
homeBase: Participation, Engagement, Alliance, and Social Validity of a Motivational Parenting Intervention

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This article examines the participation, engagement, alliance, and social validity of homeBase—a parent management intervention developed specifically to address parent engagement of elementary-level students. The intervention infuses motivational interviewing (MI) into its implementation procedures and trains behavioral coaches to use this approach as their primary interactive vehicle with parents. Process data from participants ($N = 120$) assigned to one of the two homeBase intervention conditions were examined to better understand the following dimensions: parental participation and engagement, coach–parent alliance, and the satisfaction of the homeBase intervention. Results indicate that parental participation was challenging in that 21 percent of the parents seemed unable to engage at all in the intervention. However, those who did participate were highly engaged and developed effective relationships with their coach. Parents perceived the homeBase intervention to be socially valid. There were also several interesting correlations among these measures that might potentially guide further research and practice. The authors recommend that school social work preparation programs and school districts consider including MI in curriculum and professional development efforts as a strategy for parental engagement.

KEY WORDS: *behavior disorders; family engagement; motivation; parent management training*

Childhood conduct problems and disruptive behavior disorders typically include oppositional, aggressive, and hyperactive forms of behavior and occur in as many as 15 percent to 20 percent of young children (Briggs-Gowan & Carter, 2008). Upward of 25 percent of these children come from socially disadvantaged backgrounds and contexts (Farrington & Welsh, 2007). When such challenging behaviors remain unaddressed early in childhood, they often persist across the life span and become predictive of negative life outcomes including school failure, substance abuse, poor employment, mental health problems, and criminality (Briggs-Gowan & Carter, 2008; Colman et al., 2009). Thus, early prevention of such problems has emerged as a high priority among school and community mental health providers, including school social workers, school psychologists, counselors, and behavior consultants (Posthumus, Raaijmakers, Maassen, Engeland, & Matthys, 2012).

It is well established that caregiving practices are associated with the development of challenging behavior in young children (Stormshak, Bierman,

McMahon, & Lengua, 2000). Research demonstrates that parenting practices mediate the link between risk factors such as child temperament, gender, level of aggression, socioeconomic disadvantage, and the likelihood of developing disruptive behavior disorders (Paulussen-Hoogbeem, Stams, Hermanns, Peetsma, & Van Den Wittenboer, 2008). In schools, supporting parents is a major component of school social work practice. For example, the national school social work practice model (Frey, Alvarez, et al., 2013) identifies evidence-based education, behavior, and mental health services, including those to support caregivers, as one of three practice features. In particular, Frey et al. (2016) identified school social workers' expertise in family work as unique among instructional support personnel.

The importance of caregiver behavior has stimulated vast amounts of research on interventions designed to improve parental attitudes and practices. These interventions, parent management training (PMT), are grounded in the Oregon model, developed in the 1960s based on the coercive family process work of Patterson, Reid, and

Dishion (1992). Several PMTs now exist that have produced impressive outcomes in both parent and child behavior, including (a) Incredible Years BASIC parent component (Reid, Webster-Stratton, & Baydar, 2004), (b) Parent-Child Interaction Therapy (Hood & Eyberg, 2003), (c) Triple P (Pearl, 2009), (d) Parents Plus Early Years (Gerber, Sharry, & Streek, 2016), and (e) the Family Check-Up (FCU) (Dishion & Stormshak, 2007). These programs represent decades of research demonstrating the empirical link between changes in parenting behavior and reductions in problematic child behavior along with increases in prosocial behavior.

Given the significance of positive parenting in school-based intervention, development of the homeBase intervention was partially a response to the well-documented challenge of engaging parents in PMT interventions (Eames, Daley, & Hutchings, 2009; Frey, Lee, et al., 2013). Our focus on parent engagement and motivation to change parenting practices complements PMT interventions, whose initial development was informed by social learning theory and applied behavior analysis. Our approach to parent engagement works to increase home and school collaboration across a mutually shared set of values, which are supported in the literature. Our efforts to enhance parents' desire to and confidence in changing their parenting practices, similar to the FCU intervention, stem from motivational interviewing (MI) (Miller & Rollnick, 2012), which emphasizes the parent's own goals, desires for change, and aspirations for their children's future.

The purpose of this article is to describe, based on preliminary data from an ongoing trial of the homeBase program, the extent to which parents (a) participate in the intervention, (b) are engaged in implementing the intervention procedures, (c) form effective relationships with interventionists, and (d) report homeBase as socially valid.

METHOD

The purpose of the broader study in which this analysis took place was to determine the efficacy of the First Step Next (FSN) program (Walker et al., 2015) and the homeBase (Frey et al., 2015) intervention, originally a component of FSN, for improving social, behavioral, and academic outcomes for students with disruptive behavior problems in the elementary setting. We conducted the

research in Greater Clark County Schools (Clark County, Indiana) and Jefferson County Public Schools (Louisville, Kentucky). Children were screened using the Systematic Screening for Behavior Disorders (SSBD), rank ordering, and rating procedures (Walker, Severson, & Feil, 2014). Our screening procedures included the first two SSBD stages and an additional stage to ensure that social impairment had indeed occurred in the home setting. To be eligible for participation, children had to exceed SSBD stages 1 and 2 cutoff criteria, including the critical events index (CEI) or the number of major disruptive events by the child in a given period, and have a borderline clinically significant score (that is, $T > 60$) on the Externalizing subscale of the Child Behavior Checklist: Parent Report Form (CBCL) (Achenbach, 1991). Written informed consent was obtained from parents through home visits, and the study was conducted in compliance with the appropriate internal review boards. Research staff recruited one child from each participating classroom and randomly assigned them to one of the following groups: FSN and homeBase, FSN only, homeBase only, or a business-as-usual comparison group. This analysis was conducted on students who participated during the 2015–2016 and 2016–2017 school years and were assigned to the homeBase only or the FSN and homeBase conditions.

Procedures

Following randomization, parent and child demographic information was collected and interventions were delivered depending on the randomization. Following completion of the interventions, posttest data were collected. A description of the homeBase intervention and the measures used in this analysis are presented here.

homeBase. homeBase was developed between 2008 and 2012 and is a tier 2 early intervention targeting parents of young children with early onset behavior problems. Like the FCU (Dishion & Stormshak, 2007), MI was included in response to the persistent challenges practitioners and researchers faced in fully engaging parents in PMT interventions. The intervention is supervised by a behavioral coach and includes three to six 60-minute home visits over several months to increase parent motivation and capacity to implement effective parenting practices. During homeBase, parents are encouraged to reflect on and modify their

parenting practices consistent with the five universal principles of positive behavior support developed by Sprague and Golly (2013): (1) establish clear expectations for behavior, (2) directly teach the expectations, (3) reinforce display of the expectations, (4) minimize attention for minor inappropriate behaviors, and (5) establish clear consequences for unacceptable behavior. The *homeBase Resource Manual* (Frey, Walker, et al., 2013) provides support for implementation and can reasonably be implemented by a school practitioner with moderate or advanced MI skills. The manual includes primers for coach fidelity, a curriculum with procedural intervention guidelines, program integrity monitoring tools, and a troubleshooting guide to support implementation. The intervention steps are (a) engage in values discovery, (b) assess current practices, (c) share performance feedback, (d) offer extended consultation education and support, and (e) provide closure. Parent motivation is addressed throughout the homeBase procedures.

Measures. We examined data collected across two coach-reported postintervention measures and one parent-reported postintervention measure. Participation was measured using the homeBase Coach Checklist (see Frey et al., 2015), which was developed by the authors and pilot-tested in a previous study. It is completed by the coach throughout the intervention, with coaches indicating which of the four aforementioned steps parents have completed. Engagement was assessed using an 11-item coach-reported measure that assesses parent participation and engagement in the program, which is scored on a Likert scale. Item content measures parent motivation to participate, attentiveness and responsiveness to the program's techniques and strategies, and maintenance of communication ($\alpha = .94$).

Alliance was measured with a version of the Therapeutic Alliance Scale previously used in large-scale efficacy studies (Sumi et al., 2013; Walker et al., 2009). Coaches completed an eight-item measure scored on a five-point frequency scale (ranging from never to always) assessing their relationship with the parents participating in homeBase ($\alpha = .96$). Parents completed an 18-item measure, reporting on their working relationship with the coach ($\alpha = .95$). Parents also completed an 11-item satisfaction measure after participating in homeBase ($\alpha = .91$). Coaches also completed a five-

item measure assessing the effectiveness of homeBase (Frey et al., 2015) for the family with whom they were working ($\alpha = .90$).

RESULTS

Participants

Student demographics and screening and parent demographic characteristics are presented in Table 1. Students' average age was 6.8 years ($SD = 1.3$). Seventy percent of the participating students were male, and the majority were either African American (53 percent) or Caucasian (34 percent). Note also that the CEI and CBCL scores indicate a relatively serious level of disruptive behavior for the sample. Participating parents were 35.4 ($SD = 9.9$) years of age on average, predominantly female (85 percent), and mostly African American (54 percent) or Caucasian (41 percent). Seventy-three percent of participating parents reported being employed, and 35 percent reported annual incomes below the poverty line.

We obtained coach-reported data on all 120 participating families; however, coach-reported information on parent engagement and perceived alliance with the parent were fully available for 104 families (87 percent). We obtained parent-reported data on program satisfaction and their perceived alliance with the coach from 92 families (77 percent). We compared families from whom we collected postintervention data with those from whom we were unable to obtain postintervention data. There were no statistically significant differences between the two groups with respect to student and parent demographic variables.

homeBase Participation

Of the 120 families who received the homeBase intervention, 67 families (56 percent) completed three or more steps and were considered intervention completers. Twenty-eight families (23 percent) completed either one home visit (15 percent, $n = 18$) or two home visits (8 percent, $n = 10$) and were considered partial completers. Thus, in total, 95 families either partially or fully completed the homeBase intervention. The remaining 25 families (21 percent) did not complete step 1 and were therefore considered noncompleters. Table 1 compares the demographic characteristics of families who completed some or all of the homeBase steps with families who did not complete any steps. The two groups differed on one of nine child variables

Table 1: Demographic Equivalence of homeBase Completers and Partial Completers versus Noncompleters

Demographic Characteristic	homeBase			Test Statistic	<i>p</i>
	Total (<i>N</i> = 120)	Completers and Partial Completers (<i>n</i> = 95)	homeBase Noncompleters (<i>n</i> = 25)		
Child demographic and screening characteristics					
Age, <i>M</i> (<i>SD</i>)	6.8 (1.3)	6.8 (1.3)	6.6 (1.0)	0.24	.623
Female, <i>n</i> (%)	36 (30.0)	30 (31.6)	6 (24.0)	0.54	.462
African American, <i>n</i> (%)	63 (52.5)	46 (48.4)	17 (68.0)	3.04	.081
Caucasian, <i>n</i> (%)	41 (34.2)	34 (35.8)	7 (28.0)	0.53	.465
SSBD rank					
Ranked 1st, <i>n</i> (%)	78 (65.0)	58 (61.1)	20 (80.0)	3.12	.077
Ranked 2nd, <i>n</i> (%)	30 (25.0)	25 (26.3)	5 (20.0)	0.42	.516
Ranked 3rd, <i>n</i> (%)	9 (7.5)	9 (9.5)	0 (0.0)	2.56	.110
SSBD critical events index, <i>M</i> (<i>SD</i>)	8.0 (3.1)	7.6 (2.9)	9.4 (3.7)	−2.54	.012
CBCL externalizing behavior <i>T</i> score, <i>M</i> (<i>SD</i>)	71.2 (6.0)	71.0 (6.0)	72.1 (6.1)	−0.85	.395
Parent demographic characteristic					
Age, <i>M</i> (<i>SD</i>)	35.4 (9.9)	36.8 (10.4)	29.9 (5.0)	3.14	.002
Female, <i>n</i> (%)	102 (85.0)	79 (83.2)	23 (92.0)	1.21	.271
African American, <i>n</i> (%)	65 (54.2)	49 (51.6)	16 (64.0)	1.23	.267
Caucasian, <i>n</i> (%)	49 (40.8)	42 (44.2)	7 (28.0)	2.15	.142
With BA/BS degree, <i>n</i> (%)	9 (7.5)	9 (9.5)	0 (0.0)	2.56	.110
Currently employed, <i>n</i> (%)	87 (72.5)	66 (69.5)	21 (84.0)	2.10	.148
Below poverty level, <i>n</i> (%)	40 (34.5)	31 (33.7)	9 (37.5)	0.12	.727

Notes: Reported test statistics are *t* for continuous and χ^2 for dichotomous measures. Sample sizes vary by variable based on available data. SSBD = Systematic Screening for Behavior Disorders; CBCL = Child Behavior Checklist. For the SSBD critical events index scores of 5 or higher exceed risk criteria for externalizing problems. Students with CBCL *T* scores above 63 are in the clinical range on externalizing behavior.

and one of seven parent variables. The students of families who chose not to participate in even a single home session had a higher number of reported SSBD critical events at baseline ($M = 9.4$) as compared with the students of families who did participate ($M = 7.6$). As reported in Table 1, parents who did not participate in homeBase were significantly younger ($M = 29.9$ years) than parents who did participate in the program ($M = 36.8$ years). Subsequent discussion of parent engagement and measures of social validity will be limited to the full and partial completers ($N = 95$).

Based on coach-reported data, average total engagement scores ranged from 1 to 5 on a five-point Likert scale. The mean engagement score was 3.6 ($SD = 0.8$). Thirty-one families (33 percent) had a mean total engagement score of 4 or higher, indicating higher levels of engagement. Eighteen families (19 percent) had a mean engagement score below 3, indicating low levels. A summary of the mean item-level scores and the percentage of families with low and high levels of engagement on each item based on coach report is provided in Table 2. Low engagement ranged from 6 percent

to 23 percent, with maintained communication and three questions related to actual parenting behavior change endorsed most frequently. High engagement ranged from 30 percent to 78 percent. Engagement was highest for parent attentiveness during homeBase sessions (78 percent), attending scheduled meetings and sessions (70 percent), and motivation to participate in homeBase (67 percent).

Coach-reported average total alliance scores ranged from 1.3 to 5 on a five-point frequency scale. The mean coach-reported total alliance score was 3.8 ($SD = 1.0$). Item-level coach-reported scores ranged from 3.5 ($SD = 1.3$) for “parent followed through with commitments and responsibilities” to 4.1 for the parent being approachable ($SD = 1.0$) and the parent and coach trusting one another ($SD = 0.9$). Coaches also reported that time spent working with the parent was effective and productive (M [SD] = 4.0 [1.1]) based on mean item-level scores.

Parent-reported alliance scores were higher than coach-reported scores. Average total parent-reported alliance scores ranged from 3 to 5. The mean alliance score was 4.4 ($SD = 0.6$). Sixty percent of

Table 2: Coach-Reported Parent Engagement

Item	<i>M (SD)</i>	Low	High
		Engagement %	Engagement %
The parent changed his/her own family management practices	3.4 (1.0)	16.8	44.2
The parent was motivated to participate in the intervention	3.8 (1.1)	16.8	67.4
The parent attended scheduled meetings and sessions	3.9 (1.2)	14.7	69.5
The parent changed his/her parenting techniques	3.2 (1.1)	23.2	41.1
The parent tried new techniques and/or strategies	3.4 (1.1)	20.0	50.5
The parent maintained consistent communication with me	3.6 (1.2)	21.1	63.2
The parent maintained consistent communication with the teacher	3.3 (0.9)	9.5	32.6
The parent was receptive to being educated on family management practices	3.8 (1.0)	9.5	67.4
The parent completed homework assignments on the family management plan	3.2 (1.0)	17.9	29.5
The parent was attentive during homeBase	4.0 (0.9)	6.3	77.9
The parent followed my instructions and recommendations	3.5 (1.0)	13.7	44.2

Notes: Low engagement = 1 (strongly disagree) or 2 (disagree); high engagement = 4 (agree) or 5 (strongly agree).

Table 3: Parent-Reported Satisfaction with homeBase

Item	<i>M (SD)</i>	Low	High
		Satisfaction %	Satisfaction %
The goals of the program were clearly explained to me	4.4 (0.8)	4.2	73.7
It was clear what was expected of me during the program	4.4 (0.8)	3.2	73.7
The program was easy to use	4.4 (0.7)	2.1	74.7
The program did not take much of my time	4.2 (0.9)	5.3	73.7
I enjoyed doing the activities with my child	4.5 (0.6)	0.0	78.9
I am satisfied with the change in behavior with my child	3.9 (1.1)	9.5	58.9
I noticed changes in my child's behavior	4.0 (1.0)	6.3	61.1
The program was effective in teaching my child appropriate behaviors	4.0 (1.0)	7.4	63.2
The program had a positive effect on the rest of my family	4.0 (0.9)	4.2	62.1
I received ongoing support/help from the coach	3.9 (1.0)	7.4	55.8
I would recommend the program to other parents	4.4 (1.0)	4.2	75.8

Notes: Low satisfaction = 1 (strongly disagree) or 2 (disagree); high satisfaction = 4 (agree) or 5 (strongly agree).

parents ($n = 57$) reported an alliance score of four or higher, suggesting higher levels of parent-coach alliance. In comparison, coaches reported higher levels of alliance with only 47 percent of families. For parent-reported alliance, mean item-level scores ranged from 4.1 to 4.5. Average total parent-reported satisfaction scores ranged from 2.3 to 5. The mean total satisfaction score was 4.2 ($SD = 0.6$). An item-level summary of parent satisfaction is provided in Table 3.

Correlations among Coach-Reported and Parent-Reported Measures

Within informant measures of engagement, alliance, and social validity (that is, parent satisfaction) were highly correlated. Coach-reported effectiveness scores were correlated with coach-reported

measures of parent engagement ($r = .781, p < .001$) and parent alliance ($r = .75, p < .001$). Coach-reported engagement and alliance were also highly correlated ($r = .88, p < .001$). Parent-reported satisfaction and alliance were also correlated ($r = .61, p < .001$). Coach-reported parent engagement scores were significantly correlated with parent-reported alliance ($r = .43, p < .001$) and parent-reported satisfaction ($r = .33, p = .003$). Coach-reported effectiveness scores were also significantly correlated with parent-reported alliance ($r = .29, p = .010$) and parent-reported satisfaction ($r = .33, p = .004$). Finally, coach-reported alliance was significantly associated with parent-reported alliance ($r = .37, p = .001$) but not with parent-reported satisfaction ($r = .22, p = .053$).

Correlations with homeBase Participation

Coach-reported measures were positively correlated with the number of homeBase steps completed. There were statistically significant correlations among homeBase completion and coach-reported effectiveness ($r = .43, p < .001$), parent engagement ($r = .57, p < .001$), and parent alliance ($r = .55, p < .001$). Parent-reported alliance was positively associated with completion of homeBase steps ($r = .25, p = .026$); however, the number of steps completed was not significantly associated with parent satisfaction with the program ($r = .19, p = .100$).

We examined the four process measures significantly correlated with homeBase participation (that is, parent-reported alliance and the three coach-reported measures assessing effectiveness, parent engagement, and parent alliance) in a multinomial logistic regression framework to identify the process measures driving the likelihood of completing more homeBase steps. Specifically, we used those completing all three steps (completers) as the reference group and compared them with those who completed either one or two steps. After process variables were entered into the model with a backward stepwise procedure, only coach-reported parent engagement remained. As parents' engagement scores increased, parents were more likely to have completed all three sessions than to have completed one session [$\chi^2(1, N = 95) = 11.59, p = .001$] or two sessions [$\chi^2(1, N = 95) = 4.90, p = .027$].

DISCUSSION

Engaging caregivers of young children with challenging behaviors is critically important for school social workers due to the prevalence and growth of these problems (Briggs-Gowan & Carter, 2008; Farrington & Welsh, 2007) and the relevancy of supporting caregivers in school social work practice (Frey, Alvarez, et al., 2013). This study is the first to document parental engagement related to the homeBase intervention. These preliminary results provide evidence to support the potential for the homeBase intervention and MI for engaging parents in school-based settings.

It is important to note that this study was designed for tertiary-level students with clinically significant levels of disruptive behavior in both home and school settings. The level of child baseline impairment and the high percentage (35 percent)

of parents with annual incomes below the poverty line suggest that this analysis was completed with parents who may benefit the most and be the most difficult to engage in PMT interventions. Despite their elevated risk status, over 55 percent of participating families were intervention completers, having completed three or more of the homeBase steps. Twenty-three percent of the participating families were partial completers, completing one or two homeBase steps; 21 percent of the families did not participate in any home visits. Our finding that parents of children with more critical incidents at baseline were less likely to participate provides evidence to suggest that parent engagement may be contingent on the severity of child behavior. It is surprising that younger parents were less likely to participate than older parents. This finding is particularly interesting given Dishion and Stormshak's (2007) belief that younger parents are more likely to engage in PMT because they are less likely to have undergone traumatizing transitions themselves (for example, divorce, multiple partners, severe family stress) and because they are more likely to be optimistic about positive changes during their children's primary years.

Results from the coach-reported engagement measure indicate that the overall engagement scores, parent attentiveness, and motivation to participate were rated highly by coaches. However, arguably the most important items (that is, parenting behavior change items and consistent communication with the coach) have the highest percentages of parents with low engagement from the 11-item scale. The percentage of parents rated with low engagement on these four important items is indicative of the inherent challenge in changing one's behavior. Still, this finding does not attenuate the positive outcomes represented by the percentages of parents with high levels of engagement across the same four items. Given the importance and difficulty of engaging parents in PMT interventions cited in the literature (Eames et al., 2009; Frey, Lee, et al., 2013), it was not surprising to find significant correlations between completion and the three coach-reported measures assessing effectiveness, parent engagement, and parent-reported alliance. It is interesting and important to note the findings of the multinomial logistic regression, which indicates that parent engagement was the single most important predictor of intervention completion. It will be important to examine our

parent outcomes closely when the study is complete. In particular, we should further investigate the intersection of the participation and engagement results. It is possible that the homeBase intervention will require adaptation or modifications for younger parents whose children demonstrate elevated levels of problem behavior, to affect parent and child behavioral outcomes.

This analysis has some important limitations. First, all data are based on coach and parent self-report. Although we believe the findings are strengthened by having both coach and parent reports on similar constructs (for example, alliance and satisfaction), the findings would be stronger if direct measures of participation, engagement, and alliance were included. In addition, our results are derived from primarily descriptive process measures, thus the analysis would be improved if these process measures were examined in the context of outcome data. We plan to make these findings available at the completion of our ongoing randomized controlled trial.

There are several potential implications for school social workers and other specialized instructional support personnel. First, practitioners need refined skills for engaging parents. Although MI is not the only clinical practice for accomplishing this goal, it appears to have potential for meeting this need based on the relatively high levels of engagement for parents of children with such severe levels of disruptive behavior. Furthermore, because MI skills are generalizable to nearly all interventions with adults and adolescents that focus on change, we believe that professional preparation programs might wish to consider adopting MI as part of their curriculum, particularly given the high rate of satisfaction with this intervention. Also, school districts and departments of education might consider MI as a topic for continuing education, especially in regard to their being able to establish alliance with parents.

Future research is needed to better understand parental engagement related to PMT interventions. First, it would be interesting to examine whether parental engagement in existing evidence-based PMT programs is improved by adding an engagement supplement, such as an initial MI-focused interview. In our initial randomized controlled trials, in which MI was not part of the parent interview, our parent outcome measures had relatively small effect sizes as compared with the medium-to-

large effects found on teacher outcome measures. In addition, because MI is a primary mechanism affecting parental engagement, it will be important to examine the relationship between the quality of the coach's MI and parent outcomes such as participation, engagement, alliance, and satisfaction. We are collecting MI quality data that will allow us to understand the relationship between MI quality, parental engagement, and parent and child outcomes. Second, we would like to implement the homeBase intervention with parents of younger and less behaviorally impaired children to assess differences in both engagement and outcomes. **CS**

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