# Developing an Empirically Based Model of Service

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## Measurement for Accountability

- "Best practices" -- guidelines or practices driven more by clinical wisdom, experts' opinions, or other consensus approaches that may not include systematic use of available research evidence.

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- "Evidence-based practices" -- clinical or administrative interventions or practices for which there is consistent scientific evidence showing that they improve client outcomes

## The literature on measuring model fidelity: Now growing

**What is model fidelity?**

- "Adherence of actual treatment delivery to the protocol originally developed." [Mowbray, C, Holter, M, Teague, G., and Bybee, D. (2003) Fidelity criteria: Development, measurement and validation. American Journal of Evaluation, Vol. 24, No. 3, pp. 315-340.]

## Why measure fidelity?

- Program development
- Black box outcome studies no longer acceptable
- Enhancing statistical power for outcome studies
- Quality assurance/monitoring program performance
- Emphasis on using evidence-based practices

***Reference: Mowbray, C, Holter, M, Teague, G., and Bybee, D. (2003) Fidelity criteria: Development, measurement and validation. American Journal of Evaluation, Vol. 24, No. 3, pp. 315-340.***

## How to measure fidelity?

- Identify critical model components and possible indicators (structure and process)
  - Expert opinion, Documented program model, Qualitative research, Literature reviews
- Collect data to measure indicators
  - Ratings by experts of documentation, site observations, audio/video, interviews; Surveys/interviews of practitioners or consumers
- Examine data on indicators
  - Reliability and validity

## Concerns in trying to measure Re-EDness

- A philosophy, not a treatment intervention
  - Structure (staffing levels, caseload size, frequency contact, etc.) vs. Process (program style, staff/client interactions)
  - Reliability vs. importance
- Programs widely variable
- Few "experts"
- Everything rated as highly important
- Emphasis on "becoming"; i.e., always adapting

## Q#1: Specification of the model

**Initial Set of Essential Ingredients**

- Interviews/focus groups of Re-ED experts and practitioners
- Literature review
- 100 Re-ED Essentials items
- Organized according to program structure components (e.g., values, service delivery, supervision)

## Q#2: Empirical Determination of Re-ED Distinctive Elements

Compared Re-ED group ratings on survey with non-Re-ED group ratings

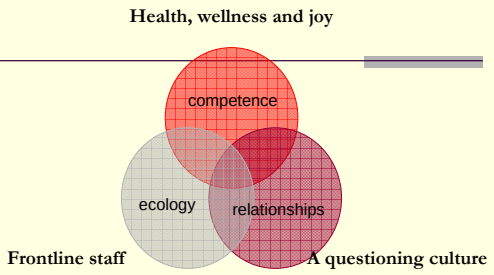
Results: 39 discriminating items

Compiled into 6 dimensions to provide essential Re-ED areas

## Results: 6 dimensions of Re-ED essentials

- Teaching and learning
- Working in child's ecology
- Front-line "staff" as primary agents of change
- Creating and enhancing relationships
- Emphasizing wellness, strength and joy
- Questioning culture to assure innovation

- [Handout of Re-ED Essentials outline]




## Q#3: Development of a Re-ED treatment fidelity measure

- Re-ED Essentials Framework ("best practices")
  - Covers the 39 discriminating essentials and 6 Re-ED dimensions with indicators for each along a continuum of Re-EDness
- Baseline from 8 sites: how the site currently operates
  - Taped interviews
  - Child/family record
- Site self-assessments using the Re-ED Essentials Framework

## Re-ED Essentials Framework

- 64 indicators covering the 39 Re-ED essentials
- Likert-like scale of four levels of each Re-ED essential along continuum of Re-EDness
- Reliability of the four-point continuum for each of the 64 Re-ED essentials
  - Test rank-order of items at the Re-ED Conference
  - Test rank-order of failed items using panel of experts
  - Result: 50 indicators on a 4-point scale from least Re-ED to ideal Re-ED in a Re-ED Framework of Essentials

**A Framework for Assessing an Agency's Level of Re-EDness**

| | Other Approaches | Re-ED Emerging | Re-ED Committed | Re-ED Leading |
|---|---|---|---|---|
| **I. Teaching and learning (dimension)** | | | | |
| ***Essential principles*** | **Indicators of the principle at this level** | **Indicators of the principle at this level** | **Indicators of the principle at this level** | **Indicators of the principle at this level** |
| *Intelligence can be taught (5), [1] Competence makes a difference (6), Self-control can be learned (7) Treatment is viewed as teaching (61)* | 1.1a Staff focus a lot of their attention on kids' problems and deficits or diagnoses. | 1.1b Staff are somewhat aware of kids' areas of competency but tend to be more focused on kids' deficits. | 1.1c Staff are aware of the importance of kids being competent in some area and balance this with concerns with remaining deficits. | 1.1d Staff show enthusiasm for how a kid is competent or how he has become competent in some area. |
| | 1.2a Treatment focus is on diagnosis and problems in areas of functioning. | 1.2b Treatment focus is on problems in areas of functioning without strong emphasis on diagnostic categorization. | 1.2c Treatment focus may address competence without emphasizing diagnostic categorizations but remains concerned with child deficits. | 1.2d Treatment focus is on building competence (without emphasis on categorization) especially in areas that are incompatible with troublesome behavior. |
| | 1.3aStaff believe that behavior is biologically based and efforts are directed primarily at addressing biological or intra-psychic causes. | 1.3b Staff believe that some aspects of behavior are fixed and create interventions that do not ask the youth to go beyond his/her capability. | 1.3c Staff believe that most behavior is learned but recognize a kid's reputation or prior tests as outer limits, preventing competence building. | 1.3d Staff believe most behavior is learned and susceptible to re-learning, then develop interventions and activities that build competence in all life areas. |
| | 1.4a Treatment is a medical and/or clinical process, focused on reducing the underlying causes of the child's current troubles. | 1.4b Treatment is a clinical process requiring an understanding of root causes of a child's problems before change can occur. | 1.4c Treatment may include active teaching of new competencies but also requires some exploration of root causes. | 1.4d Treatment is considered to be the active teaching of new skills and competencies, including relationship building. |

ials; green highlight = one of the remaining 100 Re-ED essentials whose "indicators" seemed so close in content to the 39 essentials as to be included with that it

## Future uses of the Re-ED Framework

- Self-identifying programs with high/low Re-ED scores for program development, training, technical assistance)
- Validating Re-ED Framework by comparing Re-ED and non Re-ED program scores
- Validating the Re-ED Framework by comparing it with on-site assessments that use standardized case vignettes
- And then, use for outcome studies (relationship between level of fidelity and outcomes)