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# Intervention Development Study of the 5 Key Model for Reentry: An Evidence Driven Prisoner Reentry Intervention

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### Abstract

Over the past decade and a half, substantial resources were poured into the development of prisoner reentry programs. However, the excitement that surrounded the initial roll out of reentry programs has begun to wane from a lack of substantive change to the number of individuals who return to prison. Therefore, this paper details the development of an intervention that can provide a new path forward for prisoner reentry programs. Informed by a rigorous process based on both theory and a thorough literature review of randomized controlled trials, evidence-driven interventions were identified and combined into a holistic reentry services approach.

*Keywords:* reentry, well-being, intervention development, prison, incarceration

Mass incarceration continues to be a significant public health and public safety issue in the United States. At the beginning of the 21st century, there was growing excitement and energy surrounding programs designed to aid the transition from prison to the community. Now close to two decades later, innovations in prisoner reentry programs have fallen into a rut as most are found to only have a negligible impact on recidivism and mass incarceration (Jonson & Cullen, 2015; Ndrecka, 2014).

Evidence that many of our current approaches have failed is the high rate of re-incarceration among the formerly imprisoned. Within five-years of release from incarceration, studies have found 77% are re-arrested and approximately one-half return back to prison (Durose, Cooper, & Snyder, 2014; Langan & Levin, 2001; Pew Center on the States, 2011). This high rate of recidivism into criminal justice involvement has remained stubbornly unchanged over last 20-years, and it has helped to make the U.S. one of the leading incarcerators in the world (Walmsley, 2016).

The failed transition of formerly incarcerated individuals into the community is likely a symptom of both a scarcity of access to any prisoner reentry programming (Taxman, Perdoni, & Harrison, 2007), and when such programming does exist, there is a deficiency in the quality of available services (Jonson & Cullen, 2015). However, determining what is exactly a quality reentry program is difficult to articulate because of a general lack of consistency in reentry models employed across the U.S. (Jonson & Cullen, 2015; Petersilia, 2003; Visher & Travis, 2011).

Since the advent of reentry programming, the field has almost solely relied on the primary outcome of recidivism to determine a reentry program's effectiveness at rehabilitating an individual who has released from prison. At the same time, scholars have criticized the sole

use of recidivism as an inadequate approach to measuring the success of an individual after release from prison (Gunnison & Helfgott, 2013; Petersilia, 2004; Severson, Veeh, Bruns, & Lee, 2012). When programs have attempted to capture outcomes beyond recidivism, the factors chosen have been as varied as the program models (e.g., substance use, employment, education, housing, mental health; Ndrecka, 2014). Evident by a meager national rate of only 23% of released prisoners avoiding recidivism after incarceration (Durose et al. 2014), the current approaches to reentry programming are insufficient, and with an approximate average of 11,000 people releasing from prison each week (Carson, 2018), there is an urgent need for both innovation and standardization within prisoner reentry programming. Therefore, the current article details the development of an innovative intervention that aims to promote the well-being of formerly incarcerated individuals during their transition from prison to the community, and in turn, improve their chances of post-release success.

### **The Prisoner Reentry Program Movement**

In 2000, former United States Attorney General Janet Reno (2000) delivered a speech where she posed the question: What can we do about the problem of prisoner reentry? This message from the administration of President Bill Clinton acted as a launching pad for an explosion of interest into the increasing number of former prisoners returning to U.S. communities each day. At the same time, public awareness was heightened by research showing that upwards of 95% of incarcerated individuals will return to the community (Travis, 2005), and that these returning prisoners had higher needs than in the past while facing dwindling access to available resources to address those needs (Gunnison & Helfgott, 2013; Petersilia, 2003).

The build-up in reentry programs continued apace through the early 21<sup>st</sup> century culminating in President George W. Bush's 2004 State of the Union Address and the signing into

the law of the Second Chance Act of 2007 (Public Law 110-199 2008). However, evaluations of individual programs have shown mixed results in their impact on re-incarceration (Bouffard & Bergeron, 2006; Duwe, 2012; Grommon, Davidson, & Bynum, 2013; Jacobs & Western, 2007; Roman, Brooks, Chalfin, & Tereshchenko, 2007; Veeh, Severson, & Lee, 2015; Wilson & Davis, 2006), and a large meta-analysis that examined 53 evaluations of prisoner reentry programs from throughout the U.S. found the average reduction in recidivism to be only six percent (Ndrecka, 2014). In other words, based on a benchmark recidivism rate of 50%, participation in existing reentry program models, on average, would reduce the recidivism rate to 47%, while a comparable group of former prisoners not in a reentry program would return to prison at a rate of 53% (Ndrecka, 2014).

Based on these disappointing results of current approaches to prisoner reentry programming, this paper describes the development of a theory-based, adaptive intervention designed to facilitate successful transition from prison to the community. Past efforts at development of prisoner reentry programs have failed at providing sufficient detail to allow for replication (Jonson & Cullen, 2015). Therefore, the aim of the paper is to outline the rationale, decision-making processes, methods, and findings which led to the development of an adaptive reentry intervention (i.e., 5 Key Model for Reentry) in order to provide readers with insight into the intervention itself, as well as make available a template for reentry interventions.

It is important to note that the Risk-Need-Responsivity Model (RNR) is the most widely used model of prisoner reentry programming (Andrews & Bonta, 2010). The three principles articulated by RNR and the accompanying assessment tools such as the Level of Service Inventory – Revised (LSI-R) or the Level of Service/Case Management Inventory (LS/CMI) have been integrated throughout correctional rehabilitation in the United States. Therefore, when

developing the 5-Key Model for Reentry remained consistent to the following: (1) intensity and dosage of programming is matched to an individual's presenting characteristics (i.e., the risk principle); (2) a programmatic focus on those factors most likely to change (i.e., the needs principle); and (3) individual characteristics of participants be considered when deciding both the type of intervention to use and how it is delivered (i.e., the responsibility principle).

However, while always remaining mindful in our decisions about these three principles, the 5-Key Model aims to extend beyond RNR. This is accomplished in the 5-Key Model through the inclusion of clear and defined targets for programming (i.e., the facilitators of well-being) that can be operationalized through the selection of interventions that tap into specific definitional aspects of the five key facilitators. As stated by Taxman and Caudy (2015), the RNR model and its accompanying actuarial assessment tools of dynamic risk factors are great at providing general guidance to practitioners regarding allocation of resources. Yet, there exists a "theory-to-practice gap" (Ward, 2015, p.105) within the RNR model that makes treatment planning using dynamic risk factors difficult because of a lack of detail within these broad constructs such as education/employment or family/marital (Taxman & Caudy, 2015). The 5 Key Model is guided by the Well-Being Development Framework (citation blinded for peer review). The theoretical, empirical, and conceptual underpinnings of the Well-Being Development Framework is extensively examined in a separate paper (citation blinded for peer review).

The adaptive reentry intervention ultimately developed through this intervention study is now being tested in a multi-site randomized controlled trial across four states, fifty correctional facilities, and 12 rural and urban communities. The targeted sample for the study is 2200. The results of this study will provide insight into the efficacy of the 5 Key Model including whether

there are differential responses by subgroups such as differential gender responses, cultural variations, or feasibility in rural versus urban communities.

### **Method**

The description of the intervention development process is presented in two sections. The first section provides an overview of the process of establishing a therapeutic approach based on theory and evidence. The second section describes the design of the intervention. We followed the intervention development study methodology described by Hoddinott (2015). Hoddinott defined intervention development studies as “a study that describes the rationale, decision making processes, methods and findings which occur between the idea or inception of an intervention until it is ready for formal feasibility, pilot or efficacy testing prior to a full trial or evaluation” (2015, p.1).

#### **Establishing a Therapeutic Approach Based on Theory and Evidence**

**Well-being development framework.** The development of the 5 Key Model for Reentry was guided by the Well-Being Development Framework (*citation blinded for review*). The Well-Being Development Framework is a theoretical framework that is anchored around psychological well-being and incorporates research and theory from a variety of disciplines to describe facilitators of well-being development through which service providers can guide and support clients during the transition from prison to the community. The key facilitators within the Well-Being Development Framework include: healthy thinking patterns, effective coping strategies, meaningful work trajectories, positive social engagement, and positive interpersonal relationships. See table one for definitions of each key facilitator.

[INSERT TABLE 1]

Each of the key facilitators within the Well-Being Development Framework is empirically predictive of the promotion of overall well-being among individuals transitioning from prison to the community (citation blinded for peer review). At the same time, research also suggests that each of the key facilitators also reduce recidivism as a secondary outcome (citation blinded for peer review). Therefore, the Well-Being Development Framework articulates a dual-track process by which formerly incarcerated individuals are both assisted with increasing their capacities to reach their full human potential, while also simultaneously addressing problems and barriers that compromise their efforts to make progress towards overall well-being. By drawing attention to the key facilitators that support well-being development, these research-based factors provide a vehicle for moving beyond risk-reduction toward a strength-based approach for supporting individuals as they transition from prisons to communities.

**Systematic identification of intervention and practice approaches.** Our review of the literature aimed to identify the most rigorously tested programs that were examined with adults in the criminal justice system and similar populations. Intervention and practice approaches were identified during the review of literature. Interventions are generally defined as intentionally implemented change strategies that aim to impede or eradicate risk factors, activate protective factors, reduce harm, or introduce well-being beyond harm reduction, while practice approaches are systematic approaches to practice, which draws on a distinct body of theory and, as a result, has its own specific practice terminology and interventions (Trevithick, 2000). For purposes of this study, practice approaches were considered as over-arching practices that would be integrated throughout the entirety of the program, while interventions were focused on more distinct outcomes identified for the intent of the program. Interventions that were evaluated for effectiveness across the different populations addressed mental health, substance use, tangible



life skills, cognitive skills, relational skills, job readiness, and transitional employment. In terms of practice approaches, studies that examined the effectiveness of programs in the following areas were included for review: motivational enhancement, shared decision making, decision tree, care coordination, treatment readiness, retention, and therapeutic alliance. Searches across both groups of interventions and practice approaches were examined among six populations using a set of standardized Boolean terms. These populations included those involved in the criminal justice and juvenile justice systems, substance users, those with mental illnesses, war veterans, and those who were homeless. The populations of interest were chosen due to their overlapping experiences (e.g., transitions from confinement or instability) or characteristics with those among the criminal justice involved population as well as often being overrepresented within the criminal justice population. We conducted a separate search utilizing an extensive list Boolean terms for each combination of population and intervention/practice approach in addition to the identified terms for program and randomization (see Table 2). The Boolean terms were generated in collaboration with a master's level academic librarian.

[INSERT TABLE 2]

As detailed in the PRISMA Flow Diagram (see Figure 1), articles (N = 107,515) that were published between January 2000 and December 2016 and written in English were searched for using the databases of PubMed, Ebsco, and Web of Science. At the identification phase, articles (n=102,810) were initially excluded for either being a meta-analysis or a duplicate of a previously identified article. Meta-analyses were excluded for two reasons: 1) lack of specificity around intervention guidelines and 2) the primary studies in the analysis provided redundant studies from the research our literature review already identified. After identification and exclusion of duplicates and meta-analyses, two authors independently screened the titles and

then the abstracts. During screening of the titles, articles were screened out that did not specifically mention either the target population or the intervention/practice approach. Next, review of the study abstracts were examined to verify if: 1) one of our target populations was represented in the study sample, 2) the study was a randomized controlled trial, and 3) positive effects were reported on the intervention/practice approach intended outcome(s). Combined 3,652 were excluded at this stage. Lastly, full texts of selected articles (n=1,053) were provided to the research and stakeholder team for full eligibility criteria review and intervention development procedures described further below. The study was exempt from university institutional review board approval.

[INSERT FIGURE 1]

### **Designing the Content of the Intervention**

**Preferences of potential users.** Our intention throughout the course of the intervention development study was to design an intervention to be adopted by nonprofit organizations who provide reentry services to individuals who will release from prison. Accordingly, we felt it was important to include the end users of the intervention into the intervention study development process. Therefore, we gathered a stakeholder team. The stakeholder team varied slightly by week based on individuals' availability. On average there were three to four reentry services providers, three formerly incarcerated individuals, one family member of a formerly incarcerated individual, three to four researchers present at any given meeting. Participants were not compensated for their time. The meetings were three hours each week. The meetings were held on a university campus in an urban Midwestern city. The stakeholder team met 67 times. The researchers were careful to use group facilitation strategies (e.g., indirect encounter; Rosenberg, 1989) to ensure that not one opinion dominated the discussion. The fact that sometimes different

stakeholders showed up to different meetings also assisted in this process. Prior to each meeting, attendees were provided copies of a set of studies to be reviewed that week. During the meeting, attendees would discuss five areas: 1) the quality of the study; 2) whether the study produced desired outcomes; 3) how representative the study population and context was of the reentry context; 4) the feasibility of the intervention evaluated in the study to the reentry context; and 5) whether the intervention evaluated would be acceptable to reentry service providers, to individuals getting out of prisons, and to the loved ones of incarcerated and formerly incarcerated individuals. By the end of each meeting, attendees came to consensus on which interventions described in the studies to include for further consideration. Other interventions were catalogued as no intention for future use. At the conclusion of the team meetings, the research team then compiled all stakeholder feedback on the interventions to identify the most parsimonious set of interventions based on the following criteria: 1) content overlap between interventions, 2) largest effect on target outcome and 3) elimination of any redundancy in content between the interventions. If interventions were deemed to be overlapping in their content, the decision was made based on which of the interventions, informed by the existing evidence, would have the greatest potential treatment effect for participants. After applying these criteria, an initial set of interventions and practice approaches were identified which will be detailed in the results section.

**Adaptive intervention framework.** Given the complex and multifaceted nature of the issues faced by individuals as they transition from prison to the community, programs that target this population are constantly confronted with the challenge of how to effectively individualize treatment assignment across a range of multiple needs (i.e., employment, education, housing, etc.). Therefore, as we worked through the stages of designing what ultimately became the 5 Key

Model for Reentry, we aimed to develop an intervention that provided flexibility in programming so that individuals are only receiving both the type and intensity of services required for their specific reentry situation. In order to design the program with the flexibility needed to individualize services appropriately, the authors used the adaptive intervention framework developed by Collins, Murphy, and Bierman (2004). The adaptive intervention framework requires the application of three components: 1) the specification of treatment targets; 2) use of assessment tools for each treatment target; and 3) a set of decision rules to guide how different scores on each treatment target assessment will inform assignment into services.

## **Results**

### **Initial Intervention Manual**

The findings of our extensive literature review and team-based study review resulted in an initial set of 16 interventions and practice approaches that emphasized the behavioral health and well-being development of incarcerated and formerly incarcerated individuals. We collated these 16 interventions and practice approaches into a comprehensive intervention guide which we referred to as the Comprehensive Behavioral Health manual (citation blinded for peer review). See Table 3 for a complete list of the interventions and selected study descriptions.

[INSERT TABLE 3]

The initial comprehensive behavioral health manual that we created was designed for a proposed optimal nonprofit organization with access to resources to hire highly trained staff who could provide comprehensive treatment and support services within the organization rather than referring people out to services across multiple organizations. Our rationale for developing this approach was because case management referral out to services can often times result in an individual being referred to lengthy waitlists before they are able to be seen for services. In

addition, there is little to no control over the quality of services delivered by the referred to agency. Referrals to multiple organizations can create logistical challenges for clients related to transportation or scheduling difficulties. Program hours may conflict with a client's work schedule or conflict with program hours at another organization to which the individual has been referred. Case management is a heavily relied upon strategy by reentry organizations and, when researched, the data suggests that case management has limited to no positive effects (Lattimore & Visher, 2009; Prendergast et al., 2011; Wang et al, 2012; Willison, Buck, Bieler, & KiDeuk, K, 2014). As a result of our collective anecdotal and research experience, we opted to develop what we believed would be the most impactful and comprehensive one-stop model. The Comprehensive Behavioral Health Manual includes an overview of 16 evidence-driven intervention and practice approaches, sample schedules, example client profiles, engagement and retention strategies, and accompanying assessment tools (citation blinded for peer review). It is designed to be a program manager's guide to a comprehensive reentry service delivery model. The citations, copyrights, and purchasing requirements (as applicable) to the interventions are included in the manual. See Table 3 for summaries of each intervention and an overview of at least one study that has been conducted on each of the 16 interventions.

### **Usability and Feasibility Testing**

The usability and feasibility of the Comprehensive Behavioral Health Manual was assessed by the principal investigator of the study and other core team members by obtaining feedback from meetings and presentations to would-be-users of the manual around the country. The researchers met with reentry service providers as well as gave frequent presentations on the model. Specifically, presentations were made to ten reentry service provider teams and at seven conferences nationally and one international event in Singapore. Presentations in the United

States were given in every region of the country including states of Arkansas, California, Connecticut, Florida, Illinois, Missouri, New York, Ohio, and Washington D.C. In addition, the research team examined each intervention for training costs, educational requirements for staff to deliver the intervention, and other costs and requirements. Across each of these forms of input related to usability and feasibility, several key themes were generated.

- 1) The Comprehensive Behavioral Health Manual was overwhelming to reentry service providers. Even with sample schedules and assessment tools provided in the manual, it was difficult for organizations to understand how they would be able to adopt 16 interventions and practice approaches.
- 2) Costs of many of the evidence driven interventions for the materials and/or training were prohibitive to reentry service providers with small budgets. Reentry service providers seek evidence-driven interventions that are freely accessible. When evidence driven interventions are not available, they use interventions that others provide them for free, interventions based on good intentions and prior service experience, or interventions that they hear about at conferences or find online.
- 3) Reentry service providers have high ratios of staff that do not have master's degrees – it is not uncommon for staff to have less than a bachelor's degrees. Wherein several of the interventions in the Comprehensive Behavioral Health Manual required that the interventionists have a masters degree in a helping profession. Some reentry service providers prefer to hire people with criminal histories and staff with shared lived experience tend to approach client service delivery from the perspective of what worked for them when they were transitioning from prison back to communities.

- 4) Reentry service providers are eager to deliver evidence driven services, but those service models need to be as simple as possible and easily translatable to potentially under resourced nonprofit contexts.
- 5) New intervention approaches need to fit within existing cognitive schemas about service delivery such as reliance on case plans and an emphasis on cognitive behavioral approaches, employment, and basic life skills. It is important that innovations translate how the innovation builds on first generation approaches to reentry service provision.

As a result of the feedback that we received, the research team began meeting again and searched for ways in which the initial model could be simplified, strategies for translating the well-being development framework to a practitioner community, and for alternative evidence-driven intervention models that had limited to no costs associated with them. During this process the research team continued to seek input through in-person meeting dialogue and review of materials from key stakeholders including: a community liaison board comprised entirely of formerly incarcerated individuals (~7); prospective funders and donors (>10); and practitioners (>20) around the country.

### **Development of the 5 Key Model for Reentry**

As the research team searched through additional literature and gathered input from stakeholders, it became apparent that although the concepts of the well-being development model resonated with people and although empirically validated, talking about behavioral health and well-being development as a model title was confusing for stakeholders. Much of the confusion stemmed from the fact that we had identified multiple evidence driven curriculum/treatment manuals that could be delivered for any given key facilitator in the original Comprehensive Behavioral Health Manual. For example, under the key facilitator of Effective

Coping Strategies, we proposed two substance use disorder treatment manuals, one psychological distress treatment manual, and one treatment specific to anxiety. As we examined ways to simplify the intervention, we identified one single intervention per key facilitator that was comprehensive enough that we could rely on one evidence-driven treatment manual per key facilitator to be delivered in practice. For example we selected Healthy Lifestyles to be the sole treatment manual for the key ingredient Positive Social Engagement. As we simplified the 5 Key Model to an approach that could be scalable, we also had to make compromises to strength of prior evidence to accommodate less costly interventions. This was specifically the case for the intervention that we identified for the meaningful work trajectories key ingredient. The treatment manual *Now, Next, Later* is based on research studies that identified principles for helping individuals with incarceration histories to achieve meaningful employment. We used those principles from existing literature to develop a 17-week curriculum that we piloted for feasibility and acceptability. However, the *Now, Next, Later* curriculum has not undergone a randomized controlled trial. The meaningful work trajectory key facilitator was the only facilitator in which we were not able to find an alternative intervention to the one identified for the Comprehensive Behavioral Health Manual that had undergone a randomized controlled trial. We were able to retain our original interventions for the key ingredients healthy thinking patterns and positive social engagement. We were also able to retain two of the enrollment and retention practice approaches from the original model – *role induction and cultural ecograms*. We then identified a strengths-focused, well-being oriented, and flexible intervention that had undergone randomized controlled trials and could address two of our key facilitators, effective coping strategies and positive relationships – solutions-focused brief therapy (Bavelas et al., 2013; Lindfors & Magnusson, 1997; Knekt et al., 2018). We applied solutions-focused brief therapy to a group



format for effective coping strategies and an individual session format for positive relationships. We then packaged the revised interventions and practices approaches into a facilitators guide for the 5 Key Model for Reentry. See Table 4 for the 5 Key Model selected interventions.

[INSERT TABLE 4]

The 5 Key Model for Reentry Facilitators Guide offers a program guide for potential adopters. The program guide details the well-being development framework for the 5 Key Model as well as provides instructions on how to use the guide and adopt the model. The program guide defines the five key ingredients to successful reentry outcomes (i.e., increased well-being indicated by progress on each key facilitator; reduced recidivism); aligns four evidence-driven interventions across those key ingredients; and includes enrollment and retention practice approach strategies. The program guide is accompanied by a manual kit which includes the full intervention curriculum for each intervention and practice approach –copyright and permissions information are included in the manual kit. The program guide includes a fidelity tool developed for the 5 Key Model to be used by program managers to monitor implementation of the 5 Key Model with fidelity. The guide provides a biopsychosocial intake form that is aligned with each of the five key facilitators. Finally, the guide includes the Reentry Well-Being and Assessment Tool (RWAT; citation blinded for peer review) which allows reentry participants and reentry practitioners to work together to step up, maintain, or step down services within each of the key facilitators. The RWAT is comprised of valid and reliable scales and subscales of psychometric tools and is described in full in (citation blinded for peer review). The RWAT is conducted routinely to determine a participant’s progress within each key facilitator; as a participant achieves the desired progress per key facilitator, the services in that category are removed. Thus, because the 5 Key Model is an adaptive intervention, the length of time in which a participant is

involved in services will largely be determined by their progress within and across key facilitators rather than a predetermined number of sessions or treatment hours. Development and integration of the RWAT was critical to ensuring that the 5 Key Model could be individually tailored and delivered consistent with an adaptive intervention framework.

Although the feedback the research team received from multiple stakeholders on the 5 Key Model is positive, and its empirical and theoretical support suggests that the model will have positive impacts on reentry outcomes, the extent of its impact on formerly incarcerated individuals well-being development is yet to be known. Preliminary study results from the randomized controlled trial will be available in Spring 2019. In addition to assessing 5 Key Model recipient outcomes across each key facilitator of well-being development, the trial will examine implementation outcomes such as the feasibility and acceptability of the approach as well as requisite education, experience, and training requirements of practitioners delivering the intervention.

### **Discussion**

Current approaches to reentry services are almost exclusively designed around the goal to reduce recidivism and are primarily driven by a sole focus on recidivism risk reduction. Yet, research reviews indicate that these recidivism risk reduction orientations have resulted in limited to no impact on recidivism rates (Jonson & Cullen, 2015; Ndrecka, 2014). We believe that the 5 Key Model challenges existing reentry service provision approaches, offers a model for the next generation of reentry interventions, and provides practitioners with a vehicle for focusing on those factors that are likely to promote success – the key facilitators of well-being development (citation blinded for peer review). We expect that by re-orienting the focus of

reentry service provision toward improving the well-being of formerly incarcerated individuals, that recidivism rates will also reduce as a secondary effect of improved well-being.

Given the wide variety and capacity of reentry practice settings in the non-profit sector, seeking to assure that interventions can be adapted for delivery within contextual and organizational constraints serves as a precursor for successful dissemination (Richard et al., 2015). As such, the design of the 5 Key Model for Reentry occurred with implementation, evaluation, and continuous quality improvement strategies in mind. Should research findings warrant its dissemination, other considerations for the successful implementation of the 5 Key Model across a variety of organizations include making the model accessible, easy to use, acceptable, and affordable or free. We sought to make the 5 Key Model widely accessible and easy to use by creating a facilitators guide detailing the program outline paired with full versions of the intervention manuals that have limited costs and permissions restrictions. Because the 5-Key Model was developed in concert with formerly incarcerated individuals and reentry practitioners and other stakeholders, we are hopeful that we have developed a feasible and acceptable approach. During this initial randomized controlled trial being conducted in a variety of real world service delivery contexts, we anticipate refining the model. Once the model is refined, and if study results warrant, we hope to make the model widely available for further implementation and research.

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