The Incredible Years® Series:

An Internationally Evidenced Multi-modal Approach to Enhancing Child Outcomes

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This chapter provides an overview of theory and practice of The Incredible Years® Series; reviewing research support for its efficacy, highlighting emerging developments in both the United States (US) and internationally, using examples of research and application, and including cultural adaptations or accommodations to increase inclusivity. The Incredible Years® Series was developed in the late 1970's and 80's in Seattle, US, by the first author to address child behavioral and emotional difficulties and enhance positive life outcomes, and comprises programs for parents, teachers and children (Webster-Stratton, 2016).

Child behavioral and emotional difficulties

Rates of clinically significant behavioral and emotional difficulties are as high as 6-15% in 3-12 year old children (Egger & Angold, 2006). These numbers are even higher for children from economically-disadvantaged families (Webster-Stratton & Hammond, 1998), and higher still (50%) for children in foster care in the US (Burns et al., 2004). Foster children in the UK have a ratio of 3.7:1 higher rates of disorder than children living in disadvantaged private households (defined as the parents having either never worked or worked in unskilled occupations) (Ford, Vostanis, Meltzer, & Goodman, 2007). Children with early-onset behavioral and emotional difficulties are at increased risk of developing severe adjustment difficulties, conduct disorders (CD), school drop out, violence behaviors, and substance abuse in adolescence and adulthood (Egger & Angold, 2006). However, interventions, when delivered early, can prevent and reduce the development of conduct problems, and strengthen child protective factors such as social and emotional competence, wellbeing, and school success (Kazdin & Weisz, 2010).

A variety of risk factors may contribute to early-onset of behavioral and emotional difficulties including ineffective parenting (e.g., harsh discipline, low parent involvement in school, neglect and low monitoring) (Jaffee, Caspi, Moffitt, & Taylor, 2004); family risk factors (e.g., marital conflict, parental drug abuse, mental illness, and criminal behavior) (Knutson, DeGarmo, Koeppl, & Reid, 2005); child biological and developmental risk factors (e.g., attention

deficit hyperactivity disorders (ADHD), learning disabilities, and language delays); school risk factors (e.g., poor teacher classroom management, high levels of classroom aggression, large class sizes, and poor school-home communication); and peer and community risk factors (e.g., poverty and gangs) (Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000). Three decades of research by prominent researchers such as (Dishion & Piehler, 2007; Patterson & Fisher, 2002) have consistently demonstrated the links between child, family, and school risk factors and the development of antisocial behaviors and have informed intervention development and delivery. Effective interventions for preventing and reducing behavior problems should ideally be offered, and delivered early before delinquent and aggressive behaviors become entrenched and secondary risk factors such as family isolation and lack of support, academic failure and the formation of deviant peer groups have developed. Moreover interventions should be 'multi-modal' in order to target multiple risk factors, at school/community, family, and individual level/s, and be effectively targeted to ensure that those who need support actually receive it. Furthermore group-based interventions are recommended because they have been shown to improve child behavior problems, strengthen social support, parenting skills *and* also improve parental mental health such as depression and marital conflict (Furlong, McGilloway, Bywater, et al., 2012).

The Incredible Years® (IY) Series, was designed as a set of interlocking and comprehensive training programs to prevent and treat behavior difficulties from infancy– toddlerhood through middle childhood. IY is a multi-modal program that can be utilised to intervene in multiple areas and settings through parent, teacher, and child training. The model's theory of change is that improving protective factors such as responsive and positive parent-teacher-child interactions will lead to improved school readiness and success, emotion regulation, social competence, and socially acceptable behavior in young children, subsequently leading to longer-term positive outcomes such as increased academic achievement, and reduced school drop-out, CD, and substance abuse problems in later life. See web site for logic model http://incredibleyears.com/programs/.

The following sections will outline the underlying theoretical background for the IY BASIC parent programs (baby, toddler, preschool and school-age), which are considered "core" and a necessary component of the prevention model for young children. The IY adjunct parent, teacher, and child programs, and how they are added to address family and school risk factors

and children's developmental issues, will also be presented. Information regarding IY program content and delivery methods will be briefly described, as will ways to promote successful delivery of the programs. US and international evidence base for the IY programs will be highlighted, with a section on transportability of programs and adaptations and accommodations in   different   countries.

Figure 1. The international spread of IY in 26 countries across six continents

Theoretical Background for Incredible Years Program Content & Methods

The underlying theoretical background for IY parent, teacher, and child programs include; cognitive social learning theory, particularly Patterson, Reid, and Dishion's (1992) "coercion hypothesis" of negative reinforcement developing and maintaining deviant behavior; Bandura's modeling and self-efficacy theories (Albert Bandura, 1986); Piaget and Inhelder's developmental cognitive learning stages and interactive learning method (Piaget & Inhelder, 1962); cognitive strategies for challenging angry, negative and depressive self-talk and increasing parent self-esteem and self-confidence (e.g. (Beck, 1979)); and attachment and relationship theories (e.g. Ainsworth, 1974).

These theories inform the delivery method for all the IY programs. For example, the IY

video vignettes portray parents or teachers from different cultural backgrounds using social and emotional coaching, or positive discipline strategies, or of children managing conflict with appropriate solutions. Video-based modeling, based on social learning and modeling theory (A. Bandura, 1977), supports the learning of new skills. IY group leaders use the vignettes as a tool to engage participants in group discussion, collaborative learning and emotional support. Further, participants identify key "principles" from the vignettes and apply them to their personal goals by practicing what they have learned in the group, home, or classroom. Participants have been shown to implement interventions with greater integrity when they receive coaching and feedback on their application of intervention strategies (Reinke, Stormont, Webster-Stratton, Newcomer, & Herman, 2012).

The group format is advantageous as it is more cost-effective than individual intervention; addresses risk factors such as family isolation and stigmatization, or teacher's sense of frustration and blame, and children's feelings of loneliness or peer rejection; and helps reduce resistance to the intervention through the collective group wisdom. When participants express beliefs counter to effective practices, the IY group leader draws on other group members to express alternaive viewpoints. The group leader is thereby able to elicit change talk from the participants themselves that makes it more likely they will follow through on intended changes. Group leaders always operate within a collaborative context, sensitive to individual cultural differences and personal values. The collaborative therapy process is also provided in a text for group leaders, titled *Collaborating with Parents to Reduce Children's Behavior Problems: A Book for Therapists Using the Incredible Years Programs* (Webster-Stratton, 2012b).
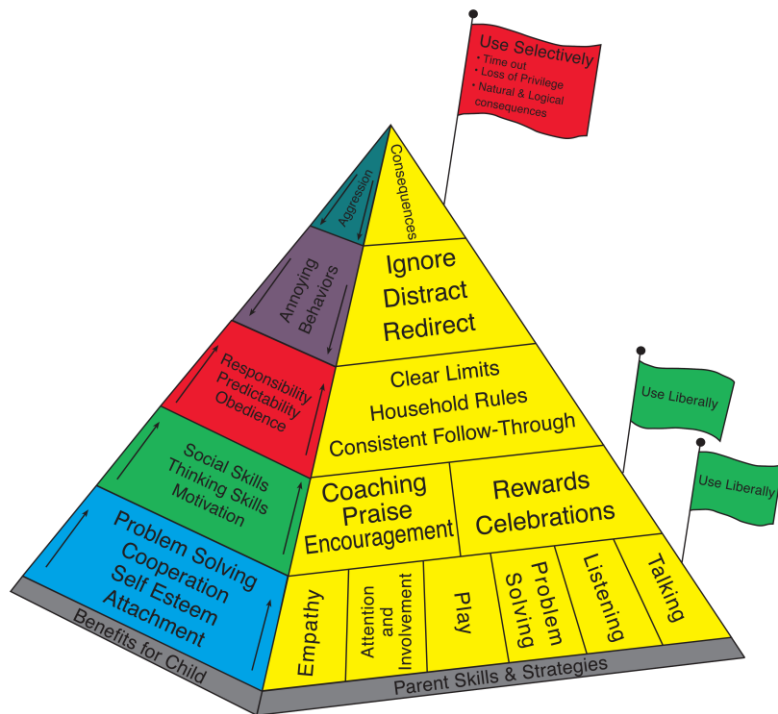
Incredible Years® Core Parent Programs

The BASIC (core) parent training consists of 4 different currciula to fit child developmental stages: 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, recently updated, programs emphasize developmentally appropriate parenting skills and include age-appropriate video examples of culturally diverse families and children with varying temperaments and developmental issues. The programs run from 9-22 weeks, depending on the

age of the child and the presenting issues of the parents and children in the group ("Incredible Years Parent program").

For all parent training programs, trained and, ideally, accredited IY group leaders/clinicians use video vignettes of modeled parenting skills (over 300 vignettes, each lasting approximately 1–3 minutes) which are shown to groups of 8–12 parents. The vignettes demonstrate child development as well as parenting principles and serve as the stimulus for focused discussions, self-reflection, problem solving, practices, and collaborative learning. The programs support parents' understanding of typical child developmental milestones and varying temperaments, child safety and monitoring, as well as age-appropriate parenting responses. Participation in the *group* based IY training program is preferable for the benefits of support and learning provided by other parents, however, a *Home-based Coaching Model* for each parenting program exists. Home-based sessions can be offered to parents who cannot attend groups, or who do not feel ready to participate in a group, or as make-up when parents miss a group session, or to supplement the group program for very high-risk families.

Program goals are tailored to be developmentally appropriate and represented in The Incredible Years Parenting Pyramid® (Figure 2). The pyramid helps parents conceptualize effective parenting tools they can use to achieve their goals. The pyramid base depicts liberally used parenting tools, which are presented in the first half of the program and form the foundation for children's emotional, social and academic learning. These include positive parent attention, communication, and child-directed play interactions designed to build secure, trusting relationships. Parents also learn how to use specific academic, persistence, social and emotional coaching tools to help children learn to self-regulate and manage their feelings, persist with learning despite obstacles, and develop friendships.

Figure 2. The Incredible Years Parent Pyramid

One step up the pyramid depicts behavior-specific praise, incentive programs, and celebrations for when goals are achieved, followed by use of predictable routines and household rules to scaffold children's exploratory behaviors and their drive for autonomy. The top half of the pyramid presents tools used more sparingly, to reduce specific targeted behaviors, such as ignoring of inappropriate behaviors, distraction and redirection, and discipline tools such as Time Out to calm down for aggressive behaviors and logical consequences. In addition, parents learn how to develop supportive partnerships with teachers by collaborating on behavior plans and how to support their child's school-related activities.

There are two basic premises of the model: 1) a positive relationship foundation must precede clear and predictable discipline strategies. This sequence of delivery of content is critical

to the program's success; 2) attention to positive behavior, feelings, and cognitions should occur far more frequently than attention to negative behaviors, feelings and cognitions. Tools from higher up on the pyramid only work when the postive foundation has been solidly constructed with secure scaffolding.

Incredible Years® Adjuncts to Parent Programs

Optional adjunct parenting programs can be used in combination with BASIC parenting programs outlined above.

1. The ADVANCE parenting program, offered after the BASIC preschool or school-age programs, was designed for selective high-risk and indicated populations and focuses on ways to reduce parents' interpersonal risk factors such as anger and depression, poor communication, lack of support, problem-solving difficulties between parents and with teachers, and children's poor self-regulation skills.

2. An adjunct to the Preschool Program is the *School Readiness Program* for parents of children ages 3–4 years that is designed to help parents support their children's preliteracy and interactive reading readiness skills.

3. An adjunct for the Toddler, Preschool, and Early School Age programs is the *Attentive Parenting Program.* This program is designed to teach parents of children 2-6 years (who do not have behavioral issues) social, emotional and persistence coaching, reading skills and how to promote children's self-regulation skills and problem-solving skills. It is also recommended as booster sessions for indicated populations following BASIC parenting program completion.

4. The *Autism Program* is for parents of children on the autism spectrum or whose children have language delays. It can be used independently or in conjunction with the BASIC preschool program.

Incredible Years® Teacher Classroom Management Program

The Incredible Years® Teacher Classroom Management (IY-TCM) program is a 6-day group-based program delivered monthly by accredited group leaders in small workshops (14-16 teachers) throughout the school year. It is recommended that trained IY coaches support teachers between workshops by visiting their classrooms, helping refine behavior plans, and addressing teacher's goals. The goals of IY-TCM include: (a) improving teachers' classroom management skills, including proactive teaching approaches and effective discipline; (b) increasing teachers' use of academic, persistence, social, and emotional coaching with students; (c) strengthening teacher–student bonding; (d) increasing teachers' ability to teach social skills, anger management, and problem-solving skills in the classroom; (e) improving home–school collaboration, behavior planning and parent–teacher bonding and (f) building teachers' support networks. The curriculum is described in the teachers' course book, *Incredible Teachers: Nurturing Children's Social, Emotional and Academic Competence* (Webster-Stratton, 2012c) (for information on IY-TCM training/delivery see (Reinke et al., 2012) or (Webster-Stratton & Herman, 2010).

Incredible Beginnings: Teacher and Child Care Provider Program. This 6-day group-based program is for day care providers and preschool teachers of children ages 1-5 years. Topics include coping with toddler's separation anxiety and promoting attachment with caregivers; collaborating with parents and promoting their involvement; promoting language development with gestures, imitation, modeling, songs and narrated play; using puppets, visual prompts, books and child-directed coaching methods to promote social and emotional development; and proactive behavior management approaches.

Helping Preschool Children with Autism: Teachers and Parents as Partners Program. This program is designed as an add-on to the IY Parent program for Children on the Autism Spectrum and to the IY TCM Program. The program focuses on how to promote language development and communication with peers and helps providers to provide social and emotional coaching and teach children self-regulation skills.

Incredible Years® Child Programs (Dinosaur Curricula)

Two versions of the IY child program have been developed. 1) In the *universal* prevention classroom version teachers deliver 60+ social-emotional lessons and small group activities twice a week, with separate lesson plan sets for three grade levels (preschool-second grade). 2) In the *small group therapeutic* treatment group accredited IY group leaders work with groups of 4–6 children in 2- hour weekly therapy sessions. This program can be offered in a mental health setting (concurrent with the BASIC parent program) or as a 'pull-out' program in school. Content is delivered using a selection of video programs (with over 180 vignettes) that teach children feelings literacy, social skills, emotional self-regulation skills, importance of following school rules and problem solving. Large puppets bring the material to life, and children are actively engaged in the material through role play, games, play, and activities. Content and structure reflects that of the parent training program, and comprises seven components: (1) Introduction and Rules; (2) Empathy and Emotion; (3) Problem-Solving; (4) Anger Control; (5) Friendship Skills; (6) Communication Skills; and (7) School Skills (for more information about the child programs (Webster-Stratton & Reid, 2003, 2004)

Choosing Programs According to Risk Levels of Populations

The BASIC parent program (baby, toddler, preschool or school-age version) is considered a mandatory or a "core" component of the prevention intervention training series. The ADVANCE program is offered in addition to the BASIC program for selective populations such as families characterized as depressed or with considerable marital discord, child-welfare referred families, or families living in shelters. For indicated children with behavior problems that are pervasive (i.e., apparent across settings both at home and at school) it is recommended that the child dinosaur training program and/or one of the two teacher training programs be offered in conjunction with the parent training program to assure changes at school or day care. For indicated children whose parents cannot participate in the BASIC program due to their own psychological problems, delivery of both the child and teacher program is optimal (see "Incredible Years Program Implementation").

Figure 3. **Levels of intervention pyramid INSERT HERE**

As seen in this figure, **Levels 1 and 2** are the foundation of the pyramid and recommend a series of programs that could be offered *universally* to all parents, day care providers and teachers of young children (0-6 years). **Level 3** is targeted at *"selective" or high-risk populations*. **Level 4** is targeted at *"indicated populations"*, where children or parents are already showing symptoms of mental health problems. For example, parents referred to child protective services because of abuse or neglect, foster parents caring for children who have been neglected and removed from their homes, or children who are highly aggressive but not yet diagnosed as having ODD or CD. This level of intervention is offered to fewer people and offers a longer and more intensive programming by a higher level of trained professionals. **Level 5** is offered as *treatment* and addresses multiple risk factors with programs being delivered by therapists with graduate level education in psychology, social work, or counseling. Additional individual parent-child coaching can be provided in the clinic or home using the home coaching protocols. Child and parent therapists work with parents to develop behavior problem plans and consult with teachers in partnerships to coordinate their plans, goals and helpful strategies. One of the goals of each of the prior levels is to maximize resources and minimize the number of children who will need these time and more cost intensive interventions at level 5.

Research evidence for the *Incredible Years* Parent Programs

Treatment and Indicated Populations: The efficacy of the IY BASIC parent treatment program for children (ages 2–8 years) diagnosed with ODD/CD has been demonstrated in eight published randomized control group trials (RCTs) by the program developer
("The Incredible Years Parents, Teachers, and Children Training Series: Program Content, Methods, Research and Dissemination, 1980–2011").
In addition numerous replications by independent investigators have been conducted (see reviews (Furlong, McGilloway, & Bywater, 2012; Menting, Orobio de Castro, & Matthys, 2013).

In the early US studies conducted by the program developer, the BASIC program improved parental confidence, increased positive parenting strategies and reduced harsh and

coercive discipline and child conduct problems compared to wait-list control groups. The results were consistent for toddler, preschool and school age versions of the programs. The first series of RCTs in the 80's evaluated the most effective training methods of bringing about parent behavior change and established that group parent training was more effective than individual parent training, and that the most effective group model combined a trained facilitator, the use of video vignettes, and group discussion. Research on the most effective program content demonstrated that the combination of the BASIC parenting program with the ADVANCE program showed greater improvements in terms of parents' marital interactions and children's prosocial solution generation. Therefore, the core treatment model for clinical populations over the last two decades has consisted of a facilitator led, group treatment model that combines the BASIC plus ADVANCE programs.

Independent studies have replicated the BASIC program's results with treatment populations in mental health clinics, or primary care settings with families of children diagnosed with conduct problems or high levels of behavior problems, e.g. (Drugli & Larsson, 2006; Gardner, Burton, & Klimes, 2006; Perrin, Sheldrick, McMenamy, Henson, & Carter, 2014; Scott, Spender, Doolan, Jacobs, & Aspland, 2001). A recent IY parent program meta-analysis including fifty studies with 4745 participants (2472 intervention families) showed IY to be effective for disruptive and prosocial child behavior by teacher and parent report and independent observations across a diverse range of families (Menting et al., 2013).

Two long-term studies from the US and UK followed up children diagnosed with conduct problems whose parents had received the IY parent program 8- to 12-years earlier. The US study indicated that 75% of the teenagers were typically adjusted with minimal behavioral and emotional problems (Webster-Stratton, Rinaldi, & Reid, 2010). This data was not significantly different from normal US population figures for children this age. The independent UK study reported that parents in the IY BASIC parent condition expressed greater emotional warmth and supervised their adolescents more closely, than parents in the control condition who had received individualized "typical" psychotherapy offered at that time. This therapy could be parent focused or child play therapy. Moreover, their children's reading ability was substantially improved in a standardized assessment in comparison to the children in the control condition (Scott, Briskman, & O'Connor, 2014).

Prevention Populations: The prevention version of the BASIC program has been tested in four RCTs by the developer with multiethnic, socioeconomically disadvantaged families in schools. These studies showed that children whose mothers received the BASIC program showed fewer externalizing problems, better emotion regulation, and stronger parent-child bonding than control children. Mothers in the parent intervention group also showed more supportive and less coercive parenting than control mothers (see review (Webster-Stratton & Reid, 2010). At least 6 RCTs by independent researchers with high risk prevention populations found that the BASIC parenting program increases parents' use of positive and responsive attention with their children (praise, coaching, descriptive commenting) and positive discipline strategies, and reduces harsh, critical, and coercive discipline strategies. (see Menting 2013 review). The trials took place in applied mental health settings, or schools and primary care practices with IY group leaders from existing staff (nurses, social workers and psychologists). The program has been shown to be effective with diverse populations, e.g. Latino, Asian, African American, and Caucasian background in the US (Reid, Webster-Stratton, & Beauchaine, 2001), and other countries, e.g. England, Wales, Ireland, Norway, Denmark, Sweden, Holland, New Zealand, Portugal, and Russia (Azevedo, Seabra-Santos, Gaspar, & Homem, 2013; Gardner et al., 2006; Hutchings, Bywater, & Daley, 2007; Hutchings, Gardner, et al., 2007; Larsson et al., 2009; Raaijmakers et al., 2008; Scott et al., 2001; Scott et al., 2010)**.** A complementary body of qualitative evidence exploring parents', foster carers', and facilitators' perceptions of IY parent program indicates acceptability is high across different populations and in different contexts (Bywater et al., 2010; Furlong & McGilloway, 2014; Hutchings, Griffith, Bywater, Williams, & Baker-Henningham, 2013; Linares, Montalto, MinMin, & S., 2006; McGilloway, Ni Mhaille, Bywater, Furlong, et al., 2012).

International Spotlight on UK and Ireland:

The BASIC program for parents of 3-6 year olds has demonstrated effectiveness in targeted RCTs in Ireland, Wales, and England (Bywater, Hutchings, Daley, Eames, et al., 2009; Little et al., 2012). In Wales the sample included families from rural and urban communities who spoke Welsh/English. In England the research was conducted in the culturally diverse, second largest English city of Birmingham. In Ireland services were delivered to both semi-rural

and urban areas, to a predominantly Catholic population. In all three trials families were eligible if their child scored over the cut-off for clinical concern on a behavioral screener, and therefore 'at risk' of developing CD. Results were similar with child behavior effect sizes ranging from .5 to .89 across the three trials. The Welsh and Irish trials (Hutchings, Bywater, et al., 2007; McGilloway, Ni Mhaille, Bywater, Leckey, et al., 2012) included independently observed parenting (by observers blind to condition) and significant differences were found between parents who were allocated to the intervention versus waiting list groups; e.g. critical parenting and aversive parenting strategies after attending IY were significantly reduced compared with control parents. The findings of these trials replicated those by the program developer. In addition, parent mental health for intervention parents improved. Effects were maintained 12 months post baseline (McGilloway et al., 2014), and 18 months post baseline (Bywater, Hutchings, Daley, Whitaker, et al., 2009). A recent review of the independent IY Series research base (Pidano & Allen, 2015) demonstrates that the BASIC parent program is the most researched from the IY series (with in excess of 20 independent replication studies with a control group), and has the most established evidence base across many cultures and countries, thus illustrating the transportability of this program. A meta-analytic review of 50 control group studies evaluating only the IY parent programs (Menting et al., 2013) found similar effect sizes for child behavior for US and European studies (d=.39 and .31 respectively), further illustrating the effectiveness of IY when transported to Europe.

Research evidence for the IY Child Programs as an Adjunct to IY Parent Programs

Treatment: Three RCTs have evaluated the effectiveness of adding the small-group child-training (CT) program to parent training (PT) for reducing conduct problems and promoting social and emotional competence in children diagnosed with ODD/CD (Webster-Stratton & Hammond, 1997; Webster-Stratton, Reid, & Hammond, 2004). Results indicated that children who received the CT only condition showed enhanced improvements in problem solving, and conflict management skills with peers compared to those in the PT only condition. On measures of parent and child behavior at home, the PT only condition resulted in more positive parent-child behavioral interactions in comparison to interactions in the CT only condition. All changes were maintained a year later and child conduct problems at home decreased over time. Results showed the combined CT + PT condition produced the most

sustained improvements in child behavior at 1-year follow-up. Therefore the CT program was recently combined with the PT program for children diagnosed with ADHD, with similar results to earlier studies with children with ODD (Webster-Stratton, Reid, & Beauchaine, 2011). There are two published RCTs by independent investigators of the CT small group program with PT (Drugli & Larsson, 2006; Pidano & Allen, 2015), with two RCTs of the CT as a stand-alone program delivered in schools being conducted in Wales, UK and at the University of North Carolina.

Prevention: One US RCT evaluated the classroom prevention (universal) version of the child program with Head Start families and primary grade classrooms in schools with economically disadvantaged populations. Teachers in intervention schools delivered the curriculum biweekly throughout the year. Results from the sample of 153 teachers and 1,768 students indicated that teachers used more positive management strategies, and students showed significant improvements compared to control schools in school readiness skills, emotional self-regulation and social skills, and reductions in behavior problems. Intervention teachers also showed more positive involvement with parents than control teachers (Webster-Stratton, Reid, & Stoolmiller, 2008). A subsample of parents of indicated children (with high levels of behavioral problems by teacher or parent report) were selected and randomly allocated to a) parent program + classroom intervention, or b) classroom only intervention, or c) control group. Mothers in the combined condition had stronger mother-child bonding and were more supportive and less critical than classroom only mothers and reported fewer child behavior problems and more emotional regulation than parents in the other two conditions. Teachers reported these mothers as more involved in school and their children as having fewer behavior problems. This suggests added value when combining a social and emotional pupil curriculum with the IY parent program in schools (Reid, Webster-Stratton, & Hammond, 2007) .

Research Evidence for IY Teacher Classroom Management (IY-TCM) Program as an Adjunct to IY Parent Programs

The IY-TCM program has been evaluated in one treatment (Webster-Stratton et al., 2004) and two prevention RCTs (Webster-Stratton, Reid, & Hammond, 2001; Webster-Stratton et al.,

2008) and five RCTs by independent investigators, including Wales (Hutchings, Martin-Forbes, Daley, & Williams, 2013) and Ireland (Hickey et al., 2014); see also review (Webster-Stratton, 2012a). Research findings have shown that teachers who participated in the training 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. A recent study has replicated the benefits of the IY-TCM program alone for enhancing parent involvement in their children's education (Reinke et al., 2014). A study comparing combinations of IY parent, teacher, and child programs found that combing either teacher or child intervention with BASIC parent training resulted in enhanced improvements in classroom behaviors as well as more positive parent involvement in their child's education (Webster-Stratton et al., 2004). Pidano and Allen (2015) identified two further (US) independent studies that combined IY-TCM with PT, both of which reported positive results for child behavior.

The Pidano & Allen (2015) review of independent IY evidence highlights the current paucity of independent RCTS of the independent teacher and child programs, and the newer parent programs (attentive, autism, baby and toddler). However, given current interest in early intervention and potential cost savings 'upstream' there has been a pull for evaluations of the IY baby and toddler programs. The authors are aware of at least four ongoing European studies in Denmark, England, Ireland, and Norway evaluating the baby, or baby and toddler, program (Pontoppidan, 2015; Bywater et al., 2016; McGilloway et al., 2014).

More longitudinal studies are also needed, however, comparative longitudinal studies are rare as intervention studies typically employ a wait-list control design so all trial participants get the intervention, but at different time points. Interestingly, although there has been a focus on combining programs simultaneously, there has been little research on establishing the effectiveness of the IY parent programs as a 'stacked' model, when delivered according to level of need. Bywater et al., (2016) are exploring the effectiveness of a universal 'dose' of the IY baby book followed by attendance in the IY baby and then toddler programs, depending on levels of parent wellbeing (a strong factor in the development of child wellbeing and social behavior). This study applies a proportionate universalism approach as advocated by (Marmott et

al., 2010) which ensures that services are delivered to those that need it most, and those that need less, receive less.

Transportability factors

Assuring Fidelity with Translations, Accommodations and Flexible Dosage. An important aspect of a program's efficacy is fidelity in implementation. Indeed, if the program is not rigorously followed (for example, if session components are dispensed with, program dosage reduced, necessary resources not available, or group leaders not trained or supported with accredited mentors), then any absence of effects may be attributed to a lack of implementation fidelity. IY BASIC parenting program research shows that high fidelity implementation not only preserves the anticipated behavior change mechanisms but is predictive of behavioral and relationship changes in parents, which, in turn, are predictive of social and emotional changes in the child as a result of the program (Eames et al., 2010). Other UK research (Little et al., 2012) demonstrates that independently observed high fidelity in IY BASIC delivery translates to improved family outcomes. Both these studies implemented the programs in more than one language using either translators or bi- or multi-lingual facilitators, and, as mentioned earlier, in very different contexts (semi-rural Wales with a total population of approximately 3 million across Wales, versus culturally diverse Birmingham City whose metropolitan area's population exceeds that of Wales as a country). It appears from these, and other studies such as in Portugal, Norway and Holland, that delivery in different contexts, in different languages, does not affect the effectiveness of the program if delivered with high fidelity. Accommodations such as translation of materials is also not sufficient a change to render the program ineffective (Menting, 2013). (Durlak & DuPre, 2008) reviewed 500 studies on prevention and health promotion programs for children, linking implementation fidelity to outcomes, and stated that perfect implementation is unrealistic (few studies achieve more than 80%), but that positive results have often been achieved with levels around 60%. The standardization of program content, structure, processes, methods and materials facilitates delivery with fidelity. However, programs can be 'tailored' to specific populations, which involves great leader skill in assuring the content and pace of program accurately reflects the developmental abilities of children, unique family culture or teacher classroom context, and baseline level of knowledge of the

participants in the group. For example program delivery may proceed at a slower pace over more sessions for parents with high complex needs, or when several translators are present. This is classed as an accommodation rather than an adaptation as the program content and processes have not changed but has been tailored to accommodate the participants' specific learning needs. Two examples in which the IY BASIC parent program has been tailored or accommodated to the population needs, without changes to the core components of the program are by Bywater et al. (2010) in a randomized study with foster carers in the UK, and by Azevedo et al., (2013) with parents of children with ADHD in Portugal. Both studies demonstrated the 'transportability' of the program across different *types* of populations, as well as contexts.

Accredited Training and Consultation. The training, supervision, and accreditation of group leaders is crucial for delivering with high fidelity (Webster-Stratton & McCoy, 2015). First, carefully selected (according to education and experience) and motivated group leaders receive 3 days of training by accredited mentors before leading their first group of parents or teachers or children. Then it is highly recommended they continue with ongoing consultation with IY coaches and/or mentors as they proceed through their first groups. They are encouraged to start videotaping their sessions right away and to review these videos with their co-leader using the group leader checklist and peer review forms. It is also recommended that they send these videos for outside coaching and consultation by an accredited IY coach or mentor.

In line with this advice IY parent group leaders in UK, Norway, Spain and Ireland research trials received the initial training as well as ongoing support during delivery of their groups. Group leaders in these studies were also required to pursue accreditation in the IY program. The process of group leader accreditation involves the leadership of at least two complete groups, video consultation, and a positive final video group assessment by an accredited mentor or trainer as well as satisfactory completion of group leader group session protocols and weekly participant evaluations. This process ensures delivery with fidelity, which includes both content delivery (required number of sessions, vignettes, role plays, brainstorms) and therapeutic skills. The whole process of coaching, consultation, and accreditation of new group leaders is carried out by a network of national and international accredited IY trainers, mentors, and coaches (8, 63, and 52 respectively) who meet yearly to share videos of their groups, workshops and coaching methods as well as learn about new research. A recent RCT

found that providing group leaders with ongoing consultation and coaching following the 3-day workshop leads to increased group facilitator proficiency, program adherence and delivery fidelity (Webster-Stratton, Reid, & Marsenich, 2014). For a detailed discussion of the building process for scaling up IY programs with fidelity see (Webster-Stratton & McCoy, 2015).

Conclusion

The IY Series is transportable, with robust evidence demonstrating positive outcomes for children and families, and teachers, in the short, medium, and long-term. The programs can be delivered as 'stand-alone' programs or in combination, and are suitable for early intervention, prevention, or treatment models to suit a variety of needs and populations, and service delivery organizations. Research has been conducted by independent researchers as well as the IY developer. The accreditation and training model supports high fidelity and the likelihood of achieving outcomes similar to those found in efficacy trials.

Future directions for research should include evaluating ways to promote the sustainability of results when offering additional program adjuncts such as IY Advance Program, or IY Child Program or ongoing booster sessions. For example children could be assigned to treatment program conditions according to their particular comorbidity combinations as research has shown that those with ADHD will fare better when teacher or child components are added to the PT program. Further research is needed to identify children for whom the current interventions are inadequate. Finally the newest IY parent programs (baby, Attentive Parenting and Autism) and the new teacher programs (Incredible Beginnings and Helping Preschool Children with Autism) are in need of RCTs to determine their effectiveness. In addition to exploring standalone programs or combination of programs across modalities (teacher, parent, child), there is a need to explore the longitudinal benefits of receiving stacked parenting interventions so that parents receive support through every developmental stage their child encounters.

Alternative designs could include Trials within Cohort studies (TWiCS) ("What are TWiCs") – a model that is shortly to test a variety of interventions (including parent interventions) in England as part of a £49 million Big Lottery funded project in Bradford to enhance outcomes for children aged 0-3 years.

At a time when the efficient management of human and economic resources is crucial, the availability of evidence-based programs to parents and teachers should form part of the public health mission. While the IY programs have been shown in dozens of studies to be transportable and effective across different contexts worldwide, barriers to fidelity may impede successful outcomes for parents, teachers and children. Lack of service/organization funding has sometimes led to IY programs being delivered by group leaders without adequate training, sufficient support, coaching and consultation, and without agency monitoring or assessment of outcomes. Frequently the programs have been sliced and diced and components dropped in order to offer the program in a dosage that can be funded. Few agencies support their group leaders to become accredited, and the program is often not well established enough to withstand staffing changes in an agency. Thus, the initial investment that an agency may make to purchase the program and train staff is often lost over time. Disseminating evidence-based programs can be thought of as like constructing a house - the building will not be structurally sound if the contractors, electricians and plumbers working on it were not certified, disregarded the architectural plan, and used poor quality, cheaper materials. To build a stable house, or to deliver an evidence-based program, it is important that the foundation, basic structure, and scaffolding is strong, and that those building the house, or delivering the program, are fully qualified or accredited. This equates to picking the right evidence-based program for the level of risk of the population and developmental status of the children, and adequately training, supporting and coaching group leaders so they become accredited and providing quality control. 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, initial investments will pay off in terms of strong family outcomes and a sustainable intervention program that can withstand staffing and administrative changes.

With the increasing blurring of organizational boundaries between services supporting families and children there is a growing shared responsibility for the 'psychological management' of conduct disorders, suggesting that evidence-based behavior management training should be included in initial training for professionals who are in regular contact with families and children, including foster carers and nursery workers.

In summary, the collective evidence suggests that the effective prevention of conduct disorder and promotion of children's social and emotional wellbeing relies on a combination of key ingredients, including:

1. an integrated, multi-agency, multimodal approach
2. the scaling up of evidence-based universal and targeted 'early' interventions
3. careful attention paid to identification of 'at risk' populations
4. ongoing training and fidelity to preserve the mechanisms of change.

Attention to these combined ingredients would help to reduce the considerable individual, family, societal and service costs that are incurred by untreated conduct problems and conduct disorder.

Figure 3. Levels of intervention pyramid
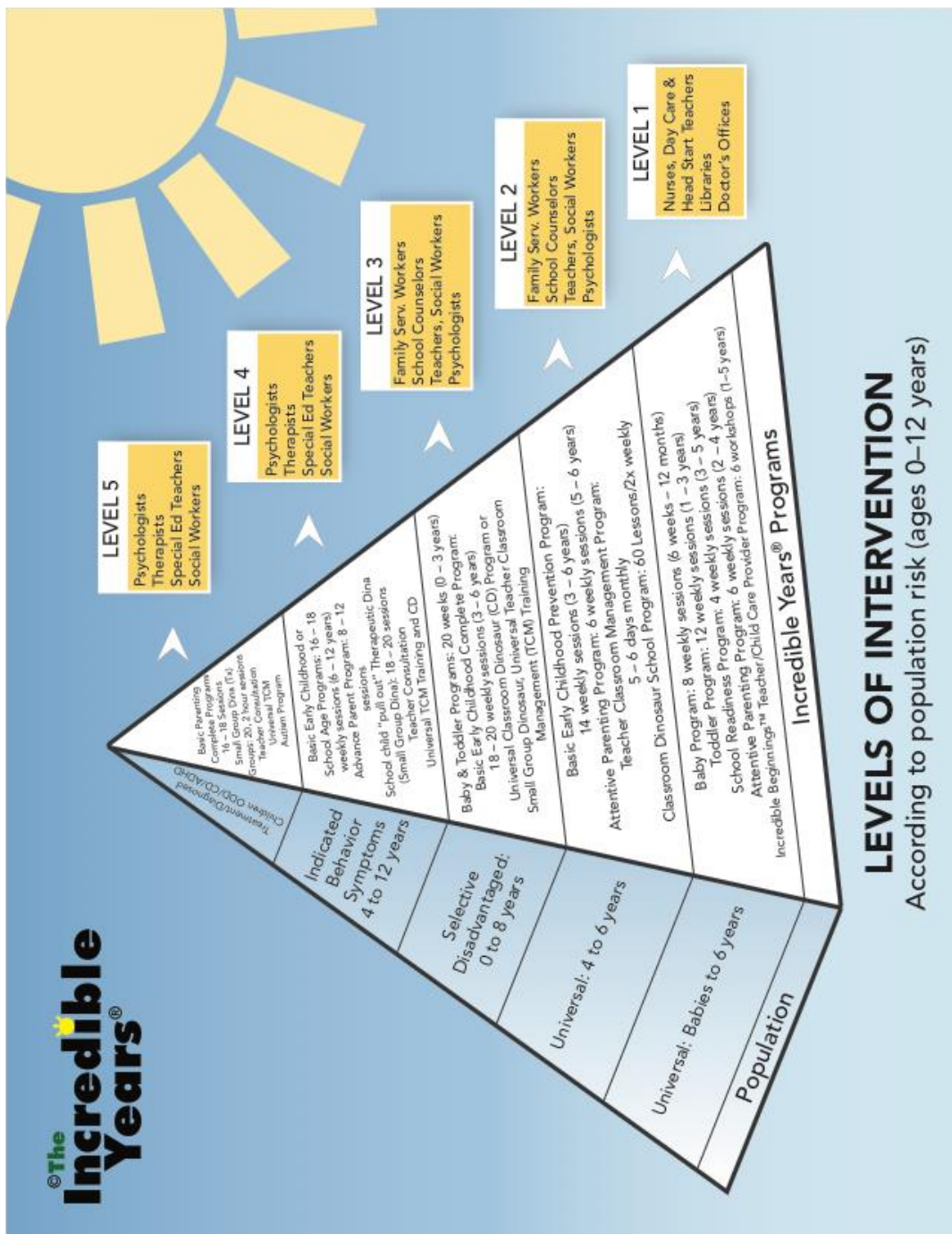
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