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8 Adopting and Implementing Empirically supported Interventions: A recipe for success

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Summary

- *Over the past thirty years, hundreds of carefully controlled studies have demonstrated that there exist today a number of effective therapies and services for children and families which can reduce behaviour problems and delinquency, improve mental health, assist abusive parents to improve their child-rearing, and increase family functioning (Weisz and Weiss, 1993).*
- *Yet in spite of this evidence, few empirically supported interventions have been widely adopted in applied settings (Kazdin, Bass, Ayers, and Rodgers, 1991).*
- *In this paper, we describe an empirically supported parenting intervention developed and evaluated by the first author, including the strategies used to make it easy for clinicians in the field to implement with integrity.*
- *Next, we describe the process by which four applied settings adopted and implemented this intervention.*
- *We believe that the lessons learned from these four examples can guide clinicians, administrators, and researchers on how to facilitate the process of adopting empirically supported interventions.*

Introduction

Over the past thirty years, hundreds of carefully controlled studies have demonstrated that there exist today a number of effective therapies and services for children and families which can reduce behaviour problems and delinquency, improve mental health, and increase family functioning (Weisz and Weiss, 1993). Among empirically supported interventions, parenting interventions based on cognitive - social learning theories have perhaps the greatest evidence of their effectiveness (Serketich and Dumas, 1996; Taylor and Biglan, 1998). Cognitive behavioural parenting interventions are one of the most effective strategies for treating disruptive behaviour problems in children, including aggressive behaviour, Oppositional Defiant Disorder and Conduct Disorder (Dumas, 1989) ; (Kazdin, 1995) and Attention Deficit Hyperactivity Disorder (Barkley, 1996; Pisterman, McGrath, Firestone and Goodman, 1989) Together these problems represent the majority of referrals for children's mental health services (McMahon and Wells, 1989). Behavioural family interventions have also been identified as one of the best strategies for the treatment (Becker *et al.*, 1995), and prevention of child abuse (Wolfe, Reppucci and Hart, 1995). They also appear promising for preventing future drug abuse among at-risk youth (Dishion and

Andrews, 1995), and for treating chronic delinquents (Bank, Marlow, Reid and Patterson, 1991). Cost-benefit analyses suggested that parent training was one of the most cost-effective strategies for preventing future juvenile delinquency and adult criminal behaviour (Greenwood, Model, Rydell and Chiesa, 1996).

Yet despite this evidence, few empirically supported interventions such as behavioural parent training have been widely adopted in applied settings (Kazdin, Bass, Ayers and Rodgers, 1991; Weisz, Donenberg, Han and Weiss, 1995). Instead, these settings have overwhelmingly adopted a wide assortment of therapeutic fads, which change every few years, and which have no empirical evidence to support their effectiveness. This state of affairs has led some reviews to suggest that, if this trend holds up, we may be faced with the following dilemma: "The good news is child psychotherapy works; the bad news is, not in real life" (Weisz and Weisz, 1993, p.96).

"Eat these lima beans they are good for you!"

Why have clinicians failed to adopt empirically supported treatments, such as parent training interventions? It reminds us of a common fact of life that even though most people know that vegetables are good for them, most still leave their lima beans on their plate and eat their fatty dessert!

But is this a problem of the research interventions not being tasty enough for clinicians to want to try them out or is it that researchers have not provided readily available descriptions of their interventions and clear recipes for clinicians to be able to offer successful interventions? Certainly it is far from easy for clinicians to find and identify empirically validated interventions. It requires the clinician to review dozens of journals, none of which are typically available in a clinical agency let alone town. Moreover to identify a best-practice for a single problem, the clinician must wade through a sea of opinion papers and poorly designed studies which claim their intervention is the best. In order to evaluate the interventions, the clinician must be versed in statistical procedures, from t-tests to structural equation modeling. Even then the research papers provide scant descriptions about the actual treatment processes and methods requiring the clinician to continue his or her pursuit to determine if a treatment manual exists. All this time (usually conducted in the clinician's spare time) is necessary to identify a single intervention for a single problem in a single population. It is perhaps no wonder that so few clinicians use research articles to help them implement treatment and are more likely to implement whatever brand of intervention is heavily marketed that year.

Researchers by and large have done a good job of developing and refining a number of creative interventions for a variety of problems experienced by children and families. However, they have done a poor job of ensuring that this information is systematically shared with people who can most use it, such as clinicians and administrators in the field or with politicians and policy makers who have the power to fund such programmes. This too is understandable. In the "publish or perish" environment of academia, original research and publications in peer reviewed journals helps to advance the researcher's career but efforts to disseminate earn relatively little prestige and is often considered a task unworthy of a significant amount of a scientist's time. Moreover, those who develop and research new interventions often have no funding to provide technical assistance to potential adopters of their programmes and may perceive it as an onerous burden when they are struggling to keep their own research programmes afloat! Nonetheless, given that we now have a number of empirically supported interventions widespread use of which could result in high social benefits (Biglan, 1995), it is time for scientists to adopt a public health perspective on these

problems. We must recognize that to significantly reduce their prevalence we must focus on strategies for disseminating empirically supported interventions to clinicians and service providers (Biglan and Metzler, in press). This should be considered a priority not a luxury.

In this paper, we describe an empirically supported cognitive-behavioural parenting intervention developed and evaluated by the first author, including the strategies used to make it easy for clinicians in the field to implement with integrity. Next, we describe four case examples of applied settings adopting and implementing this intervention. The first, beginning 1992, involved a series of Head Start preschool centres in Puget Sound, Seattle which occurred as a result of the initiation of the first author, the developer of the programme. The second, beginning in 1993, involved a children's mental health centre in Thunder Bay, Canada where the second author was working as a clinician at the time of adoption of the programme. The third, beginning in 1994, involved a children's mental health centre in Timmins, Canada, to which the second author consulted. The fourth, beginning in 1995, involved a state-wide intervention/prevention programme in Delaware which occurred as a result of the joint-initiation and collaborative efforts of the Department of Services for Children, Youth and their Families, through its Division of Family Services and the Department of Education with strong administrative and financial support from Governor Carper. All four of these sites continue to offer this programme as a part of their regular service today. For each of these examples, we describe how the decision to change first began, how administrators and clinicians were involved in supporting the new intervention, and the strategies used to ensure that the clinical integrity of the programme was maintained. We believe that the lessons learned from these four examples can guide clinicians, administrators, policy-makers, and researchers in how to facilitate the process of adopting empirically supported interventions.

The Development of the Parents and Children Series Programmes

Content and Methods of the Programmes

The original 12-week parent programme, entitled BASIC was heavily guided by the modeling literature and focused on teaching parents interactive play skills and reinforcement skills based on the early theoretical work and research of Hanf (1970) and Eyberg and Matarazzo (1980), as well as a specific set of nonviolent discipline techniques including Time Out and Ignore as described by Patterson (1982) and Forehand and McMahon (1981), logical and natural consequences, and problem-solving strategies (D'Zurilla and Goldfried, 1971; D'Zurilla and Nezu, 1982). In 1987 the programme was broadened to address other family risk factors (e.g., depression, marital distress, poor coping skills, lack of support) (ADVANCE). In 1992 it was further revised in order to make the programme more culturally sensitive, more prevention-oriented, and more usable outside of the Pacific Northwest; for instance, the programme included a higher percentage of people of colour (40%) as models in the videotape examples. Next, an older age version of the programme was developed so that it could be used with parents of children up to age nine or ten (grade 3). This included the development of a new programme entitled *Supporting Your Child's Education* aimed at teaching parents how to strengthen their children's reading and general academic readiness as well as promoting strong home/school connections. Finally, we developed a comprehensive child training intervention (Dinosaur Curriculum) which could be used by teachers and school counselors as a prevention programme for an entire classroom of students or by child therapists for directly training children with behaviour problems in feeling language, social skills, anger management and effective problem-solving.

All the interventions described above were designed to be offered as group discussions (with 12-14 parents per parent group) facilitated by trained group leaders. In the parenting

programme each parent is encouraged to have a partner or close friend participate in the programme. The group format was chosen because it fosters a sense of community support, reduces isolation and normalizes parents' experiences and situations. Moreover the group approach allows for diverse experiences with problem-solving regarding a variety of family situations as well as a cost-effective way of reaching more families.

All the family interventions have relied heavily on videotape modeling as a therapeutic method. Because the extent of conduct problems has created a need for service that far exceeds available personnel and resources, the author was convinced of the need to develop an intervention that would be cost-effective, widely applicable, and sustaining. Videotape modeling promised to be both effective and cost-efficient. Bandura's (1977) modeling theory of learning suggested that parents could improve their parenting skills by watching videotaped examples of parents interacting with their children in ways that promoted pro-social behaviours and decreased inappropriate behaviours. Moreover, it was felt that this method of training would be more accessible, especially to less verbally oriented parents, than other methods (e.g., didactic instruction, written handouts) and would promote better generalization (and therefore long-term maintenance) by portraying a wide variety of models in a wide variety of situations. Furthermore, videotape modeling has a low individual training cost when used in groups, and lends itself to mass dissemination. For a more detailed description of the programme, see Webster-Stratton and Hancock (1998).

Evaluation of the Programmes

The first author has spent the last 20 years in an academic setting engaged in the process of developing and evaluating the parent, teacher and child training interventions described above as a means to help families of young children with early onset conduct problems. More recently she has begun to evaluate these programmes as prevention programmes for high risk populations (Webster-Stratton, in press). In the late 70s she theorized that early intervention with parents of young children (ages three to seven years) would prevent young highly aggressive children from continuing on the trajectory to school drop out, drug abuse and delinquency. She proceeded to evaluate her family interventions following standard scientific procedures. These studies, published in peer reviewed journals, involved randomized controlled trials in which effects were measured according to changes in parent behaviour as well as child behaviour, using parent and teacher reports as well as actual observations of behaviour at home and in the laboratory. After much research and six randomized control group studies with various populations, she concluded that her parent interventions had sustaining effects for up to five years for at least two thirds of families (Webster-Stratton, 1996b). Results of these studies consistently showed that parenting skills and confidence were enhanced (i.e., producing more positive, nurturing and less physically aggressive and critical parenting behaviours) and children's conduct problems were significantly decreased while their social competence was increased (Webster-Stratton, 1997; Webster-Stratton, in press). Furthermore, research suggested that adding the broader-based family focus (ADVANCE) to the parent training as well as direct training for children in social skills and problem-solving (Dinosaur Curriculum) significantly enhanced treatment outcomes in terms of marital improvements and children's peer relationships (Webster-Stratton, 1994). A believer in science and logic, this researcher naively thought she had proven her point -- but little did she know she was only initiating the process of being a change agent.

Preparing the Programme for Others to Use

A number of strategies are used to implement the Parents and Children's interventions with high levels of clinical integrity. First, the programmes are packaged in an uncomplicated format enabling the clinician to readily learn the skills required. The reliance upon a series of videotapes to illustrate concepts and skills not only adds to the clinical effectiveness and efficiency of the intervention (Webster-Stratton, Kolpacoff and Hollinsworth, 1988) but it allows the clinician to focus more on the process of facilitating groups, without having to memorize and present all of the content. The videotapes are supplemented with materials for parents, including a book (Webster-Stratton,1992) as well as weekly home activities, refrigerator magnets, and refrigerator notes summarizing the key principles taught. Clinician/group leaders receive not only a session-by-session guide, but also a book which outlines the theory and collaborative process of leading groups (Webster-Stratton and Herbert, 1994) as well as a Leaders' Guide with practical guidance on topics ranging from setting up the location and room for the first session, to suggestions for engaging low income families (Webster-Stratton, 1998) and ways to promote parent support both within and outside the parent group (Webster-Stratton and Hancock, 1998).

To supplement the programme materials, training workshops are offered to introduce clinicians not only to the intervention materials and content, but also to the collaborative process involved in leading the groups. A collaborative approach to facilitating groups was chosen because it is more empowering to clients than a more hierarchical approach which is prescriptive and tends to "lecture" to parents. A collaborative approach which permits parents to determine their own goals and priorities is more likely to increase parents' self-efficacy, to promote engagement in the intervention, to reduce drop-out and resistance, and to give parents and group leaders a joint stake in the outcome of the intervention (Dweck, 1975; Meichenbaum and Turk, 1987; Seligman, 1975). Additionally, the collaborative approach is more flexible and adaptable and more likely to fit the needs of different populations.

Recognizing that receiving the materials and attending a workshop is not a guarantee that the intervention will be implemented with integrity, a group leader certification process was developed. The requirements for certification include: parent weekly and final evaluations for two complete parent group interventions (each lasting 12 weeks), two peer evaluations for each programme offered, and completion of authorized training workshops. Satisfactory peer review, parent evaluations and group attendance indicate leaders have satisfactory mastery of the content and therapeutic process to become certified as group leaders. Not only does this certification process allow clinicians to continue the learning process after the initial introduction to the programme, but it offers formal recognition to those who make the extra effort to demonstrate that they are competent to implement the intervention. Clinicians who become certified can reasonably anticipate to achieve effects similar to those achieved in the published outcome studies evaluating the programme. Clinicians who become certified group leaders are also eligible to work towards eventual certification as a trainer of other group leaders. With these materials and procedures in place, all that was needed was some applied settings with a desire to change and try something new.

The Decision to Adopt the Intervention

Introducing empirically supported interventions and innovative services into existing organizations is not an easy task. The fact that so few agencies have adopted such services is proof of this. Fortunately, researchers in a variety of fields have studied the process by which innovations diffuse, and have identified a number of critical issues (Rogers, 1995). In this section we will draw from four successful experiences the authors have had in assisting applied settings to adopt and implement the Parents and Children Series programmes with a high level of clinical integrity. Two of these were evaluated in randomized controlled trials (Taylor, Schmidt, Pepler and Hodgins, in

press; Webster-Stratton, in press). The positive results in these studies gives us confidence that we have identified a process which can lead to adoption and implementation in applied settings while maintaining the clinical integrity of the intervention.

Based upon our experience, we suggest that there are four critical tasks to achieve in assisting applied settings to adopt and implement a new intervention with a high level of clinical integrity. The first, and someways most important step is developing a desire or taste for change within someone in the system. Our experience suggests that this desire for change can occur at almost any level of the system, including front-line clinician, administrators of an agency, or the governor's office. The second step in the process involves obtaining key administrative support and recognition of the need for the new intervention. The support of administrators is essential, because they have the ability to manipulate the organizational structure, job descriptions and contingencies so that new programmes can be carried out successfully. The third step involves obtaining the support of the clinicians. These will be the front-line individuals who will be responsible for the quality of the implementation of the intervention. The final step involves implementing the programme in a manner that ensures that the clinical integrity of the programme is maintained. If these four steps are taken, there is a high likelihood not only that a self-sustaining process can be achieved to maintain the programme's implementation, but the system may initiate on its own the adoption of other empirically-validated interventions as well. Examples of how this process unfolded in four applied settings is described below. It is hoped that this description may tempt others to try some of the ingredients in this recipe for success.

Developing a taste for change

Researchers who study the diffusion of innovations have identified that the process begins by one or more individuals in a system learning about an innovation, forming a favorable opinion about it, and deciding to adopt it (Rogers, 1995). Below we describe how this process occurred in each of the four adopting sites.

The Puget Sound Head Start experience: One of the first agencies to adopt the Parents and Children Series programmes as a prevention programme in an applied setting occurred in the Head Start centres housed within the Puget Sound Educational Service District in Seattle, Washington. [Footnote: Other agencies purchased the programme prior to this, but since the developer had little or no contact with them, she has no knowledge of whether this was done with clinical integrity, or whether they maintained the programme.] The potential use of the parents, teacher and child training programmes in Head Start was of particular importance because this agency serves a population of families who are at higher risk for having children with conduct problems because of the increased number of stresses associated with living in poverty. As a result, in 1992 the first author and her colleagues from the Parenting Clinic at the University of Washington established an "information exchange relationship" (Rogers, 1995) with the administrators of the Puget Sound Head Start organization, including the education, mental health and family service coordinators. They discussed the Head Start agency goals in that district in regard to involving parents and teachers in training for managing children's behaviour problems and strengthening children's social competence. The first author presented the research showing the connection between early onset aggression in young children and later delinquency and then proceeded to present her own research evidence indicating that early aggression could be reduced considerably with the Parents and Children Series training programmes (Webster-Stratton, 1996a; Webster-Stratton, 1996b).

Head Start, as a national organization, has historically had a long standing commitment to parent involvement and parent education but in this particular district there was a clear administrative desire to offer more comprehensive parent programmes which were less fragmented

and offered more continuity of leadership throughout the year. On the other hand, the administrators in this district had less interest in training teachers to offer a social skills and problem-solving training curriculum for the children in their classrooms. Thus we established some compatible goals and a clear desire for change on the part of the administrators to strengthen their parent education programmes. This extensive consultation process resulted in the agency's senior management identifying a desire for change.

The Thunder Bay experience: In contrast to the above example, the desire for change in the Thunder Bay began in 1993 with a front-line clinician, the second author of this paper, who had just begun working as a psychologist in a Children's Mental Health Centre. He had done an exhaustive review of the literature of parent training programmes during his Ph.D. (Taylor and Biglan, 1998) and was familiar with the outcomes of the Parents and Children Series programme, and was eager to implement the programme personally. Realizing that other more established clinicians would need to be on board for this new programme to be accepted, he shared information about the programme with another psychologist in a number of meetings soon after arriving. That psychologist also had a strong commitment to the importance of empirically supported interventions, and became a critical ally in the further promotion of the programme. The decision of this individual, an established and well-respected front-line clinician, to support the desire for change was critical before efforts were made with any other clinical or administrative levels to achieve support for the new programme.

The Timmins experience: In Timmins, the desire to change was first established by the executive director of a small children's mental health centre who had heard about the programme being initiated in Thunder Bay. The second author established an "information exchange relationship" with this director, keeping him updated on the progress of the parenting groups in Thunder Bay. He, in turn, passed this information on to a group of front-line staff who became quite interested in learning more about the programme. In 1994, one year after Thunder Bay had started the programme, the executive director invited the second author to come and train some of his staff in the implementation of the programme.

The Delaware experience: In Delaware, the desire for change first was begun at a different level from the previous examples. In this state the Director of Child Mental Health (Julian Tapplin) from the Department of Services for Children, Youth and Families had spent two years researching the results of studies evaluating parenting programmes and had chosen two interventions (one targeted at young children and one at adolescents) which he wanted to implement in his state. Simultaneously, Governor Carper committed to the notion of funding mental health services for children in kindergarten through third grades who were experiencing behaviour problems. It was felt that by offering these services to targeted children early in their lives that their academic success would be enhanced, school failure reduced and ultimately crime prevented. Most importantly, administrators and policy makers in this state had decided that they would only fund interventions which had strong empirical support. Ultimately, representative Maroney and Senator McDowell were responsible for getting the funding for this project.

Even though Delaware adopted this programme later than the previous three sites, this combination of an influential administrative champion and new funding which could only be used for programmes with scientific evidence of their effectiveness, resulted in the largest adoption and implementation of the programme to date. First, a K-3 Programme was established as a collaborative partnership between the Department of Education and the Department of Services for Children, Youth and Families under the Division of Family Services in order to design a team approach to address behaviour problems in elementary schools. The efforts of this group resulted in the decision to contact the developer of the programme in 1995, and request training for family

crises workers and clinicians to conduct both parent and child training groups in schools as part of the initiation of their K-3 Early Intervention Programme.. Thus the desire for change in this setting began at a very high level, and resulted in enthusiastic administrative support.

Obtain key administrative support and recognition of the need for the new intervention

As the above examples illustrate, we believe the desire for change can be stimulated either by people inside the system or outside, and that it can first take root at almost any level of the system. Once, the desire for change has taken root somewhere, the next critical task involves getting the appropriate administrative support and recognition of the need for the new intervention. This typically involves sharing information about the potential advantages of the intervention as well as its research evaluation with the key administrators of the organization where it is hoped the intervention will be disseminated. For interventions to be offered in schools this will mean involving superintendents, principals, and teachers in informational discussions. For use in clinical agencies and health maintenance organizations it will mean involving agency directors and senior staff members. These key administrators need to be provided with written summaries of the research evaluating the intervention as well as clear descriptions of the programme's short and long-term goals. In order for an organization to consider adoption of a new intervention, the key administrators must first see that the new programme's goals are compatible with the general goals and needs of their organization. Moreover, they must perceive the relative advantages of the innovation over their existing services, particularly in terms of providing maximum gain for the largest number of clients in their organization.

The Puget Sound Head Start experience: After initial acceptance of the concept of offering parenting intervention at the Head Start administrative level, it was then necessary to generate the interest and cooperation of the superintendents, principals and other key administrative staff associated with each individual school district. This acceptance was important because Head Start centres are based within school districts and family services workers are actually hired by them, although supervised by Head Start coordinators. During meetings with these key administrators we helped translate the research for non researchers so that they understood the importance of randomized designs, control groups and observational data in obtaining an unbiased evaluation of programme outcomes. In essence we helped them understand how to critically evaluate research regarding the effectiveness of different interventions. We provided summaries of the literature in general regarding the effectiveness of parenting and child programmes along with information about how our specific programme had been evaluated and was being used in different settings with different populations.

The Thunder Bay experience: In a similar manner to that described above, in Thunder Bay the second author engaged in writing summaries of the research on the programme, and highlighting the advantages of using it within a Children's Mental Health Centre. Issues of cost-effectiveness were highlighted. Additionally, the value of evaluating the programme in an applied setting was highlighted, along with the practical issues of randomization and wait-list control groups. Ultimately middle and senior management of the agency authorized the purchase of the materials of the programme, and authorized the groups to be offered and to be evaluated.

The Timmins experience: In contrast to Thunder Bay where the second author worked and had regular personal contact with management staff, in Timmins, the communication efforts consisted of mail and occasional phone calls with the Executive Director sharing similar information to that shared in Thunder Bay. The second author sent several written summaries concerning the

programme, and kept him updated concerning the experience of implementing the groups in Thunder Bay. This information was, in turn passed on to a middle manager and a small group of front-line staff. After a year of hearing about the groups being successfully offered in Thunder Bay, sufficient interest was developed among management in Timmins to support trying the programme as well.

The Delaware experience: Although there existed top level administrative support for the programmes, the programmes were completely unfamiliar to middle management staff such as principals of schools or supervisors of family crises workers or to the teachers. Since the plan was to place family crises workers in designated schools to implement the child and parent programmes, we felt it was essential that school personnel be informed. Thus when both authors were invited to Delaware to conduct their first week-long workshop we asked our administrative supporters to invite principals (of targeted schools), teachers, and school counselors to a presentation where we reviewed the research efficacy for the programmes as well as an overview of the content, philosophy and therapeutic skills embedded in the interventions. Also attending this meeting were the family crises workers who would be trained in delivering the programme. This exchange permitted clinicians and school personnel to discuss ways they could support each other's efforts.

Mother: *What shall we bake today?*
Child: *How about chocolate chip cookies?*
Mother: *Well oatmeal-raisin cookies are probably better for you.*

Obtain the support of the clinicians

Of course, like the administrators the clinicians need to be made aware of the empirical validity of the new intervention as well as its potential advantages over existing services. However, since clinicians will be primarily responsible for the actual delivery of the intervention, it is essential that they understand more precisely the therapeutic model underpinning the intervention. Their attitudes, prior education and concerns about the therapy model must be taken into account. If this does not happen early on in the decision making process, interventions may be impeded or actively resisted because of faulty understandings of the therapeutic model or because clinicians perceive a lack of control of programmatic decisions.

The Puget Sound Head Start experience: We began this process in this district by inviting teachers, family service workers and parents from the different schools to focus groups. At these meetings we elicited their input about their priorities for what kind of content they would like covered in parenting programmes, how long they felt the parent sessions should last and what factors would motivate parents to attend. We approached the Head Start parent board to get their support and input into the programme content. At the same time we began to share with these groups some of the specifics about the philosophy and objectives of our parenting programme. For example we showed them samples of the training videotapes and training manuals. We discussed how the programme could meet their stated priorities, and what was involved in order for their staff (i.e., family service workers) to become trained as leaders of parent groups. For although the administration of Head Start was in agreement to offer more intensive parent training, the next important decision to be made was whether this particular brand of parent education was consistent with their administrative, clinician and parent values.

We found in Seattle that there was a general mistrust of behavioural approaches by the family service workers and Head Start teachers. There was concern about specific parenting approaches described in our programme such as the use of rewards and Time Out. These approaches were perceived by some of the more psychodynamic clinicians as inhuman, mechanistic and not appropriate for preschoolers. Other clinicians were threatened because they had no prior training in learning principles. Still others saw their role as case workers but did not see their professional role as including comprehensive parent education and this initially created some role identity issues. As we discussed these issues we frequently found that the behavioural jargon was foreign to them and created psychological barriers. For example, the word reward seemed to conjure up for them Skinnerian notions of giving pellets to pigeons, but on the other hand, the use of terms such as celebrations, surprises, and descriptive encouragement for children were acceptable. While the teachers professed not to believe in Time Out they were very comfortable with using a Calm Down technique which upon further examination was very similar to our Time Out approach. Thus once we got past the semantic differences and began to focus on the underlying principles (e.g., fostering parent empowerment, collaboration, nurturing and nonviolent discipline) we found many compatible philosophies and values. Being "child directed" is a key element to Head Start philosophy and once they viewed our play training tapes which are based entirely on this principle they began to see the congruence in philosophies.

However, despite the family service workers' growing enthusiasm for the programme there was considerable concern about their daily work pressures, stresses and their ability to take on any more work in an already heavy case load. In addition, we found they had prior experiences with offering brief parent education evenings on a monthly basis resulting in poor parent turnouts. Consequently, they were somewhat pessimistic about the possibility of success with a more comprehensive group-based parent programme. Their overall motivation for change in the beginning was guarded. We listened to their concerns, acknowledged the barriers, and discussed with them their ideas for how they felt family turn out could be increased.

Finally, after a year of meetings and focus groups, the administrators and clinicians made the decision to try out the parenting intervention but to postpone offering the teacher intervention. Teachers could be involved in so far as they would be trained in the parent programme but would not be expected to offer the Dinosaur social skills curriculum in classroom. We agreed upon a three year commitment to evaluate the parent programme in eight Head Start centres. This concept of trialability was attractive to them because it allowed them to see how the programme worked with parents before they adopted it on a larger scale.

The Thunder Bay experience: The process of obtaining clinician support for implementing the programme was carried out by the second author and his colleague. Copies of some of the videotapes were ordered to preview before purchasing, and these were shown to interested clinicians and middle management personnel. Brief handouts from the programme were copied and distributed, and a number of copies of the book for parents (Webster-Stratton, 1992), were shared and read by clinicians. The second author and his colleague committed to leading groups, and other volunteers were solicited from among the clinicians to co-lead groups. After four months of advocating, the first parenting groups began.

The Timmins experience: The first contact that the second author had with clinicians in the Timmins Children's Mental Health Centre was a 90-minute phone call with the Executive Director, a middle manager, and six interested clinicians. In this meeting the second author listened to staff's descriptions of their interests and goals, and described the programme to them, highlighting how it was compatible with their goals. Approximately two months later the second author visited the agency and offered a training workshop for the six interested individuals. At this agency this subgroup of six front-line staff were quite eager to try the programme, believing that the current

strategies they were using were not effective, and recognizing that their large caseloads required some form of group treatment. Shortly after the workshop, these staff immediately started leading groups.

The Delaware experience: In Delaware as we have said, we started with administrative support for our programmes. In fact our first contact with the front-line clinicians was when we arrived in Delaware to conduct a 4-day group leader -training workshop for family crises workers. We encountered considerable clinician resistance to the intervention at first.

Some of the resistance occurred because the clinicians felt mandated to offer this service and had not been consulted by their administrators. Family crises workers told us that when they were hired by the department they had not been told that conducting parent or child groups in schools was part of their job description. Some of them told us they felt unprepared to work directly with children in groups and others were concerned about their skills offering parent groups. In general there was anxiety and some anger about having to learn two different treatment approaches at the same time.

In addition, some of the resistance had to do with the notion of offering a behavioural "packaged" group programme. Those with more psychodynamic backgrounds were convinced that one-on-one individual therapy approaches with exploration of parents' family of origin was far more effective than the less private and more standardized group approach. There were also misconceptions about the use of a video-based programme, assuming that a videotape programme would be rigid, inflexible, non-therapeutic and culturally insensitive. We explained the collaborative nature of the intervention, how the videotapes were used to stimulate debate, discussions and group process, how past family history informed group discussions at times, and how the intervention focused on individual family goals and priorities. In essence, we needed to dispel the notion that because the intervention was packaged and somewhat structured, it did not mean that it was inflexible, nor did it assume a "one size shoe fits all" philosophy. Moreover, it required not less therapy skill on the part of clinicians but rather a high level of group process skill and leadership.

In both the Delaware and Seattle experience it was key for the developer and trainer of the intervention programmes to have personal contact with the clinicians. Listening to the concerns and anxieties from the clinicians about the interventions helped us to clarify misperceptions about the intervention philosophy and to explain its success with a variety of populations. It also helped us to understand how stressful role change was for them and the necessity of clinicians being empowered as part of the change process within their organizations. In fact, there is a considerable body of research attesting to the importance of clinicians being involved in the planning for any new intervention (Backer, Liberman and Kuehnel, 1986). Without considering the emotional reactions of the clinicians to the change, resistance to change may occur which will sabotage almost any innovation. In fact, personal contact as an implementation strategy has been cited as the single most important variable in promoting adoption among mental health professionals, regardless of the nature of the intervention (Backer *et al.*, 1986).

Implementation of the Intervention with Integrity

Mother: *I think you can make these cookies by yourself now, but be sure to follow the recipe carefully for cookie dough. Put in exactly what the recipe says.*

Child: *Oh I am!* (mutters to self) *I think I'll put less flour and more sugar, that will taste even better!*

An essential aspect to successful implementation of an intervention is hinged upon whether the intervention was actually carried out as intended. The absence of intervention integrity is not an uncommon flaw in programme dissemination. An intervention may not show effects when delivered in community settings, not because the programme was flawed but because the programme was inadequately implemented with inexperienced or untrained people or clinicians who did not adhere to the intervention protocols.

Once the decision has been made to adopt a new intervention in a setting then there are at least nine key elements to successful implementation. These are: (1) training in the intervention; (2) helping clinicians understand their role as change agents; (3) implementing the entire intervention, without eliminating major components or shortening the intervention substantially; (4) providing ongoing supervision and peer support to clinicians; (5) providing organizational support and internal advocates; (6) involving an external agent; (7) assuring maximal participation; (8) providing support to participants; and (9) pairing of new leaders with experienced staff.

Training in the intervention

As we have noted earlier, training workshops lasting 2-4 days were offered in all four sites to prepare group leaders in the parent training programme. This interactive training familiarized group leaders with the content, methods and processes of the intervention and permitted clinicians to ask questions and to role play group processes. These workshops have been found to be invaluable in assuring that the collaborative process is understood by clinicians (for more information, see Webster-Stratton and Herbert (1994)

Helping clinicians understand their role as change agent

Successful implementation requires clinicians to recognize their role as change agents. Our experience suggests that it is best if the first clinicians to implement a new intervention are eager to do so. For the clinician who decides s/he wants to implement a new programme s/he becomes an "innovator" in the system they work in. These people are often called "early adopters", because they are willing to take risks and try new ideas before they have become well-established interventions in the organization (Rogers, 1995). However, sometimes early adopters are unaware of what it means to be a change agent and don't realize that they must engage in the process of "social marketing" -- of being a champion for their new services to families and their professional colleagues. They also need to be prepared to deal with organizational resistance to their efforts. Part of our initial training workshops focuses on preparing these clinicians for the processes involved in becoming an innovator within their organizational system.

The most successful clinicians will be flexible, confident, enthusiastic, and committed to the programme. In addition, they must also be non-authoritarian, collaborative, well-respected, well-educated, organized, well-prepared, proactive and have a high morale. In short, they are leaders. Organization administrators would be well advised to start with training clinicians with these characteristics who indicate a willingness to try out new programmes rather than to mandate all clinicians to follow suit. Those who are not risk takers are called "late adopters" and they will reluctantly venture into new programmes only after their well respected colleagues have been shown to be successful with the programme (Rogers, 1995).

Child:	***Okay, the recipe is for 3 dozen?***
Mother:	***No that's too many! It will take too long.***
Child:	***Maybe we can cook them faster if we put the temperature higher.***

Mother: *You might think so. But if you put it higher for less time, they end up burned on the outside, but raw inside.*

Implementing the entire intervention

Another common aspect of the implementation in all four sites was that the programme was offered in full with all core components of the programme offered over a 12-14 week timeframe. We are well aware that administrators and clinicians may believe that they can eliminate parts of a mental health intervention or shorten it to be more cost effective. Experience with other empirically supported interventions shows this usually weakens or eliminates the positive effects of the programme altogether (Corrigan, MacKain and Liberman, 1994). For example, we know from the research regarding conduct disordered children that interventions of at least 20 hours in length are more effective than other shorter programmes. We also have learned that such children and their families need ongoing and continual support. Thus intervention programmes, offered early in a family's child rearing life (for example, prior to starting school) should not be thought of as an inoculation for life. Rather, successful prevention/intervention will necessitate ongoing programmes offered at critical stages in family development (e.g., preschool, transition to kindergarten, middle school and high school).

Moreover, if an intervention has been researched based on 12 sessions, two-hours a week then the clinician must assume the same standard in order to get the same results. Fewer sessions than this will dilute the effectiveness of the programme. Moreover, most intervention programmes are offered in some kind of logical order with each session building on a prior session. If the clinician suddenly decides to omit a session or start in the middle of the programme, the efficacy of the programme may be compromised considerably or may even result in harmful effects for the family.

An important distinction must be made between implementing the core elements of the programme and stifling clinical skills or flexibility. It is easy for the former to be misconstrued as the latter. For our intervention at least, group leaders are encouraged to bring their skills, experience and ideas when implementing the programme. Group leaders often bring newspaper articles, comic strips about parenting, or other similar materials to groups, as well as their own experiences and metaphors to help parents understand certain concepts. They also bring their own clinical judgement about when to take time in the group to explore an issue in greater depth, or to address a problem not related to the immediate content of the day. Thus, rather than treating the programme as a precise script to be recited at parents in a didactic manner, clinicians come to understand the fundamental principles that guide the programme include flexibility, parents collaboration in setting the agenda, and having fun. When clinicians understand this, they realize that rather than limiting the use of their clinical skills and judgement, the programme fosters and encourages it. Our experience suggests that the willingness of clinicians to continue to implement this intervention hinges on their willingness to retain the core elements of the intervention, while still bringing their clinical skills, judgement and creativity to bear in the implementation.

Providing ongoing supervision and peer support to clinicians throughout the programme

The formal training and workshop only starts the training process. In all four sites, group leaders met in regular (typically weekly) peer review sessions to review clinicians' progress and group difficulties and to provide support to each other. We are convinced that this peer support is key to the success of interventions, regardless of the degree of expertise of the group leaders involved. Often times group leaders can become discouraged or demoralized by particular families or

children and their lack of apparent success with the programme. The peer group support and objectivity helps the group leader maintain optimism for the families and to find new ways of approaching resistant parents or children. In all four sites, a peer group was established which met on a weekly or bi-weekly basis. Additionally, in Thunder Bay and Delaware, groups were videotaped in order to assess the quality of the intervention delivered. The group leaders then picked segments of these videotapes to show in their weekly peer group meetings. They could chose to share a successful strategy with their peer group or a situation in which they wanted feedback and help in finding alternative therapeutic strategies. Additionally, leaders from Thunder Bay and Delaware both sent selected tapes to the trainer for review in Seattle. This feedback to the developer and trainer of the programme was extremely helpful in designing follow-up workshops and knowing the areas of the intervention which were particularly difficult for the clinicians to implement. For example, when we reviewed tapes of the family crises workers' first groups we found that few of them were using role plays or reviewing homework activities to bring families' personal problems to life. Most were preoccupied with the videotapes and curriculum rather than the therapeutic group process. Teaching and agendas tended to be non-collaborative and prescriptive. While this is to be expected when first learning to do groups, the information was helpful to the follow-up workshops where the trainer focused on role plays and group process with the clinicians and discussed with them ways to deal with parental resistance.

Providing organizational support and internal advocates

Successful implementation also involves organizational support for the intervention. Implementation of new services requires the allegiance and active support of administrative parties. For example, job descriptions might have to be rewritten to recognize the time commitment involved for clinicians starting up and carrying out parenting groups. Even though group approaches are more cost effective than individual approaches there is still considerable clinician time spent outside the group calling parents weekly, assuring transportation and food are provided for each session, and preparing handouts and materials for the sessions. This time must be budgeted for in the clinician's day. In the beginning the administrators must provide adequate release time for the clinician to be trained in the new intervention. This will involve more than the initial training workshop. Sometimes administrators are surprised to find that the initial training does not adequately prepare their clinicians to start groups the following week! It is imperative that administrators understand that learning a new intervention will also involve considerable time studying the videotapes and training manuals and practicing with their colleagues.

Additionally it is important for administrators to understand that once parent groups are started it is still necessary to provide ongoing peer support. Group leaders will need to meet for regular supervision and review of their group dynamics. These peer review sessions between group sessions are essential to maintaining the quality of the interventions.

It will be the administrators' role to push for high quality implementation. Without these efforts, the requirement for maintaining quality falls upon those implementing it to do so on their own time, without any recognition or support for the work involved in doing it well. One of the most important ways the organization can do this is to ensure that there are one or more internal administrative champions of the programme. These people will assure ongoing support for the programme and will see that the clinicians who are adopting the programme are well recognized for their extra work and rewarded within the system. Internal advocates should be familiar with local agencies, persons with power, and know how decisions are made in the system. In other words, they are familiar with local politics. This is important because these internal advocates will need to help clinicians deal with some of the organizational resistance and unintended side effects of the new programme. Research shows that if clinicians are left to champion a programme without an active administrative champion, the clinicians who first adopt the intervention quickly burn out

from the extra work, get resentful about the lack of support, and often leave the agency (Liberman and Corrigan, 1994). Research has indicated that the interpersonal contact provided by the internal advocate is a critical ingredient in promoting adoption of new programmes, regardless of the nature of the programme (Backer *et al.*, 1986). In many ways, the administrative champions are more important to the long-term success of the intervention than the clinicians themselves.

In our Head Start project, the administrators altered some of the family service worker job descriptions so that the material covered in the parenting programme could substitute for some of the other required training areas. In addition, they funded the release of the family service workers on a monthly basis for support and supervision meetings. The time spent in supervision could be substituted for some of their other required in-service training time. They assigned part of one administrator position to oversee this new service and to communicate with the clinicians and developer/trainer about areas of concern.

In Thunder Bay and Timmins, staff were allowed to participate in a regular peer group meeting of group leaders, and the groups were promoted as one of the services offered regularly at the centre. Additionally, staff were allowed to take time off during the day time because of the increased work in the evenings for the groups.

In Delaware the job descriptions were completely rewritten to describe the family crises worker's role in schools as parent and child group leader. Each worker would be assigned to two schools where they would offer on going groups. In addition, workers provided these targeted families with weekly home visits, 24-hour crises services, individual and family counseling, and linkages to needed resources as necessary. When new family crises workers were hired their roles as child and parent group leaders in the schools were clearly described. Consequently when we conducted a second workshop a year later with new family crises workers, there was virtually no clinician resistance. By that time, job descriptions were clear and there was a support system in place. Each summer during the first two years of implementation, family crises workers spent a day a week reviewing tapes and manuals and practicing leading groups. In the second year, new workers paired up with more experienced group leaders to conduct their first groups.

Successful implementation involves an external agent

The external agent is usually the person who developed the intervention or a person who has been certified in the intervention as a trainer and has had extensive experience using it. This person serves as trainer of workshops, helps the clinicians with how to use manuals, videotapes, and handouts and provides ongoing feedback and review of group process and if possible, review of videotapes of groups. The external agent provides ongoing consultation to the programme and collaborates with the "internal advocate" to plan further training and implementation. This person also provides consultation to both the clinicians and administrators regarding the process of change itself and helps them with understanding some of the psychological resistance and unintended side effects of the intervention. The external agent/developer is also in an excellent position to advise the administrators in ways to support and reinforce the clinician's change efforts. Finally this person helps the clinician understand how to bring about innovation in the system.

Assuring maximal participation in the intervention programmes

Another threat to the success of an intervention particularly with prevention programmes is concerned with low attendance and attrition. An intervention may not be successful because very few people perceive the need for the intervention. For example, in our Head Start project we offered parent training to all parents enrolled. However, initially parents did not perceive the need for such a programme. In fact, the consensus in that community was that only parents who were court ordered or mentally ill would attend parenting programmes. Some parents may not want to

participate because they resent the intrusion into their private life, personal values and priorities. If they are experiencing difficulties with their children they may feel somehow blamed or stigmatized by an approach which emphasizes parent training. Moreover, they may not have the time or flexibility in their schedules to attend parent groups. Even highly motivated parents may not be able to continue participation because of work commitments, illness or other life events. The clinicians are critical in the marketing of the new interventions and organizing their delivery so that as many barriers be they psychological or physical are removed for families as possible.

Provide support services to participants

The most carefully implemented intervention will not achieve very much if families don't come out. Expecting highly stressed families to rush home from work, feed their children, arrange childcare, and travel to a group held far from home is simply not realistic. Our experience is that this stress and difficulty getting to evening groups is true for middle class, two-parent working families and even more so, for low-income, disadvantaged families. For example, in the Head Start project, we provided childcare and dinner was arranged for all families, and offered groups in sites close to family's homes (sometimes in housing units). In Thunder Bay, parents were encouraged to arrange their own child care, but a single baby sitter was hired to be at groups regularly for those who could not, or whose alternative plans fell through at the last minute. Additionally, rides were arranged for those families who could not get to the group another way. After these strategies were implemented, the attendance of single parents went up dramatically. In Delaware, funding was provided for buses to transport parents to their groups from their homes as well as for child care and food for parent groups. They also made funding available for helping families with particular resources, such as clothing for children and special education needs.

Pairing new leaders with experienced leaders

In our Seattle project we were fortunate to be able to pair up our trained and experienced parent group leaders from our Parenting Clinic with each of the new family service workers from Head Start. This arrangement provided ideal training because the new clinicians were mentored by a certified group leader.

In Thunder Bay, there were no experienced group leaders available for the first group. Additionally, at the time that the groups began, only the one clinician (the second author), had attended training with the programme developer. In an effort to ensure treatment fidelity, the second author spent considerable time reviewing all materials in the programme, and co-led the first three parenting groups simultaneously with three different leaders. When these groups were finished, five new groups began, each with at least one experienced group leader. Later several group leaders attended a training session with the developer, and ever since, all new group leaders have conducted their first group with an experienced leader.

In Timmins, four therapists attended a training workshop on the programme, and then spent additional time reviewing the materials together, and began the first two groups simultaneously so that they could offer each other mutual support. After this, they also followed the process of pairing new leaders with experienced leaders.

In Delaware, following a training workshop in the spring, the family crises workers spent one day a week during the summer months practicing in groups with each other to be ready for their groups to start in the fall. After the initial year of implementation, all new groups always had at least one experienced leader.

Other Recommendations

Some of the following strategies were used in a few of the sites to help ensure maximal participation in their intervention programme. We theorize that using some of these strategies will lead to stronger community buy-in to the programme which will ultimately lead to interventions that continue to be used in the long-run.

Induce the community to feel ownership of the programme

Engage key community leaders as collaborators or partners in an advisory capacity with the intervention evaluation team. The Delaware and Seattle programmes had advisory boards consisting of community leaders including superintendents of education; director and programme administrators of the Division of Family Services, Department of Services for Youth, Children and Families in Delaware (DSCYF) and Puget Sound Educational Service District in Seattle; principals of the school districts involved in offering the programmes; parent, family service worker and teacher representatives; and University of Delaware and University of Washington representatives. These advisory groups met periodically to give input into the training, delivery and evaluation of the interventions.

Make the programmes flexible in times and places they are offered

Among the four sites, the intervention has been offered in mental health centres, housing units, churches and schools near where the parents were living. Night time groups were the most successful in attracting two partners and working parents, although daytime groups were easier for some families because their children were in school.
Moreover, if the programme is being offered as prevention programme in the community make sure its advertising does not give a blaming message regarding the cause of mental health problems. For example, we advertised our Head Start programme to families as a programme designed to help children succeed in school, not a programme to reduce behaviour problems. This less stigmatizing way of recruiting parents resulted in a high turnout of parents to the programme.

Provide opportunities for interested community members to participate in development, organization, implementation, and evaluation of the programmes

In the Seattle project we asked for parent volunteers to help with family recruitment, day care , transportation and programme evaluation. In the second year of the project, 75% of the parents who had been trained the year before offered to participate in some way either by helping run day care for new parents or by attending parent orientation nights at the schools to help explain the programme and motivate new parents to participate. In the third year of the project we trained parents who had shown themselves as 'natural leaders' to be co-leaders of parent groups with the family service workers. This involvement helped parents develop a sense of ownership and investment in the programme's success and began to change the meaning of the programme in the community.

Make sure the intervention programme is culturally sensitive and adaptable to the changing needs of the community

It is important that the programme reflect the needs and characteristics of the community it serves. In Seattle, we translated the programme into Spanish and Vietnamese to try to meet some of the

language needs. We hired leaders representing different minority groups to do the evaluation interviews and to be trained to lead the groups.

Part of the collaborative process involved in this programme is to ask parents in the first session to identify their goals for the programme and to list the behaviours they want to promote in their children. Each family has their own unique goals for their children based on their values and culture. The programme then focuses on management principles which they can apply to their personal goals. In this way the programme can be culturally sensitive to individual needs and values.

In addition to trying to set up programmes that are responsive to the cultural context and the needs, demands and priorities of communities so that maximal participation is ensured, it also helpful, if possible, to collect data concerning the people who refuse to participate or drop out from the programme and why they do not want to participate. Such data helps to provide understanding of who the programme is best suited for and which groups do not find it helpful. It is not clear whether people who do not participate are those most in need of the programme or those who least need it! This information could help further the development and focus of the intervention programme (Price, Cowen, Lorion and Ramos, 1989).

Provide incentives

Particularly in the case of prevention programmes for high risk populations (where parents are not seeking help), we found it important to provide some incentives (other than food) to motivate parents to attend the parenting programme. We offered course credits to those who needed the credits for school. Occasionally lotteries were held. For example everyone who attended a group had their name put in a jar and one name was pulled out for a prize at the end of each session. All the children and parents received certificates at the end of the training programme and a special celebration party of their success. In the Head Start project we also offered a $25 bonus to parents who attended more than two thirds of the sessions (Webster-Stratton, 1998). Many parents told us that the incentives initially attracted them to the programme but after attending the session felt they would have attended anyway regardless of whether there were lotteries or bonuses.

Mother: *Well, how do the cookies look?*
Child: *They're gooier than yours are - but that's how I like them.*
Mother: *Let's see how they taste . . .*

Evaluation of the Intervention Programme

Even though a programme has been evaluated in a research setting its effectiveness within particular organizations or communities must be determined. Simple self-report measures of parenting skills and children's behaviour can be administered pre and post intervention. Consumer satisfaction measures can be completed at the end of each session as well as the end of the intervention to get feedback on the particular content of the programme covered as well as the leader skills and methods used (ie., use of videotapes, group discussion, use of book and audio-tape, homework activities, buddy calls, etc.). It is important to try to assess who the programme works for and who it doesn't work for.

In the Head Start project we had research money to evaluate our programme so we completed a detailed analyses of the programmes' effects. Results revealed significant improvements in parenting nurturance and discipline competence, increases in parent involvement with teachers and reductions in child behaviour problems that were sustained 1-year later in kindergarten. Consumer satisfaction at the end of the programme was very high with 85% of families attending two thirds of the programme (Webster-Stratton and Hammond, in press). Five years later our interventions are still being offered in these centres and Puget Sound Head Start have moved on to train other family service workers in our programmes in many of their centres. Because of their success new Head Start districts are consulting with them about starting these services. Some of the centres have written grants themselves and obtained money from charities to cover their food costs, books and other necessary supplies.

In Thunder Bay, funding was obtained from the Ontario Mental Health Foundation to evaluate the programme. Results indicated that the programme was effective at reducing behaviour problems in children, and that the programme was at least as effective and more satisfying to parents than usual services at the centre (Taylor *et al.*, in press).

In Delaware, each year they phase in 5-6 new schools and train new family crises workers. They provided a budget for their own evaluation staff in conjunction with the University of Delaware who are generating reports regarding their focus groups, and baseline inventory data. They plan to present post intervention data on the families at the end of grade three. They are currently offering programmes in 24 schools and 10 school districts. Focus groups with teachers, nurses, principals, and guidance counselors are held at the end of each school year. These indicate that principals cannot imagine their school without a family crises worker who is conducting the parent and child groups. Teachers acknowledge the value of family crises workers in helping resolve student's behaviour problems and feel they are spending more time teaching and less time disciplining students. They report better communication with parents, increased student attendance, and reduced aggressiveness. However, this year focus groups also indicated that teachers felt left out of the loop and wanted more intensive training in classroom management skills and how to engage in social skills and problem-solving training for all their students and not just for the targeted students. Consequently the administrators are planning phasing in this third aspect of their services for the next school year.

Maintenance of the intervention programme

In all four of the sites, the parenting programme continues to be used today, three and six years after the initial adoption of the programme. Where there has been strong administrative support for the programme, the continued maintenance is easier, and the number of groups offered has continued to grow each year. In some sites, administration placed a strong value on the use of empirically supported interventions. They asked regularly about how the groups were doing, and made it known to all staff that leading these groups was important. As a result, clinicians felt that their work was valued. Additionally, when administrators placed an expectation that clinicians would lead these groups, they also gave them the time to prepare and organize them as well. In contrast, in other sites where implementation of the intervention was voluntary, clinicians had to decide to work evenings to lead the groups while their colleagues chose to see their clients individually during the day. They often had to do the extra planning and coordinating involved in leading the groups on their own time. Yet in spite of these obstacles the clinicians have continued to offer the groups. This has occurred largely as a result of the dedication of individual clinicians who became champions of the programme in their centre. These individuals advocated for the programme when others resisted it. They gave of their time to ensure it was offered. This dedication and commitment ultimately resulted in new individuals joining them to offer the programme.

Expanding to adopt other empirically supported interventions

An additional, unanticipated pattern we observed in each site was that, following the initial successful implementation of the first interventions, other empirically supported interventions were adopted by the same sites. In Puget Sound Head Start, success with the parent intervention programme led them to think that there might be further benefits from the teacher training component. Currently teachers from selected centres are engaged in workshops one day a month and working with us to evaluate and further refine a teacher training curriculum that meets their needs. In Timmins, they have adopted the Dinosaur Social Skills and Problem-solving Curriculum (Webster-Stratton, 1997), and in Thunder Bay they have adopted the Dinosaur Curriculum as well as another empirically validated parenting programme for adolescents, the Adolescent Transition Programme (Dishion and Andrews, 1995). And as we mentioned earlier, in Delaware they are starting to offer our teacher training intervention in classroom management skills and how to teach all their students social skills and problem-solving skills.

These four case examples lead us to believe that a positive experience with one empirically supported intervention gives clinicians and clinical agencies a taste for other empirically supported interventions. If this is the case, this has significant implications for disseminating other empirically supported interventions. The recent failure of the large-scale Fort Bragg "System of Care" demonstration project (Weisz, Han and Valeri, 1996) has been attributed to the failure to use empirically supported interventions as basic components of the system of care. If positive experiences with one empirically supported intervention make service providers more receptive to other empirically supported interventions, then this suggests that the first intervention to be introduced should be selected carefully to be one which has a high likelihood of success. Once an agency or system has adopted one such intervention, it might be approached to integrate other interventions gradually until such an empirically supported system of care is in place.

Mother:	*Hey they taste good!*
Mother:	*How did you get them like that? Did you use less flour?*
Child:	*No I followed the recipe but. . .I added extra chocolate chips !*
Mother:	*Yummy, let's see if Gram likes them too.*

Rarely have prevention/intervention programmes shared in detail the core ingredients of their intervention recipes and therapy processes. Such information is essential in order for interventions to be successfully implemented by clinicians. For example, if the child making cookies had cut out a core ingredient such as the flour or baking soda the cookies would have been unsuccessful. On the other hand, by including all the core ingredients and adding chocolate this child improved upon the taste -- particularly for those in his family who like chocolate. Similarly, the clinician is encouraged to keep the core ingredients (not cut things they don't like such as Time Out) and then supplement the programme with their own stories, analogies, and other materials which reflect the uniqueness of the population they are working with.

Conclusion

In summary, these four experiences give us confidence that applied centres can be persuaded to adopt and implement empirically supported intervention with a high level of clinical integrity, and that they will often continue to offer these interventions after the change agent has ceased to be involved. The process began in all four sites by developing the desire for change within someone in the system. Next, support was obtained from administrators and clinicians. With this support, the implementation began, beginning with training in the intervention. In all four sites the entire intervention was implemented, with administration supporting the use of ongoing supervision and peer support. As new staff were brought into the process they received training and co-led their initial groups with an experienced leader who mentored them through the initial process. All four sites maintained contact with the programme trainer after the initial training, with clinical feedback ranging from consultation to detailed feedback on videotapes of sessions. The evaluation data available on these implementations suggests that they were effective. This recipe, like the programme itself, was sufficiently flexible to respond to the unique needs of each of the four sites, while offering sufficient guidance to ensure that the ultimate product was what the sites initially expected.

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