

From Policy to Practice: Implementation of Treatment for Substance Misuse in Québec Primary Healthcare Clinics

De la politique à la pratique : coup d'œil sur la mise en œuvre d'un programme de première ligne pour la prévention des problèmes de dépendance au Québec



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Abstract

Background and Objectives: In 2007, the Québec Ministry of Health issued a policy document that specifically mandated the development of addiction treatment services including screening, brief interventions and referral (SBIR) to be delivered by primary healthcare clinics throughout Québec. The current study examined the level of implementation of SBIR one year following the end of the mandate (2007–2012).

Approach: Semi-structured interviews were conducted with 45 participants from 21 primary health and social service centres throughout the province. Qualitative analysis was used to evaluate the level of success each centre had in implementing SBIR and to identify organizational measures that contributed to successful implementation.

Results: The results show that Québec primary health and social service centres had limited success in their efforts to integrate SBIR into their services. A comparative analysis of the centres, categorized according to their level of implementation, revealed the presence of significant organizational- and staff-level factors, including the creation of formal action plans that were conducive to the successful implementation of SBIR in primary care.

Conclusion: The findings highlight the importance of offering support and guidance, as well as a menu of specific practices that are likely to assist primary health and social services centres to implement SBIR. At the organizational level, the adoption of local action plans and formal service trajectories offers a framework that allows for horizontal and vertical integration of new practices.

Résumé

Contexte et objectifs : En 2007, le ministère québécois de la Santé publiait un document d'orientation qui confiait aux Centres de santé et de services sociaux de toute la province le mandat d'organiser l'offre de services pour le traitement des problèmes de dépendance – notamment le dépistage, l'intervention rapide et l'orientation (DIRO) – dans les cliniques de soins primaires du Québec. La présente étude avait comme objectif d'examiner le degré de mise en œuvre du DIRO un an après la fin du mandat (2007–2012).

Démarche : Des entrevues semi-structurées ont été menées auprès de 45 participants provenant de 21 centres de services de santé et communautaires dans la province. L'analyse qualitative a été employée pour mesurer le degré de succès de la mise en œuvre du DIRO dans chacun des centres et pour repérer les mesures organisationnelles qui y ont contribué.

Résultats : Les résultats font état d'un succès limité quant à l'intégration du DIRO dans les services offerts par les Centres de santé et de services sociaux au Québec. Une analyse comparée entre les divers centres, catégorisés selon leur degré de mise en œuvre, a révélé la présence d'importants facteurs aux niveaux de l'effectif et de l'organisation, notamment la création de plans d'action officiels qui ont été propices à la mise en œuvre du DIRO dans les soins de santé primaires.

Conclusion : Les résultats soulignent l'importance d'offrir du soutien et une orientation, de même qu'une liste de pratiques précises qui sont susceptibles d'aider les Centres de santé et de

services sociaux à mettre en œuvre le DIRO. À l'échelon organisationnel, l'adoption de plans d'action locaux et de schémas d'aiguillage officiels donne lieu à un cadre de travail qui permet une intégration horizontale et verticale des nouvelles pratiques.

Introduction

Over the past decade, the Health and Social Service Ministry of Québec (Ministère de la santé et des services sociaux; MSSS) recognized the importance of addressing substance abuse in Québec (MSSS 2006). Reports and research by local expert committees and academics, as well as surveys conducted by the provincial government, have noted increasing costs related to substance dependence in terms of healthcare and lost productivity (Guyon and Desjardins 2002; Schneeberger and Desrosiers 2001). Subsequently, the MSSS issued two policies related to substance dependence entitled “Plan d'action interministériel en toxicomanie 2006–2011” (*Action Plan on Addiction*) and “Offre de service—Orientations relatives aux standards d'accès, de continuité, de qualité, d'efficacité et d'efficience: programme-services dépendances, 2007–2012” (*Addictions Program and Services*) (MSSS 2006). These policy documents contained plans for a system-wide change in primary care practices by mandating Québec Health and Social Services Centres (Centres de santé et de services sociaux; CSSS¹) to provide treatment for substance dependence.

Description of the MSSS Addictions Program

As outlined in the MSSS policy documents, the new Addictions Program was designed to focus on screening, brief intervention and referral (SBIR), an evidence-based and cost-efficient set of interventions for substance abuse that are widely recognized in the scientific literature (Babor et al. 2007; Humeniuk et al. 2008; Kaner et al. 2007; Madras et al. 2009; Nilsen et al. 2008). As entry points into Québec's primary health and social service system, the CSSS were mandated to offer addiction-related services, including:

1. screening² for alcohol, drug and gambling problems and orientation to appropriate services;
2. brief intervention and referral to appropriate treatment;
3. psychosocial follow-up during specialized treatment;
4. methadone maintenance with psychosocial and medical follow-up; and
5. detoxification with psychosocial follow-up.

Repérage consisted of approximately six questions about substance use and gambling, and it was to be conducted with all clients seeking care at a CSSS, either through general services or specialized services such as mental health. Following a positive screen, further assessment, termed “*détection*,” would then determine if the client could be referred internally for a brief

intervention or externally to second-line specialized addiction services. All staff (nurses, social workers, youth workers, mental health workers, etc.) working in general services, mental health services and integrated services in perinatal and infant care were to be trained to screen, detect and refer clients to appropriate services and to be familiar with brief motivational interviewing techniques (MSSS 2009).

Specialized services including methadone maintenance treatment and detoxification with psychosocial follow-up were expected to be performed by “trained professionals” according to the Addiction Program policy document. Further details regarding the profession or training were not provided; however, it should be noted that prescription of methadone requires a licensed physician.

Implementation of the Mandate

It is notable that while the program rationale and description of services were well-outlined within the MSSS policy documents, the methods of implementation were not specified. To aid development of addiction services, the MSSS provided a two-day training workshop to healthcare professionals (HCPs) within the CSSS system entitled “Formation première ligne adulte en dépendances du MSSS” (*MSSS Frontline Training for Adult Addictions*) (MSSS 2009), and in some cases, they also provided funding to hire an addictions specialist (Landry et al. 2012). However, no specific implementation models were prescribed and thus each CSSS was expected to develop their own implementation plan and timeline.

Recent attempts by the MSSS to implement Alchochoix+, a program aimed at reducing hazardous alcohol intake (Cournoyer et al. 2009), and a Mental Health Services program (MSSS 2005b; Vallée et al. 2009) within Québec’s primary care CSSS centres have shown how slow and difficult the implementation process can be. For example, a study of the Alchochoix+ program showed that while some CSSS were successful in offering the program, many organizational barriers such as staff resistance and lack of adequate training impeded their efforts to fully implement it (Cournoyer et al. 2009). In terms of the development of Mental Health Services, a study of 15 CSSS revealed that three years following the initial launch, only a third of the CSSS had full implementation, while the remainder managed only partial to low levels of mental health service implementation (Vallée et al. 2009). Again, similar organizational- and staff-level barriers were identified as factors limiting the CSSS’s efforts to implement primary care mental health services locally.

In terms of the Addictions Program, an extensive literature review of journals and government documents indicated that there has been little examination of program implementation on a province-wide scale. Thus, the aim of the current study was to examine the level of implementation of the Addictions Program throughout the province, one year following the launch of the Addictions Program and Services mandate (2007–2012). Twenty-one CSSS from various geographical regions of Québec participated in the research study, and through a qualitative analysis of services and organizational factors, three groups of CSSS were identified with low, partial or high implementation of the Addictions Program. These groups were

compared to identify structural, staff and organizational elements that were conducive to a successful and sustainable integration of the government program. This study contributes to the field of implementation science by describing a case of real-world policy implementation that can be used to inform decision-makers regarding knowledge transfer related to evidence-based practices into primary care services.

Methodology

A qualitative approach was adopted to evaluate which Addictions Program services were offered at each CSSS, and what strategies, if any, were used to implement them. An in-depth understanding was gained by gathering testimonies from stakeholders involved in all aspects of the Addictions Program, from the initial planning phase to the day-to-day provision (Given 2008).

An invitation to participate was sent to all of the 94 CSSS in the province and a random purposeful sampling (Patton 2005) was used to select 21 CSSS from the 35 who responded positively. The 21 CSSS were identified and selected to maximize the representation of the 18 regional health districts in Québec (13 of 18 districts are represented in this study) and include centres from both urban and rural settings. The 14 CSSS that were not selected for the study were eliminated to avoid over-representation of some regional health districts, namely, the Montréal and Québec City urban regions. The study took place a year following the end of the implementation period (2007–2012). This time frame is optimal, as studies on the implementation of evidence-based practices are often done too early in the implementation process (Fixsen et al. 2005).

A logic of purposive stakeholder sampling, most commonly used for policy analysis (Given 2008), was used to recruit a maximum of four key informants per CSSS for a total of 45 participants. Participants were identified and selected based on potential involvement in the decision-making processes related to the Addictions Program within their CSSS or in the everyday functioning of the program. The positions selected for recruitment depended on the organization chart of each site but could generally be classified as:

- ✦ Director of Services ($n = 12$);
- ✦ Coordinator of Services or Program Manager ($n = 18$; addictions services, mental health services, public health or community health); and
- ✦ primary HCP designated to work in addictions ($n = 15$).

Participation in all components of the research was voluntary and informed consent was obtained. Ethical approval for this study was provided by both the McGill University Health Centre Research Ethics Board and the Research Ethics Committee of each CSSS involved in the project.

Data were collected through semi-structured interviews of approximately 1.5 hours in duration, conducted by a research assistant with extensive experience in semi-structured

interviewing and qualitative research/analysis. A supplementary checklist of currently offered addiction services was also completed by each participant. Interviews were audio-recorded and transcribed verbatim by a research assistant, and transcripts were subsequently reviewed by a second assistant to ensure accuracy and comprehensiveness.

The interview guide consisted of four sections:

1. the participant's role in the CSSS and in the Addictions Program;
2. the addiction services offered in the CSSS;
3. the implementation process of the Addictions Program; and
4. program-related training offered to CSSS staff.

When available, case documentation such as organizational guidelines and strategic plans related to the Addictions Program was collected and integrated for a more thorough understanding of the process and level of implementation of primary care addiction services at each site. Additional details regarding the study protocol and methods are available in Gill et al. (2014).

Data were sorted by case (CSSS) as the main unit of analysis to allow for an in-depth exploration of each CSSS as well as comparison of cases. A triangulation of the data from the different case participants and available in-house documentation increased the validity of the case descriptions. NVivo 9 (QSR International) qualitative data analysis software was used to manage the data. The coding strategy was based on variables associated with the primary care services outlined in the Addictions Program as well as additional themes that emerged over the course of the project. Analysis was completed through a process of familiarization with the data through multiple readings of the transcripts, identification of major themes and line-by-line coding. The analysis was guided by the Framework Analysis Method (Ritchie and Spencer 1993).

Analysis of the services and implementation data was initially done separately by two qualitative analysts, and findings were validated through cross-evaluation of the two analyses. Further validation was conducted in team meetings that included the principal investigator and research coordinator, and through a literature review of similar implementation ventures. All of these methods helped ensure trustworthiness of findings as defined by Lincoln and Guba (1985): credibility, transferability, dependability and confirmability.

Results

The sample of 21 CSSS showed great variation in the level of success they had implementing services. As shown in Table 1, a majority of the CSSS used standard tools to screen (repérage) and detect clients. Almost two-thirds of the CSSS had a formal policy for systematically screening clients; however, only a quarter of the CSSS had actually put these policies into practice. It should be noted that while some CSSS did systematically screen clients for substance misuse, those clients who tested positive were not necessarily followed up with in terms

of the next step in the recommended “déttection” procedures. This was left up to the judgment of the HCP who had completed the initial screening. Inversely, some CSSS did not systematically screen all clients (this was again left up to the discretion of the HCP); however, those who tested positive would systematically go through the déttection process. This suggested that there was some confusion on the part of many CSSS regarding the aims of the screening process, as, in principle, both screening and déttection were to be approached systematically.

TABLE 1. Primary care addiction services offered at the Health and Social Services Centres (CSSS)

Services	N = 21	%
Screening (repérage)		
Standard tool	16	76
Formal procedure	13	62
Systematic approach	5	24
Detection		
Standard tool	20	95
Formal procedure	12	57
Systematic approach	6	29
Internal orientation & referral		
Formal procedure	11	52
External orientation & referral		
Formal procedure	14	67
Intervention		
Alcochoix+	14	67
Motivational approach	13	62
Psychosocial follow-up post-treatment		
Service available	16	76
Psychosocial & medical follow-up for methadone maintenance		
Service available	5	24
Outpatient detoxification		
Service available	2	10

Regarding the referral process, half of the CSSS had implemented formal procedures for internal referrals (incidentally, this was highly dependent on the presence of a trained HCP able to offer brief interventions) and two-thirds had formal procedures for external referrals to second-line addiction treatment centres.

In terms of brief interventions, close to two-thirds of the CSSS had a trained HCP who could offer one or more forms of brief intervention:

1. individual sessions using the motivational approach; or
2. the Alcochoix+ program, a locally developed alcohol harm reduction program (Cournoyer et al. 2009).

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Psychosocial follow-up post-treatment was available in 76% of the CSSS. However, it should be noted that in most cases, respondents considered this to be an existing service that had been instituted prior to the implementation of the Addictions Program, and thus no specific actions around it had been undertaken following the issuing of the MSSS policy documents.

Very few CSSS offered services related to methadone maintenance ($n = 5$) or outpatient detoxification ($n = 2$), and in all of these CSSS, these services existed prior to the launch of the government program.

Following the analysis of services, the 21 CSSS were categorized according to their level of SBIR implementation. Three variables were considered: the presence of a systematic approach to the screening process, the presence of a formal procedure for internal and external referrals and the presence of one or more staff members trained to provide brief interventions. However, more weight was given to the existence of a systematic screening process, as this is the cornerstone of SBIR. Without systematic screening at intake, only severe cases of substance dependence are likely to be detected, which defeats the overall purpose of SBIR as a method for secondary prevention within the context of primary healthcare services (Ernst et al. 2007).

This categorization process resulted in the identification of three subsets of CSSS: a group of six CSSS where a high level of implementation of SBIR was achieved, a group of eight CSSS where implementation was partially achieved and a third group of seven CSSS where a low level of implementation was achieved. Table 2 offers an overview of these three groups.

TABLE 2. Characteristics of each level of implementation

	High implementation	Partial implementation	Low implementation
General description of services offered	<ul style="list-style-type: none"> • Formal and systematic approach to screening and detection • Formal procedures for internal or external referrals • Offer one or two types of brief interventions (motivational approach, Alcochoix+) 	<ul style="list-style-type: none"> • Formal approach to screening and detection, but not systematic (done at discretion of HCP) • Procedures for internal or external referrals in place (but often done at discretion of HCP) • Offer one or two types of brief interventions 	<ul style="list-style-type: none"> • Informal approach to screening and detection • Few internal referrals, few services in place and external referrals done at discretion of HCP • Brief interventions rarely offered

These results were then compared with the data pertaining to the implementation process. There was a correlation between the presence of certain organizational elements in each group and the level of success they had in sustainably implementing the Addictions Program.

Key elements conducive to successful implementation

The common elements identified in the high-implementation group (and, inversely, absent in the low-implementation group) concern two mutually dependent factors: organization and

staff. Both factors are intertwined: organizational changes are often made possible by the individuals involved in the Addictions Program; in turn, organizational changes allow individual staff to work efficiently. Significant organizational and staff factors are described below, and summarized in Table 3.

TABLE 3. Summary of key elements conducive to successful implementation

Organizational-level factors	Staff-level factors
<ul style="list-style-type: none"> • Development of a formal action plan and service trajectory • Internal or local addiction networks • Formal internal follow-ups and tracking • Non-hierarchical decision-making process 	<ul style="list-style-type: none"> • Priority setting by management • Presence of a full-time addiction worker • Addiction worker takes on a caseload • Additional staff members trained to offer addiction services

Organizational level

Since the Addictions Program was not intended to become a service in itself, organizational measures to support and adapt it to the local context of each CSSS became the cornerstone of successful implementation. All of the CSSS from the high-implementation group had taken such measures, while most of the CSSS from the low-implementation group had taken few or no measures to integrate the Addictions Program. The organizational measures identified below play an important role in one or both phases of the Addictions Program:

1. implementation and adaptation to the specific setting of the CSSS;
2. sustainability and evolution.

Development of a formal action plan and service trajectory

All of the CSSS from the high-implementation group had developed a formal action plan with specific measures to implement the Addictions Program locally (only one CSSS in the low-implementation group had created a local action plan). All of these CSSS also created formal service trajectories that detailed the different services involved in the Addictions Program (intake, psychosocial services, etc.), the role of the HCPs and the services that a client should receive during the SBIR process. Possible advantages to having formal action plans and service trajectories are that they both support the implementation process and provide a framework for the ongoing provision of addiction services by adapting the Addictions Program to the local setting of the CSSS.

Internal or local “addiction networks”

To give structure to the Addictions Program and facilitate ongoing communication between services and partners involved in the Addictions Program, all CSSS in the high-implementation group had created an internal or local network. Local networks included other nearby CSSS, other treatment centres and/or community organizations. The networks engaged in discussing more practical “day-to-day” issues regarding the program (e.g., how to improve

procedures and services for clients, and improve communication between internal CSSS services and second-line services).

The presence of these networks seems to have two major positive outcomes: it prevented the addiction workers (AWs) from operating in isolation, and it provided a framework for the governmental program and open lines of communications between relevant partners and services.

Formal internal follow-ups

To monitor the implementation of the local action plan, most CSSS from the high-implementation group reported having formal internal follow-ups. Generally speaking, these were fixed meetings where all those involved in making decisions regarding the Addictions Program assessed, discussed and re-evaluated the action plan. For some CSSS, this also included a tracking procedure to monitor the offer of services and ensure that the plan was actually integrated into routine practice. In fact, all the CSSS that had such tracking procedures had been able to enforce a systematic screening process. In short, internal follow-ups and tracking measures were ways to determine if the action plan was actually being put into place and allow the program to be adapted based on a continual assessment of addiction services.

Decision-making process – shared vs. hierarchical

A shared decision-making process seemed to be an important factor in successful implementation: all of the CSSS in the high-implementation group (for which data pertaining to this element are available; 5/6) had this type of decisional process in place. For the CSSS in the low-implementation group, 80% had a “hierarchical” decision-making process. A shared decision-making process was one where the AW and management worked in collaboration and the AW had the freedom to take initiative towards new ventures.

This type of decision-making process presented two advantages. By giving the AW a degree of autonomy, the program could be implemented in ways that reflected the specific needs of the client population because the AW was best positioned to assess those needs. This also minimized isolation of the AW by establishing a collaborative model. A good example of one such initiative was the organizing of “cafés” that served as social reinsertion support groups. The AW explains that this was made possible because of the support and freedom given by a supervisor:

I have that kind of openness to try things. So when I see with the [community] partners that it makes sense, well then, we talk to our managers about that. And then, well, we put it down on paper. Then at a given time, well, it becomes more ... more formal.³

Another AW, from a low-implementation CSSS, provides a counter example of being unable to follow through on initiatives owing to the hierarchical structure of their CSSS:

There's a lot of hierarchy, you know, at healthcare centres. So I can't talk to a department head. Me, I'm just supposed to get things up and running and to ... make it come alive, "detection" and "dependence", that's one of my duties. **But I don't have the right to speak to any of the managers. My manager is supposed to [...] introduce me**, eh. So my manager, there, she didn't just have me to take care of as ... She has 40 healthcare workers [to look after].

Non-hierarchical decision-making processes allowed AWs to communicate with other service and community partners, reducing their isolation and facilitating the uptake of shared knowledge. This may further explain why non-hierarchically structured CSSS were more successful: shared decision-making seems to make the AW position more attractive, which reduces turnover. Those CSSS that were unsuccessful or had limited success implementing the Addictions Program often considered isolation as one of the factors that contributed to a high turnover rate among Addictions Program workers. Alternatively, the AW and management from CSSS with successful implementation centres reported high levels of motivation and a low turnover rate.

Staff level

Management and prioritization

The priority given to the Addictions Program was, unsurprisingly, an important factor in how successful each CSSS was at implementing services. All CSSS in the high-implementation group (for which data pertaining to this element are available; 5/6) reported that the program had been made a priority by management. This meant that it was regularly discussed during general meetings and inquiries were made as to the progress of ongoing implementation efforts. Inversely, among the low-implementation CSSS group (for which data pertaining to this element are available; 4/7), all reported that the program was not a priority.

Mid-level managers seemed to be key actors in the prioritization of the Addictions Program. Their position within the organization allowed them to both initiate changes and assume leadership. Examples of mid-level management assuming leadership of the program's implementation were found among those CSSS in the high-implementation group, and the opposite attitude was found among managers in the low-implementation group:

Because me, like we say, I'm not going to put my head on the chopping block to develop a nice action plan for my managers with great ways to do things if, on the organizational front, it's not a priority. I won't put my energies there. There are other things to do ...
(Mid-level manager, low-implementation CSSS)

Presence of a full-time AW

The presence of a full-time AW seemed to play a role in the level of success the CSSS had in

the implementation of the program. All of the CSSS from the high-implementation group had a full-time AW working for them, compared with only two out of the seven CSSS in the low-implementation group. However, results showed that hiring an AW alone was not sufficient. The position of the AW needs to be supported by a structure that favours open communication with other services and local partners (as previously illustrated) and that allows for a continuity of services in the event that the person occupying the position leaves. As an AW from a CSSS in the high-implementation group explains, the presence of an internal addiction committee, along with involvement from multiple staff members, constitutes a safeguard against the discontinuity created by staff turnover:

And if I were to leave, well, it would go on with each team, this goal, shared by the direction and management team.

Some CSSS have attributed past and present failures in the implementation of the program to staff turnover, namely due to the fact that the Addictions Program heavily rested on the shoulders of a single staff member.

How the role of the AW was defined also seemed to play a part in the successful implementation of the Addictions Program. Of the 21 CSSS in this study, only five decided to opt for a strategy where the AW became the in-house addictions specialist to whom clients were referred for detection and brief interventions. Out of those five, four belonged to the high-implementation group. This strategy was considered to be optimal, as the AW provided the interventions, thus encouraging the remaining HCPs to conduct screening, particularly when they lacked experience treating patients with substance dependence. As an AW explains:

They're more ... [comfortable], because it's not scary to uncover something when you know that [...] you won't have to meet your client for another 12 sessions if you do.

Other CSSS opted for a different strategy whereby the AW did not have a caseload and was only there to support staff (e.g., coaching and co-interventions), offer training and to work on further implementation efforts. However, to be effective, a "caseload" strategy needed to be coupled with some structural elements:

1. a communication network that gave the AW access to managers and staff of other services;
2. a shared decision-making process (see previous section); and
3. one or more additional staff members who were trained to offer addiction services in case the AW left (temporarily or permanently), to ensure continuity of services.

Discussion

Two pilot studies were conducted prior to the province-wide dissemination of the Addictions Program in Québec (Saint-Jacques et al. 2012, 2009). These studies showed, among other

challenges, that training alone was insufficient to modify HCPs' practices on a long-term basis. Saint-Jacques et al. (2012) found that systematic screening peaked at 70% in a group of HCPs who underwent training in SBIR, but returned to pre-training levels seven months later.

These same studies also identified barriers to the implementation of SBIR, such as staff resistance, lack of adequate training and organizational barriers. Similar challenges also emerged in past attempts by the MSSS to implement an alcohol reduction program (Cournoyer et al. 2009) and Mental Health Services (MSSS 2005b; Vallée et al. 2009) into primary care clinics in Québec. The findings overall are consistent with a vast body of literature that shows the inherent challenges in the dissemination and implementation of SBIR (Johnson et al. 2011; Nilsen 2010; Nilsen et al. 2008; Rogers 2002) or other evidence-based practices in primary care health services (Deane et al. 2006; Johnson and Austin 2008).

In light of this, it is surprising that in their efforts to integrate addiction services into all of the CSSS in the province, the MSSS did not prescribe a specific implementation model or framework for the CSSS, despite extensive recommendations made following province-wide deployment studies (INSPQ 2009; Saint-Jacques et al. 2009). Models for policy implementation have been well-developed by the INSPQ (Institut national de santé publique du Québec), Québec's public health institute (INSPQ 2009).

This study shows the limited success a selected group of CSSS had in their efforts to integrate the Addictions Program into their existing services, as only 29% were able to implement SBIR using a systematic approach. A comparative analysis of the CSSS, categorized according to their level of success in their implementation efforts, revealed the presence of organizational- and staff-level factors that were conducive to successful implementation of SBIR into primary care health centres. Inversely, the absence of these components in the CSSS that were less successful further demonstrates the importance of these organizational- and staff-level changes in ensuring that the Addictions Program was implemented successfully.

Many of the elements identified in this study have been highlighted in the literature on implementation science. At the organizational level, the adoption of local action plans and formal service trajectories offers a framework for the realignment of organizational structures that allows for a horizontal and vertical integration of new practices (Fixsen et al. 2005).

The presence of internal networks is a key factor in ensuring communication across the organization, which in turn contributes to effective horizontal implementation (Damschroder et al. 2009; Vallée et al. 2009). At the regional level, a network that allows for good collaboration with community partners may impact sustainability of the implementation process (Tibbits et al. 2010). Internal follow-ups and monitoring play a central role in pushing the implementation process forward (Reay et al. 2013) and in making sure that policy is put into practice (Williams et al. 2011). A closed and hierarchical decision-making process has been shown to inhibit innovations (Damschroder et al. 2009), indicating that a shared decision-making process can contribute to adapting the program to the local context through local innovations.

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As for staff-level components, dedicated mid-level managers or clinical coordinators can be essential in facilitating positive organizational change (Reay et al. 2013), as they play an active role in removing barriers (Fixsen et al. 2005), assuming leadership (Cournoyer et al. 2009) and taking actions to move forward with implementation measures (Reay et al. 2013). In a context where funding is limited and competing programs have to be implemented or kept active, a mid-level manager can be key in making sure that the program he or she is responsible for is made one of the organization's priorities (Fixsen et al. 2005). Additionally, in a demonstration project, Ernst et al. (2007) posited the presence of a behavioural health specialist as instrumental in successful implementation of a full range of substance abuse services into a primary care setting. Although the AWs in the present study were not behavioural health specialists, those who took on a caseload seemed to have played a significant role in the successful implementation of SBIR into the CSSS.

This study also revealed the existence of potential confusion among the CSSS surrounding SBIR (i.e., the screening process), an issue raised by the earlier studies on Québec's addiction services (Saint-Jacques et al. 2009, 2012). Clarity of the intended intervention has been identified as a central element in a successful implementation process (Damschroder et al. 2009; Tibbits et al. 2010; Williams et al. 2011).

In terms of limitations, this study did not take into account other key elements – such as training (Tibbits et al. 2010) and organizational readiness for change (Castaneda et al. 2012) – that could shed further light on ways to ensure successful program implementation. The MSSS plans to renew its effort to implement addiction services into primary care (MSSS 2010), and findings from this study highlight the importance of offering additional guidelines and support to assist the CSSS in their implementation of SBIR.

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Notes:

1. CSSS are administrative bodies responsible for overseeing the primary health, mental health and social services needs of specific geographical regions in Québec. At the time the MSSS policies were issued, there were 94 CSSS in Québec.

2. Within the context of MSSS policy documents, screening for substance abuse and addiction involved a two-stage process including: repérage – initial screening that should be conducted systematically with all clients, and détection – a more extensive assessment performed following a positive screening, to determine the severity of the substance use, and treatment requirements.
3. Quotes were translated (from French to English) by a certified translator.

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