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# Conceptualizing integrated service delivery for pregnant and parenting women with addictions: Defining key factors and processes

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## ABSTRACT

**Objectives.** Motherhood is a time of increased motivation for entering addictions treatment and changing maladaptive patterns of substance use. However, treatment engagement is limited by challenges in navigating traditionally distinct health and social services to meet complex needs, as well as by unique barriers related to pregnancy and parenting. Integrated approaches to treatment combining services related to substance use, parenting, and maternal and child well-being are associated with improved engagement and outcomes for mother and child. A conceptual model outlining processes involved in effective integrated service delivery is currently lacking. **Methods.** Concept mapping methodology was employed with thirty stakeholders involved in service provision, research, and policy to examine their perceptions of processes supporting effective integrated service delivery for this population. **Results.** We identified seven thematic clusters comprising statements defining effective integration. Stakeholders described three central client-related clusters, defined as both mother and child. These clusters included processes reflecting accessible, holistic and coordinated care, tailored to specific and changing needs. Four inter-related clusters described a reliance on the dynamic coordination of several key 'players' (e.g., partners, agencies, ministry) at multiple levels (e.g., service delivery, policy). All clusters were characterized as rooted in a set of core values, including non-stigma, non-judgment, and empowerment. **Conclusions.** Comprehensive, continuum-based, and client-centered care for mother and child are paramount for effective integrated treatment. Our model extends this view by identifying the agency-, ministry- and partner-related processes that interact to support this type of treatment, and their relative importance. Future directions, including examination of the model in the real world are discussed.

**Objectifs.** La maternité est un moment privilégié pour trouver la motivation de suivre un traitement contre la toxicomanie et changer les modèles mésadaptés d'utilisation de substances. Cependant, l'engagement au niveau du traitement est limité par les défis de manœuvrer entre les services traditionnellement distincts de la santé et des services sociaux pour répondre aux besoins complexes, ainsi que par des obstacles uniques liés à la grossesse et la parentalité. Des approches intégrées de traitement combinant des services liés à l'utilisation de substances, aux rôles parentaux, ainsi que le bien-être maternel et infantile sont associés à l'amélioration de l'engagement au niveau du traitement et des résultats pour la mère et l'enfant. La description d'un modèle conceptuel soulignant les processus impliqués dans une prestation intégrée efficace des services fait actuellement défaut. **Méthodes.** La méthodologie de schématisation conceptuelle a été employé avec trente parties prenantes impliqués dans l'approvisionnement de services, la recherche et la politique dans le but d'examiner leur perception des processus de soutien dans une prestation intégrée et l'efficacité de ces processus pour cette population. **Résultats.** Nous avons identifié sept groupes thématiques comportant des déclarations définissant une intégration efficace. Les intervenants ont décrit trois groupes reliés essentiellement à la clientèle mère-enfant. À ces groupes thématiques ont été incorporés des processus incluant des soins accessibles, holistiques et coordonnés, adaptés aux besoins spécifiques et changeants. Quatre groupes interdépendants ont décrit unsoin de s'appuyer sur la coordination dynamique de plusieurs 'joueurs-clé' (par exemple les partenaires, les organismes, le ministère) à plusieurs niveaux (par exemple la prestation de services, les politiques de ces services). Tous les groupes étaient

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caractérisés comme encrés dans un ensemble de valeurs fondamentales, y compris la non-stigmatisation, le non-jugement, et l'autonomisation. **Conclusions.** Un traitement global, basé sur un continuum, ainsi que des soins axés sur les besoins du client, dans ce cas la mère et l'enfant, sont primordiaux pour un suivi efficace et intégré. Notre modèle prône ce point de vue en identifiant les processus reliés entre eux, tant au ministère qu'aux agences ou autres partenaires, qui interagissent pour soutenir ce type de traitement, et leur importance dans ce processus. Les orientations futures, y compris l'examen du modèle dans la pratique sont examinés.
**Mots-clés:** grossesse et rôle de parent, traitement de la toxicomanie, le service et l'intégration de systèmes, la cartographie conceptuelle.

## INTRODUCTION

Pregnancy and parenthood are paramount for women's addictions treatment, as this life stage is viewed as a period in which motivation to engage in treatment heightens[1]. Substantial research supports that prenatal substance use confers risk for children's development and mental health[2, 3]. Women with addictions experience parenting challenges, including the ability to sensitively and consistently respond to their children. Myriad, interrelated factors underlie challenges including maternal poverty, mental health disorders, trauma, and limited exposure to effective parenting models[4, 5, 6], as well as physical and emotional consequences of addiction. The relation between addiction and parenting is circular: addiction leads to parenting challenges, which in turn promote painful feelings of inadequacy, guilt, and shame[7] and perpetuate the use of substances[8].

Addressing complex underlying factors necessitates intervention in multiple areas of functioning (social, mental health, addictions) across multiple clients (mother, child). Accordingly, addressing the multifaceted needs of women requires services that traverse traditional divisions of government (e.g., community and social services, health, child welfare)[9]. Siloed approaches to service provision pose numerous barriers for pregnant and parenting women with addictions, and result in low rates of follow through[10]. Women articulate a lack of direct and ancillary services specifically geared toward pregnancy and parenting (e.g., child care, transportation) and fear being reported to child protection services or losing custody of their child [11, 12, 13, 14]. The perceived stigma and judgment that accompany being a pregnant or parenting woman with addiction[12, 13] are cited as key deterrents for help-seeking and treatment engagement.

One response to these issues has been the development of integrated treatment programs (herein, integrated treatment) that provide wrap-around, coordinated services for pregnant and parenting women with addictions. Integrated treatments are available in a number of countries, including Canada, the US, and Australia. While all share the aim of comprehensiveness, individual programs tend to be locally developed to match community needs and resources, resulting in heterogeneity in types and location of services, mandates, and partnerships[15, 16, 17, 18]. Program evaluation, expansion, and the development of best practice guidelines are hindered by limited reporting on treatment components and factors supporting feasibility[19]. Locally developed programs have the advantage of matching services with population needs, but the absence of a common conceptual model of integrated program delivery limits the evolution of this, likely critical, component of the addictions treatment system.

To date, definitions of integrated service for this population have largely reflected a focus on service *types* (i.e., programs that offer on-site pregnancy-, parenting-, or child-related services with addiction services)[15, 16, 18]. Less is known about the *processes* that underlie effective integrated service delivery, such as linkages, cooperation, coordination, and partnerships that may be essential for supporting and effectuating change[17, 20, 21].

A few studies have examined processes of integrated treatment for this population, including models of collaboration between addictions treatment and child welfare services[22] and indicators of success for co-located wrap-around services (e.g., one-stop shop)[23]. These have identified a range of thematic factors thought to support service delivery. The former divided these into contextual factors (e.g., changes in child welfare policy, regional variation in resources); enabling factors (e.g., shared purpose); processes and protocols (e.g., mechanisms for conflict resolution, communication protocols); principles and values (e.g., translating principles and values into practical guidelines); program and practice innovation (e.g., proactive support for safety and relapse prevention); and, shared outcomes capable of accounting for mother and child. The latter conceptualized processes of effective integrated service delivery at the client level (e.g., nurturing relationships with women, meeting women where they are at without judgement, promoting safety), the staff level (e.g., investing in staff development and self-care), and the system level (e.g., building a strong team and increasing access to care). While, together, these studies offer insight into within agency processes and those existing between agency and child welfare, as well as contextual factors, these processes have not yet been examined in concert within a single study. Further, methodology employed has not afforded examination of the relative importance of processes and factors within the greater gestalt of integration. Research specifying the processes of effective integrated treatment for this population that encompasses multiple models (e.g., home visiting model) and extends beyond single partnerships is needed.

This study addressed these limitations though a mixed methods investigation of expert definitions of effective integrated service delivery for pregnant and parenting women with addictions. We used concept mapping with a diverse group of professionals involved in administration, policy development, service provision, and research to generate, sort, and rank the relative importance of processes of integrated services for this population.

## METHOD

### CONCEPT MAPPING

Concept mapping is a structured multi-step method that combines qualitative and quantitative analysis to allow for the rich exploration and articulation of a complex construct[24]. Adhering to Kane and Trochim's[24] guidelines, the procedure involved three phases: 1) project planning, 2) idea generation and structuring, and 3) analysis and group interpretation of the resulting map. Feedback from the research team and stakeholders was sought throughout to ensure the understanding, feasibility and relevance of concept mapping activities.

**Project planning phase**. This study was undertaken as part of a larger provincial evaluation of integrated programs in Ontario, Canada. Phase one involved development of the focal prompt and recruitment of stakeholders. The focal prompt, *Based on your knowledge and experience, effective integrated service delivery means _____* , was developed in collaboration with the core research team for the larger study. It was intended to capture essential ingredients of effective integrated service delivery (services and processes) for this population, and was accompanied by instructions to disregard practical or resource-related limitations and focus on the ideal.

Stakeholders (N=30) were recruited from the advisory committee for the larger evaluation. The final sample included 86% of advisory committee members (30 of 35). Stakeholders brought expertise in research, service provision, management of integrated treatment programs, and related policy development. Years of experience ranged from 6 months to 37 years ($M$ = 10.5 years), and representation was obtained from differing geographical locations of Ontario (i.e., rural, urban, North, South, East and West regions). Participation was voluntary, and some individuals opted not to participate in all tasks (see Table 1).

**TABLE 1: NUMBER OF STAKEHOLDERS WHO COMPLETED EACH CONCEPT MAPPING ACTIVITY (N=30)**

| Concept Mapping Activity | n |
|---|---|
| Brainstorm Session | 17 |
| Sort | 20 |
| Rate 1 | 19 |
| Interpretation Session | |
| In person | 7 |
| Teleconference | 11 |
| Rate 2 | 19 |

*Note.* Numbers do not total to 30 as stakeholders did not necessarily partake in all activities

**Idea generation and structuring phase.** Phase two involved two tasks: a group brainstorming session to generate statements and an online sorting task completed individually by stakeholders. A total of 17 stakeholders convened for a two-hour face-to-face group brainstorming session. Stakeholders were asked to generate as many statements as possible to complete the focus prompt. Stakeholders were also invited to submit additional items anonymously through writing in the goal of increasing participation. In line with Kane and Trochim's[24] statement reduction guidelines, statements that duplicated ideas were combined and statements outside of the project scope were removed resulting in the stimulus set of statements to be sorted.

Using Concept Systems Software[25], 20 stakeholders individually placed the randomly ordered statements from the brainstorming sessions into piles that "made sense to them" or that they felt "belonged together" allowing for the generation of sorts that represented each participant's unique perspective. Stakeholders were instructed to take as much time as they needed to complete the task and that there was no right or wrong way to approach the sort. The only restrictions were that (a) all statements could not form a single pile and (b) there could not be as many piles as there were statements. In addition, stakeholders were asked to avoid creating piles according to priority or value, such as 'important' or 'hard to do' or 'other/miscellaneous' to ensure that items were being placed together based on conceptual or thematic similarity. Finally, stakeholders were asked to develop a conceptual label for each created pile that they felt "best captured its contents."

**Analysis and interpretation phase.** Phase three consisted of statistical analysis of the sorting data, generation of the concept map and a second group session (1.5 hours) during which 18 stakeholders interpreted

the resulting concept map and reached agreement on a label for each cluster. After this session 19 stakeholders completed an online survey in which they were asked to rank-order the clusters from most to least important for integrated service delivery.

## RESULTS

A total of 200 statements were generated during the brainstorming task, which when reduced produced a stimulus set of 62 unique statements (see Table 2). Stakeholders sorted statements into 5 to 8 piles ($M = 7.4$, $SD = 2.02$).

Analyses on the sorting data were carried out using Concept Systems Software[25]. Three primary data analysis steps contributed to the resulting concept map[24]. First, matrices representing each participant's sorting data were aggregated to create a group similarity matrix with values representing the number of stakeholders who grouped each pair of statements together (regardless of which other statements they included in that pile); higher values indicate greater conceptual similarity. Next, nonmetric multidimensional scaling (MDS)[26, 27] was used to iteratively place each statement as a point on a two dimensional map. The final step involved using Hierarchical Cluster Analysis to partition MDS coordinates (i.e., statements) into non-overlapping clusters reflecting similar underlying concepts according to Ward's algorithm[28]. The statements in Table 2 can be linked using the item number (left-hand column) to the statement (i.e., points) on the map presented. The relative distance between points denotes the stakeholders' perceptions of the degree of similarity between statements. The model generated a goodness-of-fit value of .27, after 10 iterations, falling within the recommended reliability range of .10 to .35[24]. This suggests that the map is a good representation of the data with little discrepancy between the input data matrix (i.e., sort data aggregated across stakeholders) and the representation of these data as points in the two-dimensional space.

Since most stakeholders sorted statements into five to eight piles, cluster solutions were reviewed iteratively, beginning with the largest cluster solution (eight clusters) down to the fewest clusters in the solution (five clusters). Statements comprising each cluster were reviewed to note where discrepancies lay between the various cluster solutions and to determine which solution was most parsimonious and conceptually sensible. The selected solution of 6 clusters was the one that authors felt best struck a balance between detail and interpretability (see Figure 1). The labels and cluster descriptions developed by stakeholders during the interpretation group session were as follows:

**Cluster 1. Holistic and Empowering Care for Mom, Baby, and Dyad.** This cluster was conceptualized as two distinct but related concentric circles, representing the delivery of service to multiple target groups (i.e., mom, baby, and dyad) and the vision or values that imbue integration (e.g., empowerment, lack of judgment or stigma), respectively.

**Cluster 2. Tailored and Continuum-Based Service Components.** This cluster reflected the need for what stakeholders described as the "right mix" of services across life stages (i.e., for women and child development), as well as processes that support this type of service delivery. It was acknowledged that a key supportive process was the development of meaningful and mutually beneficial partnerships.

**Cluster 3a. Sustainability and Organizational Health and 3b. Investing in Staff.** This cluster was seen as 2 distinct subclusters closely related through their reliance on supportive leadership and staff management. Sustainability and health reflected an orientation toward outcomes and cost-effectiveness, "reflecting on what is working and what is needed," as well as remaining up-to-date with research and clinical evidence and ensuring appropriate expertise in program evaluation. Investing in staff reflected the related abilities of programs to identify, attract, retain, and support the continued development and well-being of staff. Stakeholders highlighted that effective service integration requires long-term investment in expertise, training, and mentorship, which includes identifying training priorities and opportunities to access this knowledge. Stakeholders indicated that all staff members ought to be welcoming and knowledgeable about all parts of the system (e.g., "no wrong door").

**Cluster 4. Innovative and Coordinated Partnerships**. This cluster, which focused on what stakeholders termed "best practices from a between-agency lens," had the smallest inter-item distances on the map indicating a high degree of similarity between statements. This cluster reflected the idea that service providers can together achieve more than what is possible by each in isolation. Stakeholders highlighted the importance of bringing together unlikely partners in a meaningful way such that "each player gets something out of it." Stakeholders stated that partnerships ought to exist to bring identified and shared goals to fruition and should be developed with the client in mind. The primary benefit of forging partnerships was enhancing feasibility for meeting the diverse needs of clients. Cluster 4 also included statements pertaining to the infrastructure (e.g., collocation, shared use of resources) and processes (e.g., finding the intersection of vision, mission, and values of various partners, delineating roles, responsibilities and boundaries) needed to build and sustain effective partnerships.

**Cluster 5. Cross Ministry Coordination**. This cluster reflected broader systemic processes that support integration, such as managing risk, integrated funding,

increasing capacity, innovation, and knowledge building, exchange, and dissemination.

**Cluster 6: Accessible and Coordinated Care for Clients.** Whereas Cluster 4 was considered to represent best practices from an agency lens, Cluster 6 did so from a client lens. Each was seen as informing and reinforcing the other, in what stakeholders described as an "infinity loop." Some of the necessary components of this cluster included "enhancing access to care" (e.g., transportation, childcare, waitlists), allowing for evolution in partnerships to meet changing needs, strong communication, and shared goals. Stakeholders emphasized the notion of no wrong door and a streamlined process that minimized client burden and facilitated transitions and information sharing.

**Cluster Ranking.** Results indicated that Holistic and Empowering Care for Mom, Baby, and Dyad was considered most important, which is consistent with the group's interpretation of this cluster as forming the "foundation that informs the rest of the [map]." This cluster was followed by 2) Accessible and Coordinated Care for Clients, 3) Cross Ministry Coordination, 4) Tailored and Continuum-Based Service Components, 5) Innovative and Coordinated Partnerships, 6a) Sustainability and Organizational Health, and 6b) Investing in Staff in terms of perceived relative importance.

## DISCUSSION

Using concept mapping methodology with a diverse stakeholder group of professionals, this study explored the ideal definition of integrated service delivery for pregnant and parenting women with addictions. The resulting framework identified key processes, and illustrated their inter-relations and relative importance. At the top of the map were three clusters focusing on client-centered care, including processes that reflected accessible, holistic, and coordinated care, tailored to specific and changing needs of women, their children and the mother-child dyad. The remaining three interrelated clusters described the reliance of integration on the dynamic coordination of a number of key 'players' (e.g., partners, agencies, ministry) at multiple levels (e.g., service delivery, policy). All clusters were described as rooted in a set of core values, including non-stigma, non-judgment, and empowerment.

While the individual sorted statements more specifically apply to the population under investigation, the higher-level concepts to which they were assigned, or the clusters themselves, reflect themes that have been identified in the literature on integrated addictions programs[22, 23] and collaboration more generally.[29, 30, 31, 32] These findings move the field forward by distilling the inter-relations between clusters, as well as their relative importance.

Holistic and Empowering Care for Mom, Baby and Dyad and Accessible and Coordinated Care for Clients reflect the well-established value of client-centered care[33]. These clusters inform who the client is (mother, child, dyad) and the needs to be addressed in treatment, including potential barriers to supporting engagement (e.g., stigma, judgement, transportation, childcare), and suggest that treatment frequency and duration ought to be commensurate with client articulated goals and experiences. Our concept map and ratings highlight these clusters as being most important for effective integrated service delivery, with the notion of simultaneously balancing care for three clients representing a need unique to treating this population.

While client centered care was at the forefront of the map, clusters relating to the agency, partners, and ministry formed a foundation at the bottom of the map reflecting their role in supporting the enactment of the client-centered care clusters. The most important of these was Cross-Ministry Coordination, which was ranked as being more important than agency clusters: Sustainability and Organizational Health and Investing in Staff, and the partnership cluster: Innovative and Coordinated Partnerships. Cross-Ministry Collaboration is consistent with the contextual challenges to collaboration described by Drabble & Poole[22], including changes in policy and authority for service provision. For example, our stakeholders indicated that when the wellbeing of women and children falls under the purview of separate ministries it poses challenges with respect to caring for multiple clients simultaneously. In turn, this can limit service provision, both in terms of type of service and the recipient[22]. As can be visualized on the concept map, ministry sits between clusters relating to agency and partnerships, suggesting that cross-ministry co-ordination may be a crucial bridge for agency and partner collaboration. The visual distance between agency and partner clusters and the stated importance of partnerships for meeting complex and diverse needs of clients underscores the importance of this bridge. Cross-ministry coordination may be critical for effectuating activities between agency and partner(s) that support collaboration. For instance, ministries may play a role in ensuring sufficient and flexible program funding, supporting the development of conflict navigation and knowledge translation mechanisms, disseminating information to professionals about the implementation of policies and best practices, funding joint training initiatives, and advancing a vision for

collaborative practice[22, 23]. Examining the inter-relations between cross-ministry functioning and other clusters, as well as their relative impact on outcomes, is an important avenue for future investigation and policy-related work.

The final clusters, rated as least important for effective integration, pertained to the agency. These encompassed themes related to outcomes, ongoing evaluation, and staff recruitment, training and professional development. This finding is surprising in light of research highlighting the therapist-client relationship as instrumental for recovery. Covington[34], for instance, suggested that staff facilitate the acquisition of relational skills among women – the foundation for developing healthy relationships – through modeling. Others view these relationships as supporting the formation of a "non-addict identity" and contributing to the development of a positive sense of self and a therapeutic support network[35]. Motz and colleagues[2] and Wong[8] attribute the transformative ability of these relationships to their ability to foster growth and empowerment. Relatively lower ratings ascribed to agency-related clusters may reflect stakeholder impressions that full realization of these "in-house" functions depends upon explicit recognition of client-related clusters in concert with effective partnerships and higher order (i.e., system-level) support. In other words, other clusters may have been viewed as relatively more important for effective integration because they promote agency and staff health.

While we examined service integration in the context of programs designed specifically for pregnant and parenting women with addictions, it is possible that findings offer insight into the processes of service integration more generally. Increased recognition of the prevalence of co-occurring mental and substance use disorders in addictions treatment settings, and the wide range of legal, social, and health problems that commonly accompany addictions has led to calls for greater integration of addictions services with other health and social services[36]. With growth of the integration agenda, clear articulation and evaluation of the processes by which effective integration is achieved is critical.

Strengths of our study include the wide range of expertise that was accessed in generating the concept map, the exploration of relative importance of processes of integration, and the relevance of the model of integration for a range of programs. Although the sample size was in line with recommendations for concept mapping, the relatively small number of stakeholders meant that we were unable to explore moderating factors, such as position (e.g., researcher, clinician, policy-maker) or geographical location. Another limitation was that we were unable to incorporate the perceptions of women who have accessed and participated in these treatment programs. This decision reflects sensitivity to power differentials that exist between client and professional stakeholders, and a commitment to engaging women in research through mediums that are most likely to maximize their participation. To this end, women's perspectives and experiences are currently being sought through focus groups occurring in the larger evaluation of integrated programs. Further research should investigate the extent to which our visual representation of integration aligns with the perspectives of clients, as well as with those of stakeholders in other jurisdictions. Finally, our study is inherently conceptual. While the exercise is helpful in terms of clarifying the concept of service integration for our larger evaluation, studies are needed that assess how this visual representation maps onto practice in the real world, and to explicitly examine the relations between these integration processes and outcomes.

The complex and diverse needs of pregnant and parenting women, and their children, have implications for policy and service provision. The present study supports the notion that effective integration is more than just the co-location of services, and highlights a number of processes that are seen to play a key role in whether services are ultimately effective. These processes traverse multiple levels, pointing toward the importance of integrated policy, administration, and programming across agencies, their partners, and relevant areas of government. Values of client-centeredness, empowerment, non-judgment and holistic care serve as the foundation that guides work in this area and reminds stakeholders of their shared purpose. These insights provide some needed clarity into the concept of service integration that is critical for informing the ongoing development and evaluation of programs and policies.

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| TABLE 2: LIST OF STATEMENTS GENERATED BY PARTICIPANT GROUP ACCORDING TO CLUSTER | |
|---|---|
| **Statement #** | **Statement** |
| | **Cluster 1: Holistic and Empowering Care for Mom, Baby, and Dyad** |
| 6 | recognizing three clients – mom, baby, mom-baby dyad |
| 62 | non-judgment |
| 1 | making information readily available to mothers |
| 58 | empowerment |
| 36 | including the client's voice (e.g., in determining treatment focus, partnerships, timelines) |
| 46 | wrap around services for women and children |
| 15 | coming in and out of the system without judgment |
| 11 | looking at needs of whole person - all ages and stages |
| 13 | addressing potentially conflicting goals/needs/interests of mom, baby, and mom-baby dyad |
| 18 | stigma reduction |
| 39 | valuing lived experience |
| | **Cluster 2: Tailored Services on the Care Continuum** |
| 6 | case management |
| 22 | using a determinants of health perspective as a lens for examining client needs |
| 16 | identifying short and long-term goals |
| 7 | focusing on multiple relationships (e.g., staff, organizations, women, children, families) |
| 25 | standardized assessment |
| 38 | prevention |
| | **Cluster 3a: Sustainability and Organizational Health** |
| 23 | reflecting on what is working and what is needed |
| 34 | sustainability |
| 55 | long-term investment |
| 31 | dedicated time and expertise for program evaluation |
| 29 | access to literature about evidence |
| 9 | building on strengths of staff, management, and women |
| 19 | orienting toward outcomes and cost-effectiveness |
| 50 | evidence includes clinical experience and wisdom |
| | **Cluster 3b: Investing in Staff** |
| 3 | supportive leadership |
| 8 | secure funding |
| 45 | being able to attract and retain competitive staff |
| 41 | identifying core competencies for staff |
| 47 | system/policy-level thinking |
| | **Cluster 4: Innovative and Coordinated Partnerships** |
| 57 | integration among services and into community |
| 53 | clarity of roles and responsibilities of each partner |
| 54 | clarity of procedures for sharing client information |
| 26 | respecting the boundaries and/or limitations of each organization |
| 2 | creative and shared use of resources |
| 17 | clear organizational structure between and within organization |
| 49 | service agreements |
| 4 | collocation with other frequently accessed services |
| 21 | finding the intersection of vision, mission, and values of various partners |
| 32 | the whole is greater than the sum of its parts |
| 44 | mutual benefit of program and partner |
| 52 | collaboration |
| 35 | bringing together unlikely partners |

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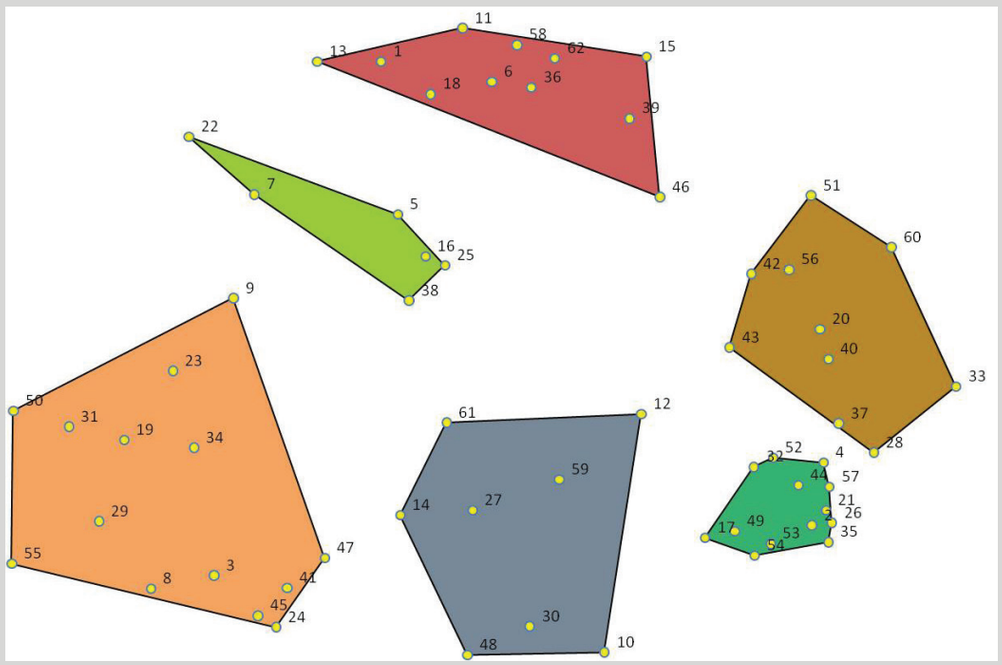
| | **Cluster 5: Cross Ministry Coordination** |
| 61 | innovation |
| 59 | increased capacity |
| 12 | a range of experience |
| 48 | integrated funding for initiatives |
| 10 | data sharing across ministries |
| 27 | having a process for navigating conflict, legal issues, and relevant legislation |
| 30 | joint education and training |
| 14 | risk management |
| | **Cluster 6: Accessible and Coordinated Care for Clients** |
| 60 | accessible system |
| 42 | continuity of care |
| 33 | each point of entry has awareness of all the potential parts of the system and services available |
| 56 | seamless |
| 28 | streamlined process of referral between partners |
| 20 | working toward a common goal |
| 51 | no wrong door |
| 43 | communicate, communicate, communicate |
| 40 | partnerships evolve over time as client's needs change |
| 37 | shared care plans |

**FIGURE 1.** ***Six Cluster Map of Effective Integrated Service Delivery Illustrating Overall Statements and Components***




**Cluster 1**: *Holistic and Empowering Care for Mom, Baby*
**Cluster 2**: *Tailored and Continuum-Based Service Comp*
**Cluster 3a**: *Sustainability and Organizational Health*
**Cluster 3b**: *Investing in Staff*
**Cluster 4**: *Innovative and Coordinated Partnerships*
**Cluster 5**: *Cross Ministry Coordination*
**Cluster 6**: *Accessible and Coordinated Care for Clients*