

Cross-training to work better together with women in Quebec who use substances: care providers' perceptions

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What is known about this topic

- Many experts recommend service integration for pregnant women and mothers, and several strategies can contribute to getting professionals with various expertise to work together.
- Cross-training has been tested over the past few years with professionals working with pregnant women and mothers; however, little is known about co-operation among professionals working specifically in substance abuse, child protection and perinatal and early childhood services.

What this paper adds

- To our knowledge, this is the first time cross-training is carried out with specific care providers working in the fields of substance abuse, child protection and perinatal.
- Findings uphold the pertinence of addressing the impacts of substance use behaviours on foetal development and parenting skills, and encouraging women to engage and persist in treatment, whether in the area of perinatal, child protection or substance abuse services.

Abstract

Some authors have called attention to the lack of service integration related to evaluation and treatment of parental substance abuse, an ongoing challenge for service providers. A cross-training project involving exchanges (immersion sessions) among clinical teams was established to improve the integration, effectiveness and coherence of interventions for pregnant women and mothers with problematic substance use, and to prevent negative impacts of substance abuse on parenting skills and on foetal and child development. The research goal was to understand, from the perspectives of care providers, how cross-training either fosters or fails to foster changes in the practices of care providers who work with young pregnant women and mothers whose use of psychotropic drugs puts them at risk of neglecting their children. The cross-training project was carried out between 2009 and 2013. During the last phase of the project, focus group data were collected from 14 different clinical teams ($N = 121$) from the fields of substance abuse, child protection, perinatal and early childhood. The responses of each focus group yielded data for thematic analysis, performed using a mixed coding approach that included predefined and emerging themes. Points of convergence and divergence were identified by comparing what was said in different groups and types of clinical settings. At the conclusion of the project, the care providers said they knew their clinical partners better, communicated more with each other and made more referrals to those partners, and were better able to express themselves clearly about the effects of psychotropic drug use on the foetus, the child and the parenting role. In conclusion, the project helped create a culture of co-operation and partnership that has direct effects on services for pregnant women and young mothers who use substances.

Keywords: parenting, perception of care providers, service evaluation, service integration, substance abuse

Introduction

The extent of substance use among pregnant women and mothers is of concern, given the effects on foetus and child development, and on parenting skills (Ministère de la Santé et des Services Sociaux (MSSS) 2009, World Health Organization (WHO) 2014). Although there are several forms of treatment for pregnant women and mothers (Marsh *et al.* 2011, Lavergne and Morissette 2012) and service integration is increasingly encouraged for clientele with multiple problems (Desrosiers & Ménard 2010, Young 2011, Finnegan 2013), 'siloeing' continues to be very widespread. The current study follows from a project that ran from 2009 to 2013 and involved cross-training by positional rotation in parental substance abuse, that is, joint training of care providers with various expertise and staff exchanges among care dispensing services. The objective of the project was to improve service integration and effectiveness of interventions for young pregnant women and mothers who use psychotropic drugs and therefore are at risk of neglecting their children. Investigating care providers' perceptions of the project's effects will enhance understanding of how cross-training as a service integration strategy has fostered changes in their practices with this population group.

Theoretical background

Between 17.7% and 34.1% of Québec women have reported drinking alcohol while pregnant. These rates are higher than those observed in other Canadian provinces, where figures vary between 10.5% and 12.4% (MSSS, 2009). Among young women, 18% of 15- to 19-year olds and 34.4% of those aged 20–24 have reported episodes of heavy alcohol use (Statistics Canada 2007). In 2008, 67.8% of women aged 15–24 reported using cannabis and 32.2% using other types of drugs (Institut de la statistique du Québec (2010). Although the prevalence of drug use during pregnancy has not been reliably documented, this profile is worrisome, especially considering that young women's pregnancies are often characterised as being unplanned. Alcohol and drug use by pregnant women has been associated with harmful effects on pregnancy, the foetus, the child and parenting skills (Finnegan 2013, WHO 2014). Therefore, it is essential to ensure coherent, continuous and integrated service provision for this young clientele. However, there are a number of barriers to engagement and retention of women in treatment services. On the one hand, regardless of their age, women are unlikely to seek help for their psychotropic drug use

because of shame, guilt or fear of losing custody of their children (Bertrand *et al.* 2007, Center for Substance Abuse Treatment 2009, Lavergne and Morissette 2012). On the other hand, some care providers report feeling helpless when faced with families' efforts to conceal their substance use behaviours (Bertrand *et al.* 2007, Young 2011); others state that their organisations' mandates, which sometimes differ from their partners', make it more difficult to define linkage points and coordinate service provision (Bertrand *et al.* 2008, Marsh *et al.* 2011), especially with child protection services (Marsh *et al.* 2011).

In Canada, the concept of integrated care as an organisational model has been developing progressively since the 1990s (Leatt *et al.* 2000). To better respond to the needs of clients presenting with complex conditions, 'integrated strategies' have also emerged: assertive community treatment, intensive case management, case management or multidisciplinary follow-up, collaborative or shared care, stepped care, liaison officer positions and individualised service plans (ISP) (Fleury *et al.* 2012).

Over the past few years, cross-training by positional rotation has been proposed as an integration strategy. Cross-training consists of jointly coaching care providers with different and complementary expertise who are from different organisations or departments within large health institutions. Sharing expertise that springs from this type of training and collaboration forged among care providers who work with similar clientele fosters better service integration. The goal is to help care providers better respond to service users' needs through enhanced skills and collaboration with network partners. Positional rotation enables some care providers who participate in cross-training sessions to do a rotation at a partner organisation so they can more deeply integrate their knowledge and skills into daily practice. Cross-training by positional rotation has helped improve service integration and continuity as well as knowledge integration into care providers' daily practice in the fields of addiction and mental health (Perreault *et al.* 2005, Young *et al.* 2007, Bertrand *et al.* 2008).

More specifically related to parenting, Marsh *et al.* (2011) literature review indicates that integration strategies have been developed since the 1990s, but mostly by substance abuse and child protection agencies or the courts. Those strategies, which lead to better coordination of services, include inter-agency agreements, prioritised access to substance abuse treatment for parents in the child protection system, involvement of the courts in treatment enrolment of parents and collocation initiatives.

To our knowledge, no study has investigated strategies designed to improve service integration in terms of intervention and collaborative effectiveness when working with parents engaged with substance abuse, child protection and perinatal services. A cross-training by positional rotation project in parental substance abuse was carried out between 2009 and 2013 in Mauricie–Centre-du-Québec (Québec, Canada). The goal of the project was to improve service integration and intervention effectiveness for young pregnant women and mothers who use psychotropic drugs and thereby are at risk of neglecting their children. The perspectives of care providers who participated in cross-training were especially useful to enhance understanding of how this strategy has contributed –or not –to achieving this goal. The current study seeks to understand, from care providers' perspectives, how a service integration strategy such as cross-training by positional rotation fosters, or fails to foster, changes in the practices of care providers who work with this population group.

Methodology

Design

This evaluative study used a qualitative descriptive study design (Sandelowski 2000, Cooper & Endacott 2007) with focus groups conducted with care providers from the fields of substance abuse, child protection, perinatal and early childhood who were involved in the cross-training project. The cross-training by positional rotation project took place between 2009 and 2013 in the Mauricie–Centre-du-Québec (Canada) region, and was funded by Health Canada's Anti-Drug Strategy Initiatives Program. Focus groups were chosen as the data collection method because this format enables participants to express themselves more freely –inhibitions are reduced when they feel supported by their colleagues. Focus groups also give participants opportunities to recall facts when they hear others talk about their situations, and allow them to simultaneously access a large amount of information (Morgan 1996, Boutin 2007).

Project background: description of the cross-training by positional rotation project

Cross-training and supervision

The project provided four training phases over 5 days: parental substance abuse (2 days); principles of motivational interviewing (2 days); ISP involving co-operation between a young woman and at least two different organisations or teams (1 day); and during

the project, motivational interviewing supervision to refine the technique. Training and supervision were given by substance abuse and early childhood experts. In all, 681 people (care providers and administrators) registered on a voluntary basis for the various training and supervision activities. Each person came from one of the organisations involved in the project.

Positional rotation

A total of 61 care providers from the organisations involved in the project completed, on a voluntary basis, an immersion session in partner services –child protection, substance abuse or perinatal services (integrated perinatal and early childhood services). Their 10-day immersions in partner organisations and clinical exchanges on the topic of parental substance abuse allowed care providers to integrate their acquired knowledge and skills into their daily practices.

Development of awareness and information tools for clients

Two pamphlets were developed: one on the effects of substances on pregnancy, the foetus and child, another concerned pregnancy and the importance of giving birth to a healthy baby. A guide was also developed for pregnant women, their spouses and parents of young children on how to change alcohol and drug consumption. These tools were distributed to all staff members of the organisations involved in the project, including individuals who had participated in cross-training by positional rotation (immersion sessions).

Development of work and co-operation tools for teams

Several strategies were implemented to encourage organisations to enhance service integration, support changes in practice and foster collaboration with clinical teams:

- 1 A joint action plan to set up consistent and integrated preventive practices that targets 10 areas for action.
- 2 A directory for young families that promotes resources in the district.
- 3 A service trajectory to help young clients better understand the process and times when partner clinics may be called on.
- 4 A communications and co-operation protocol for participating organisations that provides pertinent information to optimise service delivery to clients.

Working committees

A working committee was formed in each territory of the Mauricie–Centre-du-Québec region (Québec,

Canada) where the project was deployed: Trois-Rivières, Drummondville, Haut-St-Maurice and Arthabaska-et-de-l'Érable. Administrators and care providers were asked to join the working committees so they could follow-up on each step of project implementation and mobilisation of stakeholders. The committees were active for the duration of the project and held three to four annual meetings.

Participants

Administrators from each organisation involved in the project invited their clinical teams (verbally or by invitational letter) to take part in focus groups as part of their administrative activities. In all, 14 teams ($N = 121$ participants) participated in the focus groups: 32 individuals from child protection services, 37 from perinatal services and 52 from substance abuse services. Participants' average age was 38.5 years ($SD = 10.9$) and they had an average of 8.5 years of experience in their respective fields. Although the teams were mostly composed of psychosocial workers ($n = 109$), there were also a few nurses ($n = 6$), nutritionists ($n = 1$) and administrators ($n = 5$).

Data collection

Focus group

Focus groups with the 14 teams were held between January and December 2012; they lasted 60–90 minutes and were recorded on digital audio tape. To obtain perspectives marked by daily practice, more homogeneous expertise and richer content, clinical teams in each focus group represented one area of expertise. As a result, the 14 teams were divided into four child protection teams, five perinatal teams and five substance abuse treatment teams. After the project was explained to them, care providers and administrators signed consent forms. The project leader then guided the discussions, using an interview guide derived from the research questions. As proposed by Krueger (1994), focus group participants were asked different types of questions ranging from the general to the specific and centred on project objectives. For instance, each team was asked what impact their participation in training or immersion sessions had on their daily practice and collaboration with other organisations.

Data analysis

To provide quick feedback and enable the working committee to adjust the contents of the tools towards

drawing up and developing an action plan, a summary of each focus group was transcribed. The answers given to each question were matched with a category (L'Ecuyer 1988). The responses from each focus group yielded data for a thematic analysis, which was performed using a mixed coding approach that included predefined and emerging themes. Points of convergence and divergence were identified by comparing what was said in the different groups and types of clinical settings (Miles & Huberman 2003).

Ethical consideration

Ethical approval was required in two organisations before proceeding with data collection: Domrémy MCQ substance abuse rehabilitation centre (CERT #2009-100) and Arthabaska-et-de-l'Érable health and social services centre (CER-CHU#10-059-ART). Care providers and administrators signed consent forms after the project had been explained to them. They were also told that participation was voluntary and they could refuse to answer any of the questions or withdraw from the project without penalty.

Findings

From the data analysis, two main categories emerge, within which themes are introduced: (i) Improved knowledge and sense of competence; (ii) Changing practices.

Outcomes: improved knowledge and sense of competence

Essentially, an analysis of the observations of participants from all groups shows that improved knowledge affected how they addressed issues with their clients, the information they gave to the latter about the impacts of using substances during pregnancy and their own practices. Many care providers stated they knew the clinical partners in their districts better. Others reported making no change in their practices; feeling confused about the mandates of their organisations relative to their own knowledge about substance abuse; or experiencing conflicts with a clinical partner.

Addressing the topic of substance use and disseminating information

Most participants stressed that training sessions, especially those on parental substance use and motivational interviewing techniques, increased their abilities to address issues of substance use more

objectively and, as a result, better inform clients about the impacts of substance use on foetal and child development and parenting. Some participants reported feeling more comfortable and better prepared to bring up the topic while others noted that mothers were more straightforward and open to discussing their substance use. One perinatal care provider explained that:

The simple fact of being more at ease, less afraid and being more open to talking about it, I think that clients are also very open, much more than I expected. They talk very openly and are very honest with us. (Perinatal care provider)

Now we know more what to do with their answers. For my part, I'm a lot less afraid of bringing up the issue and of pushing a bit more because I have solutions. I know that I can refer... it's less panic inducing. I feel safer to talk about it. (Perinatal care provider)

Most child protection and perinatal care workers who participated in motivational interviewing training sessions asserted that they had particularly enjoyed the experience. They said they felt more inclined to let the person talk about her substance use and the reasons behind it. However, some participants found it difficult to apply motivational interviewing techniques, especially when they had to reflect back or point out a contradiction to the client. Moreover, those who took part in immersion sessions at a substance abuse service where motivational interviewing is used said the training helped them better integrate that approach. The following statement illustrates the challenge that arises when integrating motivational interviewing into clinical practice:

Some substance abuse care providers really work well with it, but I still have too much trouble following the thread and it's hard to do a motivational interview that lasts more than 3 minutes. I find it difficult. (Perinatal care provider)

For their part, substance abuse care providers reported finding it easier to bring up the issue of parental substance use. Having a better understanding of how activities linked to substance use can affect parents' abilities to manage their children's daily routines and overall availability for their children. The importance of meeting children's needs led several professionals to focus on those aspects when following-up with their clients. A few providers also specifically noted being able to demystify the services offered by child protection services. That was the case for this care provider:

With cross-training by positional rotation, it's easier to sell the idea that the role of youth protection isn't just to take their children away. I can sell them the idea that we're a

team and I can say, 'Look. You've been reported for such-and-such a reason and we're going to work together because really, the role of child protection services is to do everything it can to help you with your parenting role'. So it's easier to be convincing. (Substance abuse care provider)

Despite the fact that care providers from all groups stated they felt more comfortable bringing up the topic of substance use, raising mothers' awareness of the impacts of substance use or demystifying the services offered in partner clinics, some participants admitted still feeling uncomfortable with the issue of parental substance use. This was especially true for perinatal care providers. Although it is recommended that pregnant women stop using substances, some doctors contend that low consumption does not affect the foetus. Therefore, those care providers perceived that to recommend stopping substance use, or at least cutting down as a step towards stopping, was akin to going against the doctor's recommendation.

Really, I find it difficult. I have the impression that sometimes I'm going against what the doctors advise. Because a lot of people tell me, 'My doctor said it wasn't bad, that I could have some once in a while'. (Perinatal care provider)

Among the groups consulted, some providers said they occasionally intervened with pregnant women or mothers, or in support of perinatal care providers. These individuals maintained they do not have the skills to meet the needs of those women and preferred to refer them to colleagues who are better equipped to work with this clientele. The following excerpts illustrate the concerns of those care providers:

I (nutritionist) think that a social worker has better connections with the client and is in a better position to verify substance use. (Perinatal care provider)

I feel that this is beyond my competencies. Rather, my colleague from perinatal services is the one who has the skills. I also think that they are better equipped than those of us in substance abuse to meet the needs of those young women and do prevention with them. (Substance abuse care provider)

Changing practices

According to most respondents, the knowledge and skills acquired during cross-training also affected other practices with clients. This was particularly apparent for information collection or evaluation when a service was requested, during interventions and when working in partnership. By contrast, a few providers noted that their participation in some pro-

ject activities did not change their practices or the contexts in which they worked with partners.

Information collection or evaluation

Care providers in most of the child protection and perinatal services groups in the study reported being more attentive to substance use among young parents. They asked more questions about types and quantities of substances used, and the context and reasons associated with use. Moreover, one group said it had changed information collection to better document substance use habits. The following statement exemplifies what this group said:

We did something during the prenatal and then the post-natal period, but then we noticed that finally the problem was still there. Now we're reworking our data collection with a screening and evaluation questionnaire that assesses alcohol and drug use. I think this'll help. (Perinatal care provider)

In addition, most substance abuse care providers and perinatal service providers said they were more conscious of the impacts on children (lifestyle, daily routine, meeting children's needs, ensuring children's safety, effects of substance use on breastfeeding), which helped them be more specific with information collection before filing a report.

I'd say that my interventions are more in-depth with this clientele, the focus is on the parents' roles, on neglect ... when both parents are there, I try to focus on parenting skills. (Substance abuse care provider)

Now, we're more precise with the data we send (to child protection services). He told us that he has so many beers, so many joints a day. I think that before, we would've said that he was using; now I think we'll describe the type of substance involved. (Perinatal care provider)

Intervention

Many providers working with child protection groups affirmed that the knowledge they acquired enabled them to better understand the role of substance use in those parents' lives and the complications associated with stopping substance use. Once they have a better understanding of the chronic nature of substance use, some providers admitted becoming more tolerant when dealing with this issue and believing more in possibilities for recovery. In a few rare cases, providers noted that when they anticipated a parent's relapse, because prior consent had been obtained to share information, they contacted the substance abuse care provider directly so they could implement a service.

When a parent has signed an authorisation, I can call a substance abuse care provider to ask, 'How long has it been since you've seen my client? I feel that the client is becoming more fragile. Don't wait for him to contact you. Can you contact him to find out how he is doing or to make an appointment?' I did that three or four times with the substance abuse care provider and when we talked afterwards, we were on the same page. (Child protection staff member)

As for integrating into practice the tools developed during the project, most participants claimed they were not very familiar with those tools. However, the few providers who were aware of some of the tools said they used them in various ways. For instance, the guide for changing habits – a tool sometimes included in an intervention plan – was used to encourage reflection on substance use habits and put strategies in place to change substance use behaviours. Also, the guide was occasionally used to consider the impacts of substance use on parenting and thus initiate new parenting practices. As a result, the guide was sometimes discussed during meetings.

Familiarity with partners and working in partnership

In most groups consulted, care providers drew attention to the fact that joint participation in a project activity provided an opportunity to meet their clinical partners in person. A review of the impacts of substance use on pregnant women and mothers enabled most providers who participated in project activities to update their knowledge. A few participants also reported being better informed about stages of reporting to child protection, the service's follow-up process and the importance of convincing mothers to get involved.

I learned a lot about the way care providers work with people who have substance use problems. I also better understand what distinguishes us from one another: at child protection services, we take care of the kids; at substance abuse treatment centres, they take care of the parents. So the goals aren't necessarily the same. (Child protection staff member)

Also, encouraging parents to develop a good relationship with their child protection worker, even if it isn't always easy, so they can see that the workers are there to help and that it's up to them [the parents] to act. (Substance abuse care provider)

A number of participants said they talked together and formally referred clients more often. That being said, developing an ISP seemed less necessary for some providers and a work-in-progress for others:

We're discussing more with everyone. (Child protection staff member)

It's not because I ask the substance abuse care provider to come with me that there'll instantly be an ISP, but in that particular case, for the client who was there, it was important to develop an ISP with addiction services and child protection. (Perinatal care provider)

For some groups, participating in the project enabled them to cement partnerships initiated earlier; for others, new initiatives emerged. In two groups, substance abuse staff members joined with the perinatal teams to develop home-based interventions. In another group, a substance abuse care provider started regularly attending perinatal team meetings and participating in clinical discussions about parents with substance abuse problems.

Every 2 weeks, there's a perinatal services meeting where cases are discussed and the substance abuse care provider attends. At that time, we talk about how it's going with the client and we take advantage of her expertise to ask for advice. (Perinatal care provider)

Finally, in the field of substance abuse, the project coincided with the addition of two positions dedicated to working with young parents. The project thus contributed to the implementation of new initiatives in the organisation, more specifically, support groups for mothers of young children. The staff member assigned to these activities emphasised benefiting from the group's energy when raising issues concerning the impact of substance use on a child's development.

This happens in a group when a woman joins a perinatal group with other women who've already stopped using. The group is there to talk about the impacts of substance use on their kids and their parenting skills. The experiences of other participants often have more impact than just my own intervention. (Substance abuse care provider)

No change

For some care providers from different groups, participation in the project had no effect on their current practices or on working with partners. For others, there was a certain amount of confusion between being familiar with the issue and the role of the service provider, particularly in child protection. That was especially true for this individual:

It's hard because at child protection services, we have to apply the rules. So it makes me a bit confused about my values and my way of doing things. I know I have to work on that. (Child protection staff member)

The project also highlighted challenges linked to partnerships, especially regarding joint interventions with a family being monitored by child protection and substance abuse care providers. A few teams said they appreciated working in partnership, but despite every-

one's good intentions, it is sometimes still necessary to remove a child from his or her family for the child's safety. Other clinical partners expressed anger and a level of incomprehension, as can be seen here:

Although we work together, we don't necessarily go in the direction that [clinical partners] would like us to go. We don't even seem to have the same client. For instance, sometimes we have to remove a child from a family after several warnings to parents who are slow to act. Our clinical partners sometimes find this difficult to accept. (Child protection staff member)

Discussion

This study was based on an analysis of focus groups conducted with care providers from several fields, including child protection, perinatal and addiction services. The study sought to understand, from the perspectives of care providers, how a service integration strategy such as cross-training fostered changes in the practices of care providers working with young pregnant women and mothers who use psychotropic drugs and are at risk of neglecting their children.

Essentially, the findings indicate that, from the care providers' perspectives, the cross-training by positional rotation project improved knowledge and skills, and thereby helped service providers develop coherent discourses concerning the impacts of substance use on the foetus, the child and parenting. Indeed, most groups said they were more comfortable bringing up the issue of substance use and being better informed about the services provided by clinical partners in their regions. The links created through cross-training sessions by positional rotation confirm the results obtained in other fields such as mental health (Perreault *et al.* 2005, Bertrand *et al.* 2008), and support the idea that developing a common vision of a clientele reduces barriers to access (Marsh *et al.* 2011, Young 2011, Parent Child Assistance Program (PCAP) 2013). Those findings indicate that cross-training by positional rotation has contributed to changing many care providers' perceptions of clienteles with substance abuse problems – especially as regards the latter's capacity for recovery – as well as the culture of collaboration with other organisations (Young *et al.* 2007).

Our findings are consistent with those of Lavergne and Morissette (2012) concerning the effects of the willingness and desire of care providers to work cooperatively. In addition, organisational characteristics such as a will to set up formal partnership structures or to consider other difficulties among clients, such as substance use habits, contribute to successful

partnership practices (Brousselle *et al.* 2010), and promote the safety of children and well-being of families within each organisation (Young *et al.* 2007).

Improving care providers' knowledge leads to better planned interventions and associated clinical follow-up by focusing more on a client's needs and his or her desire to reach personal objectives (Mee-Lee *et al.* 2010). Whether perinatal, child protection or substance abuse services are involved, the success of the treatment plan includes these elements: addressing the impacts of substance use behaviours on foetal development and parenting skills; and encouraging women to engage and persist in treatment. Lastly, paying attention to the clientele's needs and being proactive when communicating with a substance abuse treatment organisation to reduce risks of relapse are also linked to shifts in the culture of collaboration and in the belief that clients with substance abuse issues have the capacity to recover.

Limitations and future research

It is important to note the methodological limitations of this study. Choosing the focus group format allowed us to draw an overall portrait of different groups' practices. However, it is difficult to confirm the degree to which participating care providers integrated those practices. The focus groups were led by the project coordinator, and individuals in charge of implementing the project in their organisations were also participants in the groups. Therefore, some participants may have held back information because they did not want to offend the project leaders. Also, the project spanned a 3-year period and staff changes influenced the time each participant was exposed to various project activities, thereby influencing knowledge and skills development. Moreover, remarks made during the focus groups are those of people who participated in at least one project activity and who were in a position to share their experiences. Finally, these limitations show the complexities of implementing a project that aims to simultaneously improve the services delivered by several care providers. Special attention to organisational and territorial characteristics could subsequently shed more light on improving integration of services for young parents who use psychotropic drugs and are at risk of neglecting their children.

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Conflict of interest

The authors declare no conflicts of interest and are responsible for the content of this paper.

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