Quality Training, Supervision, Ongoing Monitoring, and Agency Support: Key Ingredients to Implementing The Incredible Years Programs with Fidelity

Carolyn Webster-Stratton, Ph.D.
University of Washington

Abstract

Identification and selection of an "evidence-based," "empirically validated," or "best practices" mental health program is only the first step in service delivery. In order to obtain similar results to those published by the developer of a program, attention must be given to supervising the quality of the implementation of that program. It is important to assure that the program is delivered with the highest degree of fidelity possible. Fidelity means that the program is delivered in its entirety, using all the components and therapeutic processes recommended by the developer. The Incredible Years Parent, Teacher, and Child Training Programs have been proven in numerous randomized control group studies to be effective for promoting positive parent and teacher interactions with children, strengthening children's emotional, social, and self-regulation competence and reducing behavior problems in both prevention and clinic populations. A number of training processes are recommended to ensure that replication of the Incredible Years programs can be achieved with fidelity: standardized training, detailed treatment manuals, standardized session protocols, peer review, mentoring and supervision, and leader certification. This chapter will provide a description of these training methods and supervision processes to deliver the Incredible Years training programs with a high degree of fidelity.

Introduction

Over the past thirty years, hundreds of carefully controlled studies for children and youth have demonstrated that there are a number of evidence-based interventions that can reduce behavior problems and delinquency, improve children's mental health, and strengthen family functioning (Weisz & Weiss, 1993). Among research-tested psychotherapies, interventions based on cognitive-social learning methods have perhaps the greatest evidence of their effectiveness (Serketich & Dumas, 1996; Taylor & Biglan, 1998) particularly for treating disruptive behavior problems in children, including aggressive behavior, Oppositional Defiant Disorder and Conduct Disorder (Chambless & Hollon, 1998; Dumas, 1989; Kazdin, 2002); and Attention Deficit Hyperactivity Disorder (Barkley, 1996). Together these problems represent the majority of referrals for children's mental health services (Snyder, 2001).

Despite this compelling evidence, few of these empirically supported interventions have been widely adopted by clinicians or teachers in community settings (Kazdin, Bass, Ayers, & Rodgers, 1991; Weisz, Donenberg, Han, & Weiss, 1995). Moreover, those clinicians or "early adopters" who have taken the risk to implement these evidence-based interventions have often been faced with interpersonal, clinical, or organizational/agency challenges that have affected their ability to deliver the intervention with fidelity. Examples of interpersonal and clinical challenges include a group leader's lack of training or

therapeutic skills needed for delivering the program, difficulty understanding the theory behind core treatment components or an in ability to adapt treatment protocols for particular client situations. Examples of organizational challenges include heavy caseloads that leave clinicians little time to learn a new intervention protocol, conflicting organizational priorities (e.g., school focus on academics vs. social and emotional literacy), financial limitations on the number of sessions that can be offered, and lack of administrative support for ongoing supervision and training. These challenges can result in interventions that are delivered inadequately, due to clinician inexperience or changes in the recommended protocol (e.g., fewer sessions than recommended, or key program components omitted). The resulting dilution of the intervention leads to little improvement in child or family outcomes.

It is essential that there be a sound theoretical and research base validating the treatment regime and therapeutic change process for families. It is equally important that the key program implementation strategies or processes be described clearly and followed. In this chapter, we describe our effort to disseminate the Incredible Years Training Series, as a multifaceted program for preventing and treating early onset conduct problems in young children (ages 3-8 years), to agencies and schools.

We have identified five key elements to effective program implementation: (1) standardized treatment delivery (using comprehensive clinician manuals, well articulated protocols, videotapes and materials for parents and children); (2) standardized quality training for group leaders delivering the intervention; (3) effective supervision of group leaders; (4) on-going fidelity monitoring and certification; and (5) agency or administrative support. This chapter provides detailed information about each of these important steps to program

implementation. Before describing these key dissemination elements, we will briefly to describe the components of the intervention program. Detailed descriptions of the theory behind the program development and the therapy process can be found in other reviews (Webster-Stratton, 1998a; Webster-Stratton & Hancock, 1998; Webster-Stratton & Reid, 2004).

The Incredible Years Training Series: Content, Methods, Processes and Research

Research Theory Underlying Standardization of the Content of the Intervention Program

Our core parenting program, entitled BASIC includes the following components: child-directed play and reinforcement skills and a specific set of nonviolent discipline techniques including Time-Out, ignoring, logical and natural consequences, and problem-solving strategies. Positive parenting and relationship building skills are taught before consequences and limit setting because a strong and positive parent-child relationship is considered to be the foundation for effective discipline strategies. There is a preschool-age version of the BASIC program as well as a school-age version of the BASIC program available for use with parents of children up to age 9 or 10 (grade 4). The BASIC program has protocols for a minimum of 12 sessions (and specifies a minimum number of vignettes to be shown). However, the program may need to be extended for 2-4 sessions depending on the group size, how readily participants grasp the material, and what level of child difficulty is represented. For example, parents who have neglected their children may need extra sessions on child-directed play to foster more nurturing relationships before proceeding to the discipline component of the program. Groups using translators will require at least 3 additional sessions because of the time it takes to translate. Groups of parents with extremely

difficult children may need 3-4 extra sessions to develop incentive systems and individual behavior plans for each participant in the group. Consequently, while there are protocols indicating minimum vignettes and home activities to be completed, the group leader should pace the group according to the participants' learning ability and needs. In addition to the core, BASIC program, we have developed a 9-12 session ADVANCED program focused on helping parents cope with their interpersonal problems. This ADVANCED program includes training in communication skills, anger and stress management, problem solving, and ways to give and get support. A supplementary program, *Supporting Your Child's Education,* is also available and provides information on strengthening children's general academic skills and promoting strong home–school connections.

We recommended the BASIC parenting program as a core prevention program (12-14 sessions) for families whose children have not been diagnosed with conduct problems. For children with conduct problems, we recommend the combination of the BASIC plus the ADVANCED parenting programs (22-24 sessions). For children over the age of 5, who also have school difficulties, we recommend the addition of *Supporting Your Child's Education.* Thus, beyond the core BASIC program, additional components can be added to fit the needs of the population being served.

In addition to the parent programs, we have developed a 22-week child training program (Dinosaur Curriculum) focused on ameliorating child risk factors (deficits in cognitive problem-solving, emotion regulation, empathy skills, and play skills). The Dinosaur Curriculum includes components such as teaching emotional literacy, social skills, effective problem solving, and anger management. The program can be offered alone or in combination with the parent program. It is recommended that children with pervasive behavior problems (i.e., problems at home, at school and with peers) receive this intervention in addition to their parents receiving the parent program.

Lastly, we developed a comprehensive teacher training intervention. This program promotes the teachers' use of validated classroom management and discipline strategies to decrease classroom aggression and promote social competence as well as behavior plans developed in collaboration with parents who were receiving the parent training (Webster-Stratton & Reid, in press). Our research shows that adding either Dinosaur Curriculum or the Teacher Training program to parent training enhances treatment effects for children with pervasive behavior problems.

Intervention Behavior Change Methods and Processes

It is important that the methods and therapeutic processes used to bring about change in family dynamics are based on established behavior change methods. All three of the IY interventions are designed to be offered in a group format with group discussions facilitated by trained group leaders. The group format fosters a sense of community or peer support, reduces isolation and normalizes parents', teachers' or children's experiences and situations. Moreover, the group approach allows for diverse experiences with problem solving regarding a variety of situations as well as a cost-effective way of reaching more families.

All three interventions have relied heavily on performance training techniques such as videotape modeling, behavioral rehearsal, and live modeling as key therapeutic methods. Because the extent of conduct problems has created a need for service that far exceeds available personnel and resources, the intervention was designed to be cost-effective, widely applicable, and

sustaining. Videotape modeling promised to be both effective and cost-efficient. Bandura's (Bandura, 1989) modeling theory of learning suggested that parents or teachers could improve their behavioral interactions by watching videotaped examples of adult-child interactions that promote prosocial behaviors and decrease inappropriate behaviors. Likewise, children could learn more appropriate peer interactions by watching videotape examples of children behaving in prosocial ways. Moreover, it was felt that this method of training would be more accessible, especially to less verbally oriented parents or children, than other methods (e.g., didactic instruction, written handouts). This method also promotes better generalization (and therefore long-term maintenance) by portraying a wide variety of models representing different cultural groups and different styles of interacting in a wide variety of situations. Furthermore, videotape modeling has a low individual training cost when used in groups and has the potential for mass dissemination. For a more detailed description of the programs, see (Webster-Stratton, in press).

Research Evaluation

Each of the programs has been evaluated in randomized control group studies by the developer and replicated by independent investigators. There have been 6 randomized studies of the treatment version of the parent program (Webster-Stratton & Reid, 2003) and 3 replications by others (Scott, Spender, Doolan, Jacobs, & Aspland, 2001; Taylor, Schmidt, Pepler, & Hodgins, 1998; Spaccarelli, Cotler, & Penman, 1992). There also have been 5 studies using the parent program as a prevention program with high risk populations, two of these by the developer (Webster-Stratton, 1998b; Webster-Stratton, Reid, & Hammond, 2001) and 3 independent evaluations (Barrera et al., 2002; Gross et al., 2003; Miller Brotman et

al., 2003). In regard to the child Dinosaur Treatment model, there have been 2 randomized studies by the developer (Webster-Stratton & Hammond, 1997) and 2 independent trials (Barrera et al., 2002; Mørch, Larsson, Clifford, Drugli, & Fossum, 2004). Currently, 2 studies are underway to evaluate the effectiveness of this program as a classroom-based prevention program in schools. Finally, there are 3 trials by the developer with the teacher training program, two of which were with teachers of children with diagnosed children (Webster-Stratton et al., 2004) and one in Head Start as a prevention program (Webster-Stratton & Reid, in press). All these studies have shown consistent results in terms of short- and long-term improvements in parent or teacher interactions with children, reductions in conduct problems, and promotion of social competence. Details on the studies can be found in the following review or in the published studies (Webster-Stratton & Reid, 2003). This evidence has led to the programs being recommended as a "blueprints" or evidence-based treatment and prevention program by several review groups (Webster-Stratton, Mihalic et al., 2001).

Five Key Dissemination Strategies to Enhance Clinicians' Success at Implementation With Fidelity

Dissemination Strategy One: Standardization of Treatment Delivery Through Comprehensive Treatment Manuals, Protocols, Videotapes and Books for Parents, Teachers, and Children

A number of strategies are used to deliver the Incredible Years interventions with high levels of clinical fidelity. First, the programs are packaged in an uncomplicated

format enabling the clinician to readily learn the content and skills required. The reliance upon a series of comprehensive treatment manuals and standardized videotapes to illustrate behavioral principles and skills allows the clinician to focus on the process of facilitating groups, without having to memorize and present all of the content. The videotapes are supplemented with materials for participants, including books for parents, teachers, and children as well as standard weekly home activities, refrigerator magnets, and refrigerator notes summarizing the key principles taught. Clinicians/group leaders receive session-by-session protocols and checklists, a book that outlines the theory behind the core components, and a description of the collaborative process of leading groups (Webster-Stratton & Herbert, 1994). In addition, a detailed Group Leaders' Manual includes questions leaders can ask following each videotape vignette, the developer's interpretation of each vignette, and points for consideration. Also included in the manual are practical guidance on topics ranging from setting up the location and room for the first session, to suggestions for engaging low income families, ideas for role plays and group brainstorms, tips for making the program developmentally appropriate, ways to adjust the focus depending on whether the population is a prevention or treatment group, and ways to promote support both within and outside the group (Webster-Stratton & Hancock, 1998). These group leader manuals, session protocols, videotapes and handouts provide the blueprint which helps to assure the program is delivered with fidelity.

Dissemination Strategy Two: Quality and Standardized Training Workshops

However, providing comprehensive program materials in the form of videotapes, clinician/group leader treatment manuals, and standard handouts is necessary but not sufficient to assure intervention fidelity.

Granted these training materials will provide clinicians with the blueprint that guides the design of the intervention, but the actual construction will never be realized unless there is considerable support and qualified contractors and subcontractors. Similarily, the "therapeutic art" of program delivery is as important to the program's success as the content of the sessions. While intervention content and behavioral principles can be manualized, it is not possible to standardize warm, sensitive, caring therapeutic process. Skilled clinicians must be flexible enough to tailor the manualized interventions to the individual family's goals, culture, child temperament, child developmental level, and family circumstances.

To provide quality training in the content and process of the program, the initial core training is offered in a 3-day workshop to groups of no more than 25 clinicians. The training helps clinicians to understand the core therapeutic processes and principles that are foundational to the successful implementation of the treatment. This standardized training is offered by certified trainers and mentors who have had extensive experience delivering the program themselves and have been selected by the program developer to offer training to others. The trainers or mentors who offer these trainings continue to lead their own groups and obtain ongoing supervision and also continue to be involved clinically in leading their own groups as well as in obtaining supervision and regular updates from the program developer.

A core principle of delivering this program is the importance of using a collaborative process when facilitating groups. A collaborative approach is essential to the treatment process (and the clinician training process) because it is more empowering and triggers less resistance than a hierarchical, didactic, or prescriptive approach. A collaborative approach that permits participants to determine their own goals and to identify their own barriers is

more likely to increase self-efficacy and engagement in the intervention. Collaboration also increases cultural sensitivity and developmental appropriateness because participants can apply the program's principles to their own experiences. Collaboration is associated with reduced drop-out and resistance, and gives participants and group leaders a joint stake in the outcome of the intervention (Meichenbaum & Turk, 1987; Seligman, 1990). Additionally, the collaborative approach is more flexible and adaptable and more likely to fit the needs of participants who have varied educational backgrounds, cultures, and family experiences.

For all the same reasons that the collaborative process is important for parents, teachers, and children, it is an important process for training clinicians. In fact, the way in which this training is provided to clinicians utilizes all the same methods and processes that are used when delivering the interventions to parents, teachers, and children. For example, Incredible Years trainers "model" the collaborative process by asking the trainee clinicians to pretend to be parents and then modeling how to use the videotapes to trigger group discussions, role plays, and values exercises. After the trainer models "group leader" strategies, then s/he invites clinician discussion and analysis of the therapeutic and collaborative strategies used in the role play. Since role plays are frequently resisted by clinicians, the trainer gradually persuades clinicians of their usefulness. This is done by demonstrating how role plays or "practices" help clinicians to understand what the parent has learned as well as permitting clinicians to actively "experience" the insights they can provide to parents while in the training. It is an important goal of the trainer to convince clinicians of the value of role plays and live rehearsals because this method is an expected part of the subsequent peer review and supervisory process after the initial

training. Additionally, standardized videotapes of actual group sessions or the mentor's own group sessions are shown so that clinicians can see how the trainer works with "real life" parent or child groups. This also enhances the credibility of the trainer for the clinicians.

The trainer and mentor use well-established training techniques utilizing a variety of learning methods (discussion, modeling, practice role plays, persuasion techniques, homework activities) so that different learning styles are addressed. Again, these techniques parallel those used in the actual parent, teacher, and child groups. For example, brain-storming is a technique frequently used with parents, teachers, and children and is also used with clinicians. Trainers lead clinicians in brainstorm exercises to problem solve difficult client situations or cope with client resistance. Trainers also ask clinicians to participate in small group practices and values exercises determining the advantages and disadvantages of particular techniques (both techniques are also used for training parents and teachers). At the end of the training day, homework practice exercises and reading assignments or audiotapes are assigned. Clinicians determine their goals and barriers for delivering the program and strategize ways to overcome them. Finally, each workshop is evaluated by clinicians using forms similar to those completed by parents or teachers in the actual intervention. Clinicians see how the trainers use evaluations to tailor workshops and meet the different clinicians' needs.

Dissemination Strategy Three: Effective Supervision
Utilizing the standardized materials and attending an authorized workshop by a certified trainer or mentor is a very helpful start for a clinician but does not guarantee that the blueprint will be implemented with fidelity. Again this is analogous to the contractor who needs not

only to make sure his sub-contractors are adequately trained to do the job but also to supervise their progress and trouble shoot problem areas. After the initial training workshop is completed, the next step of learning will occur as the group leaders return to their agencies and begin to start up their own groups. Their agencies should be encouraged to provide high levels of support for clinicians who are beginning to implement the programs. Clinicians running groups need adequate time to study the materials, prepare for their sessions each week, and arrange the logistics (e.g., food, transportation, day care). Weekly peer support and consultation or supervision is recommended for any group leader, but is crucial for a clinician who is running a group for the first time. Peer support is key to the clinicians' continued learning and success at delivering the intervention, regardless of the degree of expertise of the group leaders involved. Often group leaders become discouraged or demoralized by particular families or children and their lack of apparent success with the program. The peer group support and objectivity of the mentor or trainer helps the group leader maintain optimism for the families and to find new ways of approaching resistant parents or children. It is recommended that clinicians begin right away videotaping their groups and meet weekly with their peers to review their videotapes and provide support to each other. A detailed group process checklist is provided so that clinicians can review their performance against the group process skills expected on the checklist. (See Group Process Checklist.) Additionally, clinicians complete self-evaluation forms on themselves as well as their peers and share this feedback with each other. Six categories of items are rated such as: (1) group process skills (e.g., rapport building, encouraging problem solving, reinforcing parents' ideas and learning, creating an atmosphere of acceptance and safety); (2) leadership skills (e.g., establishing ground rules, structuring

an agenda, highlighting key points, preventing sidetracking, anticipating difficulties, encouraging generalization, balancing affective, cognitive and behavioral discussion and practice, reviewing homework); (3) relationship building skills (e.g., validating and supporting parents' feelings, fostering optimism, normalizing problems, using a collaborative model); (4) leader's knowledge (e.g., provides an accurate rational for principles, understands what is developmentally appropriate, can explain and understands cognitive social learning theory and principles of behavior change); (5) leader methods (e.g., effective use of videotape modeling and role plays, uses homework and practice, engages in brainstorm sessions to identify barriers); and (6) parents' responses (e.g., parents actively engaged in asking questions, problem solving, and sharing ideas). This peer review and self-review process serves to help the clinicians to determine their strengths as well as their goals for aspects of their group process that they want to strengthen. Additionally, group leaders are encouraged to send a videotape to the trainer or mentor at some point midway through their first group for further feedback. It is also helpful to schedule a consultation with the trainer or mentor via telephone once or twice a month when groups are underway. After clinicians have completed one or two groups (about 6-9 months after training), it is helpful for clinicians to participate in a consultation workshop with trainers either on-site or in Seattle. During these consultation workshops group leaders come together with other leaders to show selected portions of the videotapes of their sessions.

The feedback and supervision of a trainer or mentor can be very useful in helping clinicians gain new ways to handle the areas of the intervention that were particularly difficult for them to implement. For example, reviews of the tapes of clinicians' first groups frequently reveal

difficulties with using the videotapes, doing role plays, adhering to protocols, tailoring the program to bring families' personal problems to life, or making the strategies developmentally appropriate. Most clinicians are preoccupied with the videotapes and manuals and food or handout preparation rather than the therapeutic group process in the beginning. New leaders tend to be noncollaborative, inflexible, and prescriptive in their approach. While this is to be expected at first, consultation with trainers and the peer review and support can help clinicians focus on ways to improve the quality of the group process and respond to individual parent or child issues. During supervision, clinicians meet in groups and select portions of the videotape of their group to show to their peers and to obtain feedback from the trainer. The trainer uses the clinicians' videotapes to trigger a re-enactment of the scenarios faced in the groups. This allows the clinicians to practice alternative ways of handling difficult group situations or questions and to gain support from their colleagues. The supervision process is nurturing, caring, and focused on acknowledging the clinician's strengths as well as practicing different strategies. With this kind of warmth from the trainer or mentor, group leaders will feel supported and empowered to work successfully with their groups.

Successful supervision when a clinician is first adopting a new evidence-based intervention also requires the trainer or mentor to help clinicians recognize their role as change agents. Our experience suggests that it is best if the first clinicians to implement a new intervention are motivated and eager to do so. The clinician who decides to implement a new program becomes an "innovator" in the system he or she works in. These people are often called "early adopters," because they are willing to take risks and try new ideas before they have become well-established interventions in the organization (Rogers, 1995). However,

sometimes early adopters are unaware of what it means to be a change agent and don't realize that they must engage in the process of "social marketing"—of being a champion for their new services to families and their professional colleagues. They also need to be prepared to deal with organizational resistance to their efforts. Part of the supervision or consultation by trainers includes preparing clinicians for the processes involved in becoming an innovator within their organizational system.

Another aspect of supervision is determining if the clinicians are adhering to session protocols and key content or principles. It is well known that clinicians believe that they can eliminate parts of a mental health intervention or shorten it to be more cost effective or even cobble together various different programs in a sort of smorgasbord intervention. Training, supervision, and certification will help clinicians (and administrators) to understand that this approach may dilute or eliminate the positive effects of the program. For example, research regarding children with conduct disorders has shown that interventions of at least 20 hours in length are more effective than other shorter programs. Moreover, research with the Incredible Years program has shown that there are incremental effects in terms of the effectiveness of the program in changes in parent and child behaviors based on the number of sessions attended. Those parents who attended greater than two-thirds of the sessions had the most effective outcomes (Baydar, Reid, & Webster-Stratton, 2003). Moreover, evidence-based interventions have been developed based on theory and a logical order, with each session building on a prior session. If the clinician suddenly decides to omit a session or start in the middle of the program, the efficacy of the program may be compromised considerably or may even result in harmful effects for the family. Just as it is important that the building contractor follow building codes

and not leave out a key structural beam, so is it important for clinicians to understand the importance of adhering to the blueprint plan.

Supervision also helps clinicians know the ways they can appropriately tailor or adapt the program to meet the needs of a particular population. An important distinction must be made between implementing the core or foundational elements of the program and stifling clinical skills or flexibility. It is easy for the former to be misconstrued as the latter. During the ongoing consultation and supervision from trainers, clinicians are encouraged to bring their knowledge and experience with the population so that they can learn ways to flexibly adapt the program to meet unique parent goals or particular child developmental needs. During supervision, they are helped to understand when it is appropriate to take time in the group to explore a particular issue in greater depth with a parent or when to address a problem not related to the immediate content of the day. Thus, rather than treating the program as a precise script or recipe to be recited at parents in a didactic manner, clinicians come to understand through supervision that the fundamental principles that guide the program include flexibility, client collaboration in setting the agenda, and having fun. When clinicians understand this, they realize that, rather than limiting the use of their clinical skills and judgment, the program actually fosters and encourages it. Our experience suggests that the willingness of clinicians to continue to implement this intervention hinges on their willingness to retain the core elements of the intervention, while still bringing their clinical skills, clinical judgment, and creativity to bear in the implementation. Supervision helps clinicians to understand the balance of individualizing and pursuing a particular parent's agenda and relating these issues to core principles that are relevant for all in the group.

Supervision and consultation may be sought initially from the Incredible Years trainers (external consultation), but it is important for agencies to begin right away to identify possible candidates for becoming mentors or internal champions in order to build their own internal supportive organizational infrastructure and supervision process. Those chosen to become mentors are certified group leaders with exceptional group leadership skills, mastery of the collaborative process, understanding of the research, and a natural desire to network and support other leaders. Those who wish to become mentors receive further training in the supervision process and in the protocols for delivering the core training workshops. Mentors have heavier review of their group tapes by trainers and have co-led training workshops with a certified trainer as part of their training. When mentors have completed this training and have received positive workshop evaluations by participants as well as trainer recommendations, they are eligible to offer ongoing authorized training workshops in their own agencies or sites. The value of this is that organizations through mentors can provide continued training and supervision of new group leaders. A new group leader would co-lead a group with a certified group leader and would receive supervision from the mentor in regard to videotape reviews. The mentor in turn, keeps in close contact with the trainer in regard to consultation on this process. The trainer provides ongoing support to the mentor in terms of individual consultation, workshops with other mentors, videotape feedback of training workshops, and further training and updates regarding the program.

Dissemination Strategy Four: On-Going Fidelity Monitoring and Certification

Part of the process of delivering the intervention includes clinicians asking group participants to complete evaluations of every group session. These weekly client

evaluations are important to the clinician continuing to provide a quality intervention because they provide ongoing feedback about how participants perceive all aspects of the training. This information can help the clinician to tailor the program to individual learning needs and to become aware of a client who may be feeling left out of the group, or misunderstood, or resistant to an idea presented. Clinicians may learn from these evaluations how participants learn best—through modeling or discussion or reading and then be able to tailor home activities accordingly for families or teachers.

A certification or accreditation process was designed to allow clinicians/group leaders to continue their learning process after the initial training in the program and to offer formal recognition to those who make the extra effort to demonstrate that they are competent to implement the intervention. The requirements for certification include: session checklists, client weekly and final evaluations for two complete series of group interventions (each lasting 12 weeks), two self- and peer evaluations for each complete program offered using the peer checklists, completion of a 3-day authorized training workshop, and a satisfactory review of a complete videotape of a group session by a trainer or mentor. Satisfactory peer review, videotape, parent evaluations, and group attendance indicate leaders have achieved satisfactory mastery of the content and therapeutic process to become certified as group leaders. Clinicians who become certified can reasonably anticipate to achieve effects similar to those achieved in the published outcome studies evaluating the program.

Once certification is achieved, then maintenance of the fidelity of the program delivery is achieved by clinicians attending consultation workshops every 2 years and by ongoing peer review of videotapes and peer support groups led within the agency. In addition, submission of session evaluations by clients and completion of session protocols should be considered part of the clinician's accountability to the agency.

Dissemination Strategy Five: Agency or Organizational Support

Successful implementation of the program with fidelity also requires organizational or administrative support for the clinicians and the intervention. Implementation of any new service requires the allegiance and active support of administrative parties. In fact, the very first decision of whether to adopt a particular intervention should ideally be a collective decision with the administrative parties and clinicians coming to consensus that the evidence-based intervention chosen best meets their goals, agency philosophy, and needs of their population served. Next, it may be necessary for administrators to rewrite job descriptions to recognize the time commitment involved for clinicians' training, starting up groups, and carrying out groups. Even though group approaches are more cost effective than individual approaches, there is still considerable clinician time spent calling parents weekly, assuring transportation and food are provided for each session, arranging day care, and preparing handouts and materials for the sessions. This time must be budgeted for in the clinician's day. Administrators must provide adequate release time for the clinician to be trained in the new intervention. This will involve more than the initial training workshop. Sometimes administrators are surprised to find that the initial training does not adequately prepare their clinicians to start groups the following week! It is imperative that administrators understand that learning a new evidence-based intervention will also involve considerable time studying the videotapes and training manuals and meeting in peer support groups to practice with their colleagues.

Additionally, it is important for administrators to understand that once parent groups are started, it is still necessary to provide ongoing peer support and supervision. Group leaders will need to meet for regular supervision and review of their group dynamics. These peer review sessions between group sessions are essential to maintaining the quality of the interventions. It will be the administrators' role to push for high quality implementation. Without these efforts, the requirement for maintaining quality falls upon those implementing it to do so on their own time, without any recognition or support for the work involved in doing it well. One of the most important ways the organization can do this is to ensure that there are one or more internal administrative champions of the program. These people (could be mentors) will assure ongoing support for the program and will see that the clinicians who are adopting the program are adhering to program protocols, working towards certification, are well recognized for their extra work, and rewarded within the system if they become certified. If clinicians are not adhering to session protocols, supervision should be scheduled to understand why the program is being altered and if the alteration will affect core program components. Internal advocates should be familiar with local agencies and persons with power and should know how decisions are made in the system. In other words, they are familiar with local politics. This is important because these internal advocates will need to help clinicians deal with some of the organizational resistance and unintended side effects of the new program. Research shows that if clinicians are left to champion a program without an active administrative champion, the clinicians who first adopt the intervention quickly burn out from the extra work, get resentful about the lack of support, and often leave the agency [Corrigan, 1994 #1592]. Research has indicated that the interpersonal contact provided by the internal advocate is a critical ingredient in promoting adoption of new programs, regardless of the nature of the program (Backer, Liberman, & Kuehnel, 1986). In many ways, the administrative champions are more important to the long-term success of the intervention than the clinicians themselves.

Administrators may be the ones to first select and persuade clinicians to learn this new intervention. They would be well advised to start with training clinicians who are flexible, confident, enthusiastic, and committed to the program. In addition, clinicians should be non-authoritarian, collaborative, well-respected, well-educated, organized, well-prepared, proactive, and have a high morale. In short, they are leaders. The program will attain a strong reputation if it begins with a few of these leaders with these characteristics who indicate a willingness to try out new programs rather than to mandate all clinicians to follow suit. Those who are not risk takers are called "late adopters" and they will reluctantly venture into new programs only after their well respected colleagues have been shown to be successful with the program (Rogers, 1995).

Administrators can also begin to build their own supportive organizational infrastructure for this program by encouraging and supporting those clinicians who become certified group leaders to work towards eventual certification as certified mentors of other group leaders. These individuals should be recognized for their expertise in the system and rewarded accordingly by increases in salary for achieving this level of expertise.

The administrative staff and internal advocates need to assure that there are plans for on-going consultation and supervision from the outside trainer. The trainer collaborates with the organizations' "internal advocate" and mentors to plan further training and consultation and to address implementation issues. This person

also provides consultation to both the clinicians and administrators regarding the process of implementing the programs and helps them with understanding some of the psychological resistance and unintended side effects of the intervention. The trainer is also in an excellent position to advise the administrators in ways to support and reinforce the clinicians' change efforts.

Summary

Implementing a new evidence-based intervention in an agency is not unlike undertaking a house remodel. The architect for the house (program developer or trainer) must work closely with the contractors (clinicians and administrators) to explain the blueprints and house design features, while the contractor assures that the optimal building codes are adhered to, that foundations are in place, and that sub-contractors are provided with the needed expertise to handle the job. Both the architect and contractor must be aware of what the family's needs and desires are for a house as well as their timeline and budget constraints. As the building continues, there will undoubtedly be change orders as the family realizes different needs or as new discoveries are made in the existing structure (e.g., asbestos) when it is uncovered. This process will necessitate a collaborative and flexible approach where each member of the team works together with open communication and a spirit of problem solving to arrive at satisfactory solutions. In a similar fashion, the clinicians must first be carefully selected and well trained and then be provided with supervision and consultation from trainers and mentors in order to assure a supportive infrastructure and quality control of the program delivery. Regular feedback from the clients (parents, teachers, and children) in the process of collaborative discussion and session evaluations will assure that the clinician is implementing the program with sensitivity and relevance according to the individual family needs, cultural background, and nature of the children's problems.

References

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.

Bandura, A. (1989). Regulation of cognitive processes through perceived self-efficacy. *Developmental Psychology, 25*, 729-735.

Barkley, R. A. (1996). Attention Deficit/Hyperactivity Disorder. In E. J. Mash & R. A. Barkley (Eds.), *Child Psychopathology* (pp. 63-112). New York: Guilford Press.

Barrera, M., Biglan, A., Taylor, T. K., Gunn, B., Smolkowski, K., Black, C., et al. (2002). Early elementary school intervention to reduce conduct problems: A randomized trial with Hispanic and non-Hispanic children. *Prevention Science, 3*(2), 83-94.

Baydar, N., Reid, J. B., & Webster-Stratton, C. (2003). Who Benefits from School-based Preventive Parent Training Programs? The Role of Mother Mental Health Factors and Program Engagement. *Child Development*.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*(1), 7-18.

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.

Dumas, J. E. (1989). Treating antisocial behavior in children: Child and family approaches. *Clinical Psychology Review, 9*, 197-222.

Gross, D., Fogg, L., Webster-Stratton, C., Garvey, C., W., J., & 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.

Kazdin, A. E. (2002). Psychosocial treatments for conduct disorder in children and adolescents. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (pp. 57-85). New York: Oxford University Press.

Kazdin, A. E., Bass, D., Ayers, W. A., & Rodgers, A. (1991). Empirical and clinical focus of child and adolescent psychotherapy research. *Journal of Consulting and Clinical Psychology, 58*(6), 729-740.

Meichenbaum, D., & Turk, D. (1987). *Facilitating treatment adherence: A practitioner's guidebook*. New York: Plenum Press.

Miller Brotman, L., Klein, R. G., Kamboukos, D., Brown, E. J., Coard, S., & L., S.-S. (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.

Mørch, W.-T., Larsson, B., Clifford, G., Drugli, M. B., & Fossum, S. (2004). *Treatment of small children with conduct and oppositional defiant disorders*. Unpublished manuscript, University of Tromsø and Norwegian University of Technology and Science, Trondheim, Norway.

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

Scott, S., Spender, Q., Doolan, M., Jacobs, B., & Aspland, H. (2001). Multicentre controlled trial of parenting groups for child antisocial behaviour in clinical practice. *British Medical Journal, 323*(28), 1-5.

Seligman, M. (1990). *Learned Optimism*. Sydney: Random House.

Serketich, W. J., & Dumas, J. E. (1996). The effectiveness of behavioral parent training to modify antisocial behavior in children: A meta-analysis. *Behavior Therapy, 27*(2), 171-186.

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.

Taylor, T. K., & Biglan, A. (1998). Behavioral family interventions for improving child-rearing: A review for clinicians and policy makers. *Clinical Child and Family Psychology Review, 1*(1), 41-60.

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. (1998a). Parent training with low-income clients: Promoting parental engagement through a collaborative approach. In J. R. Lutzker (Ed.), *Handbook of Child Abuse Research and Treatment* (pp. 183-210). New York: Plenum Press.

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

Webster-Stratton, C. (in press). The Incredible Years Parents, Teachers, and Children Training Series: Early Intervention and Prevention Programs for Young Children. In P. S. Jensen

& E. D. Hibbs (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based approaches*. Washington, D. C.: APA.

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., & Hancock, L. (1998). Parent training: Content, methods and processes. In E. Schaefer (Ed.), *Handbook of parent training, second edition* (pp. 98-152). New York: Wiley and Sons.

Webster-Stratton, C., & Herbert, M. (1994). *Troubled families -- problem children: Working with parents: A collaborative process*. Chichester: Wiley & Sons.

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. (2003). The Incredible Years Parents, Teachers and Child Training Series: A multifaceted treatment approach for young children with conduct problems. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 224-240). New York: Guilford Press.

Webster-Stratton, C., & Reid, M. J. (2004). Strengthening social and emotional competence in young children—The foundation for early school readiness and success: Incredible Years Classroom Social Skills and Problem-Solving Curriculum. *Journal of Infants and Young Children, 17*(2).

Webster-Stratton, C., & Reid, M. J. (in press). Training Head Start Parents and Teachers in a Partnership Model to Promote Children's School Readiness and Social Competence: A Strategy to Prevent Substance Abuse and Conduct Problems. In P. Tolin (Ed.), *Preventing Substance Abuse*.

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.

Weisz, J. R., Donenberg, G. R., Han, S. S., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. Special Section: Efficacy an effectiveness in studies of child and adolescent psychotherapy. *Journal of Consulting and Clinical Psychology, 63*(5), 688-701.

Weisz, J. R., & Weiss, B. (1993). *Effects of psychotherapy with children and adolescents*. London, England: Sage Publications.