Questions about Fidelity Delivery of the Incredible Years (IY) Programs

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What does it mean to deliver an evidence-based psychosocial intervention with fidelity?

Fidelity is a term defined as the degree of exactness with which clinicians adhere to, or reproduce the original program model, which was researched and found to be effective in randomized control group studies. Fidelity refers to not only delivery of the program core content and treatment dosage in the recommended sequence but also clinician's use of the clinical methods and processes employed in the original program model. In addition it refers to implementation of the program with the population for whom the program was designed.

Why does fidelity matter?

Having high program delivery fidelity has been shown to predict significant improvements in parents and childrens' behaviors across a number of different evidence-based practices (Eames et al., 2009; Scott W. Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002). On the other hand, poor program fidelity and reduced program dosage (in terms of numbers of sessions) has been shown to predict little or no change, challenging the view that some exposure to program components is better than no exposure.

How do you measure program fidelity?

It has been common practice to monitor psychosocial intervention adherence by collecting session checklists wherein clinicians check off whether they delivered specific content for the session, showed particular video vignettes, and asked participants to do particular home activities. Although these checklists are easy to complete, they are limited (as with any self-reports) by subjective bias and they do not always correlate with independent evaluations by supervisors. They also lack information about specific delivery methods and processes utilized by clinicians as well as consumer feedback and satisfaction level. Without supervision or monitoring it is not clear what clinicians may be omitting or altering or how they are actually delivering the program.

Process skills are critical to assessing fidelity delivery of IY interventions. The therapist/teacher/group leader's therapeutic relationship with parents, use of the collaborative process, knowledge about the program and child development, and the ability to address issues specific to each population are all critical aspects of fidelity. For this reason, fidelity of the IY program is assured in multiple ways by leader session checklists, by peer and self-evaluations, weekly session evaluations by participants, and by video review of sessions with standardized observational measures of delivery methods and processes. All of these elements are necessary in order to be certified/accredited as group leaders in the IY programs.

How is fidelity achieved?
Researchers of several evidence-based programs in community settings have reported their ability to promote enhanced fidelity delivery of programs with positive outcomes by providing extensive training by certified trainers and mentors, ongoing consultation and clinical group leader supervision. In comparison to clinicians who did not have this enhanced support (control condition), results were less effective (S. W. Henggeler, Schoenwald, & Pickrel, 1995; Lochman et al., 2009).

Accreditation/certification of group leaders in the various IY programs is recommended as a way to ensure ongoing consultation, support and program fidelity. Agencies and schools are encouraged to support clinicians' accreditation by planning for telephone consultation, video feedback and live group consultation by accredited mentors and trainers. Once agencies have IY group leaders who are accredited, they can begin to build a supportive infrastructure with accredited group leaders who help coach new group leaders. These experienced leaders can receive additional IY training in the peer coaching process and eventually progress to mentor status, which allows them to provide their own workshops for their agency or district. More information on the group leader, coach and mentor training progression can be found on the IY web site.
http://www.incredibleyears.com/Certification/process_GL.asp

There has been tremendous work and research of the highest quality, with IY programs in the United States, England, Wales, Norway and Holland (Webster-Stratton & Reid, 2010). Other countries, particularly Denmark and New Zealand, have made exemplary efforts to disseminate the programs with high fidelity and to support their group leaders' accreditation. For these countries, the percentage of those accredited relative to those initially trained is very high. Information on implementation examples in various countries can be found at the following link
http://www.incredibleyears.com/IA/implementation_exmples.asp

Why is there separate accreditation for the IY Baby Program (0 – 12 months), Toddler Program (1-3 years), for the Preschool (3-5 years) and School Age Program (6-12 years) and the Advance Program?

Each of these parent programs addresses a different childhood developmental stage of children's cognitive development and requires that group leaders have an understanding of the milestones and the parenting strategies most appropriate for that age group. For the baby and toddler program there is an emphasis on brain development, language development, feeding and sleeping routines, and baby-proofing homes. For the preschool program there is an emphases on school readiness skills and strategies to promote self-regulation. For the school age program, the focus is on promoting academic skills as well as promoting children's sense of responsibility, family chores and monitoring children's after school activities. The advance program focuses on marital communication and conflict management, depression management, coping skills and problem solving. The separate accreditation for each of the four parent programs is, in part, driven by the desire to ensure the content is well understood. The group leader methods and processes are the same across all the programs, so it is not unusual for those who have been accredited in

one program to make the transition to accreditation in another program with greater ease and in a shorter time frame.

Most group leaders will come to see that mentor coaching supports them, empowers them, builds their competency and motivation so they want to do this and feel professionally rewarded ~ internally if not externally. The process of accreditation is not just about filing out checklists to say that specific content was covered, but is more about the more difficult therapeutic delivery process and methods required to bring about sustained change.

Accreditation is more than having one group session video passed off regarding delivery process and methods used. It also involves IY administration checking the number of sessions offered and what length of session, attendance and drop outs, number of vignettes shown, and parent evaluations. All these must be "good enough" or accreditation is not given despite having a video passed off. The decision of what is "good enough" is considered very carefully, and according to the standards set by IY and outlined on the web site. Applications for leaders delivering the program as prevention are considered separately from those delivering the program in treatment settings since there are different issues and IY recommendations for the two delivery settings. This accreditation process is not meant to be a sort of "rubber stamp" on group leaders' paperwork, rather to enhance quality program delivery.

How has the update of the Incredible Years Parent Programs changed the certification/accreditation process?

Research has shown a strong evidence base for the IY parent program delivered both as a prevention program with high-risk populations as well as a treatment program for diagnosed children and for child welfare referred families. The original version of the prevention parent program researched was primarily 12, 2-hour weekly sessions while the treatment version researched has varied from 18-26 sessions. Three years ago the parent programs were updated with new content and video vignettes and further delineation of the content relative to developmental milestones of specific age groups. The original Basic Program was subdivided to include a Toddler version separated from the Preschool Program. The School Age Program was expanded to have a protocol for early school age (6-8 years) separate from preadolescents (9-12 years). The baby program requires a minimum of 8 sessions and the toddler a minimum of 12 sessions to be offered for accreditation with prevention populations. Experience using the baby program with child welfare families has indicated that planning for 12-16 sessions is more realistic to cover the material adequately. The Preschool Program number of sessions was expanded to 14 sessions to be able to complete the prevention program and to18 sessions for high-risk populations or, for treatment programs. The School Age program is still 12-16 sessions but the Advance program is recommended for families with highly antisocial children, which would add additional sessions. However, current economic climate has caused commissioners and other administrators to consider reducing program sessions for both treatment and prevention program deliveries. The remainder of this document is

provided to explain why the programs have been updated and lengthened and why it is important to keep the bar high for those clinicians becoming accredited in terms of sustaining fidelity of program delivery.

History of IY Parent Program Development

There are randomized control group trials (RCTs) by the developer and independent researchers showing the impact of the original BASIC parent preschool program in 12 sessions for prevention populations. This parent program was developed in the early 80's and offered in 2-hour weekly sessions over 10-12 weeks. However, it quickly became apparent that 12 sessions was insufficient to meet the needs of families with children diagnosed with conduct problems and by the end of the 80's the treatment program protocol was expanded to 20-24 sessions. Additionally, most group leaders working with economically disadvantaged families reported struggles covering all the content and practices in a 12-week time frame, especially when family background experiences were fraught with neglect and abuse. Parent feedback also indicated the need for the original Basic program to be updated and expanded to represent more culturally diverse and disadvantaged families and additional content. In 2006 the program was updated to include new content on academic, persistence, social and emotion coaching methods, information on age appropriate developmental milestones, home safety-proofing, consistent and predictable family routines, how to handle separations and reunions, and an increased emphasis on problem solving and using time out to help children learn how to calm down. Consumer evaluations indicated that these new content areas would help families and children even more than the original model.

How do you determine program length?

Before the addition of the new content outlined above, most groups already needed at least 12 weekly 2-hour sessions to deliver the key content for the preschool program; the expanded preschool program, which is more comprehensive, therefore needed more time. The expanded time frame also allows group leaders to engage in the critical group process collaborative methods such as experiential practices and reflective learning necessary for sustained change.

The developer's own ongoing experience delivering the improved Preschool Program with diagnosed children indicated that it takes a minimum of 18-20 weekly, 2-hour sessions to complete the material in a quality way. After some initial feedback from users, a compromise was made for use with prevention populations to say that a minimum of 14 weekly, 2-hour sessions might be reasonable, and a specific protocol was developed for the 14 sessions for this prevention population. However, for high risk and treatment groups, a minimum of 18 weekly, 2-hour sessions are recommended to complete the material; additionally, many group leaders working with child welfare populations and new immigrant families need *at least* 18 sessions to absorb the material and make behavior and learning changes. Program length should meet minimum requirements but be flexible enough to allow additional sessions according to parent group size, parents' mental health issues and baseline knowledge of children's developmental needs, children's diagnoses, and whether interpreters are being used.

Is the extra effort worth it? Does the "improved" program lead to improved outcomes?

There are no RCTs comparing the older version of the basic program with the updated version. However, it is important to note that the updated version contains all the same vignettes and process elements as in the older version but has been enhanced with additional vignettes, topics and methods as described earlier. The analogy might be made to the latest car models, which now include air bags, seat belts and power steering and enhancements not contained in the 80's model. Thus the new car model is safer and more comfortable. In regard to program dose regarding number of sessions offered, there are no RCTS comparing the longer and shorter IY intervention doses, but data from prevention studies by the developer comparing dosage and outcomes has shown that the more sessions offered, the higher effect sizes (Baydar, Reid, & Webster-Stratton, 2003). More does appear to be better. In the last 15 years all treatment studies conducted by the developer with the Preschool Basic program for children with diagnoses have ranged from 18-26 weekly, 2-hour sessions. A recent comparison of 20 weekly, 2-hour sessions with half the dose (10 sessions) for parents with children with ADHD found significant differences in outcomes in regard to parent and child changes. Moreover, in regard to "consumer" satisfaction, parents prefer the longer programs, and many in the older, shorter programs said on evaluations that they would have preferred "more" sessions and would like their group to continue.

Yes, 12 weekly, 2-hour sessions do work as research has shown with high-risk prevention populations. However, there is a strong rationale for more sessions, and research from our own studies as well as other evidence-based programs attests to higher treatment exposure leading to more improvements compared with lower exposure groups. It's in the nature of all good interventions that they evolve and become better over time due to continued research and quality improvements. The goal in regard to development of IY programs has always been to encourage their evolution and improvement based on research and clinical feedback, even if this becomes somewhat more difficult to deliver.

Is it better to give a little intervention to a lot of people or give a lot to relatively fewer people?

This can be a tough even heartbreaking choice with no clear answers. There are real-world limitations in achieving our goals ~ but I believe we should set the bar as high as possible. Efforts should be put in giving all high risk families quality delivery and more intervention, not less. In reality adding 2 more weekly, 2-hour sessions for the preschool prevention program (total of 14) and 18-20 for treatment with the preschool or school age programs is a small price to pay and will likely have only a small effect on how many people can be offered the program. Moreover, if results are more stable then there will be fewer people to serve in the future.

Some have argued that the parenting services need to match the school term and therefore cannot be longer than 12 weekly, 2-hour sessions. However, it has never been the practice of IY parent programs to match school schedules, rather the length of intervention should be based on the degree of risk of the population addressed and the nature of the parent and children's problems.

If all group leaders are required to run 14-18 weekly, 2-hour sessions to achieve certification or accreditation in the preschool prevention or treatment models, won't this reduce the number of group leaders who will be accredited? Won't this disincentivise individuals from seeking certification?

Certification/accreditation may not be the main issue here. In point of fact, unfortunately the number of group leaders in the past 10 years who have chosen to pursue accreditation/certification is small, relative to numbers trained in United States and United Kingdom. Countries such as Norway, Denmark, Ireland and New Zealand are doing very well due to the support provided for consultation and accreditation. It probably does not help to water down the accreditation/certification process in order to get more group leaders accredited because then fidelity of delivery is reduced. Instead those who do achieve accreditation/certification are recognized as both up-to-date on where the program is evolving and have demonstrated mastery. Lowering the bar will likely not help. If group leaders are accredited they are recognized as delivering with fidelity to the model, which achieves best results. And from that group of accredited group leaders agencies will have competent models to choose from to further develop their coaches and mentors to support new quality growth and a self-sustaining agency infrastructure.

Won't commissioners/agency administrators refuse to support IY if accreditation is too hard or the programs seem too long? Will it mean they will be less likely to deliver IY at all?

Again some commissioners may be looking for a quick and cheap fix – not only in terms of shorter programs but also in terms of expedient short-term training of leaders to achieve target numbers trained. Sustainable change ~ whether it is the group leader skills or the parent change is not quick or easy ~ time is needed to absorb, practice and get feedback. IY doesn't promise a quick fix. Possibly commissioners need education to understand that the process of accreditation is one of continuing to train group leaders until they are competent. This is not unlike an internship for doctors or electricians who work with someone accredited who models the skills and provides feedback and support for their efforts.

In a recent RCT study that is just being analyzed now from California – the group leaders who received "enhanced support" (telephone consultations and video reviews by accredited mentors) showed significantly improved skills leading groups than those who had the "train and hope" model with no further consultation or support. The enhanced group leaders were more collaborative, mediated vignettes more skillfully, provided more practical support to families (food and child care), and demonstrated a higher level of program knowledge. Research is UK has pointed to the better outcomes when group leaders deliver the program with higher fidelity to group leader skills (Eames et al., 2009).

How will IY help group leaders transition from the old program to the updated program? Will group leaders get any credit for work already conducted delivering the older program in terms of accreditation criteria?

For English speaking countries, IY has accepted the old 12 session program protocols and materials for accreditation for the past 3 years. These materials will be accepted until December 31, 2011. After this transition period, it will be necessary for group leaders to lead groups using the updated program in 14+ sessions for prevention accreditation and 18 sessions for treatment or high risk population accreditation.

Prior to December 31, 2011

- 12 weekly, 2-hour session delivery of the old program using old protocols will be considered for accreditation.

After December 31, 2011

- After December 31st, one of the two sets of groups submitted must have used the updated program and updated protocols, with a minimum of 14 weekly, 2-hour sessions for prevention populations and 18 for high risk or treatment populations. One set of the old program protocols will be accepted.
- After December 31st, 2012, all applications must use the updated program for both sets of groups.
- We will not accept less than 14 weekly, 2-hour sessions for the updated preschool basic program and recommend longer dosage.

*there are other required numbers of sessions for the different parent programs. The above numbers refer to the Basic preschool/early childhood program.

Non-English speaking Countries

Countries such as Norway or Sweden are in a separate situation from English speaking countries regarding their clock for transitioning to the new accreditation procedures. This will begin when they have completed the translated, updated program and their group leaders have this program to work with.

Summary

IY accredited mentors and trainers are available to help group leaders to deliver the updated programs and to help them understand the importance of providing comprehensive and quality delivery, especially for disadvantaged families or families with children with behavior problems. It is the hope that high risk families receive not only the full dose of the recommended parent programs but also be scaffolded at each developmental phase of their children's lives, beginning with infancy and through school age years. If such services are provided to these families there is the potential to affect the next generation of parenting. The goal is to plan for long-term effects rather than make short-term decisions based on the current budget situation.

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