the complementary roles of speech-language pathologists and early childhood stakeholders.

The concept of community speech-language pathology is a promising one because of its integrated approach that combines the work done by early childhood stakeholders and intervention workers with the reserved acts of speech-language pathologists. The concept of community speech-language pathology is based on the establishment of a continuum of collaborative community speech-language pathology services. This continuum is innovative, because it combines intervention models in the field of child development and integrates the definition of prevention from the healthcare field.

On the one hand, the continuum of collaborative community speech-language pathology services is based on an integrated service model for children and relies on universal, selective, and specific measures. This model has been discussed and applied in the Quebec City area (*Organisation des services de première ligne en déficience du langage et de la parole destinés aux enfants de la région de Québec*, Régie régionale de la santé et des services sociaux de Québec, 1998) and in the United Kingdom by the Royal College of Speech and Language Therapists (Gascoigne 2006). It enables all children to access universal services (measures) and children with more pressing needs to also access selective and specific measures.

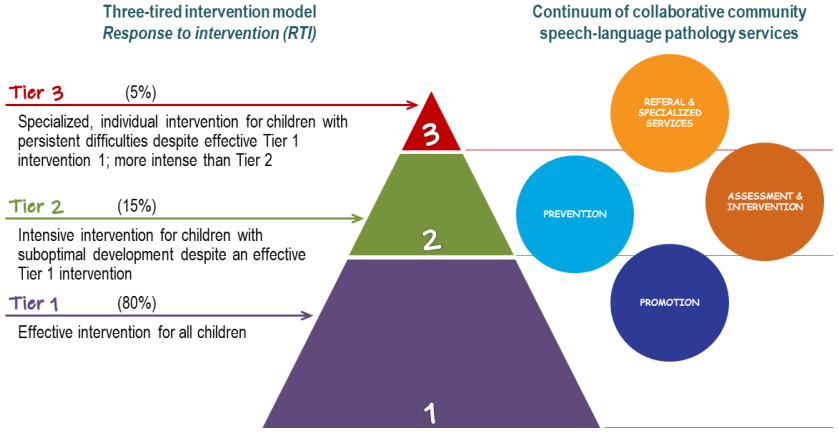


Integrated service model (adapted from Gascoigne, 2006)

On the other hand, the continuum of collaborative community speech-language pathology services is also based on a response to intervention (RTI) approach (typically used in the field of academic success), based on prevention measures. As described in *Réunir Réussir* (2013), the RTI approach is defined by three intervention types: universal, targeted, and intensive:

> *« In theory, these universal programs meet the needs of approximately 80% of the target clientele. That means that roughly 15% of young people will receive more targeted interventions, at a higher level of frequency and intensity, leaving 5% of the clientele for whom intensive, often individualized and highly personalized programs and interventions will need to be implemented. »*

Note that the prevalence of children with a language disorder is 5-7%; these children correspond to Tier 3. This is compounded by the fact that, without Tier 1 interventions, the number of children in Tiers 2 and 3 would be much higher. In fact, when needs are not met in Tier 1, they trickle down to the two other intervention tiers.



Three-tiered intervention approach – *Response to intervention (RTI)*

Along with these two models, the definition of prevention from the healthcare field, as determined by the Association of Faculties of Medicine of Canada and by the American Speech-Language-Hearing Association (ASHA), was also integrated. Primary prevention is aimed at reducing the incidence of language difficulties; secondary prevention is aimed at decreasing the negative effects associated with language difficulties (through optimal language stimulation and early intervention); and tertiary prevention is aimed at helping children with language difficulties or a language disorder (through the implementation of an adapted intervention plan and specialized speech-language rehabilitation services) (ASHA 2008).

Following an examination of these models and definitions, and given the reality in Québec[2], the continuum of collaborative community speech-language pathology services was developed to include four intervention types, ranging from promotion and prevention (1 and 2) to specialized services (4):

Intervention types

1 – **Promotion**
2 – **Prevention**
3 – **Assessment and intervention**
4 – **Referral to specialized services**

Intervention type 1 – *Promotion* is aimed at all children aged 0-5 and their parents, whereas intervention type 2 – *Prevention* is aimed at children with or at risk of developing language difficulties. Intervention type 3 – *Assessment and intervention* is aimed at children who require a speech-language pathology assessment, which will allow them to

[2] The reality in Québec, mentioned here, refers to the mandate of public sector speech-language pathologists, which changes depending on the institution where they work, and could be intervention type 3 – *Assessment and intervention* or 4 – *Referral and specialized services*, which correspond to separate mandates for speech-language pathology.

access a specific short-term intervention. However, some children will need a referral to specialized rehabilitation services (intervention type 4 – *Referral to specialized services*). This manner of organizing the complementary roles and mandates of early childhood stakeholders and speech-language pathologists—into four intervention types—ensures an ideal, effective continuum of prevention and intervention services in speech-language pathology.

Within the continuum of collaborative community speech-language pathology services, families can participate in an initial activity that meets their needs, without it necessarily being an intervention type 1 – *Promotion* activity. More specifically, the activities associated with each intervention type are not mutually exclusive and, unless otherwise indicated, they are not prerequisites to each other. Therefore, families can participate simultaneously in activities of each intervention type or participate in activities of previous intervention types. For example, the parents of a child with a possible language difficulty may have tried activities in dyads (intervention type 2 – *Prevention*) prior to receiving information during a *promotion* activity (type 1) and finally obtaining an assessment (type 3 – *Assessment and intervention*). Their child could also continue participating in *prevention* activities (type 2) while awaiting an assessment and, after the assessment, wait for an upcoming service. This structure offers the flexibility needed for a functional continuum of collaborative community speech-language pathology services.

1.2. Cross-cutting principles of the continuum of collaborative community speech-language pathology services

The cross-cutting principles reflect the philosophy of the continuum of collaborative community speech-language pathology services. They are the core principles that must guide the discussions and implementation of the continuum by the partners. They must apply to all four intervention types in order to respect the vision and objective of mobilization.

The GTM-ODL initially identified two cross-cutting principles:

- ensure the **mobilization of parents and partners** who play a role in or who influence the development of language in children;
- integrate the principles of **proportionate universalism** in order to reduce access barriers.

In testing the continuum, a need to review the cross-cutting principles arose. In fact, it was determined that the continuum of collaborative community speech-language pathology services is instead based on three cross-cutting principles:

- Community mobilization
- Proportionate universalism
- Parent approach

Community mobilization

Mobilization is the cross-cutting principle that should be considered the cornerstone of the continuum of collaborative community speech-language pathology services. Without mobilization, the continuum would not exist and would be nothing but a series of services based on good practices, with no links, continuity, or coherence between them.

The continuum of collaborative services implies an intersectoral mobilization of the stakeholders involved in the four intervention types (promotion, prevention, assessment and intervention, and referral and specialized services). Mobilization presumes that the stakeholders understand each other, consult with each other, and above all, recognize each other for their respective expertise. This is what enables them to work together to achieve common goals. The fact of having a shared vision and of working in partnerships ensures that things run smoothly within the continuum of collaborative services.

For example, the foundation of the continuum is the ability of the speech-language pathology intervention sector and the community promotion and prevention stakeholders to coordinate their services. This is a challenge that requires the ability to recognize mutual

expertise and to break out of silos in order to truly work together, while respecting the services restricted to certain stakeholders.

Below, the GTM-ODL presents a definition of the concept of mobilization, its added value, and the good practices for ensuring its success. The objective is to equip communities wishing to implement the continuum of collaborative community speech-language pathology services with the means of developing mobilization on their territories and with self-assessment tools.

1. Definition of concepts

The concept of community speech-language pathology and the implementation of the continuum of collaborative services are based on community mobilization. The concept implies a collective, and therefore collaborative, effort to support families living on the territory who have children aged 0-5 with their children's communication skills.

The term *mobilization* can be understood to mean two things: the actual movement of a thing (non-linear, non-mechanical, organic) or the reason or **motivation** for the movement. Mobilization therefore refers to the notion of movement from the perspective of an intentional acting together.

Given ths dual perspective, mobilization implies setting stakeholders in motion in the aim of achieving change (excerpt from www.communagir.org).

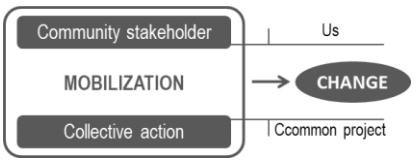


Illustration of the concept of mobilization [Communagir]

Another definition states that that:

> *"Mobilization, in the broader sense, is the action of setting forces (resources) in motion, of rallying them and bringing them together for a common purpose. Fundamentally, the process of mobilizing a local community is defined as an ongoing process rallying several partners (…) around social issues that they will have identified together. The aim of this approach is to collectively develop strategies focused on improving citizens' quality of life. In other words, the process of mobilization is in itself a strategy for developing local communities, through which all stakeholders concerned are encouraged to become agents of change."*
>
> [Grandchamp, Harris and Poitras, 2003]

Inform	Consult	Involve	Collaborate	Empower
• Light community involvement • Circulation of information from one individual to the next • Information provided to the community • Coexistence of entities ***Outcomes*** Establishes the communication channels needed for advocacy	• More community involvement • Circulation of information within the community, then bi-directionally, in search of answers • Information or comments gathered from the community • Information shared by the various entities ***Outcomes*** Develops connections	• Better community involvement • Bi-directional, participatory communications • Greater community involvement in issues • Cooperation between entities ***Outcomes*** Increases visibility for the partnership through increased cooperation	• Community involvement • Bi-directional communications • Creation of partnerships with the community on all aspects of the project, from development to solution • Creation of bi-directional communication channels by the entities ***Outcomes*** Creates partnerships and relationships of trust	• Close bi-directional relationship • Final decisions made as a community • Formation of strong partnerships by the entities ***Outcomes*** Makes health outcomes more encompassing since they affect the community as a whole, and creates a strong sense of mutual trust

Taken from CTSA (2011) p. 8, adapted from the *International Association for Public Participation*

From a general point of view, the definition of *mobilization* overlaps with that of several other terms, such as *collaboration* (see the glossary at the end of this volume). This is partially due to the fact that community mobilization can be seen as a continuum of community involvement, in the sense that the involvement and participation of individuals, as well as organizations, tends to deepen over time, as projects progress, as illustrated in the previous table.

Mobilization describes the phenomenon in broad terms, whereas elements such as collaboration or involvement refer more to states within the trajectory.

Mobilization in the context of collective action is complicated by the fact that it is the entities (organizations) that mobilize, whereas the individuals within these entities can have their own reasons or motivations. It is therefore an organizational phenomenon, but one that is quite often based on individual elements:

> *"Long-term development of activities and organizations will gradually draw in more and more people. It is therefore justifiable for strategy to focus primarily on groups, without ever forgetting to pay attention to the relationship between groups and individuals, and the opportunities for individuals to participate in their own right. Some people prefer to act individually, do not have access to the right kind of group or are restricted due to age, infirmity, or family responsibilities. Methods of consultation and involvement must allow for this. Nevertheless, on the whole it is the growth of group activity and networks which builds "social capital" and sustains long-term involvement by large numbers of people."*
>
> [Channan, 1999]

According to the summary definition of the concept, **mobilization**:

- is based on a motive or a purpose;
- progresses and evolves over time;
- represents a broader concept than collaboration or partnership;
- requires the involvement of both organizations and individuals;
- presupposes a collective movement.

2. Analysis model or framework

Understanding mobilization also requires having an analytical framework with which to identify expectations. A literature review yielded a model (Butterfoss, 2007) which we adapted into a diagram that identifies the targets of mobilization and its expected outcomes or evaluation criteria.

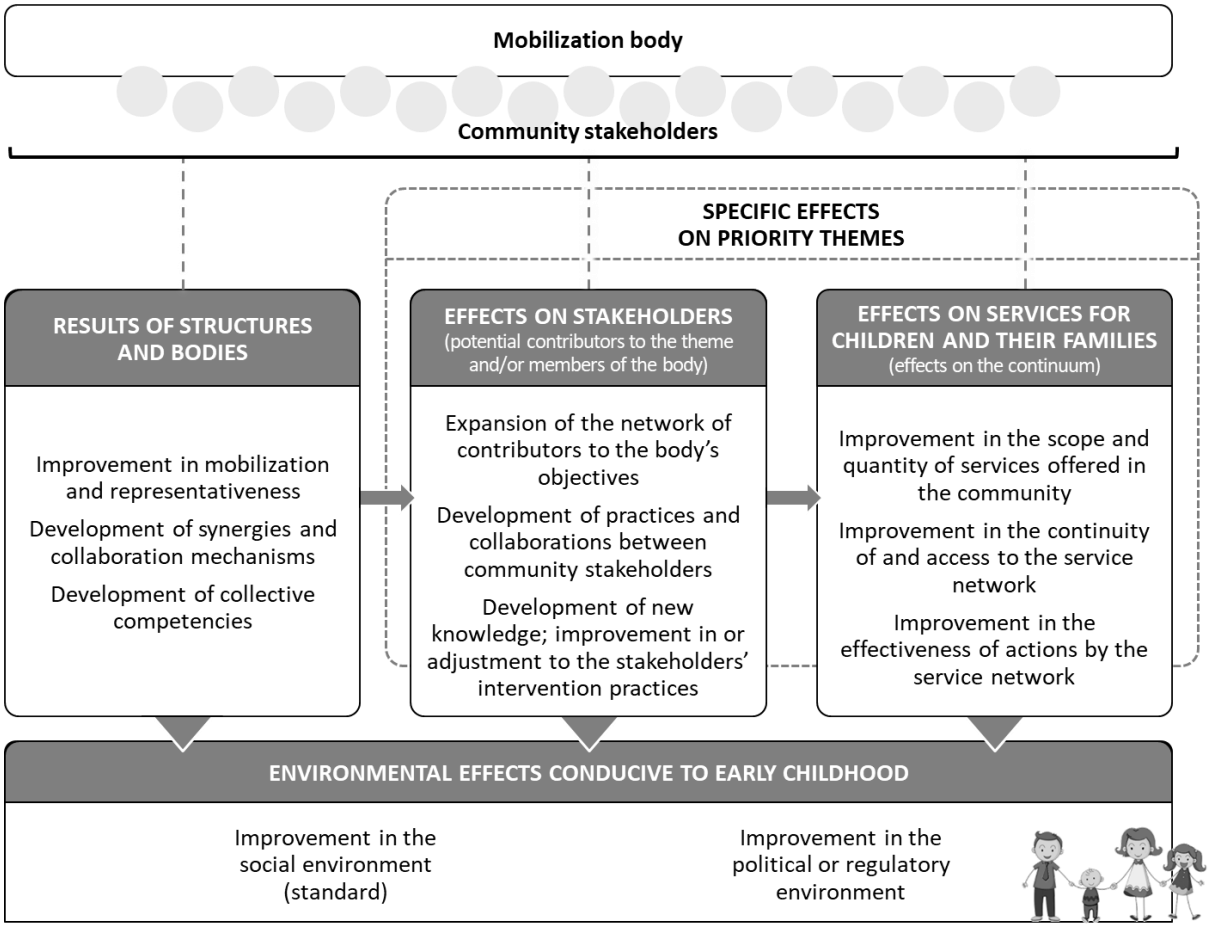
At first glance, the diagram allows us to identify the means to the ends: Mobilization requires a body (committee, panel, group, etc.) that brings together the relevant stakeholders and allows them to work together to organize the collective action within the community. Within this body are partners who work together to coordinate actions and approaches.

Subsequently, and contrary to interventions with clients, the targets of the mobilization are the community stakeholders who have the ability to influence the clienteles and environments that we are attempting to make as conducive as possible to the topic of interest.

In concrete terms, mobilization is therefore understood to be the capacity of a group of people belonging to a given body to rally a **broader** community around common objectives. This is done by:

- expanding the network of partners;
- strengthening ties between stakeholders;
- equipping agents of change;
- improving environments.

These changes (or proximal outcomes) have spinoffs on the service offer and, ultimately, on children and their families. The following diagram represents these elements:



Community mobilization analysis framework (inspired by Butterfoss, 2007)

3. Outcomes and spinoffs of public health mobilization

Improving population health requires a community-centred rather than person-centred healthcare system that is based on prevention. For the past 30 years, this has been the motivation for public health programs to increasingly turn to "*empowerment and community participation as major strategies for alleviating poverty and social exclusion and reducing health disparities […], in contrast the top-down strategies of the 1960s and 1970s*" (Wallerstein, 2006, p. 5). The literature reveals a great many typologies and definitions of terms, but few tools for measuring the added value of a collective action in a public health approach.

The Butterfoss model (2007) presented earlier indicates that the expected effects (and criteria for a successful mobilization) are as follows:

- A functional and diversified body that connects stakeholders by enabling them to focus a collective action on a common goal;
- Community stakeholders who are mobilized, connected, and better equipped to act;
- More objective-friendly environments.

This will result in a broader reach and services that are more effective, efficient, and relevant.

Empirically, according to a study by the *Victorian Health Promotion Foundation* (2003), the potential effects of mobilization are:

FOR INDIVIDUALS. Levels of participation, skills (leadership, problem-solving, negotiation), knowledge, values, empowerment, increased engagement with (or connection to) the community, and desired behavioural changes.

IN THE COMMUNITY. Changes in the makeup of membership, individuals' technical abilities and interpersonal skills (trust, communication), collective knowledge, planning and assessment skills, and resource management (financial or non-financial).

FOR THE ORGANIZATION AND SYSTEM. Changes in decision-making, organizational policies, resource allocation, partnerships, attitudes, and collective values.

Another literature review (taken and adapted from Moloughney, 2012) identified seven areas in which community mobilization made a positive impact:

1. **Agenda.** Mobilization changes the choice and focus of projects, how they are initiated, and their potential to obtain funding. New areas for collaboration are identified, and funding that requires community mobilization becomes accessible.
2. **Design and delivery.** Improvements to study design, tools, interventions, representation / participation, data collection and analysis, communication, and dissemination can be implemented. New interventions or previously unappreciated causal links can be identified through the community's knowledge of local circumstances. The speed and efficiency of the project can be enhanced by rapidly engaging partners and participants and identifying new sources of information.
3. **Implementation and change.** Improvements can be made in the way research findings are used to bring about change (e.g., through new or improved services, policy or funding changes, or transformation of professional practices), and capacity for change and the maintenance of long-term partnerships can be expanded.
4. **Ethics.** Mobilization creates opportunities to improve the consent process, identify ethical pitfalls, and create processes for resolving ethical problems when they arise.
5. **The public involved in the project.** The knowledge and skills of the public involved in the project can be enhanced, and their contributions can be recognized (possibly through financial rewards). These efforts foster goodwill and help lay the groundwork for subsequent collaborations.
6. **Academic partners.** Academic partners can gain enhanced understanding of the issue under study and appreciation of the role and value of community involvement, which sometimes result in direct career benefits. In addition, new insights into the relevance of a project and the various benefits to be gained from it can result in increased opportunities to disseminate its findings and their wider use.
7. **COMMUNITY ORGANIZATIONS.** These organizations can gain enhanced knowledge, a higher profile in the community, more linkages with other community members and entities, and new organizational capacity. These benefits can create goodwill and help lay the groundwork for subsequent collaborations.

Studies show that mobilization produces effects that lead to improved coordination of services, which then has more concrete effects on users, clients, and the public.

Successful mobilization is therefore mobilization that allows this to happen and that creates the conditions for success. Two aspects of these conditions for success are needed: create a functional body, and then trigger change in the community (put it into action and effect change on the environments).

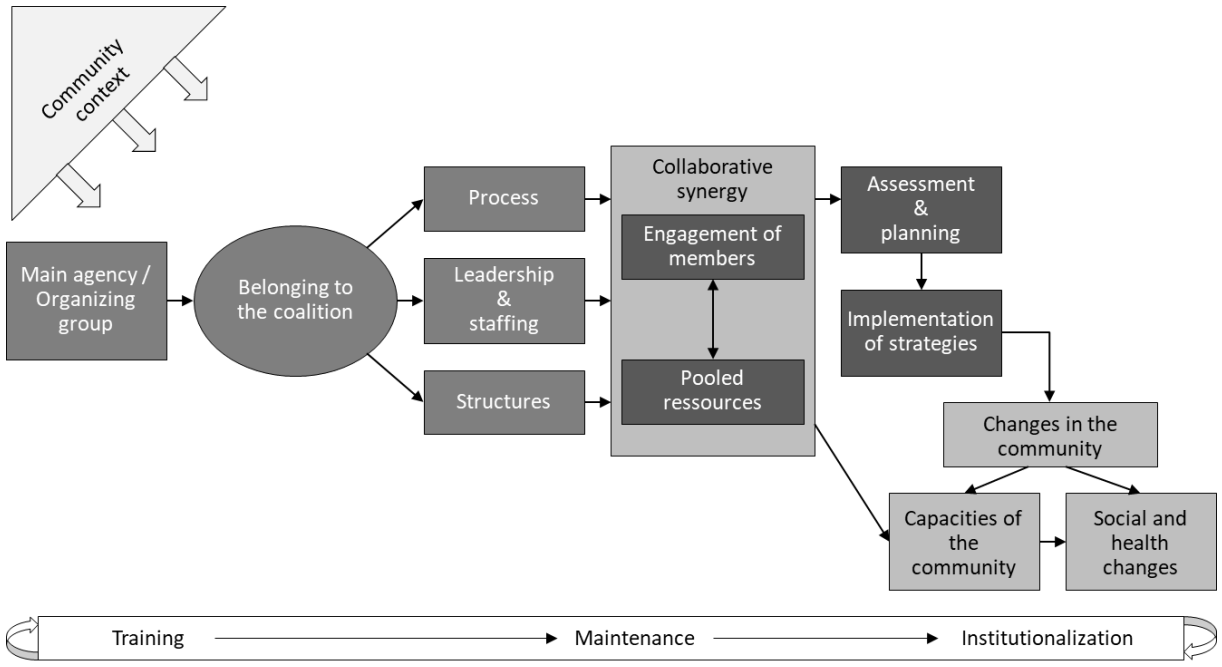
4. Means: creating a body that will mobilize the community

This section takes a closer look at Butterfoss's work, on which we based our expected effects of mobilization. Her model, combined with the collective impact model (2012), allows us to clearly identify the conditions and factors for success in terms of mobilization surrounding the specific theme of the continuum of collaborative services.

The Butterfoss model (2007 and 2012) illustrates the process leading to the creation of a coalition, which can then produce effects on the community. It attempts to synthesize and provide an overarching framework for what is known about coalitions from years of collective experiences. The theoretical underpinnings of the model stem from prior work in community development, participation and empowerment, interorganizational relationships, and social capital.

The stages of development of a coalition are as follows:

1. Response by an agency or group
2. Formation of a coalition (body) and recruiting of members
3. Development of coalition processes and structures, leadership, and human resources
4. Creation of synergies among members and pooling of resources
5. Planning and implementation of strategies aimed at achieving a common goal



Creation of a community coalition (based on Butterfoss, 2007)

The analysis framework presented earlier (page 19) is based on Butterfoss's theoretical model, although we developed the expected effects in more detail. We also postulated that coalitions, consultations, and bodies were not closed organizations, but rather tools for engaging community stakeholders. Given this, the expanded model presents other elements that need to be considered, including the body's ability to:

- expand the mobilization;
- form and strengthen ties between community stakeholders;
- equip and strengthen the ability of community stakeholders to act;
- make environments conducive.

Recommendations by the GTM-ODL

To encourage mobilization of territory partners who play a role in or who influence the development of language in children aged 0-5

- Identify the intervention territory where the continuum of collaborative community speech-language pathology services will be set up in order to establish a common, shared vision of the need for and usefulness of a continuum of collaborative community speech-language pathology services;
- In the intervention territory, identify institutions and organizations that will be involved in setting up the continuum of collaborative community speech-language pathology services: define their roles and responsibilities and the nature of their commitment;
  - ✔ Ensure the collaboration of managers from the healthcare network and from each participating organization, by identifying the nature of their collaboration and that of their team members and by formalizing each partnership.
- Determine the nature of existing mobilizations of partners and professional committees (advisory panels, project-related committees, etc.) to ensure representation for all institutions and organizations with a potential role in setting up the continuum of collaborative community speech-language pathology services. To take advantage of existing mobilizations and committees, determine who will lead and coordinate the continuum of collaborative community speech-language pathology services (definition of governance);
- For each mobilization committee, select the individual(s) who will act as liaison person(s) (community organizers, managers, representatives of partner organizations, etc.) in order to promote the vision and implementation of the continuum of collaborative community speech-language pathology services;
- Implement a communications plan, including a mechanism for disseminating and promoting the activities, materials, and resources of the continuum;
  - ✔ Ensure a forum for centralizing and facilitating the dissemination of the list of continuum activities implemented by the partners.
  - ✔ Ensure that all territory stakeholders promote the continuum in their environments.

5. Main success factors

The collective impact of community mobilization is an important factor to consider. This section presents the success factors or conditions needed for the creation of a functional body and for generating concrete outcomes in the community.

Cross-cutting success factors[3]

The text on collective impact (Hanleybrow *et al.*, 2012) identifies three conditions that must be in place before launching a collective impact initiative:

- *Leadership.* Support from an influential champion
- *Resources.* Adequate financial resources and/or funding
- *Motivation.* A sense of urgency for change

These three preconditions are important and need to be carefully evaluated at the start of the process and even during the process, in order to prevent a loss of engagement by the group. In fact, a *leader* who loses focus, a body with limited resources or financially vulnerable partners, or a loss of urgency can all contribute to a loss of mobilization.

According to the authors, the most critical factor is an *influential champion* "who commands the respect necessary to bring CEO-level cross-sector leaders together and keep their active engagement over time" (Hanleybrow *et al.*, 2012). This is also the starting point for the Butterfoss model (2009).

The *Active Living by Design* model[4] incorporates these three factors into its best practices:

1. **Diversify sources of funding.** By securing various sources of funding over time, a coalition can balance the risks and build a stronger financial portfolio.
2. **Exercise innovative leadership.** We need forward-thinking, compassionate leaders who are not afraid of failure. Leaders need to push for innovation and adapt their organization's culture, while inspiring

[3] These factors are considered cross-cutting because, while they are preconditions, they remain just as important throughout the approach.

[4] *Active Living by Design*, [n.d.], loosely adapted; NASEM, 2017.

confidence and motivation in employees, partners, and community members.

3. **Seize the opportunity for change.** We need to take advantage of opportunities as they arise. These include new partnerships, changes in leadership or funding structure, or even new conversations that emerge after tragic events. In each of these cases, opportunities can create momentum, raise the profile of a given partnership, and attract even more opportunities.

Success factors for creating a "functional" body

Once the preconditions are met, a more formal body can be created. Butterfoss (2009) identifies four conditions for the success of this type of coalition:

1. ***Membership***
2. Development of the coalition's processes and structures, **leadership** and human resources
3. Creation of synergies among members and pooling of resources
4. Planning and implementation of strategies aimed at achieving a common goal

Active Living by Design also identified four success factors for this type of body:

1. Form a broad, accountable coalition;
2. Align the missions and objectives of the various stakeholders;
3. Disseminate strategic communications with a strong identity;
4. Meet the specific needs of the community with the tools available (planning, consultations, community intervention workers, etc.).

Finally, the GTM-ODL has also identified its own success factors:

1. Definition of an intervention territory
2. Identification of stakeholders to be mobilized (mobilization plan)
3. Consolidation of the teamwork between the organizations' managers
4. Identification of the members responsible for coordinating the continuum
5. Definition and understanding of the partners' roles
6. Development of a communication plan

As such, its three sources converge and essentially focus on (a) membership, structure and leadership, (b) relationships between stakeholders, and (c) their capacities (planning, communicating, etc.). The three elements of the model initially submitted presented are present with the addition, however, of a firmly established structure, leadership, and internal coordination.

Success factors for producing concrete results[5]

The final success factors pertain to the capacity of this body or group to act on the community and to produce concrete effects in line with the selected themes. The Butterfoss model (2007), adapted above, presents four criteria:

1. Ability to mobilize the community by increasing the number and diversity of stakeholders who support and act on the target objectives;
2. Ability to tighten the links between community stakeholders acting on the target objectives;
3. Ability to equip, improve, and harmonize practices among community stakeholders;
4. Improvement in the environments conducive to the target objectives.

While also in line with the proposed model, *Active Living by Design* identifies three criteria:

1. Mobilize the community and develop leadership;
2. Collaborate with clinical and non-clinical sectors;
3. Build capacity.

In conclusion, regarding the cross-cutting principle of community mobilization, the continuum of collaborative community speech-language pathology services presupposes a capacity for mobilizing the community, namely to form links between the territory stakeholders involved in promotion, prevention, and intervention. The promotion aspect is especially dependent on the ability of the body or group to mobilize, which is what will allow us to help

[5] Idem.

as many families and have the widest, most universal reach possible.

Self-assessment

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Proportionate universalism

The members of the GTM-ODL took the bold step of integrating the concept of **proportionate universalism** as a cross-cutting principle in the continuum of collaborative community speech-language pathology services. This emerging concept in the field of public health proposes a rethinking of how services are delivered in order to achieve the greatest possible impact on health inequalities—an objective that the more commonly used universal and targeted approaches generally fail to achieve.

Although a promising concept, proportionate universalism is nevertheless difficult to apply. This is especially true because the continuum of services is a collaborative approach within communities, and not a program offered by the health sector. The broad outlines of the concept are presented below. It is important to understand that proportionate universalism is a target to aim for, by setting goals and implementing practices to that end; as such, it is a relatively long-term process.

1. Foundations of proportionate universalism: address health inequalities

Proportionate universalism takes on its full meaning when we consider the **social inequalities of health**[6], which are evident in the fact that individuals from the upper socioeconomic levels are healthier than those from the middle levels, who in turn are healthier than those from the lowest levels. This systematic tendency is called the **social gradient in health**:

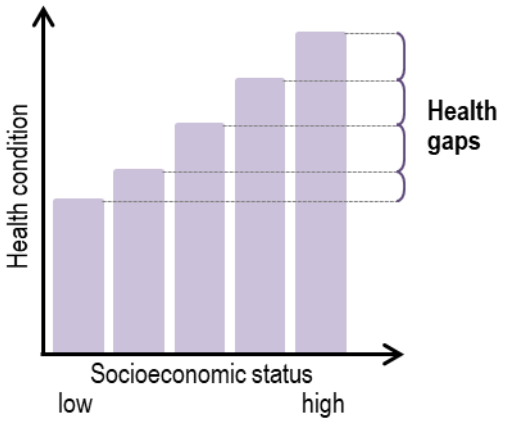
> "The social gradient in health describes the phenomenon by which those at the top of the social pyramid enjoy better health than those directly beneath them, who in turn are healthier than those below, and so on, all the way to the bottom levels."
>
> [The Black Report (1980), cited in Sen, 2009]

According to this concept, an approach that targets all social classes is needed in order to address the social inequalities of health. This is clearly illustrated in studies such as the *Québec Survey of Child Development in Kindergarten* (QSCDK), which highlights three elements:

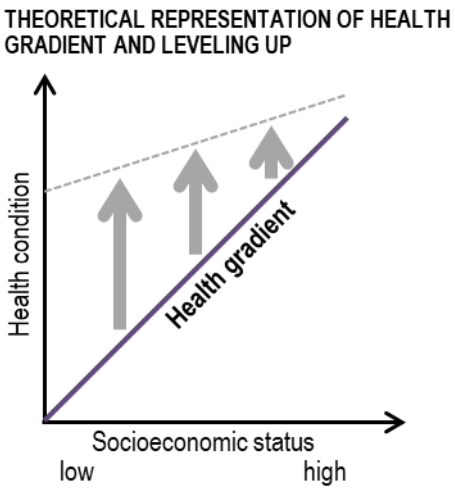
1. Vulnerable children are found in **all social groups**;
2. The **proportion** of vulnerable children is higher in disadvantaged areas;
3. The largest **number** of vulnerable children are found in middle and upper socioeconomic levels.

While the proportion of vulnerable children is highest in the most disadvantaged segments, it is crucial to remember that the number of vulnerable children is highest in those "just above" them. Addressing health inequalities—and therefore striving for equity—"means all **people** (individuals, groups and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic and environmental conditions" (National Collaborating Center for Determinants of Health, 2013).

THEORETICAL REPRESENTATION OF HEALTH GAPS



[6] The social inequalities of health refer to the relationship between an individual's health and social status. They are systemic, because they are constructed by the society of which the individual is a member (Villeval *et al.*, 2014). The differences between individuals are considered inequalities, because "[…] they are avoidable and unjust" (De Koninck *et al.*, 2008).



Theoretical representation of health gaps, health gradient and levelling up (CCNDS, 2013)

2. Definitions

Understanding the concepts of universalism and targeted approaches is a prerequisite for understanding proportionate universalism and for integrating this approach into the implementation of the continuum of collaborative community speech-language pathology services.

Initially, the **universal services approach**[7] applies to the entire population, without distinction or targeting (Tardieu, 2015). For example, vaccination, access to school, and health insurance are examples of this approach from a population perspective. This approach has the advantage of not (or hardly) stigmatizing individuals; however, it tends to exclude certain groups from the outset (obstacles to services, unequal access based on determinants, etc.). This approach can also confuse similarity with impartiality, and generally has no effects on health inequalities.

The second type of approach is the **targeted approach**. It is defined as a service offer aimed at a portion of the population on a priority basis, according to specific characteristics. As such, the approach mainly focuses on disadvantaged groups. Access to and eligibility for services is therefore based on specific selection criteria, such as income, education, and health status (Tardieu, 2015). The targeted approach can be positive (based on each person's resources) or negative (based on needs and services). The limitations of this approach are rooted in the stigmatization of service users, the large number of users who are excluded (by just failing to meet the criteria), and its inability to reduce health inequalities overall.

Proportionate universalism is a middle ground between the two previous approaches and aims to offset the limits of each one. The concept was defined by Sir Michael Marmot (2010) in his report prepared at the request of the British Department of Health:

> "Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be **universal**, but **with a scale and intensity that is proportionate to the level of disadvantage**. This is called **proportionate universalism**."

Proportionate universalism consists in:

- Offering universal interventions, while **eliminating access barriers**;
- **Increasing support (modality or intensity) based on the needs of various population subgroups**, as a means of addressing the gradient and, therefore, everyone's health.

To understand what proportionate universalism entails, it is essential to understand the following four points:

- It is applied from a *population-based perspective*;
- It requires *universal services combined with targeted services, with a scale and intensity proportionate to the level of disadvantage and needs*;
- It is reflected in *common actions* (e.g., teaching parents communication and language stimulation strategies) rather than specific activities;
- It strives for equity (not equality), namely the reduction of health inequalities.

[7] There are two broad categories of universal approaches: **general approaches** (impartial measures on which class, needs, citizenship, vaccination, etc. have no bearing) and **specific approaches** (advocacy of social rights as a means of achieving impartiality—right to health or education).

It is therefore essential to understand that proportionate universalism refers to universal services made up of distinct actions, tailored to needs and appropriate to certain subgroups.

3. Proportionate universalism and the continuum of collaborative services

The continuum of collaborative community speech-language pathology services is a proposed collective approach anchored in the concept of proportionate universalism. In fact, the promotion and prevention components of the continuum encompass both services of a universal nature (information sessions, information tools, etc.), as well as more targeted, intensive services based on the parents' needs (e.g., language stimulation dyads). It should also be noted that the continuum stakeholders are encouraged to work on reducing access barriers to the 10 essential activities of the continuum.

To achieve the universal component of promotion services, the continuum of collaborative services relies on partnerships and intersector collaboration to reach the maximum number of families in their living environments.

At first glance, the concept of the continuum appears to align perfectly with the logic of proportionate universalism. However, when implementing the continuum, it is important to consider how the approach "respects" or leans toward proportionate universalism. To do so, two aspects have been defined, which must be implemented and then evaluated:

- The ability to adjust interventions based on specific segments of the population;
- The reduction of access barriers to services.

*Proportionate universalism applied to the **planning** of the continuum*

The first step toward a proportionate universalism approach for communities that are implementing a continuum of collaborative services **is to do an exercise to better understand the population and its more vulnerable or disadvantaged segments**. The continuum planning process therefore needs to include a detailed portrait of the population and strategies for reaching the various subpopulations.

The vulnerability factors will not be the same from one community to the next. In some cases, they will be related to distance; in other cases, to sociolinguistic profiles or even other factors. It is up to each community to identify the segments to be targeted, and to develop coherent strategies (translating tools, providing interpreters as needed, visiting certain areas, etc.).

The recommended practices are therefore:

1) integrating a portrait of the population into the planning process;
2) mobilizing enough sectors to sufficiently approach universal services (in the area of promotion);
3) identifying specific strategies for adjusting services to the various segments of the population[8].

*Proportionate universalism applied to the **activities** of the continuum*

The second step toward proportionate universalism is to reduce the obstacles to the use of services. This aspect applies to the four intervention types of the continuum.

The types of barriers are as follows:

- Individual
- Social
- Physical
- Organizational
- Systemic
- Economic

The ones faced by families in a community where the continuum is present will vary depending on the situations. The following source is useful for analyzing and identifying the barriers:

http://agirtot.org/english/barriers-on-families-pathways/.

As such, any community that implements a continuum can analyze its specific situation and identify the barriers it wishes to reduce.

[8] For example, a complementary prevention activity (coffee chats about language stimulation) can be used to reach a segment overlooked by the dyads.

Recommendations by the GTM-ODL

Promote the participation of families

Families from disadvantaged areas or vulnerable situations

- Promote communication tailored to the needs and realities of the parents by applying the recommendations in Section 1.2.1;
- Target organizations or associations on the territory that work with these families, so as to promote the activities in the continuum of collaborative community speech-language pathology services;
- Create enabling conditions for families:
  - ✔ Make services more accessible to the target population;
  - ✔ Control registration costs and offer free services whenever possible;
  - ✔ Provide a drop-in daycare for siblings;
  - ✔ Provide or organize transportation;
  - ✔ Encourage flexibility in the choice of appointments (time slots and locations).

Families in rural or isolated areas

- Use existing local infrastructure and collaborate with partners in rural or remote areas to facilitate access to buildings;
- If providing local services is not possible, consider alternative methods of transportation, such as carpooling, travel vouchers, volunteer drivers, or a partnership with public transit services on the territory.

Families whose first language is not English

- Target organizations or associations on the territory that work with these families and form partnerships with them, so as to promote the activities in the continuum of collaborative community speech-language pathology services;
- Establish a pool of interpreters to facilitate first contact with the families, while encouraging all members of the family to learn French;
- Facilitate the integration of children with an immigrant background (and whose first language is not French) through the use of good practices associated with children learning French (legal obligation in Quebec; for more details, see Section 2.5. Multilingualism and communication and language development).

Proportionate universalism is therefore an interesting public health concept, because it addresses the social inequalities of health. However, since the concept was initially developed as an organizational and public health policy approach, it is somewhat difficult to apply to a collaborative community approach. An analysis of the continuum from the perspective of proportionate universalism, however, indicates that the very notion of a continuum of collaborative community speech-language pathology services is anchored in proportionate universalism, through the offering of universal services and certain more intensive interventions for the groups that need them. However, emphasizing that the concept is aligned with proportionate universalism is not enough; the concrete implementation of a continuum from this perspective requires two things in order to concretely resemble proportionate universalism:

1. Having an in-depth knowledge of the population in order to plan services tailored to the diverse range of profiles and situations;
2. Reducing access barriers to the services in the continuum.

Self-assessment

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Parent approach

The **parent approach**, or *parent as partner*, is at the centre of the continuum of collaborative community speech-language pathology services. In fact, while the continuum aims to improve communication skills in children, the **main partner in achieving this goal is the parent**, who generally accompanies the child throughout their development pathway.

The parent approach is especially important due to the fact that in speech-language pathology services (assessment, treatment, and rehabilitation), the

parent is asked to play a role in the child's treatment. It is an approach that is therefore central to the continuum.

This section defines the parent approach and explains how to integrate it into the continuum of collaborative services.

We have chosen to recommend a few principles to be incorporated into the continuum, with the understanding that this is no easy task. Groups or panels that would like to take that extra step can contact the Table de concertation en petite enfance de Saint-Hubert, which developed the *personalized approach*, along with training and tools to support communities.

1. Basic principle: The parents as first teacher

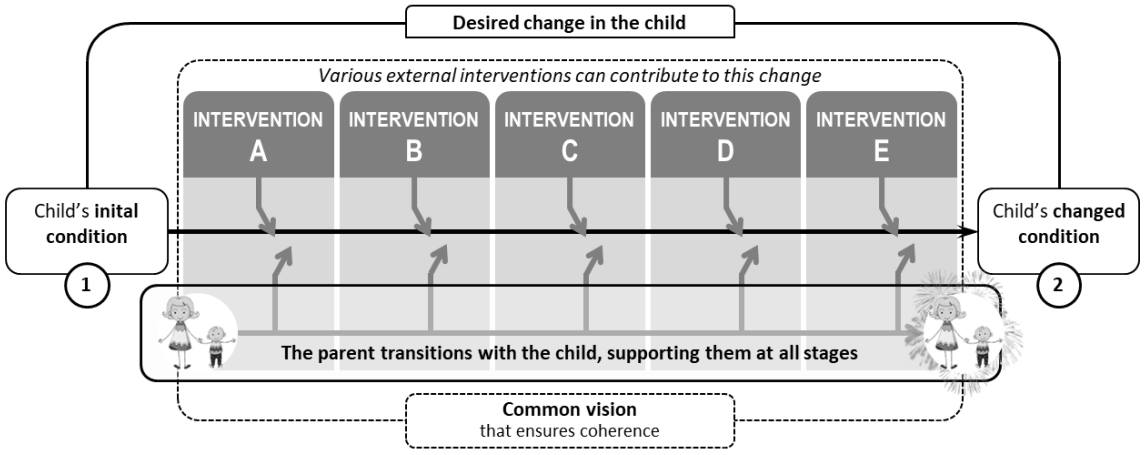
The fundamental element of a parent approach is **to recognize the parent as the child's first teacher**:

> "Parents are the first and most important influence on their children's development, and have the greatest impact on their attitudes, habits, and behaviours."
>
> [Avenir d'enfants, 2014, p. 8, citing Phillips and Shonkoff, 2000]

This means that any approach aimed at optimal child development must rely on the parents. Similarly, organizations and institutions that provide services to them must develop approaches that allow for optimal attendance and participation by parents in family activities and services.

While parents are considered to be their children's first teachers, it is important to note that this does not mean **their role is in opposition to that of intervention workers**. It is preferable to think of parents as the conductors of the parenting journey (see Latarité, 2014). All the stakeholders involved in the child's development are important, but it is the parents who provide meaning to the parenting journey.

If we consider it another way, while professionals intervene in the child's life path over a specific, limited period of time, their parents support them for their entire life. Parents therefore provide a longitudinal presence, whereas intervention workers get involved on an ad hoc basis, for varying lengths of time, as needed. The following diagram illustrates the structure of a collective management process and the parent's "longitudinal" presence in the life path.



Support for a child's change trajectory (inspired by JFL Consultants, 2017)

2. Benefits of the parent approach

In developing a parent approach, there are certain benefits that need to be emphasized, especially since this requires effort on the part of community stakeholders.

Some of the benefits identified are primarily felt by the parents, although the community of Saint-Hubert has indicated that **these benefits also made things**

easier for the intervention workers: better collaboration, decreased burden of success (interest in the process and sharing of successes with parents), and more profound changes within families led by more cooperative parents. During a presentation on their experience with the personalized approach, the partners suggested that recognizing a positive outcome from the parent's behaviour helped to:

- lower parents' resistance toward the intervention workers;
- build trust between parents and intervention workers;
- address concerns which, once trust is established, are often raised by the parents themselves;
- positively address parents' feeling of competence and self-esteem, without overdoing it with compliments and encouragement.

The impact of the parent approach on intervention workers is not very well documented; however, it is important to point it out to stakeholders in a community wishing to implement this type of approach.

As for the effects on the parents themselves, **the main impact documented relates to the feeling of parental competence**. While parental competence has long been considered a "given," the current definition of a "good" parent is at once increasingly ambiguous and exacting, causing parents to question themselves more and more often. In fact, today's parents are faced with an overwhelming number of messages, which are often mixed:

> "Parents are exposed to a plethora of child-rearing models, formulas, advice, and recommendations for dealing with their children. It can be hard to feel like a good parent when problems arise that leave the parent feeling helpless, despite the sea of information out there, which might be contradictory, not relevant to the situation, or impossible to apply without support."
>
> [Ménard, 2011]

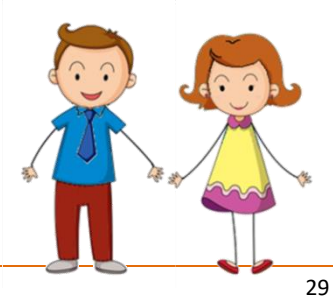
Within the framework of the continuum of collaborative services, the parent is given the tools needed to become a stakeholder in the child's communication and language development. Research has shown that, **in order for the parent to apply the knowledge acquired (aspect of competence), they must be encouraged to cultivate their feeling of competence** (Bandura, 1997; Coleman and Karraker, 1997).

The feeling of competence is developed based on the parent's **self-assessment** of their ability to fulfil their role as parent. It always includes **an aspect of suggestion**. However, it has been shown that there is a positive correlation between a parent's feeling of competence and the use of **behaviour that promotes child development**. In other words, if the parent feels competent, they will use more positive parenting practices. They will tend to respond better to their child's needs, engage in direct parenting practices, make adjustments during interactions, and perceive fewer problems with their child's behaviour. Conversely, a parent with a low feeling of parental competence will tend to use defensive and punitive practices, adopt a more passive parenting style, report a higher level of parenting-related stress, and perceive more behavioural problems in their child.

Within an ecological child development model, it therefore makes complete sense to focus part of the intervention efforts on developing this feeling of competence. This is the target of the parent approach.

3. Components of the parent approach

Integrating a parent approach into the community requires first having a good understanding of the concept of parent as first teacher and knowing the benefits of such an approach. The next step is to develop two very important components conducive to this approach: empowerment and the appreciative inquiry.



Empowerment

This is the first component of the parent approach. Empowerment is a:

> "process that aims to support and reinforce their ability to work on themselves and on their environment, in order to mobilize the resources (internal and external) needed to carry out or meet their personal and family plans, projects, or needs."
>
> [Lacharité, 2002]

For the intervention worker, the idea is to assume a position from which they can **give power back to the parent, make them feel appreciated, help them to tap into their resources and encourage them to be autonomous, rather than focusing on their shortcomings and doing things for them**. It's about accounting for the parents' knowledge and know-how, rather than seeing them as mere receptacles of the intervention worker's knowledge.

This position allows for "a balance between actions taken by the parents and those taken by the professionals" (Jean and Miron, 2002), as well as a more egalitarian relationship. Not only does this approach **strengthen the parents' feeling of competence**, it also **increases their self-esteem** and helps them to **develop problem-solving skills**.

Appreciative inquiry

The second component involves situating the parent within an **appreciative inquiry**, sometimes also called a positive inquiry. It was developed in the late 1980s by David Cooperrider and Suresh Srivastva in the Department of Organizational Behavior at Case Western Reserve University, in Ohio. It calls into question the traditional problem-solving approach, which is aimed at identifying and solving issues or problems. With the appreciative inquiry, it is more important to **emphasize the positive and the best in people** and organizations, and then to leverage that into something better.

According to the partners of the Table de concertation en petite enfance de Saint-Hubert, in order to apply an appreciative inquiry model, the intervention worker must:

- observe parent's behaviour;
- emphasize the result of positive behaviour on the child;
- report all this information to the parent.

The community of Saint-Hubert summarized the main points of this model, comparing it to one based on problem-solving:

Problem-solving	*Appreciative inquiry*
Diagnosis: Identifying a problem	Recognizing the best of "what is"
Analyzing the causes	Imagining what could be
Analyzing possible solutions	Engaging in dialogue about what could be
Developing an action or intervention plan	Innovating: creating "what will be"

In short, the ideal position is to **support** parents, rather than intervene with them.

Recommendations by the GTM-ODL

Mobilize parents

- Promote an appreciative inquiry and a participatory approach to help parents recognize their role as their child's first teacher and make them the focus of all actions related to their child (for more details, see Section 3.2. Teaching language stimulation techniques);
- Schedule different time slots for the activities in the continuum of collaborative community speech-language pathology services in order to meet the needs of families (days, evenings, and weekends), and set up communication mechanisms to ensure that all parents receive information about the promotion activities;
- Ensure that information intended for parents is written in plain language that everyone can understand; adapt written documents to the parents' literacy level.
- During regular activities in childcare or community settings, encourage parents to participate by setting aside a time for them to observe their child interacting with the group.

4. Recommended practices

There are many concrete practices for implementing a parent approach, depending on the frameworks used. In order for the implementation of the continuum of collaborative community speech-language pathology services to remain realistic, the community stakeholders must support the concept of **parent as first teacher** and work together on the positions to be taken in order to support families.

We recommend a few promising practices to expand on this concept, however, interested stakeholders can refer to the reference framework on the personalized approach created by the TPPE de Saint-Hubert or to the reference framework for the integrated prenatal and early childhood services (SIPPE).

Here are some recommended practices to implement, inspired by these programs:

- Follow the parents' pace;
- Adopt the approach in small steps;
- Reach out to families, rather than wait for them to approach us;
- Recognize the parents' efforts as often as possible;
- Emphasize the positive elements;
- Set aside time for informal interactions;
- Work with both parents;
- Consult the parents;
- Encourage direct contact;
- Personalize the message and the approach;
- Focus on transition periods;
- Focus on freely accessible locations;
- Use appropriate language.

Within the continuum of collaborative services, this can take several different forms, including:

- Setting aside time for the parents to get settled and chat with each other during the information sessions or dyads;
- Avoiding alarmist language when talking about children's issues (red flags, delays, problems, etc.) without being excessively upbeat;
- Organizing activities in areas with fewer services, meeting with parents where they live;
- Avoiding content that is too heavy or complicated during information sessions, and emphasizing the educational aspect of the activities;
- Avoiding technical jargon during activities and interventions, i.e., using plain language as much as possible;
- Highlighting what parents are already doing to stimulate language in their child.

Based on the above, it is quite clear that there are multiple possibilities that can arise from implementing the parent approach concretely within the framework of the continuum of collaborative community speech-language pathology services. The most important factor is that the community stakeholders who are involved in implementing the continuum adhere to the principles of the parent approach, and that each one adopts practices consistent with this. However, developing a collective, structured parent approach is a challenging project unto itself, which interested communities must be aware of.

Self-assessment

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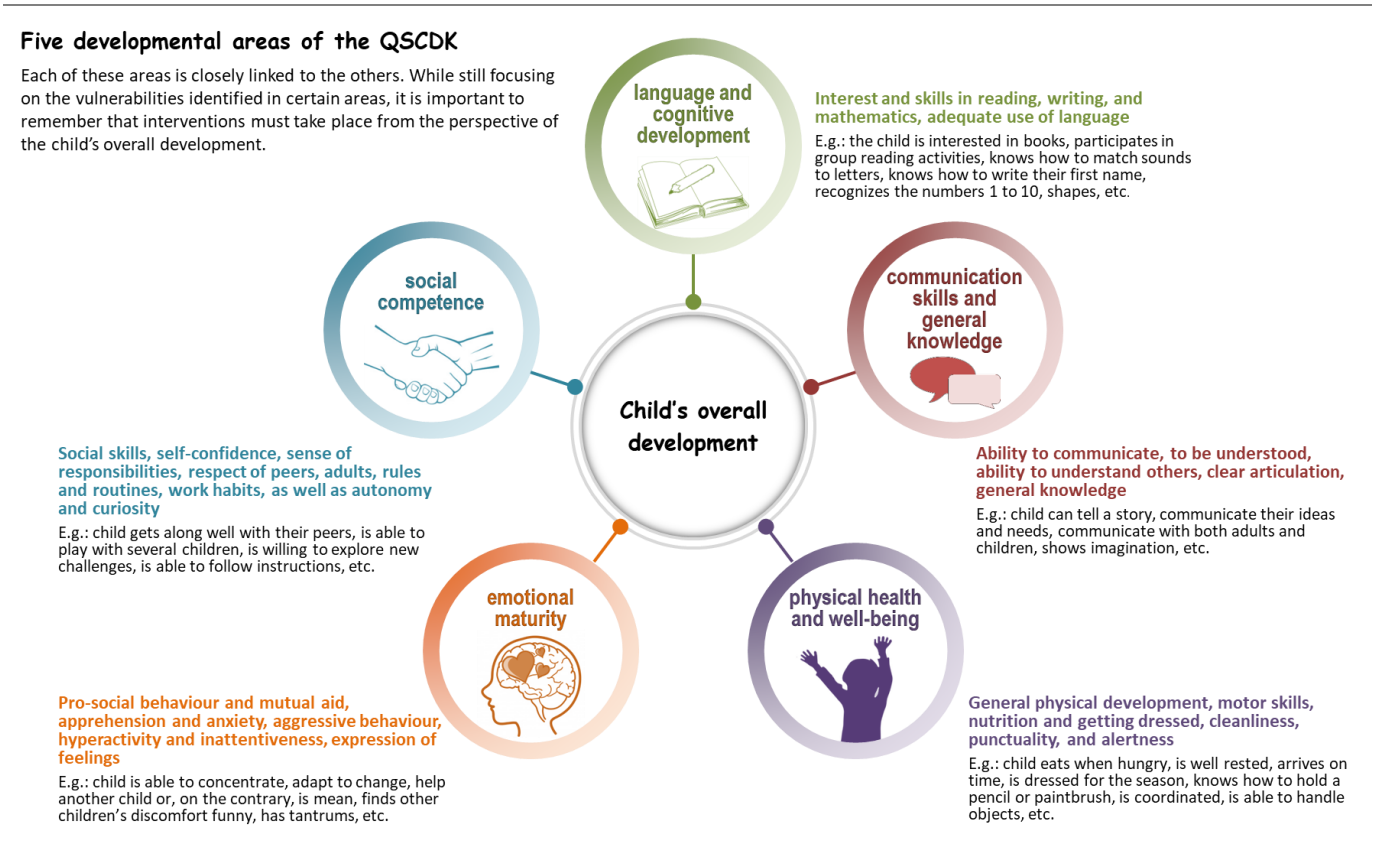
2. Communication and language development in young children

2.1. Communication and language development

Communication and language development begins at birth. The acquisition of communication begins with non-verbal skills, for example, the child answering the parent's question with a smile or expressing their needs by crying or pointing at what they want. In all interactions with their environment, the newborn is also developing their verbal comprehension skills and beginning to form sounds, which will become words and sentences as they develop. The acquisition of communication and language happens jointly and concurrently with the development of motor, cognitive, emotional, and social skills. In fact, communication and language can influence development in other spheres; for example, the acquisition of social and emotional skills is assisted by good verbal comprehension and effective communication skills, while a delay in cognitive development will affect communication and language development.



Domains of development according to the Québec Survey of Child Development in Kindergarten (QSCDK)
[proposed by the CIUSSS de Capitale-Nationale. Source: Institut de la statistique du Québec, Québec Survey of Child Development in Kindergarten 2017. Portrait statistique pour le Québec et ses régions administratives, 2018]

2.2. Risk factors associated with language development difficulties

Risk factors are defined as events, or environmental or organic conditions that increase the likelihood of a child having development difficulties. The effectiveness of early intervention programs aimed at addressing language delays depends on the early identification of at-risk children (Sylvestre 2008).

In the children who are identified, the parents and intervention workers can intervene early and preventively. In so doing, it is possible to prevent language development difficulties even before they become apparent (Reed 2005).

Risk factors are known to interact with each other. In fact, researchers in Québec have identified two patterns of interactions between risk factors and the onset of language difficulties (Sylvestre 2008; Sylvestre and Mérette 2010):

a. The specific risk factor model, inspired by Bronfenbrenner's ecological systems theory, explains that human development results from interactions between biological, psychological, and environmental factors. From this ecosystemic perspective, the risk factors are considered in a specific manner, but have repercussions on all systems in which the child is evolving, regardless of their nature;

b. According to the cumulative risk factor model, the variable with the greatest influence on the child's development is simultaneous exposure to several risk factors. Therefore, the more risk factors a child is exposed to at the same time, the greater the effect they will have on their development.

In a study by Québec researchers Sylvestre and Mérette (2010), data were collected for 66 severely neglected children between the ages of 2 and 36 months. The researchers, in collaboration with social workers and the mothers of the participating children, assessed 14 biological and psychological risk factors and 34 environmental risk factors. Based on their data analysis, they concluded that the specific factor of delayed cognitive development was a better predictor of a language delay in severely neglected children than the accumulation of biological, psychological, and environmental risk factors.

In a 2008 presentation, Sylvestre pointed out that, according to certain authors, the cumulative risk factor model is the best for predicting development outcomes.

Following a literature review on the topic, there does not appear to be a consensus in the scientific community on which model, specific factor, or accumulation of factors is most effective at predicting the onset of language difficulties in children. Although the interaction between risk factors remains to be studied, several risk factors associated with language difficulties in children are known and documented, in both the Québec and U.S. scientific literature (Daviault 2011; Reed 2005). Sylvestre *et al.* (2012) conducted a study of 96 francophone children in Québec between the ages of 18 and 36 months presenting with a language delay. The research team found an association between some of these known risk factors and the various components of speech. Their results were as follows:

- A cognitive developmental delay was associated with a delay in both receptive and expressive language;
- The fact of being male is associated with an expressive vocabulary delay, but is not associated with an overall expressive language delay. The child's young age, compared to the group average (24 months), is associated with the overall development of expressive language. According to the authors, the child's intrinsic factors are the best explanation of expressive language delays;
- A low level of education and the parental stress level are associated with a delay in receptive language. The authors concluded that, in their study, environmental factors were primarily associated with a verbal comprehension delay;
- Aspects related to the child's birth, such as a low birth weight, prematurity (Reed 2005), or a family history of language delays or disorders

(Daviault 2011; Desmarais 2007; Reed 2005), are risk factors associated with language delays and disorders.

Low family income is a risk factor associated with language delay (Reed 2005; for a review, see Desmarais 2007). The link between low socioeconomic status and language development is explained by an intermediate variable, namely parental stress (Sylvestre, 2008). Parental stress caused by low family income makes parents less receptive to their child's communication efforts, leading to suboptimal language stimulation.

The mother's level of education is linked to language development in different ways (Reed, 2005). A low level of education is directly related to the amount of language stimulation that the mother provides the child. In fact, mothers with a low education talk less and have a more limited vocabulary than mothers with a higher education. A low level of education is associated with an expressive vocabulary delay in 2-year-old children (Desmarais, 2007). A study of 2-year-old children in Québec with a language delay showed that a low parental education level was associated with a receptive language delay in children at this age (Sylvestre *et al.*, 2012).

However, attending a childcare centre allows children to better develop their conversation skills and vocabulary. This is true for all children who attend a childcare centre before age 4, regardless of socioeconomic status (Daviault 2011). It follows, therefore, that not attending a childcare centre could be considered a risk factor.

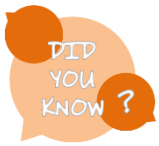
Bilingualism or multilingualism is not a risk factor associated with language difficulties in preschool children. It is even mentioned that the vocabulary of bilingual children (all known words in all languages the child is exposed to) is larger than that of unilingual children (Thordardottir 2005). However, note that EQDEM (Simard *et al.*, 2013: Québec Survey of Child Development in Kindergarten 2012) observed greater vulnerability in children with a first language other than French, or in bilingual children. This is due, on the one hand, to the effects of the normal mechanisms of second-language learning and, on the other hand, to the proportion of children who actually had vulnerabilities.

2.3. Protective factors related to language development

Protective factors are personal, family, or social resources that decrease the likelihood of a development difficulty by mitigating the negative impact of risk factors (Sylvestre 2008). There are several protective factors associated with language development. First, the **parenting practices** that promote language stimulation are a protective factor. For a parent or an intervention worker, language stimulation skills are a protective factor for good language development in children. A meta-analysis of the interventions targeting parents of children with a language delay showed an improvement in expressive language in children whose parents had participated in parent-child dyads (Roberts and Kaiser 2011). **The mother's level of education** is a second protective factor. A mother with a degree is a protective factor that can be explained by two things (Walker *et al.*, 2011). First, the mother's education influences the quality of the environment in which the child is raised. A mother with a higher education would be more likely to know more about language development, to apply strategies, and to be more aware of the developmental differences between children. Second, a mother with a degree would be more likely to demonstrate the skills needed to seek help, to obtain intervention services, to understand the material provided to parents, and to remember how to apply the material as needed.

The **child's temperament** is a third protective factor. In fact, being sociable and determined (Harrison and McLeod 2010) is a protective factor since the authors state that these personality traits make intervention easier in the event of language difficulties.

A fourth protective factor is associated with **early management**. The severity and duration of communication and language difficulties can be reduced with early detection and intervention (ASHA 2008; Ordre des orthophonistes et audiologists du Québec (OOAQ) 2009).



Adolescents and adults with a language impairment are more likely to encounter the following problems (oral presentation by Morin *et al.*, 2015):

- A disadvantage in academic learning situations and low scores on oral and written language tasks (Brownlie *et al.*, 2004; Young *et al.*, 2002);
- Difficulty managing and performing activities of daily living;
- Living with their parents in adulthood (Clegg *et al.*, 2012); demonstrating a high degree of employment-related instability and a lower economic status (Clegg *et al.*, 2012);
- Living with anxiety, depression, and emotional disorders; having deficient communication skills, which negatively affects their participation in society. On a social level, living with interpersonal (Dockrell *et al.*, 2007; Myers *et al.*, 2011; Robinson 2012) and professional problems, such as finding and keeping a job (Dockrell *et al.*, 2007).

2.4. Impact of language disorders and difficulties

Language disorders have a long-term impact, with certain spheres of day-to-day living of people affected being impacted more than others. Several researchers have studied the long-term impacts of a language disorder. In Québec, Chantal Desmarais, speech-language pathologist and researcher at Université Laval, and her team have identified the impacts on children with a language disorder (ongoing research project, Morin *et al.*, 2015). The following elements were observed by these Québec researchers, and supported by other authors in the literature who corroborate their observations (see authors in the list). Note that these studies included young people who had a severe language disorder during childhood, some of whom were in classes for children with language difficulties, and who continue to have communication and language issues into adolescence or adulthood.

There are studies specifically documenting the long-term impact of the language disorders identified during early childhood. Researchers in Ontario conducted a longitudinal study (Brownlie *et al.*, 2004; Young *et al.*, 2002) of young people with a language disorder. They established a group of 142 children with an "early language impairment," i.e., a language delay, meaning children who, during a receptive and expressive language assessment at age 5, obtained an out-of-standard score, more than one standard deviation away from the mean, on at least one of the spheres assessed. As such, there were children with mild impairments (1 sphere) and others with more severe impairments (several spheres). A control group of 142 children was used. Children with language difficulties at age 5 were shown to have the following characteristics at age 19:

- Many had difficulty reading and had learning disorders (reading, writing, and mathematics);
- Many had few friends and difficulty making friends, especially when their verbal comprehension was impaired. They also had more social anxiety than adolescents who did not have a language disorder (for a review, see Robinson 2012);
- In boys with a language disorder, there was a higher prevalence of delinquent and aggressive behaviours.

Researchers studied a cohort of 19 young people aged 13-23 with a language disorder who attended regular school. The latter were at risk being bullied at school, having poor social skills, and having problems related to autonomy (Myers *et al.*, 2011).

Another longitudinal study of adolescents with a Developmental Language Disorder showed that these young people were at risk of having behavioural, emotional, and social problems (Dockrell *et al.*, 2007).

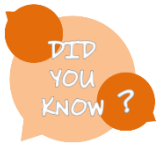
Among 26 adults with an average age of 25 who attended a special-education language class in elementary and high school due to a severe language disorder (expressive and receptive), most were not financially independent, lived with their parents, and had difficulty holding down a job and managing their finances (Clegg *et al.*, 2012).

Researchers have also demonstrated the long-term impacts of language difficulties that were identified during early childhood, but which later resolved.

A longitudinal study of 637 children (Armstrong, Marchman and Owen 2007) included four groups based on expressive vocabulary results: 1) no delay; 2)

delay at age 2, but caught up at age 3; 3) delay at ages 2 and 3, but caught up at age 5; 4) delay at ages 2, 3 and 5. The variables "mother's level of education" and "family income" were controlled for, given their known associations with expressive vocabulary. All the children were then tested in grade 1. The results showed that:

- The children in group 3 scored significantly lower on phonological processing tasks, compared to those in groups 1 and 2;
- The children with language delays that had resolved, all ages combined, scored significantly lower on auditory memory and expressive vocabulary tasks. However, these children obtained comparable scores on pre-reading tasks, such as reading simple non-words and identifying words.
- Rescorla (2009) conducted a longitudinal study of 26 children aged 24-36 months with a language delay, matched with a control group. At age 17, the children who had a language delay scored significantly lower than the children in the control group on vocabulary, grammar, and auditory working memory tasks. However, their scores were within normal range, i.e., they performed according to expectations for their age.



Young people who had a language difficulty in early childhood that resolved before they started kindergarten are more likely to:

- Have weaknesses in the phonological processing skills needed to learn how to read and write (Armstrong, Marchman and Owen 2007);
- Have an expressive vocabulary, auditory memory skills, and written grammar skills within the normal range, but nevertheless lower than their peers who did not have a language delay (Armstrong, Marchman and Owen 2007; Rescorla 2009).

2.5. Multilingualism and communication and language development

During the language development process, a child may be exposed to more than one language. This is a situation of multilingualism, in which the child is exposed to two or more languages. Languages can be learned simultaneously, for example, if the child is exposed to more than one language in their daily life. The child can also learn their first language and then be exposed to a second language, for example, at school or daycare. This is known as sequential bilingualism (Daviault 2011).

When a child grows up in a bilingual environment, it is common for one of the languages to be dominant, meaning the child masters one language better than the other, despite similar exposure time. The dominant language will generally be that of the ethnolinguistic majority, i.e., the language that is considered most used and most prestigious within a given community (Daviault 2011). In the Montérégie region, the ethnolinguistic majority speaks French (85.9%), and the linguistic minorities include English (7.9%) (Ministère de la Culture et des Communications, 2013), Spanish, Arabic, Creole, etc.

The fact of learning more than one language influences the child's overall development. In fact, an adult who interacts with a child who is learning two languages may get the impression that the child's language development lags behind that of a unilingual child. However, if their vocabulary is considered as the sum of both languages, it is comparable to that of unilingual children (Daviault 2011). A common example is that of a child who speaks a different language at home than the French spoken at daycare. As a result, their vocabulary for activities associated with home life will be in their first language, whereas their vocabulary for daycare activities (games, concepts discussed, etc.) will be in French.

According to the scientific literature, the cognitive impacts of bilingualism are positive. In particular, knowing a second language has been shown to give children an advantage in terms of learning to read and write (Schwartz *et al.*, 2007).

A portrait of the Montérégie region (Direction de la santé publique de la Montérégie, 2013) indicates that children whose first language is not French are significantly more likely, when starting kindergarten,

to present with vulnerabilities in *communication skills and general knowledge* and *cognitive and language development*.

While bilingualism is an element conducive to a child's cognitive development, why are these bilingual children more vulnerable when they first start kindergarten?

On one hand, the answer lies with the concept of second-language acquisition. For example, when a teacher fills out the EDI (Early Development Instrument) for a bilingual student, they compare the student's skills to those of the child's classmates, who are generally unilingual francophones. Therefore, when the teacher rightly reports vulnerabilities in the areas of *cognitive and language development*, and *communication skills and general knowledge*, they may simply be flagging the normal manifestations of the second-language acquisition process (Roseberry-McKibbin [n.d.]).

Second-language acquisition is divided into two types of learning:

- Social language, which speakers use every day in conversation situations. This type of contextual language is called BICS (Basic Interpersonal Communication Skills) and usually takes two years for a learner to master;
- Academic language requires a great deal of inference, with few context clues available. This aspect of language takes 5-7 years to acquire at a near-native level. It is called CALP (Cognitive Academic Language Proficiency).

Students learning a second language who master BICS are thus seen as being able to speak French well by the school staff and are considered ready to be assessed at the same level as their unilingual francophone classmates. However, the assessments are all based on CALP-type language. As a result, these students, who perform poorly on the assessments, may be mislabelled as having developmental learning difficulties. In fact, many of these students follow the normal curve in terms of CALP in a second language and therefore do not have developmental difficulties (Roseberry-McKibbin [n.d.]).

Conversely, other children who are learning a second language can in fact present with a real difficulty in language development, and possibly even a language disorder. In this case, since the cognitive process of language development is impaired, a developmental delay will be seen in all languages learned by the child.

In order to promote the integration of children who are learning French and to better guide their parents, speech-language pathologist Joëlle Chagnon created a document (Chagnon 2014) entitled *Idées et suggestions pour aider les enfants allophones en garderie ou en halte-garderie*. This document was included in the *Parlons ensemble* kit produced by the Table de concertation CONPARLE FAMILLE, on the territory of Samuel-de-Champlain.

Recommendations by the GTM-ODL

Multilingualism

In situations where an intervention worker is interacting with a family that is learning French, we recommend that the following practices be implemented (Chagnon 2014):

Advice for parents

- Speak to the child in the language they speak fluently, such as their first language;
- If the child is fluent in two languages, do not hesitate to speak to them in both languages.

Practices to be adopted with children

- Learning a few words in the child's language is a good way to reassure them and show them that their first language is important;
- To promote the integration of a child who is learning French, use the same strategies as those used with children with a language delay.

Examples
- ✔ *Use shorter sentences and emphasize key words;*
- ✔ *Give clues when speaking: point to objects, make hand gestures, etc.;*
- ✔ *Create situations where the child can play with a francophone child or a child who speaks better French.*

3. Good practices associated with communication and language development

3.1. Evidence-based practice

Québec authors Malcuit and Pomerleau (2005) wrote an article identifying effective practices for the optimal development of young children. From the outset, the authors state that this is an impossible exercise, given that implementing the practices demonstrated in the literature requires significant human and financial resources. They state: "In short, despite their goodwill and the relative generosity of those who support them, public and community organizations do not have sufficient resources to implement actions commensurate with those required by most effective practices."

In fact, it is generally difficult to implement, as a whole, the methods proven to be effective in the scientific literature. However, early childhood workers and speech-language pathologists can adopt an evidence-based practice without having to implement entire programs.

The American Speech-Language-Hearing Association (ASHA) describes evidence-based practice as the integration of three aspects:

- Data from the scientific literature on best practices related to the targeted activity or services;
- The personal experience of the person practising the activity or providing the services, i.e., the practitioner, for example, the intervention worker or the speech-language pathologist;
- The values, needs, and perspective of the person participating in the activity or receiving the services, for example, the parents and families.

With this in mind, an intervention worker who incorporates the recommendations contained in the scientific literature into their practice, relying on their professional experience and taking into account the needs of the people for whom the services are intended, is following an evidence-based approach.

The following sections were therefore written with this in mind. Each subsection describes the point of view of the scientific literature on topics associated with communication and language development. Each one ends with an insert that lists the data from the literature and the experiences of the committee members, which helped to identify evidence-based good practices.

3.2. Teaching language stimulation techniques

The teaching of language stimulation or knowledge transfer techniques in the field of early childhood education is omnipresent: training sessions for intervention workers, activities in parent-child dyads, educators or community intervention workers giving general language stimulation advice to a parent, speech-language pathologist teaching parents stimulation techniques specific to language difficulties during an indirect intervention, etc. Two interrelated approaches have been identified for establishing good practices associated with knowledge transfer in communication and language development. Note that the term *learner* used in this section refers to any adult in a learning situation involving communication and language development. As such, this term can refer to both a parent and an

intervention worker, depending on the training context. The term *trainer* refers to the person who is teaching or giving the individual or group training.

3.2.1. Appreciative inquiry in communication and language development

The *appreciative inquiry* (AI) was developed in response to traditional problem-solving methods, which generally focus on weaknesses in the person or the situation, quickly leading to a negative "degenerative spiral" (Grant and Humphries 2006).

The AI is an action research method, i.e., a social methodology involving an intervention in which researchers and stakeholders work together to bring about change in order to improve a problematic situation (Fortin and Gagnon 2010). This method focuses on the positive aspects of an organization, a community, or a person in order to drive change (Grant and Humphries 2006).

The AI can be applied to the field of language, more specifically when teaching language stimulation techniques to an adult (parent or daycare educator) in the child's environment. This technique is based on the following notion: A person will perform actions that have positive repercussions. This type of interaction therefore focuses on unconditional positive questions with the aim of emphasizing the positive (Ludema, Cooperrider and Barrett 2006). Change is therefore initiated by positive elements that are already present in the learner's attitudes and behaviours.

As part of a project aimed at children with special language needs, the U.K. government set up various initiatives, with the AI being central to one of them (Roulstone *et al.*, 2012). According to the authors, their starting point was the central tenet of the AI, which targets positive elements already in place, represented by the question "What is working well?".

They then identified three questions for children aged 8-11 and their parents:

- What is good? For example, what is good about communication, language, and speech in your day-to-day life and your relationships?
- What could be improved now?
- What could be improved in the future?

In training sessions for parents or educators on stimulating language in children, the appreciative inquiry generally works very well. For example, Rush, M'Lisa and Hanft (2003) listed questions that the trainer can ask after observing the learner interacting with the child: What happened when you […]? What things had an influence on what took place (child's desired language behaviour)? What would you do the same way the next time?

3.2.2. Coaching-based training: a winning formula

As part of a **coaching-based training** session, the teacher travels to the learner's environment. They observe, listen to, and support the learner[9] in their efforts to improve the child's language, without giving the "right answer." This is an interactive type of teaching in which feedback takes the form of an objective description of the situation, aimed at the learner and coach working together to "find solutions." The coach helps the learner to set priorities in order to improve the child's language (Neuman and Cunningham 2009).

The coaching- or mentoring-based teaching model requires intensive teaching, along with guidelines on the concepts and effective practices to be implemented. The trainer also provides individualized support and feedback on the learner's actions (Wasik and Hindman 2011). The following are elements that facilitate learning during the teaching of communication and language stimulation techniques:

- Setting specific, achievable, and meaningful goals for the learner, while focusing on elements that are not performed spontaneously by them (Rush, M'Lisa and Hanft 2003);
- Identifying the learners' needs and expectations during the training sessions. In order to target gaps in their learning, have a way to observe them interacting with the child (e.g., ask them to film themselves with their phone, organize sessions involving the parent-child dyad, offer

[9] In this case, the learner refers to both the child's parents and all other significant adults in the child's life.

training sessions at the daycare with the intervention worker present);

- Building on the parents' predisposition. As soon as a parent registers for and participates in a language development activity, they have taken action. They are therefore predisposed to enter into a coaching relationship (Rush, M'Lisa and Hanft 2003);
- Encouraging all forms of initiative by the participant;
- Offering coaching sessions in the learner's environment. In kindergarten teachers, the reading/language teaching skills were improved following coaching sessions in their own environment rather than training sessions given at a training centre near their school (Neuman and Cunningham 2009). The same is true for training sessions offered to intervention workers, which will be more effective if they take place in their own environments, such as a daycare centre or a family home, for example;
- Encouraging training sessions involving a coach. Language skills, as well as reading and writing prerequisites in pre-kindergarten children aged 3-4 in disadvantaged areas, were higher when their teacher had received training with a coach, compared to traditional training (Wasik and Hindman 2011).

A study by Sawyer and Campbell (2012) surveyed 1,500 American early childhood professionals (speech-language pathologists, occupational therapists, and specialized educators) on their method of intervening with and training people who care for children, such as parents or daycare workers. The survey results showed that three main intervention types were used by the healthcare professionals when acting as trainers, and that each of these interventions had a different goal:

- Intervention during which the learner interacts with the child while the professional, i.e., the trainer, comments and gives feedback. This helps the learner to appropriate the strategies and feel more empowered;
- Use of discussion. This type of intervention allows the trainer to get to know the learner and their needs;
- Intervention during which the trainer implements strategies through activities done with the child. This allows the learner to observe strategies and situations that are effective with the child before attempting to implement them.
- The most experienced intervention workers used all three intervention types, allocating more time to activities relating to the first type (empowerment).

A concrete example of integrating appreciative inquiry and coaching concepts into the practice of the speech-language pathologist was reported informally by Marie-Pier Gingras, a speech-language pathologist who worked for four years at a Montréal-area CLSC. Her intervention style was generally indirect, primarily with daycare educators. She mentioned that, in her experience, the best way to improve and implement language stimulation techniques was to observe the person interacting with the child (coaching-based method) and to encourage the parents or the educator to frequently reproduce the behaviours identified as the best by the speech-language pathologist (appreciative inquiry).

In terms of the content of training sessions designed to teach communication and language stimulation techniques, it was suggested that teaching interactive reading techniques while actually reading a book would be more effective than teaching general concepts about language stimulation techniques. In fact, a literature review done for a Master's thesis in speech-language pathology (Dontigny 2013) revealed that, because interactive reading is a specific technique that requires using a tool, i.e., a book, learners are more likely to master the skills learned in this training and to apply them frequently in their own environments. Conversely, in training sessions on general language stimulation skills, for example, reformulation, the gains are less likely to be correctly reproduced in the environment and at a high frequency, given the significant flexibility of this type of technique. The results observed after this type of training vary: Some studies show an increase in

intervention workers' skills, whereas others do not. As such, it is best to structure training sessions around a tool, the book being the best choice.

A study by Abel, Nerren, and Wilson (2015) indicates an improvement in expressive language skills in 4-year-old children from disadvantaged areas in Head Start-type pre-kindergarten classes following training giving to the teachers. The teacher training lasted two days: one day of lectures (video and PowerPoint presentations) and one day of coaching, where the intervention workers were asked to practice the techniques they learned. The improvements observed in the children mainly related to expressive vocabulary, compared to the children in the control class, where the teacher received no training.

Recommendations by the GTM-ODL

Coaching-based training

For all training activities aimed at acquiring communication and language stimulation skills, it is recommended to include the following practices to ensure an evidence-based approach.

Note: The recommendations apply to anyone in a learning situation during formal or informal training sessions, and therefore apply to both parents and intervention workers.

- Question the intervention worker about their needs and expectations regarding the training;
  Examples ✔ *What things work well in terms of communication (language and speech) in your day-to-day life during your interactions with the child(ren)?*
  ✔ *What things could be improved now or in the future?*
- Propose specific, attainable, and significant objectives for the intervention worker taking the training;
- Encourage all forms of initiative by the person taking the training (e.g., reformulate what the child says) and promote those that best correspond to the learning objectives;
- Promote a "turnkey" training format to present specific techniques using a tool familiar to the intervention worker, so they can bring the tool back to their environment. The use of a book is optimal, but games (memory games, lottery games, etc.) are also a good choice;
- Promote the transfer of knowledge in the intervention worker's environment (e.g., childcare centre or community organization for educators), where they can interact with children during the training;
- During group training, allocate one-third of the time to coaching scenarios, i.e., times when the intervention worker is interacting with a child or applying the techniques learned using the specific tool, as the teacher is commenting and giving feedback;
- Observe the intervention worker, encourage all forms of positive behaviour, and question them afterwards;
  Examples ✔ *What happened when you… (describe the technique)?*
  ✔ *In your opinion, what influenced… (the child's behaviour, e.g., repeating a word)?*
  ✔ *What things will you do the same the next time this situation happens?*

Recommendations related to the Speech-language pathologist's specific mandates

- Update the contents of workshops for parents and intervention workers;
- Act as resource person for the intervention workers and activity organizers .

3.3. Stimulation tools and techniques

There are several activities, tools, and techniques associated with stimulating communication and language in young children, and it is important to know which contexts and practices help to make them more effective.

3.3.1. Screening activities and tools

A screening test or tool is a set of development milestones used as indicators of the child's overall development. A language development screening test can therefore identify children who are at risk of presenting with language difficulties and determine

which children need help with language development (Gingras 2015; van Agt *et al.*, 2007).

A screening test or tool is not a comprehensive, detailed inventory of the skills a child should possess at a certain age. As such, it is important not to confuse it with observation grids (Harguinginy-Lincourt 2004), which are often used by daycare workers, for example, with the observer check-marking the behaviours demonstrated by the child, by age group. Observation grids are indicators of child development, but do not tell the user exactly when a child should be referred to speech-language pathology.

In addition to identifying language development milestones for a given age, screening tests often incorporate the notion of "red flags" or indicators, namely behaviours or the absence of behaviours in a child that justify a referral for a speech-language pathology assessment. They are essentially "warning signs" (Chagnon 2014).

Screening tools can be classified into two broad categories (Berkman *et al.*, 2015):

- Those intended for *intervention workers*. These screening tools are intended for front-line intervention workers, such as nurses, early childhood intervention workers, and healthcare professionals (e.g., *Petit guide sur le langage à l'intention des intervenants en petite enfance*, Table de concertation CONPARLE FAMILLE – Parlons ensemble, *Grille d'évaluation du développement (GED)*);
- Those designed for *parents* or guardians (e.g., *Je grandis et je communique*, pamphlet published by the Ordre des orthophonistes et audiologistes du Québec).

Some screening tools have been statistically validated, meaning that their effectiveness at accurately identifying children with a language delay and at ruling out those with no delay has been tested. Some tests, which have been validated for the francophone population in Québec, address overall development but with an *expressive and receptive-cognitive language component* (e.g., *Grille d'évaluation du développement (GED)*, Vézina 2007; *Ages and Stages Questionnaires (ASQ)*, Harguindéguy-Lincourt 2004).

The *Speech and Language Pathology Early Screening Instrument (SLPESI)*, for its part, has been validated with an English Canadian population (Carscadden *et al.*, 2010), and can therefore be used with anglophone children. This simple tool contains six questions for parents. For validation purposes, it was administered at vaccination appointments for children aged 17-23 months. Although the validation was done in a summary manner, the results were conclusive: 97% of the children screened had a language delay. In the group of children who were not screened, 95% had normal language development.

Three central concepts are associated with recognizing children who are at risk of having communication and language development difficulties: screening, case-finding, and detection. Screening is a formal, planned, and relatively quick process. The screening test typically involves the use of formal techniques applied to all children in a target group. Children with difficulties who are targeted by the screening test are identified. Case-finding is the outcome of the screening test (Billiard 2004). Finally, when an intervention worker is interacting informally with a child, an educator, or a speech-language pathologist, for example, their knowledge or experience may cause them to notice that the child appears to have a language delay. This allows them to detect the child and refer them and their family to a speech-language pathologist for a comprehensive language assessment.

Early detection is important, as it leads to early intervention in the event of a language disorder, thereby preventing the problems from worsening (ASHA 2008; OOAQ 2009). Moreover, speech-language pathologists are often the professionals who detect signs of more overarching problems in a child. In fact, language delays are not only part of the portrait of language disorders, but also of attention disorders and autism spectrum disorders, among others (Bruce and Hansson 2008). Screening children who are at risk of having language difficulties also helps to identify children who will have developmental difficulties in spheres other than language.

However, screening for language skills, and for the other spheres of development in general, is a challenge. By definition, a screening test detects an absolute condition, i.e., the presence or absence of elements justifying referral to a specialist. However, language delays are quantifiable in terms of degrees (mild, moderate, or severe delay). It is therefore possible that two children with very different language skills, such as a mild delay and a severe delay in pronunciation, will both be referred for speech-language pathology services, despite having different profiles (Eriksson, Westerlund and Miniscalco 2010).

The efficacy of implementing systematic screening for language difficulties, i.e., according to a procedure aimed at screening all 3-year-old children, is mixed. Two meta-analyses of the literature on the efficacy of language screening tests have been done—one in Germany (Kasper *et al.*, 2011) and the other in the United States (Berkman *et al.*, 2015). Both analyses sought to answer the following question, among others: "Should systematic screening of language difficulties in preschool children be recommended?" to which the authors answered no. The systematic screening of language difficulties in that particular population cannot be recommended, given the lack of reliable scientific evidence at the moment. This recommendation could therefore be revised in the future.

However, screening would be effective for children at risk of having communication and language difficulties, for example, children on a waiting list for access to speech-language pathology services. A literature review conducted by the CSSS de la Vieille-Capitale (St-Jacques and Dussault 2013) identified two screening-related measures that could effectively shorten the CLSC waiting list: a specialized educator administering the GED screening tool to all children on the waiting list, and the speech-language pathologist performing a summary assessment (case-finding).

Comment in relation to public health: There have been many discussions about the difference between *screening* and *case-finding*. These two concepts are often used interchangeably. However, screening is an activity that applies to 100% of the population, whereas case-finding identifies difficulties in a person who is suspected of having a clinical issue or who is seeking help for themselves or at the behest of a family member.

Recommendations by the GTM-ODL

Case-finding activities and tools

For language development difficulty case-finding activities, include the following practices for an evidence-based approach:

- Inform all early childhood stakeholders (nurses, educators, intervention workers, etc.) about the stages of language development.
- Train intervention workers on language development and the use of a screening grid;
- Use a screening grid or tool developed by a speech-language pathologist;
- Ensure that the language development observation tool used contains indicators for referring a child for a speech-language pathology assessment when the situation requires it;
- Immediately refer the parents of a child who appears to have communication and language development difficulties for a speech-language pathology assessment;
- Encourage the parents to consult in speech-language pathology the minute they have concerns about their child's communication or language development.

Recommendations related to the Speech-language pathologist's specific mandates

- Update the contents of the screening documents for the partners in the continuum of collaborative community speech-language pathology services;
- Support the intervention workers with their screening activities and facilitate access to intervention type 3 – Assessment and intervention (specific services).

3.3.2. Development activities for children aged 0-12 months: baby sign language

Various regions offer sign language activities for babies without developmental difficulties, and these activities illustrate the numerous benefits associated with learning sign language. However, using sign language does not accelerate oral language development (Rebecca Maftoul, speech-language pathologist and clinical director at Université de Montréal, systematic literature review; Johnston, Durieux-Smith and Bloom 2005). In fact, no serious study has demonstrated a link between sign language and improved oral language learning.

However, it appears there are some benefits indirectly associated with the use of sign language in babies. In fact, sign language could facilitate communication between parents and baby for a short time. The improvements and benefits observed and reported could also likely result from the fact that the use of sign language stimulates language precursors and a secure attachment: increased oral communication time between parents and child, eye contact, laughter, cuddles, etc. (Johnston, Durieux-Smith and Bloom 2005).

3.3.3. Activities aimed at the development of language precursors, the development of attachment, and overall development in children aged 0-12 months.

There are links between the development of language and that of emotional understanding and attachment.

Attachment is a powerful emotional bond between the parent and child that creates a sense of security in the individual (Bee and Boyd 2006). Attachment stems from behaviours by the parents, who develop synchrony between them and their child. These same behaviours also underpin the development of language precursors.

It would appear that children with a language delay develop an equally secure attachment as those with typical language development (Van IJzendoorn *et al.*, 2007). However, a team of researchers has shown that good emotional understanding is related to a secure attachment and to verbal mental age, and therefore to language skills (Rosnay and Harris 2002). Note that their conclusions are subject to reservations. More specifically, verbal mental age was determined based on an assessment of receptive vocabulary, and emotional understanding on the comprehension of scenarios that included a lot of verbal information. Emotional understanding was therefore underpinned by receptive language skills.

It is known that children with significant language disorders often have more difficulty than others identifying emotions. Among other reasons, this could be explained by the fact that these children have difficulty understanding abstract concepts and inferences (Merz *et al.*, 2015).

Merz *et al.* (2015) also mentioned that using inferential language, i.e. indirect speech, could be an effective way to stimulate the understanding of abstract concepts, and therefore emotional understanding. Examples of indirect speech include using decontextualized language and talking about past, future, or hypothetical activities or events that are not part of the immediate environment. The same authors (Merz *et al.*, 2015) postulated that, in children from disadvantaged areas, a sensitive response tailored to the child's behaviour could encourage the

development of a secure attachment, as well as optimal cognitive development, which was linked to good emotional understanding in the child.

It is possible to stimulate attachment and language development in children aged 0-12 months. The activities and tips recommended by speech-language pathologists for working on language precursors in young children promote, among other things, imitation, turn-taking, joint attention, and eye contact. These behaviours encourage synchrony, as well as verbal and non-verbal exchanges during daily activities between parents and child, thereby stimulating the creation of a secure attachment. In summary, stimulation activities that target language precursors also help to maintain a secure attachment between parents and child.

Recommendations by the GTM-ODL

Stimulation of language precursors

For parent-child dyad activities aimed at the development of language precursors in children aged 0-12 months (Daviault 2011), include the following practices for an evidence-based approach:

- Encourage parents to adopt the following strategies in activities with their children aged 0-12 months:

  Examples
  - ✔ *Call the child so that they turn their head in your direction;*
  - ✔ *Look them in the eyes when talking to them; speak in short sentences with exaggerated intonation;*
  - ✔ *Name the objects that the baby touches; name the different parts of the body, touching them at the same time;*
  - ✔ *Name the child's emotions and feelings: "You're mad"; "You're happy"; "You're hungry";*
  - ✔ *Talk about past or future activities and events;*
  - ✔ *Say the words "again," "gone," and "on the floor" often;*
  - ✔ *During bath or diaper time, grasp their feet or hands and move them in time to a short nursery rhyme. Repeat the same nursery rhyme often, accompanied by the same gestures;*
  - ✔ *Play "peek-a-boo";*
  - ✔ *Ask the child to give you the object or food that they are holding (e.g., "Give me the teddy bear"; "Give me the banana"; etc.);*
  - ✔ *Answer the child with sounds or real words when they babble or makes sounds.*

3.3.4. Intervention worker-child early literacy activities

Intervention workers can play an important role in early literacy. Several environments already incorporate reading time into their activities with children, exposing them to written language in order to prepare them for school. In their study, Québec-based researchers Lefebvre, Trudeau and Sutton (2011) identified three factors that predict written language learning in preschool children:

- *Oral language skills*, mainly expressive vocabulary (Daviault 2011; Mol, Bus and de Jong 2009);
- *Writing awareness*, which refers to knowing the alphabet and the names of the letters, as well as writing conventions, among other things;
- *Phonological awareness*.

Lefebvre, Trudeau, and Sutton (2011) compared three groups of children in a childcare centre, exposed to different activities: 1) a traditional shared reading activity, with emphasis on language and writing; 2) a so-called experimental intervention activity, in which the children were exposed to shared reading with added stimulation of phonological awareness; 3) a control group, in which children did not participate in any shared reading activity. The results showed that, in group 2 which placed an emphasis on phonological awareness, all children, regardless of socioeconomic status, showed improvement compared to the children in the other groups. Moreover, following their participation in group 2, the children from disadvantaged areas in the experimental group outperformed the children from a high socioeconomic status in the group without intervention on the three measures applied (vocabulary, writing awareness, and

phonological awareness). The intervention proceeded as follows: Each week, the children in the experimental group, aged 4 and 5, were exposed to four 20-to-30-minute sessions during which the intervention worker (Mr. Lefebvre, speech-language pathologist) led a shared reading session with the children's group (approximately 10 children). This was kept up for 10 weeks.

Recommendations by the GTM-ODL

Early literacy activities: intervention worker-child

For intervention worker-led early literacy activities, include the following practices in the training sessions for an evidence-based approach:

- Encourage intervention workers to follow training on early literacy;
- Include the following aspects according to the children's age group:

As of age 1

Encourage reading time during which the child:

Examples
- ✔ *Learns to turn the pages;*
- ✔ *Learns the direction of reading a book (start to finish);*
- ✔ *Learns that a book is an object that contains information.*

As of ages 2 and 3

During early literacy activities, focus on learning new words and on increasing vocabulary by questioning the children about the content of the book.

As of age 4

Schedule a 20-minute reading session and interact with the children about the following aspects while reading (Lefebvre, Trudeau and Sutton 2011):

Examples
- ✔ *Stop reading and point out the less common words, giving their definitions and synonyms;*
- ✔ *Stop reading and ask questions about the characters' emotions, what's going to happen next, etc.;*
- ✔ *Encourage learning about book-related concepts (e.g., cover, title, meaning of reading, etc.).*

Based on words chosen from the book, stimulate phonological awareness by asking children questions about sounds and syllables (Daviault 2011).

Examples
- ✔ *Sound out the syllables (e.g., "bottle" has two syllables);*
- ✔ *Take away syllables (e.g., if we take away the first syllable from "baseball," we get "ball");*
- ✔ *Combine syllables (e.g., if we put the first syllables from "marble" and "kettle" together, we get "market");*
- ✔ *Improve their knowledge of the letters of the alphabet;*
- ✔ *Say the sounds that the letters make (e.g., the letter "f" sounds like [fff]);*
- ✔ *Identify the first sounds of words (e.g., the word "fire" starts with [fff]).*

3.3.5. Parent-child early literacy activities

Several studies have demonstrated the benefits associated with shared reading, a type of early literacy activity. This activity between parents and child improves expressive vocabulary, in addition to exposing the child to written language and stimulating the skills needed to learn to read and write (for a review, see Lefebvre, Trudeau and Sutton 2011; Mol 2009; Mol *et al.*, 2008). It appears that good expressive vocabulary is not only favourable to reading development, but also associated with reading comprehension skills in high school (Daviault 2011).

Shared reading time between parents and their young children can have a real impact, among other things, on improving language skills. Mol *et al.* (2008) conducted a meta-analysis on the effectiveness of shared reading between parents and children. The results showed that this type of activity had an effect on improving expressive vocabulary in children aged 2 and 3. However, this activity would be significantly less effective in older children (age 4 and 5) or in

children with significant risk factors for academic learning difficulties. The latter point could be explained by two assumptions made by the authors: At-risk children have fewer inference skills, which would lessen the benefits of shared reading, or at-risk children have mothers who are less educated, which would make their reading less effective.

In one study (Roth, Paul and Pierotti 2006), the authors point out that pre-reading and pre-writing skills can be stimulated by parents through reading, but also during everyday activities.

Recommendations by the GTM-ODL

Early literacy: parent-child

For parent-child early literacy activities, include the following practices in the training sessions for an evidence-based approach (Daviault 2011, www.asha.org):

As of age 1	Encourage reading time during which the child: *Examples* ✔ *Learns to turn the pages in the right direction;* ✔ *Learns to identify the beginning and end of a book;* ✔ *Understands that a book contains information;* Encourage parents to re-read their child's favourite books often and to draw the child's attention to the words and pictures while reading.
As of ages 2 and 3	Encourage parents to draw the child's attention to written words (e.g., names of restaurants, traffic signs, food packaging, etc.); Encourage parent-child early literacy activities through training sessions (see Section 3.3.7. Parent-child dyad activities).
As of age 4	Integrate early literacy activities on a daily basis: *Examples* ✔ *Sound out syllables (e.g., in the grocery store, the word "apple" has two syllables);* ✔ *Identify the first sounds of words (e.g., the word "fall" starts with [fff]).* ✔ *Sing nursery rhymes or play games with rhyming words.* Promote activities that focus on phonemes (the individual sounds in words). *Examples* ✔ *Teach the letters of the alphabet;* ✔ *Know the sounds that the letters make (e.g., the letter "f" sounds like [fff]);* ✔ *Identify the first sounds of words (e.g., the word "fall" starts with [fff]).*

3.3.6. Parent-child early literacy activities

There are several benefits related to parent discussion groups relating to child development. The effectiveness of parent discussion groups on parenting attitudes has mainly been studied in terms of behavioural difficulties in young children.

Joachim, Sanders, and Turner (2010) examined the effectiveness of a group of parents of children aged 2-6 with behavioural difficulties, mainly during public outings. The study consisted of two groups: A group of 10 parents who attended a 2-hour meeting without their children, and a control group of parents who were not involved in any activity, but who were on a waiting list for services. The meeting structure included a time for parents to talk about issues they were having with their child, concrete strategies to adopt, a routine to be followed during public outings (e.g., to the grocery store), and a video demonstrating the strategies. Following the analysis of the questionnaires filled out by the participants in both groups, the authors observed improvements only in the group of parents who had attended the meeting. This meeting led to parents gaining more confidence in their parenting skills, reducing their use of ineffective disciplinary techniques, and observing a decrease in their child's inappropriate behaviour compared to parents in the control group. The researchers Morawska *et al.* (2011) also came to the same conclusions. Moreover, they observed an increase in the parents' perception of social support following a two-hour discussion meeting.

More recently, Dittman *et al.* (2016) conducted research on the effectiveness of a parent discussion group, again on the subject of behavioural issues in children aged 3-5. They came to the same conclusions. The researchers outlined the structure of the parent meeting: It lasted two hours, was attended by 4-6 parents, and was led by a psychologist specialized in leading Triple-P (Positive Parenting Program) groups, which are based on an appreciative inquiry. The psychologist showed the parents a PowerPoint presentation containing videos illustrating the strategies. A strategy checklist and an information booklet were given to the parents.

In one study, Lonergan *et al.* (2015) compared the effectiveness of a single-meeting parent discussion group to seven parent-child dyad meetings. Both types of interventions addressed the challenges faced by children with behavioural difficulties. The authors noted the same type of improvement in the discussion group participants as in previous studies. However, the most significant improvements, and those that were maintained over time, were observed in the parents who attended seven meetings.

In Québec, several different settings offer parent discussion groups. In the case of language information sessions for parents of young children held at a community centre, one of the organizers reported seeing advantages when the sessions were led by a speech-language pathologist versus an intervention worker. On the one hand, the participation rate was higher. On the other hand, the organizer noted that the speech-language pathologist was better equipped to answer the parents' questions and concerns about their child's language development, given their professional expertise. In addition to advising parents, the speech-language pathologist could refer them to resources for promoting good language development and managing language difficulties early on.

Recommendations by the GTM-ODL

Parent information session

During parent information sessions, include the following practices for an evidence-based approach:

- Provide information on language and communication development milestones (for more information, see Chapter 2 and the glossary in this document);
- Schedule a time during the sessions for parents to talk and compare notes about the problems they are having with their children;
- Emphasize concrete strategies and advice that are directly applicable to specific situations in the family's daily life. Be able to illustrate the strategy or advice with a scenario or a video;
- Include a straightforward document summarizing the strategies and advice given;
- If possible, organize groups of no more than 30 parents lasting a maximum of two hours;
- Provide a drop-in daycare;
- At the end of the activity, hand out information about other activities in the continuum.

Recommendations related to the Speech-language pathologist's specific mandates

- Co-host the information sessions for parents and intervention workers, in close collaboration with the community organizations;
- Advise parents on communication and language development milestones;
- As needed, refer parents to activities in the continuum of collaborative community speech-language pathology services;
- Act as a language development contact person for early childhood intervention workers and stakeholders;
- Participate in validating existing tools and in creating tools/documents associated with the promotion of communication and language development milestones.

3.3.7. Language stimulation activities in parent-child dyads

Training activities for parents in the form of parent-child dyads can improve children's language skills. Several settings offer language stimulation activities in this format. Moreover, following an assessment, the speech-language pathologist generally refers the child and their family for a speech-language pathology intervention targeted to the child's specific difficulties. This intervention can also be offered in the form of dyads. According to a systematic review of the U.S.-based literature (Law, Garrett, and Nye 2008), when parents receive guidance from a speech-language pathologist, the latter's indirect intervention results in improvements in the child's language skills in the same way as though a clinician (speech-language pathologist) had intervened directly. Improvements were also observed within both individual and group speech-language pathology sessions. It is important to note that this review was done using available studies focusing on intervention in speech-language pathology, of which there are few, making the results less reliable.

Several studies have found that parent-child dyad interventions, aimed at improving parents' ability to stimulate language in their children, have a real impact on increasing the child's language skills, mainly in the area of expressive language: pronunciation of sounds (articulation/phonology), vocabulary, and sentence structure (length and complexity). Some studies also report improvements in the area of receptive language (for a review, see Berkman *et al.*, 2015; Roberts and Kaiser 2011), although the results are sometimes contradictory (Law, Garrett and Nye 2008). Note that improvements were also observed, following parent-child dyad activities, in the development of language precursors in children as of 10 months of age (e.g., Ward 1999, cited in Berkman *et al.*, 2015). However, these results need to be considered with caution, since all the authors who have examined this subject agree that more studies are needed to confirm the expected results of indirect interventions.

The objectives of language stimulation and intervention activities, whether individual or in a group, are as follows:

> *"Counteract the impact of risk factors and promote the action of protective factors, in order to create or recreate ecological conditions conducive to the functioning of the person's communication and to help them develop the skills and competencies needed for optimal communication. The intervention capitalizes on the compensatory power of the protective factors."*
>
> [Sylvestre 2008]

Good practices associated with dyad activities involving a child have been the subject of systematic literature reviews (Berkman *et al.*, 2015; Roberts and Kaiser 2011), studies (Buschmann *et al.*, 2009; Ciccone, Hennessey and Stokes 2012), and unpublished master's degree internship reports by speech-language pathology students (Grégoire 2013; Simard *et al.*, 2013).

In terms of organizing dyad meetings, the authors of a U.S. meta-study (Berkman *et al.*, 2015) produced a summary table of the significant effects of improving children's language skills through interventions based on 6 and 8 meetings of 75 to 120 minutes. A preliminary study showed an improvement in skills with six 75-minute sessions each week (Ciccone, Hennessey and Stokes 2012). Improvements in language skills in children with a language delay were observed from age 21 months until the start of kindergarten. The groups generally target children with a maximum of 12 months' age difference, with the exception of groups targeting 2-year-olds, for example, 21-25 months (Buschmann *et al.*, 2009), 24-36 months (Girolametto *et al.*, 1994, cited in the review by Berkman *et al.*, 2015), 36-44 months, and 44-61 months (Robertson *et al.*, 1997, cited in the review by Berkman *et al.*, 2015).

Some stimulation techniques and skills taught to parents are strongly associated with an increase in the language skills of children with a language delay. The meta-analysis by Roberts and Kaiser (2011) showed that the language skills of children with a delay can

improve when the parents apply the following language stimulation techniques and parenting skills in their daily lives:

- The amount of parent-child interaction. The more time the parent and child spend interacting, the more the child will be exposed to a varied vocabulary, among other things;
- The parent's responsiveness. Responsiveness refers to the parent's verbal and non-verbal responses (e.g., eye contact, pointing, gestures, vocalization, etc.) to the child's attempts to communicate;
- Language stimuli. Both the quantity and quality of language (e.g., diverse vocabulary, using sentences adapted to the child's level, etc.) have an influence on the child's language development;
- The use of language stimulation strategies. Rewording the child's statements so they are properly constructed, expanding sentences by adding one or two words, and pointing out spatial relationships between objects are examples of strategies that promote children's language development;
- The parent's ability to ask their child open-ended or multiple-choice questions.

Finally, certain variables associated with the participants in parent-child dyad activities have been identified in the literature. With respect to the parents, there is first the willingness to get involved and to understand that this type of group can be just as effective as a traditional one-on-one intervention with a speech-language pathologist. Second, the willingness to attend the meetings is an attitude that increases the effectiveness of these interventions (Roberts and Kaiser 2011). For the children, having well-developed language precursors increases the likelihood that their language skills will improve following group interventions with the parents (Hadley *et al.*, 2011).

Recommendations by the GTM-ODL

Communication and language stimulation activities (parent-child dyads)

For all parent-child dyad activities aimed at stimulating language and communication, include the following practices for an evidence-based approach:

- Promote the following structural elements.

  Conditions
  - ✔ *Assign a maximum of five dyads to one trainer;*
  - ✔ *Offer at least of six meetings every week or every second week;*
  - ✔ *Schedule meetings to last between 75 and 120 minutes;*
  - ✔ *Favour groups of children the same age and with a similar language level: a 6-month interval for the youngest children (18-24 months) and a 12-month interval for the older ones (24-36 months, 36-48 months and 48-60 months). For example, a 4-year-old child who is not yet talking could be registered in a group of children who are younger but who have a similar level of language;*
  - ✔ *Dedicate one-third of the time to coaching situations, i.e., the parents interacting with their child while the trainer gives comments and feedback.*
- Encourage coaching-type training based on an appreciative inquiry (see the recommendations for training activities on acquiring communication and language stimulation skills (Section 3.2), which also apply to teaching language stimulation techniques to parents).
- During these sessions, teach specific language stimulation techniques based on the theme discussed.

  The stimulation techniques taught should include the following elements:
  - The techniques are aimed at communication and interaction between the parents and their child;
  - The techniques are taught as part of an everyday activity: while reading, while eating a snack, while playing with the child's own games and toys, etc.;
  - The techniques are taught using examples given by the trainer to the parents during interactions with the child;
  - The techniques are aimed at increasing the amount of parent-child interaction;
  - The techniques are aimed at improving the parents' ability to respond to their child's verbal or non-verbal communication attempts;
  - Include the following language stimulation techniques in the meetings:
    - Rewording (parents reformulate the child's statements so they are properly constructed);

- Expansion (parents repeat the child's statements by adding one or two words);
- Use of vocabulary associated with concepts: size, spatial concepts, etc.;
- Use of open-ended and multiple-choice questions with the child.

Recommendations related to the Speech-language pathologist's specific mandates

- Update the contents of workshops for parents and intervention workers;
- Attend an activity session to support the trainer, answer questions, and advise the people concerned;
- Refer the child and their parents, or confirm a referral to intervention type 3 – *Assessment and intervention* of the continuum of collaborative community speech-language pathology services;
- Act as resource person for the intervention workers and activity organizers.

3.3.8. Material loans for parents

In several regions, parents have access to toy or book loan services in order to promote their child's overall stimulation, communication, and language.

However, loaning books to parents, without any associated training, has been found to be mostly ineffective. In fact, so-called interactive reading is associated with benefits in terms of expressive vocabulary in children aged 2-3. However, this type of reading implies that parents not only read the book to their child, but also use techniques such as asking questions, giving feedback on answers, etc. Several studies reported in a meta-analysis on the subject (Mol *et al.*, 2008) showed that parents do not spontaneously use these techniques when reading with their child and that training is necessary.

Game loan services imply that the material loaned will have a positive impact on language stimulation in young children. It is known that, when playing with a child, parents generally spontaneously adopt attitudes that promote the child's language development: short sentences, exaggerated intonation, etc. These parental behaviours are positively influenced and reinforced by the children during play. However, several studies (for a review, see Vigil, Hodges and Klee 2005) have found that children with a language delay make receptivity more difficult for the parent during play, making stimulation less effective in that case. We can therefore conclude that game loan services should be accompanied by the option of participating in activities on language stimulation techniques.

Recommendations by the GTM-ODL

Material loans for parents

For material loans for parents (e.g., loans from game and book bins):

- Inform parents who use the book and game loan service of the communication and language development activities available on the territory (oral presentation, pamphlets, etc.);
- Oversee the set-up of a books and games loan or exchange system on the territory;
- Oversee the availability of book bins in public places where children and their parents are required to spend time waiting;
- Provide a variety games and books (for all ages, with and without words, etc.).

Vigil, Hodges and Klee (2005) evaluated various aspects of parental behaviour when playing with children. They observed parent-child dyads in which the children were 25 months of age on average. Two parent-child dyad groups were created for the study: one group of children with a language delay and one group of children developing normally. The authors observed that the average length of the parents' statements was the same for both groups. However, the parents of children with a language delay verbalized their actions significantly less and responded less to the child's initiatives. According to the authors, the results are attributable to the feedback loop that is created between parents and their child during play. In children with a language

delay, their feedback and attempts at conversation are less clear to the parents.

3.3.9. Summer activities for preschool children

Some authors have examined the effectiveness of summer language stimulation activities aimed at different types of children. First, U.S. studies have shown that pre-reading and reading skills in economically disadvantaged American children could be positively influenced by summer activities (for a review, see Schacter and Jo 2005). Once they start kindergarten, these children would be at a disadvantage, notably due to the lower level of written language stimulation in their family environment. Moreover, over the course of their education, these students would experience a decline in their reading skills over the summer, unlike children from the middle and upper economic classes, whose skills would improve. Schacter and Jo (2005) ran a seven-week day camp for a group of some 50 children (average age of 7), which included two hours of reading activities per day. First, the young people in the intervention group saw an increase in their reading skills by the end of the camp, compared to the control group. Moreover, their improved reading skills were maintained over time, i.e., three months and nine months after the day camp.

According to Luftig (2003), a two-week summer day camp was effective at maintaining and improving reading skills. The participants included 36 students from grades 1 to 4, who were identified as being at risk of written language learning difficulties based on their grades or economic status. These students were then divided into three groups: The first group received a group intervention, the second group received one-on-one private interventions, and the third group (control group) received no intervention. Note that students in the first two groups received an average of eight hours of learning materials spread over a period of 2-3 weeks. Compared to the control group, the author observed an improvement in the two intervention groups in terms of their reading skills, reading comprehension skills, and phonological awareness. Moreover, the youngest students, i.e., those in grade 1, benefited the most from the interventions.

Other researchers (Edmonds *et al.*, 2009) observed an improvement in oral language skills and pre-writing skills in children aged 4-5 following stimulation in a day camp environment. The summer program lasted six weeks: five days a week, three hours a day of oral language activities and pre-writing skills. Compared to the participants' skill levels prior to the day camp, significant improvements were observed in all areas that were stimulated. However, the results should be interpreted with caution given the absence of a control group.

Recommendations by the GTM-ODL

Summer activities

For summer activities with preschool children:

- Incorporate book-based activities into day camps (see sections 3.3.4. and 3.3.5. Early literacy activities);
- Incorporate the presence of speech-language pathology students into existing summer activities to provide periods of language stimulation and early literacy activities for the children who are registered.

Recommendations related to the Speech-language pathologist's specific mandates

- Update the contents of workshops for parents and intervention workers;
- Act as resource person for the intervention workers and activity organizers.

3.4. Assessment and intervention in community speech-language pathology

3.4.1. When to consult in speech-language pathology and acceptable wait times for assessments and interventions

According to the American Speech-Language-Hearing Association (ASHA, 2008), if a parent is worried about their child's language development, they should consult a speech-language pathologist, even before age 3. In reality, parents tend to wait a certain amount of time for the child's language skills to "unblock" before consulting. The ASHA points out that the amount of language learning that happens each month in a 24-month-old child is enormous. As a result, the gap between a late talker and other children their age grows very quickly. The child's delay therefore increases in proportion to the wait time.

The Association québécoise des orthophonistes et audiologistes (AQOA) also encourages parents to act as early as possible:

> ***"At what age can a child see a speech-language pathologist?***
>
> Early intervention plays a key role in supporting language and communication development and in preventing problems in children. Speech-language pathologists often work with preschool-age children to prevent and quickly intervene in the event of language difficulties. In some cases, infants under the age of 1 can benefit from the services of a speech-language pathologist (support for parents, early stimulation, children with hearing impairments, etc.). If you suspect that your child has a language, speech, or communication problem, consult a speech-language pathologist or talk to your doctor."

Acting early is also a concern for parents. As noted in a recent Québec study (Mongrain and Michallet 2015), parents of children with language development difficulties are dissatisfied with the current wait times for service and feel alone in trying to help their child with a language problem.

Québec researchers Rvachew and Rafaat (2014) have established maximum wait times for assessing and treating children with expressive language difficulties. The study concerned pronunciation difficulties, both speech and phonology related, but their conclusions can be reliably generalized to other expressive language development difficulties. In their study, they stated that the time from referral to first assessment should not exceed two months, regardless of age or risk level. This statement was based on the assumption, first, that an assessment is necessary to assess the actual risk level, and second, that the parents' and teachers' concerns are a credible indication of a language or other problem, justifying a rapid assessment.

As for the time from assessment to treatment, it should be based on the child's age and risk level, and according to Rvachew and Rafaat (2014), should be limited to 1-8 months, depending on the child's age and risk level, with the following precisions:

For high-risk children:

- 1 month for children aged 4-6;
- 3 months for children aged 0-3;
- 3 months for school-age children.

For low-risk children:

- 3 months for children aged 4-6;
- 6 months for children aged 0-3;
- 8 months for school-age children.

The factors to consider when determining the risk level associated with expressive language difficulties are:

- A recognized or documented family history of language delays, language disorders, or reading difficulties;
- Difficulties in spheres of language other than speech and phonology, such as a morphosyntactic or phonological delay;
- The child is starting school (kindergarten or grade 1) the following September;
- Language difficulties affect the child's ability to participate in activities and to fulfil their everyday roles.

In terms of receptive language, verbal comprehension difficulties, as much as cognitive communication disorders, lead to deficits in understanding concepts and instructions. While they can vary in severity, they generally have direct negative repercussions on the child's day-to-day level of functioning. Moreover,

children with receptive language difficulties, compared to expressive language difficulties only, are at higher risk of behavioural problems (Yew and O'Kearney 2013). A receptive language delay is therefore a significant risk factor that should lead to rapid intervention. Other aspects of communication and language development, such as social communication skills, can also be risk factors that influence the need for a rapid speech-language pathology intervention (for a review, see Pearce *et al.*, 2014).

Based on the child's overall language level and risk factors identified during the speech-language pathology assessment, the speech-language pathologist can determine how quickly the intervention needs to be done.

Recommendations by the GTM-ODL

Prior to the speech-language pathology assessment

Good practices associated with wait times prior to the speech-language pathology assessment and intervention:

- As needed, immediately refer the child and their parents for a speech-language pathology assessment if a language delay or language difficulties are observed;
- Avoid wait times longer than two months for children registering for speech-language pathology services;
- Aim for a wait time of 1-8 months from the speech-language pathology assessment to the start of treatment, based on the speech-language pathologist's clinical opinion.

3.4.2. Effective methods associated with waiting lists

Québec authors St-Jacques and Dussault (2013) identified certain practices recognized in the literature for improving the management of waiting lists for early childhood speech-language pathology services:

- In addition to the speech-language pathology intervention, offer parents the opportunity to participate in parent-child dyad sessions in which they learn to do the exercises and techniques recommended by the speech-language pathologist;
- Conduct interventions in small groups (maximum of 2-3 children) according to IP (intervention plan);
- The similarity between the difficulties stimulates discussion between parents and encourages them to get involved. However, the authors point out that the work involved in training the groups and writing up the files adds to the speech-language pathologists' workload;
- Centralizing the appointment management process at a call centre (as was tested in Trois-Rivières) allows the speech-language pathologists to make up lost clinic time;
- Logistical changes, such as implementing administrative services to contact parents and schedule appointments, have led to lower absenteeism rates.

3.4.3. Effective speech-language pathology intervention modalities associated with language difficulties or disorders

Historically, the profession of speech-language pathologist was conducted according to a "medical model," in which attention was focused on the diagnosis, i.e., the speech-language pathology conclusion, and on the remediation of the person's problems through individualized therapy (Llewellyn and Hogan 2000, reported by Law, Reilly and Snow 2013). Since then, other models associated with the profession of speech-language pathologist have been studied and implemented, proving to be as effective as and, in several cases, superior to the traditional, so-called curative, approach.

A document produced by the Royal College of Speech and Language Therapists of the United Kingdom (Gascoigne 2006) contained recommendations on supporting children with special language, speech, and communication needs, from the perspective of an integrated, ecosystemic approach to pediatric services. These integrated services are modeled on the approach according to which the majority of the population will use universal services, whereas a portion of the population will need selective measures, and children with special needs will absolutely require specific, specialized measures. These recommendations, which depart from the

"curative" care model, focused on four elements: providing effective services to the population, maximizing the impacts of the intervention, offering systems for strategy, and developing the workforce.

As mentioned by Law, Reilly and Snow (2013), the classical speech-language pathology intervention takes place one-on-one. More specifically, the child is assessed, with or without the parents present, and an intervention block is initiated. This intervention generally consists of an hour of activities during which the speech-language pathologist works with the child on tasks related to their difficulties. In order to promote an ecosystemic approach, the speech-language pathologist generally teaches and develops strategies with the parents so that they can do these activities at home or apply language stimulation strategies in their everyday life, in order to address the speech-language pathology objectives as often as possible in their communication with the child. The speech-language pathologist may also contact an intervention worker associated with the child, where possible (e.g., the daycare educator), to discuss the speech-language pathology objectives to be addressed in the child's environment.

Researchers have done literature reviews of the studies that have examined the most effective speech-language pathology intervention methods since the 1990s (Berkman *et al.*, 2015; Law, Garrett and Nye 2008). The conclusions all point to the fact that, according to the studies listed, an intervention done by a clinician is no more effective than an intervention done by a parent who has been trained by a speech-language pathologist. The effectiveness of the language interventions done by parents was also demonstrated by a literature review (Roberts and Kaiser 2011). No difference was observed between individual or group interventions in terms of language improvements in the children (Law, Garrett and Nye 2008). Moreover, the effectiveness of the speech-language pathology intervention, regardless of treatment modalities, has been demonstrated for some components of language (e.g., vocabulary and phonology), although the results are still mixed for others (e.g., receptive language). Compared to other fields of study on cognition, note that research in speech pathology is still relatively recent, and the authors state that more scientific evidence is needed to nuance and confirm the current conclusions.

Finally, regarding the speech-language pathology intervention, the ideal format would be to offer several intervention modalities (direct, indirect, and group), according to the needs of the child and the parents, and based on the speech-language pathologist's judgment (Gascoigne 2006).

Note that several Québec models for speech-language pathology assessment and intervention services have been documented. For examples of service offered, see the following documents (non-exhaustive list): *Plan d'action montréalais - Amélioration de la performance des services d'orthophonie pour les enfants et les jeunes* (Agence de la santé et des services sociaux de Montréal, 2009) and *Organisation des services de première ligne en déficience du langage et de la parole pour les enfants* (Régie régionale de la santé et des services sociaux de Québec, 1998).

Recommendations by the GTM-ODL

Speech-language pathology intervention

For the most effective speech-language pathology intervention modalities (direct, indirect, or group) associated with language difficulties or disorders, include the following practices:

- Teach parents and key people (community intervention workers, childcare centres, extended family members, other professionals, etc.) the skills needed for targeted stimulation of the child's language difficulties, such as a central speech-language pathology intervention activity, in order to maximize its impact on the intervention plan;
- Determine the functional impacts of the language impairment and consider the family's needs and specific situation before selecting the intervention modalities, based on the speech-language pathologist's judgment;
- Offer different speech-language pathology intervention modalities to meet the specific needs of the clientele;
- Implement language-related services for children and their families, in collaboration with the territory stakeholders and based on the child's needs.

Recommendations related to the Speech-language pathologist's specific mandates

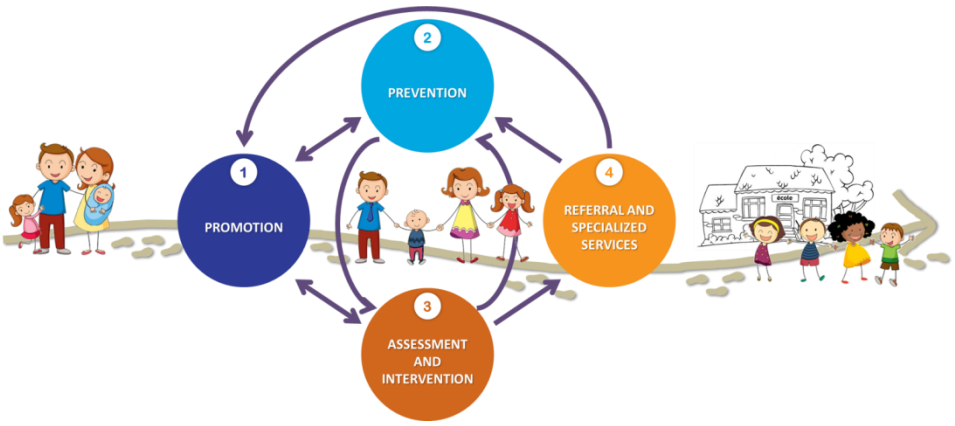
- Provide the required support to intervention workers in their individual or group activities with respect to the language difficulties of children already assessed in speech-language pathology. Offer them the speech-language pathologist's services as a reference;
- Lead activities at certain times to support the intervention workers, as required;
- In collaboration with continuum stakeholders and based on needs, organize group intervention activities for children already assessed in speech-language pathology and their parents;
- Intervene directly with the child and their parents, as needed.

Conclusion

This section establishes the theoretical and practical framework for the concept of community speech-language pathology as defined by the GTM-ODL, the outcome of a thoughtful review of knowledge on the topic of communication and language development in young children. The information and recommendations were issued according to an evidence-based approach, based on the clinical and practical experience of the GTM-ODL members, data from the scientific literature, and the needs of the families concerned.

The concept of community speech-language pathology is based on the establishment of a continuum of collaborative services comprised of four intervention types, ranging from promotion and prevention to specific services. Various tools are proposed in order to implement and operate the continuum of collaborative community speech-language pathology services on a given territory.

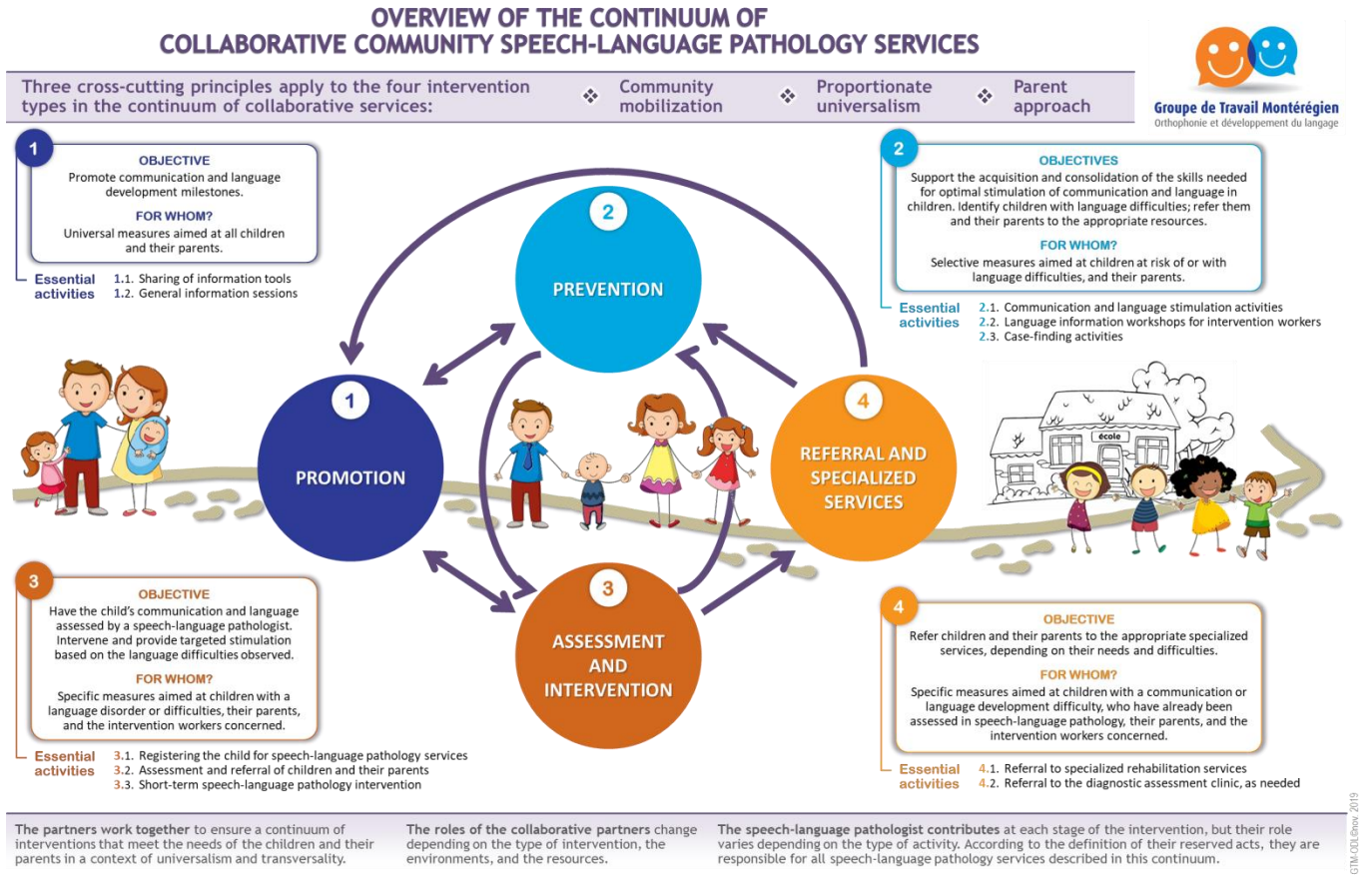
The establishment of a continuum of collaborative community speech-language pathology services is a concrete solution for facilitating access to communication and language development services, as well as access to public speech-language pathology services for young children. Parents—a child's first teachers—are the main focus of the actions of the continuum of collaborative community speech-language pathology services. The optimal implementation of such a continuum requires the mobilization and engagement of all intervention workers, as well as all stakeholders and partners concerned, working together to promote access to and continuity of early childhood communication and language development services.



Experimental framework

In 2011, the GTM-ODL produced a summary portrait of the communication and language development service offer (promotion, prevention and intervention, and specialized intervention), per CLSC territory, for children aged 0-5. This portrait highlighted the lack of resources available in the public network to support parents and their children, in particular with respect to access to early childhood speech-language pathology services. Despite this being the case, however, a series of promotion and prevention tools were found to exist. Several environments therefore had the means to stimulate communication and language in young children, including some dedicated to the parents. Unfortunately, these means were often inadequate for or not available to vulnerable families or did not correspond to good practices.

In 2015, work began to establish a common understanding in the Montérégie region of a *preventive, early, and adapted approach* to communication and language development in early childhood. This work led to the definition of the **concept of community speech-language pathology**, which takes on its full meaning in the establishment of a *continuum of collaborative services*.



Continuum of collaborative community speech-language pathology services (GTM-ODL, 2019)

To fully understand the challenges involved in implementing the continuum of collaborative community speech-language pathology services and to clearly identify the conditions for its successful rollout within a community on a given territory, a two-year period was devoted to testing the

continuum and its implementation; this was done in the form of three showcase projects in the three sectors (east, centre, and west) corresponding to the territories of the CISSS de la Montérégie. More precisely, the showcase projects were carried out on specific territories, under the responsibility of early childhood advisory panels.

The objective of these showcase projects was to provide a real-life experience of the continuum, i.e., to empirically test this innovative approach in three separate communities. As such, this step was essential in order to make the necessary corrections and adjustments to the continuum, and to document the effects of its implementation in the communities. It was also crucial for the rollout of the continuum of collaborative services, since it involved assessing the feasibility of the approach and its implementation for the communities supporting it. During the continuum test period, between September 2017 and March 2020, various types of results were reported; however, the period is too short to gauge the impacts on the experience of parents of children with communication and language development difficulties.

Methodology

The continuum of collaborative services and its implementation were assessed at three separate sites in the Montérégie region, each having geographic, demographic, and institutional differences (in the healthcare system, in the form of the mandates of the three CISSS de la Montérégie, and in the school system, in the form of the 11 school service centres, including nine French-language). The test sites were chosen at the beginning of the continuum assessment phase, according to a certain number of criteria, which were effectively prerequisites for the showcase projects, including:

- Be consistent with a concerted approach to be maintained throughout the test phase;
- Respect the continuum of collaborative community speech-language pathology service model and its recommendations;
- Contribute to the overall assessment approach for the GTM-ODL project;
- Obtain a formal commitment from management at the CISSS covering the territory;
- Have access to the services of a public-sector speech-language pathologist;
- Integrate the cross-cutting principles of the continuum of collaborative community speech-language pathology services;
- Apply the recommendations of the continuum of collaborative services regarding essential activities for each of the continuum's four intervention types;
- Develop and provide a local portrait based on the continuum of collaborative community speech-language pathology services.

The assessment approach is based on a two-fold objective. On the one hand, the assessment focuses on the implementation of the innovative approach that is the continuum of collaborative services, applied to diverse local realities. On the other hand, it examines the extent to which the proposed tools and strategies (Kit and other documents, coaching, financial support, networking, etc.) facilitate the implementation of the continuum.

1. What improvements were made to the continuum in the three showcase projects?

It is not the activities* – essential or complementary – of the continuum of collaborative services that are being evaluated, but rather the links between them within the continuum.

* Their effectiveness is pre-established since they are evidence-based practices supported by the literature.

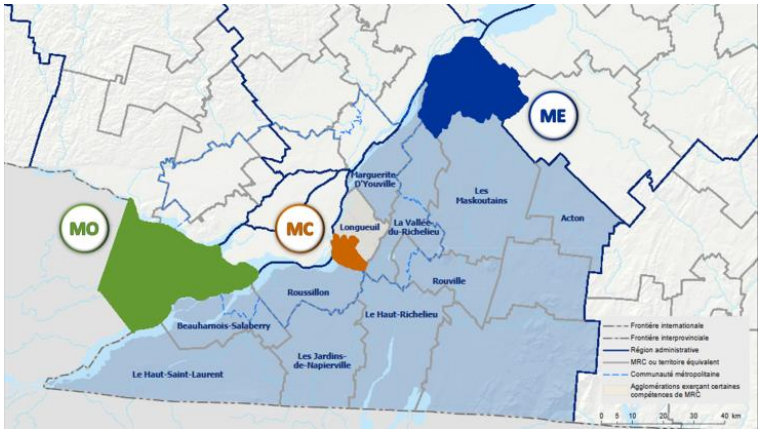
2. What is the outcome of testing the three showcase projects?

It is not the early childhood advisory panels in the three targeted sectors that are being evaluated, but rather the implementation of the continuum and the support offered.

Assessment questions (JFL Consultants, 2018)

Showcase projects in the Montérégie region

In 2017, three showcase projects were selected to implement the continuum of collaborative community speech-language pathology services on their respective territories and to participate in the assessment.



MO Montérégie-Ouest

In the community of Vaudreuil-Soulanges, under the responsibility of the ***Table de concertation petite enfance de Vaudreuil-Soulanges***.

The territory covered corresponds to that of the Vaudreuil-Soulanges RCM, i.e., 855 km^2. It includes 23 municipalities and 149,349 inhabitants[10], including 8,995 children aged 0-4 and 10,425 children aged 5-9.

ME Montérégie-Est

In the community of Pierre-De Saurel, under the responsibility of the ***Table intersectorielle Enfance-Famille Pierre-De Saurel***.

The 598-km^2 territory corresponds to that of the Pierre-De Saurel RCM. It includes 12 municipalities and 51,025 inhabitants, including 2,155 children aged 0-4 and 2,280 children aged 5-9.

MC Montérégie-Centre

In the community of Brossard/Saint-Lambert, under the responsibility of the ***Table de concertation CONPARLE FAMILLE***.

The territory is more difficult to define for this site, because it corresponds to that of CLSC Samuel-de-Champlain, which covers four sectors: the cities of Brossard and Saint-Lambert, the borough of Greenfield Park, and the Le Moyne district of the Vieux-Longueuil borough in the agglomeration of Longueuil, for a total surface area of 59 km^2. In 2016, the two cities had 107,582 inhabitants, with 5,565 children under age 5 and 5,590 children between the ages of 5 and 9. Due to the municipal mergers that took place in 2002, and to the reorganization that followed the 2006 demerger, the Greenfield Park and Le Moyne sections of Longueuil are no longer considered to be census divisions. In comparison, in

[10] Most of the demographic data come from Statistics Canada, 2016 Census. Some other data (for Longueuil, in Montérégie Centre) are from 2001.

2001, the territory had 107,910 inhabitants, including 4,885 children aged 0-4.

As such, the choice of these three sites in the Montérégie region created an opportunity to test the continuum of collaborative community speech-language pathology services and its implementation on territories that differ from each other, despite being located in the same health region[11]. The differences between the three sites hosting a showcase project are visible mainly in their respective linguistic portraits. This is clearly illustrated by looking at the three largest cities of the three showcase project territories, namely Vaudreuil-Soulanges (MO), Sorel-Tracy (ME), and Brossard (MC).

Percentage of individuals by first language (2016 Census)

	MO V.-Dorion	MC Brossard	ME Sorel-Tracy
Single answer	95.6	95.3	99.4
official languages	82.2	58.7	98.6
non-official languages	17.8	41.3	1.4
Multiple answers	4.4	4.7	0.6

So, while the three cities are quite similar in that their inhabitants are unilingual in terms of their first language, they quite obviously differ in the nature of the language spoken.

Percentage of individuals by first official language spoken (2016 Census)

	MO V.-Dorion	MC Brossard	ME Sorel-Tracy
English	30.3	24.7	1.0
French	62.9	57.4	98.6
English and French	5.9	13.5	0.3
Neither English nor French	0.9	4.4	0.1

Here, it appears that Brossard is more multilingual than the two other cities, whereas Sorel-Tracy is more unilingual francophone and Vaudreuil-Dorion has a larger proportion of anglophone inhabitants.

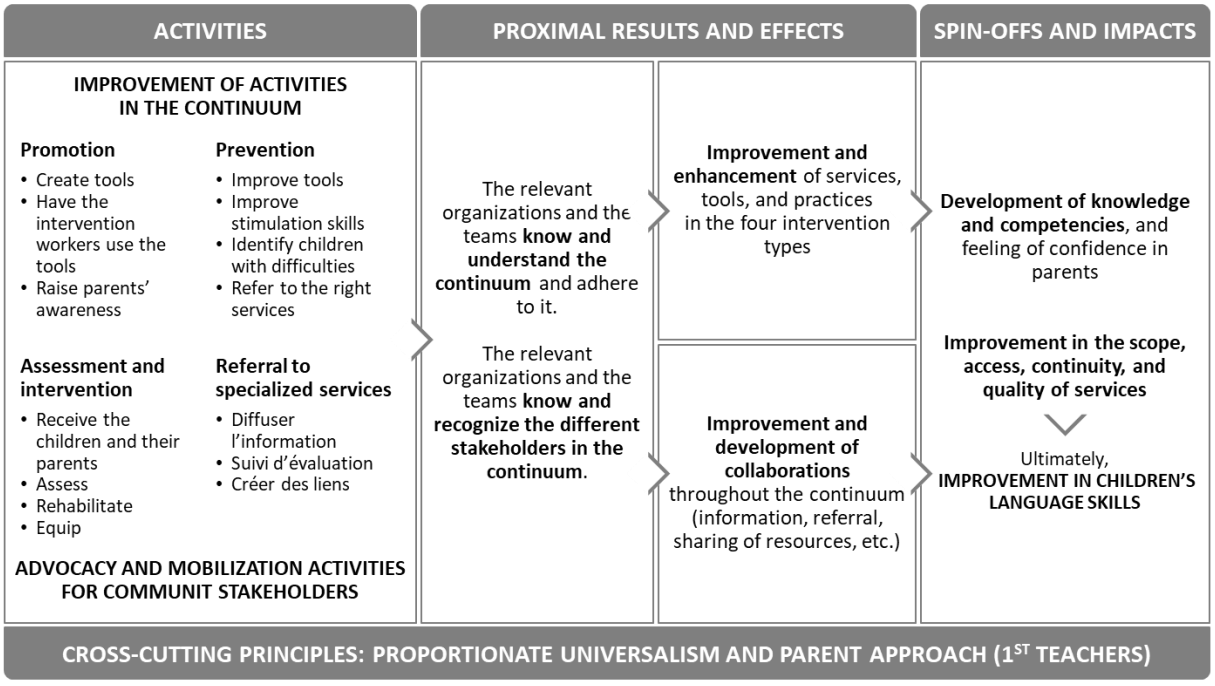
The presence of several languages spoken is a major challenge in providing communication and language stimulation services for young children. These different languages can introduce vulnerability risk factors for children as they acquire the foundations needed to develop their language skills and require the sites to implement adapted measures to meet the needs of these children and their families.

[11] Montérégie is one of 17 administrative regions in Québec. Its health region excludes the Brome-Missisquoi and La Haute-Yamaska RCMs, which belong to the Estrie region.

1. Logical framework

The distinguishing feature of the logical framework proposed for testing the continuum of collaborative services and its implementation within the three showcase projects is that it will consider the results as a whole, rather than associating them with each of the four intervention types: promotion, prevention, assessment and intervention, and referral and specialized services. Given this, and in accordance with the regional logical framework, the dimension of *knowledge* of and *adherence* to the continuum by the community stakeholders was added as a prerequisite to improving practices and services. The dimension of *reciprocal knowledge* between the continuum stakeholders was also identified as a prerequisite for the development of links and collaborations between the stakeholders (referrals, resource sharing, etc.).

Limiting the logical framework to the sole dimension of improving and harmonizing the services and practices seemed too static and overly focused on each of the four intervention types as isolated silos. However, one of the major challenges of the continuum is ensuring the smooth transfer of families and information within the continuum. Moreover, since the dimension of mobilization appeared to be somewhat overlooked, it was therefore integrated into the assessment. The revised logical framework is as follows:



Logical framework for the assessment (JFL Consultants, 2018)

2. Some general results

This section briefly presents a few highlights from the assessment conducted as part of the showcase projects. Note that the results, both for the local situations and for the entire Montérégie as a health region, are non-exhaustive.

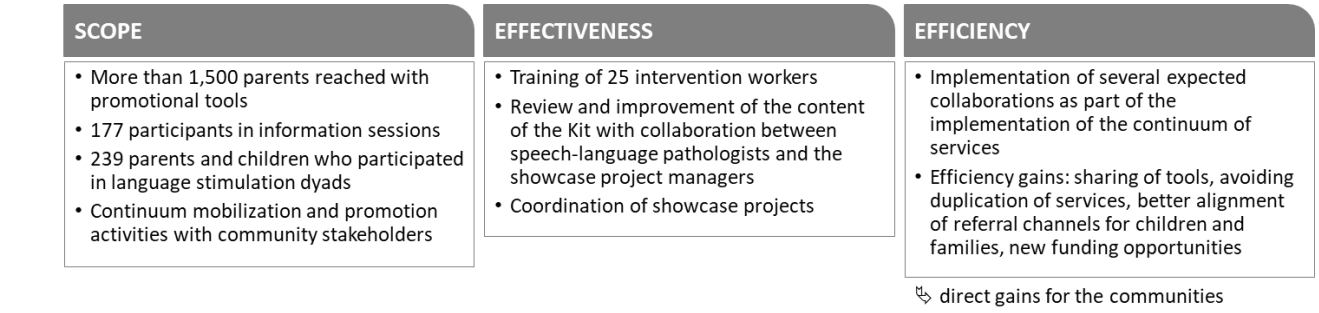
2.1. Implementation of the continuum in the three showcase project communities

Implementation of the continuum of collaborative services was documented in 2018-2019, via the collection of various data from the three showcase project communities. Data were compiled on three aspects:

- ☞ **improvement in the content** of the continuum activities;
- ☞ **mobilization efforts** aimed at reaching more stakeholders and raising awareness about the continuum;
- ☞ **new networks** (links and collaborative ties) created in communities surrounding the continuum.

The results are presented in three categories, as can be expected from this type of approach:

1. **Expand the scope** by mobilizing stakeholders;
2. **Improve effectiveness** by basing interventions on good practices;
3. **Increase efficiency** of the system by strengthening ties between stakeholders.



Results in the community (JFL Consultants, 2018)

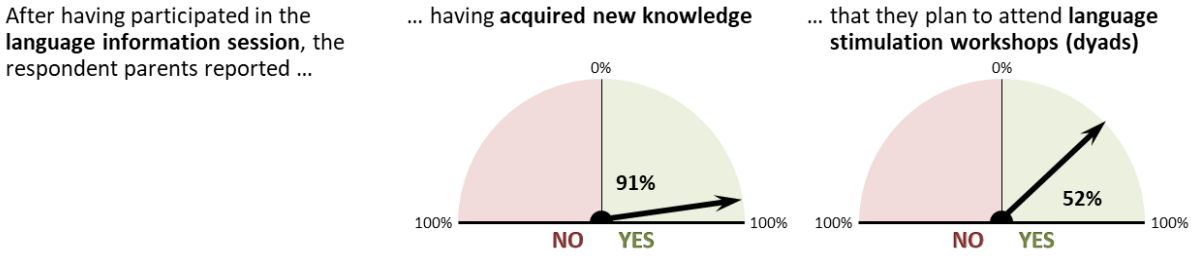
2.2. Proximal effects on the parents consulted

The continuum of collaborative community speech-language pathology services is an innovative approach to better equipping the parents of children with communication and language development difficulties. The fact of mobilizing all community stakeholders around the parents and their children should help to create a social safety net around vulnerable families, in terms of the development of communication and language skills in young children. Within an ever-evolving assessment process, it is important to document the reported effects of promotion and awareness activities on parents.

Two specific times were identified at which to document the effects of promotion and prevention activities on parents: the general information session and participation in the language stimulation activity (parent-child dyad). Questionnaires were given to the parents after participating in either of these activities.

The questions that the parents were asked following their participation in the **language information session** are intended to document the following elements, in a declarative manner:

- what they learned during the session;
- their pathway;
- effects on their attitudes;
- effects on their future decisions in supporting their children.



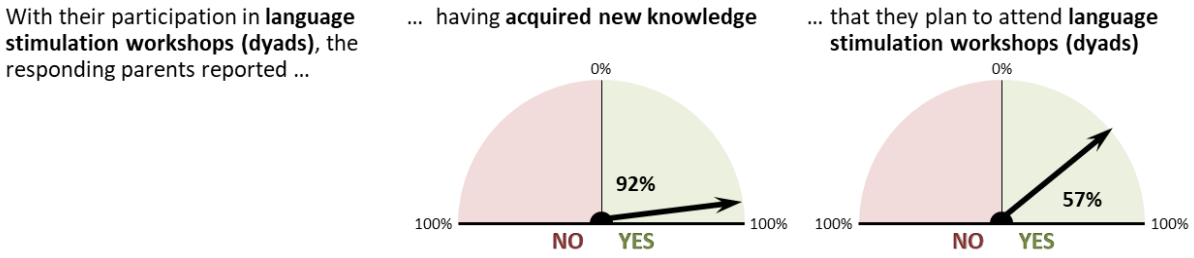
Proximal impacts of participating in the language information session (JFL Consultants, 2019)

While only just over fifty percent of parents plan to continue their active approach by participating in the language stimulation workshops, more than two-thirds of parents surveyed feel that their approach was influenced by having attended the information session. The language information session therefore

has an influence on the trajectory of these parents within the continuum of collaborative services.

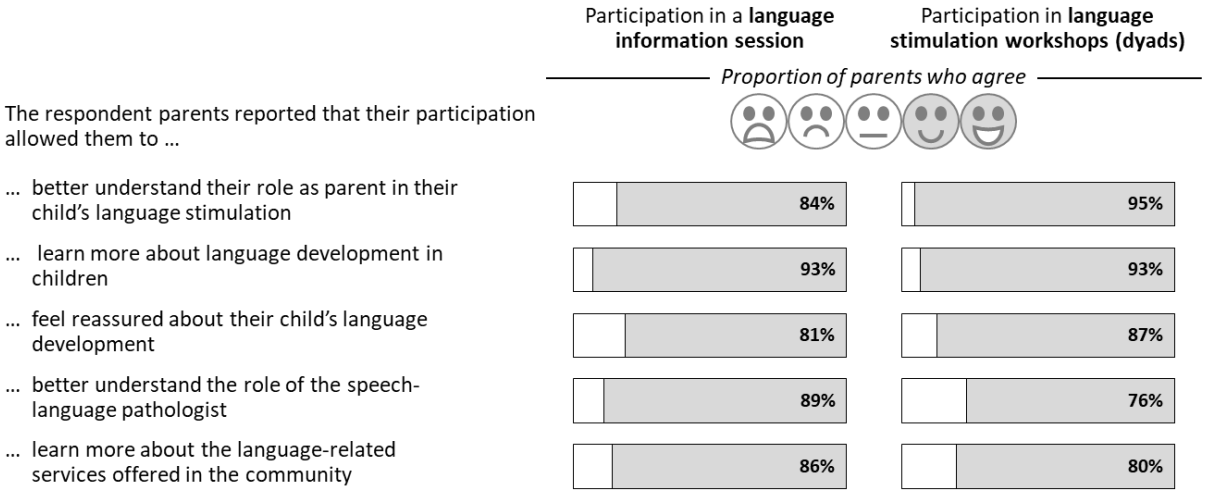
At the end of a series of **language stimulation workshops (dyads)**, another questionnaire was given to the participating parents. The questionnaire pertained to:

- the service profile and trajectory;
- the parents' assessment of the speech-language pathology services;
- the effects observed by the parents in terms of knowledge, attitudes, and expected trajectories following the dyads.



Proximal impacts of participating in the language stimulation workshops (JFL Consultants, 2019)

Here, too, more than half of the parents plan to participate in other workshops with their child. Nearly three-quarters of the parents surveyed feel that taking the language stimulation workshops helped them to identify their next steps in the continuum of collaborative services. As with the language information sessions, the communication and language stimulation workshops met their objectives, allowing the parents to acquire new knowledge and influencing their service trajectory.



Proximal impacts of participating in the language stimulation workshops (JFL Consultants, 2019)

Being thus better equipped, the parents will be able to take constructive action prior to their participation in the continuum activities. In some children with communication and language difficulties that are addressed early and effectively, these difficulties will be resolved instead of leading to more persistent problems.

General conclusion

The **continuum of collaborative community speech-language pathology services** was developed to address—in an original and innovative manner—the critical need for services in terms of the early and adapted management of communication and language difficulties observed in young children. The lack of professionals and speech-language pathology positions was long a major obstacle to obtaining adequate services. The reorganization of the public healthcare network represented another considerable challenge for parents of children with communication and language development difficulties. Moreover, certain vulnerabilities presented by the families also create challenges in terms of the children being managed effectively and the families receiving adequate support.

The work done by the GTM-ODL has led to the definition of the **concept of community speech-language pathology** and to the establishment of the continuum of collaborative services. It is important to understand that this is an approach or a philosophy for a new service delivery structure, which consists in delivering the right services, in the best conditions, in the shortest possible time, to the people who need them most—all in the aim of ensuring optimal communication and language development. The added value of this type of approach is that it mobilizes all early childhood stakeholders, on a given territory and in a given community, surrounding vulnerable families. It also creates links between the activities that are provided in the various spheres, i.e., the public health and education networks, the community organizations, and the early childcare centres. The continuum of collaborative services absolutely cannot be reduced to a series of activities, even those with a proven effect on development milestones.

The ***Kit - Community speech-language pathology and the continuum of collaborative services*** consists of three separate but complementary volumes. It was designed by the GTM-ODL to help the communities wishing to implement the continuum of collaborative community speech-language pathology services, while respecting the existing services on their territory. The ten essential activities described in the Kit can be developed sequentially, while always bearing in mind that they are interdependent. It would be misguided to believe that a community could combine all the activities into one, which is what makes the comprehensive, collaborative portrait of the service offer on the territory so essential to meeting the most pressing needs of the community.

The GTM-ODL feels that the Kit must be accompanied by training in order to facilitate its understanding and thus promote the implementation of the continuum of collaborative community speech-language pathology services. The strength of this approach does not lie solely in the activities and tools that are offered, but in the mobilization of communities and the involvement of all partners with families of children with communication and language development difficulties.

Complementary information

Glossary

Advocacy: A combination of individual and social actions designed to gain political commitment, policy support, social acceptance, and systems support for a particular health goal or program (World Health Organization 1995). These activities include, among others, information campaigns, media articles and interviews, and group training sessions for parents and intervention workers (Bélanger 2011).

Attachment and language: Attachment is a powerful emotional bond between the parent and child that creates a sense of security in the individual (Bee and Boyd 2006). Attachment stems from behaviours by the parents, who develop synchrony between them and their child. These same behaviours also underpin the development of language precursors.

Case-finding: Case-finding is the outcome of the screening test (Billiard 2004). The children identified by the screening test are referred to pre-determined services (Billiards 2004).

Communication: Communication can be verbal (e.g., a child who says, “I'm mad!”) or non-verbal (e.g., a child striking the ground to express their anger). Communication is used to express ideas and attitudes, and to influence the ideas and attitudes of others (American Psychiatric Association 2013)

Detection: Detection of a possible language delay occurs during informal interactions between an adult and a child.

Developmental Language Disorder: Developmental Language Disorder, also known as dysphasia, is a persistent and primary language impairment, meaning it affects the cognitive process of language development. A person with Developmental Language Disorder will exhibit varying degrees of impairment (e.g., mild, moderate, or severe) in their expressive or expressive and receptive language. Developmental Language Disorder is characterized by signs that vary according to the person’s progress, and by the strong likelihood of seeing little progress without intervention (OOAQ 2004). It has been suggested that 5-8% of children on average could have a language or speech disorder (Nelson *et al.* 2006), a figure that is generally rounded to 7%.

Direct intervention: Direct intervention refers to an intervention activity during which the speech-language pathologist interacts directly with the child (Law, Garrett and Nye 2003).

Early intervention: Early intervention in speech-language pathology refers to services aimed at young children aged 0-3 who risk having difficulties with speech, language, hearing, swallowing, or pre-writing skills (Paul and Roth 2011). This can include prevention services or post-assessment interventions.

Early literacy: Early literacy generally refers to the stimulation of the skills and knowledge associated with emergent literacy, which predispose the child to learning how to read and write and to an awareness of syllables and sounds. Through early literacy activities, an intervention worker can help children to understand what a book is and how to turn the pages, to understand that the printed characters contain information (Daviault 2011), or to count the number of syllables in a word. Several training courses are available to intervention workers to learn how to stimulate early literacy in children, including training sessions based on shared reading activities.

Expressive language: Expressive language is the production of language, or what is heard when a speaker says a word or a sentence.

Group intervention: A speech-language pathology intervention can be done in a group of children with common speech-language pathology intervention objectives, grouped according to age and needs. Groups may be comprised of parent-child dyads, with the speech-language pathologist interacting with the parents and the children.

Health promotion: Health promotion aims to positively influence the determinants of health in a way that gives individuals, groups, and communities greater control over their health by improving their living conditions and lifestyles (Gouvernement du Québec 2015).

Indirect intervention: Indirect intervention refers to intervention activities carried out by a third party, such as a parent or a daycare worker, trained by the speech-language pathologist (Law, Garrett and Nye 2003). Through indirect intervention, the speech-language pathologist acts as a consultant and has regular contact with the third person to track the child's progress and adjust the intervention objectives and methods, as required (ASHA 2008).

Intervention worker: Person who interacts frequently and directly with children, but who is not a family member (e.g., daycare educator, children's activity leader at a family centre).

Language: The "capacity, unique to humans, to communicate and express their thoughts through a language" (Office québécois de la langue française [n.d.]).

Language (components):

- **Language or communication precursors**: Non-verbal behaviours that allow the child, from birth to first words spoken, to acquire language and initiate communication with the people around them (Daviault 2011). These behaviours include, among others, imitation, turn-taking, eye contact, and joint attention.
- **Speech**: Speech refers to the production of sounds for the purpose of creating language. Speech includes, among other things, the articulation of sounds, flow (e.g., stuttering), and voice (e.g., loss of voice).
- **Phonology**: Phonology refers to the sounds that make up a language, i.e., the phonemes. It is the component of language that determines the inventory of its phonemes and the rules governing their distribution. *When a young child says "tuck" instead of "truck" or "fog" instead of "frog," this is explained by the normal acquisition of phonology* (Daviault 2011).
- **Morphosyntax**: Morphosyntax is the component of language that studies the ability to combine words to form a sentence (Daviault 2011), as well as the correct use of articles, pronouns, and subject-verb agreements. The following examples are morphosyntactical errors: "eat* boy candy," "cat play* ball," "balloon* fall."
- **Vocabulary, content, and lexical semantics**: These elements relate to the meaning conveyed by words (Daviault 2011). Vocabulary includes all words that are understood (receptive vocabulary) and expressed (expressive vocabulary) by the child. A child who says only a few words, who uses the word *cat* to refer to all animals, or who uses only a few different verbs may have difficulties acquiring lexical semantic knowledge.
- **Use of language and pragmatics**: Use of language refers to the reasons why a child uses language, e.g., to tell a story, comment, protest, explain, greet, etc. Use of language implies the speaker's intention to communicate. This component affects, among other things, the behaviours related to conversational skills and the organization of information into speech (Coquet 2005). Difficulties with the use of language and pragmatics in children can be expressed through certain behaviours, i.e., a child who never makes eye contact with the person they are speaking to, who often strays off-topic during conversations, or who has trouble telling a story.

Language delay or language immaturity: A language delay means that a child's language is meeting developmental milestones overall, but at a slower rate than their chronological age peers (Prelock, Hutchins, and Glascoe 2008). The delay can affect one or more components of language. For example, a 3½-year-old child who expresses themselves at the level of a 2½-year-old has a language delay. The prevalence of language delays varies according to the age of the children targeted. In children aged 30-36 months, it has been suggested that

approximately 17.5% could have a language delay, and this could be the case for one-third of young children from highly disadvantaged areas (Sylvestre *et al.* 2012).

Note: the term "delay" has been replaced, after the writing of this document, by the term "difficulty".

Language stimulation: Language stimulation is a set of activities that promote the development of language precursors, language, and speech in children (ASHA [n.d.]). The nature of the activities depends on the child's age and is linked to chronological language development. An example in a childcare centre would be an educator who, during play, notices that a child appears to have a language delay compared to the other children their age.

Multilingualism: "Quality of speaking several languages." Synonyms of multilingual are *bilingual* and *plurilingual* (Antidote [n.d.]).

Phonological awareness: The child's ability to manipulate the syllables and phonemes (sounds) that make up words (St-Pierre *et al.* 2010). This refers to activities that require children to play with syllables, such as counting them (e.g., the word *bottle* has two syllables) or combining them (e.g., if we put the first syllables from "marble" and "kettle" together, we get "market"). It also refers to playing with phonemes (the sounds that make up words). For example, saying the sounds that the letters make (e.g., the letter "f" sounds like [fff]) or saying the first sounds of different words (*pepper* starts with [p]) are activities that stimulate phonological awareness.

Prevention: The purpose of language disorder prevention activities is to reduce the risk or mitigate the effects of risk factors on a child's development (ASHA 2008) through the acquisition of protective factors. This set of medical and medical-social means is applied to prevent the onset, aggravation, or continuation of diseases, or their long-term consequences (Larousse [n.d.]).

- ➜ **Primary prevention**: Aims to reduce the appearance of language difficulties in the preschool population (ASHA 2008) using universal measures. This type of prevention applies to 100% of families and meets the needs of about 80% of them (% for information only).
- ➜ **Secondary prevention**: Aims to reduce the negative effects associated with language difficulties (ASHA 2008), i.e., through optimal language stimulation and early management based on specific measures. This type of prevention applies to families with children at risk of or with language difficulties and meets the needs of 15-20% of them (% for information only).
- ➜ **Tertiary prevention**: Aims to address existing language development problems through early intervention in speech-language pathology with the goal of preventing future difficulties (ASHA 2008). This type of prevention meets the needs of 5% of families (% for information only).

Protective factors: Protective factors are personal, family, or social resources that decrease the likelihood of a development problem by mitigating the destructive impact of risk factors (Sylvestre 2008). Several protective factors are associated with communication and language development, including:

- ➜ Parenting practices that promote language stimulation;
- ➜ The mother's level of education;
- ➜ The child's social skills and tendency for perseverance;
- ➜ Early management in speech-language pathology (Poissant 2014);
- ➜ Having a positive attitude, and being aware and informed about communication and language development and the possible associated difficulties;
- ➜ Having acquired communication and language stimulation skills.

Receptive language: Receptive language, or verbal comprehension—in addition to hearing and perceiving the sounds of a language—implies the ability to process meaning from what is heard (Daviault 2011). During early

childhood, comprehension skills are stronger than language production skills. Here is an example: A 20-month-old child who understands the sentence “Put the block in the box” actually understands the words *put*, *block*, *in* and *box*, even though they cannot produce this sentence themselves.

Risk factors: Risk factors are defined as events, or even environmental or organic conditions, that increase the likelihood of a child having development problems (Sylvestre 2008). There are several known risk factors associated with language delays and disorders, which can be directly associated with the child or their environment (Desmarais 2007; OOAQ 2009; Sylvestre and Mérette 2010).

- ➜ **Characteristics related to the child**: premature birth (before 37 weeks), prenatal exposure to drugs and alcohol, male sex, presence of a cognitive developmental delay, genetic condition, etc.
- ➜ **Characteristics related to the child’s environment**: low family income, low level of education in the mother, family history of language delays or disorders, etc.

Screening: Screening is a planned and relatively quick process that involves the use of formal techniques applied to all children in a target group. The purpose of language screening tests is to identify children with a language delay who would benefit from a comprehensive speech-language pathology assessment, followed by a language intervention (van Agt *et al.* 2007).

Speaker: Refers to a “person who makes oral statements,” namely the person who is speaking (Office québécois de la langue française [n.d.]) and the “person with whom communication is established” (Office québécois de la langue française [n.d.]).

Speech-language pathology; speech-language pathologist (reserved title): The speech-language pathologist’s field of practice consists in assessing the auditory, language, voice and speech functions, determining a treatment and intervention plan and ensuring its implementation in order to improve or restore communication for a person in interaction with their environment (*Professional Code*, CQLR c. C-26, s. 37; OOAQ, [n.d.]).

Speech-language pathology assessment: The speech-language pathologist assesses the child’s language skills and relates them to their living situation in the aim of arriving at a speech-language pathology conclusion. They explain the test results to the child and their family. They talk to them about ways and means of making communication as effective as possible. They also make the appropriate recommendations (OOAQ [n.d.]).

Speech-language pathology intervention: The speech-language pathologist teaches the child and their family strategies and methods for improving communication. They guide the family through certain processes (OOAQ [n.d.]). Within the framework of the activities covered by their field of practice (*Professional Code,* CQLR c. C-26, s. 37.1), the speech-language pathologist is the person who determines the speech-language pathology treatment and intervention plan. Depending on the speech-language pathologist’s judgment and the modalities available, the intervention may take place one-on-one or in a group, depending on the child’s needs, and in different locations, i.e., at the clinic, at the preschool or school, or at home (Law, Garrett and Nye 2003).

Stakeholder: Anyone who is involve with children aged 0-5 and their parents, and who interacts with them directly or indirectly, regardless of how often (e.g., a nurse who works with children aged 0-5, a person who organizes services at the drop-in daycare, municipal partners involved in organizing a story time activity, directors of childcare centres or health services, etc.).

Stuttering: Stuttering refers to an interruption in the flow of speaking perceived as being abnormal. It is an involuntary interruption to the flow of talking that occurs when the person tries to speak (Beausoleil 2012). Stuttering can be transient and disappear on its own, or it can persist over time.

Typical language development: Several scientific studies have examined the acquisition of language in children, and an increasing number have focused on francophone children in Québec (Trudeau 2007). These studies have

helped to establish a timeline of language development according to the various components. They have also identified errors that are commonly observed during language acquisition that are considered part of “typical” or “normal” development. Speech-language pathologists use this knowledge to determine whether a child is meeting normal language development milestones.

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