PROVIDERS EXPERIENCES DELIVERING TWO PARENTING PROGRAMS

LAYING THE GROUNDWORK: PROVIDER'S EXPERIENCES WITH IMPLEMENTING TWO PARENTING PROGRAMS TO CAREGIVERS OF CHILDREN AGED 2-6 YEARS IN ONTARIO, CANADA: A MIXED METHODS STUDY.

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TITLE: Laying the Groundwork: Provider's Experiences with Implementing Two Parenting Programs to Caregivers of Children Aged 2-6 Years in Ontario, Canada: A Mixed Methods Study.

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Lay Abstract

Effective delivery of evidence-based parenting programs is essential to promoting positive health outcomes for children and families. Unfortunately, very little research has investigated the experiences of providers delivering these programs. Due to this, our study applied a mixed methods approach that involved 83 providers who completed various readiness measures prior to program implementation, and 22 providers who participated in follow-up focus groups, 12 months after program implementation. The results of our study determined that organizational readiness, which is inclusive of training, supervision, and support, is critical to successful program delivery. Furthermore, we were able to identify barriers and facilitators of program delivery, which can inform future implementation efforts and improve program quality, while promoting positive outcomes for parents and children. This study provides unique insights into the experiences of parenting program providers in Canada and can serve as a tool to inform future program implementation and delivery efforts.

Abstract

Introduction: Parenting programs have been identified as a valuable service provision to promote quality parent-child relationships and attachment styles. The Triple P positive parenting program and the Circle of Security parenting (COS-P) program are evidence-based interventions designed to prevent behavioral and emotional problems in children. However, there is a lack of literature on the experiences of providers delivering these programs in the Canadian context. This study aimed to investigate and characterize these experiences through a mixed-methods approach.

Methods: A total of 83 providers participated in the cross-sectional portion of the study, completing readiness measures prior to program implementation. The qualitative descriptive component of the study involved a sub-group of 22 providers in semi-structured focus groups, 12 months after program implementation. Descriptive measures were analyzed using R studio V. 4.2.0, while NVIVO Version 13 was used to manage the thematic analysis of the focus groups. The mixed-methods component involved an explanatory sequential approach, which involved integrating the data via a joint display table.

Results: Organizational readiness involving training, supervision, and support were crucial for program delivery. Barriers identified included a lack of support, overwhelming workload, difficulty engaging parents, and program-specific barriers, while facilitators included positive experiences with training, teamwork, confidence, virtual delivery, and managerial support.

Discussion: The results suggest that organizational readiness is crucial to the successful delivery of these programs. Providers require training, supervision, and ongoing support to deliver these interventions effectively. Additionally, barriers and facilitators in the delivery of these programs were identified, which can inform future program implementation and improve outcomes.

Conclusion: This study provides valuable insights for organizations and providers to effectively deliver parenting programs like Triple P and COS-P by addressing barriers and facilitators of delivery, which can consequently improve parent-child relationships and attachment styles.

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I would like to thank all of the providers and parents who took part in this study. Thank you all for sharing your experiences, and for taking part in such an important research study. Hopefully, because of your contributions to this study, this will lead to better program implementation outcomes in the future.

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List of All Abbreviations and Symbols

PHF	Promoting Healthy Families
RCT	Randomized Control Trial
COS-P	Circle of Security Parenting Program
Triple P	Triple P - Positive Parenting Program
BIRCS	Brief Individual Readiness for Change Scale
EBPAS	Evidence-Based Practice Attitude Scale
ORC	Organizational Readiness for Change Measure
HiREB	Hamilton Integrated Research Ethics Board

Declaration of Academic Achievement

I, Matthew Fernandes Melo, declare this thesis to be my own work. I am the first author of this thesis document; I was involved in all aspects of the thesis project under the supervision of Dr. Andrea Gonzalez. Both Dr. Melissa Kimber and Dr. Laura Anderson were members of my thesis committee and assisted in editing and providing guidance on my work. Jenna Ratcliffe also assisted with editing and providing guidance on the qualitative results. It is to the best of my knowledge that the information in this thesis does not infringe on any copyrights.

Chapter 1: Introduction

1.1 Parenting

Parenting involves a multidimensional approach that provides knowledge, emotional support, and overall safety for children to develop physically and cognitively (Chentsova Dutton et al., 2020; Hoghughi, 1998). Five core principles of parenting that promote positive child development include: creating a safe and nurturing home environment, creating a responsive and positive learning environment, providing consistent discipline, creating reasonable expectations of the child and parent, and ensuring that parents are prepared to care of themselves throughout the parenting process (Sanders, 2021). There are several different parenting styles (Kuppens & Ceulemans, 2019), which include authoritarian (requires complete compliance), permissive (give in to the child's wishes), uninvolved (detached from the child), and the most optimal form of parenting, authoritative which involves reasoning with their child (Jago et al., 2010). It is crucial to understand that when parents implement harsh or punitive discipline strategies, this can manifest into emotional-behavioral problems in young children (Sanders, 2008; Chang et al., 2003). The quality of parenting has a significant impact on a child's development, as evidenced by its association with several child outcomes such as mental and physical well-being, as well as cognition, including language processing (Rose et al., 2009), and social competence (Salavera et al., 2022). It is therefore important to understand the effects of parenting to promote healthy developmental outcomes in children (Sanders, 2008), as well as identify, evaluate, and scale up parenting programs that can assist parents of children with socioemotional and behavioural problems to intervene early and improve their child's trajectory of functioning and quality of life. Furthermore, the goal of public health in the context of parenting is to improve and promote the well-being of families and children and prevent poor health outcomes through evidence-based

programs (Sanders et al., 2022). Increased resources, such as education and training programs for parents, can promote positive parenting behaviours, and improved health and well-being for families (Williams et al., 2019).

1.2 Parenting Programs: Theoretical Framework and Effectiveness

Evidence-based parenting programs are an essential service provision that promotes the quality of parent-child relationships and attachment styles (Bywater et al., 2022). These programs allow parents to develop practical skills and knowledge that can reduce family stress, improve family relationships, and improve child well-being (Mikton & Butchart, 2009). The main frameworks that influence and inform the strategies used within program development are social learning theory and attachment theory (O'Connor et al., 2013). These frameworks emphasize the role that parents have in teaching their children how to develop healthy coping strategies, problem-solving skills, and the ability to better manage their emotions and behaviours (Compas et al., 2014). Social learning theory is directly implicated in parenting because it explains how children learn and develop via observing and imitating the behaviours of others, such as their parents (Horsburgh & Ippolito, 2018). The theory also suggests that parents form children's behaviours by rewarding good behaviour, and disciplining undesirable behaviours (Halgunseth et al., 2013). Attachment theory is another framework that aims to understand how parent-child relationships affect the psychological development of their children (Cassidy et al., 2013). This framework suggests that parents should be emotionally available to their children, respond to their needs, and provide a secure base for their children to develop and grow (Flaherty & Sadler, 2010). The focus in attachment theory is on responsive caregiving to reinforce attachment and secure parent-child relationships (Cassidy et al., 2013), which subsequently contributes to adaptive patterns of behaviour and development (Frosch et al., 2019).

A child's primary source of experiences or exposures are in family environments, or parent-child relationships (Lind et al., 2019), thus, evidence-based parenting programs that are based on social learning theory and attachment theory may positively influence family relationships and subsequent child outcomes such as their social skills and behaviour (Sanders et al., 2022; Salavera et al., 2022). In a systematic review and meta-analysis of 130 studies on the effectiveness of various parenting interventions, it was found that parenting programs led to a reduction in child maltreatment, increased confidence and skills, improved parental mental health, and overall, a significant finding was improved child well-being based on parent's self-report measurements (Van Der Put et al., 2018). Another systematic review and meta-analysis of 11 Randomized Control Trials (RCTs) examining the effect of group-based sessions of the Triple P parenting program, compared to a waitlist control group, found that the program led to a decrease in parental mental health concerns, parent-child/parent-to-parent conflict, and child behavioural problems, as well as an improvement in parent-child relationships (Nogueira et al., 2022). To this end, parenting programs not only positively impact child behaviours, but additionally benefit parent behaviours. As another example, the CANparent Trial, which was a study of 12 freely available parenting programs, including the Comfortzone, Bringing Up Children, the Triple P program, and others, found that after participating in the programs, 88% of parents reported increased parental efficacy and parenting interest (Lindsay & Totsika, 2017), both of which have previously been found in separate studies to be associated with a decrease in child behavioural problems (Nogueira et al., 2022). In another study that investigated the impacts of the Incredible Years parenting program, it was found that regardless of parenting outcomes, participation in the parenting program led to an increase in mothers' satisfaction with life and

general well-being (Reedtz et al., 2019). In other work, it has also been ascertained that maternal life satisfaction is correlated with child and youth well-being (Richter et al., 2018).

While there are a great number of parenting programs currently offered, Triple P is one of the most widely researched parenting programs (Sanders, 1999), and the Circle of Security Parenting Program (COS-P) is one of the most commonly offered attachment-based interventions (Maxwell et al., 2020). However, more knowledge is needed on the effectiveness of the COS-P program, and there is an overall need for more knowledge regarding provider's experiences delivering both programs to increase accessibility, sustainability, and overall widespread uptake of these interventions. Thus, the focus of this thesis will be on provider's perspectives of being trained in and delivering the Triple P and COS-P parenting programs to a community sample of parents whose children are experiencing emotional and behavioural challenges.

1.3 Triple P Positive Parenting Program

The Triple P program which is derived from social learning theory and cognitive behavioural principles, focuses on self-regulation and aims to increase knowledge, skills, and confidence in parents that will prevent behavioural and emotional problems in children (Sanders, 2008). Improving parents' strategies for coping with stress and increasing their ability to self-regulate through the Triple P program can lead to an improvement in parent-child relationships (Özyurt et al., 2018). The program is split into five levels that range from media and communication strategies (level 1), up to intensive services (level 5) (Sanders et al., 2003). The program also ranges in its flexibility of delivery, from individual program delivery, which is a highly targeted intervention, to group delivery, and self-directed delivery (Sanders et al., 2003). The Triple P, specifically level 4, targets parents of children with behavioural difficulties and

broadly focuses on improving parenting skills for parents of children from 1 to 12 years of age in an individual, group, or self-directed setting (Sanders et al., 2003). Our study involved participants that were enrolled in the Triple P level 4 program, which was delivered in a group setting. The group can occur with up to 12 parents and includes five (two-hour) group training sessions and three (15-30) minute one-on-one phone consultations across eight consecutive weeks (Aghebati et al., 2014). Group content encompasses the discussion of techniques that can encourage desirable parent and child behaviour, such as managing misbehaviour, responding to disobedience, and preventing undesirable behaviours. The program has been found to be effective in diverse populations, such as parents of children with a disability and divorced families (Stallman & Sanders, 2014); evidence indicates that the program leads to an overall improvement in both nonclinical and clinical behaviour problems in children, as indicated by Cohen's d effect sizes of $d = 0.40$ and $d = 0.68$ respectively (de Graaf et al., 2008). The effectiveness of Triple P for reducing behavioural problems in young children was further emphasized by a meta-analysis of 101 studies that confirmed that Triple P program is an effective short and long-term program that improves social, behavioural, and emotional outcomes in both children and parents (Sanders et al., 2014). Alternatively, Wilson and colleagues found that the Triple P program is not effective across populations, and does not produce long-term benefits (Wilson et al., 2012). Specifically, they found that the Triple P program is not more effective than existing parenting interventions (Wilson et al., 2012). While this does raise concerns that further research is warranted to investigate the program's effectiveness, most of their claims were refuted by Sanders. Wilson et al., concluded that Triple P is not effective amongst large populations, however, in their quantitative meta-analysis, no Triple P population studies were included (Sanders et al., 2012). Furthermore, regarding the

program's effectiveness, Wilson and colleagues also disregarded parent- and family-level outcomes, and thus, it cannot be concluded with certainty, that the program is ineffective due to this (Sanders et al., 2012).

1.4 Circle of Security Parenting Program (COS-P)

The Circle of Security parenting (COS-P) program aims to prevent insecure attachment and emphasizes the vital role that parents play in providing a source of security for their children (Cassidy et al., 2017). This is achieved by increasing parent's confidence in their parenting abilities, and sensitivity, enabling them to serve as a secure base for their children (Cassidy et al., 2017). It has been found that strong attachment in childhood is essential to development, thus, this program was developed to implement ideas of attachment theory, increase caregiver sensitivity, and prevent the risk of insecure attachment amongst caregivers and children on a broader level (Cassidy et al., 2017). The program also assists caregivers in their ability to understand their children better, increase parental emotional regulation, and decrease poor parenting practices (Pazzagli et al., 2014). The COS-P program involves meeting with groups of parents of children from infancy to six years old for eight weeks (Kubo et al., 2021). The COS-P program is a cost-effective and modified version of the original COS intervention which involves easy-to-understand diagrams and sketches, engaging materials, and graphics to engage parents in the circle of security concepts (e.g., concepts related to cues and miscues, managing feelings, the pathway to security and overall relationship management) (Cassidy et al., 2017). Improving parental self-efficacy and attachment between children and their caregivers with the COS-P program can lead to an overall improvement in the parent-child relationship (Kubo et al., 2021). The COS-P program has been found to be effective in improving caregiver attachment and reducing negative parenting practices (Zimmer-Gembeck et al., 2022). This program has been

used among diverse populations which include families involved with child protective services, socioeconomically disadvantaged families, and families with children with behavioural and mental health issues (Maxwell et al., 2020). This program is advantageous because of its flexibility in timing, practicality, and it is tailored toward community-based use (Pazzagli et al., 2014). Due to the uniqueness and applicability of this program, its use has been growing and developing rapidly (Maxwell et al., 2021), although there is a paucity of effectiveness trials to date, in particular with the COS-P group format with children ages 2-6 years.

Collectively, there is longstanding evidence of the implementation of the Triple P program to improve positive parenting practices and reduce child emotional and behavioural challenges, this is despite the fact that studies have yielded mixed evidence for its effectiveness to achieve these aims. In addition, early work suggests promise for the COS-P program via its emphasis on attachment related principles, but more rigorous evidence related to its impact on actual child and parent outcomes is needed to discern its relative advantage, if any, to implementing the program instead of more heavily researched programs, like Triple P. To address this gap in the literature, a three arm RCT was undertaken to examine the effectiveness of the Triple P (level 4) and COS-P programs, compared to treatment as usual in four community-based mental health agencies in Ontario, Canada. In addition to the trial, a readiness survey prior to implementation of the programs and a parallel process evaluation were conducted to examine what factors may influence trial findings. The success of any program rests on the organizational and provider readiness for implementation (Sharma et al., 2018), which is the main focus of the current thesis.

1.5 Organizational and Provider Readiness

Organizational readiness for change involves organizational members' collective solidarity to implement a change, and their shared belief that they can jointly do so (Weiner, 2009). Provider readiness to change encompasses their specific perceptions about the engagement of organizational leaders in the change initiative, and that resources are available to support the provider to implement the program such as money, time, space, training, and accessibility to knowledge and program materials (Weiner et al., 2020). Overall, provider readiness to change captures the individual's motivation to participate in change within their organization (Austin et al., 2020). When implementing a new program, intervention, or service, organizational readiness is essential for successful program implementation (Weiner, 2009).

Provider readiness has been linked to several factors in program uptake and delivery. It is suggested that providers with positive attitudes toward evidence-based programs (Nelson & Steele, 2007) and those with more flexible supervisors are also more likely to adopt and successfully deliver these programs (Aarons, 2004). Flexible and positive supervisors were also found to promote program fidelity (Shoenwald et al., 2009). Another important factor related to provider readiness is personal and professional well-being, as well as workplace exhaustion which has been found to impact program delivery and success (Aarons et al., 2009a). In a study that evaluated provider implementation readiness amongst experienced and inexperienced providers, it was found that experienced and high-readiness providers were more successful in their program delivery and implementation (Mauricio et al., 2019). Through early insights into the relationship between readiness and program implementation, it has been shown that high readiness levels can predict successful program implementation outcomes such as increased knowledge of the program, ability to provide the service and provider satisfaction (Livet et al.,

2022). Therefore, this establishes the connection between key components of readiness and program success (Livet et al., 2022). Due to the key role that readiness plays in program implementation success (Watson et al., 2022), it is also important to identify any potential facilitators or barriers within programs that may influence implementation success and program sustainability (Rogers et al., 2021).

1.6 Barriers and Facilitators in General Parenting Program Delivery

Evidence indicates that there can be both individual- and organizational-level facilitators and barriers to successful program uptake and implementation. For example, work focused on the implementation of the Alberta family integrated care program, a program that aimed to develop parent-infant bonds in neonatal intensive care units, found that an open-minded organizational setting, program compatibility with the organization's values, having access to knowledge and resources, and keeping track of program delivery all facilitated program implementation (Zanoni et al., 2021). While examining facilitators of the Incredible Years parenting program, data indicated that successful delivery was due in part to the connection fostered between program providers and participants (Berry et al., 2022). This connection, which involved building rapport and providing encouragement throughout the delivery of program elements, assisted in motivating providers to execute delivery (Berry et al., 2022). Barriers to implementation in the Alberta family integrated care program included poor program design; overwhelming training materials, unclear instructions, and a lack of learning opportunities (Zanoni et al., 2021). Similarly, several barriers to program delivery were also identified during the Incredible Years parenting program delivery, including limited time for completing the training materials and preparation for program delivery, a lack of provider's confidence in their

delivery skills, a lack of parental and provider involvement, conflicting work obligations, and the availability of financial support (Berry et al., 2022).

Table 1: Summary of Common Organizational Barriers and Facilitators in Program Delivery

Barriers	Facilitators
• Poor program design • Overwhelming materials/ information • Unclear instructions • Lack of learning opportunities • Limited time for completing the training and preparing for program delivery • Lack of engagement from parents • Conflicting work obligations • Lack of financial support • Low program retention of providers and supervisors	• Open-minded organizational setting • Program compatibility with the organization's values • Access to resources • Organizational support of program delivery • Rapport between providers and parents • Encouragement from managers/ supervisors • Collaboration amongst providers

In Ontario, and many other regions, the COVID-19 pandemic transformed parenting program delivery from in-person programming to online, changing the landscape of program implementation for all interventions and contributed to additional barriers and facilitators to program delivery. Specifically, lack of internet access and stability, low level of experience with technology, and a lack of childcare have been identified as major barriers to the delivery of parenting programs during the pandemic (Maguire et al., 2022). Furthermore, barriers that were identified during the implementation of 14 different virtual urgent care initiatives during the pandemic involved: a lack of staffing, technological access or understanding, and an increased workload, while facilitators involved having leaders of the program to guide delivery, physician support, and provincial funding (Hall et al., 2022). These findings from virtual program delivery during the COVID-19 pandemic are directly relevant to the current study since all training took

place online and the implementation of the programs thus far have all occurred virtually, thereby adding another unique layer to providers' perspectives in our study.

1.7 Barriers and Facilitators to Triple P and COS-P Program Delivery

Previous research has identified that a more supportive work environment that encourages teamwork and collaboration amongst providers led to Triple P providers being more likely to continue to deliver the program (Asgary-Eden & Lee, 2012). In a systematic review that investigated providers' experiences delivering levels 3 and 4 of the Triple P, barriers in program delivery included a lack of participant retention, resources, experience leading groups, accessibility, training to deliver the program, and time due to providers having competing work to complete (Mytton et al., 2013). In addition, identified obstacles to delivering levels 2, 3, and 4 of the Triple P program have included organization-level barriers such as the program not being integrated into the facilitator's caseload, a lack of access to supervision, little recognition of the program in their workplace, and difficulty covering the allotted material each session (Shapiro et al., 2011). Provider-level barriers such as difficulty keeping parents engaged or not having enough time to cover the allotted materials have also created challenges for consistent implementation (Shapiro et al., 2011). Only one study has examined facilitators and barriers to COS-P delivery. In the group-based COS-P, barriers to implementation involved the program not being integrated into the providers existing workload, the lack of organizational support for the program such as manager/ supervisor assistance and reassurance during delivery, a lack of resources such to be trained in and prepare for program delivery, space, on-site materials, computers, and assistance in general (Maupin et al., 2017). Facilitators of the COS-P program involved provider's confidence and knowledge of the program, and an increased number of training sessions and materials for providers (Maupin et al., 2017).

Parenting programs are essential upstream interventions that can help promote healthy caregiver-child relationships and child outcomes (ByWater et al., 2022), although, the effectiveness and sustainability of these programs can depend on the readiness of providers and the scope of available organizational support (Mauricio et al., 2019; Rogers et al., 2021). Much of the literature focuses on either the Triple P or the COS-P program independently, and studies are either quantitative or qualitative, which is limiting because it does not allow for any contrast between the two programs, or a comprehensive understanding of a research question by combining the strengths of both quantitative and qualitative analysis. Similarly, the focus of the literature is mostly on the Triple P, there is a paucity of information on the COS-P program, and even less information about implementation barriers and facilitators in a pandemic and post-pandemic world, including facilitators and barriers to sustained virtual delivery. This study addresses these gaps by collecting both quantitative and qualitative data to examine providers readiness as well as barriers and facilitators to implementation of the Triple P and COS-P programs in an online program training and delivery setting. We applied a mixed methods approach to fully understand provider's experiences implementing both the Triple P and COS-P parenting programs using virtual delivery within the affiliated community partner organizations.

1.8 Research Questions

Quantitative Research Question:

1. Among Southern Ontario service providers participating in the Promoting Healthy Families randomized controlled trial (RCT), how do providers rate their agreement on various readiness for change measures prior to delivering the Triple P and COS-P programs to caregivers of children aged 2-6 years?

Qualitative Research Question:

2. How do Southern Ontario service providers participating in the Promoting Healthy Families RCT describe their readiness to learn and implement the Triple P and COS-P programs to caregivers of children aged 2-6 years, and what, if anything, do they perceive as factors influencing their readiness and experience of learning and implementing the programs in their practice?

Mixed-Methods Research Question:

3. How do the qualitative interviews with the Southern Ontario service providers participating in the Promoting Healthy Families RCT complement, explain, and expand on our understanding of the providers agreement of readiness for change in learning and implementing the Triple P and COS-P programs to caregivers of children aged 2-6 years?

Chapter 2: Methods

2.1 Participants

Data used in this study were collected as a part of the Promoting Healthy Families (PHF) readiness surveys and process evaluation of the Triple P and COS-P programs (Promoting Healthy Families, 2020). The PHF study involved a multi-site, three-arm, parallel-group RCT to evaluate the two parenting programs against treatment as usual. The providers were recruited from one of the four community partner organizations that received training to facilitate the Triple P and COS-P programs. These organizations were four child and youth mental health community organizations that provide services and programs to caregivers and families across Southern Ontario, Canada. Providers were recruited within each of the four partner organizations via snowball sampling to identify providers who had the most experience in delivering parenting

programs. The inclusion criteria for providers who were contacted for follow up was that they: 1) completed the training to facilitate Triple P and/or COS-P; 2) facilitated at least one full program (Triple P or COS-P or both) to completion; and 3) remained in the employment of one of the four participating community partner organizations at the time of qualitative data collection. The specific data used for this thesis were 1) the provider's readiness questionnaires, which were administered prior to training and program implementation, and 2) focus group responses, which were completed one year after delivering the programs.

2.2 Research Ethics and Consent

Consent was obtained via informed consent questionnaires in Qualtrics. Both the quantitative and qualitative portions of the study were reviewed and approved by the Hamilton Integrated Research Ethics Board (PHF RCT HiREB #13034 & PHF RCT Process Evaluation HiREB #14394).

2.3 Quantitative Study Design

The quantitative portion of this thesis involved a cross-sectional study design. Since the quantitative portion was cross-sectional, this involved administering the survey (data collection instrument) which involved the *readiness measures* (BIRCS, EBPAS, and ORC), to understand the providers' readiness to implement the programs, at one point in time, which was pre-program implementation.

2.4 Quantitative Sample

In total, 83 providers were trained in one or both parenting programs and participated in the quantitative portion of the study which involved the completion of the provider readiness questionnaires. These questionnaires, which were completed prior to program implementation, included the following measures: 1. Evidence-Based Practice Attitude Scale (EBPAS) (Aarons,

2004), 2. The Brief Individual Readiness for Change Scale (BIRCS) (Goldman, 2009), and 3. The Organizational Readiness for Change Measure (ORC) (Lehman et al., 2002). Collectively, the questionnaire items aimed to understand their confidence in their own skills, the support of the organization, their beliefs in evidence-based programming and training, and accessibility of resources within the organization.

2.5 Quantitative Measures

The demographic information that was collected and used to provide context for the qualitative results of this study involved: sex, program delivered, age, ethnicity, highest level of education obtained, experience in the field, experience running parenting groups, and experience providing individual therapy. Additionally, three measures were administered to providers.

The Evidence-Based Practice Attitude Scale (EBPAS):

The EBPAS consists of 15 items that assess four dimensions of attitudes towards the adoption of evidence-based practices including a) *Appeal:* the appeal of evidence-based practices (EBPs) for adoption; b) *Requirements*: the likelihood of adopting EBPs if required to do so by the organization or supervisor; c) *Openness:* practitioner openness and willingness to try new practices and use more structured/ manualized interventions; and d) *Divergence*: perceived divergence between research-based/academically developed interventions and current practice (Aarons, 2004). The EBPAS items were measured on a 5-point Likert scale ranging from 0 = “Strongly Disagree” to 5 = “Strongly Agree”. The total mean score was calculated from each response and greater scores indicated a greater likeliness to implement evidence-based practices in their organization. The EBPAS has been found to be a reliable and valid measure of attitudes toward evidence-based practice, the internal consistency of the scale has been found to be high and has good construct validity (Al Zoubi et al., 2018).

The Brief Individual Readiness for Change Scale (BIRCS):

The BIRCS is a four-item rapid screening instrument used to assess individual readiness for change (BIRCS; Goldman, 2009). The BIRCS items were measured on a 5-point Likert scale which ranged from 0= "Strongly Disagree" to 5= "Strongly Agree". The mean score of the scale is calculated by taking the average of all responses. Responses to each item were added and then averaged to generate a total score on the scale, with higher mean scores indicating increased readiness to apply research-based practices, while lower scores indicating that an intervention to increase readiness is needed. The BIRCS has demonstrated good psychometric properties including good internal consistency and convergent validity since it correlates with other change readiness measures (Goldman, 2009).

The Organizational Readiness for Change Measure (ORC):

The ORC is a 115-item instrument that includes four domains: 1) motivation for change; 2) adequacy of resources for the program; 3) staff attributes; and 4) organizational climate. These domains and their respective subscales include *Motivation for Change*: program needs for improvement, immediate training needs, and pressures for change; *Adequacy of Resources of the Program*: offices, staffing, training, computer access, and e-communications; *Staff Attributes*: growth, efficacy, influence, and adaptability; and *Organizational Climate*: mission, cohesion, autonomy, communication, stress, change. The ORC items were measured on a 5-point Likert scale ranging from 1 = "Strongly Disagree" to 5 = "Strongly Agree". Subscale scores were calculated by adding the scores from each question within their respective subscale and then averaging them. The total mean scale score was calculated by adding and then averaging all the subscale scores. Higher mean scores indicated increased perceived organizational readiness for change, such as the belief that the organization can successfully create change, has adequate

resources to do so, the staff are equipped for this change, and there is overall motivation for program implementation. The ORC is a reliable and valid measure of readiness for change and has been found to be related to organizational change initiative success (Ritchie et al., 2019).

2.6 Quantitative Analysis

To answer the first research question, and examine provider's attitudes toward readiness for change, the EBPAS, BIRCS, and ORC measures were analyzed with the use of the statistical analysis software, R Studio V.4.2.0. Since the study was cross-sectional, data were collected at one point in time, prior to program implementation. All data from these scales ranged from 1 = "Strongly Disagree" to 5 = "Strongly Agree". Since the study followed a quan→QUAL design, greater emphasis was placed on the qualitative portion of the study. The quantitative portion of the study served to provide context to the qualitative outcomes. To adequately answer the quantitative research question, which involved understanding provider's agreement to various readiness for change measures, the quantitative analyses of this study involved solely descriptive statistics. The quantitative measures computed for each scale and their respective subscales involved the mean, median, and standard deviations for each of the three measures, the EBPAS, the BIRCS, and the ORC scales.

2.7 Qualitative Study Design

The qualitative design of the study involved a qualitative descriptive approach, which aimed to understand a sequence of events that occurred (Sandelowski, 2000). Provider's recollection of program implementation and delivery were understood through semi-structured focus groups. Typically, qualitative descriptive studies are employed when clear descriptions of certain events are required, such as their experience being trained in and delivering the Triple P and COS-P programs (Sandelowski, 2000).

2.8 Qualitative Sample

The qualitative component of the study involved a sub-group of 22 providers, across all four organizations, that participated in semi-structured qualitative focus groups that expanded on their experiences delivering either Triple P or COS-P. Participants meeting the inclusion criteria noted above in the *participants* section, were purposefully sampled from the larger group of providers and recruited for this portion of the study via email based on availability. The providers were recruited to participate in the focus groups a year after program training and delivery.

2.9 Qualitative Focus Groups

Questions that were asked in the focus groups addressed the provider's readiness to learn and implement the Triple P and COS-P programs to caregivers of children aged 2-6 years, and the factors that influenced their readiness and experience of learning and implementing the programs within their respective organizations. The questions explored overall provider readiness to learn and implement the Triple P and COS-P program, and what barriers or facilitators they were faced with during training and delivery. The questions asked in the focus groups, found under *Appendix B*, allowed us to gain an in-depth understanding of the provider's experiences. Focus groups were conducted in the Spring of 2022, lasted roughly 60-90 minutes with around two to four providers in each, and were conducted via video conference (Zoom) by a trained Research Coordinator with experience in conducting qualitative interviews. The focus groups were then transcribed verbatim by a transcription service. Once transcribed, the data were then imported into NVivo to assist with data analysis.

2.10 Qualitative Analysis

To address the second research question, thematic analysis for applied qualitative health research was employed to understand provider's experiences of their readiness to learn and to implement the two programs, as well as to identify barriers and facilitators in program delivery. This method of qualitative analysis is similar to Braun & Clarke's thematic analysis (2006), but modified for health research (Campbell et al., 2021). The analytical process involved 1) familiarizing oneself with the data; 2) generating codes; 3) constructing themes; 4) reviewing potential themes with the thesis supervisor; 5) defining and naming themes; and 6) producing the report (Campbell et al., 2021).

After the focus groups were conducted, and the data were transcribed, the data were then imported into NVivo V.12 to assist with qualitative data management. Following the steps outlined by Campbell et al, analysis began by reading through the focus group transcripts and familiarizing oneself with the data where initial codes were generated. Specifically, the first two transcripts of the Triple P and COS-P focus groups were used to develop a code book and then the remaining transcripts were coded in NVivo using the initial codebook while also simultaneously allowing for the generation of new codes, if needed. Once coded, initial categories were broadened and eventually clustered into themes that captured the common perceptions of providers delivering the Triple P and COS-P programs. The formation of the thematic framework was an iterative process that involved going through the data again to make sure that the themes accurately represented the data. These themes were reviewed with the thesis supervisor, committee members, and the research coordinator who conducted the interviews. After being reviewed by all members, the themes were finalized, and a thematic framework was formed.

2.11 Mixed-Methods Study Design

The mixed-methods, explanatory sequential component of the study, integrated both quantitative and qualitative data to provide a more comprehensive understanding of the research question (Guetterman et al., 2015). This involved the collection and analysis of quantitative and qualitative data in two consecutive phases, quantitative followed by qualitative. Greater emphasis was placed on the qualitative data, which allowed us to explain the outcomes of the quantitative data (quan → QUAL sequential design). To ensure that the quotes from the focus groups were representative of the full data set, careful consideration was given to not only accentuate certain phenomena, but also include all aspects that were brought to light in the focus groups. To understand how the themes in the focus groups complement, explain, and expand on the provider readiness data, quantitative and qualitative data were integrated during the data interpretation stage via a joint display table and can be found in the results section. In this sense, relative quantitative outcomes such as provider's mean scores on the several measures were explained by the quotes from the providers in the focus groups. Thus, the focus group data qualitatively explained and supported the statistical analyses of the quantitative data. By integrating the data, new insights can be generated aside from just the individual quantitative and qualitative results alone (Fetters et al., 2013). According to Guetterman and colleagues (2015), data integration is a key component of mixed-methods studies, however, this is not typically practiced. Therefore, this study integrated both the quantitative and qualitative results so that they comprehensively complement each other, to emphasize the true benefits of a mixed-methods study.

Chapter 3: Results

3.1 Demographics

This study used data from the 83 providers in the Promoting Health Families study. Seventy-nine of the providers were female (95.2%) and 27 were between the ages of 30 and 39 years old (32.5%), with a mean age of 41 years old (SD = 11.5). Forty-two providers were trained in the COS-P program (50.6%), 25 were trained in the Triple P program (30.1%), and 16 were trained in both programs (19.3%). 50 participants were North American (60.2%). Nearly all participants completed post-secondary education; 36 participants held a master's degree (43.4%), and 25 held an undergraduate degree (30.1%). Thirty-eight participants reported that they had over 15 years of experience working in the field (45.8%), and 14 (16.9%) reported having 10-15 years of experience working within their specific organization. Finally, 64 (77.1%) participants reported that they had previous experience running parenting groups in general, 50 indicated that they had experience providing individual therapy (60.2%), and 40 had experience running parenting groups and providing individual therapy (49.0%). See *Table 2* for a detailed summary of sample demographics.

Table 2: Sample Demographics – Characteristics of Providers Involved in the Promoting Healthy Families RCT in Canada (n = 83).

Sex	N	%
Female	79	95.2%
Male	4	4.8%
Program trained in	N	%
COS-P	42	50.6%
Triple P	25	30.1%
Both	16	19.3%
Age	N	%
Mean	41 (SD = 11.5)	
30 - 39	27	32.5%
40 - 49	20	24.1%

20 - 29	16	19.3%
50 - 59	14	16.9%
60 - 69	6	7.2%
Ethnicity	N	%
North American/ European	61	73.5%
Caribbean, South Asian, Middle Eastern, East/ Southeast Asian, African, Métis, Oceanic, Inuit, or First Nations	14	16.9%
Latin, Central, South American	5	6.0%
Other	3	3.6%
Highest level of education obtained	N	%
Master's degree	36	43.4%
Undergraduate degree	25	30.1%
College diploma, High school diploma, or other	22	26.5%
Experience in the field	N	%
0 to 11 months	1	1.2%
1 to 3 years	9	10.8%
3 to 5 years	12	14.5%
5 to 10 years	9	10.8%
10 to 15 years	14	16.9%
Over 15 years	38	45.8%
Experience providing parenting groups	N	%
Yes	64	77.1%
No	19	22.9%
Experience providing individual therapy	N	%
Yes	50	60.2%
No	33	39.8%

3.2 Quantitative Results

All scores on the EBPAS, BIRCS, and ORC were scored on a 5-point Likert scale ranging from 1 = "Strongly Disagree" to 5 = "Strongly Agree". The analysis was split into four groups, the total provider sample (n = 83), those who were trained in the Triple P program (n = 25), the COS-P program (n = 42), and those who were trained in both the Triple P and COS-P program (n =16). The BIRCS assessed individual readiness for change. The mean score for the total sample was 4.13 (SD = 0.78); the Triple P sample was 4.22 (SD = 0.73); the COS-P sample was 4.21 (SD = 0.80), the "both" sample was 4.38 (SD = 0.77), and the median score for each

group was 4, except the median for the "both" group was 5. The EBPAS assessed dimensions of attitudes toward the adoption of evidence-based practices. The mean score for the total sample was 4.08 (SD = 0.85); the Triple P sample was 4.02 (SD = 0.86); the COS-P sample was 4.08 (SD = 0.88), the "both" sample was 4.20 (SD = 0.76), and the median score for each group was 4. The ORC assessed organizational, and staff-related factors to adopting change. The mean score for the total sample was 3.65 (SD = 0.81); the Triple P sample was 3.68 (SD = 0.82); the COS-P sample was 3.65 (SD = 0.82), the "both" sample was 3.64 (SD = 0.79), and the median score for each group was 4. For a summary of these scores, and the scores on the subscales, please refer to *Table 3*.

Table 3: Providers' Scores on the BIRCS, EBPAS, and ORC Measures

	Programs			
	Triple P only	**COS-P only**	**Both**	**Total**
BIRCS: Total Score				
Mean (SD)	4.22 (0.73)	4.21 (0.80)	4.38 (0.77)	4.13 (0.78)
Median	4.00	4.00	5.00	4.00
Range	1-5	1-5	1-5	1-5
EBPAS: Total Score				
Mean (SD)	4.02 (0.86)	4.08 (0.88)	4.20 (0.76)	4.08 (0.85)
Median	4.00	4.00	4.00	4.00
Range	1-5	1-5	1-5	1-5
EBPAS: Appeal				
Mean (SD)	4.07 (0.71)	3.90 (0.99)	4.13 (0.87)	4.00 (0.89)
Median	4.00	4.00	4.00	4.00
Range	1-5	1-5	1-5	1-5
EBPAS: Requirements				
Mean (SD)	3.99 (0.85)	4.13 (0.89)	4.25 (0.78)	4.11 (0.86)
Median	4.00	4.00	4.00	4.00
EBPAS: Openness				
Mean (SD)	3.87 (0.97)	3.97 (0.88)	4.03 (0.80)	3.95 (0.89)
Median	4.00	4.00	4.00	4.00
EBPAS: Divergence				
Mean (SD)	4.18 (0.96)	4.26 (0.88)	4.40 (0.83)	4.25 (0.89)
Median	4.00	5.00	5.00	5.00

ORC: Total Score				
Mean (SD)	3.68 (0.82)	3.65 (0.82)	3.64 (0.79)	3.65 (0.81)
Median:	4.00	4.00	4.00	4.00
ORC: Motivation for Change				
Mean (SD)	2.90 (1.14)	2.90 (1.07)	2.81 (1.03)	2.88 (1.08)
Median	3.00	3.00	3.00	3.00
ORC: Adequacy of Resources				
Mean (SD)	4.10 (1.15)	3.98 (1.07)	3.99 (1.15)	4.02 (1.11)
Median	4.00	4.00	4.00	4.00
ORC: Staff Attributes				
Mean (SD)	4.02 (0.95)	4.02 (0.92)	4.12 (0.90)	4.04 (0.93)
Median	4.00	4.00	4.00	4.00
ORC: Organizational Climate				
Mean (SD)	3.71 (1.04)	3.72 (1.02)	3.68 (0.94)	3.71 (1.01)
Median	4.00	4.00	4.00	4.00

3.3 Qualitative Results

Following program implementation and delivery, providers were invited to participate in focus groups approximately 12 months later within their organizations. Several major themes and subthemes were generated to capture provider's perceptions and experiences of being trained in and delivering the Triple P and COS-P programs for the PHF RCT; the major themes involved: 1) Provider and Organizational Readiness; 2), The Impact of the Training on Triple P and COS-P Providers; 3) Providers Perceptions of Program Delivery. The subthemes are summarized in **Table 4**.

Table 4: Major Themes and Subthemes of Program Delivery and Training

Major Themes	**Subthemes**
Provider and Organizational Readiness	• Initial Awareness and Involvement • Motivation and Interest • Insights on Confidence in Group Facilitation • Level of Organizational Support
The Impact of the Training on Triple P and COS-P Providers	• Positive Experiences with Triple P and COS-P Training Materials and Resources

	• The Impact of the Program Trainer in Triple P and COS-P • Reflection and Fidelity During Triple P and COS-P Program Delivery • The Benefits of Additional Coaching Sessions in the COS-P Program • Balancing Training Materials Expectations
Providers Perceptions of Program Delivery	• Time Constraints During Program Delivery • A Lack of Accessibility and Inclusivity of Materials and the Implications on Program Delivery • Triple P and COS-P Program Concept Challenges • Challenges Engaging Families in Program Delivery • The Importance of Teamwork and Collaboration in Program Delivery • Advantages of Virtual Program Delivery • Challenges with Virtual Program Delivery

3.3.1 Provider and Organizational Readiness

Initial Awareness and Involvement in the Program

Providers reported that within their organizations that participated in the PHF RCT, they were made aware of the research opportunity through senior administrators such as managers or supervisors via conversations, email, or both. Thus, providers noted that managers and supervisors played an important role in recruiting providers to participate in the study, heavily influencing their readiness and willingness to participate in the implementation efforts

> *"The managers and the director shared with us that the study was going on and there was an opportunity to participate."* (P1)

Motivation and Interest

Providers emphasized that they were highly motivated to learn and implement the Triple P and COS-P parenting programs. One provider expressed their interest in evidence-based parenting programs, professional development, research in general, and reducing or preventing child maltreatment as:

> *"I really enjoy researching, learning, and reading about evidence-based practice and all that type of stuff and evidence-based interventions. I found the study goal to be very interesting, looking at reducing the risk of child maltreatment in the future."* (P3)

There was also great personal interests in the parenting programs. For example, a COS-P provider emphasized their personal alignment with the COS-P program's methodology and strategies, and their own interest in attachment-focused parenting, which could benefit other families within the organization:

> *"My interest in the study is because a lot of my prior training and a lot of the work that we do here is attachment-focused or attachment-based and so I really wanted to run the group because that model interested me."* (P2)

Insights on Confidence in Group Facilitation

It was shared that group facilitation was difficult, especially for the small number of inexperienced providers. Although, once providers had the necessary knowledge and resources to learn and implement the programs, they became more comfortable in their ability to do so. This was made clear as one participant stated:

> *"You know, as I started doing it, I was much more comfortable, and I realized that I did have all the tools that I needed. I was just putting a lot of pressure on myself."* (P4)

Their confidence in group facilitation was also dependent on their past experiences delivering programs. While most providers felt comfortable running the group after several training sessions, there were still some who lacked the confidence to facilitate a group:

> *"My colleague who was going to be running the group with me really did not feel comfortable running the group. She felt like she couldn't remember any of the material. She did not feel prepared. But she had also never run any parenting groups before."* (P5)

It was essential that providers were comfortable with the group and confident in presenting the material. This was described as:

> *"I think you have to be comfortable with being with the group. You have to be comfortable with presenting the material. And then I think you have to be really good at asking questions to get further information."* (P4)

Overall, the training was described to be very helpful. However, COS-P providers strongly suggested that a mock program delivery component should be incorporated into the training as a requirement prior to facilitating the program. Implementing this directly after training, or practicing with a colleague, was seen as something that was extremely beneficial to their learning:

> *"I'd say the training overall was very good but again the real learning like the true learning was actually delivering it myself… there should really be a component where you almost have to, I don't know role play, or do some sort of a mock."* (P7)

Level of Organizational Support

Organizational support of the program was reported to be mixed and dependent on the provider's specific organization. Providers noted that some agencies were very invested in the

success of program implementation as they were adamant in continued delivery after the research component had ended:

> *"I think the agency is quite supportive of us continuing to run this group even after the research piece is over."* (P8)

In contrast, there were also several individuals that claimed that there was not much support offered at an organizational level. One participant described a lack of conversation regarding program support at their organization:

> *"I think I can speak for both me and my colleagues and say if there are conversations happening, we're not part of them. We're not hearing anything about them right now."* (P9)

This sentiment from a provider suggests that they required more guidance from the initial program facilitators to successfully implement the programs:

> *"We don't talk about the program. We talk about, its supervision, for example, I'm running the program at a certain time, but my supervisor doesn't come back and say so how did it go? Did you run into issues? Do you want to problem solve? Like the person that I do that with is outside."* (P10)

A component of program implementation that greatly benefited providers was having the support of their managers and supervisors. Providers within certain organizations found that their manager was very supportive of program implementation, throughout the entire process:

> *"We could access our manager for support and bring it to our team during rounds if there was something happening within the group dynamics that we needed. The Centre's very supportive in executing and delivering this program. They're very committed to it. And they're committed to supporting staff as well in whatever way they need."* (P12)

There were some providers who were proactive during program delivery and incorporated program delivery as a priority within the agency. Some managers were eager to learn more about the programs and support delivery. Providers shared that there have been specific managers who have acted as champions of the program supporting delivery:

> *"Our manager has really taken this on and it's part of her job now to support anybody who is facilitating it. It's going to be part of our repertoire now because people have been sharing in groups that we offer the programs in the Centre and the community."* (P8)

3.3.2 The Impact of the Training on Triple P and COS-P Providers

Positive Experiences with Triple P and COS-P Training Materials and Resources

Triple P Materials and Resources:

The providers shared that the training materials were very well formatted and greatly assisted them in program delivery. Specifically, they appreciated the clear structure of them, which helped facilitate delivery. Thus, these materials were applied and promoted confidence and readiness to implement the program. Providers expressed that training materials were a key component of program training:

> *"I personally liked the materials. They're quite different from any other trainings that I've run in that it outlined everything that you were supposed to say, what you needed to do to be prepared."* (P15)

The admiration of the training materials was further noted by participants, specifically how simple the program was to understand and allowed for easy implementation and effective outcomes such as providers and parents grasping concepts easily. The overall organization and simplicity of the program was expressed as:

> *"I find it pretty useful because of the simplicity of it. Parents can kind of catch those ideas pretty quick. It doesn't require a lot of like theory. The results, when they implement some of those ideas because they're simple so it's a simple idea for them to catch onto. Its then simple to implement. They see results quick. The delivery we got was like well organized, well timed, it was very professional."* (P19)

The role-playing aspect of Triple P delivery was well received by many. It was found to be a beneficial component in delivery and really helped providers incorporate the materials that they learned and put them into practice:

> *"I think role playing was very helpful and just kind of setting that into your own skills and tone."* (P20)

COS-P Materials and Resources:

Overall, participants found that the COS-P training materials were easy to understand and helped them immensely during program delivery. The utility of the materials made it easier for providers to successfully deliver the program which was described by one participant as:

> *"I really liked the videos. I also liked the material. Very easy to understand. Very easy for it to sink in your head… Everything was very simplified, and I really liked that. It made it easier for us to present when it was our turn to facilitate."* (P16)

The overall layout of the materials could have contributed to provider readiness to deliver the program. The manual allowed them to be equipped for program delivery and the clarity and accessibility of the manual was expressed as:

> *"I just want to speak to the manual. It's so laid out, so helpful when you're running the group, and has talking points, and all of the questions. It's very clearly labeled, documented, and easy to follow."* (P2)

The Impact of the Program Trainer in Triple P and COS-P

Triple P Program Trainer:

The program trainers were essentially the root of program delivery, as she trained the providers to deliver the program. The Triple P training materials, but specifically, the experience with the Triple P trainer in general, were very well received by providers in the study. They highlighted that the trainer did an excellent job at facilitating the group and creating an inclusive and supportive environment:

> *"I found that the trainer was very patient. She was excellent with her time management. The trainer acted as the educator and while we were training as staff it felt like we were families going through the experience. Then we got to go into breakout rooms and practice the information."* (P15)

Overall, the experience during training, and being given the opportunity to engage with others facilitated program training and effective program delivery. The support system that the trainer provided was further described by a participant as:

> *"It was great to be able to have that conversation with her and have the whole group connect and reflect on the learning together which was really valuable, we didn't have to hold it by ourselves, we were able to come back to the group, talk about our concerns and really sort of have that really in-depth learning experience."* (P5)

COS-P Program Trainer:

Similar to the experiences of the Triple P providers with their program trainer, the COS-P providers had very positive experiences with their trainer as well. Providers noted that the trainer really embodied what the COS-P program was about and served as a positive attachment figure. A very widely shared component of the focus groups involved how much the providers valued

the program trainer who delivered guidance and instruction while using COS-P principles such as holding space and silence:

> *"I just thought he was so warm, and like holding. Very nurturing. He really embodied what an attachment figure would be like even in an online training with 80 people."* (P8)

Specifically, the trainer's attributes and delivery style were very successful in communicating the program materials to providers. The trainer created nurturing and safe environments for providers to learn, which allowed for increased participant engagement:

> *"His pace, and how he delivered. Like as much as it was all crammed with information, his pace was the right pace. His intonation in his voice. His knowledge."* (P22)

Reflection and Fidelity During Triple P and COS-P Program Delivery

Triple P Reflection and Fidelity:

Fidelity checklists were self-report measures that were administered to providers to ensure that they were delivering the program as intended. Providers in the Triple P program found the checklist to be helpful during implementation to keep them on track with delivery. However, it was noted that providers required more options on the checklists to describe fidelity accurately. Regardless, the fidelity checklists were emphasized as a positive aspect of program delivery:

> *"I found the fidelity check list helpful, however, it wasn't always very accurate. So, when you were entering how much time you spent there were set numbers. I think the increments were 15 minutes, 30, an hour and up, so if you were spending less than 15 minutes on completing the fidelity check list or maybe a little more time you couldn't input those numbers. You had to stick with what was in, what was recorded in the drop-down list. The fidelity check list was pretty smooth in that it flowed with the questions that Triple P had given us when we were being trained."* (P15)

Overall, the fidelity checklists led to internal reflection and conversations as well as program awareness amongst providers. The checklists helped providers further their understanding of the program and how the delivery was being executed in general, which was expressed as:

> *"I did the fidelity check list, it was great. I think that it spun some good conversation between myself and my co-facilitator. That is always good."* (P19)

COS-P Reflection and Fidelity:

Similar to the fidelity checklists of the Triple P program, the fidelity checklists in the COS-P program were also important to providers. These checklists helped them reflect on the program, solidify their skills, and gain confidence in independently facilitating a group session:

> *"I enjoyed doing that because it gave me an opportunity to reflect on how the session went and how comfortable I was, like how I felt about the different things that were popping up, and then it helped to kind of focus again for the following week."* (P16)

The Benefits of Additional Coaching Sessions in the COS-P Program

Additional coaching sessions were an option for providers of the COS-P program. Many noted that having the additional support, and the ability to go to someone if they ran into any problems was comforting. The providers in the study who were offered additional coaching sessions found great value in these sessions, which was described by one COS-P participant as:

> *"It was really enlightening. I learned a lot, a lot of reflection, and a lot of opportunities to kind of pull apart what happened in the group and kind of find ways to improve for the next time. So extremely helpful."* (P4)

Although these sessions were helpful, many providers also reported "not being approached" or not being offered additional coaching sessions, which may have impacted the success of their delivery by not having that additional support system.

Balancing Training Materials Expectations

Providers found it very difficult to balance their time as they did not have enough time to properly engage in the training materials, absorb what they learned, and still work on existing commitments. This was described as:

> *"Watching the videos, reading the materials, all of that before the session and then going through the sessions personally it was a lot in a very short period of time especially because it required kind of like 40 hours of your own time plus the daily sessions that we were having which was a little bit overwhelming because at the same time kind of like balancing that with all of the other clients and programs that are going on at the same time."* (P1)

It was suggested that provider's confidence was low at the onset of the program because right from the beginning, they were told that they would not have enough time to get through all of the training materials. With this precedent set right at the beginning, it made it difficult for providers to continue to be motivated to get through all of the materials. One provider described their experience with this sentiment as:

> *"The trainer brought it up during the training or during one of the other sessions where he said, these sessions you're probably not going to be able to finish. Knowing that already, then why is the expectation there, when we already know that most likely, because there's so much content to cover, if we already know that we're not going to be able to cover it then why are we asked for this expectation?"* (P7)

Providers found that in big groups it was difficult to get through all of the materials because of the many questions and people contributing. However, a participant in a smaller training group (relative to the more regular, larger-sized groups) reported an overall positive experience with having fewer individuals in their training session:

> *"It seemed perfect, and they all got a chance to really reflect with each other which I would imagine in a bigger not everybody would have the opportunity to do. It's just an interesting little tidbit. I didn't think that our small group would be enough, but it was actually really lovely in that timeframe."* (P8)

3.3.3 Providers Perceptions of Program Delivery

Time Constraints During Program Delivery

There were a fair share of challenges throughout delivery, and providers in both programs found that the workload during delivery was far too much. It was emphasized by providers that expectations should be outlined for individuals to be aware of at the onset of program delivery, this included having to attend all sessions and the need for utilizing personal time to study the materials.

Providers felt overwhelmed with the amount of material they had to get through, and the pace of delivery overall, which was expressed as:

> *"It was a little fast-paced for me and I didn't understand why there were not so many more explicit explanations going on. So, I kind of had to kind of figure things out on my own a bit."* (P20)

Providers had ongoing work or caseloads while delivering the program. Thus, when it was time for the rollout of delivery, many felt overwhelmed because of their existing commitments:

> *"Talk to our bosses and get us less workload… the time was a challenge for me, just with my work, the rest of the work demands"* (P4)

A Lack of Accessibility and Inclusivity of Materials and the Implications on Program Delivery

For programs to be continuously delivered in the future, and for them to reach as many individuals as possible, accessibility and inclusivity of materials was mentioned as a specific target. Accessibility for caregivers during delivery was commonly mentioned throughout the focus groups. Providers suggested that by making materials more accessible, such as having subtitles, this would make delivery easier:

> *"Having subtitles and things like that to be a little bit more accessible, that would be really helpful."* (P1)

Another factor to consider when thinking about accessibility was that there were some providers who had children in their group with special needs. Some of these providers had no training in delivering the program to children with special needs, thus, they were not aware of specific or tailored ways to support them during delivery:

> *"Maybe they should be put in a group with a facilitator who knows how to address parents who have children with autism."* (P5)

When thinking of accessibility and sustained program delivery, language was a very important factor to consider. There were some providers that mentioned that in their groups they had some participants who did not speak English fluently. This made it difficult because they could not understand the topics being portrayed or the messages of some of the lessons and they could not effectively communicate with other parents in the group. This would additionally lead to more questions and slowing down of the group, which could have been avoided if an interpreter was present:

> *"One of our group participants, their level of English was not the one that we were told, and I think that it would have been a lot more beneficial for this parent to have the opportunity to have an interpreter or even just a book in a different language because a lot of the concepts and a lot of the conversations she was not able to necessarily participate in it."* (P1)

Many providers also really enjoyed the Triple P materials provided to them, specifically the tip sheets, but they could not share them with parents or other providers during delivery due to privacy issues. They noted that they could not access some materials outside of the workplace or share them with their clients. This led to further barriers in delivery due to the contingency of materials:

> *"Triple P turned around and said that we're not allowed to photocopy any of that, we have to purchase all of those tip sheets. But they weren't available to us electronically and that's the downer."* (P15)

Providers also mentioned that the timing of program delivery was not only important to them, but also to caregivers and their sustained engagement. They found that when program delivery was scheduled later in the day, parents could not properly engage in the materials because they were pre-occupied with other responsibilities at home:

> *"The other thing is for our group, because it was from 5 to 7:30, at that time, most of the parents were preparing their kids to have dinner, having dinner, and going to bed, so it was a mess. We had to go through bath time with the kids and the mom was carrying the computer, and then it was dinner time, and the mom was carrying the computer, and then the mom was trying to put the kids to bed."* (P1)

Triple P and COS-P Program Concept Challenges

Triple P Concept Challenges:

While many benefits of the program have been mentioned throughout, and the program was relatively clear, there were some components of the Triple P program that were confusing to participants. Given that some providers did not have a background in interpreting data or statistical analyses, many of the Triple P providers had trouble interpreting scores on the scales filled out by parents, leading to an added burden during delivery, which was described by the providers as:

> *"Maybe just highlighting them and putting a blurb as to what the parent said or if you're not a psychologist how to interpret the data so that it's a little bit easier to understand."* (P5)

It was mentioned that for future delivery, providers should be trained in this beforehand, or there should be well-laid-out instructions to do so. One participant echoed the above sentiment and mentioned that the training on this portion of the program was not consistent with how it occurred during delivery:

> *"The biggest confusion part was the scoring. Oh my gosh. They're on this long excel sheet and then to interpret it I needed to see all the data in front of me. I had to go back and retrain myself on how to figure out that information about the questionnaires. I know the people that I was working with, they didn't even know how to interpret that data. It wasn't as easy to interpret as it was presented to us in the beginning."* (P15)

Another component of the Triple P program that was confusing to providers involved the idea of logical consequences. This concept emphasizes the consequences of their child's actions, and how they were connected. Providers struggled to deliver this concept because many parents

could not grasp what this meant, and they required a lot of guidance trying to figure out what each consequence could be for every action:

> *"I can speak to the larger group, when we were going through that stuff it did strike me, I felt that with some of the families the vibe was very 'I don't want to use it', kind of like they needed a lot of handholding. Difficulty figuring out what is a logical consequence for this behaviour."* (P18)

The last concept that providers and parents struggled with involved the concept of timeouts. While this has been a concept that has been around for an extremely long time, many providers and parents actually shared their opposition to this concept:

> *"Sending a 3-year-old to be in a room by themselves, they might end up hurting themself. They may kick something. They may knock something over. They may punch something. They may get their fingers stuck in their door if they try and slam the door."* (P6)

Another provider shared their disagreement with the topic. They also mentioned that the concept of time out specifically, may make people hesitant to apply Triple P practices. Rather than helping the children this could harm them further:

> *"This one is probably the most controversial. It probably turns people off Triple P the most. I think it's very dated in the concept. We now know better and so we expect that we do better. I actually talked to Triple P about this concept because it's so controversial"* (P19)

COS-P Concept Challenges:

Similar to the Triple P program, specific concerns regarding certain aspects of the COS-P program arose during the focus groups. Many providers shared confusing aspects of the program that puzzled both the parents receiving the program and the providers delivering the material. The first component involved the concept of "Mean and Weak" which is when parents are upset

and aren't fully equipped to care for their child, thus, being the opposite of being able to support their child in the moment. Providers emphasized that it is essential to establish a safe environment with parents prior to delivering this concept to ensure there is active participation and reflection because if a safe environment is not established, caregivers could potentially feel shame. One provider shared that they didn't like the language and didn't want to label parents as mean or weak:

> *"I think what both of us struggled with was the language of Mean and Weak. Particularly Weak. We just didn't like that language. And it was hard to call people out in that way."* (P4)

Another issue that was very common amongst providers was the confusion around the concept of shark music. Shark music is when their child may need something unfavourable from their caregiver, causing discomfort to them. Providers noted that "Shark Music" did not resonate well with caregivers, and they required additional time for further explanation and examples. Some parents even changed the name of the concept:

> *"We actually had a participant who said I'm not going to call it shark music anymore because I have no idea what that means. She called it my boiling hot water and that's what she called it and she explained it and even the way she explained it others in the group we were all like oh."* (P7)

Challenges Engaging Families in Program Delivery

Something that was commonly shared as a barrier to delivery was program engagement. There were some families who did not fully commit to the program, and this led to an increased burden on providers trying to help them and accommodate them in the program. For some, scheduling was a major barrier as well, and providers had trouble keeping parents engaged in the program:

> *"It was a lot of chasing families down or they would cancel or try to reschedule. And I had half of our group. I did half and the other person did half. Thinking that I would do this for all 10 people or whatever it would be very time-consuming for me. I feel I would've needed support."* (P20)

Given that some parents did not fully engage in the program, or weren't dedicated to the learning process, this also led to parents struggling with the materials. Some parents would not put in the full time and effort, and this burdened providers as they had to make up for this in their sessions and catch up with these parents many times. It was clearly essential for providers that participants showed up ready to engage in the materials or else the participants would not fully grasp the concepts delivered to them:

> *"It seemed like there were some caregivers that were kind of half there, half not. The ones that were half kind of there half not, when you would come back to the individual calls a lot of the questions would be about content that we had discussed and as a facilitator, I am ok with giving information, but then at a certain point, I need you to read the workbook and then we can have a conversation together. The onus and the heavy lifting can't be fully on myself."* (P3)

Overall, it is essential that programs are delivered in a manner that is most engaging to participants. Providers emphasized that if parents were not engaging in the materials, they will likely stop attending sessions, making it more difficult for providers to sustain program delivery:

> *"If they're not connecting to the material then you're going to find that they're going to have a harder time, and not necessarily come to all the sessions."* (P4)

The Importance of Teamwork and Collaboration in Program Delivery

Collaboration and teamwork played a key role in provider's confidence and readiness to deliver their parenting programs. Being paired with another provider allowed them to have another person to prepare with and support them throughout delivery:

> *"Having a cofacilitator, we were able to keep each other in check and be there for each other."* (P3)

Although some providers noted that they were incredibly nervous to deliver the program, they also described that having a partner, and someone to support them, allowed for more efficient program delivery, especially when they were paired with providers who were experienced in program delivery:

> *"I was paired with someone that I hadn't actually ever worked with before, but she was so knowledgeable, she had done it so many times and I was unbelievably nervous…"* (P4)

It was also emphasized that working in teams provided a strong sense of community and safety for providers. Given that they worked closely with another individual for an extended period, and were able to share ideas and troubles with them, this provided a safety net for them:

> *"I really like that that they kept those groups consistent because you got to know people over time and that safety developed and so we were able to kind of share."* (P18)

Advantages of Virtual Program Delivery

Providers emphasized that an advantage during program delivery was having the ability to conduct the programs virtually. Some greatly appreciated that virtual delivery allowed for the reach of a larger audience in the study (including those located outside of the organization's city and catchment area):

> *"I liked that it was accessible to people. We are based in (name of region). We had clients from (name of the city), one from (name of the city), so many different areas, so it was really great."* (P13)

Many providers found the virtual nature of the program to assist in increasing attendance and removed a large barrier that is usually present, transportation. The online delivery overall made program access more convenient for both providers and parents and led to increased attendance and engagement in the program:

> *"I feel like we got pretty good attendance all the time and I feel like part of that was probably because it was virtual. I think that was helpful because the actual getting to and out of the centre could be a challenge right depending on where the families are."* (P14)

Providers also emphasized the benefits of virtual delivery, such as easy transitions into group discussions, and the ability to control the group and timing in general. Virtual delivery created a smoother delivery format for participants and allowed for more effective management of the program:

> *"I can't even imagine running the program in person because on Zoom…you have the option to take your large group and put them in breakout rooms… you are able to control the group a little more… It created a smoother flow for us in that we were able to manage that time as best as we can."* (P15)

Providers emphasized the uncertainty of in-person delivery, especially, regarding their own ability to deliver the programs in-person:

> *"I think for me, highlighting that it was done during a pandemic, I've never delivered it in person but I think it's supposed to be delivered in person. I don't know what my confidence level would be in terms of delivering it in person."* (P6)

Challenges with Virtual Program Delivery

Although the training and delivery of the virtual program had its advantages, there were also many barriers to online delivery. Many providers reported that the rapid onset of the pandemic made the transition from in-person to virtual delivery very difficult, leading to feelings of fatigue. This could suggest that virtual delivery may not be ideal for all providers, specifically those who struggle with virtual delivery/ learning environments:

> *"That was the time when everything was kind of transitioning and the whole pandemic was starting so I found it difficult only because everything was online, so I felt myself getting tired."* (P12)

Service providers also found that there was a difference in comfort levels between in-person and virtual delivery. One participant shared that virtual delivery involved an extra barrier in program delivery which is establishing a connection and rapport with participants online:

> *"When you're in-person it's very different. When you're online you have to go the extra step in trying to be comfortable with whoever is there you know. But when you're in person it's a little easier but online it's a little harder."* (P16)

One participant expressed that they would have preferred if videos were embedded in the presentations rather than individually clicking on videos themselves. This could improve the fluidity of delivery and save time during program planning. Incorporating video elements into virtual delivery can overall increase the delivery experience for providers and make the content easier to understand:

> *"I've seen lots of other presentations where you just go to the next slide and the video's there. I think that would help with the fluidity of the delivery and not us clicking the video. That took*

> *up time for us in terms of planning and we spent a bit too much time on that whereas if you would just embed the clips in the PowerPoint, it would just flow."* (P16)

While online delivery allowed providers the convenience of not having to go into a physical location to participate, some became too comfortable with being at home:

> *"I got the vibe that parents were there, they were logged on, but,I would say many of them had their cameras off and were doing other tasks at the same time."* (P17)

This was emphasized further by another participant who had experience running in-person programming and emphasized the increase in engagement they see in-person versus online:

> *"I facilitate a parenting clinic and I have both a virtual and in-person option, and I know, I'm very confident that my participants get more out of the in-person one."* (P13)

Many providers in the study emphasized their concerns regarding childcare, which was a barrier during online programming. Providers mentioned that childcare was usually offered with in-person programming, however, this was not the case with online delivery. This led to many providers noting that parents could not fully engage in the materials provided because they were distracted with their children. The presence of children in the home made it more difficult to facilitate as well, which was described by one provider as:

> *"…there were 5 participants, 3 had their kids around. As much as you appreciate and respect it, you're also thinking, how can you truly engage in this material when you have one of the kids screaming in the background or demanding something of you."* (P18)

3.3.4 Data Integration: Mixed-Method Analysis – Joint Display

To integrate the pre-implementation readiness data with the process evaluation qualitative interviews post-program implementation, a side-by-side joint display was created, which involves displaying both the quantitative and qualitative results beside each other and creating

inferences from the data (see Table 5). Patterns of the quantitative data, i.e., high or low scores on each readiness scale, are explained by quotes that provide examples to explain why the score may be high or low (Guetterman et al., 2015).

Table 5: Integration of the Quantitative and Qualitative Data: Joint Display

Initial Awareness and Involvement	
The high mean scores on the Requirements subscale suggested that providers were willing to adopt evidence-based practices if required by their supervisor, or organization. Providers were made aware of the program through managers and supervisors, and similarly found under the appeal scale, providers were generally inclined to adopt the evidence-based practices within their organization.	
High Mean Scores - EBPAS Requirements Subscale Both Mean = 4.25, SD = 0.78, Median = 4.00 COS-P Mean = 4.13, SD = 0.89, Median = 4.00 Total Mean = 4.11, SD = 0.86, Median = 4.00 Triple P Mean = 3.99, SD = 0.85, Median = 4.00	*"The managers and the director shared with us that the study was going on and there was an opportunity to participate."*
Motivation & Interest	
The high scoring on the EBPAS in general shows that providers were generally inclined to implement evidence-based practices. This was explained by many providers who emphasized that they already have existing interests in evidence-based practices and interventions and wanted to see this applied to existing clients. The high mean scores on the openness scale also emphasized provider's willingness to try new evidence-based practices and interventions. Providers were generally inclined to implement evidence-based practices to help the parents that attended their organizations.	
High EBPAS Scores – Total Scale Both Mean = 4.20, SD = 0.76, Median = 4.00 Total Mean = 4.08, SD = 0.85, Median = 4.00 COS-P Mean = 4.08, SD = 0.88, Median = 4.00 Triple P Mean = 4.02, SD = 0.86, Median = 4.00 **High Mean Scores - EBPAS Openness Subscale** Both Mean = 4.03, SD = 0.80, Median = 4.00 COS-P	*"I really enjoy researching, learning, and reading about evidence-based practice and all that type of stuff and evidence-based interventions. I found the study goal to be very interesting, looking at reducing the risk of child maltreatment in the future."*

Mean = 3.97, SD = 0.88, Median = 4.00 Total Mean = 3.95, SD = 0.89, Median = 4.00 Triple P Mean = 3.87, SD = 0.97, Median = 4.00	
Motivation and Interest	
The high mean scores on the Appeal subscale of the EBPAS indicated that providers generally found evidence-based practices appealing to them. It was found that providers who delivered both the Triple P and COS-P programs, rated even higher on this scale, which is understandable given that they were trained in both programs, they would thus most likely find evidence-based practice programs more appealing. This was explained by many providers who emphasized the appeal of evidence-based practices. The very high scores on the divergence scale also indicated that the providers believe that evidence-based practices are potentially more effective than the current programs that they use, and they are open to using practices developed by trained researchers.	
High Mean Scores - EBPAS Appeal Subscale Both Mean = 4.13, SD = 0.87, Median = 4.00 Triple P Mean = 4.07, SD = 0.71, Median = 4.00 Total Mean = 4.00, SD = 0.89, Median = 4.00 COS-P Mean = 3.90, SD = 0.99, Median = 4.00 **Higher Mean Scores in General - EBPAS Divergence Subscale** Both Mean = 4.40, SD = 0.83, Median = 5.00 COS-P Mean = 4.26, SD = 0.88, Median = 5.00 Total Mean = 4.25, SD = 0.89, Median = 5.00 Triple P Mean = 4.18, SD = 0.96, Median = 4.00	*"My interest in the study is because a lot of my prior training and a lot of the work that we do here is attachment-focused or attachment-based and so I really wanted to run the group because that model interested me."*
Insights on Confidence in Group Facilitation	
The providers scored relatively high on the BIRCS scale. These responses meant that they had high levels of individual readiness to apply research-based practices. This was explained in the focus groups as many participants emphasized the traits necessary to successfully deliver the program.	
High BIRCS Scores Both Mean = 4.38, SD = 0.77, Median = 5.00 Triple P Mean = 4.22, SD = 0.73, Median = 4.00 COS-P	*"I think you have to be comfortable with being with the group. You have to be comfortable with presenting the material. And then I think you have to be really good at asking questions to get further information."*

Mean = 4.21, SD = 0.80, Median = 4.00 Total Mean = 4.13, SD = 0.78, Median = 4.00	
Insights on Confidence in Group Facilitation	
Providers also rated highly on the staff attributes subscale of the ORC scale. This meant that providers had confidence in their own and their team's passion for growth, confidence, influence, and adaptability. Providers who were even nervous at the start found that they had all of the support and tools needed and were quickly able to adapt and successfully deliver the program with confidence.	
High Mean Scores in General – ORC Subscale – Staff Attributes Both Mean = 4.12, SD = 0.90, Median = 4.00 Total Mean = 4.04, SD = 0.93, Median = 4.00 Triple P Mean = 4.02, SD = 0.95, Median = 4.00 COS-P Mean = 4.02, SD = 0.92, Median = 4.00	*"As I started doing it, I was much more comfortable, and I realized that I did have all the tools that I needed. I was just putting a lot of pressure on myself."*
The Importance of Teamwork and Collaboration in Program Delivery	
Most participants had a great amount of experience working in the field and providing parenting groups or individual therapy. Many providers expressed in the focus groups that experience in the field, or facilitating groups led to many being more comfortable and confident in their program delivery.	
Experience In the Field 45.78% Over 15 years (n = 38) 16.87% 10 to 15 years (n = 14) 14.46% 3 to 5 years (n = 12) **Experience Providing Parenting Groups** 77.11% Yes (n = 64) **Experience Providing Individual Therapy** 60.24% Yes (n = 50)	*"I was paired with someone that I hadn't actually ever worked with before, but she was so knowledgeable, she had done it so many times and I was unbelievably nervous…"* *"I really like that that they kept those groups consistent because you got to know people over time and that safety developed and so we were able to kind of share."*
Provider and Organizational Readiness	
Providers scored low on the motivation for change subscale of the ORC. This indicated that providers believed that their current programs were not in immediate need of improvement, training, or pressure to change. However, even though providers found current practices to be effective, many still did find the new programs to be extremely effective and were advocates of the programs and delivery. Some individuals became extremely motivated and were referred to as champions of supporting program delivery. This presence of a program champion made providers strongly believe that there was organizational support.	
Low Mean Scores in General – ORC Subscale – Motivation for Change Triple P Mean = 2.90, SD = 1.14, Median = 3.00 COS-P	*"Our manager has really taken this on and it's part of her job now to support anybody who is facilitating it. It's going to be part of our repertoire now because people have been*

Mean = 2.90, SD = 1.07, Median = 3.00 Total Mean = 2.88, SD = 1.08, Median = 3.00 Both Mean = 2.81, SD = 1.03, Median = 3.00	*sharing in groups that we offer the programs in the Centre and the community."*
Provider and Organizational Readiness	
Providers rated relatively high on the adequacy of resources subscale, emphasizing that their organizations had sufficient offices, staffing, training, computer access, and e-communications. This was explained by providers as they emphasized that their organizations were very supportive of program delivery, providing anything that they may need for effective delivery.	
High Mean Scores in General – ORC Subscale – Adequacy of Resources Triple P Mean = 4.10, SD = 1.15, Median = 4.00 Total Mean = 4.02, SD = 1.11, Median = 4.00 Both Mean = 3.99, SD = 1.15, Median = 4.00 COS-P Mean = 3.98, SD = 1.07, Median = 4.00	*"We could access our manager for support and bring it to our team during rounds if there was something happening within the group dynamics that we needed. The Centre's very supportive in executing and delivering this program. They're very committed to it. And they're committed to supporting staff as well in whatever way they need."*
Level of Organizational Support	
The mean scores on the ORC scale were relatively average/ low, which could very possibly be due to the mixed response received pertaining to organizational readiness. Some providers indicated in the focus groups that their organizations were very supportive of program implementation, while others did not.	
Average/ Low Mean Scores in General – ORC Total Scale Triple P Mean = 3.68, SD = 0.82, Median = 4.00 COS-P Mean = 3.65, SD = 0.82, Median = 4.00 Total Mean = 3.65, SD = 0.81, Median = 4.00 Both Mean = 3.64, SD = 0.79, Median = 4.00	*"I think the agency is quite supportive of us continuing to run this group even after the research piece is over."* *"I think I can speak for both me and my colleagues and say if there are conversations happening, we're not part of them. We're not hearing anything about them right now."*
Level of Organizational Support	
Providers rated relatively average/ low on the organizational climate subscale of the ORC. This elucidated that some providers believed that their organization lacked cohesion, autonomy, and communication. This was explained in the focus groups as some providers found that there was very little supervision or managerial support during program delivery.	
Average/ Low Mean Scores – ORC Subscale – Organizational Climate COS-P Mean = 3.72, SD = 1.02, Median = 4.00 Triple P	*"We don't talk about the program. We talk about, its supervision, for example, I'm running the program at a certain time, but my supervisor doesn't come back and say so how did it go? Did you run into issues? Do you*

Mean = 3.71, SD = 1.04, Median = 4.00 Total Mean = 3.71, SD = 1.01, Median = 4.00 Both Mean = 3.68, SD = 0.94, Median = 4.00	*want to problem solve? Like the person that I do that with is outside."*

Chapter 4: Discussion

The present study sought to understand the relationship between provider's readiness to learn and their experiences during the implementation of the Triple P and COS-P programs. Our analysis describes provider's individual and organizational readiness, as well as provider's experiences in delivering the programs, including potential facilitators and barriers in delivery. Readiness scores across the BIRCS, EBPAS, and ORC were all relatively high pre-implementation. This could have been due to the overall high levels of education and experience of the providers that were sampled in the study. Most individuals held a post-secondary degree, had many years of experience working in the field, and had previously facilitated parenting groups or delivered individual therapy. These are individuals who likely have sufficient social and collaborative skills (Hussain & Ashcroft, 2020), are committed to producing positive outcomes in this field (Malmberg-Heimonen et al., 2016), and were likely prepared to deliver the program (Steketee et al., 2017). To expand upon this further, provider's advanced educational background, and experience facilitating groups, likely explains the high scores on the readiness for change measures. Further details regarding readiness for change and the themes that emerged throughout are described below.

The specific themes that were generated via the qualitative analysis included: *Provider and Organizational Readiness, The Impact of the Training on Triple P and COS-P Providers, and Providers Perceptions of Program Delivery*. The themes regarding readiness for change are consistent with the current literature, however, it is to the best of our understanding that the literature on investigating provider's experiences delivering both the Triple P and COS-P

parenting programs is extremely limited. There are also very few studies that have investigated this topic in general from a mixed-methods point of view, considering how scarce the literature is on COS-P program delivery. Furthermore, our study brought to light the impact that the pandemic has had on the virtual delivery of parenting programs, and programs in general, which is also consistent with current studies conducted during the pandemic (Shenderovich et al., 2022; Solis-Cordero et al., 2022). The present study specifically brought to light unique experiences regarding the training materials, teamwork and collaboration and fidelity in program delivery, which provides specific insight into program concepts. Finally, challenges in program delivery were described by providers and provided important context for the future delivery of not only the parenting programs, but future program implementation in general. Through the quantitative, qualitative, and mixed-method analyses, our study found important caveats in the provider's experiences facilitating both parenting programs. These experiences provide important context for future program considerations and sustained delivery.

The BIRCS assessed individual provider's readiness for change, and the providers across all groups in our study, Triple P, COS-P, and both, scored highly on this measure. The extremely high scores on this scale indicated increased individual readiness to apply research-based practices prior to program implementation (Goldman, 2009). The high mean score on the BIRCS suggests that, on average, providers felt ready to facilitate the group. This was echoed by participants in the focus groups as they shared how important confidence to facilitate a group was, especially during program delivery. These findings were reiterated via descriptions from providers who reported a lack of confidence and struggled during program delivery. Other studies have determined that having confidence when providing clinical care is essential for effective practice (Hecimovich & Violet, 2009); thus, the same should be applied when

facilitating parenting programs. Providers also shared that as they gained more experience in group facilitation, the greater their confidence grew. This is consistent with literature that states reinforcement is essential to strengthen confidence (Lucero & Chen, 2020).

The EBPAS, which assessed provider's attitudes toward the adoption of evidence-based practices, resulted in high mean scores on the total scale and across all subscales as well. According to Aarons (2004), this suggests that, on average, providers were likely to adopt evidence-based practices, if required by their organization or supervisor. Due to shared passion for research and evidence-based programming, prior to the program implementation, a majority of providers had positive attitudes towards evidence-based practices. This is consistent with other implementation science work that suggests that individual support of the program is essential to successful program delivery and implementation (Dagne, 2021).

Finally, the ORC measured overall readiness for change at an organizational level, however, providers scored relatively average/ low on the total scale. This mid-range/ low mean indicated that on average providers had little to moderate belief in their organization's overall readiness for change (Lehman et al., 2002). The low scoring on the ORC scale, in general, could be due to the low scores on the Motivation for Change subscale, which indicated that current programs were not in immediate need of improvement, and the Organizational Climate subscale which indicated that providers believed their organizations may have lacked the cohesion and communication necessary for change. Even though providers scored low on this scale, since they scored highly on the BIRCS, which is an indication of individual readiness for change, this could indicate that providers were very interested in program implementation but could have used more support at an organizational level to support them through program implementation. Providers scored highly on the Adequacy of Resources scale, indicating that organizations had

sufficient offices, staffing, and training, as well as the Staff Attributes scale which meant providers had confidence in their team's passion for growth, confidence, and adaptability. Analysis of the focus group data indicated that, while some participants felt that their organizations were very supportive of the program, other participants had the opposite experience, thus giving insight into the lower than expected, average ORC score. In the implementation science literature, it has been made evidently clear that organizational support is essential to successful program implementation and delivery (Weiner, 2009). Again, while some organizations were supportive, there were many providers who claimed to have not received any support from the organization and were not a part of conversations regarding the sustained delivery of the program. Despite the initial support of the research project, some providers found that they were not supported throughout the duration of program implementation. Although some managers or supervisors may have been extremely supportive at the onset of the research project and recognized its potential benefits to those in their organization, the organizational support of the program was not consistent throughout delivery. Providers also scored highly on the BIRCS and through the focus groups expressed their personal interest in the programs and implementation in general, potentially leading to higher ORC scores. Without support at the organizational level, providers are unable to successfully and efficiently deliver programs that will make an impact. This is consistent with other studies that have investigated organizational support during the adoption of evidence-based practices, and how essential it is for successful outcomes (Aarons et al., 2009b). This disconnect could be due to a lack of managerial involvement in the program. Many noted that they would need their workloads reduced due to the extensive amount of preparation involved in program delivery. Thus, with a lack of program support from a manager, or supervisor level, programs could not be delivered as effectively. A

lack of support entailed a lack of resources such as funding, additional staffing, and time, which are all necessary for successful program implementation. Although, many providers also found that their manager or supervisor acted as a support system, encouraging discussion and smooth program delivery. Throughout implementation science literature, it has been made clear that managerial support is essential to increase commitment and innovation during program implementation because increased support equates to an increased focus on allocating time and resources toward program implementation (Birken et al., 2015). In implementation science, persistence is especially important to ensure that the program will have lasting effects for continued delivery (Bowman et al., 2008). More efforts must be put in place to keep managers/ supervisors engaged and supporting program delivery.

There were both advantages and challenges associated with virtual program delivery. A unique finding of this study was that many providers enjoyed the online aspect to program delivery during the pandemic because it allowed them to have more control over the group and timing in general. The pandemic has allowed for many virtual presentations, which increased confidence due to the greater control that they had during online delivery (Chotaliya, 2022). Participants in our study stressed the significance of mock sessions in increasing their confidence in program delivery. Triple P participants found their mock sessions to be extremely helpful, however, COS-P does not have mock sessions as a part of program training. It was emphasized by COS-P providers, that having a mock session would be extremely beneficial to their training. Thus, it is strongly recommended that this is implemented in future programming to enhance training. Another positive aspect of online delivery was the increased reach that the program had because individuals who were located far from the center could participate from home; this advantage was also described in a meta-analysis on parenting programs during the pandemic

(Spencer et al., 2020). While online delivery had many positive aspects, there were also many barriers that it posed to participants. In the present study, many providers found themselves fatigued due to the transition from in-person to online delivery during the COVID-19 pandemic. This is consistent with other literature published during the pandemic, where individuals working from home noticed that prolonged exposure to screen time during their full-time work led to fatigue, headaches, and eye problems (Xiao et al., 2021). Providers in the study also found that it was difficult to personally connect to study participants in an online environment. Novel literature that emerged during the pandemic affirmed the notion that body language and social cues are difficult to read in an online environment, thus making it more difficult for individuals to personally connect with each other in a virtual environment (Paradisi et al., 2021). Regarding an online-specific barrier, during program training, the trainer played the training videos while sharing their screen which led to a lag in the video and voice output. Providers recommended that to speed up transitions and provide more clear content in an online environment, videos should be embedded in the PowerPoint presentations. In studies on speech production and visual feedback, it has been noted that during delayed visual feedback, auditory comprehension is affected (Chesters et al., 2015). Providers also found that, due to online delivery, engagement was diminished for many parents. For example, many individuals had their cameras off and were focusing on other tasks at home or even driving during program delivery. In a similar way, many studies over the pandemic found that during online learning, teachers and students have noted a massive lack of engagement in comparison to in-person classes (Walker & Koralesky, 2021). Furthermore, when programming occurs in person, usually there is childcare available, so the children are not in the room, but during online programming, some families had many children in the background which was not only distracting to providers of the program, but other parents

trying to engage in the material as well. One study during the pandemic found that even when the Triple P program was conducted online, the online version still addressed disruptive behavioural problems in children as effectively as the in-person program (Prinz et al., 2022). However, this study did not assess provider's experiences delivering the program, and as found in our study, many providers found it challenging with background distractions to effectively deliver the program. According to our results, future program implementation efforts should identify ways to reduce background distractions in an online environment and provide childcare subsidies so that parents can fully engage in the programs. Given that online learning is already a distracting environment (Aivaz & Teodorescu, 2022), future online programming should focus on ways to reduce distractions, so that implementation is seamless for parents and providers of the program.

The training materials, and teamwork specifically, had a positive impact on the delivery of the Triple P and COS-P programs. Effective training was essential to successful program delivery and was highlighted through the high praise of the training materials in this study. Participants strongly emphasized that the content in the training manuals was very comprehensive and useful in expanding their understanding of the topics explored. Research has established that training programs that are interactive and comprehensive yield more effective implementation outcomes, which allows the participants of the programs to acquire and retain knowledge efficiently (Rowe et al., 2021). In the PHF RCT, providers were given a training manual, reflection journals, and had convenient access to online materials. This allowed for an interactive and comprehensive training experience. Participants also shared that the videos were well received and were a convenient and accessible resource for providers. Video vignettes were also found to be useful to COS-P providers because they provided useful strategies to use with parents. Providers emphasized that teamwork and collaboration helped tremendously in program

delivery. Specifically, working with the same cofacilitator or someone who had experience with the program was instrumental in program success and made the delivery more enjoyable, with many noting that it would have been nearly impossible to do so alone. It has been well-established that teamwork is essential to successful program performance (Schmutz et al., 2019). In healthcare, for example, teamwork and collaboration benefit care providers by reducing work, reducing burnout and fatigue, and increasing satisfaction with their job (Bosch & Mansell, 2015), thus, it was evident in this study, and certain that for future studies, when implementing programs, teamwork and collaboration should always be a priority at an organizational level.

Other aspects that greatly facilitated program delivery involved the program trainer, reflection and fidelity, and the additional coaching sessions offered in the COS-P program. Providers in both programs strongly emphasized how instrumental the trainer was to the success of their program's training. The knowledge and skills that the trainers possessed were large facilitators of program training. They found that the trainers embodied characteristics similar to the program principles. Trainers additionally were very committed to creating a safe learning environment for all providers. In both programs, the knowledge, engagement, and commitment of trainers overall facilitated the training experience. Fidelity checklists were found to enhance reflection among providers and kept them on track. This was typically a well-received concept because it allowed them to solidify their skills and reflect on their delivery. This was an important component of program implementation as greater program fidelity leads to better outcomes for parents of the program (Bywater et al., 2019). While all of these components of program implementation served as facilitators, there were also many barriers experienced by providers during program training and delivery. Providers in the study emphasized that the additional coaching sessions, when offered to COS-P providers, contributed greatly to the

provider's knowledge and success in delivery. This is consistent with the literature on coaching as a model for facilitating the performance of care where they found that coaching led to increased well-being of nurses and benefits to patients as well (Costeira et al., 2022).

While there were many aspects to program delivery that were beneficial to providers, there were also many aspects of training and delivery that served as barriers to program implementation. Specifically, providers were overwhelmed and felt burdened by the amount of materials, had trouble balancing training materials expectations, found that there were certain aspects that lacked accessibility and inclusivity, there were specific program conceptual challenges, and challenges with engaging families in program delivery.

Providers often felt overwhelmed with the amount of content that they had to cover during training or had difficulty balancing training material expectations. In the implementation science literature, it has been determined that organizational change takes a lot of time and energy from staff (Mathieson et al., 2019), as program delivery is already a burden on providers, being overwhelmed with materials and difficult concepts can further strain these individuals. This was further explained by providers as they asserted that for future program implementation, they would need their caseloads reduced because they were extremely overwhelmed when they had to complete their regular tasks and be trained to deliver a brand-new program to them. In the future, the time commitment and expectations should be set at the onset of the study, and organizations should have protected time for providers to properly engage in the materials so that they do not have to worry about existing tasks at work. In studies regarding learning and memory under stress, previous studies have determined that it is more difficult for individuals to learn or remember concepts when placed under stress (Vogel & Schwabe, 2016). During the training program, providers were even told that they would likely not get through all of the materials

because of a lack of time. Thus, a reduced workload and condensed training materials could be very beneficial to providers. A reduced workload would allow providers to focus on training and implementation efforts, without overwhelming competing demands. Condensed materials could also allow them to absorb the knowledge more effectively. By reducing their workload and condensing training materials, providers could be more likely to achieve fidelity, and effectively deliver the program as intended. The size of the groups also had an impact on program delivery. One provider who was given a smaller group to facilitate found their group to be manageable, whereas other providers found that they could not get through all the training materials because of their large groups. Overall, providers felt that there was too much material to get through during training, and that training and delivery overall were very time-consuming for them.

Several suggestions were made to increase the accessibility and inclusivity of materials. Given that the program was delivered remotely, this means that accessibility was a large factor to program success. In the literature on web accessibility, individuals should be able to understand and learn from the materials presented to them virtually, to properly engage and learn from the materials (Alajarmeh, 2022). In the present study, providers suggested that subtitles would have been helpful in their learning process. Additionally, some providers had groups of parents that had children with various disabilities. There are several unique challenges that parents of children with disabilities face (Taderera & Hall, 2017), and providers who lack experience in this field may not be equipped to properly communicate information that needs to be tailored to be helpful to these specific parents. Similarly, providers faced difficulty when there was a language barrier between them and the parents. In healthcare, language barriers may lead to a lack of understanding from patients and less effective outcomes (Al Shamsi et al., 2020). Thus, in the future, it may be recommended to have translators or interpreters that are trained and bound by

ethical protocol to assist parents in the program, so that they can equally benefit from the program. It would also be extremely useful for providers to have access to the materials outside of the workplace, or to be able to share them with participants freely. Lastly, the time that programs were delivered was found to be important for providers. It is suggested to avoid busy times, such as later in the day when parents are typically picking up children from school, making them dinner, or putting them to bed, since providers found that during these times the parents were less likely to be engaging in the materials to the best of their ability.

While most of the program components were straightforward to providers, there were some aspects of the Triple P program that they found to be confusing, such as the interpretation of scores without proper training. Providers highlighted a need for specific instructions in interpreting the scores on various measures. This made it more time-consuming for providers to figure out how to interpret the scores, ultimately taking away from other implementation efforts, and their existing workload. Another concept that was confusing in the Triple P program involved logical consequences, it was not received very well by providers and involved a lot of explaining. Many parents also did not like the concept of timeouts and found that it was very outdated. In the COS-P program, some of the terminologies were troubling to providers. In particular, providers did not want to label parents as “Mean and Weak”, and in parallel, parents did not react well to this term. An important finding was that if this concept was introduced, it was important to create a safe environment prior to bringing this up because they didn’t want to just label parents as “bad”. Furthermore, the concept of “shark music” as referred to in the COS-P was difficult to grasp, as parents often thought of the movie “Jaws”, or the show ‘Baby Shark’s Big Show”, which led to many parents having to rename this term to understand it. Thus, given

the confusion regarding these program topics, in the future, considerations should be made in revising these concepts.

Another important aspect of program delivery was program engagement. Similar to barriers due to online delivery, many providers found that several families were not engaging in program materials and that impacted how well they would grasp concepts taught in the sessions. It would be advisable in the future for parents to have childcare, and to be in a private space where they can properly engage in the program materials to reduce distractions for providers and participants in the program. A lack of engagement led to an increased burden on providers because many parents would come back with a plethora of questions that were discussed in the group. If individuals are not engaging in materials presented to them, they will have trouble grasping concepts delivered to them and burden providers further (Deslauriers et al., 2019). This is a very important factor to consider for future planning of virtual program delivery.

4.1 Implications of Findings

The findings of this study are essential for the future delivery of parenting programs in general, and Triple P and COS-P program delivery. Prior to this study, there was a lack of literature on COS-P program delivery and provider's experiences delivering these programs as well. There was also a lack of literature understanding provider's experiences delivering programs in relation to their individual and organizational readiness. The literature on mixed-methods studies surrounding this topic is also very scarce, emphasizing the importance of this research. Although some findings in this study are complementary of other previous work, there are many findings that build upon, explain, and help us understand through a mixed-methods lens, the unique experiences with the delivery of both parenting programs. This study greatly contributes to the literature to fill this gap with valuable insights into the factors that influence

provider and organizational readiness, as well as barriers and facilitators in parenting program delivery, and program implementation in general.

The identification of factors that influence provider and organizational readiness is essential for future program delivery. In this study, we identified several of these influences such as provider's motivation to participate, their confidence to facilitate a group, rapport amongst providers, and organizational support as well as manager/ supervisor support of program delivery. In future program planning and delivery, these factors should be taken into consideration to ensure more efficient and impactful program outcomes.

Many barriers were brought to light during program delivery in general, some of which involved: online fatigue, difficulty establishing relationships in a virtual environment, a lack of fluid online delivery, active participation from participants, and a lack of childcare. Furthermore, other barriers involved overwhelming/ time-consuming materials, too many participants in training groups, and a lack of accessibility to materials such as subtitles or language barriers. Other program-specific barriers were identified such as specific conceptual challenges as well within the Triple P and COS-P programs individually.

There were also many facilitators that were identified in program delivery such as virtual delivery making the program more accessible, increasing attendance, and allowing for more control over the group. Other facilitators involved well-structured materials and planning, positive feedback from parents, supervisors, and colleagues, dedicated and influential program trainers, and collaboration and teamwork. Future programming should focus on these facilitators so that delivery can be optimized and ensure that providers have the support and resources needed for effective program delivery.

4.2 Limitations

The current study aimed to understand provider's experiences of organizational readiness as well as facilitators and barriers to program delivery. The study successfully answered the quantitative, qualitative, and mixed-methods research questions posed. However, there are several limitations that should be considered while interpreting the results of this study.

Since the study data was collected in a single geographic area, this could also limit generalizability to other areas or settings. Furthermore, the quantitative data was also self-reported by providers, which could be subject to measurement error. Since some providers may have filled the surveys out and remembered their experiences at the moment differently than what actually happened, this could impact the validity of the results. Similarly, the qualitative focus groups were conducted 12 months after training and delivery of the program. Since providers could have either forgotten or not remembered certain details of program delivery, this could also impact the validity of the results due to recall bias. Another point to mention is that secondary data were used in this study, therefore not allowing us to ask more specific questions, which could have impacted the results and the conclusions that were made. Finally, the results of this study can be subject to participation bias. Providers who participated in the follow-up study may have been early adopters due to their interest in the Triple P and COS-P programs or overall had positive experiences delivering the program, thus, making them want to participate in a follow-up study more than someone who may have had a negative experience with the program delivery. This potential bias could impact the generalizability of the results because there may have been more positive experiences in the follow-up, due to participation bias.

Chapter 5: Conclusion

The results of this study emphasized the significance of considering provider and organizational readiness, as well as barriers and facilitators in delivering the Triple P and COS-P parenting programs. The mixed methods approach to this study allowed for an exhaustive investigation into provider's experiences, overall allowing us to understand the challenges present in program delivery. Based on the provider's experiences, organizational readiness was an essential component of the study and facilitated program delivery. Thus, readiness should be prioritized in future programming. By prioritizing individual and organizational readiness, while considering potential barriers and facilitators to program implementation, public health practitioners can design and deliver effective parenting programs, and programs in general, that lead to better health outcomes at a population level. Children are the future of our population's health, and by improving parenting practices and implementing upstream approaches such as parenting programs, this may lead to better population health outcomes in the future. Thus, this study is an essential contribution to public health, the parenting program literature in general, and specifically, the literature investigating Triple P and COS-P program delivery. This study filled a gap in the literature which was mixed-methods studies investigating this topic, allowing for the qualitative experiences to complement and help us understand the quantitative outcomes. Future parenting program and public health program implementation research should take into consideration the effect of provider and organizational readiness, as well as barriers and facilitators in delivery, to allow for sustainable and effective program delivery.

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Appendices

Appendix A – Readiness For Change Questionnaire

Demographics Questionnaire

Q1 Are you?

- ○ Male (1)
- ○ Female (2)

Q2 Your birth Year

▼ 2002 (1) … 1928 (75)

Q3 Are you?

- ○ North American (1)
- ○ South Asian (e.g., East Indian, Pakistani, Sri Lankan) (2)
- ○ Caribbean (3)
- ○ Latin, Central, South American (4)
- ○ Middle Eastern (e.g., Afghani, Iranian, Iraqi) (5)
- ○ East/Southeast Asian (e.g., Chinese, Malaysian, Korean) (6)
- ○ Oceanic (e.g., Australian, Kiwi) (7)
- ○ European (8)
- ○ African (9)
- ○ Inuit (10)
- ○ Métis (11)
- ○ First Nations (12)
- ○ Other (specify) (14) _____

Q4 Highest level of education completed? Please select one.

- ○ No high school diploma or equivalent (1)
- ○ High school diploma (2)
- ○ College diploma (3)
- ○ Undergraduate degree (4)
- ○ Master's degree (5)
- ○ Doctoral degree or equivalent (6)
- ○ Other (specify) (7) _____

Q5 How much experience do you have in family-child care field?

- ○ 0 to 6 months (1)
- ○ 6 to 11 months (2)
- ○ 1 to 3 years (3)
- ○ 3 to 5 years (4)
- ○ 5 to 10 years (5)
- ○ 10 to 15 years (6)
- ○ Over 15 years (7)

Q6 How many years of experience do you have in this organization?

▼ 0 to 6 months (1) ... Over 15 years (7)

Q7 Do you have any experience in the following areas:

- Home visiting (1)
- Providing parenting groups (2)
- Providing individual therapy (1:1) (3)

Brief Individual Readiness for Change Scale

For each statement, please indicate your level of agreement or disagreement about using new parenting intervention techniques (Circle of Security or Triple P). Please answer the below questions based on the new parenting program you will be providing to families.
In general, what are your current perceptions about using the parenting intervention techniques:

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
I believe I have the skills to use them. (1)	○	○	○	○	○
I believe I have the flexibility to use them. (2)	○	○	○	○	○
I believe using them will take too much time. (3)	○	○	○	○	○
I believe I will receive the training I need to use them. (4)	○	○	○	○	○
I believe using them will improve outcomes for my clients. (5)	○	○	○	○	○

Evidence-Based Practice Attitudes Scale

Instructions The following questions ask about your feelings about using new types of therapy, interventions, or treatments. Manualized therapy, treatment, or intervention refers to any intervention that has specific guidelines and/or components that are outlined in a manual and/or that are to be followed in a structured or predetermined way. Indicate the extent to which you agree with each item using the following scale:

	Not at all (1)	To a slight extent (2)	To a moderate extent (3)	To a great extent (4)	To a very great extent (5)
I like to use new types of therapy/interventions to help my clients. (1)	○	○	○	○	○
I am willing to try new types of therapy/interventions even if I have to follow a manual. (2)	○	○	○	○	○
I know better than academic researchers how to care for my clients. (3)	○	○	○	○	○
I am willing to use new and different types of therapy/interventions developed by researchers. (4)	○	○	○	○	○
Research based treatments/interventions are not clinically useful. (5)	○	○	○	○	○
Clinical experience is more important than using manualized therapy/interventions. (6)	○	○	○	○	○
I would not use manualized therapy/interventions. (7)	○	○	○	○	○
I would try a new therapy/intervention even if it were very different from what I am used to doing. (8)	○	○	○	○	○

I would try a new therapy/intervention if:

	Not at all (1)	To a slight extent (2)	To a moderate extent (3)	To a great extent (4)	To a very great extent (5)
It was intuitively appealing? (1)	○	○	○	○	○
It "made sense" to you? (2)	○	○	○	○	○
It was required by your supervisor? (3)	○	○	○	○	○
It was required by your agency? (4)	○	○	○	○	○
It was required by your province? (5)	○	○	○	○	○
It was being used by colleagues who were happy with it? (6)	○	○	○	○	○
You felt you had enough training to use it correctly? (7)	○	○	○	○	○

Organizational Readiness for Change Scale

This survey asks questions about how you see yourself as a health professional working within a children's mental health agency within Ontario and how you see your program, more generally.

PART A**:**
Please click on one circle in the appropriate rating box to indicate the extent to which you agree or disagree with each of the following statements:

Service provider at your program needs guidance in...

	Disagree Strongly (1)	Disagree (2)	Uncertain (3)	Agree (4)	Agree Strongly (5)
Assessing client needs. (1)	○	○	○	○	○
Using client assessments to guide clinical care and program decisions. (2)	○	○	○	○	○
Using client assessments to document client improvements (3)	○	○	○	○	○
Matching client needs with services. (4)	○	○	○	○	○
Increasing program participation by clients. (5)	○	○	○	○	○
Improving rapport with clients. (6)	○	○	○	○	○
Improving client thinking and problem solving skills. (7)	○	○	○	○	○
Improving behavioral management of clients. (8)	○	○	○	○	○
Improving cognitive focus of clients during group sessions. (9)	○	○	○	○	○
Identifying and using evidence-based practices. (10)	○	○	○	○	○

Your organization needs guidance in...

	Disagree Strongly (1)	Disagree (2)	Uncertain (3)	Agree (4)	Agree Strongly (5)
Defining its mission. (1)	○	○	○	○	○
Setting specific goals for improving services. (2)	○	○	○	○	○
Assigning or clarifying staff roles. (3)	○	○	○	○	○
Establishing accurate job descriptions for staff. (4)	○	○	○	○	○
Evaluating staff performance. (5)	○	○	○	○	○

Your organization needs guidance in...

	Disagree Strongly (1)	Disagree (2)	Uncertain (3)	Agree (4)	Agree Strongly (5)
Improving relations among staff. (1)	○	○	○	○	○
Improving communications among staff. (2)	○	○	○	○	○
Improving record keeping and information systems. (3)	○	○	○	○	○

You need more training for...

	Disagree Strongly (1)	Disagree (2)	Uncertain (3)	Agree (4)	Agree Strongly (5)
Basic computer skills/programs. (1)	○	○	○	○	○
Specialized computer applications (e.g. data systems). (2)	○	○	○	○	○
New methods/developments in your area of responsibility. (3)	○	○	○	○	○
New equipment or procedures being used or planned. (4)	○	○	○	○	○
Maintaining /obtaining certification or other credentials. (5)	○	○	○	○	○
New laws or regulations that you need to know about. (6)	○	○	○	○	○
Management or supervisor responsibilities. (7)	○	○	○	○	○

Current pressures to make program changes come from…

	Disagree Strongly (1)	Disagree (2)	Uncertain (3)	Agree (4)	Agree Strongly (5)
The people being served. (1)	○	○	○	○	○
Other staff members. (2)	○	○	○	○	○
Program supervisors or managers. (3)	○	○	○	○	○

Board members or overseers. (4)	○	○	○	○	○
Community groups. (5)	○	○	○	○	○
Funding agencies. (6)	○	○	○	○	○
Accreditation or licensing authorities. (7)	○	○	○	○	○

PART B

Please click on one circle in the appropriate rating box to indicate the extent to which you agree or disagree with each of the following statements:

	Disagree Strongly (1)	Disagree (2)	Uncertain (3)	Agree (4)	Agree Strongly (5)
You have good program management at your program. (1)	○	○	○	○	○
Frequent staff turnover is a problem for your program. (2)	○	○	○	○	○
Staff training and continuing education are priorities in your program. (3)	○	○	○	○	○
Your facilities are adequate for conducting parenting programs. (4)	○	○	○	○	○
You have clinical supervisors who are capable and certified. (5)	○	○	○	○	○
Policies limit your use of the internet for work-related needs at your program. (6)	○	○	○	○	○
You learned new skills or techniques at professional training in the past year. (7)	○	○	○	○	○
Computer problems are usually repaired promptly at your program. (8)	○	○	○	○	○

Much time and attention are given to staff supervision when needed. (9)	○	○	○	○	○
You have convenient access to e-mail at work. (10)	○	○	○	○	○
Service providers in your program are able to spend the time they need with clients. (11)	○	○	○	○	○
Equipment at your program is mostly old and outdated. (12)	○	○	○	○	○
Clinical and management decisions for your program are well planned. (13)	○	○	○	○	○
More computers are needed for staff in your program to use. (14)	○	○	○	○	○
Most client records for your program are computerized. (15)	○	○	○	○	○
Support staff in your program have the skills they need to do their jobs. (16)	○	○	○	○	○
Offices in your program allow the privacy needed for individual counseling. (17)	○	○	○	○	○
Your program holds regular in-service training. (18)	○	○	○	○	○
Your program has enough service providers to meet current client needs. (19)	○	○	○	○	○
Clinical staff in your program are well trained. (20)	○	○	○	○	○
You used the internet at work recently to access parenting program information (21)	○	○	○	○	○
You have confidence in how decisions at your program are made. (22)	○	○	○	○	○
You have easy access for using the Internet at work. (23)	○	○	○	○	○

Offices and equipment in your program are adequate. (24)	○	○	○	○	○
Your program provides a comfortable reception/waiting area for clients. (25)	○	○	○	○	○
You have a computer to use in your personal office space at work. (26)	○	○	○	○	○
You meet frequently with clinical supervisors about client needs and progress. (27)	○	○	○	○	○
A larger support staff is needed to help meet the needs of your program. (28)	○	○	○	○	○
The budget in your program allows staff to attend professional training. (29)	○	○	○	○	○
Staff in your program feel comfortable using computers. (30)	○	○	○	○	○
Staff concerns are ignored in most decisions in your program. (31)	○	○	○	○	○

PART C

Please click on one circle in the appropriate rating box to indicate the extent to which you agree or disagree with each of the following statements:

	Disagree Strongly (1)	Disagree (2)	Uncertain (3)	Agree (4)	Agree Strongly (5)
You have the skills needed to conduct effective parenting programs (1)	○	○	○	○	○
Other staff often ask your advice about program procedures. (2)	○	○	○	○	○
You are satisfied with your present job. (3)	○	○	○	○	○
Learning and using new procedures are easy for you. (4)	○	○	○	○	○
You are considered an experienced source of advice about services. (5)	○	○	○	○	○

Appreciated for the job you do at work. (6)	○	○	○	○	○
Your program encourages and supports professional growth. (7)	○	○	○	○	○
You are effective and confident in doing your job. (8)	○	○	○	○	○
You are able to adapt quickly when you have to make changes. (9)	○	○	○	○	○
Keeping your counseling skills up-to-date is a priority for you. (10)	○	○	○	○	○
You give high value to the work that you do. (11)	○	○	○	○	○
You regularly influence the decisions of other staff that you work with. (12)	○	○	○	○	○

You feel...

	Disagree Strongly (1)	Disagree (2)	Uncertain (3)	Agree (4)	Agree Strongly (5)
You usually accomplish whatever you set your mind on. (1)	○	○	○	○	○
You do a good job of regularly updating and improving your skills. (2)	○	○	○	○	○
Evidence-based practices are recommended to many of our clients. (3)	○	○	○	○	○
You regularly read professional articles or books on parenting programs or practices. (4)	○	○	○	○	○
You review new techniques and strategy information regularly. (5)	○	○	○	○	○

Parenting programs are commonly used in your work. (6)	○	○	○	○	○
Other staff often ask for your opinions about counseling and treatment issues. (7)	○	○	○	○	○
You are willing to try new ideas even if some staff members are reluctant. (8)	○	○	○	○	○
Parenting programs are used with many of your clients. (9)	○	○	○	○	○
You have the skills needed to conduct effective parenting programs. (10)	○	○	○	○	○
You frequently share your knowledge of new counseling ideas with others. (11)	○	○	○	○	○
You are sometimes to cautious or slow to make changes. (12)	○	○	○	○	○
You are proud to tell others where you work. (13)	○	○	○	○	○
Parenting theories/approaches guide much of your work. (14)	○	○	○	○	○
You like the people you work with. (15)	○	○	○	○	○
You are viewed as a leader by the staff you work with. (16)	○	○	○	○	○
You consistently plan ahead and carry out your plans. (17)	○	○	○	○	○
You would like to find a job somewhere else. (18)	○	○	○	○	○
Pharmacotherapy and related medications are	○	○	○	○	○

important for many of your clients. (19)	

PART D

Please click on one circle in the appropriate rating box to indicate the extent to which you agree or disagree with each of the following statements:

	Disagree Strongly (1)	Disagree (2)	Uncertain (3)	Agree (4)	Agree Strongly (5)
Some staff members seem confused about the main goals for your program. (1)	○	○	○	○	○
The heavy staff workload reduces the effectiveness of your program. (2)	○	○	○	○	○
You frequently hear good ideas from other staff for improving treatment. (3)	○	○	○	○	○
Treatment planning decisions for clients in your program often get revised by a supervisor. (4)	○	○	○	○	○
The general attitude in your program is to accept new and changing technology. (5)	○	○	○	○	○
More open discussions about program issues are needed where you work. (6)	○	○	○	○	○
Ideas and suggestions in your program get fair consideration by management. (7)	○	○	○	○	○
Staff members at your program work together as a team. (8)	○	○	○	○	○
Your duties are clearly related to the goals for your program. (9)	○	○	○	○	○

You are under too many pressures to do your job effectively. (10)	○	○	○	○	○
Providers in your program are given broad authority in treating their clients. (11)	○	○	○	○	○
Your program staff is always kept well informed. (12)	○	○	○	○	○
Novel treatment ideas by staff are discouraged where you work. (13)	○	○	○	○	○
Mutual trust and cooperation among staff in your program are strong. (14)	○	○	○	○	○
Your program operates with clear goals and objectives. (15)	○	○	○	○	○
Staff members at your program often show signs of high stress and strain. (16)	○	○	○	○	○
It is easy to change procedures at your program to meet new conditions. (17)	○	○	○	○	○

To what extent do you feel that...

	Disagree Strongly (1)	Disagree (2)	Uncertain (3)	Agree (4)	Agree Strongly (5)
Service providers in your program can try out different techniques to improve their effectiveness. (1)	○	○	○	○	○
Staff members at your program get along very well. (2)	○	○	○	○	○
Staff members are given too many rules in your program. (3)	○	○	○	○	○

Staff members at your program are quick to help one another when needed. (4)	○	○	○	○	○
The formal and informal communication channels in your program work very well. (5)	○	○	○	○	○
There is too much friction among staff members you work with. (6)	○	○	○	○	○
Staff members at your program understand how program goals fit as part of the treatment system in your community. (7)	○	○	○	○	○
Some staff in your program do not do their fair share of work. (9)	○	○	○	○	○
Management fully trusts professional judgments of staff in your program. (10)	○	○	○	○	○
Staff members always feel free to ask questions and express concerns in your program. (11)	○	○	○	○	○
Staff frustration is common where you work. (12)	○	○	○	○	○
Management for your program has a clear plan for its future. (13)	○	○	○	○	○
You feel encouraged to try new and different techniques. (14)	○	○	○	○	○

Appendix B: Focus Group Questions

Triple P Provider Focus Group Guide

Before we begin, I'm going to start the recording and then state the date and time and my own name. The date is [month, day, year] at [time with Time Zone (EST/MT)] the Focus Group ID number is [#], and my name is: [moderator name]. Thank you for your willingness to participate in the Promoting Healthy Families process evaluation, I am grateful for your willingness to speak with me today. Today, I'm going to ask you a series of questions about your experiences with the Promoting Healthy Families Research project. Our goal for this process evaluation is to understand provider experiences of the research and training involved in the project, as well as their perspectives of the Triple P intervention to promote healthy parenting practices and positive child outcomes among families who receive the interventions. We are also curious about your experience of implementing these interventions in your practice. Your candid reflections on these topics are critical to helping us achieve our study goals. Please note that this focus group is expected to take about 90 minutes to complete. The focus group will be audio-recorded to ensure accurate capturing of your responses. Any information you provide will be de-identified, meaning that any unique information that could identify you (e.g., your name and your place of employment) will be removed. You can decline to answer any or all questions during this discussion or stop at any time. Do you have any questions about this before we begin? Ok, if a question comes up, feel free to ask it at any time, and I can always stop the tape recorder. Are you ready to begin?

WARM UP

Warm-Up A: To start, I wonder if you tell me a little bit about your role, scope of practice and length of time at [insert organization name]? Who would like to start us off?

Warm-Up B: How has your role and the way you do your work changed throughout the course of the COVID-19 pandemic?

PART A: Experience of Enrollment in the Training and Research Activities

Question 1: You have been asked to participate in this process evaluation because you have received training and are implementing Triple P as part of the Promoting Healthy Families Study. Please share with me how you became aware of and interested in participating in the Promoting Healthy Families Study?

Probes:

i. Did you encounter any challenges related to participating? If so, please share.

ii. [If participant does not mention their organization in their responses thus far]
What, if any, role did your organization play your ability to participate? [If the participant asks, organization-related factors could include things like team culture, funding structure, or leadership culture]

Question 2: I would like you to think back for a moment to Triple P training that you completed. How would you describe your training experience?

Probes

i. What did you find useful about the training for learning about Triple P?

ii. Was there anything about the training you would recommend changes to?

Question 3A: In thinking about Triple P training, how did the trainer describe the type of family that is
best suited to this model?

Question 3B: Based on your training and professional experience and how have you applied the model of Triple P in your practice thus far, how might you characterize the type of family that is best suited to this model?
PART B: Application of Triple P Support
Question 4: So far, what is your most memorable experience of using this model in your practice?
Probes
i. What about this experience or family made it so memorable?
Question 5: There are several key components to delivering Triple P, some of which may feel more or
less relevant to you in your role as a provider. For example, name some key components of Triple P?
Probes:
Are there any elements of the Triple P model that you do or do not agree with? If so, please share.?
i. Have you made any adaptations to how you deliver these components in your work? Why or why not?
ii. If you have made adaptations, what are they?
Question 6: Caregivers are required to participate in several sessions to complete the Triple P Program. What have you noticed has been important for keeping caregivers engaged in the program?
Question 7 (for providers who have completed more than one group): We know that providers have many demands on their time and are delivering several interventions to the families that they work with. How would you describe your ability to remain engaged with the Triple P program for this project over time?
Probes:
i. In what ways, if any, have team or organizational dynamics impacted your engagement? How have these dynamics influenced your use of the model?
Question 8: We are aware that some Triple P providers are provided supervision within their agency. Has this been the case for you?
If yes: how has this influenced your experience of delivering Triple P for the study
If no: what are your thoughts about the helpfulness of supervision?
Question 9A: Can you describe for me how your use of Triple P has evolved since your training?
Probe: (i; for those who have done only one group): How have you integrated your learning about Triple P into other programs and services you provide?
Question 9B: Providers are/were asked to complete fidelity checklists throughout the duration of the project. How would you describe your experience of completing these checklists?
Question 10: Caregivers in the group had a wide age range of children with differing levels of behavioural problems and parenting challenges. How does this information align with your facilitation experience?
Question 11: What do you see as the most important aspects of the facilitator role for the program?
Question 12: Did you find it easy to maintain self-regulatory approach during the delivery of Triple P?
Probes: (i) The self-regulatory approach moves the parent from self-management to self-sufficiency by promoting parental self-regulation and use of minimally sufficient intervention

techniques (providing only enough support that is needed). Some specific techniques may include flexible thinking, setting goals, problem solving and building self-efficacy and personal agency. Did you practice self regulation approach during the group? If not, why? If so, was this process easy for you to do?
(ii) What was it like for you to take on the role of coach and allow caregivers to take the lead?
Question 13 [Triple P]: How would you describe the usefulness of the homework component of Triple P for families?
Probes: (i) What do you recall hearing from caregivers about the requirements for homework?
(ii) How did you keep parents engaged in the intervention?
Question 14: Providers of Triple P are asked to interpret and discuss caregiver scores during the individual sessions. How would you describe your comfort level with interpreting these scores?
Probes: (i) How would you describe the process of discussing the scores with caregivers?
(ii) What was the influence, from your perspective, of these discussions on your relationship with caregivers?
Question 15: Triple P includes 1:1 sessions with caregivers for sessions 5, 6 and 7 – what do you think about having these 1:1 sessions?
15A: Triple P offers two additional support systems for facilitators – one is the PASS system – Peer Assisted Supervision and Support – did you use PASS during your training or while running any group sessions?
Probe: why or why not?
Probe: would you use it moving forward?
PART B: Triple P has a provider website, with online scoring system for caregiver assessment – did you use this during training, or while running group sessions?
Probe: why or why not?
Probe: would you use it moving forward?
PART C: Perceptions of Value, Impact, and Sustainability
Question 16: How would you describe the value of Triple P to promote healthy parenting and improve child outcomes among the families that you work with?
Probes:
i. What from your perspective are the most helpful aspects of Triple P/ for the families you work with?
ii. Think of a family or a few families that were enrolled in the program and for whom you believe the model had a positive impact. How would you characterize those families?
iii. What are the least useful?
iv. Think of a family or a few families that were enrolled in the program and for whom you believe the model did not have a positive impact. How might you characterize that/those families?
Question 17: What do you see as being the top three elements to Triple P? Why? How do these 'work' for the overall goals of program?
Question 18: Do you think there are any negative or unhelpful elements of Triple P? Please explain.
Question 19: In thinking about your Triple P caseload, can you describe at least one example for which you were aware about child maltreatment or concerned about the possibility of child maltreatment?
Probes
i. [If yes or no] What are your thoughts about the helpfulness of Triple P to reduce

child maltreatment for this family? What about other families or forms of child maltreatment?
ii. [If YES] What follow-up steps were taken? Is there a policy at your agency for reporting child maltreatment?
Question 20: Have there been discussions within your team or organization about how to sustain the delivery of Triple P after the project ends?
Probes:
i. What are your thoughts about the need to do this?
ii. What are your thoughts about how to do this?
Question 21: In your opinion, would it be helpful to implement this program in child mental health services across Canada?
Probes
i. What considerations would need to be made to make this happen?
ii. What challenges, if any, do you anticipate would arise?
iii. How would these considerations and challenges be best addressed?
CHECK OUT:
We are nearing the end of our focus group. To help us understand the implementation of [name program] in your organization, we are also collecting key documents from providers that are relevant to their use of the program in practice. Are there key documents that you feel our team should review and which influence how you have taken up and implemented [name program] in your practice? [if yes: request that the participant send the document to you via email].
Those are all the formal questions I had. Was there anything I didn't ask about that you think is important for us to know about your experience of delivering the Triple P intervention [thus far/throughout the project]? What about your perspective of how we promote healthy parenting practices and positive child outcomes?
WRAP-UP:
Thank you so much for your participation today.

<u>COS-P Provider Focus Group Guide</u>

The date is [month, day, year] at [time with Time Zone (EST/MT)] the Participant ID number is [#], and my name is: [moderator name]. Thank you for your willingness to participate in the Promoting Healthy Families process evaluation, I am grateful for your willingness to speak with me today. Today, I'm going to ask you a series of questions about your experiences with the Promoting Healthy Families Research project. Our goal for this process evaluation is to understand provider experiences of the research and training involved in the project, as well as their perspectives of the Triple P and COSP interventions to promote healthy parenting practices and positive child outcomes among families who receive the interventions. We are also curious about your experience of implementing these interventions in your practice. Your candid reflections on these topics are critical to helping us achieve our study goals. Please note that the focus group is expected to take about 90 minutes to complete. It will be audio recorded to ensure accurate capturing of your responses. Any information you provide will be deidentified, meaning that any unique information that could identify you (e.g., your name and your place of employment) will be removed. You can decline to answer any or all questions during the course of this discussion or stop at any time. Do you have any questions about this before we begin? Ok,

if a question comes up, feel free to ask it at any time, and I can always stop the recorder. Are you ready to begin?
WARM UP
Warm-Up A: To start, I wonder if I can go around the group and you could tell me a little bit about you and your role at [insert organization name] length of time and scope of practice? Who would like to start us off?
Warm-Up B: How has your role and the way you do your work changed throughout the course of the COVID-19 pandemic?
PART A: Experience of Enrollment in the Training and Research Activities
Question 1: You have been asked to participate in this process evaluation because you have received training and are implementing COSP, as part of the Promoting Healthy Families Study. Please share with me how you became aware of and interested in participating in the Promoting Healthy Families Study?
Probes:
i. Did you encounter any challenges related to participating? If so, please share.
ii. [If participant does not mention their organization in their responses thus far]
What, if any, role did your organization play your ability to participate? [If the participant asks, organization-related factors could include things like team culture, funding structure, or leadership culture]
Question 2: I would like you to think back for a moment to COSP training that you completed. How would you describe your training experience?
Probes
i. What did you find useful about the training for learning about or COSP?
ii. Was there anything about the training you would recommend changes to?
Question 3A: In thinking about COSP training, how did the trainer describe the type of family that is best suited to this model?
Question 3B: Based on your training and professional experience and how have you applied the model of COSP in your practice thus far, how might you characterize the type of family that is best suited to this model?
PART B: Application of COSP and Support
Question 6: So far, what is your most memorable experience of using this model in your practice?
Probes I. What about this experience or family made it so memorable?
Question 7: There are several key components to delivering COSP, some of which may feel more or less relevant to you in your role as a provider. For example [name some key components of COSP – Shark Music, etc.], what are your thoughts about the need for all the model components?
Probes:
i. Have you made any adaptations to how you deliver these components in your work? Why or why not?
ii. If you have made adaptations, what are they?
iii. Are there any elements of the COSP that you did not agree with? If so, please share?
Question 8: Caregivers are required to participate in several sessions to complete the COSP Program, what have you noticed has been important for keeping caregivers engaged in the program?

Question 9 (for providers who have completed more than one group): We know that providers have
many demands on their time and are delivering several interventions to the families that they work with. How would you describe your ability to remain engaged with the program(s) for this project over time?
Probes:
i. In what ways, if any, have team or organizational dynamics impacted your engagement? How have these dynamics influenced your use of the model?
Question 10: Some COSP providers in the Promoting Healthy Families Study have been offered [input frequency (if known) here, e.g. monthly] coaching and or reflection sessions in the model. How would you describe your experience of these sessions?
Probes:
i. What was most helpful about coaching sessions?
ii. Is there anything about these coaching sessions, that now thinking back, you would like to have changed?
Question 11A: Can you describe for me how your use of COSP has evolved since your training?
Question 11B: Can you describe for me how your use of COSP has been supported or monitored by other means in your program; for example through peer supervision, rounds, or team meetings?
Question 11C: Providers are/were asked to complete fidelity reflection checklists throughout the duration of the project. How would you describe your experience of completing these checklists?
Question 12: Caregivers in the group had a wide age range of children with differing levels of behavioural problems or parenting challenges. How does this information align with your facilitation experience?
Question 13: What do you see as the most important aspects of the facilitator role for the program?
Question 14: Did you find it easy to maintain a 'holding' environment for caregivers and regulating your own shark music during the delivery of COSP?
Probes: (i) Holding environment is creating a safe and secure place for caregivers while in group (being the hands, holding the hands). Did you practice controlling your own shark music during the group? If not, Why? If so, was this process easy for you to do?
(ii) What was it like for you to take on the role of coach and allow caregivers to take the lead?
PART C: Perceptions of Value, Impact, and Sustainability
Question 15: How would you describe the value of COSP to promote healthy parenting and improve child outcomes among the families that you work with?
Probes:
i. What from your perspective are the most helpful aspects of COSP for the families you work with?
ii. Think of a family or a few families that were enrolled in the program and for whom you believe the model had a positive impact. How would you characterize those families?
iii. What are the least useful?
iv. Think of a family or a few families that were enrolled in the program and for whom you believe the model did not have a positive impact. How might you characterize that/those families?

Question 16: What do you see as being the top three elements to this COSP? Why? How do these 'work' for the overall goals of program?
Question 17: Do you think there are any negative or unhelpful elements of COSP? Please explain.
Question 18: In thinking about your COSP caseload, can you describe at least one example for which you were aware about child maltreatment or concerned about the possibility of child maltreatment?
Probes
i. [If yes or no] What are your thoughts about the helpfulness of COSP to reduce child maltreatment for this family? What about other families or forms of child maltreatment?
ii. [If YES] What follow-up steps were taken? Is there a policy at your agency for reporting child maltreatment?
Question 19: Have there been discussions within your team or organization about how to sustain the delivery of COSP after the project ends?
Probes:
i. What are your thoughts about the need to do this?
ii. What are your thoughts about how to do this?
Question 20: In your opinion, would it be helpful to implement this program in child mental health services across Canada?
Probes
i. What considerations would need to be made to make this happen?
ii. What challenges, if any, do you anticipate would arise?
iii. How would these considerations and challenges be best addressed?
CHECK OUT:
We are nearing the end of our interview. To help us understand the implementation of [name program] in your organization, we are also collecting key documents from providers that are relevant to their use of the program in practice. Are there key documents that you feel our team should review and which influence how you have taken up and implemented [name program] in your practice? [if yes: request that the participant send the document to you via email]. Those are all the formal questions I had. Was there anything I didn't ask about that you think is important for us to know about your experience of delivering the COSP intervention [thus far/throughout the project]? What about your perspective of how we promote healthy parenting practices and positive child outcomes?
WRAP-UP:
Thank you so much for your participation today