Facilitators and Barriers to Triple P Implementation on Prince Edward Island

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improving the lives of Island families, so more children can benefit from the kind of support that I am so privileged to enjoy.

Abstract

The purpose of this study is to examine the particular facilitators and barriers to Triple P implementation facing practitioners on Prince Edward Island. Gleaned from the accumulated literature, close examination was given to specific items related to agency encouragement of parenting programs, workplace support, recognition by managers/supervisors and peers, issues related to after-hours appointments and caseload integration, lack of knowledge and skills in behavioral family intervention, coordination with other practitioners, and not having enough clients to run the program. Furthermore, the study set out to compare the experiences of those who have implemented the program in their work (implementers) and those who have not (non-implementers). A sample of 40 Triple P trained practitioners on Prince Edward Island completed an online survey, with the option of also completing a follow-up telephone interview. Overall, statistical and thematic analyses of this data found that practitioners are open, enthusiastic, and willing to implement Triple P but require significant ongoing support to maintain their efforts, including improved coordination and recognition of their work with the program.

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Parenthood is thought to be one of the greatest sources of both joy and challenge in life. The successful rearing of children is simultaneously a private and public pursuit, as parents effectively raise up and reproduce the next generation, and all of the consequences therein. Largely speaking, parents go into their duties with only the examples they've been taught and their intuition to guide them through the turbulent seas of childrearing. Parents should be aware of the great influence their actions and behaviours have to set trajectories for their children, the bidirectional nature of the parent-child relationship, and the modifiable potential of parenting practice. This modifiability has been harnessed by researchers in the creation of evidence-based parenting interventions, such as the Triple P – Positive Parenting Program. Comprehensive in intensity and scope, Triple P seeks to enhance the parenting practices of the population through the promotion of self-regulation, positive strategies, and support (Sanders, Turner & McWilliam, 2016). As with any public health initiative, implementation and sustainability prove to be a challenge. Through synthesizing the relevant literature, the power of parenting, its modifiable nature, Triple P and its successful implementation will be explored.

Attachment

The influence parents have on their children begins very early in their young lives. During infancy, a connection known as attachment develops between caregiver and child. As theorized by Bowlby (1969), attachment is a psychobiological system that explains children's sense of security based on the sensitivity, responsiveness and accessibility of their primary caregiver(s). The quality of this attachment leads to the development of internal working models these children hold for themselves and others (Holden, 2010). Should caregivers fail to respond sensitively to their infants in a reliable manner, children are at increased risk of developing insecure attachments (Bretherton, 1992). Alternatively, responsive, warm and prompt care on behalf of parents promotes secure attachments, leading to positive working models. These working models, whether positive or negative, carry with children as they age, and are transposed onto their new relationships (Holden, 2010). Additionally, the quality of attachment has a significant impact on

several areas of development, including cognitive, physical, emotional, and social (Garcia Quiroga & Hamilton-Giachritsis, 2015), and has the potential to be pervasive into adulthood (Shaver & Mikulincer, 2010).

Securely attached children are found to be more compliant, enthusiastic, persistent, cooperative and more skilled problem solvers, compared to their insecurely attached counterparts (Holden, 2010). Although the quality of attachments formed within the first 12 months of life can be pervasive throughout development, major life stressors, such as a parents' divorce, can have the potential to disrupt secure attachments (Holden, 2010). Overall, the sensitive period of infancy is to be emphasized in its power in forming attachment styles that set important trajectories in a child's development.

Social Referencing

Similar to the concept of working models, children look to their parents as models of emotional expression. In the face of ambiguous stimuli and novel situations, children look to their parents for reaction and follow their lead. This is known as social referencing (Lee, 2010). This phenomenon presents parents with clear opportunity to influence their children, for better or for worse. Parents make daily decisions of what to reflect onto their children. An example illustrated by Lee (2010) was that of a toddler taking a fall. In the seconds after, the bewildered child searches the face of their parent for reaction. Should the parent chuckle and make light of the tumble, the child's reaction may follow, with a smile and an attempt at standing. However, should a parent immediately grow worried and rush to aid, the child would reflect this anxiety in tears and fear. This pattern is a clear example of the power of intergenerational transmission of traits such as anxiety (Lee, 2010).

Social Learning Theory

In addition to modeling emotional responses, parents demonstrate behaviors that are often mimicked by their children. This is known as the social learning theory. As outlined by Bandura, children's behaviors are learned reactions guided by social models. This learning is manipulated through a series of response-reinforcement contingencies (1962). Through a process of observation, action, and

reinforcement, children learn favourable - and unfavourable - behaviours (Bandura, 1971). Given their inherent roles as behavior models, parents have the potential to encourage positive behavior through rewards, clarity, and consistency in their parenting (Smith, Brown, Feldgaier & Lee, 2015).

Punishment

Social learning theory can be clearly illustrated in the use of discipline. The use of punishment alone, physical or otherwise, is an ineffective means of promoting favourable behaviour (Bandura, 1962). Punishment, especially that which is physical, is often inconsistent and anxiety-conditioning. Without correcting the behaviour through positive reinforcement and consistency, children are left confused and avoidant of their punisher (Bandura, 1962). Physical punishment has the dangerous effect of becoming amplified in frustration over its inefficiency, as parents resort to harsher and more severe expressions of disapproval in response to bad behaviour (Bandura, 1962). Furthermore, physical punishment demonstrates aggression that is learned, and then imitated, by the child (Bandura, 1962). Taken together, the appropriate and effective response to unfavourable behavior is found in modification through positive reinforcement (Bandura, 1962).

Transactional Model of Parenting

Temperament

Although not to undercut the great influence of parents just described, the parent-child relationship is a dynamic and bidirectional force. On the part of children, their temperament can contribute to parenting. Temperament can be broadly defined as a child's basic personality formed by biologically-based individual differences (Bates & Pettit, 2015). The influence of child temperament on parenting has been demonstrated to varying levels of reliability, most notably that of fearful and negative emotionality and self-regulation (Bates & Pettit, 2015). Conversely, evidence was also found in the other direction, as warm parenting discouraged negative emotionality in children, while harsh parenting had an encouraging effect. Levels of warmth also inversely predicted levels of fear (Bates & Pettit, 2015). This give and take can be described as a transactional model of parenting (Bates & Pettit, 2015; Holden, 2010). Additionally,

it is worth noting that, while the relationship between child temperament and parenting behavior is in itself dynamic, so are these constructs themselves. Both temperaments and parenting practices are modifiable and undergo developmental and maturational changes (Bates & Pettit, 2015).

Self-regulation

Another aspect of temperament found to influence parenting is self-regulation, which includes emotional self-control (Bates & Pettit, 2015). One study showed that supportive mothering was encouraged, and restrictive mothering discouraged, by children with higher levels of self-regulation (Bates & Pettit, 2015). This emotional self-regulation is noted to be one of the most crucial developmental milestones of one's early years (Dennis, 2006). Emotional self-regulation can be assessed through observations of persistence, frustration tolerance and compliance with caregiver demands (Dennis, 2006). This capacity is crafted through the dynamic interaction of child reactivity and the control processes expended onto it. Naturally, the most notable control process on reactivity is parenting (Dennis, 2006). Emphasized again through the principles of social learning theory, parents are influential as they are both nurturant and powerful in relation to their children (Maccoby, 1992).

Socialization

Guided by a child's temperament, parents work to balance their child's natural reactivity with practices attempting to modify it. For example, fearful children require only a conservative amount of control to be dissuaded from risky behaviour, while fearless children require more effortful, warm, and controlling practices to keep them in line (Dennis, 2006). This notion once again complements concepts of bidirectionality and transactional models of parenting, by introducing a third concept of goodness-of-fit (Dennis, 2006). Goodness-of-fit posits that a child's temperamental characteristics effect their socialization (Dennis, 2006). "Socialization" is a loaded term that encompasses many areas of social development, including conscience, resistance to temptation, internalization of values, postponement of gratification, moral development and out-of-sight compliance to parental requirements (Maccoby, 1992).

In early years, children rely heavily on their parents as external sources of regulation, but this reliance gradually decreases with age and maturation (Dennis, 2006).

Negative Emotionality

A pronounced aspect of emotional self-regulation attempts in early childhood is that of negative emotionality. Particularly in times of spikes in independence, such as toddlerhood, fussiness, resistance to soothing and irritability can be common (Lipscomb, Leve, Harold, Neiderhiser, Shaw, Ge & Reiss, 2011). Two phenomena accompany this increase in negative emotionality: decrease in parental efficacy and increase in over-reactive parenting (Lipscomb et al., 2011). Parent efficacy is an extension of Bandura's (1977) work on self-efficacy, as it relates to their internal feelings and perceptions of their performance as parents (Lipscomb et al., 2011). Although it is possible for some delusions in one's efficacy, generally speaking, higher indications of self- and parent-efficacy result in better outcomes (Lipscomb et al., 2011). This is also illustrated in the example of mothers perceiving their children to be more difficult also showing lower parent-efficacy indications (Lipscomb et al., 2011).

Following from low parent-efficacy and perceived difficult behavior of children, parents are more likely to be pushed in the direction of over-reactive parenting. This type of parenting is characterized as harsh, irritable and angry, which is not only ineffective, but also has the potential to lead to externalizing problem behavior in childhood and adolescence, such as acting out and aggression (Lipscomb et al., 2011). Again, linking back to principles of social learning, parental displays of aggression and lack of emotional control are observed, learned, and reflected back by children (Lipscomb et al., 2011; Bandura, 1962). Albeit limited, there is some indication that perceptions of parent-efficacy increase as children age and parents become more accustomed to their roles and routines (Lipscomb et al., 2011).

Parenting Styles

In addition to "over-reactive" parenting, three parenting styles have been well-studied and documented in literature: authoritative, authoritarian and permissive. These three styles are distinct from one another in terms of their levels of warmth and control, or, in the terms of leading researcher in the area

Baumrind (1989), responsiveness and demandingness. Authoritative parents strike the optimal balance between warmth and control. They set firm limits and expectations for children, coupled with affection and clear communication (Holden, 2010). Authoritarian parents put emphasis on control and discipline, and are generally less concerned with fostering independence and affectionate relationships (Holden, 2010). Finally, permissive parents emphasize only the warm and affectionate dimensions of parenthood, neglecting appropriate limit setting and discipline (Holden, 2010).

Overall, authoritative styles of parenting have been found to be the most successful. Children reared in this style display greater social skills, including friendliness and cooperative behaviour, general competence, and independence (Holden, 2010). Parents using an authoritative style exerted a calculated level of control and demandingness, matched with equal amounts of accessibility and reasoning with their children. This produces children who were high in self-control, self-reliance and contentment (Baumrind, 1989). On the other hand, authoritarian styles are found to diminish children's competence, lessening their independence, achievement-orientation, and sense of assertiveness (Holden, 2010). The stark lack of warmth to balance the demandingness of the authoritarian styles results in children found to be withdrawn and distrustful (Baumrind, 1989). Additionally, children reared permissively were found to lack in competence, independence, and achievement orientation, as they were not guided by clear instruction or discipline (Holden, 2010). Baumrind (1989) describes children raised in a permissive style as "immature" (p. 352).

With these effects in mind, it is important to note that, just like other dimensions of parenting, formation of parenting styles could be a reciprocal process between parent and child (Holden, 2010). It is not out of the question to postulate that an agreeable child would bring forth an authoritative style of parenting, while a more rambunctious and strong-willed child would require firmer control and discipline. However, the suggestion of optimal parenting being supported by an intentional balance of warmth and control remains supported by research (Holden, 2010; Baumrind, 1989).

Parental Guidance

Through the employment of the styles just described, along with the other considerations of parenting discussed, Holden (2010) suggests that parents can guide the development of their children in three ways: *establishing trajectories*, thereby determining the direction of development, *mediating* those trajectories, by exerting their influence and controlling their environment and understandings, and *modifying* the speed of those trajectories by controlling exposure to experiences that would encourage development. Holden (2010) makes it clear that parenting is "a multidimensional, multi-activity endeavor" (p. 95).

Taken together, research clearly suggests that parents hold a tremendous amount of influence and power over the development of their children. Their parenting practices and daily choices of limit-setting, communication, affection and discipline, in large part mold their young ones. It is imperative that parents are made aware of this power they hold and its potential to bring about the best in their children. It was summed up well by Smith et al. (2015), that "of all the risk factors for children's adjustment problems, parenting is one of the most modifiable" (p. 131).

Evidence-Based Parenting Interventions

In response to this modifiability, researchers have put forth effort into creation of evidence-based parenting interventions. These interventions work to guide parents through programs of varying intensity in response to particular parenting challenges. Programs that have garnered the most support are the Incredible Years Program, Parent Management Training - Oregon Model, Parent-Child Interaction Therapy and Triple P - Positive Parenting Program (Sanders, Kirby, Tellegan & Day, 2014). All of these programs find their root in social learning theory, and work to incorporate a holistic approach to intervention, including behavioral, cognitive and developmental principles (Sanders et al., 2014). Outcomes of these programs have been encouraging, as they have resulted in fewer behavioral and emotional problems of children, and improved mental health, conflict-resolution and child-rearing practices of parents (Sanders et al., 2014). Their shortcoming, however, is the nature of their reach, as

public funding typically is reserved for only those characterized as high-risk. This narrow focus has hampered the preventative and comprehensive power of these interventions (Sanders et al., 2014).

Triple P

Triple P stands apart from other evidence-based parenting interventions, in that it comprehensively covers the spectrum of scope and intensity, through a multilevel system addressing both targeted and universal concerns (Sanders & Kirby, 2014). As previously discussed, Triple P finds its foundation in social learning theory. It is additionally influenced by applied behavior analysis, child development and developmental psychopathology research, social information processing models and public health principles (Sanders et al., 2016). It aims to equip parents with the knowledge, skills and confidence to deal effectively with the challenging of childrearing (Sanders & Kirby, 2014).

Minimal Sufficiency

Triple P goes about achieving this aim through a principle of minimal sufficiency. As outlined by Sanders and Kirby (2014), minimal sufficiency is the principle of achieving clinical outcomes in the most cost- and time-efficient manner possible. This principle also works to ensure that the needs of individual families are met, without neglecting the needs of the wider population (Sanders et al., 2016). The solution to this challenge proposed by Triple P is a multilevel system of increasing intensity and narrowing scope (Sanders et al., 2016). The levels are briefly outlined as follows:

Levels of Programming

Level 1: Universal promotional strategies. This level is the widest in scope and the lowest in intensity. Essentially, this first level of Triple P is designed to be applicable to all parents. Through the use of mass social marketing campaigns, such as posters and commercials, Level 1 aims to spread the message of positive parenting, suggest simple strategies and destigmatize and normalize the notion of assistance in parenting (Sanders et al., 2016). The positive connotations of this approach are meant to counter the "alarmist, sensational, or parent-blaming messages in the media" (Sanders et al., 2016, p.

135). This level most closely matches a public health approach to parenting interventions, and is most accessible to the general population.

Level 2: Selected Triple P/Brief Primary Care Triple P. As alluded to in its title, this level narrows slightly, as it focuses on specific parenting concerns, such as disobedience or bedtime problems (Sanders et al., 2016). Programming for this level is employed through short sessions delivered by primary care or community services. Sessions can either be 10-20 minute individual slots, or in 90-minute group seminar style. This level is found to be particularly helpful as part of transition programs (such as orientation to kindergarten or preschool), or as a refresher course for parents who have previously completed a higher level intervention (Sanders et al., 2016).

Level 3: Primary Care Triple P/Triple P Discussion Groups. The intensity of intervention increases, with 3-4 half-hour individual sessions or 2-hour group discussions, surrounding targeted concerns. The intervention strategies are aimed at being preventative, selective and skill-building. Parents are guided through active skills training and the use of tip sheets and workbooks on common developmental and behavioral problems (Sanders et al., 2016). This moderate level of intensity encourages parents to develop transferable and generalizable skills for various challenges (Sanders et al., 2016).

Level 4: Standard Triple P/Group Triple P/Self-Directed Triple P/Triple P Online Standard. It is at this level that higher-risk families are targeted for intervention. Children in these families have either met diagnostic criteria for problem behavior, or have detectable subclinical problems. The goal of these inventions is to prevent the worsening of problem behavior (Sanders et al., 2016). Sessions are offered in various formats, including individual, group, self-directed and online, and focus skills and strategies are meant to be customizable to individual family needs. The skills and strategies taught include: monitoring problem behaviour, establishing clear limits and rules, backing up instructions with logical consequences, and arranging engaging activities in high-risk situations (Sanders et al., 2016). Although these strategies

are designed and selected to meet the specific needs of each family, they are also meant to be generalizable across circumstance and setting, both at home and in the community (Sanders et al., 2016).

Level 5: Enhanced Triple P. As it is the highest level of intensity, this form of intervention is used in particularly high-risk circumstances, which lower levels cannot fully address, additionally complicated by other factors of adversity (Sanders et al., 2016). At this level, sessions are longer and more focused, covering topics such as risk of child maltreatment, obesity and divorce. Areas of focus include partner support and communication, mood management and stress coping skills, and anger management skills for parents (Sanders et al., 2016).

Self-Regulatory Framework

With this tiered system of delivery, and the flexibility of programming to be customized for unique family needs, Triple P is exceptionally comprehensive. By design, Triple P seeks to enhance the "knowledge, skills and confidence of parents" (Sanders & Kirby, 2014, p. 250). Much of this is accomplished through its self-regulatory framework, in which parents are encouraged to outline exactly what goals, values, skills and behaviors they would like to see in their family life. This intentionality allows parents the control and unique consideration they desire and deserve, and avoids programming coming across as prescriptive, impersonal or overbearing (Sanders & Kirby, 2014). Going further, Triple P programming is designed to be accessible to parents of all demographics. Written resources are at a grade 6 literacy level, video components are used to demonstrate skills, and cultural and ethnic considerations and adaptations are made available (Sanders et al., 2016).

Empirical Support

This comprehensive design has yielded considerable empirical support. As reported in the Sanders et al. (2016) meta-analysis, significant short-term effects were found in all interventions levels for children's social, emotional, and behavioral outcomes, parenting practices, parenting satisfaction and efficacy, parental adjustment, parental couple relationship, and observed child behaviour. Additionally,

there were also significant longer-term effects found, including observed parent behavior (Sanders et al., 2016).

Dissemination

However, as holistically as this program is conceptualized, its success depends greatly on its dissemination and implementation. Jointly, between the University of Queensland and Triple P International, Triple P programming is disseminated. Calculated implementation is then guided by current research in implementation science, culminating in a non-linear 5-phase Implementation Framework (Sanders et al., 2016). These 5-phases are as follows: Engagement: the selection of appropriate practices and programs for a particular organization; Commitment and Contracting: ensuring that practitioners are in agreement about desired program outcomes; Implementation Planning: the preparations made within the organization to accommodate desired program outcomes; Training and Accreditation: standardized practitioner training and skill development; and, Implementation and Maintenance: ongoing support and evaluation to ensure success and sustainability (Sanders et al., 2016).

This phased approach is meant to promote self-regulation and minimal sufficiency (Sanders et al., 2016). Care is taken to ensure that implementation procedures are crafted uniquely for the needs and capacity of each participating organization. To do so, critical activities are outlined at each phase, and Implementation Consultants are made available for timely support (Sanders et al., 2016). This emphasis on self-regulation and minimal sufficiency is in effort to promote maximum community benefit and sustainability (Sanders et al., 2016).

Cost-Effectiveness

A large part of this sustainability is the cost-effectiveness of Triple P. Generally, the costs of implementing Triple P are picked up by public health care payors. A major cost is the training of practitioners, including the cost of attending training and reimbursement of lost office days (Foster, Prinz, Sanders & Shapiro, 2008). While this can an expensive venture, it is offset by the advantages of being proactive towards parenting and problem behavior. It has been well-established that harsh parenting styles

combined with emotional and behavioral problems in children create many issues, both long- and short-term, public and private. The cumulative effect of problem behavior continuously wears at a child's competence and functioning. This cycle can spin itself in the direction of substance abuse, delinquency, academic failure and risky sexual behaviour (Foster et al., 2008).

At its most extreme levels, including children who were maltreated, the societal costs skyrocket. Involvement in the judicial system, child protection services, and mental health facilities is extremely costly. These costs only continue to snowball, given the intergenerational transmission of victimization caused by abuse and neglect (Foster et al., 2008; Prinz, Sanders, Shapiro, Whitaker & Lutzker, 2009). Foster et al. (2008) report that, in the US, behavioral and emotional problems of children (particularly conduct disorders) are extremely harmful and costly. The harm to the youth and society exceeds $400 billion per year. With these massive financial burdens in mind, Sanders et al. (2016) state that, based on child maltreatment costs alone, for every $1 invested in interventions, there is $6 return. When also considering education, crime, property and health care costs, that return increases to $8.80 (Sanders et al., 2016.

Public Health Approach

As demonstrated, addressing the roots of child maltreatment is a wise and fiscally responsible direction for public health policy. Instead of being crisis-driven and reactionary, proactive and preventative measures most comprehensively and effectively meet society's needs. Moreover, with Triple P's multi-level system design, targeting both the public and those at particular risk, costs are diffused as more and more people are exposed to the program (Foster et al., 2008).

This wide exposure, and its preventative scope, finds form in a public health approach (Prinz et al., 2009). Sanders & Kirby (2014) define a public health approach as the balancing and blending of universal and targeted interventions, in order to address the needs of the entire population. Without exclusively isolating vulnerable populations, a public health approach, like that of Triple P's, works to destigmatize the

acquiring of parenting support. This destigmatization is a crucial step in normalizing support services so important to the prevention of tragedies, such as child maltreatment (Sanders & Kirby, 2014).

Prevention

This preventative effect was demonstrated in a 2009 U.S. study of Triple P investigating child maltreatment. To facilitate the study, the counties of a southeastern state were designated as either control or experimental. Experimental states were given the training and resources necessary to implement Triple P into their existing social support structures. At a 2-year follow up, three indicators of child maltreatment were assessed: substantiated cases of child maltreatment, child-out-of-home placements, and child maltreatment injuries. Large effect sizes were found in all of these indicators between counties with Triple P implementation and controls (Prinz et al., 2009). The demonstrated success of this large-scale preventative effect speaks volumes of the population-level/public health approach to parenting interventions.

As encouraging as these results are, the study's authors warn of the risk of failing to ensure maintenance and sustainability of a program like Triple P. Prinz et al. (2009) state, "[t]his approach is not the equivalent of a parenting vaccine, where a single shot exposure will afford continuing protection for the population" (p. 9).

Criticisms

Bias

A thorough analysis of Triple P would not be possible without consideration of any criticisms presented. A meta-analysis by Wilson, Rush, Hussey, Puckering, Sim, Allely, Doku, McConnachie and Gillberg (2012) outlined several pointed critiques. Firstly, as several studies attracted volunteer participants through the use of media advertisements, outcomes are inherently more likely to be biased. Wilson et al. (2012) stated that these families would likely be already presenting with difficult behaviors untypical of the average family. Furthermore, as these parents are responding to an advertisement, they are likely more motivated, literate, and confident. All of these factors combined would increase levels of compliance, and

therefore also levels of response and positive outcomes (Wilson et al., 2012). Secondly, Wilson et al. (2012) draw attention to the large number of evaluations that go unpublished by Triple P, and their lack of trial registration. Authors urge Triple P researchers to implement a compulsory clinical trial registration in order to maintain legitimacy (Wilson et al., 2012).

Conflict of Interest

The largest criticism surrounded issues of conflict of interest. Wilson et al. (2012) pointed to the heavy developer involvement in studies of Triple P. Although recognition was given to the fact that developer involvement is typical in the beginning stages of a program of this nature, the pervasiveness of this heavy involvement in Triple P is flagged as a potential conflict of interest (Wilson et al., 2012). Wilson et al. (2012) question whether Triple P personnel are being forthcoming about potential conflicts surrounding royalty payments from sales of training and program materials. Building on this concern, Wilson et al. (2012) assert that Triple P personnel may be selectively reporting positive outcomes, and intentionally choosing to not replicate developer-led studies.

Public Health Approach

As a result of this substantial criticism, Wilson et al. (2012) suggest that targeted interventions with at-risk families are more effective and appropriate than those with a population-level scope. Additionally, a caution is delivered to health care providers and policymakers, as they go about selecting which programs to invest in. The argument is made that these professionals and organizations should be as rigorous in their careful evaluation of behavioural interventions, such as Triple P, as they are with pharmaceutical agents and medical devices (Wilson et al., 2012).

Triple P Defense

In response, Sanders, Pickering, Kirby, Turner, Morawska, Mazzucchelli, Ralph & Sofronoff (2012) addressed these critiques, labelling some as “misleading and inaccurate” (p. 2). Counter-criticisms were made to the method of pooling studies by Wilson et al. (2012), failing to account for the complexity of the differing levels of intervention intensity. In regards to accusations of bias and conflict of interest,

Sanders et al. report that this is unfounded, as over 300 different authors across dozens of institutions and countries contribute to Triple P literature. Of the 140 outcome studies, 43% of authors did not involve a University of Queensland author, and none of the program authors own shares in Triple P International (Sanders et al., 2012).

Reaffirming the foundational principles of Triple P, Sanders et al. (2012) stand by their choice to be highly developer-led, as they believe that this encourages critical self-reflection and steady improvement of programs. More pointedly, Sanders et al. (2012) defend a population/public health approach, as highly targeted approaches are argued to create their own form of sampling bias, greater potential for stigmatizing parenting, and fail to adequately address prevalence rates of problem behavior and child maltreatment. There is agreement, however, among the authors that a clinical trial registry would be desirable in an effort to ensure transparency (Sanders et al., 2012; Wilson et al., 2012).

Implementation

As previously mentioned, Triple P programming is managed by a purveyor organization called *Triple P International.* This organization is mandated to actively disseminate, and support the increased program reach of Triple P, while maintaining its quality and consistency (McWilliam, Brown, Sanders & Jones, 2016). An organization dedicated to implementation is a crucial aspect of effective evidence-based intervention, as success of the program is null and void if it cannot be properly implemented and sustained. Conceptually, the process of dissemination can be viewed as a continuum of knowledge transfer from passive to active, including: diffusion, dissemination and implementation (McWilliam et al., 2016). Diffusion can be seen as "letting it happen" with no clear planning as to the process, dissemination as "helping it happen", and implementation as "making it happen" (McWilliam et al., 2016, p. 637). Triple P International is dedicated to "making it happen", and does so through study in the field of implementation science (McWilliam et al., 2016).

Implementation science is a systemic approach to the adopting and integration of evidence-based innovations, with the aim of improving outcomes (McWilliam et al., 2016). As outlined by McWilliam et

al. (2016), these strategies work to achieve three key outcomes: "first, improving program utilization usage rates of trained practitioners by creating concrete strategies to support organizations to *make it happen* rather than *let it happen*; second, improving the long-term sustainability of Triple P within implementing organizations by planning for sustainability from the early stages of the implementation process; and third, supporting the expansion of Triple P within communities by using a population health approach, given the benefits of this approach for communities" (p. 638).

Diffusion of Innovation

Included in implementation science, is the theory of Diffusion of Innovation. This theory posits that there are factors indicating the successful implementation of an innovation, such as a parenting intervention. These factors are: the compatibility of the new innovation, the observability of the results of the innovation, the relative advantage of the innovation, and the ability of adopters to pilot or test the new innovation (Sanders, Prinz & Shapiro, 2009). More specifically to evidence-based practices (EBP), such as Triple P, there are six critical implementation factors, including: acceptability of the EBP, suitability of the EBP, motivations of practitioners involved, practitioner experiences with being trained in EBP, organizational support of the EBP, and impact of the EBP on process and outcome services (Sanders et al., 2009). Additional factors include the EBP's fit within a community organization and the collaborative relationships between researchers and communities (Sanders et al., 2009).

Practitioners

To achieve greater parental exposure and population-level prevention, Triple P implementation is provided through training practitioners at various existing service agencies. Practitioners who receive training are professionals of various fields interacting with families, including health, education, and social services (Sanders et al., 2009). Because Triple P programming is an additional aspect to their workloads and mandates, there are naturally various facilitators and barriers to successful integration, implementation, and sustainability of the intervention.

Facilitators

Facilitators are those factors which have been found to encourage successful implementation. Related to high program use are: training in Group Triple P, receiving positive feedback from parents, exposure to only minor or moderate workplace barriers, seeing observable changes in children or families, and consultation with other Triple P practitioners" (Sanders et al., 2009). Practitioners who use Triple P the most are known to incorporate the principles of the program into their work more generally in matters not specifically related to Triple P (Sanders et al., 2009).

Training

Foundational to successful implementation is effective training of practitioners. In order to ensure proper program delivery, practitioners must be able to demonstrate core competencies outlined by the program (Seng, Prinz & Sanders, 2006). Acquiring these competencies is done through a training model that integrates three approaches: active skills training, self-regulation, and systems-contextual perspective (Seng et al., 2006). Active skills training includes modeling, rehearsal, practice and feedback of skills, as well as goal-setting. Self-regulation encourages this goal setting by practitioners through self-monitoring, -evaluation, and -appraisal of their strengths and weaknesses. Finally, the systems-contextual perspective widens the scope of focus to include the social and organizational context within which these practitioners work. This perspective should work through the particular barriers facing practitioners, in order to further promote skill development, confidence, and motivation (Seng et al., 2006). Effective training is crucial because it increases both usage and successful adherence, which results in optimal outcomes for those seeking support (Seng et al., 2006).

Barriers

Barriers to practitioner usage of Triple P include: lack of access to consultation or supervision, lack of recognition by colleagues, lack of overtime or time in lieu for after-hours appointments, clash with other after-hours commitments, lack of knowledge or skill in behavioral family intervention, clash with theoretical orientation or preferred approach, not being integrated with caseload or other work responsibilities, and difficulties coordinating with other practitioners involved with the family (Sanders et

al., 2009). Generally, practitioners were hindered from high program usage because of low confidence in parent consultation work and use of Triple P, and low workplace support (Sanders et al., 2009).

Openness to innovation

Asgary-Eden & Lee (2011) outline how programs can be implemented in either a bottom-up or a top-down fashion, starting with practitioners at agency levels, or a governing body, respectively. On Prince Edward Island, the implementation of Triple P has been a top-down process, in which various provincial departments have collaborated in the support and funding of the program. While these processes are different, resistance from service providers and administrative assistants is found to be common to both, even when these parties had previously reported openness to the implementation (Asgary-Eden & Lee, 2011). This resistance is thought to materialize when challenges and complications in the program rollout are inevitably encountered (Asgary-Eden & Lee, 2011).

Encouraging Usage and Adherence

As it is a running theme throughout Triple P programming and vision, a balance struck between adherence to the evidence-based protocol and being flexible and customizable to the unique needs of particular clients is a significant challenge to implementation. Particularly when programs are not well-funded, the risk of neglecting program components and materials is greater (Asgary-Eden & Lee, 2011). The most commonly cited reasoning for omitting material are time constraints and perceived irrelevance for particular parents (Asgary-Eden & Lee, 2011).

In an effort to combat this resistance and material omission, Asgary-Eden and Lee (2011) make suggestions, including organizing and leading pre-implementation focus groups, information sessions, or informal drop-in times. This attempt at preparedness is further encouraged by acquiring proper funding, as well as necessary space and materials, setting up supervision and peer support networks for practitioners, introducing practitioners to new clinical concepts and research before official training, and establishing evaluation frameworks (Asgary-Eden & Lee, 2011). Furthermore, it is important for workplaces to foster a

sense of pride and accomplishment in regards to the successful implementation of Triple P, as this further increases usage rates (Asgary-Eden & Lee, 2011).

Usage

This issue of usage is a very important aspect of implementation. Usage indicates not only whether practitioners use the program, but also how often they deliver it. For a practitioner to be trained but to not utilize the program is a substantial hidden cost that does a disservice to the program, the funders, and the practitioners' acquired skills (Asgary-Eden & Lee, 2012). Usage is encouraged by adequate office resources and training, as well as practitioner investment and supervision (Asgary-Eden & Lee, 2012). Beyond usage is the issue of adherence, or whether a program is delivered with fidelity to its protocol. Proper adherence is encouraged when agencies have strong administrative support and formalized policies for their commitment to the program. Workplaces perceived to have poor atmospheres result in the lowest adherence rates. This atmosphere would include coworker conflict, professional role distinction and cooperation, adequate space and resources, sufficient staff, turnover rate, and motivation and commitment levels of practitioners (Asgary-Eden & Lee, 2012). Somewhat surprisingly, it was found that in times of high agency adherence in general, the more experienced practitioners were less likely to adhere than were less experienced practitioners. Conversely, when general agency adherence was low, experienced practitioners were more likely to adhere (Asgary-Eden & Lee, 2012).

Naturalistic Settings

Related to agency atmosphere is the consideration of creating a natural environment for clients to feel comfortable about seeking support. Families of low socioeconomic status perceive the most stigma towards programs such as Triple P, and this contributes to the fact that they are the hardest to reach (Frantz, Stemmler, Hahlweg, Pluck & Heinrichs, 2015). This is unfortunate, given that this demographic is also the most at risk for child maltreatment and would therefore stand the most to gain from a preventive support program (Afifi, Taillieu, Cheung, Katz, Tonmyr & Sareen, 2015). In an effort to destigmatize the process of help-seeking for parents, interventions should be offered out of a natural setting with a natural

group, such as a preschool with all of the parents of children enrolled (Frantz et al., 2015). This natural setting not only further extends the program's reach, but also fits well into a busy family's normal routine (Frantz et al., 2015). While a setting as practical as this example is not always possible, the concept of natural settings and best practice ought to be transferable to the various agencies which employ Triple P. Care has to be taken to navigate the unique social service infrastructures of various agencies and communities (Frantz et al., 2015).

Sustainability

Beyond implementation, sustainability must be planned for. As defined by Mancini and Marek (2004), sustainability is "the capacity of programs to continuously respond to community issues" (p. 339). As an agency grows to adapt the program and integrates it into practitioners' workload, attention must be paid to maintaining the founding goals and objectives outlined at the outset. However, that being said, programs must also be able to evolve alongside family and community needs, as it is the benefits, not the activities themselves, that need to be sustained (Mancini &Marek, 2004). Sustainability, then, can be described as being composed of 7 key elements: leadership competence, effective collaboration, understanding of the community, demonstrating program results, strategic funding, staff involvement and integration, and program responsivity (Mancini & Marek, 2004). Sustainability is best ensured through early planning as part of the implementation process (Mancini & Marek, 2004).

The importance of sustainability planning is not to be understated. Evidence-based interventions can be unsuccessful for one of two reasons: intervention failure or implementation failure (Hodge, Turner, Sanders & Filus, 2016). As demonstrated in the supporting empirical evidence (see Sanders et al. 2014), Triple P is presented as a successful and effective program. The challenge, therefore, is in the implementation. As previously outlined, there are a number of facilitators and barriers to this process. The ongoing monitoring and maintenance required to sustain a program as comprehensive as Triple P is a substantial undertaking. Like implementation, sustainability is increased by workplace cohesion, ensuring staff awareness of the program's goals and mission, focusing on workgroup trust, outlining methods of

resolving disagreements, fostering of leadership/practitioner empowerment, and respect for the needs of the community (Hodge et al., 2016).

It is clear that parenting and childrearing is a tremendously important aspect of human development, with far-reaching effects. It is in society's best interests to promote and enhance positive parenting practices, as they serve to rear prosocial, competent and independent children (Sanders et al., 2014). These practices can be supported through evidence-based interventions, such as Triple P. To be successful and garner the most comprehensive and preventative approach, programs should be delivered in a tiered fashion of narrowing scope and growing intensity. This not only promotes self-regulation and principles of minimal sufficiency, but is also cost-effective and serves to destigmatize the seeking of parenting support. However, these programs can only be as effective as their implementation process allows. Great study and ongoing maintenance is in order to ensure appropriate and well-supported integration of these programs into existing social service agencies. The many facilitators and barriers outlined are to be addressed at an agency level, sensitive to the unique structure of each organization. Beyond implementation, sustainability of a program is only possible through prudent planning and continuous monitoring. As comprehensive as Triple P is, dedication is required on the part of funders, organizations, practitioners, and parents to continue to see successful program outcomes.

Present Study

The purpose of this study is to examine the particular facilitators and barriers to Triple P implementation facing practitioners on Prince Edward Island. Gleaned from the accumulated literature, close examination was given to specific items related to agency encouragement of parenting programs, workplace support, recognition by managers/supervisors and peers, issues related to after-hours appointments and caseload integration, lack of knowledge and skills in behavioral family intervention, coordination with other practitioners, and not having enough clients to run the program. Furthermore, the study set out to compare the experiences of those who have implemented the program in their work (implementers) and those who have not (non-implementers).

With the recognition that Triple P is relatively new to PEI, it was hypothesized that caseload integration would be a significant barrier to practitioners, as they work to adapt their routines to incorporate the program. Additionally, it was hypothesized that implementers would report higher levels of workplace support than non-implementers, and that, in general, non-implementers would report more barriers.

Methods

Participants

Participants categorized themselves into the following agencies: Health and Wellness: Public Health and Children's Services (11), Health and Wellness: Community and Mental Health (7), Community Groups (7), Education, Early Learning and Culture (7), Family and Human Services (5), Family or Parent Education/Resource Centre (3), Health and Wellness: Hospital Services (3), Early Childhood Education Centre (1), Health and Wellness: Addictions (1) and Justice and Public Safety (1). Of these practitioners, 9 reported that they currently supervise staff that work with parents or families, 29 reported that they do not and 2 did not respond.

Instrument

The instrument used in Sanders, Prinz & Shapiro (2009) and Seng, Prinz & Sanders (2006) was requested and subsequently modified to meet the particular needs of this study. After repeated attempts at accessing both instruments, only the Sanders, Prinz & Shapiro (2009) instrument was acquired. This instrument was developed for use in a South Carolina Triple P Initiative study. The purpose of the study was to explore multidisciplinary service providers' levels of program use and particular facilitators and barriers to their usage. This 79 item instrument was developed as a 20 minute telephone interview and included the following sections: sociodemographic characteristics of providers, confidence in parent consultation skills, adequacy of training in parent consultation skills, self-efficacy in Triple P, program use and facilitators and barriers to use. Data collected via the instrument was analyzed through binary logistic

regressions to investigate the univariate relationship between each predictor and use versus non-use and high versus low use.

This instrument was modified from a telephone survey to an online questionnaire administered via the program LimeSurvey, and was tailored to the purposes of this study. It began with a demographic section which categorized participants based on the type of agency they worked for, their level of training, and usage of Triple P. Next, practitioners were asked a series of likert scale questions pertaining to their attitudes of and experiences with evidence-based practices, as well as possible facilitators and barriers to their Triple P use and implementation. Finally, participants were asked to rate their levels of confidence in their ability to conduct parent consultations about child behaviour.

Modifications included removing all telephone contact information, introductory scripts, eligibility criteria, education-related demographic questions, South Carolina specific location questions, reason for not participating, and descriptions of agency question. Questions regarding usage various levels Triple P were modified to reflect those offered on PEI, and a question asking what level(s) of Triple P were you trained and accredited in was added. Words "State" and "County" were changed to "Province" and "Public", respectively. Likert scale acronyms were simplified and replaced with a 1-5 scale. Items mentioning "Triple P Training Consultants" were modified with "PEI Triple P Coordinator".

Several questions were added, including: "Contact with other PEI Triple P leaders/organizers has been helpful", "An obstacle to using Triple P is insufficient access to consultation or supervision with my manager", "An obstacle to using Triple P is insufficient access to consultation or supervision with my peers", "An obstacle to using Triple P is the lack of recognition by managers/supervisors in the workplace for Triple P work", and "An obstacle to using Triple P is the lack of recognition by peers in the workplace for Triple P work". Opportunity for additional comments and an invitation to participate in an optional follow-up telephone interview was also added, as well as an opportunity to select a Family Resource Centre towards which a $10 was to be made. See instrument in Appendix 1.

The optional 15-minute follow-up telephone interview was semistructured and included open-ended prompts. The purpose of this interview was to further explore particular facilitators and barriers to provide context and enrich findings. Interview prompts were tailored to each participant, asking them to elaborate on all obstacles (questionnaire items 53-73) for which they indicated "Agree" or "Strongly Agree". An example of a prompt would be, "You indicated the following as an obstacle to implementation: An obstacle to using Triple P is the unavailability of overtime or time-in-lieu for after-hours appointments". Would you mind elaborating? After inviting the participant to elaborate on all indicated obstacles, the participant was asked, "Overall, what do you perceive as the greatest barrier to your Triple P use and implementation?" and "Overall, what do you perceive as the greatest facilitator to your Triple P use and implementation?". Lastly, participants were asked, "Is there anything else about Triple P use and implementation that you think would be useful for me to know?".

Procedure

This research proposal was submitted for review and approval by the University of Prince Edward Island Research Ethics Board and the Health PEI Research Ethics Board. Upon approval, all 90 practitioners on Prince Edward Island trained and accredited in Triple P were invited via email to complete the online questionnaire. The contact information of these practitioners was provided via the PEI Triple P steering committee. See appendix 2 for the email invitation script. Due to moves in positions and leaves, only 88 of these practitioners were contacted. The initial invitation was sent May 15th, 2017 with subsequent reminders sent to non-responders on May 24th and June 6th. In total, there were 40 respondents. Of these respondents, 22 indicated their interest in participating in a follow-up telephone interview. Interested participants were contacted for interviews June 2-6, and 12 interviews were conducted between June 6th and 15th 2017.

Questionnaire results were analyzed quantitatively through descriptive statistics and t-tests. Possible differences between implementers and non-implementers were explored.

The follow-up interviews were conducted over the phone, and included prompts for participants to elaborate on particular facilitators and barriers that they indicated in their questionnaires. These interviews were approximately 15 minutes, during which the principal investigator took detailed notes of responses via Microsoft Word. Identifying information was removed from data before qualitative thematic analysis was conducted.

Results

Training, Accreditation and Usage

In regards to the level(s) of training and accreditation reported by respondents, Level 3 Primary Care (birth-12 years) and Level 4 Standard (birth-12 years) were the most common, with 21 and 16 respectively. See Table 1 for the full responses.

Table 1

Level(s) of Training, Accreditation and Usage (all respondents)

Level	# of Respondents Out of 40 Trained and Accredited	# of Respondents Out of 31 Who Have Used
Level 2 Seminars (birth-12 years)	8	6
Level 2 Seminars (teen)	1	0
Level 3 Primary Care (birth-12 years)	21	17
Level 3 Primary Care (teen)	1	0
Level 3 Discussion Groups (birth-12 years)	7	4
Level 4 Standard (birth-12 years)	16	11
Level 4 Group (birth-12 years)	11	3
Level 4 Group (teen)	9	1
Level 4 Stepping Stones (birth-12 years)	12	9

Of the 40 respondents, 31 indicated that they have implemented Triple P through their work, 8 indicated that they had not and 1 did not respond. These responses were used as comparison groups to investigate any differences between implementers and non-implementers.

Among implementers, Level 3 Primary Care (birth-12 years) was the most commonly used level (See Table 1).

Participants were asked to report with how many families had they used Triple P with during the 4 weeks prior to the questionnaire. Results ranged from 0 to 10 families served. See Table 2 for all responses.

Table 2

Number of Families Worked with in the Past Four Weeks

Number of Families Worked With	Responses
0	13
1	6
2	6
5	2
6	1
7	2
10	2

Implementers were then asked to indicate with how many families they had used Triple P with during the 12 months prior to the questionnaire. Zero implementers reported working with no families, 21 reported working with 1-9 families, 5 reported working with 10-19 and 5 reported working with 20+ families.

In regards to using Triple P with families outside of work, 7 participants indicated they had, 32 indicated they had not, and 1 did not respond. The types of outside settings/situations indicated were instances of informal advice-giving at the houses of friends and family, church, and private practice.

Only 1 of the 40 respondents indicated supervising one or more staff that uses Triple P with families.

When asked how often participants told parents that the name of the service was Triple P, 35 indicated 75-100% of the time, 1 indicated 50-75%, 1 indicated 25-50%, 0 indicated less than 25% and 2 indicated "never".

Attitudes Toward New Interventions

Likert scale questions were then asked regarding participants' attitudes towards using new interventions. In response to attitudinal statements, participants were invited to indicate their level of agreement, ranging from 1 = Not at all, 2 = To a Slight Extent, 3 = To a Moderate Extent, 4 = To a Great Extent and 5 = To a Very Great Extent. In general, participants held positive attitudes. The most variation was found for the item "Clinical experience is more important that using manualized therapy/interventions" (M = 2.49, SD = .961, n = 37). See table 3 for full responses.

Attitudes Toward Using New Interventions

Typically, participants also indicated their likelihood to adopt a new therapy or intervention if it were found to be intuitively appealing, it "made sense" to them, it was required by their supervisor, agency, or province, it was being used by colleagues who were happy with it, and when they felt they had enough training to use it correctly. See table 4 for full responses.

Attitudes Toward Evidenced-Based Practices

Positive attitudes were also found in regards to evidence-based practices. The item "You are supportive of the use of evidence-based practices" resulted in (M = 4.65, SD = .597, n = 34). Some support for a preventative and proactive approach was always found through item "You would support a more expensive evidence-based program over a less expensive unproven program" (M = 3.83, SD = 1.342, n = 36). Less support was found in regards to the implementation capacity of agencies, as evidenced in the item "Public agencies have sufficient resources to implement evidence-based practices" (M = 2.48, SD = 1.064, n = 33). See table 5 for full responses.

Participants also expressed strong intention to get better informed about, and encourage the use of, evidence-based practices, as found in items "Get better informed about evidence-based practices" (M = 4.31, SD = .710, n = 36), and "Advocate for evidence-based practices in meetings and other exchanges with your coworkers or colleagues" (M = 4.00, SD = .894, n = 36). See table 6 for full results.

Table 3

Attitudes Toward Using New Interventions (all respondents)

Item	N	Mean (Possible Range 1-5)	Standard deviation
I like to use new types of therapy/interventions to help my clients	36	4.36	.639
I am willing to try new types of therapy/interventions even if I have to follow a treatment manual	36	4.31	.624
I know better than academic researchers how to care for my clients	36	2.14	1.046
I am willing to use new and different types of therapy/ interventions developed by researchers	37	4.54	.558
Research based treatments/interventions are not clinically useful	36	1.14	.351
Clinical experience is more important than using manualized therapy/interventions	37	2.49	.961
I would not use manualized therapy/interventions	36	1.25	.554
I would try a new therapy/intervention even if it were very different from what I am used to doing	36	4.17	.845

Facilitators and Barriers

Generally, participants responded positively in terms of facilitating factors, as evidenced in item "Your organization welcomes change and innovation" (M = 3.97, SD = .883, n = 33). Success of Triple P was also reported through item "Triple P is producing change in children and families" (M = 4.03, SD = .718, n = 30).

Table 4

Likelihood of Adopting a New Intervention (all respondents)

Item	N	Mean Possible Range (1-5)	Standard deviation
If it was intuitively appealing?	36	4.39	.688
If it "made sense" to you?	37	4.59	.498
If it was required by your supervisor?	37	4.00	1.080
If it was required by your agency?	37	4.05	.911
If it was required by the province?	37	3.95	1.053
If it was being used by colleagues who were happy with it?	37	4.22	.976
If you felt you had enough training to use it correctly?	37	4.51	.692

In terms of barriers, the most significant obstacles found were: "An obstacles to using Triple P is Triple P not being integrated with caseload or other responsibilities at work" (M = 3.15, SD = 1.482, n =

33), “An obstacle to using Triple P is difficulty engaging families” (M = 3.00, SD = 1.368, n = 32), “An obstacle to using Triple P is after-hours appointments clashing with other commitments” (M = 2.94, SD = 1.523, n = 32) and “An obstacle to using Triple P is covering session material in the scheduled time” (M = 2.94, SD = 1.391, n = 33). The relatively larger standard deviations for these items reflect variability in participants’ experiences regarding barriers. See table 7 for full results.

Table 5

Attitudes Towards Evidence-Based Practices (all respondents)

Item	N	Mean (Possible Range 1-5)	Standard Deviation
Evidence-based programs are more likely to make a positive difference in the lives of children than are programs that are not evidence-based	36	4.03	.910
Paying for evidence-based prevention and treatment practices now will decrease the cost of dealing with future problem behaviors	36	4.06	1.068
You would support a more expensive evidence-based program over a less expensive unproven program	36	3.83	1.342
In general, your colleagues and co-workers support the use of evidence-based practices	36	4.19	.749
Public agencies have sufficient resources to implement evidence-based practices	33	2.48	1.064
You are supportive of the use of evidence-based practices	34	4.65	.597
You are willing to pay higher taxes to fund evidence-based programs to help children develop successfully	35	3.29	1.319

Table 6

Intention to Encourage Use of Evidence-Based Practices (all respondents)

Item	N	Mean (Possible Range 1-5)	Standard Deviation
Advocate for evidence-based practices in meetings and other exchanges with your co-workers and colleagues	36	4.00	.894
Encourage service providers to use evidence-based practices	36	3.89	.919
Get better informed about evidence-based practices	36	4.31	.710
Argue against the adoption and implementation of evidence-based practices	36	1.33	.632

Implementers Versus Non-Implementers

Two-tailed Independent Sample T-Tests were performed to examine any potential differences between implementers (those who responded affirmatively to survey question "Have you ever used Triple P with families through your work?") and non-implementers (those who responded negatively) on ten specific test items. Those items were as follows:

- Your agency encourages delivery of parenting programs such as parent training, parent education or parent support
- Staff in your workplace provide support for Triple P
- An obstacle to using Triple P is the lack of recognition by managers/supervisors in the workplace for Triple P work
- An obstacle to using Triple P is the lack of recognition by peers in the workplace for Triple P work
- An obstacle to using Triple P is the unavailability of overtime or time-in-lieu for after-hours appointments
- An obstacle to using Triple P is after-hours appointments clashing with other commitments

Table 7

Facilitators and Barriers to Implementation (all respondents)

Item	N	Mean (Possible Range 1-5)	Standard Deviation
Your organization welcomes change and innovation	33	3.97	.883
Providing services to families is a central focus of your agency or organization	33	4.45	.833
Your agency encourages delivery of parenting programs such as parent training, parent education, or parent support	33	3.97	1.262
Staff in your workplace provide support for Triple P	32	3.44	1.390
Supervision, consultation, or case discussions have been helpful for the use of Triple P	32	3.59	1.132
Contact with PEI Triple P Coordinator has been helpful	31	3.65	.877
Contact with other PEI Triple P leaders/organizers has been helpful	31	3.58	.848
Triple P is producing change in children and families	30	4.03	.718
Feedback from parents regarding Triple P is positive	32	4.09	.734
Your knowledge and skills in behavioral family intervention make it easier to use Triple P	31	4.10	.908
Triple P can be tailored to the needs of families	33	4.12	.740
Knowledge of ways to track and measure behavior change makes it easier to use Triple P	33	4.09	.723
Setting specific goals or agendas for sessions makes it easier to use Triple P	33	4.18	.727
Triple P parent resource materials are helpful	33	4.27	.626
Triple P practitioner resource materials are helpful	33	4.12	.696
The self regulation theoretical framework of Triple P is useful	33	4.21	.696
Studies showing Triple P's effectiveness justify its use	31	4.23	.669

with families			
An obstacle to using Triple P is insufficient access to consultation or supervision with the Triple P coordinator	32	2.75	1.437
An obstacle to using Triple P is insufficient access to consultation or supervision with my manager	31	2.42	1.455
An obstacle to using Triple P is insufficient access to consultation or supervision with my peers	31	2.71	1.553
An obstacle to using Triple P is the lack of recognition by managers/supervisors in the workplace for Triple P work	33	2.52	1.372
An obstacle to using Triple P is the lack of recognition by peers in the workplace for Triple P work	33	2.30	1.212
An obstacle to using Triple P is the unavailability of overtime or time-in-lieu for after-hours appointments	32	2.59	1.563
An obstacle to using Triple P is after-hours appointments clashing with other commitments	32	2.94	1.523
An obstacle to using Triple P is Triple P not being integrated with caseload or other responsibilities at work	33	3.15	1.482
An obstacle to using Triple P is difficulty engaging families	32	3.00	1.368
An obstacle to using Triple P is keeping parents on track during consultations	33	2.79	1.269
An obstacle to using Triple P is covering session material in the scheduled time	33	2.94	1.391
An obstacle to using Triple P is the lack of progress by children or families	33	2.09	.805
An obstacle to using Triple P is not enough knowledge and skills in behavioral family intervention	33	2.24	1.173
An obstacle to using Triple P is difficulty coordinating	33	2.33	1.267

with other practitioners involved with the family			
An obstacle to using Triple P is not having enough clients	33	2.12	1.364
An obstacle to using Triple P is a clash with your theoretical perspective or with your preferred intervention approach	31	1.97	.983
An obstacle to using Triple P is Triple P resource materials not readily available	33	1.55	.754
An obstacle to using Triple P is difficulties applying Triple P to the needs of the child or family	33	2.12	1.111
An obstacle to using Triple P is difficulties tailoring the program to individual families	33	2.12	.992
An obstacle to using Triple P is use of readily available baseline monitoring measures	32	2.00	.984
An obstacle to using Triple P is setting specific goals or agendas for sessions	33	1.67	.645

- An obstacle to using Triple P is Triple P not being integrated with caseload or other responsibilities at work
- An obstacle to using Triple P is not enough knowledge and skills in behavioral family intervention
- An obstacle to using Triple P is difficulty coordinating with other practitioners involved with the family
- An obstacle to using Triple P is not having enough clients

There was a significant difference in the scores for one item: "Staff in your workplace provide support for Triple P" between implementers (M = 3.85, SD = 1.156, n = 26) and non-implementers (M = 1.80, SD = .837, n = 5); t(29) = -3.751, p = .001 (two-tailed). See table 8 for full results.

Qualitative Analysis

In addition to quantitative data analysis, thematic analysis was performed on follow-up telephone interview data. Interviews were structured by asking participants to elaborate on particular obstacles they identified in the survey. Themes that emerged were: barriers to parents, difficulty with caseload integration, issues of overtime/time-in-lieu, challenges in centralized coordination and support, and perceptions of program success.

Barriers to Parents

Paramount to all other obstacles is the issue of getting parents to the invention sessions. Among practitioners interviewed, getting parents to sessions, and subsequently keeping them committed, is a significant obstacle to effective implementation. As stated by one participant, "...if you can't get them there, there is no program". Participants noted that essentially all parents inevitably face a multitude of practical obstacles in terms of scheduling and coordination. While recognizing that most parents work day-time jobs, evening sessions may be their only option. However, offering evening sessions is a bit of a double-bind. For parents, making themselves available in the evening means coordinating additional childcare (therefore incurring more expenses), finding transportation, and fitting a session into their already full family schedule. For most practitioners, offering a session in the evening is considered "overtime", and there may not be the administrative framework in place to fairly compensate their work (see "Caseload Integration"). Additionally, practitioners reported difficulty finding accessible after-hours locations to offer session from.

Besides the more practical obstacles to getting parents to sessions, participants also expressed some parental misunderstanding about the program. As stated by one participant, "Clients who want us to fix their child, they don't think that they need parenting help. There aren't enough parents that have the insight to know that they need the parenting interventions. And there are even fewer that follow through". This notion of "fixing" a child instead of modifying parenting behavior is a challenge to the spirit of the

Table 8

Independent Samples T-Tests: Implementers vs. Non-Implementers

Variable	Implementers			Non-Implementers				
	N	Mean	SD	N	Mean	SD	t	Sig. (2-tailed)
Your agency encourages delivery of parenting programs such as parent training, parent education or parent support	27	4.22	1.086	5	3.20	1.304	-1.879	.070
Staff in your workplace provide support for Triple P	26	3.85	1.156	5	1.80	.837	-3.751	.001
An obstacle to using Triple P is the lack of recognition by managers/supervisors in the workplace for Triple P work	27	2.48	1.341	5	3.00	1.581	.774	.445
An obstacle to using Triple P is the lack of recognition by peers in the workplace for Triple P work	27	2.33	1.240	5	2.40	1.140	.112	.912
An obstacle to using Triple P is the unavailability of overtime or time-in-lieu for after-hours appointments	26	2.58	1.579	5	3.00	1.581	.549	.588
An obstacle to using Triple P is after-hours appointments clashing with other commitments	27	3.00	1.494	4	3.00	1.826	.000	1.000
An obstacle to using Triple P is Triple P not being integrated with caseload or other responsibilities at work	27	2.93	1.517	5	4.20	.837	1.811	.080
An obstacle to using Triple P is not enough knowledge and skills in behavioral family intervention	27	2.26	1.163	5	2.00	1.414	-.444	.660
An obstacle to using Triple P is difficulty coordinating with other practitioners involved with the family	27	2.41	1.279	5	2.20	1.304	-.332	.742
An obstacle to using Triple P is not having enough clients	27	2.00	1.330	5	2.40	1.517	.606	.549

program. Without this understanding, practitioners feel like parents do not commit and invest in the program (e.g., completing charting, homework) and therefore do not see favourable outcomes. However, participants did acknowledge that many parents dealing with problem child behavior are also facing a whole host of other complex personal difficulties, and may not see themselves as able to prioritize a program such as Triple P.

Related to getting parents in the door, keeping them engaged can be equally as difficult. Participants noted the tendency for attendance to drop off through the course of sessions. However, as the principle of minimal sufficiency is a pillar to Triple P, some participants expressed a struggle to trust that parents had become sufficiently equipped in the short time with the program. Many participants perceived a lack of commitment on behalf of parents in terms of making time for monitoring, charting, and homework. This perceived resistance by the parents led to frustrations over lack of progress. Participants expressed the need to communicate with parents that the more they put into the program, the more they will get out.

An additional complication to keeping parents committed is navigating the sensitive material implicated. Some participants perceived lack of trust between parents and practitioners, particularly when the parents were not existing clients of the practitioner. Participants expressed not wanting parents to feel as though their privacy is being invaded, or to act out of defensiveness should they feel that they are under a microscope. Participants believe that, in large part, this defensiveness is fueled by a fear of child protection services becoming involved. Without honesty and trust between practitioners and parents, program outcomes will inevitably be stunted.

Caseload Integration

As previously alluded to, there are significant structural barriers to Triple P integration into practitioner caseloads. Difficulty integrating Triple P into an already full caseload was the most common obstacle cited by participants. Participants expressed feeling a significant strain on their time, energy and resources as they work to balance all of their services. Significant coordination is required to integrate a

new program into one's caseload, and that can feel impossible when there are existing waitlists for regular practitioner services. Participants stated that making time to integrate Triple P requires the full support and understanding of managers, so exceptions to caseloads can be made.

The issue of productivity benchmarks was a striking theme throughout interviews. Many participants explained how their workplace productivity is calculated by the completion of particular tasks. In many cases, it was expressed that work with Triple P is not accurately reflected in these benchmark calculations, leading practitioners to be disincentivized and unsupported in their attempts at program implementation. For example, one participant explained how running an hour-long group session would only count as 1 point towards their productivity benchmark, even though hours of preparation time would have been required and multiple sets of parents were served simultaneously. This grossly inaccurate reflection of productivity is a major barrier to practitioners, and a reality that managers must recognize. Some participants suggested that the PEI Triple P Steering Committee needs to advocate for better workload integration with managers so that practitioners have the opportunity to implement.

However, even with understanding managers, participants expressed a general lack of time and space in their schedules for Triple P. The extra preparation, scoring and scheduling time, and need for connection with peers and resources pose a significant barrier. As described by one participant, Triple P is "always on the side of the desk". Generally, participants expressed lack of space in their already heavy caseloads to successfully implement Triple P. Some participants suggested that, instead of adding Triple P to the caseloads of existing practitioners, additional service workers be trained in Triple P to offer the program. One participant (only) suggested that a college-level diploma program could be a good fit for training and accrediting Triple P practitioners who can then dedicate their caseloads to the program.

After-hours/time-in-lieu

Connecting the issues of caseload and barriers to parents, some participants described their attempts at offering Triple P sessions after-hours. One participant described how they saw some success through co-facilitating an evening session, as it allowed for shared coordination both on-site and in preparation for

the sessions. However, for most participants, offering sessions in the evening is not a feasible option. Some are not permitted to collect overtime or time-in-lieu, as part of their job description. Most participants also expressed how, due to their own family-life, it is very difficult to offer evening sessions. As busy parents themselves, many practitioners express their inability to modify their personal lives around Triple P implementation. This feeds back into the aforementioned double-bind of evenings being preferable (in some ways) for parents, but not for practitioners.

Coordination

Another theme that emerged through the interviews was issues of coordination. First, participants expressed difficulty coordinating with other practitioners involved with the families served. Indicated reasons for this were issues of consent and ineffective communication platforms. Second, many participants expressed a need for strong, steady leadership for the implementation of Triple P on PEI. Many experienced difficulty connecting with and feeling supported by the PEI Triple P Steering Committee and Coordinator. One participant likened their experience to "working in a silo" and another perceived that their feedback was being ignored. It was suggested by a few interview participants that someone should be solely responsible for coordination of Triple P on the island; that it should not fall on the shoulders of someone already trying to juggle a heavy workload. The spirit of this suggestion is that coordination can be centralized, so as to best encourage implementation, communication and support. Although the online platform *Slack* is intended to facilitate this communication and support, some participants perceived it as falling short of meeting their needs, especially as it is an additional system to learn and make time for. Without all practitioners using it often, coordination is not as effective as it could be. A centralized intake coordinator focused on communication with and between practitioners is suggested to mitigate these concerns.

Session Length

Concerns around session length was another theme that emerged through the interviews. A few participants commented that is it difficult to cover all of the material within the outlined session timeframe.

Specifically, participants noted that the first session was particularly challenging to keep within outlined length because of the time it takes to explain the program and complete paperwork. Participants explained how, with the subject nature implied in these interventions, conversation and session focus can shift depending on the needs of the family. Participants expressed a need for flexibility so as to not rush through important issues emerging in sessions, and to ensure that parents are learning about strategies that work for them.

Advertising and Stigma

A final theme that emerged was that of challenges of advertising and stigma. Participants commented that Triple P is not getting enough public exposure and that parents may be experiencing some stigma around accessing parenting interventions. As stated by one participant, "There is a need to help people understand that parent training isn't about not being a good enough parent – it's about wanting to be the best that you can be. You need a license to catch a fish – why the stigma around parenting courses?". Participants also suggested that advertising and destigmatization occur through more effective communication platforms such as social media, where parents are already getting recommendations from friends and family. Overall, the message from participants was to "meet parents where they are at".

Other Concerns

Although not a complete theme, it is worth noting the concerns expressed around training. One participant suggested that Triple P training and accreditation be undertaken by college-level diploma programs. The participant expressed that having Master's level practitioners implementing the program was "a waste of resources", perceived little success of the program, and suggested that that the Strongest Families program would be a better investment for PEI. Additionally, some frustration was expressed over the lack of training opportunities for particular levels of Triple P, which is hindering their full implementation potential, specifically Stepping Stones training.

Perceptions of Success

Despite all of these barriers discussed, interviews revealed a strong perception of program success. Most participants believe in the effectiveness of the program and support the vision and pillars of its design. Many commented on the helpfulness of resources and the collaborative, parent-centered and practical focus of the program. Particularly, many participants noted how straightforward and user friendly the program's tip sheets and parent strategies were. One participant stated that the program was "changing lives" and giving parents the confidence and strategies that improve the entire family dynamic.

Discussion

Main Findings

This study produced several important insights that will be able to inform and improve Triple P implementation on PEI. These include: practitioners' attitudes towards - and likelihood to adopt - new interventions, support of evidence-based practices, and exploration of particular facilitators and barriers to implementation.

Positive Practitioner Attitudes Toward New Interventions. As a relatively new program to PEI, openness on the part of practitioners is a fundamental precursor to success. Overall, a strong willingness to try novel interventions was found among practitioners. This is a promising indication that most barriers experienced to implementation are not derivative of fundamental opposition to program adoption or misunderstandings about new interventions. Efforts to improve Triple P implementation and adoption on PEI will, one might expect, be bolstered by this openness expressed by practitioners.

Positive Practitioner Attitudes Toward Evidence-Based Interventions. Similarly, practitioners support evidence-based interventions, reported positive perceptions of their effectiveness, and expressed intention to encourage their use. However, slightly less support was found when it came to the financial reality of implementing these programs. In particular, less support was found in regard to paying higher taxes and investing in more expensive evidence-based practices. This is likely related to the reported perception that public agencies do not have sufficient resources to implement these practices. Again, it

would seem that the attitudinal foundation of successful implementation is found among practitioners, and therefore barriers faced are more likely to be of a practical nature.

Facilitators. In addition to the supportive perceptions of, and attitudes toward, new interventions and evidence-based practices, other facilitating factors were evidenced through survey responses. Generally, participants found their workplaces to be encouraging and supportive, and perceived Triple P to be effective, well-designed and user-friendly. These perceptions were amplified in interviews, where many participants expressed how practical the program's parent resources and strategies were. Additionally, the program's focus on instilling parent confidence and empowerment was met with much enthusiasm by participants and contributed to the successes many of them see through the program. The intentional and comprehensive roll-out of Triple P on PEI is meant to harness the efficiency of uniform training, effective communication and coordination, and therefore the empowerment and best service of families in need. Overall, it would seem that these objectives are being moderately well-met, but that practical obstacles stand in the way of its full potential.

Barriers. As noted in the results, the more significant obstacles to implementation reported were: difficulty with caseload integration, difficulty engaging families, the clashing of after-hours appointments with other commitments, and covering session material in the scheduled time. Telephone interviews contextualized these barriers and provide tangible direction for their mitigation.

First, as hypothesized, the issue of caseload integration was a significant obstacle reported by participants. This is an understandable dilemma, and one that requires conscientious planning to undertake successfully. Practitioners trained and accredited in Triple P most often have brimming schedules, long waitlists, and many tasks onto which their attention needs to be divided. Asking them to incorporate an additional program into their workload necessitates recognition of their energy, resources and time. With the leadership of the PEI Triple P Steering Committee, managers should be aware of the demands placed on practitioners and adjust support accordingly. A perfect example of this need is the issue of benchmarks, or productivity measures.

As a significant theme emerging from interviews, many practitioners are effectively discouraged from integrating Triple P into their caseload because their efforts with the program are not appropriately recognized within their management. Without proper recognition of their productivity, it is unfair to expect practitioners to sacrifice their valuable and limited time and energy. One mechanism to address this problem is to focus efforts on workplace and managerial support of the Triple P program, so that there is a uniform understanding of its requirements. The administrative, preparatory, implementation and maintenance aspects of Triple P completed by practitioners ought to be fairly reflected in their workplace productivity measures. With this recognition and support, practitioners can more reasonably integrate the program into their caseloads.

Second, even with workplace support, the program can only see traction when families are effectively engaged. This challenge is twofold: getting parents to the program, and keeping them committed. Creative problem-solving is required to handle the practical obstacles facing parents, such as scheduling, childcare, and transportation. Practitioners acknowledge that family life can be hectic, and attending a possibly stigmatized parenting course is unlikely to be given top priority, let alone receive sustained commitment for the duration of a full program.

In addition to the practical concerns, conceptual misunderstandings must also be addressed, such as this notion of parents wanting a "fix" for their child, or the lack of recognition of the importance of charting and monitoring in order to see favourable outcomes. Addressing these challenges is the joint responsibility of the practitioners and management, as these are stumbling blocks for all areas of health and behavior modification. Structured opportunities for peer consultation about approaches to these common challenges could be especially useful. At the end of the day, practitioners cannot force the commitment of parents, but can work to provide the conditions most conducive to their success.

Third, the issue of after-hours appointments clashing with other commitments is a practical yet serious barrier to implementation. It would seem the general assumption is that evenings are best for parents to attend sessions, even with the additional considerations of childcare and transportation.

Obstacles to practitioners offering evening sessions are inability to work after-hours, lack of accessible facilities, and challenges accommodating their own personal lives. Any feasible solution would have to bridge these challenges. For example, ideally, practitioners would be able to choose to offer an evening session of Triple P, with full recognition of productivity and the benefits of time-in-lieu. Sessions could be given out of community centres that are familiar and close to parents, perhaps even with childcare offered onsite. Although idyllic, without a comprehensive solution such as this to this double-bind, many families will continue to go unserved.

Fourth, difficulty covering session material appears to be a combination of shortcomings of resources (for example, the expressed concern that a session video is too long), and the realities of the subject nature naturally taking the session off track. It ought to be recognized that, given the messiness of parenting (and particularly, challenges in parenting), sessions will inevitably be varied and largely subject to the unique needs of each family. Although all efforts should be made to streamline and improve upon the helpfulness of resources, flexibility ought to be offered to these sessions. This represents another opportunity for structured peer consultation.

Comparisons Between Implementers and Non-Implementers. Within the 10 items selected for comparison, only one significant difference was found between implementers and non-implementers. As hypothesized, implementers reported more workplace support than non-implementers. This would seem to be a crucial element of successful implementation, given the structural support needed to run a program like Triple P.

It is worth noting that the small sample greatly limited the power of these significance tests. It is possible that there are other meaningful differences between implementers and non-implementers that were not captured in this sample.

Methodology

As only Triple P trained and accredited practitioners were eligible to participate in this study, a small sample size was to be expected. Electronic invitations to participate were intentionally worded to

encourage both those who had and had not implemented Triple P within their work to partake in the study. Unfortunately, of the 88 practitioners contacted, only 40 completed the questionnaire. Twelve participated in a follow-up interview, by which time saturation was reached. With less than half of the potential sample participating in the questionnaire, results need to be interpreted with caution. It is possible that those who chose not to take part in the study have meaningfully different attitudes and experiences.

However, through the combination of the online questionnaire and telephone interview, this study was able to benefit from both quantitative and qualitative data. This richness is an asset of the study, as it provided a more complete picture than either instrument could on its own.

Using a modification of the Seng, Prinz & Sanders (2006) questionnaire instrument allowed for comparisons to be made between studies. In its original use, the instrument was employed as a telephone interview and reached an exceptional 97% of the potential sample of 579 service-providers. Results from that study indicated lower reports of barriers by participants than the present study. The robustness of their sample, and the low ratings of obstacles may point to some caveats in study design. Perhaps the large response was due to a strong expectation from management that practitioners participate in the study, and perhaps responses were influenced by social desirability biases during telephone interviews. In the present study, response rates were relatively low, as the research was done independently of any official Triple P body or employer. However, an online platform such as that of the present study should be less influenced by social desirability biases. It is of course also completely possible that the participants in Seng, Prinz & Sanders (2006) genuinely experienced fewer barriers than did those of this study.

In the survey instrument's subsequent use by Sanders, Prinz & Shapiro (2009), 94% of the potential sample responded. Results related to barriers in that study were similar to those of the present study. The items most rated as high obstacles were: unavailability of overtime or comp-time for after-hours appointments, Triple P not being integrated with caseload or other responsibilities at work, after-hours appointments clashing with other commitments and low availability of clients.

By modifying this instrument into an online questionnaire, and pairing it with an optional follow-up telephone interview, context was provided. For example, high agreement to the item "An obstacle to using Triple P is insufficient access to consultation or supervision with the Triple P coordinator" could be indicative of various experiences. Perhaps one participant has attempted consultation or supervision with the coordinator only to be met with inconsistent support; another participant experiences a relatively substantial amount of consultation or supervision with the coordinator but still perceives it to be lacking; and another was not even aware of the role of the Triple P coordinator. By inviting participants to elaborate on their responses, these discrepancies can be reduced.

Limitations

An obvious limitation of this study is the small sample size. With only 40 respondents, fewer than half those eligible, the generalizability of research findings is limited. Additionally, those who had not yet implemented Triple P in their work were especially under-represented; they may have doubted their ability to meaningfully participate, or may not have seen participation as a meaningful use of their time. Alternatively, it is possible that the low number of non-implementers is reflective of current implementation rates on PEI, but reports from Triple P organizers suggest this is not the case. In either case, the low sample combined with low number of non-implementers meant that the Two-Tailed Independent Samples T-Tests in this study lack substantial power.

Recommendations for Future Research

Partnering with the PEI Triple P Steering Committee might be the best approach to future research of Triple P implementation on PEI. With this joint effort in the spirit of improving implementation, and therefore making best use of public funds, research originating from the Steering Committee may more strongly encourage participation. With higher participation, many ambiguities, such as those described in the limitations, would be reduced. Future research would benefit from a more concrete understanding of the differing experiences between implementers and non-implementers.

Another avenue of future research is how to best engage families. As repeatedly referenced, accommodating the needs of both families and practitioners to even set up a session is absolutely essential to implementation. Future research could explore the particular barriers to parents accessing services like Triple P, and therefore work towards crafting solutions to reduce these challenges. Whether it be issues of stigma, transportation, or complex health needs, more understanding of these potential clients would be a valuable step in improving programming.

Lastly, future studies could investigate what means of coordination and communication best serve a program like Triple P. What model of leadership most effectively addresses the needs for support and consultation? For example, perhaps a full-time coordinator need to be in place. Perhaps instead of only one coordinator for the province, each county should have a part-time coordinator who communicates regularly with managers to receive reports on Triple P usage.

Implications for Triple P Implementation on PEI

This research illuminates areas of improvement for Triple P implementation on PEI. First, the issue of benchmarks. As described in the results, the efforts of many practitioners are not being accurately recognized through productivity measures. Not only is this perceived to be unfair, but it suggests a lack of understanding on behalf of management, or ineffective policies, and serves to disincentivize practitioners from implementation. The findings of this study suggest that agencies reevaluate their benchmark measures and work towards modifying them to more accurately reflect work efforts. This would involve more communication between the Triple P Steering Committee, managers and practitioners.

Second, related to the communication breakdowns implicated in benchmark misunderstandings, coordination efforts by the Steering Committee and Coordinator could be improved. Many participants expressed challenges in coordination and communication, essential aspects of sustained implementation. It was suggested that someone take on coordination of Triple P on PEI as their sole responsibility. This would allow them to focus their efforts and remain vigilant to changing needs. With a coordinator exclusively focused on the success of the Triple P, challenges could be resolved in real-time, and

practitioners could feel more connected with the program and each other. This coordinator could be responsible for connecting co-facilitators, finding accessible evening locations for sessions and coordinating client referrals. This proactive approach to coordination may mitigate many of the obstacles indicated by participants.

Third, the research suggests that more intentional efforts to engage families must be made. As suggested for future research, a more informed understanding of barriers to parents accessing Triple P must be sought. If logistical concerns are the root of disengagement, creative problem-solving is needed to find the best offerings for parents. If stigma is preventing parents from attending sessions, advertising and destigmatization campaigns would be worthwhile endeavours.

Lastly, a significant barrier to a few participants was a lack of training opportunity for specific levels of Triple P, particularly Level 4: Stepping Stones. In order to make the most of practitioners' expertise and clientele, the Triple P Steering Committee could offer training regularly that meets their needs.

Conclusion

Overall, this study suggests that foundations for successful implementation of Triple P on PEI have been laid. Participants expressed openness towards new interventions, perceptions of effectiveness of evidence-based practices, usefulness of Triple P program resources, and strong support of Triple P's agenda of instilling parental confidence and empowerment. These facilitators are encouraging signs of potential. Barriers to implementation are found in aspects of administration, coordination and communication. With a more concerted effort to increase understanding between all parties (Steering Committee, coordinator, managers, practitioners, and clients), creative solutions can be found to overcome these obstacles. The findings of this study show that practitioners are open, enthusiastic, and willing to implement Triple P on PEI but require significant ongoing support to maintain their efforts.

References

Afifi, T., Taillieu, T., Cheung, K., Katz, L., Tonmyr, L., & Sareen, J. (2015). Substantiated Reports of Child Maltreatment From the Canadian Incidence Study of Reported Child Abuse and Neglect 2008: Examining Child and Household Characteristics and Child Functional Impairment. *Canadian Journal of Psychiatry*, *60*(7), 315-323.

Asgary-Eden, V., & Lee, C. (2011). So now we've picked an evidence-based program, what's next? Perspectives of service providers and administrators. *Professional Psychology, Research and Practice*, *42*(2), 169-175. doi:10.1037/a0022745

Asgary-Eden, V., & Lee, C. (2012). Implementing an evidence-based parenting program in community agencies: what helps and what gets in the way?. *Administration and Policy in Mental Health and Mental Health Services Research*, *39*(6), 478-488. doi:10.1007/s10488-011-0371-y

Bandura, A. (1962). Punishment revisited. *Journal of Consulting Psychology*, *26*(4), 298-301. doi:10.1037/h0043740

Bandura, A. (1971). *Social learning theory*. New York: General Learning Press.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84,* 191-215.

Bates, J. E., & Pettit, G. S. (2015). Temperament, parenting, and social development. In J. E. Grusec, P. D. Hastings, J. E. Grusec, P. D. Hastings (Eds.), *Handbook of socialization: Theory and research, 2nd ed.* (pp. 372-397). New York, NY, US: Guilford Press.

Baumrind, D. (1989). Rearing competent children. In W. Damon, W. Damon (Eds.), *Child development today and tomorrow* (pp. 349-378). San Francisco, CA, US: Jossey-Bass.

Bowlby, J. (1969). *Attachment & Loss: Vol. 1. Attachment.* New York, NY: Basic Books.

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology, 28,* 759-775.

Dennis, T. (2006). Emotional self-regulation in preschoolers: the interplay of child approach reactivity, parenting, and control capacities. *Developmental Psychology*, (1), 84-97.

Foster, E., Prinz, R., Sanders, M., & Shapiro, C. (2008). The costs of a public health infrastructure for delivering parenting and family support. *Children and Youth Services Review*, 30, 493-501.

Frantz, I., Stemmler, M., Hahlweg, K., Pluck, J., & Heinrichs, N. (2015). Experiences in Disseminating Evidence-Based Prevention Programs in a Real-World Setting. *Prevention Science*, (6), 789-801. doi:10.1007/s11121-015-0554-y

Garcia Quiroga, M., & Hamilton-Giachritsis, C. (2016). Attachment Styles in Children Living in Alternative Care: A Systematic Review of the Literature. *Child & Youth Care Forum, 45*(4), 625-653.

Hodge, L., Turner, K., Sanders, M., & Filus, A. (2016). Sustained implementation support scale: Validation of a measure of program characteristics and workplace functioning for sustained program implementation. *The Journal of Behavioral Health Services & Research*, doi:10.1007/s11414-016-9505-z

Holden, G. (2010). Chapter 4: The controversy over parental influence. *Parenting: a dynamic perspective* (pp. 83-104). Thousand Oaks, CA: Sage.

Lee, C. (2010). Families matter: psychology of the family and the family of psychology. *Canadian Psychology*, (1), 1-8.

Lipscomb, S., Leve, L., Harold, G., Neiderhiser, J., Shaw, D., Ge, X., & Reiss, D. (2011). Trajectories of Parenting and Child Negative Emotionality during Infancy and Toddlerhood: A Longitudinal Analysis. *Child Development*, *82*(5), 1661-1675.

Maccoby, E. (1992). The role of parents in the socialization of children: An historical overview. *Developmental Psychology, 28,* 1006–1017.

Mancini, J. A., & Marek, L. I. (2004). Sustaining Community-Based Programs for Families: Conceptualization and Measurement. *Family Relations*, (4). 339-347.

McWilliam, J., Brown, J., Sanders, M., & Jones, L. (2016). The Triple P Implementation Framework: The Role of Purveyors in the Implementation and Sustainability of Evidence-Based Programs. *Prevention Science*, (5), 636-645. doi:10.1007/s11121-016-0661-4

Prinz, R., Sanders, M., Shapiro, C., Whitaker, D., & Lutzker, J. (2009). Population-based prevention of child maltreatment: The U.S. Triple P system population trial. *Prevention Science*, 10(1), 1-12.

Sanders, M., Prinz, R., & Shapiro, C. (2009). Predicting Utilization of Evidence-Based Parenting Interventions with Organizational, Service-Provider and Client Variables. *Administration and Policy In Mental Health And Mental Health Services Research*, *36*(2), 133-143.

Sanders, M., Pickering, J., Kirby, J., Turner, K., Morawska, A., Mazzucchelli, T., & ... Sofronoff, K. (2012). A commentary on evidenced-based parenting programs: redressing misconceptions of the empirical support for Triple P. *BMC Medicine*, *10.* 145. doi:10.1186/1741-7015-10-145

Sanders, M., & Kirby, J. (2014). A Public-Health Approach to Improving Parenting and Promoting Children's Well-Being. *Child Development Perspectives*, (4), 250-257. doi:10.1111/cdep.12086

Sanders, M., Kirby, J., Tellegen, C., & Day, J. (2014). The Triple P-Positive Parenting Program: A systematic review and meta-analysis of a multi-level system of parenting support. *Clinical Psychology Review*, *34.* 337-357. doi:10.1016/j.cpr.2014.04.003

Sanders, M., Turner, K., & McWilliam, J. (2016). In Ryzin, M., Kumpfer, K., Fosco, Go., and Greenberg, M. (eds.), Family-based prevention programs for children and adolescents: Theory, research, and large-scale dissemination (pp. 134-159).

Seng, A., Prinz, R., & Sanders, M. (2006). The Role of Training Variables in Effective Dissemination of Evidence-Based Parenting Interventions. *International Journal of Mental Health Promotion*, *8*(4), 20-28. doi:10.1080/14623730.2006.9721748

Shaver, P. R. & Mikulincer, M. (2010). An attachment-theory framework for conceptualizing interpersonal behaviour. In Horowitz, L. and Strack, S. (Eds.), *The handbook of interpersonal psychology:*

Theory, research, assessment and therapeutic intervention (pp. 17–36). New Jersey, NJ: John Wiley.

Smith, P., Brown, J., Feldgaier, S., & Lee, C. (2015). Supporting Parenting to Promote Children's Social and Emotional Well-being. *Canadian Journal of Community Mental Health, 34*(4), 129-142. doi:10.7870/cjcmh-2015-013

Wilson, P., Rush, R., Hussey, S., Puckering, C., Sim, F., Allely, C., & ... Gillberg, C. (2012). How evidence-based is an 'evidence-based parenting program'? A PRISMA systematic review and meta-analysis of Triple P. *BMC Medicine, 10*(1), 130. doi:10.1186/1741-7015-10-130

Appendix 1

Questionnaire

Facilitators and Barriers to Triple P implementation on Prince Edward Island Questionnaire

1. Your name: _____
2. Please indicate which category applies to your agency.

a.	Early Childhood Education Centre	
b.	Family or Parent Education/Resource Centre	
c.	Education, Early Learning and Culture	
d.	Family and Human Services	
e.	Community Groups	
f.	Health and Wellness: Community and Mental Health	
g.	Health and Wellness: Addictions	
h.	Health and Wellness: Public Health and Children's Services	
i.	Health and Wellness: Hospital Services	
j.	Justice and Public Safety	
k.	Other	Name:

3. Do you currently work with parents or families? Y1 N2
4. Do you currently supervise staff that work with parents or families? Y1 N2

5. Please indicate which level(s) of Triple P were you trained and accredited in.

a.	**Level 2 Seminars (birth-12 years)**	
b.	Level 2 Seminars (teen)	
c.	Level 3 Primary Care (birth-12 years)	
d.	Level 3 Primary Care (teen)	
e.	Level 3 Discussion Groups (birth-12 years)	
f.	Level 4 Standard (birth-12 years)	

g. Level 4 Group (birth-12 years)
h. Level 4 Group (teen)
i. Level 4 Stepping Stones (birth-12 years)

6. Have you ever used Triple P with families through your work? Y1 N2

[IF NO, SKIP TO Q# 7]

IF YES: Please indicate which levels of Triple P that you use.

		Y1	**N2**
a.	**Do you use Level 2 Seminars (birth-12 years)**		
b.	Do you use Level 2 Seminars (teen)	Y1	N2
c.	Do you use Level 3 Primary Care (birth-12 years)	Y1	N2
d.	Do you use Level 3 Primary Care (teen)	Y1	N2
e.	Do you use Level 3 Discussion Groups (birth-12 years)	Y1	N2
f.	Do you use Level 4 Standard (birth-12 years)	Y1	N2
g.	Do you use Level 4 Group (birth-12 years)	Y1	N2
h.	Do you use Level 4 Group (teen)	Y1	N2
i.	Do you use Level 4 Stepping Stones (birth-12 years)	Y1	N2
j.	In the last 4 weeks that you worked, with how many families have you used Triple P?	Number:	
k.	In the last 12 months that you worked, with how many families have you used Triple P?	0 | 1-9 | 10-19 | 20+	

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7. Have you ever used Triple P with families outside of work? Y1 N2

[IF NO, SKIP TO Q# 8]

IF YES: Please indicate which levels of Triple P that you use.

		Y1	**N2**
a.	**Do you use Level 2 Seminars (birth-12 years)**		
b.	Do you use Level 2 Seminars (teen)	Y1	N2
c.	Do you use Level 3 Primary Care (birth-12 years)	Y1	N2
d.	Do you use Level 3 Primary Care (teen)	Y1	N2
e.	Do you use Level 3 Discussion Groups (birth-12 years)	Y1	N2
f.	Do you use Level 4 Standard (birth-12 years)	Y1	N2
g.	Do you use Level 4 Group (birth-12 years)	Y1	N2
h.	Do you use Level 4 Group (teen)	Y1	N2
i.	Do you use Level 4 Stepping Stones (birth-12 years)	Y1	N2
j.	In the last 4 weeks, with how many families have you used Triple P outside of a work setting (e.g. volunteer seminar given at one's school or church)?	Number:	
k.	In the last 12 months, with how many families have you used Triple P outside of work?	0 | 1-9 | 10-19 | 20+	
l.	In what type of outside situation do you use Triple P?	Location:	

8. Have you ever supervised one or more staff that uses Triple P with families? Y1 N2

[IF NO, SKIP TO Q#9]

IF YES: Please indicate which levels of Triple P that you supervise.

a.	**Do you supervise Level 2 Seminars (birth-12 years)**	**Y1**	**N2**
b.	Do you supervise Level 2 Seminars (teen)	Y1	N2
c.	Do you supervise Level 3 Primary Care (birth-12 years)	Y1	N2
d.	Do you supervise Level 3 Primary Care (teen)	Y1	N2
e.	Do you use Level 3 Discussion Groups (birth-12 years)	Y1	N2
f.	Do you use Level 4 Standard (birth-12 years)	Y1	N2
g.	Do you supervise Level 4 Group (birth-12 years)	Y1	N2
h.	Do you supervise Level 4 Group (teen)	Y1	N2
i.	Do you supervise Level 4 Stepping Stones (birth-12 years)	Y1	N2

j. In the last 4 weeks that you worked, with how many families have you supervised the use of Triple P?

0	1-9	10-19	20+

k. In the last 12 months that you worked, with how many families have you supervised use of Triple P?

0	1-9	10-19	20+

l. How many staff do you supervise in use of Triple P? Number:

9. When you have used Triple P with parents, how often have you told parents that the name of the service is Triple P?
   a. Never
   b. With less than 25% of the parents
   c. With 25% to 50% of the parents
   d. With 50% to 75% of the parents
   e. With 75% to 100% of the parents

To what degree do you agree with each item using the following scale: ***1 = Not at All*** ***2 = To a Slight Extent*** ***3 = To a Moderate Extent*** ***4 = To a Great Extent*** ***5 = To a Very Great Extent***						
10.	I like to use new types of therapy/interventions to help my clients	1	2	3	4	5
11.	I am willing to try new types of therapy/interventions even if I have to follow a treatment manual	1	2	3	4	5
12.	I know better than academic researchers how to care for my clients	1	2	3	4	5

13.	I am willing to use new and different types of therapy/ interventions developed by researchers	1	2	3	4	5
14.	Research based treatments/interventions are not clinically useful	1	2	3	4	5
15.	Clinical experience is more important than using manualized therapy/interventions	1	2	3	4	5
16.	I would not use manualized therapy/interventions	1	2	3	4	5
17.	I would try a new therapy/intervention even if it were very different from what I am used to doing	1	2	3	4	5

If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:						
18.	it was intuitively appealing?	1	2	3	4	5
19.	it "made sense" to you?	1	2	3	4	5
20.	it was required by your supervisor?	1	2	3	4	5
21.	it was required by your agency?	1	2	3	4	5
22.	it was required by the province?	1	2	3	4	5
23.	it was being used by colleagues who were happy with it?	1	2	3	4	5
24.	you felt you had enough training to use it correctly?	1	2	3	4	5

For each of the following items, please use the following response scale: **1 = *Strongly Disagree* 2 = *Disagree* 3 = *Neither Agree nor Disagree* *4 = Agree* *5 = Strongly Agree*						
25.	Evidence-based programs are more likely to make a positive difference in the lives of children than are programs that are not evidence-based	1	2	3	4	5
26.	Paying for evidence-based prevention and treatment practices now will decrease the cost of dealing with future problem behaviors	1	2	3	4	5
27.	You would support a more expensive evidence-based program over a less expensive unproven program	1	2	3	4	5
28.	In general, your colleagues and co-workers support the use of evidence-based practices	1	2	3	4	5
29.	Public agencies have sufficient resources to implement evidence-based practices	1	2	3	4	5

30.	You are supportive of the use of evidence-based practices	1	2	3	4	5
31.	You are willing to pay higher taxes to fund evidence-based programs to help children develop successfully	1	2	3	4	5

What is the extent to which you expect to engage in the following activities in the next year? (Please use the following response scale):

1 = ***Definitely NO*** **2 =** ***Probably NO*** ***3 = Not Sure***

4 = Probably Yes ***5 = Definitely Yes***

32.	Advocate for evidence-based practices in meetings and other exchanges with your co-workers and colleagues	1	2	3	4	5
33.	Encourage service providers to use evidence-based practices	1	2	3	4	5
34.	Get better informed about evidence-based practices	1	2	3	4	5
35.	Argue <u>against</u> the adoption and implementation of evidence-based practices	1	2	3	4	5

	Please indicate whether you agree or disagree with each of the following statements. These statements are about things that may or may not have to do with the use of Triple P. Your choices for each statement are: **1 = Strongly Disagree 2 =Disagree 3 = Neither Agree nor Disagree** **4 = Agree 5 =Strongly Agree**					
36.	Your organization welcomes change and innovation	1	2	3	4	5
37.	Providing services to families is a central focus of your agency or organization	1	2	3	4	5
38.	Your agency encourages delivery of parenting programs such as parent training, parent education, or parent support	1	2	3	4	5
39.	Staff in your workplace provide support for Triple P	1	2	3	4	5
40.	Supervision, consultation, or case discussions have been helpful for the use of Triple P	1	2	3	4	5
41.	Contact with PEI Triple P Coordinator has been helpful	1	2	3	4	5
42.	Contact with other PEI Triple P leaders/organizers has been helpful	1	2	3	4	5
43.	Triple P is producing change in children and families	1	2	3	4	5
44.	Feedback from parents regarding Triple P is positive	1	2	3	4	5
45.	Your knowledge and skills in behavioral family intervention make it easier to use Triple P	1	2	3	4	5
46.	Triple P can be tailored to the needs of families	1	2	3	4	5
47.	Knowledge of ways to track and measure behavior change makes it easier to use Triple P	1	2	3	4	5
48.	Setting specific goals or agendas for sessions makes it easier to use Triple P	1	2	3	4	5
49.	Triple P parent resource materials are helpful	1	2	3	4	5
50.	Triple P practitioner resource materials are helpful	1	2	3	4	5
51.	The self regulation theoretical framework of Triple P is useful	1	2	3	4	5
52.	Studies showing Triple P's effectiveness justify its use with families	1	2	3	4	5
53.	An obstacle to using Triple P is insufficient access to consultation or supervision with the Triple P coordinator	1	2	3	4	5
54.	An obstacle to using Triple P is insufficient access to consultation or supervision with my manager	1	2	3	4	5

55.	An obstacle to using Triple P is insufficient access to consultation or supervision with my peers	1	2	3	4	5
56.	An obstacle to using Triple P is the lack of recognition by managers/supervisors in the workplace for Triple P work	1	2	3	4	5
57.	An obstacle to using Triple P is the lack of recognition by peers in the workplace for Triple P work	1	2	3	4	5
58.	An obstacle to using Triple P is the unavailability of overtime or time-in-lieu for after-hours appointments	1	2	3	4	5
59.	An obstacle to using Triple P is after-hours appointments clashing with other commitments	1	2	3	4	5
60.	An obstacle to using Triple P is Triple P not being integrated with caseload or other responsibilities at work	1	2	3	4	5
61.	An obstacle to using Triple P is difficulty engaging families	1	2	3	4	5
62.	An obstacle to using Triple P is keeping parents on track during consultations	1	2	3	4	5
63.	An obstacle to using Triple P is covering session material in the scheduled time	1	2	3	4	5
64.	An obstacle to using Triple P is the lack of progress by children or families	1	2	3	4	5
65.	An obstacle to using Triple P is not enough knowledge and skills in behavioral family intervention	1	2	3	4	5
66.	An obstacle to using Triple P is difficulty coordinating with other practitioners involved with the family	1	2	3	4	5
67.	An obstacle to using Triple P is not having enough clients	1	2	3	4	5
68.	An obstacle to using Triple P is a clash with your theoretical perspective or with your preferred intervention approach	1	2	3	4	5
69.	An obstacle to using Triple P is Triple P resource materials not readily available	1	2	3	4	5
70.	An obstacle to using Triple P is difficulties applying Triple P to the needs of the child or family	1	2	3	4	5
71.	An obstacle to using Triple P is difficulties tailoring the program to individual families	1	2	3	4	5
72.	An obstacle to using Triple P is use of readily available baseline monitoring measures	1	2	3	4	5
73.	An obstacle to using Triple P is setting specific goals or agendas for sessions	1	2	3	4	5

74. How confident are you in conducting parent consultations about child behavior?

1-not at all confident 2 3 4 5 6 7-very confident

75. We would welcome hearing about any additional comments you may have about the facilitators and barriers in your experience of Triple P on PEI:

_____
_____
_____
_____
_____

76. Would you be open to being contacted for a follow-up telephone interview about your experience?

Yes	No

If YES, please indicate your contact information

Email:
Telephone Number:

77. Thank you for completing this questionnaire. As a token of our thanks, we would be pleased to make a $10 contribute to the Family Resource Centre of your choice. Please check below which Centre you would like the gift directed toward.

Alberton	Kids West Inc.	
Charlottetown	CHANCES Family Centre	
Montague	Families First Resource Centre	
Souris	Main Street Resource Centre	
Summerside	Family Place	
Wellington	Cap Enfants	

Thank you very much for your time and participation. If you have any additional comments or questions about the study, please do not hesitant to contact me.

Grace McCarvill
gmmccarvill@upei.ca
(902) 314-0180

Appendix 2

Email Participation Invitation

My name is Grace McCarvill and I am a UPEI psychology honours student under the supervision of Dr. Philip Smith. My thesis research is investigating the facilitators and barriers to Triple P implementation on Prince Edward Island. I am inviting all Triple P trained practitioners on PEI to complete an online questionnaire that will be sent via email _(date)_____. This questionnaire will take approximately 25 minutes of your time, with an option of indicating your interest in a follow-up telephone interview of approximately 20 minutes. Your participation in this study will provide valuable information to enhance Triple P usage, maintenance and sustainability, promoting positive outcomes for island families. As a small token of our appreciation for your time, upon completion of the questionnaire you will be asked to indicate which Family Resource Centre on the island you would like a $10 contribution to be made to on your behalf.

Appendix 3

Participation Information Form

You have been invited to participate in a research project on Implementation of Triple P on Prince Edward Island conducted by Grace McCarvill under the supervision of Dr. Philip Smith in the Department of Psychology at the University of Prince Edward Island. This study is being conducted to fulfil the requirements of Psychology 490: Honours Thesis. The aim of this project is to investigate the facilitators and barriers to the implementation of Triple P among all accredited practitioners on Prince Edward Island. Through gaining insight into the implementation process, meaningful improvements can be made to enhance practitioner usage and program success. As Triple P is a publicly funded program, it is important that it is well-supported and understood, so as to make good use of resource and energy. As a participant, you will be asked about your experience with Triple P.

You are invited to complete a questionnaire via LimeSurvey, an online survey platform. This questionnaire is composed primarily of close-ended questions, but also leaves space for additional comments. At the end of the questionnaire, you will be given the opportunity to indicate whether you are interested in completing an additional follow-up telephone interview. The follow-up interview will consist of open-ended questions regarding specific questionnaire items that had been identified in the results as barriers. During the interview, detailed notes will be taken in order to perform a qualitative analysis. Participation in the questionnaire will take approximately 15 minutes of your time, with the optional follow-up interview adding an additional 15 minutes.

Your participation in the research project will pose no harm to you. Your participation in this research project is entirely voluntary. You may stop your participation in the research project

at any time, without penalty or prejudice. All information collected in the course of this project will remain confidential and identifying information will be separated from all responses before data analysis. Only Grace McCarvill and Dr. Philip Smith will have access to the data resulting from this research project.

Upon completion of the project, all Triple P practitioners invited to take part in the study will be emailed an executive summary of the results, along with information on how to obtain an electronic copy of the completed thesis. All data resulting from the research project will be retained for a period of 5 years after the completion of the project, after which time it will be destroyed. In return for your participation in this research project, you will be able to select the Family Resource Centre of your choice to which a $10 donation will be made.

If you have any questions or concerns about this research project, you may consult with Dr. Philip Smith, ph. (902) 566-0549, email: smithp@upei.ca or Dr. Jason Doiron, Chair of the Department of Psychology, ph. (902)566-0519, email: jpdoiron@upei.ca. For access to the full results of the research project once these are available, please contact Grace McCarvill, ph. (902)314-0180, email: gmmccarvill@upei.ca

Appendix 4

Consent Form

I consent to participating in research on the facilitators and barriers to Triple P implementation on Prince Edward Island. I understand that all (approximately 80) Triple P accredited practitioners have been invited to partake in this research, and that responses will undergo descriptive statistics to identify perceived facilitators and barriers, as well as attitudes toward work circumstances involving Triple P implementation. I understand that my participation involves completion of an online questionnaire with the option to also complete a follow-up telephone interview. If I agree to complete a telephone interview, I understand that any quotations from the interview will be used only if they cannot identify me. I understand that my participation would serve as a benefit to me by advancing knowledge on implementation, thereby working towards improving program outcomes in my work. I understand that there are no known risks of completing this questionnaire.

I have read and understood the material about this study in the Information Letter, and understand that:

1. My participation in the study is entirely voluntary;
2. I may discontinue my participation at any time without any adverse consequence;
3. My responses will be kept confidential and all identifying information will be separated from responses before data analysis, except where the researcher is required by law to report them;
4. Once all data have been submitted and identifiers removed, I will no longer have the opportunity to request that my data be removed from the study;
5. I have the freedom not to answer any question included in the research;

6. I understand that my continuing with the study indicates my consent.

7. I understand that I can contact the UPEI Research Ethics Board at (902) 620-5104, or by email at reb@upei.ca if I have any concerns about the ethical conduct of this study.

PERMISSION TO USE HONOURS PAPER

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Name of Author:

Department:

Degree:

Year:

Name of Supervisor(s):

In presenting this paper in partial fulfillment of the requirements for an honours degree from the University of Prince Edward Island, I agree that the Libraries of this University may make it freely available for inspection and give permission to add an electronic version of the honours paper to the Digital Repository at the University of Prince Edward Island. I further agree that permission for extensive copying of this paper for scholarly purposes may be granted by the professors who supervised my work, or, in their absence, by the Chair of the Department or the Dean of the Faculty in which my paper was done. It is understood any copying or publication or use of this paper or parts thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University of Prince Edward Island in any scholarly use which may be made of any material in my paper.

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