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Implementing an Evidence-Based Parenting Program With Adherence in the Real World of Community Practice

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This study examined group leaders' adherence to The Incredible Years Parenting Program's components and collaborative process during a yearlong dissemination in a large multicultural city and universal prevention context. Mixed methods were used to evaluate adherence and develop an understanding of the barriers and facilitators of therapist fidelity. Results suggest that the protocol and collaborative group processes were implemented with a high degree of adherence with the three exceptions of role plays, videotape modeling dosage, and "buddy calls." A number of interconnected barriers with implications for future implementation were identified. Key contributors to adherence included the training and structure of the program, emphasis on accountability and ongoing session monitoring, and important aspects of supervision and group leader qualities.

Keywords: *treatment fidelity; adherence; The Incredible Years; parent training; evidence-based; transportability; implementation*

Estimates place the prevalence of child mental health disorders at an alarmingly high rate of between 14% and 26% (Brandenburg, Friedman, & Silver, 1990; National Institute of Mental Health, 1990; Offord, 1992) and as high as 35% for children from very low-income families (Webster-Stratton & Reid, 2003). Preventing or interrupting the development of child emotional and behavioral problems is widely regarded as a national priority and public health concern (Health Canada, 2002; Sanders, 1995; U.S. Department of Health and Human Services, 1999, 2001). Research suggests that prevention and early intervention in the form of parent training and family-based services provide the greatest opportunity for impeding negative developmental outcomes by teaching more effective child management strategies that increase positive parent–child interactions and minimize coercive or neglectful ones (Smith & Stern, 1997; Taylor & Biglan, 1998). Though most evidence for parent training comes from studies of high-risk children and families, it has been argued that parenting groups should be offered universally as part of children's and parents' natural environments (Biglan & Taylor, 2000; Sanders, Cann, & Markie-Dadds, 2003).

Parent training has demonstrated impressive evidence of efficacy with over several hundred studies and recent meta-analyses reporting improved parenting practices and/or child behavior (Barlow & Parsons, 2004; Bunting, 2004; Serketich & Dumas, 1996). Among the multiple programs targeting prevention and early intervention with high-risk families, The Incredible Years (IY; Webster-Stratton & Herbert, 1994) has been recognized as an exemplary empirically validated model (Brestan & Eyberg, 1998; Kazdin & Weisz, 1998; U.S. Department of Health and Human Services, 1999). The 12-week IY parenting program (IYPP) is designed to help families with young children with early onset of serious conduct problems and focuses on strengthening parent–child relationships and helping parents to foster positive child

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behaviors and effectively manage both common and more serious behavior problems. Consistent with fundamental principles of social work practice, the IYPP uses a collaborative rather than a didactic approach to learning and aims to empower parents and increase their parenting confidence and self-efficacy. Group leaders encourage parents to set their own goals, problem solve, and offer each other support (Webster-Stratton & Reid, 2003). Based on social learning (G. R. Patterson, 1982) and modeling and self-efficacy theories (Bandura, 1977, 1982), the IYPP emphasizes experiential learning methods for producing changes in parenting (Webster-Stratton, 1998). Videotape modeling and role play are key intervention methods and, together with home activities, provide for performance rehearsal, discussion, and feedback. The IYPP is an excellent example of an evidence-based parent-training model, which lends itself to implementation by social workers in diverse community settings.

There are challenges, however, to implementing evidence-based interventions in community practice and achieving the same outcomes as in the traditionally university-based efficacy studies (Kazdin & Weisz, 1998; Schoenwald & Hoagwood, 2001; Weisz et al., 1995). Effectiveness can be compromised when interventions previously found to be efficacious are not implemented with fidelity, that is, in the manner they were developed and validated (Elliott & Mihalic, 2004; Huey et al., 2000; Webster-Stratton, 2004). As the field moves toward the use of structured evidence-based programs, the need to maintain fidelity outside of research settings is critical. Fidelity encompasses multiple dimensions including adherence, differentiation, and competence (Moncher & Prinz, 1991; Perepletchikova & Kazdin, 2005). This study focuses on adherence, the degree to which the intervention is delivered as intended with all the prescribed components and processes.

The question of adherence is offset with that of local adaptation: research-based treatments may require adapting for diverse community settings and clients. The challenges of maintaining treatment fidelity and recognizing issues of external validity when extending an empirically validated treatment to a new population and context are clearly interrelated. The IY is a flexible process-oriented model; at the same time that the program content and group process procedures are detailed in a comprehensive manual, intervention principles emphasize "fitting" treatment to individual families and practice realities, thus overcoming many of the concerns associated with evidence-based treatments (Webster-Stratton, 2001). The standardized procedures, materials, and training workshops promote model fidelity (Webster-Stratton, 2004).

Over the past 20 years, the IYPP has been evaluated in randomized control group studies and in replications by independent researchers. The results support the model's effectiveness in enhancing parenting skills and confidence, reducing maternal depression, promoting positive parent-child interactions, and decreasing child conduct problems, while improving child social competence (Scott, 2005; Webster-Stratton et al., 2001). Gains have been sustained for up to 5 years for at least two thirds of the families (Webster-Stratton et al., 2001). Of note for the current research, a number of studies were prevention trials in low-income child care centers with ethnically diverse families (Brotman Miller et al., 2005; Gross et al., 2003; Gross, Fogg, & Tucker, 1995). The successes of the IYPP in treating child conduct problems and the increasing emphasis on bridging the gap between treatment efficacy and effectiveness has led to the adoption of the program in Headstart, Surestart, mental health agencies, and schools in several states (Bunting, 2004; Hutchings & Webster-Stratton, 2004; Webster-Stratton & Taylor, 1998) and to independent replications in community settings in the United States, New Zealand, Canada, England, and Norway (Lees & Ronan, 2005; Miller et al., 1999; J. Patterson et al., 2002; Scott, 2005; Taylor et al., 1998).

In light of the IYPP's evidence base and increasing international dissemination, it is important to understand implementation in the context of fidelity and local adaptation to new community and cultural contexts to advance knowledge of best practices to foster the effective transport of an evidence-based parenting program into real-world treatment settings. In this study, we systematically and *prospectively* examined protocol adherence from the perspectives of the group leaders and supervisor during a yearlong dissemination across multiple community child care sites (early learning centers) to address a gap in the literature. The research objectives were to (a) evaluate adherence to the IYPP and (b) develop an understanding of barriers and facilitators of group leader fidelity in implementing the IYPP in community child care settings.

METHOD

The research was carried out in a large multicultural city, in early learning centers, so called to acknowledge the importance of quality child care and curriculum for brain development and young children's learning and social capacity. The lead agency, a prominent children's mental health center, partnered with three other community

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agencies, all four of which operated multiple child care sites. The IYPP was rotated among each agency's available sites in order to reach as many parents as possible. We report here on a total of 10 parenting groups, each conducted at a different early learning center site, during winter (3), spring (2), and fall (5) over a 1-year period. The sample is a convenience sample of group leaders whom the lead agency hired specifically to facilitate the groups and who gave informed consent to be a part of the study.

Sites

The early learning centers serve a range of parents across ethnic groups and socioeconomic levels; thus, the participants in the IY groups had a diversity of backgrounds and needs. Many were immigrant women from a wide variety of cultures for whom English was not their first language. Three of the 10 IY groups were conducted in workplace centers where parents had higher educational levels and more resources. Five groups primarily served parents from lower-income neighborhoods. Two additional groups specifically served teen mothers who were enrolled in a supportive program that also provided housing and opportunities for educational upgrading. The groups ranged from 7 to 13 parents, with 84 attending more than half the sessions. Parent demographics are not available for the first two rounds as originally this was a study of treatment fidelity only. We later received funding and ethics approval for a pilot study of outcomes, and in the third round, parents enrolled in the IY groups were recruited to participate in the research on a completely voluntary basis. Parent data from the third (fall) cycle of groups show that over a third of participants noted English as their second language, all were mothers, 60% had annual incomes under $25,000, and 85% had competed high school.

Group Leaders

Two leaders coled weekly 2-hour IYPP groups at each site. Fourteen different leaders co-led the groups in varying combinations across the winter, spring, and fall time periods. Leaders were assigned to sites where their knowledge and background could be most useful to participants; they included 3 women of color and leaders fluent in each of Spanish, Farsi, and Cantonese. The group leaders were skilled and experienced helping professionals whose clinical experience ranged from 4 to 20 years (M = 10 years). They all had a solid background in child development and family dynamics and were familiar with group work skills and dynamics and some adult learning principles. Most worked full-time as family and child clinicians. The majority (11) had an MSW. The other 3 were trained in Early Childhood Education or Child and Youth Work, which are community college diplomas with focused child development and child care training.

Training and Supervision

All group leaders attended a 3-day training conducted by a certified trainer affiliated with the IY program in Seattle. Supervision was provided by the Manager of Early Intervention Services at the lead agency, a master's-level counseling psychologist with an extensive background in conducting and supervising parenting groups and over 20 years experience as a family and child therapist. She also attended the initial training and consulted as needed with IY staff in Seattle. Leaders were given paid time and the expectation to read *The Incredible Years* book (Webster-Stratton, 1992) and supporting literature so that they would clearly understand and could apply the program's theoretical and research foundations. Key principles raised in training were reinforced by the supervisor individually and/or at leader meetings. To encourage fidelity, she came early to observe each site's first group and reviewed methods for introducing the IYPP and its core concepts. She continued to observe, troubleshoot, and provide feedback at every site's first session for each new cycle of groups.

Treatment Fidelity Measures

Mixed methods were used to evaluate leaders' protocol adherence and capture thematic details in understanding factors that facilitate and hinder therapist fidelity. Adherence was assessed using multiple perspectives and data collection methods implemented by the lead agency as part of quality assurance in adopting the IYPP. Two of the measures (Leader Session Checklist, Leader Rating Scale), created by the program's developer, are routinely used in dissemination to encourage and assess fidelity. Thus, adherence checks were being implemented regardless of the research process but were formalized and independently analyzed for research purposes. Ethical protocol was therefore developed and followed so that informed consent was obtained, participation was voluntary, and confidentiality was assured. The ethics protocol received institutional approval from the University Health Sciences Ethics Review Board.

Quantitative measures. The Leader Session Checklist is a content adherence checklist that designates the key content and activities to be covered and asks whether or not each component of the session's protocol, such as brainstorming benefits and barriers to new techniques and role-playing specific skills, was implemented. The

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TABLE 1: Mean Scores and Ranges for Group Adherence to The Incredible Years Parenting Program (*N* = 10) ADD ZERO AFTER MEANS WITH ONE DECIMAL PLACE IN LOWER SECTION?

Total	Round 1		Round 2		Round 3		Yea
Measures	Mean	Range	Mean	Range	Mean	Range	Mean
Leader Session Checklist (%)[a]							
Overall	82	(77-87)	84	(76-92)	82	(66-94)	83
Vignettes	70	(57-79)	74	(64-83)	47	(22-91)	64
Role play	47	(33-67)	63	(42-83)	52	(17-83)	54
Buddy calls	49	(17-86)	65	(29-100)	41	(0-86)	52
Leader Rating Scale[b]							
Overall	4.68	(4.56-4.77)	4.29	(4.26-4.31)	4.39	(4.01-4.7)	4.45
Vignettes	4.40	(3-5)	4.29	(3.71-4.57)	4.35	(3.86-4.86)	4.34
Role play	4.33	(1-5)	2.96	(1.38-5)	3.83	(3.38-4.5)	3.71
Group process skills	4.70	(3.99-4.91)	4.70	(4.55-5)	4.72	(4.05-5)	4.71
Leadership skills	4.80	(4.58-5)	4.48	(4.27-4.67)	4.41	(3.94-4.92)	4.56
Relationship skills	4.77	(4.53-5)	4.43	(4-4.8)	4.45	(3.81-5)	4.55
Knowledge	4.78	(4.5-5)	4.63	(4-5)	4.72	(4.33-5)	4.71
Methods/promo skills	4.53	(4-5)	4.06	(3.67-4.6)	4.20	(3.22-5)	4.26
Parent's responses	4.89	(4.33-5)	4.92	(4.67-5)	4.68	(4.33-5)	4.83
Set up	4.81	(4.33-5)	4.55	(4.2-5)	4.17	(3-5)	4.51
Beginning topic	4.75	(4.5-5)	4.17	(3.33-5)	4.45	(3.3-5)	4.46
Home activities	4.83	(4.6-5)	4.17	(3.86-4.44)	4.43	(3.71-5)	4.48
Ending group	4.62	(4.2-5)	3.92	(3.17-4.67)	4.26	(3.5-4.67)	4.25

a. Leader Session Checklist: The percentage of adherence was computed by dividing the number of completed components by the total number of possible components in each session.

number of items ranges from 5 to 10 because although some program components (e.g., reviewing home assignments) occur weekly, each checklist is session specific. Leaders also indicate which of the core and optional videotape vignettes were shown. One checklist was completed together by both coleaders immediately following the group for each of the 12 sessions. The Leader Rating Scale is a 92-item instrument completed following observation of one 2-hour parent group session to evaluate the quality and integrity of program delivery focusing on the collaborative processes and intervention methods. The 12 subscales (see Table 1) include ratings of leaders' overall group process, leadership, and relationship skills and those related specifically to effective use of vignettes, practice and role plays, and home activities. For example, leaders are rated on scale items assessing whether and how well they validate and support parents' feelings, foster a collaborative model (Relationship Building Skills scale), use vignettes to trigger appropriate discussions, refer to parents' personal goals when discussing vignettes and learning principles (Showing the Vignettes scale), use role plays in a spontaneous fashion, and offer detailed descriptive praise of the role play and what was learned (Practice and Role Plays scale). The Manager of Early Intervention Services observed the fourth and eighth session (or one within a week if she had scheduling conflicts) at each of the sites in each parenting group cycle and completed this instrument using 5-point Likert-type scales. Leaders were observed twice during each group for a total of 20 supervisor fidelity observations.

Qualitative data collection. There were four distinct sources of qualitative data. Audiotapes of group leaders' joint supervisory meetings focused on discussion of IYPP implementation issues and program fidelity. The supervisor conducted these for all group leaders at least once for each cycle of groups for a total of five taped meetings. Additionally, she maintained and summarized ongoing supervisory notes for tracking the process of change in adopting the IYPP model as well as providing feedback to leaders. The two quantitative fidelity measures described above also yielded qualitative data. On the Leader Session Checklist, we asked for open-ended narrative comments describing departures from procedures and rationale, session "gems," and other observations. On the Leader Rating Scale, detailed fidelity notes on the intervention processes and methods were written immediately following the observations and numerical ratings.

Data Analysis

Leader Session Checklists were analyzed for the percentage of overall adherence to program components and the percentage of core vignettes shown in the session. The level of adherence was obtained by summing

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the number of components and required vignettes checked as implemented and dividing these numbers, respectively, by the total number of components and required core vignettes to yield percentage fidelity. Following the qualitative analysis of 1 cycle of groups illustrative of the synergistic process in mixed methods (see below), we began to also compute the percentage of protocol role plays implemented, adherence to buddy call procedures, and the percentage of sessions in which any role play occurred and any core *or* optional vignettes were shown and discussed. Percentages were calculated for each session at each site, and the mean percentage was calculated across the 12 sessions for each site, across the sites for each cycle or round of groups, and across the 3 rounds for the overall mean for the 10 IYPP groups conducted during the study year. In total, 117 Leader Session Checklists were completed; 1 parent group had been cancelled due to snow and 2 checklists were missing for unknown reasons. The Leader Rating Scale was analyzed for observational ratings of adherence to each of the 10 IYPP core methods and process components subscales and for overall adherence to the collaborative process (total score). These scores were computed for each observation and for the mean of the two observations at each site and again then analyzed across sites for each cycle of groups and across the 3 rounds for the overall means for the year.

Qualitative Data Analysis

Establishing trustworthiness and authenticity of the qualitative data occurred through maintaining detailed notes (audit trail), audiotaping of group leader meetings (confirmability of data), persistent observation with participants (group meetings, observations of sessions), prolonged engagement (3 cycles of groups), and negative case analysis as recommended by Padgett (1998). Authenticity of data and findings was further enhanced by member checking after themes were established and shared in a meeting of group leaders, who had opportunities to confirm, argue, or expand the themes identified by the researchers. Huberman and Miles (1994) suggest implementing means of ensuring that an authentic picture of the reality is presented. We believe that taking the findings back to the leaders was one way to check for authenticity.

Group leader meeting tapes were transcribed, and data were subjected to intensive content analysis for thematic development using open and axial coding as described by Strauss and Corbin (1998). The therapist and supervisor notes were coded in the same manner for thematic analysis. Multiple coders were used to maximize consistency and breadth of themes and to increase researcher neutrality and reduce bias (Huberman & Miles, 1994). Three researchers carried out independent analyses and then discussed the themes and subthemes until satisfactory agreement was reached. Quotes are offered as evidence of the themes for confirmability. We also engaged in an iterative process of moving between identification of qualitative themes and checking of quantitative scores on subcategories for closer examination. This form of data triangulation assisted in the refining of themes and determining enduring themes.

RESULTS

The results reported are based on both the quantitative and qualitative adherence measures for the 10 parenting groups. These data converge, suggesting that the IYPP protocol and collaborative group processes were implemented with high fidelity with the three exceptions described below. As suggested in the literature, we report both the degree to which all components were implemented according to the manual throughout intervention and adherence to carrying out each intervention component across sessions (Perepletchikova & Kazdin, 2005). See Table 1 for all means and ranges. Overall Year 1 treatment adherence to program components on the Leader Session Checklist was 83%, comparing favorably with assessment of the Blueprints Program fidelity; 74% of their sites reported 86% to 100% implementation of core components at the end of the 2nd year based primarily on self-report staff interviews and surveys (Elliott & Mihalic, 2004). Similarly, adherence to the IYPP processes and methods was rated high on the Leader Rating Scale during the two supervisory observation sessions, with an overall mean for Year 1 of 4.45. Of particular note, fidelity to the IYPP collaborative group process was consistently high across rounds, with a mean rating across sites for Year 1 of 4.71 for leader group process skills, 4.56 for leadership skills, and 4.55 for relationship skills. These findings contrast with reports in the literature, suggesting leaders' early IY groups focused on the content of the curriculum rather than adhering to the essential group process protocol (Webster-Stratton & Taylor, 1998). Observational ratings indicate that leaders demonstrated their knowledge of the IYPP components including the underlying cognitive-behavioral and child development principles and providing clear, convincing rationales with a mean of 4.71 across sites. They showed high adherence to reviewing and integrating parents' between-session home activities into the group process (M = 4.48) even though the qualitative data suggest barriers related to English as a second language (ESL) in maintaining adherence to home activities review.

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A variety of methods were used to promote learning and skill acquisition ($M = 4.26$), although scores in this subcategory partially reflected the variability of adherence to selected methods such as role play. Other ratings were similarly high (see Table 1). As we later discuss, these findings should be interpreted with caution given that leaders may be particularly attentive to adherence to the IYPP when under observation.

The same three IYPP components with lower fidelity in the quantitative data emerged clearly in the qualitative analysis. These departures were examined consistent with Padgett's (1998) strategies for ensuring trustworthiness using negative case analysis. The first two, using role plays and showing all designated vignettes in each session, are core IYPP components with varying levels of implementation fidelity that could potentially affect program effectiveness. The case of videotape modeling raises dosage questions with the mean percentage of core vignettes shown across sites in Year 1 at 64% on the Leader Session Checklist and a mean rating of 4.34 for observations on the Leader Rating Scale. However, at least some vignettes were shown in most sessions; optional vignettes sometimes replaced core ones when leaders thought they better fit parent situations. Videotape modeling, with either core or optional vignettes, occurred in at least 8 and often all 11 sessions that called for vignettes ($M = 10.1$). Program adherence to role plays was lower across sites on both the Leader Session Checklist ($M = 54\%$) and on the Leader Rating Scale ($M = 3.71$). The mean number of sessions in which at least one role play occurred, out of the 10 sessions the protocol specifies role playing, is 5.9 across sites, ranging from as few as 2 to 9. Reasons for lower adherence to role plays are presented in detail through thematic analysis in the next section. The third component with low adherence is buddy calls, a part of the IYPP protocol intended to decrease parent isolation and increase support among group members, developed in response to research on attrition in parent training. Across sites, the mean for adherence to buddy call procedures was 52% on the Leader Session Checklist. This could be interpreted as a minor program departure in a universal prevention setting, unlikely to impact program effectiveness as parents often have pre-existing supports or "buddies" in their natural ecology and can approach one another more informally in child care once they've met in group.

Analysis of the multiple sources of qualitative data suggest overall program adherence with the three noted exceptions and several themes regarding barriers to protocol adherence in general as well as specifically to videotape modeling, role plays, and buddy calls. Thematic development proceeded until saturation, suggesting enduring themes; categorical saturation is achieved when no more new themes emerge and repetition of themes consistently occurs (Creswell, 1998).

Barriers to Adherence

As analyses of the data proceeded, nine themes emerged that constituted barriers to protocol adherence. Though presented as distinct categories, these themes overlap and are interconnected.

Balancing parent preferences with structured program components. In trying to adhere to the IYPP *collaborative versus an expert approach,* leaders were challenged to balance parents' personal preferences for learning with other core components of the protocol. This theme was a recurring one throughout the sessions usually because of parents' preference for *discussion:* "it is very hard to cover the agenda because of the large group and there is a lot of discussion," "less vignettes were shown to make time for more discussion." Leaders' desire to *keep parental involvement high* and maintain a working partnership particularly manifested as a barrier when they were running out of time for vignettes or role plays. Parents' involvement decreased with new activities that lacked familiarity such as role plays.

Time constraints. Time constraints clearly emerged as a barrier to adherence, especially with large groups where it was difficult to balance the *amount of session content* with the active involvement of all parents. *ESL issues* lengthened the time needed for group participation and reviewing *homework*. Leaders also reported insufficient time for new homework at session end. Some parents attended the groups inconsistently or were tardy due to pressures in their own lives—"either work issues or trouble settling children in the child care"—thus further hindering effective use of time.

Language (ESL). Language issues were related to the *time* needed to translate or express oneself in a second language, and to *difficulties in understanding* both written and verbal materials as, for example, "some parents had difficulties understanding the videos because of language" and "parents who had difficulty with English could not do the written assignments." Language interconnected with time constraints and balance, balancing the additional needs of the ESL parents with collective needs. "Sometimes we have to be patient, as people are struggling with language and having trouble explaining themselves."

Relevance. In many sites, parents were unanimous and unambiguous about not needing extra support and not wanting to use *buddy calls*. Moreover, parents saw

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each other while picking up their children and, at one site, lived in the same building. In any case, leaders noted that parents often were too tired for calls by the end of the day. Relevance figured predominantly in discussions of videotape modeling. *Vignettes* were perceived as unrealistic since they included few examples of single parents, a number showed only fathers, and often the focus was just on one child. Some parents thought they did not adequately cover common concerns like sibling conflict and bullying. Both parents and leaders said the vignettes of younger children were not sufficiently responsive to developmental needs despite the program's 3- to 8-years old target age range. Leaders reported that parents found the videos outdated, often redundant, and at times incongruent, for example, "the vignettes do not match the teaching points of the topics. It [time out] should be used as a last resort yet vignettes show minor things to be timed out (e.g., not hanging up coat)."

Role play reluctance. Both parents and group leaders displayed a degree of reluctance with role playing. The data suggest a number of reasons including anxiety, self-consciousness, parents feeling engaging in role plays was childish, and parents not experiencing them as or *thinking* they would be useful. The most consistent subthemes that emerged, however, were *balancing parents' preference for discussion as an alternative*, *lack of time,* and *leaders' own discomfort*. Notably, leaders regarded role plays as time consuming, contributing to the difficulty of balancing program components: "Because of discussion time didn't have time for role plays"; "We have more trouble fitting in the role plays because they are time consuming." When a leader expresses that "evaluations show that parents enjoyed group discussions and did not find role play as helpful," it is important to consider the factors that may have contributed to this sentiment. Leaders' own personal comfort level in engaging the group in role plays influenced whether they were incorporated into the sessions. Those who hesitated about doing role plays or were uncomfortable being directive may have let time decide for them when really the underlying issue was their own discomfort: "like anxiety about role play, I think everybody in our group had that and group leaders too sometimes"; "We weren't so great at role plays and neither were the parents. . . . They preferred to have discussion."

Confusion/concerns with time out. Several barriers to adherence in teaching time out were identified. In a *universal group,* many children did not have disruptive behavior; rather, they were shy, anxious, or attention seeking, so parents did not see the need for time out. Leaders often thought that time out was "over taught"; adhering to the manual with the many diagrams of coercive cycles was overwhelming and unnecessary for a lot of parents. Parents also experienced *confusion between home use of time out and child care policy* disallowing its use. Differentiating between the two was critical since to be timed out in child care could lead to feelings of shame and humiliation whereas time out done well at home would not create that situation. Leaders reported a host of other parent concerns, for example, "[parents] don't like time out because they think that *it doesn't work*." Other parents thought time out was *unsuitable,* citing "concerns about abandonment, letting kids scream" or about *safety,* including the book/vignettes allowance of doing time out in a bathroom, laundry room, or behind locked doors. There were parents who felt time out did not fit their child's temperament or their own parenting style. Lastly, some parents were uncomfortable with time out in terms of their *values and cultures;* notably, use of time out (and other discipline strategies) was one of the few areas where culture emerged as a subtheme.

Structure of the materials and manual. The structure of the IY materials emerged as both a barrier and a facilitator (see below). There were areas of the manual that were puzzling and hard to follow including "the lack of flow" where one had to flip through several pages to find handouts and exercises, the combination of two topics in one session so in some groups the curriculum spilled over into the next session, and similarly, the inclusion of two home assignments in one session, which parents found difficult to complete. As noted, there were some mismatches between manual instructions and the videotape modeling (e.g., time out).

Disconnect between high-risk/clinical and universal preventive IYPP groups. Parent *reactions to specific IYPP strategies* and confusing *role boundaries* for leaders were barriers to the IY protocol developed for a selected/indicated population. Leaders noted that the buddy calls' lack of relevance for many of the child care parents was not the typical reaction when they conducted IY groups in the children's mental health centers, where parents presumably might have less adequate social supports. Likewise, in these groups, all the parents did not report problematic child behaviors that warranted *time out* in contrast to parents in other contexts. Group leaders experienced tension in certain situations about *boundaries* between a teaching versus a clinical role. For example, regarding *follow-up calls*, some leaders felt that it was intrusive to call after a participant missed a session or dropped out. Group leaders used their judgment as to when to make modifications as well as when to offer a service referral or take on a more therapeutic role but on the whole reflected the sentiment,

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"I think because the program was developed for high risk situations and they did put in all of these things to help and maybe it isn't appropriate for a parenting group" (i.e., in universal settings).

Lack of control. Often, barriers to adherence were those likely to occur in busy child care centers with shared space, for example, trouble settling children into child care, the distracting presence of non-IY participants in the center, and malfunctioning video equipment. This type of barrier was identified in two thirds of the Leader Session Checklist "Gems and Departures." Noting these on weekly checklists may have served to communicate them to the supervisor in her role as troubleshooter and liaison between the group leaders and community service partners.

Facilitators of Adherence

The data revealed five significant facilitators to program adherence, primarily related to the IYPP structure, aspects of supervision, and leader characteristics.

Highlighting and reinforcing fidelity. A predominant theme, especially in the tapes of group leaders' meetings, was the supervisor's role in continually and supportively underscoring the importance of maintaining the program's core elements. She promoted fidelity by consistently engaging in the following five steps: (a) validating concerns when discussing barriers or departures, (b) providing the rationale and underlying principle and/or research base for the IY component, (c) maintaining a collaborative stance rather than a hierarchical one with leaders, (d) engaging in mutual problem solving, (e) and focusing on the goal, that is, how to address the barriers and be responsive to a parent's or group's needs while retaining fidelity. The supervisor often referred to the research. For example, while affirming concerns about the outdated or staged look of vignettes, she reminded leaders that this did not necessarily speak to their usefulness: "Reiterating the importance of vignettes in general—(research) shows they are helpful even if parents don't like them." The data show that leaders began to mirror the supervisor's model and highlighted the role of adherence with one another. In the observation narrative comments, a parallel theme emerges, *making connections and individualizing,* whereby leaders follow a similar process with parents. They facilitate adherence to the program by validating parents' own issues in an individualized and sensitive way, provide rationales, and reinforce core IY principles and practices by tying them to parents' goals for their child and unique family situation.

Supervisor responsiveness and support. Leaders valued the supervisor's responsiveness and the provision of concrete resources which facilitated implementing the manual. One leader's comment, "Definitely [supervisor name] makes it easier for us," sums up this strong and pervasive theme in the data. Her attentiveness before each site's first group session by bringing out the videotapes, *The Incredible Years* parent handbooks, and photocopies of a complete set of materials for the round (e.g., home activity sheets, weekly evaluations, leader forms) reduced the pressure on leaders when "rushing to get ready for group." At meetings, she sought feedback on the support needed: "What are your thoughts and ideas about what would be helpful right now? Is there anything more useful that I could be doing?" Moreover, she responded immediately to issues, from small ones when a leader noted "that handouts were much better on color paper" to the larger one of insufficient hours allotted for preparation time.

IY training, structure, and materials. The training and written materials provided group leaders with the research foundation to understand the IYPP content and format and the importance of adhering to protocol. Leaders appreciated the structure and guidance of a manualized program and the videos: "I find the structure made it easier, made me want to run this group, I didn't have to do all the thinking, it was there." Despite some issues with the training manual, most agreed: "it is clear and well written, full of good points."

Monitoring fidelity and problem-solving barriers. A strong theme emerged in the data around both supervisor's and leaders' accountability to monitoring adherence, understanding the reasons for departures, and ensuring the program's responsiveness to parent needs while problem solving collaboratively to overcome barriers to maintaining fidelity. The supervisor consistently prompted leaders: "Weekly evaluations [parent] and follow up calls give us a way to make sure we are being responsive to parents, and our own leader checklists will give us feedback about what we are and aren't doing." "Please note which [vignettes] you used on leader checklist and why if skipped or added vignettes." "Let's make notes of barriers to doing home activities which are core to the group." Leaders followed through on monitoring departures and almost always documented the reasons, such as, "role play felt forced today—feel that is better to skip a role play than to force it and have it feel unhelpful." Demonstrating their commitment to adherence, at one site, leaders wrote that they did not show all the designated vignettes but "chose according to the 'needs' of the group" [only after] "discussed and approved by [supervisor]." The group leaders' meetings' tenor of problem solving when addressing barriers clearly came through in the data.

Leaders' openness to self-monitor, report departures, and be observed likely reflects the manner in which the importance of fidelity and the procedures were initially

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presented and the supervisor's ongoing collaborative stance with them: "When I observe groups, it will be in the same spirit, to learn and understand the needs of each group and how and why the group leaders have made any modifications to meet the needs of their particular parents"; "Our motto always was, that any departure was OK, they could trust their judgment or suggest something, as long as they had a rationale or a clinical reason for it."

Group leader fit and belief in the importance of the IYPP. Leaders' belief in the IYPP core components and collaborative process was an underlying theme articulated during member checking:

> You might find that people self select, cause I agree with you, when I came to it, I really liked the material, and agreed with most of it—with the foundation, so I choose to continue doing it, where others might not like it, find it too rigid, so you find people that will adhere to it because they like it.

"I think you do things that you believe in, and most of us are philosophically similar."

DISCUSSION AND APPLICATIONS TO SOCIAL WORK PRACTICE

There is relatively little research on implementing evidence-based programs with fidelity in community settings. This study's findings support and add to our understanding of adherence challenges and facilitators reported in the literature (Elliott & Mihalic, 2004; Webster-Stratton, 2004). Criterion for acceptable fidelity and overall integrity has not yet been established. Based on our current knowledge from treatment outcome studies, however, Perepletchikova and Kazdin (2005) suggest that 80% to 100% represents high fidelity, supporting the high overall adherence of the IYPP implementation despite some variability across selected components. The ratings may also be considered an indicator of leader competence since the Leader Rating Scale measures the quality of implementation as well as protocol adherence. Key contributors to adherence included the training and structure of the IYPP and important aspects of supervision and group leadership.

Effective supervision is critical in ensuring that evidence-based interventions are implemented with fidelity when disseminated (Webster-Stratton, 2004). The program supervisor had a strong understanding of the IYPP and encouraged high-quality implementation and accountability through her commitment to supporting group leaders and her responsiveness and follow-through along with the provision of concrete resources. The results of this study are consistent with literature that suggests that adherence is increased when supervision and monitoring procedures are strong (Schoenwald et al., 2000; Webster-Stratton, 2004). Leaders were actively on board as collaborators with the supervisor in tracking adherence: They self-monitored and consistently documented departures and reasons with an amazing completion rate of the weekly session checklists. Not only did checklists promote accountability and alert the supervisor to ongoing fidelity issues, but they may also have been a cue for adherence, a positive side effect of measurement reactivity. It is worth underscoring that the attention to adherence and procedures was implemented as part of the agency's supervisory process, suggesting feasibility for adherence monitoring in social work community settings.

Feeling part of a working group seemed significant for leaders' sense of ownership and responsibility for high-quality implementation. Their joint meetings allowed discourse on the balance between adherence and adaptation and for problem solving of concerns or barriers. Meetings were highly collaborative and productive, providing many opportunities to reinforce fidelity. The leaders' commitment to and belief in the value of the IYPP's core components is consistent with the research on "buy-in" needed to boost adherence in dissemination. Protocols may be implemented with greater fidelity when the intervention is regarded as highly effective and appropriate for the identified population or problems (Perepletchikova & Kazdin, 2005).

A few of the findings on barriers to adherence are particularly noteworthy. ESL was a much greater barrier to adherence than cultural factors; this reinforces some studies' findings that cultural adaptations are not necessarily required in transporting empirically based interventions tested in efficacy trials to community settings (Elliott & Mihalic, 2004). Studies of one prevention program even suggested that culturally adapted program versions improved engagement and retention of ethnically diverse families but not necessarily outcomes, perhaps because of compromised fidelity (Kumpfer et al., 2002). While leaders reported rich cultural discussions within groups, culture was not perceived as a major barrier to program fidelity, a significant finding as this study was conducted in one of the most multicultural cities in the world across highly diverse community child cares.

The relevance of culture will be further assessed in a 2nd year of data collection and explored in more depth in an end-of-study focus group with all leaders. In the meantime, as the IYPP is implemented with diverse populations, our current findings underscore how ESL issues affect delivery. Working with translators may increase parents' program exposure and adherence, especially around the collaborative process and newcomer families. This barrier could be addressed by partnering with community agency staff fluent in parents' first languages and perhaps increase community access and sustainability of the IYPP.

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The lower adherence to videotape modeling and role play, coupled with parents' preference for discussion, was striking. IY research has shown that group discussion with videotape modeling and leader input is more effective than discussion without video vignettes (Webster-Stratton, 1990; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). Future studies are needed to examine the dosage question and evaluate parenting and child outcomes. Role play is an effective learning tool commonly used in parent training groups, and three or four brief role plays each session is recommended (Webster-Stratton & Hancock, 1998), a goal not attained here. Webster-Stratton (2004) also finds that role play adherence is a common challenge and a vital one to address. Collaborative problem solving to overcome barriers to role plays must give equal attention to decreasing group leaders' discomfort as is given to overcoming parents' reluctance. We hope to develop a richer understanding of this barrier in the ongoing data and focus group.

This study has a number of limitations, being an investigation of the natural unfolding of implementation over time of an evidence-based parenting program in community settings. As the fidelity data are either self-report or supervisor observation, the research could be strengthened by independent observation or videotaping and coding of sessions, but this was not possible with available resources. Although there were multiple sources and reporters of group leaders' data, measurement reactivity and a systematic bias cannot be ruled out. It is possible that leaders enhanced performance under observation by their supervisor in order to "look good." We tried to mitigate this potential bias by acknowledging leaders' years of clinical experience in our initial presentation of the research and in ongoing contacts with them and by establishing a climate whereby they were seen as collaborators in improving program implementation. Leaders were encouraged to report rather than minimize departures so as to increase our understanding of the adaptations made and the transportability of the IYPP to this highly multicultural and universal prevention context. Although underreporting cannot be ruled out, leaders did check off departures on the Leader Session Checklists and reported them in the qualitative data. The role play observational data also show that the supervisor's presence did not *necessarily* lead to higher ratings; in fact, at two sites, there was no role play at all during an observation. Further, all program adherence measures and analyses were implemented to maintain focus on the fidelity with which the IYPP was delivered to parents rather than on the evaluation of a specific leader. For example, co-leaders filled out Leader Session Checklists jointly, and one Leader Rating Scale was completed on both leaders jointly during observations. The supervisor's dual role was a further limitation. While she was particularly suitable to observe and conduct ratings because of her sophisticated knowledge of the IY protocol, administering the program and acting as a research team member may have presented a conflict of interest. Her investment in seeing the program implemented with high fidelity might have clouded her neutrality. On the other hand, her strong rapport with the group leaders, and their trust in her judgment and years of experience, may also have prompted genuine disclosures of departures and problems. This in turn may have led to the truly open discussions about barriers and facilitators of adherence.

The lack of published information on validation of the quantitative adherence measures is a consideration in assessing the results and speaks to the underdeveloped field of measuring adherence of evidence-based interventions and linking fidelity to outcomes (Moncher & Prinz, 1991; Perepletchikova & Kazdin, 2005). The Leader Session Checklist and Leader Rating Scale were designed by the IYPP originator based on components demonstrated to be essential for program effectiveness: Some such as videotape modeling and the collaborative process were specifically supported by research, while others reflected experience and "best practices." However, the triangulation of findings with clear and consistent patterns across different methods and data sources, and their stability over time of the 3 cycles of the IYPP, increases confidence in the results. The complementarity of the methods allows us to go beyond assessment of the level of intervention fidelity to understanding the adherence departures and more fully elaborate on the barriers and facilitators involved (Sandelowski, 2000). Second-year data collection will determine if any patterns in adherence emerge over a longer period. No clear patterns were observed over the three rounds of groups in the 1st year.

We believe this research contributes to a richer understanding of the transportability of the IYPP by combining quantitative adherence monitoring with the unique ongoing perspectives of the group leaders and supervisor. In order to implement evidence-based interventions in a manner consistent with the way they achieved desirable outcomes in treatment efficacy studies, practitioners in community agencies need critical supports to ensure adherence to a program's protocol. The study identifies barriers to implementing one evidence-based parenting program in universal prevention settings as well as key facilitators of intervention fidelity. Although a few barriers that arose are specific to universal prevention, the overall findings should be useful to a range of organizations and social workers interested in adopting research-based programs.

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