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Identifying pre-implementation barriers, facilitators and strategies for integrating a co-designed, technology-assisted parenting program within an adult mental health service

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Abstract

Background

Children of parents experiencing mental health challenges are at an increased risk of mental health issues themselves. Parenting interventions can improve parent and child outcomes; however, parents often face barriers to accessing them. Delivering technology-assisted parenting programs within adult mental health services may overcome barriers by providing accessible, family-focused support and minimising demands on services. Yet little is known about how these programs can be efficiently and appropriately implemented in adult mental health settings. This study aimed to: 1) understand the perceived barriers and facilitators to implementing a co-designed, technology-assisted parenting program in an adult mental health service, from the perspective of service providers, and 2) use this understanding to develop practical strategies to guide the implementation of such programs in practice.

Methods

Individual interviews were conducted with 13 service providers (*n* = 9 clinicians, *n* = 4 managers). Data collection and analysis were informed by the Consolidated Framework for Implementation Research (CFIR). Implementation strategies were drawn from the Expert Recommendations for Implementing Change (ERIC), with the CFIR-ERIC Matching Tool used to link identified barriers with targeted implementation strategies.

Results

We identified 22 CFIR constructs as facilitators and 12 as barriers. Eighteen implementation strategies were suggested for overcoming these barriers, with many strategies falling within the ERIC clusters ‘Use evaluative and iterative strategies’ (*n* = 5) and ‘Train and educate stakeholders’ (*n* = 4).

Conclusions

Findings highlight key factors influencing the implementation of a technology-assisted parenting program into an adult mental health service and suggest actionable strategies to mitigate barriers. Health services aiming to enhance parental mental health and family functioning through embedding technology-assisted parenting programs can use these findings to guide implementation.

1. BACKGROUND

Parental mental health issues or challenges, such as depression and anxiety, are associated with approximately a twofold increased likelihood of mental health challenges in children [1, 2]. Poor parental mental health has also been associated with less positive parenting and more negative parenting such

as reduced warmth and increased parenting stress, aversive parenting and ineffective discipline [3–7]. Research suggests that this parenting may be an important pathway in the intergenerational transmission of mental health challenges to children, particularly when families lack adequate supports [8–10]. Notably though, experiencing mental health challenges does not prevent parents from parenting effectively [11], and parenting is a modifiable factor that can be improved with intervention [12, 13]. For instance, several parenting interventions for parents experiencing mental health challenges have demonstrated improvements in parenting and child outcomes [14–16]. However, these parents often encounter increased barriers to accessing parenting support including fluctuating symptoms, competing life stressors, stigma and social isolation [17–19].

Delivering parenting support within adult mental health services that parents are already accessing may overcome many of these barriers by leveraging existing parent-clinician relationships [20], considering parenting within the context of parental mental health symptoms [21], and reducing the burden and stigma associated with contacting a separate parenting service [4, 22]. It also enables mental health clinicians to adopt a family-focused approach that can enhance the recovery of parents, by recognising parenting as an important part of the parents' wellbeing and identity [23]. This may allow services to provide higher quality and more relevant mental health care, since addressing parenting draws on children as a key motivation for parental engagement in treatment and aligns with parents' desires to have their parenting role supported by their mental health clinician [21, 24–26]. Moreover, evidence indicates that among parents with mental health challenges, addressing both parenting and parental mental health in combination may produce broader benefits for parent wellbeing, parenting and child outcomes than addressing either domain on its own [27, 28]. As such, these family-focused interventions may represent an efficient and cost-saving use of resources, since they have the potential to improve multiple interrelated family outcomes in one service [29, 30].

Despite these potential benefits, parents are not consistently provided with parenting support when accessing care for their mental health, with parenting and mental health interventions often delivered separately [31, 32]. Although there are an increasing number of in-person interventions that aim to embed parenting support into adult mental health services [14, 33–35], implementation and use in real-world settings is often constrained by several clinician, organisational and parent-level barriers. Clinician-level barriers include lack of clinician confidence, knowledge, skills, time and training to deliver family-focused support [20, 36–38]. These challenges are exacerbated by organisational or service-level barriers, including limited resources, high workloads, staff shortages, lack of workplace support and predominantly individualised models of mental health care that prioritise treating individual clients over involving the family [20, 39–41]. Additionally, there are several parent-level barriers to engagement such as lack of time, transportation challenges, low energy and childcare responsibilities [19, 42]. Such barriers highlight the potential value of integrating technology-assisted parenting programs into existing adult mental health settings, with parenting support delivered partly or completely via digital platforms [43]. Compared to face-to-face interventions, digital programs may minimise demands on clinicians, utilise fewer resources, lower costs and improve accessibility and flexibility for parents [44–46]. A

growing body of research also suggests that technology-assisted parenting programs are acceptable and can improve parenting and child outcomes among parents with mental health challenges [46–48].

Yet technology-assisted parenting programs have not, to our knowledge, been integrated into adult mental health care for parents seeking mental health support, leaving uncertainty about the feasibility of their implementation. A range of factors can influence the uptake of family-focused programs in practice, including clinician attitudes, limited time and training, organisational resources, caseload pressures, and the fit of the intervention with the daily practices of clinicians and parents [19, 20, 39]. Indeed, research indicates that interventions demonstrating efficacy in controlled research settings may not be successfully adopted or produce the same outcomes in clinical practice, often due to such contextual factors [49, 50]. Additionally, the research-to-practice gap is often quite lengthy, resulting in long delays between the development of evidence-based interventions and their integration into routine care [51, 52]. Collectively, these challenges underscore the importance of examining how technology-assisted parenting programs can be efficiently and successfully integrated in real-world mental health settings, including identifying and mitigating any clinician, organisational or parent-level barriers to implementation and uptake.

The implementation science field focuses on investigating factors and processes that encourage the uptake of evidence-based research into routine use [52]. It encompasses two aims: first, understanding barriers and facilitators that influence implementation, and second, designing and using strategies to address barriers and strengthen facilitators, to promote adoption of interventions [49]. Implementation science highlights the importance of assessing contextual factors, as the compatibility between an intervention and the organisation where it is delivered is known to influence implementation success and sustainability [53, 54]. Since the quality of implementation is positively associated with intervention outcomes [55], it is beneficial to assess facilitators and barriers before implementation, to allow refinement of implementation strategies and the intervention prior to delivery [56].

Several frameworks and tools support consistent interpretation and reporting of implementation factors and strategies, enabling clear comparisons across studies [57]. The Consolidated Framework for Implementation Research (CFIR) is one such implementation science framework, commonly used to systematically identify and report factors that influence intervention uptake [58]. Originally published in 2009 [59] and updated in 2022 [58], the CFIR was developed by synthesising existing research on factors impacting implementation success. It comprises a structured set of constructs used to assess implementation facilitators and barriers across key domains, including organisational context, characteristics of individuals involved, and features of the intervention itself [60]. While the CFIR focuses on determinants of implementation, the Expert Recommendations for Implementing Change (ERIC) provide a comprehensive list of practical strategies to support implementation [61]. The CFIR-ERIC Matching Tool was developed to guide strategy selection by linking identified CFIR barriers with expert-endorsed ERIC strategies [62]. However, given the substantial variability in expert opinions regarding which ERIC strategies best address each CFIR barrier, the tool's recommendations should be applied cautiously [62]. Nevertheless, together the CFIR and ERIC offer a widely accepted foundation for

prospectively identifying implementation determinants, linking barriers to actionable strategies and supporting consistent reporting across studies. The CFIR-ERIC Matching Tool may therefore assist pre-implementation planning when integrating technology-assisted parenting programs into adult mental health services, to enhance care for parents seeking mental health support.

Therefore, this study aimed to 1) explore barriers and facilitators to implementation from the perspectives of service providers involved in supporting parents seeking mental health care, and 2) identify actionable strategies to inform the implementation of a co-designed, technology-assisted parenting program within adult mental health services.

2. METHODS

2.1. Study Setting

This study was conducted in partnership with a large community health organisation in Victoria, Australia that provides a range of mental health, medical, allied health, dental and social services across multiple federal, state and private funding sources. The current study examined pre-implementation planning processes for integrating a technology-assisted parenting program specifically within the organisation's adult mental health services. These services provide free or low-cost psychological therapy for individuals with mild-to-severe non-acute mental health challenges, gambling concerns and alcohol and other drug use. The organisation provides services to a diverse client population, with a particular focus on individuals from culturally and linguistically diverse backgrounds, and those experiencing socioeconomic disadvantage or complex social needs. While conducted within one service context, the study findings have potential relevance for similar adult mental health settings seeking to embed parenting-focused supports into routine care.

2.2. Participants

Participants (*n* = 13) were service providers employed at the collaborating health organisation in clinician or service management roles. Clinicians (*n* = 9) worked within the organisation's mental health services, were English speaking and had experience providing mental health support to parents of children aged 5–11 years. One clinician also held a team leader and clinical supervisor position. Another had transferred to the organisation's family services within the last four months; however, they were included due to their recent experience in the mental health service and expertise in supporting families and parenting. Clinicians were all women, aged 27–54 years (M = 43 years) and included counsellors (*n* = 2), social workers (*n* = 3), a psychologist (*n* = 1) and a registered nurse (*n* = 1). Clinicians reported their cultural backgrounds as Australian / New Zealand (n = 3), European (n = 2), South Asian (n = 2) and one each of Pacific Islander and Māori. One clinician declined to provide demographic information beyond their primary area of practice.

Managers (*n* = 4) were English speaking and employed in organisational leadership roles related to supporting parents, families or service innovation. Although not all worked directly within the mental

health services, they contributed organisational-level perspectives relevant to the implementation of new programs across the broader service context. Managers included three women and one man, ranging in age from 54 to 61 years (M = 57.8 years). Managers reported their cultural backgrounds as Australian / New Zealand (n = 4) and European (n = 1). One manager oversaw the mental health and wellbeing services, two managed child and family services and one held a senior general manager role. Participants were not required to have prior knowledge about the co-designed parenting program. Table 1 provides demographic characteristics for all participants.

Table 1
Demographics of service provider participants (*n* = 13).

Demographic characteristic	**n**	**%**
Age in years (*n* = 12)		
25–34 years	1	8.3%
35–44 years	3	25%
45–54 years	5	41.7%
55–64 years	3	25%
Gender (n = 12)		
Women	11	91.7%
Men	1	8.3%
Ethnic/Racial background (n = 12) *		
Australian / New Zealand	7	58.3%
European (e.g., United Kingdom, Malta)	3	25%
South Asian (e.g., India, Sri Lanka)	2	16.7%
Pacific Islander (e.g., Fiji)	1	8.3%
Māori	1	8.3%
Profession (n = 12)		
Counsellor	2	16.7%
Social Worker	3	25%
Registered Nurse	1	8.3%
Psychologist	1	8.3%
Team Leader + Psychologist	1	8.3%
Service Manager + Social Worker	2	16.7%
Service Manager + Occupational Therapist	1	8.3%
Service Manager + Executive Leadership	1	8.3%
Years of experience working in discipline (n = 12)		

Note: Primary area of practice was provided by all participants (*n* = 13). Other demographic characteristics are based on 12 respondents, as one clinician opted not to provide further demographic information.

Demographic characteristic	n	%
Age in years (*n* = 12)		
0–10 years	3	25%
11–20 years	4	33.3%
21–30 years	4	33.3%
31–40 years	1	8.3%
Primary area of practice (n = 13) *		
Mild-to-severe mental health challenges	6	46.2%
Gambling concerns	2	15.4%
Alcohol and other drug concerns	1	7.7%
Family and parenting concerns	1	7.7%
Service management	4	30.8%
Note: Primary area of practice was provided by all participants (*n* = 13). Other demographic characteristics are based on 12 respondents, as one clinician opted not to provide further demographic information.		

* Service providers could report more than one ethnic/racial background and primary area of practice; these percentages do not sum to 100%.

2.3. Study Design and Procedure

This qualitative interview study involved participants completing a short demographic questionnaire via REDCap (Research Electronic Data Capture) [63, 64], before taking part in a semi-structured interview. The interview schedules were informed by prior relevant research [65] and example questions developed by the CFIR authors [60, 66]. The CFIR developers recommend selecting and assessing a subset of CFIR constructs relevant for each project, rather than assessing every construct [58, 60]. For this study, we focused on key constructs from the Innovation Domain (innovation relative advantage, innovation adaptability), Inner Setting Domain (tension for change, compatibility, incentive systems, available resources, access to knowledge and information) and Individuals Domain (high-level and mid-level leaders, innovation deliverers: capability and opportunity). These domains were selected as they capture core determinants of implementation at the intervention, organisational and individual levels, which are considered particularly relevant to the adoption of family-focused and parenting programs within service contexts [19, 20, 67]. Open questions asking for general feedback were also included. All interviews were conducted during the service provider's regular working hours. See Supplementary File 1 for the interview schedules.

2.4. The Co-designed, Technology-Assisted Parenting Program: PiP Kids-PMH

‘Partners in Parenting Kids—Parental Mental Health (PiP Kids-PMH; herein ‘the program’) is a technology-assisted parenting program co-designed with parents with lived and living experience of seeking mental health support, and mental health service providers [68]. It is an adapted version of Partners in Parenting Kids (PiP Kids; formerly Parenting Resilient Kids or PaRK), a digital program that equips parents with evidence-based parenting strategies to lower the risk of anxiety and depression in their primary-school aged children [69]. A randomised controlled trial found PiP Kids produced larger improvements in parenting behaviours than a factsheet intervention [70]. Higher engagement was also associated with greater improvements in preventive parenting, parental acceptance and parental psychosocial health-related quality of life as well as less parental psychological control and lower levels of impairment in child health-related quality of life [71]. These results, alongside adaptation of PiP Kids for family services for parents of children facing adversity [72], highlight its potential for implementation within mental health services.

The process of co-designing the adapted program for the collaborating mental health service has been described previously [68]. Briefly, the content and features of PiP Kids were refined to align with the needs and preferences of parents with lived and living experience of seeking mental health support, as well as the service providers who support them, to enhance implementation and use. The intended adapted parenting program includes up to fourteen 15–25-minute interactive online modules designed to provide parents with practical parenting strategies. Content is written in simple, strengths-based language and contextualised to parenting when experiencing parental mental health challenges. The current prototype comprises three modules covering the topics *Talking with children about parental mental health* (two parts across two modules) and *Showing affection and acceptance*, with content on self-care and help-seeking incorporated throughout. Each module concludes with reflection questions to support parents in setting personalised goals, applying learned strategies and identifying areas where they may need additional support from clinicians or their wider support network.

To complement the online modules, a brief clinician-support component was designed for integration within parents’ existing mental health therapy sessions. Clinicians support parents by tailoring strategies to the parents’ mental health and family circumstances, troubleshooting barriers, reinforcing strengths and providing normalisation, encouragement and emotional support. Discussions are flexibly guided by parents’ responses to the end-of-module reflection questions, which they may choose to share with their clinician. A co-created written summary of the key parenting takeaways and goals from each therapy session was also designed to help parents remember and implement strategies. Lastly, a clinician training package was incorporated, including self-paced online modules and supervision within existing supervision sessions, to support clinicians in delivering the clinician-support component.

2.5. Data Collection

Prior to the interview, service providers watched a brief video during their own time, which demonstrated the parenting programs' key components, intended benefits, co-design process, screenshots from the online modules and details of the clinician-support component and clinician training package. Semi-structured, individual qualitative interviews were then conducted using the relevant interview schedule (Supplementary File 1) to assess service provider perspectives on implementation barriers and facilitators. Prior to data collection, these schedules were trialled with colleagues of the first author who have experience in qualitative research, resulting in minor improvements to the wording of questions.

Interviews (*n* = 13) were carried out between October 2024 and March 2025 and conducted via a secure web conferencing platform (Zoom) with audio and video recording. During all interviews, only the first author and participant were present. Interviews ranged in duration from 42 minutes to 59 minutes, with a mean of 52 minutes.

2.6. Data Analysis

Interviews were transcribed automatically via Zoom or a third-party transcription service and manually checked for accuracy by the research team. Service providers were given the option to review their transcript for alignment with their experience of the interview [73]; however, no participants made any changes. Transcripts were analysed with the support of NVivo qualitative software (version 15.3.2), using Braun and Clarke's [74, 75] reflexive thematic analysis approach. Reporting was guided by Braun and Clarke's [76–78] recommendations for producing high-quality thematic analysis. These guidelines were used as reflective prompts during manuscript preparation, rather than as prescriptive checklists, consistent with their position that many rigid criteria may be incompatible with reflexive thematic analysis [79, 80].

Data were analysed deductively using the updated CFIR to identify barriers and facilitators to implementation. The updated CFIR includes 48 constructs and 19 subconstructs across five domains: individuals (roles subdomain: 9 constructs; and characteristics subdomain: 4 constructs), innovation (8 constructs), inner setting (11 constructs, 10 subconstructs), implementation process (9 constructs, 6 subconstructs), and outer setting (7 constructs, 3 subconstructs) [58]. Guided by this framework, we followed the six-phase process of reflexive thematic analysis [75, 81]. Initially, the first author familiarised herself with the data by reading transcripts repeatedly. Each transcript was initially coded openly before organising themes according to the CFIR domains and constructs, to ensure any relevant findings not covered by the CFIR were captured as inductive themes. The content of themes was continually refined throughout analysis. Within each CFIR construct/theme, codes were further reviewed and classified as a barrier, facilitator or suggestion for improvement. Differences in manager and clinician responses to the same construct were examined and are reported below if identified, or if findings only apply to one group.

We then used the updated CFIR-ERIC Matching Tool to inform the selection of implementation strategies for addressing the identified CFIR barriers. The ERIC contains 73 discrete implementation strategies, each describing one action aimed at supporting implementation [61]. The CFIR-ERIC Matching Tool lists

each CFIR barrier alongside all ERIC strategies and shows the percentage of implementation experts who recommended each strategy for addressing that barrier [62]. Strategies are categorised by level of expert endorsement, with Level 1 strategies endorsed by more than 50% of experts as among their top seven strategies for addressing that CFIR barrier, whereas Level 2 strategies are those endorsed by 20–49% of experts as one of their top seven strategies [62]. For each barrier identified, the two most strongly endorsed ERIC strategies were considered as potential implementation strategies. If the research team deemed any strategies irrelevant to the study-specific barrier, they were not included.

However, as the CFIR-ERIC Matching Tool is based on the original version of the CFIR [59], several new constructs in the updated CFIR that do not map directly to the earlier version (e.g., Innovation Deliverers, Compatibility) are not yet covered by the tool. For these constructs, strategies were selected according to how the corresponding data would have been coded using the original CFIR, to ensure all identified barriers could be linked to implementation strategies.

2.7. Researcher Positionality and Reflexivity

This research was grounded in a critical realist approach and a contextualist epistemology [75]. From this perspective, interview data were treated not as a direct reflection of an objective reality but as the participants' perception of their experiences, shaped by their personal and professional contexts. These data were also co-produced through researcher-participant interaction and our interpretation and reporting of data, both of which were influenced by our own positionality and context. This approach enabled us to explore the subjective experiences of service providers, while reflecting on how our decisions and interpretations affected the findings.

All interviews and data analysis were conducted by the first author, a female provisional psychologist in the advanced stages of her clinical psychology PhD training, with interests in parenting, mental health and evidence-based interventions. The first author also led the co-design of the parenting program [68] and therefore had prior relationships with five clinicians and one manager who participated in that study. The remaining co-authors who reviewed the findings and manuscript included professors and an academic with expertise in parenting interventions, parental mental health, co-design and human-computer interaction and qualitative research, as well as service providers with experience in clinical service delivery and management, several of whom have personal experience of parenting. During the interviews, the schedules guided the questions asked, however, the exact prompts varied based on what the first author interpreted as relevant for each discussion. The first author recorded reflexive field notes during and after each interview to document her reflections, including how her choices may have influenced participant responses.

2.8. Ethics Approval

All study procedures were approved by the Monash University Human Research Ethics Committee (approval number #44564).

3. RESULTS

Themes were organised using the CFIR domains and constructs, with study-specific definitions for implementation facilitators and barriers within each construct. Suggestions for improvement as identified by service providers are also detailed within the relevant CFIR domain below. In total, 22 facilitators and 12 barriers were identified. See Fig. 1 for an overview of the identified facilitators and barriers across each CFIR domain. Supplementary File 2 provides additional illustrative quotes for each theme. Quotes are labelled C or M for clinician or manager participants, respectively.

Note

Based on Damschroder et al. [58]. Image adapted from The Centre for Implementation [82], Consolidated Framework for Implementation Research (CFIR). Copyright 2025 by The Centre for Implementation.

3.1. Individuals Domain

The Individuals Domain of the CFIR focuses on the characteristics and roles of the people involved in implementation (i.e., parents, clinicians, supervisors, team leaders and managers).

3.1.1. Individuals Domain Facilitators

Innovation deliverers' capability: Clinician skills and experience. Most clinicians described themselves and their colleagues as having the *"competence and knowledge and skills for the program"* [C2], even without extensive professional experience delivering parenting support. However, personal parenting experience was seen as likely enhancing clinician confidence.

Innovation deliverers' motivation: Clinicians who find parenting interesting and important. Clinicians reported that those who are *"interested in the topic"* [C1] of parenting or view it as an important area of focus will likely be more inclined to implement the program with clients.

Innovation recipients' opportunity: Parents' emotional capacity and access to technology. Participants suggested that parents with more stable mental health would be more likely to have the emotional space and time to engage with the program and "*think about their own children's mental health"* [C1]. Participants also emphasised that most parents *"have a mobile phone or a laptop or a tablet"* [M3] and are comfortable using these devices, particularly following COVID-19, making it possible for them to engage in the online modules.

Innovation recipients' motivation: Parent openness to parenting support and online mediums. Service providers noted that *"a lot of parents are very open to [parenting support]"* [C6], which is essential for their involvement in the program. Specifically, it was suggested that several parents *"prefer… telehealth and online"* [M2] support and likely appreciate the flexibility of not having to attend in-person groups.

High-level leaders: Manager endorsement and provision of training time. Participants stated that managers are likely to play a key role in program implementation by discussing the program's value,

regularly *"acknowledging it, having it be something that's really embedded"* [C7], addressing clinician anxieties and allowing dedicated time for training.

Mid-level leaders: Team leader and supervisor endorsement and support. Team leaders and supervisors were also seen as important for discussing the program in team meetings, *"talking about the benefits it has for both clinicians and the client"* [C9] and providing supervision. Clinicians also suggested that supervisors should complete program training to ensure they can effectively supervise clinicians.

3.1.2. Individuals Domain Barriers

Innovation deliverers' capability: Some clinicians lack personal or professional parenting experience. Clinicians expressed concern that some clinicians *"who haven't been parents… [or] who don't have experience working with children"* and families may lack confidence in supporting parents through the program, and that these clinicians *"may need a little bit more support"* [C1].

Innovation deliverers' motivation: Some clinicians lack interest or willingness to support parenting. Clinicians reported that a lack of willingness could be a barrier for some clinicians, including those who view the program as extra work, are uninterested or uncomfortable working with parenting or see it as outside their role as a mental health clinician. *"Some people just want to do their work, and that's it, they don't want to invest any more time"* [C3].

Innovation recipients' opportunity: Poor parental mental health. Participants indicated that parents experiencing severe or unmanaged mental health challenges likely *"won't have the capacity"* [C8] to engage with the online modules. It was suggested that these parents would likely require additional support to engage or may first need to focus on stabilising their mental health and accessing *"more intense [parenting] services"* [C9], before introduction of the program could be considered.

Innovation recipients' opportunity: Competing parent priorities. Service providers described that some parents face competing demands, including caregiving responsibilities, housing issues, work and other life stressors which can leave *"very limited capacity to do [the program] outside of session"* [C6]. Participants emphasised that these immediate stressors often dominate session time *"as [clients] come in from week to week with different types of issues"* [C2], which could reduce opportunities to discuss the parenting program.

Innovation recipients' motivation: Parent fear of child protection involvement. One clinician suggested that some parents' willingness to engage with the program may be affected by fears that *"child protection are going to get called"* or that they may *"lose [their] kids for having a mental illness"* [C7].

3.2. Innovation Domain

The Innovation Domain of the CFIR focuses on the characteristics of the innovation being implemented, in this case, the PiP Kids-PMH parenting program (see Section 2.5 for details).

3.2.1. Innovation Domain Facilitators

Innovation adaptability: Flexible and tailorable. Participants liked that parents could *"take control over"* which modules to complete, and "*the clinician [could]…recommend particular modules"* [C1] depending on parent needs. They appreciated that the program could be introduced at different points in the parent's service journey, completed at the parent's own pace and at any time of day, flexibly paused and resumed depending on changes in parents' mental health, and revisited as needed. One clinician specifically liked that parents could *"debrief and really tailor the [strategies]"* [C6] to their unique family context through the clinician-support component.

Innovation design: User-friendly and accessible. Service providers valued the program's *"user-friendly… interactive"* [C1] design including its clear language, visuals, audio, lived experience examples and activities. Summaries at the end of each module and therapy session were valued for reinforcing learning. Participants also felt the program was simple and achievable with a small number of short modules and the ability to access it on phones, not just computers. *"15 to 20 minutes per module feels very doable."* [C6].

Innovation design: Helpful content. Participants found the program content to be useful and relevant including the helpline resources and key topics focused on self-care, showing warmth and *"talking to their kids about their own mental illness"* [C7].

Innovation design: Strengths-based and inclusive. Service providers commented on the program's inclusive and strengths-based approach including representation of different cultures in images, normalisation and validation of parent experiences and focus on parent strengths. *"It builds self-esteem… it's focused on their strengths"* [C5].

Innovation evidence base: Evidence-based information. Managers liked the program's *"evidence-based information"* [M2] focusing on the intergenerational impact of parental mental health on parenting and strategies to support children's mental health.

Innovation relative advantage: Hybrid structure efficiently enhances care. Service providers valued the program's structure that provides parents with *"online modules… [to] teach them the strategy"* while clinicians focus on answering questions, personalising and *"helping them employ the strategy"* [C6]. They indicated this approach enhances parent care and *"encourages them to be a bit more self-sufficient"* [M4], while optimising session time and minimising extra work for clinicians. Participants felt the program structure would *"open those discussions"* on sensitive topics by providing a shared starting point that normalises and *"helps with information gathering around family dynamics"* [C4], mental health and other barriers.

Innovation relative advantage: Consolidates resources. Participants appreciated that the program consolidates parenting information in one place, noting that this approach reduces the risk of information being lost or forgotten, promotes consistent practice across clinicians, saves time from searching for resources, and "*support[s] the clinician in delivering a comprehensive support, rather than scattered"* [C6].

Innovation relative advantage: Integrates parenting with parental mental health. Service providers liked that the program focuses specifically on parenting in the context of parental mental health, noting that such programs are uncommon and *"add much more value than a generic offering"* [M4]. They viewed the program as a helpful additional resource that reminds clinicians to incorporate parenting into sessions where relevant, *"to enhance parental mental health, but also family functioning"* [C4].

3.2.2. Innovation Domain Barriers

Innovation adaptability: Difficult to culturally and linguistically translate digital programs. Participants emphasised the need to translate the program for parents where English is not their first language, however, they noted challenges with translating digital interventions. These include the cost of translating programs into multiple languages, *"many dialects within each language"* and cultural differences, for example, in *"attitudes towards mental health"* [M3].

Innovation relative advantage: Digital format may limit accessibility. Service providers detailed how the program's technology-assisted design may make access difficult for some parents who have *"limited means… small data allowances"* [M4], unstable internet, lack of suitable devices or low technology literacy. These barriers, while seen as decreasing over time, were still noticeable for some families experiencing socioeconomic disadvantage.

Innovation design: Cognitively demanding content pages. Clinicians reported that the hard work and *"amount [of text] on some of the pages"* [C8] of the modules may be inaccessible or daunting for parents experiencing mental health challenges or attention difficulties. Service providers also noted that the program requires reading and writing which may be difficult for parents with *"a lower level of educational attainment"* [M4].

3.2.3. Suggested Improvements for the Parenting Program

Service providers suggested enhancing the program's accessibility and inclusivity by incorporating *"some of the information… into a video"* [C8] or audio instead of text, adding content and wording specific to alcohol and other drug use, including *"family structures"* beyond *"nuclear families"* such as *"different gender families"* [C4], and further refining the program so it can tailor itself based on parents' individual characteristics.

Participants recommended expanding program content to include different parenting styles, family violence, healthy habits, emotion regulation for parent and child, family activities and communication and identifying and managing worsening parent and child mental health.

Clinicians suggested that it would be helpful if they were able to access parents' module progress and responses via automated emails or a shared dashboard to encourage parent accountability, provide a sense of support between sessions, reduce reliance on parent memory and provide clinicians with *"a heads up before… the session about… things that [parents] might want to bring up"* [C7].

It was also mentioned that it might be beneficial if parents could access the program while waiting to start sessions with their clinician or continue using it once they have finished sessions, however, it was suggested that this might limit opportunities to discuss what they have learned. *"They could be on a waitlist… but in the meantime, they could start on this"* [C3].

3.3. Inner Setting Domain

The Inner Setting Domain focuses on the setting where the innovation is implemented. In this study, this included services within the collaborating organisation that work with parents of children aged 5–11 years, with a focus on the mental health services as the primary site of implementation.

3.3.1. Inner Setting Domain Facilitators

Access to knowledge and information: Clinician training. Service providers identified the *"training package for clinicians"* as helpful for providing them with *"a good amount of confidence"* in supporting parents [C6]. Participants valued that training would provide them information on the content of modules, how to support parents, guiding questions to ask and referral pathways.

Clinicians also liked that training would be cost-free and could be brief since it would focus on familiarising them with the program rather than teaching extensive parenting skills. One manager specifically liked that training would highlight how *"the skills [clinicians] already have"* [M1] can be applied when supporting parenting.

Available resources (Materials and Equipment): Existing technology within organisation. Technology resources within the organisation were seen as helpful for parents to use during sessions to share their progress or print program resources. *"We bring our laptop in session… we have access to [a] printer and scanner… have access to all of that to help [parents]"* [C3].

Compatibility: Fits with existing sessions and practices. Service providers described the parenting program as naturally fitting within and complementing their mental health sessions. They felt it aligns with existing practices including providing parenting support, tailoring strategies to individual clients and *"prescription of… something for [parents] to try out at home"* [C6] that is reviewed during sessions. Participants appreciated that program check-ins would be within existing sessions, to minimise additional work for clinicians between sessions.

Existing assessment processes were also seen as providing multiple opportunities to identify parenting concerns and introduce the program. *"We have multiple times where this can be brought up… in our assessment process"* [C5].

Incentive systems: Tangible and intangible incentives for clinicians. Acknowledgement in performance reviews, dedicated professional development hours for program training or extra pay were identified as likely to encourage clinicians to deliver the program. Service providers also repeatedly emphasised that

"seeing the result of how it can improve or be helpful to [clients]" [C2] would be highly motivating, with several considering it the most meaningful incentive.

One clinician suggested having a mandatory recruitment target at a team level could help them prioritise the program. However, other service providers suggested that making the program optional would incentivise clinicians to use it when relevant as *"a disincentive for any of these programs is when they're shoved down anyone's throats about having to use them"* [M3].

Mission alignment: Parent-led and linked with goals. Participants valued that the program is parent-led, consistent with the organisation's focus on being guided by parent needs. They liked that parents could set the pace and choose when to focus on parenting. *"I loved… that it needs to be parent-led… that's very important, because this program is designed for them"* [C4].

Service providers also highlighted that the program would be most appropriate and useful when it is explicitly linked to the parents' mental health goals and *"goal-directed care plan"* [C9].

Tension for change: Program needed to fill gaps in care. Participants highlighted a clear need for the program, due to *"a huge gap"* regarding *"not enough education provided to kids or parents"* [C1], the high number of parents with mental health issues and limited parenting support options within the organisation.

Additionally, the program was seen as filling a gap in *"early intervention"* for families not affected by family violence or acute mental health crises but still at risk of experiencing difficulties in parenting, as these families were viewed as *"slipping through the cracks"* [C6] of existing services.

3.3.2. Inner Setting Domain Barriers

Access to knowledge and information: Limited supervision time to support program implementation. One clinician noted that existing individual supervision is often *"taken up with debriefing and supporting… high-risk clients"* [C6], leaving little opportunity to discuss the program as planned. Additionally, clinicians reported *"at the moment [they] don't have the [group] reflective space"* [C2] to discuss the program, noting that the only available reflective practice is with other organisations and focused on different programs.

Available resources (Funding): Constraints on existing funding models. Service providers expressed concerns that for services that rely on appointment-based funding and reporting requirements, clinicians must record their time against key performance indicators (KPIs). Non-direct client activities such as training are often not reimbursed, limiting flexibility to implement new programs. *"Some of our programs may not… look at this as being paid time or reportable time… that can make clinicians very anxious if they can't report on the time they're spending"* [M1].

One manager questioned how the program could be operationalised within existing funding, noting that *"a parent might… get a great outcome, but [the service] can't acquit to that outcome through [their] funders"*, as completing self-directed modules, in their view, do not translate into reportable outcomes. This

manager also raised concerns that licensing or operating costs for new programs can become cost-prohibitive when implemented across a large health organisation and suggested the need for an economic analysis to better understand funding considerations.

Lastly, participants reported limited capacity within the mental health services to fund parents' access to devices or the internet if they lack this. *"We do have funding available in family services… we can help clients to purchase electronic devices… whereas [in] counselling… [they] don't… have that"* [C4].

Compatibility: Possible misalignment between program and existing session numbers and frequency. In services with capped session numbers, some clinicians expressed concern that the number of sessions is already limited as *"[they're] only allowed to offer twelve"*, so attempting to address the parenting program as well as *"reducing depression, improving mood [and] stabilising people"* [C8] may be difficult.

Clinicians also reported that for clients that attend appointments infrequently there is a risk they could *"start and finish [multiple] modules before… the next session"*, limiting opportunity to *"check in with them as they're completing modules"* [C7]. Additional sessions were described as ideal; however, this was perceived as likely infeasible within capped services.

Relative priority: Multiple competing programs. Service providers described multiple competing initiatives and that clinicians *"can't be involved in all these different trainings"* [M1], which may limit program uptake. For example, in the gambling service, one clinician speculated that this program may not be a priority compared to other interventions such as support groups.

Work infrastructure: High clinician workloads. Clinicians' heavy workloads and pressure to conduct back-to-back sessions were seen as likely limiting time for training and implementing the program. Available time was described as fluctuating over time for each clinician, making it difficult to predict when they could engage. *"It's the workload, the communication regarding that workload… the pressure"* [C4].

3.3.3. Suggested Improvements for Clinician Training

Clinicians emphasised the importance of adding ongoing support beyond the initial training including dedicated program check-ins, follow ups with program developers and reflective space or *"peer support"* with other clinicians delivering the program, to foster a community of practice where clinicians can get *"validation, encouragement… [and] support each other"* [C4]. One clinician suggested including video examples of clinician-client interactions within the training, so clinicians can see practical demonstrations of how to support parents *"in that… more real time format"* [C7].

3.4. Implementation Process Domain

The Implementation Process Domain of the CFIR focuses on the actions and strategies necessary for successful implementation of the innovation (i.e., the parenting program).

3.4.1 Implementation Process Domain Facilitators

Doing: Trial program and make improvements. Trialling the program and training in practice was seen as essential for service providers to form clearer views on barriers and facilitators. They also highlighted the value of learning health cycles to iteratively implement, understand challenges and *"take bits and pieces from there… to strengthen the whole program"* [C4].

Engaging deliverers: Program summary and reminders for clinicians. Service providers emphasised the potential value of a succinct summary or *"little kind of blurby thing"* to encourage clinicians to deliver the program, by helping them remember it's *"main points"* [M1], feel confident in its benefits and easily explain it to parents.

Participants highlighted that *"it is important to just [provide] a reminder"* to prompt clinicians to use the program when appropriate, as it would not be relevant for every client, as well as *"gentle reminder[s]"* [C1] to check in with parents completing the program. Suggestions included ongoing email reminders, brief checklists or a menu of service offerings.

Engaging recipients: Program introduction and support for parents. Participants emphasised that clearly introducing the program, either through a clinician or brief video, would be important to attract parents to engage. They said this introduction should be *"in very simple language"*, non-judgemental, low-pressure and delivered after *"rapport building"* [C4], to avoid parents feeling criticised. They suggested highlighting the program's supportive, validating approach and its benefits not only for children but also parents.

To facilitate ongoing parent engagement, the need for clinician support was emphasised including helping parents set up the program and *"having regular sessions"* to discuss progress, problem solve *"barriers faced"* and provide *"support with contextualisation"* [C6]. They also suggested reinforcing engagement through external motivators such as rewards for participating or opportunities for parents to *"come together and celebrate"* [C4] progress with parent peers.

Reflecting and evaluating: Evaluate program outcomes. Service providers emphasised the importance of collecting parent feedback and outcome data to obtain *"some good evidence around"* [M3] program effectiveness. Integrating the program within *"an underlying client management system"* was seen as supporting this evaluation by collecting data on program use and *"link[ing] it directly to the client records"* [M4].

Teaming: Team collaboration and referrals.*"Team-based care things… case conferencing, even team-based allocation… [and] secondary consults"* were viewed as helpful team-based approaches to ensure families could access the program even if their "*primary clinician"* [M4] was unfamiliar with it. Participants highlighted that teams and clinicians not involved in program delivery could promote the program and refer parents to clinicians who are delivering it.

3.4.2. Suggested Improvements for Program Implementation

Service providers suggested the program also be delivered by *"other teams"* beyond the mental health services, for example by *"family services"* or child-focused teams. These services were viewed as well positioned to deliver the program as they work with parents and families, *"they're all trained"* [C8] clinicians and some offer home-visits that could reinforce strategies at home.

Integrating the program across services was seen as allowing more clients to benefit by *"creating more [access] opportunities than simply sitting it within a mental health service"* [M4]. However, service providers emphasised that the program should be framed and delivered in ways that align with each service's scope of practice (i.e., family services focusing on building parenting capacity rather than mental health therapy).

3.5. Outer Setting Domain

The Outer Setting Domain of the CFIR focuses on the broader setting in which the Inner Setting operates. In this study, this referred to other organisations, resources, events or attitudes in the broader community outside of the collaborating health organisation.

3.5.1. Outer Setting Domain Facilitators

Local conditions: Community organisations. Participants emphasised how *"local libraries"* [M3] and *"cafes"* [C6] could support implementation if parents lack internet or a safe home environment, by offering safe, family-friendly spaces with internet access.

3.6. Implementation Strategies

The updated CFIR-ERIC Matching Tool was used to guide the selection of implementation strategies for addressing each CFIR barrier described above. Table 2 presents the CFIR barriers identified in this study, their definitions according to the CFIR and specific to this study and the corresponding ERIC implementation strategies suggested for each barrier. ERIC strategies have been grouped into their relevant cluster [83] and operationalised in the context of this study.

[Please insert Table 2 here. As this table is formatted in landscape orientation, it has been provided as an additional file titled "Bennett et al Table 2"]
Table 2. CFIR barriers and corresponding ERIC implementation strategies informed by the CFIR-ERIC Matching Tool.

CFIR Domain CFIR Construct: ***Barrier definition***	Study-specific definition	ERIC Strategy Cluster	ERIC Strategy	Study-specific definition
Individuals Domain Innovation deliverers' capability: *Individuals who are directly or indirectly delivering the innovation do not have interpersonal competence, knowledge, and skills to fulfil Role. **	Some clinicians lack personal or professional parenting experience	Train and educate stakeholders	Conduct ongoing training	Deliver ongoing training that is tailorable to clinicians' existing skills and confidence levels.
		Train and educate stakeholders	Provide ongoing consultation	Offer external consultation with program developers and/or internal supervision that is tailored to the clinicians' ongoing practice and level of confidence.
Individuals Domain Innovation deliverers' motivation: *Individuals who are directly or indirectly delivering the innovation are not committed to fulfilling Role. **	Some clinicians lack interest or willingness to support parenting	Train and educate stakeholders	Conduct educational meetings	Run educational meetings with clinicians that highlight the relevance and benefits of addressing parenting and using the parenting program within adult mental health service provision.
Individuals Domain Innovation recipients' opportunity: *Individuals who are directly or indirectly receiving the innovation do not have availability, scope, and power to fulfill Role. **	Parents with poor mental health may find it difficult to engage with the online modules	Use evaluative and iterative strategies	Obtain and use patients / consumers and family feedback	Gather ongoing parent and family feedback on barriers during early implementation to refine program delivery and determine the best times in the service journey for program introduction.
		Engage consumers	Involve patients / consumers and family members	Actively include parents and their family in refining how the program is introduced and

CFIR Domain CFIR Construct: *Barrier definition*	Study-specific definition	ERIC Strategy Cluster	ERIC Strategy	Study-specific definition
				structured to match their emotional capacity.
	Competing parent priorities within and between sessions may impact parents' ability to engage	Use evaluative and iterative strategies	Obtain and use patients / consumers and family feedback	Obtain parent feedback to identify common competing priorities and adjust expectations for program use or inform optimal timing for program introduction.
		Engage consumers	Involve patients / consumers and family members	Collaborate with parents to identify how to flexibly integrate the program into their life and counselling sessions in ways that fit competing demands.
Individuals Domain Innovation recipients' motivation: *Individuals who are directly or indirectly receiving the innovation are not committed to fulfilling Role.* *	Parents' willingness to engage may be affected by fear of child protection involvement	Use evaluative and iterative strategies	Obtain and use patients / consumers and family feedback	Acquire feedback from parents regarding their concerns about child protection, to inform how the program is framed and introduced to minimise concerns.
		Engage consumers	Involve patients / consumers and family members	Engage parents in co-designing messaging and engagement strategies for the program that address parent concerns about child protection involvement.

CFIR Domain CFIR Construct: ***Barrier definition***	Study-specific definition	ERIC Strategy Cluster	ERIC Strategy	Study-specific definition
Innovation Domain Innovation adaptability: *The innovation cannot be modified, tailored, or refined to fit local context or needs.*	Difficult to culturally and linguistically translate digital programs	Adapt and tailor to context	Promote adaptability	Identify which program features and content can and should be culturally and linguistically adapted while preserving essential elements.
Innovation Domain Innovation relative advantage: *The innovation is not better than other available innovations or current practice.*	Digital program format may limit accessibility for parents with low technology literacy or access	Use evaluative and iterative strategies	Conduct local needs assessment	Obtain and analyse data regarding technology literacy and access barriers for parents, to inform implementation decisions.
Innovation Domain Innovation design: *The innovation is not well designed and packaged, including how it is assembled, bundled, and presented.*	Cognitively demanding content pages may be difficult for some parents	Adapt and tailor to context	Promote adaptability	Where possible, adapt the presentation of content to low burden methods (e.g., audio, video, simplified text) while maintaining the core elements of the program.
Inner Setting Domain Access to knowledge and information: *Guidance and/or training is not accessible to implement and deliver the innovation.*	Limited supervision time to support program implementation	Train and educate stakeholders	Develop educational materials	Consider developing and implementing dedicated program-specific supervision time such as brief dedicated peer supervision.
Inner Setting Domain Available resources (Funding): *Funding is not available to implement and deliver the innovation.*	Constraints on existing funding models may limit the organisation's capacity to adopt and scale the program	Utilise financial strategies	Access new funding	Identify new or existing funding streams that could be utilised to support parent technology access and justify the program within billable and

CFIR Domain CFIR Construct: ***Barrier definition***	Study-specific definition	ERIC Strategy Cluster	ERIC Strategy	Study-specific definition
				reportable service activities.
Inner Setting Domain Compatibility: *The innovation does not fit with existing workflows, systems, and processes.* *	Possible misalignment between program and existing session numbers and frequency	Adapt and tailor to context	Promote adaptability	Clarify how the program can be flexibly integrated when counselling sessions are limited or infrequent while maintaining core program content and features.
		Develop stakeholder inter-relationships	Conduct local consensus discussions	Facilitate discussion with clinicians, team leaders and managers to assess how the program can fit within sessions or if/where it may be possible to allocate additional resources such as extra sessions or brief follow ups between sessions.
Inner Setting Domain Relative priority: *Implementing and delivering the innovation is not important compared to other initiatives.*	Multiple competing programs may limit clinician uptake	Utilise financial strategies	Alter incentive / allowance structures	Consider introducing incentives or workload allowances / reductions to increase the perceived priority and feasibility of implementing the program.
Inner Setting Domain Work infrastructure: *Organisation of tasks and responsibilities within and between individuals and teams, and general staffing levels, does*	High clinician workloads limit time for training and program delivery	Use evaluative and iterative strategies	Assess for readiness and identify barriers and facilitators	Continue to assess staffing levels, workload pressures, leadership support and other organisational

CFIR Domain CFIR Construct: ***Barrier definition***	Study-specific definition	ERIC Strategy Cluster	ERIC Strategy	Study-specific definition
not support functional performance of the Inner Setting.				resources to understand and address service readiness and the barriers and facilitators to implementation.

* *Note:* These constructs are new to the updated CFIR and are therefore not covered by the CFIR-ERIC Matching Tool, which is based on the original CFIR; for these constructs, ERIC strategies were selected based on how the data would have been coded within the original CFIR.

4. DISCUSSION

This study sought to create actionable strategies to support the implementation of a co-designed, technology-assisted parenting program within an adult mental health service by exploring barriers and facilitators from the perspectives of service providers who work with parents accessing mental health care. To our knowledge, this is the first study of its kind to conduct pre-implementation planning with the aim of embedding a technology-assisted parenting program into an existing adult mental health setting. We identified 22 CFIR constructs as facilitators and 12 as barriers. Eighteen implementation strategies were identified for addressing these barriers, many of which were aligned with the ERIC clusters 'Use evaluative and iterative strategies' (*n* = 5) and 'Train and educate stakeholders' (*n* = 4). The identified implementation facilitators, barriers and strategies are discussed below, drawing on existing literature on parenting and family-focused practice and suggestions for future research.

4.1. Facilitators

In the Individuals Domain, clinician skills, experience, interest and perceived importance of parenting were seen as likely to facilitate program uptake. This aligns with prior research where clinicians' skills and attitudes have repeatedly been identified as key factors in the implementation of in-person support [19, 41]. Interestingly, clinicians generally believed that their team would have sufficient clinical skills to support parents through the program, in contrast to past findings that mental health workers providing face-to-face services often perceived their skills as too focused on individualised mental health therapy to be competent in family-focused practice [20, 39]. This finding suggests that a technology-assisted parenting program, where clinicians are not expected to have extensive parenting knowledge and skills, may be particularly achievable for clinicians in existing mental health services. Parent emotional capacity and openness to parenting support were also identified as key facilitators, similar to research suggesting the importance of parent readiness and willingness prior to engaging in family-focused work [38, 84]. Notably, service providers suggested that many parents are motivated to engage in online

parenting support and have access to the required devices, which has been described previously [44, 48]. Successful implementation was also thought to depend on team leader and manager support, including promoting the program, embedding it in routine practice and allowing time for training, reflecting findings from previous studies on family-focused practice [19, 39, 41]. Support from trained supervisors to check-in with clinicians and motivate them to use the program where relevant was also emphasised and described previously [53, 85].

Regarding the Innovation Domain, the program's flexibility and adaptability were valued, including the ability for parents to choose different modules, revisit content and tailor strategies to their needs through the clinician-support component, supporting past findings involving parents with mental health challenges [86, 87]. Consistent with previous findings on technology-assisted programs, the modules were valued for enabling parents to access content at any time and progress at their own pace [88, 89]. Participants suggested that allowing parents to access modules before starting or after finishing with the service could be beneficial, although further research is needed to determine how a clinician-support component could be delivered in this context. Participants appreciated that the program's design was user-friendly, engaging, simple and achievable through features such as audio clips, short modules with breaks, content summarises and accessibility on mobile devices, similar to feedback on other programs for parents experiencing mental health challenges [16, 47]. Program content was considered helpful, including the focus on self-care, parental warmth, talking with children about parental mental health, and referrals to external services, aligning with past research on the importance of these topics for this parent population [48, 87, 90]. Participants highlighted additional topics for future iterations of the program, such as parent and child emotion regulation, healthy habits, managing worsening parent and child mental health, and family communication. These topics are already addressed in other modules of the original PiP Kids program and could therefore be readily adapted for this context, with content added to address the specific needs of parents with mental health challenges. Our findings also align with prior research calling for parenting programs to adopt an evidence-based, strengths-based and culturally inclusive approach [22, 35, 39], although participants recommended better representing diverse family types and including content specific to alcohol and other drug use to cater to more families.

Service providers appreciated the program's hybrid technology-assisted structure as it was seen to enhance care without overburdening clinicians, consistent with evidence that lower-intensity family-focused interventions may be most feasible in adult mental health settings [39, 91, 92]. The program was also perceived as providing clinicians the opportunity to open conversations about sensitive parenting topics, which has been described previously [93], however, clinicians felt their support of parents could be enhanced if they had access to parent module progress between sessions. Although feasibility concerns were raised regarding this feature in our initial co-design study [68], its repeated emphasis suggests future research may benefit from exploring how it could be feasibly integrated into technology-assisted parenting programs for mental health settings. Additionally, participants liked that the program consolidates parenting resources in one place, consistent with findings suggesting that a centralised hub of information may facilitate clinician implementation of family-focused practice [94]. Finally, the program's explicit focus on parenting in the context of parental mental health was considered

particularly important, noting that such integrated content is uncommon yet valued for engaging and supporting these parents [48, 95]. Participants appreciated that the program encouraged clinicians to integrate parenting within adult mental health sessions to enhance both parental mental health and family functioning, reflecting broader views that parenting and parental mental health recovery are intertwined [23, 86] and ideally supported by the parents' mental health clinician [21].

Findings in the Inner Setting Domain suggested that clinician training was viewed as crucial for program implementation, consistent with past research suggesting that even when clinicians are open to incorporating parenting programs, training is essential to build clinician confidence [38, 96]. The provision of free, brief and online training was also appreciated, similar to prior findings [39], however, clinicians suggested adding video demonstrations of client interactions to enhance learning. The organisation's existing technology resources were viewed as another facilitator, given that available digital resources within services may impact delivery of online family-focused practice [97]. Importantly, the program was perceived to fit well with existing clinical practices including provision of parenting support, the incorporation of program discussions within existing sessions and use of between-session homework tasks. This finding is particularly important given that compatibility between the implementing service and the new intervention has been identified as a key factor in implementation success [54, 84, 98]. Furthermore, service providers appreciated that the program focused on being parent-led, which complements the approach of the current organisation and other mental health services to also be led by the parents' presenting concerns and what they choose to focus on [26]. Participants suggested that linking the parenting program to the parents' mental health goals and care plan would likely support program use, given that adult mental health services focus primarily on the individual and their mental health needs [40]. Together, findings suggest the importance of the program being compatible with not only the service's existing processes but also its main goals.

Consistent with prior literature, service providers suggested that offering incentives to clinicians may facilitate clinician delivery, with the witnessing of benefits to families being the most frequently mentioned motivator [39, 53]. Interestingly, one clinician proposed that a mandatory team recruitment target could incentivise clinicians to prioritise the program, whereas others felt making it optional would encourage individual clinician uptake. This aligns with research indicating that, although mandates have been introduced to promote family-focused practice, they alone may be insufficient to ensure consistent implementation [32, 99], suggesting the need for broad implementation strategies including addressing clinician and organisational barriers to involvement [39]. Additionally, service providers indicated that the program fills important service gaps related to early intervention, supporting parents with mental health challenges and providing internal parenting support within the organisation, consistent with gaps highlighted in prior literature [100]. This represents a noteworthy facilitator, given that clinicians are more likely to adopt programs they perceive as addressing a clear need, with early intervention identified as a meaningful target of family-focused interventions [41, 101].

Facilitators within the Implementation Process Domain included an emphasis on initial small-scale program implementation to allow service providers to reflect on barriers and facilitators and iteratively

refine delivery. This approach aligns with literature suggesting that embedding cycles of implementation and improvement within service provision may help bridge the research-to-practice gap, as it allows programs and implementation strategies to be tested and refined based on real-world experience [102, 103]. Consistent with previous research, providing clinicians with a summary of the intervention and program reminders was also identified as helpful for encouraging clinicians to engage [17, 41]. Introducing the program to parents was also considered essential for supporting their engagement with the parenting program, including presenting it in a simple, non-judgemental way, highlighting benefits for both parents and children and offering it after a trusting therapeutic relationship has been established, consistent with prior recommendations [17, 39, 40, 92]. Ongoing support for parents was considered essential, including peer support and clinician guidance, which have been valued in other parenting programs for parents with mental health challenges [16, 18, 104]. This finding reinforces existing evidence emphasising the value of adding human support to online parenting programs [105–107] and digital mental health interventions [108–110]. Findings from this and other studies also indicate the importance of evaluating programs [19, 111] and ensuring interagency and interdisciplinary collaboration and referrals [26, 84] to support successful implementation of family-focused practice. Additionally, participants suggested embedding the program within family or child-focused services as well as mental health services to increase reach. This finding is consistent with past research indicating that family services could also be well-placed to deliver a largely self-directed parenting program [17]. Collectively, these findings suggest that technology-assisted programs like PiP Kids-PMH may have the potential to be flexibly implemented across different service types to support family-focused practice, although differences in setting will need to be explored in further research. Lastly, in the Outer Setting Domain, service providers suggested that local community organisations, including libraries and cafes [112, 113], could support program implementation by providing internet access and a safe environment for program completion.

4.2. Barriers

Within the Individuals Domain, identified barriers align with prior research suggesting that some mental health clinicians lack professional or personal experience and therefore confidence in supporting parenting [20, 96]. To address this, we suggest implementation strategies focused on delivering ongoing supervision and training tailored to clinicians' unique experiences and confidence [111, 114]. Although the current and prior studies suggest that many clinicians view parenting as an important factor to address [92], some view family-focused practice as requiring additional time and effort that they are unwilling to undertake [115]. Additionally, some clinicians feel family-focused work such as parenting interventions falls outside their role as a mental health clinician, which may increase reluctance to implement such approaches [41, 116]. We recommend organisational-level activities such as facilitating educational meetings with clinicians as an appropriate ERIC strategy to emphasise the relevance of integrating parenting programs into routine clinical practice and the benefits not only for parents and families but also for clinicians.

Poor parental mental health was also identified as a key barrier, which is unsurprising given that it has previously been found that worsening symptoms, fluctuating mood and low energy can impact parents' opportunity to engage with parenting support [39, 42]. Consistent with prior research, participants stated that these parents may require additional support to engage in a largely self-directed program, or may instead need mental health stabilisation [86] or higher intensity family-focused interventions [39], before considering stepping down to lower-intensity support. Engagement with the program may also be constrained by competing demands such as work, childcare responsibilities, poverty or housing concerns, which has been identified previously [19, 84]. Together, these findings highlight the need for implementation strategies that actively seek ongoing parent and family feedback on engagement barriers and involve parents in tailoring how and when the program is delivered. Lastly, concerns about child protection involvement and potential custody loss, previously documented in the literature [40, 85], may deter parent participation. We suggest that addressing this requires directly eliciting parent concerns and co-designing how the program is framed, introduced and delivered.

Within the Innovation Domain, a key barrier was the time and cost associated with culturally and linguistically adapting digital interventions, consistent with evidence regarding the potential benefits yet challenges of such adaptations [117–120]. To enhance feasibility, an appropriate implementation strategy could be to identify and adapt elements that require cultural and linguistic changes, while maintaining other program components. Consistent with existing literature, participants also raised concerns that some families experiencing socioeconomic disadvantage may lack internet access, appropriate devices or data to engage with online programs [53, 121], with digital inequalities persisting despite overall improvements in access [122]. A local needs assessment is recommended to understand technology literacy and access within the target community. Furthermore, concerns were raised that text-heavy content may be difficult for parents with mental health challenges and/or lower education levels, consistent with previous findings [17, 123]. Adapting materials into lower-burden formats, such as audio and video, may improve accessibility and engagement [16, 17].

Within the Inner Setting Domain, existing individual supervision and group reflective spaces, intended to support program delivery, were perceived as largely focused on high-risk clients or other programs, leaving little time for program-specific discussions. This barrier is concerning, as inadequate supervision has been linked to low clinician motivation and high discontinuation of parenting interventions [84]. Clinicians highlighted the need for ongoing program-specific support beyond initial training, particularly peer supervision, consistent with evidence highlighting the value of individual supervision, team supervision and consultation with program developers in sustaining family-focused practice [20, 85]. Funding constraints were also highlighted as a barrier, reflecting broader concerns that family-focused interventions may struggle in under-resourced mental health services that prioritise individualised mental health support [39, 124]. Although the hybrid intervention may minimise costs and resources, further evaluation is needed to assess alignment with existing funding structures as well as service benefits relative to costs [29, 53].

Additionally, service providers raised concerns about implementing the program in services with limited session numbers and frequency, noting the challenge of addressing parents' presenting mental health needs while also supporting program delivery. This suggests the need to clarify how core program features can be maintained while flexibly adapting delivery to fit community mental health contexts [19]. Engaging clinicians and managers in structured discussions may help identify how the program can be feasibly integrated into existing sessions or supplemented with brief parent check-ins between sessions.

Competing priorities, heavy workloads, and time constraints were also identified as barriers to clinician uptake, consistent with previous research on in-person family-focused support [19, 38]. These findings suggest that despite the technology-assisted design, workload pressures may continue to limit implementation of both face-to-face and digital parenting support. Relevant ERIC strategies include introducing incentives or workload adjustments to enhance feasibility and prioritisation of parenting programs, alongside ongoing assessment of workload and organisational capacity to support implementation.

4.3. Implications

The current pre-implementation findings have implications for the collaborating health service and the field of family-focused mental health care. Sharing these insights can inform refinement and application of implementation strategies to support the initial small-scale integration and evaluation of the adapted parenting program. This initial evaluation of implementation outcomes and program efficacy can subsequently inform decisions about scaling up the program within the organisation and potential expansion to other organisations.

Interestingly, many of the identified implementation strategies relate to the ERIC clusters 'Use evaluative and iterative strategies' (*n* = 5) and 'Train and educate stakeholders' (*n* = 4). This aligns with existing literature indicating that the key drivers of family-focused practice include clinicians' attitudes, skills, confidence and beliefs [38, 41], highlighting the central role of clinician training. However, research also suggests that even when clinicians are trained and perceive family-focused work as important and part of their role, other factors such as lack of clinician time and parent competing demands can still prevent clinicians from supporting parenting [20, 39]. This indicates that successful integration of technology-assisted parenting programs will likely also require ongoing use of evaluative and iterative strategies such as assessing parent and organisational readiness and identification of barriers and facilitators before and during implementation efforts. Overall, these implementation strategies highlight the need to educate clinicians, managers, parents and other end-users about new interventions, while continuously assessing and incorporating their feedback to ensure the program aligns with local needs and service contexts.

Furthermore, many barriers and facilitators identified in the current study mirror those reported in previous research on implementing face-to-face family-focused interventions for parents experiencing mental health challenges. These findings are consistent with the principles outlined by Reupert et al. [125], which emphasise the need for cross-sector collaboration, workforce development, organisational

commitment, and sustained support when working with families affected by parental mental health challenges. This study therefore reinforces the need for systemic, organisation-wide approaches and multifaceted implementation strategies to ensure family-focused practice becomes an embedded and sustained part of adult mental health care [20, 111].

4.4. Strengths and Limitations

This study has several strengths. By including clinicians and managers, we captured perspectives on barriers and facilitators at the service delivery and organisational levels. Applying the CFIR across data collection, analysis and reporting, combined with mapping to ERIC strategies via the CFIR-ERIC Matching Tool, enables transparency and comparability across implementation studies. Recruiting clinicians from all mental health services within the organisation, including those working with mild-to-severe mental health challenges, gambling concerns and alcohol and other drug use, enabled examination of implementation factors across diverse service contexts.

Several limitations of this study should also be noted. First, recruited participants were likely those with strong interest in parenting and family-focused service innovation [41], which may help explain why more facilitators than barriers were identified. While these service providers are most likely to be involved in initial program implementation, capturing the perspectives of a broader range of staff would be important for program sustainability. Second, most participants were women, all drawn from a single organisation and only one held a senior general leadership position, potentially constraining the range of views captured. Although women make up a significant majority of the current healthcare workforce [126, 127], future research should include more men, additional service settings and more executive managers.

Third, research suggests that experts differ widely about which ERIC strategies best address specific CFIR barriers [62], meaning alternative strategies may also be appropriate. To strengthen contextual fit, we plan to further operationalise and refine the selected strategies with the collaborating health organisation. Finally, as noted in our co-design study [68], the participating service already integrates parenting support into routine care. While consistent with a broader shift towards family-focused practice in Australia [128], this may limit transferability of findings to services that do not prioritise family-orientated care.

5. CONCLUSIONS

To our knowledge, this is the first study to examine pre-implementation barriers and facilitators to integrating a technology-assisted parenting program within an adult mental health service, offering novel insights for implementation science, parenting interventions, parental mental health research and healthcare. Using the CFIR-ERIC approach, we identified key contextual determinants and actionable strategies to support integration of a co-designed, technology-assisted parenting program for parents seeking mental health support. Key facilitators include clinician skills, confidence and training, parent readiness, adequate technological resources, leadership support and alignment of interventions with

existing service practices. Although this study focused on the adapted PiP Kids program within one community health service, the findings are likely relevant for other parenting interventions delivered across diverse mental health services. Healthcare organisations seeking to embed family-focused or technology-assisted parenting support within adult mental health services may draw on these findings to inform program design and implementation planning.

Abbreviations

The following abbreviations are used in this manuscript:

CFIR	Consolidated Framework for Implementation Research
ERIC	Expert Recommendations for Implementing Change
KPIs	Key Performance Indicators
PaRK	Parenting Resilient Kids
PiP	Partners in Parenting
PiP Kids-PMH	Partners in Parenting Kids—Parental Mental Health
REDCap	Research Electronic Data Capture

Declarations

Ethics approval and consent to participate

The study was approved by the Monash University Human Research Ethics Committee (ID #44564 approved 20/09/2024). Informed consent was obtained from all participants in the study.

Consent for publication

Not applicable

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available to protect participant privacy and anonymity. Deidentified summaries of the data are available from the corresponding author on reasonable request.

Competing interests

M.B.H.Y. is a co-author of the Partners in Parenting Kids (PiP Kids) program, which forms the basis of the program examined in this research. She receives no financial benefits from the program or the current study. The authors declare no other competing interests.

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Authors' contributions

M.B. – Conceptualisation, Methodology, Formal analysis, Investigation, Project administration, Visualisation, Data curation, Writing: original draft. A.R. – Methodology, Supervision, Writing: review and editing. L.W. – Methodology, Supervision, Writing: review and editing. P.O. – Methodology, Supervision, Writing: review and editing. S.G. – Methodology, Resources, Writing: review and editing. H.V. – Methodology, Resources, Writing: review and editing. G.P. – Resources, Writing: review and editing. M.B.H.Y. – Conceptualisation, Methodology, Supervision, Writing: review and editing.

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Declaration of generative AI in the writing process

During preparation of this work, the authors used ChatGPT to refine draft text by improving grammar, syntax, and readability of expression. After using this tool, the author(s) reviewed and edited the content as needed and take full responsibility for the content of the published article.

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Figures

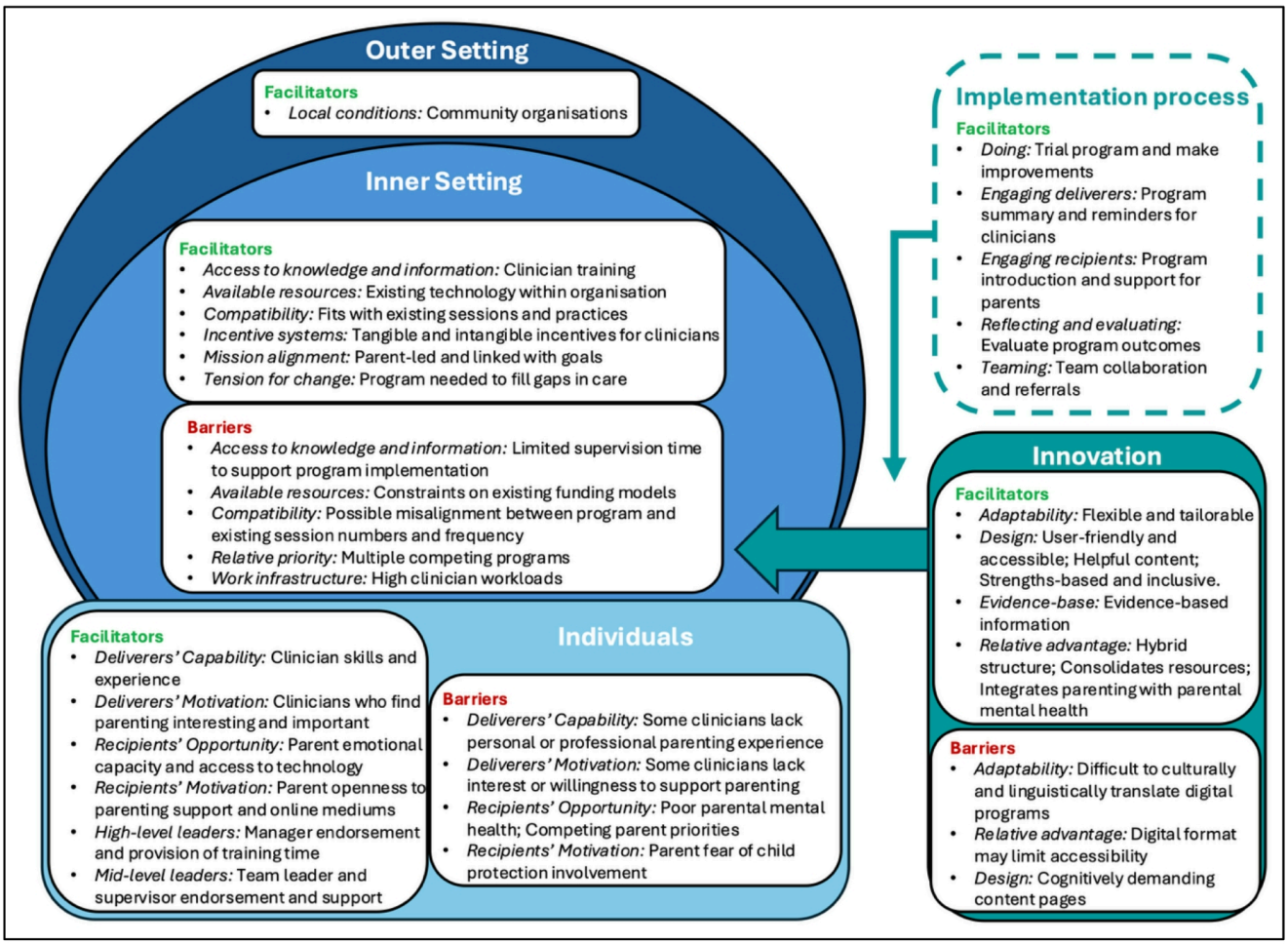

Figure 1

CFIR Barriers and facilitators identified from interviews with service providers.

*Note.*Based on Damschroder et al. [58]. Image adapted from The Centre for Implementation [82], Consolidated Framework for Implementation Research (CFIR). Copyright 2025 by The Centre for Implementation.

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