

HEALTHY MOTHERS, HEALTHY FAMILIES: Evaluating integrated treatment for pregnant and parenting women who use substances

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- With thanks to our full project team, project advisory panel, students, and participants



Evolution of Integrated Treatment Programs in Ontario

1990's

Small specialized addiction services for moms

General addiction treatment agencies

2002

ECD funding

Expansion

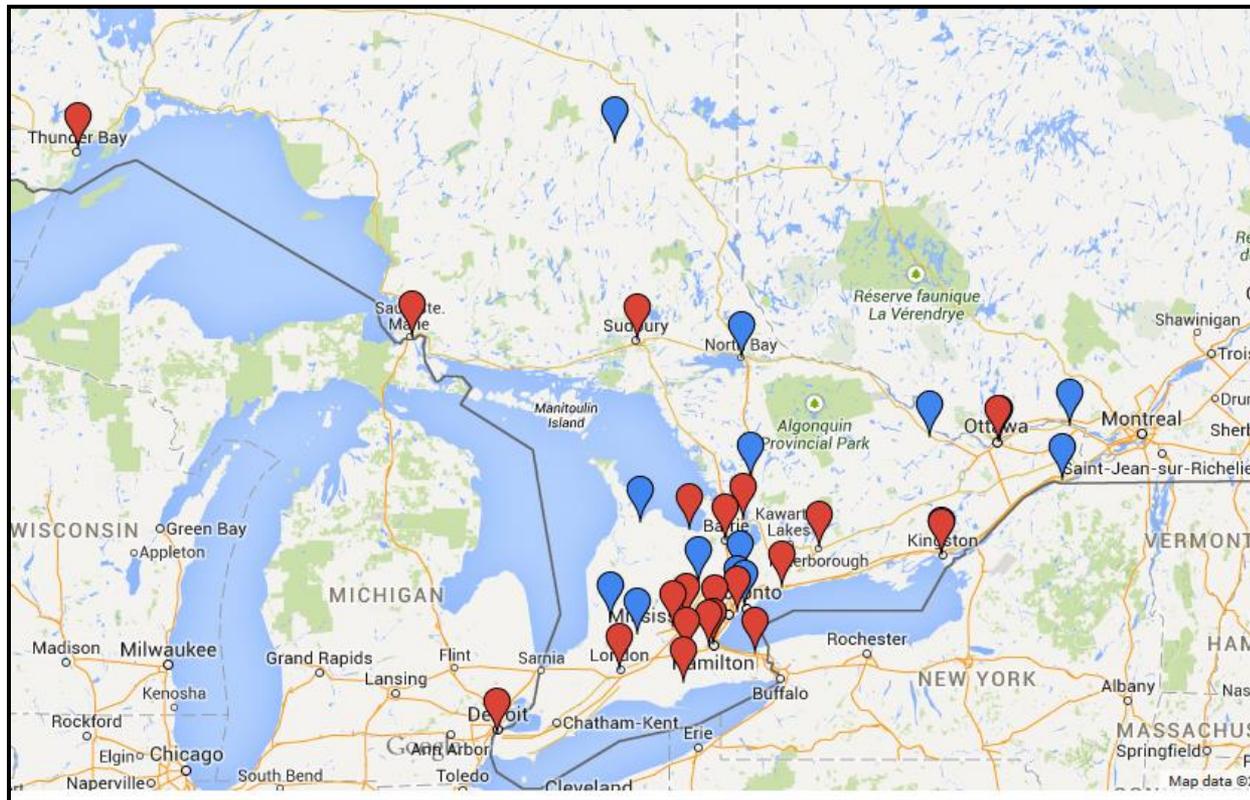
Development

Partnership building

Adaption and evolution

2018

Early Childhood Development (ECD) Addiction Initiative



Evaluation objectives

1. Describe the characteristics of women attending integrated treatment
2. Describe and define the integrated treatment model:
Expert view and on the ground

Focus on key services and processes that support effective care

Evaluation objectives

3. Evaluate the effectiveness of integrated treatment programs, including:
 - Client satisfaction and perceptions of care
 - Client engagement
 - Maternal and child health outcomes
 - Cost effectiveness

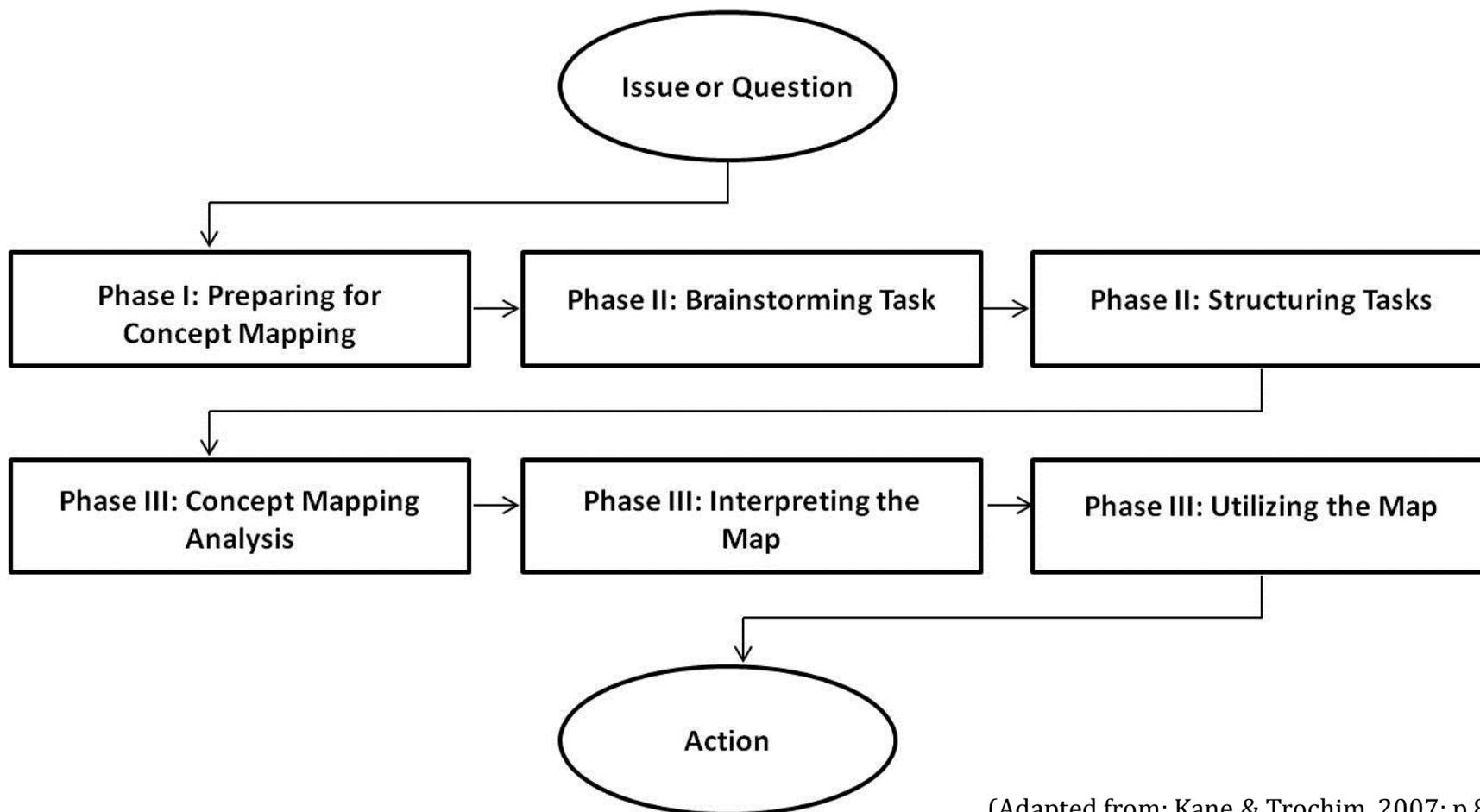
Healthy Mothers, Healthy Families

PHASE 1

In an ideal world, effective integrated service delivery means...



Concept Mapping



(Adapted from: Kane & Trochim, 2007; p.8)

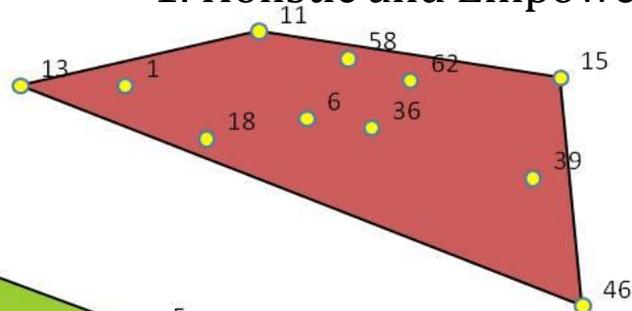
Effective integrated service delivery means...

Cluster 2:

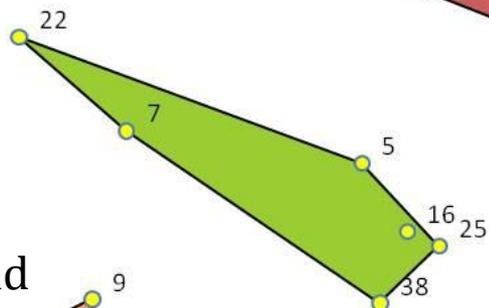
Number	Statement
5	case management
7	focusing on multiple relationships (e.g., staff, organizations, women, children, families)
16	identifying short- and long-term goals
22	using a determinants of health perspective as a lens for examining client needs
25	standardized assessment
38	prevention

Effective integrated service delivery means...

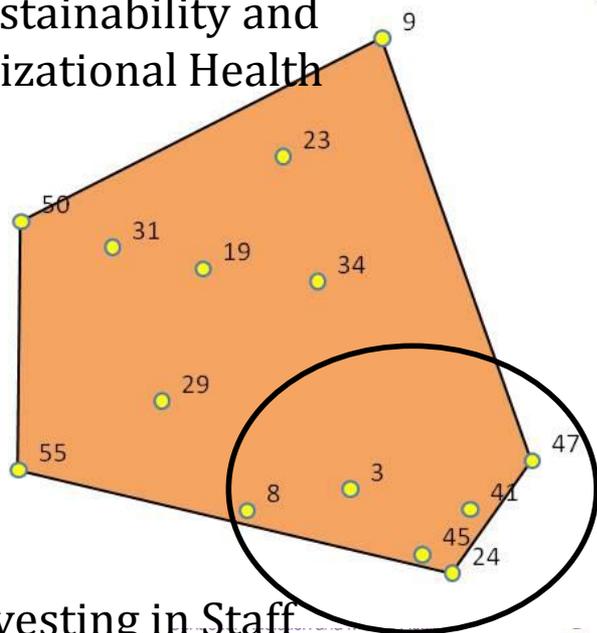
1. Holistic and Empowering Care for Mom, Baby, and Dyad



2. Tailored and Continuum-Based Service Components

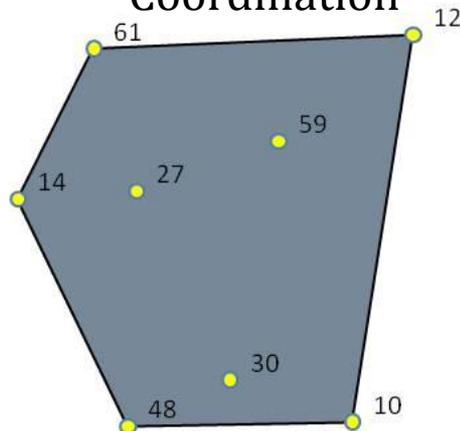


3a. Sustainability and Organizational Health

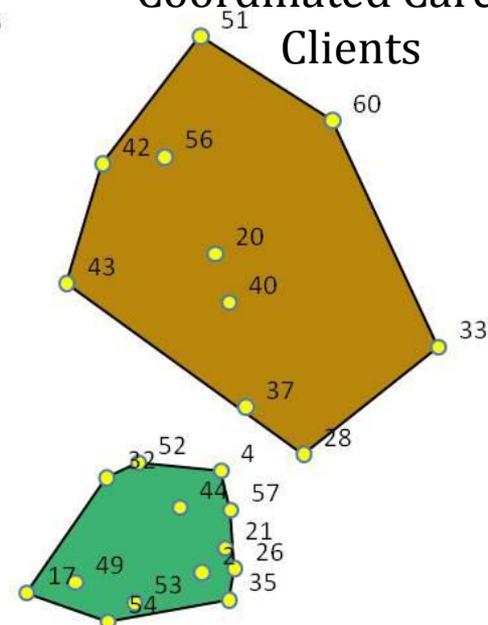


3b. Investing in Staff

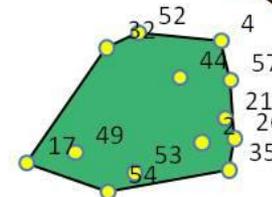
5. Cross Ministry Coordination



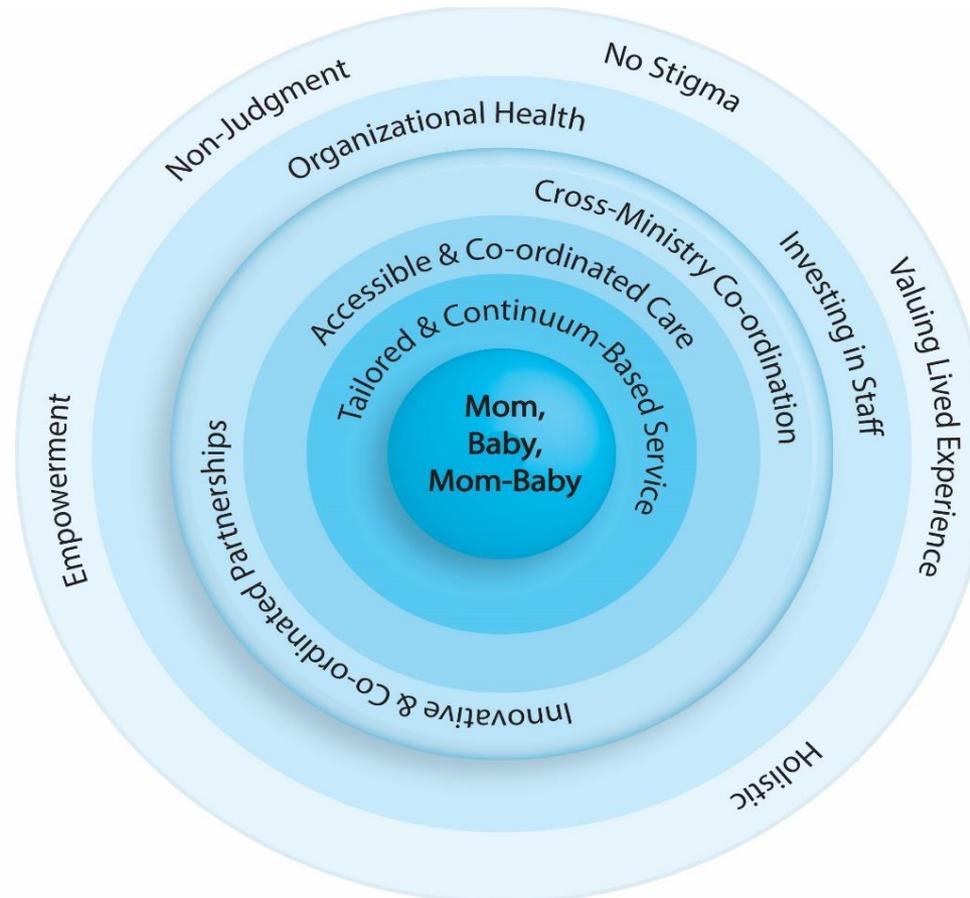
6. Accessible and Coordinated Care for Clients



4. Innovative and Coordinated Partnerships



Effective integrated service delivery means...



Healthy Mothers, Healthy Families

PHASE 2

What does integration look like on the ground
in Ontario ECDs?



Learning about Ontario's ECD Programs

12 site visits

15 ECD counsellors /
front-line workers

22 ECD executive
directors
and program
managers

106 mothers

And

18 partner agency
staff and

12 agencies
without ECD
programs

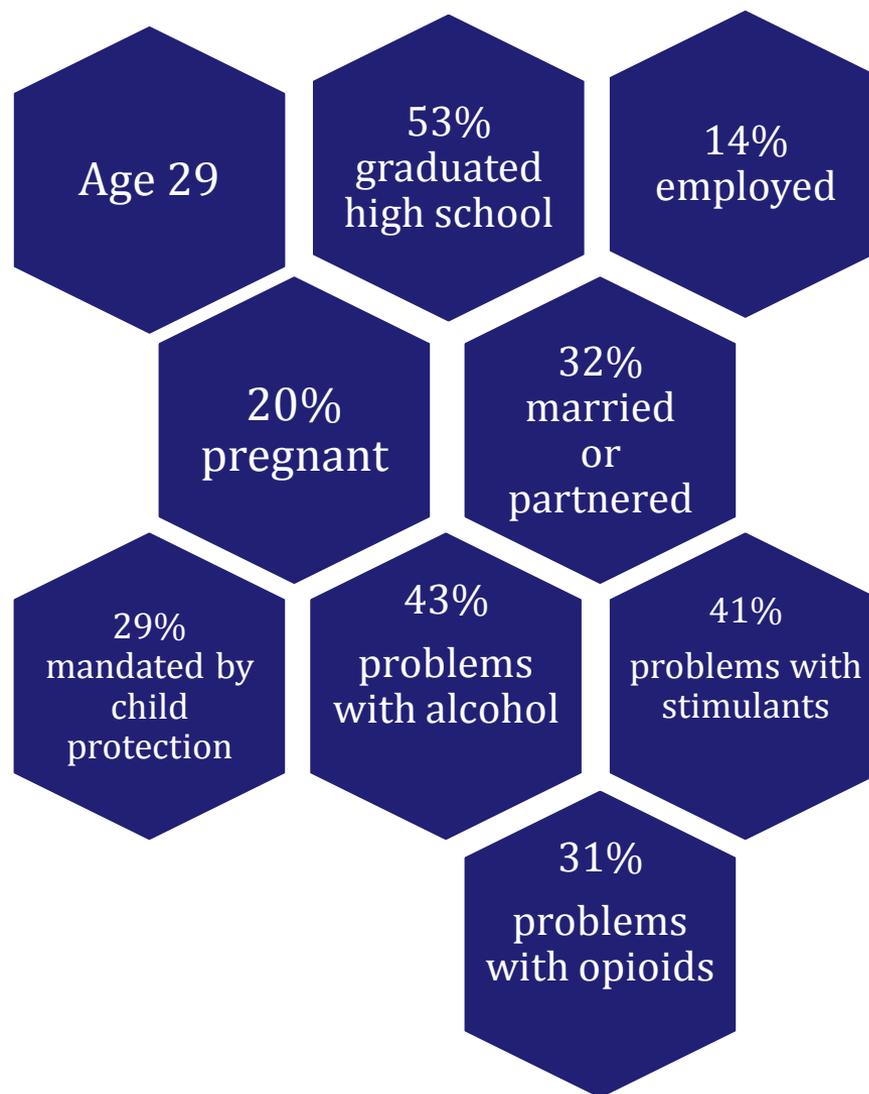
Analysis of DATIS
data



What we learned:

1. Client characteristics

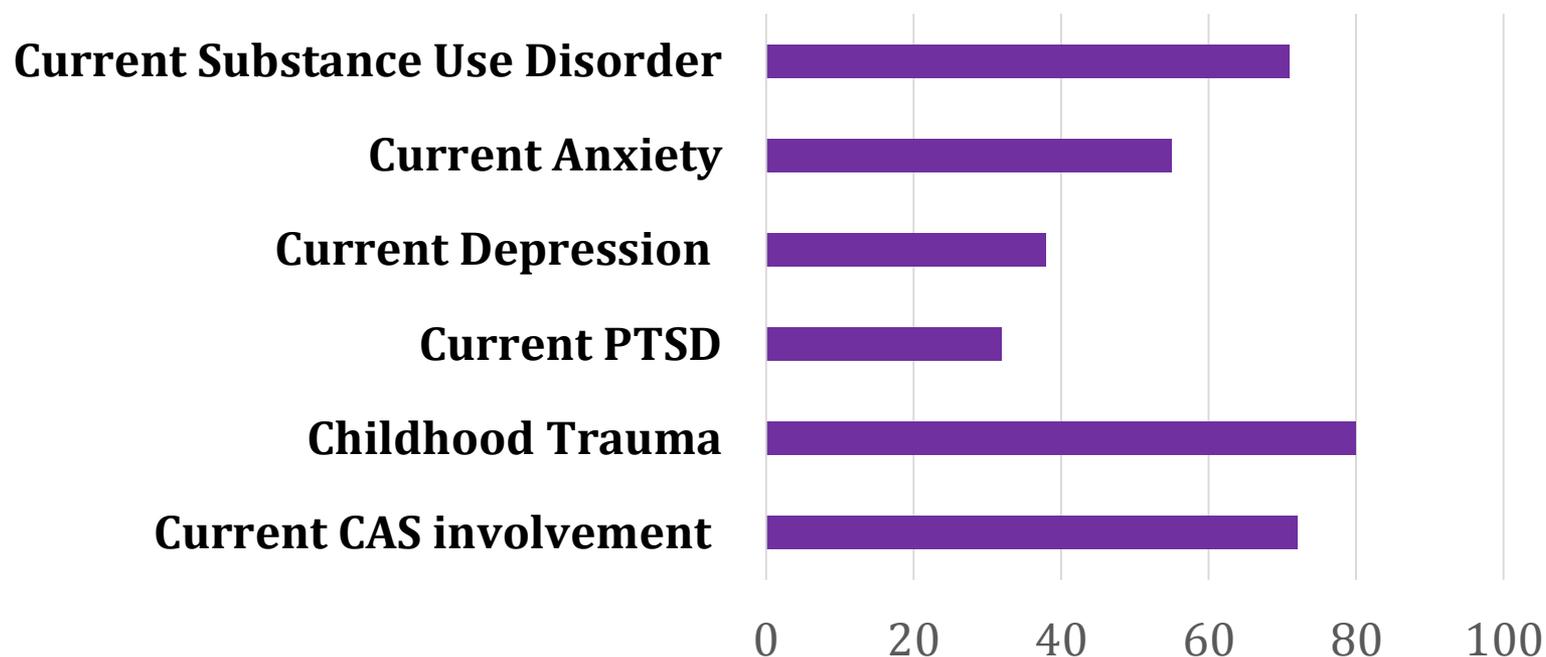
Profile of women admitted 2008-2014 (N=4,968)



Prepared with
support from:

DATIS
DRUG AND ALCOHOL TREATMENT INFORMATION SYSTEM

Profile of maternal mental health and child protection involvement (N=65)

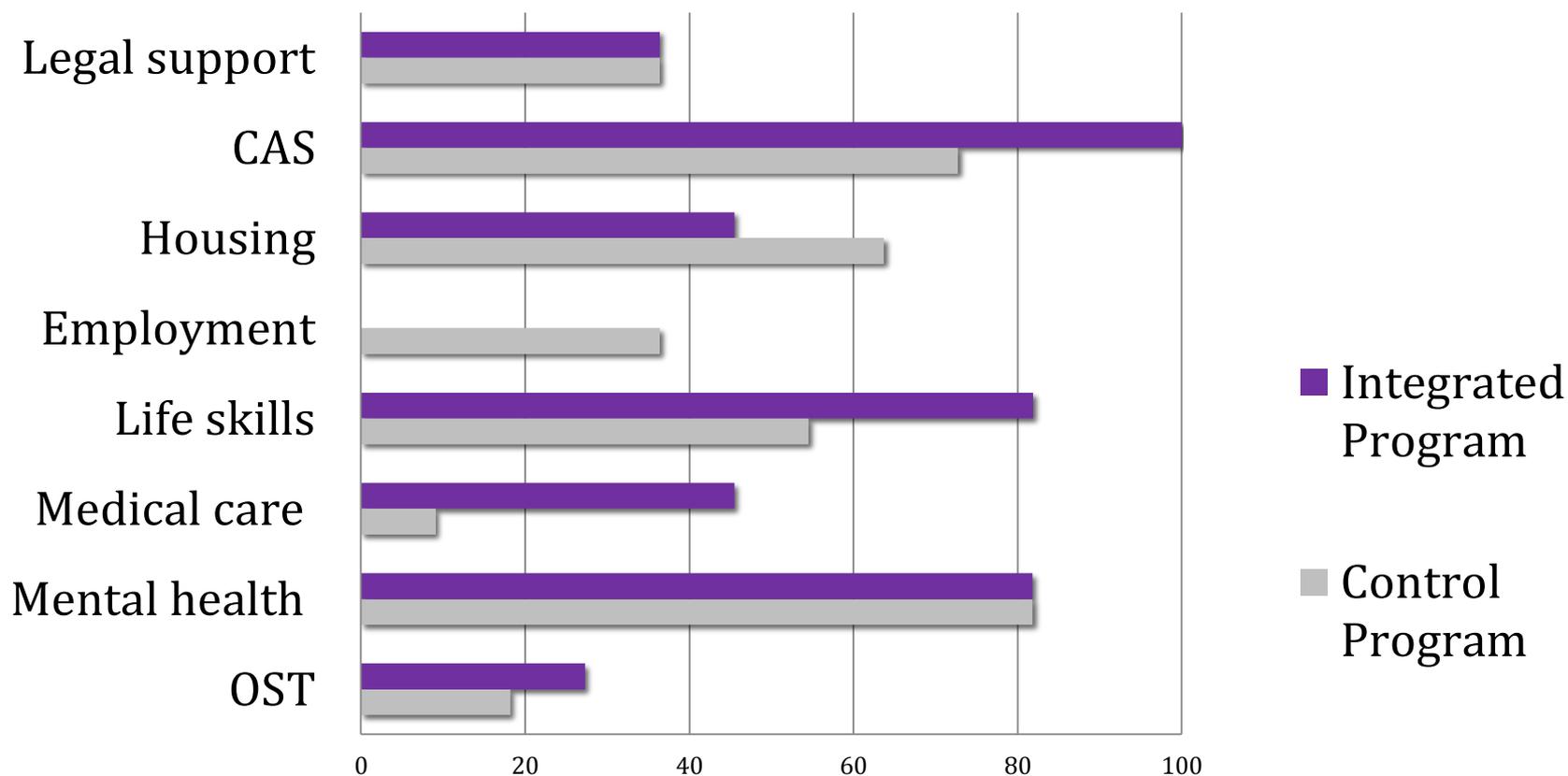


What we learned:

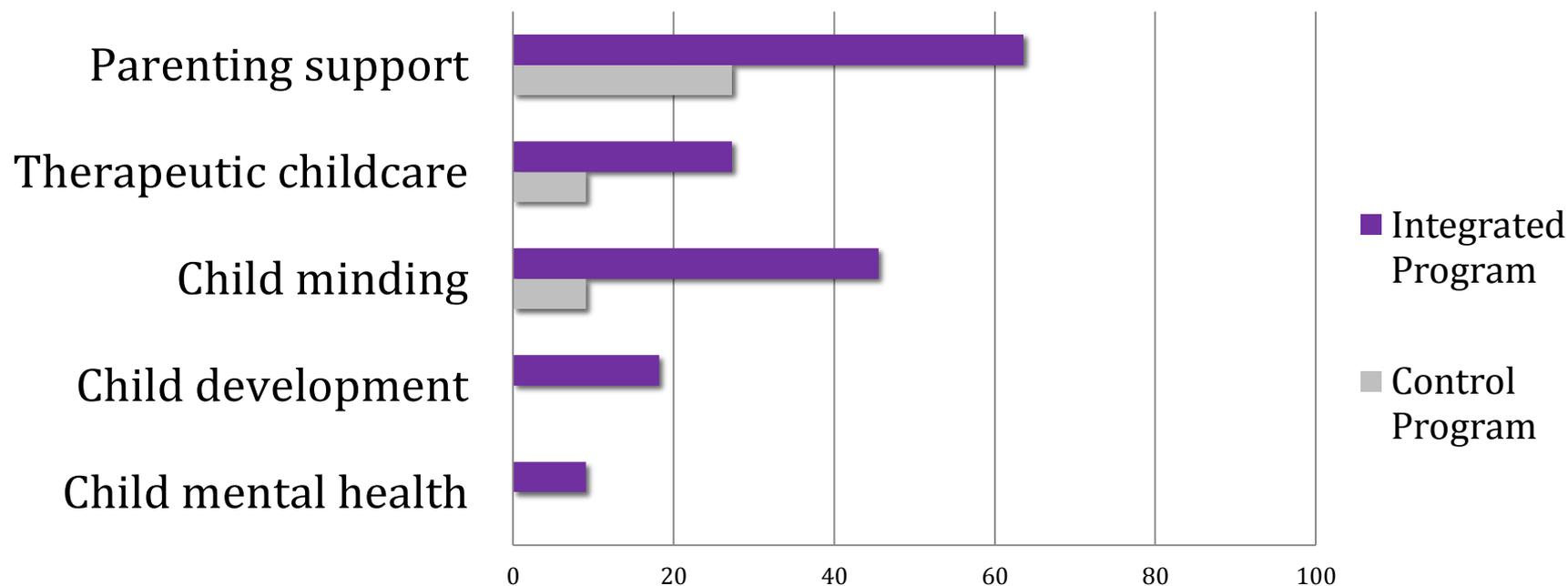
2. Service characteristics

Tailored and continuum-based services

Services provided in-house



Services provided in-house



	Control	Integrated
Mean	4.36 (SD 2.11)	6.91 (SD 0.94)
Range	0-8	6-8

What we learned:

3. Women's engagement in services

Client participation

N=29 ECD programs, 7-year period (2008-2014; N=5162 women).

- 14% of women did not attend a second visit
- For those who did, programs averaged 12 days between first and second visit
- Program length averaged 15 visits over 18 weeks

Research summary

Factors influencing pregnant and parenting women's engagement in substance use treatment in Ontario

Predictors of participation

Client-level predictor	Length between first and second visit	Length of treatment (retention)	Number of visits
Age	↓	↑	↑
Education		↑	↑
Social Assistance	↑		↑
Marital Status			↓
Pregnancy		↑	↑
Problem substance	Alcohol↑ Opioid↑	Stimulant↑	Stimulant↑
Injection drug use	↓		
Freq. of substance use	↓		↑
Treatment mandate	Legal, child ↑		Legal ↓

Women's perceptions of care

OPOC-MHA Subscale	Integrated (N=106)	Non-integrated (N=207)	t	p	Cohen's <i>d</i>
	M (SD)	M (SD)			
Accessing Services	3.56 (0.51)	3.48 (0.50)	1.28	.200	.158
Within Services	3.68 (0.43)	3.51 (0.45)	3.23	.001	.386
Overall Perception of Care	3.65 (0.44)	3.51 (0.42)	2.76	.006	.325

Integrated treatment sample: 105 women across 12 ECD programs

Non-integrated: 207 women from norming sample used for OPOC development
(Rush et al., 2014)

What would further improve the client experience?

- More accessible locations/transportation support
- Timing of sessions
- Programs for mothers with school-aged children
- Need for larger and more private spaces
- More childcare
- More staff
- More group sessions and “one-on-one” with the workers
- Ability to remain in program for longer time
- Better partnerships (particularly with child welfare)

What we learned:

4. Key processes of care

Key processes of care

Fostering **emotion regulation** and supporting **executive function**



Fostering Emotion Regulation: **Developing Trust**

Clients

- Non-judgment and safety
- Empathetic listening
 - *“Use me as a bridge”*
- Seeing strengths
- Commitment to women’s goals

Counsellors

- Taking time needed
- Being seen/familiar
- Transparency about CAS
- Starting with social determinants of health
- Telling story to one worker
- Non-judgment and listening

Fostering Emotion Regulation: Understanding emotion and supporting emotion regulation

Clients

- Want to know deep down what is wrong
- “Feel” with you every minute
- Help calm you when you are upset or angry
- Prepare you for emotional challenges
- Talk about what is important now - your stressors not the addiction plan

Counsellors

- Support processing of emotions
- BE THERE for challenge times (e.g., court, child welfare, abuse)
- Teach and model evidence-based strategies
 - Cognitive Behaviour Therapy
 - Dialectical Behaviour Therapy
 - Mindfulness

Fostering Emotion Regulation: Understanding emotion and supporting emotion regulation

“When I bring that little girl up, that’s not the mom, that’s still the little girl, they’re like, oh my god, it just makes sense. It’s almost, it’s relief, I feel like some of this makes sense now because I could never understand ...why I would do such a thing...make such stupid choices...”

“The shame that comes with that, to understand that this was a little girl making these choices, and of course she is going to, when we’re four years old, we don’t know any better, when we’re a teenager we’re rebelling. Something awful happened, and you’re stuck there, nobody ever helped you through that...”

“...nobody ever took their hand and said, let’s walk through, let’s heal, walk this path of healing. I think that piece is enlightening for people...and it can help just to remove some of that shame that they carry all the time. Shame is so huge, and so demobilizing.”

Fostering Problem Solving: **Goal Setting**

Clients

- Develop action plan
- All areas of need
- Prioritizing

Counsellors

- Empower women to “own” goals
- Flexible
- Identify challenges not seen
- Identify and help to see when action is not aligned with goals
- Providing accurate information (e.g., Parenting, impacts of substance use)

Fostering Problem Solving: **Accommodate** Information processing

Clients

- Help navigate services and simplify procedures
- Cueing, contacting, reminding
- Adapt delivery of information to how women learn

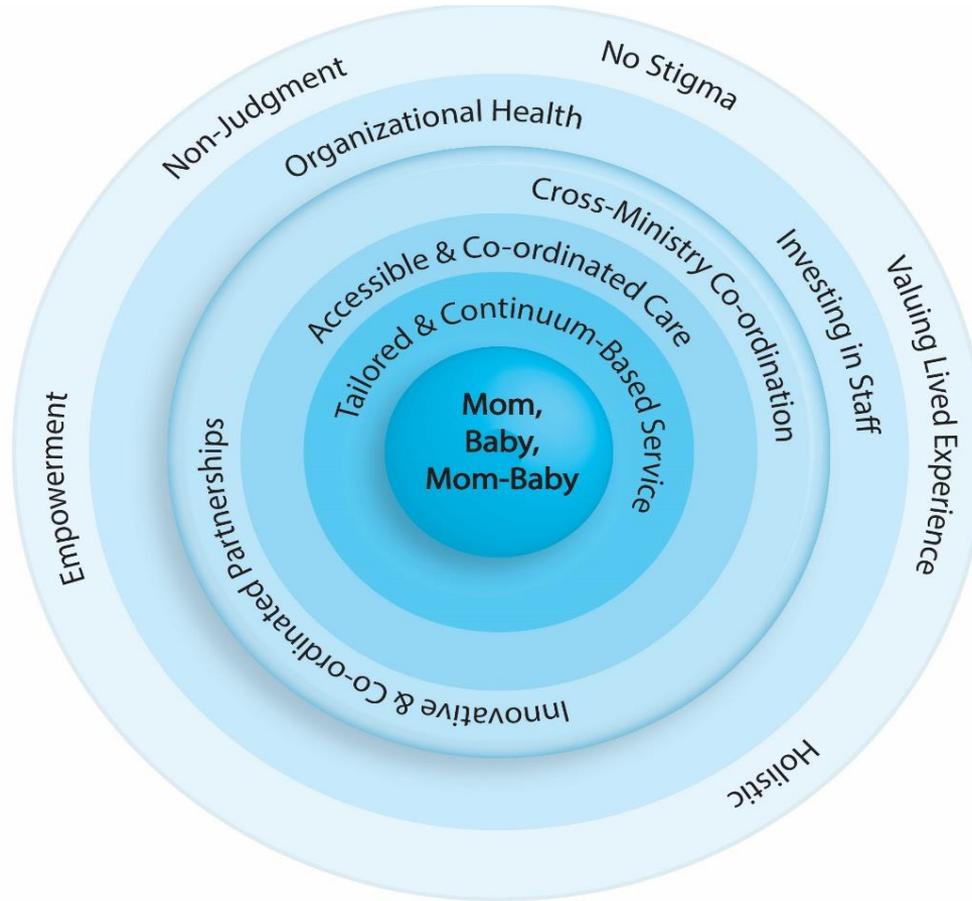
Counsellors

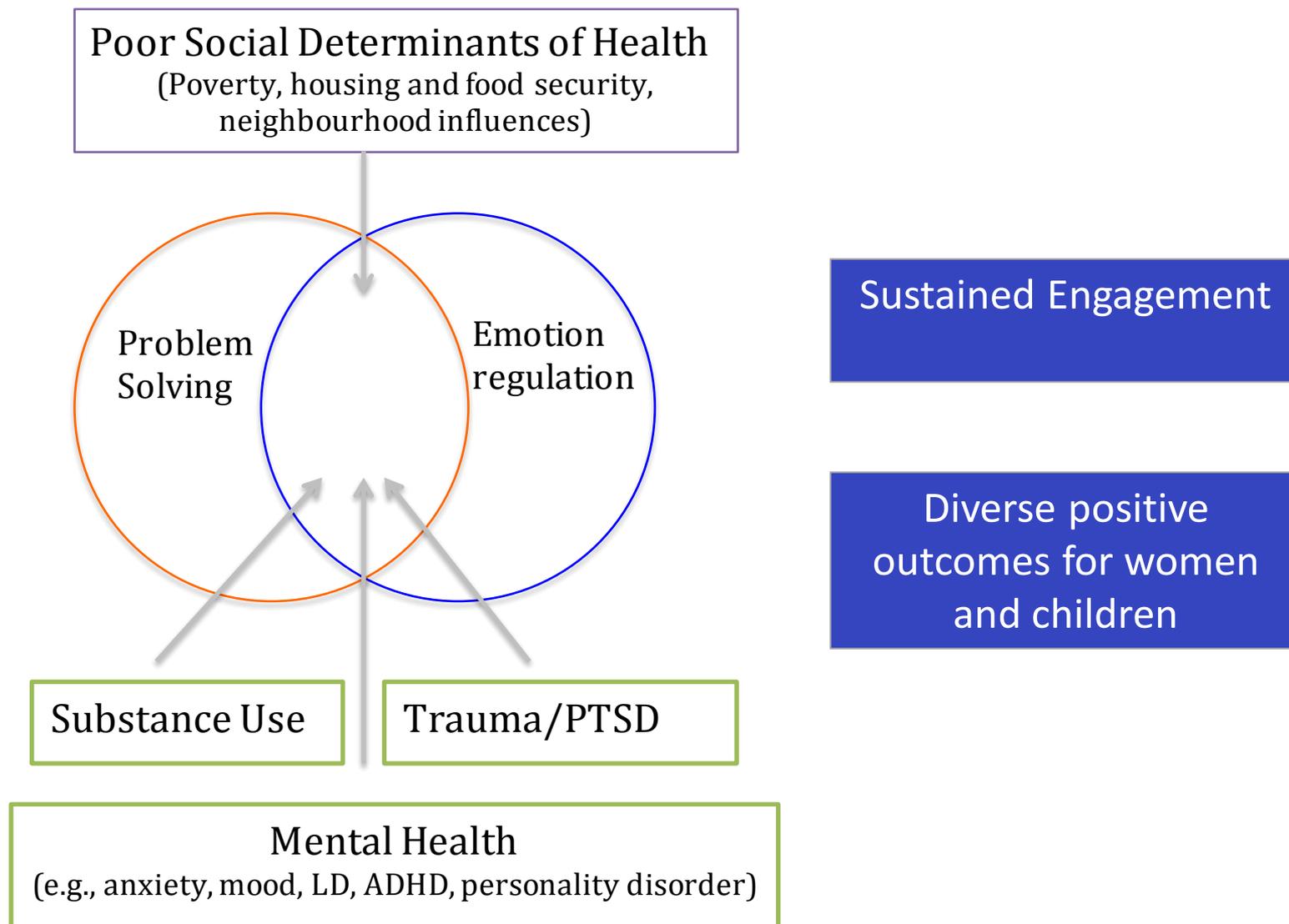
- Give support at the level needed (Teach, model, decrease demands)
- Prepare scripts
- Help with paperwork
- Time management
- Organization

Cueing...

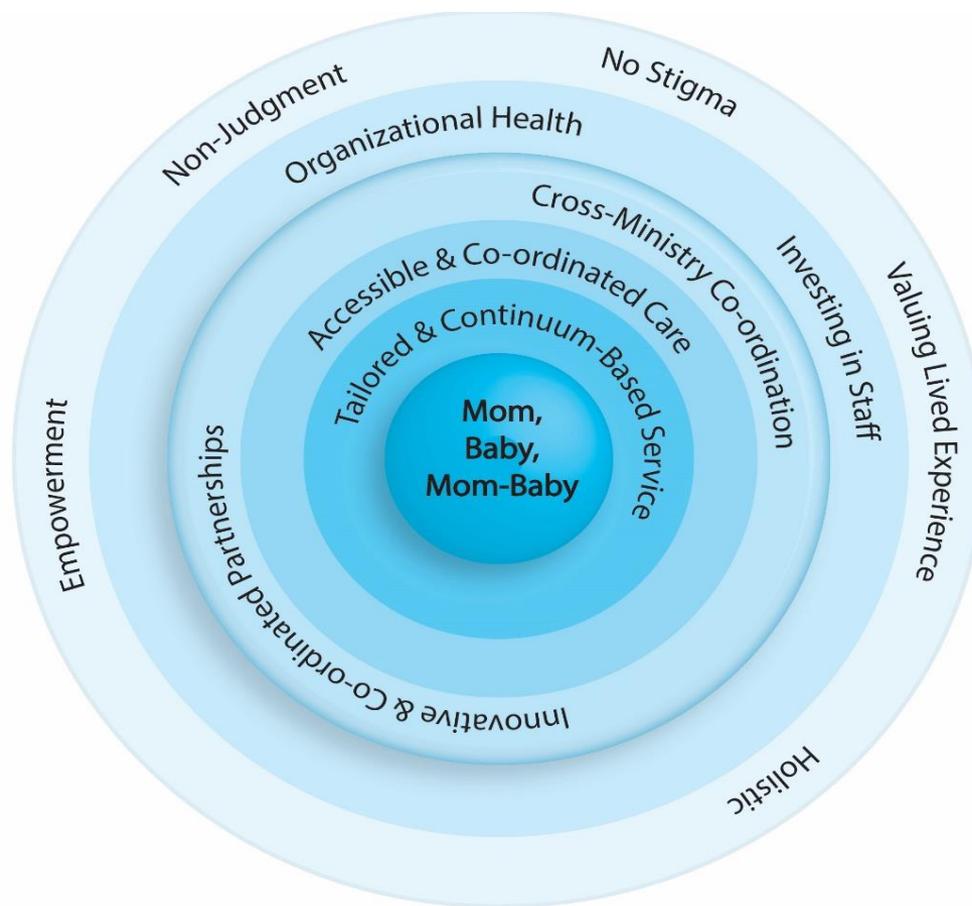


How do these results fit with our concept map?





Not just a single agency or service provider... integrated care is about partnerships and integrations across traditionally distinct services



What we learned:

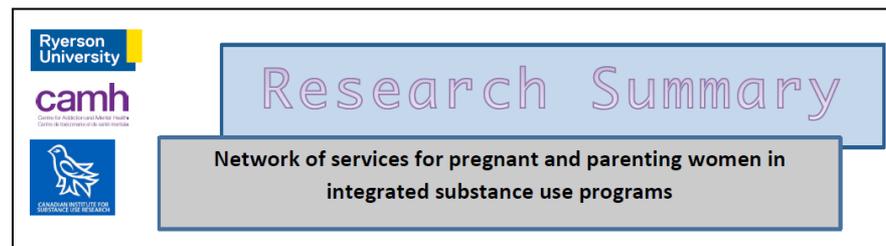
5. Community care networks

“our options here are you collaborate, you work together, and you refer, or you don’t have access to services for your clients. There’s usually more demand than we can accommodate in terms of services so it is in our best interest to collaborate.”

(Service partner)

Partnerships...

... service agencies in your community to which you refer and accept clients, agencies with which you have service and/or data sharing agreements, and/or services that you typically help your clients access



Partnerships...

Mental health and substance use services

Opioid agonist/substitution therapy (OAT/OST)

Child protection services (CAS)

Parenting or child support

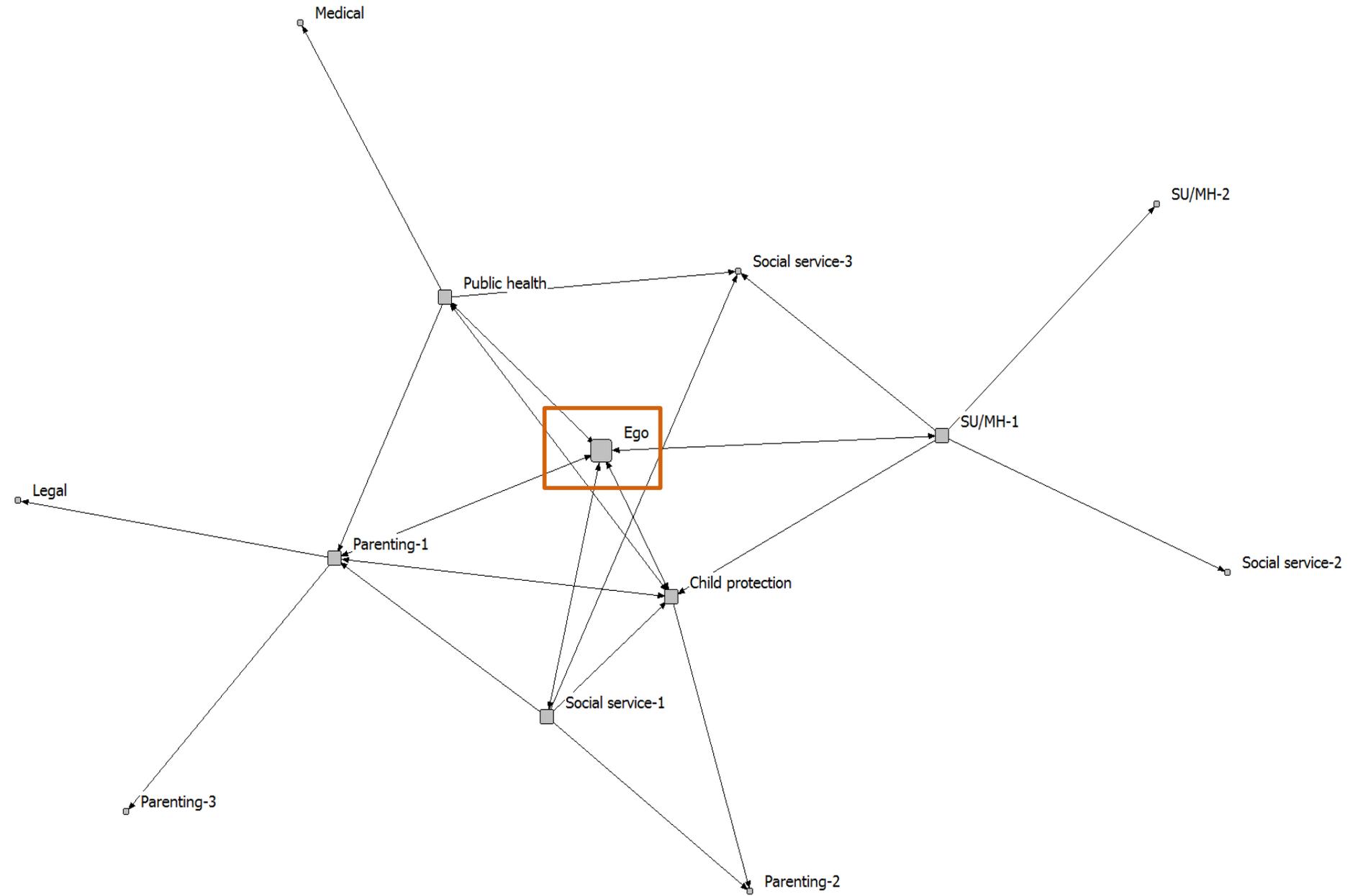
Prenatal care

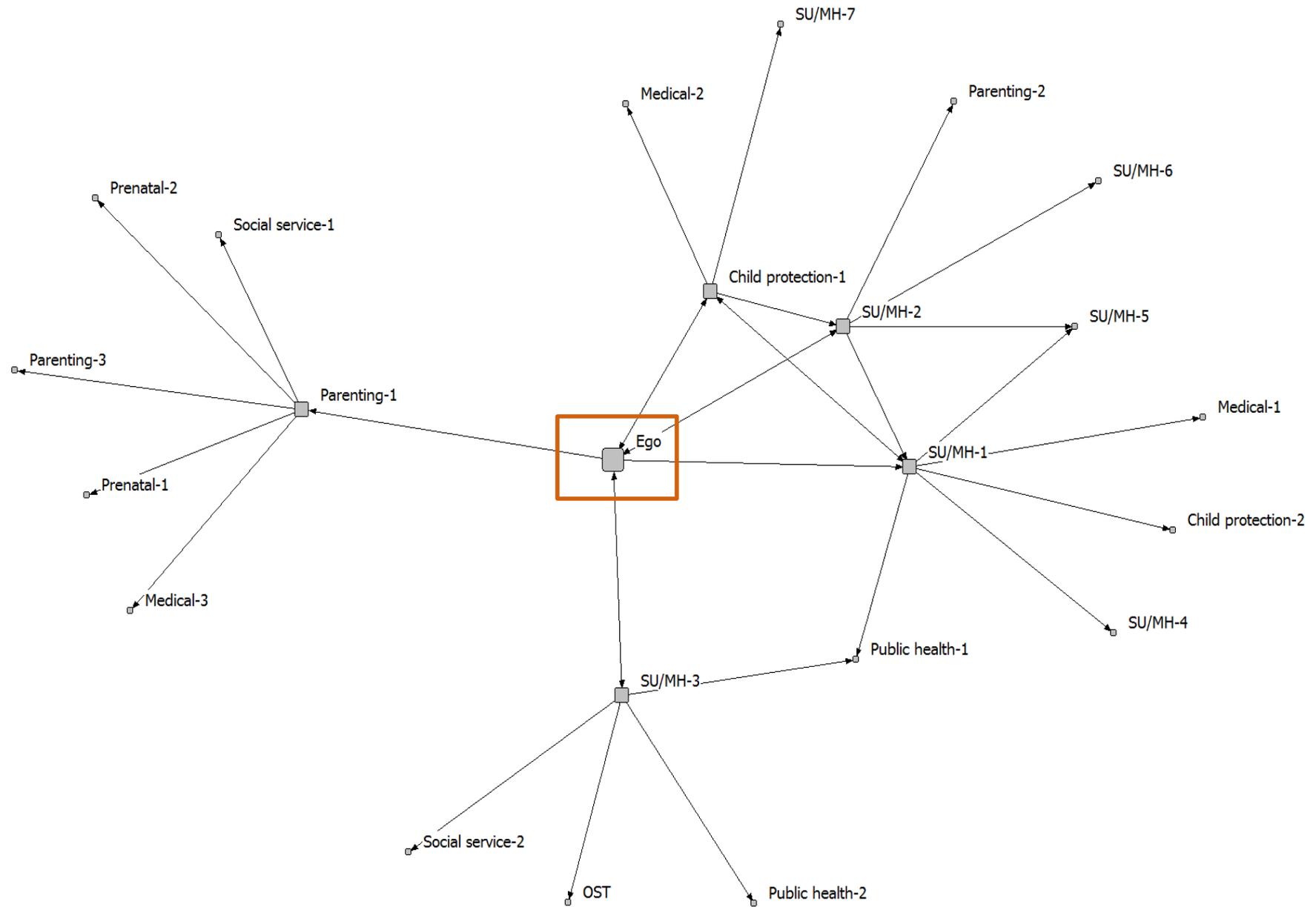
Medical and primary care

Public health

Social services

Legal services





Composition of community care networks

- Key role of child protection services
- Many directly connected to other mental health/substance use services (excluding OAT), parenting/child support, and social services
- Other health care services (OAT, primary and prenatal care) and legal services were rare

Structure of community care networks

- Networks varied in cohesiveness
- Most ties to the integrated treatment programs were reciprocal (60% to 100%)
- Integrated treatment programs commonly brokered connections between services in their communities

What we learned:

6. Integration and partnerships

Integration survey results

- What services are offered in partnership
- Level of coordination for different services
- Satisfaction

What format do partnerships take on the ground?

- Partner comes to the ECD site to offer programming
- Inter-agency meetings with clients (all stages of treatment)
- Resource sharing (knowledge and tangible basic needs)
- Referrals – ideally both ways!
- Client information sharing
- Community level complex case review meetings
- Agency boards
- Community planning committees

How do partnerships form?

- Driven by service provider relationships and knowing that “one person”
- Noticing “what is missing” in the work with clients
- Being aware of who is absent at planning tables
- Identifying duplication of services (and wanting to avoid)
- Purposeful outreach and education
- Noticing patterns in who clients are working with/who referred by
- Co-location (least common)

Partnerships: integration and satisfaction

How would you describe your partnership activities?

Awareness Communication Cooperation Collaboration



On a scale of 0-5, how satisfied are you with the partnership?

Partnerships with child mental health

- Relative to non-integrated programs, integrated programs were more likely to have a partnership that is cooperative or collaborative
- Satisfaction varied, but was relatively low for both integrated and non-integrated programs

Partnerships with maternal mental health

- No major differences between integrated and non-integrated programs
- Offered in-house in most programs
- When offered through partnership, satisfaction varied but was high on average

What facilitates or hinders innovative and collaborative partnerships?



4 key processes of partnerships

- Clear roles and responsibilities
- Effective communication
- Shared expertise
- Shared resources

Why is this important?

What are the barriers?

Clear roles and responsibilities

Why important?

- Share the load
- Client not pulled in too many different directions
- Supports problem-solving and perspective-taking

Clear roles and responsibilities

Current Barriers

- Differing mandates
- Differing perspectives between workers at an single agency
- Staff turnover
- No formal agreements
- Stepping into another's role when you have knowledge
- Limited time, lack of flexibility

Effective communication

Why important?

- Supports relationships and trust
- Aids understanding of client needs/goals/expectations
- Supports accessible, flexible care
- Facilitates understanding of each others' mandates and roles
- Allows for challenges to be caught early
- Supports inter-professional learning
- Models a core skill for clients

Face to face communication is best

Effective communication

Current Barriers

- “Refer and forget”
- Different mandates and view of who is the client
- Negative experiences colour expectations
- No time
- Staff turnover (at partner sites)
- Consent, not being in the circle of care

Undermines sense of usefulness and trust in relationship
Challenges lead to stress, negative emotions

Shared expertise

Why important?

- System is overtaxed
- Efficiency
- Improves relationships – feel valued and see value in others
- Enhances knowledge of co-occurring needs and resources
- Brings people together which facilitates communication, relationship building, shared expertise

Shared expertise

Current Barriers

- Requires up to date knowledge of partner services, knowledge and expertise, referral process/how to engage
- Better relationships, trust, respect, positive reputation → more openness to expertise (may be harder initially)
- No time
- Need expertise in the moment but not readily available

Shared resources

Current Barriers

- Agencies don't have enough to meet their own needs
- Concerns about sustainability of funding
- No formal agreement – leaves vulnerable to: organizational change & staff turnover
- Funding is organized around agencies rather than systems
- Confusion about what is funded within agency
- Location/Timing

Partnership facilitators

Individual Partnership Level

Management

1. Formal agreements and terms of reference with review.
2. Awareness of partnerships, resources needed, and importance

Service Providers

1. Communication needs to be planned for
 - Face to face is best
 - Flexible and immediate
2. Shared, clearly articulated goals for clients
3. Open discussion of roles, responsibilities

↑ sustainability

Partnership facilitators

- **Systems level**
 - Community level working groups
 - Shared consent forms and intake process
 - Clarity of mandates – who is client, how referrals made, limits
 - Regular sharing of expertise, services, successes/challenges
 - Shared training
 - More clarity about funding rules (and flexibility within communities)
 - Community picnics and information sharing events

Partnership facilitators

Time

Space

Money

Staff

Partnership facilitators

Co-location:

- One stop shop has often been cited as the ideal
- Ease of access for staff and clients
- Enhances efficiency (e.g., shared intake)
- Promotes face-to-face communication – “easier to get to know workers”
- Sharing of resources and training
- Easier to connect with partners who are harder to connect with (e.g., doctors)

HOWEVER – Still dependent upon all other processes

Partnership facilitators

Co-location Models:

- One stop shop (community-level/systems driven or integrated program driven)
- Co-location (part/full-time) of frequent partners (e.g., ECD housed in CAS; Housing housed in ECD)

Healthy Mothers, Healthy Families

PHASE 3 – in progress

Maternal and child health outcomes



Healthy Mothers, Healthy Families

Key messages:

- All about relationships
- Evidence of high levels of engagement after admission
- Possible efforts needed in outreach for pregnant women
- Central focus is maternal health and well-being
- Development of partnerships with services for child mental health and development
- Development of partnerships with physicians