Bringing The Incredible Years® Programs to Scale

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

Incredible Years Program Background: Theoretical Foundation, Methods, and Goals

The Incredible Years® (IY) Parent Program for young children was originally developed more than three decades ago for my doctoral dissertation at the University of Washington (Webster-Stratton, 1981, 1982b). The main underlying theoretical background for the program was grounded in the theory that giants and researchers of the 1970's developed including cognitive social learning theories about the development of antisocial behaviors in children (Patterson, Reid, & Dishion, 1992), modeling and self-efficacy theory (Bandura, 1977, 1982), developmental cognitive stages and interactive learning methods (Piaget & Inhelder, 1962), and attachment relationship theories (Ainsworth, 1974; Bowlby, 1980). The IY Parent Program content was designed to reduce the malleable family risk factors that had been shown to lead to the development of conduct problems and social-emotional problems in young children. These risk factors included: ineffective parenting, harsh discipline, poor attachment, chronic neglect, poor monitoring and parent isolation and lack of support.

The IY Parent Program focused on breaking the negative, coercive parent-child cycle as described by Patterson (Patterson et al., 1992) by teaching parents proactive discipline methods and ways to build positive relationships and attachment through child-directed play, positive attention, coaching methods and praise as well as by strengthening parents' support networks with friends, family and teachers. The program initially targeted parents of young children (ages 3 to 8 years) with disruptive behavior problems with the following short-term goals: improve parent-child relationships, replace harsh discipline with proactive discipline, improve parent-teacher partnerships, and increase parent support. It was hypothesized that targeting these parenting changes when children were young would lead to improved children's social competence, emotional regulation, school readiness and prevention of social and emotional problems. The long-term goals were to prevent the development of conduct disorders, peer rejection, academic failure, delinquency and substance abuse.

Before beginning doctoral work in 1977, I was trained in a parent training method developed by Connie Hanf (Hanf & Kling, 1973) called "bug in the ear" training. With this personalized approach parents were videotaped playing with their children and then shown selected video segments by therapists in order to give them feedback regarding more effective parenting approaches. After these videotape feedback sessions, the parents played with their child in a clinic room wearing a small earpiece so that they could be coached by the therapist who was watching them through a one-way mirror. I was instantly entranced with the idea of using video as a training tool for parents but felt the individualized, video feedback approach with tailored editing and coaching was too costly and time consuming to meet the needs of increasing numbers of parents wanting help managing their children's misbehavior. I wondered if parents could learn from watching standardized videotapes of other parents managing common child misbehaviors and whether this learning could happen in a group format. Despite the skepticism at the time of what was thought to be a more impersonal approach without actual practice experiences with children, Bandura's modeling and self-efficacy theories suggested

otherwise. To test this idea for my doctoral study research, I used personal savings to fund the development of a standardized videotape parent program and conducted my first randomized control group study to evaluate the effectiveness of such an approach for improving parent-child interactions and reducing behavior problems. I hypothesized the parents would learn more through videotape modeling than by verbal-based lecture approaches, which were common at that time, and that offering the program in a discussion problem solving format to groups of parents, would not only be more cost effective but would provide often isolated and stigmatized parents with much needed support.

My first study (Webster-Stratton, 1981, 1982a, 1982b) with middle-class, non-clinic mothers showed significant improvements in mother-child interactions compared with control group mothers and children based on independent observations. Manuscript reviewers were unimpressed with the potential of this initial video modeling parent training approach because of the low risk nature of population studied. The reviewer feedback led to my second randomized control group study with low income families whose children were diagnosed with Oppositional Defiant Disorder. Using personal funding I improved the parenting program curriculum and video vignettes using friends and parent volunteers as models who had participated in the first study. Based on this revised parent program curriculum I applied for my first research NIH grant to evaluate its potential as treatment for high risk parents and children. This expanded revision of the parent program became the bedrock of the current Incredible Years Parenting program and these original vignettes still comprise some of the vignettes shown today. Little did I know that these experiences and my ultimately successful grant application would lead me to a research career spanning 35 years of conducting multiple RCTs evaluating video-based modeling group-based programs. These program are now used throughout North America and in over a dozen countries.

Incredible Years® Parent, Teacher and Child Series 2014
In the past decade the IY Parent Program has been further refined to include 4 independent parent programs designed for parents of children at different developmental stages, covering the age span from birth to 12 years of age. Moreover, new DVDs and curriculum programs were created, produced and funded by myself for training for teachers and for children. The IY series currently exists as a set of interlocking and comprehensive training programs for parents, teachers, and children. Each of these programs can be used independently, depending on the setting in which they are delivered, but research suggests that for diagnosed children and high-risk families, the effects are additive when used in combination. Each of the programs is thematically consistent, includes the same theoretical underpinnings, and is based on the developmental milestones for each age stage. The manuals, books, DVDs and trainings for all programs have been refined and updated in recent years based on research and participant feedback with both high-risk prevention populations and treatment populations.
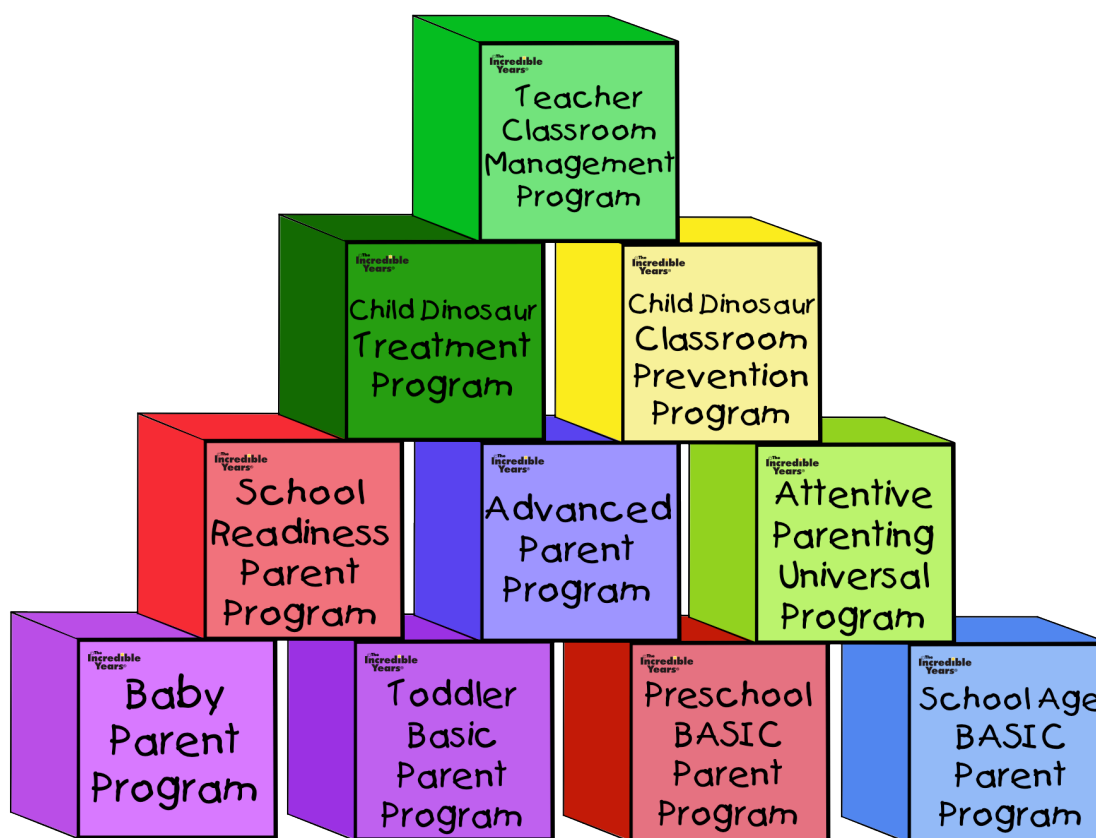
IY Building Blocks for Promoting Children's Social & Emotional Competence

Currently the BASIC (core) IY Parent Program Series consists of 4 different programs tailored to the developmental stage of the child: Baby Program (4 weeks to 9 months), Toddler Program (1- 3 years), Preschool Program (3-5 years) and School-Age Program (6–12 years). Each of these core programs emphasizes developmentally appropriate parenting skills and includes age-appropriate video examples of culturally diverse families and children with varying temperaments and developmental issues. In addition to the four BASIC parent programs there are three adjunct parent programs. The School Readiness and Attentive Parenting Programs are shorter programs designed as universal interventions for low risk families. The Advance Parent Program is designed for high risk and treatment families and is offered after the BASIC Preschool or Toddler programs are completed. In addition to parenting, the Advance Program focuses on parents interpersonal issues such as anger and depression management, effective communication and problem solving.

For teachers there is one IY Teacher Classroom Management Program for children ages 3 to 8 years which has separate protocols and recommended vignettes for preschool teachers and primary school teachers. For children there are two child training programs including a prevention Classroom Child Program (3-8 years) and a Treatment Small Group Child Program (4-8 years) (aka Dinosaur School). The specific objectives for each of these programs can be found on the web site http://incredibleyears.com/about/incredible-years-series/objectives/. The programs target universal, selective and indicated populations as well as treatment populations of diagnosed children including:

        • high-risk socioeconomically disadvantaged families

      • child protective service referred famlies and foster parents
      • children with conduct problems and ADHD
      • children with internalizing problems and developmental delays

Research Evidence Summary For IY Parent Programs

      The efficacy of the IY parent programs for treatment of children (ages 2–8 years) diagnosed with ODD/CD, and ADHD has been demonstrated in eight published randomized control group trials (RCTs) by the program developer and more than six RCTs by independent investiagors. See article for review of studies (Webster-Stratton & Reid, 2010). Results have consistently shown improved parent-child interactions, and reduced harsh discipline, conduct problems, ADHD symptoms, and internalizing symptoms compared to wait-list control groups. Similar results were found for the toddler, preschool and school age versions of the programs. Several studies have also shown that IY treatment effects are durable 1-3 years post treatment. Additionally, an 8- to 12-year follow-up study of families treated because of their preschool children's conduct problems indicated that 75% of the teenagers were typically adjusted with minimal behavioral and emotional problems (Webster-Stratton, Rinaldi, & Reid, 2010). A second recent 7-10 year follow-up study indicated that parents with antisocial children who participated in the basic IY parent program expressed greater emotional warmth and supervised their adolescents more closely, than parents in the control condition who received the usual individualized psychotherapy in mental health clinics. Moreover, their children's reading ability was substantially improved in a standardized assessment compared to the control condition children (Scott, Briskman, & O'Connor, 2014).

      Several of the early RCTs attempted to determine the critical ingredients of the parent intervention programs. For example, the second trial compared the video-based group therapy program with the personalized one-on-one bug in the ear approach, considered at the time to be the gold standard for treatment with a wait-list control group. Results showed that both treatment groups were significantly improved compared to the control group, and there were no outcome differences between the high-cost, one-on-one therapy and the video-based group approach However, the video-based group approach was five times more cost-effective than one-on-one therapy (Webster-Stratton, 1984). A third study evaluated the most useful and cost-effective component of the video-based group therapy approach. Parents were randomly assigned to four conditions: individually administered video program, group therapy alone with no video, video-based group therapy, and wait-list control group. Treatment component analyses indicated that the combination of group discussion, a trained group leader and video modeling produced the most lasting results in comparison to treatment that only involved one of these three treatment components. However, surprisingly the individually-administered video program was effective in improving parent and child behaviors in comparison to the control group and was at least as effective as the group therapy alone condition (Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). This led to a fourth RCT that compared the individually-administered video program, clearly the most cost-effective approach with and without therapy consultation and a wait list control group. Parents in the consultation condition reported higher program satisfaction and their children were observed to have significantly fewer behavior problems than children in the condition that did not provide consultation suggesting the combined treatment was superior (Webster-Stratton, 1990). However, follow-up analyses indicated that 39% of mothers and 41% of teachers continued to report behavior problems in the clinical range. These findings indicated the self-administered program with or without consulation should not be the sole treatment used

for parents with children with conduct problems and again suggested the added advantage of therapist support for parents. Another RCT examined the effects of adding the Advance parent intervention to the BASIC intervention. Parents were assigned to BASIC training or BASIC plus Advance training. The results indicated the combined treatment brought about significantly more improvements in parents and children's problem solving abilities compared to parents and children in the BASIC-only condition (Webster-Stratton, 1994).

In addition to the above mentioned treatment studies the developer conducted 3 RCTs using the video-based group approach with multi-ethnic, socioeconomic disadvantaged Head Start famlies (Reid, Webster-Stratton, & Beauchaine, 2001; Webster-Stratton, 1998; Webster-Stratton, Reid, & Hammond, 2001) and at least 6 RCTS have been conducted by independent investigators with selective prevention populations including those representing Latino, Asian, African American and Caucasian families. Results across these studies have been consistent showing increases in positive parenting, decreases in harsh discipline, reductions in behavior problems and increases in social competence. A recent meta-analytic review examined the IY parent program studies regarding disruptive and prosocial behavior in 50 studies where the IY intervention group was compared with control or a comparison group. Results were presented for treatment populations (i.e., diagnosed children) as well as selective (i.e., high risk) and indicated (i.e., with symptoms) prevention studies. Findings indicated the IY program was successful in improving child behavior in a diverse range of families, especially for children with the most severe cases and the program was considered "well-established" (Menting, Orobio de Castro, & Matthys, 2013).

Research Evidence Summary for Adjuncts to IY Parent Programs

After 15 years of research in regard to the IY Parent Programs exploring the best methods of training parents, expanding the content according to feedback, and researching effectiveness for parents and children, it become clear that while parents could bring about changes in their children's behavior at home there were no consistent results from the various studies regarding changes in children's behaviors at school. Consequently, I developed teacher and child training programs to see if we could bring about more sustained changes in children's behaviors across settings by combining this training along side parent training.

IY Teacher Programs: The IYTeacher Classroom Management program combined with the IY parent program was evaluated in one treatment RCT for children with conduct problems (Webster-Stratton, Reid, & Hammond, 2004) and two selective prevention RCTs in Head Start centers (Webster-Stratton et al., 2001; Webster-Stratton, Reid, & Stoolmiller, 2008) and five RCTs by independent investigators (see review (Webster-Stratton, 2012b). For the treatment trial for children with conduct problems, when the parent training only condition was compared with parent plus teacher training and a control condition, results showed consistently better classroom outcomes for children in the condition that had combined parent and teacher training (Webster-Stratton et al., 2004). In general findings have consistently shown that teachers who participated in the IY Teacher Classroom Management program used more proactive classroom management strategies, praised their students more, used fewer coercive or critical discipline strategies, and placed more focus on helping students to problem solve. Intervention classrooms were rated as having a more positive classroom atmosphere, increases in child social competence and school readiness skills, and lower levels of aggressive behavior.

IY Child Programs: There have been three RCTs by the developer evaluating the effectiveness of the IY Small Group Child Training program (aka Dinosaur School) (Webster-Stratton & Reid, 2003) for reducing conduct problems and promoting social and emotional competence and problem solving in children diagnosed with ODD/CD and ADHD (Webster-Stratton & Hammond, 1997; Webster-Stratton et al., 2004) (Webster-Stratton, Reid, & Beauchaine, 2011) and one by an independent evaluator (Drugli & Larsson, 2006) . One RCT evaluated the effects of child training alone without parent intervention in comparison with parent plus child training and a control condition for children with conduct problems. Overall results indicated that the combined parent and child interventions showed the most positive effects over an array of behaviors. The combined approach was superior to the child training only intervention in reducing children's problem behaviors and had the most sustained effects at 1-year followup. Children in the combined intervention group showed a 95% decrease in negative behaviors from baseline, compared to reduction of 74% for those in child only condition and 60% for parent only condition (Webster-Stratton & Hammond, 1997). The most recent study evaluated the effects of the IY Parent Program used in combination with the child small group child training in comparison to a control group for children diagnosed with ADHD. Results showed significant treatment effects for children's externalyzing, hyperactivity, inattentive and oppositional behaviors as well as emotional regulation, social competence and problem solving according to parents, teachers and independent classroom observations (Webster-Stratton, Reid, & Beauchaine, 2011).

One RCT evaluating the classroom prevention version of the child program was conducted with Head Start families and primary grade classrooms in schools addressing economically disadvantaged populations. Results from multi-level models of reports and observations of 153 teachers and 1,768 students indicated that teachers used more positive management strategies and their students showed significant improvements in school readiness skills, emotional self-regulation and social skills, and reductions in behavior problems in the classroom. Intervention teachers showed more positive involvement with parents than control teachers. Satisfaction with the program was high regardless of the grade levels (Webster-Stratton et al., 2008).

Making the Decision to Disseminate ~ Challenges and Successes

When I started working full time at the University of Washington in 1980 as Director of the Pediatric Nurse Practitioner (PNP) Program, I had no goals to become either be an academic researcher, or to develop a business to disseminate intervention programs. Rather I was passionate about clinical work to help families manage their children's developmental and behavior problems and finding an effective, cost-effective and supportive way of doing that. For the first 12 years I taught courses to PNPs about family therapy and parenting interventions utilizing some of my program materials while also writing grants to evaluate the parenting program. Because I had originally funded the filming, editing and video production program costs with personal funds and not as a university employee, I retained full ownership of the IY program. In 1987 I had a contract with the university that acknowledged this ownership and permitted me to use the programs for training and grant research purposes and outlined that all further work related to marketing, trainings and further product development would be done separately at my own expense outside of the university. Since then I have submitted financial

disclosure forms yearly and participated in ongoing reviews in regard to potential conflict of interest.

It wasn't until 15 years after publication of my first study and 5 additional randomized control group studies with the parent program, that I began to be contacted for information about obtaining program materials and training possibilities. Largely these requests came from countries such as UK and Norway who had reviewed the research evidence and were interested in both delivering the IY programs as well as researching their effectiveness for use in their population. This upsurge in interest from others to deliver the parent programs combined with the loss of one of my grants led to my decision to start an independent business to disseminate the programs. I began by hiring an administrator to answer requests, set up training workshops, and to disseminate training materials as well as a consultant trainer who had previously worked with me on my research grant before it ended. A few years later, when my NIMH Research Scientist Award ended, as a tenure-track professor I was faced with the decision of returning to a much heavier teaching load to justify my university salary, staying on research money myself but letting go of most of my clinical staff at the Parenting Clinic, or making an increased commitment to dissemination. I decided to give up half my tenure salary and go half time at the university. My career then half-time doing research at the Parenting Clinic and the other half time engaged in disseminating the Incredible Years Programs with the goal of improving training materials and protocols and consulting with others.

Having spent two decades as the architect of the Incredible Years Series researching, redesigning, adapting and expanding comprehensive clinician/group leader manuals and protocols, I believed we had the tools to begin the construction project of disseminating the Incredible Years Programs. It seemed that it would be easy for therapists to deliver the programs with fidelity because of the use of DVDs, comprehensive manuals and clear session protocols. Moreover, at that time it was unclear to me whether clinicians would even need training because I thought everything was clearly articulated in the DVDs, manuals and plans. However, I quickly learned that developing an evidence-based program is only the first building block of many foundational blocks needed to construct a quality and stable program. It was clear from my video reviews of therapist parent or child group sessions that neither the DVDs or workshops alone were sufficient to promote fidelity delivery. I had much to learn about preventing and overcoming the agency barriers involved in implementing an evidence-based program as well as the difficulties of bringing about changes in therapist behaviors. This real world experience led to my successful grant application to study ways to promote therapist fidelity delivery of the IY programs and indicated the need for therapists to have ongoing coaching and support after their initial training workshops as well as for agency administrators to understand how they can support their therapists to achieve certification.

Eight years after working half-time at the university, when my last research grant was not funded I decided to retire from the university. I had been incredibly fortunate to have had many years of grant funding and it seemed the right time to pursue the dissemination journey in more depth. This has allowed me to update all the programs, DVDs and books as well as to develop new training programs, to help other researchers research the IY program effectiveness with other populations and to promote fidelity delivery of the programs through the accreditation process.

At this time, several clinicians and researchers who had worked at the University

Parenting Clinic for 15+ years made the transition to the process of dissemination with me. They became the core of the IY Seattle-based training staff. They, along with a few trainers who had been replicating the program in other countries, continue to support our current network of new coaches, mentors, and trainers all over the world.

Scaling up the IY Programs with Fidelity ~ A Collaborative Building Project

While the Incredible Years programs have been shown in dozens of studies to be transportable and effective across different contexts worldwide, unfortunately, barriers to fidelity delivery impede the possibility for successful outcomes for parents, teachers and children. Such barriers include organizations that were ill-prepared or unready to take on the building project, administrators who failed to select clinicians with the motivation and background necessary for the work, and who had little time for recruitment and engagement of community participants. Moreover, most organization visions were short term with limited financial resources. Seldom was there a long-term agency plan, or adequate funding for project managers, logistical support, quality clinician training or on-going clinician support and consultation, or for internal quality control and assessment. All of these barriers are likely to result in a low clinician job satisfaction, poor quality delivery and failure to achieve program sustainability. Thus, the initial investment that an agency may make to purchase the program and train staff is often lost over time and may even led to poor outcomes. At times IY programs were sliced and diced and offered by ill prepared and unsupported clinicians because of financial pressures to reduce program dosage with the belief that a little is better than nothing at all. In addition to agency barriers, clinicians also had their own set of barriers including a weak background in cognitive social learning and developmental theories, resistance, lack of familiarity or comfort with group therapy methods, and difficulty in understanding what it means to deliver or adapt an evidence-based program with fidelity to different populations. Clinicians also experienced stress related to a lack of ongoing coaching, support and consultation to learn a new program while being pressured at the same time to serve more clients while reducing the number of sessions provided. Their job satisfaction was deteriorating as they were asked to take on more EBPs.

The metaphor I use for scaling up an evidence-based program (EBP) is that it is like building a house where there must be an architect (program developer), a contractor (agency administrator), onsite project managers (mentors and coaches) and a construction team (clinicians). If there are barriers to any of these links the building will not be sound. For example, when there are agency and therapist barriers to disseminating evidence-based programs,it is as if the contractors hired electricians and plumbers who were not certified, disregarded the architectural plan and used poor quality, cheaper materials. Under these conditions, everyone would agree the building will not be structurally sound. Just like building a stable house, it is important that the foundation and basic structure for delivering evidence-based programs be strong. This will includes the following: 1) picking the right evidence-based program for the level of risk of the population and developmental status of the children; 2) adequately training, supporting and coaching clinicians so they become accredited; and 3) providing quality control by the agency administrator. In addition, providing adequate scaffolding through the use of trained and accredited coaches, mentors and administrators who can champion quality delivery will make all the difference. With a supportive infrastructure surrounding the program delivery, initial investments will eventually pay off in terms of strong family outcomes and a sustainable intervention program that can withstand staffing and administrative changes.

The Incredible Years Program Training Series has been set up with a supportive infrastructure of 8 building blocks designed to promote program fidelity. These include accredited IY trainers, mentors and coaches and an accreditation/ certification procedure that assures that the architectural plan is adhered to and that strong supportive scaffolding is provided for group leaders or therapists. One of the strengths of the IY series has been the attention given to fidelity adherence and certification/accreditation. Dissemination research has informed our decisions and focused attention on rigorous standards about the optimal clinicians, program methods, dosing, training (Lochman et al., 2009; Webster-Stratton, Reid, Hurlburt, & Marsenich, 2014), and mentoring requirements for successful implementation in the short- and long-term (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005).

It is evident that in order to replicate the published results obtained by the research, attention must be given to the fidelity with which EBPs are implemented in the field. Fidelity, also referred to as intervention or program integrity, refers to the degree of exactness with which clinicians adhere to, or reproduce, the original training program model features, with the goal of replicating original research outcomes (Schoenwald & Hoagwood, 2001). Programs must be implemented with fidelity to the original model to preserve the behavior change mechanisms that made the original model effective (Arthur & Blitz, 2000). Fidelity for IY can be conceptualized in three dimensions: 1) program adherence, or delivery of core program components such as utilizing recommended session protocols, video vignettes, and intervention dosage (minimum number of sessions) in the recommended sequence, 2) clinician competence, or the IY group facilitator's skill level when using the training methods such as experiential practices and role plays, collaborative training processes and learning principles employed in the original IY program model, and 3) program differentiation, or implementation of the program for the population for whom the program was designed (prevention vs. treatment). In addition to the three dimensions outlined here, participant responsiveness, or the level of engagement and attendance in the program, is an important component of intervention fidelity. In other words, fidelity encompasses both the quality and quantity of EBP training delivery. Further information regarding what must be submitted to IY headquarters for accreditation see the web site for parent clinician certification http://incredibleyears.com/certification-gl/basic-program/

Convincing evidence exists that high program delivery fidelity is predictive of significant positive outcomes across a number of different EBPs, notably parent training programs (Eames et al., 2009; Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002; Wilson & Lipsey, 2007). On the other hand, poor program fidelity, including, reduced program dosage and poor quality delivery has been shown to predict little or no change, challenging the view that some exposure to program components is better than no exposure. Numerous studies have shown that dosage (Baydar, Reid, & Webster-Stratton, 2003; Lochman, Boxmeyer, Powell, Roth, & Windle, 2006) and quality of program delivery methods and processes are related to effect size of outcomes (Eames et al., 2009; Scott, Carby, & Rendu, 2008). Research has also shown that adding consultation and supervision for clinicians increases fidelity of program delivery (Henggeler et al., 2002; Lochman et al., 2009; Raver et al., 2008; Webster-Stratton, Reid, Hurlburt, & Marsenich, 2011; Webster-Stratton et al., 2014)**,** which in turn leads to better outcomes. Taken together these findings regarding EBPs lend support to the assertion that higher dosages of these programs and quality delivery lead to more robust effects. Sadly, despite this compelling research most mental health agencies are reducing EBP's dose and content due to budget barriers.

A critical question is how to sustain fidelity of the IY programs within the same organization over time. Additional challenges arise when the goal is to expand the application of a program within a single agency to entire systems with fidelity, be it a school district, or an entire state or country (i.e., scaling up). Even after successfully scaling up, there is still a need to sustain fidelity over time throughout the system (Kellam & Langevin, 2003). At each of these levels of extension, questions arise about selection criteria for who will be trained, with what kind and how much training, and consultation is needed. Additionally, decisions need to be made about how fidelity will be monitored and supported including attention to what social, organizational and political structures or policies will need to be put in place and what type of monitoring model will be employed.

The remainder of this article describes how we are attempting to scale up the IY programs slowly and carefully with fidelity by engaging in a collaborative building project with strong connecting links between the developer, agency administrator, mentors, coaches, clinicians and families using 8 key foundational building blocks or fidelity tools, which promote adherence to key program principles and protocols.

Building Block #1: Assuring Organization Readiness

Ideally agencies have assessed their community risk factors, prioritized their needs and identified their goals and target population (age of children and level of risk) in order to be sure they are choosing the EBP that is the best fit for them. IY's website provides an agency readiness questionnaire called "*Launching IY Programs in Your Organization*" to help organizations determine their goals and decide if they have adequate clinical staff, managerial support, human and financial resources, venue, equipment and day care facilities and capacity to deliver the program. This questionnaire also helps them think about their organizational capacity for providing ongoing support, monitoring, fidelity checks and program evaluation.

http://incredibleyears.com/programs/implementation/starting-the-programs/

 When agencies contact the IY Seattle office, they are asked to review the IY *Agency Readiness Questionnaire* carefully and talk with their clinicians as well as their community partners to be sure they are ready to take on this program delivery. Agencies that go through this process are able to evaluate whether the program is a good match for their needs, goals, and philosophies. They also begin to see the financial and staffing commitment needed to implement the program with fidelity. We have found that it is important for agencies to go through this questionnaire with our administrative staff, rather than do the questionnaire independently. This ensures that agencies fully understand what it means to implement the program with fidelity. This questionnaire has 8 steps including assessing their need, the match between IY program philosophy and organizational goals, organization commitment and human resources, financial resources and capacity, organizational space, recruitment and family support capacity, infrastructure support, program evaluation plans and long term maintenance. This questionnaire can be found on this web site link http://incredibleyears.com/for-administrators/

Building Block #2: Assure Standardized Quality Training for Carefully Selected Group Facilitators

Selecting group facilitators. It is recommended that each organization prepare a

minimum of 2-3 clinicians for training in the new program. Those chosen to deliver these programs should ideally have Masters or higher degrees or professional diplomas in an appropriate field – psychology, social work, nursing, school counseling, teaching, or counseling. They also should have prior experience working with parents and children and preferably have had prior training in child development, behavior management, and cognitive social learning theory. In particular, those chosen should be comfortable or interested in the idea of leading groups and motivated to support families, teachers and their children. These professionals should be allowed to participate in the choice to learn the program rather than being mandated to take the training. They also must be given time to learn the program and to receive supervision and consultation. In addition, selection criteria for clinicians should include interpersonal qualities of empathy, sense of humor, collaborative nature, group leadership skills, and ability to work within a structured program.

IY Training Philosophy. The IY Series is frequently misunderstood as a fixed-dosage, inflexible, curricular-driven, behavior-based EBP. Instead, the IY Series is better understood as a set of principle-driven, dynamic interventions that were developed in applied settings and that are flexibly adapted to each cultural context for parents or teachers managing children with varying developmental abilities. The programs integrate cognitive, emotion and behavior concepts equally and are based on ongoing discussions and collaboration between participants and training group facilitators (see therapist/group facilitator text (Webster-Stratton, 2012a)). The big ideas or principles, video-based vignettes, and participant books give structure to the programs, but flexible implementation gives voice to the participants and helps ensure the content fits the context of their lives. By using a principle-driven framework and flexible delivery strategies, the IY programs have proven to impact parent, child, and teacher emotions and behaviors across a wide range of settings with culturally diverse groups of participants in repeated and rigorous evaluation studies (Webster-Stratton & Reid, 2010).

The IY program utilizes self-reflective and experiential practice learning, group support and problem solving, and specific training methods that facilitate participants in learning important behavior management and relationship building skills along with helping them manage their own emotional self-regulation and stress. Part of using the IY program model successfully is for clinicians to understand how to tailor or adapt the program according to the individual goals of each participant as well as group goals. Clinicians can achieve flexible applications of the manual when there is understanding of the program at multiple levels, including the program model, content, training methods, and delivery principles built into the program to promote a culturally and developmentally responsive structure for delivering the program to diverse populations. Evidence of the success of the IY implementation and adaptation processes comes from the high attendance and participant satisfaction ratings by parents and teachers in prior IY studies in varied contexts and multiple countries (Menting et al., 2013).

Initial Workshop Training. In addition to providing clinicians with comprehensive training manuals, fidelity protocols, handouts and DVDs of sample group sessions, the initial training for all the IY programs is a 3-day training workshop with no more than 25 clinicians. The collaborative process of training clinicians models the therapeutic methods and processes that they will use when delivering their own parent or teacher groups.

The 3-day training workshops are delivered by accredited IY trainers and mentors who have had extensive experience delivering the IY programs themselves, as accredited clinicians.

They show standardized videos of actual group sessions so that clinicians in training can observe and model how to work with groups of parents, teachers or children. Once clinicians become accredited, some are invited to participate in IY coach and mentor training because they have been identified as being exemplary models for demonstrating fidelity to the IY group processes and methods. IY coaches receive specific training in coaching methods and within their agencies can provide ongoing support to new clinicians. From the accredited coach group, some are selected for further training to become mentors and are permitted to offer authorized workshops within their agency or defined district. This allows organizations to build their own supportive infrastructure.

Building Block #3: Provide Ongoing Feedback and Consultation for Clinicians

Active, collaborative, self-reflective and principles-based training workshops are necessary but not sufficient to result in fidelity of implementation delivery or program outcomes. After the initial 3-day training workshop, clinicians need release time to study the manuals, protocols, video vignettes as well as the sample DVD group sessions, to practice and prepare their sessions and materials, and to arrange logistics (e.g., food or day care, handouts, transportation, venues). Furthermore research has shown (Webster-Stratton et al., 2014) that combining the initial training workshop with ongoing mentoring, coaching and consultation maximizes the learning for IY clinicians as they begin to implement the program and contributes greatly to fidelity of program delivery. Other studies with different EBPs have also shown that high program delivery fidelity predicts significant improvements in parents and children's behaviors (Eames et al., 2009; Henggeler et al., 2002; Lochman et al., 2009).

Before deciding to implement the program, administrators must look at the structure of the service delivery within their agencies and build in time for new group leaders to deliver the groups. We typically recommend that new clinicians be allowed 6 hours per week to deliver a group (this included studying and preparing materials, contacting parents between groups, group delivery, and meeting with co-leaders and or supervisors). Very often clinicians are expected to deliver the program in addition to all their regular workload, or are allocated 2 hours a week to deliver the 2-hour group. This is will result in program failure and clinician burn out.

It is also recommended the new clinicians obtain outside support, encouragement and consultation from IY accredited mentors and trainers regularly during their first 2–3 sets of groups. Ideally new clinicians should have 4–5, 1-hour consultations during delivery of their first group and ongoing consultation as needed. Clinicians new to EBPs need help distinguishing between implementing the core or the foundational elements of the program and stifling clinical flexibility. In consultation, clinicians are encouraged to discuss their experiences and helped to select the appropriate vignettes and practices for their specific group so they collaboratively tailor the program to individual participant goals and to specific child developmental needs. Clinicians come to understand that the principles that guide the program include being flexible, collaborative with the parent or teacher in setting the agenda, culturally-relevant and fun, rather than following a precise script to be recited or lectured at passive group participants. When clinicians understand this, they realize the program actually encourages the use of their clinical skills and judgment but also provides them with a blueprint (known as the parent or teacher pyramid) of where they are going. The most effective clinicians are those who retain the core elements and principles of the program while bringing their clinical creativity to bear in the implementation. Consultation from IY trainers helps them balance pursuit of a particular group

member's goals in relation to the group process and issues that are relevant for the entire group.

Clinician support and consultation from accredited IY mentors and trainers can take several forms and may evolve within an organization depending on its size. For those sites that are implementing the program for the first time, clinician consultation and coaching is arranged through outside IY accredited trainers at the IY Seattle headquarters via regular telephone or Skype consultations. These trainer consultants have been accredited themselves as clinicians, coaches and mentors and have had extensive experience delivering the programs and training others world wide. Clinicians are also encouraged to submit a DVD of one of their group sessions from their first group for detailed feedback from accredited mentors. After clinicians have had experience delivering the program, about 6 to 9 months after training, it is recommended that they participate in an in-person group consultation training with IY trainers or mentors either onsite at the agency, or in Seattle**.** These group consultation workshops involve small numbers of clinicians (no more than 12) who come together to share selected portions of their DVDs regarding their delivery of the program. Peer sharing and feedback along with IY mentor or trainer coaching regarding these videotaped sessions can be a huge asset in helping clinicians gain new ways to handle problems that are particularly difficult for them. Our data indicates that clinicians, who receive ongoing coaching, support and video feedback from mentors and/or trainers during their first three sets of groups are more successful in when they apply for accreditation (see criteria below).

Building Block #4: Develop Peer Support Networks within Agencies

Weekly peer support and time for planning sessions is key to continued learning and successful intervention, regardless of a clinician's level of expertise or education. Often, clinicians feel a lack of confidence when learning a new program such as a group-based model and may become discouraged when a particular family or child fails to progress. Site-based peer group support in addition to outside IY mentor or trainer consultation helps the clinician to maintain optimism and to find new approaches for resistant parents, teachers or children. Clinicians are encouraged to begin videotaping their groups right away and to meet weekly with peers for video review and for mutual support. IY recommends that teams of clinicians from the same agency are trained together so that they can participate in this peer review process. It is extremely difficult for an isolated clinician to receive the support he or she needs to conduct groups. Clinicians from the same agency or locale are encouraged to join the peer-review process immediately after training, even if they do not have an active group at the time. When clinicians share their work and offer constructive support, they not only aid each other in conducting IY groups but also empower themselves as self-reflective thinkers, learners, self-managers, and evaluators.

Building Block # 5: Adhere to Program Dosage, Order, and Protocols

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

Program order and protocols: IY program protocols for every group session are carefully designed according to age group targeted and population addressed and crafted in a sequence so that one session builds on the prior session learning. For example the IY Parenting Pyramid serves as the architectural plan for delivering the content and helps parents conceptualize effective tools and how they will help them achieve their goals. The base of the pyramid includes tools such as positive attention, child-directed play, coaching methods, and behavior-specific praise. These are used liberally to enhance secure and trusting relationships and this foundation must be strong and precede discipline strategies. Sometimes untrained clinicians skip these early tools because parents request immediate help with discipline problems. To do the program with fidelity, clinicians must learn to trust that the earlier positive parenting strategies are crucial to the success of the later discipline units, and that sometimes parents need even more time working on the foundation of the pyramid before they are ready to move on to the discipline portion.

Program Dosage. Over the past 30 years IY programs have been systematically refined and updated based on ongoing experiences delivering these programs, observational evaluations of behavior outcomes that were changed or not changed and participant feedback. While the first RCT in 1979 with a low-risk, prevention population was 4, 2-hour sessions, the program was gradually lengthened with each study in order to cover all the required content for populations at different levels of risk, to allow time for group relationships to develop, and for the collaborative group discussion and practice components. Currently the length of the parent program protocols vary from 12-26, 2-hour weekly sessions depending on whether it is a treatment, selective or indicated prevention population, the specific program being delivered (Baby, Toddler, Preschool, School Age, Advance) and whether translators are used. A minimum of 18-20 two hour sessions are recommended for clinical populations (children with ADHD or conduct problems), and families referred to Child Protective Service. Groups that require an interpreter will also take 18-20 sessions because of the time that it takes to cover the material in both languages. With high-risk prevention populations we have found that effect sizes increase with the more sessions that parents attend (Baydar et al., 2003). For low risk prevention populations the protocol recommends a minimum of 14 sessions. Clinicians are encouraged to do "make-up" sessions for parents who miss a group session due to illness or schedule conflicts so that they get the full benefits of the intervention.

The recommended number of sessions for these protocols is considered the *minimum number of sessions needed*, but some groups may require more sessions depending on their goals, education and needs, difficulties with understanding the material, degree of severity of children's problems or attachment problems, pace of parents' learning and the size of the group. In order to prevent the ongoing antisocial trajectory with high risk families and to promote children's social and emotional competence and positive relationships among the parents and with clinicians it is necessary for some parents to make significant changes in their parenting and discipline strategies, attachment with their children and involvement in their children's education. This process of relationship building between parents and children and with other parents and changing entrenched patterns of parent–child interactions as well as their emotions and cognitions takes sufficient time as well as development of safety and trust in the group. Offering fewer than the minimum number of recommended sessions for prevention or treatment populations will result in reduced effectiveness of the outcomes of the IY program, but clinicians should have the flexibility to add additional sessions, depending on the groups' needs.

Building Block # 6: Promoting Group Facilitator Accreditation and Development of Accredited Peer Coaches and Mentors

A certification or accreditation process allows clinicians to continue to be supported in their learning of the IY program after the initial training workshop and for agencies to recognize those who strive to become more competent at delivering the programs. Requirements for accreditation include the following: adherence to the required number of minimum session protocols with the majority of core vignettes shown and recommended practices; strong participant attendance with few drop outs; positive weekly and final client evaluations for two complete groups; two self- and peer-evaluations for each complete program offered using the peer content and the methods checklists; completion of a 3-day authorized training workshop; and satisfactory review of a complete video of a group session by an IY trainer who rates the leader's adherence to the program content and methods, as well as their therapeutic skill in the collaborative process using the group process checklists. See web site: www.incredibleyears.com/certification/process_GL.asp

Clinicians who satisfactorily fulfill the requirements for accreditation are adhering with fidelity to delivery of the content and the therapeutic process. Clinicians who become accredited can reasonably anticipate to achieve effects similar to those achieved in the published outcome studies evaluating the program.

To sustain program fidelity and prevent drift away from fidelity, accredited clinicians are encouraged to continue to attend ongoing consultation workshops offered by accredited trainers and mentors and to continue participating in peer-review groups within their agency. Client evaluations and completed session protocols are also part of the clinician's accountability to the agency.

Accredited clinicians with exceptional group leadership skills, peer respect, and a desire to provide support to other leaders are eligible to be nominated by their agency for additional training to become accredited *IY peer coaches* and may eventually proceed to become *accredited mentors*. Peer coaches receive further training in peer coaching and video review processes. They are expected to co-lead groups with new clinicians and to provide them with ongoing support and feedback about the program. They review videos of their sessions and give new clinicians feedback.

IY mentors are accredited clinicians and peer coaches who have been selected to receive more extensive training in a particular IY program workshop delivery and are permitted to offer authorized training workshops within their agency or a defined district. Prospective mentors are selected because they have delivered many groups, are passionate about their work and eager to help others, have received ongoing video reviews and participated in supervision and consultation workshops, and co-lead training workshops with an accredited IY trainer. Site-based mentors receive ongoing outside support and consultation from IY trainers, participate in yearly workshops with other mentors, obtain video feedback on their coaching and workshop delivery process, and participate in further training, and updates regarding new program developments and research. The certification/accreditation progression is outlined on this link to the web site http://incredibleyears.com/certification-gl/

Building Block #7: Supportive Agency or School Infrastructure and Support

No EBP can be faithfully implemented without adequate resources and internal managerial support for the clinicians delivering the program. The decision to adopt an EBP, such as IY, should reflect a consensus among clinicians, teachers, community members and administrators that the choice of intervention model best meets their goals, the agency or school philosophy, and the needs of their teachers, families and children in their community. In other words, there is a good innovation-agency-clinician values fit. It may be necessary for administrators to readjust clinician job descriptions to recognize their time commitments to ongoing training, peer support, supervision, recruiting for and carrying out new interventions. Even though group approaches are more cost effective than individual approaches, administrators may not understand the additional time or costs needed to assure transportation and food for each session, to arrange day care, to prepare materials for each session, to do make up sessions for families, and to make the weekly calls to participants. In many cases, even if administrators recognize the importance of these elements, insurance reimbursement may not be set up to support this model. Frequently private insurance will only reimburse clinicians for individual therapy sessions or reimburse group therapy at such a low rate that it is impossible cover the costs of the group through insurance. If socio-economically disadvantaged families are targeted for prevention programs, special attention must be paid to transportation, day care and meals, otherwise families will have difficulties accessing programs and attendance will be low. Sometimes administrators are surprised to find that the initial 3-day training does not prepare their clinicians to start groups the following week. It is imperative that administrators understand that preparation time is needed to start a new EBP which involves not only clinicians studying the DVDs and training manuals and meeting in peer-support groups to practice with their colleagues as described above but also time to recruit families, to assure appropriate referrals, and to organize appropriate day care which may also involve some additional training.

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

Administrators may select promising clinicians and persuade them to learn this new intervention. The program will attain a strong reputation if it begins with a few enthusiastic clinicians rather than if it begins with a mandate that all clinicians or teachers adopt the program.

Those who are not risk takers, *late adopters*, will venture into new programs only after respected colleagues are successful (Everett M. Rogers, 1995; E.M. Rogers, 1995). Encouraging and supporting selected clinicians who become accredited to continue training to become accredited as peer coaches or mentors builds the infrastructure of a sustainable program. At first, the IY trainers provide direct support to the clinician, as detailed in Building Block #3. However, the goal is to make agencies or schools self-sufficient in their ongoing training and in their support of the program. Administrators can also provide important reinforcement to clinicians by recognizing and rewarding those who work to become accredited and achieve high quality delivery of the program. Reinforcement, both social and tangible, is important to their ongoing commitment and adherence to this program. Moreover, when administrators promote accreditation as a way of supporting evidence-based practice, clinicians appreciate that they are working toward goals and a philosophy that is highly valued by the organization.

### Building Block #8: Monitor Quality Assurance and Evaluation

IY mentor and trainer training quality assurance. Quality assurance procedures are used consistently throughout all aspects of IY training. First, only IY accredited trainers or mentors provide the training. Individuals who enter the mentor training process are supervised by accredited trainers and mentors and receive in-person feedback from them. When they have completed this training and are ready to do a solo workshop, they offer a workshop and submit videos of this workshop for review by an IY trainer. They also submit the workshop protocol checklist documenting what they have covered in the workshop along with workshop evaluations from participants. All accredited mentors or trainers who do workshops must submit daily evaluations of their workshops along with their workshop checklist and daily attendance list to Incredible Years Headquarters in Seattle. If there are issues in regard to evaluations the IY administrator follows up to explore the issue and whether it can be remedied. Participant registration each day at workshops is entered into an IY data bank acknowledging completion of the complete training.

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

Clinicians who have offered the IY program with high fidelity have had considerable support and ongoing monitoring by their workplace administrators. Such administrators have supported their work towards accreditation, monitored their ongoing evaluations and given clinicians time for peer review and technical support. The role of the workplace or administration in promoting and monitoring program fidelity, monitoring and sustainability is further described in an article on the web site (Webster-Stratton, 2006).

In addition, we recommend that administrators conduct ongoing program evaluation by collecting assessments of desired program outcomes. Specific outcome measures used may vary by the agency setting and the level of intervention. Ideally, agencies should collect baseline and

follow-up data about changes in child externalizing and internalizing symptoms as well as changes in parenting or teacher classroom management skills. When possible, we encourage agencies to use some of the same measures used in the trials that established the program efficacy: high quality parent- and teacher-rating scales such as the Achenbach Child Behavior Checklist (Achenbach & Rescorla, 2000) and the shorter symptom reports such as the Eyberg Behavior Checklist (Eyberg & Pincus, 1999). A useful measure of parenting behaviors is also available on the IY website. If possible, it is important for agencies to track other tangible outcomes associated with the program including group attendance and parent and teacher feedback; child academic achievement and school attendance; and feedback from other care providers who work with the child and family.
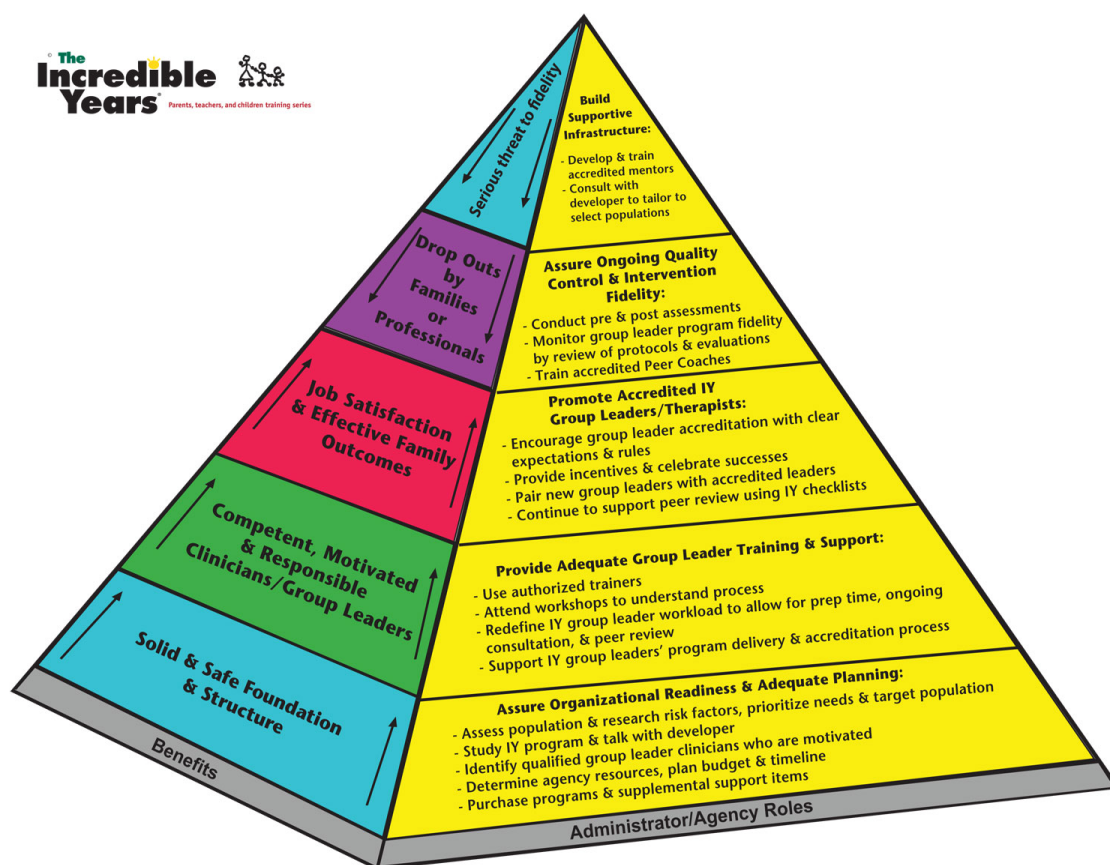
Incredible Years®Administrator/Project Leader Pyramid

This IY pyramid details for administrators or IY project leaders how they can promote fidelity delivery of the program. As can be seen on this pyramid the building blocks #1, 2, 3 and 4 are the bottom two levels comprising the foundation of this pyramid. These lead to a safe and supportive agency foundation with competent, motivated clinicians. In the middle level 3 when clinicians become accredited (blocks 5 and 6), this leads to increased clinician job satisfaction as well as effective family outcomes. The top two levels (blocks 7 and 8) assures that the administration is monitoring quality control and building agency support with in-house accredited coaches and in some cases a mentor. This achievement leads to reduced staff drop out, on going training as needed and prevents any serious threats to program fidelity. These key

building blocks assure fidelity program dissemination and replication of results similar to the original research.

Incredible Years® Supportive Infrastructure

Job Description

Title

IY Accredited Trainer
- Provides consultancy, training and support for mentors and coaches
- Continues to train group leaders
- Reviews DVDs of mentors' and coaches' workshops for accreditation

IY Accredited Mentor (Specific to Type of Program, Designated Agency or Geographical area)
- Provides accredited 3-day training workshops to Group Leaders (teachers or therapists)
- Provides telephone consultations to Group Leaders and Coaches
- Reviews DVDs of group leader groups for accreditation
- Provides consultation workshops for group leaders

Accredited Group Leader Peer Coach (by type of program)
- Assists & observes group leaders with delivery of group program
- Provides DVD feedback of new group leader's program delivery
- Conducts individual meetings with group leaders regarding goals, behavior plans, and additional support
- Attends mentor 3-day training (when invited by mentor)

must be accredited first as group leader to be peer coach

Accredited Group Leader of Parent, Teacher or Child Groups
- Delivers program to parents or teachers or offers children classroom curriculum or small group therapy
- Meets with peer coach for DVD review, planning and feedback regarding behavior plans
- Collaborates with parents and with teachers to promote consistency of strategies, learning and goals across settings (home and school)
- Attend consultation days with mentor or trainer
- Submits materials to IY for accreditation

Parents, Teachers or Children

Successful Implementations

The Incredible Years Series is widely used in Canada, Denmark, England, Finland, Ireland, Australia, New Zealand, Norway, Portugal, Russia, Wales, Scotland, Sweden, the Netherlands and USA. Currently there are 8 accredited trainers, 63 mentors and 52 peer coaches providing training and support in 15 countries. Over the past 10-12 years these countries have trained a substantial number of clinicians who are offering the programs in a variety of settings including Head Start, Sure Start and primary grade schools, primary care doctor's offices, mental health centers, community health centers, jails, families' homes, YMCA, homeless shelters, and businesses (e.g. Goodwill offers the program to some employees). Professionals such as nurses, doctors, social workers, psychologists, teachers and community mental health works have targeted not only parents and teachers for this training but also foster parents, day care workers, teen parents and early childhood teachers.
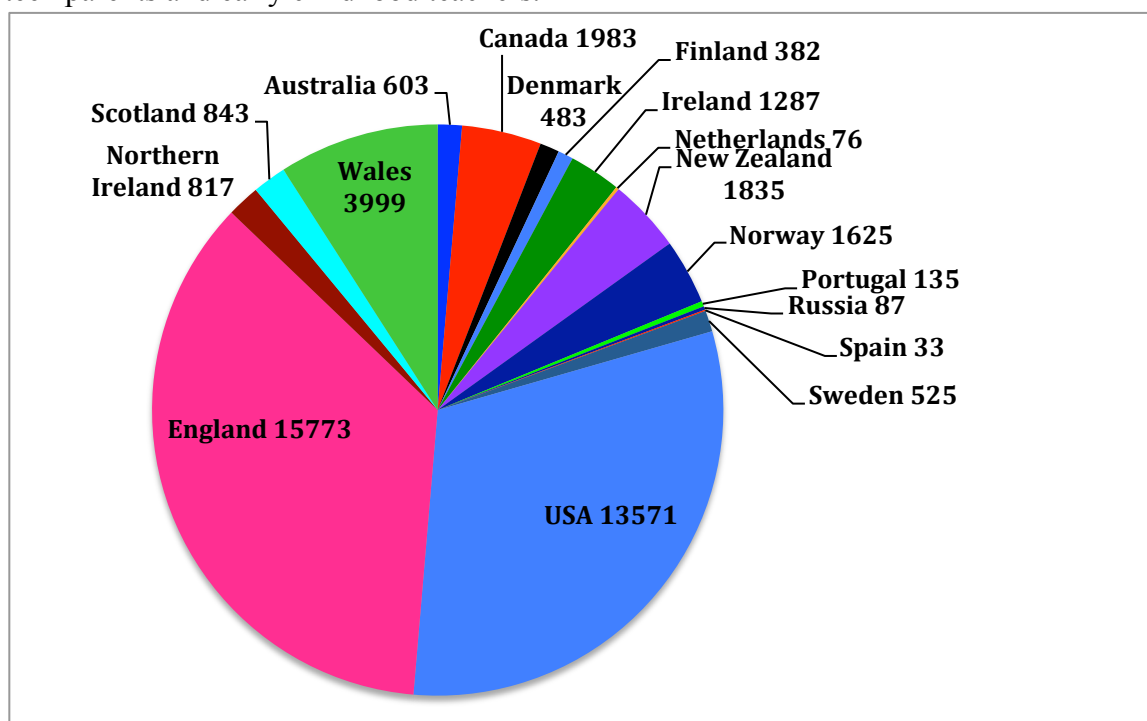
Number of Clinicians Trained in IY Parent, Teacher and Child Programs

The program has been delivered with fidelity on small and large scales in a variety of settings. Model programs include agency level implementation in the Morrison Mental Health Center in Portland, Oregon, and the Children's Hospital Los Angeles (CHLA); city-wide implementation through the Toronto Public Health Nurses; state level implementation in California, Colorado, Pennsylvania, and Ohio; and country level implementation in Denmark, England, Ireland, New Zealand, Norway, and Wales. These successful implementation models all share the common features of state or government financial support and one or more staff members who developed a strong interest in advancing IY in that setting. These internal champions gradually developed expertise in IY, often conducted research evaluations with their population, shared information with colleagues, and developed a plan for rolling out the program over time. Although the detailed strategies described above may sound daunting to consider all at once, they provide organizations and countries with a roadmap to be revisited as an agency or states or countries gradually adopt and scale up IY programs. Moreover, through problem

solving conversations with IY headquarters and trainer team, collaborative plans can be made to determine how to make IY uniquely fit in the context of a particular organization or country using the guidelines and principles described above.

Summary

My experience scaling up IY has taught me that EBP program development must be thought of as an ongoing building process rather than an endpoint. New data will continually emerge to inform real world clinical practice and each unique setting or environment can inform improvements or adaptations to the construction process and further research.   For example, our work with the child welfare referred families led us to expand parent training to include the Advance program focused on interpersonal problems such as depression and anger management and problem solving and to develop protocols for home-coaching sessions to supplement the group experience. And, our experience with having a subsample of children in our studies with co-morbid ADHD and autism spectrum diagnoses has led us to develop additional vignettes to show how the program can be used for this population.   Additionally, the IY Series implementation manuals (including handouts, books and resources given to participants) have been recently updated with new research and feedback, video VHS have been replaced by DVDs with more cultural diversity and languages, and even the suggested number of sessions have been refined based on over 30 years of experiences and participant feedback. An important implication for prevention and dissemination science is understanding that effective programs continue to evolve and improve based on internal audits and feedback. As a parallel, consider that the safety features of cars continuously improve. Few people, when given the option, would opt to drive the old model without safety additions. Gathering data on what works, eliciting ongoing feedback, and actively participating in the implementation of the intervention across a variety of contexts provides the needed information to improve interventions and meet the needs of broader culturally diverse populations.

Agencies such as schools, mental health centers, and hospitals charged with improving the well-being of children and families now have good options for selecting EBPs that are grounded in an extensive research base. At the same time, it has become clear over the past decade that successful implementation of evidence-based programs, including the IY series, requires a serious sustained commitment of personnel and resources. We have learned much about the necessary ingredients for successful transporting efficacious practices like IY into real world settings. Most importantly, we have learned that IY can be disseminated with high fidelity and sustained over time. Some of the critical factors include selecting optimal clinicians to deliver the program; providing them with quality training workshops coupled with ongoing supportive mentoring and consultation, on-site peer and administrative support; facilitative supports; and ongoing program evaluation and monitoring of program dissemination fidelity. Certainly it requires a collaborative team to bring about innovative change. Although it may be tempting for convenience sake and short-term resources to ignore the growing dissemination literature, doing so almost certainly will result in weak and unsustainable programs. Given that there are considerable time and costs involved in delivering even ineffective programs, a much wiser choice would be to invest resources in programs known to sustain high quality evidence-based practices. Only then can we be sure our building construction is solid and our time and efforts have not been wasted.

Achenbach, T. M., & Rescorla, L. A. (2000). *Manual for the ASEBA Preschool Forms and Profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, and Families.

Ainsworth, M. (1974). Infant-mother attachment and social development: Socialization as a product of reciprocal responsiveness to signals. In M. Richards (Ed.), *The integration of the child into the social world*. Cambridge: Cambridge University Press.

Bandura, A. (1977). *Social learning theory*. Englewood Cliffs: Prentice-Hall, Inc.

Bandura, A. (1982). Self-efficacy mechanisms in human agency. *American Psychologist, 84*, 191-215.

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

Bowlby, J. (1980). *Attachment and loss: Loss, sadness, and depression*. New York: Basic Books.

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

Eames, C., Daley, D., Hutchings, J., Whitaker, C. J., Jones, K., Hughes, J. C., & Bywater, T. (2009). Treatment fidelity as a predictor of behaviour change in parents attending group-based parent training. *Child: care, health and development*, 1-10.

Eyberg, S. M., & Pincus, D. (1999). *Eyberg child behavior inventory and Sutter-Eyberg behavior inventory—revised: Professional manual*. Odessa, FL: Psychological Assessment Resources.

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

Hanf, E., & Kling, J. (1973). Facilitating parent-child interactions: A two-stage training model.: University of Oregon Medical School.

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

Lochman, J. E., Boxmeyer, C., Powell, N., Lou, L., Wells, K., & Windle, M. (2009). Dissemination of the Coping Power program: Importance of intensity of counselor training. *Journal of Consulting and Clinical Psychology, 77*(3), 397-409.

Lochman, J. E., Boxmeyer, C., Powell, N., Roth, D., & Windle, M. (2006). Masked intervention effects: Analytic methods for addressing low dosage of intervention. *New Directions for Evaluations, 110*, 19-32.

Menting, A. T. A., Orobio de Castro, B., & Matthys, W. (2013). Effectiveness of the Incredible Years Parent Training to Modify Disruptive and Prosocial Child Behavior:A Meta-Analytic Review. *Clinical Psychology Review, 33*, 901-913.

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

Piaget, J., & Inhelder, B. (1962). *The Psychology of the Child*. New York Basic Books.

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

Reid, M. J., Webster-Stratton, C., & Beauchaine, T. P. (2001). Parent training in Head Start: A comparison of program response among African American, Asian American, Caucasian, and Hispanic mothers. *Prevention Science, 2*(4), 209-227.

Schoenwald, S. K., & Hoagwood, K. (2001). Effectiveness, transportability, and dissemination of interventions: What matters when? *Journal of Psychiatric Services, 52*(9), 1190-1197.

Scott, S., Briskman, J., & O'Connor, T. G. (2014). Early Prevention of Antisocial Personality: Long-Term Follow-up of Two Randomized Controlled Trials Comparing Indicated and Selective Approaches *American Journal of Psychiatry*.

Scott, S., Carby, A., & Rendu, A. (2008). Impact of Therapists' Skill on Effectiveness of Parenting Groups for Child Antisocial Behavior. London: King's College, Institute of Psychiatry, University College London.

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

Webster-Stratton, C. (1982a). The long term effects of a videotape modeling parent training program: Comparison of immediate and 1-year followup results. *Behavior Therapy, 13*, 702-714.

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

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

Webster-Stratton, C. (1990). Enhancing the Effectiveness of Self-Administered Videotape Parent Training for Familis of Conduct-Problem Children *Journal of Abnormal Child Psychology, 18*(5), 479-492.

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

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

Webster-Stratton, C. (2006). Quality Training, Supervision, Ongoing Monitoring, and Agency Support: Key Ingredients to Implementing The Incredible Years Programs with Fidelity. In K. T. Neill (Ed.), *Helping Others Help Children: Clinical Supervision of Child Psychotherapy*: American Psychological Association

Webster-Stratton, C. (2012a). *Collaborating with Parents to Reduce Children's Behavior Problems:A Book for Therapists Using the Incredible Years Programs* Seattle, WA Incredible Years Inc.

Webster-Stratton, C. (2012b). *The Incredible Years Parents, Teachers, and Children's Training Series: Program Content, Methods, Research and Dissemination 1980-2011*. Seattle Incredible Years.

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

Webster-Stratton, C., & Reid, M. J. (2003). Treating conduct problems and strengthening social emotional competence in young children (ages 4-8 years): The Dina Dinosaur treatment program. *Journal of Emotional and Behavioral Disorders, 11*(3), 130-143.

Webster-Stratton, C., & Reid, M. J. (2010). The Incredible Years Parents, Teachers and Children 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, 2nd edition* (pp. 194-210). New York: Guilford Publications.

Webster-Stratton, C., Reid, M. J., & Beauchaine, T. P. (2011). Combining Parent and Child Training for Young Children with ADHD. *Journal of Clinical Child and Adolescent Psychology, 40*(2), 1-13.

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

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

Webster-Stratton, C., Reid, M. J., Hurlburt, M., & Marsenich, L. (2011). Improving therapist fidelity during EBP implementation.

Webster-Stratton, C., Reid, M. J., Hurlburt, M., & Marsenich, L. (2014). Improving therapist fidelity during EBP implementation. *Psychiatric Services.*

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

Webster-Stratton, C., Rinaldi, J., & Reid, J. M. (2010). Long Term Outcomes of the Incredible Years Parenting Program: Predictors of Adolescent Adjustment. *Child and Adolescent Mental Health, 16*(1), 38-46.

Wilson, S. J., & Lipsey, M. W. (2007). School-based interventions for aggressive and disruptive behavior: Update of meta-analysis *American Journal of Preventive Medicine*(33), 130-143.