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DISSEMINATING INCREDIBLE YEARS SERIES EARLY-INTERVENTION PROGRAMS: INTEGRATING AND SUSTAINING SERVICES BETWEEN SCHOOL AND HOME

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The Incredible Years (IY) Series is a well-established set of parent, teacher, and child programs for treating and preventing conduct problems and promoting social competence and emotional regulation in young children. The purpose of this article is to describe the development of this evidence-based series within the context of a prevention science framework. We first summarize the conceptual grounding of the intervention series including the risk and protective factors that are targeted by IY. We then review the extensive literature demonstrating the impact of the various programs. The bulk of this article, however, focuses on the challenge of disseminating evidence-based programs with high fidelity. To help overcome these challenges, we describe a model and a set of strategies for implementing IY in community and school settings with high fidelity, so as to help reduce the population prevalence of major childhood mental disorders. © 2009 Wiley Periodicals, Inc.

The biggest obstacle for schools in providing prevention and intervention services to children with emotional, behavioral, and school readiness problems does not lie in the failure to appreciate the importance of addressing these problems or in a lack of available evidence-based programs. Indeed, a substantial body of research has clearly shown that young children with early-onset behavioral problems are at significantly greater risk of having severe antisocial difficulties, academic underachievement, school drop out, violence, and drug abuse in adolescence and adulthood (Costello, Foley, & Angold, 2006; Egger & Angold, 2006). More than two decades of research has also identified a number of high-quality programs for parents and teachers which have been shown to reduce childhood conduct problems and strengthen social competence and in turn prevent secondary outcomes involving crime and violence (Snyder, 2001). Rather the greatest challenge for schools is to select, implement, and sustain these programs with fidelity. Dissemination of evidence-based programs is often compromised by low adherence to protocols, misapplication to wrong populations, inadequate resources, and poor infrastructure, support, training, and planning (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). This article is about the development of one such program and the strategies and implementation perspective that are needed for schools to successfully implement and sustain it with high fidelity.

Nearly 30 years ago, Webster-Stratton (1981, 1982) introduced the Incredible Years (IY) Parent program as a new video- and group-based parent-training method for reducing behavioral problems and promoting social and emotional competence in young children (ages 3–8). The IY Training Series now includes three complementary curricula for parents, teachers, and children, all of which include similar training methods and processes. These programs were designed to reduce the multiple risk factors associated with poor parenting and classroom management practices, early-onset conduct problems and emotional difficulties in young children. The series has been the subject of extensive empirical evaluation. All three programs have been widely endorsed by various review groups including the Office for Juvenile Justice and Delinquency Prevention (OJJDP) as 1 of 11 "blueprint"

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model violence prevention evidence-based programs for treating and preventing disruptive behavior disorders (Webster-Stratton, Mihalic, et al., 2001).

The purpose of this article is to situate this evidence-based IY Series within the context of a prevention science framework and to present a model for implementing IY in community and school settings with high fidelity. We describe the conceptual grounding of the intervention series including the risk and protective factors that are targeted by IY. We also summarize the literature demonstrating the impact of the various intervention programs. The bulk of this article, however, will focus on recommendations for disseminating IY programs with fidelity to target specific populations so as to help reduce the population prevalence of major childhood mental disorders. We have learned from decades of research that selecting an evidence-based program is only the first step to effective program dissemination. Indeed, successful implementation requires organizational commitment to train dedicated staff and to create an infrastructure for providing timely training, skillful supervision and mentoring, adequate resources, and ongoing process and outcome evaluations.

Prevention Science Framework

The IY Series is grounded in cognitive social learning theories about the development of antisocial behaviors in children. It was largely influenced by the burgeoning literature regarding the development of antisocial behaviors that emerged in the 1960s and 1970s and that have continued to expand during more recent decades. Extensive research over the past 40 years has demonstrated consistently the links between child, family, and school risk and protective factors and subsequent development of antisocial behaviors and academic underachievement. Several prominent researchers (e.g., Dodge, 1993; Moffitt, 1993; Patterson, Reid, & Dishion, 1992) have helped coalesce this literature into strongly supported theories about the development of antisocial behaviors.

The extensive literature base on the development of antisocial behaviors highlights some obvious implications for interventions. First, early intervention timed to key developmental periods is critical. Treatment–outcome studies suggest that interventions for Conduct Disorders (CD) are of limited effect when offered in adolescence, after delinquent and aggressive behaviors are entrenched, and secondary risk factors such as academic failure, school absence, and the formation of deviant peer groups have developed (Dishion & Piehler, 2007; Offord & Bennet, 1994). Second, effective interventions need to target multiple risk factors across various settings. The increased treatment resistance in older CD probands results in part from delinquent behaviors becoming embedded in a broader array of reinforcement systems, including those at the family, school, peer group, neighborhood, and community levels (Lynam et al., 2000). Significant advances in the conceptualization and practice of prevention science in mental health emphasize that interventions must target multiple risk and protective factors as early as possible in children's development and be tied to theoretical and life-course models.

For these reasons, the IY treatment programs were designed to prevent and treat behavior problems when they first begin (infancy/toddlerhood through middle childhood) and to intervene in multiple areas and settings through parent, teacher, and child training. Early intervention across contexts can counteract risk factors and strengthen protective factors, thereby helping to prevent a developmental trajectory to increasingly aggressive behaviors and mental health problems.

In this section, we review literature regarding the specific risk and protective factors associated with antisocial behaviors in children, describe each IY program that targets these factors, and summarize evidence supporting each program. We divide the section into the following domains: schools and teachers, children and peers, and parents and families.

Schools and Teachers

School Risk Factors

The transition to elementary school represents a crucial developmental milestone for the child exhibiting aggressive and/or disruptive behaviors. If elementary school teachers of such children fail to consistently provide responsive and nurturing teaching, reinforcement for prosocial behavior, and effective proactive discipline, a coercive cycle may be established whereby children's oppositional and negative behavior is reinforced by the teachers' harsh or critical responses or giving in to their demands. Research has shown that teachers with students with Oppositional Defiant Disorder (ODD), CD, or Attention-Deficit/Hyperactivity Disorder (ADHD) in their classroom find that these coercive behaviors tend to dominate their interactions, making teaching them difficult and unpleasant (Shores et al., 1993). This results in teachers' providing less instruction and easier tasks to such children than to those children who do not exhibit such difficult behaviors (Carr, Taylor, & Robinson, 1991). Moreover, teacher reinforcement for positive behavior when they are behaving appropriately is infrequent, and reprimands given to them are often not contingent on behavior (Bierman et al., 1992; Stormont, Smith, & Lewis, 2007). As Patterson and colleagues (1992) have described, these patterns of negative or coercive interactions at school contribute to a cascade of negative outcomes for children with antisocial behaviors including peer rejection, negative school reputations, academic failure, and further escalation of their antisocial problems.

IY Teacher Programs

The IY Teacher Training (IY-TT) program is a 6-day (offered monthly) group format program for teachers, school counselors, and psychologists designed to interrupt the negative cycle of disrupted teacher and peer social relations and environments. Training targets effective classroom management strategies for dealing with misbehavior; preventing negative reputations and bullying; promoting positive relationships with difficult students; using coaching strategies to strengthen students' social skills, friendships, and emotional regulation in the classroom, playground, bus, and lunchroom; and (for teachers) using collaborative problem-solving processes and positive communication with parents (e.g., the importance of positive home communication, home visits, and successful parent conferences and coordinated behavior plans). A complete description of the content of this curriculum is described in the book that teachers use for the course titled, *How to Promote Social and Academic Competence in Young Children* (Webster-Stratton, 2000).

Evidence Supporting the Teacher Programs

The IY-TT program has been evaluated as part of a larger treatment package for children with conduct problems and for selective higher risk populations that included child and/or parent training groups or intensive mental health consultation. It was first evaluated in a randomized trial with 159 children diagnosed with conduct problems (Webster-Stratton, Reid, & Hammond, 2004). The study compared child and parent training with and without IY-TT. Teachers who received IY-TT were observed postintervention to use more praise and be more nurturing, consistent, and confident than control teachers. Additionally, children in classrooms with teachers who received IY-TT were significantly less aggressive with peers and more cooperative. Similarly, a randomized prevention trial with 272 children from Head Start found that, in classrooms of teachers receiving IY-TT, students were observed to have higher on-task behavior, increased prosocial behaviors, and decreased aggression (Webster-Stratton, Reid, et al., 2001). More recently a study (Webster-Stratton, Reid, & Stoolmiller, 2008) showed similar effects in Head Start, kindergarten, and first-grade settings for the IY-TT intervention combined with the IY child dinosaur classroom social, emotional, and

problem-solving curriculum, which is described later in text. Additionally, Raver and colleagues (2008) found strong effects ($d = 0.52$ to 0.89) for a multicomponent intervention that included the IY-TT program on classroom climate and teacher behaviors in 36 Head Start classrooms (602 students). These results are promising; future research is needed to evaluate the specific effects of IY-TT on student academic outcomes.

Children and Peers

Child Biological and Developmental Risk Factors

Life-course-persistent antisocial behaviors are linked to early maladaptive development of the child's internal organization system and developmental abilities. Children with conduct problems are more likely to have neurocognitive symptoms and certain temperamental characteristics such as inattentiveness, impulsivity, ADHD, and high rates of aggressive responsiveness. Other child factors have been implicated including depressive symptoms (Webster-Stratton & Herman, 2008) and deficits and/or delays in social-cognitive skills, social and emotional play skills, emotional regulation, and peer interactions (Dishion & Piehler, 2007). Children with conduct problems tend to define problems in hostile ways, seek less information, generate fewer alternative solutions to social problems, and anticipate fewer consequences for aggression. They may also distort social cues during peer interactions and make attributions of hostile intent to neutral interactions (Dodge & Price, 1994). Low academic achievement often manifests itself in these children during the elementary grades and continues through high school. These children enter school with poor school readiness skills, cognitive deficits, and language and developmental delays, which further increase the likelihood of behavior problems in the classroom (Malecki & Elliott, 2002). In turn, these behavior problems reduce the children's access to learning opportunities, further exacerbating any preexisting learning problems.

IY Child Programs (Dinosaur Curricula)

There are two versions of the IY child program, each designed to mitigate the child risk factors and promote protective factors for the onset and maintenance of conduct problems described earlier in this article. In the selective prevention classroom version, teachers deliver 60 social-emotional lessons and small-group activities twice a week, with separate lesson plans for preschool, kindergarten, and first- and second-grade classrooms. The second version is a small-group therapeutic Dinosaur school where accredited IY group leaders work with groups of 4–6 children in 1- to 2-hour therapy sessions. The program can be offered as a "pull out" therapy program twice a week for an hour in schools, or can be offered in 2-hour sessions while the parents participate in the parent group. This 22-week program consists of a series of DVD programs (more than 180 vignettes) that teach children appropriate classroom behavior, problem-solving strategies, social skills, feelings literacy, and emotional self-regulation skills. Organized to dovetail with the content of the parent-training program, the program consists of seven main components: (1) Introduction and Rules; (2) Empathy and Emotion; (3) Problem Solving; (4) Anger Control; (5) Friendship Skills; (6) Communication Skills; and (7) School Skills.

Evidence Supporting the IY Child Programs

To date, the developer has conducted two randomized studies evaluating the effectiveness of the IY small-group child-training (IY-CT) program for reducing conduct problems and promoting social competence in children diagnosed with ODD/CD. The first treatment study (Webster-Stratton & Hammond, 1997) evaluated the effectiveness of the IY-CT alone, compared to parent training alone (IY-PT), to parent plus child training and to the control group. Children who received IY-CT alone

showed significant improvements in problem solving and conflict-management skills compared to children in the control and IY-PT groups. Analyses of the clinical significance of the results suggested that the combined IY-CT + PT condition produced the most significant improvements in child behavior at 1-year follow-up.

A second treatment study for children with ODD/CD (Webster-Stratton, Reid, & Hammond, 2004) tested the additive effects of combining the IY-TT program with either the parent or child program alone or of all three combined. Results indicated that children in treatment conditions that included TT or CT were observed in the classroom to be significantly less aggressive with peers and showed more positive social skills than children in control or PT conditions. Treatment combinations that added either child or teacher training to the parent training were most effective and sustained outcomes at 1-year follow-up.

A recent selective prevention study evaluated the classroom Dinosaur curriculum in Head Start and elementary schools that serve high numbers of economically disadvantaged children. Results of reports and independent observations of 153 teachers and 1,768 students showed significant improvements in children's conduct problems, self-regulation, and social competence in intervention classrooms compared with control classroom students. Effect sizes comparing intervention versus control group outcomes postassessment showed that the intervention had small-to-moderate effects on children whose baseline behavior was in the average range, but had large effects on children with high initial levels of conduct problems (Webster-Stratton et al., 2008).

Parents and Families

Parent and Family Risk Factors

According to Patterson and colleagues (1992), serious antisocial behavior is linked to specific parenting practices during the toddler years when parents fail to bond with their children or to provide responsive and nurturing parenting. Parenting risk factors associated with the development of conduct problems include permissive, neglectful, rigid, and/or inconsistent parenting, harsh or abusive discipline, and low monitoring. These parenting risk factors interact synergistically with biological and developmental child risk factors noted earlier.

Parents and children develop coercive interactions similar to teacher interactions that stem in part from a negative reinforcement pattern in which the parent acquiesces to children's defiant requests and escalating demands (Patterson et al., 1992). In turn, the parent responds with harsh or abusive discipline practices when the child escalates to severe misbehavior. Specific parent interpersonal characteristics put parents and children at risk for developing these maladaptive interactions including parent psychopathology, interparental conflict and divorce, maternal insularity, and lack of support. Finally, low income is a significant risk factor for the early onset of conduct problems in young children. Poverty and its related aggregation of stressful risk factors (i.e., unemployment, crowded living conditions, high life stress, low education, illness, and high residential mobility) have deleterious effects on parenting, including the development of parenting risk factors such as abusive disciplinary practices and difficulty providing protective factors such as consistent nurturing, positive attention, cognitive stimulation, regular routines, ongoing monitoring, and school involvement.

IY Parent Program

The IY Parent Programs target many of these family/parent risk factors for the development of antisocial behaviors by equipping parents with skills and resources needed to create healthy home environments. The BASIC parent programs target four separate age groups: baby (0–1 year), toddler (1–3 years), preschool (3–6 years), and school age (6–12 years). Each of these

recently updated programs includes age-appropriate examples of culturally diverse families, children with varying temperaments, and added emphases on building protective factors such as positive parent–child interactions and social and emotional coaching, predictable routines, proactive discipline, and supporting their children's academic success by collaborating with schools and teachers. The baby program is 8–9 weekly, 2-hour sessions with parents and babies present. The BASIC toddler parent-training program is usually completed in 12-weekly, 2-hour sessions, whereas the preschool and school-age programs are 18–20 weekly sessions. The foundation of the program uses video vignettes of modeled parenting skills (more than 300 vignettes, each lasting approximately 1–3 minutes) shown by two trained group leaders to groups of 8–12 parents. The videos demonstrate social learning and child development principles and serve as the stimulus for focused parent group discussions, problem solving, and collaborative learning. The group model of training is designed to reduce the parent isolation risk factor by building parent support networks.

In addition to the BASIC parenting programs, there are also three supplemental or adjunct parenting programs to be used with particular populations: the ADVANCE parenting program, which addresses parents' interpersonal risk factors, and two SCHOOL Readiness Programs, which focus on reading interactions, ways to coach children's homework, after-school monitoring, and collaboration with teachers. A review by Desforges and Abourchaar (2003) has shown that parent involvement in a child's learning accounts for at least 10% of variance in academic attainment not explained by social class. The content of the BASIC, ADVANCE, and SCHOOL programs is also provided in the text that parents use for the program, titled *The Incredible Years: A Trouble-shooting Guide for Parents of Children Ages 3–8 Years* (Webster-Stratton, 2006a).

Evidence Supporting the Parent Program

The efficacy of the IY parent treatment program for children (ages 2–8 years) diagnosed with ODD/CD has been demonstrated in seven published randomized control group trials by the program developer and colleagues at the University of Washington Parenting Clinic (Reid, Webster-Stratton, & Hammond, 1997, 2007; Webster-Stratton, 1981, 1982, 1984, 1990a, 1992, 1994, 1998; Webster-Stratton & Hammond, 1997; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988; Webster-Stratton, Reid, & Hammond, 2004). In all of these studies, the BASIC program has been shown to improve parental attitudes and parent–child interactions and reduce harsh discipline and child conduct problems compared to wait-list control groups. The results were consistent for the early childhood and school-age versions of the programs. Treatment component analyses indicated that the combination of group discussion, a trained group leader, and video modeling produced the most lasting results in comparison to treatment that involved only one of the three training components (Webster-Stratton et al., 1988, 1989). In addition, the BASIC program effects have been replicated in five research projects by independent investigators in mental health clinics or doctor's offices with families of children diagnosed with conduct problems (Drugli & Larsson, 2006; Lavigne et al., 2008; Scott, Knapp, Henderson, & Maughan, 2001; Spaccarelli, Cotler, & Penman, 1992; Taylor, Schmidt, Pepler, & Hodgins, 1998), as well as in studies with indicated populations (children with symptoms) and selective populations (families living in poverty) (Gardner, Burton, & Klimes, 2006; Gross et al., 2003; Hutchings et al., 2007; Miller Brotman et al., 2003). These replications were "effectiveness" trials in applied mental health settings or schools, not a university research clinic, and the IY group leaders were existing staff (nurses and psychologists) at the centers or doctor's offices. Three of the above replications were conducted in the United States, two in the United Kingdom, and one in Norway. This illustrates the transportability of the BASIC parenting programs to other cultures. In one of the studies (Webster-Stratton, 1994), we found additive benefits of the ADVANCE program on children's prosocial solution generation

and parents' marital interactions and depression symptoms. Consequently a 20- to 24-week program that combines BASIC plus ADVANCE has become our core treatment for parents of children diagnosed with ODD/CD or ADHD. Several studies have also shown that IY treatment effects are durable (Webster-Stratton, 1990b) for very high risk populations. Perhaps most notable is an 8- to 12-year follow-up of families of children diagnosed with ODD who were treated with the IY BASIC parenting program. Interviews with 83.5% of the original study parents and adolescents (ages 12–19 years) indicated that 75% of the teenagers were typically adjusted with minimal behavioral and emotional problems (Webster-Stratton, Rinaldi, & Reid, 2009). Level of coercive interactions between parents and children posttreatment was the strongest predictor of children who had poor long-term outcomes.

In the past decade, we have also evaluated the parent programs used as a selective prevention program with multiethnic, socioeconomically disadvantaged families in three randomized studies with Head Start families delivered in schools. Results of the first two of these studies suggest the program's effectiveness as a method of preventing the development of conduct problems and strengthening social competence in Head Start children (Webster-Stratton, 1998; Webster-Stratton, Reid, & Hammond, 2001). A recent study with elementary school children evaluated the effects of the parent intervention delivered in schools with an indicated, culturally diverse population (Reid, Webster-Stratton, & Hammond, 2007). Children who received the intervention showed fewer externalizing problems, better emotion regulation, and stronger parent–child bonding than control children did. Mothers in the intervention group showed more supportive and less coercive parenting than control mothers did (Reid et al., 2007). A table with details of all of these studies and findings is available from the authors upon request.

Large-Scale Dissemination and Sustainability: A Model for Implementing the IY Series to Prevent Child Emotional and Behavior Problems by Population Risk

Levels of Intervention

The prevention science model suggests that reducing the population prevalence of childhood disorders will require a continuum of supports across settings for all children from infancy onward. In the next section, we describe five levels of intervention for delivering various IY programs in a manner that is consistent with this prevention science paradigm.

The IY programs chosen for dissemination depend on the level of risk and ages of the children targeted for service by the agency or school. As seen in Figure 1, Level 1 is the foundation of the pyramid and focuses primarily on a series of programs that can be offered universally to all parents of infants and toddlers. By providing these early supportive contexts for all children, it is possible to promote optimal social, emotional, and academic development and to reduce the number of children who will need additional supports later in life (Perry, Pollard, Blakley, Baker, & Vigilante, 1996; Shaw, Owens, Giovannelli, & Winslow, 2001). Level 2 also fosters "universal" prevention by offering appropriate IY programs to all parents and teachers of children ages 3–6 years, thus enhancing the capacity of adults at home and school to provide structured, warm, and predictable environments. The IY Parent BASIC and IY-TT programs have self-administered manuals so that parents and teachers can access the information through self-learning modules, instead of needing to attend groups, thus making them especially amenable to widespread dissemination for low-risk populations.

Level 3 targets "selective" or high-risk populations. These are populations that are socioeconomically disadvantaged and highly stressed because of increased family risk factors related to poverty. Such families would benefit from a continuum of services offered as children develop from infancy to school age including more intensive parent and teacher training as well as access to the classroom Dinosaur (Dina) social and emotional skills curriculum. This investment in building

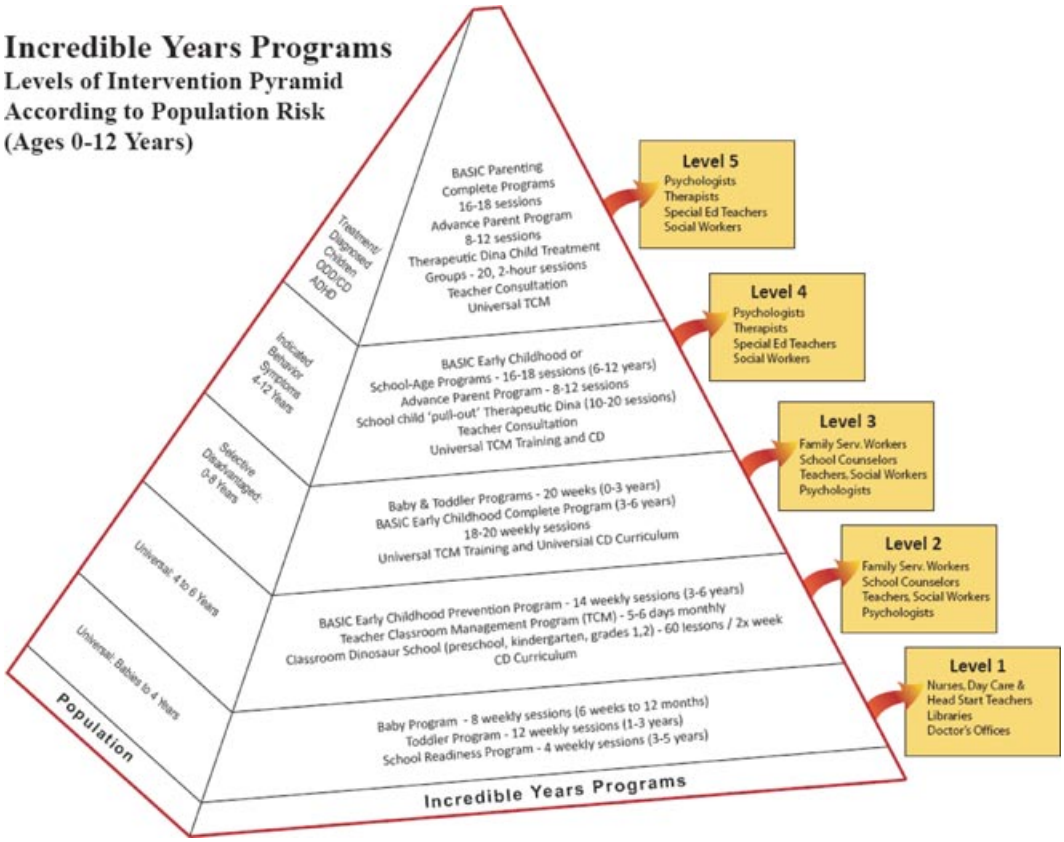

FIGURE 1. Levels of intervention pyramid.

the social and emotional abilities in the first six years of life for these vulnerable children can help to break the intergenerational transmission of disadvantage. In turn, reducing the contextual risks associated with poverty and promoting child well-being during these early years decrease the likelihood that these children will need more intensive and expensive interventions in the future. It promises hope for an environment early in life that ensures optimal early brain development and school readiness and prevents children from falling behind academically and entering a negative trajectory leading to later academic failure, crime, and violence.

Level 4 on the pyramid is targeted at "indicated populations," children or parents who are already showing symptoms of problems (e.g., parents referred to Child Protective Services because of abuse or neglect, foster parents caring for children who have been neglected or removed from their homes, or children who are highly aggressive but not yet diagnosed as having ODD or CD). As can be seen on the pyramid, this level of intervention is offered to fewer families and offers a longer and more intensive parenting program by a higher level of trained professionals. In addition, children with symptoms of externalizing or internalizing problems might be pulled out of class twice a week for the small-group therapeutic Dinosaur Social Skills, Emotion, and Problem Solving therapeutic intervention delivered by school psychologists or counselors or specially trained social workers or special education teachers. This extra training reinforces the classroom learning of this program and allows these children to return to a classroom where peers understand how to respond more positively to their special needs.

Level 5 is the most comprehensive intervention, addressing multiple risk factors, and is usually offered in mental health clinics by IY group leaders with graduate level education in psychology, social work, or counseling. One of the goals of each of the prior levels is to maximize resources and minimize the number of children who will need these time- and cost-intensive interventions at Level 5. In addition to the parent group-based programs, if parents need individual coaching, this can be provided in supplemental home visits. Trained home visitor IY coaches also have protocols for working with parents at home to reinforce the skills that they are learning in their groups. Successful interventions at this level are marked by an integrated team approach with clear communication among all the providers and adult caregivers in the various settings where these children spend their time.

Training and Dissemination Model: Seven Strategies for Delivering IY Programs With Fidelity

Identification of evidence-based programs to be offered to particular populations is only the first step in preventing and treating conduct problems and promoting social, emotional, and academic competence in children. To replicate the published results obtained by the research, attention must be given to the quality of the program implementation and the degree to which a program is delivered with the quality intended by the developer. Many empirically validated programs have been adopted in different settings with widely varying outcomes. In fact, a low-quality delivery of a best practice program (Gottfredson et al., 2000) may not produce any effective results at all. Until recently, little emphasis has been placed on the best ways to implement programs with fidelity. Some agencies or schools do not recognize the importance of adhering to the program's protocols, dosage, and clinical recommendations and feel that implementation of at least a few program sessions will be better than doing nothing at all.

Programs must be implemented with fidelity to the original model to preserve the behavior change mechanisms that made the original model effective (Arthur & Blitz, 2000). This means that programs must be offered with all the core components being delivered using the recommended protocols, video vignettes, program dosage, and clinical methods and processes for the prescribed number of sessions. Even after successful effectiveness trials, the critical questions are how to sustain fidelity of intervention within the same setting over time. Additional challenges arise when the goal is to expand the application of an intervention to entire systems with fidelity, be it a school district or an entire state (i.e., scaling up). Finally, even after successfully scaling up, there is a need to sustain fidelity over time throughout the system (Kellam & Langevin, 2003). At each of these levels of extension, questions arise about selection criteria for who will be trained, with what kind and how much training, and when the training will occur. Additionally, decisions need to be made about how fidelity will be monitored and supported including attention to what social, organizational, and political structures will need to be put in place and what type of mentoring model will be employed.

One of the strengths of the IY Series has been the attention given to fidelity and adherence. Available dissemination research has informed our decisions about the optimal dosing, training, and mentoring requirements for successful implementation in the short and long term (Fixsen et al., 2005). We now will identify key dissemination strategies to assure delivery of the IY programs with fidelity and adherence to key program principles and protocols.

Strategy 1: Assure Standardized Quality Training for Carefully Selected Group Leaders and Teachers

Selecting Group Leaders. We recommend that each agency or school prepare a minimum of two group leaders or teachers for training in the new program. Those chosen to deliver these programs should ideally have Masters or higher degrees or professional diplomas in an appropriate

field—psychology, social work, nursing, school counseling, or teaching, for example. They also should have prior experience working with parents and children and preferably have had prior training in child development, behavior management, and cognitive social learning theory. In particular, persons chosen should be comfortable leading groups and motivated to support families, teachers, and their children. These professionals should not be mandated to take the training or sent to a training without planning how their workload will be readjusted to allow them time to learn the intervention and to receive supervision and consultation. In addition, group leader selection criteria should include interpersonal qualities of empathy, sense of humor, collaborative nature, group leadership skills, and ability to work within a structured program.

Strategy 2: Provide Ongoing Supervision and Consultation for Group Leaders and Teachers

Evidence-based training workshops by themselves are necessary but not sufficient to result in fidelity of implementation delivery (changes in teacher or group leader behavior or adherence to protocols) or program outcomes (clinical changes in consumers). After the initial training workshop, group leaders and teachers first need release time to study the manuals and DVDs, to practice and prepare their sessions and materials, and to arrange logistics (e.g., food or day care, handouts, classroom materials, transportation). Furthermore, research has shown (Joyce & Showers, 2002) that combining the initial training workshop with ongoing mentoring, coaching, and consultation maximizes the learning for clinicians as they begin to implement the program and contributes greatly to fidelity of program delivery. We recommend that IY-accredited mentors provide this support, encouragement, and consultation regularly for the group leaders during their first 2–3 sets of groups. Ideally new leaders should have 3–4, 1-hour consultations during delivery of their first program and ongoing consultation as needed.

Group leader consultation, feedback, and emotional support from IY mentors and trainers can take several forms and may evolve within an agency or school. For those sites that are implementing the program for the first time, group leader or teacher consultation and coaching will be arranged through IY headquarters via regular telephone consultations with IY-accredited trainers. Group leaders are also encouraged to submit a DVD of a group session or lesson from their first group for detailed feedback. After group leaders or teachers have had experience delivering the program, approximately 6–9 months after training, it is recommended that they participate in an in-person group consultation training with IY trainers or mentors either on-site at the agency or school or at the IY headquarters in Seattle**.** In these consultation workshops, group leaders or teachers come together to share selected portions of their videos regarding their delivery of the program. Peer sharing and feedback along with IY mentor coaching regarding videotaped sessions can be a huge asset in helping group leaders and teachers gain new ways to handle problems that were particularly difficult for them. We believe that group leaders who receive this initial training coupled with ongoing supervision, support, and video feedback from mentors and trainers during their first three complete sets of programs delivered will be ready to submit their application for accreditation as group leader (see criteria later in text).

Strategy 3: Develop Peer Support Networks Within Agencies or Schools

Weekly peer support and time for planning sessions or classroom lessons are key to continued learning and successful intervention, regardless of a group leader's or teacher's expertise. Often, group leaders or teachers become discouraged when a particular family or child fails to progress. Peer group support in addition to IY trainer or mentor consultation helps the leader to maintain optimism and to find new approaches for resistant parents, teachers, or children. We recommend that group leaders begin videotaping their groups right away and meet weekly with peers for video review

and for mutual support. It is the policy of the IY program to train teachers or group leaders from the same agency so that they can participate in the peer-review process. Individuals are not trained to work without a peer support network. When group members share their work and offer constructive support, they not only aid each other in conducting IY groups but also empower themselves as self-reflective thinkers, self-managers, and evaluators.

Strategy 4: Adhere to Program Dosage, Order, and Protocols—Ensuring Implementation Fidelity

Program Fidelity. Monitoring group leaders' adherence to session protocols, key content, and therapeutic process principles is another aspect of supervision. Many agency administrators and clinicians believe that they can eliminate parts of a mental health intervention or shorten the number of sessions offered to be more cost effective. They may even cobble together different programs in a smorgasbord intervention. Training, supervision, and accreditation help group leaders, and administrators understand that this approach may dilute or may eliminate the positive effects of the program.

Over the past 18 years, all of our IY control group treatment studies have evaluated the combined IY BASIC + ADVANCE programs for families of children with ODD, CD, ADHD, and/or conduct problems. In various studies over the years, the length of the program has varied from 12 to 26 sessions. We recently compared the results for families with children with ODD and ADHD randomly assigned to a 20-week, 2-hour session program with those assigned to a condensed 10-week, 2-hour session program. Results showed significantly better outcomes for the children in the 20-session program than for those in the 10-session program. These results support the benefits of the longer dosage program and are consistent with other studies with similar populations that have shown that programs with the most significant and highest effect sizes are 20 sessions or more (Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002). It is important that group leaders make an effort to provide "make-up" sessions for parents who miss a group session due to illness or schedule conflicts so that they get the full benefits of the intervention.

Our prevention parent program is typically offered in 14–24 sessions that are 2–2 1/2 hours in length. Interventions for non–English-speaking populations with translators run 18–20 sessions. All of our studies with Child Protective Services–referred families have run 16–20 sessions. With these high-risk prevention populations, we have found that effect sizes increase with more sessions provided (Baydar, Reid, & Webster-Stratton, 2003). The newly updated preschool program (ages 3–6 years) recommends a minimum of 14 sessions for prevention populations and 20 sessions for children with conduct problems or for families referred by Child Protective Services. Offering fewer than the recommended number of sessions for prevention and treatment populations will result in reduced effectiveness of the IY program.

IY protocols for every group session or classroom lesson are carefully designed according to age group and population addressed and in a sequence of delivery so that one session builds on the prior sessions and learning. The recommended number of sessions on the protocols is considered the *minimum number of sessions needed*, but groups may require more sessions depending on their goals and needs, difficulties with the material, degree of severity of children's problems, the pace of learning, and the size of the group. To prevent the ongoing development of ODD/CD, it is necessary for parents to make clinically significant reductions in their coercive interactions. This process of relationship building between parents and children and changing entrenched intergenerational patterns of parent–child interactions as well as their emotions and cognitions takes sufficient time.

A critical distinction must be made between implementing the core or the foundational elements of the program and stifling clinical flexibility. It is easy for the former to be misconstrued as the

latter. In supervision, group leaders are encouraged to discuss their knowledge and experience, so they collaboratively tailor the program to unique parent or teacher goals or to child developmental needs. Group leaders and teachers come to understand that the principles that guide the program include being flexible, collaborative, culturally relevant, and fun, rather than following a precise script to be recited to parents, teachers, or children. When leaders understand this, they realize that the program actually encourages the use of their clinical skills and judgment. The most effective group leaders and teachers who deliver this program are those who retain the core elements of the intervention while bringing their clinical creativity to bear in the implementation. Supervision helps them to balance pursuit of a particular group's goals in relation to the group process and issues that are relevant for the entire group.

Strategy 5: Promoting Leader Accreditation

A certification or accreditation process allows group leaders and teachers to continue their learning process after the initial training workshop and to recognize persons who strive to become more competent at delivering the programs. Requirements for accreditation include the following: adherence to session protocols; parent or teacher attendance; positive weekly and final client evaluations for two complete groups; two self- and peer-evaluations for each complete program offered using the peer content and the methods checklists; completion of a 3-day authorized training workshop; and satisfactory review of a complete video of a group session by an IY trainer who rates the leader's adherence to the program content and methods, as well as his or her therapeutic skill in the collaborative process. Satisfactory peer review, video, evaluations, adherence to protocols, and group attendance indicate fidelity of program delivery of the content and the therapeutic process necessary for accreditation. Group leaders who become accredited can reasonably anticipate to achieve effects similar to those achieved in the published outcome studies evaluating the program.

To sustain program fidelity and prevent drift away from fidelity, accredited leaders are encouraged to continue to attend ongoing consultation workshops and to participate in peer-review groups within their agency. Client evaluations and completed session protocols are also part of the clinician's accountability to the agency. From these accredited individuals, agencies or schools may identify one or two individuals for additional training to become accredited *IY peer coaches* or mentors. Such individuals are accredited group leaders with exceptional group leadership skills, mastery of the collaborative process, and desire to provide emotional support for other leaders. Peer coaches receive further training in peer coaching and video-review processes. They are expected to co-lead groups or lessons with new leaders or teachers and to provide them with ongoing support and feedback about the program. They review videos of their sessions and give new leaders feedback.

IY mentors are accredited group leaders and possibly peer coaches who have been selected to receive more extensive training in IY workshop delivery and are permitted to offer authorized training workshops within their agency or school. Prospective mentors have delivered many groups and received ongoing reviews, participated in supervision and consultation workshops, and co-led training workshops with an accredited IY trainer. Mentors receive ongoing consultation from IY trainers, participate in yearly workshops with other mentors, obtain video feedback on their supervision process, and participate in further training and updates regarding new program developments and research.

Strategy 6: Supportive Agency or School Infrastructure and Support

No program can be faithfully implemented without adequate resources and internal managerial support for the group leaders or teachers delivering the program. The decision to adopt an evidence-based intervention, such as IY, should reflect a consensus among clinicians, teachers, and

administrators that the choice of intervention model best meets their goals, the agency or school philosophy, and the needs of their teachers, families, and children. In other words, there is a good innovation–agency–clinician values fit. It may be necessary for administrators to readjust clinician and/or teacher job descriptions to recognize their time commitments to ongoing training, peer support, supervision, and recruiting for and carrying out new interventions. Even though group approaches are more cost effective than individual approaches, administrators may not understand the time or money needed to assure transportation and food for each parent session, to arrange day care, to prepare weekly materials, to provide makeup sessions for families or teachers, and to make the weekly calls to parents and teachers. If socioeconomically disadvantaged families are targeted for prevention programs, special attention must be paid to transportation, day care, and meals, otherwise families will have difficulties accessing programs and attendance will be low. Sometimes administrators are surprised to find that the initial training does not prepare their clinicians or teachers to start groups the following week. It is imperative that administrators understand that preparation time is needed to start a new evidence-based intervention that involves not only leaders studying the DVDs and training manuals and meeting in peer-support groups to practice with their colleagues as described earlier in this article but also time to recruit families, to assure appropriate referrals, and to organize appropriate day care, which may involve some additional training.

The administrative staff and internal advocates need to assure that there are plans for ongoing consultation and supervision from the outside IY trainer. An IY trainer is an accredited group leader and mentor who either has a doctorate or has worked with the developer of the program for many years. The IY trainer collaborates with the organization's internal advocate or mentor, provides consultation to clinicians and administrators regarding program implementation, and anticipates possible barriers and difficulties with high-fidelity dissemination. Changes may be necessary in policy, regulation, funding, and support. The IY trainer is in an excellent position to advise the administrators in ways to support clinicians' change efforts. The IY Agency Readiness Questionnaire (available on the IY Web site) can help administrators understand what is needed to support the clinician's training, the needs for logistical support, and ongoing consultation and supervision. This will be important for them to understand at the start to assess the feasibility of implementing this program. It is best if there is an administrative champion within the agency who understands the workings of his or her own organization, as well as the requirements of the new program. Research shows that clinicians who are left to champion a program without an active administrative supporter quickly burn out from the extra work, resent the lack of support and time, and often leave the agency (Corrigan, MacKain, & Liberman, 1994). Interpersonal contact provided by the internal advocate is a critical ingredient in adoption of new programs (Backer, Liberman, & Kuehnel, 1986). Administrative champions are often more important than the clinicians to the long-term success of the intervention.

Administrators may select promising clinicians and persuade them to learn this new intervention. The program will attain a strong reputation if it begins with a few enthusiastic leaders or skilled teachers rather than if it begins with a mandate that all clinicians or teachers adopt the program. Persons who are not risk takers, *late adopters*, will venture into new programs only after respected colleagues are successful (Rogers, 1995). Encouraging and supporting accredited group leaders to continue training to become accredited as peer coaches or mentors builds the infrastructure of a sustainable program. At first, the IY trainers provide direct support to the clinician or teacher, as detailed in Strategy 4. The goal, however, is to make agencies or schools self-sufficient in their ongoing training and in their support of the program. Administrators can also provide important reinforcement to group leaders or teachers by recognizing and rewarding those who work to become accredited and achieve high-quality delivery of the program. Reinforcement, both social and tangible, is important to their ongoing commitment and adherence to this program. Moreover, when

administrators promote accreditation as a way of supporting evidence-based practice, group leaders and teachers appreciate that they are working toward goals that are highly valued by the organization.

Strategy 7: Monitor Quality Assurance and Evaluation

IY Mentor and Trainer Training Quality Assurance. Quality assurance procedures are used consistently throughout all aspects of IY training. First, only IY-accredited trainers or mentors provide the training. Once they begin training as mentors they are supervised by accredited trainers and mentors and receive in-person feedback from them. When they have completed this training and a mentor feels that they are ready to do a solo workshop, they offer a workshop and submit videos of this workshop for review by an IY trainer. They also submit the workshop protocol checklist documenting what they have covered in the workshop along with workshop evaluations from participants. All accredited mentors or trainers who do workshops must submit daily evaluations and final evaluations of their workshops along with their workshop checklist and daily attendance list to IY headquarters in Seattle. Participant registration each day at workshops is entered into a data bank acknowledging completion of the entire number of training hours.

Evaluating Group Leader or Teacher Evaluations and Adherence to Program Model. Embedded in the training of group leaders or teachers are efforts to enhance the quality of program delivery. Part of the delivery of this program (and accreditation process) includes weekly evaluations by participants, final summative evaluations, submission of attendance registers, and completion of each session's protocols. Completion of these detailed session protocols allows administrators to determine if group leaders or teachers are adhering to program fidelity such as showing required video vignettes, engaging in recommended practice exercises and brainstorms, and using the key learning principles. It is also possible to determine if parents or teachers are doing the recommended home activities or classroom behavior plans and reading chapters and succeeding in achieving their goals.

Group leaders who have offered the IY program with high fidelity have had considerable support and ongoing monitoring by their workplace administrators. Such administrators have supported their work toward accreditation, monitored their ongoing evaluations, and given group leaders time for peer review and technical support. There are numerous strategies specific to the role of the workplace or administration in promoting and monitoring program fidelity, rewarding leaders who become accredited, and planning for ongoing sustainability (strategies that are too lengthy for this article and are further described in an article on the Web site) (Webster-Stratton, 2006b). Additionally on this site there is an IY implementation quality questionnaire that administrators can complete to assess the quality of their program delivery.

In addition, we recommend that administrators conduct ongoing program evaluation by collecting assessments of desired program outcomes. Specific outcome measures used may vary by the agency setting and the level of intervention. Ideally, agencies should collect baseline and follow-up data about changes in child externalizing and internalizing symptoms as well as changes in parenting or teacher classroom management skills. When possible, we encourage agencies to use some of the same standardized measures used in the trials that established the program efficacy. It is important for agencies to track other tangible outcomes associated with the program including group attendance and participant feedback, child academic achievement and attendance, and feedback from other care providers who work with the child and family.

Suggestions for Advancing IY Practice in School Settings—Where to Begin?

Agencies that have been most successful in adopting and implementing IY as described earlier in this article all share something in common: one or more staff members who developed a strong interest in advancing IY in that setting. These champions gradually developed expertise in IY, shared

information with colleagues, and developed a plan for rolling out the program over time. Although the detailed strategies described may sound daunting to consider all at once, we provide them as a road map to be revisited as a school gradually adopts IY programs. A good place to begin is to learn more about IY (by reading articles, attending workshops, or visiting the Web site) and then to share this information with one or more colleagues. Through conversations with IY headquarters and team discussions, school personnel can determine how to make IY fit into their setting using the guidelines described.

Connecting IY to Other Prevention Initiatives

IY also can be integrated with other universal prevention programs. Most notably, schoolwide Positive Behavior Supports (PBS) has been implemented in more than 7,000 schools across the United States and has been shown to reduce population incidence of behavior problems (Bradshaw, Koth, Bevans, Ialongo, & Leaf, 2008). The effect of schoolwide PBS may be enhanced by broadening its scope. First, although PBS attends to the multiple subsystems within schools, more structured supports may be needed at the classroom and student levels (i.e., schoolwide PBS does not include specific teacher or child curriculum). Given that IY and PBS have similar theoretical groundings, the IY-TT and Classroom Dina Child programs may provide an ideal complement to the PBS model. Second, PBS was developed to promote positive school climates and does not have a systematic method for supporting parents and families. Offering the IY Parent programs within PBS schools holds promise for promoting consistent environments across home and school settings.

Using Existing Service Structures

Many public schools now house family resource centers to support school–parent connections. These centers have developed with the growing recognition of the importance of family support to ensure student learning and reduce behavior problems at school. These centers may provide an optimal home for the IY Series both in terms of personnel and space. One model that has been supported by research is the EcoFit model (Dishion & Kavanagh, 2003). Staff devoted to these centers would be a logical choice for IY group leader training. These centers offer universal services (such as information and brochures). The IY DVD series and books would be a perfect complement to the libraries of each of these centers, giving all families access to these resources. The families of children showing early signs of emotional or behavior problems (self-referred or referred by school staff) receive a Family Checkup (see Dishion & Kavanagh, 2003), an intensive evaluation of child and family strengths and symptoms followed by personalized feedback delivered using motivational interviewing strategies. The Family Checkup meeting culminates with a menu of options for pursuing additional supports and services to address any identified problem areas. Depending on the specific problems and goals, any or all of the IY programs could be on the menu of options for parents to select their preferred intervention.

Future Research and Adaptations

All of the research with IY has been with selective and indicated prevention populations and diagnosed children. There is a need for population-level trials that evaluate the effectiveness of universal interventions (see Figure 1) on a large scale to parents of children 0–6 years and for teachers or day care providers of this age group.

Additionally, recent literature suggests that future evaluations of all IY programs should consider potential collateral benefits. Given its focus on promoting child competencies and providing supportive and structured environments, the IY Series may prove helpful in addressing other common child symptoms beyond conduct problems. For instance, emerging evidence suggests that the IY

parent and child programs also help children with ADHD (Hartman, Stage, & Webster-Stratton, 2003) and depressive symptoms (Webster-Stratton & Herman, 2008). The IY parent program also has been shown effective for court-referred or child welfare families and for foster parents (Linares, Montalto, MinMin, & Vikash, 2006; Webster-Stratton, 2006c).

Conclusion

Agency and school personnel charged with improving the well-being of children and families now have several options for delivering best practices in their work that are grounded in an extensive research base. At the same time, it has become clear over the past decade that successful implementation of evidence-based programs, including the IY Series, requires a serious sustained commitment of personnel and resources. We have learned much about the necessary ingredients for successfully transporting efficacious practices like IY into real-world settings. Most important, we have learned that IY can be disseminated with high fidelity and sustained over time. Some of the critical factors include selecting optimal group leaders or teachers to deliver the program; providing them with quality training workshops coupled with ongoing supportive mentoring, consultation, peer, administrative, and facilitative supports; and ongoing program evaluating and monitoring of program dissemination fidelity. Although it may be tempting for the sake of convenience and short-term resources to ignore the growing dissemination literature; doing so almost certainly will result in ineffective and unsustainable programming. Given that there are time and costs involved in delivering even ineffective programs, a much wiser choice would be to invest resources in programs known to sustain high-quality, evidence-based practices. Only then can we be sure that our time and efforts have not been wasted.

References

Arthur, D. H., & Blitz, C. (2000). Bridging the gap between science and practice in drug abuse prevention through needs assessment and strategic community planning. Journal of Community Psychology, 28, 241–255.

Backer, T. E., Liberman, R. P., & Kuehnel, T. G. (1986). Dissemination and adoption of innovative psychosocial interventions. Journal of Consulting and Clinical Psychology, 54, 111–118.

Baydar, N., Reid, M. J., & Webster-Stratton, C. (2003). The role of mental health factors and program engagement in the effectiveness of a preventive parenting program for Head Start mothers. Child Development, 74(5), 1433–1453.

Bierman, K. L., Coie, J. D., Dodge, K. A., Greenberg, M. T., Lochman, J. E., & McMahon, R. J. (1992). A developmental and clinical model for the prevention of conduct disorder: The FAST Track Program. Development and Psychopathology, 4, 509–527.

Bradshaw, C. P., Koth, C. W., Bevans, K. B., Ialongo, N., & Leaf, P. (2008). The impact of school-wide Positive Behavioral Interventions and Supports (PBIS) on the organizational health of elementary schools. School Psychology Quarterly, 23(4), 462–473.

Carr, E. G., Taylor, J. G., & Robinson, S. (1991). The effects of severe behavior problems in children on the teaching behavior of adults. Journal of Applied Behavior Analysis, 24, 523–535.

Corrigan, P. W., MacKain, S. J., & Liberman, R. P. (1994). Skill training modules - A strategy for dissemination and utilization of rehabilitation innovation. In J. Rothman & E. J. Thomas (Eds.), Intervention research: Design and development of human service. New York: Hawthorne Press.

Costello, E. J., Foley, D. L., & Angold, A. (2006). 10-year research update review: The epidemiology of child and adolescent psychiatric disorders: II. Journal of American Academy of Child and Adolescent Psychiatry, 45(1), 8–25.

Desforges, C., & Abourchaar, A. (2003). The impact of parental involvement, parental support and family education on pupil achievement and adjustment: A literature review. Research Report RR433. London: Department for Education and Skills.

Dishion, T. J., & Kavanagh, K. (2003). Intervening in adolescent problem behavior. New York: Guilford Press.

Dishion, T. J., & Piehler, T. F. (2007). Peer dynamics in the development and change of child and adolescent problem behavior. In A. S. Masten (Ed.), Multilevel dynamics in development psychopathology: Pathways to the future (pp. 151–180). Mahwah, NJ: Erlbaum.

Dodge, K. A. (1993). Social-cognitive mechanisms in the development of conduct disorder and depression. Annual Review of Psychology, 44, 559–584.

Dodge, K. A., & Price, J. M. (1994). On the relation between social information processing and socially competent behavior in early school-aged children. Child Development, 65, 1385–1397.

Drugli, M. B., & Larsson, B. (2006). Children aged 4-8 years treated with parent training and child therapy because of conduct problems: Generalisation effects to day-care and school settings European Child and Adolescent Psychiatry, 15, 392–399.

Egger, H. L., & Angold, A. (2006). Common emotional and behavioral disorders in preschool children: Presentation, nosology, and epidemiology. Journal of Child Psychology and Psychiatry, 47, 313–337.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature (Vol. FMHI Publication #231). Tampa, FL: University of South Florida, The National Implementation Research Network.

Gardner, F., Burton, J., & Klimes, I. (2006). Randomized controlled trial of a parenting intervention in the voluntary sector for reducing conduct problems in children: Outcomes and mechanisms of change. Journal of Child Psychology and Psychiatry, 47, 1123–1132.

Gottfredson, G. D., Gottfredson, D. C., Czeh, E. R., Cantor, D., Crosse, S., & Hantman, I. (2000). A national study of delinquency prevention in school. Ellicott City, MD: Gottfredson Associates, Inc.

Gross, D., Fogg, L., Webster-Stratton, C., Garvey, C., Julion, W., & Grady, J. (2003). Parent training with families of toddlers in day care in low-income urban communities. Journal of Consulting and Clinical Psychology, 71(2), 261–278.

Hartman, R. R., Stage, S., & Webster-Stratton, C. (2003). A growth curve analysis of parent training outcomes: Examining the influence of child factors (inattention, impulsivity, and hyperactivity problems), parental and family risk factors. The Child Psychology and Psychiatry Journal, 44(3), 388–398.

Henggeler, S. W., Schoenwald, S. K., Liao, J. G., Letourneau, E. J., & Edwards, D. L. (2002). Transporting efficacious treatments to field settings: The link between supervisory practices and therapist fidelity in MST programs. Journal of Clinical Child & Adolescent Psychology, 31(2), 155–167.

Hutchings, J., Gardner, F., Bywater, T., Daley, D., Whitaker, C., Jones, K., et al. (2007). Parenting intervention in Sure Start services for children at risk of developing conduct disorder: Pragmatic randomized controlled trial. British Medical Journal, 334(7595), 1–7.

Joyce, B., & Showers, B. (2002). Student achievement through staff development (3rd ed.). Alexandria, VA: Association for Supervision and Curriculum Development.

Kellam, S. G., & Langevin, D. (2003). A framework for understanding "evidence" in prevention research and programs. Prevention Science, 4, 137–153.

Lavigne, J. V., LeBailly, S. A., Gouze, K. R., Cicchetti, C., Pochyly, J., Arend, R., et al. (2008). Treating Oppositional Defiant Disorder in primary care: A comparison of three models. Journal of Pediatric Psychology, 33(5), 449–461.

Linares, L. O., Montalto, D., MinMin, L., & Vikash, S. (2006). A promising parent intervention in foster care. Journal of Consulting and Clinical Psychology, 74(1), 32–41.

Lynam, D. R., Caspi, A., Moffitt, T. E., Wikstrom, P. H., Loeber, R., & Novak, S. (2000). The interaction between impulsivity and neighborhood context on offending: The effects of impulsivity are stronger in poorer neighborhoods. Journal of Abnormal Child Psychology, 109, 563–574.

Malecki, C. K., & Elliott, S. N. (2002). Children's social behaviors as predictors of academic achievement: A longitudinal analysis. School Psychology Quarterly, 17, 1–23.

Miller Brotman, L., Klein, R. G., Kamboukos, D., Brown, E. J., Coard Irby, S., & Sosinsky Stout, S. L. (2003). Preventive intervention for urban, low-income preschoolers at familial risk for conduct problems: A randomized pilot study. Journal of Child Psychology and Psychiatry, 32(2), 246–257.

Moffitt, T. E. (1993). Adolescence-limited and life-course-persistent antisocial behavior: A developmental taxonomy. Psychological Review, 100, 674–701.

Offord, D. R., & Bennet, K. J. (1994). Conduct disorder: Long term outcomes and intervention effectiveness. Journal of the American Academy of Child and Adolescent Psychiatry, 33, 1069–1078.

Patterson, G., Reid, J., & Dishion, T. (1992). Antisocial boys: A social interactional approach (Vol. 4). Eugene, OR: Castalia Publishing.

Perry, B. D., Pollard, R. A., Blakley, T. L., Baker, W. L., & Vigilante, D. (1996). Childhood trauma, the neurobiology of adaptation and use-dependent development of the brain: How "states" become "traits". Infant Mental Health Journal, 16, 271–291.

Raver, C. C., Jones, S. M., Li-Grining, C. P., Metzger, M., Champion, K. M., & Sardin, L. (2008). Improving preschool classroom processes: Preliminary findings from a randomized trial implemented in Head Start settings. Early Childhood Research Quarterly, 23, 10–26.

Reid, M. J., Webster-Stratton, C., & Hammond, M. (2007). Enhancing a classroom social competence and problem-solving curriculum by offering parent training to families of moderate-to-high-risk elementary school children. Journal of Clinical Child and Adolescent Psychology, 36(5), 605–620.

Rogers, E. M. (1995). Diffusion of innovations. New York: The Free Press.

Scott, S., Knapp, M., Henderson, J., & Maughan, B. (2001). Financial cost of social exclusion: Follow up study of antisocial children into adulthood. British Medical Journal, 323, 191–194.

Shaw, D. S., Owens, E. B., Giovannelli, J., & Winslow, E. B. (2001). Infant and toddler pathways leading to early externalizing disorders. Journal of American Academy of Child and Adolescent Psychiatry, 40, 36–43.

Shores, R. E., Jack, S. L., Gunter, P. L., Ellis, D. N., DeGriere, T. J., & Wehby, J. H. (1993). Classroom interactions of children with behavioral problems. Journal of Emotional and Behavioral Disorders, 1, 27–39.

Snyder, H. (2001). Child delinquents. In R. Loeber & D. P. Farrington (Eds.), Risk factors and successful interventions. Thousand Oaks, CA: Sage.

Spaccarelli, S., Cotler, S., & Penman, D. (1992). Problem-solving skills training as a supplement to behavioral parent training. Cognitive Therapy and Research, 16, 1–18.

Stormont, M., Smith, S. C., & Lewis, T. J. (2007). Teacher implementation of precorrection and praise statements in Head Start classrooms as a component of a program-wide system of positive behavioral support. Journal of Behavioral Education, 16, 280–290.

Taylor, T. K., Schmidt, F., Pepler, D., & Hodgins, H. (1998). A comparison of eclectic treatment with Webster-Stratton's Parents and Children Series in a children's mental health center: A randomized controlled trial. Behavior Therapy, 29, 221–240.

Webster-Stratton, C. (1981). Modification of mothers' behaviors and attitudes through videotape modeling group discussion program. Behavior Therapy, 12, 634–642.

Webster-Stratton, C. (1982). Teaching mothers through videotape modeling to change their children's behaviors. Journal of Pediatric Psychology, 7(3), 279–294.

Webster-Stratton, C. (1984). Randomized trial of two parent-training programs for families with conduct-disordered children. Journal of Consulting and Clinical Psychology, 52(4), 666–678.

Webster-Stratton, C. (1990a). Enhancing the effectiveness of self-administered videotape parent training for families with conduct-problem children. Journal of Abnormal Child Psychology, 18, 479–492.

Webster-Stratton, C. (1990b). Long-term follow-up of families with young conduct problem children: From preschool to grade school. Journal of Clinical Child Psychology, 19(2), 144–149.

Webster-Stratton, C. (1992). Individually administered videotape parent training: "Who benefits?" Cognitive Therapy and Research, 16(1), 31–35.

Webster-Stratton, C. (1994). Advancing videotape parent training: A comparison study. Journal of Consulting and Clinical Psychology, 62(3), 583–593.

Webster-Stratton, C. (1998). Preventing conduct problems in Head Start children: Strengthening parenting competencies. Journal of Consulting and Clinical Psychology, 66(5), 715–730.

Webster-Stratton, C. (2000). How to promote social and academic competence in young children. London, England: Sage Publications.

Webster-Stratton, C. (2006a). The Incredible Years: A trouble-shooting guide for parents of children ages 3-8 years. Seattle: Incredible Years Press.

Webster-Stratton, C. (2006b). Treating children with early-onset conduct problems: Key ingredients to implementing the Incredible Years Programs with fidelity. In T. K. Neill (Ed.), Helping others help children: Clinical supervision of child psychotherapy (pp. 161–175). Washington DC: American Psychological Association.

Webster-Stratton, C. (2006c). Working with families who are involved in the child welfare system. Unpublished manuscript, University of Washington at Seattle.

Webster-Stratton, C., & Hammond, M. (1997). Treating children with early-onset conduct problems: A comparison of child and parent training interventions. Journal of Consulting and Clinical Psychology, 65(1), 93–109.

Webster-Stratton, C., & Herman, K. (2008). The impact of parent behavior-management training on child depressive symptoms. Journal of Counseling Psychology, 55(4), 473–484.

Webster-Stratton, C., Hollinsworth, T., & Kolpacoff, M. (1989). The long-term effectiveness and clinical significance of three cost-effective training programs for families with conduct-problem children. Journal of Consulting and Clinical Psychology, 57(4), 550–553.

Webster-Stratton, C., Kolpacoff, M., & Hollinsworth, T. (1988). Self-administered videotape therapy for families with conduct-problem children: Comparison with two cost-effective treatments and a control group. Journal of Consulting and Clinical Psychology, 56(4), 558–566.

Webster-Stratton, C., Mihalic, S., Fagan, A., Arnold, D., Taylor, T. K., & Tingley, C. (2001). Blueprints for violence prevention, book eleven: The Incredible Years - parent, teacher, and child training series. Boulder, CO: Center for the Study and Prevention of Violence.

Webster-Stratton, C., Reid, M. J., & Hammond, M. (2001). Preventing conduct problems, promoting social competence: A parent and teacher training partnership in Head Start. Journal of Clinical Child Psychology, 30(3), 283–302.

Webster-Stratton, C., Reid, M. J., & Hammond, M. (2004). Treating children with early-onset conduct problems: Intervention outcomes for parent, child, and teacher training. Journal of Clinical Child and Adolescent Psychology, 33(1), 105–124.

Webster-Stratton, C., Reid, M. J., & Stoolmiller, M. (2008). Preventing conduct problems and improving school readiness: Evaluation of the Incredible Years teacher and child training programs in high-risk schools. Journal of Child Psychology and Psychiatry, 49(5), 471–488.

Webster-Stratton, C., Rinaldi, J., & Reid, J. M. (2009). Long term outcome of the Incredible Years parenting program: Predictors of adolescent adjustment.Unpublished manuscript, University of Washington at Seattle.