Knowledge Exchange Initiative 1474

Development of a Treatment Strategy for Promoting Resilience and Positive Mental Health Outcomes in Children and Youth of Mothers with Addictions

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Executive Summary

Children of mothers who abuse substances are a high risk population that has received increased attention in recent years within the context of women’s substance abuse treatment. Given their increased risk for a host of negative developmental and mental health outcomes, including impaired physical growth, development, and health, poor cognitive functioning and school performance, emotional and behavioural problems, psychiatric disorders, and substance abuse (Barnard et al., 2004), primary, secondary, and tertiary levels of intervention are needed that address the needs of children of mothers with substance abuse issues. Enhancing parenting and the parent-child relationship is central to promoting positive outcomes, due to the increased likelihood of challenges that mothers experience in their parenting due to issues associated with their substance use (e.g., the emotional lability that is associated with intoxication or withdrawal) and comorbid psychopathology.

Integrated programs – programs that provide maternal substance abuse treatment services, as well as services that address the motherhood needs of women and the needs of their children – have been developed over the past 20 years to meet the needs of this high risk population. There are currently 14 integrated programs in Ontario that provide services that address both the needs of the mother and child in the context of a substance abuse treatment program. Most programs have developed in a grassroots manner, harnessing relationships between local services providers (e.g., child welfare, nursing, children’s mental health) based on the needs of the families they serve.

Drs. Karen Milligan and Alison Niccols (members of the working group for this project) recently led the completion of a series of meta-analyses examining the effectiveness of integrated programs in North America. While there was a growing literature on evidence-based practices for women with addictions, there were few research studies or best practices guidelines for how to best address the needs of children of mothers with addictions. One of the primary reasons for developing integrated programs is improving child outcomes; however, our
review of programs in Canada and our recent meta-analysis of comprehensive programs revealed that little is known about what child or parent services are needed and few controlled studies (K=3) on the short and long-term outcomes for children.

Given this limitation in the literature, this Knowledge Exchange Initiative was undertaken to meet the following objectives:

1. To develop a working group of individuals involved with mothers with substance abuse issues and their children.
2. To examine possibilities for future collaboration across programs and sectors.
3. To discuss child outcomes and best practices for promoting positive outcomes in children of mothers with addictions
4. To identify key services that contribute to the success of integrated programs
5. To develop a multi-site evaluation framework for examining child and parenting outcomes.

As part of this project, a team of stakeholders from relevant sectors in Ontario was developed, including addictions, mental health, children welfare, and policy. The team met for seven monthly meetings (3 in person and 4 by teleconference). The meetings focused on discussion of best practices and challenges in providing child and parenting services in integrated programs, conceptualization and definition of integrated programs, and development of an evaluation framework for future research. In addition to the team meetings, additional research was undertaken to further inform the group process. More specifically, a survey of integrated programs in Ontario was completed to develop a more detailed picture of integrated programs in Ontario and the child and parenting service provided. Literature reviews were also completed on parenting and child outcomes and measures used in previous treatment research; models of integration and parenting programs currently being offered in integrated programs in Ontario; and integration science.

The stakeholder working group experience truly depicted a developmental group process. Many of the conceptualizations of integrated programs that members of the group held
prior to joining the group were challenged and new perspectives were formed. The key lessons learned from the project included (1) challenging our understanding of how integrated programs should be operationalized in order to take into account the heterogeneity of programs; (2) identifying key philosophical or theoretical tenants that underlie integration – namely keeping the mother and child ‘in mind’; and (3) the need to develop best practices for treatment and research methods that are consistent with philosophical frameworks (i.e., mother-child relationship/attachment).

Our working group plans to continue the exciting and challenging work that we have commenced. Given the lessons learned, we believe that it is currently too premature to develop a multi-site evaluation framework as originally proposed. Before this can be developed, an essential task for the group is to define and evaluate “integration” of Ontario-based integrated programs. This will provide essential understanding of the key components of integration and will inform our process evaluation, as well as the identification of programs to be included in a multi-site study. To develop this understanding, we will be applying The Centre of Excellence in Child and Youth Mental Health Knowledge Exchange Initiative (July 2012).
**Project Overview**

*Purpose of Initiative*

Children born to women who used substances during their pregnancy are at greater risk for physical and mental health problems, including higher rates of emotional and behavioral problems (Wilens, Biederman, Kiely, Bredin, & Spencer, 1995), major psychiatric disorder (65%; Luthar, Cushing, Merikangas, & Rounsaville, 1998), and use alcohol and drugs (Legrand, Iacono, & McGue, 2005). In Canada, the Better Beginnings Better Futures’ research team has shown that children prenatally exposed to alcohol, and even more so the combination of alcohol and tobacco, show increased risk for negative outcomes in terms of school readiness at age 4 and teacher and parent-reported internalizing and externalizing behaviour problems at age 8 (Parker et al., 2011).

While these children may be at increased risk due to prenatal exposure, parenting factors likely also contribute to the poor outcomes for children. Despite their best intentions, women with substance abuse issues are at risk for a wide range of parenting deficits (Mayes et al., 2002). Parenting can be operationalized as skills (e.g., interacting sensitively, facilitating sleeping and eating routines), attitudes (e.g., empathy, positive approaches to behaviour guidance), knowledge (e.g. understanding child development), or capacity (e.g., maternal custody, lack of need for child protection services involvement). Parenting among mothers with substance abuse issues may be impaired by the primacy of satisfying their addiction over the welfare of themselves and their children, the emotional lability that is associated with intoxication or withdrawal, the impairment from chronic drug use, and their consequent unavailability to their children. Further, women with substance abuse issues often have high levels of comorbid psychopathology and personality problems, which can impair emotional responsiveness and cognitive abilities and negatively impact parenting.

Given that children born to mothers who abused substances are at significant risk for poor developmental outcomes and that approximately 200,000 Canadian women aged 15 years
or older struggle with alcohol or drug dependence (Canadian Community Health Survey, 2002), with the majority of women in this age group being parents (70%, U.S. Department of Health and Human Services, 1999), the development of accessible and engaging treatments that address the diverse and significant needs of families (mother and child) are needed. Furthermore, treatment for mothers with substance abuse issues and their children may represent an important opportunity for breaking the intergenerational cycle of addiction and dysfunction and improving parenting. However, women with substance abuse issues report difficulties using conventional systems of care (for reasons including fear of losing custody of children, guilt, stigma, and lack of transportation), and request comprehensive services provided in a caring, ‘one-stop’ setting (Luthar et al., 1998). Given the barriers, risks, and outcome implications, researchers, clinicians, and policy makers recommend that substance abuse treatment programs address women’s needs as well as their children’s needs through comprehensive, integrated services in centralized settings for both women and children (Luthar et al., 1998). This recognition has resulted in the development of numerous integrated treatment programs (those that include on-site pregnancy-, parenting-, or child-related services with addiction services), both residential and outpatient. Integrated residential programs or “therapeutic communities” offer long-term (15-18 months) treatment services to women and their children. Both types of programs typically are comprehensive and include group and individual addiction treatment, maternal mental health services, trauma treatment, parenting education and counseling, life skills training, prenatal education, medical and nutrition services, education and employment assistance, child care, children’s services, and aftercare.

Connections is an Ontario-based research team that is working on developing and evaluating a knowledge transfer and exchange strategy to improve services for women with substance use issues and their children in Canada. Members of this team recently completed a national survey of addiction treatment centres in Canada and found that approximately 50% do not provide pregnancy-, parenting-, or child-related services, with very few providing services for
children under 5 years (Niccols et al., 2010). Most program managers reported referring children with identified needs to other agencies. Although this strategy may seem appropriate, especially given that addiction agencies may not have child mental health expertise, the likelihood of follow through on referrals is low. Shulman et al. (2000) found that, while only 10% of mothers in addictions treatment followed through on referrals for child development evaluations off site, 85% attended appointments when they were offered as part of their addictions treatment. Furthermore, on-site pregnancy, parenting, and early child development services (i.e., integrated programs) are associated with improved birth, parenting, and child outcomes among women with substance use issues and their children (Ashley et al. 2003; Motz et al. 2006; Niccols & Sword 2005).

While there is a growing literature on evidence-based practices for women with addictions, there are few research studies or best practices guidelines for how to best address the needs of children of mothers with addictions. Given this gap in knowledge and relevant research, the objectives of this knowledge exchange project were:

1. To develop a working group of individuals involved with mothers with substance abuse issues and their children.
2. To examine possibilities for future collaboration across programs and sectors.
3. To discuss child outcomes and best practices for promoting positive outcomes in children of mothers with addictions.
4. To identify key services that contributes to the success of integrated programs.
5. To develop a multi-site evaluation framework for examining child and parenting outcomes.

**Summary of the Project**

As part of this project, a team of stakeholders from relevant sectors in Ontario was developed, including addictions, mental health, children welfare, and policy. The team met for seven monthly meetings (3 in person and 4 by teleconference). The meetings focused on
discussion of best practice and challenges in providing child and parenting services in integrated programs, conceptualization and definition of integrated programs, and an evaluation framework for future research. In addition to the team meetings, additional research was undertaken to further inform the group process. More specifically, a telephone survey of integrated programs in Ontario was completed to develop a more detailed picture of integrated programs in Ontario and the child and parenting service provided. Literature reviews were also completed on parenting and child outcomes and measures used in previous treatment research; models of integration and parenting programs currently being offered in integrated programs in Ontario; and integration science.

Identification of the target population for the project and relevant stakeholders

Drs. Karen Milligan (Director of Research and Psychology, Integra) and Wendy Sword (Professor and Chair of Research in the Department of Nursing, McMaster University) took the lead role on this project. Both Drs. Milligan and Sword are members of the Connections research team that has been actively working on the development of relationships with stakeholders in the area of treatment for mothers with substance abuse issues for the past 5 years. A networking model was used to develop our full composite of stakeholders, in which we started with our Connections group and agencies we had been involved with and asked stakeholders to identify other individuals who they felt would be appropriate stakeholders. An emphasis was placed on having broad representation across sectors (e.g., treatment programs, research, policy, child welfare), and geographical region, and culture (e.g., inclusion of representatives working with first nations communities).

A detailed list of stakeholders is presented in Table 1.
### Table 1. Membership List of Stakeholder Working Group

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<thead>
<tr>
<th>Member Name</th>
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<tr>
<td>Karen Milligan</td>
<td>Connections – Co-Investigator Director of Psychology and Research, Integra</td>
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<td>Toronto</td>
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<td>(Project Lead)</td>
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<tr>
<td>Wendy Sword</td>
<td>Connections – Principal Investigator Associate Professor and Assistant Dean (Research) in the School of Nursing, McMaster University</td>
<td>Research</td>
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<td>(Project Co-lead)</td>
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<tr>
<td>Alison Niccols</td>
<td>Connections – Primary Investigator Psychologist/Clinical Director, Infant-Parent Program Associate Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University</td>
<td>Research</td>
<td>Hamilton</td>
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<td>Integrated Program (New Choices)</td>
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<tr>
<td>Ainsley Smith</td>
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<td>Ellen Lipman</td>
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<td>Julie Horning</td>
<td>Catholic Children's Aid Society of Hamilton</td>
<td>Child Welfare</td>
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<td>Shelia Penny</td>
<td>Hamilton Children's Aid Society</td>
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<td>Sue Kennedy</td>
<td>Alternatives for Youth</td>
<td>Youth Substance Abuse Treatment</td>
<td>Hamilton</td>
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<td>Peter Braunberger</td>
<td>Psychiatrist</td>
<td>Psychiatry</td>
<td>Thunder Bay</td>
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<tr>
<td>Betsy Radke</td>
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<td>Integrated Substance Abuse Treatment</td>
<td>Sault Ste. Marie</td>
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<tr>
<td>Mary Motz</td>
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<td>Toronto</td>
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Activities Summary

Below is a summary of activities of the working group. Agendas and minutes were prepared for each meeting and are summarized below. Full documents are available from Dr. Karen Milligan.

Working Group Meetings

Meeting #1 (Phone): September 28, 2011 – Orientation and team introduction meeting. The team was introduced and project rationale and objectives for the project were discussed. Agenda for first meeting was developed.

Meeting #2 (In-Person): November 3, 2011 – Presentation of research completed by stakeholder group members. Dr. Karen Milligan, Dr. Wendy Sword, and Ms. Ainsley Smith presented on findings from their recent meta-analyses on the effects of integrated treatment programs on parenting, child, and birth outcomes. Dr. Mary Motz presented findings from their recent evaluation of Breaking the Cycle. Group discussion was facilitated on the needs of children of mothers with substance abuse issues, keystone services for positive child outcomes, and supports and challenges to their implementation. The interconnection of mother and child outcomes was emphasized throughout the discussion. The group discussed how an evaluation
framework could be developed to promote stakeholder support and overcome barriers to study children over the long-term.

Meeting #3 (Phone): December 12, 2011—Presentation of the results of the telephone survey completed with integrated programs in Ontario (see Appendix A). The group discussed the parenting and child related services and the extent to which they address the needs of mothers with addictions. Barriers and strategies to implementation and research of integrated programs were also discussed.

Meeting #4 (In-Person): January 30, 2012 - Presentation of the results of the telephone survey completed with integrated programs in Ontario (see Appendix A). Parenting and child related services were reviewed and a definition of integrated programs was discussed. A disconnect was identified between the identified philosophical approach of organizations – attachment and mother-child relationship - and services focused on parent education and skills training. Given this disconnect, the group discussed the possible need to shift the conceptualization of integrated programs from a one-stop shop model (or type and number of services provided model) to a model that includes more process orientated variables focused on effective integration, such as a program's capacity for relationships and processes that connect mothers and their children to appropriate services. Principles and processes of integration were considered. Strategies and barriers to effective integration were discussed.

Meeting #5 (Phone) – March 1, 2012 – Key themes of defining integrated programs were reviewed as related to accessibility of services and quality of relationships between different sectors. Integration was further conceptualized as the consideration of both the mother and the child as clients and the ability to “keep the needs of the mother and child in mind” in all activities related to service delivery.
Meeting #6 (In-Person) - March 29, 2012 – Literature review on integration was presented, including measures of integration identified in the literature (see below for further details). Based on group member experience and the review of the literature, the group developed a list of key components to consider when defining integration. For example:

**Services**

- Services are client driven and address needs of both mother and child – flexibility to address need when appropriate
- Include pregnancy and prenatal
- Assessment – intake focused on mother and child

**Attitudes**

- Shift in perspective to be more inclusive
- Respect context of relationship and trauma
- Keeping mother and child in mind
- Capacity (knowledge and skills)

**Staff Training and Experience**

- Staff experience, including both work in field and life experience (personal or significant people in life), in addictions, mental health, child development, child welfare
- What knowledge and skills are needed to be able to do work (ex. integration, collaboration, parent-child issues, trauma)?
- Understanding of attachment and developmental expectations

**Policy**

- Who is the client – keeping mother and child in mind
- Related to policy and funding
- Client is relationship between mother and child
Training and Education

- Staff background, education
- Extent to which program support professional development related to children, attachment, trauma

Administration

- Autonomy
- Attitudes: Assumption that mothers are caring parents
- Quality of relationships between staff and partner agencies/emphasis on relationship
- Help families’ voices to be heard in mainstream environment

Barriers

- Prejudices and judgments that deter mothers from accessing services
- Compassion fatigue – support needed for carers, therapists, workers
- Role flexibility to meet clients’ needs – whose job is it to meet mothering needs of client?
- Attitudes towards collaboration to meet needs

Based on this discussion, planning began for a future qualitative study to examine integration in the context of integrated substance abuse treatment programs in Ontario. Funding opportunities for this research through the Ontario Centre for Excellence in Child and Youth Mental Health were discussed.

Research Completed to Support Stakeholder Working Group Process

1. Environmental Scan of Integrated Substance Abuse Treatment Programs in Ontario

Objective: Previous research by Connections (e.g., meta-analysis of integrated programs and national survey) highlighted the heterogeneity of services and models of treatment for mothers with substance abuse issues and their children. A telephone survey of integrated programs in Ontario was undertaken to provide a detailed picture of integrated programs in this province.
More specifically, information regarding treatment program philosophies and models, services available for mothers and their children, and barriers for implementation and research were collected to inform our stakeholder working group’s definition of integrated programs and development of our evaluation framework.

Participants. Integrated programs were identified based on their inclusion in the Early Childhood Development Addiction Initiative Final Report (Cathexis, 2006). Of the 18 integrated programs contacted, 14 programs agreed to participate in the survey.

Procedure. Integrated programs were contacted by telephone for 15-20 minutes by the project’s research assistant, Laura Greenberg. Interviews were generally completed with directors, program managers, and frontline staff who reported being knowledgeable about the child and parenting related services offered by their program. The survey included questions about the population served, philosophical approach related to parenting and children, child and parenting related services provided, interest and barriers to participation in research, and child outcomes of interest in future research.

Results. Results of the survey are presented in Appendix A. The results of this survey were consistent with our previous research and underscored the heterogeneity of integrated programs in Ontario. While almost all programs espoused following an attachment or relationship-based theoretical philosophy, there was considerable heterogeneity in terms of the programs offered. Given that a number of the services were identified as providing manualized parenting and child programs, a further review was completed to identify their objectives (e.g., parenting skill development, relationship development) and key components (e.g., psychoeducation, parent-child interaction). A summary of manualized parenting programs is presented in Appendix C. Of particular interest, was the finding that the programs offered tended to focus more on development of parenting skills rather than attachment or improving the quality of the parent-child relationship – which was more consistent with the stated treatment philosophies of programs.
**Discussion.** The findings of the survey were helpful for the stakeholder group in identifying those integrated programs that are more integrated from a service perspective (i.e., the number and types of services provided for mothers and their children). These findings also spurred on debate within the working group about the meaning of integration *beyond* service provision, particularly for programs located in rural communities who do not have the resources to have all services located in-house. Based on this discussion the stakeholder working group developed a new conceptualization of integration that included not only service provision but process variables that are essential to effective integration (i.e., keeping mother and child needs in mind across all services).

**Limitations and Next Steps.** Results were based on the knowledge of one informant per program. Some informants provided information on only the specific services delivered through their branch of the program while other informants provided information on the services delivered through the agency as a whole. In addition, open-ended questions used in the survey may not have included all relevant programs and services provided. Further research is needed to examine vision, mandates, and services provided at integrated programs.

**2. Review of Parenting Programs Offered by Integrated Programs in Ontario**

Based on the survey of integrated programs in Ontario, there were 14 manualized parenting programs being provided for mothers with substance use issues. A review of available literature was completed and specifically examined the aim, theoretical rationale, format, key curriculum, and evidence-base of these parenting programs.

The majority of programs were primarily psychoeducational and skills training based, with the objectives of increasing parent’s knowledge, enhance parenting skills, and building parenting confidence. The over-arching aim of the majority of parenting programs was to change maladaptive patterns of parent-child interaction in order to prevent child maltreatment, decrease children’s problem behaviors, and improve parent and child coping. Strategies were
frequently provided for enforcing routines, behaviour management, communication, and coping. These programs primarily focused on responding to problem situations, such as child misbehavior or conflict. Only four parenting programs offered focused on attachment with an aim to improve the quality of the parent-child relationship.

In terms of program format, most programs adopted an adult learning model based on experiential learning through reflection, information, practice, and feedback. Several programs used video illustrations and encouraged parents to role play and practice at home between sessions. There were three programs that included in session work with both mother and child. A summary of the 14 programs is provided in Appendix C.

3. Review of Measures of Parenting and Child Outcomes used in Integrated Outcome Studies

A literature review of parenting and child outcomes assessed and measures used was completed to inform the development of research questions and associated measures for our evaluation framework and potential measures. A summary of measures is provided in Appendix B.

4. Literature Review on Integration Science

A literature review on integration science was undertaken to inform the stakeholder working group discussions of how best to define “integrated programs” and identification of key components and processes that support effective integration. Relevant research studies, theoretical papers and policy documents (N= 19) were identified and reviewed, including papers from the fields of integrative health, substance abuse treatment and child welfare, and children’s services. Overall, the literature on integration appeared to lack consistency and clarity in the terminology and goals of multiple services working together. The term “integration” appears to not be easily differentiated from “collaboration”, “interdisciplinary”, and other models of services
working together. There is some literature that suggests models of multiple services working together can be positioned on a continuum from services being parallel to one another with each individual performing within their scope of practice to services being integrated with multiple services working together (Axelsson & Axelsson. 2006; Boon et al., 2004). Integration describes professionals from different disciplines working together under a common policy, organization, and structure (Boon et al., 2009). It involves the alignment of multiple systems of independent organizations with unique goals and objectives (Boydell, Bullock & Goering, 2009). Consultation, collaboration, and coordination fall along the middle of the continuum. Models that are higher on the continuum have a broader philosophy; increased structural complexity and role flexibility; more effective processes of communication, participant involvement, individualization, and synergy; and greater complexity and diversity in outcomes (Boon et al., 2004). Several models of integration are also described in the literature, suggesting that an appropriate model of integration must consider client characteristics, service system relationships, existing capacity, geographic characteristics, and the community’s readiness for change (CMHAO, 2006).

There is a significant body of literature focused on identifying the critical factors to successful integration efforts, including research on theory of integration and collaboration (ex. Mattessich, 2005), integrative health care (ex. CMHAO, 2006), collaborative practice between substance abuse treatment and child welfare (e.g., Drabble, 2011; Greene, Rockhill, & Burrus, 2008; Marsh, Smith & Bruni, 2011), and integration and collaboration in children’s services (e.g., Howarth & Morrison, 2007; Johnson et al., 2003). Common factors were identified including service providers being equal partners with common vision, philosophy, values, and purpose. Management/leadership that promotes a “collaborative mindset” was thought to support successful integration. Formal and informal agreements across services were identified as important for clear articulation of principles and practices, as well as defining shared outcomes. There must be mechanisms and processes in place for communication and information sharing,
planning and problem solving, role clarity and security, assessment, and continued learning and cross-training. Integration depends on good working relationships between staff based on trust, mutual respect, and an understanding of the cultures of cooperating agencies. Resources are also needed for successful integration, including funds, staff, material, time, and leadership. Previous collaboration experiences and a favorable social and political climate increase the success of integration.

The literature also described challenges of integration related to the fragmentation of systems. Differences exist between services in who is the client, approach to treatment, and endorsed judgments and decisions. Barriers exist to successful integration due to conflicts in values, perspectives, and expectations; communication problems; issues with funding and human resources; ignorance of knowledge from other systems; individual personalities that impede the process; and issues with consistency in staff and leadership. The integration of substance use treatment and child welfare is further complicated by differences in regulatory environments and administrative structures, treatment philosophies and timeframes, assessment strategies, and standards of success and failure.

Suggestions are identified in the literature to improve collaboration through training and education, policy and structural changes, development and dissemination of program models, development of collaborative leadership teams at regional policy and local practice level, and knowledge translation of these opportunities. It is recommended that policy be proactive in supporting successful integration, allocating resources, promoting best practices, and evaluating programs and policies. There is a need for future research to further examine supports that facilitate effective and accessible services, especially from a Canadian perspective.

An annotated bibliography of the integration science literature reviewed is provided in Appendix D.
Conclusion & Recommendations/Next Steps

Lessons Learned from the Project

The stakeholder working group experience truly depicted a developmental group process. Many of the conceptualizations of integrated programs that members of the group held prior to joining the group were challenged and new perspectives were formed. The following are a few of the major themes or lessons that came out of the project:

The Heterogeneity of Integrated Programs in Ontario and the Challenge of Operationalization

We were fortunate to have five integrated programs represented in our working group, all with very diverse locations (rural, urban), cultures (e.g., first nations), and treatment models. We were also able to collect descriptive data from most of the integrated programs in Ontario to better understand their treatment programs. The heterogeneity between the programs was striking, with no two programs looking alike. Interestingly, most programs held similar treatment philosophies regarding the parent/child component of their services – a focus on enhancing the parent-child relationship which was informed by attachment theory. The manner in which this treatment philosophy was articulated, differed by factors such as resources, staffing, partner agencies, location, and training. Given this heterogeneity, the working group was quite challenged in the task of operationalizing integrated programs and determining how programs could be selected for a multi-site study. We harnessed our experience and knowledge of this specific population and treatment field and completed research on implementation science within children’s mental health and child welfare. This was helpful in developing meaningful questions to inform the next chapter of work to be completed by our working group – a qualitative study focused on integration within this field and the processes that support it.
Keeping the Mother and Child in Mind

An important theme that came out of the challenge of operationalizing integration was a return to key philosophical tenets of the program – the provision of service to BOTH mother and child. We spoke about how this is central to all services provided, whether mother directed or child directed, and that this is often one of the greatest challenges in terms of integration. While this concept is quite complex and cuts across all levels of service, administration, and policy, a simple example might include if a mother is receiving detox treatment, the relationship or impact on the child needs to be considered. Individuals across the systems also need to keep the mother and child in mind when developing treatment goals to ensure a fit for both individuals and the relationship. This can be very difficult and was discussed using the analogy of two clocks – with the child’s readiness possibly being different from the mother’s for a given intervention. This is a theme that we will carry forward in our development of our evaluation framework and our discussion of best practices.

Disconnect between Treatment Philosophy, Parent/Child Services, and Outcome Measures

Given our initial focus on services (number, type) as a means of quantifying integration, the working group spent considerable time speaking about the types of services offered and this also formed a central part of the survey completed with programs. Interestingly, while most programs identified themselves as embracing a parent-child relationship/attachment focus, most of the manualized programs offered by programs were more psychoeducational and parenting-skill based in nature. Similarly, outcome measures focused mainly on child outcomes (e.g., development, behaviour problems) or parenting skills, rather than the relationship. This disconnect is an area that our working group plans to address in our continued work on treatment evaluation and best practices.
Impact of Project on Stakeholders, Organization, and Community

As can be clearly seen from the lessons learned above, this project was highly valuable from both a process and product perspective. From a process perspective, this was an excellent opportunity to bring together individuals working with mothers with substance abuse issues and their children from different sectors (research, addictions treatment, child mental health treatment, child welfare, and policy), from different geographical regions across Ontario, and from different cultures, including First Nations. This diversity invited a range of perspectives, that ultimately challenged our initial conceptualization of integrated programs and pushed us to think outside of the common view of integrated programs being limited to one-stop shop programs that provide mother and child services in one setting. For example, comparing small programs staffed by two addiction workers in northern Ontario to larger, more comprehensive one-stop shop programs in southern Ontario, enabled us to recognize other important process that may facilitate the provision of integrated services (e.g., partnerships with other agencies). Representatives from smaller programs reported that they felt that their voice was heard and that their view of integration had, in fact, been integrated into our working conceptualization. Sharing of views and experiences between research, treatment programs, and child welfare was also very helpful in increasing our shared understanding. For example, members of our group working in child welfare were surprised to learn that 80% of mothers involved in child welfare have substance abuse issues and recognized the impact of this on their work with families.

Further Plans for Knowledge Exchange Activities

Our working group plans to continue the exciting and challenging work that we have commenced. Given the lessons learned, we believe that it is too premature to develop a multi-
site evaluation framework at this time. Before this can be developed, an essential task for the group is to define and evaluate “integration” of Ontario-based integrated programs. This will provide essential understanding of the key components of integration and will inform our process evaluation, as well as the identification of programs to be included in a multi-site study. To develop this understanding, we will be applying The Centre of Excellence in Child and Youth Mental Health Knowledge Exchange Initiative (July 2012). We will continue to expand our working group to include experts in integration and program administration (e.g., Karen Smith, Executive Director with Child Abuse Council).
References


Boydel, K.M., Bullock, H., & Goering, P.N. *Getting our acts together: Collaborations in child and youth mental health*. Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. March 2009.


(2006). "I thought there was no hope for me": a behavioral intervention for urban mothers with problem drinking. *Qualitative Health Research, 16*, 1252-1266.


chemical dependency treatment program. In *PhD thesis* Loyola University of Chicago.


### Appendix A: Telephone Survey of Integrated Programs Results

#### Population Identified as Client

<table>
<thead>
<tr>
<th>Population</th>
<th>Number of Programs</th>
</tr>
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<tbody>
<tr>
<td>Pregnant and/or parenting women and their children</td>
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</tr>
<tr>
<td>Children aged 0-6 years</td>
<td>7</td>
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<tr>
<td>Children aged 0-3 years</td>
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<tr>
<td>Children living with mother</td>
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</tr>
<tr>
<td>Pregnant and/or parenting women (child not identified as client)</td>
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#### Philosophical Approach

<table>
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<td>No parenting/child related</td>
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<td>Historic trauma theory</td>
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#### Parenting and Child Related Services

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<td>Physical health services</td>
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#### Barriers to Involvement in Research

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<td>Worries about client protection and care</td>
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Appendix A: Telephone Survey of Integrated Programs Results Continued

Types of Services Offered at Ontario Programs

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<th>Service</th>
<th>ABC A Better Choice</th>
<th>Amethyst</th>
<th>Breaking the Cycle</th>
<th>Heart Space</th>
<th>Hope Place</th>
<th>Iris Addiction Services</th>
<th>Mother Voice</th>
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<td>Stonehenge</td>
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### Appendix B: Measures of Child and Parenting Outcomes in Published Literature

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<tr>
<th>Category</th>
<th>Measure</th>
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<td>Denver + scales of independent behavior</td>
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<td></td>
<td>Child Development Inventory</td>
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<td></td>
<td>Battelle</td>
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<td><strong>Child Behavior</strong></td>
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<td>Behavior Assessment System for Children</td>
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<td>Child Behavior Checklist</td>
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<td>Behavior and Emotion Rating Scale (BERS-SQ)</td>
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<td>Growth</td>
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<td>Head circumference</td>
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<td>Weight, length</td>
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<td></td>
<td>Pediatric Complications Scale</td>
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<td>% Seeing Doctor</td>
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<td>Child Health Concerns</td>
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<td>Immunizations</td>
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<td></td>
<td>NCAST feeding scale (scores above 55)</td>
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<td><strong>Parenting</strong></td>
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<td>Parenting Stress Index (PSI)</td>
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<td>Child Abuse Potential (CAP)</td>
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<td>Adult-Adolescent Parenting Inventory (AAPI)</td>
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<td>Parental Acceptance/Rejection Questionnaire</td>
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<td>Refusal Skills</td>
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<td>Family Cohesion Scale</td>
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<td>Parenting Knowledge Scale</td>
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<td>Parenting and Childcare Questionnaire</td>
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<td>Parenting Skills Questionnaire</td>
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<td>Parenting Sense of Competence</td>
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<td>Parenting Locus of Control – short form</td>
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<td>Maternal Postnatal Attachment Scale</td>
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<td>Parent-Child Relationship Inventory</td>
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<td>Interaction Rating Scale (mother + child)</td>
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<td></td>
<td><strong>Custody</strong></td>
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<td>% living with mother</td>
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<td></td>
<td>% lost custody</td>
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<td></td>
<td>% involved with Client Protection Services</td>
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<td></td>
<td>% reunified with parents</td>
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<tr>
<td></td>
<td>% living in foster care</td>
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Appendix C: Manualized Parenting Programs used in Ontario Integrated Substance Abuse Treatment Programs

POSITIVE PARENTING PROGRAM: TRIPLE P
(ABC: A Better Choice)

AIM: To prevent severe behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents – (a) enhance knowledge, skills, confidence, self-efficacy, and resourcefulness of parents, (b) promote nurturing, safe, engaging, nonviolent, and low conflict environments for children, (c) promote children’s social, emotional, language, intellectual, and behavioral competencies through positive parenting practices.

TARGET POPULATION/MODEL: 5 levels of intervention on tiered continuum of increasing strength: (1) universal information strategy, (2) brief 1-2 session primary health care intervention to provide early anticipatory developmental guidance, (3) 4 session intervention that target children with mild-moderate behavior difficulties and include some active skills training for parents, (4) individual or group parent training program (8-10 sessions) for high-risk individuals who children do not yet meet diagnostic criteria for behavior disorder, (5) enhanced behavioral family intervention program (max 3 sessions per each of 3 components) for families where children have severe behavior problems complicated by parenting difficulties from other sources of family distress and adversity (ex. Depression, martial conflict)
Program targets 4 different developmental periods: infancy, toddlers, preschoolers, primary schoolers.

THEORETICAL FRAME:
Social learning models of parent-child interaction – identify learning mechanisms, which maintain coercive and dysfunctional patterns of family interaction and predict future antisocial behavior in children and specifically teaches parents positive child management skills as an alternative to coercive parenting practices

Social information-processing models – role of parental cognitions targeted by encouraging parents to identify alternative social interaction explanations for child’s behavior

FORMAT:
Level 4 - Provision of information combined with active skills training and support
Teaches parents to apply parenting skills to broad range of target behaviors both in the home and community settings. Specific strategies used to promote generalization and maintenance of parenting skills across settings and over time (ex. Planned activities training).
Provides opportunities for learning through observation, discussion, practice, and feedback.
Videos are used to demonstrate positive parenting skills then practiced in small groups with constructive feedback. Homework tasks completed between sessions. Four follow-up telephone sessions for 10-15 minutes between sessions to support practice.

Level 5 – Enhanced Triple P – extends Level 4 intervention in an individually tailored program based on clinical judgment and family need after experience in previous intervention program
Offer three therapy modules individually or in combination: (1) home visits, (2) coping skills, (3) partner support (for 2 parent families)
KEY CURRICULUM:
Level 4 – Group: Child management skills including providing brief contingent attention following desirable behavior, how to arrange engaging activities in high-risk situations and how to use calm clear instruction, logical consequences for misbehavior, planned ignoring, quiet time, and timeout.
Level 5 – Enhanced Triple P – Extends focus to include martial communication, mood management, and stress-coping skills for parents – (1) Home visits – self-directed to identify and overcome obstacles in implementing strategies, (2) Coping Skills – identify dysfunctional thinking patterns and introduce coping skills such as relaxation, coping statements based on stress inoculation training, challenging unhelpful thoughts, and developing coping plans, (3) Partner Support – introduce to skills to improve consistent use of positive parenting strategies, communication, and support for each other’s parenting efforts.

EVIDENCE-BASED – One of the only evidence-based parenting programs available worldwide. Founded on 30 years of clinical and empirical research.


BEYOND THE BASICS
(ABC: A Better Choice)

ABOUT: Parenting group developed by Aisling Discoveries Child and Family Centre aimed at parents of children less than 6 years who are involved with a child welfare agency and required to attend parenting education classes.

TARGET POPULATION: Parents of children less than 6 years who are involved with a child welfare agency and required to attend parenting education classes.

AIM: Short-term objectives to provide knowledge acquisition in a supportive milieu to increase knowledge of appropriate parenting skills, alternatives to physical discipline, and developmental stages of children aged 0-6, and increase positive parenting skills, decrease use of negative discipline, and improve the quality of parent-child interactions. Long-term objectives are to maintain knowledge, increase positive parenting skills, reduce child maltreatment, and increase parents’ use of community/social supports.

MODEL: Ten 90 min session group of 8-12 parents with male and female co-facilitators.

RATIONALE AND THEORETICAL FRAME: Strength-based, family-centered approach. Effective parenting skills can be taught to change adverse patterns of parent-child interaction. It can be difficult for parents involved with child welfare to participate in community parenting groups due to stigma or not meeting criteria for participation because their children are not living with them.
FORMAT: Curriculum and resource manual developed to encourage active learning through participation. Provides information about positive parenting practices to increase knowledge of child development, appropriate discipline techniques, and child safety. Explains effective parenting techniques to guide and redirect children’s behavior which increases parents’ confidence in their parenting role. Provide information about available community resources.

KEY-CURRICULUM:
- Week 1 – Getting Started - challenges of parenting
- Week 2 – Learning through play – child development
- Week 3 – Appropriate discipline – discipline without hitting, spanking, or shaking
- Week 4 – Inappropriate discipline - ways not appropriate to discipline a child
- Week 5 – Time Out – ways to guide and redirect child’s behavior
- Week 6 – Importance of routines – ways to add structure and routines to benefit the child
- Week 7 – Munching without misery – ways to improve feeding and mealtimes
- Week 8 – Quality family activities – ways to help increase family outings and activities
- Week 9 – Building self-esteem – ways to boost parents and children’s self-esteem
- Week 10 – Review, feedback, and celebration

EVIDENCE-BASE: Evaluation study findings supported effectiveness in advancing parents’ knowledge about their children, changing harmful attitudes and parenting practices, and high recipient satisfaction. Program operating in Toronto area since 2001.


PARENTING BASICS GROUP (Hope Place)

ABOUT: An adaptation of the Beyond the Basics Parenting Group to incorporate the dimension of looking at the impact of substance use on parenting.

TARGET POPULATION: Parents of children under 6 years who are involved with a child welfare agency and required to attend parenting education classes AND who are using or have used drugs and/or alcohol in the past.

MODEL: 11-session program.

EVIDENCE-BASE: Developed in 2011 through a partnerships between Halton Region, Halton Children's Aid Society, Reach Out Centre for Kids (ROCK) and Hope Place Centres

SOURCE: [http://www.hopeplacecentres.org/beyondthebasics.html](http://www.hopeplacecentres.org/beyondthebasics.html)
NURTURING PARENTING FOR FAMILIES: Families in Substance Abuse Treatment and Recovery
(Pinewood Centre – Umbrella Program)

ABOUT: The Nurturing Parenting Programs are a family-centered initiative designed to build nurturing parenting skills as an alternative to abusive and neglecting parenting and child-rearing practices. Nurturing Parenting for Families programs are designed for the prevention and treatment of child abuse and neglect. Programs have been identified according to the standard levels of primary, secondary (intervention), and tertiary (treatment) prevention. The programs have been adapted for special populations. Families in Substance Abuse Treatment and Recovery is a tertiary prevention program adapted for families in substance abuse treatment and recovery.

TARGET POPULATION: Families in Substance Abuse Treatment and Recovery is aimed at partners of parenting adults in treatment and recovery, extended family members who may be parenting children of substance abusing adults, and adults in treatment and/or recovery for substance abuse problems and who are in parenting relationships with their children. Children do not need to be present in the home.

AIM: Programs are designed to build self-awareness, positive concept/self-esteem, and empathy; teach alternatives to hitting and yelling; enhance family communication and awareness of needs; replace abusive behaviors with nurturing behaviors; promote healthy physical and emotional development; and teach appropriate role and developmental expectations.

RATIONALE AND THEORETICAL FRAME: Nurturing philosophy focused on development of empathy, self-worth, self-awareness, empowerment, discipline with dignity, appropriate family roles, and age-appropriate expectations of children’s development. Substance Abuse Treatment and Recovery built on principle of relational development. Essential factors targeted within parent-child relationship: (1) mutuality – dynamic interactive sensitivity and responsiveness, (2) authenticity – freedom and ability to live within relationship and high level of exposure and vulnerability, (3) empathy – disclosure and sharing of oneself leads to increased understanding, acceptance, and awareness of self and other.

MODEL: 17 group-based sessions. Parents and children attend separate groups that meet concurrently.

FORMAT: Interventions are family based where parents and their children learn similar knowledge and skills. There are 17 topic areas presented in the program in addition to topics focused on men and fathers. Each session begin with information about topic and group process. Activities and exercises are designed to promote group participation and interaction. Activities implemented to foster positive parenting skills and self-nurturing, home practice exercises, family nurturing time, and activities to promote positive brain development in children. Assessment strategies are built into the program to help facilitators and parents chart their successes. Lesson guides, DVDs, parent handbooks, and assessment inventories are provided for facilitators.
KEY CURRICULUM:
Parents explore their childhood experiences, their fears, and their strengths. Parents explore effects of substance abuse on themselves and their families, and strengthen their recovery. Parents develop self-awareness and build nurturing skills using a variety of techniques and activities that accommodate different learning styles. Parents explore their own process of development as adults in recovery, and examine the parallels and differences in the development of their children. Parents and children learn how to play games, sing songs, and have fun as a family.

- Week 1 – Hope
- Week 2 – Growth and Trust
- Week 3 – Families and Substance Use
- Week 4 – Feelings
- Week 5 – Self-esteem
- Week 6 – Communication
- Week 7 – Confrontation and Problem Solving
- Week 8 – Body Talk
- Week 9 – What Babies Teach Us
- Week 10 – Managing Stress
- Week 11 – Setting Boundaries
- Week 12 – Schedules and Routines
- Week 13 – Safety and Protecting Children
- Week 14 – Guiding Behavior
- Week 15 – Knowing our Values
- Week 16 – Recovery: Loss and Love
- Week 17 – Having Fun

EVIDENCE-BASE: Nurturing Parenting Programs used nation wide in US. Founded on significant research and evaluation studies, including specific to substance abuse treatment and prevention.


COPEING WITH TODDLER BEHAVIOR
(New Choices)

ABOUT: COPEing with Toddler Behavior is a parent training program that adapts the COPE model used for parents of very young children.

AIM: To train parents in effective parenting styles and strategies for parenting children in late infancy/toddlerhood.

TARGET POPULATION: Parents of children of 12- to 36-months old at risk for disruptive behavior disorders at varying levels of socioeconomic status and social risk.
RATIONALE AND THEORETICAL FRAME: Early intervention, group approach, non-targeted approach
Improving parental emotion regulation and modifying parent-child interaction as an effective approach to decrease disruptive behavior and improve child outcomes.
Coping Modeling Problem Solving Approach – active learning approach in which participants identify common parenting errors depicted by videotaped models, discuss their consequences, suggest alternatives, and identify the advantages of alternative approaches.

FORMAT: 8-session program of 10-25 parents
Parents sit at tables of 4-6 parents each and watch video clips of parents making exaggerated errors in common parent-child interaction scenarios. Discussion of errors, alternatives, and their impact are facilitated in the small and large group. Structured homework assignments are provided for parents to practice their skills and discussed in the following session with peer support for efforts.
Snacks, childcare, and help with transportation provided to help enlist and sustain group involvement.

KEY CURRICULUM: Topics include how to use an authoritative parenting style and foster a positive parent-child relationship, have appropriate developmental expectations, prevent challenging behaviors by planning ahead, using praise, and giving choices, respond to challenging behavior by setting limits, redirecting, and ignoring inappropriate behavior, and modify the environment to limit conflict.

EVIDENCE-BASE: Coping Modeling Problem Solving Approach proved more effective than didactic parent training in randomized control trial
COPEing with Toddler Behavior supported improvements in parenting and child behavior in a randomized control trial.


MOM AND KIDS TOO

ABOUT: Day treatment program at the Jean Tweed Centre providing substance use and parenting support.

TARGET POPULATION: Pregnant and parenting women with substance use issues and their children aged 0 to 6.

AIM: To increase attachment between mother and child and to improve parenting and coping skills for mothers with substance use issues.

FORMAT: 21-day treatment program runs 3 days a week over 7 weeks.
Breakfast provided.
Flexible program to allow mothers to attend to other needs in life, such as employment, doctor, etc.

KEY CURRICULUM: Program adds parenting skills, child development, and mom and kids playtime to the core components of substance use treatment.

EVIDENCE-BASE: None.


**PARENTING WISELY**
(Iris Addiction Services)

ABOUT: Parenting Wisely is a parenting skills education system available in CD-ROM or online format. The program combines videotaped modeling with an interactive computer program. Parenting Wisely: Young Children is available for parents of children aged 3 to 9.

TARGET POPULATION: All parents of children aged 3 to 18. Program is targeted at low-income, single parents whose children exhibit mild to moderate behavior problems, including children at-risk for substance abuse and delinquency. It was written at a fifth-grade reading level.

AIM: To facilitate the learning of necessary skills for the healthy well-balanced raising of children aged 3 to 18.
To change coercive parent-child interactions that give rise to antisocial behavior.
To reduce problem behaviors and increase communication and family unity.

THEORETICAL FRAME:
Cognitive-behavioral model – reframing and restructuring methods to foster behavior change
Family systems approach –Functional Family Therapy model – family members’ actions seen as interdependent
Social learning model
Computer format minimizes stigma and judgment so parent free to really learn

FORMAT: Program can be completed in as little as one 2-3 hour session at any internet ready computer. Most common administration is individual, but group administration is also used. The video series can be used as curriculum for group parenting education. Group administration can include group discussion and support for parents. The program can also be used in conjunction with other family or parenting interventions. Iris Addiction Services uses Parenting Wisely as curriculum for group parenting education.
Program presents videos of problem situations that are common to families. In group administration, the video illustrates common ways in which parents try to handle the problem situation and how these solutions play out. Parents discuss and reflect on the most effective and adaptive method for responding to the problem situation.

In individual administration, the video is interactive. After viewing the problem situation, the parent selects the method that they would usually use to respond to the child’s problematic behavior from a list of solutions. The parent watches the selected solution play out in the video. The parent continues to choose and reflect on responses until choosing an effective and adaptive method. The parent is then provided with question-and-answer feedback, prompting the parent to think about the effectiveness of the chosen response. A quiz is then provided on the newly learned skill.

Parents using the program also receive a workbook to take home. The workbook contains review questions, glossary of terms, and detailed instructions and practice exercises to aid in the implementation of skills.

KEY-CURRICULUM (Parenting Wisely: Young Children): 7 typical problem situations are presented: misbehaving at the grocery store, interrupting telephone conversations, problems getting along with friends, how to parent when stepparents or grandparents also live in the household, school and homework problems, sibling fighting, and how to get children off to bed and ready for school on time.

Skills addressed: redirection, active listening, “I” statements, nondirective play, fostering social skills, communicating with school, time out, and setting limits/consequences.

Iris Addiction Services – Parenting Wisely Curriculum includes 11 sessions
- Week 1: Protective and Risk Factors – Six Principles of Effective Parenting
- Week 2: When Children Act Up in Public – redirection, planning Ahead, and nondirective play
- Week 3: When Children Interrupt Conversations and Phone Calls – improving compliance and increasing independent play
- Week 4: Helping Children do Housework – Doing Chores - point system
- Week 5: Helping Children to go to Bed On-time – response cost
- Week 6: Solving Stepparent-Stepchild Conflict – active listening
- Week 7: Helping Children Solve Conflict with their Friends – “I” statements
- Week 8: Controlling Sibling Arguing – time out and assertive discipline
- Week 9: Helping Children Get Ready for School – building social supports
- Week 10: Helping Children with Poor Marks or School Trouble
- Week 11: Summary and Conclusion

EVIDENCE-BASE: “Well documented and tested programs that guarantee results”
Extensive research and clinical tests show that use of Parenting Wisely results in increased knowledge and use of good parenting skills, decrease in child behavior problems, improved problem solving, reduced spousal violence and violence towards children, and high program completion rates.
Listed in the National Registry of Evidence-based Programs and Practices OJJDP “Exemplary Program”
CONNECTIONS PROGRAM
(Breaking the Cycle)

ABOUT: The Connections Program was developed at Breaking the Cycle in response to ongoing evaluation of programs and services.

TARGET POPULATION: Substance-involved women parenting children aged 0 to 6 who have experienced domestic violence.

AIM: To address the impact of domestic violence on child development, parenting and substance use recovery.
To support substance-involved mothers and protect infants and young children.

FORMAT: 10-week group intervention.
Context of program delivery in an intensive and comprehensive program for mothers and children.

KEY CURRICULUM:
- Week 1 – Starting the conversation about domestic violence
- Week 2 – What happened when we were kids matters now
- Week 3 and Week 4 – Lifelong exposure to domestic violence
- Week 5 – Experience of domestic violence in adult relationships
- Week 6 – Impact of domestic violence on brain development in children (incl. importance of attachment and positive relationships)
- Week 7 – Positive parenting
- Week 8 – Practicing self-care
- Week 9 – Promoting self-esteem
- Week 10 – Closure and looking forward

EVIDENCE-BASE: Quantitative and qualitative data showed participants made changes in their understanding of and their behaviors in unhealthy relationships to the benefit of their children.


NOBODY’S PERFECT
(Breaking the Cycle)

ABOUT: A community-based parenting program developed in the early 1980s by the Public Health Agency of Canada and the four Atlantic provincial departments of health. In 1987, it was introduced and adopted nationally. The Public Health Agency of Canada oversees the program.
from the federal level. There is a well-established infrastructure of partnerships with provinces, territories, and non-governmental organizations.

TARGET POPULATION: Parents of children from birth to 5 years who are young, single, have low income, little formal education, or who are isolated culturally, geographically, or socially.

AIM: To improve parents’ capabilities to maintain and promote the health of their young children. The specific objectives of the program are (a) to increase participants’ knowledge and understanding of their children’s health, safety, and behavior, (b) to effect positive change in the behavior participants in relation to their children’s health, safety, and behavior, (c) to improve participants’ confidence and self-image as parents, (d) to improve participants’ coping skills as parents, and (e) to increase self-help and mutual support among parents.

THEORETICAL FRAME:
Human ecological theory – context matters in lives of children and context impacts parents’ ability to parent their children. Program supports parents in the communities in which parents live by fostering social support and promoting capacity to problem-solve and access resources in community. 
Adult learning model, learner-centered, and strength-based – Parents play active role in learning process and parents’ own experiences are recognized and valued. Based on principles of democracy, respect, and mutual support

FORMAT: Program builds on parents’ existing knowledge and capabilities through group discussion and problem-solving learning activities. Facilitators reinforce learning with experiential activities that encourage fun and mutual support. The approach includes (1) involving parents in what they want to learn, (2) creating a friendly, safe, and non-judgmental atmosphere, (3) encouraging discussion, (4) creating learning activities that enable parents to understand their situation and involve some of their own problems, (5) being prepared to change the plan to suit needs and interests, and (6) encourage self-help and mutual support. Nobody’s Perfect can be delivered in a group or individual setting. Number of sessions ranges.

KEY CURRICULUM: Key topics are generally covered but no “set” curriculum. Program is designed to be flexible to meet the needs of each group of parents. Parents play an active role in the learning process and decide what they want to learn. Facilitator responds to the needs identified by the group itself.
Resource materials include series of booklets, children’s growth chart (illustrated child development chart), and emergency phone number stickers. The booklets are user-friendly and designed to be attractive and non-threatening to individuals with a low literacy level, presenting information using clear, simple text and colorful drawings. Booklets include:
- Safety – accident prevention (especially child-proofing) and first aid
- Body – growth, health, common childhood illness/conditions
- Behavior – teaching or guiding children’s behavior and solving common behavior problems
- Mind – cognitive and emotional development, importance of play, and how to play with children of different ages
- Feelings (new booklet) – draw on attachment theory – emotional needs of children and encourages empathy rather than punitive responses for guiding behavior
EVIDENCE-BASE: The program has been proven to impact parents’ community engagement and social support, parental knowledge of child development, parenting behavior and parent-child interaction, parental health and well-being, and problem-solving. Several studies have found Nobody’s Perfect to reduce social isolation and increase parenting skills and confidence. Over 5,000 community workers, parents, and public health professionals have been trained as facilitators in Canada. In Ontario, the program is delivered through 300 agencies. The program was cited by the Supreme Court as an example of a successful federal initiative to promote the use of non-physical forms of discipline and positive parenting.


MAKE THE CONNECTION
(Breaking the Cycle)

ABOUT: A prevention program focused exclusively on supporting the parent-infant relationship based on the Hanen Parent Programs – “It Takes Two to Talk” and “You Make the Difference in Helping Your Child Learn”. MTC 0-1 for babies and MTC 1-2 for toddlers.

TARGET POPULATION: Every parent can benefit, but particularly useful for infants at-risk of attachment or communication problems due to infant factors and parent factors: limited social supports, unresolved parenting history, lack of confidence in parenting capacity, teen parenting, struggle with addiction, infant with difficulties (ex. Low birth weight, sensitive temperament), adjusting to a new county, or other life stressors.

AIM: To promote positive connections between parents and their baby to promote secure attachment, communication, and brain development.

THEORETICAL FRAME:
Attachment theory and parent infant communication theory – development occurs within the context of a relationship
Adult learning theory - Experiential, adult learning approach – reflection, information, practice, and feedback

FORMAT: Program can be offered in 9 week group format, home visits, or adapted for drop-in programs. Group usually includes 8-10 families.
Learning process enhanced by supportive interaction between parent and facilitator to parallel a nurturing parent-infant relationship: connecting, communicating, and facilitating. Videotaping is used to help parents recognize positive aspects of interactions, become more aware of child’s signals, and provide positive feedback to support parents.
Session format includes: 30 minutes of guided parent-infant play activities including songs, social interaction, and exploration, 30 minutes of parent reflection and discussion of a theme, and 30 minutes for refreshments and mingling while parents are individually videotaped playing with their infant.

KEY-CURRICULUM: Parents will learn responsiveness to baby’s emotional cues, sustaining two-way communication, adjustment to moods and temperament, and awareness of their own parenting history and parents’ attention to their own needs for support. Core messages derived from themes in early development and parenting literature as essential for attachment, relationships, healthy emotional growth, and brain development:

- Make the Connection with Love – parent’s responsiveness, emotional and physiological regulation and positive sense of self; parents guided to use own relationship to understand what toddler needs from them
- Make the Connection with Language – two-way communication, joint attention, gestural/symbolic language; ideal language input and conversational practice to promote toddler’s language development
- Make the Connection with Learning – support infant/toddler’s natural curiosity and motivation to learn

EVIDENCE-BASE: Making the Connection being used as universal and fist stage prevention parenting program across Canada. It is based on current principles and previously researched learning formats, particularly from the Hanen Program. Research from the Institute of Child Study, U of T teased out key elements for positive parent-infant outcomes. Toronto Public Health is currently conducting evaluative research.

SOURCE: http://firstthreeyears.org/index.html

PARENT-CHILD MOTHER GOOSE PROGRAM
(Breaking the Cycle)

ABOUT: National structure governed by a Board of Directors from across Canada with regional offices and local programs. Program focuses on pleasure and power of using rhymes, songs, and stories together.

TARGET POPULATION: Parents and their babies and young children in need of support for any reason.

AIM: Parents gain skills and confidence which can enable them to create positive family patterns during their children’s crucial early years, and give their children healthy early experiences with language and communication.

Many goals to the program, including strengthening the parent-child bond, enhancing family literacy, linking parents with other resources in the community, and building a supportive group where all families can feel comfortable.
RATIONALE AND THEORETICAL FRAME:
A rich oral language experience fosters parent-child bonding, producing a warm social and emotional environment for developing the confidence of parents and the nurturing of children. Attachment theory – coach attachment skills through tool of oral rhymes and storytelling - sharing words, actions, images, and feeling of rhymes and stories enhances the relationship between parents and children.

FORMAT: Group experience for parents and their babies and young children. Teaching is directed to the parent and children participate as appropriate to their developmental level. Pace is slow and relaxed with repetition of material. Atmosphere is accepting and supportive, creating a feeling of community and mutual support within the group. Program can be run in a variety of settings.

KEY CURRICULUM: Activities focus on interactive rhymes and songs. Print versions of the rhymes and songs are supplied at the end of a series of meetings so participants can internalize some of the material to use in their everyday lives. Storytelling is an integral part of the program with stories targeted at the adults and maybe stories that parents can learn and tell to their children.

EVIDENCE-BASE: Program developed after two pilot programs for Children’s Aid that dramatically demonstrated the effectiveness of the approach. The Parent-Child Mother Goose Program has been running programs for over 20 years. It was rated the most popular and effective program in Canada in a 2006 survey by Family Resource Programs Canada entitled “Making Choices: Parenting and Parent-Child Programs that Fit”.

SOURCE: http://www.nald.ca/mothergooseprogram/
http://ckc.tcf.ca/org/211

ANGER/STRESS H.E.L.P. (Healthy Emotions, Loving Parents) Program
(Iris Addiction Services)
ABOUT: The Young/Single Parent Support Network identified the need for a program to address issues of anger and stress. Program developed by a committee of representatives from local agencies. These agencies included the Ottawa-Carleton Health Department, community health centre representatives, Rideau High School, Algonquin College, the Children’s Hospital of Eastern Ontario, Probation Services, the Children’s Aid Society, two parent participants, and several others.

TARGET POPULATION: Teen parents and young single parents. Can be adapted to suit the needs of a variety of groups.

AIM: To address how issues of anger and stress affect the lives of young/single parent families. To provide participants with skills for coping with everyday stresses. To build awareness and reinforce positive parenting behavior.
RATIONALE: The program provides participants with tools and skills for coping with everyday stresses and angry feelings so not expressed inappropriately to the child. It is designed to build self-awareness and reinforce positive attitudes and behaviors.

FORMAT: 20-week course organized into a series of five modules, with each module consisting of four 2 hour sessions. Participants discuss and practice new skills. They are encouraged to try out new approaches outside of the group and report on their experiences. Program uses activities, role-playing, movies, group discussions and activities such as crafts.

KEY CURRICULUM: Emphasis on education and prevention. In each module, parents learn to develop awareness of a problem or potential problem and identify alternative solutions to these problems. Modules include:

- Anger
- Self-Confidence
- Coping
- Parenting
- Stress

EVIDENCE BASE:


YOU MAKE THE DIFFERENCE
(Breaking the Cycle)

ABOUT: You Make the Difference is a Hanen Parent Program. The program has recently been cut. While Hanen trained professionals continue to provide You Make the Difference and materials continue to be available to the public, professionals are no longer being trained to deliver the program. You Make the Difference is a preventative program focused on parent-toddler language promotion.

TARGET POPULATION: Parents of all young children, especially those who are at-risk for developing a language delay.

AIM: To foster the parent-child relationship and promote the child’s everyday opportunities to learn social and language skills.

To support parents in connecting with their young children while fostering self-esteem and learning during the natural conversations of daily living.

RATIONALE: Effective parent-child communication and interaction should enhance the relationship between a parent and child and promote children’s social, cognitive, and language development.

FORMAT: Nine weekly sessions for groups of parents.
For part of each session, leader talks to parents about how they interact with their children and about additional strategies that could enhance this interaction. For the remaining part, parents play with their children to give them a chance to practice new strategies. Video footage is recorded of the play sessions with the aim of capturing moments where parents are responsive to their children and creating a good learning environment. Videos are played back to parents at the following session to help build confidence and see the difference of their behaviour on their children. Supported by guidebook and videotapes.

KEY CURRICULUM:
Modules include:
- You Make the Difference
- Allow Your Child to Lead
- Adapt to Share the Moment
- Add New Experiences and Words
- Go with Games
- Move Forward with Music
- Get Hooked on Books
- Create! Create! Don’t Hesitate
- Connecting isn’t Always Easy- But it’s Always Worth the Effort

EVIDENCE BASE: Pilot study showed high degree of parental satisfaction with program format, content, and outcomes.


**RIGHT FROM THE START**
(New Choices)
ABOUT: Right from the Start is an attachment-based parenting course to enhance parents’ skills in reading infant cues and responding sensitively.

TARGET POPULATION: Any parent or caregiver of an infant under 24 months, including those at risk for social, emotional, behavioural, or developmental difficulties.

AIM: To improve parent-child interaction in order to foster infant attachment security.
To provide networking opportunities through group participation that will have a positive impact on parenting.

RATIONALE AND THEORETICAL FRAME:
Attachment theory – sensitive caregivers are significantly more likely to have securely attached infants
Coping Modeling Problem Solving - active adult learning principles – participants formulate and state their own solutions to parenting challenges in order to improve understanding of impact on infant, enhance attitude change and commitment, and increase feelings of personal competence and control
FORMAT: 8 weekly 2-hour sessions. Parents watch video segments demonstrating common parent-child interaction challenges followed by discussion of the video in small groups and large group. Discussion includes identifying the parenting error and its short and long term consequences then suggesting potential solutions and their advantages. Homework assignments provide opportunities to practice new skills.

KEY CURRICULUM:
Session content includes:
- Week 1: Attachment Security – what is it and why is it important?
- Week 2: Parent-child Interaction – how do you show me you love me?
- Week 3: Child and Parent Personality – I am unique and so are you
- Week 4: Disengage Cues – I don’t like what you’re doing right now
- Week 5: Engage/Approach Cues – I like what you’re doing right now. I need you.
- Week 6: Following your Child’s Lead – this is what I’m interested in right now
- Week 7: Building a Healthy Relationship – I like being with you
- Week 8: Wrap Up

EVIDENCE BASE: Right From the Start has been conducted in early years centres, child care settings, children’s treatment centres, churches, schools, recreation centres, prisons, and hospitals. Research has shown the program to be as effective as home visiting in improving infant attachment security and maternal sensitivity. The program is one of six leading practices recommended for national publication by Accreditation Canada.

Appendix D: Integration Science – Annotated Bibliography


This article develops a framework for collaboration in public health to guide research and practice. The need for integration is described as resulting from the increased fragmentation of responsibility in services due to the functional and structural differentiation of organizations dealing with public health. The different forms of integration can be described along a continuum of inter-organizational relations, ranging from autonomy of organizations in consultation to a merger of organizations with coordination, cooperation, and collaboration in the middle of the continuum. A distinction is drawn between horizontal integration (between organizations of the same hierarchical level or status) and vertical integration (between organizations of different hierarchical levels or status). Different forms of integration can be effective depending on the degree of differentiation. The most successful forms of inter-organizational collaboration are stable multidisciplinary teams that have been sustained over a long time period. A multidisciplinary team must go through the developmental stages of forming, storming, norming, and performing. The management of inter-organizational collaboration can be described in relation to the developmental stages of team building, including facilitation of contracts, conflict management, trust management, and facilitation of work/contracts.


This study addresses the lack of consistency and clarity in intended goals for terminology related to multiple services working together, such as integration, collaboration, and interdisciplinary. The study explored the meaning of the terms “integration” and “collaboration” to chiropractic and family physician teams working in primary care settings. Semi-structured interviews were conducted with 16 key informants, with a majority from Canada and a few from the US. Results showed that practitioners clearly differentiated between the two terms. Integration was described as professionals from different disciplines working together under a common policy, organization, and structure. Organizational and structural components of integration included defined referral mechanisms, practice guidelines, treatment planning, and decision-making. Collaboration was described as a model of team care that enabled professionals of different disciplines to work together while maintaining their autonomy and distinct paradigms, formal structures, and policies. Cooperative sharing of information and accessing unique treatments of different providers were included in collaboration. Collaboration was identified as a precondition to integration. Participants endorsed strong models of collaboration, but conveyed resistance to models of integration that limited their autonomy. It is concluded that the terms of “collaboration” and “integration” should not be used interchangeably.

This paper illustrates seven different models of team-oriented health care practice. The models can be positioned on a continuum from a non-integrative to a fully integrative approach to patient care and related to four key components of integrative practice: philosophy/values, structure, process, and outcomes. Policy makers will need to consider a health care system that incorporates a number of different models for different types of care, including different models to best fit patients’ unique needs.

**Models of Team Health Care Practice along Continuum**

1. **Parallel** - characterized by independent health care practitioners working in a common setting
   - each individual performs his/her job within his/her formally-defined scope of practice
2. **Consultative** - expert advice is given from one professional to another; this may be via direct personal communication, but is often via a formal letter or referral note
3. **Collaborative** - practitioners, who normally practice independently from each other, share information concerning a particular patient who has been (is being) treated by each of them
   - these collaborations are ad-hoc in nature and usually occur informally on a case-by-case basis
4. **Coordinated** - a formalized administrative structure requires communication and the sharing of patient records among professionals who are members of a team intentionally gathered to provide treatment for a particular disease or to deliver a specific therapy
   - a case coordinator (or case manager) is responsible for ensuring that information is transferred to and from relevant practitioners and the patient
5. **Multidisciplinary** - is characterized by teams, managed by a leader (usually not a physician) that plans patient care
   - one or two individuals usually direct the services of a range of ancillary members who may or may not meet face-to-face
   - each individual team member continues to make their own decisions and recommendations which may be integrated by the team leader
   - is a highly articulated and formalized outgrowth of coordinated practice
6. **Interdisciplinary** - emerges from multidisciplinary practice when the practitioners that make up the team begin to make group (usually based on a consensus model) decisions about patient care facilitated by regular, face-to-face meetings
7. **Integrative** - consists of an interdisciplinary, non-hierarchical blending of both conventional medicine and complementary and alternative health care that provides a seamless continuum of decision-making and patient-centered care and support
   - is based on a specific set of core values that include the goals of treating the whole person, assisting the innate healing properties of each person, and promoting health and wellness as well as the prevention of disease
   - employs an interdisciplinary team approach guided by consensus building, mutual respect, and a shared vision of healthcare that permits each practitioner and the patient to contribute their particular knowledge and skills within the context of a shared, synergistically charged plan of care

As one move along continuum from parallel practice to integrative,

- **Philosophy**
  - emphasis on whole person, diversity of health care philosophies, and number of determinants of health considered increases
reliance on the biomedical scientific model decreases

- **Structure**
  - complexity increases
  - reliance on hierarchy and clearly defined roles decreases

- **Process**
  - communication, number of participants involved, individualization, synergy & the importance of consensus increases
  - practitioner autonomy decreases

- **Outcomes**
  - complexity and diversity of outcomes increases

**Boydell, K.M., Bullock, H., & Goering, P.N. Getting our acts together: Collaborations in child and youth mental health.** Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. March 2009.

The goal of this project was to understand how child and youth mental health organizations could operate to provide more seamless services. A literature review was conducted with attention to developing strategies and linkages between agencies.

Children’s Mental Health Ontario and the Ministry of Children and Youth Services have produced *A Shared Responsibility: Ontario’s Policy Framework for Child and Youth Mental Health* (2006) and the MCYS has more recently produced *Realizing Potential* which demand stronger partnerships and cross-sectoral collaboration to provide coordinated care for children and youth.

Integration is defined by the Ontario Ministry of Health and Long-Term Care: “Integration is defined broadly to encompass the process of effectively managing the alignment of multiple systems of independent (and interdependent) organizations with unique goals and objectives.” A review of the literature showed that integration was effective to enhance access to services, increase community-based services, more timely assessment and referral, and improved satisfaction with services. Research showed that integration did not necessarily save money and demanded up-front costs, but there are some cost savings over the long term. It is advised that gains in the quality of care and experience offset cost.

Nine central themes were identified in the literature as critical factors in successful integration efforts:

1. Produce a clear statement of philosophy enshrined in policy
2. Create standardized system-level screening and outcome assessment
3. Involve families and young people
4. Construct a learning organization
5. Support communities of practice (CoPs)
6. Attend to leadership issues
7. Consider and interagency council
8. Ensure formal contracts/agreements
9. The innovative role of the boundary spanner

The need to assess networks and interagency linkages is proposed. Evaluation efforts are needed to determine the effectiveness and efficacy of integration, including both the process and product.

This paper reviews and updates the conceptualization and measurement of network integration structure using the Integration of Human Services Measure. The Integration of Human Services Measure evaluates the integration of networks by assessing the perspective of all the service agencies participating in the network. Each service agency rates observed and expected integration processes. All network service agencies are rated by each service agency on a five-domain scale of increasing integration. The measure is used to calculate network extent, scope, depth, congruence, and reciprocity. The tool has been used to successfully measure integration in a number of networks in Ontario, including the evaluation of community agencies working with children 0-6 years of age, Healthy Babies Healthy Children, and agencies that service persons with HIV/AIDS.


The purpose of this report is to assist CMHA branches to consider integration and to guide discussions with other providers and LHIN. The report provides a range of integration models and success factors.

Four types of integration are described: horizontal (integration of similar services), vertical (integration of different services under a hierarchical continuum), clinical/service (coordination of care to enhance continuity), and functional (coordination or administrative/support functions across organizations to create shared policies and practices). Degrees of integration are defined and business models that support integration are presented. The most appropriate system design for implementation should consider client characteristics, service system relationships, existing capacity in the system, geographic characteristics, and the community’s readiness for change.

This report describes lessons learned in the integration process. In order for integration to be successful, providers must come to the table as equal partners with a common vision and there must be mechanisms for formal and informal communication, including building census and resolving conflict. A checklist of critical success factors for integration is provided (Collaboration: What makes it work. Amherst Wilder Foundation. St. Paul, Minnesota, 1992).


This study examines the factors that may facilitate or impede the development of collaborative models between child welfare, substance abuse treatment, and dependency courts. In-depth qualitative interviews were conducted with professionals across these disciplines who had been involved in collaborative policies, programs, and procedures in California. A content analysis identified key themes related to the development of collaborative policies, practices, and programs.
Preconditions for successful collaboration emerged from the analysis, including history of prior local collaboration, vision and initiative of individuals in leadership, leadership at multiple levels, realization of the mission to improve client outcomes through collaboration, and commitment from across fields. Themes were identified related to organizational factors that advanced collaboration, such as adopting a specific model of collaboration, developing mechanisms for planning and problem solving, relationships between front-line staff in different fields, and continued training and cross-training to learn about each discipline. Themes were also identified related to the everyday workings of collaboration, such as developing communication protocols, building and maintaining good working relationships within and between stakeholders and levels of the organization, and acculturating staff to collaborative norms. The interviews revealed factors that hindered collaboration, including conflicts in values, perspectives, and expectations; communication problems, especially related to privacy of clients; issues in funding and human resources; fragmentation of systems due to separate funding, mandates, and staff; individual personalities that impede the process; and issues with consistency in staff and leadership.


The purpose of this study was to explore the similarities and differences in values and perceived capacity for collaboration between child welfare and substance use treatment fields.

The study examined two measures used: the Collaborative Values Inventory (CVI) and Collaborative Capacity Instrument (CCI). These instruments were developed by Child and Family Futures (CFF) and are currently used by the National Center for Substance Abuse and Child Welfare (NCSACW). The CVI is used to assess similarities and differences in beliefs and values between individuals from different systems. It is composed of 47 statements about values and beliefs rated on a Likert-type scale, 2 statements rating the proportion of predicted proportion of client success in substance abuse and child welfare service, and a question to identify the most important causes of problems impacting children, families, and communities from 25 options. The CCI is used to assess perceptions of collaboration in their region on 10 areas: (a) underlying values and principles, (b) daily practice related to screening and assessment, (c) daily practice related to client engagement and retention in care, (d) services to children, (e) joint accountability and shared outcomes, (f) information sharing and data systems, (g) training and staff development, (h) budgeting and program sustainability, (i) working with related agencies, and (j) working with communities and supporting families. Each statement is rated on a Likert-type scale. It also includes 2 questions to rate their region’s substance abuse treatment and child welfare services on a Likert-scale based on gender-specific, culturally relevant, geographically accessible, family-focused, age-specific responses to children’s needs, and adequacy of adolescent treatment.

Survey data was collected from a purposive sample of 350 respondents in California, including managers, supervisors, and front-line staff who work with families affected by substance abuse and involved with child welfare. Almost all respondents identified the importance of addressing from both substance abuse and child welfare issues, suggesting a starting point for collaborative
Parent and Child Outcomes in Integrated Programs for Maternal Substance Abuse

efforts. Child welfare respondents were more likely to suggest that substance use services should place greater priority on allocating treatment to women referred from child welfare services. Respondents from both fields agreed that client confidentiality was a significant barrier to collaboration. Results identified a belief in the importance of child welfare services targeting children from substance abusing families combined with low scores on available services for children. Fundamental differences were revealed between the fields in their conceptualization of addiction and effective parenting. Respondents from the substance use field were more likely to perceive addiction as a disease and agree that parents who abuse substances cannot be effective parents. The substance use field also had stronger disagreement that there are enough financial resources for services, reflecting differences between the fields in resources or perceived needed and available resources. Twenty practices were more commonly reported in counties that had a strong history of collaboration, ranging from the use of multidisciplinary teams for case planning to the inclusion of planning for integration in multiyear budgeting.


This study explored the factors that supported or hindered collaboration between substance use treatment and child welfare in a Canadian context. Qualitative interviews were completed with 24 managers and direct service staff from these two fields in different regions of British Columbia. Themes in policies and trends that impact collaboration across systems were identified. Adoption of a harm reduction approach was described as increasing partnership between substance use treatment and child welfare, yet many respondents reported variability in practice of a harm reduction approach in child welfare. Changes in child welfare policy and practice over time were described to better address the multiple needs of families, reduce fragmentation in services, encourage collaboration with parents and substance use counselors, and increase pressure for collaborative assessments and timely intervention for substance use problems. A number of respondents from child welfare described tension in adopting newer values related to working with substance-abusing families, especially in regards to supporting the mother. The relocation of authority and leadership for substance use services in British Columbia at different provincial branches was described to have a negative impact on collaboration. The brief placement of substance use treatment in the Ministry of Child and Family Development initiated some efforts in collaborative practice, but many problems and unintended consequences also occurred, such as fear of accessing addiction services when located within child welfare. Resources and normative practices were described to vary across regions, especially between large and small communities. Efforts to reduce systems’ fragmentation were described at the provincial and local level, yet issues with fragmentation continued to persist. Themes were also identified in relation to cross-cutting enable factors that were critical to initiating, developing, and sustaining collaboration. Respondents described the need to develop a shared purpose that recognized the overlap in clients and compatibility of the overarching missions between systems. A shared purpose developed from leadership in articulating and advancing a vision of collaborative practice with buy-in at all levels. Respectful relationships were also described as important. In addition, respondents discussed the value of sharing research and evaluation studies related to collaboration across fields of practice.
Respondents discussed themes related to principles and values in developing formal agreements across systems or direct service plans for families, especially regarding conflicts in assessment of risk. Written articulation of principles and practices and translation into specific practices were valuable. Cross-system planning bodies were important to realizing collaboration.

Successful collaboration was described in relation to specific intersecting practices: safety and relapse prevention; “not closing the door” on families by focusing on strengths, stressing child placement with the mother, and developing individualized plans for families; and adopting innovative programs with holistic services.

Processes and protocols that advanced collaboration included working in partnership on collaborative planning, mechanisms for mediation and conflict resolution, communication protocol and guidelines, and continued learning.

There was emphasis described on defining and aligning shared outcomes for collaboration. The ideal outcomes across systems involved both child safety and improved health, and parenting capacity for mothers.

Collaboration was considered impeded by disconnections between systems, especially differences in mandates, definition of who is client, approaches to treatment, and how roles of providers are perceived in each system. Further disconnections occurred in daily practice with differences between the judgments and decisions of specific workers, negative interactions with workers in other systems, and ignorance of knowledge from other system. Problems were described in flow of communication, particularly in relation to confidentiality and information sharing. A non-collaborative and rigid orientation to practice and scarcity or resources were also identified as barriers.

Perceived opportunities for improving collaboration included training and education, policy and structural changes, development and dissemination of program models, development of collaborative leadership teams at the regional policy and local practice level, and knowledge translation of these opportunities.


There is a growing emphasis on service integration and collaborative service delivery, yet the specific mechanisms for how to accomplish collaboration and expected outcomes of collaboration are not clear. This study explores collaborative processes to benefit substance-abusing families involved with child welfare, as well as the supports and barriers to building successful collaborations. Qualitative interviews were completed with 104 representatives from child welfare, substance-abuse treatment, and family court systems in a medium-sized northwest US city.

Analyses suggested three primary mechanism of collaboration. First, increasing communication and information sharing among and between agencies and parents was suggested to improve the quality of case monitoring and relapse support, help providers better meet families’ multiple service needs, improve the quality of decision-making about a case, ensure demands on parents are not conflicting or overwhelming, and provide parents with consistent messages and expectations about what they need to do for reunification. Second, creating a team of supportive individuals was suggested to lead to better accountability for meeting parents’ needs, improve the quality of service provision, provide parents with someone to fall back on, and exert a powerful psychological effect of parents through showing positive regard and consistent support.
Third, building shared value systems was suggested to overcome mistrust, increase cross-systems understanding, and improve future collaboration. Identified barriers to collaboration included providers’ mistrust and lack of understanding of other agencies’ perspectives, confidentiality concerns, logistical and resource concerns, time pressure imposed by Adoption and Safe Families Act (ASFA) timelines, and turnover among AOD treatment providers. Identified supports to collaboration included cross-system trainings and forums, family decision meetings including different players, court’s authority to promote effective work between treatment and child welfare and to develop service plans, meetings in general, and a positive attitude towards collaboration or “a collaborative mindset”.


The focus of this paper is on the frameworks, challenges, and implications of collaboration in order to move towards a higher level of integrative services with child welfare. Five levels of collaboration are identified based on the literature: (1) communication, (2) cooperation – joint work on a case-by-case basis, (3) coordination – more formalized joint working without sanctions for noncompliance, (4) coalition – joint structures sacrificing some autonomy, and (5) integration – structures merge to create new joint identity. Governments are increasingly recognizing the interconnected nature of child welfare issues and advocating for integration of localized services as a response to best meet needs. Integrative services are characterized by a unified management system, pooled funds, common governance, whole systems approach to training, information, and finance, single assessment and shared targets. However, emphasis on establishing higher-level collaboration can create systems without the support of working relationships. Evaluation of collaboration should measure quality, focusing on outcomes rather than output.

Ingredients for collaboration:

A. Predisposing factors: history of agency relations, existing informal networks, individual agency cohesion
B. Mandate: shared need/anxiety for joint working, political support, shared goals connected to core business, co-terminosity, strategic planning, capacity to collaborate, links to other partnerships
C. Membership and leadership: appropriate level of representation, understanding of membership vis-à-vis core business and level of collaboration, impact on change on membership, service uses as primary stakeholders, collaborative champions
D. (a) Machinery: governance, collective accountability, information systems, shared performance indicators, audit, service delivery coordination, common assessment, partnership model, funding
   (b) Process: shared values, multi-disciplinary training, building trust, role clarity, role security and respect, communication, shared training, engaging practitioners
E. Outcomes – clear, qualitative, measured over time

The importance of shared goals is stressed in the literature on collaboration to provide direction and a basis for measuring effectiveness; however, the mandate for collaboration often does not identify shared goals resulting in insufficient motivation and clarity. Collaboration can be motivated by anxiety in addressing the problem alone or political support and incentives.
Political mandates and policies for collaboration must be supported by government initiatives, performance targets, and funding streams that reinforce its priorities. Process is the interactional and relational component of collaboration.


This review of the literature describes different factors attributed to the lack of collaboration between child welfare and AOD and similarities in proposed interventions for collaborative efforts between the fields. The lack of collaboration between child welfare and AOD relates to providers having a limited understanding of each other’s field. Differences exist in definitions of client, determining successful outcomes, and competing timelines. Collaboration is further hindered by a shortage of AOD treatment and the perpetual crisis of child welfare in making decisions about child protection and internal problems due to large caseloads, staff turnover, and general lack of resources. Strategies suggested for effective collaboration are simplified into 7 requirements: (1) development of a common philosophy, (2) strengthening prevention efforts, (3) increasing availability, access, and appropriateness of AOD treatment for families, (4) supporting recovery, (5) improved staff development and multidisciplinary training of staff, (6) development of clear protocol and standards for assessment, referral, and follow-up, and (7) quality assurance. Funding is an issue in establishing collaboration and addressing barriers in service from child welfare and AOD.


This article provides an overview of the theory of collaborative advantage: a practice-oriented theory of management issues involved in working together across organizations. Collaborative advantage relates to potential synergy from collaborative work and collaborative inertia is a contrasting concept that relates to the disappointing outputs of collaboration. The theory of collaboration advantage describes a structured set of overlapping themes that capture issues contributing to success and failure of collaborative situations. The themes aimed to build a practice-related understanding of collaboration rather than a how-to-guide. The article discusses themes of common aims, power, trust, membership structures, and leadership. The theory aims to capture the complex micro-processes of collaboration.


This study identified factors related to success of collaborations in children’s services and identified problems and solutions in the collaboration process. Interviews were conducted with thirty-three stakeholders from nine state departments and three private social service agencies in Ohio. Contributing factors for successful collaborations were willingness to work together, strong leadership, sharing a common vision, trust, commitment, previous collaboration experiences, support of federal and state funding, sharing sense of urgency and necessity, having no choice but to collaborate due to limited resources, good communication, no resistance to change, and
understanding the cultures of cooperating agencies. Accordingly, contributing factors for unsuccessful collaborations were lack of support from upper management/leadership, lack of commitment, lack of common visions and goals, lack of trust, lack of financial support, turf issues/resistance to change, lack of communication, lack of time, violation of existing rules/regulations, lack of understanding of collaborating agencies’ cultures, no negative consequences of not collaborating, and change of personnel.

Seven factors were identified as most important to successful interagency collaboration:

1. Commitment
2. Communication
3. Strong leadership from key decision makers
4. Understanding the culture of collaborating agencies
5. Engaging in serious preplanning
6. Providing adequate resources for collaboration
7. Minimizing turf issues

Solutions for overcoming barriers to successful collaboration were identified as enhanced communication, commitment, involvement of key persons who are decision makers, pressure from community or public to get the job done, development of trust and respect, interagency support (sharing resources, providing technical support), threat/elimination if not collaborate, being sensitive to others’ needs, and revising rules and regulations that hinder collaboration.


This article provides a review of empirical literature on the need for integrated, coordinated, and evidence-based practices for substance-abusing women involved in the child welfare system. A review of the research shows that integration of substance abuse and child welfare services is complicated by differences in regulatory environments and administrative structures, treatment philosophies and timeframes, assessment strategies, and standards of success and failure. Evidence is provided that the lack of integration and coordination between systems causes damage for children and families and prevents the provision of effective treatments. Strategies at the systems level are recommended from the research, including flexible financing, educational strategies, and increased administrative flexibility. Comprehensive services that meet women’s co-occurring needs have been shown to improve child welfare outcomes. Research suggests that four ingredients or service mechanisms are key to the development of a comprehensive model: (1) access services designed to increase linkage to substance abuse services, (2) outcome-targeted services or substance abuse counseling, (3) matched services to clients’ descriptions of need, and (4) client-provider relationship. The evaluation of services should consider both intermediate (ex. Treatment duration/completion), and ultimate outcomes (ex. Reunifications and reductions in drug use).


Collaboration is defined as “a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to a definition of mutual relationships and goals, a jointly developed structure and shared responsibility, mutual authority and accountability for success, and sharing of resources and
The ingredients for successful collaboration were identified by synthesizing the findings of 40 studies on collaborative initiatives. Twenty factors were identified under six categories. The Wilders Collaboration Factors Inventory is a self-assessment tool can use to determine their standing on factors that influence the success of collaborations.

Ingredients for Successful Collaboration

1. Environment
   - History of collaboration or cooperation in the community
   - Collaborative group seen as a legitimate leader in the community
   - Favorable political and social climate

2. Membership characteristics
   - Mutual respect, understanding, and trust
   - Appropriate cross-section of members
   - Members see collaboration as in their self-interest
   - Ability to compromise

3. Process and structure
   - Members share a stake in both process and outcome
   - Multiple layers of participation
   - Flexibility
   - Development of clear roles and policy guidelines
   - Adaptability
   - Appropriate pace of development

4. Communication
   - Open and frequent communication
   - Established informal relationships and communication links

5. Purpose
   - Concrete, attainable goals and objectives
   - Shared vision
   - Unique purpose

6. Resources
   - Sufficient funds, staff, materials, and time
   - Skilled leadership


This paper identifies key facilitators, challenges, and other issues related to the integration of mental health and substance use services and systems to guide discussion and concrete planning, policy, and research development. The rationale for integration is based on the needs of people with co-occurring disabilities and their families, in addition to underlying factors which need to be better understood, such as cost-efficiencies and consumer demand. A targeted and strategic approach to integration is discussed at both services-level (integration of clinical and psychological services in a single site or across providers working collaboratively) and systems-level integration (structures and processes that support integration, including adequate resources). It is recommended that organizations at a national level (ex. Health Canada) and provincial/territorial jurisdictions should be proactive in supporting integration activities. There is a need for more program and policy evaluation to identify the most helpful systems-level supports to facilitate effective and accessible services. Normative data is needed on Canadian
integration strategies to date and lessons learned. Movement towards integration should be influenced by a strengths-based paradigm and population health perspective.


This study examined the practices, organizational conditions, and staff characteristics that promoted or hindered collaboration between child welfare and substance abuse treatment in everyday settings. Front-line staff (n=216) and administrators (n=20) from child welfare and substance abuse were surveyed.

A survey was developed for the study to measure the practices of inter-agency collaboration of individual staff members from child welfare and substance abuse treatment. Collaborative behaviors were measured on a 7-item scale including questions addressing general collaborative practices and a 4-item scale including questions addressing only specific collaborative practices. Measures also included intention to collaborate, knowledge and skills to collaborate, advantages and disadvantages of collaboration, normative pressures to collaborate, expectancies of collaboration, role overload, and organizational climate. Survey development involved conducting focus groups of staff from both systems, reviewing a draft of individual items in interviews with key informants, and pilot testing the instrument in an agency from each system. Analyses were conducted using multi-level (HLM) regression models.

Results showed that staff were more likely to collaborate with staff from the other type of agency when they have positive attitudes towards collaboration and see more advantage, and they are more confident in their knowledge about how to collaborate. Staff were also more likely to collaborate when they perceived more organizational policies that promoted or required collaboration; however, administrator reports of the number of collaborative policies were not related. In addition, staff working in organizations where staff reported higher levels of role overload and emotional exhaustion were more likely to collaborate, which raises an interesting question of direction of influence. Results showed that 74% of variation in collaborative practices is at the individual level rather than the organizational level. Individual-level variation accounts for within-organization variation and between-organization variation in collaborative practices.


This article describes a systematic literature review conducted to guide the planning and implementation of integrated health systems. Ten universal principles are identified of integrated healthcare systems. The principles include (1) comprehensive services across the continuum of care, (2) patient focus, (3) geographic covering and rostering, (4) standardized care delivery through interprofessional teams, (5) performance management, (6) information systems, (7) organizational and cultural leadership, (8) physician integration, (9) governance structures, and (10) financial management.