



Assessing influences on intervention implementation: Revision of the Usage Rating Profile-Intervention ☆



Amy M. Briesch ^{a,*}, Sandra M. Chafouleas ^b, Sabina Rak Neugebauer ^b, T. Chris Riley-Tillman ^c

^a Northeastern University, USA

^b University of Connecticut, USA

^c University of Missouri, USA

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ABSTRACT

Although treatment acceptability was originally proposed as a critical factor in determining the likelihood that a treatment will be used with integrity, more contemporary findings suggest that whether something is likely to be adopted into routine practice is dependent on the complex interplay among a number of different factors. The Usage Rating Profile-Intervention (URP-I; Chafouleas, Briesch, Riley-Tillman, & McCoach, 2009) was recently developed to assess these additional factors, conceptualized as potentially contributing to the quality of intervention use and maintenance over time. The purpose of the current study was to improve upon the URP-I by expanding and strengthening each of the original four subscales. Participants included 1005 elementary teachers who completed the instrument in response to a vignette depicting a common behavior intervention. Results of exploratory and confirmatory factor analyses, as well as reliability analyses, supported a measure containing 29 items and yielding 6 subscales: Acceptability, Understanding, Feasibility, Family-School Collaboration, System Climate, and System Support. Collectively, these items provide information about potential facilitators and barriers to usage that exist at the level of the individual, intervention, and environment. Information gleaned from the instrument is therefore likely to aid consultants in both the planning and evaluation of intervention efforts.

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Research-based improvements in human services lag far behind other industries. We think the reason is that human services are far more complex than any other industry. With computers, automobiles, pharmaceuticals, and other manufactured products ... the *product is the intervention* and its performance depends very little on the user of the product ... In human services, the *practitioner is the intervention*. The science and quality have to be built into hundreds of thousands of practitioners situated in a variety of provider organizations that function within uniquely configured state and federal service systems (Fixsen, Blasé, Naoom, & Wallace, 2009, pp. 531–532).

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* Corresponding author at: 404 International Village, Northeastern University, Boston MA 02115, USA.

E-mail address: a.briesch@neu.edu (A.M. Briesch)

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1. Introduction

Particularly within the past decade, increased attention has been focused on the need to identify programs and practices proven effective in promoting the academic and behavioral success of students in schools. Task forces, for example, have been convened to identify, synthesize, and disseminate information regarding the evidence in support of a particular intervention (e.g., National Registry of Evidence-Based Programs and Practices: www.nrepp.samhsa.gov; What Works Clearinghouse: <http://ies.ed.gov/ncee/wwc/>). Despite the fact that the collective knowledge of evidence-based interventions has expanded, limited work has been conducted in order to understand the extent to which these interventions are actually being used in local settings. When use of evidence-based interventions has been investigated in fields such as medicine, results have suggested inconsistent and, many times, ineffective delivery of service across practitioners (Chassin, Galvin, & National Roundtable on Health Care Quality, 1998; President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1998). Furthermore, survey research within the field of education (Agran & Alper, 2000; Burns & Ysseldyke, 2009) has indicated that both general and special education teachers' use of evidence-based interventions varies substantially. Poor student outcomes have often been blamed on the gap that exists between the dissemination of effective interventions by researchers and their adoption in local classrooms (Greenwood & Abbott, 2001; Kutash, Duchnowski, & Lynn, 2009). Many explanations for the research-to-practice gap have been proposed, including the limited usability of evidence-based interventions in typical applied settings (Greenwood & Abbott, 2001; Riley-Tillman, Chafouleas, Eckert, & Kelleher, 2005). Thus, to guide recommendations for practice and future research, efficient tools are needed for assessing those factors believed to influence intervention usage. Although many terms have been used throughout the literature to describe the process of carrying out an intervention (e.g., intervention integrity, implementation fidelity), we deliberately use the term *usage* here in order to emphasize our interest in both initial and sustained practice. That is, the definition of usage implies both initial (or immediate) use as well as use that is habitual or customary. The aim of this study was to further develop and refine a self-report instrument that captures information related to a myriad of factors hypothesized to influence the likelihood of school-based intervention usage.

1.1. Early work on implementation: emphasis on acceptability

Historically, a “publish and hope” approach has been used to disseminate information about evidence-based interventions. As such, researchers laid out best practices within the literature with the expectation that potential consumers would find, and subsequently implement, these interventions given demonstrated effectiveness. This approach meant that many interventions were developed with minimal or no input from the potential consumers, and, as a result, were either underutilized or not utilized at all (Witt & Elliott, 1985). In the 1980s, however, researchers began to pay more systematic attention to understanding consumer opinion. Specific emphasis was placed on the concept of *treatment acceptability*, or “whether treatment is appropriate for the problem, whether treatment is fair, reasonable, and intrusive, and whether treatment meets with conventional notions about what treatment should be” (Kazdin, 1980, p. 259). Treatment acceptability is linked to *social validity*, which focuses on subjective measurement of issues such as the social significance of goals, social appropriateness of procedures, and social importance of effects in concert with objective client outcomes (Wolf, 1978). Treatment acceptability was hypothesized as a crucial factor in determining the a priori likelihood that a particular treatment would be used by consumers and therefore whether or not the treatment would ultimately be effective (Witt & Elliott, 1985).

A substantial literature base was built throughout the 1980s, which focused on describing the acceptability of various treatments for behavior problems both within (e.g., Martens, Witt, Elliott, & Darveaux, 1985; Witt & Martens, 1983) and outside (e.g., Kazdin, 1980; Kazdin, French, & Sherick, 1981) of classroom settings. Teachers, students, and parents were provided with analog case study descriptions and asked to rate the acceptability of one or more treatment options designed to decrease problem behavior (e.g., time-out and positive reinforcement; Finn & Sladeczek, 2001). Within these individual lines of research, unique assessment instruments (e.g., the Treatment Evaluation Inventory, Kazdin, 1980, and the Intervention Rating Profile-20, Witt & Martens, 1983) were developed in order to assess the degree to which consumers liked a particular intervention and found it suitable for the problem at hand. Generally, findings indicated that those treatments rated as more acceptable were those that (a) were believed to be more effective, (b) had fewer adverse side effects, (c) could be implemented by the classroom teacher, and (d) required less time, effort, and skill to implement (Reimers, Wacker, & Koepl, 1987).

Given the thrust of these conceptual models of treatment acceptability (e.g., Reimers et al., 1987; Witt & Martens, 1983), the logical assumption was long held that the more acceptable a treatment was, the more likely it was to be used by potential consumers. This assumption was left untested, however, for quite some time. The limited studies that have specifically investigated the relation between treatment acceptability and usage in more recent years have found weak results. In one study by Sterling-Turner and Watson (2002) for example, the correlations between observed treatment integrity and both pretreatment acceptability ($r < .01$) and post-treatment acceptability ($r = .13$) were found to be extremely low, suggesting “little overlap between what individuals say they will do and what they actually then do” (p. 46). A weak correlation (i.e., $r = .32$) between teacher-reported acceptability and treatment integrity observations was also identified in a more recent study which investigated academic interventions designed for use with students with ADHD (Mautone et al., 2009). Noell (2008) offered an apt analogy, highlighting the fact that although most individuals would find a healthy diet and exercise to be acceptable, a much smaller percentage of the population actually implements these practices in daily life. Taken together, these findings suggest that additional factors beyond acceptability should be considered when attempting to predict and explain actual intervention usage.

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