

EVIDENCE-BASED
PRACTICES

KIT

Knowledge Informing Transformation

Consumer- Operated Services

Evaluating Your Program



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Evaluating Your Program



Consumer- Operated Services

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Evaluating Your Program

Evaluating Your Program is a resource to help program leaders evaluate their programs using fidelity and outcome assessment tools. These evaluations may be done as self-assessments or as external evaluations.

Self-assessments are conducted by the program leadership and membership itself for various purposes such as program development or quality improvement. External evaluations are conducted by people outside the program, often professional evaluators from universities or government. The purpose of external evaluations may be for research or to demonstrate that the program is achieving desired outcomes or meeting evidence-based practice (EBP) standards.

Evaluating Your Program offers guidance for both internal and external evaluators in preparing for and conducting fidelity assessments and outcome evaluations for consumer-operated services.

The Fidelity Assessment Common Ingredients Tool (FACIT) is highlighted and the FACIT protocol, scoresheet, and an Excel Workbook User's Guide are included in the appendices. The Peer Outcomes Protocol (POP) is also discussed as an instrument for outcome evaluation with information on how to access this resource.

For references, see the booklet, *The Evidence*.

Consumer-Operated Services

This KIT is part of a series of Evidence-Based Practices KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of the Consumer-Operated Services KIT, which includes seven booklets:

How to Use the Evidence-Based Practices KITs

Getting Started with Evidence-Based Practices

Building Your Program

Training Frontline Staff

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Consumer-Operated Services



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Consumer- Operated Services

Evaluating Your Program

Preparing for an Assessment or Evaluation

This section provides basic information and tips for preparing for any kind of program assessment or evaluation. It includes information about why and how to conduct an assessment or evaluation, common concerns, and measurement tools. It also differentiates between a fidelity assessment and an outcome evaluation.

Why conduct a program assessment or evaluation?

How is your consumer-operated service performing in relationship to its goals? What peer practices are staff members following to meet the needs of program participants or members? How is your consumer-operated service affecting participants' efforts to recover?

An organizational evaluation helps to answer these and other questions that affect the quality of the programs that your consumer-operated service delivers. The evaluation also will enable your organization to meet the growing call for accountability from federal, state, local, and private funding sources.



It is clear that as states adopt a recovery-based approach to mental health by delivering evidence-based practices, consumer-operated services need to conduct evaluations to examine the fidelity and effectiveness of the peer activities they provide. However, the call for accountability from funders and for responsiveness to participants poses challenges for program leaders.

In a national survey of data needs of peer support programs, Campbell (1997a) found that almost 40 percent of the programs surveyed felt that collection of member information would discourage people from using the services, and 43 percent felt that it would financially burden the organization.

On the other hand, evaluation has been instrumental in helping consumer-operated services respond to growing demands for evidence-based practices and has provided these organizations with opportunities to deliver peer services more effectively.

The capacity of program leaders to monitor and improve program quality and outcomes has been established through recent nationwide initiatives. These projects give the program the scientific tools required to assess and tailor services so they better meet the needs of individuals with mental illnesses. The Consumer-Operated Services Program (COSP) Multisite Research Initiative is among the most notable nationwide efforts successfully completed by peer providers.

A growing number of consumer-operated program leaders have learned basic evaluation skills (Campbell, 1997b), and the value of including consumers in the process has been demonstrated. The validity of survey tools may be improved when consumers serve as investigators, coordinators, surveyors, data managers, analysts, or focus group members. In addition, improvements may occur in the quality of the following:

- The interview process;
- Data interpretation; and
- Dissemination strategies.

Recent studies have found that consumer-operated programs have reduced expenses, generated income, increased efficiency, and increased service demand by implementing quality improvement practices that incorporate evaluation findings (Campbell and Leaver, 2003).

In addition, consumers who participate in evaluation projects experience both economic and personal benefits, including the opportunity to help other consumers, increase communication and job-related skills, and enhance their self-esteem.

One of the first steps in conducting a fidelity assessment or outcome evaluation is to decide why you want to do it. For example,

- Is it required by your funder?
- Are you interested in program quality improvement?
- Do you want to demonstrate and document success to enhance future funding?

The purpose and goals shape the methods and tools used to conduct the assessment or evaluation. Make sure that everyone involved—including any outside evaluators—understands and agrees with the identified purposes and goals.

Defining fidelity assessment and outcome evaluation

Fidelity assessments and outcome evaluations are not the same thing. This section distinguishes between them.

About fidelity assessments

Fidelity assessments measure whether a program operates according to standardized practices.

Fidelity assessments use objective rating systems (also called tools, measures, or instruments) with instructive protocols to determine the extent to which program components adhere to established models, theories, or philosophies.

The fidelity measures developed for consumer-operated services enable program leaders to pinpoint program departures from standard practices and models (Holter, Mowbray, Bellamy, MacFarlane & Dukarski, 2004; Johnsen, Teague & McDonel-Herr, 2005). Research findings to date indicate that fidelity assessments should be used to inform strategic planning, staff training, program development, and other quality improvement initiatives.

About outcome evaluations

Outcome evaluations measure whether a program achieves desired results for participants.

While fidelity assessments look at how services are provided, outcome evaluations measure program successes and consumer satisfaction and achievements. Some outcomes are concrete and observable, such as the number of days a consumer has been employed or has remained in independent housing. Others are more subjective and personal, such as gaining a sense of empowerment or being satisfied with services.

It is important to measure outcomes as well as fidelity. Good fidelity alone does not necessarily guarantee effectiveness and poor fidelity does not prohibit achieving desired outcomes. In addition, fidelity results cannot identify groups of people for whom services are effective.

Concerns about program assessment and evaluation

Although the value of assessments and evaluations has been demonstrated through research and field experiences, the benefits may not be readily apparent. In addition, conducting these studies may create financial or administrative challenges.

Common concerns

Some consumer-operated service program leaders and participants are skeptical about implementing evidence-based practices (Essock et al., 2003). Consumers ask “whose evidence?” and “evidence of what?” They point out that measures of fidelity to standardized practices may provide results that are antithetical to the consumer movement’s goals or belief systems.

For example, some consumers resist efforts to collect program and member data, believing these activities destroy the program’s ability to provide participants with an informal, safe, noncoercive environment.

Some peer providers also are concerned by the desire of mental health authorities or other funding agencies for a comparative framework using an objective system such as FACIT to evaluate the performance of consumer-operated services.



Financial and administrative challenges

Smaller consumer-operated services may face significant challenges in implementing fidelity and outcome studies. For example:

- Staff may lack the necessary knowledge and skills; and
- Costs for fidelity assessments and outcome evaluations and for implementing and monitoring the results (including personnel, equipment, and software) may be prohibitive.

Addressing these challenges

Addressing these challenges requires identifying opinion leaders among members, staff, and advisors and communicating with them clearly, honestly, and calmly to build support for the assessment and/or evaluation.

It also requires flexibility in responding to financial, organizational, and community concerns. For example, peer providers should use basic assessment methods until the service has reached organizational capacity to take on more complex approaches.

You also will need to take an inventory of what the organization has and what it needs to successfully conduct analyses and implement evidence-based practices.

Who can conduct an evaluation?

When a program decides to conduct an evaluation, it must first decide whether it will be done as a self-assessment or whether outside evaluators will be hired. Minimally, a two-person team should conduct the evaluation, but there can be more people on the team. A team provides multiple sets of ears to make sure things are heard accurately and many hands to help with note taking and other tasks. Regardless of the choice of “who,” it is important that the evaluators fully understand the goals, questions, and procedures of the evaluation.

It is also important to avoid potentially biased evaluators who are invested in the program “looking good” (or bad). Evaluators should not have a conflict of interest such as being on the organization’s board of directors or working as the program leader. Such dual responsibilities put the evaluators in a compromised position about the information learned about the program, staff, and members. If the evaluation is to be done as a self-assessment, it is ideal to establish a Continuous Quality Improvement (CQI) team made up of members to lead the evaluation. Neighboring programs could also exchange evaluators to reduce conflicts of interest.

Which measurement tools to use?

Once you decide to proceed with a program assessment or evaluation, you will need to make choices about which measurement tools to use and who should conduct the study.

A program may elect to use any of a variety of tools for fidelity assessments or outcome evaluations. However, a fidelity assessment tool, the FACIT, and an outcome evaluation tool, the Peer Outcomes Protocol, have been developed to respond to the informational needs of consumer-operated services.

This section provides more information about these two measurement tools.

The Fidelity Assessment Common Ingredients Tool (FACIT)

FACIT incorporates key components of the peer support and self-help philosophy. The tool:

- Was developed by leaders in consumer-operated services;
- Is based on program choice; and
- Is intended to build skills and to empower users.

A copy of the FACIT can be found in the appendices of this booklet, along with a Users' Guide.

FACIT's history and success

FACIT has a relatively short history, but programs throughout the United States have begun to adopt the scale. FACIT was developed as part of the Consumer-Operated Services Programs Multisite Research Initiative (1998–2006). This collaborative effort enabled peer providers and researchers to (1) identify a set of standard elements common to consumer-operated services and (2) develop a tool to measure the extent to which programs used these common elements or ingredients.

As part of the initiative, members of consumer-operated services collaborated with researchers to generate a list of common peer-run program ingredients (Johnsen, Teague, & McDonel-Herr, 2005). The ingredients were developed from a comprehensive review of peer literature that generated more than 170 items and a national “concept-mapping” effort in which program leaders ranked and sorted the items to identify peer support competencies (Campbell, Dumont, & Einsphar, 1999).

The list of common ingredients was tested in two rounds of multisite visits. During the first round, conducted from 1999 through 2001, researchers and consumer-providers pilot-tested FACIT and determined that it successfully measured common program ingredients. In the second series of visits, FACIT was successfully used to measure the presence of the common ingredients in eight programs.

FACIT has undergone extensive psychometric testing and has demonstrated discriminant validity, meaning that it can be used to differentiate between peer-run programs and traditional mental health services. The tool also has demonstrated predictive validity, which means that it can be used to tie scores to consumer outcomes, particularly those related to recovery and well-being. These outcomes include hope, empowerment, meaning of life, self-esteem, and social support as measured in the subscales of the Composite Well-Being Measure (Campbell et al., 2006).



Components of a FACIT assessment

Collecting information from multiple sources helps evaluators more accurately capture how services are provided and identify the common ingredients incorporated in the program. FACIT components include the following:

- An interview with the program director;
- Focus groups conducted with staff and program members or participants;
- Observations of daily program activities, (including program groups, provision of services by staff, and informal participant interactions); and
- A review of program materials.

Smaller programs may not have the number of staff needed for a focus group. In these cases, staff may be interviewed individually.

The Peer Outcomes Protocol (POP)

As the number of peer-run programs continued to grow during the past two decades, so did the demand from program leaders for an outcome assessment with measures derived from mental health consumers' experiences and points of view. In response, the POP Project was initiated.

POP's history and success

The POP was largely designed, tested, and implemented by consumer researchers, advocates, and program leaders who had mental illnesses. Direction was provided by Dr. Jean Campbell of the Program in Consumer Studies and Training at the Missouri Institute of Mental Health.

The POP Project was developed between 1995 and 2000 and funded by the University of Illinois at Chicago's National Research and Training Center on Psychiatric Disability. The POP has been successfully used by consumer-operated programs throughout the United States.

More information and copies of the POP instrument can be found at the POP Web site: <http://www.cmhsrp.uic.edu/nrtc/pophome.htm>.

Evaluating Your Program

Conducting a FACIT Fidelity Assessment

This section provides information for organizing, preparing for, and conducting a FACIT fidelity assessment. It discusses the FACIT Team, preliminary organizational inventory, organizing the assessment process, conducting and scoring the assessment.

The appendices to this booklet contain the FACIT protocol, scoresheet, and an Excel Workbook User's Guide designed to tabulate FACIT data over time.

The FACIT Team

This section provides information to help you select evaluators for conducting a FACIT assessment. It identifies key evaluator responsibilities and provides tips for selecting individuals to serve on the FACIT Team.

Key FACIT Team responsibilities

The FACIT Team members must conduct interviews and focus groups, observe program activities, collect the required data, and analyze the results in ways that will help programs improve their fidelity to evidence-based practices. Furthermore, the team must ensure that the information is collected with respect for the confidentiality of the respondents and the data and recorded carefully, with provisions made for ensuring its accuracy.



FACIT Team members should have experience as interviewers or focus group leaders. They also should be comfortable using the data collection and analysis software available to the program. In addition, they should be culturally aware and have the competencies needed to conduct successful interviews and focus groups with members of the major demographic/racial/ethnic groups involved in the consumer-operated program.

Selecting the FACIT Team

Two evaluators are usually selected to work together as the FACIT Team. They may be either independent consultants familiar with the program and the consumer support philosophy or program staff, members, and advisors.

Working with an independent FACIT Team may be the better option if these evaluators are truly objective and competent. Options for finding relatively low-cost external evaluators include the following:

- Arranging with other neighboring consumer-operated programs to exchange evaluators;
- Hiring an outside evaluation team from a local community or an academic institution; and
- Asking the local mental health authority to volunteer staff to conduct the FACIT assessment.

Because of financial circumstances, however, in-house evaluators often are selected. They can conduct fidelity assessments in a capable, competent manner. Members of the advisory committee or board of directors may be trained and may rotate responsibility for completing fidelity assessments. Alternatively, if the organization has a quality improvement team, its members may be designated to undertake the FACIT processes.

Taking inventory

In addition to selecting the assessment tools and evaluators, you should determine what the organization needs to get from the assessment. This requires inventorying the program's strengths and weaknesses.

It can feel daunting to think about inventorying organizational strengths and weaknesses in preparation for conducting the assessment. However, the Readiness Assessment Checklists provided on the next pages may provide a useful structure and a set of helpful prompts for conducting this inventory.

Readiness Assessment involves two separate checklists:

- General Knowledge; and
- Program Structure, Personnel, Resources.

The Readiness Assessment Checklists and instructions for using them are found on the following pages.

Tips for Selecting Evaluators

Peer providers should—

- Select individuals not centrally involved in providing program services.
- Be wary of the potential biases of evaluators who are invested in seeing the program “look good” or who do not fully understand the ingredients common to consumer-operated services.
- Select evaluators who can work together as a team.
- Make evaluation personnel decisions early in the planning stages of the evaluation.

What do you need for data collection and analysis?

The methods you use for data collection depend on the data you want to collect. Once you have agreed-upon outcomes, identify the methods you have available for collecting the information you need. These methods may be as simple as using and collecting activity sign-in sheets and maintaining an updated list of program members.

Consult with prospective evaluators and other consumer-operated programs about other efficient data collection methods. Frequently used data collection methods include surveys, focus groups, and interviews.

Determine your program's software and hardware needs by reviewing in-house capabilities and resources identified by the Readiness Assessment Checklist.

Consult with prospective evaluators and staff from other consumer-operated programs who have conducted assessments. Required equipment and software commonly include: computer capacity, spreadsheet software (e.g., Microsoft Excel), basic office supplies, and a telephone.

Other actions

In addition to reviewing items identified in the checklists, you should thoroughly examine the program's mission and gather feedback from members about where improvements are needed.

After this inventory is completed and possible evaluators are identified, you are ready to undertake the specific preparations discussed in the next section.



Readiness Assessment Checklists

Part 1: General Knowledge

Part 1 of the Readiness Assessment Checklist, General Knowledge, is structured to help leaders, staff, and members identify topics about which they want to learn more before they proceed. At the bottom of the Part 1 checklist, note topics where you need more information. Please refer to the resources in *The Evidence* booklet included in this KIT for sites and sources to help you find this information. Consider also consulting with state and local evaluation experts at area universities and at the consumer technical assistance centers.

Check any areas that you feel you do NOT understand. Cross out items that do not apply to your organization.

At the end of the checklist, note other areas that were not listed where you have questions, and list what steps you might take to address these questions.

- The purpose of consumer-operated services
- The history of the consumer movement and peer support services
- The meaning of “consumer-operated” and “member-run”
- The meaning of the “recovery” concept
- How your program’s fidelity to the program model will be measured
- How the system for collecting outcome data will work
- Roles of staff/members/volunteers at a consumer-operated program
- Leadership development
- How to motivate your staff in implementing FACIT peer practices
- Administrative tasks (e.g., budget, personnel, supervision)
- Specific admission criteria for your program
- How to conduct staff and membership meetings
- The relationship between the program and advisory groups and/or the board of directors
- How to facilitate peer support groups
- Techniques for writing proposals or reports
- How to develop a marketing plan or conduct community outreach
- How to establish a collaborative relationship with traditional mental health providers
- Methods for preparing a program manual

NOTES

Part 2: Program Structure, Personnel, and Resources

Part 2 of the Readiness Assessment Checklist, Program Structure, Personnel and Resources, includes practical matters that should be considered; these are grouped into seven subject areas. The lists are offered as general tools to help your consumer-operated service reach its own goals. Use this list to identify elements that are in place in your organization and those that need further development.

Check items that have been completed. Cross out items that do not apply to your organization. Note the next steps you may want to take to obtain or complete the items you did not check.

2.1 Staffing and Membership

The organization has the following:

- A director
- A program coordinator
- A bookkeeper or outsourced bookkeeping services
- Support group facilitators
- Quality improvement team
- A mission statement
- Written job descriptions
- Staff training programs
- Volunteer recruitment and training programs
- Staff reflecting the cultural diversity of the local community
- Empowerment of staff/membership in decision-making
- Written membership criteria
- Posted membership rules

There are written personnel policies concerning the following:

- Maintaining confidentiality
- Prohibiting sexual harassment
- Complaints and grievances (staff/members)
- Maintaining a substance-free environment

NOTES

2.2 Program Budget

The organization has funding for the following services and items:

- Competitive salaries and fringe benefits
- Rent, utilities, and facility maintenance
- Required types of insurance
- Telephone and communication equipment (e.g. pagers, cell phones, Internet access, postage meter)
- Office supplies (e.g., pens, paper, toner)

Office equipment, including the following:

- Computer(s)
- Fax machine(s)
- Copier(s)
- Printer(s)

Office furniture, including the following:

- Storage and file cabinets
- Desks
- Chairs
- Table(s)

Travel and transportation resources, such as the following:

- Vehicle lease/purchase
- Travel reimbursement
- Bus passes

NOTES



2.3 Facility and Equipment

The organization—

- Is situated in a safe location that is convenient for the community it serves.
- Has the space, equipment, and technology needed to offer programs in a consumer-friendly environment and to enable staff to carry out their duties efficiently.
- Provides reasonable access for people with disabilities.

NOTES

2.4 Program Resources and Materials

- Volunteer recruitment and training programs
- Computer/Internet access for members
- Peer support and wellness literature
- A calendar of activities
- A newsletter or Webpage
- Display(s) of motivational/artistic/recovery-focused materials
- A community resource list
- Supplemental resources, such as the following:
 - Videos/DVDs/computer games
 - Art materials
 - A small refrigerator and microwave or kitchenette

NOTES

2.5 Data Collection and Quality Improvement

The organization has these resources:

- Computer/Internet access for members
- A system in place for capturing and analyzing data

- A process for providing information to key stakeholders and incorporating their responses
- Mechanisms for tracking followup activities

NOTES

2.6 Services

The organization provides the following:

- Formal peer support groups
- Recreation
- Greeter/new member orientation
- Informal peer-to-peer support
- Wellness management
- Skills training
- Job readiness
- Meals/snacks
- Advocacy

NOTES

2.7 Program Marketing and Outreach

The organization has the following marketing/outreach tools:

- Brochure(s)
- Flyers/posters
- Access to free advertising in media outlets (e.g., newspaper, cable television, public radio)
- Representatives on community provider boards and committees
- Representatives participating in community initiatives
- A referral system

NOTES

Preparations for a FACIT assessment

Next steps include appointing an individual responsible for coordinating the assessment and identifying key responsibilities to be shared between the two of you and those to be taken by the FACIT Team. Responsibilities include gathering key materials, promoting recruitment, and ensuring that confidentiality and other requirements are met throughout the assessment.

Assign an assessment coordinator

If working with an outside evaluator, it is important to have one key person at the consumer-operated program as an assessment coordinator or liaison. The assessment coordinator links the evaluators and the program, communicates its purpose and scope to program staff and participants, and provides logistics such as scheduling and gathering required materials. If the organization has a quality improvement team, the coordinator should be a member of this group.

Create a schedule

One of the coordinator's main responsibilities is developing a schedule that includes the required interviews, focus groups, and site observations. This should be developed well in advance of the site visit to respect competing time demands on the program director, staff, evaluators, and participants.

A 2-day site visit is optimal for conducting the assessment. Each interview or focus group session should run between 90 minutes and 2 hours, with time allowed for refreshments. The text box provides a sample agenda for a site visit.

Sample FACIT Agenda

Day One	Morning		
	8:00-8:30	Review agenda	
	8:30-11:30	Interviews/focus groups for staff	
	Afternoon		
	Noon-2:00	Lunch and facility tour, observation of activities	
	2:30-4:00	Interview program director	
Day Two	Morning		
	9:00-11:00	Conduct focus group with program members	
	11:00-noon	Review program materials	
		Afternoon	
	Noon-1:00	Lunch	
	1:00-2:00	Observe peer support group and other activities	
	2:00-3:00	Conduct exit interview (optional)	

Gather key documents

The efficiency of the assessment is enhanced when program materials and documents are gathered beforehand. This involves collecting the information identified in the FACIT Materials Checklist and preparing a packet of these materials for each evaluator. The FACIT Team will review these materials with the director during the site visit and will use them in the FACIT scoring.

The text box provides a FACIT Materials Checklist that outlines the key documents to be prepared for the FACIT Team.



FACIT Materials Checklist

- Articles of incorporation
- Agency mission statement/philosophy
- Organizational structure/organizational chart
- Bylaws
- Advisory council/board minutes from the last 12 months
- Program operating budget
- Policy and procedures manual
- Sexual harassment and grievance policies
- Satisfaction survey
- Participant demographics (if collected)
- Unduplicated monthly attendance record
- Reports to funders or annual reports
- Activity calendar/newsletter
- Training manuals
- Job descriptions
- Brochures
- Letters or advertisements soliciting volunteers

Recruit members for focus groups

The program leader, FACIT Team, and assessment coordinator may assist with recruiting program members for focus groups. The program leader should ensure that recruitment is initiated and invite staff and members to participate in interviews or focus groups as appropriate.

Between 15 and 20 individuals should be recruited to participate in the member focus group. To minimize selection bias, the recruited consumers should be a cross-section of the individuals who typically attend the program.

One method for recruiting program members is to simply post a flyer at the program inviting them to participate. In addition, the event may be noted in advance on the organization's calendar of events. To further promote participation, the FACIT process might be discussed at a member meeting.

Participants also might be recruited using random selection. In this process, the names of all program members are put in a hat and selected through a chance drawing. Those selected are then invited to attend. If not enough people agree to participate, a second drawing is conducted.

Maintain participant confidentiality

Program members, staff, and the FACIT Team should ensure that confidentiality procedures are followed. Ultimately, however, the program leader is responsible. Before the assessment begins, he or she should carefully review the confidentiality procedures with all of the involved parties.

Points to consider include the following:

- Participation in interview/focus groups is voluntary. However, a written informed consent form is not required when data are used solely for quality improvement purposes rather than for research.
- A breach in confidentiality could arise during a focus group if a person divulges private information about his or her mental health experiences to other participants. Because all focus group participants are program members, by definition they are self-identified consumers of mental health services. Therefore, little or no harm should result if a group member discloses his or her status as a person with a mental illness.

However, there should be a discussion about the necessity for participants to not repeat anything heard in the focus group. Reminding participants that confidentiality protections in a focus group are the same as those protections in a peer support group should build understanding and enhance cooperation.

- Each interview or focus group must be held in a private setting.
- FACIT Team members must be cautioned not to share anything that is said during an interview or focus group session with other program members.
- No one other than a participant or FACIT Team member should sit in on interviews or a focus group.

Maintain confidentiality of data

All data collected from the assessment activities are confidential. The program leader and FACIT Team should take great care in explaining this to participants and in following procedures to ensure that data are kept confidential.

The program leader has responsibility for data confidentiality when the information is onsite. If the FACIT Team takes the data, the team is responsible for ensuring confidentiality.

Assessment data, such as FACIT scoresheets and interview/focus group notes and audiotapes, are to be stored in a locked file cabinet. This information should be kept for about 3 years; it may be needed to help address any data quality questions or for use in possible re-analyses.



FACIT Team tasks

The following tips about preparing for the FACIT process are pertinent for, and directed to, both internal and external evaluators. All FACIT Teams conduct similar activities and have similar responsibilities. These include conducting interviews and focus groups, observing regular program activities, collecting and analyzing the data, and developing a report assessing how well the program follows evidence-based practices.

The best environment for conducting an assessment is created when everyone involved in the process wants to learn the facts and use them to improve their consumer-operated program.

Establish a shared understanding of assessment goals

After discussion with the program leader, communicate the assessment goals to program staff and members. Keep in mind that the most successful assessments are those in which all parties agree with the following:

- They want to understand the program's strengths and weaknesses so they can plan for its ongoing success; and
- This can best be done using standardized, scientifically established measures.

If program staff or members fear that the program will lose funding or “look bad” if it does not score well, then the accuracy of the data may be compromised.

Clarify reporting procedures

The FACIT Team should clarify who will receive a copy of the fidelity assessment results and any reports that are prepared. Report recipients may include administrators, staff, and/or participants in the consumer-operated service as well as members of the board of directors or advisory committee. The team also should determine whether the report will be sent via e-mail, fax, or surface mail.

Review, tailor, and organize assessment materials

The FACIT Team should review and prepare specific materials for the assessment. This includes the following:

- Reviewing the FACIT materials in *Appendices A and B* and tailoring (as needed) key forms for use in specific assessments; and
- Developing an understanding of the history, operations, and beliefs of consumer-operated programs. To this end, FACIT Team members may benefit from reading *On Our Own Together: Peer Programs for People with Mental Illness* (Clay, 2005), a book on developing peer-run programs that addresses the philosophy and history of the movement and the tools needed for success.
- Each team member should prepare a binder containing program information and assessment tools. The contents should include program contact information and directions, the agenda, and tailored sets of questions and prompts for the interviews and focus groups. The binder also should include the FACIT scoresheets, sample program materials, and other items that will be of use such as name tags for the evaluators and focus group participants.

Other preparations

Other preparations include the following:

- Ensuring that recording equipment is working and that related supplies, such as extra batteries, are included in the equipment brought to the program;
- Contacting the program leader and/or assessment coordinator before the site visit to ensure that (1) the schedule is fully understood by all parties and provides adequate time for key activities and (2) appropriate space has been reserved for conducting interviews and focus groups; and
- Talking with the program leader about whether an exit interview will be conducted.

The FACIT Team: Scoring the assessment

This section provides guidance to help FACIT Teams correctly score the FACIT data obtained from the interviews, focus groups, and program observations.

FACIT Team debriefing and followup

After the focus group concludes, the FACIT Team should briefly write out short observations of the event. Characteristics of the physical environment that helped or hindered the process need to be noted. Describe the way the group dynamics unfolded.

For example, did leaders emerge? How was the flow? What did the comfort level appear to be? Also document what worked and what seemed to block the interview/focus group processes.

The team also should follow up on any missing data, beginning by contacting the program leader.

FACIT scoring

The team should review the FACIT protocol (*Appendix A*), scoring sheet (*Appendix B*), and FACIT Excel Workbook User's Guide (*Appendix C*).

Each member should independently review the data collected, rate the scales, and tally the item scores. Team members should then compare their ratings and resolve any disagreements using the conciliation process and record the consensus rating.



As part of the scoring process, the team should carefully evaluate the relevance and quality of the evidence collected for each item. Evidence includes the following:

- Comments made by staff and members during interviews and focus groups;
- Observations of environment and interactions;
- Materials available to program members (e.g., newsletters, calendars, brochures, pictures of member activities, member artwork);
- Organizational policies and procedures;
- Staff training manual;
- Board and member meeting minutes;
- Informal discussions;
- Previous evaluations; and
- Satisfaction and outcome reports.

A FACIT Team member needs to engage in “detective work” of a sort, following up on comments gathered through interviews or focus groups and collecting documentation to substantiate assertions. This includes comparing various pieces of evidence to determine the optimal item scores.

The highest rating for each item should be reserved for programs that clearly meet the criteria for that rating. In no case should a partial score or fraction of a rating point be assigned.

For example, if staff says that the program has a strong arts component, the evaluator should look at the studio, art materials, and participant artwork to get a better sense of participants’ opportunities in this area. In general, evaluators will obtain a more accurate assessment by using the comparative approach than from relying on a single source.

Pointers on how to resolve possible problems with interpreting data include the following:

- Rate the program based only on currently implemented activities and practices. Do not score a program based on past or future activities and practices.
- If members differ considerably in their responses to the same question, look for other data. For example, where one respondent provides an answer but expresses uncertainty about it while another provides a different answer but is quite certain about it, look for other documentation, such as newsletter articles, calendar listings, and flyers. If there is any question about program activities and practices that cannot be verified by the evidence, call or e-mail program staff or members for further clarification.

Initial rating

To complete the initial ratings, each FACIT Team member should independently complete the FACIT scoresheet. This involves the following steps:

- Assemble all relevant information. This includes interview and field notes, documentation provided prior to the FACIT assessment, other documentary material (e.g., annual reports), and any previous FACIT assessments.
- Review all relevant material, highlighting information that can be used to help formulate particular ratings. Make decisions based on the totality of the evidence available.
- For ratings that are difficult to make, review the evidence and the wording associated with each possible score. There might not be a perfect match available in the possible scoring choices. In that case, find the score that best describes the item.

Conciliation

The process used to bring FACIT Team members' scores together for a common rating is called conciliation. Rather than relying on simple averaging of responses from team members, conciliation relies on team dialogue to reach a joint decision.

If team members identify a discrepancy in ratings, they should take the following conciliation steps:

- Refer to the FACIT scoresheet to help understand the issues intended to be rated under the specific item.
- Share all information used to arrive at the individual decisions.
- Use all of the data to come to a joint decision about the appropriate rating for the program on the particular item.

Special problems

Certain problems may complicate the conciliation process. This section addresses the most common difficulties and suggests solutions. It is critical that the FACIT Team members rule out all other alternatives before assigning a score of "0."

Information is inadequate or not available

Team members should attempt to rate the program on every item of the FACIT. In some cases, however, they may feel that they do not have adequate information. There may be several reasons for the lack of information, each of which might have its own specific remedy:

- During the FACIT evaluation, the team neglected to collect certain information or ask certain questions of one or more members or staff. In this case, the team should attempt, as possible and appropriate, to contact the program and gather additional information prior to the initial scoring of FACIT items.
- An item on the FACIT scoresheet is not applicable to the program. A FACIT Team member may feel that a particular item is not applicable. If the team agrees, the N/A (not applicable) notation should be written in the rating cell and a brief explanation should be included. No score is recorded.
- The team did not collect any evidence related to an item on the FACIT scoresheet because the practices being rated are not demonstrated within the program. This is distinct from the previous situation. If the practices are not in evidence but are applicable to the organization, they should be scored "1." In general, the score 1 should be reserved for practices that are not demonstrated.



The optimal item rating appears to be between two scores

There may also be times when an assessor believes that the true rating for a particular item falls somewhere between two available values. If the FACIT Team member is still in doubt after carefully reviewing the options, he or she should assign the lower of the two values to the item.

Substantial disagreement between raters

In the rare cases in which conciliation is impossible, each member should write out his or her opinion, with references to supporting evidence. These documents should be sent to a superior or supervisor for a final decision. It is more helpful to the program if final ratings are determined by the actual evaluators rather than by an outside party. Therefore, FACIT Team members are urged to conciliate and arrive at agreements whenever possible.

Data entry

After coming to an agreement about the ratings, team members should total and record them where indicated on the FACIT scoresheet and begin data entry using the Microsoft Excel Spreadsheet provided with this KIT. More information about scoring is provided in *Appendix B*.

Evaluating Your Program

Conducting an Outcome Evaluation

This section of the KIT presents the basics of conducting an outcome evaluation. Information is provided about the following:

- Creating an evaluation plan;
- Identifying key outcomes to be measured;
- Selecting outcome measures and data collection methods; and
- Using the Peer Outcomes Protocol (POP).

With this information, you can develop an evaluation plan that is focused on ongoing quality improvement and tailored to the consumer-operated program.

Create a plan

Begin an outcome evaluation by developing a long-term plan that incorporates peer support and self-help principles and addresses critical questions.

Key principles

Consumer-operated programs consistently apply peer support and self-help principles. Therefore, outcome evaluations must have these characteristics:

- Be consumer-directed;
- Empower the program and participants;



- Always respect member choice; and
- Include meaningful member input.

Critical questions

Outcomes, as well as measurement tools and methods, should be carefully selected based on their value in achieving program goals. As part of the selection process, consider the following:

- Which outcomes are most closely associated with program objectives and values?
- Which outcome tools and methods best align with program objectives and values?
- How can these tools be optimally employed to accurately measure the selected outcomes?
- How, when, and where should outcomes be measured?
- Who should be included in the sample group to accurately reflect the diversity of the membership?
- What types of resources (e.g., funding, staff, time, and training) are required to conduct the outcome evaluation and how will they be obtained?

Appropriately applying the principles and answering the questions also requires paying thoughtful attention to the issues of confidentiality and informed consent. More information about these issues is included in the earlier *Conducting a FACIT Fidelity Assessment* section of this booklet.

Select knowledgeable evaluators

Outcome data should be collected and evaluated by trained personnel. This task may be assigned to the program leader or other staff responsible for quality improvement. Alternatively, members of the program advisory committee or board, as well as independent consultants, might be selected to take on this responsibility.

The assigned personnel will need to be appropriately trained. Many of the commonly used protocols, such as POP, include training resources.

Kinds of outcomes

Program evaluation involves measuring two types of outcomes:

- Core outcomes related to members' growth, and
- Program satisfaction outcomes linked to specific events, approaches, and activities offered by the organization.

A third set of outcomes also should be considered by programs offering specialized services such as housing, education or work support, respite, and so forth.

Core outcomes

Core outcomes are common to all peer-run programs and reflect the program's general operating principles—supporting self-help and promoting recovery and resiliency. Core outcomes include hope, personal empowerment, sense of self or personhood, social connectedness, and belief that one's life has meaning. Standardized tools, primarily self-reports, have been developed to measure these outcomes in ways that value an individual's unique experiences and accomplishments. These tools can be used to generate both short- and long-term results.

Program satisfaction outcomes

Program satisfaction outcomes look at participants' attitudes toward the organization's services, practices, staff, and environment. They are invaluable indicators of how well the program is serving its members. Information is collected through subjective measures, such as self-reports, and objective measures, such as program data analyses. These tools indicate that even short-term program participation can have positive outcomes.

Outcomes for specialized programs

An additional set of outcomes should be measured to look at specialized services that target specific populations. For example, outcomes related to drug and alcohol use should be collected from programs providing special services for mental health consumers with co-occurring substance use disorders. Some of the measures must be repeated over an extended period of time before significant results are produced.

Select appropriate outcomes for the evaluation

Identify key core outcomes for the first evaluation. Lessons learned from conducting this first study can be incorporated into later, more complex evaluations. For help identifying the first set of outcomes, review the key questions in the beginning of this section and think through possible ramifications.

Simpler outcome evaluation methods include holding member focus groups or conducting brief, one-shot surveys that use established measures to determine the impact of services on a limited number of participant outcomes.

Developing a logic model can be extremely helpful in selecting appropriate outcomes for more developed consumer-operated programs. Basically, a logic model analyzes the work of the service into four categories or steps: inputs (resources), activities, outputs (short-term results), and outcomes (longer term impact).

University of Idaho Extension has produced a five-page guide to basic logic models, available at <http://www.uiweb.uidaho.edu/extension/LogicModel.pdf>. For a more detailed guide on logic model development and use, consult the W. K. Kellogg Foundation's *Logic Model Development Guide: Using Logic Models to Bring Together Planning, Evaluation, and Action*. The document is available from <http://www.wkkf.org/>. It includes an introduction to model development, sample logic models, exercises, and a resource list.



Outcome measures

Work with the evaluator to identify appropriate outcome measures and data collection methods for the consumer-operated service. Select a combination of measures and collection methods that work well together and will provide enough data to generate significant results.

It is best to start with simple, straightforward outcome measures and data collection methods. These may be expanded after the organization's leaders and members have become accustomed to participating in evaluations and using the findings to improve the consumer-operated services.

Standard protocols

Consumer-operated programs are highly encouraged to adopt a commonly used evaluation protocol that has been used to evaluate other programs. A protocol is a set of questions to be asked or information to be gathered often, and a specific approach to be used to collect the data.

Creating a new, “home-grown” protocol requires considerable skill in scale development, testing, and analysis to ensure that the protocol is reliable and valid. Adopting a standard or commonly used evaluation protocol requires far less expertise and effort.

Commonly used protocols may focus on a single outcome (e.g., hope) or measure a group of outcomes. Many of these protocols have been shown to be valid and reliable in evaluating consumer-operated services and can be adapted for use by different programs. These include the following:

- Herth Hope Index (Herth, 1991);
- Meaning of Life Framework Subscale (Life Regard Index, Battista and Almond, 1973);
- Subjective Social Inclusion Scale (QOL Interview excerpts, Lehman, 1983);
- Empowerment/Making Decisions Scale (Rogers, Chamberlin, Ellison & Crean, 1997); and
- Recovery Assessment Scale (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999).

However, even though individual single-outcome tools may be valid and reliable, combining them psychometrically is more complex than it may appear. This approach is feasible for programs with sufficient resources to hire a professional evaluator.

The POP was developed to make evaluation easier by providing both single and multiple outcome measurement options and by including evaluator training. The following section explains the POP in more detail.

Using the Peer Outcomes Protocol

For many consumer-operated programs, the Peer Outcomes Protocol (POP) may be the most useful evaluation tool. The POP is consistent with peer support philosophy. In addition to being developed primarily by consumers, the tool was developed to help ensure that consumer values were included in outcome measurements. The POP (1) recognizes and utilizes proven consumer abilities to conduct survey and outcome studies and (2) is designed to be administered by consumers.

The POP has seven independent modules that can be used together or separately, so programs can measure the outcomes relevant to their goals.

Each module focuses on one of the following topics: demographics, service use, employment, community life, quality of life, well-being, and program satisfaction. Every outcome module includes objective as well as subjective items. Self-report items ask specifically about the effects of peer support on the particular outcome domains.

The instrument, a manual describing how to administer the POP, a question-by-question guide, a set of response cards, and related background information can be downloaded from the National Research and Training Center on Psychiatric Disability (NRTC) Web site: <http://www.cmhsrp.uic.edu/nrtc/pophome.htm>.

The POP meets key criteria that facilitate the use of any outcome evaluation protocol by a consumer-operated program. See the text box below.

The Peer Outcomes Protocol meets criteria for use in consumer-operated services

- **Adaptive Utility:** Each module may be presented as a separate unit. Programs may collect data on a subset of domains.
- **Simplicity:** The measures included are accessible to, and easily collected by, any community-based peer support program. Sophisticated computer technology and advanced expertise in program evaluation are unnecessary.
- **Flexibility:** The protocol offers multiple methods for data collection and management. It provides guidelines for matching methodology with program resources, infrastructure, and information needs.
- **Face Validity:** POP measures are relevant for consumer-operated programs and readily understood by nonresearchers.
- **Responsiveness and Sensitivity:** The POP was developed by and for persons with psychiatric disabilities as a tool for collecting outcome information about recovery, personhood, empowerment, well-being, employment, and community life.
- **Human Subjects Protections:** The POP places top priority on respecting the rights of people from whom data are being collected. The tool promotes adherence to participants' rights to privacy, confidentiality, and informed consent. POP principles promote voluntary participation and easy access to one's own data and aggregated data reports.
- **Collaboration:** POP principles emphasize member participation in all aspects of the evaluation; this includes planning, data collection and analysis, quality assurance, and the application and dissemination of results.

Data collection

Examples of data collection methods are outlined below. Select the one (or more) that fits best with your outcome measurement tool. Often, more than one method is needed to collect enough data in a reasonable amount of time.

In general, data are collected via mail or telephone or through in-person interviews with individuals or groups.

Mail surveys are cost-efficient, anonymous, and require less time to administer than other data collection methods. They can be used to reach a broad range of people, including recipients who do not have phones or who are unavailable for other types of interviews. However, mail surveys have low response rates (usually because they are time consuming), and they exclude individuals who cannot read the language used in the questionnaire.

Telephone surveys may be an efficient way to reach people who do not or cannot respond in writing or in person. They may be particularly useful for collecting data based on open-ended questions. However, telephone surveys are more expensive than mail surveys because interviewers must be trained to administer the survey. In addition, it can be difficult to gain consent during a telephone call and the sample will be limited to people who have telephone service.

One-on-one interviews yield the highest response rates. They also allow for in-depth probing and prompting to obtain data. In addition, the informed consent process can easily be used to ensure confidentiality. However, personal interviews are expensive: interviewers must be trained and paid, and scheduling conflicts may lead to losses of both time and money.

Group interviews have some of the advantages of one-on-one interviews, but prompting and probing for information may be more difficult. In many cases, however, these limitations are offset by lower administration costs.

Enter, summarize, analyze, and interpret data

Once data are collected, they must be coded and entered into the data analysis system using a standardized process. Initially, data may be entered and summarized using a simple report form and hand-tallying system. However, a computerized system that includes commonly used software such as SPSS or Access will greatly simplify collecting and analyzing data and preparing reports as the program grows. Over time, it may be most cost-effective to collect data in an electronic format and outsource more complex data analysis and report preparation to private firms or local academic institutions.

Evaluating Your Program

Reporting and Using Results

As the program develops its quality improvement efforts, fidelity assessments and outcome evaluations become invaluable assets for developing a program truly responsive to consumer needs and interests. As members' familiarity with assessment and evaluation principles and activities grows, you may wonder how the program ever operated without these processes in place!

This section focuses on reporting and using FACIT results for quality improvement. Additional information about using Peer Outcomes Protocol as part of the evaluation process is available at the National Research and Training Center on Psychiatric Disability Web site, <http://www.cmhsrp.uic.edu/nrtc/pophome.htm>

Baselines and benchmarks

The first fidelity assessment establishes the program baseline and is a starting point for efforts to become an evidence-based peer practice. The baseline scores can help you identify or confirm the existence of program strengths and weaknesses, especially when compared with the national FACIT benchmarks.

The national benchmarks are the aggregated FACIT scores from the eight consumer-operated programs that participated in the Consumer-Operated Services Program (COSP) Multisite Research Initiative. Since these programs were geographically diverse, represented multiple program models, and met the federal criteria for a consumer-operated program, their aggregated FACIT scores are a useful standard for gauging



individual program performance. More information about comparing program and benchmark scores is included in *Appendix C*.

Over time, comparisons of fidelity assessment results for the program will help you track the program's progress toward meeting its goals. Comparisons with the national benchmarks also will provide insight about how well the program is doing.

This KIT will enable you to make comparisons over time using traditional bar graphs and longitudinal plots. The graphs and plots are powerful feedback tools because they help program leadership develop an accurate long-range perspective on participation and outcomes.

You can use a longitudinal plot to track results for a specific outcome, a set of related outcomes (domain), or an entire program. A single plot can also contain longitudinal data for multiple programs or groups of members, enabling the leadership to make meaningful comparisons.

Share your results

The single factor that will most likely determine the success of quality improvement efforts is the ability to give useful and timely feedback to program members and staff. To influence program and individual practices and to help various audiences appreciate the value of conducting fidelity assessments, the data must be (1) translated into understandable and meaningful information and (2) tailored for each specific audience.

Prepare reports explaining the assessment results and share them with the program participants at member and staff meetings. Also report the results to your advisory board or board of directors and seek their feedback.

By sharing the fidelity reports, you can help create a learning organization characterized by adaptive

responses to information that aims to improve program operations and member outcomes. In addition, you can gain greater credibility with, and support from, other stakeholders within the continuum of care by sharing evaluation information, including FACIT reports, with them.

Writing FACIT reports: An overview

FACIT reports presenting different types of information may be needed for different audiences. For example, the board of directors may want to see everything, but an annual report to the funder may focus on only key successes and challenges.

The following overview is meant to guide the writing of a general report. However, this information can be adapted for drafting other types of FACIT reports.

Purpose of the report

The team or individual responsible for quality improvement should write a report using the FACIT scores to help identify the program's strengths and weaknesses and offer recommendations for program improvement.

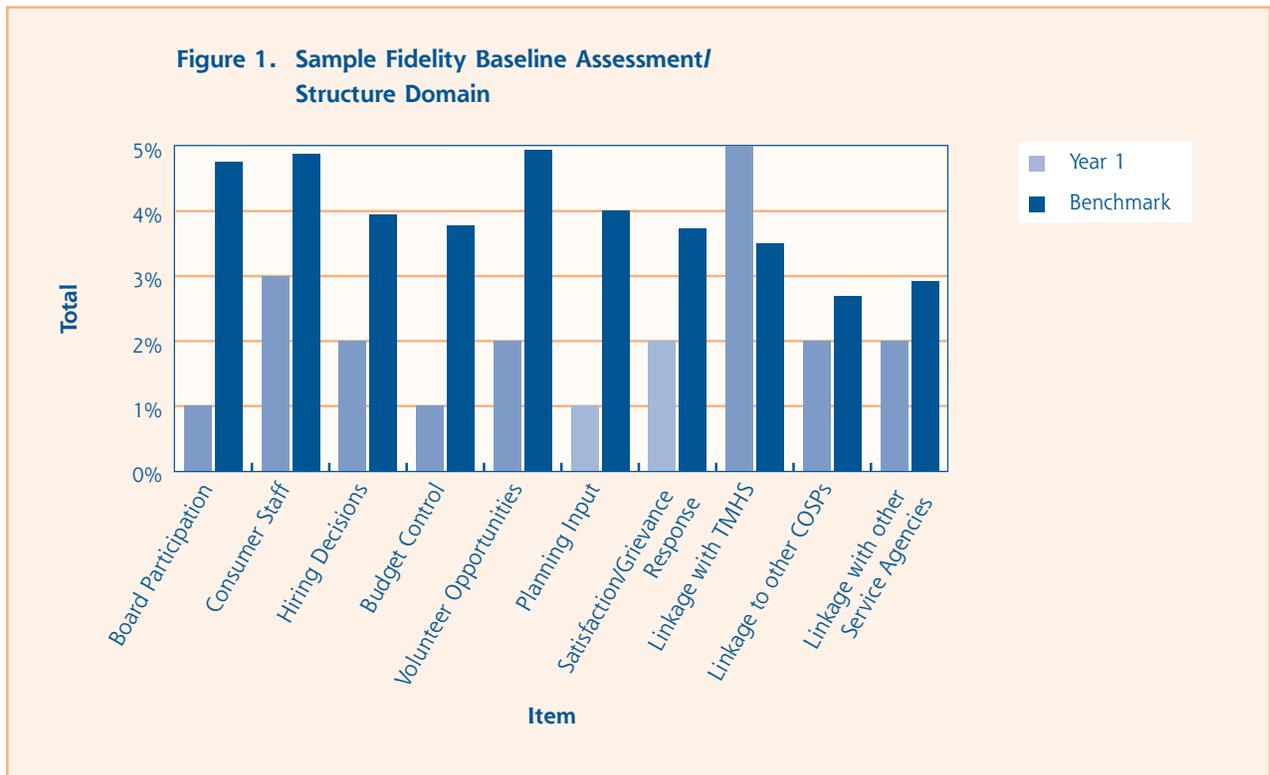
The report should be informative, factual, and constructive. It should be based in part on input from members and other evaluation participants. The report should be simple and reader friendly and provide information about both the overall program and specific topics.

The Excel program provided with this KIT will display data in both numerical and graphed formats. The graphic data displays are powerful tools. Coupled with explanatory text, they can be used to create effective formal documents (such as reports and slide presentations) that explain the program's strengths, weaknesses, and goals to members, advisors, and other key audiences.

Use tables and graphs to explain your data

Visual representations can make it easier for readers to understand key points in a report. The graphs and tables illustrate key FACIT results for consumer-operated programs. For example, Figure 1 is an Excel-generated bar graph showing first year or baseline results for individual peer practices within the structure domain.

Figure 1 also compares first year results to the national FACIT benchmarks. Notice how easy it is to see how the two compare. Strengths and weaknesses as compared with the national benchmarks are apparent, making it easier to identify priorities for program development and quality improvement planning.

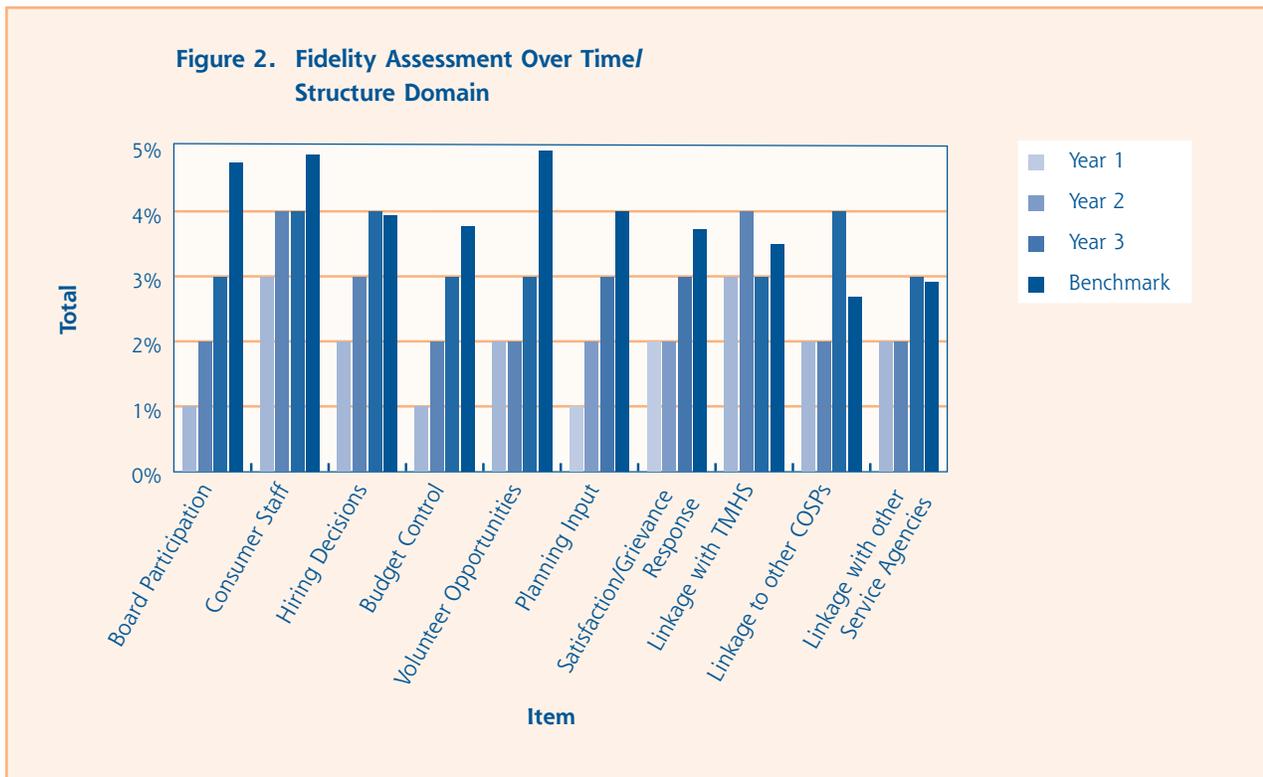


As additional assessments are conducted over time, bar graphs can be generated that display changes in the program's FACIT results. Two examples are included below.

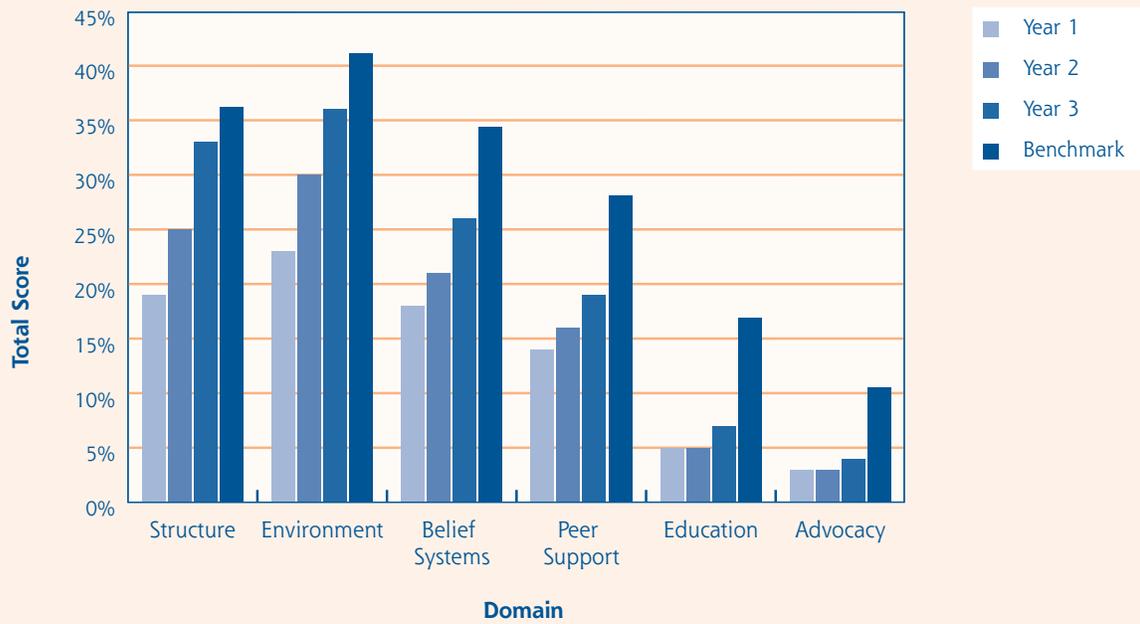
Figure 2 displays the results of one program's three annual assessments of program structure highlighting the individual peer practices within the structure domain. Figure 3 shows the scores in all program domains for three years of annual assessments.

Both figures also provide visual comparisons with the national benchmarks.

This chart makes it easy to see changes on the same item from year to year and also to compare them with the national benchmark. Is the program moving closer toward fidelity? Where are the most gains? What areas should be prioritized for further development?



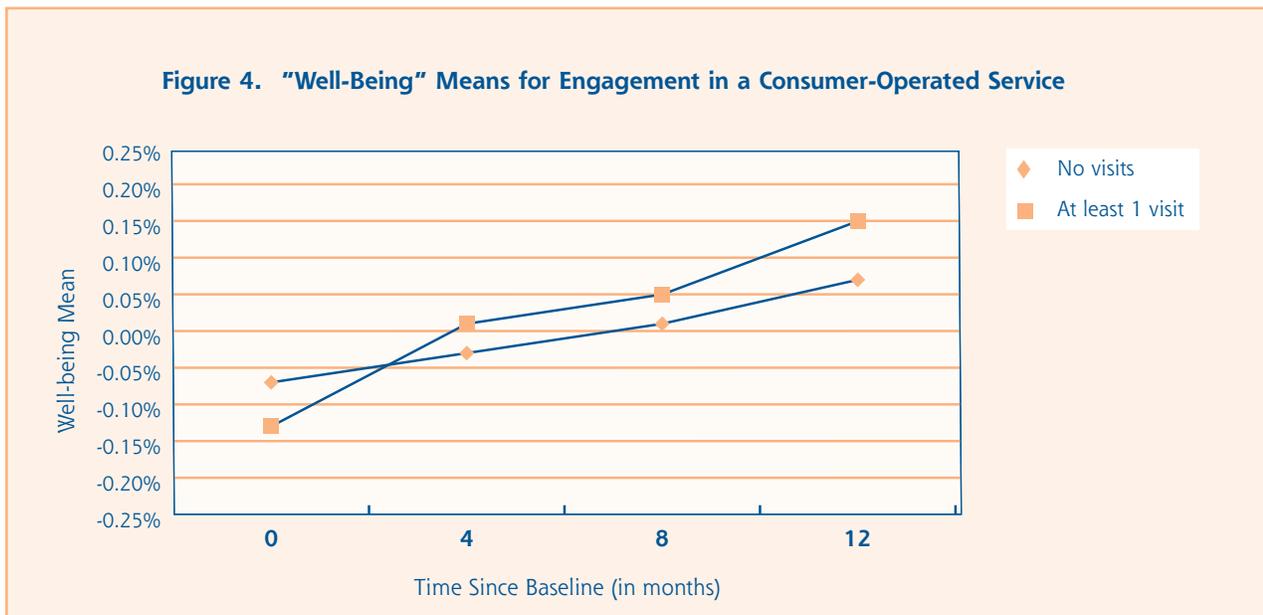
**Figure 3. Fidelity of All Domains Over Time/
Comparison of Domain Scores to National Benchmark**



The bar graphs are easily generated. They may be supplemented with other outcome displays; however, most of these are dependent on sophisticated analyses and will probably require support and consultation to “crunch the numbers” and produce the reports. One exception is the longitudinal plot.

programs that participated in the COSP Multisite Research Initiative. One group visited the program at least once and the other never visited during the 12-month study. The longitudinal plot shows that participation in a consumer-operated service program (at least one visit) is associated with greater well-being outcomes.

Figure 4 is a longitudinal plot comparing levels of well-being for two groups of consumers, those who did and those who did not attend one of the eight



Additional resources

This brief overview is meant to give you some ideas and practical advice for proceeding with fidelity assessments and outcome evaluations.

Additional resources are available at the National Research and Training Center on Psychiatric Disability Web site: <http://www.cmhsrp.uic.edu/nrtc/> and in the *Evidence* booklet of this KIT.





Evaluating Your Program

Appendix A: FACIT Protocol

For technical assistance on FACIT materials contact:

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Fidelity Assessment Common Ingredients Tool

Facit Protocol
June 2007

Introduction

The FACIT review includes two important elements:

1. Observing the physical environment and existing social relationships; and
2. Using structured questions to interview program leaders, staff, and members.

The evaluators use information from both the observations and interviews to determine the program scores that they then record on the FACIT scoresheet. Some of the elements to be observed are discussed below. The structured questions to be used in interviews begin on page 40.

FACIT Team observations

As part of the collection of evidence about the presence of the common ingredients, the FACIT Team will tour the program facility and observe the program activities and environment. FACIT Team members are particularly encouraged to observe and take notes regarding common ingredients not readily available through the interview or focus group.

Some things to observe include the following:

Safety

- Written rules of behavior or policies of expulsion are non-coercive.

Physical Environment

- The furniture looks comfortable.
- Peers appear relaxed and at ease with each other.

Social Environment

- Staff is out on the floor interacting with members.
- One might not be able to distinguish staff from members by clothing or attitude.
- Everyone is on a first name basis.

Sense of Community

- People know each other by name.
- Members come together to make decisions about the program.
- There are photos of members at retreats and other social events such as camping trips and celebrations.
- A newsletter published by members covers the organization's activities and community events, and may feature art, poetry, and prose.



Acceptance and Respect for Diversity

- In member interactions there appears to be an acceptance of differences and a willingness to learn about differences.
- There is minimal usage of clinical labels in conversation and in written materials about the consumer-operated service. Stigmatizing language is eschewed.

Spiritual Growth

- People are able to talk about spiritual growth, be accepted, and not considered to have religious delusions.

Peer Support

- Newsletters, mission statements, and other documents convey peer support principles.
- There are displays of written stories, poetry, or artwork created by members as part of telling their stories. There are a variety of avenues to tell stories. There is evidence that consumers have control over when and for whom they tell their stories.
- Members are encouraged to work to help other peers and to move the consumer movement forward.
- Materials about the history of the consumer movement are available, and members have access to documents, newsletters, position papers, and written testimony from other consumers and consumer organizations.

Peer Mentoring and Teaching

- There is evidence of formal matching of members by staff.
- An established leadership exists within peer support groups and classes.

Recovery

- Newsletters, mission statements, and other program documents convey a recovery philosophy.
- Self management problem-solving strategies are in evidence.
- Formal educational programs are available for problem solving, such as anger management classes.
- There is evidence of informal exchange of personal experience to enhance individual problem-solving abilities.

Formal Skills Practice

- Formal or informal teaching and practice of daily living skills, vocational skills, job readiness, communication skills, goal setting, and assertiveness skills occurs on a regular basis.

Interviews and focus groups: Suggested introductory script

Introduction

Hello, our names are _____ and we are members of the FACIT Team. FACIT stands for the Fidelity Assessment Common Ingredients Tool.

Our team is gathering information about the organization to find out how well the program is delivering peer support services.

The results of our work will be shared with members and staff of your consumer-operated program so you can develop a plan to improve some things you do, add activities and new ways to offer peer support, and celebrate your successes.

Like many of you, “I have also received mental health services” (or “I attend a consumer-operated program”).

Explain purpose

As program members (or staff) you have been asked to participate in this focus group to talk about the things the program is doing or needs to be doing to create a place where consumers can grow, change, and reclaim productive lives in their communities.

Many people use the term *recovery* to describe this process of growing, changing, and claiming our place back in our communities.

We will tape record our discussion, but the tape will not be shared with anyone but the FACIT Team members.

We will use the tape to check what was said if we miss something in our notes or disagree with each other about what was said. The tape will be stored in a locked cabinet and destroyed after we report the results to your program.

Clarify and answer questions

ASK: **Do you have any questions?**

[*Note:* Take time to make sure all questions are fully answered to the participant’s satisfaction.]

Let’s take a few minutes and have each of you introduce yourselves. Please just use your first names.

[*Note:* Use this time to create a comfort zone for participation.]

Explain guidelines for discussion

Before we begin the focus group, there are a few guidelines we’d like you to follow:

- Say whatever you think is true for you. There are no “right” or “wrong” answers.
- Make as many comments as you want because we are trying to generate as many responses as possible.
- Respect the person who is speaking, do not interrupt him or her, and do not criticize anyone else’s ideas. We can ask each other for clarification though, if we need to.
- Give everyone a chance to share his or her own ideas by speaking briefly and sticking to the point.



- Speak from your own experiences.
- Personal information that is shared here stays here.

[*Note:* Often people will say they want what is said in the room to stay in the room. This gives people ownership over the rules. Posting the rules is good because, if someone is monopolizing or criticizing another person’s input, then the facilitator can point to the rules and gently remind him or her—“this is what we all agreed to.”]

Does anyone want to add any other rules so you all can feel comfortable participating?

Now we can begin the focus group discussion.

Semi-structured interview/focus group questions

The following sections provide general and FACIT-specific questions for the program:

- Director;
- Supervisory staff;
- Nonsupervisory staff; and
- Member focus groups.

Questions for the director

General questions:

- What expectations should a consumer have about being a member/participant here?
- In what way are members expected to be accountable for their actions here?
- How is the pace at which a member wishes to participate or be involved in the program respected?
- How is recovery an important component here, and how is it defined?
- How is spirituality viewed, and how is it expressed in the program?
- In what ways do members have a chance to “tell their stories”?
- Do participants receive information about the consumer movement here?
- How is crisis prevention handled here?
- What type of emphasis is placed on participants being able to identify their own needs?

- How do participants learn to deal effectively with entitlement agencies (such as the Social Security Administration or HUD)?
- How would you describe your relationship with traditional mental health providers in your community?
- If you could change anything you wanted about the program, what would you change first?

FACIT questions:

Board Participation

Do you have a board or decisionmaking group?
If so—

- Is the board (or decisionmaking group) elected, and by whom?
- What percent of the board (or decisionmaking group) identify themselves as consumers?
- Does the board (or decisionmaking group) make binding policy?
- How often does the board (or decisionmaking group) meet?

Consumer Staff

- What percentage of the staff identify as consumers?
- What staff/leadership positions do consumers hold?

Hiring Decisions

- Is there a written policy regarding who can be hired as staff in the program?
- Who is involved in hiring decisions?

Budget Control

- Who develops the budget? Are consumers involved?
- Who signs checks? Is this a consumer?
- Who decides the salaries of the staff? Are consumers involved in these decisions?
- Who is authorized to sign contracts on behalf of the agency? Is this a consumer?

Planning Input

- Are there organizational or strategic planning meetings? If yes, how is member input solicited?
- Are there meetings in which members can state their desired changes for the program? Are requested changes addressed and accommodated as soon as possible?
- Are there changes that staff or members would like to make but that your funding sources or laws/regulations preclude you from making?

Satisfaction/Grievance

- Does your program have a grievance policy?
- Does your program conduct satisfaction surveys?
- Are there forums at which members can raise their concerns about the program and offer suggestions?

Traditional Mental Health Services

- To what extent do you exchange information with traditional service providers? Provide referrals to them? Receive referrals from them? Exchange resources with them?



Lack of Coerciveness

- Are there any program requirements for member participation in the program or peer support groups?

Recovery

- Are there members who no longer participate in the program because they got the support they needed from the program (such as became employed or managed their symptoms)?
- What is the program doing to promote recovery or to show that it embraces recovery?

Crisis Prevention

- What are some of the ways that the program prevents crises or helps members who are in crisis?

Questions for supervisory staff

Note: If there is no supervisory staff in this program, these questions may be answered by the program leadership.

General questions:

- How long has each of you worked here?
- What expectations should consumers/participants have about receiving services here?
- What is the most important thing you can do for a member/participant?
- In what ways are members accountable for their actions here?
- How is the pace at which the member wishes to be involved respected here?
- What is the importance of recovery here and how is it defined?

- How is spirituality viewed here, and how is it supported in the program?
- When do members have a chance to “tell their stories”?
- Do members receive information about the consumer movement here?
- How is crisis prevention practiced here?
- What type of emphasis is placed on participants being able to identify their own needs? Is staff responsive to those needs?
- How do participants learn to deal effectively with agencies responsible for entitlement programs (such as the Social Security Administration or HUD)?
- How would you describe your relationship with the traditional mental health service community?
- If you could change anything you wanted about the program, what would you change first?

FACIT questions:

Satisfaction/Grievance

- Are there forums at which members can raise their concerns about the program and make suggestions or recommend changes?
- How are personal and program concerns of members addressed by the program?

Traditional Mental Health Services

- To what extent does the program exchange information with traditional service providers? Provide referrals to them? Receive referrals from them? Exchange resources with them?
- To what extent does staff participate in local service network meetings?
- Are members forced or coerced to follow through with referrals?

Local Proximity

- Is the program located within walking distance of the center of town or where there is a major concentration of consumers?

Access

- How close is the program to the nearest bus line?
- Does the program provide or arrange for transportation to/from the program?
- Does the program supply bus tickets or taxi vouchers?

Hours

- What are the program's hours of service?
- Which days is the program open?
- How are decisions on the hours/days of operation made?
- Are there arrangements that members can make to receive support after hours?
- Does the program remain open after other programs close?
- Is the program open on evenings, weekends, and/or holidays?

Cost

- What fees are there for program membership/attendance?
- What fees are there for participating in any program activities?

Accessibility

- Is the program accessible for members with physical disabilities? Does it have wheelchair ramps and necessary accommodations in the bathrooms available?
- Are program materials prepared in various ways to accommodate members with physical disabilities such as offering Braille or large print versions of written materials?
- Does the program have a TTY system available for individuals who need it? Does the program have a contract to use relay services?
- To what extent do persons with disabilities other than psychiatric disabilities actually attend the program and participate in activities?

Lack of Coerciveness

- What requirements are there for participation in program activities?

Sense of Community

- How does program staff link individual members together for mutual support or activities?

Peer Principle

- Do staff members disclose their psychiatric disabilities to other members?
- Have staff shared their recovery stories with other members?

Helper's Principle

- Describe a recent experience in which you helped someone at the program.
- Was this experience helpful in any way for you, as well as being helpful to the person you helped?



Empowerment

- How has being involved as a staff member at the program helped you make positive changes in your life?
- What was it that helped you make these changes?
- How does program participation help you feel that you have more control over your life?
- How does participation help you feel that change in the mental health system is possible?

Group Empowerment

- Do you feel pride in being a program member?
- Do you feel that you can contribute/make an impact on the program?

Member Choice

- What types of programs or activities does the program offer?

Recovery

- What is the program doing to promote recovery or to show that it embraces recovery?

Spiritual Growth

- Are there opportunities to share spiritual beliefs?
- What happens if someone shares their spiritual beliefs with other members?

Exploration of Meaning and Purpose

- What activities, such as writing, artwork, or poetry, are there to help or encourage people to express meaning and purpose in life?

Formal (Scheduled) Peer Support Groups and Individual Peer Support Relationships

- How often do formal peer support groups meet?
- How many members participate in formal individual or group peer support?

Informal (Unscheduled) Peer Support Groups and Individual Peer Support Group Relationships

- How often do informal peer support groups meet?
- How many members participate in informal individual or group peer support?

Crisis Prevention

- What are some of the ways that the program helps people who are in crisis?

Peer Mentoring and Teaching

- How has someone at the program been a mentor to you?

Job Readiness Activities

- Please provide examples of program efforts to improve: (1) communication skills or confidence of participants, (2) assistance in preparing resumes, (3) practice in employment interviews, and (4) support in setting up employment interviews.

Formal Self-Advocacy Activities

- Does participation in this program help members to obtain services from other community agencies?

Questions for nonsupervisory staff

General questions:

- How long has each of you worked here?
- What expectations should consumers have about receiving services here?
- What is the most important thing you can do for a consumer?
- In what way are members expected to be accountable for their actions here?
- How is the pace at which the member wishes to participate or be involved respected here?
- What is the importance of recovery here, and how is it defined?
- How does this program support members in using spirituality as part of their recovery?
- How do members have a chance to “tell their stories” of emotional distress and recovery here?
- Do members receive information about the consumer movement here?
- How is crisis prevention handled here?
- How does the program help members to identify their own needs and make sure that those needs are taken care of? How do members have a chance to learn to deal effectively with entitlement agencies (for example, HUD or Social Security)?
- If you could change anything you wanted about this program, what would you change first?

FACIT questions:

Hiring Decisions

- Is there a written policy regarding who can be hired as program staff?

Budget Control

- Who decides the salaries of the staff? Are any consumers involved in these decisions?

Volunteer Opportunities

- Is there an opportunity to become staff after participating in the program or volunteering in it?

Planning Input

- Are there membership meetings in which members can state their desired changes?
- If members request changes, are these requests reviewed and adopted as appropriate?

Satisfaction/Grievance

- How are concerns of members addressed?

Traditional Mental Health Services

- To what extent do you exchange information with traditional service providers? Provide referrals to them? Receive referrals from them? Exchange resources with them?
- To what extent does staff participate in local service network meetings?
- Are members ever forced or coerced to follow through with referrals?



Accessibility

- To what extent do persons with disabilities (other than psychiatric disabilities) actually participate in activities at the program?

Lack of Coerciveness

- Are there program rules for members?
How were they developed? How are they shared with members?

Sense of Community

- As staff, how do you link or bring together individual program members?

Peer Principle

- Does staff disclose to members that they have psychiatric disabilities?
- Does staff share their recovery stories with members?

Helper's Principle

- Describe a recent experience of helping a member.
- Was this experience meaningful for you? Why?

Empowerment

- How has being involved in the program helped you make positive changes in your life?
- How were you able to make these changes?
- How has participation in the program enabled you to have more control over your life?

Group Empowerment

- Do you feel pride in being a program member?
- Do you feel that you are making an impact on the program?

Member Choice

- What types of activities are offered at the program?
- Do members have the option to select from a variety of activities?

Recovery

- Are there members who have moved on with their lives because they got the help they needed from the program?
- Are there former members who left the program because they became employed?
- How do you define recovery?
- What does the program do to promote recovery or to show that it embraces recovery?

Spiritual Growth

- Are there opportunities for members to share their spiritual beliefs?
- Do members feel comfortable discussing their spiritual beliefs?

Exploration in Meaning and Purpose

- Are there activities that help or encourage members to explore meaning and purpose in their lives, such as through writing, artwork, or poetry?

Formal (Scheduled) Peer Support Groups and Formal Individual Peer Support Relationships

- How often do formal peer support groups meet?
- How many members participate in formal individual or group peer support?

Informal (Unscheduled) Peer Support Groups and Informal Individual Relationships

- How often do these groups meet?
- How many consumers participate in informal individual or group peer support?

Crisis Prevention

- What are some of the ways that the program has helped members who were in crisis?
- Has participation in the program helped members avoid crises?

Peer Mentoring and Teaching

- Is there anyone at the program who has been a mentor to you? Are you a mentor to other members?
- Please provide examples of program efforts to improve: (1) communication skills or confidence of members, (2) assistance in preparing resumes, (3) practice in employment interviews, and (4) support in setting up employment interviews.

Formal Self-Advocacy Activities

- Does participation in this program help members obtain services from other community agencies?

Questions for consumer focus groups

General questions:

- How would you describe this consumer-operated program to a friend, also a mental health consumer, who is considering coming here?
- What expectations should consumers have about receiving services here?
- How are you and other members expected to be accountable for your actions here?
- How is the pace at which you wish to participate or be involved in program activities respected here?

- How is recovery an important component here and how is it defined?
- Is spirituality an important component of the program, and how is it supported at the program?
- How do you have a chance to “tell your stories” of distress and recovery here?
- Do you receive information about the consumer movement here?
- How is crisis prevention handled here?
- How does staff encourage members to identify their own needs and desires and how does the program make sure that desired changes are positively addressed?
- How do you learn to deal effectively with agencies providing entitlements (such as HUD or Social Security) at the program?
- What is helpful about coming to the program? What is difficult about coming here?
- Tell me about one thing you would like to change at the program.

FACIT questions:

Member Input

- Are there membership meetings in which members can state their desired changes at the program?
- If changes are desired, how does the program respond to these requests?
- Have there been times that you have been pressured to participate in any program activities that you didn't want to attend?

Program Rules

- Do you feel safe at the program?
- Are you aware of any program rules that apply to member participation?



Sense of Community

- How does staff try to link or bring together individual program members?
- When you are not at the program, do you participate with other members in any activities that are not part of the program?
- Do you feel connected or share a bond with other people at the program?

Peer Principle

- Does staff disclose their psychiatric disability to program members?
- Does staff share their stories of distress and recovery with members?
- Do you share your experiences of having psychiatric disabilities with each other?

Helper's Principle

- Can you describe an experience of helping someone out recently while at the program?
- How was this experience helpful to you?
- Do you ever feel pressured to follow the advice of your program peers?

Empowerment

- Has being involved in the program helped you make any positive changes in your life? How were you able to make these changes?
- How does participation enable you to have more control over your life?
- Does participation in the program make you feel that change in the mental health system is possible?

Group Empowerment

- Do you feel pride in being a program member?
- Do you feel that you can contribute to or make an impact on the program?

Member Choice

- What types of activities are offered at the program? Are these activities that you usually chose to participate in?
- Do you have a choice of various activities when attending the program?

Recovery

- Do you know of any former members who have left the program because they became employed?
- As a program member, do you have the choice when to leave the program or how long to remain?
- Describe what the program is doing to promote recovery or to show that it embraces recovery.

Spiritual Growth

- Are there opportunities to share your spiritual beliefs with other program members?
- Do you feel comfortable discussing your spiritual beliefs with others at the program?

Exploration in Meaning and Purpose

- What activities help or encourage you to explore meaning and purpose in your life through writing, artwork, or poetry?

Crisis Prevention

- What are some of the ways that the program has helped members that are in crisis?
- How has participation in the program helped you stay out of the hospital and use alternative methods to help you through a crisis?

- How has participation in the program helped you avoid crisis?

Peer Mentoring and Teaching

- Is there anyone at the program that has been a mentor to you? In what way?

Job Readiness Activities

- Can you provide any examples of efforts at the program to: (1) help you improve your communication skills or confidence, (2) assist you in preparing resumes, (3) help you practice employment interviews, or (4) support you in setting up employment interviews?

Formal Self-Advocacy Activities

- Are you more assertive when receiving services from traditional mental health agencies because of your participation in the consumer-operated program?
- Do you feel that you are effective in obtaining services from other community agencies due to participation in the program?



Evaluating Your Program

Appendix B: FACIT Scoresheet

For technical assistance on FACIT materials contact:

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Scoresheet

Program Name _____
 Site Visitor _____

Site Visit Date _____ Score _____
 Conciliated Score _____

Ingredient	Definition	Anchored Scale	Assigned Score
1. STRUCTURE			
1.1. Consumer Operated			
1.1.1. Board Participation	Consumers constitute the majority (at least 51%) of the board or group that decides policies and procedures.	<ul style="list-style-type: none"> ■ No member of the board is self-identified as a consumer. ■ Up to 50% of the board members self-identify as consumers. ■ 51% of the board members self-identify as consumers but less than 51% of the officers self-identify as consumers. ■ 51% or more of the board self-identify as consumers and more than 51% of the officers self-identify as consumers. ■ 90-100% of the board members self-identify as consumers and all of the officers self-identify as consumers. 	_____
1.1.2. Consumer Staff	With limited exceptions, staff consists of consumers who are hired by and operate the consumer-operated service.	<ul style="list-style-type: none"> ■ No staff member self-identifies as a consumer. ■ Up to half of staff self-identifies as consumers. ■ 51% or more of staff self-identifies as consumers, but less than 51% of administrators self-identify as consumers. ■ 51% or more of the staff self-identifies as consumers and more than 51% of administrators self-identify as consumers. ■ 80-100% of staff self-identifies as consumers and all administrators self-identify as consumers. 	_____
1.1.3. Hiring Decisions		<ul style="list-style-type: none"> ■ Consumers are not involved in any hiring decisions. ■ Consumers have some involvement in hiring decisions. ■ Consumers are responsible for making most of the hiring decisions (50% or more). ■ Consumers are responsible for making all hiring decisions. 	_____
1.1.4. Budget Control	Consumers have control of the consumer-operated service's operating budget.	<ul style="list-style-type: none"> ■ Consumers are not involved in the development or control of the budget. ■ Consumers have some involvement in the development and control of the budget. ■ Consumers are responsible for the development and control of most of the budget. ■ Consumers are responsible for the development and control of the entire budget. 	_____
1.1.5. Volunteer Opportunities	Volunteer opportunities for consumer-operated program members may include board and leadership positions, unpaid jobs, and paid staff positions.	<ul style="list-style-type: none"> ■ No consumers serve as volunteers at the consumer-operated program. ■ Less than 25% of the volunteers are self-identified as consumers. ■ Between 26% and 50% of the volunteers are self-identified as consumers. ■ Between 51% and 75% of the volunteers are self-identified as consumers. ■ Between 76% and 100% of the volunteers are self-identified as consumers. 	_____



Ingredient	Definition	Anchored Scale	Assigned Score
1. STRUCTURE			
1.2. Participant Responsive			
1.2.1. Planning Input	The consumer-operated program is responsive to the needs and preferences of its members.	<ul style="list-style-type: none"> ■ There are no realistic opportunities for member input. ■ There are some opportunities for member input, but the consumer-operated program does not display a commitment to implementing recommended changes. ■ There are some opportunities for member input but the program displays minimal commitment to implementing recommended changes. ■ There are many opportunities for member input and the program displays a commitment to implementing recommended changes. ■ There are multiple avenues for member input and the consumer-operated program displays a significant commitment to implementing recommended changes. 	—
1.2.2. Member Dissatisfaction/ Grievance Response	Members have formal ways to indicate dissatisfaction with their consumer-operated program and to have grievances addressed.	<ul style="list-style-type: none"> ■ There are no formal or informal opportunities to express grievances or dissatisfaction with the consumer-operated program. ■ There are some formal or informal opportunities for members to express grievances or dissatisfaction with the consumer-operated program, but the organization does not display a commitment to implementing desired changes. ■ There are some formal or informal opportunities for members to express grievances or dissatisfaction with the consumer-operated program, but the organization displays minimal commitment to implementing desired changes. ■ There are many formal or informal opportunities for members to express grievances or dissatisfaction with the consumer-operated program and the organization displays a commitment to implementing desired changes. ■ The consumer-operated service program has a formal, written policy for addressing grievances; regularly assesses member satisfaction and holds membership meetings; and displays a significant commitment to implementing desired changes. 	—

Ingredient	Definition	Anchored Scale	Assigned Score
1. STRUCTURE			
1.3. Linkage to Other Supports			
1.3.1. Linkage with Traditional Mental Health Services		<ul style="list-style-type: none"> ■ The consumer-operated service has no reported linkage to traditional mental health services. ■ There is a report of minimal linkage with traditional mental health services. ■ There is a report of moderate linkage with traditional mental health services. ■ The consumer-operated service has reported intense linkage with traditional mental health services, but this involvement is not reciprocated. ■ The consumer-operated service has reported intense linkage with traditional mental health services and this involvement is reciprocated. 	<p style="text-align: center;">——</p>
1.3.2. Linkage with Other Consumer-Operated Services		<ul style="list-style-type: none"> ■ The consumer-operated service has no reported linkage to other consumer-operated services. ■ There is a report of minimal linkage to other consumer-operated services. ■ The consumer-operated service has reported moderate linkage to other consumer-operated services. ■ The consumer-operated service has reported intense linkage to other consumer-operated services, but this involvement is not reciprocated. ■ The consumer-operated service has reported intense linkage to other consumer-operated services and this involvement is reciprocated. 	<p style="text-align: center;">——</p>
1.3.3. Linkage with Other Service Agencies		<ul style="list-style-type: none"> ■ The consumer-operated service has reported no linkage with other service agencies. ■ The consumer-operated service has reported minimal linkage with other service agencies. ■ The consumer-operated service has reported moderate linkage with other service agencies. ■ The consumer-operated service has reported intense linkage with other service agencies, but this involvement is not reciprocated. ■ The consumer-operated service has reported intense linkage with other service agencies and this involvement is reciprocated. 	<p style="text-align: center;">——</p>
TOTAL			



Ingredient	Definition	Anchored Scale	Assigned Score
2. ENVIRONMENT			
2.1. Accessibility			
2.1.1. Local Proximity	Members can walk to the consumer-operated service, or the program comes to the consumer.	<ul style="list-style-type: none"> ■ The consumer-operated service is physically remote from any population cluster. ■ The consumer-operated service is close to, but not in, a population cluster. ■ The consumer-operated service is located within a population cluster, but minor improvements are possible. ■ The location of the consumer-operated services is optimal—at the very center of a population cluster. It is difficult to conceive of further improvements. 	_____
2.1.2. Access	Consumers are able to get to the consumer-operated service either by bus or by transportation arranged and/or paid for by the consumer-operated program.	<p>Use the following Rating Scale for 1a, 1b, 2, and 3</p> <p>0 = Very Poor, 2 = Poor, 4 = Fair, 6 = Good, 8 = Optimal</p> <ul style="list-style-type: none"> ■ Speed and convenience in terms of: proximity to means and routes of access, variety of means and routes, and multiplicity of areas served: <ul style="list-style-type: none"> a) For local participants: 0 2 4 6 8 b) For regional/remote participants: 0 2 4 6 8 ■ Congestion of access, traffic, and parking: 0 2 4 6 8 ■ Safety of access and neighborhood: 0 2 4 6 8 <p>ADD the points given to 1a, 1b, 2, and 3: _____</p> <p>Use the chart below to assign a TOTAL score:</p> <p>1 = 0-5 points 2 = 6-10 points 3 = 11-14 points 4 = 15-19 points 5 = 20-24 points</p>	_____
2.1.3. Hours	Hours of operation are geared to the needs of participants.	<ul style="list-style-type: none"> ■ Hours of operation are extremely limited and rigidly set. ■ Hours of operation are limited. ■ Consumer-operated service in operation 40 hours per week, but might not be open during needed hours. ■ Consumer-operated service in operation more than 40 hours per week and is open some evenings and weekend hours. ■ Consumer-operated service hours conform to the hours most needed by members. 	_____
2.1.4. Cost	Programs are either free or charge a nominal fee. Consumer-operated service use is not dependent on ability to pay.	<ul style="list-style-type: none"> ■ Services are priced without regard to ability to pay or are dependent on insurance or income. ■ Services are modestly priced but no provisions are made for an individual's ability to pay. ■ Services are modestly priced and there are some provisions for an individual's ability to pay. ■ All services are free or modestly priced and provisions are made for an individual's ability to pay. ■ All services are free of charge. 	_____

Ingredient	Definition	Anchored Scale	Assigned Score
2. ENVIRONMENT			
2.1. Accessibility			
2.1.5. Accessibility	Efforts are made to ensure that consumers with physical and sensory as well as psychiatric disabilities can participate in consumer-operated service programming.	<ul style="list-style-type: none"> ■ The consumer-operated service pays no attention to accommodations of persons with physical and sensory disabilities. A gross lack of accessibility is readily apparent to observers. ■ The service makes some provisions for persons with physical/sensory disabilities, but gaps in accessibility may create barriers for some potential participants. ■ The service is generally accessible but improvements can be imagined (e.g., the consumer-operated service has accessible entrance and toilets but lacks TTD). ■ The consumer-operated service is fully accessible to persons with a wide range of disabilities, and the program is committed to accommodating individual differences. 	——
2.2. Safety			
2.2.1. Lack of Coerciveness	<p>The consumer-operated service provides a non-coercive, safe milieu. Fears due to past trauma are appreciated and assuaged, including trauma induced by the mental health system.</p> <p>There are no threats of commitment, clinical diagnoses, or unwanted treatments forced on members except in cases where suicide or physical danger to other participants is imminent.</p>	<ul style="list-style-type: none"> ■ Members are required to be in formal treatment to participate in the consumer-operated service. ■ The consumer-operated service strongly encourages, but does not require, members to be in formal treatment to participate. ■ The consumer-operated service strongly encourages members to participate in peer support programs. ■ The consumer-operated service encourages members to participate in peer support programs. ■ The consumer-operated service encourages members to choose whether or not to participate. 	——
2.2.2. Program Rules	Norms/rules to protect the physical safety of participants are developed by and for consumers—either by the members or by consumer staff—and they are agreed to by all participants.	<ul style="list-style-type: none"> ■ Inadequate controls/safeguards. Members frequently feel unsafe or are victims of crimes. ■ Inadequate controls/safeguards. Members sometimes feel unsafe or are victims of crimes. ■ Adequate controls/safeguards. Members feel safe from physical harm/crime. Rules not developed by members. ■ Adequate controls/safeguards. Members feel safe from physical harm/crime. Rules developed by members. However, no procedures in place to address violations of rules. ■ Adequate controls/safeguards. Members feel safe from physical harm/crime. Rules developed by members and procedures in place for when rules are violated. 	——



Ingredient	Definition	Anchored Scale	Assigned Score
2. ENVIRONMENT			
2.3. Informal Setting			
2.3.1. Physical Environment	The consumer-operated service offers a comfortable setting with spaces arranged to create a sense of safety, belonging, and support.	<ul style="list-style-type: none"> Lack of physical comfort in the consumer-operated service that is perceived by a sizeable minority of participants as intolerable or as extremely objectionable. Shortcomings in physical comfort are significant in the consumer-operated service, but would rarely be considered intolerable. The consumer-operated service offers settings in which the majority of members feel physically comfortable, even though there is obvious room for improvement. The consumer-operated service not only meets all obvious requirements for physical comfort, but makes efforts to ensure that even minor aspects of the environment add to member comfort. 	—
2.3.2. Social Environment	<p>Rigid distinctions between members and staff such as “provider” and “client” do not exist.</p> <p>While some program components may be structured, there remains a sense of freedom and self-expression.</p>	<ul style="list-style-type: none"> Obvious devaluation of members with differentiation between members and staff, such as strict separation of staff and member areas. Minor distinctions exist, such as that members may have to knock on staff doors, but not vice versa. Staff attitudes are somewhat cold and distant, with minor distinctions between staff and members apparent. Staff treats members with openness, directness, and sincerity. Minor distinctions between staff and members are present. Staff/member interaction appears near ideal with openness, directness, and sincerity. No sense of inequality or staff/member distinctions are apparent. 	—
2.3. Informal Setting			
2.3.3. Sense of Community	The consumer-operated service provides a sense of fellowship in which people care about each other and create community together.	<ul style="list-style-type: none"> Formal relationships among members, but little opportunity to informally relate with others or develop a sense of belonging. Formal relationships among members, but some opportunity to informally relate with others or develop a sense of belonging. Both formal and informal relationships among members with considerable opportunities for participants to informally relate with others or develop a sense of belonging. General comfort among participants characterized by extensive opportunities for warm, interpersonal interactions, sense of belonging, and numerous opportunities to socialize with other consumer-operated service participants. 	
2.4. Reasonable Accommodations			
NOTE: Additional items about reasonable accommodations are under “Accessibility” (section 2.1.5.).			
2.4.1. Timeframes	No pressure to join the consumer-operated service and no time limit for participation. Schedules are flexible and adapted to individual needs.	<ul style="list-style-type: none"> Strict limitation of tenure in program; no opportunity for flexibility based on individual need. Some time limits, but also some flexibility based on individual need. No formal time limits, with some expectation of continued participation based on individual need. No time limits, with expectations about continued participation based on individual need. 	
TOTAL			

Ingredient	Definition	Anchored Scale	Assigned Score
3. BELIEF SYSTEMS			
3.1. Peer Principle	<p>Relationships are based upon shared experiences and values. Staff and members share their experiences of having psychiatric disabilities.</p> <p>The relationships are characterized by reciprocity and mutuality.</p> <p>A peer relationship implies equality, along with mutual acceptance and mutual respect.</p>	<ul style="list-style-type: none"> ■ Self-disclosure is limited, and no staff/leaders are identified as mental health consumers. Staff/leaders who are mental health consumers do not reveal this to consumer-operated service participants. ■ Some self-disclosure by program staff/leaders, but this is limited to one or a few instances. ■ Self-disclosure is common, but not universal among staff/leaders and participants within the consumer-operated service. ■ Self-disclosure is almost universal—both participants and staff/leaders characterize their relationships as mutual/reciprocal. 	<p>—</p>
3.2. Helper's Principle	<p>Helping oneself and others is a corollary of the Peer Principle. Working for recovery of others facilitates personal recovery.</p> <p>Help or advice is friendly rather than professional and does not demand compliance. All services within the consumer-operated program are based on peer-to-peer relationships.</p>	<ul style="list-style-type: none"> ■ No consumer-operated service participants report the experience of helping others. ■ A few participants report some experience helping other program participants. ■ Some participants report the experience of helping other participants. ■ Most participants report the experience of helping other participants. 	<p>—</p>
3.3. Empowerment			
3.3.1. Personal Empowerment	<p>A sense of personal strength and efficacy, with self-direction and control over one's life.</p>	<ul style="list-style-type: none"> ■ No members agree that being involved with the consumer-operated service has helped them make positive changes in their lives. ■ Some members agree that being involved with the consumer-operated service has helped them make positive changes in their lives. ■ About half the members agree that being involved with the consumer-operated service has helped them make positive changes in their lives. ■ Most members agree that being involved with the consumer-operated service has helped them make positive changes in their lives. ■ All members agree that being involved with the consumer-operated service has helped them make positive changes in their lives. 	<p>—</p>
3.3.2. Personal Accountability	<p>Consumers are expected, but not forced, to be accountable for their actions and to act responsibly. Self-reliance is encouraged.</p>	<ul style="list-style-type: none"> ■ Consumer-operated service staff/leaders are often patronizing, placing few or no demands on participants. ■ Consumer-operated service staff/leaders are somewhat patronizing, placing few or no demands on participants. ■ Consumer-operated service staff/leaders are rarely patronizing but place few demands on program participants. ■ Consumer-operated service staff/leaders are never patronizing and place modest demands on participants. ■ Consumer-operated service staff/leaders encourage a high level of participant accountability and self-reliance. 	<p>—</p>



Ingredient	Definition	Anchored Scale	Assigned Score
3. BELIEF SYSTEMS			
3.3. Empowerment			
3.3.3. Group Empowerment	<p>Belonging to an organized group that is recognized by the larger community contributes to the empowerment of participants.</p> <p>Members take an active role in the governance and decisionmaking processes within the consumer-operated service.</p>	<ul style="list-style-type: none"> ■ There is no participant recognition of belonging to a group or to the consumer-operated service. ■ There is some participant recognition and feelings of membership in a group. ■ There is significant participant recognition and feelings of membership in the group. Membership affords opportunity for participants to contribute to consumer-operated service activities and planning. ■ There is high participant recognition and feelings of membership in the group. Membership affords great opportunity for participants to contribute to consumer-operated service activities and planning within and beyond the group. 	——
3.4. Choice	<p>Participation in the consumer-operated service is completely voluntary. Consumers are regarded as experts in defining their own experiences and in choosing services that best suit them. Choice of services includes the right to choose none.</p>	<ul style="list-style-type: none"> ■ Limited choice is apparent to participants. Participation is involuntary. ■ Members can choose to participate or not. ■ Members have the choice to participate and the opportunity to choose between at least two activities. ■ Members have the choice to participate and the opportunity to choose between at least two activities with different levels/forms of participation. ■ Members have the choice to participate in a wide array of program activities with different levels/forms of participation, including the opportunity to shape the activity. 	——
3.5. Recovery	<p>A positive recovery process acknowledges strengths and enhances well-being. Recovery cannot occur without hope, which provides the person with all the essential elements of recovery: the courage to change, to try, and to trust.</p> <p>The recovery process is different for each individual and, therefore, it is never defined rigidly, or forced on others.</p>	<ul style="list-style-type: none"> ■ There is little or no recognition of a need for a hope-oriented recovery approach in the mission statement or in materials describing the program. ■ There is some recognition of a need for a hope-oriented recovery approach in the mission statement or in materials describing the program. ■ The mission statement and materials describing the consumer-operated service include a clear statement of a hope-oriented recovery approach. ■ Not only does the mission statement and materials describing the consumer-operated service include a clear statement of a hope-oriented recovery approach, but staff and members can articulate the approach. 	——

Ingredient	Definition	Anchored Scale	Assigned Score
3. BELIEF SYSTEMS			
3.6. Spiritual Growth	Spiritual beliefs, practices, and subjective, transcendent experiences are respected as an aspect of an individual's search for meaning and purpose in life. Such beliefs are not labeled as symptoms of illness. However, a consumer-operated service may have restrictions about proselytizing for a particular religion during the hours of operation.	<ul style="list-style-type: none"> ■ Expressions of spirituality and/or explorations of meaning and purpose are not allowed or are discouraged within the consumer-operated service. ■ Expressions of spirituality and/or explorations of meaning and purpose are neither discouraged nor encouraged within the consumer-operated service. ■ Expressions of spirituality and/or explorations of meaning and purpose are allowed within the program and consumers feel comfortable sharing their beliefs, but there is little opportunity for consumers to share their beliefs. ■ Expressions of spirituality and/or explorations of meaning and purpose are respected within the program and consumers have opportunities to share their beliefs. 	_____
TOTAL			



Ingredient	Definition	Anchored Scale	Assigned Score
4. PEER SUPPORT			
4.1. Peer Support			
4.1.1. Formal Peer Support	<p>Organized mutual support groups based on common experience in which peers are available to each other for empathy and to share experiences and information.</p> <p>Trained peers offer individual support and information as part of the formal consumer-operated service.</p>	<ul style="list-style-type: none"> ■ No formal peer support is offered to consumer-operated service members. ■ Some formal peer support groups are offered to consumer-operated service members, but opportunities for these groups are on an irregular basis. ■ At least one formal peer support group is offered to consumer-operated service members on a regular basis. ■ More than one formal peer support group is offered to consumer-operated service members on a regular basis. ■ Numerous peer support groups and other peer support services are offered to consumer-operated service members on a regular basis. 	<p>——</p>
4.1.2. Informal Peer Support	<p>Mutual support is provided in unscheduled group interactions and within individual relationships.</p>	<ul style="list-style-type: none"> ■ The consumer-operated service offers no opportunities for peers to provide support to each other on an informal basis. ■ The consumer-operated service offers few opportunities for peers to provide support to each other on an informal basis. ■ The consumer-operated service offers some opportunities for peers to provide support to each other on an informal basis. ■ The consumer-operated service offers many opportunities for peers to provide support to each other on an informal basis, and actively engages in the development of strong mutual peer relationships. 	<p>——</p>
4.2. Telling Our Stories	<p>Sharing personal accounts of life experiences as a mental health consumer is a cornerstone of promoting peer well-being and recovery.</p> <p>Opportunities to tell one's story and open discussion about such stories are embedded in peer support groups, in peer-to-peer interactions, at public forums, and within boards and committees.</p> <p>Sharing life experiences may also be a tool for public education.</p>	<ul style="list-style-type: none"> ■ Sharing stories is actively discouraged on the basis that the practice has negative effects on the individual or the groups. ■ The consumer-operated service has some provisions for sharing of stories about one's personal experiences and beliefs. However, these opportunities are limited or superficial. ■ The consumer-operated service limits telling stories to social situations. ■ The consumer-operated service provides regular opportunities for sharing stories among program participants. ■ The consumer-operated service provides numerous formal and informal opportunities for sharing stories within the program and to the larger community. 	<p>——</p>

Ingredient	Definition	Anchored Scale	Assigned Score
4. PEER SUPPORT			
4.2.1. Artistic Expression	<p>Artistic expression is seen as a vital component of the consumer-operated service. It is valued as a way to explore personal meaning, express and expand talents, facilitate empowerment, and educate others about mental illness.</p> <p>Consumer-operated program members have the time, space, materials, and assistance to express themselves through artistic endeavors.</p>	<ul style="list-style-type: none"> ■ There is no provision or outlet for artistic expression. ■ There are some provisions or outlets for artistic expression, but these are minor or rare. Few resources are available. ■ There is one regular artistic outlet with adequate resources (such as an art class or ongoing newsletter). ■ There are regular artistic outlets with adequate resources that provide multiple opportunities for artistic expression. ■ There are regular artistic outlets with enhanced resources that provide multiple opportunities for artistic expression using a variety of media. Artwork is prominently exhibited at the consumer-operated service. 	_____
4.3. Consciousness Raising	<p>Members learn about the consumer movement, are encouraged to look beyond themselves, to work together, to help fellow peers, and to contribute to a larger consumer community.</p>	<ul style="list-style-type: none"> ■ Most members think of themselves as uniquely ill or malfunctioning, keep their illness a secret, and feel disconnected and ashamed of it. ■ Some members think of themselves as uniquely ill or malfunctioning, keep their illness a secret, and feel disconnected and ashamed of it. ■ Most members do not think of themselves as ill or malfunctioning. They feel comfortable in connecting to a larger consumer community, but may not feel confident in contributing to this community. ■ Most members recognize themselves as a valuable part of a larger consumer community and feel confident contributing to this community. 	_____
4.4. Crisis Prevention			
4.4.1. Formal Crisis Prevention	<p>Members and staff learn to recognize psychiatric problems and how to address them before they escalate. Symptoms are reduced, involuntary commitment minimized, and recovery is fostered through individual or group peer support.</p>	<ul style="list-style-type: none"> ■ No formal provisions are made for crisis prevention. ■ At least one peer practice or program is available for formal crisis prevention; however, it is inconsistently used. ■ At least one consistently used peer practice or program is available for formal crisis prevention. ■ Multiple peer practices and programs are consistently used for formal crisis prevention and these appear to be effective. 	_____
4.4.2. Informal Crisis Prevention	<p>Organic or spontaneous mutual support serves as a means of averting crises outside of any formal framework.</p>	<ul style="list-style-type: none"> ■ No informal provisions are made for crisis prevention. ■ At least one peer practice is available for informal crisis prevention; however, it is inconsistently used. ■ At least one consistently used peer practice is available for informal crisis prevention and appears to be effective in providing regular outreach to members. ■ Multiple peer practices are consistently used for informal crisis prevention and these appear to be effective in providing regular outreach to members. 	_____

Ingredient	Definition	Anchored Scale	Assigned Score
4. PEER SUPPORT			
4.5. Peer Mentoring and Teaching		<ul style="list-style-type: none"> ■ Few members of the consumer-operated service report that there are others within the program that they look up to. ■ Some members report that there are others within the program that they look up to. ■ Most consumer-operated service members report that there are others within the program that they look up to. ■ Almost all consumer-operated service members report that there are others within the program that they look up to, and from whom they can receive guidance, support, and companionship. These relationships occur without regard to title or position within the consumer-operated service. 	<hr style="width: 20px; margin: 0 auto;"/>
			TOTAL

Ingredient	Definition	Anchored Scale	Assigned Score
5. EDUCATION			
5.1. Self Management/Problem-Solving Strategies			
5.1.1. Formally Structured Problem-Solving Activities	<p>Practical skills promote strategies related to personal issues, symptom management, and support needs. The focus is on every day, practical solutions to human concerns.</p> <p>Regular activities focus on the development of skills or the dissemination of needed information; these activities use structured formats and include specific objectives.</p>	<ul style="list-style-type: none"> ■ No classes with structured curriculum designed to teach self management or problem solving are offered to consumer-operated service members. ■ Occasional classes provided for a small proportion of participants (up to 24%) with no structured curriculum or <p>Classes currently are under development but have not yet been offered or Staff is trained in problem solving and self-management, but there is little evidence of the practical use of these techniques.</p> <ul style="list-style-type: none"> ■ There is evidence that classes with a formal curriculum in problem solving and self-management are being offered, and a substantial minority (25 – 49%) of members have participated in classes with structured formats designed to teach self-management and problem-solving strategies. ■ There is evidence that classes with a formal curriculum in problem-solving and self-management are being offered, and a majority (50 – 74%) of members have participated in classes with structured formats designed to teach self-management and problem-solving strategies. ■ There is evidence that classes with a formal curriculum in problem solving and self-management are offered, and most or all consumer-operated program members (75 – 100%) have participated in classes with structured formats designed to teach self-management and problem-solving strategies. 	<p>——</p>
5.1.2. Receiving Informal Problem-Solving Support		<ul style="list-style-type: none"> ■ Less than 20 percent of members report that they received informal support in self-management or problem-solving assistance. ■ Unstructured, peer-to-peer exchange of personal, lived experience is encouraged to enhance individual problem-solving abilities. ■ A significant minority of members (20 – 39%) report that they have received informal support in self-management or problem-solving assistance. ■ About half of the members (40 – 59%) report that they have received informal support in self-management or problem-solving assistance. ■ A majority of members (60 – 79%) report that they have received informal support in self-management or problem-solving assistance. ■ Most or all of the members (80 – 100%) report that they have received informal support in self-management or problem-solving assistance. 	<p>——</p>
5.1.3. Providing Informal Problem-Solving Support	<p>Peers help each other solve problems on an ad hoc basis using skills that they have acquired through the consumer-operated program or independently.</p>	<ul style="list-style-type: none"> ■ Less than 20 percent of the participants report that they have provided informal support in self-management or problem-solving assistance. ■ A significant minority of participants (20 – 39%) report that they have provided informal support in self-management or problem-solving assistance. ■ About half of participants (40 – 59%) report that they have provided informal support in self-management or problem-solving assistance. ■ A majority of participants (60 – 79%) report that they have provided informal support in self-management or problem-solving assistance. ■ Most or all of the participants (80 – 100%) report that they have provided informal support in self-management or problem-solving assistance. 	<p>——</p>



Ingredient	Definition	Anchored Scale	Assigned Score
5. EDUCATION			
5.2. Education/Skills Training and Practice			
5.2.1. Formal Skills Practice	<p>Peers teach and are taught skills that will equip them for full participation in the community. These include daily living, vocational, job readiness, and communication skills. These also include relationship and assertiveness skills and goal setting.</p> <p>Members develop and improve social skills in a natural social environment.</p> <p>This is often the first step toward creating or re-establishing valued roles in the community and reintegrating into community life.</p>	<ul style="list-style-type: none"> ■ No evidence of formal skills training or skills practice within the program. ■ A small proportion (1 – 24%) of consumer-operated service members are involved in formal skills training focused on employment. ■ A minority (25 – 49%) of consumer-operated service members are involved in formal skills training focused on employment. ■ A majority (50 – 74%) of consumer-operated service members are involved in formal skills training focused on employment. ■ Most (75 – 100%) consumer-operated service members are involved in formal skills training focused on employment. 	—
5.2.2. Job Readiness Activities	<p>Opportunities are available to acquire skills that are directly relevant (e.g., resume writing) or indirectly relevant (e.g., public speaking) to employment.</p>	<ul style="list-style-type: none"> ■ No evidence of job readiness activities within the consumer-operated service. ■ Less than one-quarter of consumer-operated program members are involved in job readiness activities that could lead to some type of employment. ■ A minority (25 – 49%) of consumer-operated program members are involved in job readiness activities that could lead to some type of employment. ■ A majority (50 – 74%) of consumer-operated program members are involved in job readiness activities that focus on employment. ■ Most (75 – 100%) consumer-operated service members are involved in job readiness activities that focus on employment. 	—
TOTAL			

Ingredient	Definition	Anchored Scale	Assigned Score
6. ADVOCACY			
6.1.1. Formal Self Advocacy Activities	Consumer-operated program members learn to identify their own needs and to advocate for themselves when there are gaps in services. Consumer-operated program members learn to become active partners in developing their own service plans with traditional organizations, and to deal effectively with entitlement agencies and other services.	<ul style="list-style-type: none"> ■ There is no formal self advocacy training, or informal, peer-to-peer self advocacy support. ■ Less than one quarter of the members have participated in formal self advocacy training, or informal, peer-to-peer self advocacy support. ■ A minority (25 – 49%) of members have participated in formal self advocacy training, or informal peer-to-peer self advocacy support. ■ A majority (50 – 74%) of members have participated in formal self advocacy training, or informal, peer-to-peer self advocacy support. ■ Most (75 – 100%) members have participated in formal self advocacy training, or informal, peer-to-peer self advocacy support. 	<p style="text-align: center;">—</p>
6.2 Peer Advocacy	Members of the consumer-operated program assist other peers in resolving problems they may encounter on a daily basis in the community, such as problems with treatment providers, community service agencies, family members, neighbors, landlords, or other peers.	<ul style="list-style-type: none"> ■ There is no evidence of peer advocacy. ■ Peer advocacy is a rare event or occurred on a one-time basis. ■ There is some evidence of peer advocacy that happens in relation to other activities. ■ There is evidence of formal peer advocacy, primarily provided by staff at the consumer-operated program. ■ Most members are involved in providing peer advocacy. All members consider themselves as peer advocates. 	<p style="text-align: center;">—</p>
6.2.1. Outreach to Participants	The consumer-operated program makes concerted efforts to keep members informed of current activities and opportunities within and outside the program.	<ul style="list-style-type: none"> ■ No evidence of outreach to members. ■ Some, but rare evidence that the consumer-operated program informs members by using Internet, newsletters, flyers, brochures, or holding regional conferences. ■ Some evidence that the consumer-operated program regularly informs members by using Internet, newsletters, flyers, brochures, or holding regional conferences. ■ Most members are informed by the consumer-operated program through Internet, newsletters, flyers, brochures, or holding regional conferences. There is a regular and strong advocacy content in materials. ■ All members are informed by the consumer-operated program through multiple channels such as the Internet, regular newsletters, flyers, brochures, or holding regional conferences. There is a regular and strong advocacy content in materials. 	<p style="text-align: center;">—</p>
Total			



FACIT Scoresheet Totals		
Domain	Rater Score	Conciliated Score
1. Structure		
2. Environment		
3. Belief Systems		
4. Peer Support		
5. Education		
6. Advocacy		
Total		

Evaluating Your Program

Appendix C: FACIT Excel Workbook User's Guide

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This Excel Workbook User's Guide was developed as a companion piece to *Appendix A: FACIT Protocol*, and *Appendix B: FACIT Scoresheet*.

This User's Guide provides a brief overview of the development of the FACIT; an Excel 2003 Workbook (on the CD-ROM that is included as part of this KIT) developed for your consumer-operated service to chart the scores on each of the Common Ingredients Domains; and a User's Guide to the features of the workbook.

The content of this User's Guide

- About the COSP Multisite Research Initiative
- FACIT Excel Workbook
- Workbook Features
- National FACIT Benchmark
- Program Worksheet
- Entering Data
- Password Procedure
- Copying Charts
- Printing Charts

About the COSP Multisite Research Initiative

The Consumer-Operated Services Program (COSP) Multisite Research Initiative was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) from 1998 to 2007. The research mandate was to explore the impact of consumer-operated services when used as an adjunct to traditional mental health services for adults with serious mental illness.

The primary goals of the initiative were to—

- Examine the effect of consumer-operated services on empowerment, housing, employment, social inclusion, and satisfaction with services and
- Determine how participation in consumer-operated services affects costs for inpatient hospitalization, crisis intervention, and emergency room utilization as well as how it offsets costs in housing, criminal justice, vocational rehabilitation, physical health care, and income support.

There were also secondary goals for the study. These were to create strong, productive partnerships among consumers, service providers, and researchers, and disseminate the knowledge gained about the effectiveness of consumer-operated programs and the specific components that contribute to their success.

With more than 1,800 participants, the COSP Multisite Research Initiative was the largest and most rigorous study of consumer-operated services in history. Interviews were administered at baseline, 4, 8, and 12 months to adult mental health consumers randomized to one of two groups:

- Using traditional mental health programs only or
- Using traditional mental health programs and consumer-operated services.

Results of the study provided evidence that the well-being of people with mental health diagnoses is strengthened through participation in consumer-operated programs.

To ensure that the well-being outcomes found in the study could be attributed to the peer practices of the participating consumer-operated services, it was also determined that fidelity to the consumer-operated service model needed to be measured. It is impossible to forge a causal link between peer practices and wellness outcomes without knowledge that peer support practices are being delivered.

**Consumer-Operated Services
Common Ingredients Domains**

- Structure
- Environment
- Belief Systems
- Peer Support
- Education
- Advocacy

Fidelity measures provide an objective rating system to assess the extent that components of a program are faithfully implemented according to intended program model and belief system. Most important, by measuring both outcomes and fidelity best practices can be identified.

The Fidelity Assessment/Common Ingredients Tool (FACIT) was developed to assess the presence and strength of these “common ingredients.” During an extensive collaborative process with consumer-operated service providers and researchers, a set of 46 common ingredients of consumer-operated programs was identified across six different domains.

Following the procedures described in the FACIT Protocol (See *Appendix A* of this booklet), two members of a FACIT evaluation team conducted a formal site visit at the consumer-operated program.

Using the FACIT Scoresheet (see *Appendix B* of this booklet), they scored the program for each anchored item representing the common ingredients. If there was a discrepancy between scores given by individual team members, a conciliatory process was used to resolve these differences.



FACIT Excel Workbook

The FACIT Excel Workbook that is on the CD-ROM that is included as part of this KIT was developed as a simple data entry system for the consumer-operated program's scores on each of the 46 common ingredients items entered in the FACIT scoresheet. In addition, it can automatically produce charts based on the scores.

The data are to be used by individuals charged with program quality improvement to determine the fidelity of a consumer-operated service to evidence-based peer practices, and to monitor any changes to the program over time.

Scores for each of the domains and specific items can help a program identify its strengths and weaknesses in providing peer support. The scores can also point to particular areas where peer competency training is required, changes are needed to build program leadership and member input, or facilities and activities must be expanded to promote the recovery and well-being of its membership.

During the first year that a consumer-operated service participates in a quality improvement program, the FACIT evaluation team assesses the organization to establish a baseline or starting point for quality improvement efforts to become an evidence-based peer practice.

The conciliated score of the two team members is entered into the Excel Workbook worksheets. In subsequent years, the consumer-operated service continues to conduct yearly assessments that can be compared to a national benchmark and to the program's individual baseline.

The national FACIT benchmark represents the aggregated FACIT scores from the eight consumer-operated programs that were selected to participate in the COSP Multisite Research Initiative. Their aggregated FACIT scores are a useful standard from which to compare individual program performance because these organizations are geographically diverse, represent multiple program models, and met the federal criteria for a consumer-run program.

Workbook features

The FACIT Excel Workbook is designed in Excel 2003 and consists of three worksheets. A worksheet is the Excel document used to store and work with data, and is also called a spreadsheet. A worksheet consists of cells that are organized into columns and rows. A worksheet is always stored in a workbook. There are tabs at the bottom of the screen identifying the names of the different worksheets.

Once you click on a tab, the name of the worksheet is highlighted, so you know which worksheet is currently opened.

The FACIT Excel Workbook contains three worksheets:

- National benchmark;
- Name of the specific consumer-operated service; and
- The chart for the consumer-operated service (e.g., Hope Center Chart).

See Figure 1 below for a screen shot example of the data workbook with the three tabs for each of the worksheets contained in your FACIT Excel workbook.

The National FACIT Benchmark Worksheet

The first worksheet, *Benchmark*, is to be used as a point of reference to evaluate the FACIT scores of a consumer-operated program.

The Benchmark worksheet contains each of the six FACIT domains and has the 46 common ingredients items associated with each of these domains. There is a column called *Range*, which displays the range of scores for each item. There are anchored scores for each of the 46 items, and ranges of 1-4 or 1-5 for each item with “0” used in special cases.

For example, under the Structure domain, the first item scores board participation. There are anchored scores from 1 to 5. The lowest score, which is 1, indicates that no member of the board is self-identified as a consumer. The highest score, 5, indicates that between 90 percent and 100 percent of the board self-identifies as consumers.

There is also a column, *Average*, that reports the average score of the eight sites included in the COSP Multisite Research Initiative. This number is the national FACIT benchmark and can be compared with your organization’s score for each item in the six domains.



Figure 1: National Benchmark Worksheet Screenshot Showing the Three Tabs of the Workbook

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	Fidelity Assessment Common Ingredients Tool (FACIT)												
2			Range	Average									
3													
4	1. STRUCTURE		10 to 48										
5	1.1 Consumer Operated												
6		1.1.1 Board Participation	1 to 5	4.75									
7		1.1.2 Consumer Staff	1 to 5	4.88									
8		1.1.3 Hiring Decisions	1 to 4	3.94									
9		1.1.4 Budget Control	1 to 4	3.78									
10		1.1.5 Volunteer Opportunities	1 to 5	4.93									
11	1.2 Participant Responsive												
12		1.2.1 Planning Input	1 to 5	4									
13		1.2.2 Satisfaction/Grievance Response	1 to 5	3.72									
14	1.3 Linkage to Other Supports												
15		1.3.1 Linkage with TMHS	1 to 5	3.5									
16		1.3.2 Linkage to Other COSPs	1 to 5	2.69									
17		1.3.3 Linkage with Other Service Agencies	1 to 5	2.91									
18	Total Structure Score												
19													
20	2. ENVIRONMENT		11 to 50										
21	2.1 Accessibility												
22		2.1.1 Local Proximity	1 to 4	3.09									
23		2.1.2 Access	1 to 5	4.13									
24		2.1.3 Hours	1 to 5	3.38									
25		2.1.4 Cost	1 to 5	4.56									
26		2.1.5 Reasonable Accommodation	1 to 4	2.94									
27	2.2 Safety												
28		2.2.1 Lack of Coerciveness	1 to 5	3.59									
29		2.2.2 Program Rules	1 to 5	4.44									
30	2.3 Informal Setting												
31		2.3.1 Physical Environment	1 to 4	3									
32		2.3.2 Social Environment	1 to 5	4.56									
33		2.3.3 Sense of Community	1 to 4	3.69									
34	2.4 Reasonable Accommodation												
35		2.4.1 Timeframes	1 to 4	3.75									
36	Total Environment Score												
37													
38	3. BELIEF SYSTEMS		9 to 40										
39		3.1 Deep Principles	1 to 4	3.72									

The Consumer-Operated Service Worksheet

Figure 2 below shows an example of consumer-operated service data in the Structure domain.

The second worksheet has the name of your consumer-operated service on the tab. Once opened, you will see each of the six domains, with the items for each of the domains.

Figure 2: Consumer-Operated Service Worksheet: Year 1 Scores Entered in the Structure Domain

	Conciliated Score			Benchmark	
	Yr 1	Yr 2	Yr 3		
1. STRUCTURE					
1.1 Consumer Operated					
1.1.1	Board Participation	1		4.75	
1.1.2	Consumer Staff	3		4.88	
1.1.3	Hiring Decisions	2		3.94	
1.1.4	Budget Control	1		3.78	
1.1.5	Volunteer Opportunities	2		4.93	
1.2 Participant Responsive					
1.2.1	Planning Input	1		4	
1.2.2	Satisfaction/Grievance Response	2		3.72	
1.3 Linkage to Other Supports					
1.3.1	Linkage with Traditional Mental Health Services	5		3.5	
1.3.2	Linkage to Other Consumer-Operated Services	2		2.69	
1.3.3	Linkage with Other Service Agencies	2		2.91	
	Total Structure Score	21	0	0	36.19

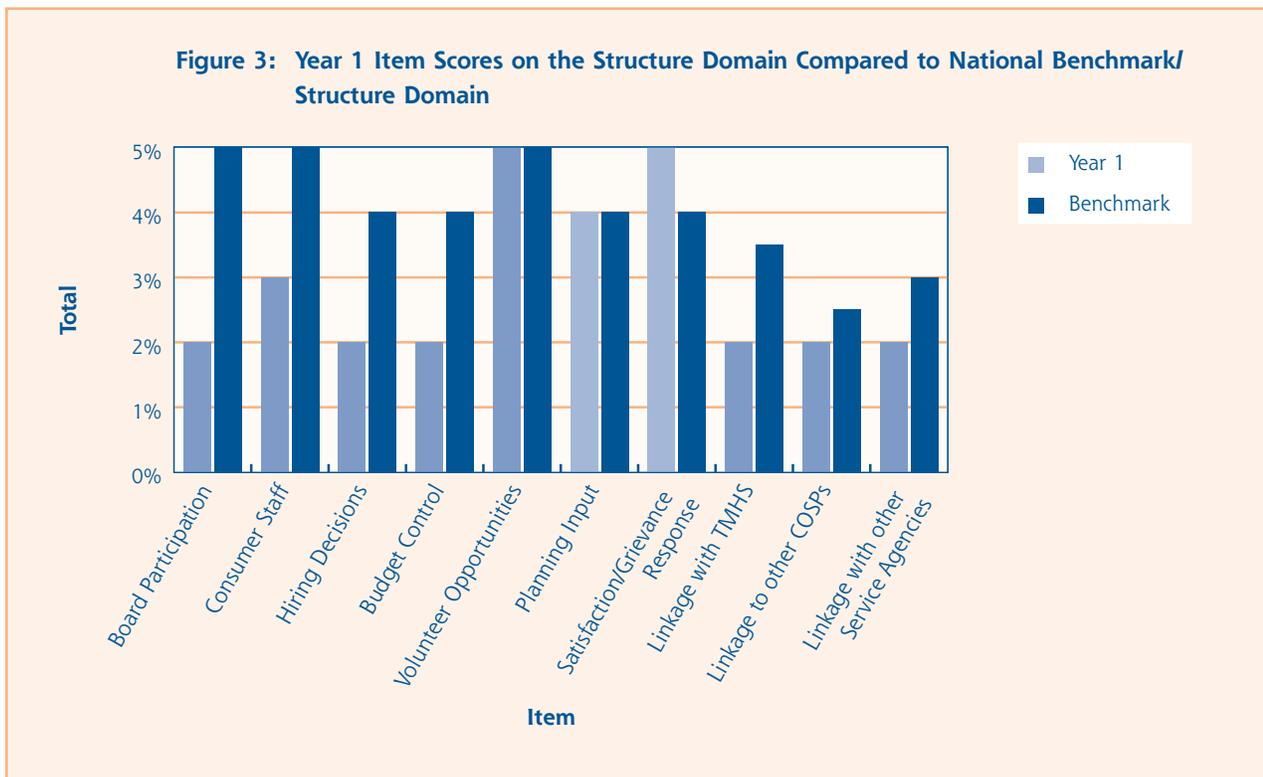


As you enter the data, you will see a chart that compares the score for each item to the national benchmark scores. The charts are next to each of the domains and will automatically reflect the number that is entered. Figure 3 provides an example of Year 1 Item scores on the Structure Domain compared to the national benchmark.

Looking at Figure 3, it is plain to see the areas that are below the national benchmarks as well as those where the consumer-operated service is equal to or higher than the national average.

For example, look at Board Participation and see how much lower it is than the national benchmark.

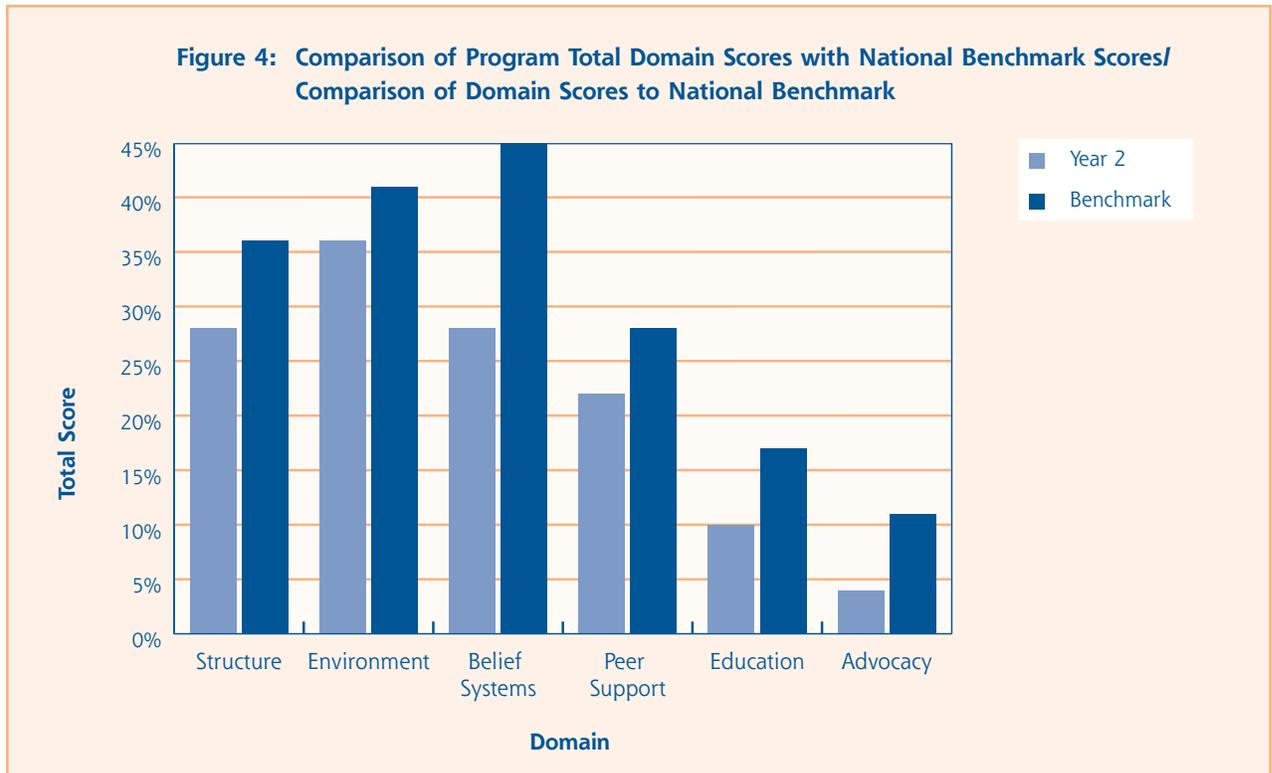
Also, notice that in regard to the items Planning Input and Satisfaction with the Grievance Process, the national benchmark equals or exceeds the national average. The colors of the bars on the chart were chosen to clearly show differences when printed or copied in black and white.



The Consumer-Operated Service Chart Worksheet

The third tab of the workbook contains a chart that maps the program's total domain scores against the national benchmarks. This chart is automatically produced based on the total scores that are calculated by the worksheet for each of the domains.

Figure 4 is an example of what this chart looks like. Notice that the chart does not provide information on all 46 individual practices assessed by the FACIT, just the aggregate results for the six common ingredient domains. Again, it is easy to see how the program compares with the national benchmarks for each domain.



Entering data

Someone responsible for quality improvement at the consumer-operated service will be responsible for entering the scores from the annual FACIT administration.

The only data that need to be entered are on the worksheet with the name of your consumer-operated service name on the tab.

Be careful to enter the scores in the correct cells, as there are some rows that do not contain data. The total scores and charts are automatically produced based on the data you enter.

Be careful to enter the scores for each item on the proper line and cell of the worksheet. Titles are entered on the worksheet to correspond to the actual FACIT scoring sheet, so there are some cells that do not require numeric entry.

The total score for each domain is automatically calculated, so it is important to enter the data into each cell. Copying and pasting numbers into cells or ranges of cells may make it impossible for the software program to correctly calculate the total.

Data protections

The Consumer-Operated Service Worksheet has been protected to prevent anyone from accidentally changing, moving, or deleting the data. This prevents accidental input, as an entry in these cells would erase the formulas that calculate the totals. The benchmark numbers and charts are also protected.

To aid in data entry, those cells that do not require a numeric entry have been protected, and therefore will not allow entries. Any modifications to the worksheets will require the protection feature to be disabled. To disable the protection feature, please refer to the “Password Procedure Feature” below.

The software program will block the entry of scores outside the range for any item. For example, the range is from 1 to 4 for the Structure domain item “Hiring Decisions.” If you try to enter a “5,” you will get an error message stating that the range is from 1 to 4. Delete the incorrect entry and enter the correct score for that item.

Password procedure

To make any changes to the worksheet, please use the following steps:

1. Open the workbook, and select the “Agency Name” worksheet tab.
2. On the toolbar, select Tools |Protection|Unprotect Sheet.
3. A password is required to remove the protection status. The password is “facit” and should be entered in all lower case letters.

It is recommended that the protection status be reinstated. To accomplish this, please follow these steps:

1. On the toolbar, select Tools |Protection|Protect Sheet.
2. At this point, select a password of your choice. It is highly recommended to use password protection, so you can either reinstate the password of “facit” or choose a new password to be used by your agency.
3. Confirm the password by reentering the password that you chose.

Copying charts

The password protection feature prevents accidental entries, but it also prevents copying charts for reporting purposes. Therefore, please use the following steps to copy a chart:

1. Open the workbook and select the “Org Name” worksheet tab.
2. On the toolbar, select Tools |Protection|Unprotect Sheet.
3. Enter the password of “facit” or the one you have chosen.

4. Click on the chart that you want to copy.
5. On the toolbar, select Edit|Copy.
6. Go to the document that you want to Paste the chart into, and select Edit|Paste. You can change the size of the chart once it is in the document.
7. Once you have completed copying the charts you want, remember to turn the protection on by deselecting the chart (just click in a blank cell) selecting Tools|Protection|Protect Sheet.
8. Enter the password of your choosing.
9. Confirm the password by reentering the password that you chose.

Printing charts

Take the following steps to print a chart:

1. Open the workbook and select the “Agency Name” worksheet tab.
2. On the toolbar, select Tools |Protection|Unprotect Sheet.
3. Enter the password “facit” or the one you have chosen.
4. Click on the chart that you want to print.
5. On the toolbar, select File|Print. In the print dialogue box, make sure the “Selected Chart” radio button is selected under the “Print What” section.
6. Once you have completed printing the charts you want, remember to turn the protection on by deselecting the chart (just click in a blank cell) and selecting Tools|Protection|Protect Sheet.
7. Enter the password of your choosing.
8. Confirm the password by reentering the password that you chose.



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