©The Incredible Years®

Parents, teachers, and children training series

2019 Incredible Years® Mentor Meeting

Islandwood, Bainbridge, WA, Sept 3-5

Tailoring the Incredible Years® to Fit: Childrens' Development, Family, Culture and Implementation Strategies

WELCOME TO THE INCREDIBLE YEARS® 2019 MENTOR MEETING AT ISLANDWOOD, ON BAINBRIDGE ISLAND, WA!

We are so excited to see you all and happy you were able to travel to this rejuvenating destination. Our theme for this year's meeting is **Tailoring the Incredible Years to Fit ~ Children's Development, Family, Culture, and Implementation Stategies**.

Our prior experiences at IslandWood leads us back here by ferry because it is a relaxing atmosphere away from the everyday hustle and bustle where we can focus on meaningful collaboration and learning together. We want to give you an overview and guidelines for the meeting days. Please refer to the **map provided** to help you navigate (or ask an IslandWood staff member to help guide you if you get lost).

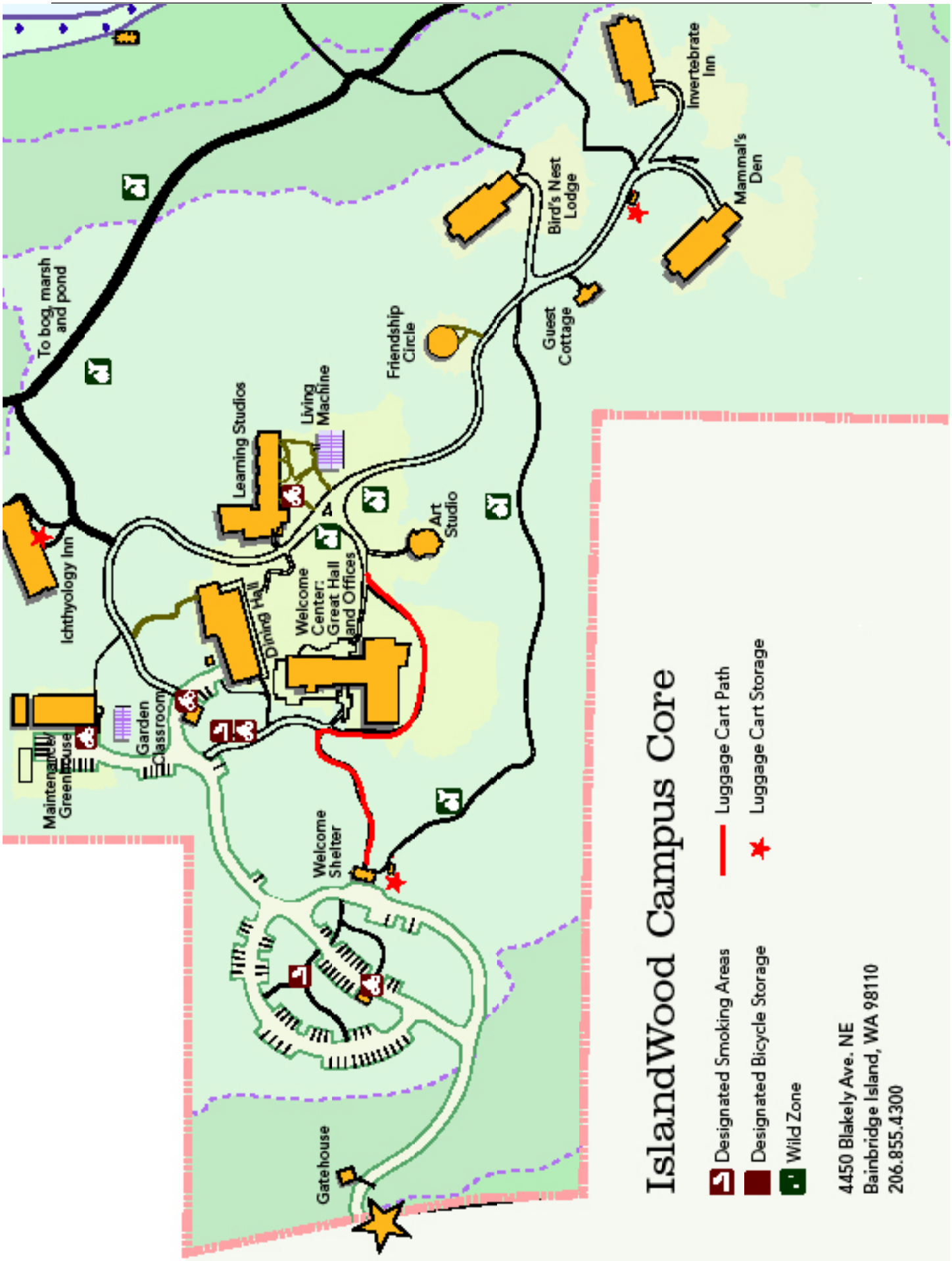
Our first day (Tuesday, September 3rd) we will all meet together for research presentations in the **Great Hall**. Coffee will be provided in the meeting room. From 4:00-6:30pm you can check in to your rooms, get settled, catch up with other mentors, and explore IslandWood. *IslandWood has many different activities and we hope you will take advantage of these or ask the staff for other ideas of things to do.* After dinner we will have dessert and coffee/tea in the **Friendship Circle** area.

On **Wednesday** you will be served a hot breakfast in the **Dining Hall** at **7:30am**. We will meet all together in the **Great Hall**, and then you will break up into groups. Pay close attention to your group name/location! *There are different groups for each of the days*. Be sure to review the **Coach/Presenter roles** document in these handouts. Coffee and snacks will be brought to your meeting rooms throughout the day.

On **Thursday** you will again start with breakfast in the **Dining Hall at 7:30am**, and then meet in the **Great Hall** as a whole group for presentations. After the morning break we will break into groups. **Pay attention to the groups for Thursday - they are DIFFERENT from the groups you were in the day before!** We look forward to our **celebration dinner** that evening, which begins at **7:00pm** and will take place in the **Great Hall**.

Finally, please note we have not arranged assigned seating for any of your meals, however *we really encourage you to spend time with new people who you don't know as well!* You are an incredible group and we hope you have a chance to do some networking and meet new mentors.

Please enjoy your stay here and let us know any questions that come up. Carolyn and Jamila will be available at the meeting and also IslandWood staff will be around as well, so don't hesitate to ask questions!


IslandWood Campus Core
Designated Smoking Areas
Designated Bicycle Storage
Wild Zone
Luggage Cart Path
Luggage Cart Storage
4450 Blakely Ave. NE
Bainbridge Island, WA 98110
206.855.4300
To bog, marsh and pond
Ichthyology Inn
Maintenance/ Greenhouse
Garden Classroom
Dining Hall
Welcome Center: Great Hall and Offices
Learning Studios
Living Machine
Art Studio
Friendship Circle
Guest Cottage
Bird's Nest Lodge
Invertebrate Inn
Mammal's Den
Welcome Shelter
Gatehouse

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2019 Incredible Years® Mentor Meeting
Islandwood, Bainbridge Island, Sept 3-5

Tailoring the Incredible Years® to Fit: Children's Development, Family, Culture, and Implementation Strategies

TUESDAY,
September 3rd

TIME	ACTIVITY/PRESENTER	LOCATION
7:30-7:40 AM	Meet at Seattle ferry terminal and get on ferry	Seattle
7:55 am	Ferry leaves Seattle for Bainbridge Island	
8:30 am	Arrive Bainbridge Island, get on Bus	Bainbridge
9:00-9:30 am	Registration	
9:30-9:50 am	Carolyn - Introduction (20 mins)	Great Hall
9:50-10:30 am	Caroline White: *Building Sustainable Implementation: UK Government Recommendations* (30 mins)	Great Hall
10:20-10:30 am	Break	
10:30:noon	Amanda Fixsen & Erin Albrecht: *Implementation in Support and Scale of the Incredible Years in Colorado* (90 mins)	Great Hall
12:00-1:15 PM	Lunch	Dining Hall
1:15-2:15 pm	Diane Rzegocki: *Implementing IY in the West Bank* (1 hour)	Great Hall
2:15-2:30 pm	Break	
2:30-4:00 pm	Break out groups (Implementation, Tailoring to culture group, and Video review group)	Great Hall Guest Cottage
4:00-6:30 pm	Free time	
6:30-7:30 pm	Dinner	Dining Hall
8:00-10:00 pm	Fire Circle	

BREAKOUT GROUPS, 2:30-4:00pm

PATTERNS:
Implementation
Great Hall
Cathy (Discussion Leader)
Amanda
Angie
Anna
Caroline
Carolyn W-S
Ceth
Desiree
Eadaoin
Erin
Julie
Micah
Siri
Stephnie
Suzy

BUTTONS:
Parent Video Review
Guest Cottage
Bethan
Jane
Kim
Lisa (Video)
Maria (Coach)
Peter
Sean

PINS:
Tailoring to Cultural Groups
Great Hall
Tania (Discussion Leader)
Bjorn
Carolyn R
Dean
Diana L-H
Diane R.
Emily
Jens
Kimberlee
Lindsay
Michele

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WEDNESDAY, September 4th

Tailoring the Incredible Years® to Fit: Children's Development, Family, Culture, and Implementation Strategies

Time	Activity/Team	Location
7:30-8:30 am	Breakfast	Dining Hall
8:30-9:45 am	Carolyn: Coaching in a Developmental Way (75 mins)	Great Hall
9:45-10:15 am	Lisa & Tania (30 mins): *Tailoring for Maori - The Power of Whakawhanaungatanga, Aroha and Wairua in Group Delivery*	Great Hall
10:15-10:30	Break	
10:30-11:45 am **Patterns** **Needles** **Thread** **Scissors**	Break Out Groups (Video Review, Home Coaching) **Home Coaching Training** **Video Review Parent** Stephanie Video/Cathy Coach **Video Review Parent** Maria Video/Carolyn R. Coach **Video Review Teacher/Child** Kim Video/Desiree Coach	 Great Hall Ichthyology Room 102 Room 103
11:45-1:00pm	Lunch	Dining Hall
1:00-2:15 pm **Patterns** **Needles** **Thread** **Scissors**	Break Out Groups (Video Review, Video Reliability, Home Coaching) **Home Coach Training Continued** **Video Reliability** Carolyn W-S **Video Review** Peter Video/Sean Coach **Video Review** Suzy Video/Emily Coach	 Great Hall Ichthyology Room 102 Room 103
2:15-2:30pm	Break	
1:00-2:15 pm **Patterns** **Needles** **Thread** **Scissors**	Break Out Groups (Video Review, Video Reliability, Home Coaching) **Home Coach Training Continued** **Video Reliability** Carolyn W-S **Video Review** Micah Video/Lindsay Coach **Video Review** Michele Video/Suzy Coach	 Great Hall Ichthyology Room 102 Room 103
4:00-4:30 pm	Wrap Up (Video of parents sharing ASD experiences - Diana)	Great Hall
4:30-6:30 pm	Free Time or Join Peter for Olympics in the front of the Dining Hall from 5:00-6:00 pm	
6:30-7:30 pm	Dinner	Dining Hall

See next page for group assignments.

WEDNESDAY BREAK OUT GROUPS

VIDEO BREAKOUT GROUPS, 10:30am–11:45pm

PATTERNS:
Home Coach Training
Great Hall

Anna
Ceth
Dean
Diana L-H
Jens
Kimberlee
Lisa
Tania

NEEDLES:
Video Review Parent
Ichthyology Room

Caroline W.
Cathy (Coach)
Lindsay
Peter
Sean
Stephanie (Video)

THREAD:
Video Review Parent
Learning Studio 102

Bethan
Bjorn
Carolyn R (Coach)
Emily
Jane
Maria (Video)
Siri

SCISSORS:
Video Review Teacher/Child
Learning Studio 103

Angie
Desiree (Coach)
Eadaoin
Julie
Kim (Video)
Micah
Michele
Suzy

VIDEO BREAKOUT GROUPS, 1:00–2:15pm

PATTERNS:
Home Coach Continued
Great Hall

Anna
Ceth
Dean
Diana L-H
Jens
Kimberlee
Lisa
Tania

NEEDLES:
Video Reliability
Ichthyology Room

Bethan
Bjorn
Caroline W.
Carolyn W-S
Cathy
Desiree
Eadaoin
Jane
Kim
Siri
Stephanie

THREAD:
Video Review
Learning Studio 102

Julie
Lindsay
Micah
Peter (Video)
Sean (Coach)

SCISSORS:
Video Review
Learning Studio 103

Angie
Carolyn R.
Emily (Coach)
Michele
Suzy (Video)

VIDEO BREAKOUT GROUPS, 2:30–3:45pm

PATTERNS:
Home Coach Continued
Great Hall

Anna
Ceth
Dean
Diana L-H
Jens
Kimberlee
Lisa
Tania

NEEDLES:
Video Reliability Cont.
Ichthyology Room

Bethan
Bjorn
Caroline W.
Carolyn W-S
Cathy
Desiree
Eadaoin
Jane
Kim
Siri
Stephanie

THREAD:
Video Review
Learning Studio 102

Julie
Lindsay (Coach)
Micah (Video)
Peter
Sean

SCISSORS:
Video Review
Learning Studio 103

Angie
Carolyn R.
Emily
Michele (Video)
Suzy (Coach)

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2019 Incredible Years® Mentor Meeting
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THURSDAY, September 5th

Tailoring the Incredible Years® to Fit: Children's Development, Family, Culture, and Implementation Strategies

Time	Activity/Team	Location
7:30-8:30 am	Breakfast	Dining Hall
8:30-9:15 am	Carolyn: Updates (45 mins)	Great Hall
9:15-9:45 am	Siri (30 mins): *Parent Group Leader Training as a University Course, the new training model in Norway*	Great Hall
9:45-10:15 am	Micah (30 mins): *IY Implementation in Los Angeles County: Adapting to Change & Creating Opportunities*	Great Hall
10:15-10:45 am	Dean (30 mins): *Promoting Filipino Parent Enrollment in IY using Culturally Tailored Video: An RCT*	Great Hall
10:45-11:00 am	Break	
11:00-noon	Break Out Groups (Video Review)	
Patterns	**Video Review Parent** Dean Video/Caroline Coach	Great Hall
Needles	**Video Review Parent** Tania Video/Jane Coach	Ichthyology
Thread	**Video Review Child** Julie Video/Micah Coach	Room 102
Scissors	**Video Review Teacher** Anna Video/Peter Coach	Room 103
noon-1:00 pm	Lunch	
1:00-2:15 pm	Break Out Groups (Video Review)	
Patterns	**Video Review Parent** Cathy M Video/Diana L-H Coach	Great Hall
Needles	**Video Review Parent** Ceth Video/Siri Coach	Ichthyology
Thread	**Video Review Teacher/Child** Eadaoin Video/Angie Coach	Room 102
2:15-2:30 pm	Break	
2:30-4:00 pm	Break Out Groups (Teacher ASD, Video Review)	
Patterns	**Teacher ASD** Carolyn W-S	Great Hall
Needles	**Video Review Parent** Bethan Video/Tania Coach	Ichthyology
Thread	**Video Review Parent** Emily Video/Caroline Coach	Room 102
Scissors	**Video Review Teacher/Child** Angie Video/Kim Coach	Room 103
4:00-4:30 pm	Wrap Up	Great Hall
4:30-7:00 pm	Free Time	
7:00-11:00 pm	Closing Dinner	Great Hall

See next page for group assignments.

THURSDAY BREAK OUT GROUPS

VIDEO BREAKOUT GROUPS, 10:45am–NOON

PATTERNS:
Video Review Parent
Great Hall

Bjorn
Caroline (Coach)
Dean (Video)
Diana L-H
Emily
Jens
Kimberlee
Lindsay
Maria
Stephanie

NEEDLES:
Video Review Parent
Ichthyology Room

Bethan
Carolyn R.
Cathy
Ceth
Jane (Coach)
Lisa
Sean
Siri
Tania (Video)

THREAD:
Video Review Child
Learning Studio 102

Angie
Julie (Video)
Micah (Coach)
Suzy

SCISSORS:
Video Review Teacher
Learning Studio 103

Anna (Video)
Desiree
Eadaoin
Kim
Michele
Peter (Coach)

VIDEO BREAKOUT GROUPS, 1:00–2:15pm

PATTERNS:
Video Review Parent
Great Hall

Bjorn
Caroline
Cathy M
Dean
Diana L-H (Coach)
Emily
Jens (Video)
Lindsay
Maria
Stephanie

NEEDLES:
Video Review Parent
Ichthyology Room

Bethan
Carolyn R.
Ceth (Video)
Jane
Lisa
Kimberlee
Sean
Siri (Coach)
Tania

THREAD:
Video Review Child/Teacher
Learning Studio 102

Angie
Anna (Coach)
Desiree
Eadaoin (Video)
Julie
Kim
Micah
Peter
Michele
Suzy

VIDEO BREAKOUT GROUPS, 2:30–4:00pm

PATTERNS:
Teacher Autism
Great Hall

Desiree
Eadaoin
Jane
Julie
Lindsay
Maria

NEEDLES:
Video Review Parent
Ichthyology Room

Bethan (Video)
Carolyn R.
Cathy
Ceth
Lisa
Sean
Siri
Tania (Coach)

THREAD:
Video Review Parent
Learning Studio 102

Bjorn
Dean
Caroline (Coach)
Diana L-H
Emily (Video)
Jens
Kimberlee
Stephanie

SCISSORS:
Video Review Child/Teacher
Learning Studio 103

Angie (Video)
Anna
Kim (Coach)
Micah
Michele
Peter
Suzy

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2019 Incredible Years® Mentor Meeting
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FRIDAY, September 6th

Tailoring the Incredible Years® to Fit: Children's Development, Family, Culture, and Implementation Strategies

Time	Activity/Team	Location
7:30-8:30 am	Breakfast	Dining Hall
8:30-9:00 am	Check out and load bus	
9:15 am	Bus leaves for ferry	
9:40-10:15 am	Ferry back to Seattle	

INCREDIBLE YEARS MENTOR/TRAINERS RETREAT EVALUATION 2019

PLEASE FILL THIS OUT AND RETURN TO IY STAFF AT THE END OF THE MEETING

Please rate the following aspects of the 2019 Incredible Years® Mentor Meeting:

1. **Usefulness of Presentations (Tueday, Wednesday, Thursday)**

   not helpful neutral helpful very helpful

2. **Usefulness of Home Coaching Workshop**

   not helpful neutral helpful very helpful

3. **Usefulness of presenter/coach format for group video sharing (Tues/Wed/Thurs)**

   not helpful neutral helpful very helpful

4. **Usefulness of discussion groups (Implementation, Video Reliability, Tailoring to Cultural Groups, Teacher Autism Taster)** *Rate the ones you attended.*

   not helpful neutral helpful very helpful

5. **Usefulness of sharing videos of groups or workshops with other mentors**

   not helpful neutral helpful very helpful

Please rate the following aspects of the location and services:

1. **Meals/snacks provided by Islandwood**

   1 2 3 4 5

2. **Overall location/area**

   1 2 3 4 5

3. **Lodging and amenities**

   1 2 3 4 5

4. **Final dinner**

   1 2 3 4 5

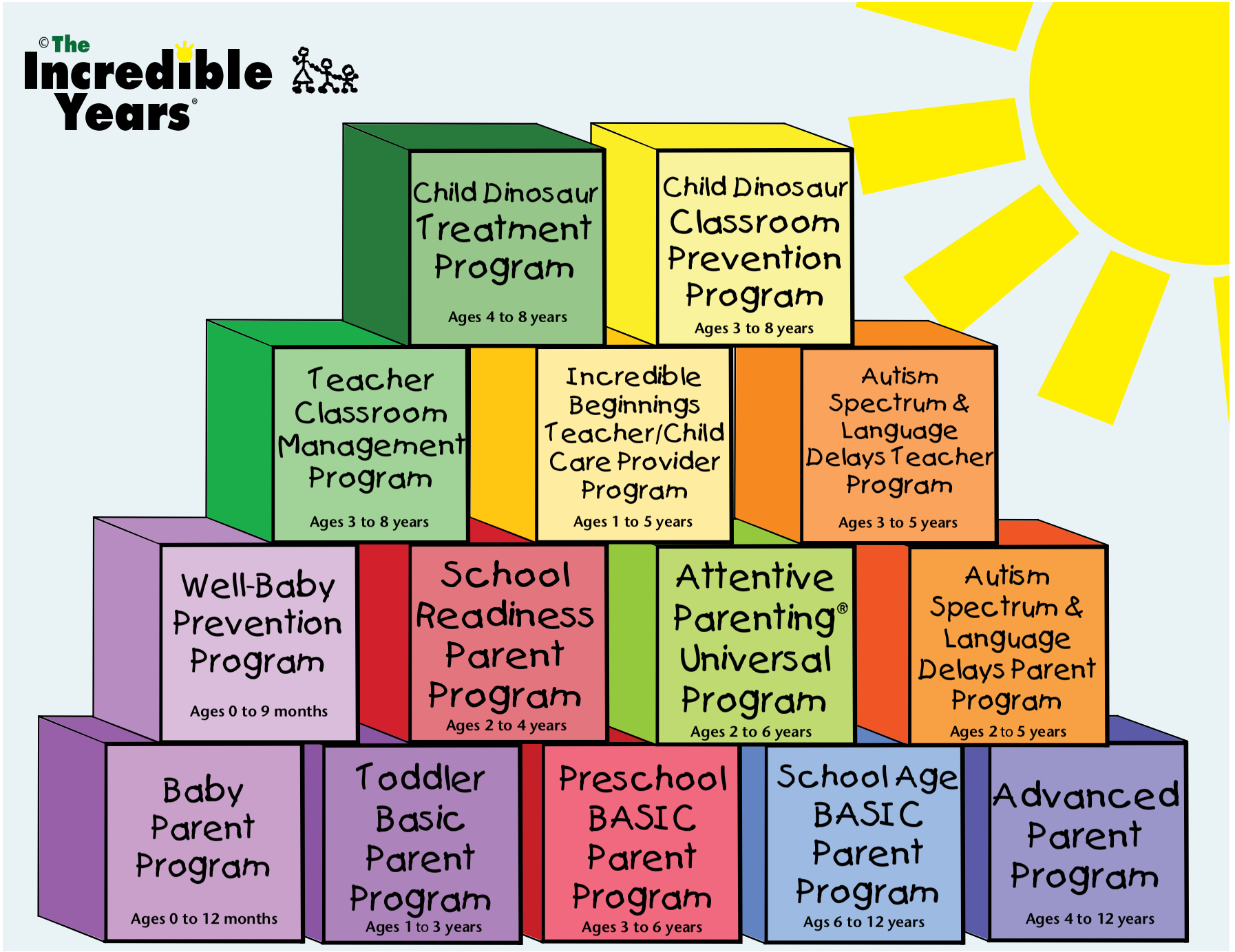
PLEASE SEE OTHER SIDE

Additional questions:

1. What was the most useful part of this meeting?

2. Which topics or activities would be most useful to you for our next mentor meeting?

3. Other comments? We value your suggestions for how to make this meeting the most useful it can be to you. Please let us know your thoughts.


©The Incredible Years®
Child Dinosaur Treatment Program
Ages 4 to 8 years
Child Dinosaur Classroom Prevention Program
Ages 3 to 8 years
Teacher Classroom Management Program
Ages 3 to 8 years
Incredible Beginnings Teacher/Child Care Provider Program
Ages 1 to 5 years
Autism Spectrum & Language Delays Teacher Program
Ages 3 to 5 years
Well-Baby Prevention Program
Ages 0 to 9 months
School Readiness Parent Program
Ages 2 to 4 years
Attentive Parenting® Universal Program
Ages 2 to 6 years
Autism Spectrum & Language Delays Parent Program
Ages 2 to 5 years
Baby Parent Program
Ages 0 to 12 months
Toddler Basic Parent Program
Ages 1 to 3 years
Preschool BASIC Parent Program
Ages 3 to 6 years
School Age BASIC Parent Program
Ags 6 to 12 years
Advanced Parent Program
Ages 4 to 12 years

WELCOME NEW MENTORS! 2019

Emily Haranin

Emily Haranin is a licensed psychologist at Children's Hospital of Los Angeles (CHLA) and an assistant professor of clinical pediatrics at the University of Southern California (USC) Keck School of Medicine. She is actively involved in CHLA's APA-accredited predoctoral internship and postdoctoral fellowship psychology training programs. Prior to her work at CHLA, she worked with children and families impacted by chronic trauma and poverty through an NGO in Puebla, Mexico. As a bilingual psychologist, Emily has been leading IY Preschool BASIC and School Age BASIC groups in both English and Spanish for the past 8 years. She became a certified group leader in 2015 and then completed her Peer Coach training and certification. She has also been trained in the Autism Spectrum & Language Delays Parent and Teacher programs, the Advanced program, the Attentive Parenting program, and the Small Group Dinosaur Curriculum.

Michele Jones

Michele is an Early Intervention Teacher with the Ministry of Education in Napier, New Zealand, where she delivers both parent and teacher groups and coaches other IY group leaders in her area. She has been delivering IY parent groups since 2005, was accredited and began parent peer coaching in 2011. She began delivering teacher groups in 2011, was accredited in 2012 and began teacher peer coaching in 2014.

Stein Grondalen

Stein Grondalen is a special education teacher with hands-on experience from working with challenging children. He has worked with the IY TCM since 2005 and has been in charge of more than 30 groups of teachers in workshops. He has been a peer coach since 2012. Stein is also certified as a NME trainer (Neurosequential Model in Education). He is presently working as supervisor and coordinator at the City of Oslo "Competence unit for student behaviour and learning environment" in Brusetkollen school and resource center and at RBUP (Regional child and youth psychiatric center.) He is a mentor in training and visited Seattle this spring, attending a workshop with Jamilla. His earlier work experience include several years as a teacher and special education teacher in Norwegian public schools and in a community special education school for children with behaviour challenges.

2019 NEW ACCREDITED MENTORS

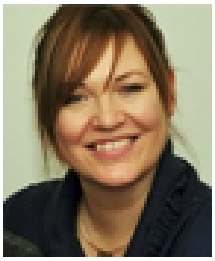
Jens Andersen
(New Zealand)
Basic Parent

Megan Marsh
(England)
Baby Parent

GROUP LEADER ACCREDITATIONS
Kari Walmsness, Basic Parent
Dianne Lees, Parent ASD
Sherrell Prebble, Parent ASD
Tania Anstiss, Parent ASD

PEER COACH ACCREDITATIONS
Suzy B Hannen, Classroom Dina
Emily Haranin, Basic Parent

2018 NEW ACCREDITED MENTORS



Astrid Honoré (Denmark)
Basic Parent

Kate Rhee (Scotland)
Home Coach Mentor

Carolyn Rubenstein (USA)
Basic Parent

Lindsay Sherman (USA)
Basic Parent

Joanne Singleton (England)
Basic Parent

GROUP LEADER ACCREDITATIONS

Jeanne Gordon, Parent ASD
Jane Davidson, Incredible Beginnings
Kimberlee Shoecraft, Incredible Beginnings

PEER COACH ACCREDITATIONS

Anne Breese, Basic Parent
Ditte Maria Ravn, Basic Parent

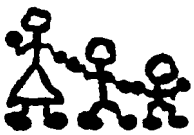
COACH AND PRESENTER ROLES

AS THE **PRESENTER** FOR A SESSION, YOU WILL BE RESPONSIBLE TO:

- Find your slot on the agenda: note the day, time, and allotted length of time
- Prepare your DVD segment ahead of time - select 1 or 2 segments of video (total 10-15 min) of your group session or workshop delivery for participant feedback and bring the DVD with you!
- Identify the goals for your presentation.
- Determine when you have had enough feedback.
- Reflect on your strengths and what you have learned from the discussion and future goals.

AS THE **COACH** FOR A SESSION, YOU WILL BE RESPONSIBLE TO:

- Keep track of the time agenda for your presenter's session.
- Assure the presenter is in a safe environment and the feedback from participants is productive.
- Assist the presenter in making sure his or her goals are addressed.
- Allow everyone to participate with ideas and questions.
- Help scaffold the process of reflecting on the presenter's group leader process and methods demonstrated.
- Set up practice exercises as needed.
- Summarize what was learned from the discussion.



Training and Expectations for Mentor Status
Mentor Agreement

Candidates selected for mentor training are those who have achieved certification/accreditation as group leaders for the copyrighted Incredible Years® parent, teacher or child programs. They have extensive experience as group leaders for numerous groups and have the desire to mentor and support new group leaders. In addition to their advanced clinical skills, they have been recognized by accredited mentors, trainers and their agency supervisors for their excellent leadership skills and training capabilities.

Incredible Years reserves all of its copyrights and other intellectual property rights in its programs. This Mentor Agreement does not authorize any appointed certified mentor or anyone else to make derivative works of the programs or to copy, use, publish or distribute them without express written permission from Incredible Years. This Agreement does not give the certified mentor any rights or permissions to create derivative works or to offer courses under the Incredible Years name and brands with any other works than the unmodified and unaltered programs specifically offered by Incredible Years.

Mentor-in-Training

After nomination by an accredited mentor or trainer, the candidate will:

- Submit an additional group tape (post certification) for ongoing feedback and supervision from trainer.
- Attend consultation workshops.
- Participate with a trainer or mentor in leading a consultation day, and when possible attend peer coaching training.
- Watch a trainer or mentor do a workshop (following the training protocol checklist).
- Participate with a trainer in co-leading a workshop (each day mentor does more of the training)
- Decide with the trainer if mentor is ready to do a workshop alone (maybe decide to co-lead a second workshop with a trainer).
- Lead a workshop independently and video parts of training to be sent to trainer (no more than 3 hours)
- Submit video of workshop, list of participants, attendance and evaluations of workshop to IY
- Begin to mentor new group leaders by co-leading with them.

*see checklist of training steps for more details.

Certified Mentors and Term

Once mentors have been accredited or certified, then s/he (the certified mentor) can offer "authorized" workshops in their agency or specified district, which geographic area is to be determined in discussion with IY with written confirmation (email is acceptable).

Certified mentors are responsible for setting up the venue, deciding on the fee (if there is one), advertising, arranging food and handouts etc. (See tips for setting up a workshop handout.) The appointment of a certified mentor is made by Incredible Years and are subject to the laws of the State of Washington, USA, where Incredible Years has its offices. Incredible Years may at its sole discretion immediately terminate any appointment if the certified mentor violates the terms and conditions of this Mentor Agreement. Termination of any appointment or this Agreement does not terminate any of the copyright, trademark and other intellectual property rights in the programs and is not the sole recourse for Incredible Years if there is any breach of this Agreement or any infringement or other violation of such intellectual property rights in the programs. Any dispute arising from this Agreement or infringement or violation of any of the intellectual property rights in the program shall be subject to arbitration under the rules of the American Arbitration Association in Seattle, Washington, USA.

Subject to the preceding paragraph, the appointment as a certified mentor shall be ongoing as long as mentors attend the annual mentor meeting at least every two years, follow updated protocols and use updated materials. However Incredible Years may elect to bring any action or proceeding in any court or forum having jurisdiction over the certified mentor to protect the intellectual property rights of the programs that are the subject of this Agreement. The prevailing party in any arbitration or litigation shall be entitled to recover its reasonable fees and costs (including attorney or expert fees) as may be awarded in the arbitration award or by a court.

A certified mentor agrees to and shall observe the following:

- To let IY administrator know prior to delivering a workshop of the dates and place of the workshop. This may be posted on web site if desired.
- To adhere to workshop protocol checklists to be sure core training components are covered.
- To provide standard workshop handouts & check with IY staff that the most current handouts are being used.
- To only offer the workshops to trainees within the mentor's defined agency/district. Workshops outside a mentor's agency/district is by prearranged agreement with Incredible Years, on a case-by-case basis. (10% rule allows 10% of participants to come from out of the mentor's district.)
- To attend mentor retreats at least every two years to learn about new research, new adaptations and new programs.
- To respect and not infringe upon or otherwise violate the copyrights and trademarks of the Incredible Years® programs.
- Not to create derivative works or to offer courses under the Incredible Years name and brands with any other works than the unmodified and unaltered programs specifically offered by Incredible Years, and in all such cases only with advanced written permission from Incredible Years.

A certified mentor shall submit to IY the following materials immediately upon completion of a workshop:

____ Names and addresses are completed on database
____ Completed workshop checklist
____ Daily participant evaluations (tallied on summary sheet)
____ Payment of US $25/participant fee (send payments with evaluations and/or ask Incredible Years office for invoice)

Certified mentor consultation and support for new group leaders within agency

In addition to certified mentors offering workshops within the certified mentor's agency or district, a certified mentor is expected to provide ongoing mentoring/consultation and support to group leaders who have received their training workshops. This may be done in the form of videotape reviews, telephone consultation, and/or group review of videotapes and/or consultations.
Certified mentor continuing supervision and consultation
Certified mentors are expected to participate in mentor meetings and consultations with IY trainers every 1-2 years. During these mentor meetings new materials and new research will be presented. In addition, mentors meet to share videotapes of their workshops, groups, and supervision. They share new approaches they have used to training parents and/or new group leaders. New training protocols, handouts and programs are explained at these meetings.

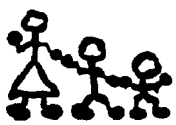
AGREED:

For good and valuable consideration as set forth above, by signing below I accept and agree to the above terms and conditions of this Mentor Agreement. I also agree that a pdf or faxed or other electronic or digital copy of this Agreement signed by me shall have the same force and effect as the original hard-copy with my signature. This Mentor Agreement is subject to Incredible Years accepting and appointing me as a certified mentor:

_____ Date: _____
Name:

Title (if any)
Organization

Contact Information:



Do's and Don'ts to be in compliance with Incredible Years® Copyright, Trademark, Brand Law*

*This is intended to be a helpful guide – for full regulations see Brand License Agreement

DO

- Attend an Incredible Years® Certified/Accredited training (or make sure someone within your agency has done so).
- Read and sign the Incredible Years® Brand License Agreement, then send it back to the Incredible Years®. (See contacts below.)
- Read the Terms and Conditions that are posted on the Incredible Years® website (www.incredibleyears.com) for further clarification regarding copyright works that are available for your use.
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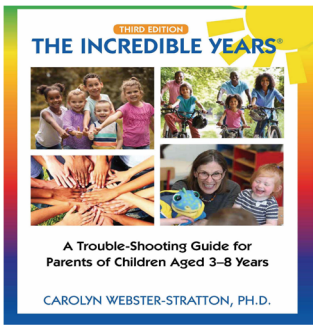
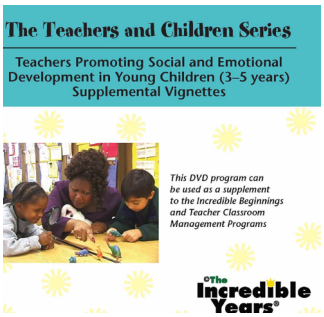
NEW MATERIALS



Third Edition *Incredible Years* Book

School Age Basic Parent Program Flash Drive



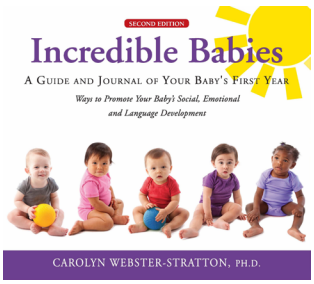
Supplemental Vignettes for Teacher Programs

Preschool Basic Parent Program Flash Drive (English and Spanish)

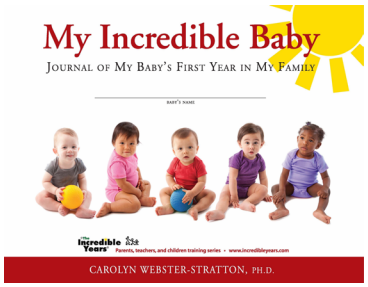
Classroom and Small Group Dina Programs Flash Drive

Experts in Action DVD for ASD Program

Baby Parent Program Flash Drive



Second Edition *Incredible Babies Book*



My Incredible Baby Journal

Incredible Years Program New Materials 2017-19

2017

- New refrigerator notes for screen time/homework (preschool and school age versions)

  http://www.incredibleyears.com/download/resources/parent-pgrm/Refrigerator-Notes-on-screen-time-ages-2-6.pdf

  http://www.incredibleyears.com/download/resources/parent-pgrm/Refrigerator-Screen-time-3-pagesE280A2-6-12-years.pdf

  http://www.incredibleyears.com/download/resources/parent-pgrm/Refrigerator-Notes-HomeworkE280A2-8-12.pdf

- Articles for coping with trauma for parent & child programs

  http://www.incredibleyears.com/wp-content/uploads/Trauma-informed-IY-approaches-combined.pdf

  http://www.incredibleyears.com/wp-content/uploads/Dina-Curriculum-prepares-children-to-cope-with-trauma-4-26-17-1.pdf

- Home coaching article

  http://www.incredibleyears.com/download/Home-Coaching-Chapter-3-28-16.pdf

- Time Out/Time In article

  http://www.incredibleyears.com/wp-content/uploads/Time-out-Time-In-Webster-Stratton.pdf

- Agency Do's and Don'ts for Using Incredible Years Programs with Fidelity*

  http://www.incredibleyears.com/download/administrators/Dos-and-Donts-to-Use-Incredible-Years-Programs-with-Fidelity.pdf

2018

- Guidelines for sending in mentor solo videos

  http://www.incredibleyears.com/download/resources/mentors/Tips-for-Preparing-Mentor-Solo-Workshop-Video-for-Review.pdf

- Peer Coach nomination & application forms *(p. 31-33)*

  http://www.incredibleyears.com/download/certification/Peer-coach-nomination-form_042018-editable.pdf

  http://www.incredibleyears.com/download/certification/Peer-Coach-Certification-Checklist-Parent.pdf

  http://www.incredibleyears.com/download/certification/Baby-Parent-Peer-Coach-Certification-Checklist.pdf

http://www.incredibleyears.com/download/certification/Classroom-Dina-Peer-Coach-Certification-Checklist.pdf

http://www.incredibleyears.com/download/certification/Small-Group-Dina-Peer-Coach-Certification-Checklist.pdf

http://www.incredibleyears.com/download/certification/TCM-Peer-Coach-Cert-Check-list-8-16.pdf

- Editable teacher behavior plans (2 versions)

  http://www.incredibleyears.com/download/resources/teacher-pgrm/NEW-IYTCM-Behavior-Plan_editable_US-version.pdf

  http://www.incredibleyears.com/download/resources/teacher-pgrm/NEW-IYTCM-Behaviour-Plan_editable-UK-version.pdf

- Editable autism behavior plans

  http://www.incredibleyears.com/download/resources/parent-pgrm/Autism-Program-editable-handouts-and-record-sheets.pdf

- TCM Detailed Behavior Plan Sheets (6 pages) Editable

  http://www.incredibleyears.com/download/resources/teacher-pgrm/Editable-Behavior-Plan-Sheets_for-workshops-1-6.pdf

- Autism checklist with new protocol (added sessions)

  http://www.incredibleyears.com/download/resources/parent-pgrm/Autism-Program-Agendas-and-Checklists-033018-WEB.pdf

- Assessing play and language levels for children with ASD

  http://www.incredibleyears.com/download/resources/parent-pgrm/Assessing-Childrens-Play-and-Language-levels.pdf

- Incredible Years baby program survey prestest

  http://www.incredibleyears.com/download/Evaluations/Baby-Program-Survey_Web.pdf

- Babies Home Coaching Satisfaction questionnaire

  http://www.incredibleyears.com/download/Evaluations/Baby-Home-Coach-Final-Parent-Satisfaction-Questionnaire-2-2-18.pdf

- Promoting a Healthy Lifestyle handout (for preschool and school age parent programs)

  http://www.incredibleyears.com/download/resources/parent-pgrm/Promoting-Healthy-Lifestyle-Preschool-Prog3-Part1.pdf

- Baby Leader manual update
- *Incredible Babies* book update
- Requirements to Run IY Groups with Fidelity* *(p. 34-35)*

  http://www.incredibleyears.com/download/administrators/Requirements-to-run-IY-groups-with-Fidelity.pdf

- Translation checklist/application* *(p. 36-39)*

  http://www.incredibleyears.com/download/administrators/IY-Translation-checklist-form_v2_092517.pdf

2019

- Responding to Child Dysregulation (for teachers and parents)* *(p. 40-43)*

  http://www.incredibleyears.com/download/resources/parent-pgrm/Responding-to-dysregulation-and-teaching-children-to-self-regulate_parent_v4.pdf

  http://www.incredibleyears.com/download/resources/teacher-pgrm/Responding-to-Dysregulation-Teaching-Children-to-Self-Regulate_teacher_v1.pdf

- Incredible Beginnings Vignettes to supplement TCM* *(p. 44-45)*

  http://www.incredibleyears.com/download/resources/teacher-pgrm/how-to-use-IB-Vignettes-to-supplement-TCM-program-10-25-18.pdf

- Autism Program Vignettes to supplement TCM* *(p. 46-47)*

  http://www.incredibleyears.com/download/resources/teacher-pgrm/how-to-use-IY-ASD-Teacher-Topics-to-Supplement-TCM-10-25-18.pdf

- Supplemental Vignettes for Incredible Beginnings Program with more Diversity* *(p. 48)*

  http://www.incredibleyears.com/download/resources/teacher-pgrm/NEW-Agendas-and-Checklists-for-Incredible-Beginnings-Program-with-Supplemental-Vignettes-100918.pdf

- Baby Buzz Form

  http://www.incredibleyears.com/download/resources/parent-pgrm/new-Baby-Buzz-form-12.2018.pdf

- Autism Buzz Form* *(p. 49)*

  http://www.incredibleyears.com/download/resources/parent-pgrm/ASD-parent-buzz-form.pdf

- Autism Parent House Form - *Assessing My Child's Play and Language Levels* (p. 50)*

  http://www.incredibleyears.com/download/resources/parent-pgrm/Parent-handout-My-Childs-Play-and-Language-Levels.pdf

- Basic Parent House Form - *How I am Incredible* (p. 51)*

  http://www.incredibleyears.com/download/resources/parent-pgrm/How-I-am-Incredible-Parent-house_v7_062119.pdf

- Tips for Using Puppets for Parents and Teachers* *(p. 52-55)*

  http://www.incredibleyears.com/download/resources/puppet_handout-for-parents-and-teachers.pdf

- Autism Parenting Pyramid* *(p. 56)*

  http://www.incredibleyears.com/download/resources/parent-pgrm/autism-pyramid_06_19_web.pdf

Measures

- Attentive Parenting Survey
  http://www.incredibleyears.com/download/Evaluations/Attentive-Parenting-survey.pdf
- Teacher/Child Care Provider Practices Inventory (for Incredible Beginnings)
  http://www.incredibleyears.com/download/research/Teacherchildcare-provder-practices-inventory.pdf
- Parent Practices Inventory (updated 2019)* *(p. 57-60)*
  http://www.incredibleyears.com/download/Evaluations/PPI_updated-032619.pdf
- ASD-T Teacher Questionnaire for Children with ASD
  http://www.incredibleyears.com/download/Evaluations/ASD-T-questionnaire_v5.pdf
- ASD-P Parent Questionnaire for Children with ASD* *(p. 61-64)*
  http://www.incredibleyears.com/download/Evaluations/ASD-P-questionnaire_v3.pdf

Fidelity Forms (new & revised)

- 3-day Basic Parent Workshop protocol update
  http://www.incredibleyears.com/download/resources/mentors/Basic-Workshop-protocol_3-Day_032619.pdf
- Skype Consultation Call Tips and Prep Form
  http://www.incredibleyears.com/download/resources/mentors/Skype-Consultation-Tips-for-Mentors.pdf
  http://www.incredibleyears.com/download/resources/mentors/skype-call-prep-form.pdf
  http://www.incredibleyears.com/download/Skype-Consultation-Tips-for-Group-Leaders.pdf
- Mentor Consultation agenda
  http://www.incredibleyears.com/download/resources/mentors/ConsultationDay_Training-Protocol.pdf
- 2-day Home Coaching Training
  http://www.incredibleyears.com/download/resources/mentors/Parent-Home-Coach-Training-Protocol-2-Day.pdf
- Parent Collaborative Process Checklist update* *(p. 65-69)*
  http://www.incredibleyears.com/download/Evaluations/2019-parent-Collaborative-process-checklist.pdf
- Teacher Collaborative Process Checklist update
  http://www.incredibleyears.com/download/Evaluations/2019-revised-teacher-collaborative-process-checklist.pdf
- Workshop Evaluation form update *(p. 70)*

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Studies evaluating TCM Program

2017

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Herman, K. and W.M. Reinke, Improving Teacher Perceptions of Parent Involvement Patterns: Findings from a Group Randomized Trial. School Psychology Quarterly, 2017. 32(1): p. 89-104.

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Murray, D.W., Rabiner, D.L., Kuhn, L., Pan, Y., Sabet, R.F. Investigating teacher and student effects of the Incredible Years Classroom Management Program in early elementary school. Journal of School Psychology, 2017.

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Thompson, A., Herman, K., Stormont, M. A., Reinke, W., Webster-Stratton, C. Impact of Incredible Years on Teacher Perceptions of Parent Involvement: A Latent Transition Analysis Journal of School Psychology, 2017. 62: p. 51-65.

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Reinke, W.M., K. Herman, and N. Dong, The Incredible Years Teacher Classroom Management Program: Outcomes from a Group Randomized Trial. Prevention Science, 2018: 19, 1043-1054.

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Ford, T., et al., The effectiveness and cost-effectiveness of the Incredible Years Teacher Classroom Management programme in primary school children: results of the STARS cluster randomized controlled trial. Psychological Medicine, 2018: p. 1-15.

http://www.incredibleyears.com/article/the-effectiveness-and-cost-effectiveness-of-the-incredible-years-teacher-classroom-management-programme-in-primary-school-children-results-of-the-stars-cluster-randomised-controlled-trial/

Sebra-Santos, M.J., et al., Promoting Mental Health in Disadvantaged Preschoolers: A Cluster Randomized Controlled Trial of Teacher Training Effects. Journal of Child and Family Studies, 2018.

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Sicotte, R., et al., Moderating Role of the Form of Maltreatment Experienced by Children on the Effectiveness of a Parent Training Program. Child Maltreatment, 2018: p. 1-10.

http://www.incredibleyears.com/article/moderating-role-of-the-form-of-maltreatment-experienced-by-children-on-the-effectiveness-of-a-parent-training-program/

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Sebastian, J., K. Herman, and W.M. Reinke, Do organizational conditions influence teacher implementation of effective classroom management practices: Findings from a randomized trial. Journal of School Psychology, 2019. 72: p. 134-149.

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Kong, M. and A.T. Kit-Fong, The Incredible Years Parent Program for Chinese Preschoolers with Developpmental Disabilities. Early Education and Development, 2018. 29(4): p. 494-514.

http://www.incredibleyears.com/article/the-incredible-years-parent-program-for-chinese-preschoolers-with-developmental-disabilities/

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http://www.incredibleyears.com/article/teaching-children-to-problem-solve-through-puppet-play-interactions/

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http://www.incredibleyears.com/article/promoting-enrollment-in-parenting-programs-among-a-filipino-population-a-randomized-trial/

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Reviews/Chapters

Bell, Z., et al., Improvements in Negative Parenting Mediate Changes in Children's Autonomic Responding Following a Preschool Intervention for ADHD. Clinical Psychological Science, 2017: p. 1-11.

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http://www.incredibleyears.com/article/delivering-the-incredble-years-small-group-child-program-in-an-elementary-school-setting/

Leijten, P., et al., Research Review: Harnessing the power of individual participant data in a meta-analysis of the benefits and harms of the Incredible Years parenting program. The Journal of Child Psychology and Psychiatry, 2017.

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White, C., Building sustainable parent interventions in the early years. In Improving The Psychological Wellbeing Of Children and Young People K. Hunt and A. Laffan, Editors. 2018, Jessica Kingsley London p. 71-92.

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Incredible Years
Coaching and Mentoring Gems

Date _____ Group Leader(s) _____ Coach/Mentor _____

Program: Parent ☐ Teacher ☐ Child ☐ Video viewed? ☐ Topic _____ Date for next meeting _____

Fidelity Issues Discussed:

- ☐ Attendance
- ☐ Participant evaluations
- ☐ Home activities engagement
- ☐ Principles
- ☐ Mediating vignettes & Number
- ☐ Role play/practices/ buzzes & Number
- ☐ Participant goals
- ☐ Tailoring to needs
- ☐ Weekly calls
- ☐ Session checklists
- ☐ Peer & self-evaluation forms
- ☐ Group process checklists
- ☐ Self-reflection inventories
- ☐ Accreditation/ Certification
- ☐ Coaching evaluation

Group leader prior goals reviewed:

Group leader goals for group DVD review:

Issue problem solved and practiced:

Summary of Key Learning:

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Incredible Years
Coaching and Mentoring Gems

New Goals and Plans:

Coach/Mentor Actions:

Additional Notes:

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Incredible Years Peer Coach Application

This form should be filled out by the peer coach nominee in collaboration with the mentor or trainer who is nominating the group leader to become a Peer Coach.

Name of nominated peer coach:

Name of mentor/trainer nominating peer coach:

Which IY program is nominee applying to coach in?

Date originally trained & name of trainer/mentor (include all IY trainings):

Date of accreditation as a group leader (include all IY programs):

Number of groups delivered since training (specify number of groups for program you are applying in):

Educational background and professional experience of nominee:

Name of agency and person supporting this nomination:

Nominee's role in agency:

District peer coach will serve:

Nominee's plans to continue to offer IY groups alongside peer coaching work:

Attach:

1. Letter from nominee briefly stating reasons for wanting to become a peer coach
2. Agency letter of support (include coaching plan and financial commitment to peer coach training, consultation and on-going support of peer coach):
3. Mentor/trainer letter of support

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Checklist of Training Steps Required for Certification of an IY Basic Parent Peer Coach

The training requirement of an experienced Incredible Years Peer Coach involves a process similar to that for Group Leader Certification. The difference is that Peer Coach training embraces a broader experience in supervision principles and components of providing videotape review and support to new group leaders. When all the training steps (listed below) are achieved, observed and confirmed, a candidate may apply for accreditation/certification as a qualified IY Peer Coach.

Candidate's name _____

address _____

email _____ Date: _____

Step 1
Qualifications for Basic Parent Peer Coach Candidates:

___ Basic Parent Group Leader Certification/Accreditation
Date accredited _____

___ Number of Basic Parent Groups Completed To Date (minimum 6)

___ Nomination Letter Submitted by Mentor (nominating candidate for coach training)
Mentor Nominating: _____

___ Peer Coach Nomination form completed and submitted to IY

NOTE: When the conditions outlined in Step 1 have been accomplished, a candidate is qualified to attend peer coaching training as shown in Steps 2-5

Step 2 (Steps 2 & 3 may be carried out simultaneously)
Peer Coach Training:

___ 1-Day (or 2 half-days) Peer Coaching Workshop conducted by Certified Trainer
Name of Trainer and Date: _____

___ 1-Day Consultation Workshop reviewing videos of own video-review practice conducted by Certified Trainer
Name of Trainer and Date: _____

___ Peer coaches work with 6 new Basic Parent group leaders (3 dyads) and review the videos of their sessions with them. They will complete self-evaluations and group leaders complete leader evaluations of their coaching given.

Step 3

Basic Parent Peer Coaching Video Review by Trainer:

___ Presentation of Video of Basic Parent Peer Coaching to Trainer for review

Dates of Trainer Review of Peer Coaching :_____

Others Observed: _____

___ Evaluation of Peer Coaching by Trainer *(To be completed by Trainer)*

Step 4

Basic Parent Peer Coaching Completed:

___ Completed Basic Parent Peer Coaching with 3 Dyads: *(6 different people/3dyads with a minimum of 4 sessions per dyad*; list names of group leaders for whom you provided coaching)*

___ Evaluations from group leaders receiving peer coaching *(See form - minimum of 6 evaluations required)*

___ Self-evaluations of peer coaching given *(See form - minimum of 3 evaluations required - match selfevaluation with the dyads in previous line)*

___ Letter explaining your interest and goals for peer coaching

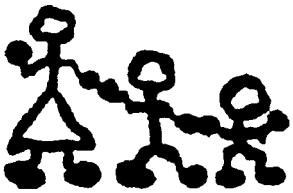
Step 5

Application for Basic Parent Peer Coaching Accreditation:

When all of the above training experiences have been achieved, observed and confirmed, a candidate may apply to the Incredible Years Advisory Council for Accreditation and Certification as a Qualified IY Basic Parent Peer Coach.

Note: It is important for group leaders to realize that obtaining peer coaching on their video does not satisfy the final qualifications for accrediting a group tape. This must still be done by an accredited mentor or trainer

* At least one session per dyad must be done in person and videotaped. Skype calls are permitted in place of some in-person meetings if distance requires. Please see the Skype call protocols for use by coaches and participants.



Requirements to Run Incredible Years® Groups with Fidelity

Group Leader Qualifications:

• At least one MA level group leader per group (each group must be run by two group leaders). If no MA level therapist is available, exceptions may be made for BA level group leaders with extensive experience working with families (ability to collaborate with parents, understanding of child development and social learning theory). Please provide evidence of experience/qualifications.

Program Delivery:

• Offer the recommended minimum number of group sessions for chosen IY program. For Basic IY Parent program, this is 14-16 sessions for the prevention protocol and 18-20 for treatment protocol. Group leaders should be allowed some flexibility to add more sessions as needed according to group size, educational background, use of translators and group needs.

• Provide make up sessions when families miss (make-up sessions are counted in parent attendance counts)

• Provide group leaders with sufficient time for 2-2 ½ hour groups plus weekly program prep time, calls to parents between sessions, review of home activities, session video reviews/peer review, and attendance at coaching/supervision and consults (6-10 total hours per week). Post-certification less time may be spent (6-8 hours per week).

Consultation and Coaching:

• Have group leaders regularly video group sessions

• Group leaders should receive on-going support during group delivery. This may be obtained in the following ways (4 times per group):

-In person or skype coaching sessions with IY peer coach

-In person or skype consultation with IY trainer from Seattle

-Submission of group video to Seattle as part of accreditation/certification process

Accreditation/Certification:

• All group leaders are expected to work towards certification. Below are suggested guidelines/benchmarks:

During first year of implementation: trained group leaders submit at least 1-video to Seattle for complete review.

During second year of implementation: group leaders are working on certification and submit a second video to Seattle for certification. It is anticipated that about half of group leaders would obtain certification during the second year.

During third year of implementation: Remaining trained group leaders continue

with the certification process. Sites collaborate with IY to determine whether one of their certified group leaders is eligible to become a Peer Coach in the program.

Note: additional funding should be available for sites that choose to train a Peer Coach. See web site for more detailed information about certification expectations for group leaders and peer coaches.

Supervision and Coaching of IY Groups:

- Supervision and coaching of IY group leaders is ideally conducted via in-person meetings with a trained Peer Coach who reviews videos with the group leaders and conducts role play practices.
- While a site is building capacity of Peer Coaches, certified group leaders may provide support to newer group leaders.
- Sites that do not have access to either a Peer Coach or certified group leader are able to obtain consultation through IY in Seattle.

Overall Support Network:

- Ideally an agency (or region) will work towards eventually developing a mentor who will oversee the overall delivery and fidelity of the IY program. The mentor is authorized to provide training for new group leaders and expected to support regional peer coaches.
- Each large agency (or region) would have peer coaches who provide local support and regular coaching.

Maintaining Fidelity after Accreditation/Certification:

Even expert group leaders benefit from on-going feedback and discussions about their work. Without fidelity checks, it is easy for group leaders to drift from the original model. In order to assure that certified group leaders continue to deliver the program with fidelity, we recommend the following:

- Accredited group leaders should lead at least one group every 19 months
- Accredited group leaders should participate in a fidelity check every 18 months (this could be a coaching session with an accredited peer coach, a video review of a group by a mentor or trainer, or an in-person or skype consultation with a mentor or trainer.

See link below for more information on bringing the IY programs to scale:

http://www.incredibleyears.com/wp-content/uploads/Bringing-IY-Programs-to-Scale.pdf

Application Process for translating Incredible Years® (IY) materials

We have had many requests for translations for IY programs into different languages and while we are excited about the possibilities of having more of our materials translated, the process of translating materials and DVDs is complex and time consuming. Incredible Years, Inc. coordinates and oversees the translation process in order to assure quality control of translated materials. There must be a contract in place with Incredible Years Inc. before translations can be undertaken. Please note there are important decisions to be made regarding what elements of the IY program will be translated first. We regret that we cannot undertake all requested translations and that there may be a waiting list for when we can begin a new translation contract.

Here are some important considerations:

- Contracts between Incredible Years®, Inc. and your agency are required before any translations can be undertaken because all materials are copyright protected. Failure to have a contract when translating IY materials will be a copyright violation.
- The best translation projects are done when Incredible Years Inc. works with those who have attended accredited IY trainings and have had experience delivering the program. Working with experienced IY group leaders (who speak the requested language as well as English) for checking the translation process is important because this assures that the meaning and understanding of the translated program is preserved. Translation contracts are only set up with agencies that have group leaders with extensive experience delivering the IY program.
- In non-English-speaking countries, we recommend that the program is first used by bi-lingual group leaders who can use the English leader manuals and texts and can access training and consultation in English while getting training and experience utilizing the program with their population.
- The agency/organization requesting the translation is responsible for paying for all costs associated with the translation. The total cost of the translation will be provided by Incredible Years Inc. on the basis of bids/quotes from reputable Seattle translation and/or video companies who have worked with Incredible Years Inc. for over 20 years and will be included in the contract. A payment schedule will be agreed upon prior to beginning translation.
- All translations are done in Seattle to ensure consistent quality of translations. The agency/organization will be asked to proof-read and check translations to be sure the translation is authentic and high quality.
- All translations must be presented with graphic formatting identical to the English version. Graphics work is also done in Seattle to ensure consistent quality.
- Completed translated versions of participant handouts are placed on the Incredible Years web site for use by others; they are still the copyright of Incredible Years after translation.
- Translation of program participant handouts should be the priority for any new IY program being offered since these are the materials that are given directly to parents, teachers and children who are less likely to speak English than the professionals delivering the programs. Translation of leader manuals and Video/DVDs are a later step once program has been piloted and found effective by participants.

- In countries where group leaders do not speak English, translation of detailed leader manuals may be necessary.
- For program video/DVD vignettes, subtitled translation is recommended rather than voice over (dubbing). Subtitled translations are easier and cheaper to produce and are more acceptable to participants watching the programs.
- There is a separate contract arrangement for translation of books written by Carolyn Webster-Stratton.

If you are interested in applying to translate one of the IY programs, you will need to complete our **Translation Request Application (see the last 2 pages of this document)**. Please read our translation checklist on the next page prior to completing your application.

9 Step Translation Checklist

Complete **Translation Request Application**. Please note, if you do not have extensive experience with the program that you are requesting to translate, your application is not likely to be accepted.

1. Incredible Years (IY) Inc. will approve or deny your request for translation. Note: IY retains all rights to translated materials.
2. If your request is approved, IY will provide you with a bid/quote for the cost of translation using our selected translation company and our video production company (if applicable).
3. If you accept the bid, IY will provide a contract for your review including payment schedule and anticipated translation timeline.
4. To start, a sample translation of a few pages will be set to you so that you can check that the dialect and translation are acceptable to your audience. Translation will not proceed until you have approved these sample pages.
5. If sample pages are approved, translation will begin on the full project. When the first draft of the translation is complete, the draft documents will be sent to you for review.
6. Your agency will review the documents and will be able to make edits for suggested wording changes. This is your only chance to make changes to the document.
7. IY will incorporate your changes into the documents and complete the graphic design portion of the project. If your project involves video/DVDs, the subtitles will be added to the videos after the translations have been approved.
8. Final documents or video/DVDs will be provided to your agency for review. No new changes can be made, but you may check to make sure that all your prior edits were incorporated into the final document.
9. After final payment is received, the participant handouts will be made available on the website, or your product will be produced and available for you to purchase (manuals, books, or video/DVDs).

Application for Incredible Years Translation

Agency Name _____

Main Contact Person _____

Official Title _____

Phone Number _____

Email Address _____

Financial Officer (person or department responsible for payment) _____

Phone Number _____

Email Address _____

Describe your experience using IY programs at your agency _____

_____

_____

_____

_____

_____

Please list the accredited Group Leaders at your agency _____

_____

_____

_____

_____

_____

Select program to translate:

Parent Programs

- ☐ Baby Program (0-1 years)
- ☐ Toddler Program (1-3 years)
- ☐ Preschool Basic Program (2-8 years)
- ☐ School Age Basic Program (6-12 years)
- ☐ Autism and Language Delays Program for Parents (2-5 years)
- ☐ Teacher/Parent Partnership Program for Children with Autism (2-5 years)
- ☐ Advanced Program (4-12 years)
- ☐ Attentive Parenting Program (2-6 years)

Child Programs

☐ Classroom Dinosaur Program (3-8 years)

☐ Small Group Dinosaur Therapy Program (4-8 years)

Teacher Programs

☐ Teacher Classroom Management Program (3-8 years)

☐ Incredible Beginnings Program (1-5 years)

☐ Teacher/Parent Partnership Program for Children with Autism (2-5 years)

Select materials to translate:

☐ Participant Handouts

☐ Full Leader's Manual

☐ DVDs (subtitling)

Goals, plans with implementing IY programs and reasons for wanting to translate materials:

_____

_____

_____

_____

Funding source (grant, etc.) _____

_____

_____

_____

Is there any additional information you would like to share with us? _____

_____

_____

_____

_____

_____

Request Approved _____ Denied _____

Contract to be completed: _____

Signed _____

Date _____

Responding to Child Dysregulation and Teaching Self-Regulation

Carolyn Webster-Stratton, Ph.D.

My child is upset, angry, defiant & beginning to dysregulate

Parent Self-Talk

"My child is upset because… and needs help to self-regulate and problem solve."

"I can stay calm. This will help my child to stay calm."

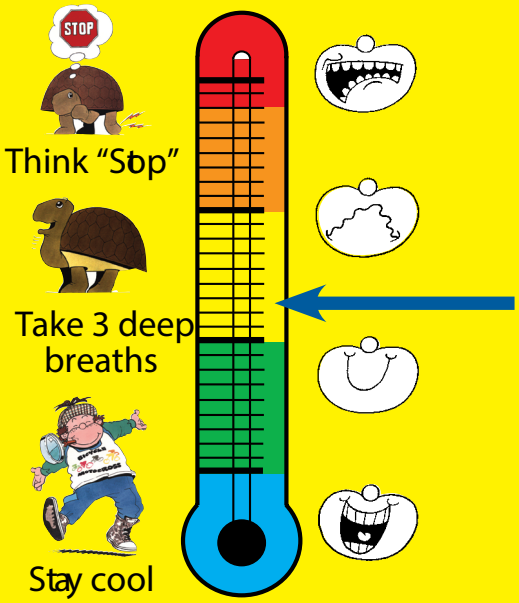
"I can ignore this behavior as long as he is not hurting someone or breaking something."

"I can be supportive without giving too much attention to disruptive behavior."

"If my child is responsive and cooperative to my coaching, then it's a good time to coach. If my coaching makes her angrier, then she needs space and privacy to calm down."

Parent Response

- Model deep breathing, patience and being sympathetic to child
- Help child use calm down thermometer and take deep breaths
- Redirect child to another activity
- Ignore child's dysregulated behavior as long as behavior is not unsafe
- Label child's emotion and coping strategy: "You look angry, but you are trying hard to stay calm with breathing and remembering your happy place."
- Stay nearby and be supportive.
- Give attention and coaching to behaviors that encourage your child's coping and emotion regulation.



Slow Down

When children are angry and dysregulated, parents may also feel angry and out-of-control and may respond by yelling, criticizing, or spanking. At these times, Time Out can provide time and space for the parent, as well as the child, to self-regulate. Here are some tips for parent self-regulation:

- STOP and challenge negative thoughts and use positive self-talk such as: "*All children misbehave at times. My child is testing the limits of his independence to learn that our household rules are predictable and safe.* This is normal for children this age and not the end of the world."
- Do some deep breathing and repeat a calming word: "relax," "be patient," "take it easy."
- Think of relaxing imagery or of fun times you have had with your child.
- Take a brief break by washing your face, having a cup of tea, putting on some music, or patting the dog. Make sure your child is safe and monitored.
- Focus on coping thoughts such as: " *I can help my child best by staying in control.*"
- Forgive yourself and be sure you are building in some "personal time" for relaxation.
- Ask for support from someone else.
- Reconnect with your child as soon as you are both calm.

Like your child you can get yourself into a "green" calm state and try again.

My child continues to dysregulate and becomes aggressive

Parent Self-Talk

"My child is out of control and too dysregulated to benefit from prompts to calm down or to discuss solutions to problems."

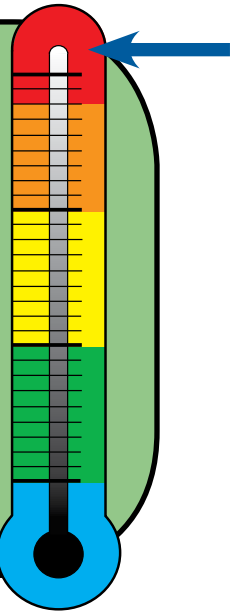
"I need to give my child time away from attention to calm down so he doesn't hurt someone."

"I have taught my child how to use the Time Out or Tiny Turtle chair to calm down so I can do that now. "

"Time Out is a safe and respectful way for my child to learn to reflect and self-regulate."

Parent Response

- I say, "Hitting is not allowed, you need to go to Time Out to calm down. " (This place has a calm down thermometer to remind my child of what to do in Time Out to calm down.)
- I wait patiently nearby to let him re-regulate and make sure others don't give this disruptive behavior attention.
- I give him privacy and don't talk to him during this calm down time.
- When he is calm (3-5 minutes), I praise him for calming down.
- I support my child to re-enter an activity or routine.



My Child Is Calm Now

Parent Self-Talk

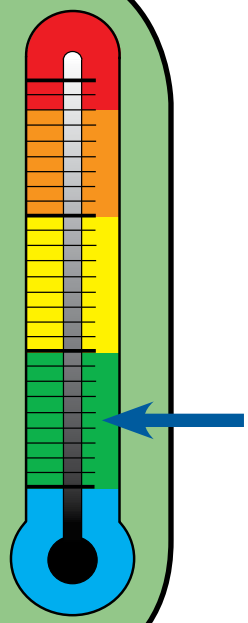
"Now I can reconnect with my child and help her learn an alternative way to solve her problem."

"She is learning she gets more attention for positive behavior than inappropriate behavior."

"I can help her learn to express her frustration and anger in more appropriate ways."

Parent Response

- I praise my child for calming down
- I distract my child to a new learning opportunity.
- I do not force my child to apologize because insincere apologies do not teach empathy
- I engage her in something else so that we have positive Time In together and she feels loved.
- I start using social coaching as my child plays
- I also look for times when she is calm, patient, happy, or friendly.
- I use emotion coaching to help her understand these self-regulated feelings get my attention.
- If she starts to dysregulate again, I name her uncomfortable feelings, help her express these verbally, and prompt her to remember her coping strategies.
- During times when my child is calm, I use puppets, games, and stories to help her learn alternative solutions to common childhood problem situations.



Bottom Line

My child learns that taking a Time Out feels like a safe and secure place to calm down; it is not punitive or harsh and isolating; my child understands that when he has calmed down, he can join in family or peer activities without blame and has a new opportunity to try again with another solution to his problem. He feels loved when this strategy has been used and has sometimes seen his parents or teachers use this same strategy when they are angry. My child gets far more Time In attention from me for positive behaviors than negative behaviors. He feels loved and secure when using Time Out because it gives him time to re-regulate and try again in a loving environment. Time Out provides me with a chance to take a deep breath and calm down so I can respond to my child in a calm, firm, consistent, nurturing or caring manner.

Incredible Beginnings Training Program Supplemental Vignettes to Enhance Preschool Focus for IY-TCM Program

If you happen to also have purchased the **Incredible Beginnings Program** for training teachers working with preschool children (ages 3-5 years) in addition to the IT-TCM teacher training program (ages 4-8 years), you might want to consider adding a few of the IB vignettes to this training, particularly if your teachers are working with young children with language delays. Below you will find some possible vignettes focused on preschool children that might be considered as additions to the current TCM training protocol. The process would be to select a few of these vignettes to replace a few of TCM vignettes. In particular, we encourage the use of the teacher reflections vignettes so teachers can see how others are using the coaching methods.

Another option is to use these vignettes as a follow-up booster consultation session after you have completed the 6 days of TCM.

Day 1: TCM Topics Building Positive Relationships with Students and Proactive Teacher

IB Program 1 (Relationships)

-Vignettes 9a and 9b: Distressed boy saying goodbye to mom.

-Vignette 16: Reunion with mom at the end of the day

Vignettes 9 and 16 are toddler vignettes, but could be used for preschool teachers who have children with separation problems.

IB Program 5 (Proactive)

-Vignette 13: Washing hands routine

-Vignette 17: Circle time, making a choice

-Vignette 23: Ending the day

Day 2: TCM Topic Attention, Coaching, Encouragement, and Praise

IB Program 2, Part 2 (Language development/Academic Coaching)

-Vignette 29: visuals to enhance language, playdough poking (coaching for child with limited language and play skills)

-Vignette 30: Amelia balls (good example of academic coaching)

-Vignette 31: Dinosaur reading together (good example of interactive reading with one child)

-*Teacher Reflections: Language Development*

Day 3: TCM Topics Motivating Students Through Incentives

No IB Vignettes to use on this day

Day 4: TCM Decreasing Inappropriate Behavior—Ignoring and Redirecting

IB Program 6, Part 1: (Positive Behavior Management)

-Vignette 7: Follow through with instructions (clean up time Amelia)
-Vignette 22: Ignore and then Calm Down (boy on floor near sink)

IB Program 6, Part 2: (Positive Behavior Management)

-*Teacher Reflections (Managing Misbehavior)*

Day 5: TCM Decreasing Inappropriate Behavior (Consequences and TO)

No IB Vignettes to use on this day

Day 6: Emotion Regulation, Social Skills and Problem-Solving

IB Program 3, Part 2 (Social Coaching)

-Vignette 22: Asking and Sharing, Amelia and playdough (social coaching)
-Vignette 23: Asking and Waiting, Amelia and playdough
-*Teacher Reflections: Social Coaching*

IB Program 4, Part 2 (Emotion Coaching)

-Vignette 28A: Anger Thermometer: Ben and Malcolm
-*Teacher Reflection: Emotion Coaching*

IB Program 6, Part 2 (Positive Management)

-Vignette 43: Problem Solving with Words (Amelia and Joe playdough)
-Vignette 46: Wally Book—"I'm being teased" (Ben and Malcolm)

ASD-Teacher Program Supplemental Vignettes to Enhance Autism Focus for the IY-TCM Program

If you happen to also have purchased the **Incredible Years ASD Teacher Program *Helping Preschool Children with Autism*** for training teachers working with children on the autism spectrum (ages 2-5 years) in addition to the IY-TCM teacher training program (ages 4-8 years), you might want to consider adding a few of the ASD program vignettes to this training, particularly if you are working with young children with ASD or delayed language development. Below you will find some possible vignettes focused on preschool children with ASD or language delays that might be considered as additions to the current TCM training protocol. The process would be to select a few of these vignettes to replace a few of TCM vignettes. In particular, we encourage the use of the teacher reflections vignettes so teachers can see how others are using the coaching methods.

Another option is to use these vignettes as a follow-up booster consultation session after you have completed the 6 days of TCM.

Day 1: TCM Topics Building Positive Relationships with Students and Proactive Teacher

No ASD-Teacher Vignettes on this day

Day 2: TCM Topic Attention, Coaching, Encouragement, and Praise

ASD-T Part 1: Promoting Language Development

~ Vignette 3: Descriptive Commenting and Visual Prompts to Build Language (visuals to enhance language for child with limited language and play skills) play dough poking

~ Vignette 6: Encouraging Joint Play Sharing (intentional communication between Hudson and Payton)

~ Vignette 10: Teacher-Directed Practices: Asking and Sharing (prompting Hudson to ask for crackers at snack time)

~ Vignette 11: Using Snack Cards to Promote Social Communication (favorite toy snack cards)

~ Vignette 13: Snack Menus to Enhance Language (cereal, raspberries)

~ Vignette 4: Child-Directed Play and Pre-Academic Coaching (academic coaching with Amelia and hammering balls)

~ *Teacher Reflections: Language Development (good summary with examples)

ASD-T Part 2: Promoting Social Interactions

~ Vignette 13: Using books to teach social skills (one-on-one parent with Amelia Oscar book, Reading with CARE)

Day 3: TCM Topics Motivating Students Through Incentives

No ASD-Teacher Vignettes on this day

Day 4: TCM Decreasing Inappropriate Behavior—Ignoring and Redirecting

ASD-T Part 3: Promoting Emotional Literacy and Self-Regulation

~ Vignette 14: Ignore First and then use Calm Down Strategy (boy on floor at sink, ignore and then deep breathing

Day 5: TCM Decreasing Inappropriate Behavior (Consequences and TO)

ASD-T Part 3: Promoting Emotional Literacy and Self-Regulation

~ *Teacher Reflections: Managing Misbehavior* (summarizes use of proximal praise, predictable routines, visual supports, ignoring and behavior plans)

Day 6: Emotion Regulation, Social Skills and Problem-Solving

ASD-T Part 2: Promoting Social Interactions

~ Vignette 3: Using Dramatic Play to Prompt Verbal Social Interactions
~ Vignette 9: Coaching Listening Asking & Sharing (Amelia play dough social coaching)
~ Vignette 10: Coaching Waiting for a Turn (play dough Amelia)
~ Vignette 14 & 15: Using Play Scripts to Promote Joint Play (Payton and Hudson with picture script cards)
~ Vignette 18A & B: Social Coaching on the Playground (teacher using picture cards so Hudson can choose activity? And ask someone to play.
~ * *Teacher Reflections: Social Coaching* (good summary with examples)

ASD-T Part 3: Promoting Emotional Literacy and Self-Regulation

~ Vignette 3: Reading to build Emotional Literacy (silly monkeys with toddlers)
~ Vignette 7: Using Puppets in Pretend Play to Build Emotional Vocabulary
~ Vignette 10A: Using the Calm Down Thermometer to Help Tiny (teacher with poster and Hud son and Caze)
~ Vignette 10B: Face-to-Face & Joint Attention (Hudson smell the flower and blow out the candle)
~ * *Teacher Reflections: Emotion Coaching* (talk about how they use emotion coaching, puppets, and calm down thermometer, breathing)

NEW! Teachers Promoting Social and Emotional Development Program

Supplement to Teacher Programs

This supplement (42 Vignettes on 1 DVD, 1 hr 28 min) is now incorporated as a standard part of the Incredible Beginnings program and protocols. This DVD can also be ordered separately to supplement the TCM Program.

Incredible Years Buzz!

Leader's Name: **E-mail:** **Date:**

Check what we've accomplished!

- Child Directed Play
- Preacademic Coaching
- Persistence Coaching
- Social Coaching
- Emotion Coaching
- Pretend & Puppet Play
- Interactive Reading
- Self-Praise
- Praise & Rewards
- Songs & Gestures
- Self-Care
- Using Visual Cue Cards
- Social, Sensory Likes
- Limit Setting
- Ignore, Redirect & Distract
- Staying Calm
- Getting Support
- Teach Children to Calm Down & Self-Regulate
- Practice Exercises

Reminders

Principles

Personal Goals and Planned Practices

The Incredible Years

www.incredibleyears.com

How I am Incredible!

My support people:	My Language Level *(e.g., no spoken language, visual language, 1-2 words, echolalic, good language):*
My Play Level *(e.g., play alone, anxious or withdrawn, want to initiate play with others but don't know how, initiate but inappropriate):*	My Sensory Likes *(e.g., trucks, swinging, music, water play, bananas):*
My Sensory Dislikes *(e.g., loud noises, certain smells):*	My Parent's Goals for Me: *(e.g., make a friend, more words, follow directions):*

How I am Incredible!

Child's Name and Age: _____

Adults that Support My Growing and Learning:	My Temperament *(e.g., activity level, adaptability, physical sensitivity, intensity, distractibility, persistence, predictability, quiet, anxious, angry):*
My Play and Language Level *(e.g., play alone, anxious or withdrawn, want to initiate play with others but don't know how, initiate but my social interactions are inappropriate, very few words, lots of language, inappropriate language):*	My Favorite Activities *(e.g., reading, soccer, games, music, cooking, building activities, drawing, pretend play):*
Social, Emotional, Persistence, Language and Academic Skills I am Learning *(e.g., helping others, calm down methods, speaking politely, taking turns, listening):*	My Parent's Goals for Me: *(e.g., helping my child follow directions, to better at school, improve his/her academic success, reduce my own anger and stress):*

Tips for Using Puppets to Promote Preschool Children's Social and Emotional Development

Carolyn Webster-Stratton Ph.D.

Visit www.incredibleyears.com to learn more!

Preschool children are working to accomplish the important developmental milestones of learning social and friendship skills including beginning to share, help others, initiate social interactions, listen, and cooperate with peers. They are also working on emotional regulation skills including emotional literacy, self-control over aggressive behaviors, ability to wait and accept limits, and beginning problem solving skills.

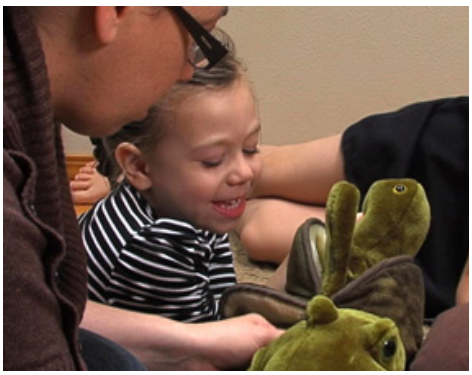
One of the ways to promote social and emotional skills in preschool children is through the use of puppet play. Puppet play is effective because it helps the parent/teacher enter into the child's imaginary world and allows children to experience the feelings of other characters (early empathy development) and learn important social behaviors and conversation skills.

With puppets, dolls, or action figures you can act out stories you are reading with children, make up fantasies, and explore solutions to pretend problems. You may be nervous at first using puppets, but try it out and before long you will experience the joy of entering into your child's thoughts, feelings and imagination, one of the most intimate places you can be at this age.

Here are a few things to have your puppet do when playing with child:

Puppet Scenarios:

• **Puppet models greeting child.** For example, "Hi I am Tiny Turtle. What is your name?" When the child tells your puppet his/her name, puppet thanks him/her for being so friendly. (Modeling friendly social greetings.)



• **Puppet models interest in child.** For example, "What do you like to do?" When the child tells your puppet his/her interests, puppet also shares his/her interests. (Learning how to get to know someone.) You can also prompt the child to ask the puppet what s/he likes to do? (Learning how to show interest in someone else.)

• **Puppet asks for help.** For example, "I can't get this block to go together, can you help me?" When the child helps your puppet, your puppet compliments his/her helping behavior. (Learning to ask for help as well as how to help a friend.)

• **Puppet shares his/her emotion.** For example, "I am embarrassed because I can't ride my bike. Do you know how to ride a bike?" Ask the child what your puppet is feeling. Encourage or prompt the child to say something to make the puppet feel better. (Learning to express emotions and think about another person's emotions.)

• **Puppet shares something with child.** For example, "I see you looking for green blocks, would you like my green block." (Modeling sharing.) If child takes your puppet's block, say "I'm happy to help you". (Connecting sharing action with emotion.)

• **Puppet waits for his turn.** For example, "I am going to wait until you finish that game, then can I have a turn?" If child gives your puppet a turn, puppet thanks him and tells him it makes him feel happy to have such a friend.

Note: If the child does not have the language skills to respond verbally to the puppet, it is still good for the puppet to model the words involved in the social interaction. You can also structure interactions that involve nonverbal responses from the child. "Would you share that with me?" "Would you like to shake the puppet's hand?" "Can you help me build this tower?" This way, the focus is on the child's friendly behavioral response to the puppet. You and the puppet can provide the verbal structure. This will support the child's eventual language development in these social situations.

Parent/Teacher Praise: Parents/teachers can use a silly/different voice for the puppet character and then go out of role as parent/teacher to praise the child for his or her social skills. Parents/teachers can look for opportunities to comment and praise the child when she/he waits, takes turns, helps, offers a friendly suggestion, asks for help, shows interest or empathy, is gentle and listens well with your puppet.

Parent/Teacher Prompts: In these puppet plays parents/teachers can prompt a child's appropriate social responses by whispering in his/her ear some ideas for what to say to the puppet. For example, "you can tell the puppet you like to play with trucks." Or, "you can say please can I have that book?" Don't worry if the child doesn't use your suggestion, just move on to something else as compliance is not required. Often times the child will copy your suggestion and then you can praise him/her for such nice asking or sharing.

Remember: Keep it simple, have fun, and do not have your puppet model negative behaviors. Try using puppets when reading stories to act out the character's feelings and communication.

For more information, please visit: www.incredibleyears.com, and see "Wally's Detective Books for Solving Problems" (set of 4). To order materials, visit www.incredibleyears.com/order/

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www.incredibleyears.com

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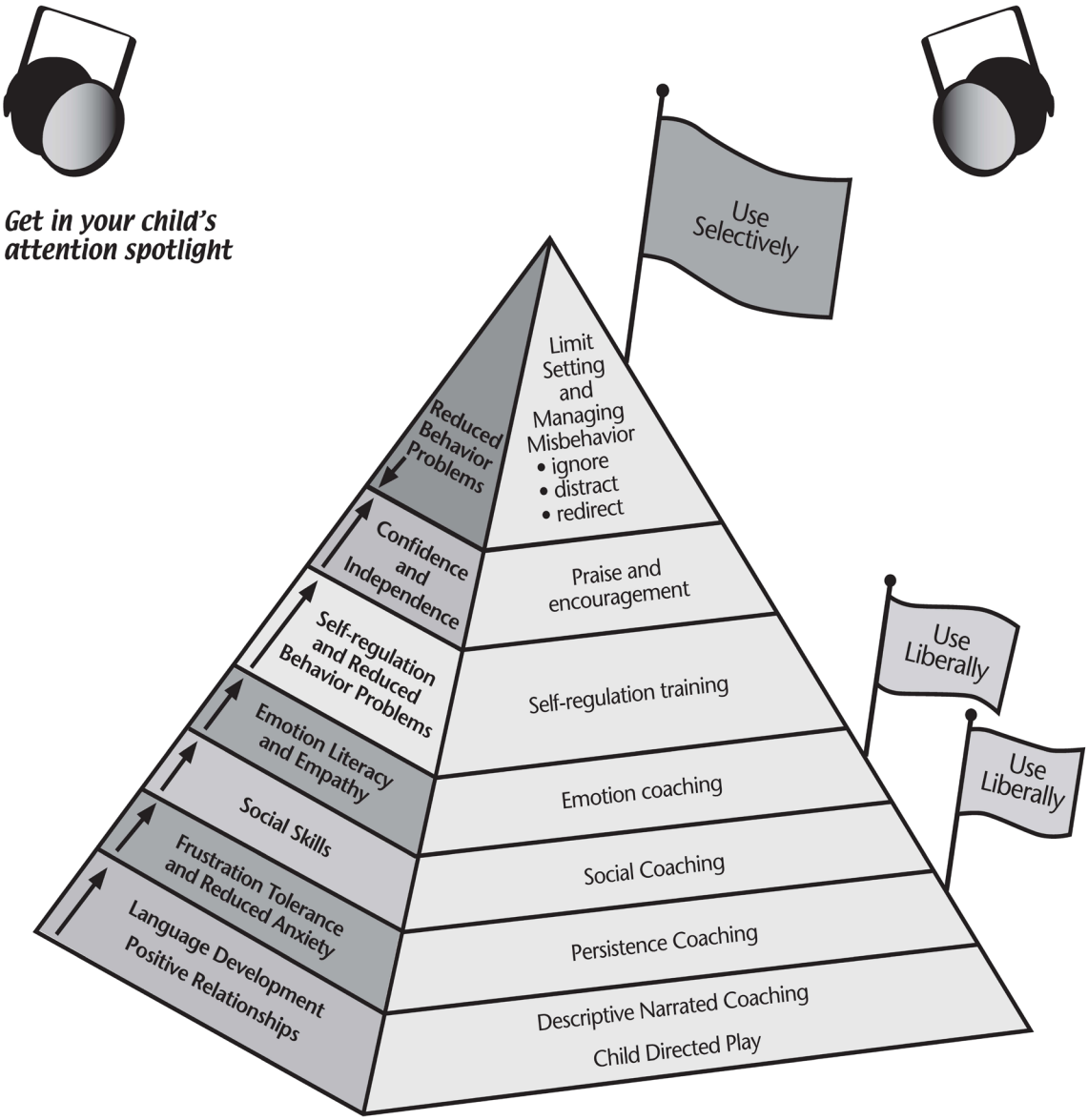

Parent Pyramid Autism Program

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THE INCREDIBLE YEARS®
Parent Practices Interview
Revised (2019)

Time 2 CID ____ ____ ____ ____
Mom ○ Dad/Other ○
Office Use Only

This section asks questions about different ways of disciplining children to reduce their misbehavior.

1. The following is a list of things that parents have told us they do when their children misbehave. In general, how often do you do each of the following things when your child misbehaves (that is, does something s/he is not supposed to do)?

	Never	Seldom	Sometimes	About half the time	Often	Very often	Always
a. Notice it but not do anything about it (ignore).	○	○	○	○	○	○	○
b. Raise your voice (scold or yell).	○	○	○	○	○	○	○
c. Get your child to correct the problem or make up for his/her mistake.	○	○	○	○	○	○	○
d. Threaten to punish him/her (but not really punish him/her).	○	○	○	○	○	○	○
e. Give him/her a time out.	○	○	○	○	○	○	○
f. Take away privileges (like TV, playing with friends).	○	○	○	○	○	○	○
g. Give your child a spanking/smacking (on bottom).	○	○	○	○	○	○	○
h. Slap or hit your child (but not spanking).	○	○	○	○	○	○	○
i. Give your child extra work chores.	○	○	○	○	○	○	○
j. Problem solve with your child.	○	○	○	○	○	○	○

2. If your child hit another child, how likely is it that you would discipline your child in the following ways?

	Not at all likely	Slightly likely	Somewhat likely	Moderately likely	Quite likely	Very likely	Extremely likely
a. Notice it but not do anything about it (ignore).	○	○	○	○	○	○	○
b. Raise your voice (scold or yell).	○	○	○	○	○	○	○
c. Get your child to correct the problem or make up for his/her mistake.	○	○	○	○	○	○	○
d. Threaten to punish him/her (but not really punish him/her).	○	○	○	○	○	○	○
e. Give him/her a time out.	○	○	○	○	○	○	○
f. Take away privileges (like TV, playing with friends).	○	○	○	○	○	○	○
g. Give your child a spanking/smacking (on bottom).	○	○	○	○	○	○	○
h. Slap or hit your child (but not spanking).	○	○	○	○	○	○	○
i. Give your child extra work chores.	○	○	○	○	○	○	○
j. Problem solve with your child.	○	○	○	○	○	○	○

3. If your child refused to do what you wanted him/her to do, how likely is it that you would use each of the following discipline techniques.

	Not at all likely	Slightly likely	Somewhat likely	Moderately likely	Quite likely	Very likely	Extremely likely
a. Notice it but not do anything about it (ignore).	○	○	○	○	○	○	○
b. Raise your voice (scold or yell).	○	○	○	○	○	○	○
c. Get your child to correct the problem or make up for his/her mistake.	○	○	○	○	○	○	○
d. Threaten to punish him/her (but not really punish him/her).	○	○	○	○	○	○	○
e. Give him/her a time out.	○	○	○	○	○	○	○
f. Take away privileges (like TV, playing with friends).	○	○	○	○	○	○	○
g. Give your child a spanking/smacking (on bottom).	○	○	○	○	○	○	○
h. Slap or hit your child (but not spanking).	○	○	○	○	○	○	○
i. Give your child extra work chores.	○	○	○	○	○	○	○
j. Problem solve with your child.	○	○	○	○	○	○	○

Parent Practices Interview (Page 2)

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4. In general, how often do the following things happen?

	Never	Seldom	Sometimes	About half the time	Often	Very often	Always
a. If you ask your child to do something and s/he doesn't do it, how often do you give up trying to get him/her to do it?	○	○	○	○	○	○	○
b. If you warn your child that you will discipline him/her if s/he doesn't stop, how often do you actually discipline him/her if s/he keeps misbehaving?	○	○	○	○	○	○	○
c. How often does your child get away with things that you feel s/he should have been disciplined for?	○	○	○	○	○	○	○
d. If you have decided to punish your child, how often do you change your mind based on your child's explanations, excuses or arguments?	○	○	○	○	○	○	○
e. How often do you show anger when you discipline your child?	○	○	○	○	○	○	○
f. How often do arguments with your child build up and you do or say things you don't mean to?	○	○	○	○	○	○	○
g. How often is your child successful in getting around the rules that you have set?	○	○	○	○	○	○	○
h. How often does the kind of punishment you give your child depend on your mood?	○	○	○	○	○	○	○

5. This is a list of things that parents might do when their child behaves well or does a good job at something. In general, how often do you do each of the following things when your child behaves well or does a good job?

	Never	Seldom	Sometimes	About half the time	Often	Very often	Always
a. Notice it but not do anything about it (ignore).	○	○	○	○	○	○	○
b. Praise or compliment your child.	○	○	○	○	○	○	○
c. Give your child a hug, kiss, pat, handshake or "high five."	○	○	○	○	○	○	○
d. Buy something for him/her (such as special food, a small toy) or give him/her a prize or sticker for good behavior.	○	○	○	○	○	○	○
e. Give him/her an extra privilege (such as cake, go to the movies, special activity for good behavior).	○	○	○	○	○	○	○
f. Give points or stars on a chart.	○	○	○	○	○	○	○
g. Not even notice.	○	○	○	○	○	○	○

	Never	Seldom	Sometimes	About half the time	Often	Very often	Always
6. In the past week, how often did you play with your child?	○	○	○	○	○	○	○
7. In the last 2 days, how many times did you praise or compliment your child for any thing she did well?	○	○	○	○	○	○	○

Parent Practices Interview (Page 3)

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	Never	Seldom	Sometimes	About half the time	Often	Very often	Always
8. How often do you use books or puppets to encourage your child to learn problem solve?	○	○	○	○	○	○	○
9. How often do you problem-solve with your child to solve real life problems?	○	○	○	○	○	○	○
10. How often do you spend time reading with your child?	○	○	○	○	○	○	○

11. Please rate how much you agree or disagree with the following statements.	Strongly disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly agree
a. Giving children a reward for good behavior is bribery.	○	○	○	○	○	○	○
b. I shouldn't have to reward my children to get them to do things they are supposed to do.	○	○	○	○	○	○	○
c. I believe in using rewards to teach my child how to behave.	○	○	○	○	○	○	○
d. It is important to praise children when they do well.	○	○	○	○	○	○	○
e. I would like to praise my child more often than criticize him/her, but it is hard to find behaviors to praise.	○	○	○	○	○	○	○
f. If I give my child praise or rewards to encourage good behavior, s/he will demand rewards for everything.	○	○	○	○	○	○	○
g. If my child is having trouble doing something s/he is supposed to do (such as going to bed, picking up toys), it is a good idea to set up a reward or an extra privilege for doing it.	○	○	○	○	○	○	○
h. When your child eats healthy food, how likely are you to praise him/her for this choice.	○	○	○	○	○	○	○

12. Please rate how much you agree with the following statements:							
a. I have made clear rules or expectations for my child.	○	○	○	○	○	○	○
b. I have made clear household rules or expectations for my child about not fighting, stealing, lying, etc.	○	○	○	○	○	○	○
c. I have made clear rules or expectations for my child about going to bed, getting up on time and doing chores.	○	○	○	○	○	○	○
d. I take time to engage in play or spend special time with my child.	○	○	○	○	○	○	○
e. I have set clear limits on the amount of time my child can be using "screen time."	○	○	○	○	○	○	○

13. Please rate how likely you are to do the followings things.	Not at all likely	Slightly likely	Somewhat likely	Moderately likely	Quite likely	Very likely	Extremely likely
a. When your child completes his/her chores, how likely are you to praise or reward your child?	○	○	○	○	○	○	○
b. When your child does NOT complete his/her chores, how likely are you to punish your child (such as taking away a privilege or imposing a consequence on him/her)?	○	○	○	○	○	○	○

Parent Practices Interview (Page 4)

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13 (continued). Please rate how likely you are to do the followings things.

	Not at all likely	Slightly likely	Somewhat likely	Moderately likely	Quite likely	Very likely	Extremely likely
c. When your child fights, steals, or lies, how likely are you to punish your child?	○	○	○	○	○	○	○
d. When your child goes to bed or gets up on time, how likely are you to praise or reward your child?	○	○	○	○	○	○	○
e. When your child does NOT go to bed or get up on time, how likely are you to punish your child?	○	○	○	○	○	○	○

14. About *how many hours in the last 24 hours* did your child spend at home without adult supervision, if any?

○ None ○ 1/2-1 hour ○ 1 1/2-2 hours ○ 3-4 hours
○ Less than 1/2 hour ○ 1-1 1/2 hours ○ 2-3 hours ○ More than 4 hours

15. Within the LAST 2 DAYS, about how many total hours was your child involved in activities outside your home *without adult supervision,* if any?

○ None ○ 1/2-1 hour ○ 1 1/2-2 hours ○ 3-4 hours
○ Less than 1/2 hour ○ 1-1 1/2 hours ○ 2-3 hours ○ More than 4 hours

	None or almost none	About 25%	About 50%	About 75%	All or almost all
16. Please answer the following:					
a. What precentage of the time do you know where your child is when s/he is away from your direct supervision?	○	○	○	○	○
b. What percentage of the time do you know exactly what your child is doing when s/he is away from you?	○	○	○	○	○
c. What percentage of your child's friends do you know well?	○	○	○	○	○

	Strongly disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly agree
17. How much do you agree or disagree with the following statements?	○	○	○	○	○	○	○
a. It is very important for me to know where my child is when s/he is away from me?	○	○	○	○	○	○	○
b. Parents who check up on how their child behaves at friends' houses are too anxious about their child.	○	○	○	○	○	○	○
c. Giving children lots of free, unsupervised time helps them learn to be more responsible.	○	○	○	○	○	○	○
d. Children who are not superivsed by an adult are more likely to develop behavior problems.							

Incredible Years®
Parent Strategies Questionnaire for Children with Autism (2-5 years)

Teacher/Childcare Provider (name): _____

Promoting Social, Emotional, Language and Academic Development in Children with Autism In this section we would like to get your idea of how confident you are in using the following strategies.	Very Unconfident	Somewhat Unconfident	Neutral	Confident	Very Confident
1. Simplifying and tailoring your language according to your child's individual language development?					
2. Identifying the specific ABCs: antecedents (A) that will motivate and prompt your child's target behaviors or words (B) and rewarding its occurrence with positive consequences (C).					
3. Being able to get in your child's attention spotlight to engage him or her in social and emotional learning opportunities?					
4. Being able to ignore and redirect your child's unwanted behaviors, giving your attention back when she or he behaves in the targeted way?					
5. Helping your child regulate his or her emotions?					
6. Using puppets and pretend play to teach your child social and emotional skills and to enhance communication?					
7. Using your child's sensory likes and dislikes such as auditory, tactile, visual, smell, taste/oral, proprioception (body space/balance/need for movement or stillness) to enhance his or her learning opportunities?					
8. Adapting teaching and materials to use your child's most effective learning mode (visual, auditory, motoric, sensory/tactile)?					
9. Managing your child's challenging behavior and following through with behavior plans and goals?					
10. Working with your child's classroom/early childhood teachers?					
11. Setting up structured play dates to help your child practice specific social skills?					
12. Developing and using visual supports (e.g., choice boards, command cards) to enhance your child's social, emotional and language learning?					

A. Specific Teaching Techniques to Enhance Language Development In this section we'd like to get your idea of how often you use the following strategies to promote your child's language learning.	Rarely/Never	Sometimes	Half the Time	Often	Very Often
1. Participate in child-directed, narrated play to increase interactive involvement and joint attention from my child.					
2. Use enthusiastic voice tone, songs, imitation, modeling, simple language, repetition and commenting using the "one up rule" to increase my child's verbal communications.					
3. Use descriptive academic coaching language to promote language skills (e.g., colors, shapes, positions, names of objects).					
4. Use visual prompts, gestures, preferred objects, books, and sensory likes, to strengthen language communication and joint interaction.					
5. Use verbal prompts, partial prompts, and pauses to wait for my child to look, gesture, or respond verbally before continuing.					
6. Use puppets to model and engage children in social communication.					

B. Specific Teaching Techniques to Enhance Social Development In this section we'd like to get your idea of how often you use the following strategies to promote your child's social learning.	Rarely/Never	Sometimes	Half the Time	Often	Very Often
1. Use social coaching to model, prompt practice, label, and praise social behaviors such as sharing, waiting, eye contact, helping, listening, asking, turn taking, and initiating an interaction.					
2. Use puppets to model, prompt, label, and practice social behaviors.					
3. Praise and reward my child for using appropriate social friendship skills.					
4. Identify specific social behavior goals for my child according to his/her play stage.					
5. Use books, games, and visual pictures to prompt, signal, and practice targeted social behaviors with my child.					
6. Use sensory social routines to enhance my child's arousal for learning.					
7. Comment on and praise prosocial peer models to increase my child's focus on appropriate social behavior					
8. Use intentional communication to help my child be aware of other children and their needs, interactions and to promote their joint attention and empathy during play activities.					
9. Set up peer playdates to promote my child's interactions with others and provide social coaching during these interactions.					

C. Specific Teaching Techniques to Enhance Emotional Development and Self-regulation In this section we'd like to get your idea of how often you use the following strategies to promote your child's emotional development.	Rarely/Never	Sometimes	Half the Time	Often	Very Often
1. Use emotion coaching to model, prompt, and label emotion language in my child.					
2. Model emotion language through words and facial expressions for my child.					
3. Use persistence coaching language to encourage my child's continuous effort to do a task. (e.g., "that's hard, but you keep trying!")					
4. Use pictures cards and photographs that portray people in various feeling states to teach my child emotion vocabulary and prompt his or her to use these visuals to express emotions.					

continued on next page

C. Specific Teaching Techniques to Enhance Emotional Development and Self-regulation *(continued)* In this section we'd like to get your idea of how often you use the following strategies to promote your child's emotional development.	Rarely/Never	Sometimes	Half the Time	Often	Very Often
5. Help my child understand how others feel through modeling, acknowledgement, mirroring back, labeling feelings, voice tone, and intentional communication.					
6. Recognize early cues of emotional dysregulation in my child and prompt his or her use of calm down strategies.					
7. Focus more of my attention on positive emotions than on negative emotions.					
8. When coaching negative emotions, also coach appropriate coping strategies (e.g , you are feeling mad but you are taking three deep breaths to calm your body down).					
9. Use story books to teach my child emotion words and promote empathy and guided practice.					
10. Use puppets that share their feelings to prompt my child's emotional language, social responses and empathy for others.					
11. Use visual self-regulation cards such as calm down thermometer, breathing, or turtle picture with my child.					

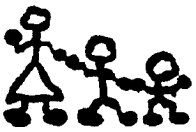
D. Specific Teaching to Enhance Behavior Management Strategies In this section we'd like to get your idea of how often you use the following strategies to promote your child's positive behaviors and decrease their inappropriate behaviors.	Rarely/Never	Sometimes	Half the Time	Often	Very Often
1. Give my child choices when possible.					
2. Use visual prompts, verbal and nonverbal signals and/or command cards to remind my child of our household rules, schedule, and appropriate behavior.					
3. Prepare my child for transitions with a predictable and visual routine.					
4. Give face-to-face praise paired with smiles, eye contact, enthusiastic tone of voice, and sensory likes to reward desired behavior.					
5. Reward self-regulation, joint attention, and responses to instructions with child's sensory likes.					
6. Wait for my child's response when asking a question about his or her wants.					
7. Use visual cues, gestures, and simple words to distract and redirect when my child is angry or frustrated.					
8. Ignore misbehavior that is not dangerous to my child or another child.					
9. Help other siblings or peers to understand my child's misbehavior and to respond to it with understanding and without reinforcing its occurrence.					
10. Set up problem solving scenarios with puppets to practice appropriate social responses to situations that are difficult for my child. (e.g., ask a friend to play, going to a birthday party)					

E. Strategies for Working with Teachers and School	Never	1–2 Times a Year	Once a Month	Once a Week	Daily
1. Use a system for regular school communication about my child (face-to-face communication, texts, notes, calls, meetings).					
2. Ask my child's teacher to tell me about how I can help support my child's school learning goals at home.					
3. Set up opportunities for to participate in classroom activities.					

continued on next page

E. Strategies for Working with Teachers and School *(continued)*	Never	1–2 Times a Year	Once a Month	Once a Week	Daily
4. Partner with teachers to provide ideas, materials, and support for classroom activities.					
5. Share with teachers my awareness of my child's sensory likes and dislikes and how these can be used to help motivate my child's learning.					
6. Share with teachers the ABC of behavior change in my child.					
7. Collaborate with teachers on a home-school behavior plan and share goals for my child.					
8. Becoming more aware of local opportunities to attend parent groups specifically for parents of children with autism.					

F. Planning and Support	Never	1–2 Times a Year	Once a Month	Once a Week	Daily
1. Review my progress in achieving the goals for my child and myself.					
2. Collaborate with other parents for solutions and support.					
3. Read the *Incredible Years Parent Book*.					
4. Manage my stress level utilizing positive cognitive strategies and gaining support from friends, family and teachers when needed.					



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Parent Group Leader Collaborative Process Checklist (rev. 2019)

This checklist is designed for group leaders to complete together following a session, or for a group leader to complete for him/herself when reviewing a video of a session. By watching the video of a session and looking for the following points, a leader can identify specific goals for progress. This checklist is designed to complement the checklist for the specific session, which lists the key content that should be covered.

Leader Self-Evaluation (name):_____

Co-leader Evaluation:_____

Certified Trainer/Mentor Evaluation:_____

Date:_____

SET UP *Did the Leaders:*	**YES**	**NO**	**N/A**
1. Set up chairs in a semicircle that allowed everyone to see the TV? (Avoid tables.)	____	____	____
2. Sit at separate places in the circle, rather than both at the front?	____	____	____
3. Write the agenda on the board?	____	____	____
4. Have last week's home activities ready for the parents to pick up, complete with praise and encouragement written on them?	____	____	____
5. Plan and prepare for daycare in advance?	____	____	____
6. Prepare and lay out the food, in an attractive manner?	____	____	____

REVIEW PARENT'S HOME ACTIVITIES *Did the Leader:*			
7. Begin the discussion by asking how home activities went during this past week - how they addressed their short term goals?	____	____	____
8. Give every parent the chance to talk about his/her experiences and select parents strategically for spontaneous practice to demonstrate successes or refine approach?	____	____	____
9. Praise and encourage parents for what they did well and recognize their beginning steps at change, rather than correct their process?	____	____	____
10. Highlight key "principles" that their experiences illustrate? (e.g., write them on flip chart or paraphrase idea in terms of how it addresses their goals.)	____	____	____

	YES	NO	N/A
11. Explore with individuals who didn't complete the home activities what made it difficult (barriers) and discuss how they might adapt home activities to fit their needs and goals?	____	____	____
12. Ask about and encourage "buddy calls"?	____	____	____
13. If a parent's description of how they applied the skills makes it clear that s/he misunderstood, did the leaders accept responsibility for the misunderstanding rather than leaving the parent feeling responsible for the failure? (e.g., "I'm really glad you shared that, because I see I completely forgot to tell you a really important point last week. You couldn't possibly have known, but when you do that, it's importnat to..." vs "You misunderstood the assignment. Remember, when you do that, it's important to...")	____	____	____
14. Make sure that the discussion is brought back to the specific topic at hand after a reasonable time without letting free flowing discussion of other issues dominate?	____	____	____
15. Limit the home activity discussion (aprroximately 20-30 minutes) to give adequate time for new learning?	____	____	____

WHEN BEGINNING THE TOPIC FOR THE DAY
Did the Leader:

16. Begin the discussion of the topic with open-ended questions to get parents to think about the importance of the topic?	____	____	____
17. Do the benefits and/or barriers exercise regarding the new topic?	____	____	____
18. Paraphrase and highlight the points made by parents - write key points on the board with their name?	____	____	____

WHEN SHOWING THE VIGNETTES
Did the Leader:

19. Focus parents on what they are about to see on the vignettes and what to look for?	____	____	____
20. Pause vignette to ask an open-ended question about what parents thought was effective/ineffective in the vignette (focus on parent thoughts, feelings & behaviors, and child's perspective)?	____	____	____
21. Acknowledge responses one or more parents have to a vignette?	____	____	____
22. Paraphrase and highlight the points made by parents - writing key points on the flip chart?	____	____	____
23. Move on to the next vignettes after key points have been discussed, rather than let the discussion go on at length?	____	____	____
24. Use vignettes to trigger appropriate discussions and/or practices, tailored to children's developmental level?	____	____	____

	YES	NO	N/A
25. Redirect group to the relevance of the interaction on the vignette for their own lives (if parents become distracted by some aspect of the vignette, such as clothing or responses that seem phony)?	____	____	____
26. Refer to parents' goals for themselves and their children when discussing vignettes, learning principles and setting up practices?	____	____	____

PRACTICE AND ROLE PLAYS
Did the Leader:

27. Get parents to switch from talking about strategies in general to using the words they could actually use? (e.g., from "She should be more specific" to "She could say, John, you need to put the puzzle pieces in the box.")	____	____	____
28. Ensure that the skill to be practiced has been covered in the vignettes or discussion prior to asking someone to role play practice it. (This ensures the likelihood of success.)	____	____	____
29. Do several large group role plays/practices over the course of the session? Break down practices according to child developmental readiness. Number of role plays: _____	____	____	____
30. Do role plays/practices in pairs or small groups (following large group practices) that allow multiple people to practice simultaneously? Dyads should be matched by child language and play ability.	____	____	____
31. Use all of the following skills when directing role plays:			
a. Select parents and give them appropriate roles?	____	____	____
b. Skillfully get parents engaged in role plays/practices?	____	____	____
c. Provide each person with a description of his/her role (age of child, level of misbehavior, developmental level)?	____	____	____
d. Provide enough "scaffolding" so that parents are successful in their role as "parent" (e.g., get other parents to generate ideas for how to handle the situation before practice begins)?	____	____	____
e. Invite other workshop members to be "coaches" (call out idea if the actor is stuck)?	____	____	____
f. Pause/freeze role play/practice periodically to redirect, give clarification, problem-solve different approach, or reinforce participants?	____	____	____
g. Take responsibility for having given poor instructions if role play/practice is not successful and allow actor to rewind and replay?	____	____	____
32. Process role play/practice afterwards by asking how "parent" felt and asking group to give feedback?	____	____	____
33. Process role play by asking how "child" felt in role?	____	____	____
34. Solicit feedback from group about strengths of parent in role?	____	____	____

	YES	NO	N/A
35. Offer detailed descriptive praise of the role play/practice and what was learned?	____	____	____
36. Re-run role play, changing roles, involving different parents, or with child of different play or language developmental level or temperament (being in role as child is helpful for partents to experience their child's perspective is a different way of responding)?	____	____	____

LEADER GROUP PROCESS SKILLS
Did the Leader:

37. Build rapport with each member of group?	____	____	____
38. Encourage everyone to participate?	____	____	____
39. Use open-ended questions to facilitate discussion and reflection?	____	____	____
40. Reinforce parents' ideas, foster parents' self-learning and confidence?	____	____	____
41. Encourage parents to problem-solve when possible?	____	____	____
42. Foster idea that parents will learn from each others' experiences?	____	____	____
43. Help parents learn how to support and reinforce each other?	____	____	____
44. Foster parents' understanding of the value of developing their own support network?	____	____	____
45. Identify each family's strengths?	____	____	____
46. Create a feeling of safety among group members?	____	____	____
47. Create an atmosphere where parents feel they are decision-makers and discussion and debate are paramount?	____	____	____
48. When needed, provide parents with information about important child developmental milestones?	____	____	____
49. Explore parents' cognition, affect modulation, and self-regulation as well as behaviors?	____	____	____
50. Help parents understand the relationship between thoughts, feelings and actions for themselves and their children?	____	____	____
50. Encourage parents to model, prompt, teach, and discuss with their children calm down methods for coping with traumatic events?	____	____	____

ENDING GROUP - REVIEW & HOME ACTIVITIES
Did the Leader:

50. Begin the ending process with about 15 minutes remaining?	____	____	____
51. Summarize this session's learning? (One way to do this is to review or have the parents review each point on refrigerator notes out loud.)	____	____	____

	YES	NO	N/A
52. Review or have parents review the home activity sheet, including why it is important, and how they will try to do it?	____	____	____
53. Talk about any adaptations to the home activity for particular families?	____	____	____
54. Show support and acceptance if parents can't commit to all the home activities? (Support realistic plans.)	____	____	____
55. Have parents complete the Self-Monitoring Checklist and commit to goals for the week?	____	____	____
56. Ask about buddy check ins (by phone, email or text)?	____	____	____
57. Have parents complete the evaluation form?	____	____	____
58. End the session on time?	____	____	____

REMEMBER: The goal in the group sessions should be to draw from the parents the information and ideas to teach and learn from each other. Parents should be the ones who generate the principles, describe the significance, highlight what was effective and ineffective on the video, and demonstrate how to implement the skills in different situations. Remember, people are far more likely to put into practice what they have discovered, talked about and experienced rather than what they have been told to do. Modeling, experiential learning and support are key Incredible Years principles.

Summary Comments:

Incredible Years® Group Leader Training
Workshop Evaluation

Date:_____Workshop Content:____Parent____Child____Teacher (check type)

The following questions are part of an evaluation of the workshop that you have participated in. The information we obtain will help us to evaluate and continually improve the workshops we offer. Thank you for taking the time to complete this questionnaire. Please use back of page if needed for additional comments.

THE WORKSHOP DAY___1___2___3

1. What part of the workshop was most helpful to you? What did you like the best?

2. What did you like the least about the workshop? What could be improved?

TEACHING EVALUATION

The IY leader's teaching and leadership skill was:

very poor below average average above average excellent

The IY leader's methods and processes modeled and demonstrated were:

not helpful neutral somewhat helpful helpful very helpful

The learning derived from the IY video example vignettes were:

not helpful neutral somewhat helpful helpful very helpful

The workshop practices/role plays/buzzes/break-out groups were:

not helpful neutral somewhat helpful helpful very helpful

The group discussion and involvement was:

very poor below average average above average excellent

The written handouts and readings were:

not helpful neutral somewhat helpful helpful very helpful

Additional Comments:

EVIDENCE-BASED PRACTICE IN CHILD AND ADOLESCENT MENTAL HEALTH
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Delivering the Incredible Years® Dina Treatment Program in Schools for Early Elementary Students with Self-Regulation Difficulties

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ABSTRACT

The purpose of this paper is to describe the implementation of an evidence-based treatment, the Incredible Years® (IY) Small Group Dina Dinosaur Treatment program, as delivered in elementary schools to address the needs of children in kindergarten through second grade with self-regulation difficulties. Adaptations for school-based delivery of 17 intervention groups across three cohorts and 11 schools from an ongoing randomized controlled trial are described, and implementation data including qualitative feedback from school stakeholders are presented. Results show that, with implementation supports, this adapted model can be delivered in schools with fidelity comparable to the clinic-based model, although several activities were delivered at lower dosage in the low-income urban schools as compared with low-income rural or better resourced schools. Satisfaction among school counselors, teachers, and parents was consistently high. Implementation challenges include logistics such as space and scheduling, program fit with school practices and policies, use of specific treatment strategies such as time-out within the school context, capacity of school personnel to deliver the program, and selection of students and group composition. Lessons learned can inform adaptation and delivery of other evidence-based clinic treatments in school settings.

KEYWORDS

School-based mental health; self-regulation; elementary; implementation; evidence-based treatments

Young children with self-regulation difficulties are unable to manage frustration and other strong emotions, interfering with their ability to follow expectations and rules; inhibit inappropriate, impulsive and aggressive behaviors; solve problems; appropriately express emotions; and organize behavior to achieve goals (Blair & Razza, 2007; Raver et al., 2012). Such dysregulated behaviors create impairment at home and with peers, and markedly increase risk for school suspensions (Bradley, Doolittle, & Bartolotta, 2008), special education referrals (Walker, Ramsey, & Gresham, 2003), and substance use and violence (Dishion & Connell, 2006; Garland, Boettiger, & Howard, 2011). Self-regulation is considered a central process underlying mental health (Gross & Muñoz, 1995), and contributes to impairment in children diagnosed with Attention-Deficit/Hyperactivity Disorder and Oppositional Defiant Disorder (Bunford, Evans, & Wymbs, 2015; Mullin & Hinshaw, 2007), and other mental health disorders (Buckner, Mezzacappa, & Beardslee, 2009).

Schools are an ideal setting to provide interventions for young children at risk for mental health disorders (Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). They provide great opportunity for helping children learn and generalize social and emotional skills to enhance their academic and cooperative learning. Schools also hold potential for addressing significant gaps in children's mental health service delivery indicated by estimates that only about half of the children needing services receive them (Merikangas, Nakamura, & Kessler, 2009); those from ethnic minority groups are especially likely to be underserved (Foster & Connor, 2005). The vital role of schools was recognized by the Surgeon General (U.S. Department of Health and Human Services, 1999) and President's New Freedom Commission on Mental Health (New Freedom Commission on Mental Health, 2003)

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nearly two decades ago. There is also ample documentation that schools provide mental health services to more students than clinics (Farmer, Burns, Phillips, Angold, & Costello, 2003; Rones & Hoagwood, 2000) and reduce financial and structural access barriers (Taras & American Academy of Pediatrics Committee on School Health, 2004). And while there has since been growing consensus on the value of school mental health services, models of how to effectively integrate such services into schools are lacking, particularly at the targeted level (Atkins, Hoagwood, Kutash, & Seidman, 2010).

Systematic reviews show that school-based mental health interventions can be effective (Baskin, Slaten, Sorenson, Glover-Russell, & Merson, 2010; Hoagwood et al., 2007), and many evidence-based programs can be implemented in schools (Kratochwill et al., 2008). Yet, clinic-based programs are often implemented in schools unsuccessfully, with poor quality and/or reduced dosage (Atkins, Frazier, Adil, & Talbott, 2003). Challenges include gaining teacher and administrator buy-in, limited school personnel time and resources, and misalignment with school philosophy (Forman, Olin, Hoagwood, Crowe, & Saka, 2009). Langley, Nadeem, Kataoka, Stein, and Jaycox (2010) also noted barriers related to school accountability for academic rather than social-emotional outcomes, logistics (e.g., pulling children from class for program participation, finding space for groups), and limited parent involvement.

One specific challenge in implementing mental health programs in schools is that many were developed for delivery in clinics (Reddy, Newman, De Thomas, & Chun, 2009), raising questions about adaptations and implementation supports that may be needed to address contextual differences in settings. Clinic-based models often assume parent involvement and can encourage parents to reinforce skills students learn in the program. Program curricula are likely to be based on traditional therapy clock hours, often more generous than time available in schools for students to participate in programs. Clinics serving children with disruptive behavior may also have resources to manage highly dysregulated behaviors (e.g., additional staff, special time-out room) which schools do not. Also, school staff may not have the same level of clinical training as licensed mental health clinicians. Still, schools offer opportunities for staff to prompt, monitor, and praise children's use of targeted skills, and provide access to teachers to reinforce children's skills in the classroom as well as to implement behavior plans. Thus, there is a need to closely examine efforts to adapt evidence-based programs for school settings, including the success of implementation delivery and issues that arise in doing so.

Purpose of the paper

The purpose of this paper is to describe the adaptation and implementation of an evidence-based clinic program, the Incredible Years® Small Group Dina Dinosaur Treatment Program (IY® Dina), in an elementary school setting. This work is based on an ongoing randomized controlled trial, for which outcome data are not yet available. Describing our implementation experience here will support interpretation of forthcoming efficacy results, and may facilitate adaptation and implementation of other clinic-based programs for schools.

The IY® Dina small group program was selected for examination because it has been delivered in schools, albeit without implementation evaluation (Hutchings, Bywater, Daley, & Lane, 2007; Venter et al., 2012), and has been identified as having high potential for adoption (Joseph & Strain, 2003). It also shows "potentially positive" effects as a universal school intervention (U.S. Department of Education, Institute of Education Sciences, What Works Clearinghouse, 2011), and has demonstrated efficacy with clinical samples as a small group program (Larsson et al., 2009; Webster-Stratton & Hammond, 1997; Webster-Stratton, Reid, & Beauchaine, 2011; Webster-Stratton, Reid, & Hammond, 2004).

Other well-defined programs considered promising for emotion regulation and behavior by the What Works Clearinghouse take universal approaches [Caring School Communities (Battistich, 2003); Positive Action (Flay & Allred, 2003)], which are not designed to meet students' mental health needs. Or, they utilize an individualized approach [e.g., First Step to Success which requires 60 hours of a behavior coach's time per child (Walker et al., 2009)], which is likely less cost effective than group programs. Although there are other programs for schools adapted from clinic-

based models that address challenging behaviors in young students [e.g., Teacher–Child Interaction Training; TCIT (Lyon et al., 2009)], our interest was in a group program consistent with "Tier 2" school intervention models for supporting students who do not respond to universal interventions, but may not require individual services like First Step.

We first describe the IY® Dina program originally developed for clinic delivery, followed by our delivery adaptations and implementation supports to maximize feasibility for the school context and program efficacy. We then address the following implementation questions using data from three cohorts of an ongoing randomized controlled trial (RCT) study: 1) To what extent can the adapted program be delivered with fidelity in elementary schools, as conjointly delivered by mental health clinicians and school counselors? 2) How satisfied are school staff with the program and their involvement in it? 3) What are the implementation challenges that may inform delivery of other clinical programs into schools? Given the nature of implementation questions, we did not have specific research hypotheses but report data that may be used to generate hypotheses for future research. We close with lessons learned and implications for translating clinic-based programs to school settings.

Methods

Description of IY® Dina for delivery in clinics

IY® Dina is part of a comprehensive series of preventive and treatment programs for parents, teachers, and children aged 3–8 years (Webster-Stratton & Reid, 2017) with or at risk for conduct problems or ADHD (Webster-Stratton & Reid, 2013). Grounded in relationship and cognitive social learning theory, developmental theory, and active learning methods, IY® Dina is delivered in groups using a collaborative process. Several aspects of the IY® series explicitly target self-regulation difficulties with strategies to inhibit impulsivity, increase persistence and frustration tolerance, use emotion language and calm-down methods, and identify and solve social problems.

IY® Dina was developed for delivery in clinics by two skilled mental health clinicians during 2-hour weekly sessions typically held concurrent to a parent training group (Webster-Stratton et al., 2011), usually over 18–22 weeks. Curriculum content spans seven units: learning school rules, how to be successful in school (e.g., raising your hand, checking your work, keeping eyes on the teacher, not talking out), detecting and understanding feelings, problem-solving steps, controlling anger, friendship skills, and how to talk with friends. Group leaders teach this content with methods developmentally appropriate for young children (e.g., video-modeling, sociodramatic play with puppets, role play, singing) and small group activities designed to support skill application and scaffolding of skills through explicit feedback and reinforcement (or "coaching"). A typical session includes a whole group circle time lesson, a small group activity, snack, and coached playtime.

IY® uses a discipline hierarchy that relies on high doses of positive reinforcement with frequent labeled praise for positive behaviors. Group leaders use tangible reinforcers (e.g., hand stamps, stickers, scented markers, fish crackers) and special privileges (e.g., child gets to lead a wiggle break, be a helper, have a special job, wear a cape) for positive behaviors. A token economy system allows children to earn chips for positive behaviors that can be traded for small prizes in every group meeting. Other behavior management systems include individual special challenges and team challenges for which a prize can be earned. These systems are kept separate from punishment strategies; once an incentive is earned, group leaders will not take it away.

To address negative behaviors, group leaders primarily use strategies such as redirection, distraction, and selective ignoring to extinguish unwanted behaviors, accompanied by differential attention and praise given to other children's positive behaviors. Other discipline strategies include logical and natural consequences, and privilege removal. Time-out is used for unsafe behaviors that cannot be ignored such as aggression. IY® conceptualizes time-out as a space where children go to calm down and use coping strategies (e.g., deep breathing, self-talk, positive imagery) to self-regulate. Like other evidence-based treatments including Defiant Children (Barkley, 2013), Parent–Child Interaction Therapy (Eyberg et al., 2001), and Helping the Noncompliant Child (McMahon & Forehand, 2003), IY® uses a series of steps beginning with letting the child know

what the behavior was that earned time-out and options should the child initially refuse to go (e.g., warnings, privilege removal, time-out "on the spot" where the rest of the group is moved to a different part of the room). IY® also explicitly teaches children time-out, using videos and practice prior to implementing it (Webster-Stratton, 2016).

IY® Inc. strongly encourages group leaders to have a background in mental health, child development, and teaching. Prior to delivering the program, group leaders participate in an authorized 3-day training to learn to deliver curriculum content (content leader role) and reinforce and manage children's behavior (process leader role). Training methods include discussion, video and live modeling, and behavioral practice. Group leaders are eligible for program certification after delivering the program to two cohorts and must pass a series of delivery and fidelity reviews by accredited trainers with IY® Inc.

Adaptations and implementation supports for school-based delivery

Delivery adaptations

In consultation with the program developer, we made several adaptations to make IY® Dina more feasible for school-based delivery (Table 1). Our adapted model involved conducting sessions twice a week for 45 minutes each. Thus, one 2-hour, weekly session from the clinic-based model was typically delivered in two school-based sessions. As a result, the 18 lessons in the original curriculum were delivered in approximately 36 sessions over 18–20 weeks. The structure of the 45-minute sessions was comparable to the 2-hour sessions, with two exceptions. Due to time constraints, snack time was eliminated as is coached play. But, because coaching is important for scaffolding children's skill acquisition, we provided "recess coaching," where a group leader coached children on the playground about 30 minutes per week. This supported children's use of skills in a natural context and strengthened the group leader's relationship with the children. And, this added time made the total dosage of our school-based model equal to the clinic-based model. We considered the twice weekly 45-minute small group lessons combined with the weekly 30-minute recess coaching sessions to be the core components of our school-based adaptation of IY® Dina.

Table 1. Comparison of clinic model and adapted model for school-based delivery.

Clinic Model	Adapted Model for School-Based Delivery
• Eighteen 2-hour lessons delivered weekly over 18–20 weeks	• Thirty-six 45-minute sessions delivered twice a week over 6 months • Instead of including coached play during the session, weekly recess coaching (about 30 minutes per student) • Bi-monthly check-in calls for parents • Three parent meetings* • Monthly 1:1 teacher consultation meetings • In-service sessions for teachers on topics related to young children's self-regulation (2 hours total)
• Co-leaders typically are licensed mental health professionals	• Co-leaders are mental health professionals or trainees from research team, paired with a school counselor
• Originally developed for children with ODD and Conduct Disorder	• Students nominated by teachers as having broadly defined self-regulation difficulties • Enrolled students must have an SDQ Total Difficulties score >12, in addition to meeting other inclusion criteria
• Parents bring children to group and pick them up	• Group leaders' contact with parents is typically by phone or through parent meetings

Our adapted model paired school counselors with a study team clinician as the two group leaders, reflecting recommendations to create partnerships between school staff and community clinicians as an implementation support for school-based mental health programs (Forman et al., 2009; Langley et al., 2010). The approach of engaging school counselors to conjointly deliver programs with external mental health staff is not utilized often (Weare & Nind, 2011), but has been successful in small group programs in schools with older elementary students (Lochman & Wells, 2003). Moreover, our conjoint delivery model reflects an integrated, inter-agency approach to

supporting school mental health with community resources, an approach recommended to address the President's 2002 New Freedom Commission Goals (Stephan et al., 2007).

School counselors are considered ideal partners given that their roles involve supporting children's social-emotional skills through classroom guidance lessons, small group programs, and 1:1 support (American School Counselor Association, 2005). School counselors are typically more available to provide interventions to students than are other school-based mental health providers (e.g., school psychologists, social workers). Finally, school counselors are encouraged to adopt evidence-based counseling practices (Dimmitt, Carey, & Hatch, 2007), yet they may lack training and experience to do so. Having them trained and engaged as co-leaders also provides potential advantages to clinic-based models, in that school counselors are available to prompt, monitor and reinforce the skills students learn in the program throughout the day, as well as reinforce the program's approach with teachers and parents.

Given the critical importance of caregivers in supporting children's learning in IY® Dina, our model included activities to engage teachers and parents in the program and encourage them to support students' generalization of skills to the classroom and home settings. Group leaders provided 1:1 in-person or phone consultation to teachers with students in the program at least bi-monthly and involved sharing information about the skills students are learning; how teachers can support students to use these skills in the classroom; and brainstorming behavioral goals and strategies to address teachers' concerns. These meetings were scheduled at teachers' convenience. We also provided 2 hours of teacher in-service meetings focused on young children's self-regulation development and how teachers can support this learning, drawing from material provided in the IY® Teacher Classroom Management Program. Typically scheduled after school or during grade-level planning meetings with refreshments provided, attendance at these meetings was specifically requested for teachers who had children enrolled in the program though some schools encouraged other faculty to attend as well. Ideally, IY® Dina materials would be shared with teachers but was not done here to protect against contamination of teachers with students randomized to the control group. These opportunities for supporting teachers and extending their knowledge were additional benefits of study involvement beyond the monetary stipend they received for their participation.

Delivering IY® Dina in clinics involves parents attending the IY® parent program; our adapted model included three parent meetings where information about what students were learning in the program and video of their child's group were shared. Parents discussed chapters in *The Incredible Years: A Trouble-shooting Guide for Parents of Children Aged 2–8 Years* (Webster-Stratton, 2006) which was given to them. Meetings included a brief parent–child activity so parents could practice giving their child positive attention and reinforcement, akin to the weekly home activities for children and parents to complete. Dinner, transportation money, language interpreters, and child care were provided to support attendance. Meetings were typically held in the evening, but some were held during or after school to accommodate parent work schedules. Like the clinic model, parents got consultation calls from a group leader at least bi-monthly.

Implementation supports

In addition to the required 3-day IY® Inc. training, we provided supervision and peer consultation to support group leaders' intervention delivery and skill development: monthly meetings for all school counselors and study clinicians, weekly group supervision, video consultation and written feedback from the program developer twice a month, and individual supervision as needed. Facilitated by the first author (a licensed clinical psychologist), peer consultation meetings involved group leaders setting goals for feedback and sharing video, followed by discussion of their strengths and suggestions to try next time which are practiced via role play. Group leaders who delivered the program at least twice were supported in applying to become certified, which involved video review of sessions by an IY® certified trainer and detailed written feedback.

Another important implementation support is having a strong working relationship with a district liaison, typically an administrator who

supervises the school counselors such as the Student Services Coordinator or Director of Student Resources. We developed and maintain these partnerships through regular and proactive communication, including in-person meetings, and by being responsive to school requests and concerns. This partnership has been critical in identifying appropriate schools to target, ensuring that we obtain support from principals to deliver the program's core components, and problem-solving concerns when they arise.

Intervention sample and school context

As part of an ongoing RCT study, we enrolled and randomized 172 students, of whom 86 participated in IY® Dina across 17 intervention groups.[1] Written parent permission was obtained with support from school counselors for 57% of students nominated by their teachers as needing intervention, and 63% met full inclusion criteria including elevated social behavioral difficulties [≥12 on the Strengths and Difficulties Questionnaire (Goodman, 1997)], which provides a clear risk threshold often used for inclusion of students needing intervention in research studies. Also, students in this sample demonstrated self-regulation difficulties on the widely used Emotion Regulation Checklist (Shields & Cicchetti, 1997). The average sample score for the Negativity/Lability scale was 2.39 which is considerably higher (worse) than a normative preschool sample (M = 1.42; Danisman, Iman, Demircan, & Yaya, 2016). Also, the average Emotion Regulation total score was 2.69, which is lower (worse) than the average for 7- and 10-year olds in a large geographically representative sample (M = 3.32; Blair et al., 2015). Students with autism spectrum disorder, full-time placement in special education classrooms, significant intellectual deficits and non-proficiency in English based upon school staff report were not included, as the intervention was not designed for such students.

Our intervention sample is racially-ethnically diverse (56% Black, 23% White, 14% Latinx, and 7% Multiracial). Most students received free or reduced lunch (73%) and were male (67%). Per parent report, 24% had been diagnosed with a mental health disorder; 65% of these with ADHD. Drawn from four districts in the Southeastern U.S., 6 of our 11 schools (64%) were from an urban school district, with high representations of ethnic minority and low-income students (78–100% free or reduced lunch). Four schools were from rural communities, with considerable socio-demographic diversity (28–79% free or reduced lunch); the other school was from a well-resourced district in a university community.

Each of our 17 groups (Cohort 1: 4 groups, Cohort 2: 8 groups, Cohort 3: 5 groups) were comprised of 3–6 first and second graders from multiple classrooms in the same school; most groups had 5 or 6 students. Groups were also comprised of students from both grade levels with two exceptions where we had a group of all first graders and another group of all second graders. The program was delivered by six research clinicians, who were all White females with masters' degrees and backgrounds in counseling psychology, school psychology (including two doctoral-level trainees), and social work. Their school counselor co-leaders were nine White females, four Black females, and one Black male. Four doctoral students in clinical psychology and school psychology also helped deliver the program as part of their practica, serving as a third co-leader who primarily provided additional behavior management support.

Procedures and measures

Fidelity

Fidelity data were collected using three types of measures.

Intervention dosage. For implementation of the small group lessons, recess coaching, parent meetings, and teacher consultation meetings, study clinicians documented the occurrence of these activities using a web-based data entry system designed by the study team. For small group lessons, study clinicians recorded when they delivered each session, resulting in a total number of sessions needed for each intervention group to cover the content in the 18 IY® Dina lessons. In

[1]There were 87 students randomized to the intervention group. One student did not participate in the intervention due to parent preference related to receipt of other services, and these data are not reported here.

addition, study clinicians indicated whether the student was present or not for each session. Because the number of total sessions varied by intervention group, student dosage was calculated by the percent of sessions attended. Similarly, clinicians recorded the days on which they provided recess coaching to each student, yielding a total number of recess coaching sessions per student. Clinicians recorded when they met with a teacher and the duration of each meeting using the following categorical scale: 1 = 0–5 minutes, 2 = 6–10 minutes, 3 = 11–15 minutes, 4 = 16–20 minutes, 5 = 21–25 minutes, 6 = 26–30 minutes, 7 = 31–35 minutes, 8 = 36–40 minutes, 9 = 41–45 minutes, 10 = 46–50 minutes, 11 = 51–55 minutes, 12 = 56–60 minutes, and 13 = Over 60 minutes. This scale was utilized because of reliability concerns in recording exact number of minutes.

For the teacher in-service and parent meetings, dosage information was collected using attendance sign-in sheets to calculate the number of teachers at each meeting and the percent of meetings attended by parents, respectively.

Program adherence. Study clinicians completed session adherence checklists of specific activities expected for each lesson that was created by the program developer and are part of the standard program implementation. Items reflect expectations for intervention delivery in clinic settings. Adherence checklist items were reviewed by the first two authors in collaboration with the program developer, and it was determined that few items were not applicable (e.g., greet parents upon arrival) to our school-based model. Program adherence was calculated as the percentage of activities completed and was calculated for all items on the checklist (clinic-based model) as well as excluding the not applicable items (school-based model).

Delivery quality. To evaluate delivery quality, 61 videos of group sessions were rated by a certified IY® trainer not involved with program implementation using a measure of session quality created by the developer. Videos were selected randomly (i.e., two full lessons per intervention group, resulting in 3–4 videos per group). Five of the measure's 92 items produce a score for overall session quality. Items were rated on a 5-point scale (1 = not at all, 3 = sometimes, 5 = frequently/extremely well).

Intervention satisfaction

Satisfaction data were collected from parents, teachers, and counselors using three measures.

Parent satisfaction. Parents completed a paper-pencil questionnaire where they rated their satisfaction with the program on three items on a 7-point scale (1 = extremely unhelpful, 2 = unhelpful, 3 = somewhat unhelpful, 4 = neutral, 5 = somewhat helpful, 6 = helpful, 7 = extremely helpful). In addition, parents completed open-ended questions to indicate what they found was most helpful about participating in the program for them and for their child, along with any suggestions they had about the program. Items on this questionnaire were adapted from the IY® Small Group Dina Parent Satisfaction Questionnaire.

Teacher satisfaction. Teachers rated their satisfaction with various aspects of the intervention related to participation for their student and for themselves, using the 7-point scale described above. Teachers also completed open-ended questions on what they found most helpful about participating in the program, plus any suggestions they had about the program.

Counselor satisfaction. Counselors completed a 39-item questionnaire adapted from the Incredible Years® Parent and Teacher Satisfaction Questionnaires, containing 22 items focused on the ease of use and helpfulness of the group methods and format based on a 7-point scale (1 = extremely difficult to use/unhelpful, 4 = neutral, 7 = extremely easy/extremely helpful). Counselors also rated the helpfulness of the following intervention supports: training and consultation, 3 items; co-leader support, 5 items; and teacher in-service and consultation, 4 items, using the same 7-point scale. In addition, counselors completed five open-ended questions to indicate what they liked about participating in the program, how their participation impacted their professional development and practice, and suggestions for improving the program.

Data analysis plan

Analyses for quantitative data were primarily descriptive such as means, standard deviations, ranges, and frequency counts conducted using SPSS version 25. While recognizing limited power for detecting school-level variability in our data, given differences in our implementation experience across schools, we also explored group differences by type of school (low-income urban n = 5, low-income rural n = 2, better resourced n = 3) using ANOVA with Hochberg post-hoc testing. Qualitative theme analysis was conducted by the first and fourth authors. Using content analysis guidance in Saldaña (2015), this involved examining the open-ended responses, grouping them into similar content areas, and drawing themes from these groupings.

Results

Fidelity

Intervention dosage

Table 2 provides an overall summary of intervention dosage results relative to intervention delivery. On average, it took 35 sessions for a group to complete all 18 IY® Dina lessons (range = 32–40), with 36 expected given our group structure. Across 17 groups and 11 schools, we had 88% average student attendance (range = 16–100%). Six of 86 students (7%) attended less than 70% of the sessions, which was most commonly associated with a high number of absences from school or moving out of the school where the intervention program was provided. Students completed an average of 47% of the homework assigned during group, although this was highly variable (SD = 32%, range = 0–100%). We also delivered an average of 13.2 recess coaching sessions per student (range = 2–20). The sessions most often covered skills for making friends (53% of sessions), followed by solving problems (46%) and following recess rules (40%).

Table 2. Summary of intervention dosage results relative to intervention delivery.

		Intervention Dosage		
Intervention Component	Implementation*	Mean	SD	Range
Child group attendance	36 groups per child	88%	18%	0–100%
Child recess coaching sessions	Weekly sessions	13.22	3.73	2–20
Teacher consultation sessions	Monthly sessions	6.78	2.64	2–16
Parent meeting attendance	3 meetings per child	54%	39%	0–100%

*Implementation occurred over an 18–20 week period.

For the 1:1 teacher consultation sessions facilitated by study clinicians, there was an average of 6.78 contacts per year for each teacher (range = 2–16), about one per month lasting 6–10 minutes each on average. Almost 80% of teachers involved in the study attended at least one in-service meeting, with an average attendance rate of 63% (mean of 1.6 of 2.4 sessions offered). In addition, 15 additional teachers attended who were not involved in the study, as this was offered as a universal support to schools. Finally, parent meeting attendance (2–3 meetings, depending on year of the study) was 54%, with 74% attending at least one meeting and more than 50% attending two meetings. Parents also received an average of 3.5 individual phone calls.

Regarding variation in implementation that may be related to type of school, there was a trend [F(2,85) = 2.37, p = .10] towards differences in student group attendance, such that students in low-income urban schools (free and reduced lunch rates >70%) had lower attendance (84%) as compared to the low-income rural schools (94%) and the better-resourced schools (92%). Significant differences with similar effects were seen [F(2,80) = 20.80, p = .00] in the percent of homework students completed (low income urban = 31%, low-income rural = 73%, higher income = 67%) and the number of recess coaching sessions [F(2,85) = 2.56, p = .08], averaging 12.00 for low-income urban, 16.43 for low-income rural, and 13.83 for better-resourced schools, with statistically significant post-hoc differences between low-income urban and rural. For teacher consultation meetings [F(2, 85) = 2.56, p = .08], low-income urban school teachers received fewer meetings (5.35) than higher resourced schools (6.74), but not low-income rural schools (5.57). Although not statistically significant overall, there were similar differences for parent group attendance [F(2,85) = 2.07, p = .13], with parents from low-income urban schools attending fewer sessions (48%) than parents from better-resourced schools (68%), but this was not significantly different from parents in low-income rural schools (51%).

Program adherence

Based on items reflecting our adapted model, our adherence rate across the 17 groups by group leader report was 91% and was 93% when calculated based on clinic model expectations (i.e., all adherence checklist items). These adherence rates suggest high content adherence and little differences between our adapted model and the clinic model. There were no significant differences across groups by type of school in overall adherence. However, there were differences in the total number of vignettes shown [$F(2,16) = 4.10$, $p = .04$], with urban low-income schools showing fewer vignettes (40.67) than rural low-income schools (63.67), and higher resourced schools with a number in between these two (53.80).

Delivery quality

As shown in Figure 1, overall fidelity as rated from video by an independent reviewer was 3.9 on a 1–5 scale. Group leader knowledge was rated as the highest possible score of 5.0, which may reflect the extensive supervision and consultation supports provided. Fidelity to session protocol and student engagement and scaffolding was rated as between "sometimes" and "often," with scores of 3.8. The lowest rating, indicating that activities occurred sometimes (3.2), was in the number of vignettes shown. Indeed, examination of the actual number of vignettes suggests that on average, one vignette was shown per group rather than two as is expected for a session of this length of time, per guidance from the developer. This may reflect some of the challenges in the groups, to be described further. There were no significant differences among types of schools in fidelity of program delivery as rated by an independent expert.

Intervention satisfaction

Among responding parents ($n = 66$ of 86), most were satisfied or very satisfied (≥6 on 1–7 scale) with the overall program (93%), the parent meetings (95%), and the Incredible Years® parent book (84%). Also, 95% reported that talking with the study clinician was helpful or very helpful, and 97% would recommend the program to others. Parents' responses to open-ended questions most strongly reflected

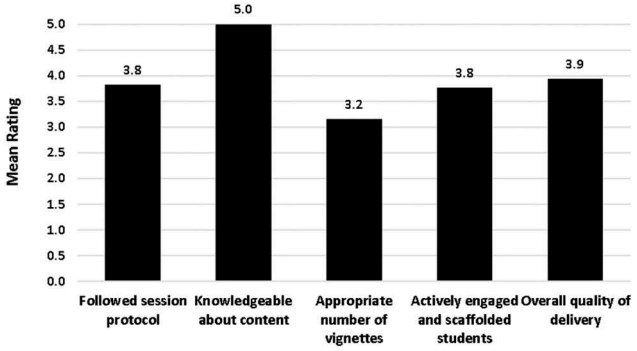

Figure 1. Independent expert ratings of session quality ($n = 61$)[a]. 1–5 scale where 1 = Not at all, 3 = Sometimes, 5 = Frequently/extremely well[a]exploratory analyses showed no differences by school type.

themes of feeling that learning specific social and emotion regulation skills were most helpful to their child. Parents most often reported that their child liked the puppets and certain activities (e.g., making a "teasing shield"), and forming positive relationships with peers in the group and the group leaders. Parents frequently suggested that the program run longer or begin earlier in the child's developmental/educational trajectory, along with requests for more parent involvement and support (Kurian, Murray, & LaForett, 2018).

Based on teacher satisfaction surveys focused on specific students who participated in the intervention ($n = 84$ of 86 possible students, based on 77 teacher ratings), 48% were satisfied with the students' progress in the intervention (≥6 on 1–7 scale) and 68% were at least somewhat satisfied (≥5). In contrast, most teachers were satisfied or highly satisfied with the 1:1 consultation and in-service meetings (82% and 71%, respectively), and 71% would recommend the program to another teacher or parent. In response to open-ended questions about their own participation, the strongest themes showed teachers valuing opportunities to develop their own behavior management skills (Kurian, LaForett, & Murray, 2018).

There were no differences in parent or teacher satisfaction. However, there was a trend towards differences in teachers' perceptions of improvement in the major problems that prompted student referrals to the program [$F(2,160) = 3.01$, $p = .05$], with teachers in the low-income urban schools seeing less

improvement (M = 4.20) than those in low-income rural (M = 4.77) and better-resourced schools (M = 4.72).

Counselors' satisfaction ratings (Figure 2) showed relatively high ratings overall for the ease of use (average rating 5.2 on 1–7 scale) and helpfulness of methods (5.9 on 1–7 scale). They rated ignoring and using puppets lower for ease of use, but also perceived these methods as very helpful. This disparity may reflect growth areas for counselors' skills, and ones that they perceive as having high pay off and benefit for students. Of note, they perceived time out and vignettes as relatively less useful than other methods. Counselors also had generally high ratings of helpfulness of the supports they received to deliver the small group and other intervention activities (Figure 3), reflecting our successful partnership approach and the potential value of these other intervention activities for other school-based mental health programs.

Counselors also gave unsolicited feedback on how their participation as a group co-leader benefitted their professional development, reporting an increase in their skills to manage behavior and more effectively praise and ignore students. Similarly, they described having gained understanding of challenging students and how to teach them social-emotional skills in "fun" ways. They also commented on how delivering IY® Dina helped them support teachers and deliver classroom-level supports, making them better equipped to suggest and model effective strategies to use with challenging students (e.g., calm-down thermometers). Finally, counselors described using intervention materials for classroom guidance activities.

Discussion

We next summarize key findings and reflect on our implementation questions related to: 1) fidelity, 2) satisfaction, and 3) implementation challenges. We address each of these within the context of considerations for future delivery of IY® Dina in schools. Though our conclusions certainly reflect our study's relatively small sample of schools and selected students, our implementation challenges are consistent with those of other school mental health programs (Forman et al., 2009; Langley et al., 2010). Therefore, we believe that this work has broader implications for implementing clinical programs in schools.

Dosage and fidelity

Based on our data, we conclude that IY® Dina can be delivered in schools with a moderate to high level of fidelity expected to produce positive results when highly skilled clinical research staff partner with school counselors. Still, considerable time and resources were required for the training, consultation, and implementation supports to do so. And, there were areas where our delivery could have been enhanced (e.g., number of vignettes shown). Without external grant funding, fidelity could become a concern particularly for schools with greater adversity (e.g., more economically disadvantaged; staff experiencing significant stress; high numbers of students with extremely challenging behaviors). We also expect that challenges related to logistics (e.g., space, scheduling) might be more difficult to overcome outside of a research context absent principal and district

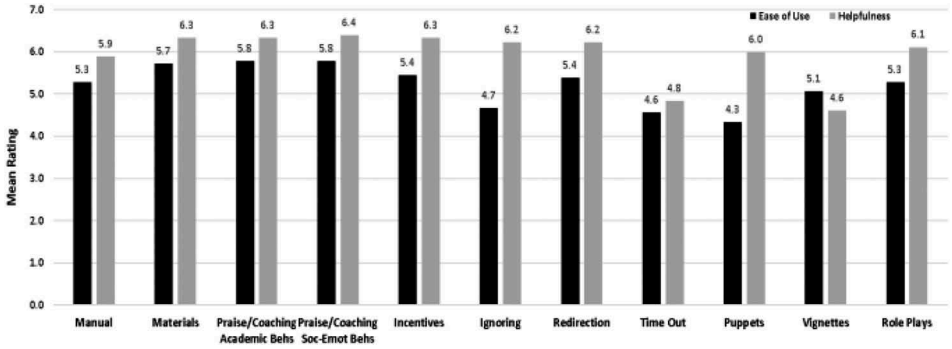

Figure 2. Counselor ratings of IY teaching methods (n = 17).
1–7 scale where 1 = extremely difficult to use/unhelpful, 4 = neutral, 7 = extremely easy/extremely helpful.

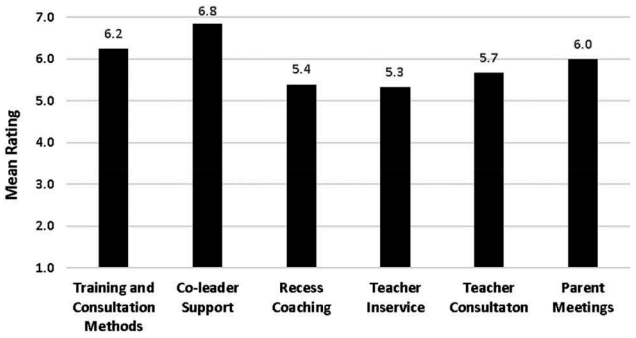

Figure 3. Counselor ratings of perceived helpfulness of other intervention supports and activities (n = 17).
1–7 scale where 1 = extremely unhelpful, 4 = neutral, 7 = extremely helpful.

staff commitment to support program delivery and compensation for school staff.

Contextual variability

There were also interesting findings related to variations in implementation by the urbanicity and income level of our participating schools. In general, it appears that low-income urban schools received a lower dosage of the intervention as defined by child group attendance, recess coaching sessions, homework completion, parent meeting attendance, and teacher consultation sessions (although given our limited statistical power, not all of these differences were significant). Groups delivered in these schools also showed fewer vignettes, considered a core component of the intervention, although overall adherence and fidelity by group leader self-report of content and activities and by delivery quality rated by an objective expert did not differ. Of note, low-income rural schools did not demonstrate this pattern and in fact showed the best implementation on several measures. This finding is consistent with other work suggesting that rural and urban poverty are distinctly different contexts (Tine, 2017). Although we encourage caution in interpreting these exploratory findings, such contextual variability appears important to consider in future school implementation research.

Satisfaction

An important consideration for future delivery of IY® Dina in schools is parent, teacher, and counselor satisfaction, which may impact district administrators' decisions to support the program. Our parent meeting attendance was 54% overall, which is better than average for school-based interventions (Garbacz, Herman, Thompson, & Reinke, 2017; Minney, Lochman, & Guadagno, 2015). Most parents had at least some involvement and were quite satisfied with the program and their child's participation, and this did not seem to vary by the poverty or urbanicity of the school. Indeed, we heard numerous unsolicited comments about parents who engaged with their schools in positive ways for the first time as a result of the program, and about parents who praised the program at unrelated school and district meetings.

For teachers, satisfaction with student progress was notably lower than satisfaction with the program itself, and this seemed to be particularly true for teachers in the low-income urban schools. This may be related to the initial severity of students' behavior and teachers' expectations for behavior change, which they communicated to our study clinicians. Indeed, in other analyses we have presented, teacher satisfaction was associated with decreases in students' hyperactivity/impulsivity (Masked for review, 2018b). Qualitative data are also encouraging in that teachers reported many benefits to their knowledge and skills from the in-service meetings and consultation, despite these not being core components of the program. Interestingly, their perceptions of student improvement were moderately associated with the 1:1 consultation they received (Masked for review, 2018b).

Counselors reported clear professional development benefits and rated all therapeutic methods as at least *somewhat useful* and the majority as *useful*. They also informally reported applying knowledge and skills learned in the program to other students, programs, and practices may increase schools' capacity for providing effective social-emotional learning supports. Overall, satisfaction data suggest that IY® Dina may meet professional development and service needs within schools that support its future use in this setting.

Implementation challenges

Capacity building needed for counselor skills

Even with extensive consultation support, acquiring the breadth of skills needed for effective group leadership was challenging for many of our

counselors. This seems to reflect counselors' lack of training in the clinical skills and intensive behavior management needed for young students with significant self-regulation difficulties. Encouragingly, some of our counselors greatly developed these skills during the intervention. Two successfully achieved certification in the program, and another passed the video portion of certification (3 of 4 who were eligible), reflecting 20% of the 15 school staff who co-delivered groups with us.

One of the biggest challenges for many counselors was understanding the behavioral principles underlying the positive reinforcement systems and strategies to reduce inappropriate behavior. For example, they struggled with the rationale of rewarding children for expected behaviors, the high reinforcement rates needed to shape behavior, and resisting the urge to mix reward and punishment systems. Also, concepts such as ignoring minor disruptive behaviors and withdrawing adult attention during time-out were difficult for some to implement consistently. Others struggled with the dynamic nature of group therapy for children with challenging behaviors, which requires group leaders to constantly monitor behaviors, respond quickly to prevent problems, and engage the group in a very active, child-focused way (e.g., singing songs, physical movement). Overall, 3 of the 15 school staff who co-led groups struggled to develop the competencies needed (about 20%), similar to the number who mastered program delivery. Our experience with school counselors is consistent with research that has identified limitations in the knowledge and skills of school-based personnel for serving students with significant mental health difficulties (Koller & Bertel, 2006).

Misalignment with school discipline systems

One of the biggest implementation challenges we encountered was navigating differing philosophies between the IY® positive discipline approach to managing behavior and schools' discipline policies. Some of our partner schools utilized zero-tolerance policies that press adults to respond to certain behaviors and incidents with immediate and sometimes significant consequences (e.g., in-school suspension). These approaches can inadvertently reinforce inappropriate behaviors or discourage a student from trying to do better. Also, wording of classroom and school rules sometimes led to inconsistent responses to student behavior. Finally, some schools utilized consequences such as walking laps around the playground and writing sentences (e.g., "I will not _____."), which are inconsistent with the IY® positive discipline approaches.

Scheduling and time

One challenge was identifying a time to hold the two weekly 45-minute sessions during non-instructional time. When recruiting schools, we sought commitments from principals to assist with creative scheduling options, which was helpful. But in schools where we served students across grade levels, there were limited overlapping blocks of non-instructional time. For children struggling with self-regulation who are also more likely to have academic difficulties, it is critical that the intervention does not further reduce academic learning opportunities. We learned to avoid lunchtime and tried not to schedule during recess given the importance of physical activity for many of the participating students.

Working in 11 schools over three years, we found a few options such as during designated "intervention" time, when teachers implement specialized academic interventions for students who need them. We also scheduled groups to overlap with the beginning or end of recess. Finally, we scheduled some groups at different times within the week (e.g., 9:00 am on day one, 10:25 am on day two). Nonetheless, it was difficult to find options to make up missed sessions due to inclement weather or unexpected scheduling issues.

Finally, our study clinicians took on most of the responsibility for planning the lessons and doing other tasks that school counselors typically would not have time to do. Based on several randomly distributed surveys assessing their weekly intervention time and tasks, study clinicians spent an average of 5 hours per week preparing and delivering the two sessions, reflecting significant time to select vignettes and activities, anticipate behavioral challenges, and prepare materials. The extent to which any of this time reflected over-preparation or activities specific to the research context of our delivery is unknown. Surveys indicated that counselors spent about half this amount of time, reflecting at least 1 hour of preparation per week.

Space

Delivering the group with fidelity assumes the space is big enough to hold up to six children and at least two adults comfortably (seated either in chairs or on the floor) for whole group activities and for small group activities. Space is needed to show video vignettes with a television and DVD player or a computer with projector. Further, there must be enough space to have a designated time-out area away from other children in the room. Finally, given that many children in these groups are likely to be inattentive, impulsive, or show other disruptive behaviors, it is recommended that the space has minimal distractions. However, it can be challenging to find such a space within schools given overcrowding and other school space policies. Available spaces typically are not set up to match an ideal therapeutic classroom. At some schools, we have held groups in counselors' offices, which are often small and may have distracting items that cannot be removed. This can impact delivery quality by increasing challenges with managing children's behavior.

Despite these challenges, we used creative approaches to maximize space and minimize set up/clean up burden such as using large poster boards with Velcro slots to attach cue cards and other materials, tri-fold poster boards and pocket charts with visual displays prepared ahead of time, and non-traditional surfaces (e.g., doors, windows) for displays. We also used a cell phone-sized projector and a sheet for a screen when there was not enough room for a TV. To reduce children's distractibility, we turned shelves to face walls or covered them with butcher paper. With limited space, group leaders worked to keep reinforcers (e.g., token economy materials, stickers) out of children's reach, often keeping them on their person (e.g., wearing a pouch or fanny pack). These strategies minimized some of the challenges related to space while still maintaining intervention fidelity.

Time-out

Space limitations may reduce the effectiveness of time-out when there is not enough physical distance between the time-out space and other reinforcing activities in the group. This close physical proximity can make it especially difficult for group leaders and the other children to ignore disruptive behaviors from the child in time-out. In addition to limited space for putting two children in time-out at the same time if needed, it may not be possible to move other children in the group so that a time-out can be done "on the spot" if a child refuses to go. When a child is so dysregulated that the group is disrupted (e.g., screaming loudly, destroying group materials), one group leader grabbed a bag prepared ahead of time with materials for a fun activity and take the rest of the group in the hallway or to the playground while the dysregulated child remained in the room with the other group leader. This allows the dysregulated child to serve a time-out "on the spot" and typically prevents further escalation.

Student selection/group heterogeneity

Given our study's RCT design and inclusion criteria, students assigned to the intervention group had a wide range of clinical difficulties. Most demonstrated significant hyperactivity and impulsivity often with oppositional and aggressive behavior, yet others had impairing social skills deficits and internalizing difficulties (Cavanaugh et al., 2017). Students also varied in developmental and cognitive abilities, SES, exposure to negative sequelae associated with living in poverty, and gender. Within-group variability at times created challenges in delivering the curricula and with group dynamics, which would be less likely in a non-RCT context as schools could strategically determine group composition. Ideally, this would involve children with different temperaments, so that not all are hyperactive or have social or language delays (Webster-Stratton & Reid, 2003).

There are some provisions in the curriculum that help group leaders respond to the needs of different children in the groups. One of the most useful aspects involves identifying special challenge goals that are individualized for each child. This strategy is particularly valuable for supporting students with severe behaviors who may be hard to accommodate in a small group setting. Also, small group activities provide a natural time to divide groups based on abilities (e.g., by grade level) or to create peer modeling opportunities (e.g., pairing a more verbal child with one who is less verbal). Finally, group leaders look for ways to leverage the

cognitive and academic skills of specific children by giving them special privileges with leadership roles (e.g., reading instructions or other information for the group, leading a group review).

Summary and application to practice

Lessons learned and future directions

One of the most important lessons learned is that our conjoint delivery approach with school counselors appears valuable, particularly for building long-term mental health capacity in schools. As noted, elementary school counselors are ideal group leaders in many ways given their backgrounds and roles within the school. Across school districts, counselor interest in learning the program and their satisfaction in delivering it was quite high. Although some counselors struggled to develop the skills and competencies needed for high-quality program delivery with a modest amount of training (e.g., 3 initial days plus 2-hour monthly consultation and coaching meetings), several others were very successful in their skill development as validated by their certification through IY® Inc. We believe that providing professional development to school mental health staff may have broad, long-term impact on students and schools. At the same time, the inadequacy of preservice training in mental health for school counselors is an issue warranting attention (Koller & Bertel, 2006). Our conjoint delivery model aligns well with counselors' needs for support and is consistent with recommendations for community clinicians to actively collaborate with school staff to deliver services (Weist et al., 2005). The feasibility of this approach is evidenced by a national survey of school districts that found about half contracted with external mental health agencies for services (Teich, Robinson, & Weist, 2008), which could theoretically include IY® Dina. To ensure feasibility for school counselors with this approach, mental health consultants still would need adequate preparation time which may exceed that of other clinical programs, a question ripe for empirical testing.

We also gained appreciation for how school contextual factors influence program delivery, which we suspect may impact child outcomes in future planned analyses. Based on qualitative observation, some teachers in schools with greater adversity were less receptive to consultation suggestions, and appeared more likely to interact with students in ways that were counterproductive to supporting students' application of newly learned self-regulation skills. Of interest are exploratory analyses showing that we were not able to implement as many teacher consultation and recess coaching sessions in our lowest-income school district and this clearly impacted our delivery of vignettes, a core group component. Still, student and parent attendance and parent/teacher satisfaction did not differ, which is encouraging. Our experience is consistent with research showing a negative impact of teacher stress on their delivery of social-emotional programs (Larson, Cook, Fiat, & Lyon, 2018) and weaker intervention effects in more economically disadvantaged schools (Conduct Problems Prevention Research Group, 2010).

One approach for addressing such implementation concerns in schools with significant adversity is to utilize the Positive Behavior Intervention Support (PBIS) implementation framework (Sugai & Horner, 2006) which suggests that strong universal "Tier 1" programs focused on effective use of school-wide reinforcement and discipline systems be implemented prior to selective "Tier 2" social-emotional pull out programs. In practice, this might involve assessing a school's climate and positive behavior systems to determine readiness for a small group program like IY® Dina. In schools where strong systems are not already in place, it may make more sense to focus on implementing PBIS first, particularly given evidence that targeted school mental health interventions are more effective when positive discipline practices and universal social-emotional supports are in place (Weare & Nind, 2011). This is certainly understandable in that it increases the likelihood that students' newly learned skills will be encouraged and reinforced, enhancing the potential benefits of a targeted program. With a larger sample of schools, this is also a hypothesis that could be explicitly tested.

Given the implementation challenges we encountered delivering this program, even with adaptations, schools may want to consider different but perhaps

other valuable ways to use IY® Dina in the future, which may involve reaching more students and/or minimizing intervention preparation time demands on counselors. Indeed, some of our counselors expressed interest in using some of the curricula and activities within classroom guidance lessons. IY® has a version of Dina Dinosaur School designed specifically for delivery in pre-k and early elementary classrooms (Webster-Stratton & Reid, 2004). This is a universal preventive approach that could benefit many more students but may not provide the level of intensive skills training that some students need. Some counselors also suggested pulling 2–3 students at a time for small group work targeting students' needs in a specific area (e.g., following school rules, emotion regulation, and friendship). The curricula lend well to this modular approach, which would be more consistent with the shorter groups (6–8 sessions) counselors typically provide. While the efficacy of this approach has not been evaluated, one small trial ($n = 12$) of program implementation for only half its dosage did not find significant behavioral effects (Hutchings et al., 2007). Examining outcomes for student participation in different units of the program that are well matched to areas of impairment would be a useful future research direction. Finally, combining programs designed to increase child skills with more comprehensive parenting programs such as has shown benefits in prior IY® research could also be considered (Reid, Webster-Stratton, & Hammond, 2007).

Implications for delivery of clinical programs in schools

Beyond considerations for delivery of IY® Dina in schools, we believe our work has several implications for delivery of other clinical programs in this setting, particularly other small group programs. First, it seems important to consider the fit of the program's philosophy with school policies and practices, especially around discipline. It may be helpful to explore this as part of a school "readiness assessment" related to PBIS as noted above and to address any potential mismatches early and directly. It also appears that both parents and teachers value opportunities for their own skill building, which might be provided through workshops or consultation (for teachers). Such collateral supports may facilitate intervention skill generalization and potentially strengthen child outcomes. Again, the specific value of these supports could be empirically examined in future research to inform cost-benefit decisions.

Given that this implementation of a school mental health program was well supported with federal grant funds in this study, funding for similar programs outside of this context must also be considered. As noted, one funding mechanism is through contracted school mental health services that are already being provided by approximately half of school districts nationally (Teich et al., 2008), and perhaps more currently. In addition, there are national nonprofit organizations like Communities in Schools that partner with school districts to obtain long-term external funding for initiatives like this. Other delivery options noted previously that would be lower cost include schools adapting the program for universal implementation as a classroom guidance program which has shown positive effects (Webster-Stratton, Reid, & Stoolmiller, 2008), or delivering it to fewer students in fewer sessions that are more targeted to specific student need. However, this latter approach does not have established efficacy, and the former may not meet the needs of the highest risk students.

In addition, for group programs targeting students' mental health needs, students should be selected with several clinical considerations in mind. Some students may need a greater level of support than can be provided in a group context, even with a 1:2 or 1:3 ratio (at least for younger students with severe emotional or behavioral difficulties). Group composition should also be considered, as including students with a history of conflict or certain combinations of characteristics can create negative peer dynamics. Though this can be a therapeutic opportunity, it can also disrupt the group process and interfere with fidelity. One way to ensure positive peer dynamics is to include some students who are less impaired or perhaps even positive role models for other group members (Bierman et al., 2017). This must be balanced, of course, with the need to adequately justify students' time out of class for intervention programs.

In sum, there is great potential for the translation of clinical programs to school settings. The potential benefits of doing so to increase service

reach and improve children's mental health outcomes are great, warranting continued efforts to identify and address implementation challenges such as those encountered in this study.

Disclosure statement

No potential conflict of interest was reported by the authors. Dr. Murray is a trained mentor in the Incredible Years Teacher Classroom Management Program, and receives compensation from community organizations for providing trainings and consultation. Dr. Webster-Stratton disseminates the Incredible Years interventions and stands to gain from a favorable report. She has agreed to distance herself from primary data handling and analysis. We are grateful to our research team and the school personnel, students and parents who contributed to the success of this project.

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CHAPTER 21

THE INCREDIBLE YEARS® SERIES: AN INTERNATIONALLY EVIDENCED MULTIMODAL APPROACH TO ENHANCING CHILD OUTCOMES

Carolyn Webster-Stratton and Tracey Bywater

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 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 1970s and 1980s in Seattle, Washington by the first author of this chapter, to address child behavioral and emotional difficulties and enhance positive life outcomes, and it 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% to 15% in 3- to 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 United States (Burns et al., 2004). Foster children in the United Kingdom have a ratio of 3.7:1 higher rates of disorder than children living in disadvantaged private households (defined as households in which the parents have either never worked or work 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 dropout, violent 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, well-being, 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, low monitoring; Jaffee, Caspi, Moffitt, & Taylor, 2004); family risk factors (e.g., marital conflict, parental drug abuse, mental illness, criminal behavior; Knutson, DeGarmo, Koeppl, & Reid, 2005); child biological and developmental risk factors (e.g., attention deficit hyperactivity disorder [ADHD], learning disabilities, language delays); school risk factors (e.g., poor teacher classroom management, high levels of classroom aggression, large class sizes, poor school–home communication); and peer and community risk factors (e.g., poverty, gangs; Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000). Three decades of research by prominent

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researchers such as Dishion and Piehler (2007) and Patterson and Fisher (2002) have consistently demonstrated the links among child, family, and school risk factors and the development of antisocial behaviors, and this research has 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, lack of support, academic failure, and the formation of deviant peer groups have developed. Moreover, interventions should be multimodal, in order to target multiple risk factors at the school/community, family, and individual levels, and they should 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 and parenting skills, and improve parental mental health (e.g., depression, marital conflict; Furlong et al., 2012).

The Incredible Years series was designed as a set of interlocking and comprehensive training programs to prevent and treat behavior difficulties from infancy and toddlerhood through middle childhood. Incredible Years is a multimodal program that can be utilized to intervene in multiple areas and settings through parent, teacher, and child training. The model's theory of change holds 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 dropout, CD, and substance abuse problems in later life (see http://incredibleyears.com/programs/ for the logic model).

The following sections will outline the underlying theoretical background for the Incredible Years Basic (baby, toddler, preschool, and school-age) parent programs, which are considered core and necessary components of the prevention model for young children. The Incredible Years adjunct parent, teacher, and child programs, and how they are used to address family and school risk factors and children's developmental issues, will also be presented. Information regarding Incredible Years program content and delivery methods will be briefly described, as will ways to promote successful delivery of the programs. The international and U.S. evidence base for the Incredible Years programs will be highlighted, with a section on transportability of programs as well as adaptations and accommodations in different countries (see Figure 21.1).

THEORETICAL BACKGROUND FOR INCREDIBLE YEARS PROGRAM CONTENT AND METHODS

The underlying theoretical background for Incredible Years parent, teacher, and child programs includes cognitive social learning theory, particularly Patterson, Reid, and Dishion's (1992) coercion hypothesis of negative reinforcement developing and maintaining deviant behavior; Bandura's (1986) modeling and self-efficacy theories; Piaget and Inhelder's (1962) developmental cognitive learning stages and interactive learning method; 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 Incredible Years programs. For example, the Incredible Years video vignettes portray parents or teachers from different cultural backgrounds using social and emotional coaching or positive discipline strategies, or children managing conflict with appropriate solutions. Video-based modeling, grounded in social learning and modeling theory (Bandura, 1977), supports the learning of new skills. Group leaders use the vignettes as tools to engage participants in group discussion, collaborative learning, and emotional support. Furthermore, 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

FIGURE 21.1. The international spread of The Incredible Years® in 26 countries across six continents. Adapted from "Implementation Examples," by The Incredible Years®, 2018 (http://www.incredibleyears.com/programs/implementation/implementation-examples/). Copyright 2018 by The Incredible Years®. Adapted with permission.

of intervention strategies (Reinke, Stormont, Webster-Stratton, Newcomer, & Herman, 2012).

The group format is advantageous because it is more cost effective than individual intervention; addresses risk factors such as family isolation and stigmatization, teachers' senses of frustration and blame, and children's feelings of loneliness or peer rejection; and helps reduce resistance to intervention through sharing the collective group wisdom. When participants express beliefs counter to effective practices, the group leader draws on other group members to express alternative viewpoints. The group leader is thereby able to elicit discussion of change from the participants themselves, which makes it more likely that 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 Incredible Years Basic (core) parent training programs consist of 4 different curricula to fit child developmental stages: the baby program (4 weeks to 9 months), the toddler program (1–3 years), the preschool program (3–5 years) and the school Age program (6–12 years). Each of these recently updated programs emphasizes developmentally appropriate parenting skills and includes age-appropriate video examples of culturally diverse families and children with varying temperaments and developmental issues. The programs run for 9 to 22 weeks, depending on the age of the child and the presenting issues of the parents and children in the group.

For all parent training programs, trained and—ideally—accredited Incredible Years 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 eight to 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, and age-appropriate parenting responses. Participation in the group-based Incredible Years 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 to compensate 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 21.2). 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 and 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, persevere with learning despite obstacles, and develop friendships.

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 and logical consequences for aggressive behaviors. In addition, parents learn how to develop supportive partnerships with teachers by collaborating on behavior plans and supporting their children's school-related activities.

There are two basic premises of the model: (a) a positive relationship foundation must precede clear and predictable discipline strategies, and this sequence of delivery of content is critical to the program's success; and (b) 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 positive foundation has been solidly constructed with secure scaffolding.

INCREDIBLE YEARS ADJUNCTS TO PARENT PROGRAMS

Optional adjunct parenting programs can be used in combination with the Incredible Years Basic parenting programs outlined above, as follows:

1. The Incredible Years 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 to 4 years, which 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 universal prevention program is designed to teach parents of children 2 to 6 years old (who do not have significant behavioral issues) social, emotional, persistence, and preacademic coaching methods as well as how to promote their children's reading, self-regulation, and problem-solving skills. It is also recommended in the form of 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.

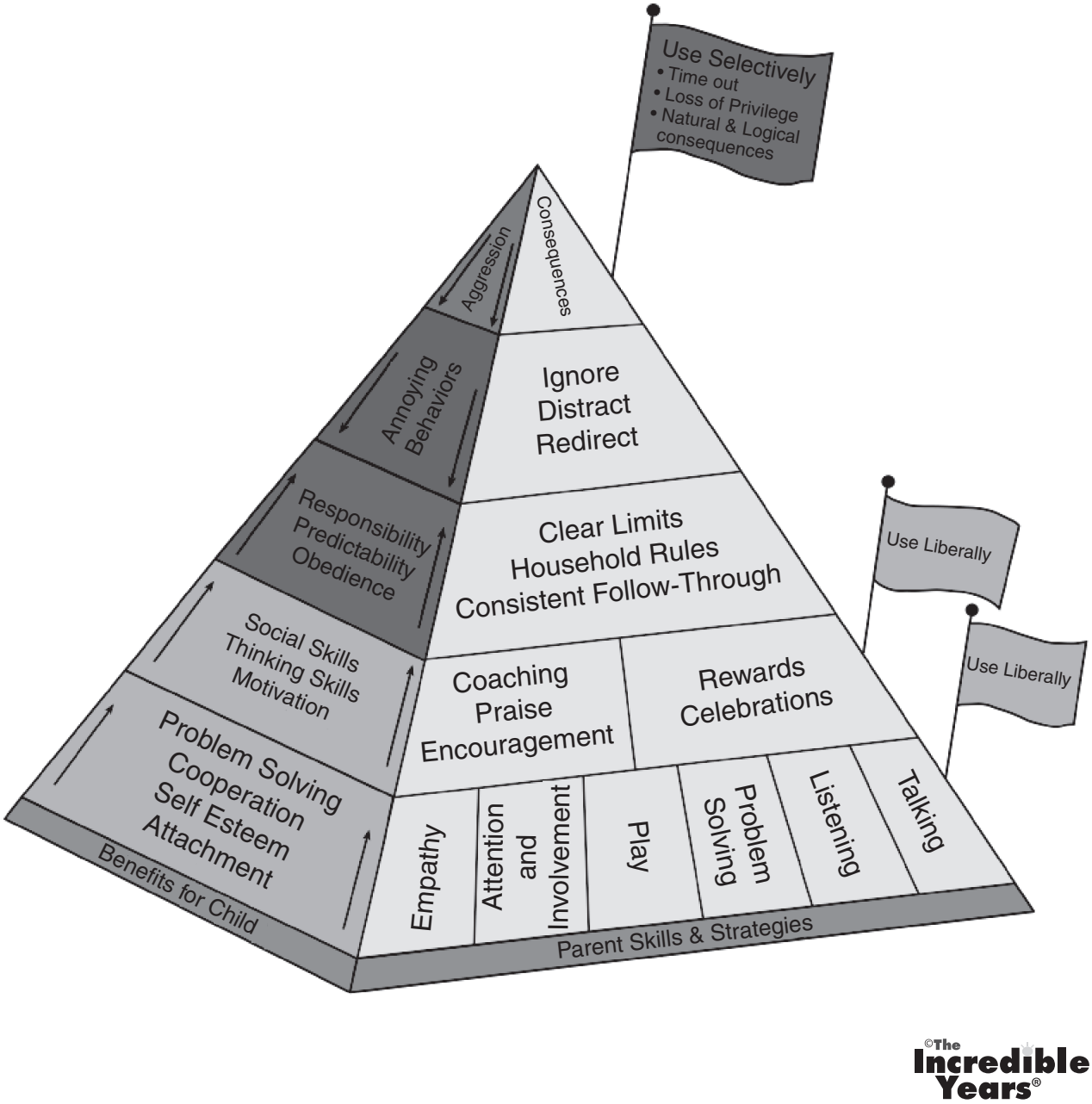

FIGURE 21.2. The Incredible Years Parenting Pyramid®. Adapted from "Supplemental Materials," by The Incredible Years®, 1984 (http://www.incredibleyears.com/programs/parent/supplementals/). Copyright 1984 by The Incredible Years®. Adapted with permission.

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 (including 14–16 teachers) throughout the school year. It is recommended that trained Incredible Years coaches support teachers between workshops by visiting their classrooms, helping refine behavior plans, and addressing teachers' 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 more information on IY-TCM training and 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 of ages 1 to 5 years. Topics include coping with toddlers' 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 Incredible Years 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 Incredible Years child program have been developed: (a) 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 through second grade); and (b) in the small group therapeutic treatment group, accredited Incredible Years group leaders work with groups of 4 to 6 children (ages 4–8 years) 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 schools. Content is delivered using a selection of video programs (with over 180 vignettes) that teach children literacy, social skills, emotional self-regulation skills, and the 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. The content and structure of the child program reflects that of the parent training program and comprises seven components: (a) introduction and rules; (b) empathy and emotion; (c) problem-solving; (d) anger control; (e) friendship skills; (f) communication skills; and (g) school skills (for more information about the child programs, see Webster-Stratton & Reid, 2003, 2004).

CHOOSING PROGRAMS ACCORDING TO RISK LEVELS OF POPULATIONS

The Basic parent programs (baby, toddler, preschool, or school-age versions) are considered mandatory or core components of the prevention intervention training series. The Advance program is offered in addition to the Basic program for selective populations such as parents characterized as depressed or those 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 training program and/or one of the two teacher training programs be offered in conjunction with the parent training program to assure child behavior 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 (Incredible Years Program Implementation, 2013).

As seen in Figure 21.3, Levels 1 and 2 are the foundation of the pyramid and involve a recommended series of programs that could be offered universally to all parents, day care providers, and teachers of young children (age 0–6 years). Level 3 is targeted at selective or high-risk populations. Level 4 is targeted at indicated populations, in which children or parents are already showing symptoms of mental health problems (e.g., 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, children who are highly aggressive but not yet diagnosed as having oppositional defiant disorder [ODD] or CD). This level of intervention is offered to fewer people and offers 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 home coaching protocols. Child and parent therapists work with parents to develop behavior problem plans and consult with teachers in partnerships to coordinate 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 more time- and cost-intensive interventions at Level 5.

RESEARCH EVIDENCE FOR THE INCREDIBLE YEARS PARENT PROGRAMS

Treatment and Indicated Populations

The efficacy of the Incredible Years Basic parent treatment program for children (ages 2–8 years) diagnosed with ODD and/or CD has been demonstrated in eight published randomized control group trials (RCTs) by the program developer (Webster-Stratton, 2013). In addition, numerous replications by independent investigators have been conducted (for reviews, see Gardner, 2012; Menting, Orobio de Castro, & Matthys, 2013).

In the early U.S. 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 with waitlist control groups. The results were consistent for toddler, preschool, and school age versions of the program. The first series of RCTs in the 1980s 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 with 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 2 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 and 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 Incredible Years parent program meta-analysis including 50 studies with 4745 participants from 2472 intervention families showed the program to be effective for disruptive and prosocial child behavior as measured by teacher and parent report and independent observations across a diverse range of families (Menting et al., 2013).

Two long-term studies from the United States and United Kingdom followed up with children diagnosed with conduct problems whose parents

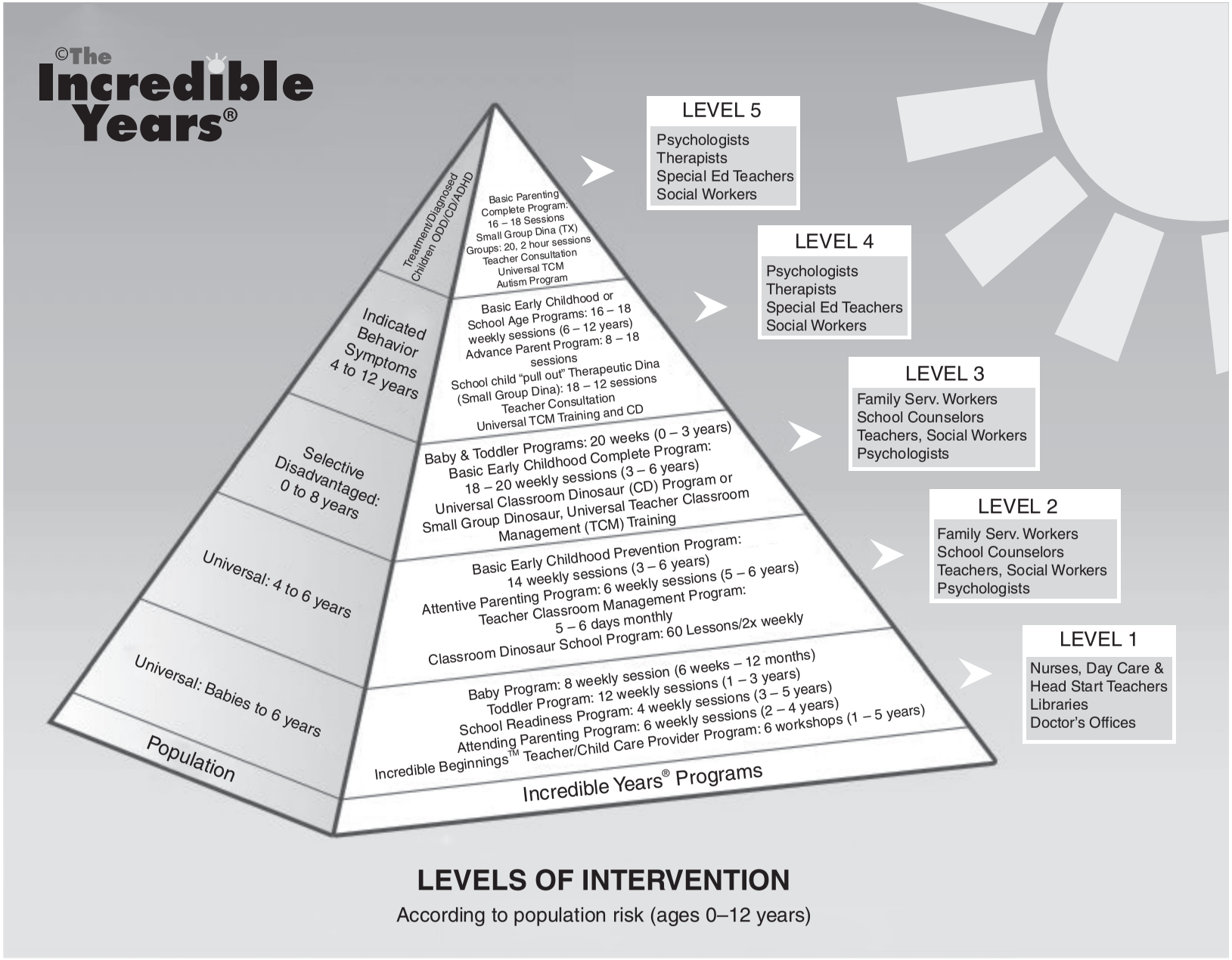

FIGURE 21.3. Levels of intervention pyramid. Adapted from "Implementing the Programs," by The Incredible Years®, 2010 (http://www.incredibleyears.com/programs/implementation/). Copyright 2010 by The Incredible Years®. Adapted with permission.

had received the Incredible Years parent program 8 to 12 years earlier. The U.S. study indicated that 75% of the teenagers were typically adjusted, with minimal behavioral and emotional problems (Webster-Stratton, Rinaldi, & Reid, 2011). The data were not significantly different from U.S. national rates of adjustment for children of the same age. The independent U.K. 10-year follow-up study reported that parents who had participated in the Incredible Years Basic parent program expressed more emotional warmth and supervised their adolescents more closely than parents in the control condition who had received individualized typical psychotherapy (parent-focused or child play therapy) offered at that time. Moreover, their children's reading ability was substantially improved in a standardized assessment in comparison with the children in the control condition (Scott, Briskman, & O'Connor, 2014).

Prevention Populations

The prevention version of the Basic program has been tested by the developer in four RCTs 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 (for a review, see Webster-Stratton & Reid, 2010). At least six 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 (e.g., praise, coaching, descriptive commenting) and positive discipline strategies, and reduces harsh, critical, and coercive discipline strategies (see Menting et al., 2013). The trials took place in applied mental health settings, schools, and primary care practices with Incredible Years group leaders drawn from existing staff (nurses, social workers, and psychologists). The program has been shown to be effective with diverse populations, for example, individuals with Latino, Asian, African American, and European backgrounds in the United States (Reid, Webster-Stratton, & Beauchaine, 2001), and other countries such as England, Wales, Ireland, Norway, Denmark, Sweden, the Netherlands, New Zealand, Portugal, and Russia (Azevedo, Seabra-Santos, Gaspar, & Homem, 2014; 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 Incredible Years parent programs indicates parent program acceptability is high across different populations and in different contexts (Bywater et al., 2011; Furlong & McGilloway, 2015; Hutchings, Griffith, Bywater, Williams, & Baker-Henningham, 2013; Linares, Montalto, Li, & Oza, 2006; McGilloway, Ni Mhaille, Bywater, Furlong, et al., 2012).

INTERNATIONAL SPOTLIGHT ON THE UNITED KINGDOM AND IRELAND

The Basic program for parents of 3- to 6-year-olds has demonstrated effectiveness in targeted RCTs in Ireland, Wales, and England (Bywater et al., 2009; Little et al., 2012). In Wales, the sample included families from rural and urban communities who spoke Welsh or English. In England, the research was conducted in the culturally diverse city of Birmingham (the second largest city in England). In Ireland, services were delivered to a predominantly Catholic population in both semirural and urban areas. In all three trials, families were eligible if their child scored over the cut-off level for clinical concern on a behavioral screener and were 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, & Daley, 2007; McGilloway, Ni Mhaille, Bywater, Leckey, et al., 2014) 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; for example, critical parenting and aversive parenting strategies were significantly reduced in parents who attended the Incredible Years program compared with control parents. The findings of these trials replicated

those by the program developer. In addition, parent mental health improved for intervention parents. Effects were maintained at 12 months postbaseline (McGilloway et al., 2014) and 18 months postbaseline (Bywater et al., 2009). A recent review of the independent Incredible Years series research base (Pidano & Allen, 2015) demonstrates that the Basic parent program is the most researched from the series, with greater than 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 Incredible Years parent programs (Menting et al., 2013) found similar effect sizes for child behavior for studies in the United States and Europe ($d = .39$ and .31 respectively), further illustrating the effectiveness of the programs when transported to Europe.

RESEARCH EVIDENCE FOR THE INCREDIBLE YEARS CHILD PROGRAMS AS ADJUNCTS TO 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 (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 with 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 with 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 plus 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 CT as a stand-alone program delivered in schools being conducted in Wales and at the University of North Carolina (LaForett et al., 2018).

Prevention

One RCT conducted in the United States evaluated the use of the classroom prevention (universal) version of the Incredible Years child program with Head Start families and in 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 in school readiness skills, emotional self-regulation, and social skills, as well as reductions in behavior problems, compared with control school classrooms. Intervention teachers also showed more positive involvement with parents than control teachers (Webster-Stratton, Reid, & Stoolmiller, 2008). A subsample of parents of indicated children (i.e., those with high levels of behavioral problems reported by teacher or parent) were selected and randomly allocated to (a) the parent program plus classroom intervention, (b) classroom-only intervention, or (c) control group. Mothers in the combined condition had stronger mother–child bonds and were more supportive and less critical than classroom-only intervention mothers, and they also 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 Incredible Years parent program in schools (Reid, Webster-Stratton, & Hammond, 2007).

RESEARCH EVIDENCE FOR THE INCREDIBLE YEARS TEACHER CLASSROOM MANAGEMENT PROGRAM AS AN ADJUNCT TO 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); see also Webster-Stratton, 2012a and five RCTs by independent investigators, including trials conducted in Wales (Hutchings, Martin-Forbes, Daley, & Williams, 2013), Ireland (Hickey et al., 2017), Norway (Fossum, Handegård, & Drugli, 2017), England (Ford et al., 2018), and the United States (Reinke, Herman, Dong, in press). 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 for enhancing parents' involvement in their children's education (Reinke et al., 2014). A study comparing combinations of Incredible Years parent, teacher, and child programs found that combining either teacher or child intervention with Basic program parent training resulted in enhanced improvements in classroom behaviors as well as more positive parent involvement in children's education (Webster-Stratton et al., 2004). Pidano and Allen (2015) identified two additional independent studies in the United States that combined IY-TCM with PT, both of which reported positive results for child behavior.

The Pidano and Allen (2015) review of independent evidence highlights the need for more RCTs with the child programs and the newer parent and teacher programs (attentive, autism, baby, and incredible beginnings). However, given current interest in early intervention and potential cost savings later in life, there has been a pull for evaluations of the Incredible Years baby and toddler programs. The authors of this chapter are aware of at least four ongoing European studies in Denmark, England, Ireland, and Norway evaluating the baby, or baby and toddler, programs (Bywater et al., 2016; McGilloway et al., 2014; Pontoppidan, 2015).

More longitudinal studies are also needed; however, comparative longitudinal studies are rare, as intervention studies typically employ a waitlist control design in which all trial participants receive the intervention but do so 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 Incredible Years 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 Incredible Years baby book followed by attendance in the baby and then toddler programs, depending on levels of parent well-being (a strong factor in the development of child well-being 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 that those that need less intervention 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. Incredible Years 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 U.K. research (Little et al., 2012) demonstrates that independently observed high fidelity in Incredible Years Basic delivery translates to improved family outcomes.

Both of these studies implemented the programs in more than one language, using either translators or bilingual or multilingual facilitators, in very different contexts (semirural Wales, with a total population of approximately 3 million across Wales vs. 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 those conducted in Portugal, Norway, and the Netherlands that delivery in different contexts or 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, Orobio de Castro, & Matthys, 2013). Durlak and DuPre (2008) reviewed 50 Incredible Years 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 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 that the content and pace of programs accurately reflect 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 a greater number of sessions for parents with highly 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 have been tailored to accommodate the participants' specific learning needs. Examples in which the Incredible Years Basic parent program has been tailored or accommodated to population needs, without changes being made to the core components of the program, include a randomized study with foster carers in the United Kingdom (Bywater et al., 2011) and a study with parents of children with ADHD in Portugal (Azevedo et al., 2014). 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, experience, and interest) and motivated group leaders receive 3 days of training by accredited mentors before leading their first group of parents, teachers, or children. Then, it is highly recommended that they continue with ongoing consultation with Incredible Years 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 coleader 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 Incredible Years coach or mentor.

In line with this advice, Incredible Years parent group leaders in United Kingdom, Norway, Spain, Ireland, and Portugal 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 program. The process of group leader accreditation involves the leadership of at least two complete groups with greater than 80% attendance, 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 (e.g., 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 Incredible Years trainers, mentors, and coaches (of which there are currently 8, 63, and 52, respectively) who meet annually to learn about new research and share videos of their groups, workshops, and coaching methods. An RCT found that providing group leaders with ongoing consultation and coaching following the 3-day workshop led 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 Incredible Years programs with fidelity see Webster-Stratton & McCoy, 2015).

CONCLUSIONS AND FUTURE DIRECTIONS FOR RESEARCH

The Incredible Years series is transportable, with robust evidence demonstrating positive outcomes for children, families, and teachers in the short, medium, and long term. The programs can be delivered as stand-alone programs or in combination, and they are suitable for early intervention, prevention, or treatment models to suit a variety of needs, populations, and service delivery organizations. Research has been conducted by independent researchers as well as the series 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 the Incredible Years Advance program, child program, teacher 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. The newest Incredible Years parent programs (baby, attentive parenting, and autism) and the new teacher programs (Incredible Beginnings and Helping Preschool Children with Autism) are also in need of RCTs to determine their effectiveness. In addition to exploring stand-alone programs or combinations of programs across modalities (teacher, parent, child), there is a need to explore the longitudinal benefits of receiving stacked parenting interventions so that parents, especially families referred by child welfare, receive support through every developmental stage that their child encounters. Alternative designs could include trials within cohort studies (TWiCS), a model that will be used to test a variety of interventions (including parent interventions) in Bradford, England as part of a £49 million project supported by the Big Lottery Fund to enhance outcomes for children aged 0 to 3 years (Dickerson et al., 2016).

At a time when the efficient management of human and economic resources is crucial, the availability of evidence-based programs for parents and teachers should form part of the public health mission. While the Incredible Years 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 services and organizational funding has sometimes led to the programs being delivered by group leaders without adequate training, support, coaching and consultation, agency monitoring, or assessment of outcomes. Frequently, the programs have been sliced and diced and components dropped in order to offer the program at a level that can be funded. Few agencies support their group leaders becoming 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 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; 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 among 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 child conduct disorder and the promotion of responsive parenting and children's optimal social and emotional well-being and school readiness rely on a combination of key ingredients, including

1. an integrated, multiagency, multimodal approach;
2. the scaling up of evidence-based universal and targeted early interventions;
3. careful attention paid to identification of at risk populations; and
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 ODD, conduct problems, and attention deficit disorder.

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Innovation of Incredible Years: Where we have been and where do we go from here?
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Draft not for distribution

Chapter for book Designing Effective Prevention and Public Health Programs: Expert Program Developers Explain the Science and the Art edited by Mark Feinberg.

The Incredible Years (IY) Series developer reviews the rationale and theories underlying the framework structure, content, methods, processes and rationale for the development of the Incredible Years Parent, Teacher and Child Programs. She discusses her early personal and professional experiences leading to her passion to develop, evaluate and continue to refine cost-effective, group-based video-based intervention programs for supporting parents of young children (birth to 12 years) in parenting strategies that strengthen their children's social, emotional, language and academic development as well as prevent child abuse and neglect and treat child conduct problems. Based on the first decade of her research and experiential lessons learned from working with parents she takes this learning further to develop and evaluate new video-based programs for training teachers and children in order to expand the impact and breadth of outcomes to a variety of populations such as children with conduct and internalizing problems, ADHD, developmental delays and autism as well as higher risk populations due to poverty and new immigrant status. Once the evidence based for these programs had been established she then explores a parallel training process of using group-based video modeling, role play practice and experiential learning, support and collaborative methods for training and certifying IY clinicians, coaches and mentors and ensuring that the programs are delivered with fidelity within agencies.

Innovation of Incredible Years: Where we have been and where do we go from here?

Starting Point

At this late stage in my career I am often asked, "What prompted you to develop the Incredible Years (IY) programs 40 years ago? What was your motivation for the collaborative group and video mediated methods you used in your intervention programs to change parent, teacher, and child behaviors? Why did you choose a research career?" As I look back now on my life journey, I confess there never was a master plan to become an academic professor, or to develop a business training others. Rather just the opposite, my primary goal was to become a better clinician to help families and children. The growth and development of the IY programs seems to have come about because of personal experiences, a particular passion, research studies, collective action, and ultimately a measure of serendipity.

Development of a Strategy and Theory of Change ~ Historical Roots

I believe that my love of children must have arisen from my 15 years of summers at a YMCA camp in Ontario both as a camper and then as a counselor. Modeling theory would also suggest that I was motivated to try to bring about positive change in children's lives in part because my father was a model mentor for innovation, always working to make things better and accepting of the benefits of technology. In 1950 he filed a patent for the O'Cedar sponge mop that he designed so women could stand while cleaning the floor, rather than be on their hands and knees. He encouraged my passion for photography, as I joined him in his dark room printing black and white photos from film and later processing pictures in Photoshop and printing in digital format. I am told by my parents that even as a baby I was fascinated by observing people as apparently my favorite activity was being tied up on the clothes line or put in my pram outside (regardless of temperature) to watch people. As a teenager I loved taking pictures of people and still love sharing my picture heaving travel blogs with friends. Ultimately my photography and video obsession resulted in my developing video-based intervention programs for parents, teachers, and children, evaluating treatment outcomes via video observations, and using video to assess clinician intervention sessions and trainer workshop effectiveness. My early experiences working in a dark room with film progressed to reproduction of digital pictures via the computer and taught me to expect change and to learn from it.

Several key mentors in my early 20's influenced my philosophy of helping others and my theory of how people might be motivated to change their habits. After completing my training as a nurse at the University of Toronto, I worked in Sierra Leona, Africa with an African physician. The goal was for me was to train local people with at least 3rd grade education to help pregnant women eat healthier food and to breast feed rather than bottle feed.

While teaching women to eat more nutritious foods to increase their babies' healthy birth weights seems like a goal that mothers would embrace, I found my advice was resisted or ignored. I had brought a generator with me so that I could show slides of people eating healthy foods and urinating in designated spots (so as to prevent schistosomiasis). This slide show seemed like magic to the African people as they had not previously seen what photographic images came from cameras, so while my teaching efforts didn't change behavior it did provide good entertainment. Before long I learned that the reason that these mothers didn't eat much during pregnancy was because they would have big babies that they could not deliver due to Rickets and flattened pelvises. This in turn lead to serious tears and fistulas that could not be surgically fixed. I also learned that mothers bottle fed rather than breast fed because powdered milk was being sent to them from America and they believed it was the more modern way. Moreover, the idea of walking a mile from a rice field to urinate in a hole was completely unrealistic. From this experience, I learned to ask parents about their own goals for their lives, to understand their individual circumstances, and to explore the reasons for their decisions. Moreover, this wise, African physician mentor whose father was the local paramount chief helped me understand the importance of respecting culture, community involvement and being collaborative while integrating modern medicine and concepts alongside traditional approaches. He had set up a local board of 20 paramount chiefs from nearby villages who would send out via drums (a precursor to emails) some of my recommendations about healthy life style concepts, including the value of breast feeding. Traditional African shamans were always included in helping treat patients alongside modern medicine. It became clear to me that the motivation for behavior change comes about not as a result of telling others what to do, but from a collaborative, experiential, and culturally sensitive relationship between families, communities and clinicians.

My subsequent Yale graduate school experiences while becoming a pediatric nurse-practitioner (PNP) and obtaining a degree in public health involved a master's theses where I evaluated delivery of modern medicine to the Cree and Ojibwa First Nation people living on an island in Hudson Bay, Ontario. As the only non-native person on the island, I found pregnant mothers hiding for fear of being sent south by plane to deliver their babies in hospital. They preferred to have their babies in their own tents with women around them and were terrified of modern delivery rooms and the method of delivering babies with their legs in the air. I met a Cree man who having had polio and given leg braces had discarded them due to their weight and difficulty geting into his canoe. Again it seemed modern methods were being imposed without understanding the culture and values of the families. Subsequently I received a summer grant to interview Navajo women about their parenting methods and for two years as a PNP with Tlingit, Haida, and Tsimshian people in Alaska. Part of the time I was the "toy library lady" bringing in different toys on home visits to teach parents how to stimulate child development through play. I became convinced that "talking therapy" alone was not enough for parent behavior to change; I felt that change needed to be experiential, collaborative, culturally sensitive and supported by a strong and trusting relationship with the clinician.

Dr. Kate Kogan was my third important mentor during my graduate doctoral studies in educational psychology. She had been trained by Connie Hanf (1973) to use the "bug-in-the ear" video feedback and coaching methods with parents who had children with developmental delays. Her research outcomes were compelling (Kogan & Gordon, 1975). My voluntary work with her re-ignited my earlier photographic passion. I was convinced that videotape and performance methods could be a more valuable therapeutic and teaching tool than verbal cognitive approaches. I recall vividly the very first parent I worked with having a dramatic effect on me. After showing her edited tape of her interactions with her child she started to cry. She said, "*I have always seen my mother as very critical but have never seen the same behavior in myself."* Seeing the video of herself set the stage for a self-reflective process of emotion and behavior change. While I was entranced with the idea of using video feedback and bug-in-the ear coaching methods as a therapeutic tool with families, I realized that this personalized method was costly and time consuming involving hours of editing and wouldn't meet the needs of increasing numbers of parents wanting help managing their children's misbehaviors. I wondered if parents could learn from watching standardized videotape vignettes of other parents managing common behavior problems and whether this learning could happen in a group format. There was considerable skepticism and disbelief that this more impersonal group and collaborative parent approach without individualized parent-child play coaching would work to change parent behavior. To test this idea, for my doctoral study research I developed a standardized video-based parent program based on the videos I had filmed from my bug-in-the-ear parent experiences. With this 4 week, 2-hour session program I conducted my first randomized control group study to evaluate the effectiveness of such an approach for improving parent-child interactions and reducing behavior problems. I hypothesized the parents would learn more through videotape modeling, group discussion and home practices with their children than from verbal-based lecture approaches, which were common at that time. I believed that offering the program in the form of video vignettes designed to trigger self-reflection, group problem solving, and practices would be more cost effective and would provide often isolated and stigmatized parents with much needed support. The program initially targeted parents of young children (ages 3 to 6 years) exhibiting disruptive behavior problems with the following short term goals:

improve parent-child relationships, replace harsh discipline with proactive discipline, improve parent-teacher partnerships, and increase parent support. I hypothesized that targeting these parenting changes when children were young would lead to improved children's social competence, emotional regulation, school readiness, and prevention of social and emotional problems. The long-term goals were to prevent the development of conduct disorders, peer rejection, academic failure, delinquency, and substance abuse.

Creating Content

The basic parent content that was the underpinning of the video vignettes I developed for the first Incredible Years parent programs came from the research of theoretical giants of the 1970's including cognitive social learning theories about the development of antisocial behaviors in children (Patterson, Reid, & Dishion, 1992). Their theory of change focused on breaking the negative, coercive parent-child cycle by teaching parents proactive discipline methods. The parent content related to different children's developmental milestones was derived from Piaget's developmental cognitive stages and interactive learning methods (Piaget & Inhelder, 1962). The impetus for developing content related to building positive parent-child relationships came from attachment theories such as Ainsworth and Bowlby (Ainsworth, 1974; Bowlby, 1980). Finally, the cognitive strategies for challenging angry and depressive self-talk, and the importance of developing support systems came from Beck's research (1979) amongst others.

My first step was to take my theoretical understanding and put the IY content framework and sequence together. At the time there was some belief that parents should begin training by learning discipline (aka punishment) to manage their children's aggressive behavior because this was parents' primary goal; however, based on my earlier experiences, I felt that encouraging more positive parent-child interactions and relationships would be the necessary foundation for eventual behavior change. From Hanf's child-directed play concepts and my prior play therapy experiences, I developed content related to coaching language known as *descriptive commenting* that involved describing children's actions as if to a person who could not see the child. Based on subsequent studies and my experiences with parents and children with conduct problems who had language delays, emotional regulation difficulties and social skills deficits who targeted the specified positive child behaviors they wanted to see more of, I expanded this descriptive commenting to include 2 other types of coaching known as *social coaching and emotion coaching*. Social coaching includes using descriptive language for the child's social behaviors: "You just shared those blocks with your sister," and emotion coaching includes describing the child's feelings, "You look so proud of your picture. I saw that you worked hard on it!" These two coaching methods also include teaching parents to model and prompt social behaviors and emotional states in a non-directive way. Social and emotion modeling examples by the parent include: *"I'm going to be your friend and share my cars with you." Or, "I'm feeling frustrated, but I'm going to take a deep breath and try again to put the puzzle together."* Parent prompting examples include: *"If you want a turn, you can say: 'can I have a turn, please?'" or "I can see that you're angry. I bet you can stay calm and take a deep breath."* A few years later after working with children with ADHD (about 40% of our sample of children with diagnoses of Oppositional Defiant disorder also had ADHD symptoms), I expanded the coaching methods further to include *persistence coaching* in an effort to help parents understand how they could promote children's focus and ability to persist, stay calm and self-regulate when distracted or frustrated or bored. Parent persistent coaching examples include, *"That's a hard problem, but you are really sticking with it." Or, "I can see that didn't work the first time you tried it, but you are staying patient and trying again to figure it out. I think you are going to figure it out."* These highly refined child-directed coaching approaches plus the addition of commonly used strategies such as labeled praise and rewards morphed from an original 2 session dissertation project on this topic to nine 2-hour sessions. Today this comprises the first 50% of the Incredible Years Basic Parent Program content. It seemed clear from the weekly session parent evaluations and initial research outcomes that this foundational coaching and relationship work strengthened many of the children's positive behaviors and self-regulation skills that served to replace their inappropriate, impulsive behaviors and resulted in more positive child outcomes. This positive attention, in turn, rewarded the children's continued use of these positive approaches, reduced parents' use of negative or critical parenting and enhanced parent-child attachment. In subsequent years using these coaching methods with new immigrant families and other cultural groups, the descriptive commenting and coaching methods were expanded further to assure that ELL parents understood that they could describe and coach adding a second language to assist children with bilingualism. Moreover, I found that children often shared more when their parents spoke their own language and when they engaged in fantasy play utilizing pretend characters and puppets than when they would share without a puppet. This resulted in expanding training so that parents understood the importance of pretend play and using puppets or toy characters to model and prompt social, emotion and persistence strategies. For example, a parent using a puppet could share with the child during play his feelings of sadness that his dog died, or disappointment his friend wouldn't play with him, or happiness he was

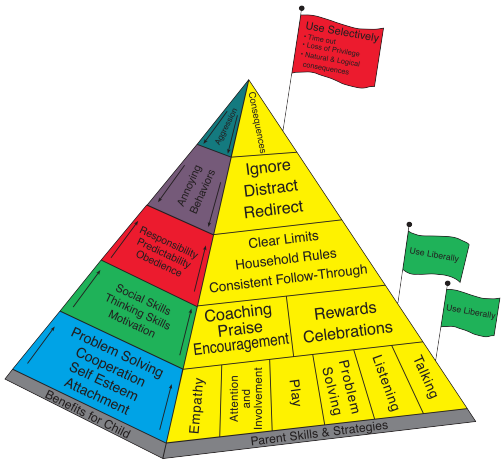
learning to read in order to open up the opportunity for the child to talk about similar feelings. Since many childrens' conduct problems are a manifestation of single or multiple traumatic family life experiences, the parents use of puppets or pretend characters to bring up common trauma themes or life events similar to what their children may have experienced was a way to open up difficult communication between them at a safe and relaxed time.

Contrary to some parent programs available at the time I felt it was not necessary for parents to achieve mastery in the coaching or praise concepts before moving on to the content related to decreasing child behaviors parents wanted to see less of as these foundational relationship principles were always referred to and strengthened in subsequent sessions as part of the collaborative learning process. I remember saying frequently, "*we never master parenting, but keep learning ourselves and adjust as our children develop new skills or new problems*". The 2nd half of the parent program content was focused on establishing consistent household rules, effective limit setting and appropriate responses to misbehaviors. It was apparent from our interviews with parents that often homes had no clear routines or rules and limits were either non-existent (permissive) or overly coercive and controlling (authoritarian). Based on the work of Baumrind's *authoritative parenting* (1966) I felt it was important to help parents understand how to achieve a balance of power with clear and simple household rules, developmentally appropriate limits and regular routines along side respectful, nurturing and empathic responses before using discipline methods. This parent goal in itself often resulted in improved child behavior. Next I added content strategies to manage misbehavior starting with the least intrusive methods such as distraction, redirection, and planned ignoring for toddlers followed by similar approaches plus some other consequences for preschoolers and school age children. I first learned about a Time Out procedure at an APA parent training workshop in the 80's. This approach taught parents how to keep children who wouldn't stay in Time Out by hitting them with a 2-inch dowel rod. However, intuition, modeling and attachment relationship theory convinced me this was not a method I wanted to employ in this way. Instead my Time Out approach was taught not as a punishment, nor were children ever restrained in Time Out but this method was used as a respectful way to teach children how to calm down as well as to remove parent attention which may have been reinforcing their negative behaviors. This approach was only used for children over age three and usually tailored for children with developmental delays such as children with ADHD or with poor attachment with their caregiver because of prior trauma until the foundational nurturing relationship was firm. This approach was further refined to have children learn and practice how to take a Time Out to calm down before parents actually used it. This Time Out refinement came about after visiting a friend who wanted help disciplining her 3 boys who were constantly fighting. I was showing her the Time Out video vignettes, and her boys came in and asked to watch. This resulted in a family discussion at a time when they were calm and receptive to this information followed by a practice with them in using Time Out to calm down. Since they were sports fanatics the idea of Time Out appealed to them. Later on that weekend visit when one of the boys hit his brother and was sent to Time Out, he went without resistance. I was convinced this worked well because of the prior teaching and practice of the procedure with the children. Subsequent to this unplanned personal experience, I incorporated teaching children how to take a Time Out to calm down as a standard part of our Time Out training for parents, teachers and children. I developed new vignettes showing how parents can explain Time Out to calm down to their children (at times when they were calm) and then how to practice this with them using positive self-talk, deep breathing and imagery. Parents also learned to use a turtle puppet to explain to children how to use "turtle power by withdrawing into their shell and coming down before trying again to solve a problem. Later when the Incredible Years Child Dinosaur program was developed and children practiced Time Out in the first child group sessions, I found that this approach enhanced not only therapists' success with the approach with children but also parents in the parent group reported being more successful using this method at home. In a recent doctoral dissertation (Houlihan, 2013) of the IY child program when children were interviewed they said they found Time Out was a safe place to calm down and then try again. In our clinic often parents would tell us that their children actually reminded them of the rules for taking Time Out.

The decision to incorporate beginning problem solving skills as the last content training component for preschool and school age children (not for toddlers) was made to be sure that parents first had developed a positive relationship with their child as well as confidence in their limit setting and discipline approaches. When this is in place children will already have developed some positive social skills and emotion management strategies so as to be able to engage in problem solving discussions and come up with possible appropriate solutions.

A decade later after delivering and researching the Child Dinosaur Curriculum, which heavily relied on therapists' use of large, child-size puppets (Wally Problem Solver) to help with the teaching of children, we began to incorporate more teaching of parents in how to use puppets, imaginary toy characters and pretend play to model social skills such as helping, sharing, taking turns, and complimenting and well as to demonstrate empathy and emotional language, as well as how to use puppets to teach children problem solving strategies. Parents learned to use puppets to help children talk about feelings, practice self-regulation strategies such as deep breathing, positive

imagery, positive self-talk, muscle relaxation and managing traumatic situations. I developed a series of children's books called *Wally's Detective Books for Solving Problems at Home and at School* (e.g., death of a cat, feeling blamed or left out, lying, reacting to mother's crying, being afraid of staying overnight, fear of dad's anger, losing something etc.). These books presented many common child problem scenarios at home and at school and prompted parents and children to talk about how to solve the problems. After parents read a problem scenario to the child and discussed possible solutions, then using puppets together they practiced acting out possible solutions. After engaging in this fun play activity they can look to the back of the book and see what solutions Wally (one of our puppets) came up with. I recall using Molly Manners, a puppet in Dinosaur School who strategically shared a problem one of the children in the group had, that she had stolen her friend's Barbie doll and needed help solving the problem. The girl in the group responded by saying, "I once had that problem" and then taught Molly how she could be honest with her friend and demonstrated how she would confess and apologize. This approach of using puppets to share problems that mirror children's lives and then encouraging children to help the puppets to find and practice solutions is a powerful method of engaging children in learning problem solving methods, dealing with stressful experiences and developing language skills as they develop their own story solutions. Even for children past the the preoperational stage of cognitive development (3-6 years), who understand that puppets aren't real are still motivated to engage in this imaginary phase of cognitive development enjoy playing being "detectives" and role playing solutions to the hypothetical problems. Moreover, engaging in a child's imaginary world creates an intimate bond and a high level of trust between the parent and child. About ten years ago I recall a boy in our ADHD study who also had Autism who had to be taken out of the child group because he was overstimulated by the noise and hyperactivity in the room. I worked with him individually with my Wally puppet and discovered he had much more language, empathy and social skills than I ever had observed in the child group. This convinced me of the importance for training parents in using puppets not only for children on the autism spectrum but also for children with behavioral problems. In fact, our recent work in the past 3- 4 years with the autism parent program has resulted in expanding our BASIC program to include not only more puppet use and pretend play but also use of songs, more nonverbal gestures, games and visual prompts. This is especially emphasized in the treatment protocol and for higher risk populations.

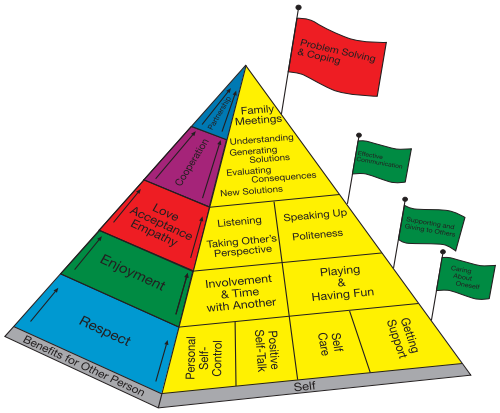


Parenting Pyramid®

The Incredible Years

This content sequence, first developed in 1980 but used in a less complex way in my doctoral dissertation, formed the essential elements and sequence of the Incredible Years parenting pyramid content (see parent pyramid) to become the bedrock of the current Incredible Years Parent Program as well as the IY teacher and child programs which are based on the same principles taught to different audiences. See review paper for this research on the BASIC program (Menting, Orobio de Castro, & Matthys, 2013) .

Through my work with parents of children with conduct problems and ADHD, I became aware that content about parenting was necessary but not sufficient. Parents of these children were experiencing stress, marital discord, depression, isolation, poverty, trauma and interpersonal problems that interfered with their ability to parent effectively in calm and consistent ways. Almost a decade after developing the BASIC IY program, I developed the Advance program to address some of these additional risk factors with content focused on adult interpersonal factors such as cognitive stress and depression management, anger management, problem solving for parents and with teachers, building support networks, and teaching children to problem solve and to use self-regulation skills. Interestingly this program was developed after I had my own children and personally realized the impact of emotions on parenting skills. There were times when I intellectually knew I should ignore my child's misbehavior but could not because of my emotional response. Our research showed that the addition of the Advance program to the BASIC program led to significant improvements in parent and children's



Pyramid for Building Relationships

problem solving abilities (Webster-Stratton, 1994) and became one of the essential components of our treatment protocols for children with conduct problems and ADHD. Moreover, the trauma informed elements of Advance content began to be integrated into my revised versions of the BASIC treatment program manual including practice and buzz assignments regarding parent affect regulation and cognitive coping methods such as self-praise and rewards for achieving short term goals, positive self-talk, challenging negative self-talk, focused deep breathing, positive imagery and self-care. This parent approach was consistent modeling with the way we were teaching parents to use Time Out as a method for children to learn to calm down and self-regulate as well as for themselves.

Video Vignette Development

The truth is that I developed the idea for a group video-based program from personal experiences, intuition, a passion for photography and subsequently searched for theories that would validate my methodological approach. Fortunately, the rationale for the collaborative, modeling and self-reflective therapy methods I proposed could be found in Bandura's modeling and self-efficacy theory (Bandura, 1977, 1982). I was inspired to use video vignettes as a way to model and explore the benefits of positive parent-child responsive interactions, child-directed play, praise, coaching methods and discipline approaches as described above. Mediating the vignettes to trigger group discussions, problem-solving, exploration of potential barriers, and to set up coached practices allowed clinicians to tailor or individualize strategies to specific children or family situations as well as to strengthen parents' support networks with friends, family and teachers. Moreover, I discovered that video vignettes of parent-child interactions helped to normalize common parent traps and de-stigmatize their sense of failure as well as to help parents be more empathic to children's viewpoints, different developmental milestones and temperaments.

I began developing the child-directed play material in 1981 by filming hundreds of hours of parents and preschool children playing together. Originally I built a mock kitchen and living room studio set and filmed parents playing with their children with a series of toys I provided. There were no planned scripts as I understood from the theory of modeling that parents would be more likely to model parents who they perceived as natural, unrehearsed, and similar to themselves. Many of the parents were people who were friends or had been in my doctoral dissertation study and were interested in being taped in support other parents. I spent thousands of hours examining these tapes to find the 30-second to 1-minute vignettes that illustrated a point about responsive, child-directed play. Here intuition and my gut reaction eventually determined my choice of over 300 small video segments for the first parent program. I would describe this process as a bit like searching for love, you can't exactly define what you are looking for, but you know it when you see it. Originally my programs had contrasting examples of effective and ineffective vignettes of parent-child interactions but gradually I edited out many of the ineffective parent-child interaction strategies. I learned that the negative examples had a powerful effect on the parents, were often dysregulating for them, and were always the vignettes parents remembered the best. I wanted parents to have images of calm, patient, and loving parent-child interactions and not of parents yelling or criticizing their children for their misbehavior. Currently there are fewer negative interaction vignettes in the programs than earlier versions and those less effective vignettes are fairly typical and set up to allow parents to share and practice how to improve upon the interactions and to be compassionate toward the parent models and their efforts in order to normalize their responses. This process is empowering for the parents as they sometimes recognize themselves and learn a better way to manage a particular situation.

In later years when our large expensive cameras with fourteen-inch reels of 2-inch wide quad videotape film ($300 per one hour reel) became smaller, easier to use, and less expensive with the digital revolution, I was able to move the filming into parents' homes so that I could get more natural examples of mealtimes, getting dressed, toilet training, taking a bath, doing a chore, resisting going to bed or doing homework. For some programs I also was the 2nd camera person who did the close ups while the professional camera man would get the wide shots. I frequently felt I knew where the camera should be before my camera man did and this was likely because I knew what I was looking for. I developed many more vignettes than can be shown in a group session in order to give group leaders options to choose vignettes according to the specific group's ethnicity, age, gender and temperament of children. In recent years I also added vignettes of parents or teachers talking about their experiences in the IY parent program. This was valuable because it helped forecast parents' success with the program if they continued to use the strategies and showed how other parents had helped foster their children's social and emotional development.

Once I had put together a set of vignettes that demonstrated a specific concept such as emotional coaching, I then wrote narrations to proceed each set of vignettes. The narration's purpose was to review the main developmental, social, emotional, or behavioral principle and to focus the parents on what to watch for while viewing the vignette. I also felt a summary narration would assure that the information parents got was accurate, clear, and focused and would prevent groups or clinicians going off on other tangents unrelated to primary topic for

a particular session. In the leader manual I also suggested open-ended leader questions related to parent or child cognitions, behaviors or emotions for each of the vignettes. The objective was to keep the discussion focused on the key learning principles that the leader wanted the parents to discover and apply these to their individual goals in discussion and practices.

IY Processes and Methods Development

Once I developed the vignettes and key content, my next learning process was how clinicians could effectively mediate these vignettes to build on the strengths of the parents by inviting safe discussion, parent reflection, problem solving and parent discovery of the key principles as well as using them to trigger practices based on parents' unique goals for themselves and their children. In other words, what were the important clinical methods and processes underlying fidelity delivery of a video-based program? This included how clinicians should handle parents' resistance to new concepts, or vignettes, or suggestions to practice? How often should a clinician pause a video vignette to foster parent group discussions and discovery of important interaction principles, or to trigger a practice related to their individual goals for themselves and their children? How many vignettes should be shown in one session? How much time should be spent on video versus live modeling techniques, or discussion versus practice exercises in order to bring about change in parents' thoughts or feelings or behavioral patterns? What is the correct program dosage and how will the intervention protocols be different for prevention intervention versus treatment for children with diagnoses or higher risk populations? How can clinicians use the video vignettes to motivate parents to do the assigned home activities? How collaborative or prescriptive does the clinician leadership style needed to be? When would confrontation or direct teaching be useful? How can the clinician ensure training is culturally sensitive? How are individual family needs and goals addressed alongside overall group process and learning? What adaptations are made to the program for less educated parents, parents from different cultural backgrounds, or children with different developmental issues? How much attention is given to changing parents' thoughts and emotions and past experiences versus targeted behaviors? It became clear to me in watching hundreds of video hours of different clinicians delivering the program over many years that in addition to clinicians having adequate cognitive social learning and child development knowledge, clinician relationship characteristics (affect, warmth, humor, support, leadership) and having the clinically therapeutic and collaborative skills to promote the parent discovery process and to tailor the program principles to parents' goals with group practices was an important determinant of positive parent outcomes. As technology improved from early VHS machines where you could not "freeze" a vignette for discussion or skip vignettes to DVD format, vignettes could be used in more therapeutic and collaborative ways. The digital DVD revolution allowed me to develop menus so that clinicians could more easily choose the best vignettes for a particular group and could easily freeze vignettes for discussion, role plays and rewind to view again. Eventually I developed both a *parent group leader process checklist and a self- and peer evaluation form* as well as *session protocols* for treatment vs prevention program delivery. **(See web site http://www.incredibleyears.com/certification-gl/basic-program/.** I have written much about the IY collaborative process of developing group rules, tailoring to personal goals, mediating video vignettes, promoting self-reflection and self-monitoring, setting up group planned practices and spontaneous practices, implementing and reinforcing home practice experiences and enhancing group support (Webster-Stratton, 2012). Each session format starts with a benefits-barriers exercise that encourages parents to discuss their personal challenges to using the skills being taught as well as to explore the benefits for using them in terms of how they will help them achieve their goals. The discussions use a problem solving format, that is, identifying the problem, identifying the alternative positive opposite behavior, practicing possible solutions, reviewing barriers and how to overcome them and reviewing both short term and long term goals. I believe these methods and processes are key to participant's ability to make meaningful changes.

This lead to emphases on key IY relationship clinician strategies which are looked for when a clinician goes for certification. Here are the key roles:

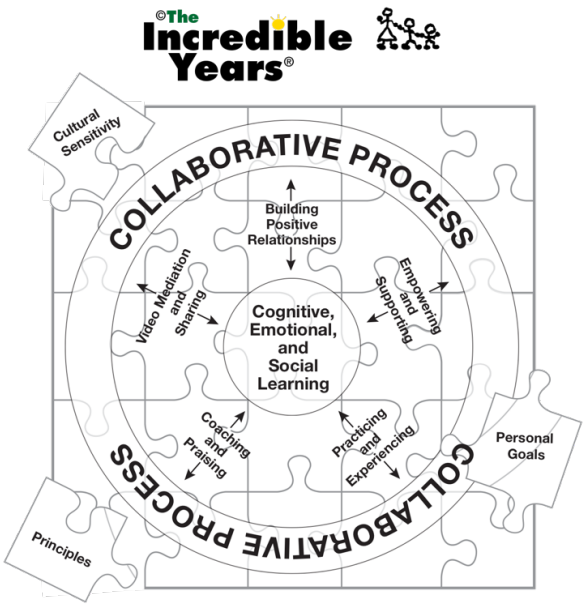
Clinician Role #1: Building positive and collaborative relationships through strategic self-disclosure, humor, optimism and encouragement, advocating, individual goal setting and weekly clinician phone calls.

Clinician Role #2: Empowering parents through praise and validation, modifying powerless thoughts, promoting self-empowerment, respecting and valuing cultural diversity.

Clinician Role #3: Building parents' support team through group support, parent buddy calls, family support.

Clinician Role #4: Using evidence-based teaching and learning methods such as explanation and persuasion, generalizing and contextualizing the learning process, principles training, tailoring the teaching process to individual parent's learning style, reviewing and summarizing, individual behavior support planning, weekly home activity practice assignments, weekly reading assignments, self-monitoring checklists, weekly evaluations and effective time management.

Clinician Role #5: Interpreting & changing parents' cognitions through the use of analogies and metaphors such the IY parent tool box, reframing parents' perspectives and cognitions, prophesizing positive success as well as resistance and setbacks and making connections to temperament styles and past experiences.
Clinician Role #6: Leading and challenging parents to stay focused, setting limits and sufficient group structure, pacing group learning depending on parents' prior knowledge and experience, dealing with resistance and helping parents evaluate the benefits and barriers of the skill the parents were learning.



The Incredible Years Collaborative Learning Process

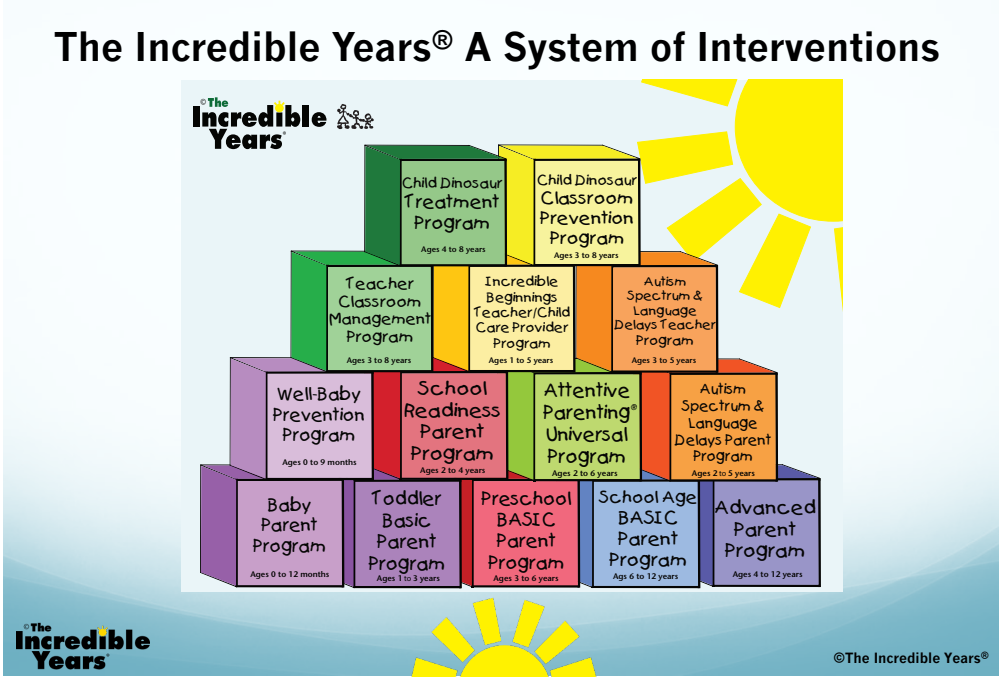
How Research Affected Incredible Years Ongoing Program Development

Throughout my 35-year career I continued to offer parent groups on a regular basis. This clinical work funded by my NIH grants to conduct randomized control group trials (RCTs) was the fuel that motivated me to revise and improve the IY programs because of the ongoing weekly session evaluations from parents and video reviews of our sessions. In addition, final summative parent evaluations plus parent and teacher reports on standardized measures and observations of parent-child interactions meant that I could find out what worked or didn't work to improve parent or child behaviors in comparison to wait-list control families. For example, one of my first studies focused on the value of using a video-based modeling group approach compared with the more personalized bug-in-the ear approach. Once this research revealed that the video-based modeling group approach was as good as the one-on-one approach but provided more social support, was more cost efficient, and actually resulted in more sustained results at 1-year follow-up (Webster-Stratton, 1984) I was committed to the group model as one of the core therapeutic IY methods. Subsequent research helped me understand other key components of program delivery and to tailor my interventions to include the most effective group methods, processes, and content.

Refining and Expanding

The IY Parent Program content emerged from the risk factor research and was designed to reduce the malleable family risk factors including ineffective parenting, harsh discipline, maternal depression, poor attachment, chronic neglect, marital discord, lack of support, and low parent involvement with teachers. It was also designed to increase protective factors such as responsive, nurturing parenting, positive thinking, problem solving and stress management, positive discipline and parent and teacher support networks. After 15 years of research exploring the best methods of training parents, it became clear that while the IY Parent programs could impact children's behavior at home, these changes at home did not necessarily generalize to classrooms or with peers. Consequently, the IY Teacher Classroom Management Program and Child Dinosaur Programs were developed to see if the addition of one or both of these programs could bring about more sustained changes in children's behaviors across settings. The

IY Teacher and Child Programs content focused on reducing school risk factors such as poor classroom management skills, poor social and emotional teaching, teacher stress, low parent involvement, and classroom aggression. Protective factors to be increased included teacher proactive teaching strategies, positive teacher-parent relationships, school support networks, and children's emotional regulation, positive friendships, effective problem solving, and school readiness skills. The underlying theory is that positive school experiences when children are young will strengthen children's social, emotional, and academic development and in the long term prevent the development of conduct disorders, peer rejection, academic failure, depression, delinquency and substance abuse. See web site for parent, teacher and child program objectives and content and research studies. http://www.incredibleyears.com/research-library/



Over three decades of research, The Incredible Years Series has become a system of interlocking interventions that use similar cognitive, emotional, and behavioral clinical methods to include parents, teachers, and children. All focus on the same key outcomes, but act through different channels and with different developmental foci. All the programs include the following methods: video and live modeling, group discussion and problem solving, short- and long-term goal setting, experiential practice exercises in the group and at home, promoting cognitive and emotional self-regulation and self-care and building support networks. This learning occurs in a collaborative, reflective, and supportive atmosphere where teachers, parents and children are encouraged to "discover" the solutions and builds on their strengths and experiences. The programs can be used independently, but research suggests that for diagnosed children and high-risk families, the effects are additive when used in combination. Each of the programs is thematically consistent, includes the same theoretical underpinnings, and is based on the developmental milestones for each age stage. There are a minimum number of sessions required but clinicians are encouraged to expand on the number of sessions according to group needs. The treatment protocols are longer than the prevention protocols in order to allow more time for individualization, enhanced practices and showing more vignettes.

New DVDs and curriculum programs and training videos have continued to be refined and created for different populations. For example, the parent program now has 4 different versions for distinct developmental ages from infants to preteens. I found parent groups covering parenting for children ranging in age from toddler to pre-adolescent often resulted in confused parents using developmentally inappropriate parenting strategies such as trying to problem solve with a toddler or failure to understand how to promote family responsibility in a school age child. It was important that parents understood the developmental milestone for each age group. I also developed a shorter, universal parent intervention program designed for all parents of children 2-6 years (Attentive Parenting), a new program for day care providers and preschool teachers working with younger children (1-2 & 3-5 years) (Incredible

Beginnings) and two new programs for parents and teachers working with young children on the autism spectrum (2-5 years).

Making the Decision to Disseminate ~ Challenges and Successes

Because I had originally funded the filming, editing, and video production program costs with personal funds and not as a university employee, I retained full ownership, copyright and trademark for the IY program. In 1987 I had a contract with the university that acknowledged this ownership and permitted me to use the programs for training and grant research purposes and outlined that all further work related to marketing, trainings, and further product development would be done at my own expense outside of the university. Up until my retirement (2011) I submitted financial disclosure forms yearly and participated in ongoing reviews regarding potential conflict of interest.

Eighteen years after publication of my first study with the parent program, I began to be contacted for information about obtaining program materials and training possibilities. Largely these requests came from countries such as UK, Norway, Denmark, New Zealand, and the Netherlands who had reviewed the research evidence and were interested in both delivering the IY programs as well as researching their effectiveness for use in their population. This upsurge in interest from others combined with reduced grant funding led to my decision to start an independent business to disseminate the programs. This was not in my career plan but would allow me to fulfill my goal of helping others deliver the IY programs with fidelity! I began by hiring an administrator to answer requests and set up training workshops as well as staff to help design manuals and further develop training materials. A few years later, when my NIMH Research Scientist Award ended, as a tenure-track professor I was faced with the decision of returning to a much heavier teaching load to justify my university salary, staying on research money myself but letting go of most of my clinical staff at the University Parenting Clinic, or making an increased commitment on my own to dissemination. I decided to give up half my tenure salary and reduce my time at the university. My career then consisted of half-time research at the university and the other half time engaged in disseminating the Incredible Years Programs with the goal of improving training materials and intervention protocols, training other clinicians in program delivery and consulting with others doing research with IY programs.

Having spent three decades as the developer of the Incredible Years series researching, redesigning, adapting, and expanding comprehensive clinician manuals, video vignettes and protocols, I believed we had the tools to begin disseminating the Incredible Years Programs. I thought it would be easy for clinicians to deliver the IY programs with fidelity because of the use of videos, comprehensive manuals, parent, teacher and child books, and clear session protocols. At that time, it was unclear to me whether clinicians would even need training because I believed everything was clearly articulated in the videos, leader manuals and protocols. Moreover, we had videos of sample group sessions designed to model and show clinicians how to deliver the programs. However, I quickly learned that developing an evidence-based program is only the first of many foundational steps needed to construct a quality and stable program. It was clear from my video reviews of clinician group sessions than neither the videos or workshops alone were sufficient to promote fidelity delivery. Clinicians needed help understanding how to tailor the discussions and learning to individualize key management principles to parents' and teachers' settings, goals, and cultural context as well as children's development level and diagnoses. I also had much to learn about overcoming the agency barriers involved in implementing an evidence-based program as well as the difficulties of bringing about changes in clinician cognitions, emotions and behaviors and resistance to a protocol-driven group approach. This real-world experience led to a successful grant application to study ways to promote clinician fidelity delivery of the IY programs. The results of this study revealed the added benefits of ongoing coaching and support for clinicians after their initial training workshops as well as training to help agency administrators understand how to support their clinicians to achieve certification (Webster-Stratton, Reid, & Marsenich, 2014). As I learned from our work with parents, for clinicians to change their clinical approach from an individual perspective to a group collaborative video-modeling experiential evidence-based program, ongoing consultation and support would be needed not just a workshop. When my last research grant was not funded, I retired from the university to pursue the dissemination journey in more depth by providing quality training and consultation by certified trainers and mentors and promoting fidelity delivery of the programs through the certification/accreditation process.

Lessons learned

As the developer of an evidence-based program (EBP) I did not understand that I would need to do more than develop the most important content and processes for program delivery and show positive research results. This was perhaps the easiest part. I found it was also necessary to develop a comprehensive training process including ongoing support and consultation for the clinicians as well as for the administrators. The metaphor I use for developing and scaling up an EBP is that it is like building a house where there must be an architect (program

developer) who takes advantage of changing technology and collaborates with the family as to their traditions, needs and goals, a committed contractor who monitors quality of building structure (agency administrator), onsite project managers to support and train construction builders (mentors and coaches) and a well-trained team of construction builders (clinicians). If there are barriers to any of these links the building will not be sound. For example, when there are agency and clinician barriers to disseminating evidence-based programs, it is as if the contractors hired electricians and plumbers who were not certified, disregarded the architectural plan and used poor quality, cheaper materials. Under these conditions, everyone would agree the building will not be structurally sound. Just like building a stable house, it is important that the foundation and basic structure for delivering evidence-based programs be strong. This includes careful agency program selection, support for clinicians, agency/administrative buy-in, and adequate funding. With a supportive infrastructure surrounding the program delivery, initial investments will eventually pay off in terms of strong outcomes and a sustainable intervention program that can withstand staffing and administrative changes.

The Incredible Years Program Training Series has been set up with a supportive infrastructure of 8 building blocks designed to promote program fidelity. These include accredited IY trainers, mentors and coaches, and an accreditation/ certification procedure that assures that the architectural plan is adhered to and that strong supportive scaffolding is provided for clinicians. One of the strengths of the IY series has been the attention given to fidelity adherence and certification/accreditation. For more information about how to scale up the IY programs slowly and carefully with fidelity be engaging in a collaborative project with strong links between the developer, agency administrator, trainers, mentors, coaches, clinicians, teachers and families using 8 key foundational building blocks or fidelity tools see the following article (Webster-Stratton & McCoy, 2015).

Successful Implementations

The Incredible Years Series is now widely used in 18 countries. Currently there are 8 accredited trainers, 75 mentors, and 110 peer coaches providing training and support to IY clinicians. Over the past 10-12 years these countries have trained a substantial number of clinicians who are offering the programs in a variety of settings including Head Start, Sure Start, and primary grade schools, primary care doctor's offices, mental health centers, community health centers, jails, families' homes, YMCA, homeless shelters, private practices, and businesses. Professionals such as nurses, doctors, social workers, psychologists, teachers, and community mental health works have targeted not only parents and teachers for this training but also foster parents, day care workers, teen parents, and early childhood teachers. The programs have been delivered with fidelity on small and large scales in a variety of settings. These successful implementation models all share the common features of agency, state, or government financial support and one or more staff members who developed a strong interest and passion for advancing IY in that setting. These internal champions gradually developed expertise in IY, often conducted research evaluations with their population, shared information with colleagues, and developed a plan for rolling out the program over time. Although the detailed strategies described above may sound daunting to consider all at once, they provide organizations and countries with a roadmap to be revisited as an agency or states or countries gradually adopt and scale up IY programs. Moreover, through problem solving conversations with IY headquarters and the developer and trainer team, collaborative plans can be made to determine how to make IY uniquely fit in the context of a particular organization or country or state using the Incredible Years guidelines and principles described.

Lessons Learned and Next Steps

My experience scaling up IY has taught me that EBP development must be thought of as an ongoing building process rather than an endpoint. New data will continually emerge to inform real world clinical practice and each unique setting or environment can inform improvements or adaptations to the construction process and further research. For example, our work with child welfare referred families led us to expand the number of sessions needed for this population as well as to include the Advance program that focused on interpersonal problems such as depression, anger management, and problem solving and also to develop protocols for home-coaching sessions to supplement the group experience. Our experience working with a subsample of children in our studies with co-morbid ADHD and Autism Spectrum diagnoses led us to develop additional vignettes and programs to address these populations. Additionally, the IY Series implementation manuals (including handouts, books and resources given to participants) are constantly being updated with new research and feedback, video VHS technology has been replaced by DVDs and USBs and now includes more cultural diversity and languages, and even the suggested number of sessions has been expanded upon because of more complex and culturally diverse populations and children's different needs and also because of years of experiences and feedback from participants as to what they want help with. An important implication for prevention and dissemination science is understanding that effective programs continue to evolve and improve based on internal evaluation audits and feedback. As a parallel, consider

that the safety features of cars continuously improve. Few people, when given the option, would opt to drive the old model without the research proven safety additions. Gathering data on what works, eliciting ongoing feedback, and actively participating in the implementation of the intervention across a variety of contexts provides the needed information to improve interventions and meet the needs of broader culturally diverse populations.

Agencies charged with improving the well-being of children and families now have good options for selecting EBPs that are grounded in an extensive research base. The field has learned much about the necessary ingredients for successful transporting efficacious practices like IY into real world settings with diverse cultural populations. Some of the critical factors include selecting optimal clinicians to deliver the program; providing them with quality training workshops coupled with ongoing supportive mentoring and consultation, on-site peer and administrative support; facilitative supports; and ongoing program evaluation and monitoring of program dissemination fidelity. At the same time, it has become clear to me that successful development and implementation of evidence-based programs, requires a serious sustained commitment of personnel and resources. After almost four decades of working at providing research evidence to justify the use of these programs I can see that whether you are trying to change parent, or teacher, or therapist behaviors, or agency administration and funding policies, bringing about change is not simple and requires a committed, persistent and collaborative team who believe change is possible and are not undaunted despite resistance. Moreover, I have also learned that technology such video is an important adjunct tool but not sufficient because in the end as I learned years ago in Africa it is the ongoing relationship building that is key to bring about innovative change. Only if we invest the resources in methods known to sustain high-quality evidence based practices can we be sure our building construction is solid and our time and efforts have not been wasted. My mother used to complain that I was always trying to change things. While that is true, I will tell you that I have had fun doing this and seeing the changes in children makes it well worth the effort.

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