Fidelity of implementation

Date: May 2013

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This report was researched and written to address the question: *According to the literature, what measures, processes and frameworks exist to help measure the fidelity of implementation of evidence informed practices?*

We prepared the report given the contextual information provided in our first communications (see Overview of inquiry). This report is a summary of the literature found in a non-systematic search and may include practices your agency already uses. As this paper is a summary of existing evidence, it does not give explicit practice or policy recommendations and is meant as a reference.

Research is constantly evolving. As the literature changes, so does our idea of what is considered the “best available evidence”. Research is a powerful starting point for organizational decision making, but it also has limitations and should be interpreted carefully. Findings can be affected by methodological issues, and efficacy studies might translate differently in each real-world setting. This reinforces the importance of incorporating evaluation into the implementation and delivery of evidence-informed practices and programs. This report contains the findings of a rapid scan of the research literature, but evidence-informed decision making should also draw upon agency expertise, program evaluation and client perspectives to ensure the best possible outcomes.

Thank you for contacting Evidence In-Sight for consultation on your question. Please do not hesitate to follow up with the lead author or to contact us at 613-737-2297
1. Overview of inquiry
This report was provided for a cohort of agencies working with the Centre’s implementation support program involved in a three-year funded support program to implement a new evidence-informed intervention of their choice. The agencies were interested in compiling a list of existing fidelity measures and processes for each of their selected evidence-informed practices. However, it was important to provide a context within which to understand the various fidelity measures, so the topic was expanded to summarize fidelity of implementation as it is understood in the literature. The focus question of this report is: what measures, processes and frameworks exist to measure the fidelity of implementation of evidence informed practices?

The depth of information on this topic was limited, but the field is growing rapidly. While implementation and practice fidelity are widely discussed, there is limited quality evidence on frameworks and measures for individual evidence-based/evidence-informed practices and programs.

2. Summary of findings
• It is important to measure implementation fidelity because it helps determine whether positive or poor client outcomes are attributable to the intervention itself or a result of its implementation.
• There are multiple views and conceptualizations of implementation fidelity and its measurement, which can result in inconsistent research findings.
• Implementation fidelity involves measurement in five potential areas:
  1. The extent to which there is adherence to core intervention elements
  2. The level of exposure or “dose” of the intervention the client experiences
  3. The quality of practice delivery
  4. The level of participant involvement and responsiveness, including engagement
  5. The extent to which the program is different from similar interventions
• Knowing a program’s core components is essential to determine which elements of an evidence-informed program must be delivered as originally intended, and which can be adapted to suit local practice considerations.
• Implementation fidelity is fundamental but does not on its own mediate the effect of the intervention on outcomes. Outcomes and implementation both need to be carefully evaluated to assess the factors that contribute to client experiences.
• Predictive and discriminative validity are both important considerations when selecting or creating a fidelity measure.

3. Answer search strategy
• Literature searches were conducted in the following databases: University of Saskatchewan and University of Ottawa Electronic Databases (MEDLINE, PsycINFO, EMBASE, CINAHL, Psychology and Behavioural Sciences Collection), and Google Scholar.
• Varying combinations of the following search terms were used: fidelity, implementation fidelity, fidelity of implementation, adherence, integrity, evidence-informed practices, evidence-based practices, intervention fidelity, adaptation, and core components.
4. Findings
Implementation has been described as a “critical bridge” between evidence-informed programs, approaches, and treatments and their actual impact on intended recipients (Rowe et al., 2013). It is essential to understand the processes that support good implementation, and fidelity of implementation (FOI) is one important part of this.

FOI is the extent to which the intervention is delivered as intended by program developers (Carroll et al., 2007; Century et al., 2010; Rowe et al., 2013), but the way it is discussed in the literature is inconsistent. Even the terminology used varies in the literature (for example, FOI has also been referred to as adherence, integrity, and quality of implementation) (James Bell Associates, 2009), which makes it difficult to compare studies (Blase & Fixsen, 2013).

4.1 Why is fidelity of implementation important?
Although there is no consistent definition in the literature, FOI is still an important aspect of implementation planning and evaluation. For instance, a meta-analysis of the implementation of health prevention and promotion programs for children found that the quality of implementation was an important determinant of program outcomes (Durlak & DuPre, 2008). The authors found effective implementation increases the likelihood of program success and can lead to stronger benefits for participants. Given the breadth and depth of programs included in the meta-analysis the authors felt confident in their conclusion that the level of fidelity with which a program is implemented affects program outcomes (Durlak & DuPre, 2008).

It is important to measure FOI as it can help to determine whether poor outcomes are a result of the treatment itself or of its application (Blase & Fixsen, 2013; Forgatch, Patterson & DeGarmo, 2005; Schoenwald, et al., 2011). Table 1 illustrates how measuring fidelity and outcomes can help an agency make decisions about program and practice adjustments within a quality improvement framework.

<table>
<thead>
<tr>
<th>Satisfactory outcomes</th>
<th>Unsatisfactory outcomes</th>
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<tbody>
<tr>
<td>High Fidelity</td>
<td>Low Fidelity</td>
</tr>
<tr>
<td>• Continue to monitor fidelity and outcomes</td>
<td>• Re-examine the intervention</td>
</tr>
<tr>
<td>• Consider scale-up</td>
<td>• Modify the fidelity assessment</td>
</tr>
<tr>
<td></td>
<td>• Select a different intervention</td>
</tr>
<tr>
<td></td>
<td>• Modify the current intervention</td>
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<td></td>
<td>• Improve implementation supports to boost fidelity</td>
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The earlier a program is able to measure fidelity, the more opportunity there is to identify and correct problems that may affect outcomes. The effect implementation has on outcomes may also explain why studies of particular interventions obtain different results, even though they seem to be identical otherwise (Carroll et al., 2007).

4.2 Conceptualizing implementation fidelity
Dane & Schneider’s (1998) conceptualization of implementation fidelity identifies five core implementation elements:

1. Adherence: the extent to which the core practice components are delivered as intended.
2. Exposure (dose): the number of sessions implemented, the length of each session or the frequency with which program components were implemented.

3. Quality of delivery: how the program is delivered, can include things such as practitioner enthusiasm or preparedness.

4. Participant responsiveness: participant response to program sessions, such as their level of engagement.

5. Program differentiation: degree to which core components differ from one another and from other programs (Dane and Schneider, 1998).

While the literature seems to agree that fidelity involves the measurement of these five aspects, there are inconsistencies in how each term is defined and measured. Dane and Schneider (1998) noted it is increasingly important to define these categories in systematic ways as implementation fidelity research moves forward. Without this consistency it is difficult to compare across studies. In addition, the way this framework is used to measure fidelity varies across research. Some studies state that all aspects need to be assessed in order to determine intervention fidelity and some state that each individual element can effectively substitute for others to assess fidelity (Carroll, 2007). Most studies measuring fidelity only look at adherence, followed by dosage as the second most common aspect examined (Durlak & DuPre, 2008; Dane & Schneider, 1998).

Implementation fidelity includes both structural and process elements (Mowbray et al., 2003). Structural elements are the service delivery framework and include items such as measures of staffing levels and characteristics, caseload size, and frequency and intensity of contacts. Process elements are how service is delivered and include program style, staff-client interactions, client-client interactions, and individualization of treatment (Mowbray et al., 2003). Together, structural and process elements can provide critical information about whether or not implementation is taking place with fidelity and areas where it needs to be adjusted.

The “core components” (or “critical components”) approach is another way to conceptualize implementation fidelity. Knowing the core components of an intervention and measuring their fidelity during implementation helps to know if program issues are arising as a result of the intervention itself, or because of implementation problems. They are the essential features of a program (Century et al., 2003) and are the “functions or principals and related activities necessary to achieve outcomes” (Blase & Fixsen, 2013 p.1). A well operationalized service delivery program includes core components as one of four defining features (Blase & Fixsen, 2013):

1. The context of the program.
2. The core components.
3. The active ingredients to operationally define the core components.
4. Practical strategy for assessing the behaviours and practices that reflect the program’s values, principles, active ingredients and activities.

Few evidence-informed practices have well defined core components that specify the dose, strength and adherence required to produce positive outcomes (Blase & Fixsen, 2013; Dane & Schneider, 1998; Durlak and DuPre, 2008). Identifying and validating core components can be done by testing the mechanisms that are expected to produce change and then developing and validating fidelity measures that encompass the core components (Blase & Fixsen, 2013). However, while some researchers have been able to more clearly articulate a program’s core components
(Forgatch et al., 2005), most studies do not assess core intervention components and even fewer link them to outcomes (Dane & Schneider, 1998). As a result, the literature is a poor source of information for core components and there is little empirical evidence to support the core components that are identified by program developers (Blase & Fixsen, 2013).

Despite these challenges in identifying and assessing core components, they are essential to achieving good outcomes. Michie and colleagues (2009) state that in order to implement interventions that provide benefits to the client, the core components need to be known. They liken it to pharmacology by describing that aspirin has a different active ingredient than statins do and as a result each medication impacts physiological and pathological outcomes in different ways. According to these authors, the identification of core components “may allow for more efficient and cost effective introduction of an intervention and lead to confident decisions about the non-core components that can be adapted to suit local conditions at a local site”. Identifying core components determines what to measure to maintain fidelity and what can be adapted to suit local conditions.

Two other conceptualizations combine the dimensions of fidelity, critical components, and structure and process approaches (Century et al., 2003). Century and colleagues (2010) felt that Dane and Schneider’s (1998) model could not be measured, because the concepts and their relationships to one another were not clearly defined. Table 2 maps a framework intended to help determine what to measure for fidelity of implementation of educational instructional materials, but could be adapted to mental health agency purposes.

**Table 2: Conceptual framework of aspects of implementation fidelity**

<table>
<thead>
<tr>
<th>Fidelity of implementation (Adherence)</th>
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<tr>
<td>Categories of critical components</td>
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<tr>
<td>Structural critical components (Structure)</td>
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<tr>
<td>Categories of differentiation (Differentiation)</td>
</tr>
<tr>
<td>Procedural (Exposure, dose)</td>
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<tr>
<td>Common across interventions</td>
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<tr>
<td>Unique to Interventions</td>
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</table>

In this model, adherence is seen as synonymous with FOI rather than a dimension of it. The framework is split into structure and process components. Structural components include exposure and dosage, which may include the number of sessions implemented or the length of each session. Process components include quality and qualitative aspects of program delivery such as practitioner enthusiasm, preparedness, attitude towards program and student/client responsiveness. Differentiation is an analytic process, not a dimension of fidelity, and it determines the degree to which the critical components that distinguish one program from another are present or absent. It is a process that is happens before, during, and after the measurement of implementation but not a part of the FOI measurement. It is a part of the framework but not a critical component in and of itself. This framework is useful because it shows one way that all of the concepts identified by Dane and Schneider (1998) can be used to measure FOI.
Another conceptual framework based on the Dane and Schneider (1998) components by Carroll and colleagues (2007) is below:

This framework shows the key components of implementation fidelity and how they relate to one another. Similar to the previous example, fidelity is measured by the extent to which there is adherence to the core components of the intervention, including content, frequency, duration and dose (i.e. implementation fidelity is “high” if all of these are adhered to). How well the components are adhered to is moderated by the following variables (Carroll et al., 2007):

- The complexity of an intervention can range from simple to complex and how well it is described can range from detailed to vague. If an intervention is not clearly described it can lead to lower levels of adherence. Similarly, if an intervention is too complex and allows for lots of variation in the delivery it can lead to poor implementation of key components.
- Facilitation strategies are the support strategies that optimize and standardize implementation fidelity. Examples of this include ensuring everyone is receiving the same training and providing support so intervention delivery is standardized for everyone delivering the intervention.
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- The quality of delivery refers to whether or not the intervention is delivered in a way that will achieve predicted outcomes. For example, in a program with both active and verbal teaching, only using verbal teaching may moderate the ability to achieve predicted outcomes.
- Participant responsiveness entails how the participants view and engage in an intervention. If participants are not engaged then implementation fidelity may be low. This moderator also encompasses the engagement of the person delivering the intervention. If the person is not engaged in what they are delivering it may affect their adherence to it in a negative way.

The broken line between adherence and outcomes represents that implementation fidelity is fundamental but does not on its own mediate the effect of the intervention on outcomes. There are other variables that need to be considered, perhaps that the intervention itself is poor. Finally, the authors suggest that when outcomes are analyzed core components of the intervention may be identified that are imperative to achieve positive outcomes and determine the minimum requirements for high implementation fidelity. The authors identify that more research is needed to test their framework and clarify the moderating impacts of the components.

It is important to discriminate between fidelity of implementation (FOI) and fidelity of intervention. FOI is how a program is implemented as opposed to adherence to the evidence-informed practice itself (Blase and Fixsen, 2005). Being clear on the difference, but measuring both, helps identify implementation strategies that contribute to improving intervention fidelity. The two concepts are interrelated but distinct. Table 3 illustrates some of the differences between implementation fidelity and intervention fidelity considerations:

**Table 3: Intervention and implementation fidelity**

<table>
<thead>
<tr>
<th></th>
<th>Intervention fidelity</th>
<th>Implementation fidelity</th>
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</thead>
<tbody>
<tr>
<td><strong>Context</strong></td>
<td>Things that need to be in place beforehand in order for a program to operate with fidelity</td>
<td>Concepts such as an established relationship with a qualified purveyor</td>
</tr>
<tr>
<td><strong>Compliance</strong></td>
<td>Ensuring use of intervention processes prescribed by the program and not those proscribed by the program</td>
<td>Ensuring adherence to components such as interview practice, supervision models</td>
</tr>
<tr>
<td><strong>Competence</strong></td>
<td>How skilled the practitioner is at using the core intervention components in service delivery</td>
<td>Having skillful training and supervision</td>
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</table>

There are very few studies that compare these two types of fidelity, and the literature generally does not make a clear distinction between them. When selecting measures of implementation fidelity, agencies should be clear what it is that they intent to evaluate so that the correct type of measure is used.

These conceptualizations of implementation fidelity summarized above lack consistency in many ways, and while some are designed to be a more universal conceptualization (e.g. core components, Dane and Schneider’s five elements), others are designed for specific interventions (hybrid frameworks). The key to any model, especially if it is going to be
evaluated, is to ensure criteria are operationalized and developed into measures which can be analyzed, verified and related to client outcomes (Mowbray, 2003). One way to start conceptualizing implementation fidelity criteria for a specific evidence-informed program is to examine the current research literature, speak to experts, or adapt well-established frameworks that already exist (Mowbray, 2003).

4.3 Measuring implementation fidelity
Understanding implementation fidelity of an evidence-informed practice is a key step in implementation planning, and an evaluation plan should follow from the conceptualization. The most commonly identified ways of measuring fidelity include assessment by experts or supervisors based on documentation or videotaped sessions, client records, site observations, and checklists or interviews completed by those delivering or receiving the service (Mowbray et al., 2003; Schoenwald & Garland, 2012).

Most of the available literature focuses on adherence because it is the most often measured aspect of implementation. Adherence can be measured through ratings by experts, completion of existing fidelity scales by families, supervisors, clinicians and clients, and checklists of core components (Mowbray, 2003). Observation is used most frequently to assess adherence (Schoenwald & Garland, 2012).

Not all fidelity criteria are measurable with the same reliability, feasibility or cost (Mowbray, 2003). For example, structure criteria include measuring staffing levels, case load size, budget and frequency of contacts. Process criteria include program style, staff-client interactions and emotional climate. Measuring structural criteria is less subjective and can use existing data and process criteria. Measuring process criteria often requires more time, effort, cost and may be less reliable. Conceptualizing fidelity of implementation and making an evaluation plan early in the implementation planning helps in understanding the differences and to plan for barriers.

Fidelity measurement assumes discriminative and predictive validity. Discriminative validity is a measure’s ability to differentiate between programs adhering to the model and those that do not. Predictive validity tells if the implementation of the program will achieve similar outcomes as found in the research that established its effectiveness. Predictive and discriminative validity are both important considerations when selecting or creating a fidelity measure. If a measure does not have discriminative validity, an agency may be unable to tell if the program is adhering to the intended model. Without predictive validity the agency will not know if negative or positive outcomes are related to the implementation process or the intervention itself. This is important because higher fidelity as measured by a scale should result in better outcomes (Bond, Becker & Drake, 2011).

Many fidelity scales used for adherence measurement do not have predictive validity (Schoenwald & Garland, 2012). In one review, only 35% of scales described their psychometric properties and predictive validity was reported for only 10% (Schoenwald & Garland, 2012). Bond and colleagues (2011) suggest five reasons for this lack of predictive validity:

1. Some practices have not been adequately defined.
2. Some interventions are clinically complex, which complicates fidelity measurement.
3. For many psychosocial practices the criterion measure for success is not clearly specified and practices with more diffuse goals or less objectively defined outcome measures have more difficult pathways to establishing predictive validity.
4. Predictive validity will be weaker if the evidence-informed practice itself is less effective.

5. Psychometric studies of fidelity scales using programs as the unit of analysis by definition require large multi-site studies, which are difficult and expensive to conduct.

Effective measurement involves using measures with sound established psychometric properties that have been developed with a clear purpose in mind. A key question as it pertains to effective measurement is “What decisions do I need to make on the basis of these scores?” (Schoenwald & Garland, 2011, p. 35). Effective measurement should be developed through the application of a specific measurement theory.

Efficient measurement considers the contextual fit of a measure, including resource implications (time, money, training, equipment) of the measure. If the measure is not efficient and useful for the specific context it is unlikely it will be used. Effective measurement ensures measuring what is required for the evaluation, and efficient measurement ensures that the measure is useful in a specific context. Table 4 outlines the key considerations for each of these in the context of measuring intervention (treatment) fidelity (Schoenwald & Garland, 2012, p.36).

Table 4: Effective and efficient measurement considerations

<table>
<thead>
<tr>
<th>Characteristics of effective instruments</th>
<th>Characteristics of efficient instruments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose and Theory</strong></td>
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<tr>
<td>A clear primary purpose that guides all steps of development.</td>
<td>Different end users may desire different purposes (e.g. training, quality assurance).</td>
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<tr>
<td><strong>Definition of adherence</strong></td>
<td></td>
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<tr>
<td>Aspects of the treatment considered essential are identified. The operations indexed (e.g. behaviours, procedures, techniques) are clear and consistent. The indicator of adherence to the items is defined and valid.</td>
<td>Adherence definition must be understood and deemed applicable by end users. If multiple purposes will be served, the definitions must make sense for these purposes.</td>
</tr>
<tr>
<td><strong>Data collection and scoring</strong></td>
<td></td>
</tr>
<tr>
<td>Criteria are established for the timing and frequency of data collection and for qualifications of raters or respondents. Data collection method is specified.</td>
<td>The time, training, expertise, equipment, and materials can be made available within the administrative, supervisory and documentation practices of an organization. Data collection conforms to ethical and professional norms.</td>
</tr>
<tr>
<td><strong>Scoring</strong></td>
<td></td>
</tr>
<tr>
<td>Scores map onto the purpose of the measure.</td>
<td>Scores need to be easily interpretable.</td>
</tr>
</tbody>
</table>

Program implementation is a continuous process, because it involves continuous assessment and adjustment. As a result, measurement also needs to be ongoing. However, it is important to find a balance between unnecessarily consuming resources and losing an opportunity to intervene before too much drift occurs (Mowbray, 2003).
5. Next steps and other resources
An appendix is attached that summarizes some currently existing measures for evidence-informed programs being implemented by agencies in Ontario. Given the scope and time limitations of this report, measures are listed and briefly described but not rated for local usefulness.

Knowing what works and receiving training on an evidence-informed practice or program is not sufficient to actually achieve the outcomes that previous evaluations indicate are possible. A program that has been shown to improve mental health outcomes for children and youth but that is poorly implemented will not achieve successful outcomes (Fixsen et al, 2005). In order for a program to be evidence-informed, it needs to be applied with fidelity to the design and it needs to be implemented using supportive “drivers” related to staff competency, organizational leadership, and organizational capacity. Choosing a practice is an initial step toward implementation, but the implementation drivers are essential to ensure that the program reaches appropriate clients, that outcomes are successful, and that clinical staff members are successful in their work.

For assistance in planning, doing and using program evaluation to strengthen services, the Centre of Excellence has free consultation services. Contact the evaluation support service:
http://www.excellenceforchildandyouth.ca/support-tools/evaluation

For assistance in planning to implement a community assessment, contact our implementation support team:
http://www.excellenceforchildandyouth.ca/support-tools/implementation

For information on youth and family engagement (evidence-informed practices that should be integrated into all services), including training opportunities:
http://www.excellenceforchildandyouth.ca/training/youth-engagement

For general mental health information, including links to resources for families:
http://www.ementalhealth.ca
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References


The search for fidelity measures as seen below was limited to the evidence-informed practices being implemented by the first cohort of PACE agencies. Two places where additional information can be found for existing fidelity measures not related to those being implemented by PACE agencies are:

- The California Evidence Based Clearinghouse for Child Welfare: [http://www.cebc4cw.org/implementation-resources/](http://www.cebc4cw.org/implementation-resources/)

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Where it can be found</th>
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<tbody>
<tr>
<td>TF-CBT Rating Form – Supervisor</td>
<td>Supervisors complete the measure for each of their supervisees. They indicate on a scale of 1 (never) to 5 (almost always) the frequency with which the supervisee implemented TF-CBT with a high degree of skill in a number of key dimensions. It is an 11 item measure that was created by Cohen (2005) one of the TF-CBT developers. With one sample was found to have a Chronbach’s alpha of .92 (Ebert et al., 2012).</td>
<td>Discussed in the following paper: Ebert, L. Amaya-Jackson, L. Markiewicz, J.M., Kisiel, C., &amp; Fairbank, J.A. (2012). Use of breakthrough series collaborative to support broad and sustained use of evidence-based trauma treatment for children in community practice settings. Administration and Policy in Mental Health, 39, 187-199. Access: Contact scale creator.</td>
</tr>
<tr>
<td>TF-CBT Practice Checklist Self-Report</td>
<td>Clinicians self-report on their adherence to the TF-CBT treatment model. Assesses the frequency, on a 5 point scale 1 (never) to 5 (almost always), in which the clinician engages in specific activities delivering TF-CBT during the past two months. With one sample, alpha coefficients ranged from .68 to .93 with an overall alpha of .95. The scale was created by Deblinger and colleagues (2005).</td>
<td>Discussed in the following paper: Ebert, L. Amaya-Jackson, L. Markiewicz, J.M., Kisiel, C., &amp; Fairbank, J.A. (2012). Use of breakthrough series collaborative to support broad and sustained use of evidence-based trauma treatment for children in community practice settings. Administration and Policy in Mental Health, 39, 187-199. Access: Contact scale creator.</td>
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<tr>
<td>Toolkit/Series</td>
<td>Description</td>
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<tr>
<td><strong>NCTSN Learning Collaborative Toolkit</strong></td>
<td>The focus of this toolkit is for successfully developing and leading Learning Collaboratives. However, there is a section on Metrics that can be tracked monthly that may be useful, in terms of measuring fidelity. There is a “Sample Improvement Metrics Summary Form from TF-CBT Learning Collaborative” and a “Monthly Tracking Form for Therapists from TF-CBT Learning Collaborative” that may be also be helpful.</td>
<td>Markiewicz, J., Eber, L., Ling, D., Amaya-Jackson, L., &amp; Kisiel, C. (2006). Learning Collaborative Toolkit. Los Angeles, CA and Durham, NC: National Centre for Child Traumatic Stress.</td>
</tr>
<tr>
<td><strong>Trauma-Focused Cognitive-Behavioral Therapy Toolkit</strong></td>
<td>This toolkit was designed to help clinicians learn and deliver TF-CBT effectively in a practice setting. It was developed by TF-CBT developers and researchers and clinicians at the University of Missouri in Columbia and Washington University in St. Louis. In terms of fidelity the toolkit includes a TF-CBT fidelity checklist, TF-CBT treatment steps tracking form, TF-CBT supervisor’s adherence checklist and a TF-CBT supervisee rating form. No validity or reliability was reported for these measures.</td>
<td>Hawley, K., McMillen, C., Proctor, E. (n.d.) Trauma-focused cognitive-behavioural therapy toolkit. St. Louis, MO: Washington University.</td>
</tr>
<tr>
<td><strong>How to Implement Trauma-Focused Cognitive Behavioral Therapy and TF-CBT Brief Practice Checklist</strong></td>
<td>There is a section in this implementation toolkit that addresses fidelity. This includes these three key fidelity standards. The measure included in the toolkit tracks the timing and implementation of specific TF-CBT components. It is designed to help therapists and supervisors determine if fidelity is being maintained.</td>
<td>Child Sexual Abuse Task Force and Research &amp; Practice Core, National Child Traumatic Stress Network. (2004). How to Implement Trauma-Focused Cognitive Behavioral Therapy. Durham, NC and Los Angeles, CA: National Center for Child Traumatic Stress.</td>
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**Dialectical Behaviour Therapy (DBT) Fidelity Measures and Supporting Documents**
It is noted on SAMHSA’s National Registry of Evidence Based Programs and Practices that practical and intervention specific measures for intervention fidelity are available for this EBP. However, they do not appear to be easily accessible. NREPP suggests contacting the following people to gain more information on implementation:

Behavioral Tech, LLC  
(206) 675-8588  
information@behavioraltech.org

Kathryn E. Korslund, Ph.D., ABPP  
(206) 616-7324  
korslund@uw.edu

**Cognitive Behavioural Therapy (CBT) Fidelity Measures and Supporting Documents**

It was difficult to find fidelity measures for CBT in general. Most available measures seem to be designed for specific CBT programs but not CBT generally.

**Evidence-Informed Family Centred Practice**

No specific fidelity measures could be found for evidence-informed family centred practice. However, during a search the Supported Employment Fidelity Scale was found and the format of this may be amendable to this particular EIP, depending on its conceptualization. For more information about the Supported Employment Fidelity Scale refer to the following article:

Bond, G.R., Becker, D.R., & Drake, R.E. (2011). Measurement of Fidelity of Implementation of Evidence Based Practices: Case Example of the IPS Fidelity Scale. For a copy of the scale go to: