



STRATEGIES TO ACCESS HEALTH AND SOCIAL SERVICES FOR ENGLISH-SPEAKING OLDER ADULTS IN QUEBEC: A QUALITATIVE CASE STUDY

Alexandra Ethier and Annie Carrier

Volume 40, Number 1, 2023

URI: <https://id.erudit.org/iderudit/1100660ar>

DOI: <https://doi.org/10.7202/1100660ar>

[See table of contents](#)

Publisher(s)

Canadian Association for Social Work Education / Association canadienne pour la formation en travail social (CASWE-ACFTS)

ISSN

2369-5757 (digital)

[Explore this journal](#)

Cite this article

Ethier, A. & Carrier, A. (2023). STRATEGIES TO ACCESS HEALTH AND SOCIAL SERVICES FOR ENGLISH-SPEAKING OLDER ADULTS IN QUEBEC: A QUALITATIVE CASE STUDY. *Canadian Social Work Review / Revue canadienne de service social*, 40(1), 5–27. <https://doi.org/10.7202/1100660ar>

Article abstract

Considering that French is the dominant language in Quebec, that relatively few francophone providers of health and social services are able to speak English, and that English-speaking older adults (OAs) have low levels of bilingualism, anglophone OAs are more likely than their francophone peers to face language barriers when accessing health and social services. However, little is known about the strategies English-speaking OAs put into place to overcome the difficulties encountered due to language barriers when they access these services. We therefore aimed to document the strategies used by English-speaking OAs when, due to language barriers, they faced difficulties in accessing health and social services. We conducted a qualitative case study with ten English-speaking OAs in the Eastern Townships in Quebec. Through interviews and document reviews, we collected data which we then analyzed thematically. We identified seven strategies used by English-speaking OAs: investigating for health- and access-related information in English, creating their own services, entering the health and social services system offered in French, entering the health and social services system with help from others, putting the responsibility of overcoming the language barrier on the provider, splitting that responsibility, and taking on the responsibility. Our results highlight a potential burden associated with the involvement of the English-speaking community in enabling English-speaking OAs to access health and social services.

STRATEGIES TO ACCESS HEALTH AND SOCIAL SERVICES FOR ENGLISH- SPEAKING OLDER ADULTS IN QUEBEC: A QUALITATIVE CASE STUDY

Alexandra Ethier

Annie Carrier

Abstract: Considering that French is the dominant language in Quebec, that relatively few francophone providers of health and social services are able to speak English, and that English-speaking older adults (OAs) have low levels of bilingualism, anglophone OAs are more likely than their francophone peers to face language barriers when accessing health and social services. However, little is known about the strategies English-speaking OAs put into place to overcome the difficulties encountered due to language barriers when they access these services. We therefore aimed to document the strategies used by English-speaking OAs when, due to language barriers, they faced difficulties in accessing health and social services. We conducted a qualitative case study with ten English-speaking OAs in the Eastern Townships in Quebec. Through interviews and document reviews, we collected data which we then analyzed thematically. We identified seven strategies used by English-speaking OAs: investigating for health- and access-related information in English, creating their own services, entering the health and social services system offered in French, entering the health and social services system with help from others, putting the responsibility of overcoming the language barrier on the provider, splitting that responsibility, and taking on the responsibility. Our results highlight a potential burden associated with the involvement of the English-speaking community in enabling English-speaking OAs to access health and social services.

Alexandra Ethier is a PhD candidate at the École de réadaptation, in the Faculté de médecine et des sciences de la santé, at the Université de Sherbrooke. Annie Carrier is an Associate Professor at the École de réadaptation, in the Faculté de médecine et des sciences de la santé, at the Université de Sherbrooke.

Canadian Social Work Review, Volume 40, Number 1 (2023) / Revue canadienne de service social, volume 40, numéro 1 (2023)

Keywords: access, health services, social services, official language minority, language barriers, strategies

Abstré : Les personnes âgées d'expression anglaise (PAEA) du Québec sont à risque de rencontrer des barrières linguistiques, considérant le pourcentage élevé de dispensateurs de services sociaux et de santé qui ne parlent pas anglais et le niveau élevé d'unilinguisme des personnes âgées d'expression anglaise. Toutefois, les stratégies utilisées pour surmonter les difficultés d'accès aux services sociaux et de santé liées à la barrière linguistique sont méconnues. Nous documentons donc les stratégies utilisées par les personnes âgées d'expression anglaise pour faire face aux difficultés causées par la barrière de langue qu'elles rencontrent lorsqu'elles accèdent les services sociaux et de santé. Nous avons mené une étude de cas qualitative auprès de dix personnes âgées d'expression anglaise en Estrie et analysé les données recueillies (entretiens, documents) thématiquement. Nous avons identifié sept stratégies : investiguer pour obtenir des informations, créer ses propres services sociaux et de santé, entrer dans le système de services sociaux et de santé en français et avec l'aide d'autres personnes, laisser la responsabilité linguistique au dispensateur de services sociaux et de santé, partager les responsabilités et prendre cette responsabilité. Nos résultats soulèvent des inquiétudes par rapport au fardeau vécu par la communauté anglophone concernant le support informel qu'elle offre pour permettre aux PAEA d'accéder aux services sociaux et de santé.

Mots-clés : accès, services de santé, services sociaux, minorité de langue officielle, barrière linguistique, stratégies

FOR HEALTH AND SOCIAL SERVICES USERS, the negative effect of language barriers — that is, difficulties experienced when people who speak different languages attempt to communicate verbally or in writing without a shared proficient language (Tenzer et al., 2014) — can impact their access to these services (Bartlett et al., 2008; Bowen, 2001; de Moissac & Bowen, 2017). Access to health and social services is defined as “the opportunity to identify healthcare needs, to seek, to reach, to obtain or use health and social services and to actually have the need for services fulfilled” (Levesque et al., 2013, p. 8). Access is dynamically influenced by the characteristics of the users and the characteristics of the services themselves. Language barriers are associated with a reduced likelihood of receiving both preventive services (Woloshin et al., 1997) and follow-up appointments from health and social services professionals (Sarver & Baker, 2000), and they have been shown to impact users' health (De Moissac & Bowen, 2019; Flores et al., 2003). They are also associated with preventable adverse events such as unintended injury or complications (Bartlett et al., 2008) and could be associated with

premature death because of the difficulty in being understood when communicating one's health state (de Moissac, 2016). Language barriers can also lead to additional testing (Parsons et al., 2014) that can be unnecessary or invasive, and to invalid consent (Borowski et al., 2019; Bowen, 2004).

In Quebec, English-speaking older adults (OAs) are at increased risk of encountering language barriers when accessing health and social services compared to younger English-speakers. Only 85% of physicians and approximately 50% of other health and social services professionals (e.g., nurses, social workers, psychologists) can speak English (Trempe & Lussier, 2011). Moreover, anglophone OAs are more likely to be unilingual compared to other English-speaking age groups (Pocock, 2013). English-speaking OAs seem to mobilize specific strategies to overcome the language barriers they face. Previous studies have provided anecdotal examples of these strategies. For example, English-speaking OAs may travel out of their region to access health and social services provided in English (Carter & Pocock, 2017; Pocock, 2013) because these services are mostly concentrated in the greater Montreal area. Consequently, few English health and social services are left for anglophone OAs located in rural areas (Pocock, 2013).

Other strategies seem to rely on an OA's social capital. Of the many authors who have defined social capital (e.g., Bourdieu, 1980; Coleman, 1998; Putnam, 2001), most describe it as access to resources through social networks (Bouchard & Gilbert, 2005). Social capital can be linked to access to health and social services, because those with high social capital can easily find health- and access-related information — or they can create their own informal health and social services, in parallel to the provincial system (Kawachi & Berkman, 2000). For English-speaking communities, high social capital seems to be linked to the ability to access health and social services. Indeed, to find information related to health and social services in English (Quebec Community Groups Network [QCGN], 2014), anglophone OAs turn to their English-speaking community (Pocock, 2009). During consultations, OAs reported that when they encountered a language barrier, they were able to engage in their care by getting French services interpreted with the help of caregivers (Sanderson, 2020).

Documenting the strategies OAs put into place to overcome language barriers is important for two reasons. First, recent changes in the Quebec health and social services system (e.g., Bill 25, Bill 10) have led to the merging of public health and social service institutions (Bourque & Quesnel-Vallée, 2014; Falconer & Quesnel-Vallée, 2014). It has been suggested that, for the English-speaking community, Bill 25 has had negative impacts (Pocock, 2009). Regarding Bill 10, the provision of English-language health and social services has been entrusted to French-speaking administrative boards that report directly to the

Ministry of Health and Social Services — including to both the minister and the public servants who enforce Bill 10. For small English-speaking communities, such a reporting structure may have weakened bilingual service provision within public health and social service organizations (Bourhis, 2017). These two changes may have given rise to new difficulties for English-speaking OAs in accessing health and social services.

Second, research about language barriers in Quebec could be beneficial not only for the English-speaking communities of Quebec, but also for other language minorities. In Canada, the right to access health and social services in one's own language is protected by provincial and federal laws for English-speaking Canadians in Quebec and French-speaking Canadians living outside Quebec (e.g., Act Respecting Health Services and Social Services, 1991, s. 15; Charter of the French Language, 1977, s. 1; Official Languages Act, 1985). However, language barriers remain for these populations (Bouchard et al., 2012; Drolet et al., 2015; Ethier & Carrier, 2022a, 2022b). Furthermore, Indigenous people and immigrants who speak neither French nor English do not have such explicit legal protections. Studies have documented the difficulties that people without language-related legal protections have in accessing health and social services because of language barriers (Cameron et al., 2014; Kalich et al., 2016; Ngwakongnwi et al., 2012). Canadian healthcare policy aims to “facilitate reasonable access to health services without financial or other barriers” (Canada Health Act, 1984, s. 3); to bring this policy into action, we need to know about the strategies that such populations have developed to counter language barriers so that we can develop recommendations to support health and social services users who do not speak French in Quebec or English in other provinces. Such knowledge would allow two things. First, knowledge of existing strategies could enable us to identify which language-related difficulties are encountered, and as such, to intervene to reduce those barriers. Second, it could also give us tools to complement the strategies used by English-speaking OAs, making it easier for them to access health and social services.

Despite their relevance for language minorities, the strategies used by English-speaking OAs when they deal with language barriers have yet to be directly addressed in scholarly research. As such, we aimed to document strategies used by English-speaking OAs when facing difficulties in accessing health and social services due to language barriers.

Assumptions and Conceptual Framework

In preparing our study, we drew on our experiential knowledge of unilingual, English-speaking OAs. Based on our experience, we assumed that English-speaking OAs encountered language barriers when attempting to access health and social services in Quebec and that social capital was important in mitigating these barriers. This experiential

knowledge resonates with empirical and theoretical knowledge. Indeed, social capital has been identified as an important concept in studies of health and of access to health and social services for official language minorities in Canada (Bouchard et al., 2006). We therefore conducted this research with the conceptual frameworks of social capital (Bourdieu, 1980) and a critical approach to understanding access to health and social services (Levesque et al., 2013).

We also chose to publish our results in English in a bilingual Canadian journal for two main reasons. First, research about access to health and social services for English-speaking OAs in Quebec is already available in French (Ethier & Carrier, 2022a, 2022b). Second, we sought to inform interested and affected parties in their main language — specifically, the unilingual, English-speaking population of Quebec and the population outside of Quebec involved in the access to health and social services for linguistic minorities.

Methods

Case studies allow for in-depth, multifaceted explorations of complex and emerging phenomena and issues, while qualitative research allows access to the perceptions and the meaning participants give to their experiences (Cobb & Forbes, 2002; Patton, 2015). As such, we conducted a single qualitative case study (Yin, 2009) focused on the strategies used by English-speaking OAs in Quebec's Eastern Townships to access health and social services. The case study includes the context, the case, and the units of analysis (Yin, 2009). We chose the Eastern Townships because it has the highest percentage of English-speaking OAs of all Quebec's English-speaking communities (Pocock, 2013) and because previous studies have recommended further research exploring the access to health and social services for this community (Centre intégré universitaire de santé et de services sociaux de l'Estrie – Centre hospitalier universitaire de Sherbrooke [CIUSSS de l'Estrie – CHUS], 2016). Finally, our units of analysis are English-speaking OAs living in the Eastern Townships recruited according to the inclusion and exclusion criteria detailed below. In accordance with qualitative case studies (Yin, 2009), we collected different types of data. We used interviews to provide in-depth explorations of phenomena with which participants had substantial experience; these interviews enabled us to explore new ideas reported by the participants as we conducted each interview (Charmaz & Belgrave, 2012). To describe our sample, we used socio-demographic questionnaires; to supplement our interview data, we analyzed documents (Creswell & Poth, 2018).

We also used a research notebook to report our audit trail and engage in reflexivity (e.g., bias, values, and experiences) and, as such, to inform readers about our positionality when we undertook the study (Creswell & Poth, 2018). We are both French speakers. Ethier, the first author,

comes from a Caucasian background and has had many previous contacts with the English-speaking community due to her education, and Carrier, the second author, comes from an Italian immigrant family and holds a Master of Laws degree in access to health and social services.

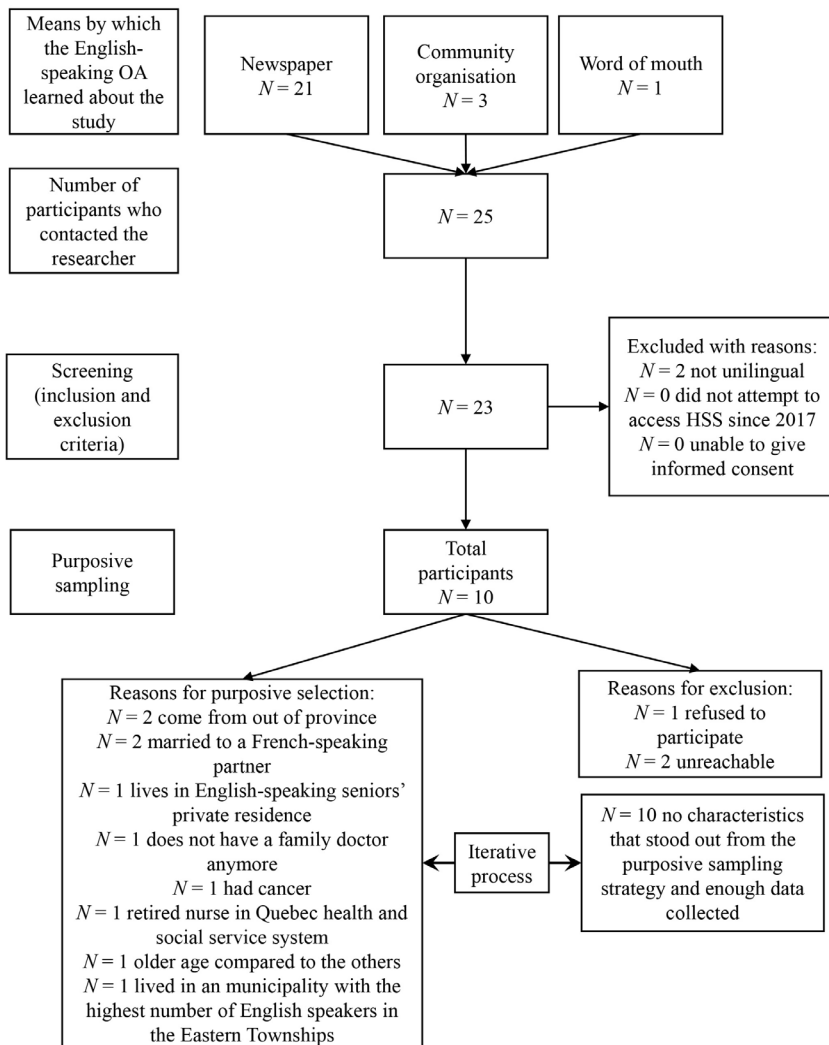
Sampling and Recruitment

We obtained ethical approval by the CIUSSS de l'Estrie – CHUS (#2020-3250). To be part of our study, participants had to live in the Eastern Townships, be at least 65 years old, and consider themselves unilingual English-speakers. They had to have attempted to use any of the health and social services corresponding to the broad priorities in *Promoting the health and well-being of English-speaking seniors in Quebec: A community model* (Community Health and Social Services Network [CHSSN], 2016) since 2017, as the access programs had been updated in 2016 (Ministère de la Santé et des Services sociaux, 2017). We defined an “attempt” as a concrete action to get a service. For example, thinking about getting an appointment was not considered an attempt to access health and social services. We excluded participants if they were unable to give informed consent. We recruited participants through word-of-mouth, an interview in a local newspaper, and local community organizations (e.g., non-profit organizations, churches). To ensure a diverse sample (e.g., gender, age, town, state of health), we used a purposive sampling strategy (Fortin & Gagnon, 2016). When applicable, we explained to excluded participants the rationale behind their exclusion (see Figure 1 for sampling and recruitment).

Data Collection

We conducted ten semi-structured interviews (ranging from 40 to 120 minutes), of which nine took place in the participants' homes and one at the Research Centre on Aging. We used the CHSSN conceptual model to design the interview guide (CHSSN, 2016). One methodological expert and two content experts (one unilingual, English-speaking nurse and one specialist in health and social services for OAs) reviewed our interview guide to ensure the validity of our questions (Creswell & Poth, 2018). We also tested our interview grid with three English-speaking OAs who were unrelated to the research project. Through open-ended questions, the guide explored participants' experiences as English-speaking OAs in health and social services. The guide included questions such as, “What do you wish to discuss with me today related to your access to health and social services?” and “Tell me about the language you speak when you receive health and social services.” In concordance with Yin (2009), as data collection and analysis evolved, we adjusted the interview guide to gain a deeper understanding of the phenomena under consideration and to explore rival explanations. For example, we made sure to use specific

Figure 1. Sampling and Recruitment.



questions to explore participants’ access to health and social services in general, as well as obstacles to access caused by language barriers and those not caused by language barriers.

We used a sociodemographic questionnaire at the end of the interview to collect contextual data regarding the age, health status, and last engagement with health and social services for each participant. Health status was collected to understand the reasons behind the use of health and social services. We collected documents related to health and

access from participants and from the community. Following the analysis of each interview, we contacted all participants to gain further insight on topics that were not discussed in depth and to confirm our analysis.

Data Analysis

As we are both experienced in qualitative research, data analysis was both iterative and simultaneous with data collection, following case study principles (Yin, 2009). We analyzed the data in five phases according to Braun et al. (2019): familiarizing, generating codes, constructing themes, revising and defining themes, and producing the report. First, during familiarization, we created verbatim transcriptions of the data from the audio-recorded interviews after each interview session. We transcribed data from the socio-demographic questionnaire into a spreadsheet. We recorded the title of each document in a grid, as well as a short description of what the document was about. We then read each transcript to ensure rigour and to become familiar with the data.

Second, we systematically generated codes from chunks of text to help develop meaningful patterns. Codes identified and provided a label to chunks of text that were relevant to the research objective (Braun & Clarke, 2012). We individually coded transcripts from each participant.

We developed two types of codes. The first type was related to the experience of accessing health and social services. These codes allowed the identification of potential difficulties and strategies put into place by English-speaking OAs. To ensure rigour, we defined these codes in a lexicon. The second type of codes were contextual data codes, such as state of health and use of health and social services. We compiled the contextual data codes into the spreadsheet with the socio-demographic data. During the coding, we also identified relationships between pairs of codes. These relationships linked potential difficulties with the strategies implemented by English-speaking OAs. For example, participants told us about how, when the provider spoke French (code: “Language of provider — French”), they asked for English health and social services (code: “Asking for English health and social services”). As such, when codes were put into a relationship, that relationship was noted in the lexicon, and both codes contained the relationship in their definition.

Third, once all the interviews were coded, we analyzed the codes to identify the themes — that is, the strategies used by English-speaking OAs to overcome the difficulties they encountered. To do so, we aggregated similar codes to create potential themes. Based on our assumptions and conceptual framework, we only categorized the codes that were related to language. We thus determined whether each code was related to a difficulty that arose from the language barrier. If they were related, we categorized that code as a “difficulty,” and then grouped similar

difficulties together. For example, we grouped together difficulties with phone calls (e.g., voicemails and calls being transferred, encountering “press 9 for English”). Once all difficulties were identified, we looked at the relationships that were a part of each theme. When a theme included both a difficulty and a strategy that drew on social capital, the strategy was added to the theme and became the major focus of the analysis.

Fourth, to revise and describe the themes, we had to assess internal consistency and external heterogeneity (Patton, 1990). More precisely, as a team, we discussed if the codes within each theme were similar enough and if all the themes were sufficiently different. If potential themes did not correspond to our internal homogeneity and external heterogeneity criteria, we disaggregated them to create new ones. When revising the themes, we integrated the data that we extracted from the documents. To extract data from the documents, we compared their goals. To do so, we asked ourselves: “What is this document about?” We then wrote the goal of the document in a spreadsheet (e.g., list of services available, fall prevention actions). Then, we categorized similar goals. We identified two types of goals: one that supports access to health and social services, and one that offers health-related information. We then calculated the frequencies for each goal and reported them in the applicable theme.

Fifth, we reviewed the themes that passed the internal homogeneity and external heterogeneity assessments to create our final list of strategies. We described each theme in a Microsoft Word document, in which we identified each of the following: theme name, description of the strategy and associated difficulties, codes included, information from the document (when applicable), and illustrative quotations from the transcriptions.

Finally, to describe our sample, we analyzed the contextual data quantitatively with median, frequency, and, due to the small sample size, ranges. Our results were validated by non-profit organizations supporting English-speaking OAs in their access to health and social services.

Findings

Ten English-speaking OAs took part in this study (Figure 1). Most of them were women and were married or in a common-law relationship; their median age was 82 years old. They knew between 0 and 10 different English-language health and social services and used a variety of these, such as physicians, physical activity groups, and volunteer activities. In fact, our participants identified 22 different health and social services, meaning English-speaking OAs were able to use health and social services in a French-speaking system.

What Are the Strategies Used to Overcome Difficulties in Accessing Health and Social Services Due to the Language Barrier?

Presented below are the seven strategies used by English-speaking OAs when facing difficulties in attempting to access health and social services. We have put each strategy in **bold**, and their corresponding difficulties are underlined.

Investigating for Health- and Access-Related Information in English.

To increase their knowledge about health and social services or about how to access them, English-speaking OAs implemented many actions that can be summed up as making an **investigation**. OAs using this strategy researched the availability of English-language health and social services through several avenues. For example, to learn about health and social services, most English-speaking OAs turned to word-of-mouth. In some communities, word-of-mouth seemed successful: “[I learned about health and social services] [j]ust by talking to neighbours or talking to people that I met through the church. Mostly through neighbours just to find out” (PB3¹). However, for some English-speaking OAs, word-of-mouth was not a successful strategy, since other English-speaking OAs may not know about relevant English-language health and social services. As such, they did not have any information to share.

Word-of-mouth was not the only approach that English-speaking OAs used to investigate for information. One action implemented by English-speaking OAs was to consult the newspaper. For example, some read the only available local English-language newspaper. Others read a French-language newspaper, since it contains a section written by an English writer which highlights information related to health and social services. Another action that participants used to gain information was to consult community-based organizations. Indeed, a number of local non-profit organizations offer talks in the communities or distribute pamphlets in English, which respond to English-speaking OAs’ health needs. Even if no English-speaking OAs had these at home, we counted 50 different pamphlets available in English from the two most often-accessed non-profit organizations. Churches were also a source of information for many of our participants.

Investigation is necessary because English health and social services are not sufficiently advertised in English. This insufficiency is corroborated by the few documents we were able to collect from English-speaking OAs. Indeed, only two of the three documents that we collected pertained to accessing health and social services: one for a walk-in clinic and the other to register to a list for a primary care doctor.

Creating Their Own Services. In some situations, our participants described countering insufficient access to English-language health and social services by **creating** the service — that is, creating their own informal alternatives to formal health services. This strategy was mostly pursued

for preventive services, such as physical activity groups, and for social inclusion, such as creating one's own Bible-study group. Our participants described using a creation strategy because, while investigating, English-speaking OAs sometimes identified that the health and social services available do not respond to their needs. For example, one informal, community-based physical activity group was set up after an English-speaking instructor became too sick to lead a formal group. Replacing him would have been too expensive for the English-speaking OAs, so they created their own physical activity group.

Furthermore, English-speaking OAs provide help to each other when in need, which is another way to create health and social services: "One of the women was pretty sick a while ago and there were various members of the congregation that called her and gave her help. [. . .] we keep track of one another quite well" (PA1). This peer support seems to be pursued because of the few caregivers able to be accessed by English-speaking OAs, due to the outward migration of their children from the province.

Entering the Health and Social Services System Offered in French and Entering the Health and Social Services System With Help From Others. When English-speaking OAs attempt to enter the health and social services system, they often encounter interactive voice response systems (i.e., recorded messages stating the options that need to be pressed to get to a specific department, with cues such as "press 9 for English"). English-speaking OAs reported that they avoid pressing 9 for English and **use the system in French**. Our interviewees reported that, when they pressed 9 for English, they would encounter long delays and would still receive French-speaking providers or documentation. Furthermore, some English-speaking OAs reported that they now **access health and social services with the help of other people**. For example, in a private seniors' residence, English-speaking OAs reported that they ask a nurse to call the provider and to obtain for them the required documents in English. These strategies are necessary because the interactive voice response systems are inadequate. As such, using both strategies mentioned above ensures that they reach the receptionist faster and receive the documentation in English.

Another reason for needing others' help to access health and social services is because the voicemail messages from health or social service providers are often left in French. Despite turning to other people, such as French-speaking neighbours, to access health and social services, this strategy does not always guarantee the best outcomes. Indeed, even the French-speaking neighbours or friends sometimes did not understand French voicemails: "So, he [the French-speaking neighbour] listened to it four times, and he said, 'I don't know what he [the health professional] wants. [. . .] I don't know if he wants you to send the requisition or if he wants you to go to the hospital [and take] him have an appointment there with him, or if he wants both'" (PB8). As such, English-speaking OAs will

need to take additional steps to ensure they can access health or social services. In that situation, the participant did both of the options that were mentioned in the voicemail.

Putting the Responsibility of Overcoming the Language Barrier on the Provider, Splitting the Responsibility, and Taking on the Responsibility. Once they have entered health and social services, English-speaking OAs must use strategies when they communicate with providers. We identified three types of strategies that our participants put into place. The first type put the responsibility on the provider to offer English health and social services. The second one split the responsibility, putting it on both the English-speaking OA and the provider. The third one put the responsibility on the English-speaking OA. These strategies were necessary because English-speaking OAs would encounter difficulties when they spoke and understood a language different than the one spoken and understood by the health or social services provider. As such, difficulties in conversations would arise, which in return would limit the English-speaking OAs' engagement in their care. The three types of strategies are discussed below.

The first type of strategy is to **put the responsibility on the provider** — that is, participants made it necessary for their health and social service providers to communicate with the English-speaking OAs in English. For example, English-speaking OAs reported that they sometimes only speak in English, without first requesting health and social services in English. Another strategy consists of asking for English health and social services: “And [the technician] will, of course, first start to speak in French. And I will say, ‘Could you please tell me in English what you are saying?’” (PA7). However, our participants provided warnings about this strategy. They noted that the way the request was made is important to having a good experience when receiving health and social services. Furthermore, they noted that neither strategy guarantees that the health and social services provider will answer in English or will go get someone who can speak English.

The second type of strategy is to **split the responsibility** — meaning that the English-speaking OAs reached a compromise with their service provider. Our interview participants reported that they would start a dialogue, meaning that they made an effort to speak the provider's language. In so doing, they created a climate of openness. They might, for example, start speaking a few words in French: “You start a dialogue. Just say a few words in French. And you will see that they are gonna be receptive, they will see that at least you are trying” (PB3). As such, the health or social service provider would see the English-speaking OAs' effort and adjust accordingly.

The third type of strategy is to **put the responsibility on the English-speaking OAs** — that is, give them the burden of enabling their own access to care. This strategy arose due to their repeated contact with

health and social services, in which they were aware that they might not get an English-speaking provider. As such, they came prepared to their appointments, with, for example, a caregiver who could interpret for them. This strategy was often used by English-speaking OAs, but had some limitations. For example, English-speaking OAs reported being excluded from conversations, because the provider would speak only with the informal interpreter, or because the informal interpreter would not interpret the complete details of the discussion to the English-speaking OA.

Discussion

In our identification of strategies used by English-speaking OAs when facing difficulties accessing health and social services, we identified seven strategies, most of which relied on information sharing and mutual assistance. As such, these seven strategies can be seen as community-based and linked to social capital. The number of strategies, as well as the need to use them, also highlights the complexity of Quebec's health and social services system for non-French speakers.

Community-Based Strategies and Social Capital: Their Impacts on Health

For English-speaking OAs' access to health and social services — and, ultimately, for their health — our results highlight the importance of resources linked to social networks, which is often described as “social capital” (Bourdieu, 1980). Indeed, to access health and social services, English-speaking OAs reported that they investigate, which mostly consisted of turning to the community to counter a lack of English-language information related to health or access to health and social services. For example, English-speaking OAs reported that they relied on word-of-mouth, newspapers, and community organizations, since the information coming from public organizations was inaccessible to them. They also reported turning to their neighbours or members of their church for help when they were sick or they needed support in accessing French-language health and social services. Both strategies (i.e., investigating and turning to others) rely on resources that are available through the social networks English-speaking OAs have within their communities. Among other things, these elements could explain how they manage to access health and social services despite the language barriers observed in this study and others (e.g., Kishchuk, 2010; Pocock, 2019). Consequently, their access to health and social services can positively impact their health (Levesque et al., 2013) and improve their quality of life (Gulzar, 1999).

Even if social capital seems to generate positive outcomes — including improved health and access to health and social services for English-speaking OAs — it can also have negative outcomes (Portes,

1998; Putnam, 2001). Two interrelated negative outcomes have been observed for the English-speaking community. First, there is a heavy reliance on informal caregivers in the English-speaking community (e.g., family, friends, non-profit organizations), which can put a major stress on these people. This heavy reliance on informal caregivers among English-speaking OAs can be explained by the high prevalence of self-perceived poor health, chronic arthritis (Pocock, 2015, 2019), and need for assistance with daily activities (Bouchard et al., 2018), especially since accessing homecare services can be difficult (Carter & Pocock, 2017). However, the availability of informal caregivers in the English-speaking community is also limited, as younger generations have left Quebec (Pocock, 2013). As such, since OAs represent a large proportion of the English-speaking population (Pocock, 2013), the few available informal caregivers are themselves often English-speaking OAs. For example, in 2018, 28% of English-speaking OAs reported engaging in volunteer work to care for other English-speaking OAs and 13.5% of English-speaking OAs reported providing caregiver services to a vulnerable or dependent person (Pocock, 2019). However, informal caregivers may experience major stress related to their caregiving role. Indeed, 47.9% of English-speaking OAs feel that caregiving limits their opportunities to realize their full potential as an OA (QCGN, 2014). This limitation could be explained by the fact that the available English-speaking informal caregivers tend to provide high levels of care — with many informally working more than 10 hours per week (Pocock, 2006, 2013). Thus, informal caregivers seem to be at risk of experiencing caregiver burden (Senate Canada, 2011). This heavy reliance on informal caregivers is corroborated by different studies among the English-speaking population in Quebec (e.g., Pocock, 2013, 2019; Sanderson, 2020). As such, these strategies seem to be recurrent and not specific to the community of the current study. Consequently, our findings could have implications for most English-speaking communities in Quebec.

Complexity of Quebec's Health and Social Services Systems for Non-French Speakers

In our study, the strategies used by English-speaking OAs showed the additional work required to access health and social services, which gave varying outcomes: some strategies seemed to be successful (i.e., creating one's own informal alternative service), while others seemed to have mixed results (i.e., investigating, bringing an informal interpreter). Health and social services systems are complex (Kannampallil et al., 2011). Adding to this complexity, English-speaking OAs must navigate an ever-changing health and social services system. Indeed, in the last 20 years, the Quebec health and social services system has undergone two major reforms. Introduced in 2003, Bill 25 merged locally based public

health and social service institutions (local community service centres, hospitals, and residential and long-term care centres) to create 95 centres for health and social services (CSSS). The provincial government's goal was to provide direct health and social services according to the local population's needs and to reduce spending (Bourque & Quesnel-Vallée, 2014). In 2015, Bill 10 led to the restructuring of the health and social services system by merging 182 public health and social service institutions, including 95 CSSS with public child and youth protection centres and public rehabilitation centres (Quesnel-Vallée & Carter, 2018), which resulted in the creation of 22 mega-organizations across the province known as integrated health and social services (CISSS) or integrated university health social services (CIUSSS) (Gouvernement du Québec, 2018). The reform aimed to improve accessibility, quality, safety, and efficiency of health and social services (Bourque & Quesnel-Vallée, 2014).

Bill 25 was implemented with accountability agreements and performance indicators to measure if CSSS responded to local population needs and reduced spending (Bourque & Quesnel-Vallée, 2014). In Quebec, agreements and performance indicators set the priorities for the institutions because their financing depends on their performance (Carrier, 2021). These accountability agreements were supposed to include performance indicators related to access programs (Carter, 2008) — that is, programs aiming to make English-language health and social services accessible, according to organizational resources (financial, human, etc.). To achieve greater access to health and social services, the English-speaking community's participation in the organization and governance of health and social services was promoted within the access programs (Kosseim et al., 2018). Thus, even if its aim was not language-related, the merger, paired with the access programs, were seen as a lever to make health and social services more responsive to local English-speaking communities' needs (Carter, 2008). However, the merger did not seem to produce the expected outcomes, namely because no English-related performance indicators tied to accountability agreements were included. As such, the English-speaking non-profit organizations perceived that the needs of the English-speaking communities were set aside by CSSS's administration board (Pocock, 2009). Following Bill 10, the situation remained: no English-related performance indicators were made part of the accountability agreements between the CISSS/CIUSSS, and the Ministry of Health and Social Services (e.g., Ministère de la Santé et des Services sociaux, 2016, 2017, 2018). As such, since language barriers were not taken into consideration in accountability agreements, English-speaking OAs might have encountered difficulties in accessing health and social services. Indeed, the range of health and social services offered by institutions tends to be limited to those measured by performance indicators, since they are linked to financing (Carrier, 2021; Ceci, 2006;

Sarrazin, 2014). Consequently, CISSS/CIUSSS might have little incentive to make English-language health and social services a priority, since they gain no financial benefits by doing so. Such lack of accountability or financial incentives could explain why English-speaking OAs needed strategies and additional effort to access health and social services.

Implications for Practice, Policy, and Research

With English-speaking OAs, interventions could be beneficial for the English-speaking community's health and well-being if they take into consideration that English-speaking formal and informal caregivers are highly sought-after. Since informal caregivers seem to be heavily relied on in minority-language communities (Campbell et al., 2014; Ngwakongnwi et al., 2012), other minorities could benefit from such interventions. From a policy perspective, incorporating language-based performance indicators in the accountability agreements could be a first step to measuring if access programs facilitate English-language health and social services. Finally, research could document the direct outcomes of reforms on access to health and social services for the English-speaking population.

Limitations

Our study has two major potential limitations. First, a specific subset of OAs who access English-language health and social services might have been more inclined to contact our research team to discuss their experiences than another subset of this population. However, we believe that this limitation was addressed by our varied recruitment and sampling strategies. Second, it was sometimes difficult to obtain answers from the participants, since some of our questions were theoretical. To counter this limitation, we gave them examples, offered definitions in layman's terms during the interview, or contacted participants after the interview to obtain further details.

The main strength of this study is its rich descriptions of the experiences of English-speaking OAs when accessing health and social services. While case studies are sometimes criticized for lack of rigour (Brown, 2008; Hyett et al., 2014), our constant validation with corresponding experts (i.e., for the interview guide, data analysis process, results) ensured the credibility of our results (Dahl et al., 2000).

Conclusion

Language barriers can have detrimental outcomes for health and social service users. In Quebec, one group at risk of encountering language barriers is English-speaking OAs. English-speaking OAs — especially those who live outside of Montreal — are often unilingual and must interact with

health or social service providers who have limited levels of bilingualism. Studies have documented language barriers faced by English-speaking OAs, but not the strategies they implemented to overcome these barriers. Thus, we aimed to document the strategies used by English-speaking OAs when faced with difficulties in accessing health and social services due to language barriers. Our results highlight seven strategies: 1) investigating for health- and access-related information in English, 2) creating their own services, 3) entering the health and social services system offered in French, 4) entering the health and social services system with help from others, 5) putting the responsibility of overcoming the language barrier on the provider, 6) splitting that responsibility, and 7) taking on the responsibility.

Because most strategies seem to rely on the English-speaking community (e.g., asking for help, asking for interpretation), they raise concerns about the potential informal care burden experienced by the community to help English-speaking OAs to access health and social services. Navigating and accessing health and social services in Quebec requires more efforts from anglophone OAs than it does from francophone OAs. Reforms to health and social services over the last 20 years seem to have added complexities for English-speaking OAs and might potentially be a reason why they resort to strategies that draw on their social capital. These strategies point to possible interventions to improve access to health and social services for English-speaking OAs. Since other language minority groups appear to share these strategies, our results and implications are also relevant for non-English- and French-speaking populations across Canada.

AUTHORS' NOTE

At the time of the study, Alexandra Ethier was a scholarship recipient from the Social Sciences and Humanities Research Council and the Fonds de recherche du Québec – Santé #296650. Alexandra Ethier is now a scholarship recipient from the Canadian Institute of Health Research #476590 Canada Graduate Scholarships – Doctoral program scholarship. Annie Carrier is a Fonds de recherche du Québec – Santé #296437 Junior I researcher.

The authors would like to thank participants and community organizations for their time, and François Lauzier-Jobin for his insightful comments on the methodology.

NOTE

1. A: lives in a town where English speakers are in “high” minority (very few speakers); B: lives in a town where English speakers are in “low” minority (more English speakers).

REFERENCES

- Act Respecting Health Services and Social Services, CQLR 1991, c. 42.
- Bartlett, G., Blais, R., Tamblyn, R., Clermont, R. J., & MacGibbon, B. (2008). Impact of patient communication problems on the risk of preventable adverse events in acute care settings. *Canadian Medical Association Journal*, 178(12), 1555–1562. <https://doi.org/10.1503/cmaj.070690>
- Borowski, D., Koreik, U., Ohm, U., Riemer, C., & Rahe-Meyer, N. (2019). Informed consent at stake? Language barriers in medical interactions with immigrant anaesthetists: A conversation analytical study. *BMC Health Services Research*, 19(1), Article 597. <https://doi.org/10.1186/s12913-019-4389-2>
- Bouchard, L., Chomienne, M.-H., Benoit, M., Boudreau, F., Lemonde, M., & Dufour, S. (2012). Do chronically ill, elderly francophone patients believe they are adequately served by Ontario's health care system?: Exploratory study of the effect of minority-language communities. *Canadian Family Physician / Le médecin de famille canadien*, 58(12), E686–E687.
- Bouchard, L., & Gilbert, A. (2005). Capital social et minorités francophones au Canada. *Francophonies d'Amérique*, (20), 147–159. <https://doi.org/10.7202/1005343ar>
- Bouchard, L., Gilbert, A., Landry, R., & Deveau, K. (2006). Social capital, health, and francophone minorities. *Canadian Journal of Public Health / Revue canadienne de santé publique*, 97(Suppl. 2), S16–S20.
- Bouchard, L., Sampasa-Kanyinga, H., & Mukaneza, A. (2018). *Profil santé des communautés anglophones en situation minoritaire au Québec*. Université d'Ottawa; Institut du savoir Montfort.
- Bourdieu, P. (1980). Le capital social. *Actes de la recherche en sciences sociales*, 31, 2–3.
- Bourhis, R. Y. (2017). Bilingual health care in Quebec: Public policy, vitality, and acculturation issues. In M. Drolet, P. Bouchard & J. Savard (Eds.), *Accessibility and active offer: Health care and social services in linguistic minority communities* (pp. 349–396). University of Ottawa Press.
- Bourque, M., & Quesnel-Vallée, A. (2014). Intégrer les soins de santé et les services sociaux du Québec: La réforme Couillard de 2003. *Health Reform Observer / Observatoire des réformes de santé*, 2(2), Article 1. <https://doi.org/10.13162/hro-ors.02.02.01>
- Bowen, S. (2001). *Barrières linguistiques dans l'accès aux soins de santé*. Santé Canada.
- Bowen, S. (2004). *Language barriers within the Winnipeg Regional Health Authority: Evidence and implications*. Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg. http://torontohealthequity.ca/wp-content/uploads/2013/02/Language_Barriers_within_the_Winnipeg_Regional_Health_Authority_Evidence_and_Implications.pdf
- Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper (Ed.), *APA handbook of research methods in psychology, Vol. 2: Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57–71). American Psychological Association. <https://doi.org/10.1037/13620-004>
- Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019). Thematic analysis. In P. Liamputtong (Ed.), *Handbook of research methods in health social sciences* (pp. 843–860). Springer. https://doi.org/10.1007/978-981-10-5251-4_103

- Brown, A. P. (2008). A review of the literature on case study research. *Canadian Journal for New Scholars in Education / Revue canadienne des jeunes chercheurs et chercheurs en éducation*, 1(1), 1–13.
- Cameron, B. L., del Pilar Carmago Plazas, M., Salas, A. S., Bourque Bearskin, R. L., & Hungler, K. (2014). Understanding inequalities in access to health care services for Aboriginal people: A call for nursing action. *Advances in Nursing Science*, 37(3), E1–E16.
- Campbell, R. M., Klei, A. G., Hodges, B. D., Fisman, D., & Kitto, S. (2014). A comparison of health access between permanent residents, undocumented immigrants and refugee claimants in Toronto, Canada. *Journal of Immigrant and Minority Health*, 16, 165–176. <https://doi.org/10.1007/s10903-012-9740-1>
- Canada Health Act, RSC. 1984, c. C-6.
- Carrier, A. (2021). « Performance » et pratique professionnelle dans les services de soutien à domicile offerts aux aînés : Effets et actions possibles pour assurer un développement durable. *Phronesis*, 10(4), 156–178. <https://doi.org/10.7202/1083982ar>
- Carter, J. (2008). What future for English language health and social services in Quebec? In R. Y. Bourhis (Ed.), *The vitality of the English-speaking communities of Quebec: From community decline to revival* (pp. 87–106). Centre d'études ethniques des universités montréalaises.
- Carter, J., & Pocock, J. (2017). *Report on the health and social services priorities of English-speaking communities in Quebec*. Community Health and Social Services Network. <https://ckol.quescren.ca/en/lib/L88B5EF9/download/D6B84CX8/carter-2017-report-on-the-health-and-social-services.pdf>
- Ceci, C. (2006). 'What she says she needs doesn't make a lot of sense': Seeing and knowing in a field study of home-care case management. *Nursing Philosophy*, 7(2), 90–99. <https://doi.org/10.1111/j.1466-769X.2004.00258.x>
- Charmaz, K., & Belgrave, L. L. (2012). Qualitative interviewing and grounded theory analysis. In J. F. Gubrium, J. A. Holstein, A. B. Marvasti & K. D. McKinney (Eds.), *The SAGE handbook of interview research: The complexity of the craft* (2nd ed., pp. 347–365). SAGE. <https://dx.doi.org/10.4135/9781452218403>
- Charter of the French Language, CQLR. 1977, c. 5.
- Centre intégré universitaire de santé et de services sociaux de l'Estrie – Centre hospitalier universitaire de Sherbrooke. (2016). *Responding better to the needs of the linguistic and cultural communities in Estrie*. <https://numerique.banq.qc.ca/patrimoine/details/52327/2795833>
- Cobb, A. K., & Forbes, S. (2002). Qualitative research: What does it have to offer to the gerontologist? *The Journals of Gerontology: Series A*, 57(4), M197–M202. <https://doi.org/10.1093/gerona/57.4.M197>
- Coleman, J. S. (1998). Social capital in the creation of human capital. *American Journal of Sociology*, 94, S95–S120.
- Community Health and Social Services Network. (2016). *Promoting the health and well-being of English-speaking Seniors in Quebec: A community model*. <https://chssn.wpenginepowered.com/wp-content/uploads/2021/08/Community-Model-Seniors-2019-En.pdf>

- Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). SAGE.
- Dahl, K., Larivière, N., & Corbière, M. (2000). L'étude de cas : illustration d'une étude de cas multiples visant à mieux comprendre la participation au travail de personnes présentant un trouble de la personnalité limite. In M. Corbière and N. Larivière (Eds.), *Méthodes qualitatives, quantitatives et mixtes : dans la recherche en sciences humaines, sociales et de la santé* (pp. 73–96). Presses de l'Université du Québec.
- de Moissac, D. (2016). *Accès aux services de santé et d'interprète-accompagnateur : l'expérience des communautés minoritaires à faible densité de francophones au Canada*. Société Santé en français. <http://www.reseausantene.ca/wp-content/uploads/2018/05/Experience-communaute%CC%81s-minoritaires.pdf>
- de Moissac, D., & Bowen, S. (2017). Impact of language barriers on access to healthcare for official language minority francophones in Canada. *Healthcare Management Forum*, 30(4), 207–212. <https://doi.org/10.1177/0840470417706378>
- de Moissac, D. & Bowen, S. (2019). Impact of language barriers on quality of care and patient safety for official language minority Francophones in Canada. *Journal of Patient Experience*, 6(1), 24–32. doi: 10.1177/2374373518769008
- Drolet, M., Arcand, I., Benoît, J., Savard, J., Savard, S., & Lagacé, J. (2015). Agir pour avoir accès à des services sociaux et de santé en français: Des francophones en situation minoritaire nous enseignent quoi faire! *Canadian Social Work Review / Revue canadienne de service social*, 32(1–2), 5–26. <https://doi.org/10.7202/1034141ar>
- Ethier, A., & Carrier, A. (2022a). L'accessibilité des services sociaux et de santé chez les minorités de langue officielle du Canada et les facteurs influant sur leur accès : Une étude de portée. *Linguistic Minorities and Society / Minorités linguistiques et société*, (18), 197–234. <https://doi.org/10.7202/1089185ar>
- Ethier, A., & Carrier, A. (2022b). Conséquences des barrières que rencontrent les aînés d'expression anglaise pour avoir accès aux services sociaux et de santé. *Journal of Eastern Township Studies / Revues d'études des Cantons de l'Est*, 50, 29–52
- Falconer, J., & Quesnel-Vallée, A. (2014). Les disparités d'accès aux soins de santé parmi la minorité de langue officielle au Québec. *Recherches sociographiques*, 55(3), 511–529. <https://doi.org/10.7202/1028377ar>
- Flores, G., Laws, M. B., Mayo, S. J., Zuckerman, B., Abreu, M., Medina, L., & Hardt, E. J. (2003). Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*, 111(1), 6–14. <https://doi.org/10.1542/peds.111.1.6>
- Fortin M-F. & Gagnon, J. (2016). L'échantillonnage. In M-F. Fortin and J. Gagnon (Eds.) *Fondements et étapes du processus de recherche : méthodes quantitatives et qualitatives* (3rd ed., pp. 260–282). Chenelière.
- Gouvernement du Québec. (2018). *Integrated Health and Social Services Centres (CISSS) and Integrated University Health and Social Services Centres (CIUSSS)*. <https://www.quebec.ca/en/health/health-system-and-services/service-organization/ciuss-and-ciuss>
- Gulzar, L. (1999). Access to health care. *Journal of Nursing Scholarship*, 31(1), 13–19. <https://doi.org/10.1111/j.1547-5069.1999.tb00414.x>

- Hyett, N., Kenny, A., & Dickson-Swift, V. (2014). Methodology or method? A critical review of qualitative case study reports. *International Journal of Qualitative Studies on Health and Well-being*, 9(1), Article 23606. <https://doi.org/10.3402/qhw.v9.23606>
- Kalich, A., Heinemann, L., & Ghahari, S. (2016). A scoping review of immigrant experience of health care access barriers in Canada. *Journal of Immigrant and Minority Health*, 18, 697–709. <https://doi.org/10.1007/s10903-015-0237-6>
- Kannampallil, T. G., Schauer, G. F., Cohen, T., & Patel, V. L. (2011). Considering complexity in healthcare systems. *Journal of Biomedical Informatics*, 44(6), 943–947. <https://doi.org/10.1016/j.jbi.2011.06.006>
- Kawachi, I., & Berkman, L. F. (2000). Social cohesion, social capital, and health. In L. F. Berkman & I. Kawachi (Eds.), *Social epidemiology* (pp. 174–190). Oxford University Press.
- Kishchuk, N. (2010, March 23–24). *Health determinants and health promotion in the English-speaking community of the Eastern Townships* [Conference presentation]. New Insights Symposium.
- Kosseim, M., Prata, G., & Martin, I. (2018). *Guide pour l'élaboration du programme d'accès aux services de santé et aux services sociaux en langue anglaise*. Ministère de la Santé et des Services sociaux. <http://collections.banq.qc.ca/ark:/52327/3443512>
- Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, 12, Article 18. <https://doi.org/10.1186/1475-9276-12-18>
- Ministère de la Santé et des Services sociaux. (2016). *Ententes de gestion et d'imputabilité 2015–2016*. <https://publications.msss.gouv.qc.ca/msss/document-001595/>
- Ministère de la Santé et des Services sociaux. (2017). *Ententes de gestion et d'imputabilité 2016–2017*. https://publications.msss.gouv.qc.ca/msss/fichiers/2016/EGI-2016-2017_MSSS-CIUSSS-CHU_Sherbrooke.pdf
- Ministère de la Santé et des Services sociaux. (2018). *Ententes de gestion et d'imputabilité 2017–2018*. <https://publications.msss.gouv.qc.ca/msss/document-001940/>
- Ngwakongnwi, E., Hemmelgarn, B. R., Musto, R., Quan, H., & King-Shier, K. M. (2012). Experiences of French speaking immigrants and non-immigrants accessing health care services in a large Canadian city. *International Journal of Environmental Research and Public Health*, 9(10), 3755–3768. <https://doi.org/10.3390/ijerph9103755>
- Official Languages Act, RSC 1985, c. 31.
- Parsons, J. A., Baker, N. A., Smith-Gorvie, T., & Hudak, P. L. (2014). To 'get by' or 'get help'? A qualitative study of physicians' challenges and dilemmas when patients have limited English proficiency. *BMJ Open*, 4, Article e004613. <https://doi.org/10.1136/bmjopen-2013-004613>
- Patton, M. Q. (1990). *Qualitative evaluation and research methods*. SAGE.
- Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). SAGE.

- Pocock, J. (2006). *Social support networks in Quebec's English-speaking communities: Building community vitality through social capital strategies*. Community Health and Social Services Network.
- Pocock, J. (2009). *Language, gender and generation: The social economy approach to health and the case of Estrie's English-speaking communities* [Unpublished doctoral dissertation]. Carleton University. ProQuest Dissertations and Theses Global.
- Pocock, J. (2013). *Bien vieillir dans sa langue, sa culture et sa communauté: Enjoying your senior years in your own language, culture and community: Federal support from key institutions and a portrait of English-speaking seniors in Quebec*. Office of the Commissioner of Official Languages. <https://canadacommons.ca/artifacts/1237604/bien-vieillir-dans-sa-langue-sa-culture-et-sa-communautaire/1790675/>
- Pocock, J. (2015). *Canadian Community Health Survey (2011–2012): Findings related to the mental and emotional health of Quebec's English-speaking communities*. Community Health and Social Services Network. https://chssn.wpenginepowered.com/wp-content/uploads/2021/08/Mental-Health-cchs2011-2012_analysis.pdf
- Pocock, J. (2019). *Baseline data report 2018–2019 part 1 (telephone survey)*. Community Health and Social Services Network. <https://ckol.quescren.ca/fr/lib/SBVS7W88/download/TWSGJIQ7/pocock-2019-baseline-data-report.pdf>
- Portes, A. (1998). Social capital: Its origins and applications in modern sociology. *Annual Review of Sociology*, 24, 1–24.
- Putnam, R. (2001). Social capital: Measurement and consequences. *Canadian Journal of Policy Research*, 2(1), 41–51.
- Quebec Community Groups Network. (2014). *Moving forward: Building research capacity related to Quebec's English-speaking seniors*. <https://qcgnc.ca/2010715seniors-action-plan-html/>
- Quesnel-Vallée, A., & Carter, R. (2018). Improving accessibility to services and increasing efficiency through merger and centralization in Quebec. *Health Reform Observer / Observatoire des réformes de santé*, 6(1), Article 2. <https://doi.org/10.13162/hro-ors.v6i1.3216>
- Sanderson, D. (2020). Language related difficulties experienced by caregivers of English-speaking seniors in Quebec. *SAGE Open*, 10(3), 1–12. <https://doi.org/10.1177/2158244020951261>
- Sarrazin, S. (2014). *L'impact de la réforme du réseau de la santé et des services sociaux en 2004 sur l'exercice du travail social en santé mentale : le cas du CSSS Gatineau* (Cahier no. 14-03). Chaire de recherche du Canada en organisation communautaire
- Sarver, J., & Baker, D. W. (2000). Effect of language barriers on follow-up appointments after an emergency department visit. *Journal of General Internal Medicine*, 15, 256–264. <https://doi.org/10.1111/j.1525-1497.2000.06469.x>
- Senate Canada. (2011). *The vitality of Quebec's English-speaking communities: From myth to reality*. <http://publications.gc.ca/site/eng/408254/publication.html>
- Tenzer, H., Pudenko, M., & Harzing, A.-W. (2014). The impact of language barriers on trust formation in multinational teams. *Journal of International Business Studies*, 45, 508–535. <https://doi.org/10.1057/jibs.2013.64>

- Trempe, N., & Lussier, M.-H. (2011). *La connaissance et l'utilisation de la langue anglaise par les professionnels de la santé et des services sociaux au Québec*. Gouvernement du Québec. <https://chssn.wpenginepowered.com/wp-content/uploads/2011/09/ConnUtiliAnglaisProfSSSQc-1.pdf>
- Woloshin, S., Schwartz, L. M., Katz, S. J., & Welch, H. G. (1997). Is language a barrier to the use of preventive services? *Journal of General Internal Medicine*, *12*, 472–477. <https://doi.org/10.1046/j.1525-1497.1997.00085.x>
- Yin, R. K. (2009). *Case study research: Design and methods* (4th ed.). SAGE.

