
Presenter: Stewart Redshaw PhD
Research and Practice Development Manager
MERCY FAMILY SERVICES
stewart.redshaw@mfsq.org.au

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Presentation Outline

• Personal Introduction

• PART 1: Introducing the ‘DMERTTS’ framework

• PART 2: The Issues and barriers to achieving Implementation Fidelity in community-based settings
Personal Introduction - a 20 year journey

• Currently work as Mercy Family Services’ (MFS) Research and Practice Development Manager – since 2003

• 21 years experience with MFS in a range of capacities including direct care, program coordinator, manager/director, and research & practice development (including 16 years as a member of the Leadership Team)

• The never-ending struggle between day-to-day service delivery and the need to ensure that what we do is best practice (based on the literature), documented (Models of Practice) and monitored and evaluated in a valid and timely manner … not to mention the effort of maintaining quality staff and high-functioning teams

• The DMERTTS Framework has emerged and evolved from within this practice, research and management experience
PART 1: The DMERTTTTS Framework

- The basic components

**D**ocumentation  
**M**onitoring & **E**valuation  
**R**eporting  
**T**raining  
**T**eamwork  
**S**upervision
PART 1: The DMERTTS Framework

Turn to the handout
PART 1: The DMERTTS Framework
Implications for effective implementation:

Summary of key points:

• Having a clearly articulated ‘Model of Practice’ (clinically-based and/or using logic design principles)

• Using a comprehensive range of monitoring and evaluation strategies to examine quality and effectiveness of services, programs, and specific interventions

• Monitoring implementation fidelity of the Model of Practice

• Reporting back to the funding/practice/academic community (subjecting practice to peer review) and critically …

• Giving due attention to training, teamwork (developing and maintaining high functioning clinical teams/workgroups), and multi-dimensional supervision practices

Essential Conclusion: Without clinical leadership, management & administrative support and high functioning staff & workgroups … Implementation fidelity at the program level is less likely
PART 2: The DMERTTS Framework
The implementation – over the next several years:

• The framework provides the **foundation** and **scaffolding**

• The next stage of the process involves **identifying, sourcing or creating a comprehensive collection** of administrative data collection tools, psychometric and psychosocial/clinical evaluation tools etc... for each of the measures in the DMERTTS Framework

• An **audit** will be conducted on each MFS program to determine which DMERTTS activities are currently in place, and which strategies need to be developed...

• A **Tailor-made** DMERTTS will be developed for each program, informed from both the ground-up (current practice), and top-down (recommended contemporary evidence-based research and best practice literature)

• Organisational **structural support** - Senior Practitioners, and Data/Evaluation support staff across MFS will help support implementation.
BUT …

Now this is all very well … but in the *real world settings* of many community-based services, there are many issues and barriers to implementing a broad quality framework like this … and (ultimately), achieving implementation fidelity.
PART 3: Barriers to Implementing the DMERTTS and (ultimately) to achieving Implementation Fidelity

A) Community agencies’ primary responsibility is generally service delivery ... not research or advanced evaluation strategies (though this is changing*).

There are so many work pressures on front-line practitioners that meeting the requirements of a framework like the DMERTTS is not on their radar ... and understandably so ...

Implementing new monitoring and evaluation strategies can face resistance from increasingly time-poor front-line practitioners
PART 3: Barriers to Implementing the DMERTTS and (ultimately) to achieving Implementation Fidelity

B) Community agencies often report to multiple funding bodies and/or stakeholders so they need to draw on multiple practice frameworks, quality frameworks, multiple knowledge types and research and evaluation strategies to meet accountability requirements and work towards implementation fidelity.

This means that the combined knowledge & skills needed (i.e., personnel) to effectively ‘be across’ all these areas can be difficult to find in one, or even a handful of staff.

It is also unlikely that many community agencies (especially smaller to medium size) have the funding to employ the people needed to fulfil such roles.
PART 3: Barriers to Implementing the DMERTTS and (ultimately) to achieving Implementation Fidelity

Now moving from these general issues to those directly related to the DMERTTS Framework ...

C) DOCUMENTATION:

Few Community agencies have comprehensive documented ‘Models of Practice’ or ‘Practice Frameworks’ (that are ‘logic’ and/or ‘clinically-based’)

Finding people to research, write, and maintain up-to-date practice frameworks can be difficult

Access to the current research and practice literature is difficult, and can be very, very expensive
PART 3: Barriers to Implementing the DMERTTS and (ultimately) to achieving Implementation Fidelity

D) MONITORING and EVALUATION:

Where ‘Models of Practice’ or ‘Practice Frameworks’ do exist, the **implementation of those models is often not monitored**, or is **inadequately monitored** (often because of competing organisational/service/program activities)

Again, as said previously, **finding staff with the right skill mix** to undertake the complex range of tasks required can be a challenge
PART 3: Barriers to Implementing the DMERTTS and (ultimately) to achieving Implementation Fidelity

E) REPORTING:

The demands for accountability type reporting is becoming increasingly complex and time consuming and understandably takes priority.

Finding and supporting practitioners with the time and capacity to develop additional organisational monographs, conference presentations and/or articles for peer-reviewed journals on their excellent work can be a difficult balancing act between the demands of day-to-day work and finding time for these extra activities.
PART 3: Barriers to Implementing the DMERTTS and (ultimately) to achieving Implementation Fidelity

Training, Teamwork & Supervision

Organisational leadership and support for training, teamwork, and supervision is often limited or inadequate, seriously undermining a program’s capacity to deliver quality services and adhere to program guidelines.

Lack of or limited understanding of the need for managerial/organisational support for quality practice and clinical oversight.

Developing and maintaining a Skilled staff, high-functioning teams, and multi-dimensional & high quality supervision is a critical foundation for achieving quality work and (ultimately) implementation fidelity, but often suffers because of day-to-day pressures and other priorities.
Basic Conclusion ....

For Community Services to even begin to lay the foundation for *Implementation Fidelity*, it is critical that the following are addressed:

- Clinical Oversight
- Management and Organisational Support
- Administrative and Practical Support
- Dissemination of Work Throughout the Sector
- Multi-dimensional Supervision
- High Functioning Teams
- Training
Where to from here ...

Practicing what I preach ...(disseminating our work for critical review)... I would love any feedback or constructive suggestions you have about the DMERTTS framework

My job for the next several years is to **negotiate the many barriers** discussed and build on the DMERTTS ... both the framework (the associated measures, tools, instruments and evaluative strategies), and the supporting organisational structure (senior practitioners and data support officers)

A parallel process ... The Mercy Family Services’ Client Information System (CMS) ... the computer system that underpins the DMERTTS Framework. Facilitated by Brian Kissell, MFS IT Manager. Soon to be published:


Selected References


Metz, A. (2010). Core components for successful implementation: Applying core implementation components in ECE research, evaluation, and technical assistance: EPG Child Development Institute, University of North Carolina.


