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ORIGINAL ARTICLE

Wraparound programmes for pregnant and parenting women with substance use concerns in Canada: Partnerships are essential

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Abstract

Wraparound programmes, wherein multiple services are offered at one location, are effective in engaging pregnant or parenting women experiencing substance use and other complex challenges while also addressing gaps in services between the health, child welfare and addictions fields. Evaluations of these programmes have demonstrated positive outcomes; nevertheless, few studies have focused on how programmes' cross-sectoral partnerships are structured and the difference these partnerships make. Drawing on the *Co-Creating Evidence* study, a three-year Canadian evaluation of eight multi-service programmes in six provinces, this article examines the partnerships that make wraparound service delivery possible. The study used a mixed-methods design involving interviews, questionnaires, output and de-identified client data; this article reports on qualitative findings only. Sixty service partners and 108 programme staff were interviewed in 2018 and 2019. Qualitative data analysis techniques were applied; NVivo12 software (QRS International, Melbourne, Australia) was utilised to facilitate the analyses. In terms of the programmes' partnership characteristics, overall, programmes more commonly formed partnerships with child welfare, health services (e.g. primary care, public health and perinatal care) and specialised health services such as mental health services, maternal addictions and Opioid Agonist Therapy. The programmes had fewer partnerships with housing, income assistance, Indigenous cultural programming, infant development and legal services. Key benefits of partnerships included: clients' improved access to health and social care, addressing social determinants of health; partners' increased knowledge about the significance of trauma in relation to women's substance use; improved child welfare outcomes and strengthened cultural safety and (re)connection. Key challenges included: tensions between partners regarding differing perceptions, mandates and responsibilities; personal differences and systemic barriers. Lastly, by means of steady dialogue and collaboration, partners increased their appreciation and use of the trauma-informed, harm reduction approaches that are central to wraparound programmes.

KEYWORDS
collaborative practice, FASD prevention, gender, multi-service programme delivery, programme evaluation, service partnerships, women's substance use

1 | INTRODUCTION

A recent national evaluation of programmes for pregnant and parenting women with substance use issues revealed the vital role of partnerships amongst community agencies in providing wraparound care (Rutman et al., 2021). Women's substance use is often linked to a complex mix of adverse experiences including trauma, past or current sexual, emotional or physical abuse, intimate partner violence, mental health concerns, child welfare involvement and physical health conditions; many women experience concurrent social determinants of health challenges such as poverty, poor housing or homelessness, food insecurity, racism, colonisation and little or no social and family supports (Andrews et al., 2018; Espinet et al., 2013; Finnegan, 2013; Latuskie et al., 2018; Marcellus et al., 2015; Pepler et al., 2014). In addition, women who are pregnant and parenting often experience personal, programmatic and systemic barriers that impede their seeking services, such as the fear that they will be judged by others including service providers or that they will be reported to child protection services (Finnegan, 2013; Nathoo et al., 2013; Stone, 2015).

Research has demonstrated that collaboration between systems can positively influence women's willingness to engage in health services and improve their well-being, as well as that of their children (Canfield et al., 2017; Drabble, 2011; Drabble & Poole, 2011; Poole & Urquhart, 2009; Sword et al., 2013; Urbanoski et al., 2018). For example a coordinated and collaborative approach between child welfare and addictions treatment services has been shown to decrease barriers to engagement, leads to better health outcomes for neonates and mothers and reduce the likelihood of child welfare apprehensions (Andrews et al., 2018; Drabble, 2011; Drabble & Poole, 2011; Huebner et al., 2017).

Development and management of partnerships can be both rewarding and frustrating; the idiosyncratic nature of each partnership must be addressed within its own context. Vangen and Huxham's (2010) research on the interorganisational nature of public management noted that successful partnerships are founded on the management of at least four core elements: aims, trust, culture and knowledge transfer. Alignment of aims between organisations such as the addictions, health and child welfare sectors has traditionally been difficult to achieve due to differing roles, purposes, values and legislative frameworks. In her US-based research involving child welfare workers and addictions providers, Drabble (2011) noted that inter-sectoral conflicts pertaining to differences in values, perspectives and systems, compounded by problems with communication, often impeded collaborative service delivery. Researchers have proposed the development of shared values as one strategy for overcoming these differences (Drabble, 2011; Drabble & Poole, 2011).

According to Vangen and Huxham (2010), trust, another mainstay of collaborative partnerships is also a pre-requisite in terms of risk-taking. Partnerships between programmes that place a high value on harm reduction and trauma-informed practice, as wraparound programmes do, and other agencies such as provincial child welfare organisations, require a willingness to embrace a certain degree of risk-taking. At the same time, wrapround programmes typically rely on a mix of formal and informal partnerships and cross-sectoral relationships to offer their array of services (Nathoo et al., 2013; Rutman et al., 2020). Trust informs both types of partnerships with intersectoral informal relationships between practitioners often providing the basis for overcoming perspectives on risk that can take longer to manage within the formal partnerships structure.

Sword et al.'s (2013) analysis of the partnerships of Canadian agencies offering women's addictions treatment services found that these programmes most often partnered with mental health services but had fewer connections with social services agencies, child protection and prenatal care. More recently, a multi-site evaluation of Canadian integrated treatment programmes for pregnant and parenting women documented the programmes' cross-sectoral partnerships (Milligan et al., 2017; Urbanoski et al., 2018). Child protection, mental health and other addiction-related services and child support services were common partners of these programmes. Other forms of healthcare including specialised services such as Opioid Agonist Therapy, primary care and prenatal care were far less common as partners (Urbanoski et al., 2018). While this study highlighted the value of cross-sectoral partnerships, particularly between the substance use and child protection sectors, it also acknowledged the challenges associated with overcoming differing understandings of substance use and definitions of success (Urbanoski et al., 2018).

Complementing but distinct from integrated treatment programmes, wraparound programmes—wherein multiple services are offered at one location—have been shown to be effective in engaging pregnant or parenting women experiencing substance use and other complex challenges (Andrews et al., 2018; Motz

What is known about this topic

- Multi-service programmes offering basic needs support, perinatal, primary, mental healthcare and substance use services are particularly effective for women with substance use concerns who may avoid engaging with formal health or social care.
- A coordinated, collaborative approach between health and social care sectors decreases barriers to service access and improves outcomes for mothers and infants.
- Outcomes of service partnerships include improved access to and reduced fragmentation of services and improved child welfare outcomes.

What this paper adds

- Description of how partnerships operate within wraparound programmes for women with substance use and complex concerns.
- Evidence of benefits of partnerships, both for clients of wraparound programmes and for staff and service partners of these programmes.

et al., 2019; Pepler et al., 2014; Rutman et al., 2020). These multi-service programmes do not use addiction as the entry point, but rather focus on addressing the health needs of pregnant and early parenting women who also have substance use and other complex challenges. Wraparound programmes enable clients to access a variety of services including primary and prenatal care, trauma and substance use recovery, well baby checks, housing advocacy, cultural programming, parenting groups and child welfare services. For Indigenous women, the importance of culture as part of healing and well-being underscores the value of including Indigenous cultural programming and services (Rowan et al., 2014; Sasakamoose et al., 2017).

Despite the importance of the partnerships that enable wraparound programmes to operate, there is a gap in the research literature in terms of the description and analysis of these partnerships and their impacts for clients, staff, service partners and service systems. Drawing on the *Co-Creating Evidence* study, this article aims to address this knowledge gap and chronicles the formal partnerships that make wraparound service delivery possible within programmes for pregnant and early parenting women who have substance use and complex challenges.

1.1 | Co-Creating Evidence Evaluation project

The *Co-Creating Evidence: National Evaluation of Multi-Service Programmes Reaching Women at Risk* (CCE) project was a 3-year evaluation of eight different holistic programmes located in six jurisdictions, serving women at high risk of having an infant with prenatal substance exposure.

The first of its kind in Canada, the study ran from 2017 to 2020 and was funded by the Public Health Agency of Canada. Each programme was unique in that it was developed in response to local and regional dynamics, including the community's existing services, gaps, resources and partnership opportunities. Nevertheless, all programmes addressed fragmentation of services for substance-using pregnant women or mothers, including their multiple intake experiences, poor coordination of services and multiple entry points for service access. To achieve this, the programmes provided some combination of health, wellness, cultural, social and practical supports for their clients. Figure 1 provides a thumbnail description of the services and programming of each of the eight participating programmes, as well as their geographical location.

A primary eligibility criterion for inclusion in seven of the eight programmes in the CCE study was the woman's problematic substance use; the eighth programme, located in a region with very few services, focuses on pregnant/parenting women who were at risk by virtue of being young (age 16–24) and possibly socially isolated. Four programmes have a high percentage of clients who identify as Indigenous and thus also prioritise Indigenous cultural programming. Four out of the eight programmes are operated by a health authority and four are operated by a community-based agency (i.e. non-profit organisation). Regardless of how they were organised, all programmes employ a multi-service approach intended to help remove barriers to accessing specialised health and social care by providing services and supports identified in the literature as meeting women's holistic needs.

Previous articles on the CCE project have focused on the study's interim findings (Rutman & Hubberstey, 2019), clients' perspectives on why they sought help as well as their most significant changes (Hubberstey et al., 2019), programme structure and clients' perspectives on the programmes' approaches (Rutman et al., 2020), and on wraparound from an Indigenous perspective (Van Bibber et al., submitted for publication). This article focusses on partnerships as an essential component of service delivery and addresses the questions:

- What are the characteristics of partnerships in wraparound programmes;
- What are the benefits of partnerships and,
- What are the challenges associated with partnerships?

2 | METHODS

2.1 | Study design

The Co-Creating Evidence study was guided by principles of collaboration (Berghold & Thomas, 2012), including fostering meaningful partnerships and relationships with programme staff and stakeholders, promoting participatory processes, developing a shared understanding of the programmes and evaluative thinking (Cousins et al., 2015; Shulha et al., 2016). In line with these principles, at the outset of the project, the project team convened an introductory day-long in-person meeting with the eight programme leaders in order to collaboratively identify a theory of change and to articulate the theoretical/philosophical foundations, approaches, key activities and anticipated outcomes of the programmes collectively. Bi-monthly virtual meetings were held with programme sites to discuss key issues related to data collection and analysis and to solicit feedback regarding project findings and knowledge translation. A national Advisory Committee, created at the beginning of the project, met two to three times a year to provide guidance and feedback on key facets of the project. The project was approved by an ethics review committee.

The study used a mixed-methods design involving semi-structured interviews (individual and small group), questionnaires, output/programme data and client intake/outcome 'snapshot' data. Data were gathered in two ways: (a) by the project team, via face-to-face, semi-structured individual interviews and questionnaires with clients and interviews (individual and small group) with staff and service partners in spring 2018 and fall 2019; and (b) by the programme sites, who collected quantitative output data and client-based data from April 2018 through to September 2019.

RAISING HOPE • Regina, Saskatchewan • Opened in 2013; the only fully residential program in the CCE study.
Funded by the Ministry of Social Services, Sask. Health Authority and the Department of Justice, Canada; operated by SWAP, a community-based agency with an Indigenous housing organization as a partner.

Core services/ programming
- Supported housing (18-unit apt building)
- Mental health/trauma counselling
- Cultural programming
- Food/nutrition & basic needs support
- Child care
- Drop-in /peer connections

In-kind services on-site
Primary health: Primary care physician
Health and wellness: Addictions counsellor; wellness therapist
Child welfare: SK government child welfare social worker
Parenting: Regina Early Learning Centre – Triple P Parenting

Contracted services
Health & wellness: Psychologist; art therapist; life skills & healing

Co-located services
n/a

MOTHERING PROJECT • Winnipeg, Manitoba • Opened in 2013, program of Mt Carmel Clinic.
Funded by Healthy Child Manitoba and Winnipeg Regional Health Authority.

Core services/ programming
- Outreach; transportation and accompaniment; Drop-in groups
- Substance use counselling
- Life skills & mental health/trauma groups
- One to one support in variety of life areas
- Cultural programming
- Food/nutrition & basic needs support

In-kind services on-site
Primary health: Nurse; public health nurse
Health & wellness: Trauma counsellor; speech therapist
Childcare: Family Worker – Daycare Inclusion Specialist
Parenting: Parent Student Support Program; Families First

Contracted services
n/a

Co-located services: Mt Carmel Clinic
Primary health: Primary care physician, nurse practitioner, public health nurse, midwifery

BREAKING THE CYCLE • Toronto, Ontario • Opened in 1995, operated by Mothercraft (non-profit society)
and funded by the Public Health Agency of Canada and the Ontario Ministry of Child, Family and Community Services.

Core services/ programming
- Pregnancy outreach support
- Substance use counselling; relapse prevention groups
- Life skills & mental health/trauma groups
- Food/nutrition & basic needs support
- Child care
- Parenting/support groups
- In-home visits weekly re: parenting
- Early intervention services for children

In-kind services on-site
Primary health: Public health nurse
Health & wellness: Addictions worker
Children's health: Developmental pediatrician (& FASD assessment); speech language services; infant development
Child welfare: ON government child welfare social worker participates in bi-weekly team meetings
Correctional services: Probation officer

Contracted services
Health & wellness: Psychological associate; clinical child psychologist

Co-located services
n/a

BABY BASICS • New Glasgow, Nova Scotia • Opened in 1999; program of Kids First,
a community agency and funded primarily by Public Health Agency of Canada's CPNP and CAP-C programs.

Core services/ programming
- Drop-in prenatal/postnatal groups and peer connection
- Food/nutrition & basic needs support; transportation support to access program
- Child care
- In-home support when needed

In-kind services on-site
Primary health: Public health nurse
Health & wellness: Trauma-Informed Parenting Support program; groups re: intimate partner violence and healthy relationships

Contracted services
n/a

Co-located services
n/a

HERWAY HOME • Victoria, British Columbia • Opened in 2013 after 5 years of planning.
Funded and operated by Island Health, with additional funding from Children's Health Foundation of Vancouver Island.

Core services/ programming
- Outreach
- Drop-in/wellness groups
- Substance use and trauma support groups & counselling
- One to one support in variety of life areas
- Prenatal/postnatal group
- Food/nutrition & basic needs support

In-kind services on-site
Primary health: Primary care physician; physicians specializing in addictions & maternity care; public health nurse (PHN); nurse practitioner
Health & wellness: Community nutritionist; dental hygienist
Children's health: PHN, immunizations, well baby checks

Contracted services
Housing: Rent supplements; 4 care home beds for women age 16-24

Co-located services
n/a

SHEWAY • Vancouver, British Columbia • Opened in 1993 – 1st program of its kind in Canada.
Funded and operated by Vancouver Coastal Health, with additional resources from BC Ministry for Children and Family Development, Vancouver Native Health Society, BC Ministry for Social Development and Poverty Reduction & YWCA.

Core services/ programming
- Outreach; Drop-in, parenting skills groups
- Substance use groups & counselling
- One to one support in variety of life areas
- Primary health: Primary care physicians; addictions & maternity care physician; nurses; psychiatrist
- Child welfare: BC government child welfare social worker
- Cultural programming
- Food/nutrition & basic needs support

In-kind services on-site
Health & wellness: Dental hygienist; occupational therapist; physiotherapist
Income support: Community Intervention Specialist
Children's health: Paediatrician; speech & language therapist

Contracted services
Health & wellness: Music therapist
Legal: Lawyer

Co-located services
Housing: YWCA supportive housing
Daycare: YWCA day care

MAXXINE WRIGHT • Surrey, British Columbia • Opened in 2005 after extensive community planning.
Funded and operated by Fraser Health, with additional in-kind support from the BC Ministry for Children and Family Development and the BC Ministry of Social Development and Poverty Reduction.

Core services/ programming
- Primary health: Public health nurse; nurse practitioner; prescriptions; opioid agonist therapy
- Substance use counselling
- Prenatal/postnatal services
- Children's health: Immunizations, baby weight, well baby checks

In-kind services on-site
Primary health: Physician specializing in obstetrics; maternal-fetal medicine
Health & wellness: Psychiatrist/ reproductive psychiatry
Income support: BC government income assistance worker
Children's health: Paediatrician; infant development worker
Child welfare: BC government child welfare social worker

Contracted services
Health & wellness: Doulas; Midwives

Co-located services: Atira Women's Resource Society
Food support; parenting: drop-in groups; daily meal
Prenatal/postnatal: Pregnancy outreach worker
Housing: Supportive housing
Daycare: Atira Daycare
Cultural: Elder services

H.E.R. Pregnancy Program • Edmonton, Alberta • Opened in 2011.
Funded primarily by Alberta Health and operated by Streetworks, a non-profit community-based organization.

Core services/ programming
- Outreach; weekly drop-in group
- One to one support in variety of life areas
- Prenatal/postnatal: on-site STI and pregnancy testing
- Child welfare support
- Food/nutrition & basic needs support; transportation and accompaniment

In-kind services on-site
n/a

Co-located services: Boyle Street Community Services
Health & wellness: Wellness
Children's health: 'Health for 2'
Child welfare: AB government child welfare social worker
Cultural: Elder services

FIGURE 1 Capsule description of programmes in the study

2.2 | Data collection processes and instruments

This article presents data from qualitative interviews only, all of which were undertaken with programme managers, staff and service partners during the site visits in 2018 and 2019, as well as documents provided by the programmes (e.g. detailed programme descriptions). Interviews with programme partners focused on partners' perspectives on the partnership and any practice-related and organisational impacts of the partnership. The interview topics included: describing the nature of the relationship with the programme and the duration of the relationship; whether the partnership was formal or less formal; partners' perspectives on the strengths and challenges of the partnership and partners' perspectives on the outcomes and impacts of the programs for clients, service partners and service systems. Interviews with programme staff included topics relating to the programme's goals, foundational principles and approaches, operational issues (e.g. staffing, training, supervision, funding), partnerships and the programme's impacts on clients, families and community partners.

2.3 | Participants

Sixty service partners took part in individual or small group interviews. Each of the eight Programme Leads identified key service partners to invite to be interviewed for the study; thus, the sample was created through a nominated sampling approach. Table 1 provides information regarding service partners' professions and organisational affiliation. Prior to commencing an in-person interview, all informants provided written informed consent; all informants interviewed by phone provided verbal informed consent.

Additionally, a total of 108 interviews were conducted with staff of the eight programmes. Programme staff who participated in an interview came from diverse professional backgrounds (see Table 2). All programme staff participating in an interview provided written informed consent prior to commencing the interview.

2.4 | Data analysis

For the interviews with programme staff and service partners, qualitative data analysis techniques were applied; NVivo12 software (QRS International, Melbourne, Australia) was utilised to facilitate the analyses. (see Hubberstey et al., 2019; Rutman & Hubberstey, 2019 for additional information about the study's data analysis techniques). Each researcher coded the transcripts separately and identified preliminary themes inductively, highlighting naturally occurring patterns in the data, including words, phrases or ideas most commonly voiced by participants. This work formed the basis of the thematic analysis (Braun & Clarke, 2006; Thorne, 2000). To strengthen the study's rigour, the project team engaged in multiple discussions during which they reviewed one another's emerging reflections and ideas about the thematic analysis. Any differences in the researchers' interpretations were resolved through discussion and review of the supportive textual evidence for each theme. There was no difference in the nature of themes emerging from individual interviews in comparison with themes emerging from the small group interviews.

3 | FINDINGS

The findings presented in this article are organised into two subsections: partnership characteristics and partnership benefits.

3.1 | Partnership characteristics

As depicted in Figure 2, all the programmes participating in the Co-Creating Evidence study relied on formal and informal partner relationships; their core services and programming were delivered through a combination of programme staff, in-kind services onsite and contract or co-located services. Formal partnerships denoted through written agreements helped define roles, established limits of confidentiality, facilitated information sharing and communication. These partnerships typically encompassed: participation in case meetings (e.g. at Breaking the Cycle); information sharing agreements (e.g. at Breaking the Cycle); secondment of staff to work on-site (e.g. at Sheway and Maxxine Wright) and access to resources (e.g. at HerWay Home and Sheway). Informal relationships or collaborative arrangements between programmes and community services were typically arranged between senior staff and thus relied on mutual goals, shared clientele, common values and approaches, and a sense of trust and common purpose. Programmes that were part of the same overall care system—that is part of a health authority—tended to rely on their relationships with the various facets of the healthcare system for access to a range of services, without necessarily having formal agreements in place. Common partnership activities included: sharing staff, mutual referrals, exchanging client information, attending case conferences or joint case planning meetings, sitting on community advisory committees and attending or offering training.

In addition, some of the programmes were founded on the basis of strategic formal partnerships between health authorities and other government and community-based organisations. For example the Maxxine Wright programme involved a partnership between a health authority and a large non-profit agency known for its housing and support services for women and their families. The Raising Hope programme involved a partnership between a non-profit organisation serving street workers and an Indigenous housing agency. These partnerships encompassed agreements regarding shared staff, programme operations, funding and information exchange. Co-location of services was another characteristic of some of the programmes, which ensured access to an array of complementary services such as supportive housing and childcare

TABLE 1 Service partner informants' profession, sector and organisational affiliation

Service partner sector/profession	Organisational affiliation	Total
Child welfare, e.g.: a. Child welfare social worker b. Child welfare services supervisor or manager c. Maternity/hospital/NICU social worker	Government Government//CAS Hospital/Health Authority	15
Health, e.g.: a. Physician: Maternal addictions physician b. Nurse practitioner c. Public health nurse or manager d. Perinatal nurse, outreach or programme coordinator	Health Authority/hospital NGO; Health Authority Government/Health Authority NGO; Health Authority	15
Mental health, e.g.: a. Clinical psychologist b. Psychologist/mental health manager c. Counsellor d. Art therapist; music therapist	Private Government Health Authority; private Private	6
Substance use, e.g.: a. Alcohol & Drug or Intake Counsellor	NGO; Health Authority	3
Housing, e.g.: Supportive housing staff/manager a. Supported housing worker or manager b. Outreach coordinator, transition house	NGO NGO	5
Cultural, e.g.: Indigenous Elder, Indigenous agency a. Elder or knowledge keepers, boyle street b. Aboriginal family development worker c. Aboriginal health services manager	NGO; Health Authority NGO Health Authority	7
Food/nutrition, e.g.: a. Public health nutritionist	Government	1
Children's health, e.g.: Infant mental health a. Infant mental health consultant	Private	1
Parenting, e.g.: a. Family support programme worker or coordinator b. Parent/student support programme Coordinator=	NGO NGO	3
Basic needs, e.g.: a. Income assistance worker	Government	2
Other: Researcher	University	1
Other: Programme funder/government policy maker	Government	1
Total		60

(e.g. Sheway, Maxxine Wright and Mothering Project) and health, wellness and Indigenous cultural supports (H.E.R. and Mothering Project). Furthermore, programmes serving a high percentage of Indigenous clients tended to form partnerships with organisations that offered Indigenous cultural programming (on-site) and/or that facilitated linkages to traditional knowledge and practices in the community.

Overall, the programmes more commonly formed partnerships with: child welfare services; health services (e.g. primary care, public health, prenatal and postnatal services); specialised health services such as addictions and mental health services, maternal addictions and Opioid Agonist Therapy. The programmes less frequently had partnerships with: housing; income assistance services; probation; Indigenous health services; detox; infant development/child health services and legal services. One programme also had an ongoing partnership with local universities, which enabled it to pursue an active research agenda.

3.2 | Partnership benefits—Perspectives of programme staff and partners

All programme staff and service partners interviewed spoke about the positive impacts of their partnerships. Their perspectives are described below.

3.2.1 | Partnerships help improve access to services, health equity and address social determinants of health challenges

A number of service providers observed that the partnership with their programme helped clients address social determinants of health challenges that might otherwise impede clients' ability to engage with important services. For example at one programme, partnership with Correctional Services enabled clients to see their Probation Officer

TABLE 2 Programme staff interview informants, by position/profession

Programme staff position/profession	Total
Leadership & admin, e.g.: a. Programme Director/Manager/Coordinator, Clinical Supervisor, Agency Executive Director, Medical Office Assistant	32
Health: Physician a. Primary care physician b. Psychiatrist	6
Health: Nurse a. Nurse b. Public health nurse	10
Health: Nurse practitioner a. Nurse practitioner	3
Health: Midwife a. Midwife	2
Mental health, e.g.: a. Counsellor b. Clinical psychologist	5
Dental health a. Dental hygienist	1
Substance use a. Alcohol & drug counsellor	1
Case manager a. Case Manager/counsellor	5
Outreach, e.g.: a. Outreach worker b. Pregnancy outreach programme Worker	11
Child welfare a. Child welfare social worker	5
Housing: Residential support a. Residential support/home care worker	4
Food/nutrition a. Dietician	2
Children's health/development a. Infant development programme worker b. Parent–infant therapists c. Child development worker	8
Child care a. Childcare worker	5
Culture a. Cultural Liaison	1
Parenting: Family support a. Family support worker b. Aboriginal family support	2
Peer support a. Peer support worker	1
Other—Time-Limited Project a. Project Coordinator	1
Other—Research a. Graduate student researchers	2
Total	108

on-site at the programme in a space that felt safe for themselves and their child(ren), thereby reducing the potential for clients to incur additional legal system charges. In this partner's words:

> Women's biggest convictions are due to Failure to Comply or Failure to Attend; by having the probation officer come to [the programme], women are able to complete their probation without incurring additional charges. Also, women are being met in the community where they and their children feel safe. (07-S1)

Similarly, a service partner at another programme spoke of the benefits of partnership as a means to enable clients to access quality childcare while they participated in a trauma-informed parenting group, offered on-site at the wraparound programme by the service partner, for people who were survivors of violence or trauma:

> [The programme] was a natural partnership for two reasons: they provide quality childcare and they provide a safe cover for women. It is not so obvious to anyone if a woman is going to a group there - she won't encounter as many questions – but that would be different if she were going to something at the Transition House. (08-P1)

As a related point, programme staff and service partners noted that an important benefit of partnerships was that they eased the referral process between the programme and other facets of the care system. As a result, clients were more likely to receive the services they required and experienced reduced service fragmentation. One partner commented:

> We share our expertise across disciplines. I can hook the women up with the right person on the team, such as the A&D counsellor, and I can do it a lot more easily than if that person were located somewhere else. (06-P1)

3.2.2 | Partnerships increase partners' understanding of clients' experiences, challenges and needs

Several partners observed that collaboration with the programme had improved their understanding of clients' lived experiences of poverty and other social determinants of health factors. Speaking about the impacts of the partnership, one hospital-based social worker stated:

> It's heightened my awareness of what may be going on for families who I see at [the] hospital, who are involved with the Ministry of Children and Family Development and/or whose parents live in poverty - all the issues that families deal with. (02-P1)

At two of the programmes, income assistance staff were on-site weekly so that they could meet with clients to address their

Operated by	Health Authority				Community-based agency			
Program	HWH	SW	MW	MP	HER	RH	BTC	BB
Focus on at-risk pregnant and early parenting women	✓	✓	✓	✓	✓	✓	✓	×
Services Provided								
Food, nutrition	★	★	⊙	★	★	★	★	★
Basic needs, including transportation	★	★	★	★	★	★	★	★
Housing	♦	♦⊙	⊙	♦	♦	★	♦	♦
Child welfare support	★	⊙	⊙	★	★	⊙	♦	
Substance use – individual or group	★	★	★⊙	★	★⊙	⊙	★	♦
Mental health/violence and trauma support	★	★	♦★	★	♦★	★	★	★⊙
Primary care	★	★	★	⊙	♦	♦★	♦	♦
Prenatal/post-natal	★	★	★	★	♦★	♦⊙	♦	♦★
Child health	★	★	★	★	♦	★	★	♦
Child assessment/early intervention	♦⊙	★⊙	⊙	★	♦	♦★	★	♦
Childcare on site	★	★	⊙	★		★	★	★
Parenting programming	♦★	★	★⊙	★	♦	⊙	★	★
Cultural programming	♦	★	⊙	★	⊙	★	♦	
Drop-in/peer connections	★	★	★⊙	★	★	★	★	★

× Young pregnant/parenting women aged 16-24 years of age
★ Services provided on site by staff/program
♦ Services accessed in community via formal or informal partnership
⊙ Services provided on site through a combination of in-kind contribution by the program funder or partner, paid contract and/or as a co-located service

FIGURE 2 Services and activities offered on site

income-related needs. This was a departure from the caseless model used by the provincial ministry in charge of income assistance and allowed their staff to more fully understand clients' circumstances:

> In this job we don't have caseloads anymore, so we don't get to know anyone. I think that being able to sit with people one-to-one is so important. I'm better able to make assessments when I'm one-to-one with women at the programme. I think that our experience going to the programme has affected the work we do and is a positive shift for everyone. (02-P2)

3.2.3 | Partnerships increase partners' understanding of the impacts of trauma and the interconnected issues related to women's substance use

Many service partners spoke about gaining knowledge about trauma and its relationship to women's substance use. For example one manager of child welfare services noted that, as a result of the partnership and close working relationship with the programme, her social workers had enhanced their understanding of addictions, including factors that can lead to relapse:

> [Programme staff's] expertise in understanding substance use, relapsing, "triggers" is helpful; they do a really good job in helping our social workers understand triggers. (07-P1)

Moreover, as this informant commented, as a result of their collaborative working relationship with the programme, social workers gained an understanding of all clients' risk factors.

> In child welfare, there's an expectation that we know a lot about risk factors, for example mental health, intimate partner violence, etc., but sometimes workers feel lost. [The programme] helps them understand these factors. (07-P1)

Similarly, public health nurses working with one programme commented that they had learned more about addictions and trauma, and importantly, about the impact of trauma on people's lives:

> I've seen them be stronger Public Health Nurses. Their whole scope of practice has increased; they have learned about complex trauma and its impact on women's lives. (07-P2)

3.2.4 | Partnerships promote shifts in service providers' attitudes and increased use of best practice approaches

Partners also noted that as a result of learning more about the impacts of trauma and the context to women's substance use, they and other colleagues had shifted their attitudes towards clients and adopted a less judgemental approach:

> We go to the [programme] staff and ask, "Help me understand what the woman's experience is." Staff bring back a broader perspective and understanding around trauma. Our workers are less blaming; they are recognizing that what we are seeing is a result of trauma rather than intentional non-compliance. There's greater understanding of trauma and its impact on parenting. (07-P3)

Furthermore, as a result of observing programme staff's use of non-judgemental and culturally informed approaches, service partners had made shifts in their practice in keeping with a more compassionate and trauma-informed approach.

> We talk a lot about this in the Food Mentor training: how to make this approach non-judgemental and kind when working with clients. (08-P2)

One child welfare service partner noted that these shifts had happened at both the individual and the organisational level:

> We are looking toward putting in place a structure within the organization so that we can be more trauma-informed. (07-P4)

3.2.5 | Partnerships help improve mother–child connection and child welfare outcomes

Some of the programmes in the study developed relationships with provincial child welfare authorities and co-located a government social worker on-site as part of the programme's integrated service delivery model. This approach supported clients to develop positive relationships with child welfare workers, which in turn resulted in improved mother–child connections and reduced likelihood of the infant being removed from the woman's care at birth.

> I help build a connection between the provincial child welfare ministry and the moms. If a woman voluntarily asks for child service involvement, I will then know what she needs to do before having the baby. Usually that is to find housing, go to addictions counsellor, take parenting course, and deal with mental health if that is an issue. Then when the baby is born, the ministry social worker can tell what has occurred and the conversation/decision about the baby is easier. (02-P4)

3.2.6 | Partnerships support Indigenous cultural connections

Programme staff and partners spoke of the value of partnerships with community-based Indigenous organisations; this was particularly the case for programmes that prioritised providing Indigenous cultural programming and/or culturally grounded services yet were not able to offer these services via their own core staff or integrated/in-kind staffing. These partnerships were also a source of training and information for programme staff.

> We are in the process of solidifying a formal partnership with Native Child and Family Services. They will be doing training with us on Indigenous approaches/cultural safety and also informing us about programmes and resources in the community. (07-S2)

> We work hard to embed traditional foundational training on cultural safety by bringing Elders in once a week and having an Indigenous staff mentor who has been there a long time. (02-P5)

3.2.7 | Partnerships facilitate cross-sectoral understanding of programmes' and partners' services, roles and clients

The sharing of programme information enabled programme staff and service partners to become more familiar with each other's services and roles, and importantly, to develop trusting relationships.

> We have an excellent working relationship with them. [Programme staff], the provincial child welfare ministry, [the health authority]and Best Babies get together every two months to talk about their programmes. This has become a tight connection between us all. (01-P1)

Along these lines, one programme included the regional child protection agency in its regularly scheduled bi-weekly clinical team meetings, a practice that was highly regarded as a way of enhancing problem solving and communication on behalf of clients.

> We trust that when we refer our clients to [the programme], that they are going to be served very well. (07-P5)

Cross-sectoral partnering can also present challenges and tensions, most often between the programmes and child welfare authorities. Differences in philosophy as well as institutional barriers underscored these tensions.

> Where the team runs into trouble though is when they have to work with a different (child welfare) office in another part of the city. We did a lot of work regarding the harm reduction approach. Some social workers are still more punitive and haven't really made the change. (04 S1)

> The challenge at a systems level is that there is so much turnover in social workers in child protection. Maybe half of the workers in the office know about our programme. (05-S3)

Differences in attitude were another source of tension, requiring constant attention and communication to ensure that the opportunities to work through differences are available.

> We are all supporting the same women, so ideally, we should be working together and not in opposition. But there has been some opposition at times, which is reflective of our different styles. We are medical people with our own standards, and they are more grassroots. The longer we work together, the better it does get and the more we trust each other. (04-P1)

Nevertheless, through their ongoing commitments to working together, trusting relationships were developed that enabled programmes and partners to negotiate their differences.

> Sometimes the differences in the two agencies – our partner and the health authority – can create barriers. But fortunately, we have a relationship with each other and have put in enough time that we are willing to work through the sticky points. We have regular Collaborative Practice meetings that involve the three partners every 2-3 months. (03-P1)

> We all have different tolerance levels about risk, but we have strong communication and relationships and because they are so willing to work with us, we have developed a trust in each other that allows us to get through sticky points/issues. (07-S2)

Ultimately, all programmes and their partners agreed that partnerships reinforced a multidisciplinary perspective and provided opportunities for strategic knowledge exchange.

> The biggest strength is to have a close working relationship with the shared goal to support marginalized women with their pregnancy. We are on the same page and aligned on wanting positive outcomes for women, women supported and healthy. (04-P1)

> We increasingly recognizing that more heads are better around the table, and that having everyone there is a better benefit to women and their families. Working with [the programme] reinforces the importance of collaboration and our understanding that all disciplines have something to contribute. (03-P2)

3.2.8 | Partnership demonstrates for clients the value of working together

Finally, in some instances, the visibility of the partnership between programme staff and partners helped demonstrate for clients the value of positive relationships.

> We are sitting in on each other's programmes/groups. This is a way to learn new skills, hear what each other has to say, and to demonstrate positive working relationships for our clients. (03-P2)

4 | DISCUSSION

Numerous studies have demonstrated the importance of a collaborative, multidisciplinary approach when working with pregnant and

parenting women with substance use issues (Andrews et al., 2018; Drabble & Poole, 2011; Gopman, 2014; Meixner et al., 2016; Motz et al., 2019; Women's Services Strategy Group, n.d). Extending this body of literature, the Co-Creating Evidence study explored the benefits of inter-sectoral collaboration and partnerships within the context of eight different Canadian wraparound programmes serving pregnant and parenting women with complex concerns including substance use. The findings from the Co-Creating Evidence study affirmed this partnership approach as best practice in engaging pregnant and parenting women with substance use issues, mobilising the full range of social and health supports they require and overcoming systematic barriers and service gaps. This study also has contributed to the literature by producing additional knowledge about the impacts of partnerships, not only for clients and their families, but for multidisciplinary service providers and service systems in which they work.

Previous studies identified factors that help facilitate and support partnerships, for example community level working groups, formal agreements, regular communication, shared understanding of roles and responsibilities and co-location (Urbanoski et al., 2018). In the current study, all programmes engaged in some or all of these activities. Moreover, the programmes participating in the Co-Creating Evidence study were both creative and flexible when developing partnerships, seeking opportunities in areas in which they did not have the resources or expertise as well as with services with whom they had a common cause, for example mutual clients, a shared desire to 'wrap support' around women and their families in order to meet their evolving needs, and aligned approaches (harm reduction, trauma-informed practice). This flexibility allowed the programmes to tailor their partnerships to take advantage of community or regional resources and their respective goals. Two programmes provided their clients with vouchers for local farm markets as a result of local community partnerships. Not only did this mean that women and their families were supported nutritionally, but it also facilitated clients' connection with community in ways that were non-stigmatising (Rutman et al., 2020). Furthermore, at one programme, a partnership with probation services meant that women received proactive assistance with their criminal justice files so that this did not become one more barrier or reason not to seek help.

Indigenous perspectives on wellness closely align with wraparound programmes including that culture is viewed as healing (Henry et al., 2019; Rowan et al., 2014; Van Bibber et al., submitted for publication). As such, fostering connections and partnerships with Indigenous agencies and services was also very important for several programmes; those that had a significant Indigenous clientele sought partnerships that fostered access to traditional knowledge for clients and their children and training opportunities and self-care supports for programme staff.

Importantly, the partnerships between programmes and key services/sectors meant that fragmentation between services was reduced and women experienced improved access to the range of health and social determinants services and supports they and their families required. Given that women's reasons for seeking help are typically multi-faceted (Hubberstey et al., 2019) and that a relationship-based approach is often central to their decisions regarding continued attendance (Motz et al., 2020), it is important that they can access services within a setting that they trust, or if they have to go elsewhere, that those services are delivered in a manner consistent with the programmes' overall values of being respectful, non-judgemental and trauma-informed. Partnerships are key to facilitating women's access to services and to educating partners about best practices.

In relation to child welfare outcomes—one of the strongest reasons for women seeking help—actively partnering with child protection services meant that everyone could work collaboratively in breaking down communication barriers, addressing child protection concerns and misunderstandings, and improving mother–child connections. Over time, there was a noticeable increase in the number of infants who were in their mother's care (Rutman et al., 2021).

Furthermore, by means of steady dialogue, collaboration and communication about clients, roles, responsibilities and services, partners and staff became more trusting of each other. Cross-sectoral co-location of staff at the wraparound programme appeared to help overcome some of the challenges associated with working across institutions and to enable partners to develop deeper understandings of clients' experiences and complex challenges. As a result, they gained appreciation for the connections between trauma and substance use and reported being more willing to embrace the trauma-informed, harm reduction and non-judgemental approaches that are central to wrapround programmes.

Finally, although the Co-Creating Evidence study did not employ a framework for analysis of partnerships, such as that proposed by Vangen and Huxham (2010), the findings are consistent with their research, demonstrating the benefits that arise from partnerships when there is: a balance of formal and informal roles between partners; a commitment to constant communication and problem-solving; inclusion of diverse perspectives; and, a desire to build trust. Knowledge transfer as an outcome of the partnerships also emerged as a theme, particularly in relation to partners' increased awareness and understanding of the value of the programmes' theoretical values and approaches and their realisation of clients' strengths and potential as parents.

4.1 | Study limitations

All eight programmes volunteered to participate in this study. The on-site interviews with programme staff involved all programme managers and aimed to involve all other key staff; however, it was not always possible to involve all staff given that the site visits were 3 days in duration. In terms of the interviews with service partners, the study employed a nominated sampling approach: Programme managers and staff were asked to identify their (primary) service partners, and the project team followed up with invitations to participate in the study. For both staff and service partners, we employed a volunteer sampling

approach. We recognise that this approach could have resulted in bias of some sort. Nevertheless, as this article focuses on describing the structure and impacts of the programmes' partnerships, we have no reason to believe that staff or partners holding less positive perspectives were disinclined to participate in the study. Moreover, the guided conversational approach to interviewing facilitated participants to share their diverse experiences and perspectives.

5 | CONCLUSIONS

Through a mixture of programme staff, co-location with other services, shared services and staff and relationships with service partners, the programmes involved in the Co-Creating Evidence study are helping to reduce fragmentation between the health, child welfare and addictions fields. As well, some programmes sought partnerships to support clients' connections with Indigenous cultural practices. Numerous benefits to the partnership approach were noted by partners and programme staff including an expanded understanding of the impacts of trauma and its connection with substance use and greater understanding of each other's services, roles and clients. Ultimately, partners' greater appreciation for clients' experiences and support needs has resulted in benefits for clients, most notably improvements in mother-child connections and child welfare outcomes and access to prenatal/postnatal healthcare.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

AUTHORS' CONTRIBUTIONS

All authors designed the study and were involved in its funding acquisition. CH, DR, NP and MVB were the Project Leads; CH, DR and MVB conducted the data collection and performed the qualitative analyses. CH wrote the first draft of the manuscript; DR reviewed, edited and contributed to subsequent drafts. All authors have approved the final manuscript.

ETHICS APPROVAL

The study received ethics approval from the University of British Columbia Office of Research Ethics (H17-02168), Vancouver Costal Health Authority, Island Health Authority, Fraser Health Authority, and York University.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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