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Bringing The Incredible Years® Programs to Scale

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Abstract

The Incredible Years® (IY) program series is a set of interlocking and comprehensive training programs for parents, teachers, and children. This article briefly reviews the theoretical foundations, goals, and research underlying these programs. The main purpose of the paper is to describe how the IY programs have been scaled up slowly and carefully with fidelity by engaging in a collaborative building project with strong links between the developer, agency or school administrator, mentors, coaches, clinicians, and families using eight foundational building blocks or fidelity tools. © 2015 Wiley Periodicals, Inc.

Incredible Years Program Background

The series of programs addresses multiple risk factors across home and school settings known to be related to mental health problems in adolescents. The IY parent program content was designed to reduce the malleable family risk factors, including, but not limited to, ineffective parenting, maternal depression, poor attachment, and low parent involvement with teachers. It was also designed to increase protective factors such as responsive, nurturing parenting, and support networks. The IY teacher and child programs' content focused on reducing school risk factors such as poor classroom management skills and classroom aggression. Protective factors to be increased included teacher proactive teaching strategies, positive teacher–parent relationships, and children's emotional regulation. The underlying theory is that positive parenting and teaching relationships when children are young will strengthen children's positive development and, in the long term, prevent the development of negative adjustment problems. (See http://incredibleyears.com/programs for logic models.)

Research Evidence Summary for IY Programs

The efficacy of the IY parent programs for treatment of children diagnosed with ODD/CD and ADHD has been demonstrated in multiple randomized control group trials (RCTs) (see Webster-Stratton & Reid, 2010). Results consistently show improved outcomes, such as reduced harsh discipline, conduct problems, and internalizing symptoms. Several studies have also shown that IY treatment effects are durable from one to three years posttreatment. 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 had minimal behavioral and emotional problems (Webster-Stratton, Rinaldi, & Reid, 2010). A second 7- to 10-year follow-up randomized control group 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, and their children's reading ability was substantially improved in a standardized assessment, compared with families who received "usual mental health services" (Scott, Briskman, & O'Connor, 2014).

A recent meta-analytic review examined the IY parent program studies regarding disruptive and prosocial behavior in 50 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).

The IY teacher classroom management program combined with the IY parent program was evaluated in several RCTs; results showed consistently better classroom outcomes for children in interventions that

combined parent and teacher training (Reid, Webster-Stratton, & Hammond, 2007; Webster-Stratton, Reid, & Hammond, 2004).

There have been several RCTs evaluating the effectiveness of the small-group child-training program; overall results indicated that the combined parent and child interventions showed the most positive effects over an array of behaviors for diagnosed children (Webster-Stratton & Hammond, 1997; Webster-Stratton, Reid, & Beauchaine, 2011).

Scaling Up the IY Programs With Fidelity—A Collaborative Building Project

While the IY programs have been shown in dozens of studies to be transportable and effective across different contexts, unfortunately, barriers to fidelity delivery initially impeded program delivery and outcomes. Such barriers include organizations that were not able to build adequate implementation infrastructure, as well as administrators who failed to select clinicians with the background necessary for the work. Moreover, most organization visions were short term, with limited financial resources. Seldom was there a long-term agency plan, or adequate funding, or ongoing clinician support and consultation, or internal quality control. All of these barriers are likely to result in a low clinician job satisfaction, poor quality delivery, and failure to achieve program sustainability.

Scaling up an evidence-based program (EBP) is like building a house: 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 building links, the building will not be sound. Just like building a house, it is important that the foundation and basic structure be strong. The key foundational components must include the following: (a) picking the right EBP for the level of developmental status of the children, (b) adequately training and coaching clinicians so that they become accredited, and (c) providing quality control. In addition, providing adequate building scaffolding through the use of trained and accredited coaches, mentors, and administrators who can champion quality delivery greatly increases the likelihood of success.

Program fidelity is key to having a supporting infrastructure, as convincing evidence exists that high program delivery fidelity is predictive of significant positive outcomes across a number of different EBPs (Eames et al., 2009; Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002). Fidelity 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). Numerous studies have shown that dosage (Baydar, Reid, & Webster-Stratton, 2003; Lochman, Boxmeyer, Powell, Roth, & Windle, 2006) and quality of program delivery methods are related to effect size of outcomes (Eames et al., 2009; Scott, Carby, & Rendu, 2008). Research has also shown

that adding consultation, coaching, and supervision for clinicians increases the fidelity of program delivery (Henggeler et al., 2002; Lochman et al., 2009; Raver et al., 2008), which in turn leads to better outcomes.

Fidelity for IY builds upon Dane and Schneider's (1998) implementation framework and is broadly conceptualized in five dimensions: (1) program adherence, or delivery of core program components; (2) intervention exposure/dosage, recommended sequence, and length of time recommended; (3) clinician competence, or the IY group facilitator's skill level when using the training methods; (4) program differentiation, or tailored for the population served (prevention vs. treatment), which also determines program dosage; and (5) participant responsiveness and satisfaction with clinician (therapeutic alliance).

The remainder of this article describes how IY programs have been scaled up with fidelity by engaging in a collaborative building project with strong connecting links between the developer, agency administrator, mentors, coaches, clinicians, and families using eight key foundational building blocks that promote adherence to key program principles and protocols.

Building Block #1: Assure Organizational Readiness and Adequate Planning. Prior to scaling up any program, agencies should assess community risk factors, prioritize their community needs, and identify their goals and target population in order to be sure that they are choosing the EBP that is the best fit for them. The IY website provides an agency readiness questionnaire called "Launching IY Programs in Your Organization" to help organizations determine their goals and decide whether they have adequate clinical staff, managerial support, human and financial resources, and 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. Agencies that go through this process are able to evaluate whether the program is a good match for their needs, goals, and philosophies and to determine whether they have adequate funding sources. This process helps them to see the financial and staffing commitment needed to implement the program with fidelity.

Building Block #2: Assure Standardized Quality Training for Selected Group Facilitators. Prior to beginning any program, organizations must assess whether or not they have adequate staff to administer their program well. If an organization does not meet the minimum qualifications, the program should reassess whether or not the intervention is appropriate for the target community. For example, for the IY program it is recommended that each organization prepare a minimum of two to three clinicians for training.

Staff Qualifications. Those chosen to deliver these programs should ideally have master's or higher level degrees or professional diplomas in an appropriate field, such as psychology, social work, school counseling, or teaching; have prior experience working with parents and children; and,

preferably, have had prior training in child development, behavior management, and cognitive social learning theory. Group leader skill level must include a person who is respected as capable of providing skilled leadership while at the same time being collaborative, nurturing, and empathetic. Therapeutic alliance and the relationship between the clinician and group participants is an important factor in determining regular attendance and motivation to change (Webster-Stratton, Reid, & Marsenich, 2014). If it seems unrealistic that the staff will either meet these qualifications or get additional consultation, the organizations should carefully reexamine whether or not the IY is a good fit for their community.

Training Philosophy. Understanding the training philosophy associated with a particular intervention is also critical for successful implementation. For example, is the program a fixed-dosage, inflexible program, or is there flexibility built in? The IY series is a set of principle-driven, dynamic interventions that were developed in applied settings and that are flexibly adapted to each cultural context. 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, 2012). The big ideas or principles, video-based vignettes, and participant books give structure to the programs, but flexible, responsive implementation gives voice to the participants and helps ensure that the content fits the context of their lives.

Initial Workshop Training. Whether a program needs a formal training session is a critical step to understanding how programs can be scaled up to a larger degree. In the case of the IY program, a three-day training workshop with no more than 25 clinicians is required prior to program administration. This workshop is delivered by accredited IY trainers and mentors who have had extensive experience delivering the IY programs themselves. The collaborative process of training clinicians models the therapeutic methods and processes that they will use when delivering their own parent, teacher, or child groups. During this workshop, standardized videos of actual group sessions led by accredited clinicians are used so that clinicians in training can observe and model how to work with groups of parents, teachers, or children.

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 three-day training workshop, clinicians need time to study the manuals and materials, to practice and prepare their sessions, and to arrange logistics. Furthermore, research has shown (Webster-Stratton, Reid, & Marsenich, 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', teachers', and children's behaviors (Eames et al., 2009; Henggeler et al., 2002; Lochman et al., 2009).

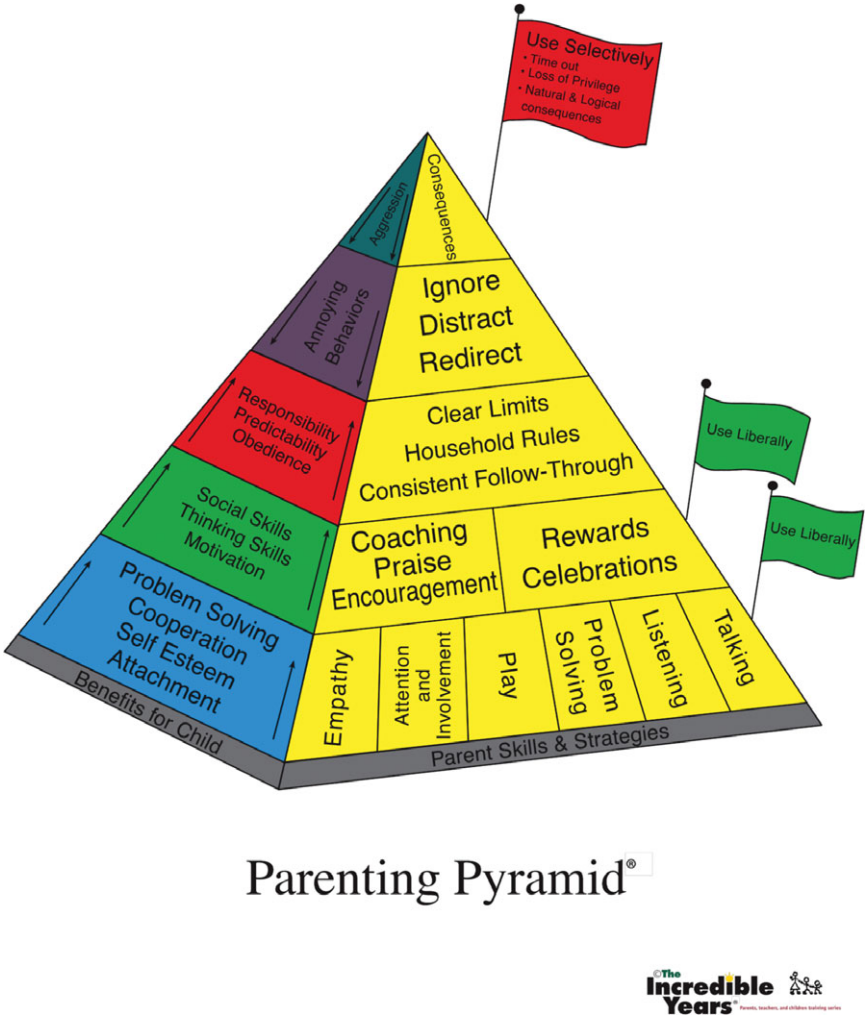
Before deciding to implement the program, administrators must look at the structure of the service delivery within their agencies and build in time for new group leaders to deliver the groups. We typically recommend that new clinicians be allowed six to eight hours per week to deliver a group (this includes studying and preparing for sessions). Very often, clinicians are expected to deliver the program in addition to all their regular workload and existing responsibilities, or are allocated two hours a week to deliver the two-hour group. This 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 two to three sets of groups. Clinicians new to EBPs need help distinguishing between implementing the core or the foundational elements of the program and stifling clinical flexibility. In consultation, mentors help clinicians tailor the program to specific needs. Clinicians come to understand that the principles that guide the program include being flexible, 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; see Figure 7.1) of where they are going.

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 are arranged through outside IY accredited trainers. Clinicians are also encouraged to submit a DVD of one of their group sessions for detailed feedback. After clinicians have had experience delivering the program, about six to nine months after training, it is recommended that they participate in an in-person group consultation training with IY trainers or mentors. These group consultation workshops involve small numbers of clinicians 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, can be a huge asset in developing a support system that helps clinicians gain new ways to handle problems that are particularly difficult for them.

Building Block #4: Develop Peer Support Networks. Weekly peer support and time for planning sessions are 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 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 troubleshoot issues. When clinicians share their work and offer

Figure 7.1. The Incredible Years® Parenting Pyramid®



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. 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 (see Figure 7.1) 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. Sometimes untrained clinicians skip these early tools because parents request immediate help with discipline problems. To achieve the desired outcomes, clinicians must learn to trust that the earlier positive parenting strategies are crucial to the success of the later discipline units.

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 four two-hour sessions, the program was gradually lengthened to cover 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 varies from 12 to 26 two-hour sessions. With high-risk prevention populations, we have found that effect sizes increase with the more sessions that parents attend (Baydar et al., 2003).

The recommended number of sessions for these protocols is considered the *minimum number of sessions needed*. Some groups may require more sessions, depending on the degree of severity of children's problems or attachment problems, pace of parents' learning, and the size of 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.

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. Group leaders who achieve accreditation are acknowledged for delivering the program with fidelity and therefore are believed to achieve results similar to the developer's published results.

Some of the requirements for accreditation include: strong positive weekly and final client evaluations for two complete groups; two self- and peer-evaluations, using the peer content and the methods checklists; completion of a three-day authorized training workshop; and satisfactory

review of a complete video by an IY trainer (see www.incredibleyears.com/certification/process_GL.asp).

Accredited clinicians with exceptional group leadership skills, peer respect, and a desire to provide support to other leaders are eligible to be nominated 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 meet individually with group leader dyads to goal set, review videos of their session, provide support, and set up practices to reenact session scenarios with new approaches. Coaches participate in a similar accreditation process to group leaders by submitting videos of their coaching sessions and evaluations from those they coached. Fidelity of quality of coaching provided posttraining to group leaders is as important as their initial workshop training. This ongoing coaching is critical to being able to scale up with fidelity.

IY mentors are accredited clinicians and peer coaches who have been selected by IY trainers 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. 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 the IY website (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. It may be necessary for administrators to readjust clinician job descriptions to recognize their time commitments to ongoing training, peer support, supervision, and recruiting for and carrying out new interventions. Even though group approaches are more cost effective than individual approaches, administrators may not understand the additional time or costs needed to assure transportation and food for each session, to arrange day care, to prepare materials for each session, or to make weekly calls, to name just a few.

In addition, sometimes administrators are surprised to find that the initial three-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 that involves not only clinicians studying the DVDs and training manuals and meeting in peer support groups to practice, but also time to recruit families, to assure appropriate referrals, and to organize appropriate day care.

The administrative staff and internal advocates commonly referred to as "champions" need to ensure 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. 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 has shown 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).

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 everyone adopts the program. Those who are not risk-takers, the *late adopters*, will venture into new programs only after respected colleagues are successful (Rogers, 1995). Encouraging and supporting selected clinicians who become accredited to continue training to become accredited as peer coaches or mentors build the infrastructure of a sustainable program. At first, the IY trainers provide direct support to the clinician (see 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. Moreover, when administrators promote accreditation as a way of supporting EBP, clinicians appreciate that they are working toward goals and a philosophy that are highly valued by the organization.

Building Block #8: Monitor Quality Assurance and Evaluation. Quality assurance procedures and ongoing program evaluation ensure the continued quality of training programs.

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 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 IY headquarters for every workshop.

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 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 whether clinicians are adhering to program fidelity.

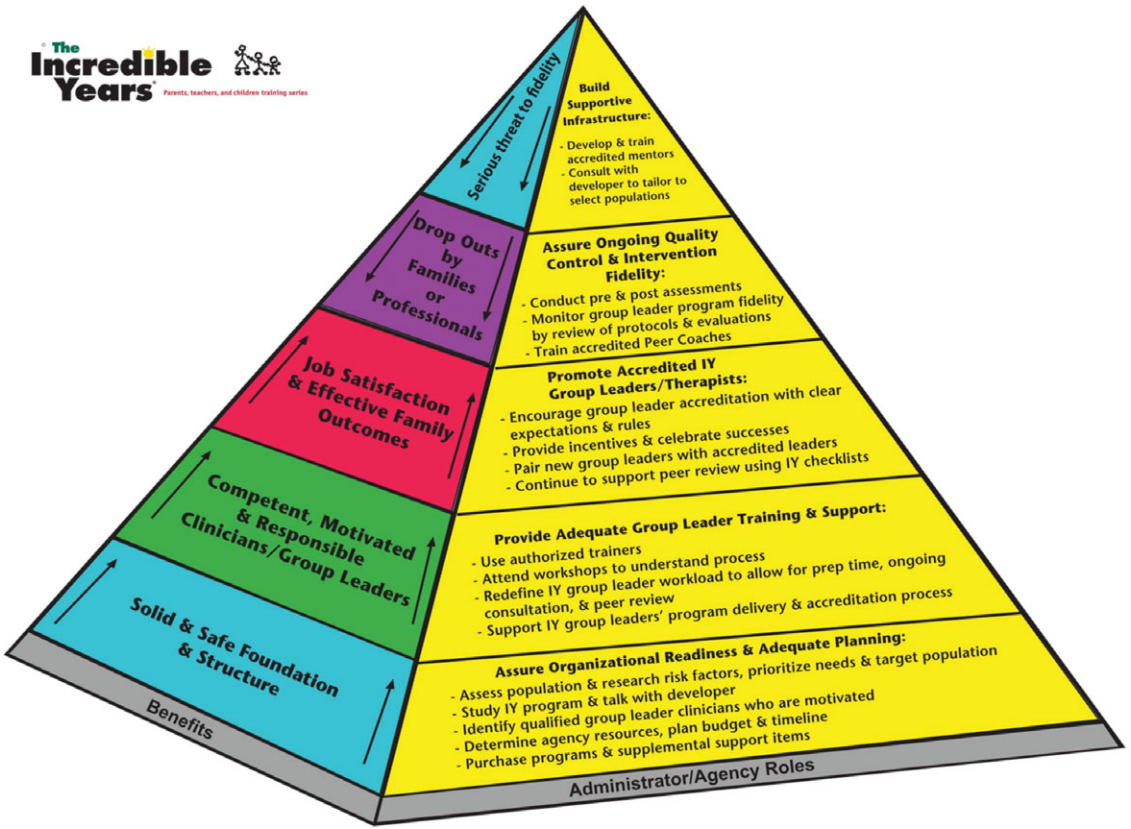
In addition, we recommend that administrators conduct ongoing program evaluation by collecting assessments of desired program outcomes. Specific outcome measures used may vary. Ideally, agencies should collect baseline and follow-up data about changes in child externalizing and internalizing symptoms, 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, such a high-quality parent- and teacher-rating scale. If possible, it is beneficial 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.

This IY pyramid (see Figure 7.2) 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 careful planning and organization readiness, adequate funding, quality training, and 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 fidelity program delivery and clinician job satisfaction, as well as effective outcomes. The top two levels (blocks #7 and #8) ensure that the administration is monitoring quality control and building agency support with in-house accredited peer coaches and in some cases an IY mentor. This achievement leads to reduced staff dropout, promotes ongoing training as needed, and prevents any serious threats to program fidelity.

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 a focus on interpersonal problems, and to develop protocols for home coaching sessions to supplement the group experience. In addition, the IY series implementation manuals have been recently updated with new research and feedback, and even the suggested number of sessions has been refined based on more than 30 years of experiences and participant feedback. An important implication for prevention and dissemination science is understanding that effective programs continue to evolve and

Figure 7.2. The Incredible Years® Administrator/Project Leader Pyramid



improve based on internal audits and feedback. By way of analogy, consider how 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 provide 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 EBPs, including the IY series, requires a serious sustained commitment of personnel and resources. 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, as well as on-site peer and administrative support; providing facilitative supports; and ensuring ongoing program evaluation and monitoring of program dissemination fidelity. Certainly it requires a collaborative team to bring about innovative change. Given that considerable time and costs are involved in delivering even ineffective programs, a much wiser choice would be to invest resources in programs known to sustain high-quality EBPs. Only then can we be sure our building construction is solid and our time and efforts have not been wasted.

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