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## Assessing treatment fidelity in an RTI case study framework

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ASSESSING TREATMENT FIDELITY  
IN AN RTI CASE STUDY  
FRAMEWORK

Thesis

Submitted to

The School of Education and Allied Professions of the  
UNIVERSITY OF DAYTON

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The Degree

Educational Specialist in School Psychology

by

Daniel Joseph Trunk

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SCHOOL PSYCHOLOGY PROGRAM  
DEPARTMENT OF COUNSELOR EDUCATION AND HUMAN SERVICES  
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WE HEREBY APPROVE THE THESIS SUBMITTED

BY

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ENTITLED:

Assessing Treatment Fidelity in an RTI Case Study Framework

AS PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

Educational Specialist in School Psychology

Chair

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## ABSTRACT

### ASSESSING TREATMENT FIDELITY IN AN RTI CASE STUDY FRAMEWORK

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Research-based academic and behavioral interventions are implemented in schools in order to increase positive student performance, as well as to ensure students are receiving best-practice methods of service delivery. Treatment fidelity, or treatment integrity, is an important aspect of interventions which measures the degree to which an intervention is implemented as planned. This investigation built upon previous studies that sought to examine the relationship between various levels of treatment fidelity and student outcome. Ten academic and ten behavioral case studies were examined and placed into one of two treatment fidelity groups: One treatment fidelity group consisted of case studies with 90% or above treatment fidelity percentages, while the other group consisted of case studies with below 90% treatment fidelity percentages. Effect sizes for each group were calculated and compared. Percentage of non-overlapping data points were calculated for behavioral case studies and compared between treatment fidelity groups. The results revealed minimal

differences between the mean treatment fidelity percentages for the two treatment fidelity groups. Unintended results provide evidence of lower levels of treatment fidelity leading to large positive student outcomes, supporting previous research. Research limitations and areas of future research are provided.

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## CHAPTER I

### INTRODUCTION

Upon the reauthorization of IDEA in 2004, the U.S. Department of Education ruled that school districts are not required to take into account whether a child demonstrates a severe enough discrepancy between his or her intellectual and achievement abilities to be qualified for special education (Merrell, Ervin, & Gimpel, 2006). Instead, schools are able to make special education decisions by evaluating a student's academic or behavioral response to research-based interventions. Unlike a more traditional model of special education determination, response to intervention is a preventive model because it allows for multiple tiers of intervention to be introduced at early stages in student development (Justice, 2006). These interventions, along with the progress of the student, are monitored over time to help ensure positive student outcomes. Frequent progress monitoring also allows interventions to be modified to meet the needs of the student. However, one potential source of error in the data-based decision making of the response to intervention model is the lack of treatment fidelity that may occur when implementing research-based interventions.

### Significance

The current study is significant because it aims to investigate the relationship between various levels of treatment fidelity of tier-III interventions and the associated student outcomes. More specifically, the researcher expects to find that, in general, higher levels of treatment fidelity are associated with positive student outcomes. As school districts begin using the response to intervention model for making determinations regarding the existence of specific learning disabilities, the need for high-quality, researched-based interventions increases. Interventions targeted at addressing specific skill or performance deficits may help interventionists determine if true disabilities exist, or if deficits are due to other variables (e.g. lack of quality instruction, environmental variables, etc.). Monitoring the fidelity with which interventions are implemented allows school psychologists and other educators to make more valid conclusions regarding a student's response to intervention. By providing data to show the relationship between intervention fidelity and student outcomes, this study will help decision-makers make more accurate and valid determinations regarding student specific learning disabilities.

## CHAPTER II

### LITERATURE REVIEW

Recent federal and state educational mandates such as Individuals with Disabilities Education Act (IDEA), standards-based instruction, and high stakes testing have driven various educational research and teaching communities to adopt more school-based research strategies (Lane, Bocian, MacMillan, & Gresham, 2004). Evidence-based initiatives such as response to intervention (RTI) redefined how various academic disabilities are identified and addressed within the public school system (Justice, 2006). Despite these educational advancements, students in schools today continue to struggle with a multitude of academic and behavioral problems, even after specific interventions have been implemented. These continued struggles may be a result of a lack of adherence to the specified intervention procedures, or treatment fidelity.

#### Treatment Fidelity

Treatment fidelity refers to the degree to which an academic or behavioral intervention is implemented as it was designed. Treatment fidelity may also be referred to as treatment integrity, intervention integrity or intervention fidelity (Goss, Noltemeyer, & Devore, 2007; Moncher & Prinz, 1991). By

maintaining a high level of intervention fidelity when implementing research-based interventions in schools, teachers, school psychologists and other interventionists can be confident that changes in a student's academic progress or behavior are due to the intervention, and not other, extraneous variables. Similarly, the lack of treatment fidelity in school-based academic and behavioral intervention studies compromises knowledge of the relationships between independent and dependent variables (Gresham, Gansle, Noell, Cohen, & Rosenblum, 1993). However, insuring that interventions are implemented correctly is often more difficult than initial treatment development (Noell et al., 2000), as implementation requires actual hands-on activities that may not have been anticipated during intervention development.

Treatment fidelity monitoring is an essential part of the intervention process; however, often times it is overlooked. As Wilkinson (2006) explained, during consultation, school psychologists often assume that the consultee's verbal agreement will result in the intervention being carried out as planned. However, many times this is not the case. Without an appropriate measure to determine the actual fidelity of an intervention, the true fidelity may be overestimated. This may result in invalid outcome data regarding the effectiveness of the intervention as well as problems replicating the intervention in similar behavioral and academic cases.

Although the literature is limited, an intuitive relationship between treatment fidelity and treatment outcomes seems to exist: Interventions that are poorly

implemented appear less likely to be effective (Noell et al., 2005). Similarly, Noell et al. (2005) stated that the limited evidence available suggests the importance of treatment fidelity in achieving successful treatment results. Noell, Gresham, and Gansle (2002) examined the impact of three varying levels of treatment fidelity on students' mathematics performance. Six students, all referred for poor math performance, received a computer-delivered delayed prompt providing either a counting strategy, accuracy feedback or an animated praise sequence. Prompts were delivered at either all, two-thirds or one-third of the trials, each representing a fidelity variation. Overall, the authors found better student outcomes to be associated with more prompt implementation. Similarly, poorer student outcomes were associated with less prompt implementation.

Several recent studies demonstrated the effect varying levels of treatment fidelity have on behavioral interventions. Although in research, behavioral interventions are likely to be implemented with near-perfect fidelity (Wilder, Atwell, & Wine, 2006), Gresham et al. (1993) found that only 14.4% of the 181 experimental studies examined published between the years of 1980-1990 systematically measured and reported fidelity data. Fidelity measures in practice settings may be much lower considering the absence of direct experimenter control. Furthermore, Gresham, MacMillan, Beebe-Frankeberger and Bocian (2000) reviewed 65 intervention articles published in three major disability journals between January 1995 and August 1999 and found that only 18.5% actually measured and reported treatment fidelity data.

Rhymer, Evans-Hampton, McCurdy and Watson (2002) manipulated varying levels of treatment fidelity in a toddler aggressive behavior study. Time-out interventions were implemented at varying fidelity levels and the frequency of aggressive behaviors committed by the 18-month-old participant was recorded. The authors found a decrease in aggressive behavior to be associated with the 75% and 100% treatment fidelity levels. Similarly, Wilder et al. (2006) examined the compliance percentages of two children when receiving a three-step prompting procedure at different levels of fidelity adherence. The treatment fidelity levels for the prompting procedure were 100% fidelity, 50% fidelity and 0% fidelity. The highest percentage of compliance was obtained when the prompting procedure was carried out with 100% fidelity. Similarly, the lowest percentage of compliance was obtained when the prompting procedure was not implemented at all (Wilder et al., 2006).

McEvoy, Shores, Wehby, Johnson, and Fox (1990) investigated the importance of treatment fidelity in children's social skills training. The authors taught 12 special education teachers specific teaching, planning, and monitoring procedures to promote positive social interactions. The fidelity of the teachers' implementation of these procedures was monitored and recorded through direct observations. The authors then compared the outcomes of the third of students whose teachers implemented the social skills training procedures the least, with the third of students whose teachers implemented the social skills training procedures the most. The data from the

study showed superior outcome measures of the students whose teachers were in the high fidelity group compared to the students whose teachers were in the low fidelity group during direct instruction.

### Methods of Recording Treatment Fidelity

There are several methods for recording treatment fidelity that teachers, school psychologists and other school personnel can use when implementing interventions with students. Witt (1997) cautioned that practitioners should not assume talking about implementing an intervention properly will lead to successful implementation. Instead, direct assessment of fidelity is necessary throughout the intervention. By rigorously recording treatment fidelity throughout the entire implementation period, conclusions about the effect the intervention (independent variable) have on the student's academic or behavioral performance (dependent variable) can be made with confidence.

A common method for monitoring treatment fidelity is a self-report method. The self-report method requires the teacher to track the extent to which he or she successfully implemented each component of the intervention (Lane et al. 2004). Generally, the teacher or person carrying out the intervention checks each step of the intervention on a self-report form, which lists each component of the intervention. Each step on the form should be clearly and operationally defined to be certain there is no confusion between what the teacher may think needs to be done and what actually needs to be done. Cochrane and Castle (2006, as cited in Goss et al.) added that self-report methods of fidelity monitoring could also be conducted through behavioral

interviews in which the intervention agent is asked to indicate the degree that each component of the intervention was implemented as planned.

Although self-report methods of monitoring treatment fidelity are commonly used, there are problems inherent in using these approaches (Witt, Gresham, & Noell, 1996). Wickstrom, Jones, LaFleur, and Witt (1998) found the accuracy of treatment fidelity data decreases as the level of methodological rigor for recording such data increases. For example, a teacher may report a higher level of treatment fidelity when using a self-report form than actually occurred. They found that level of treatment fidelity reported by teachers (54%) differed greatly compared to the level of treatment fidelity revealed by direct observation by an outside source (4%).

Direct observation is another method that is frequently used to monitor treatment fidelity. Gresham et al. (2000) described three steps in properly conducting a direct observation of treatment fidelity: a) operationally defining each component of the treatment, b) assessing whether each listed component occurs or does not occur during the implementation process, either live or through videotape, and c) calculating the percentage of components implemented correctly. Lane et al. (2004) suggested a similar process, only adding an initial step which included a detailed list or task analysis of the components of the intervention. According to Moncher and Prinz (1991), direct observation data from outside personnel are the most useful in determining the true fidelity of a treatment. Direct observation



methods are often used in experimental studies to increase the reliability of the treatment fidelity measures.

Permanent products may also be used as a source for documenting treatment fidelity. Permanent products can be defined as work samples that students produce as a result of an intervention (Goss et al., 2007). For example, if an intervention for a student who was struggling to write complete sentences was to have that student write a designated number of complete sentences per night, the student's written work could then be examined. A benefit of using permanent products is that they are easy to collect and analyze, because they are completed student work. Also, permanent products result in minimal disruption to the classroom and do not require the teacher to take on any additional responsibilities in the fidelity evaluation process (Lane et al. 2004).

Witt, Noell, LaFleur and Mortenson (1997) used permanent products to determine the degree to which four teachers implemented an intervention designed to improve the academic performance of elementary students in a general education classroom. In this study, the score at the top of the students' completed work was used as a permanent product, signifying that the teacher had successfully graded that particular work. Also, reward slips given to the students by the teachers were kept in a special box and tallied to calculate the percentage that proper reward steps were taken by the teacher. Witt et al. (1997) noted the use of permanent products for fidelity data collection as being a strong point of the study.

### Factors that Influence Treatment Fidelity

Although knowledge of treatment fidelity as well as knowledge of the various ways to monitor treatment fidelity are important when developing and implementing interventions, these alone may not guarantee the intervention will be carried out as designed. Awareness of factors that may lead to increased levels of intervention fidelity may be important to know before starting an academic or behavioral intervention. Telzrow and Beebe (2002) discussed several factors that may increase treatment fidelity.

According to Telzrow and Beebe (2002), the first factor that may influence the fidelity of an intervention is the empirical support the proposed intervention has received. Interventions which have been implemented in applied settings and have gained empirical support were referred to as *effective treatments* by Lonigan, Elbert and Johnson (1998). Empirical support in such applied settings is important because control over the independent variables may not be feasible. Using empirically supported interventions also allows practitioners to later replicate successful interventions with confidence that the success of the student was due to the intervention and not extraneous variables.

The second factor is that an intervention should focus on a student's keystone behaviors. Among the possible target behaviors, the behavior or skill that is selected for intervention should be essential for promoting change in the student's current performance. Telzrow and Beebe (2002) describe keystone behaviors as pivotal, meaning when such a behavior is enhanced,

improvements become evident in a number of performance domains. By targeting a specific keystone behavior, positive performance in other skills or behaviors related to that keystone behavior may increase. An example of this may be implementing an intervention to increase the amount of time students are in their seats. When students are out of their seat, they may display other undesirable behaviors such as touching other students, failing to complete work, playing with materials in the classroom, and excessively sharpening pencils. By implementing an intervention to address out-of-seat behavior (i.e. the keystone behavior), all behaviors related to this out-of-seat behavior will decrease as in-seat behavior increases.

The facilitator's perception of acceptability of the intervention is the final factor that may influence the degree to which an intervention is implemented as designed. For example, teachers and other interventionists may be more likely to implement an intervention with fidelity if it is easy to implement. Lane et al. (2004) concluded that, in general, "as the intervention increases in terms of complexity and time requirements, the level of treatment fidelity decreases" (p. 41). Also the perceived effectiveness of the intervention may increase its acceptability. Telzrow and Beebe (2002) defined perceived effectiveness as the degree to which the interventionist believes the intervention will influence the identified problem. Interventionists may be more likely to implement a treatment with fidelity if they feel it has potential to have a positive effect on the student's performance.

The current study investigates the relationship between treatment fidelity and student outcome across a variety of academic and behavioral intervention methods. The study expands on previous research (Rhymer et al., 2002; McEvoy et al., 1990) that examined treatment fidelity of one type of intervention method and the associated student outcomes.

## CHAPTER III

### METHOD

#### Participants

The participants in this study included graduate students from the University of Dayton completing their internship for the school psychology program. There were 15 students in the internship group for the 2007-08 academic year, and 11 of the 15 elected to participate in the study. Interns who chose to participate in the study were placed in 11 different public schools in central and southwestern Ohio. Informed written consent was obtained from all the participants (see Appendix A) prior to the onset of the study. Participation in the study was voluntary and individuals could choose not to participate without penalty. Participants were informed that they could discontinue their participation at any time. There was no compensation for their participation in the study. As specified in the Internship Manual from the University of Dayton school psychology program, interns worked with individual K-12 students in their intern settings. Each intern was supervised by a licensed school psychologist from the district and by the university school psychology faculty.

### Design

Twenty individual single-subject-design case studies were completed and evaluated as part of the study. A convenience sampling method was used to gather participants for this study. The relationship between treatment fidelity and outcome data for each case study was examined in a quasi-experimental design.

### Dependent Variable

The dependent variable in this study was student outcome in each behavioral and academic case study, as determined by effect size. Although effect size statistics were calculated consistently across interventions, each individual effect size signified student outcome for different student behaviors or academic skills, depending on the skill or performance deficit the intervention was intended to address.

### Independent Variable

The independent variable in the study was the percentage of treatment fidelity for each individual academic or behavioral intervention implemented by the participants of the study. Interventions were selected using a problem-solving methodology (see Appendix B), and intervention fidelity was monitored throughout the implementation period by using a treatment fidelity checklist.

### Procedures

As part of the culminating requirements in the school psychology graduate program at the University of Dayton, school psychology interns were

required to complete one academic case study and one behavioral case study in their assigned schools during their internship year. Each case study involved implementing research-based interventions with at-risk students and measuring student outcome. The interns completed these case studies following a specific problem solving approach for single-subject research designs (see Appendix B for case study rubric). Parental consent (Appendix C) was obtained for each case study and authorized permission for assessment, intervention, observation, interviews, and record review.

A copy of each intern's treatment fidelity checklist was made prior to the onset of the intervention implementation period. The intervention implementers were observed during one treatment session for each behavioral and academic intervention in 70% of the case studies. The observer used the copied intervention fidelity checklist, designed in the context of the case study, to determine the fidelity of the observed intervention session. After each observed intervention session, inter-rater reliability between the observer and the implementer was determined by dividing the total number of agreements made during the observation by the number of possible agreements.

Intervention fidelity was determined for each academic and behavioral intervention. The individual who implemented the intervention used an intervention fidelity checklist to mark each component of the intervention as it was completed during each intervention session. Intervention fidelity was calculated within and between intervention sessions. To calculate within-

session fidelity, the number of completed steps during each intervention session was divided by the number of designed intervention steps. Between-session fidelity was calculated by averaging the within-intervention fidelity over the entire course of the intervention implementation period. Therefore, the between-sessions intervention fidelity percentage represented the overall treatment fidelity percentage for the entire intervention period.

Student outcome for each academic and behavioral intervention was calculated using the effect size statistic. The effect size was calculated for each academic and behavioral case study to determine the impact that the intervention had on student performance.

### Data Analysis

Twenty case studies were used as individual single-case designs. Descriptive statistics were generated for both treatment fidelity and student outcomes. Student data were organized into two groups: High Treatment Fidelity ( at or above 90%) and Mild-to-Moderate Treatment Fidelity ( below 90%). Student outcome for each case study was determined by calculating effect size for each academic and behavioral intervention. The mean effect size for the High Treatment Fidelity and Mild-to-Moderate Treatment Fidelity groups were calculated for all case studies and compared. Further mean effect sizes were also calculated for the two subgroups of academic and behavior case studies, and the results were compared.

The percentage of non-overlapping data points (PND) was calculated for each behavioral intervention. For an intervention designed to increase the



target behavior, the percentage of non-overlapping data points was calculated for each group by determining the percentage of the intervention data points that fell above the highest baseline data point. For an intervention designed to decrease the target behavior, PND was calculated by determining the percentage of the intervention data points that fell below the lowest baseline data point. Mean PNDs were calculated and compared for the High Treatment Fidelity behavioral intervention and Moderate-to-Low Treatment Fidelity behavioral intervention groups.

Inter-rater reliability was calculated during at least one intervention session for 70% of the case studies. This reliability was determined by dividing the total number of rater agreements by the number of possible agreements on each intervention fidelity checklist. The mean inter-rater reliability percentage was calculated. Intervention fidelity during the observed intervention sessions was also reported.

## CHAPTER IV

### RESULTS

The results of the study indicate 15 case studies were placed in the High Fidelity Group (treatment fidelity between 90-100%) and 5 case studies were placed in the Moderate-to-Low Fidelity group (treatment fidelity <90%). Of the five case studies placed in the Moderate-to-Low Fidelity group, four of these case studies were behavioral case studies and one was academic. Inter-rater reliability was calculated during one implementation session for 70% of the academic and behavioral interventions (14 of 20 case studies). Inter-rater reliability percentages for the 14 case studies ranged from 95% to 100%. During the observation where 95% inter-rater reliability was calculated, the interventionist recorded 100% treatment fidelity while the observer recorded 95% treatment fidelity. The overall inter-rater reliability percentage across the observed intervention sessions was 99.6%. Further, based on the data from the observed intervention sessions, 13 of the 14 observed interventions were implemented with 100% treatment fidelity, while 1 intervention was implemented with 95% fidelity. Based on these data, it can be stated with a high degree of confidence that intervention fidelity percentages reported by interventionists were accurate.

Effect sizes were calculated separately for the High Fidelity group and Moderate-to-Low Fidelity group using the *d*-index, which is calculated by subtracting the mean of the baseline data from the mean of the intervention data and dividing by the standard deviation of the all the data. The mean effect size for the interventions in the High Fidelity group was 1.393, while the mean effect size of the interventions in the Moderate-to-Low Fidelity group was 1.694. The range of intervention fidelity in the High Fidelity Group was 90% to 100%, while the range of intervention fidelity in the Moderate-to-Low Fidelity group was 60% to 89%. The range of effect size calculations in the High Fidelity group was .08 to 2.3, while the range of effect size calculations in the Moderate-to-Low Fidelity group was 1.43 to 2.23. The mean effect size for academic interventions in the High Fidelity group was 1.413 compared to the fidelity of the sole academic case study in the Moderate-to-Low Fidelity group, which was 1.45. The mean effect size for behavioral interventions in the High Fidelity group was 1.362 compared to a mean fidelity of 1.755 for the Moderate-to-Low Fidelity group.

Mean treatment fidelity percentages and effect sizes were calculated and compared for the 10 academic and 10 behavioral case studies. The mean treatment fidelity percentage for the academic case study interventions was 97.1% fidelity compared to a mean fidelity percentage for the behavioral case study interventions of 90.1%. The mean effect size for the academic case studies was 1.417 while the mean effect size for the behavioral case studies was 1.519.

The percentage of non-overlapping data points (PND) was calculated for each behavioral intervention. For an intervention designed to increase the target behavior, the percentage of non-overlapping data points was calculated for each group by determining the percentage of the intervention data points that fell above the highest baseline data point. For an intervention designed to decrease the target behavior, PND was calculated by determining the percentage of the intervention data points that fell below the lowest baseline data point. The mean PND for behavioral interventions in the High Fidelity group was 66% compared to the mean PND for behavioral interventions in the Moderate-to-Low group, which was 83.75%.

Table 1 provides the treatment fidelity percentage, effect size, and PND (where appropriate) data for each of the 20 case studies, as well as the assigned fidelity group (H- High Fidelity group; M-L – Moderate-to-Low Fidelity group). If a linear relationship existed between treatment fidelity and student outcome, a correlational analysis would have been conducted. However, based on visual analysis of the data, correlational analyses were not appropriate. That is, there was not a clear relationship between treatment integrity and student outcome.

Table 1

*Case study treatment fidelity and outcome data*

| <b>Case Study</b> | <b>Tx Integrity</b> | <b>Effect Size</b> | <b>Treatment Group</b> | <b>PND</b> |
|-------------------|---------------------|--------------------|------------------------|------------|
| Academic 1        | 100%                | 1.07               | H                      | *          |
| Academic 2        | 100%                | 2.24               | H                      | *          |
| Academic 3        | 95%                 | 1.001              | H                      | *          |
| Academic 4        | 99%                 | 1.8                | H                      | *          |
| Academic 5        | 99%                 | 1.25               | H                      | *          |
| Academic 6        | 99%                 | 1.6                | H                      | *          |
| Academic 7        | 90%                 | 1.04               | H                      | *          |
| Academic 8        | 100%                | 1.58               | H                      | *          |
| Academic 9        | 89%                 | 1.45               | M-L                    | *          |
| Academic 10       | 100%                | 1.14               | H                      | *          |
| Behavior 1        | 83%                 | 1.43               | M-L                    | 100%       |
| Behavior 2        | 100%                | 1.61               | H                      | 85%        |
| Behavior 3        | 95%                 | 0.08               | H                      | 0%         |
| Behavior 4        | 83%                 | 1.85               | M-L                    | 100%       |
| Behavior 5        | 100%                | 0.95               | H                      | 50%        |
| Behavior 6        | 100%                | 1.81               | H                      | 100%       |
| Behavior 7        | 80%                 | 2.23               | M-L                    | 81%        |
| Behavior 8        | 100%                | 1.42               | H                      | 66%        |
| Behavior 9        | 60%                 | 1.51               | M-L                    | 54%        |
| Behavior 10       | 100%                | 2.3                | H                      | 95%        |

*\*Note: PND cannot be calculated for academic interventions*

## CHAPTER V

### DISCUSSION

This study sought to extend previous research that examined the relationship between intervention treatment fidelity and student outcome. Further, this investigation sought to expand on such research by examining student outcome as it related to various intervention methodologies (i.e. independent variables), as they relate to the target behavior or academic skill in each case study. The initial intent of the study was to show a linear relationship between high treatment fidelity percentages and positive student academic and behavioral outcome. However, after examining the data collected through the study, a linear relationship did not exist between the treatment fidelity percentages of 20 academic and behavioral tier-III case studies and student outcome (see Table 1). Nineteen of twenty case studies reported treatment fidelity percentages above 80%, and nineteen of twenty case studies reported effect sizes in the high range (above .8).

Unintended results emerged which support previous studies indicating lower limits of treatment fidelity leading to high degrees of student outcome (Rhymer et al., 2002; Wilder et al., 2006). In the current study, a large positive student outcome (effect size 1.51) existed with a treatment fidelity percentage

of 60%. Rhymer et al. (2002) reported positive student outcomes to be associated with treatment groups receiving interventions implemented with both 75% and 100% fidelity. Further, Wilder et al. (2006) found positive student outcomes to be associated with treatment groups receiving interventions implemented with treatment fidelity percentages as low as 50%. These findings may indicate that interventions implemented with as low as moderate to high treatment fidelity should still yield positive student outcome in both academic and behavioral interventions. Treatment fidelity limits from 50% to 100% should be considered valid when determining student outcome in tier-III academic and behavioral interventions.

The current study confirmed previous studies which showed interventionists are likely to implement interventions with a high degree of fidelity when they are being observed. As direct observation of an intervention session may be an effective way to monitor treatment fidelity (Gresham et al., 2000), it may also lead to high percentages of treatment fidelity. That is, when being observed, interventionists may tend to implement interventions with higher degrees of fidelity compared to when implementing an intervention in a one-on-one session with a student. Based on the data obtained through observation of 70% of the academic and behavioral case studies, interventionists consistently implemented interventions with high fidelity. Although it is not practical to observe every intervention session when working with students, intermittent observations may lead to higher overall fidelity percentages.

It is also important to address that, although previous research has shown high levels of fidelity may lead to more positive student outcomes, treatment fidelity alone is not sufficient for the demonstration of functional relationships between independent variables and dependent variables (Gresham, 1997). That is, although an intervention may be implemented with a high degree of fidelity, this alone is not enough to ensure the intervention will be successful. Interventionists must implement rigorous problem identification, problem analysis, and hypothesis testing methodologies to ensure chosen research-based interventions are designed to address specific student deficits. If the wrong academic skill or target behavior is identified, the success of the intervention may be limited. This could cause the interventionist or other decision-making educators to make invalid conclusions regarding the student's response to intervention. This is especially true as districts across the United States are moving towards an RTI model of specific learning disability identification.

### Limitations

One limitation of the study was that the interventionists in each academic and behavioral case study were school psychology interns implementing tier-III interventions as required by their training program, with case study reports being submitted for a grade. Newly trained school psychology interns may tend to implement interventions with higher degrees of treatment fidelity compared to teachers or other interventionists implementing interventions in schools. Further, high-stakes internship assignments may increase work



productivity and effort, which may cause the treatment fidelity percentages in each case study to be higher than what may be found in actual practice. Comparative data from Ohio elementary school intervention assistance teams (IATs) were sought but unavailable. These data would have provided a useful comparison group.

A second limitation of the study was that all academic and behavioral interventions were completed in a naturalistic school setting. That is, interventions were completed with elementary school students in a real school setting. Because of this, there was no attempt to control for the varying levels of treatment fidelity with which interventions were implemented. Intervention fidelity may have been affected by natural variables such as student attendance, interventionist case-load, and school schedule.

A third limitation of the study was that each intervention was defined and implemented independently of other interventions. Although this is beneficial when comparing between-intervention data, it may also have negative implications. For example, one case study intervention may have been implemented five days a week for 30 minutes a day, while another case study intervention may have been implemented only two days a week for 20 minutes. This may have consequences when determining the actual time spent one-on-one with the case-study student compared to the overall treatment fidelity.

A fourth limitation of the study was the small sample of participants ( $n=20$ ). A higher number of participants may have allowed other statistical measures

to be used to analyze outcome data. A fifth limitation was that, although all interventions were research-based, they were not all of equal power. That is, one intervention may intrinsically have a higher impact on student performance when compared to another. This may cause effect size ratings to be higher for some interventions when compared to others due to individual intervention factors.

A sixth limitation of the study was that not all pupils selected as case study students were at equal academic skill or behavioral performance levels. As case studies were completed with students across K-6 settings, students presented a wide variety of skills, which may have affected the rate of improvement in both academic and behavioral interventions. Finally, the study was completed with a relatively homogenous sample of case study students chosen to receive intervention. Each case study was completed in a central or southwestern Ohio public elementary or middle school. Incorporating students of more diverse ethnic, cultural, and behavioral backgrounds may increase the external validity of the data (Nist & Joseph, 2008)

### Future Research

Additional studies with future school psychology interns (or other closely monitored school personnel) should be conducted while simultaneously collecting actual intervention assistance team data. This would allow researchers to examine differences between experimental case studies as well as those students going through school IAT processes. Future research examining student outcome associated with various predetermined levels of

treatment fidelity would also help provide evidence for levels of treatment fidelity necessary to produce positive student outcomes. Finally, further research should be conducted examining various levels of treatment fidelity as they relate to the number of intervention steps and length of intervention. A third variable in such research may include intervention acceptability ratings based on intervention length.

### Conclusion

The initial hypothesis of the current study stated that higher levels of intervention treatment fidelity would lead to greater academic and behavioral student outcome when compared to lower levels of intervention treatment fidelity. Although this hypothesis was not supported through research data, the current study provided evidence supporting previous research showing moderate levels of treatment fidelity leading to high levels of student outcome. The data from the current study demonstrate evidence which shows an intervention may lead to a large, positive student outcome ( $ES > .8$ ) when implemented with between 60% and 100% treatment fidelity. These findings are particularly useful when making special education decisions regarding a student's response to academic or behavioral interventions. In particular, interventions implemented with 60% or higher treatment fidelity showed results in positive student outcomes. If small or no gains are made, confident special education eligibility decisions can be made.

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## APPENDIX A

### Informed Consent to Participate as a Research Subject

**Project Title:** Improving Student Outcomes through RTI: The Value of Utilizing a Case Study Rubric

**Investigators:** Daniel Trunk, Julie Rabatsky, and Norine Veeneman

**Purpose of Research:** This research seeks to investigate the relationship between three measures of case study fidelity procedures and student outcomes.

**Expected Duration of Study:** This study will take place during the 2007-2008 academic school year.

**Procedure:** During your school psychology internship you will be completing two pupil case studies according to the specifications of a rubric adopted by the National Association of School Psychologists. While completing these assignments, you will be interviewed following the hypothesis testing section of both the behavioral and academic case studies. Interviews will be tape recorded and last approximately 20 minutes. Prior to the implementation of each intervention, your treatment fidelity measure will be photo copied to allow researchers to observe treatment fidelity throughout each case study. Further, you will be observed implementing the intervention for a percentage of the intervention sessions. You will turn in your completed case studies at the end of the 2007-2008 school year and your case studies will be reviewed by the research team and student outcome data will be analyzed.

**Alternative Procedures:** There are no alternative procedures for this research study.

**Anticipated Risks and / or Discomfort:** There are no anticipated risks or discomforts as a result of this study. The study involves observing and collecting data from case studies that are mandatory for completion of graduation with the Ed.S. Degree from the University of Dayton.

**Benefits to the Participant:** There are no anticipated benefits to the participants of this study.

**Confidentiality:** Participation in this study will be kept confidential. No further consent is needed from the parent(s) of the students which the case studies are being conducted as informed consent must be obtained from the student's parent(s) prior to the beginning of each case study. Outcome data from the interventions will be reviewed at the conclusion of the case study upon submission to the internship advisors. Field observation notes will be kept confidential and anonymous. Data will be stored in a locked file cabinet



in the Counselor Education office in Chaminade Hall at the University of Dayton. Data will be destroyed three years following the completion of data analysis.

**Contact Person for Questions or Problems:** If you have a question during the research period, please contact Sawyer Hunley, Chaminade Hall Room 301, 937-229-3624. Questions about the rights of the participant should be addressed to Jon Nieberding., Chair of the Committee for the Protection of Human Subjects, Kettering Labs Room 542, +0104, 937-229-4053.

**Consent to Participate:** I understand that participation in this study is voluntary. I understand that I have the right to discontinue your participation in this study at any time. The investigators above have answered all questions regarding the research project, my participation, and issues of confidentiality. I have received a copy of this consent form and I voluntarily will sign.

---

Signature of Participant

---

Date

---

Signature of Investigator

## APPENDIX B

### Case Study Rubric

#### Section 1.0

**Local Norms:** Local norms and outcome goals were established for class.

|     | Outstanding   | Competent   | Needs Development  |
|-----|---|---|--|
| 1.1 | <input type="checkbox"/> Teacher consultation provided both classwide behavioral and/or academic goals and a target date to accomplish the classwide goals  | <input type="checkbox"/> Teacher consultation provided only classwide behavioral and/or academic goals or a target date to accomplish the classwide goals | <input type="checkbox"/> Teacher consultation did not provide classwide behavioral and/or academic goals and a target date to accomplish the classwide goals |
| 1.2 | <input type="checkbox"/> The class goal statement(s) was written in observable, measurable terms, and was based on the all of the following:<br><input type="checkbox"/> Review of curriculum for academic goals, AND<br><input type="checkbox"/> Task analysis for academic and/or behavioral target goals, AND<br><input type="checkbox"/> Description of class-wide instructional methods to address the academic and/or behavioral target goals | <input type="checkbox"/> The class goal statement(s) was written in observable, measurable terms  | <input type="checkbox"/> The class goal statement(s) was NOT written in observable, measurable terms   |
| 1.3 | <input type="checkbox"/> Local norms were established through direct observation, criteria-based instrument(s), or curriculum-based measurement (Classes that do not have established local norms will need to have at least 3 administrations of each measure conducted over a several week period to determine average rate of change per week or stability for class.)   | <input type="checkbox"/> Local norms were established through direct observation, criteria-based instrument(s), or curriculum-based measurement           | <input type="checkbox"/> Local norms and/or goals were underdeveloped  |
| 1.4 |   | <input type="checkbox"/> Technology was used in the gathering and synthesis of data   | <input type="checkbox"/> Technology was not used in the gathering and synthesis of data  |

| Rating for 1.0   |  |   |  |  |
|--|--|---|--|--|
| <input type="checkbox"/> <b>Outstanding:</b><br>All components in the Competent and Outstanding categories are checked | <input type="checkbox"/> <b>Substantially Developed:</b> All components in the Competent category plus some components in the Outstanding category are checked | <input type="checkbox"/> <b>Competent:</b> All components in the competent category are checked | <input type="checkbox"/> <b>Threshold Development:</b> Some components in the competent category are checked | <input type="checkbox"/> <b>Needs Development:</b> Only components in the Needs Development category are checked |

**Section 2.**  
are

**Problem Identification & Analysis:** The at-risk student and academic/behavioral concern(s) identified and clarified.

|            | <b>Outstanding</b>   | <b>Competent</b>   | <b>Needs Development</b>   |
|------------|--|--|--|
| <b>2.1</b> |  | <input type="checkbox"/> One at-risk student is identified   | <input type="checkbox"/> One at-risk student was not clearly identified  |
| <b>2.2</b> |  | <input type="checkbox"/> The at-risk student's academic and/or behavioral concern(s) is identified and operationally defined using class goals and local norms   | <input type="checkbox"/> The at-risk student's academic and/or behavioral concern(s) is identified but NOT operationally defined using class goals and local norms |
| <b>2.3</b> |  | <input type="checkbox"/> The problem was identified and defined collaboratively  | <input type="checkbox"/> The problem was NOT identified and defined collaboratively  |
| <b>2.4</b> |  | <input type="checkbox"/> A baseline for the at-risk student is established for the concern(s)  | <input type="checkbox"/> A baseline for the at-risk student is NOT established or is inappropriate   |
| <b>2.5</b> | <input type="checkbox"/> <b><u>Skill analysis</u></b> was conducted and included <b><u>all of the following:</u></b><br><input type="checkbox"/> Error analysis,<br><input type="checkbox"/> Direct observation of skill,<br><input type="checkbox"/> Criteria-based assessment, OR curriculum-based assessment  | <input type="checkbox"/> <b><u>Skill analysis</u></b> was conducted and included <b><u>one or more</u></b> of the following:<br><input type="checkbox"/> Error analysis,<br><input type="checkbox"/> Direct observation of skill,<br><input type="checkbox"/> Criteria-based assessment, OR curriculum-based assessment  | <input type="checkbox"/> No skill analysis was conducted, or analysis was inappropriate for the identified concern(s)  |
| <b>2.6</b> | <input type="checkbox"/> <b><u>Performance analysis</u></b> was conducted and included <b><u>all of the following:</u></b><br><input type="checkbox"/> Record review for historical documentation of pertinent information,<br><input type="checkbox"/> Student interview,<br><input type="checkbox"/> Ecological or situational analysis of concern (e.g., routines, expectation-skill match, relationships, classroom environment, adult/teacher support, cultural issues)<br><input type="checkbox"/> Direct observation (e.g., on-task)<br><input type="checkbox"/> Parent interview | <input type="checkbox"/> <b><u>Performance analysis</u></b> was conducted and included <b><u>one or more</u></b> of the following:<br><input type="checkbox"/> Record review for historical documentation of pertinent information,<br><input type="checkbox"/> Student interview,<br><input type="checkbox"/> Ecological or situational analysis of concern (e.g., routines, expectation-skill match, relationships, classroom environment, adult/teacher support, cultural issues)<br><input type="checkbox"/> Direct observation (e.g., on-task)<br><input type="checkbox"/> Parent interview | <input type="checkbox"/> No performance analysis was conducted, or analysis was inappropriate for the identified concern(s)  |

| <b>Rating for 2.0</b>   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> <b><u>Outstanding:</u></b><br>All components in the Competent and Outstanding categories are checked | <input type="checkbox"/> <b><u>Substantially Developed:</u></b> All components in the Competent category plus some components | <input type="checkbox"/> <b><u>Competent:</u></b> All components in the competent category are checked | <input type="checkbox"/> <b><u>Threshold Development:</u></b> Some components in the competent category are checked | <input type="checkbox"/> <b><u>Needs Development:</u></b> Only components in the Needs Development category are checked |

|  |   |  |  |  |
|--|---|--|--|--|
|  | in the Outstanding category are checked |  |  |  |
|--|---|--|--|--|

**Section 3.0**      **Hypothesis Testing:** Hypotheses were developed and tested

|            | <b>Outstanding</b>  | <b>Competent</b>   | <b>Needs Development</b>   |
|------------|---|--|--|
| <b>3.1</b> |   | <input type="checkbox"/> Hypotheses were generated through collaboration with teacher and/or parent  | <input type="checkbox"/> Hypotheses were generated without collaboration with teacher and/or parent  |
| <b>3.2</b> | <input type="checkbox"/> Multiple hypotheses were developed to identify the cause or source of each problem   | <input type="checkbox"/> A hypothesis was developed to identify the cause or source of each problem  | <input type="checkbox"/> No hypotheses were developed  |
| <b>3.3</b> | <input type="checkbox"/> Each of the multiple hypotheses was tested to confirm the cause or source of the problem using one or more of the following methods:<br><input type="checkbox"/> Direct observation,<br><input type="checkbox"/> Analogue assessment,<br><input type="checkbox"/> Functional assessment,<br><input type="checkbox"/> Self-monitoring assessment,<br><input type="checkbox"/> Other | <input type="checkbox"/> One hypothesis was tested to confirm the cause or source of the problem using one or more of the following methods:<br><input type="checkbox"/> Direct observation,<br><input type="checkbox"/> Analogue assessment,<br><input type="checkbox"/> Functional assessment,<br><input type="checkbox"/> Self-monitoring assessment,<br><input type="checkbox"/> Other | <input type="checkbox"/> Hypothesis testing did not occur  |
| <b>3.4</b> |   | <input type="checkbox"/> The hypothesis reflected awareness of individual differences (e.g., biological, social, linguistic, cultural)   | <input type="checkbox"/> The hypothesis did NOT reflect awareness of individual differences (e.g., biological, social, linguistic, cultural) |
| <b>3.5</b> |   | <input type="checkbox"/> Hypothesis testing linked the academic and/or behavioral problem(s) with the intervention   | <input type="checkbox"/> Hypothesis testing did NOT link the academic and/or behavioral problem(s) with the intervention                     |

| <b>Rating for 3.0</b>  |  |   |  |  |
|--|--|---|--|--|
| <input type="checkbox"/> <b>Outstanding:</b><br>All components in the Competent and Outstanding categories are checked | <input type="checkbox"/> <b>Substantially Developed:</b> All components in the Competent category plus some components in the Outstanding category are checked | <input type="checkbox"/> <b>Competent:</b> All components in the competent category are checked | <input type="checkbox"/> <b>Threshold Development:</b> Some components in the competent category are checked | <input type="checkbox"/> <b>Needs Development:</b> Only components in the Needs Development category are checked |

**Section 4.**

**Intervention:** Intervention was implemented and monitored

|      | <b>Outstanding</b>   | <b>Competent</b>  | <b>Needs Development</b>  |
|------|--|---|---|
| 4.1  |  | <input type="checkbox"/> Goal statement(s) was written in observable, measurable terms  | <input type="checkbox"/> Goal statement was NOT written in observable, measurable terms   |
| 4.2  |  | <input type="checkbox"/> Goal statement(s) emerged from the problem analyses and hypothesis testing   | <input type="checkbox"/> Goal statement(s) did NOT emerge from the problem analyses and hypothesis testing  |
| 4.3  |  | <input type="checkbox"/> Intervention(s) was developed collaboratively  | <input type="checkbox"/> Intervention(s) was NOT developed collaboratively  |
| 4.4  |  | <input type="checkbox"/> Intervention(s) logically linked to the referral question  | <input type="checkbox"/> Intervention was NOT linked to referral question   |
| 4.5  |  | <input type="checkbox"/> Intervention(s) logically linked to the hypothesis   | <input type="checkbox"/> Intervention(s) did NOT logically link to the hypothesis   |
| 4.6  |  | <input type="checkbox"/> Intervention(s) logically linked to the goal statement   | <input type="checkbox"/> Intervention(s) did NOT logically link to the goal statement   |
| 4.7  | <input type="checkbox"/> Logistics of setting, time, resources and personnel required for intervention and data gathering were defined and implemented           | <input type="checkbox"/> Intervention(s) was described including procedures for one or more of the following:<br><input type="checkbox"/> Promoting new or replacement behaviors/skills<br><input type="checkbox"/> Increasing existing behaviors/skills<br><input type="checkbox"/> Reducing interfering problem behaviors<br><input type="checkbox"/> Facilitating generalization | <input type="checkbox"/> Intervention(s) was NOT described in enough detail to ensure appropriate implementation  |
| 4.8  | <input type="checkbox"/> Support was provided to justify the use of the intervention as evidence-based practice (e.g., research literature, functional analysis) | <input type="checkbox"/> Intervention(s) was implemented  | <input type="checkbox"/> Intervention(s) was limited to determination of eligibility for special education services or referral for services external to the school and/or the home |
| 4.9  | <input type="checkbox"/> Acceptability of intervention by teacher, parent and child was verified   | <input type="checkbox"/> Intervention reflected sensitivity to individual differences, resources, classroom practices, and other system issues  | <input type="checkbox"/> Intervention did NOT reflect sensitivity to individual differences, resources, classroom practices, and other system issues                                |
| 4.10 | <input type="checkbox"/> Treatment/intervention fidelity was monitored to assure appropriate implementation  | <input type="checkbox"/> Intervention(s) was monitored  | <input type="checkbox"/> Intervention(s) was NOT monitored  |

| <b>Rating for 4.0</b>  |  |   |  |  |
|--|--|---|--|--|
| <input type="checkbox"/> <b>Outstanding:</b><br>All components in the Competent and Outstanding categories are checked | <input type="checkbox"/> <b>Substantially Developed:</b> All components in the Competent category plus some components | <input type="checkbox"/> <b>Competent:</b> All components in the competent category are checked | <input type="checkbox"/> <b>Threshold Development:</b> Some components in the competent category are checked | <input type="checkbox"/> <b>Needs Development:</b> Only components in the Needs Development category are checked |

|  |   |  |  |
|--|---|--|--|
|  | in the Outstanding category are checked |  |  |
|--|---|--|--|

**Section 5.0 Evaluation and Recommendations:** Data were gathered and documented to demonstrate efficacy of intervention.

|      | Outstanding  | Competent  | Needs Development   |
|------|--|--|---|
| 5.1  | <input type="checkbox"/> Goal attainment was plotted at the end point and compared to baseline   | <input type="checkbox"/> Progress monitoring data were plotted on a graph or chart   | <input type="checkbox"/> Progress monitoring data were NOT plotted on a graph or chart  |
| 5.2  | <input type="checkbox"/> Goal attainment was plotted at the end point and compared to the desired goal   | <input type="checkbox"/> Data were provided as evidence of measurable, positive impact toward stated goal  | <input type="checkbox"/> Data were NOT provided to document student progress  |
| 5.3  |  | <input type="checkbox"/> Single-case design was specified (e.g., changing criterion, withdrawal, multiple baseline, alternating treatments) to prove efficacy of intervention  | <input type="checkbox"/> Single-case design was not specified (e.g., changing criterion, withdrawal, multiple baseline, alternating treatments) to prove efficacy of intervention |
| 5.4  |  | <input type="checkbox"/> Current technologies were used to present data  | <input type="checkbox"/> Current technologies were not used to present data   |
| 5.5  | <input type="checkbox"/> Data were obtained through <b>multiple methods</b> and were presented in support of student's progress from two or more of the following:<br><input type="checkbox"/> Direct observation<br><input type="checkbox"/> Rating scale<br><input type="checkbox"/> Peer comparison<br><input type="checkbox"/> Self-monitoring<br><input type="checkbox"/> CBM<br><input type="checkbox"/> Other | <input type="checkbox"/> Evidence in support of student's progress from <b>one</b> of the following:<br><input type="checkbox"/> Direct observation<br><input type="checkbox"/> Rating scale<br><input type="checkbox"/> Peer comparison<br><input type="checkbox"/> Self-monitoring<br><input type="checkbox"/> CBM<br><input type="checkbox"/> Other | <input type="checkbox"/> No evidence was provided in support of student's progress  |
| 5.6  | <input type="checkbox"/> Intervention quality and fidelity were monitored with a formal measure  | <input type="checkbox"/> Intervention quality and fidelity were monitored but the formal measure was not clearly specified   | <input type="checkbox"/> Intervention quality and fidelity were not monitored   |
| 5.7  | <input type="checkbox"/> Effectiveness of intervention was examined collaboratively  | <input type="checkbox"/> Effectiveness of intervention was examined, but evidence of collaboration in the examination was not included   | <input type="checkbox"/> Effectiveness of intervention was not examined   |
| 5.8  | <input type="checkbox"/> Intervention limitations and side effects were described  | <input type="checkbox"/> Intervention limitations or side effects were described   | <input type="checkbox"/> Intervention limitations and side effects were not described   |
| 5.9  | <input type="checkbox"/> Strategies for follow-up were developed collaboratively   | <input type="checkbox"/> Suggestions for follow-up were provided   | <input type="checkbox"/> Suggestions for follow-up were NOT provided  |
| 5.10 | <input type="checkbox"/> Goal Attainment Follow-up Guide was developed prior to initiation of intervention.<br><input type="checkbox"/> Level of goal attainment was determined<br><input type="checkbox"/> Changes in intervention and/or   | <input type="checkbox"/> Level of goal attainment was determined<br><input type="checkbox"/> Changes in intervention and/or follow-up recommendations were made.   | <input type="checkbox"/> Level of goal attainment was not determined.   |

|      |   |  |  |
|------|---|--|--|
|      | follow-up recommendations were made, as indicated by Follow-up Guide.   |  |  |
| 5.11 | <input type="checkbox"/> Effect size was calculated and demonstrated a positive, measurable outcome.                            | <input type="checkbox"/> Effect size was calculated.                           | <input type="checkbox"/> Effect size was not calculated.                           |
| 5.12 | <input type="checkbox"/> Percent of Non-overlapping data points was calculated and demonstrated a positive, measurable outcome. | <input type="checkbox"/> Percent of Non-overlapping data points was calculated | <input type="checkbox"/> Percent of Non-overlapping data points was not calculated |

| Rating for 5.0   |  |   |  |  |
|--|--|---|--|--|
| <input type="checkbox"/> <b>Outstanding:</b><br>All components in the Competent and Outstanding categories are checked | <input type="checkbox"/> <b>Substantially Developed:</b> All components in the Competent category plus some components in the Outstanding category are checked | <input type="checkbox"/> <b>Competent:</b> All components in the competent category are checked | <input type="checkbox"/> <b>Threshold Development:</b> Some components in the competent category are checked | <input type="checkbox"/> <b>Needs Development:</b> Only components in the Needs Development category are checked |

| Overall Rating for Case Study (A rating of Competent or higher is required to pass)                  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> <b>Outstanding:</b><br>Case study is rated Outstanding in all five Sections | <input type="checkbox"/> <b>Substantially Developed:</b> Case study is rated Competent or higher for all Sections and Substantially Developed or higher in one or more sections | <input type="checkbox"/> <b>Competent:</b> All five Sections of the Case Study are rated competent | <input type="checkbox"/> <b>Threshold Development:</b> Some but not all Sections are rated Competent | <input type="checkbox"/> <b>Needs Development:</b> Sections are only rated Needs Development |

Case study submitted by: \_\_\_\_\_ Date: \_\_\_\_\_

Case study reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

## APPENDIX C

### Parent Permission Form

(Date)

Dear Mr. and Mrs. (Insert Name):

Please accept this request for permission for your son/daughter, (Insert Name), to participate in one of my University of Dayton internship assignments. I am employed by the (Insert School District) School District as an intern school psychologist, and am in my final year of training to earn a license as a school psychologist from the Ohio Department of Education. I work under the supervision of (Insert Supervisor), a (Insert School District) licensed school psychologist, as well as the supervision of Dr. James Evans, a faculty member in the School Psychology Program at the University of Dayton.

One of my required internship assignments is to conduct an academic case study. (Student's) teacher, (Insert Teacher Name), has expressed her wish for help in improving (Insert Concern). The study involves gathering some information about (Student) by interviewing (Student) and his teacher, by observing (Student) in class, and by asking him to demonstrate his skills to me during some exercises I will administer to him. This information will be used to design some different ways to teach (Student) in order to improve his or her skills. The effectiveness of the methods will be monitored and changed as needed to make them better. You will receive progress reports and a final report after the teaching methods have been used.

Please feel free to ask questions of any of the following people at any time.

(Field Supervisor): (Phone Number) or (E-mail Address)

(Field Supervisor): (Phone Number) or (E-mail Address)

Dr. James Evans: (937) 212-8554 or  
mailto:[James.Evans@notes.udayton.edu](mailto:James.Evans@notes.udayton.edu)

Sincerely,  
(Intern School Psychologist)

Please sign one copy of this letter below to indicate whether you grant or refuse permission, and return it to me at the above address. Keep the other copy for your records.

\_\_\_\_\_  
Signature to Grant Permission

\_\_\_\_\_  
Signature to Refuse Permission



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