

Evaluating COSPs: Learning to Use the FACIT

A Training Manual for Peer Evaluator Teams

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Introduction

How are Consumer-Operated Service Programs (COSPs) performing in relationship to their goals? What peer practices is staff following to meet the needs of program members? How are COSPs impacting member efforts to recover?

It is clear that as states adopt a recovery-based approach in mental health services through the delivery of evidence-based practices, COSPs need to examine the fidelity and effectiveness of the peer services they provide. However, the call for accountability from funders for responsiveness to needs of COSP members through program evaluation poses challenges for peer providers.

As COSPs struggle to find ways to finance and build a data support infrastructure with quality improvement processes and trained personnel, peer providers are faced with demands to

- adapt the informal peer culture to formal data collection requirements;
- build staff evaluation skills;
- hire additional staff or consultants with evaluation expertise;
- collect data, compute findings, and manage electronic databases; and,
- learn to integrate evaluation findings into program reporting, fund-raising, public policy, and quality improvement efforts.

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

On the other hand, evaluation has had an instrumental role in helping COSPs respond to growing demands for evidence-based peer practices (EBPs), and has provided the opportunity for COSPs to deliver services in more effective ways. Recent efforts of COSPs across the nation to use the tools of science to respond to pressing social and environmental problems facing persons diagnosed with mental illness, and most notably the successful completion of the Consumer-Operated Service Program (COSP) Multisite Research Initiative, has established the capacity of consumer-providers to monitor and improve the quality and outcomes of peer service delivery through use of the Fidelity Assessment Common Ingredients Tool (FACIT).

To the extent that program evaluation has contributed to COSP service delivery based on thoughtful application of improved methods for assessing programs, mental health consumers have supported and facilitated that process. In the past decade, the consumer research community has developed information systems and evaluation protocols that recognize the role of peer values and incorporate consumers' experiences and points of view.

Further, a growing number of peer providers have learned the basic skills of evaluation (Campbell, 1997b). The inclusion of consumers in evaluation roles such as investigator, coordinator, surveyor, data manager, analyst or focus group member has been found to improve the validity of survey tools, the quality of the interview process, data interpretation, and dissemination strategies. 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 increased self-esteem. In the past decade, COSP data support systems have begun to reduce expenses for services, generate income, increase program efficiency, and increase service demand by incorporating evaluation into COSP operations through continuous quality improvement (CQI) (Campbell and Leaver, 2003).

Since 2005, the Missouri Department of Mental Health has funded implementation of the Fidelity Assessment Common Ingredients Tool (FACIT), an evaluation protocol found in the COS Evidence-based KIT available through the Substance Abuse and Mental Health Services Administration that measures the structure, values, and processes of consumer-operated programs as a means to promote the development of evidence-based consumer-operated drop-in centers and warmlines. With field-testing now successfully completed in Missouri, the second phase of the Missouri FACIT Project is building a statewide Peer Evaluator Team (PET) composed of eight to ten trained consumers to conduct the Fidelity Assessment Common Ingredients Tool (FACIT) annually at the five drop-in centers and five warmlines funded by the state. In addition, the COSPs are now using the FACIT results for Continuous Quality Improvements and program reporting. Professor Jean Campbell, PhD, a well-known consumer researcher at the Missouri Institute of Mental Health in St. Louis, directed the FACIT field-testing and training of the PETs, and is currently providing technical assistance and supervision of the Missouri FACIT Project under contract with the state. The goals of this effort are multiple:

- Establish a viable statewide consumer evaluation team,
- Improve the operations and quality of COSP service delivery,
- Facilitate the transition to recovery-based programs,
- Establish MO COSPs as evidence-based practices,
- Improve the outcomes of the persons who attend the programs to recover and reintegrate into their communities, and
- Enable the consumers who become evaluators to learn new skills and become leaders within the mental health consumer community.

Building on the consumer action research knowledge base and the ongoing experience in field-testing the training and implementing Peer Evaluator Teams (PETs), this training manual will guide consumers in how to look for and evaluate evidence found in Consumer-Operated Service Program (COSPs) of practices, supports, attitudes and resources shown to promote the well-being of mental health consumers on a program by program basis.

To make my own position about evaluation explicit, I believe that evaluation is basic—like reading, writing, and arithmetic. I believe that evaluation should be a fundamental skill, an integral part of any educated citizen’s repertoire. I also believe that anyone can learn the basic skills of evaluation. This does not deny the education and expertise of professional evaluators, it simply reaffirms the right of every citizen to use evaluation to foster improvement and self-determination within a context of social justice. We need every tool we can find to respond to the pressing social and environmental problems we face. Evaluation has an instrumental role to play in helping us to respond to our problems, adapt, and build the future.

--David M. Fetterman, Empowerment Evaluation



Overview of the Missouri FACIT Project

In response to the President's New Freedom Commission on Mental Health Report (July, 2003), mental health systems in America increasingly face demands that they operate from a recovery orientation, and that they deliver consumer-operated services and supports in ways that facilitate and promote the process of recovery for persons with mental illness. The Missouri Department of Mental Health (MDMH) took the first step towards transforming the drop-in center services and peer phone support services it supported into efficient organizations that provide evidence-based peer practices with the release of a revised RFP in April, 2006. In addition to establishing the minimum number of hours of operation and required support, socialization and recreation activities, the RFP added as a condition of funding the development of a standardized training packet, program manual, community resources guide, marketing/advertising plan, and participation in a monthly conference call with other drop-in center and peer phone support service contractors. Further, programs were expected to conduct data collection (daily log of activities and unduplicated count of monthly attendance) and report service activity on a monthly basis to Missouri DMH, and to participate in the evaluation of program services. This marked the beginning of the Missouri FACIT Project (2005-2013).

With the award of five drop-in centers and five peer phone support programs (warm lines), the DMH contracted with Dr. Jean Campbell, Director of the Program in Consumer Studies and Training at the Missouri Institute of Mental Health, to assist Julie Carel, Critical Service Manager, in implementing the required program enhancements for evidence-based practices, providing technical assistance, and monitoring contractual compliance. During the first years of the Missouri FACIT Project called the Raising All Boats Initiative (2005—2008), the COSPs were encouraged to develop program leadership, improve communication and organization among peer providers, understand the science of evidence-based peer practices, evaluate their service delivery system, and to begin to transform to a recovery-based model. The tools and materials to accomplish these efforts were field-tested and key accomplishments reported.

A monthly teleconferences among the drop-in centers led to the creation of SCOPE (Supporting Consumer Operated Program Evolution), a statewide consumer provider network composed of staff and members of the drop-in centers, whose mission is mutual support and empowerment among peer programs through shared skills and learning, leadership building, and community collaboration. A listserv was established and a packet of journal articles and periodicals related to consumer issues and peer support are distributed monthly by mail to SCOPE members and shared with consumers attending the drop-in centers. In addition, SCOPE members developed a PowerPoint presentation describing each of the drop-in centers and their mutual work as part of the consumer provider network

One 2-day site visit was made by Julie Carel and Dr. Jean Campbell to each drop-in center in order to rate program fidelity to the established evidence-based practices for consumer-operated

service programs. Implementing the FACIT (Fidelity Assessment Common Ingredients Tool) protocol and scoring sheet, the site visitors were able to objectively assess the extent that components of each program were faithfully implemented according to intended program model, belief system, and practices. A data entry and reporting system was designed by the Missouri Institute of Mental Health (e-FACIT) to record all item scores(48 items) and to automatically generate item and domain bar graphs for comparison with national benchmark, chart subsequent assessment trends, and identify program strengths and weaknesses. At a day-long meeting in Jefferson City at the conclusion of year 01 activities, results of the FACIT were shared with drop-in center staff and next steps planned for establishing continuous quality improvement teams at each program and conducting FACIT self-assessments.

In 2007, the five warm line programs joined the SCOPE, added to the listserv, received the packet of materials, and began participating in the monthly teleconferences. At a meeting in Jefferson City they were introduced to the concept of evidence-based peer practices and began the process of revising the FACIT to make it applicable to warm lines. On-going teleconferences have been scheduled with program representatives to complete the FACIT revisions and to undertake site visits to score the fidelity of the warm lines.

Because of the dedicated support of MDMH towards developing evidence-based peer practices, Missouri was selected as one of three sites by the Center for Mental Health Services, SAMHSA, to participate in a two month field review of the COSP Evidence-Based Practices Tool Kit. The COSP Tool Kit is a comprehensive resource for peer-run programs with sections on evidence-based practices, staff training, evaluation, and a short, introductory documentary among the offerings. During the review period, two drop-in centers, key stakeholders, and appropriate MDMH personnel reviewed the toolkit, used it as desired, and provided feedback on its usefulness. In particular, the drop-in centers used their FACIT scores to help identify sections of the Tool Kit for staff training. Another section of the Tool Kit helped the programs develop their continuous quality improvement teams by providing the FACIT Protocol, Score Sheet, e-FACIT and Users' Guide. Ongoing technical assistance was available by Dr. Campbell, who was also the National COS Evidence-based Kit Field Review Assessor in addition to her work for MDMH.

At the Alternatives 2007 Conference held in St. Louis, members of SCOPE offered a three-hour Institute entitled "Raising All Boats: How Missouri Consumers Are Improving Peer-Run Program Quality and Outcomes." Missouri drop-in centers talked of their understanding of the philosophy, work and healing power of peer-run programs and of a growing commitment to a vision of building hope for recovery by working together to adopt evidence-based peer practices.

In 2008 the Missouri FACIT Project completed the drop-in services field-test of the Fidelity Assessment Common Ingredients Tool (FACIT) and program self-assessment efforts. Programs were debriefed and feedback on FACIT self-assessment process collected. A report was prepared on Drop-in FACIT findings, field study results, and recommendations for future assessments of program fidelity to evidence-based practices.

The Raising All Boats Initiative continued to field-test the Warmline FACIT and site visits/assessments of all of the warmlines were completed by the spring of 2009 as final versions

of Warmline FACIT materials including Protocol, Scoring Sheet, data entry program, and related assessment materials were prepared. All programs were debriefed and feedback on the assessment process was collected. All of the drop-in programs and the warmlines developed reports on FACIT findings, field study results, and recommendations for future assessments of program fidelity to evidence-based practices.

Based on the results of the Raising All Boats Initiative and field-study, Julie Carel and Dr. Campbell assisted in the development of the Peer Phone Services RFP and the Drop-in Center Services RFP in 2010 as the Missouri FACIT Project entered its second phase. The key component of those RFPs included the requirement that all grantees continue to use the FACIT as a continuous quality improvement tool. However, since self-assessment had not proven to be a recommended method to implement the FACIT at some of the programs, and interrater reliability was poor between program evaluators, statewide Peer Evaluator Teams (PETs) were organized and trained to conduct annual assessments in phase two of the Missouri FACIT Project (2009—2012).

In general, during phase two the PETs brought greater consistency to the FACIT Scores among the COSPs and built an ongoing pool of skilled consumers to facilitate continuous quality improvement, greater accountability, and improved recovery outcomes of participants among the COSPs. The Missouri FACIT Project is now entering phase three as it moves forward to conduct another FACIT Training of PETs (August, 2013) and to join other evidence-based practices in Missouri in implementing statewide monitoring standards under Missouri DMH leadership and support.



”We Are the Evidence” (Part 1) The Story of Consumer Research

“Research ought to and can enhance consumer choice, power, and knowledge.”

--Jeanne Dumont, PhD

Consumer/Survivor Mental Health Research and Policy Workgroup

Since the 17th century and the dawn of scientific methods, persons diagnosed with mental illness were involved in research as objects to be observed by scientists for changes in reactions or functioning as a result of some bio-medical “treatment”. With the rise of survey research in the 1950s, they were also used as subjects who responded to questions posed by scientists to measure their subjective physical and mental states. In the past 30 years, consumers around the globe have taken on empowered roles as part of the mental health research enterprise: as employees such as an interviewer or research assistant; as partners involved in some aspect of the planning, designing, and conducting of the research project with professional researchers in control; and as independent researchers designing, conducting, analyzing data, and publishing the results of research projects (Campbell, Ralph & Glover, 1993).

One finds great similarities between mental health consumer struggles and other ethnic minorities, women, homosexuals, and people with physical disabilities who have been labeled, dismissed and denied control and responsibility for their own lives. Traditionally disempowered and stigmatized groups in society have protested, organized self help groups and civil organizations, and become involved in research as part of a civil rights movement.

In the 1970s, the first consumer researchers looked to the work of Dr. Kenneth Clark who had compiled the social science evidence that segregation had an impact on black schoolchildren’s mental status cited in the landmark U.S. Supreme Court’s ruling in *Brown v. Board of Education of Topeka*, 347 U.S. 483 (1954) which ended centuries of segregation in U.S. schools. They also studied the actions of the members of Act-Up, a gay activist group, who challenged AIDS researchers at professional meetings, and encouraged people participating in clinical trials of HIV medications to break the research protocols in order to compel the Federal Drug Administration to begin distributing these life extending drugs before the research studies were completed. Most notably, they were informed by women scientists who resisted traditional research methodologies by developing a feminist epistemology that was both emancipatory and participatory based on the principles of cooperation.

The Hill House Project in Cleveland, Ohio (1979) was one of the earliest efforts to involve users/consumers/survivors in the design of the research instruments and data collection of efforts in the United States. The professionals who directed the research demonstrated that Hill House members had the expertise to identify and classify their feelings (Prager & Tanaka, 1979). The investigators proclaimed, “Representing the consumer’s perspective on the meaning of mental

illness and the correlates of ‘getting better’, the process of client involvement in evaluation design and implementation is not only realistic and feasible; it is, we feel, a professional necessity whose time is overdue” (p. 51).

In 1986, the California Network of Mental Health Clients wrote a successful research proposal to the California Department of Mental Health to investigate what factors promote and deter the well-being of people with severe mental illness in California (Campbell & Schraiber, 1989). They believed that social science held out the possibility of improving the quality of life for people with psychiatric diagnoses in California. The investigators insisted that it was essential to the project that mental health users/consumers/survivors conduct the research. The participants needed to speak for themselves through research about the quality of their everyday lives.

The Well-Being Project was the first survey research project in history that was developed, administered, and analyzed entirely by persons diagnosed with mental illness. It began informally with a group of users/consumers/survivors telling their life stories. As they came upon experiences that triggered questions for the surveys that were to be developed, they wrote them down on colored index cards and piled them in the middle of the room. In the end, the group had generated over 400 cards with questions about what factors promote or deter our well-being. Most of the questions developed had never been asked before. The survey questionnaires that evolved from that process were very different from those developed by mental health professionals. The questions asked produced very different results that challenged the common assumption that experts knew what was in the best interest of persons with mental illness.

Using a mixed method approach, The Well-Being Project surveyed over 500 mental health consumers, family members, and service providers and collected over 40 hours of recorded testimony. The subsequent findings were presented in two volumes, a 56 minute video documentary, and a compendium book of testimony, poetry, prose and art. The project contributed both new knowledge about the power of personhood in promoting well-being and new understandings of the importance of consumer perspective in conducting research and evaluation.

Campbell and Schraiber (1989) understood that “Well-being is not a neutral category or set of variables impinging on everyday life from the outside. It is composed of experiences and relationships which not only determine particular choices and decisions at particular times, but also structures experientially how those choices are defined” (p. 3). Mental health researchers did not recognize the extent to which an individual’s identity, psyche, and sense of self derive from social context. In order to get inside this dynamic, a social science that could capture the fullness of experience, the richness of living was crafted. The point of departure was the focused points of human experience—individual perceptions, beliefs, and feelings. These constituted the most important units of analysis. However, in order for this approach to succeed, it also had to empower all project participants by valuing individual insight, work and knowledge. Most decisions involving the development and execution of The Well-Being Project were made by consensus.

Ultimately, The Well-Being Project was about people coming to voice. This was the critical lesson for the user/consumer/survivor researchers that were to follow. Biomedical research ignores the meaningful human aspects that encompass personal and social needs and all the factors that differentiate people from symptoms, brains, or molecules. This effort never was intended to be a survey on “mental illness,” or for that matter, on emotional or psychological

problems. Rather, by not categorizing people under psychiatric labels, and by focusing on the promotion of wellness, it underscored the basic humanity and uniqueness of the individual through its research protocol and in the content of its findings.

Further, the incongruities identified in the survey results between the perceptual and experiential framework of those that managed and delivered mental health services and those that received such services brought into question the appropriateness of the opinions and studies of mental health professionals when contrasted with the insights and preferences of consumers and their families.

In the ongoing years, the concept of the “consumer perspective” and the need to develop multi-stakeholder approaches within program evaluation began to gain currency among progressive forces in state and federal government agencies and in the mental health field in general. In 1989 the National Association of State Mental Health Program Directors (NASMHPD) approved a position paper that recognizes that former mental patients/mental health consumers have a unique contribution to make to the improvement of the quality of mental health services in many areas of the service delivery system. The paper recommended that consumer contributions should be valued and sought in areas of program development, policy formation, program evaluation, quality assurance, systems designs, education of mental health service providers, and the provision of direct services.

Adopting the slogan “Nothing about me, without me,” mental health consumers moved rapidly to be involved in the design and implementation of mental health services research and evaluation. Growing numbers of professionals and policymakers responded to consumer demands by redesigning professional roles and creating opportunities for people who receive services to provide input and perspective. Rapp, Shera and Kisthardt (1993) observed that research concerning the care and treatment of people with mental illness has not been consonant with an emphasis on empowerment and argued that “research should amplify ‘the voice of the consumer’ by attending to the context of research, the vantage point, the process of formulating research questions, the selection of interventions to be tested, the selection of outcomes and measures, and the dissemination of research results” (p. 727). Many professional efforts to accommodate consumer participation had failed to include persons diagnosed with mental illness at all key stages of the research and data collection process. However, there continued to be broad experimentation in participatory styles of research and evaluation that led to the development of empowering consumer roles in research and evaluation (Campbell, Ralph & Glover, 1993).

To more effectively influence the mental health system nationally, consumer researchers and policy-makers organized the Consumer/Survivor Mental Health Research and Policy Workgroup to develop consumer-defined outcome measures. To support their policy efforts, consumers identified the needs and preferences for housing and supports, profiled state mental health systems, introduced the consumer satisfaction team, and promoted the use of focus groups.

Consumers as researchers, administrators and providers began to apply sophisticated data and health informatics strategies to public policy debates, peer-run services, and the conduct of science itself (Campbell, 1997). In a series of focus group sessions supported by the Center for

Mental Health Services (CMHS), the Consumer/Survivor Mental Health Research and Policy Work Group, a coalition of consumer leaders and researchers, began a systematic articulation of outcomes of mental health services and supports from a consumer perspective. Concept-mapping, a computerized software program that facilitated the organization and analysis of focus group interactions was used in the inquiry because the methods were structured and replicable on the one hand, and participatory and democratic on the other hand. Further, Jeanne Dumont, consumer researcher, was one of the developers of the program.

From the brainstorming, sorting, and ranking sessions, “maps” were generated that identified domains and performance indicators. According to participants, traditional mental health services pathologized problems in living, held low expectations of consumer achievement, were paternalistic, offered a limited range options, and defined anger as symptomatic. The most frequently identified concerns were (1) mental health provider threats of involuntary treatments, (2) subtle forms of coercion, (3) lack of respect, and, (4) debilitating side effects of psychotropic medications. Recovery, personhood, well-being and liberty were identified as valued outcomes (Consumer/Survivor Mental Health Research and Policy Work Group Task Force Reports, 1992). It was noted by participants that traditional researchers seldom developed measures of detrimental effects of treatment and care (negative outcomes) and positive psychological outcomes such as recovery were missing from most research studies. Building on these preliminary studies consumers advocated for a value-based Consumer-Oriented Mental Health Statistics Improvement Program Report Card which included the performance indicators they had identified.

Key to the current growing recognition of peer-run services as an evidence-based practice was the continued support of the federal government to promote self-help alternatives as part of a broader policy effort to reform psychiatry through patient self-advocacy. Consumer involvement in mental health services was mandated by federal law and actively promoted by projects at the federal and state levels (Parrish, 1989; National Institute of Mental Health, 1991). With federal and state support through block grants and other federal funding such as research demonstration initiatives, the number of peer-run service models continued to expand throughout the 1990s and evaluation of these efforts produced a wealth of descriptive and quasi-experimental data from consumers who directed or were involved in key research projects on peer-run programs. Most notably, in 1977 the National Institute of Mental Health launched the CMHS Community Support Program (CSP), now located within Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). This federal program has long supported the development of consumer-focused and recovery-oriented services by helping consumers organize mutual support group, resulting in 1985 with the funding of the first national consumer Alternatives conference in 1985 and continues annually. The Community Support Program (CSP) in the Center for Mental Health Services also funded 144 local service demonstration projects designed to implement and evaluate peer-run services during the period from 1988-1991. Although only one evaluation project was headed by a consumer, a review of these programs was subsequently conducted by Van Tosh & Del Vecchio, well-known consumer professionals, and published by the federal government (2000).

Today, consumers with research training direct large studies, head evaluation companies, become part of a research team, or partner with professionals to consult on research protocols,

evaluate programs, develop positive psychological measures of recovery such as well-being and empowerment, and conduct rigorous quantitative studies of peer-run services.

The Peer Outcomes Protocol (POP) Project developed, field-tested, and disseminated an evaluation protocol to measure service and programmatic outcomes for mental health community-based peer support programs. Funded as part of the 1995-2000 University of Illinois at Chicago's (UIC) National Research and Training Center (NRTC) on Psychiatric Disability, it was largely designed, directed, and implemented by researchers, advocates, and providers who had a diagnosis of mental illness. The POP is a modularized instrument, each outcome domain measured with objective as well as subjective items. Self-report items ask specifically about the effects of peer support on the particular outcome in question. A manual describing how to administer the POP, a question-by-question guide, the survey instrument, a set of response cards, and a report on the psychometric properties of the protocol are available on the NRTC website (<http://www.psych.uic.edu/uicnrtc/pophome.htm>).

Mental Health Recovery: What Helps and What Hinders? (Onken, Dumont, Ridgway, Doran & Ralph, 2002) was a national research project for the development of recovery facilitating system performance indicators that evolved from collaborative efforts among a team of consumer and professional researchers, state mental health authorities, and a consortium of sponsors. The project involved a grounded theory inquiry concerning the phenomenon of recovery, creation of prototype systems-level performance indicators, and pilot testing. Structured focus groups and grounded theory qualitative research methods were used in nine states with a diverse cross-section of 115 consumers to gain knowledge on what helps and what hinders mental health recovery. The research team then used a process of qualitative coding and member checks to develop a single set of emergent themes and findings that informed a conceptual paradigm for organizing and interpreting the phenomenon. Two sets of performance indicators were developed with small scale prototype testing involving eight state mental health authorities and approximately 200 consumers. The final combined set of indicators was incorporated into a stand alone recovery orientation systems level measure that is rapidly becoming a standard in the field.

The growing evidence base of the effectiveness of peer-run services and the high quality of the evidence encouraged policy efforts to expand peer supports within the continuum of community care. In an experimental research demonstration project, Dumont and Jones (2002) discovered that access to a crisis hostel program produced healing/recovery and greater sense of empowerment than traditional hospital-based services. Campbell and others in the Consumer-Operated Service Program (COSP) Multi-site Research Initiative (2008) found that peer-run service programs are effective as an adjunct to traditional mental health services in improving the outcomes of adults diagnosed with serious mental illness and established a significant link between the service elements of peer-run programs and positive psychological functioning.

The COSP Multisite Research Initiative (Clay, Schell, Corrigan & Ralph, 2005) represented a major advance in bringing the voice of persons with mental illness into dialogue with researchers to deepen the understanding of the programs and services that consumers have developed for themselves to promote recovery. It was the largest and most rigorous study of consumer-operated services ever conducted and one of the most participatory involving significant numbers of consumers at all levels of the project in meaningful research roles. Funded by the Substance Abuse and Mental Services Administration, it utilized a randomized, controlled trial design with

an optimized, common *a priori* hypothesis and an intent-to-treat analysis. Analysis of over 1600 participants revealed that those offered consumer-operated services as an adjunct to their traditional mental health services showed significant gains in hope, self-efficacy, empowerment, goal attainment and meaning of life in comparison to those who were offered traditional mental health services only. Further, the greatest gains in well-being were found for the group of participants who actually used the peer services the most and variations in well-being effects across sites were unrelated to formal COSP models of peer service delivery.

From the growth of consumer participation in research over the past two decades a unique model of scientific inquiry referred to as Consumer Action Research (CAR) or Consumer-Directed Research has emerged as a participatory model in the field of mental health services research. CAR organizes research from the bottom-up or at the grassroots. The point of departure in consumer action research is the engaged participant: productive, conscious, thinking, feeling, creative, honoring others' values & choices, coming to voice, and respectfully listening. CAR combines respect for the consumer perspective as an important component of the investigative process with the recognition of study participants as study partners. Issues of ownership and control of the process and the data are confronted through the composition of an evaluation story, including personal accounts of the impact of the study on evaluators and participants. In all cases, knowledge exchange is a key goal in addition to the production of new knowledge to advance the cause of social justice and promote wellness of persons with mental illness.

Consumer Action Research Model

- Research is organized from the bottom-up
- Consumer perspective is sought & respected
- Participants are seen as study partners
- Issues of ownership & control are confronted
- Evaluation story is told
- Personal impact is captured
- Knowledge exchange is a key goal

Advocates of CAR believe that persons with mental illness have an insider's understanding of the expectations of service recipients and the ways in which traditional providers meet and fail to meet these expectations. Likewise, research with consumer participation can take advantage of the consumer perspective to increase the meaningfulness and usefulness of investigations.

Methods that utilize a participatory style of research where the groups being studied are consulted at every stage of the process, and assisted and encouraged to carry out research themselves have been shown to enrich and validate the knowledge that is produced. The involvement of insiders in combination with the overall inclusion of many stakeholder groups improves the accuracy of the description of the organization, the service delivery system and a broad range of outcomes. Participatory models have the capacity to examine the context in which evaluation occurs to go beyond the statistics that record numbers to include the meaningful interactions of those living with a psychiatric diagnosis. They can flesh out descriptions of gendered and racial experiences rather than simply analyzing variables of sex and race, and, most importantly, they can develop collaborative relationships between mental health consumers and mental health service providers that extend beyond the evaluation effort. As a result, new questions, methods and ways of interpreting data have emerged in the margins of traditional services research.

The growth and acceptance of consumer-professional partnerships through CAR projects shows the potential for progress when different scientific cultures work together in relationships of mutuality and respect. However, the inclusion of diverse groups within the conduct of research has presented interesting challenges that “expert-driven” models of research have proven inadequate to address. In particular, the empowerment of mental health consumers in the administration, design, implementation, and analysis activities has necessitated an on-going dialogue between consumers who are study participants, consumer researchers, and non-consumer researchers to reach common ground regarding issues of authority, expertise, and language.

It is important to remember that mental health programs, including those that are consumer-operated, function within a political system in which data are often exercised in struggles for influence. There is no common language or experiences that would naturally bring different constituencies together. Values and goals that arise from culturally dissimilar experiences tend to separate people and polarize discussion. Bridging differences between people on a personal level needs to be supported through group activities that promote respect, understanding, and appreciation of the difficulties that collaboration presents.

In order to accommodate the diverse cultures now part of the research environment, it is necessary to pause and encourage critical discourse, and to incubate new relationships and ideas as participatory processes are established. CAR has offered the opportunity to consumers and professionals to look within, and to “re-search” in a literal sense the terrain of a priori assumptions about how research should be conducted and by whom. Scientific rigor in methods and practices must be maintained since the weight of disbelief in public policy will surely demand that consumer researchers push harder for clarity in research designs and data quality. Ultimately, consumer participation in research tests the proposition that the integration of diverse cultures into the conduct of research ought to and can enhance scientific knowledge that is useful and meaningful for all participants.



"We Are the Evidence" (Part 2) A Review of COSP History and Research

Americans Discover the Power of Self Help

Over the past four decades, participation in self help groups has become an important way for people to help each other cope with various problems and life crises. Approximately 7.5 million Americans belong to as many as one-half million self help groups, addressing a range of illnesses, addictions, disabilities, and conditions (Lieberman & Snowden, 1994).

Most self help groups developed in response to the need for human interaction. Members come together to share experiences, feelings, and practical ways of handling problems. Self help has a focus that does not seek to make basic changes in outlook or personality, but to sustain the ability of members to cope with a difficult situation. The two-way interaction of giving and receiving help is therapeutic in itself. Numerous research studies show that participation in self help groups can help people significantly improve the quality of their lives.

Studies also showed that support groups reduce the need for medical care and hospitalization. Ample evidence established that personal networks and social activities were important for well-being of people with mental illness. Researchers observed that social ties provided mentally ill individuals with opportunities for appropriate behavior, nondependent relationships, and reciprocal social exchange—all of which are essential for normal functioning.

A Loneliness that Humbled the Spirit

Paralleling the rise of self help, in the 1970s large numbers of psychiatric patients were discharged from psychiatric hospitals only to find themselves adrift in uncaring communities: isolated, lonely, and lacking meaningful relationships. Limited financial resources restricted their social activities as fear and ignorance among American citizens stigmatized persons with mental illness and resisted their integration into community life. Media's frequent portrayals of persons with mental illness as dangerous validated community rejection

Organized Socialization

Early professional psychiatric rehabilitative programs recognized the need for autonomy and free association among individuals who had been socially disabled by institutionalization. Therefore, socialization was taught, promoted, and evaluated as part of rehabilitation initiatives.

A clubhouse approach was developed by a group of consumers called We Are Not Alone (WANA) in the 1950s to provide mutual support after they left a state hospital. This program was adapted by professionals to build an intentional therapeutic community composed both of people who have a serious mental illness and general staff who work within the clubhouse. Social support is organized with attendance sometimes prescribed as part of individual treatment plans. They provide training in common living skills such as riding the bus, paying bills, and grocery shopping.

Professionally constructed social relationships become opportunities for both the delivery of mental health services and various types of human interaction. Reflecting the pervasive clinical beliefs of the 70's and 80's that people cannot manage their psychiatric problems and will remain chronically mentally ill, professional rehabilitation programs often sustain low expectations for members to recover and occupy meaningful roles within society.

Reaching Across

Lack of understanding, respect and trust between mental health consumers and professionals prompted persons with mental illness to reject both clinical and rehabilitation programs and to develop peer-run alternatives. Early attempts at peer support were followed by the organization of patients' rights groups like the Insane Liberation Front in Portland, Oregon, and the Mental Patient's Liberation Project in New York City

The heart of the patients' rights movement was situated within the local group. Started by a small number of people, members would come together through a common sense of injustice and the belief that through organization they could bring about change in the mental health system. Some programs operated within traditional hierarchies with officers and held formal meetings. Others had more egalitarian structures with shared decision-making and no formal leadership.

Activities included organizing support groups, advocating for hospitalized patients, lobbying for changes in laws, public speaking, publishing newsletters, developing creative and artistic ways of dealing with consumers.

The groups communicated through *Madness Network News*, a newspaper nationally distributed by and for people with mental illness, and they met at conferences. The Community Support Program funded the first annual national consumer Alternatives conference in 1985.

From 1988-91 the federal government supported 14 service demonstration projects designed to implement and evaluate consumer-operated peer support services including drop-in centers, outreach programs, businesses, employment and housing programs, and crisis services. Centers for self help research and self help technical assistance centers run by mental health consumers/survivors such as the National Empowerment Center in Lawrence, Massachusetts, and the National Mental Health Consumers' Self help Clearing House in Philadelphia, Pennsylvania were federally funded.

In a study of 104 self help groups, Emerick (1990) classified groups based on structure, affiliation, and service model along an ideological continuum from radical, separatist groups such as The National Alliance of Psychiatric Survivors, to conservative groups that allowed

professionals to act as leaders in partnership with consumers/survivors such as Recovery Inc. and Emotions Anonymous.

Two major service models emerged. The social movement groups offered legal advocacy, public education, technical assistance, and information-referral networking. The individual therapy groups offered more “inner-focused” individual change through group support meetings. Two-thirds of the groups were identified as social movement groups. More than 70% were found to have little to no interaction with mental health professionals. Forty-three percent held anti-professional attitudes.

From Separatism to Inclusion

Throughout the 1990s, people with mental illness began to organize on a national level around empowerment and strengthening the consumer voice, championing the South African disability motto “Nothing About Us, Without Us.” Groups opposed traditional mental health system treatments such as day treatment, involuntary commitment, forced drugging, and the use of seclusion and restraints. They also began to emphasize concepts such as “service recipient,” consumer choice, and treatment “partnerships” of clinicians and clients within the mental health system.

Some consumer leaders started to advocate for consumer inclusion in the administration, provision, and evaluation of mental health services as a tool of system reform. Peer support services also began to move from being separate from mainstream mental health services to developing partnership with traditional mental health providers. Some professional mental health agencies employed consumers in designated positions to provide peer services such as case management.

In 1996, Chamberlin, Rogers, & Ellison found that members used about seven mental health services in one year, and about half were currently taking psychiatric medications. In most instances, the relationship of peer-run support programs and professional services were not formalized within an integrated system of care, but they maintained ad hoc or informal relationships.

The Consumer Vision of Recovery

The concept of recovery was not situated in the engineered interventions offered by mental health rehabilitation programs. For those labeled with psychiatric disorders learning to live with a mental disease still meant remaining an outcast from society—subjected to intense prejudice and discrimination, and denied meaningful work and decent housing. To consumers recovery has always implied having hope for the future, living a self-determined life, maintaining self-esteem, and achieving meaningful roles in society.

Rather than developing within a model of rehabilitation, a combination of recovery-based beliefs, relationships, skills, and community were to be found in the humanized environments of modern peer-run support programs by the mental health consumers themselves.

The Modern COSP

Today, COSPs are generally defined as peer-run self help organizations or groups that are administratively and financially controlled by mental health consumers. Most important, they provide persons with mental illnesses the experience of giving and receiving peer supports in empowering ways. Peer-to-peer supports encourage consumers to confront personal priorities and to rebuild their sense of self and purpose.

COSPs have a unique set of core beliefs, structures, and approaches to helping that are very different from traditional mental health services. For example, while traditional mental health services treat mental illness through biomedical approaches, COSPs promote mental wellness through peer-to-peer approaches based on the concept of self help.

They offer mutual support, community-building, services, and advocacy. COSPs provide participants with opportunities to “tell one’s story,” engage in formal and informal peer support, be mentored and become a mentor, learn self-management and problem solving strategies, practice skills for employment and everyday life, express oneself creatively, and to advocate for oneself or other peers.

Key Ingredients of Consumer-Operated Services Programs Identified

Over the past three decades, COSPs have matured, diversified and increased in numbers across the United States (Campbell, 2005). The authors of a 2002 national survey estimated that there were 3,315 mutual support groups, 3,019 self help organizations run by and for mental health consumers and/or family members, and 1,133 consumer-operated services in the United States (Goldstrom, Campbell, Rogers, Lambert, Blacklow, Henderson & Manderscheid, 2005). Mutual support groups reported that 41,363 people attended their last meetings; self help organizations boasted a total of 1,005,400 members; while consumer-operated services had 534,551 participants in one year. A follow-up analysis of this data revealed that of the 7,467 mental health groups and organizations identified in the survey, there were approximately 2,100 mental health consumer organizations run by consumers for the purpose of providing services to other consumers (Goldstrom, Campbell, Rogers, Lambert, Blacklow & Henderson, 2004).

Today, there is a broad variety of COSP models, including:

- Drop-in centers;
- Mutual support groups;
- Peer educator and advocacy programs;
- Multi-service agencies with benefits counseling and case-management;
- Specialized supportive services focusing on crisis respite, employment, housing;
- Peer phone services (warmlines); and
- Recovery and wellness centers

An emerging evidence-base of qualitative and quantitative studies and corroborative literature has produced a growing consensus among experts, policy-makers, administrators and consumers that COSPs meet scientific and stakeholder criteria for effectiveness.

- In *Mental Health: A Report of the Surgeon General* (1999) the benefits to mental health service recipients who participated in self help, consumer-operated service programs, and traditional mental health services where consumers are employed as staff were finally recognized within the mental health community.
- In 2003, *The President's New Freedom Commission on Mental Health* acknowledged the emergence of the COSP evidence-base and further recommended that consumers and families be fully involved in orienting the mental health system towards recovery.

From 1998 until 2008, SAMHSA funded the largest study of consumer-operated services programs in history. One thousand eight hundred and twenty-seven (1,827) adult mental health consumers participated in a randomized control trial of eight COSPs led by a research coordinating center at the Missouri Institute of Mental Health and a steering committee composed of site investigators, government project officers and consumers.

The Consumer Operated Services Program (COSP) Multi-site Research Initiative (1998-2008) found 46 common ingredients (CIs) of consumer-operated service programs and identified key peer practices that effectively promote psychological well-being, empowerment and hope of recovery among participating adults diagnosed with severe mental illness or impairment. The multi-site findings suggest that when consumer operated services programs are integrated within the continuum of community care they enhance opportunities for mental health consumers to live, work, learn, and participate fully in the community. The COSP common ingredients are used as the basis of the Fidelity Assessment Common Ingredients Tool (FACIT) which was developed by mental health consumer providers as part of the COSP multisite study.

As part of the federal effort to identify and implement evidence-based practices in real-life settings in order to transform mental health services into a recovery-based system of care, SAMHSA released the *Consumer-Operated Services Program Evidence-Based Practice KIT* for national distribution in 2010.



Understanding Recovery

“Wellness functions as an internal resource, with hope the wellspring of motivation for change. When well-being is combined with the treatment of mental illness and favorable external resources and opportunities, hope can jump-start involvement in new activities and empower consumers to sustain their recovery journey.”

--Jean Campbell, PhD
Program in Consumer Studies & Training

In the early 20th century Emil Kraepelin, the father of modern psychology, projected a degenerative future for those persons diagnosed with schizophrenia that was unresponsive to treatment. Endorsed by the psychiatric field, this pessimistic perspective imposed a life sentence of limited possibilities and dreams for persons diagnosed with mental illness. A century later, The Final Report of the President’s New Freedom Commission on Mental Health (July, 2003) recommended that mental health care become recovery-oriented in its services and goals so persons with mental illness can live, work, learn, and participate fully in the community. Further, it envisioned a transformed mental health system in which consumers play a significant role in shifting the current system to a recovery-oriented one by participating in planning, evaluation, research, training, and service delivery.

However, in order for the mental health system to make even the first halting steps towards moving beyond the patchwork relic of symptom management and the acceptance of long-term disability to embracing structures, values and processes that actively facilitate recovery and build resilience, we must broaden our understanding of wellness and move from the clinic and hospital to the community as the haven of recovery possibilities.

The National Consensus Statement on Mental Health Recovery (SAMHSA, 2007) defines recovery as “...a journey of healing and transformation, enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.”

In the mental health literature there are basically three related recovery constructs: (1) recovery as a naturally occurring phenomenon; (2) recovery as the result of participating in a variety of services; and, (3) recovery as a beacon of hope for life satisfaction. However, recovery cannot be sufficiently defined using these construct because there is an inherent lack of consensus around the definition of recovery due to the conflict between recovery as outcome and recovery as process. Typically, recovery in the traditional sense represents an endpoint to mental illness and a return to normalcy in which the consumer accomplishes life goals in work and housing as well

as improved psychological well-being and quality of life. Family groups and mental health providers generally gravitate to these outcomes, the consumer “gets better” by overcoming the symptoms and disabilities that created problems within the family and in society.

Many consumers reject this approach because it implies the use of externally imposed criterion of wellness. For some consumers recovery is a personally meaningful goal that motivates and inspires rather than an abstract construct devoid of individual purpose and vision. They embrace the dynamic nature of disability and recovery by seeking renewal through psychological well-being and empowerment. Being “in recovery,” they tell of a nonlinear approach to the day’s challenges that better captures their life experiences as persons who are making efforts to deal with their symptoms and improve their lives.

The discussion of recovery as a naturally occurring phenomenon centers on the rule of thirds: one third of follow up samples from studies of persons with diagnosed with schizophrenia no longer used the mental health system entirely but were living normal lives, another third had achieved similar outcomes with ongoing support from the mental health system, and the final third showed a continued course of symptoms and remission even with treatment and supports. A review of ten long-term studies that tested Kraepelin’s assumptions about the course and outcome of schizophrenia revealed “more varied and positive outcomes than typically expected by clinicians” (p. 79), and that the course and outcome of schizophrenia varies with socio-cultural context with persons residing in developing countries doing better than those in advanced countries. The authors concluded that these findings suggest that recovery is a real possibility for persons with mental illness and that research should now concentrate on the investigation of what it means to recover and what conditions foster it rather than focusing on issues related to the existence of recovery.

It is apparent that there is no clear consensus within the mental health community today about what people are recovering from, what the process of recovery is, or what the outcomes of recovery are. In fact, there is a large schism in the literature between biomedical approaches to the treatment of mental illness and those based on social and existential factors advanced in empowerment theory. However, this struggle is no mere question of the relative efficacy of different practices and treatments or of coming to common ground among competing perspectives, but rather that it is one facet of a clash of moral and spiritual outlooks grounded in the challenge to the historical predominance of the medical model and paternalism that has dominated psychiatry.

Consumers have been the leaders and tireless advocates in the development of the concept of recovery, recovery-based services, and measures of recovery. Through the work of consumer researchers and peer providers over the past 30 years, consumers have continued to push back against the practices of the traditional mental health system and to confront biomedical research at the point of knowledge production. They valorized consumer voice as a tool for science and brought a value-based approach to performance measurement that was able to tease out the importance of existential outcomes such as personhood, empowerment, hope and well-being in the lives of persons with mental illness. To a large extent, the vision that recovery is possible for all individuals diagnosed with mental illness was the result of a struggle waged by consumers through scientific papers and personal narratives, professional conference presentations, board

and committee representation, and up close and personal advocacy to change disease-based system of chronic mental illnesses to a caring system based on trust, hope, and a belief in the potential of each person to lead a full life.

The theme of the 2005 Alternatives Conference “Leading the Transformation to Recovery” reflected this understanding. Dan Fisher stated, ““During the twenty years of Alternatives Conferences, our movement has inspired the nation to see that recovery is possible for all individuals. This history of consumer leadership played a role in recovery becoming the goal of the New Freedom Commission on Mental Health. Alternatives 2005 is an opportunity for consumer/survivors to continue to lead this transformation.”

According to NEC Director, Judene Shelley, "Like the mythological phoenix bird that rises from its own ashes in new power, many of us find new ways of being, functioning and making a difference. We rise from extreme emotional distress and use our experiences of personal recovery to transform our systems of care into caring systems."

The Empowerment Recovery Paradigm

- Studies have shown that treatment of illness and promotion of wellness are divergent, but parallel processes.
- Traditional mental health programs primarily treat mental illness (bio-medical remediation of deficits).
 - Focus on the reduction of risk factors to prevent illness.
- Peer support primarily promotes mental wellness (nurtures positive, subjective human strengths).
 - As positive subjective states are engendered, the consumer develops protective factors and begins to thrive.

The Empowerment Recovery Paradigm as articulated by mental health consumers has become the clarion call for a radical change in the intellectual framework and service delivery system design for mental health care in America. However, most professionals shy away from exploring the political context in which the definition of recovery is embedded, and therefore, the long entrenched battle consumers have waged against the science and practice of the medical establishment for an empowerment theory of recovery is largely absent from the discourse. Yet, without consideration of the political environment, the demands of mental health consumers become simply issues of competing perspectives rather than profound issues of social justice.

Most consumers have to capacity to adapt and adjust to life’s circumstances; to be resilient and bounce back after loss or illness; to go beyond recovery in the clinical sense; and, to live lives of meaning and purpose. For years consumers have pointed to the many persons diagnosed with mental illness who have recovered on their own to become integrated, productive citizens within the community without any intervention by the mental health system. The mental health community has shown great resistance in accepting this particular concept of recovery because it implicitly challenges the belief in inevitable chronicity of mental illness and the ironclad

necessity for traditional mental health treatments. In fact, providers and administrators have historically appeared more comfortable when viewing persons with mental illness as never being really recovering but living in a perpetual process of recovery. Others are secure in their belief that recovery outcomes are a result of treatment modalities that cure or prevent illness.

As persons are confronted with mental illness they may respond in the following ways:

Survive (chronicity)

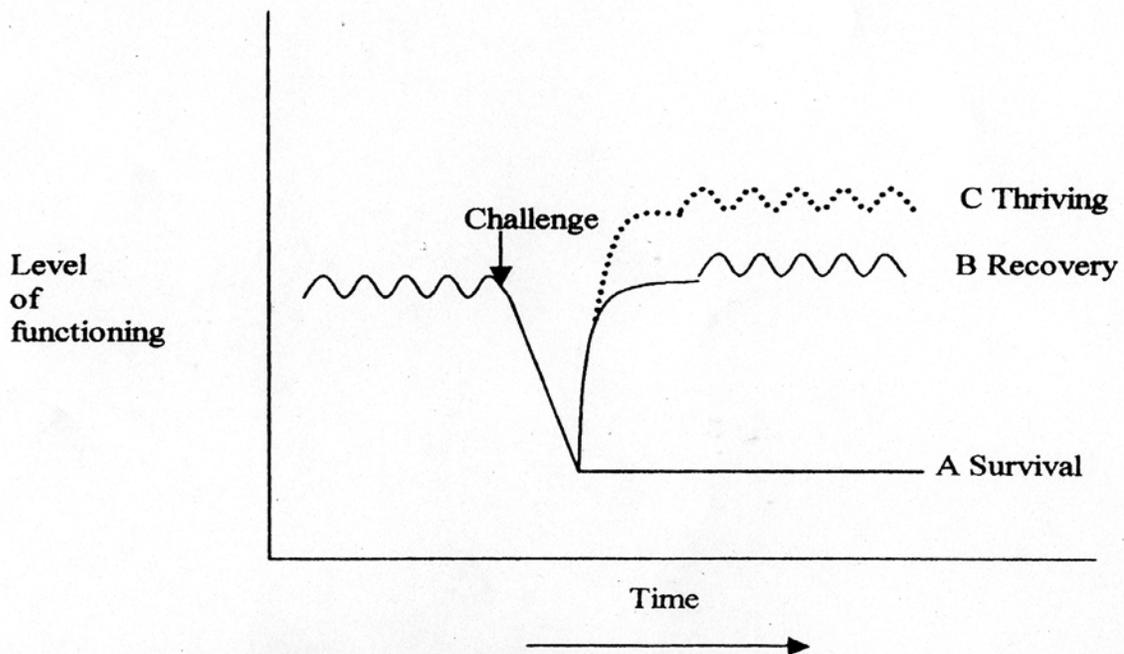
--continue to function, albeit in an impaired fashion

Recover

--homeostatic equilibrium of functioning, return to previous state

Thrive

--grow beyond original level of psychosocial functioning to add value to life



Outcomes of challenge: potential consequences for a single hypothetical stressor.

Not all mental health consumers, family members, professionals, administrators or policymakers agree on a particular theory of recovery, or set of clinical practices that can promote recovery, or even the historical roots of recovery. It is necessary to expand the discussion of recovery to include recognition that well-being is critical to a recovery based system of care. Well-being motivates, supports and sustains recovery. Hope, a key factor of well-being, is unanimously recognized by consumers as one of the most important determinants of recovery, providing persons with the courage to change, to try and to trust.

Based on personal experience, Deegan (1988) describes the process of recovery as a transition from despair, anguish, and pessimism to a new hope that life can be different, a hope born out of the presence of another person ready to provide support and care. Leete explains that "Having some hope is crucial to recovery; none of us would strive if we believed it a futile effort" (Leete, 1989, p. 32).

Research has demonstrated that positive thinking and expectations promote psychological and physical well-being, while negative thoughts and expectations contribute to the development of illness, stifle efforts to cope, and interfere with social support and medical recovery. Further, it has been discovered that hope stimulates recovery not only through the maintenance of more positive expectations for improvement but also through counteracting depression and diminishing the risk for suicide among people with psychiatric disabilities. A number of studies have identified the correlation between hopelessness and the potential for suicide and have recognized hopelessness as a reliable predictor for risk of suicide. At the same time, hope-inspiring interventions have been recommended as a powerful treatment for suicide prevention.

In the field of psychiatric rehabilitation, Anthony (1993) emphasizes the relational aspect of hope and its connection to recovery: hope emerges when there is a person one can trust, a professional who believes in better outcomes--even when clients do not believe in themselves. The relational nature of hope determines the important role of practitioners' hopefulness in promoting the recovery of people with psychiatric disabilities.

Sustaining hope for persons with mental illness in the community may be the most important lesson for persons in the mental health field who confront a fragmented system of care, feeling disconnected and often inadequate, frustrated in their attempts to provide ready access to quality care, and not sure what the calls for transformation to a recovery-based system really mean for the millions now living with mental illness. A hopeful environment will not only contribute to the well-being of persons with mental illness, but to the mental health practitioners and other professionals who provide services and treatment. Hope of recovery also validates peer support practices as consumers reach forward to focus on life instead of illness, to build dreams and find new purpose.

How it all adds up...

1 + 1 = 3

■ **TREATMENT OF ILLNESS**

+

■ **PROMOTION OF WELLNESS**

= RECOVERY

Helen Keller wrote, “When one door closes another opens. But we often look so long and so regretfully upon the closed door that we fail to see the one that has opened for us.” Today the mental health field stands before a door opening onto new possibilities for persons with mental illness to recover and lead meaningful lives in the community. There is considerable misunderstanding and resistance as the shift towards wellness gathers momentum and new ways of delivering treatments and services are being introduced. Efforts to identify the structures, beliefs, and processes of American communities that promote well-being is a beginning step in an important undertaking, and as first steps go, it will leave a small but not unremarkable footprint as consumers and professionals lean into the emerging recovery paradigm.



The Common Ingredients of Peer Practices

Know what you are looking for...

Members of the Peer Evaluator Team must have a working knowledge of the Common Ingredients (CIs) of peer practices to be able to evaluate COSPs for evidence of recovery-based structures, values, and processes. The CIs are the core component of the empowerment recovery paradigm in mental health. The presence of the CIs within a COSP promotes the mental health of the people who participate in the program. Therefore, identification of CIs will be the basis of your evaluation: concrete evidence (documents, testimony, and observable phenomena) of CIs.

What are the Common Ingredients?

The Consumer Operated Services Program (COSP) Multi-site Research Initiative (1998-2008) identified 46 common ingredients of consumer-operated service programs that produced wellness outcomes in the persons who attended these programs including: increase in hope, empowerment, meaning in life, goal attainment and self-efficacy.

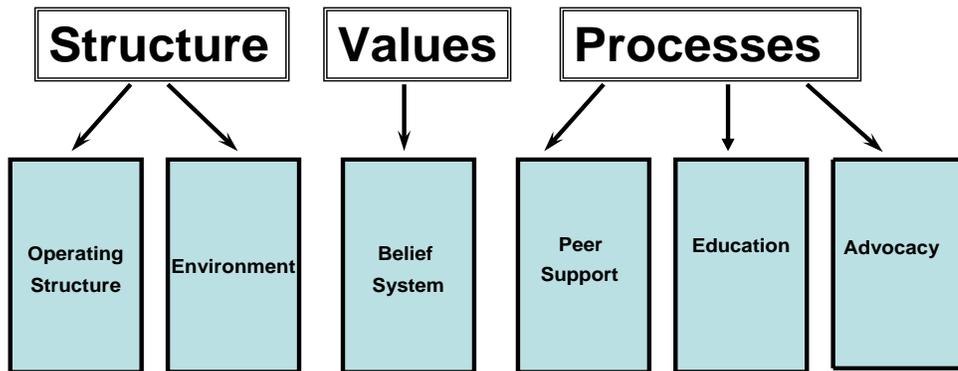
An evaluation tool called the FACIT (Fidelity Assessment Common Ingredients Tool) was developed by consumer providers using the CIs to determine the presence and character of the CIs in a COSP Program. The CIs were organized into the over-arching categories of Structure, Values and Processes and then sorted into domains within the categories based on similarity in peer practice content.

Structure reflected the “relatively stable characteristics of providers of care, of tools and resources they have at their disposal, and of the physical and organizational settings in which they work” (Donabedian, 1980, p. 81). It encompassed the domains of Program Structure and Program Environment.

Values related to the core set of principles, standards, morals and ethics that unite the program and its membership. Values were organized into the Belief System domain.

Processes referred to specific and observable activities in services or in methods of delivering those services. It was composed of the Peer Support, Education, and Advocacy domains.

CI Categories



1. OPERATING STRUCTURE

The COSP operating structure clearly distinguishes it from traditional mental health services. It is administratively and financially controlled by mental health consumers who plan, deliver, and evaluate their services. On the other hand, a traditional mental health provider offers services in community-based settings that are operated by mental health professionals.

Consumer-Operated

- **(CI 1)** Consumers constitute at least 51 percent of the board or group who decide policies and procedures.
- **(CI 2)** With limited exceptions, staff and volunteers consist of consumers who are hired by and operate the COSP.
- **(CI 3)** Consumers are responsible for making COSP hiring decisions.
- **(CI 4)** Consumers control the operating budget.
- **(CI 5)** Volunteer opportunities for COSP participants may include board and leadership positions, unpaid jobs, and paid staff positions.

Responsive to Participants

- **(CI 6)** The COSP is responsive to the needs and preferences of COSP participants. There are many opportunities for member input and the program displays a commitment to implementing recommended changes.
- **(CI 7)** Participants have formal ways to indicate dissatisfaction with their COSP and to have grievances addressed.

Linkage to Other Supports

- (CI 8) COSPs establish links to traditional mental health services.
- (CI 9) COSPs establish links to other COSPs.
- (CI 10) COSPs establish links to other service agencies within the community.

2. ENVIRONMENT

Environment captures the operational features of the program and includes both the physical and emotional space. The COSP environment fosters participant inclusiveness, and safety.

Accessibility

- (CI 11, CI 12) Consumers are able to get to the program by walking or taking public transportation, or the services come to the consumer.
- (CI 13) Hours of operation are geared to the needs of participants.
- (CI 14) COSPs are free to participants or charge a nominal fee.
- (CI 15) Efforts are made to insure that consumers with physical, sensory, or psychiatric disabilities can participate in COSP programming.

Safety

- (CI 16) The COSP provides a non-coercive, safe milieu. Fears due to past trauma are appreciated and assuaged, including trauma induced by the mental health system. There is no threat of commitment, clinical diagnosis, or unwanted treatment forced on participants except in cases where suicide or physical danger to other participants is imminent.
- (CI 17) Program rules to protect the safety of participants are developed by consumers for consumers—either by the participants themselves or by consumer staff—and agreed upon by all participants.

Informal Setting

- (CI 18) The physical environment of the COSP offers participants a comfortable setting with spaces arranged to create a sense of safety, belonging and support.
- (CI 19) Within the social environment there are no rigid distinctions between participants and staff such as “provider” and “client” do not exist. While some program components may be structured, there remains a sense of freedom and self-expression.
- (CI 20) The COSP creates a sense of fellowship in which people care about each other and together create a community.
- (CI 21) There is no pressure on consumers who attend the COSP to participate in COSP programming or any time limit to begin participation. Program schedules are flexible and adapted to diverse individual needs.

3. BELIEF SYSTEMS

The COSP belief system is a core set of principles and values that unite the program in an evolving culture of hope of recovery, social connectedness, empowerment, and meaning in life.

Peer Principle

- (CI 22) Relationships are based on shared experiences and values and are characterized by reciprocity and mutuality. Staff and participants share their experiences of having psychiatric disabilities.

Helper's Principle

- (CI 23) The helper's principle recognizes that working for the recovery of others facilitates personal recovery. Help and advice are friendly rather than professional and do not demand compliance.

Empowerment

- (CI 24) Personal empowerment is encouraged and supported. The COSP helps participants develop a sense of personal strength through programming that builds personal strength and efficacy.
- (CI 25) Consumers are expected to be accountable for their actions and to act responsibly.
- (CI 26) Participants take active roles in the governance and decision-making processes within the COSP. There is significant participant recognition and feelings of membership to the group.
- (CI 27) Participation is completely voluntary. Participants choose the services or activities that best suit them. A choice between two or more services or activities should be available. However, the expression of choice also includes the right to choose none.

Recovery

- (CI 28) The COSP supports and encourages the hope of recovery as a positive process that is forward-focused, acknowledges individual strengths, and enhances participant well-being. Recovery is recognized as different for each individual and, therefore, is never rigidly defined or forced on participants.

Acceptance and Respect for Diversity

- (CI 29) Every person is afforded acceptance, respect and understanding based on his or her uniqueness and value as an individual or member of a diverse subgroup. There is broad acceptance of non-dangerous behaviors for which participants are not threatened with expulsion from the COSP. Behavior is regarded in common human terms rather than interpreted through clinical labels. There are accommodations available for diverse subgroups.

Spiritual Growth

- (CI 30) Spiritual beliefs, practices, and transcendent experiences are respected as an aspect of an individual's search for meaning and purpose in life. Spiritual beliefs are not labeled as symptoms of mental illness. However, a COSP may have restrictions about proselytizing for a particular religion during the hours of operation.

4. PEER SUPPORT

Peer support refers to the concept of consumers helping and empowering each other. The peer-to-peer relationship implies reciprocity, equality, and mutual acceptance and respect. Peer support takes many forms. It can be as simple as two people getting together over a cup of coffee, or it can involve a formal group structure with facilitating rules that guide group discussion, education, advocacy, or creative expression.

Peer Support

- (CI 31) Formal peer support is offered within organized mutual support groups and is based on common experiences. Peers are available to each other for empathy and to share experiences and information. Formal support groups may supplement informal peer support.
- (CI 32) Informal peer support is mutual support based on common experiences that occurs in unscheduled group interactions and within individual relationships. Individual program participants are available to each other to listen with empathy and compassion.

Telling Our Stories

- (CI 33) Sharing personal accounts of life experiences as a mental health consumer is a cornerstone of promoting peer- well-being and recovery. 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. Sharing life experiences may also be a tool for public education.

Artistic Expression

- (CI 34) Artistic expression is seen as a vital component of a COSP. It is valued as a means to explore personal meaning, express and grow talents, facilitate empowerment, and educate others about mental illness. COSP members have the time, space, materials, and assistance to express themselves through artistic endeavors.

Consciousness-Raising

- (CI 35) COSPs provide opportunities for consumers to learn about the consumer movement. Participants are encouraged to look beyond themselves, to work together, to help fellow peers, and to contribute to a larger consumer community. New participants discover commonality with others, leading to hope and empowerment.

Crisis Prevention

- (CI 36) Formal crisis prevention occurs when members and staff learn to recognize psychiatric problems and how to address them before they escalate. Through individual or group peer support, by peer counselors, or by education and advocacy, COSPs can minimize involuntary commitments.
- (CI 37) Informal crisis prevention occurs when spontaneous mutual support occurs that averts a psychiatric crisis outside of any formal peer support framework.

Peer Mentoring and Teaching

- **(CI 38)** Consumer staff and leaders serve as positive role models to other consumers and to each other. Individual participants act as mentors to others. Consumers teach skills and strategies to other consumers, either formally or informally.

5. EDUCATION

Many COSPs focus on education of their members and the larger community. Although topics for educational activities should be determined by group interests, certain topics are so inherently important to COSPs that they are reflected in the common ingredients. Among these core topics are recovery and wellness, employment, and mental health planning and policy-making.

Formally Structured Self-Management and Problem-Solving Strategies

- **(CI 39)** COSPs teach and model practical skills and promote strategies related to personal issues, symptom-management, and helping to resolve support needs. The focus is on practical solutions to human concerns. Formally structured problem-solving activities are offered on a regular basis with skill development objectives. Members teach and learn skills that will equip them to participate fully in the community, such as daily-living skills, vocational skills, job readiness, communication skills, goal setting, and assertiveness skills.

Receiving Informal Problem-Solving Support

- **(CI 40)** The COSP provides a natural social environment where consumers develop and improve social skills. There is an unstructured, peer-to-peer exchange of personal, lived experiences that can enhance an individual's problem-solving abilities.

Providing Informal Problem-Solving Support

- **(CI 41)** Peers help each other to solve problems on an ad hoc basis using skills that they have acquired through the COSP or through lived experience.

Formal Skills Practice

- **(CI 42)** Peers teach and are taught skills within a formal group setting that will equip them for full participation in the community such as daily living skills, vocational skills, job readiness, communication skills, relationship-building, goal setting, anger management, and assertiveness skills.

Job Readiness Activities

- **(CI 43)** The COSP provides opportunities to acquire skills that are directly relevant to working such as resume writing or are indirectly relevant such as public speaking.

ADVOCACY

Self advocacy, peer advocacy, and system advocacy are embraced within the pressure-free environment of the COSP. Peers support each other in learning how to find one's own voice, to speak on behalf of another, or to support the common cause of members or consumers in general by testifying before a legislative committee or serving on a board or committee. COSPs engage in public education initiatives to bring about positive changes in attitudes about persons with mental illness.

Formal Self-Advocacy Activities

- (CI 44) COSP members learn to identify their own needs and to advocate for themselves when there are gaps in traditional mental health services. Peers learn to become active partners of professional mental health providers in developing their own service plans and how to deal effectively with entitlement and other service agencies.

Peer Advocacy

- (CI 45) Peers assist each other in resolving problems they may encounter in hospitals and in the community with treatment providers, community service agencies, family members, neighbors, landlords, and peers.

Participant Outreach

- (CI 46) The COSP makes concerted efforts to keep members informed of current activities and opportunities outside of the COSP.

COSP Multisite Study Results: Common Ingredients & Outcomes

The COSP multi-site study found the FACIT to be an objective, structured way to determine the extent that a peer-run services program faithfully implemented the COSP model, processes, and values (Johnsen, Teague & McDonel Herr, 2005). It identified characteristic differences between COSPs and traditional mental health programs and differences between COSP program models, and helped to establish evidence of a strong relationship between an increase in well-being and recovery-oriented program features. In particular, CIs that support inclusion and self-expression were found key to promoting hope, empowerment, meaning in life, and self-efficacy among participants.

KEY INGREDIENTS

Environment Domain (Inclusion CIs)

- Services free of charge
- Program rules ensure physical safety, developed by consumers
- No hierarchy, sense of freedom and self-expression, warmth among participants and staff
- Sense of community, fellowship, mutual caring, and belonging

- Lack of coerciveness, no threats or unwanted treatment, tolerance of harmless behavior, emphasis on participant choice

Peer Support Domain (Self-Expression CIs)

- Opportunities for telling one's story in visual arts, music, poetry
- Opportunities for sharing life experiences
- Structured groups for listening, empathy, and compassion based on common experience

When results of the FACIT are analyzed, researchers are able to pinpoint program weaknesses, clarify program strengths, and associate various program outcomes to key CIs. Such capabilities advance the capacity of researchers, peer providers, and mental health administrators to promote evidence-based practices in developing consumer-operated services, to guide quality improvements in mature COSPs, and to identify and measure “consumer-friendly elements” of traditional mental health programs.



Getting Started with the FACIT

Key stakeholders who are implementing an evidence-based approach to operating a COSP may find themselves asking two questions:

- Has the COSP been implemented as planned?
- Has the COSP resulted in the expected participant outcomes?

Asking these two questions and using the answers to help improve your COSP is a critical component for ensuring the success of your efforts to operate an evidence-based COSP.

- To answer the first question, collect fidelity measures which capture how services are provided.
- To answer the second question, collect outcome measures which capture the program's results.

Why you should collect fidelity measures

Fidelity measures give you an objective, structured way to gain feedback about program development and about how services are being provided. Experience suggests that the fidelity measures developed for COSPs are an excellent method to pinpoint program weaknesses, while helping to clarify program strengths (Holter, Mowbray, Bellamy, MacFarlane & Dukarski, 2004; Johnsen, Teague & McDonel Herr, 2005).

Ongoing monitoring also allows you to study local innovations to the COSP model while ensuring that the program does not drift from evidence-based peer practices. Therefore, fidelity measurement can inform strategic planning, staff training, program development and other quality improvement initiatives.

The Fidelity Assessment/Common Ingredients Tool (FACIT) is recommended to assess the extent that components of these programs are faithfully implemented according to the intended COSP model, practices, and values. Use of the FACIT helps to advance COSPs as evidence-based practices. Use of a fidelity measure encourages programs to follow practices that have been shown to improve effectiveness to produce outcomes such as well-being, hope, empowerment, self-esteem, and social connectedness.

Why you should collect outcome measures

While fidelity measures capture how services are provided, outcome measures capture the program's results. Every mental health program—whether considered treatment, rehabilitation, support, or wellness promotion—has short term, intermediate and long-term goals for its recipients. In addition, consumers have goals for themselves which they hope to attain by participating in a mental health program. These goals translate into outcomes, and outcome measurement can translate into being accountable to the needs and desires of consumers for recovery and integration into mainstream patterns of social functioning.

Some outcomes directly result from participating in a COSP, such as gaining hope of recovery after being in a group with other peers and hearing their recovery stories. Other outcomes are indirect, such as getting a job as a result of being motivated by the hope of recovery. On the other hand, if a consumer gets a job as a result of participating in a supported employment program, then this outcome is probably a direct result of the services the person received.

Some outcomes are concrete and observable, such as the number of days a consumer has been employed in a month, or has remained in independent housing. Others are more subjective and private, such as gaining a sense of empowerment or being satisfied with services.

On the one hand, it is important to measure outcomes to assess the effectiveness of a service program in serving its recipients. Good fidelity does not necessarily guarantee effectiveness and poor fidelity does not prohibit achieving desired outcomes. Also, fidelity cannot tell a program for whom services are effective. On the other hand, there are significant challenges for small, independent service agencies such as COSPs in implementing ongoing outcome monitoring:

- Service providers lack the necessary knowledge and skills;
- Organizational dynamics undermine quality improvement efforts to implement and maintain a management information system; and
- The costs for outcome monitoring (including personnel, equipment, and software) are prohibitive when balanced against service costs.

Therefore, until a COSP has reached organizational maturity, secured stable funding, and developed a quality improvement program based on fidelity assessment that is integrated into the operations of COSPs, outcome measurement should only be initiated using the simplest methods. These include holding member focus groups or conducting short, one-shot surveys using established measures to determine the impact of services on a very limited number of participant outcomes.

Facing challenges from the consumer community

Some peer providers are skeptical of the concept of evidence-based practices in mental health (Essock, Goldman, Van Tosh, Anthony, Appell et al, 2003). Consumers ask “Whose evidence?” and “Evidence of what?” They point out that by measuring fidelity to the COSP model the FACIT standardizes peer practices that maybe antithetical to their goals or belief system. For example, some programs resist efforts to collect program and member data, believing these

activities destroy their ability to provide participants an informal, safe, non-coercive environment.

The desire of mental health authorities or other funding agencies for a comparative framework using an objective rating system such as the FACIT to evaluate COSP performance is also of concern to peer providers.

Such issues about evidence-based practices are common not only for peer-run programs, but for mental health providers in general. Failure to embrace evidence-based practices for persons with mental illness in real-world settings is a recurring theme in the literature (Drake, Goldman, Leff, et al, 2001). Policy-makers and administrators struggle with how to close the gap between science and service delivery (Committee on Quality of Health Care in America, 2001; Weisz, Sandler, Durlak & Anton, 2005) in the face of “existing state laws, administrative policies, funding priorities, advocates’ concerns, and program staffing” (Corrigan, Steiner, McCracken, Blaser & Barr, 2001, p. 1598).

The basic question for COSPs is whether the concept of evidence-based practices has any meaningful application for those programs that desire to improve their practices and participant outcomes using this approach? Has the COSP Multisite Research Initiative produced a fidelity measurement tool that can speak to the values and practices of your program? Can tools such as the Fidelity Assessment Common Ingredients Tool (FACIT) or the Peer Outcomes Protocol (POP) be faithful servants of a voluntary, peer-run quality improvement effort that empowers peer providers to take charge of their future in a mental health environment that increasingly demands evidence-based practices?

Reaching consensus about evidence-based practices

Before deciding whether or not to use an evidence-based approach in delivering peer services, consider the following information about how the methods and tools discussed in this document were developed and how they should be used.

The FACIT was developed by peer providers who were members of the COSP Consumer Advisory Panel in collaboration with consumer researchers based on a list of common ingredients of peer-run programs (Johnsen, Teague & McDonel Herr, 2005). This list was informed by a comprehensive review of peer literature which generated over 170 items and a national concept-mapping endeavor where peer providers ranked and sorted the items in order to identify peer support competencies (Campbell, Dumont & Einsphar, 1999). Therefore, the FACIT is representative of the best knowledge of peer providers about COSPs.

In this manual, the FACIT has been designed as a self-assessment tool with flexibility features built into the process so that it can be used at the discretion of individual COSPs. The FACIT Protocol is based on program choice, and is intended to build skills and be empowering. In order to use the FACIT, a COSP should re-examine its mission and gather feedback from staff and members to determine what areas of the FACIT it might want to improve. A Continuous Quality Improvement webinar and forthcoming manual have been developed for COSPs by the Program

in Consumer Studies and Training at the Missouri Institute of Mental Health to facilitate using the FACIT for COSP quality improvement.

As the number of peer-run programs continued to grow throughout the past three decades, so did the demand from peer providers for an outcomes protocol with measures derived from mental health consumers' experiences and points of view.

In 1996 the Program for Consumer Studies and Training at the Missouri Institute of Mental Health undertook a five-year project in collaboration with The National Research and Training Center on Psychiatric Disability at the University of Illinois-Chicago to develop, field-test, and distribute an evaluation protocol that measured the outcomes and satisfaction of community-based peer support programs that were operated by mental health consumers.

The Peer Outcomes Protocol Project (POPP) was developed by consumers and embodied consumer values. The Peer Outcomes Protocol (POP) is consistent with peer support philosophy, recognizes and utilizes proven consumer abilities to conduct survey and outcome studies, and was designed to be administered by consumers. It has seven independent modules that can be separated so programs can measure the outcomes they have identified as relevant to their particular services.

When the FACIT and the POP are used as instructed, they should not corrupt the integrity or autonomy of your program, but rather enable you to better serve your membership and secure the respect and funding your COSP deserves.

Moving Forward

Whether you are a new, young or mature COSP your program could benefit from fidelity and outcome measurement within the consumer-operated, member-run quality improvement framework described in this document. The following pages will tell you how to:

- pinpoint strengths and weaknesses of your COSP,
- formulate action plans to improve your COSP,
- help participants achieve their goals, and
- deliver peer services both efficiently and effectively.

How do you know if your COSP is ready to begin providing evidence-based peer services to program members?

The EBP Readiness Assessment can direct your thinking to the processes and administrative tasks required to develop an evidence-based COSP. Answering these questions will help you generate an ongoing “to-do” list (or implementation plan) to guide your next steps in becoming an evidence-based COSP.

EBP Readiness Assessment

The EBP Readiness Assessment is a check list to be used by new, young or mature programs to help them decide if they are ready to implement evidence-based practices, and if they have the necessary baseline resources, personnel, practices, and functions to successfully use the FACIT Protocol and the Peer Outcomes Protocol to monitor this effort. Remember that this check list is a tool for planning and decision-making—COSPs are not expected to have all the items when they begin to establish evidence-based practices.

EBP Readiness Assessment: Part 1

GENERAL KNOWLEDGE

Check any areas that you feel you do NOT understand.

- | | |
|--|---|
| <input type="checkbox"/> The purpose of a COSP | <input type="checkbox"/> Administrative tasks (budget, personnel, supervision) |
| <input type="checkbox"/> The history of the consumer movement and peer support services | <input type="checkbox"/> Specific admission criteria for your program |
| <input type="checkbox"/> The meaning of “consumer-operated” and “member-run” | <input type="checkbox"/> How to conduct staff and membership meetings |
| <input type="checkbox"/> The meaning of the concept of recovery | <input type="checkbox"/> How the COSP relates to advisory groups and/or a Board of Directors |
| <input type="checkbox"/> How your program’s fidelity to the COSP model will be measured | <input type="checkbox"/> How to facilitate peer support groups |
| <input type="checkbox"/> How the system for collecting outcome data will work | <input type="checkbox"/> How to write proposals or reports |
| <input type="checkbox"/> Role of staff/members/volunteers at a COSP | <input type="checkbox"/> How to develop a marketing plan or conduct community outreach |
| <input type="checkbox"/> Leadership development | <input type="checkbox"/> How to establish a collaborative relationship with traditional mental health providers |
| <input type="checkbox"/> How to motivate your staff in implementing the peer practices identified in the FACIT | <input type="checkbox"/> How to prepare a program manual |

NOTE OTHER AREAS THAT WERE NOT LISTED WHERE YOU HAVE QUESTIONS:

EBP Readiness Assessment: Part 2

Check items that are planned, already in place, or have been completed. On the last page, note the next steps you may want to take to obtain or complete the items you did not check.

STAFFING AND MEMBERSHIP

- | | |
|--|--|
| <input type="checkbox"/> Director (responsible for hiring and supervising staff, maintaining budget, etc.) | <input type="checkbox"/> Staff reflects cultural diversity of the community in which the program operates |
| <input type="checkbox"/> Program Coordinator (responsible for developing and maintaining program activities) | <input type="checkbox"/> COSP empowers staff/membership in decision-making |
| <input type="checkbox"/> Bookkeeper or outsource bookkeeping services | <input type="checkbox"/> Membership criteria |
| <input type="checkbox"/> Support group facilitators | <input type="checkbox"/> Membership rules |
| <input type="checkbox"/> Quality Improvement Team | <input type="checkbox"/> Reasonable accommodations for disability access |
| <input type="checkbox"/> Written job descriptions | <input type="checkbox"/> Written personnel policies <ul style="list-style-type: none">● Confidentiality● Sexual harassment● Complaint & grievance (staff/members)● Substance-free environment |
| <input type="checkbox"/> Staff training | |
| <input type="checkbox"/> Volunteer recruitment and training | |

FACILITY AND EQUIPMENT

- | | |
|---|---|
| <input type="checkbox"/> Central location in the community the COSP serves | <input type="checkbox"/> Storage room |
| <input type="checkbox"/> Several rooms for different activities | <input type="checkbox"/> Outdoor smoking area |
| <input type="checkbox"/> Comfortable furniture | <input type="checkbox"/> Free telephone access for members (local calling) |
| <input type="checkbox"/> TV and DVD/VCR player | <input type="checkbox"/> Separate office <ul style="list-style-type: none">● Basic office supplies● Meeting table and chairs |
| <input type="checkbox"/> Access to washer/dryer and shower or arrangement at another site | |

- File cabinet with lock
- Telephone
- Fax machine

- Computer with internet access
- Printer
- Postage

RESOURCES

- | | |
|---|--|
| <input type="checkbox"/> Computer/internet access for members | <input type="checkbox"/> Supplemental Resources |
| <input type="checkbox"/> Peer support and wellness literature | <ul style="list-style-type: none"> ● videos/dvds/computer games ● art materials ● snacks ● small refrigerator and microwave or kitchenette ● library (book shelf and books) |
| <input type="checkbox"/> Coffee pot and coffee | |
| <input type="checkbox"/> First aid kit | |

DATA COLLECTION AND QUALITY IMPROVEMENT

- | | |
|---|--|
| <input type="checkbox"/> Unduplicated count of attendance | <input type="checkbox"/> Membership list |
| <input type="checkbox"/> Sign-in sheets | <input type="checkbox"/> System to monitor fidelity and outcomes |

SERVICES

- | | |
|---|--|
| <input type="checkbox"/> Formal peer support groups | <input type="checkbox"/> Wellness management |
| <input type="checkbox"/> Recreation | <input type="checkbox"/> Skills training |
| <input type="checkbox"/> Greeter/new member orientation | <input type="checkbox"/> Job readiness |
| <input type="checkbox"/> Informal peer-to-peer support | <input type="checkbox"/> Meals/snacks |
| <input type="checkbox"/> Advocacy | |

PROGRAM MATERIALS

- | | |
|--|--|
| <input type="checkbox"/> Posted membership rules | <input type="checkbox"/> Mission Statement |
|--|--|

- Calendar of Activities
- Newsletter or Webpage

- Motivational/Artistic/Recovery-focused materials displayed
- Community Resource List

PROGRAM MARKETING AND OUTREACH

- COSP Brochure
- Flyers/Posters
- Free Advertising in media outlets (newspaper, cable television, public radio)

- COSP representatives on community provider boards and committees
- COSP participation in community initiatives
- Referrals

PROGRAM BUDGET

- Competitive salaries and fringe benefits
- Rent, utilities and facility maintenance
- Telephone and communication equipment
 - Pagers
 - Cell phones
 - Internet
 - Postage
- Office supplies
 - Pens
 - Copy paper
 - Toner
 - File folders
 - Other
- Office equipment
 - Fax machine
 - Copier
 - Printer

- Office furniture
 - Storage and file cabinets
 - Desks
 - Chairs
 - Table
- Travel and transportation
 - Vehicle lease/purchase
 - Travel reimbursement
 - Bus passes
- Required insurances

NEXT STEPS

Conducting your first fidelity assessment

Before a program begins to provide evidenced-based peer services, they should have a fidelity assessment conducted to determine if the program already has the common ingredients of a COSP in place. During the first two years of implementing an evidenced-based COSP, a program should plan to assess their structure, values and practices at least once a year. After the COSP has matured and achieved the desired fidelity in the most important areas as identified by the membership, the program may choose to conduct an assessment once every two years and, instead, begin to focus on the collection of outcomes.

Programs that have successfully implemented evidence-based practices indicate that they should continue to evaluate fidelity to ensure that they do not drift away from peer beliefs or desired practice patterns.

Moreover, once the evidence-based peer practices are in place, the program may be tailored to meet individual needs of the consumer community that is being served. Ultimately COSPs will want to use fidelity assessments with outcomes monitoring to understand whether any program changes have positively affected program participants.

How to use COSP fidelity measures

The Fidelity Assessment Common Ingredients Tool (FACIT) has been developed to monitor how COSP practices are delivered. The FACIT has 46 program specific items. Each item is rated on a 5-point anchored scale. The scale items fall into six domains:

- Program structure,
- Environment,
- Belief systems,
- Peer support,
- Education, and
- Advocacy.

While quality-improvement fidelity measures have been developed and are used to assess all evidence-based practices, the length of time that these measures have been used and the level of psychometric testing varies.

The FACIT has a relatively short history, but it has undergone extensive psychometric testing in the Consumer-Operated Service Program Multisite Research Initiative as described by Johnsen, Teague, and McDonel Herr (2005). The FACIT has demonstrated discriminate and predictive validity and, in fact, has begun to be adopted by programs throughout the United States. The FACIT has been found to differentiate between peer-run programs and traditional mental health services.

Regarding predictive validity, the COSP Multisite Study found significant correlations between FACIT scores and consumer outcomes such as hope, empowerment, meaning of life, self-esteem, and social support as measured in the subscales of the Composite Well-Being Measure (Campbell, Lichtenstein, Teague, Johnsen, Yates, Sonnefeld, et al., 2006).

Who can conduct fidelity assessments?

Fidelity assessments can be conducted either internally through a quality improvement program at the COSP or externally by an outside assessment team. The goal is to select objective and competent FACIT assessment team members. The validity of the FACIT scoring will depend on:

- The knowledge and experience of the person(s) making the ratings,
- Access to accurate information pertaining to the ratings, and
- Objectivity of the ratings.

When a COSP decides to conduct a self-assessment or to use outside assessors it must be careful to avoid the potential of biased raters who are invested in seeing the program “look good” or who do not fully understand COSP common ingredients.

It is important that the ratings be made objectively and based on hard evidence. Circumstances will guide decisions about who will conduct fidelity assessments, but programs need to make sure that the assessment process will foster fair and objective scoring by involving assessors who are not centrally involved in providing program services. In particular, to make sure that the assessment is objective and staff and member confidentiality is maintained, assessors should not have any conflicts of interest such as being a member of the board of directors or a program staff member which would place the assessor in a compromising position regarding information learned about the program, staff, and members.

To insure the reliability of the findings, two raters are needed to conduct all fidelity assessments. Only persons who have training or experience in interviewing and data collection procedures should conduct assessments. They should attend a training for Peer Evaluator Team (PET) members, carefully study the FACIT Training Manual and FACIT Scoring Tool, and follow the procedures as detailed.

Additionally, assessors need to understand the history, operations, and beliefs of COSPs. Members of the FACIT assessment team would benefit by reading *On Our Own Together: Peer Programs for People with Mental Illness* (Clay, S. [Ed.], 2005), a book which contains the knowledge necessary to develop a peer-run program and addresses the philosophy, history and tools one would need to be successful.

COSPs can take different approaches to recruit assessors. The pre-existing COSP quality improvement team, if one exists, can be designated to conduct the FACIT or a new team can be organized from the COSP membership. Neighboring COSPs could exchange assessors, an outside evaluation team could be hired from the local community or an academic institution, or the mental health authority could volunteer staff to conduct the FACIT. In Missouri, we have field-tested most of these approaches and have now decided to organize the consumer statewide Peer Evaluator Teams (PETs) to conduct the annual FACIT for the ten DMH-funded COSPs.

If a COSP chooses to use a consultant or trainer to assist with implementation of evidence-based peer practices, that person should be involved in the assessment process to enhance any technical assistance that may be required.

Whichever approach is adopted, COSPs are encouraged to make their fidelity assessment decisions early in the planning stages of implementing evidence-based peer practices.

How to conduct fidelity assessments

A number of activities take place before, during, and after a fidelity assessment. In general, assessments include:

- Interview with program director
- Focus groups with staff and program members or participants,
- Observation of program groups, staff service provision, and informal participant interactions, and
- Collection and review of program materials.

Collecting information from multiple sources helps assessors more accurately capture how services are provided and identify the COSP common ingredients in the program. A two-day site visit is optimal for acquiring this information.

Before the Fidelity Assessment

Prepare for your fidelity assessment

A detailed protocol has been developed to help you understand each item on the FACIT, the rationale for why it was included, guidelines for the type of information you should collect during the site visit, and instructions for completing the ratings. Assessors need to be trained to use this protocol prior to the program site visit to assure that all assessors apply and score the FACIT in a consistent manner.

The FACIT Training Manual and support materials, and the fidelity measures found in the FACIT Scoring Tool should be used in full. Collecting evidence in order to score all the items on the FACIT will allow your program to gain a comprehensive understanding of how strongly it has incorporated the COSP common ingredients and delivers COSP evidence-based peer practices.

Create a timeline for the assessment

Assessments require you to carefully coordinate efforts and to have good communication. Therefore, it may be useful to list all of the necessary activities leading up to and during the visit. For example, the timeline might include a note to make reminder calls to confirm assessment dates and schedule, recruitment for focus groups, and progress in materials collection.

Establish a lead person at the COSP

You should have one key person at the COSP who arranges the assessment and communicates beforehand the purpose and scope of the assessment to COSP staff and participants. Typically this person will be a member of the quality improvement program. Exercise common courtesy in scheduling well in advance and respecting the competing time demands on COSP staff and participants.

Establish a shared understanding of assessment goals

It is essential that assessors communicate the goals of the assessment to COSP staff and program participants. The most successful assessments are those in which assessors and COSP staff and participants share the goal to understand how the program is progressing according to evidence-based practices. If staff or participants fear that they will lose funding or look bad if they don't score well, then the accuracy of the data may be compromised. The best environment for doing the assessment is that everyone involved is interested in learning the truth and improving the COSP based on that information.

Develop an Agenda for the FACIT

In order to conduct a FACIT evaluation the equivalent of 1.5-2 full days are needed on-site at the program. However, the agenda for a FACIT evaluation will vary according to the needs, characteristics, and schedules of the program. The FACIT team should rely on a designee of the COSP director to represent those needs, and to identify and schedule interviews in advance of the visit. The contact person will maintain close communication during this preparatory phase to make certain that the FACIT Agenda addresses the needs of both the COSP and the FACIT team.

Sample FACIT Agenda

Day One

A.M.

8:00-8:30	Review Agenda
8:30-10:00	Supervisory staff interviews
10:00-11:30	Line staff interviews

P.M.

Noon 2:00	Lunch and tour of facility
2:30-4:00	Interview with Executive Director

Day Two

A.M.

9:00-11:00	Focus Group (COSP Members)
11:00-noon	Review Program Materials

P.M.

Noon-1:00	Lunch
1:00-2:00	Observe peer support group
2:00-3:00	Exit Interview

Timing

- Feel free to alter the order of interviews to meet the needs of the COSP.
- Allow about 15 minutes between interviews for room changes, restroom breaks, and “downtime” for FACIT team members.
- Allow 90 minutes for most interviews or focus groups.

Indicate what you will need during the assessment

In addition to the purpose of the assessment, briefly describe what information will be needed from the COSP director, staff, and focus group participants, and how long each interview or focus group will take to complete. Be sure to include in the assessment observation of at least one peer support group. This is often an important factor in determining when the visit should be scheduled.

Although a written informed consent process is not necessary to conduct the FACIT, assurances of confidentiality and informed consent must be discussed with all assessment participants and subsequently followed by FACIT assessment team members and the quality improvement program.

The assessment is most efficient if the COSP director gathers beforehand as much as possible program materials and documents. Therefore, provide the program director with a materials checklist and request that the COSP prepare two packets (one for each assessor) with these materials. The contents of the packets will be reviewed with the program director during the site visit and used during the FACIT scoring.

Reassure the program director that you will be able to conduct the assessment, even if all of the requested information is unavailable. Indicate that some of the information is more critical than other information, but make every effort to obtain all the available materials prior to scoring.

Clarify reporting procedures

FACIT assessors should share fidelity results with all members of the quality improvement team if there are more members than the two who will conduct the assessment. All members should participate in the preparation of the final report. The quality improvement program will need to clarify with the program director who should receive a report of the fidelity results. Recipients may include:

- COSP administrators,
- COSP staff
- Members of the COSP Board of Directors or Advisory committee,
- COSP members/participants,
- External funding agents, and

- Others as deemed appropriate by the COSP.

The PET should also clarify how the COSP would like the report to be distributed. For example, the PET may mail, fax, or email the report and follow-up to discuss the results in a face-to-face meeting or by conference call.

Organize your assessment materials

Several worksheets and forms have been created to assist you in conducting your assessment. These are to be found in the FACIT protocol and include the following:

- Sample Site Visit Agenda
- FACIT Materials checklist
- FACIT Site Visit Observations
- FACIT Interview Questions (program director)
- FACIT Focus Group Questions (members)
- FACIT Focus Group Questions (staff)
- FACIT Scoring Sheet

These worksheets should be organized into a binder for each assessment team member to use to collect and enter information. FACIT team members should keep their score sheets in their respective binders for individual scoring following the fidelity assessment.

During your assessment

Tailor your terminology

To avoid confusion in interviews and focus groups, tailor the terminology you use. For example, a COSP may use *member or participant* to refer to *those persons who attend the program*. Every program has specific job titles for particular staff roles. By adopting the terminology used at the COSP, you will improve communication.

Track Information

During the evaluation, assessors must be sure to enter all responses to interview and focus group questions and to complete all the checklists and forms on the appropriate pages in their binders. Further, if any unusual circumstances occur while conducting the assessment, the details of the circumstance should be noted in the binder in addition to a “to-do” list of questions or requests that must be followed up with the COSP at a later date.

Before you leave, check for missing data.

Conducting Interviews and Focus Groups

The evaluators need to focus on any differences between perceptions of program functioning and actual functioning: how program services are implemented, the expression of staff and member attitudes and behaviors, and the presence of CIs. Therefore, the primary activity of the evaluation team consists of conducting a series of semi-structured interviews with a schedule of questions, some with individuals and others in focus groups.

A list of persons to be interviewed or participate in a focus group and a schedule of questions to be asked in all interviews and focus groups has been developed and should be followed when conducting the FACIT.

The evaluators should recruit around 15 mental health consumers for each program focus group. In order to minimize selection bias in recruiting consumers, participants should be typical of individuals who attend the program. A flyer or notice encouraging consumers to attend the focus group should be posted at places where program members frequent or put in the program events calendar or newsletter. The FACIT may be discussed at a public meeting at the program that consumers attend.

Interviews and focus group should have a conversational tone. One team member leads the interview or focus group, but both team members record responses to the questions in their FACIT binder. An interview or focus group lasts about 1½-2 hours, including time for refreshments. Cookies work great! Interviews and focus groups are audio-taped for reference during FACIT scoring.

Information in the FACIT, *except for the actual interview questions*, can be shared with participants. However, the PET should take every precaution to get participants to respond spontaneously and the team should avoid “hallway discussions” in advance that may make responses artificially congruent.

Frequently Asked Questions

➤ Why conduct FACIT interviews and focus groups?

Interviews and focus groups provide an excellent forum for gathering information about the presence of common ingredients. An interview or focus group allows you to ask semi-structured questions and to be creative when probing for more details. They are most useful when the goal is to hear people talk about their experiences in their own words. You can see the intensity of emotion on an issue through an interview or focus group.

➤ What is a FACIT interview or focus group?

Usually it is a 90 minute moderated discussion, held in a private setting, which includes as little as one interviewee or about 10-15 persons in a focus group.

➤ **How are people recruited for a FACIT focus group?**

All participation is voluntary. One method for recruiting participants is to contact the director at a consumer program or to simply post a flyer inviting consumers to attend. Schedule the event on the program calendar. Allow all members who show up (up to 20 members) to participate. A more scientific method for recruitment is random selection where the names of all the consumers who attend a program 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, then a second drawing is conducted.

➤ **How many FACIT interviews and focus groups should be held?**

Hold at least one focus group with consumers, and conduct interviews or a focus group with all persons identified in the FACIT Protocol (Program Director, Supervisory Staff, Line Staff/Volunteers/Facilitators). If there are issues in which subgroups have differing opinions (for example: people of color vs. general membership, or female members vs. male members) hold interviews or focus groups with each particular subgroup as time and resources allow.

➤ **Who runs the FACIT interviews or focus groups?**

The PET members facilitate the interviews and focus groups. Before conducting an evaluation, team members must receive interviewer training, and learn how to run a focus group from participation in practice sessions. If possible, it is useful to try to match the moderator with the type of group to be conducted. In other words, use a Hispanic moderator for interviews/focus group with Hispanics, use a female moderator when conducting an interview/focus group with women only. Matching the interviewer or moderator with the person/group promotes a freer flow to the dialogue.

➤ **What questions should be asked?**

Schedules of interview and focus group questions based on Common Ingredients corresponding to the FACIT Score Sheet will be developed for the primary persons to be questioned (key informants). However, team members gather information from multiple sources and activities. Not all of the questions provided in the schedule need to be asked, nor is there usually time to cover everything.

➤ **Can observers come to the interviews or focus groups?**

No, the interviews and focus group sessions should be held in private to assure participant confidentiality. Participants will more likely share their responses and be honest with answers if they feel safe and can trust the process not to reveal what they individually have said.

➤ **How are interviews and focus groups responses analyzed?**

Written notes of each response are to be recorded during the interviews and focus groups. The interviewer can use another team member's notes if both taking notes and interviewing or moderating a focus group interferes with the flow of the dialogue.

The Day of the Focus Group or Interviews

The PET members need to be at the place where the focus group or interview is to be held at least 60 minutes ahead of time to ensure that everything is in place.

If the PET is conducting a focus group, the participants are to be greeted as they arrive, given a nametag with only their first names, and then offered refreshments (cookies). The evaluation team members begin by introducing themselves and reviewing the purpose of the meeting. A suggested opening has been developed to provide guidance.

The second major task is creating a comfort zone for participation. The opening script provides some guidance. The main introductory points that need to be covered include:

- Have participants do quick introductions.
- Review guidelines for participation.
- Let participants know that if they decide after hearing a question that they would not like to respond, they are free not to do so.
- Let participants know that they are free to take a break at any time during the focus group, if they need to.
- Ask the participants directly as to what makes them feel comfortable and work to accommodate these requests. (Give them some of the responsibility in creating the comfort zone.)
- Generate interest and enthusiasm for the task at hand.

Once the introduction tasks are completed, one PET member begins the focus group discussion (That person is called the facilitator). There are several things to attend to in facilitating the discussion and managing the group dynamics. The other team member takes notes and assists with any needed logistical support that may be required.

The following procedures need to be followed during a focus group or interview:

- The facilitator must stick to the questions as written. Consistency in questioning is necessary. All the question sets for the interviews and focus groups will be provided at a PET Tune-Up prior to the beginning of evaluations. The schedule of questions will be divided into “general questions” developed to capture values and perceptions and “FACIT questions” which are linked to specific items in the FACIT. However, not all of the questions need to be asked since many questions are answered as part of another response in the focus group or interview. It is recommended that the general questions are always asked and the FACIT questions are selected as needed.
- Responses need to be paced to ensure that there is time to cover all necessary questions.
- The discussion needs to be guided in such a way as to be sure that each participant has a “roughly equal chance” to answer questions.

- If someone asks the facilitator to explain a question or define a word in a question (such as “What is meant by control, choice, or hope?”), the facilitator should say, “Whatever it means to you” rather than try to define the word or concept. Defining a question or word could change the meaning of the question and not provide the information needed to score the FACIT.
- Participants are asked to be specific about their experiences. If someone is generalizing, they should be asked to give an example. However, they should only speak about their own experiences.
- If only a few participants have spoken, the group should be asked, “Would anyone who hasn’t said something about this question like to say something before we move on?” or “Does anyone have something to add that hasn’t already been said?”
- Sometimes it is difficult to get complete, detailed responses to a question. Other times participants get sidetracked by going off on a tangent. Therefore, the facilitator needs to redirect the discussion or prompt participants to continue talking and provide more detailed responses. Be sure to let a participant complete his/her thoughts before you probe. Use the phrases that follow in the next section to probe or prompt participants.

PROBES AND PROMPTS

- That's something we're definitely interested in hearing more about. What can any of you tell us about that?"
- "How has this played out in your life?"
- "Tell me more."
- "I am not quite following you, could you provide me with an example?"
- "Does anyone have a similar (or different) perspective?"
- "Tell me what it was like."
- "You look puzzled."
- "You look like you have something to say, or you have a different point of view."
- "Could you tell me a short story about that?"

Suggested Script for Starting an Interview or Focus Group

Hello, our names are _____ and we are the Peer Evaluation Team or PET members. We are here today to conduct a focus group (or interview) as part the FACIT evaluation that is ongoing for COSPs throughout the state. FACIT stands for the Fidelity Assessment Common Ingredients Tool. We are here to gather information about your program in order to find out how well the structures, values and processes promote the well-being of its members. The results of our work will be shared with program staff and board members as well as program members as a way to help improve some things you do, and to develop new ways to support recovery from mental illness, and to celebrate your successes.

As mental health consumers (or give official title of interviewee) you have been asked to participate in this focus 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 this community. Many people use the term "recovery" to describe this process of growing, changing and claiming a place back in the community.

Do you have any questions?

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.]

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

- Say what ever you think is true for you. There are no right or wrong answers.
- Make as many comments as you wants to (we are trying to generate as many responses as possible).
- Respect the person who is speaking; do not interrupt him/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 being 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 remind him or her gently —“this is what we all agreed to.”]

Focus Group Questions (SAMPLE for PET training)

WARM LINE FOCUS GROUP (RESPONDERS)

1. How long has each of you worked here?
2. What expectations should callers have about receiving support and information here?
3. What is the most important thing you can do for a caller?
4. Do you feel you that callers are expected to be accountable for their actions here?
5. Is the pace at which the caller wishes to participate or be involved respected here?
6. Is recovery an important component here and how is it defined?
7. Is spirituality (search for meaning and purpose) an important component of the program and how is it integrated into the program?
8. Do staff/responders/callers have a chance to “tell their stories” here?
9. Do staff/responders/callers receive information about the consumer movement here?
10. How is crisis prevention handled here?
11. Is there an emphasis placed on callers being able to identify their own needs and staff/responders insuring that needed information and supports are provided?
12. Do callers have a chance to learn to deal effectively with entitlement agencies (for example HUD or Social Security)?
13. If you could change anything you wanted about this warm line, what would you change first?

FACIT Materials Checklist

- Articles of Incorporation
- Agency mission statement/philosophy
- Organization structure/organizational chart
- By-laws
- Advisory Council/Board minutes from the last 12 months
- Program operating budget
- Policy and Procedure Manual
- Sexual harassment and grievance policies
- Satisfaction survey
- Participant demographics
- Unduplicated monthly attendance record
- Program reports
- Activity schedule/calendar/newsletter
- All forms used by the agency
- Training manuals
- Job descriptions
- Brochures
- Letters or advertisements soliciting volunteers
- COSP initiatives and outreach materials

Document Reviews

Besides interviews and focus groups, evidence of CIs is found in written documents such as newsletters, reports, brochures, posts on bulletin boards, flyers, and policies and procedures to name a few examples. The PET should collect written documentation of CIs using the FACIT Document Checklist and review the materials prior to scoring the COSP.

Observations

As part of the collection of evidence about the presence of common ingredients, PET will take a tour of the COSP and spend time observing program activities the environment, and social interactions. In particular, the team is encouraged to observe and take notes regarding information on common ingredients not readily available by interview or focus group.

FACIT OBSERVATIONS (SAMPLE)

Drop-In Center

Physical Environment

- The furniture looks comfortable.
- People 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 consumers 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 might be retreats such as overnights and camping trips.
- There could be a newsletter that updates consumers to COSP events, etc.
- There is minimal usage of clinical labels and stigmatizing language in conversation and in written materials about the organization.

Peer Support

- There are products of telling of stories, i.e. written stories, poetry, or artwork.
- There are a variety of avenues to tell stories.
- There is evidence that the consumer has control over when and who s/he can tell his/her story.
- There is an availability of materials from other sources such as documents, newsletters, position papers and written testimony from other consumers in the movement.

Peer Mentoring and Teaching

- There is an established leadership of the peer support groups and classes.

Self Management Problem-Solving Strategies

- There is evidence of formal educational programs for mental health consumers in problem-solving such as offering an anger management class.
- There is evidence of informal exchange of personal experience among consumers to enhance individual problem-solving abilities.

Confidentiality Protections and Evaluator Conduct

All participation in interviews and focus groups is voluntary. Although an informed consent form is not required when data are solely used for quality assurance rather than research, care should be taken to assure interview/focus group participants that their participation is voluntary and all data collected are confidential.

Further, hard copy data such as FACIT Score Sheet or interview/focus group notes and audio-tapes are to be stored in a locked file and destroyed after reporting is completed.

Each interview or focus group must be held in a private setting and the PET should not share with others outside of the evaluation what is said during an interview or focus group session. Also, no one other than a participant should be allowed to sit in on interviews or a focus group.

Further, team members should not record the names of any persons interviewed, although interviews and the focus groups will be audio-taped. Anonymity is to be maintained in that responses are never to be attributed or attributable to individuals without permission.

A breach in confidentiality could arise in the conduct of a focus group when a person divulges private information about his/her mental health experiences to other participants. Because all focus group participants would already be identified as consumers, which by definition means they are self-identified consumers of mental health services, little or no harm should result from disclosing one's 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. By reminding participants that confidentiality protections in a focus group are the same as those protections in a hospital can help gain cooperation.

Another potential for harm relates to the fears that the evaluation will in some way result in a program being shut down. Care should be taken to assure participants that any results of the evaluation will not endanger program funding. Team members need to explain that the evaluation is being conducted to help the COSP improve the quality and delivery of services.



After the FACIT

Follow-Up

If necessary, you should follow-up on any missing data. This would include discussing with the interviewees any discrepancies between data sources that arise after the evaluation has been completed.

Review the Evidence

After the FACIT visit is completed, each team member will review all evidence and individually rate the COSP using the FACIT Score Sheet. After independently rating the COSP on each item, team members will share their scores and use a process of conciliation to come to consensus to produce a common rating.

Evidence includes such things as testimony collected during interviews and focus groups, observations of environment and interactions, materials available to staff and members such as newsletters, calendars, brochures, pictures of activities, artwork, program rules and policies and procedures, and satisfaction and outcome reports.

Types of Evidence

Team members are asked to review all available information about the COSP to score an item. This includes the following types of evidence:

- responses of all persons interviewed in the course of the FACIT evaluation;
- all documentation provided by the program or gathered by the PET;
- previous FACIT assessments (if available);
- observations made by the team members during the program tour; and,
- information gathered during informal exchanges with staff and consumers.

Always use good sense to evaluate the relevance and quality of the evidence that is collected. A team member is something like a detective who follows up on leads gathered through interviews or focus groups, keeps an eye on what is going on to substantiate what one is told, and collects documentation.

1. Collaboration among multiple pieces of evidence is best in determining an item score. The ultimate purpose of collecting different types and sources of evidence is to engage in a type of triangulation that can generate more valid scores. There is considerable methodological theorizing to suggest that this approach is more likely to provide an accurate overall assessment than relying on a single source.
2. Only rate evidence of CIs that presently exists. Do not score a CI of the FACIT based on structure, beliefs or processes from the distant past or those planned for sometime in the future.
3. Probe and follow-up with questions to determine the status of a piece of information. For example, if someone informs the PET members that a CI is offered in the COSP, inquire when it was last offered and how often it is offered.
4. Where PET members find considerable difference in the statements of informants to the same question, they must use their best judgment in arriving at an appropriate rating. For example, where one informant provides an answer but expresses uncertainty about it while another provides a different answer but is quite certain about it, the PET member should give the second answer more weight than the first.
5. Look for documentation and physical evidence as well. Is there a newsletter article about the activity or is it on a calendar? Is there a flyer posted? If the COSP boasts of an arts program, ask to see the artwork produced.
6. If a COSP interviewee informs the evaluation team members that it offers formal peer support groups, be sure to observe at least one such group. Also, observe what else is going on at the during the support group meeting to determine if members have choices in participating in program activities.
7. If there is any question about COSP activities and practices that cannot be verified by the evidence that was collected, follow-up by telephone or email to get further clarification.

Score the C-FACIT

After the assessment has been completed and the evidence reviewed, use the C-FACIT Score Sheet to score the COSP for CIs. Both PET members should independently review the data collected, rate the scales, and tally the item scores. In a teleconference with a designated DMH representative, the evaluators then compare their ratings and resolve any disagreements using the conciliation process. The conciliated FACIT Score Sheet will be sent by certified delivery to DMH for data:

Initial Scoring

The procedures in this manual must be followed by PET members in making their initial ratings of the COSP and in conciliating these responses for a final score.

Evaluation team members are expected to *independently* rate the COSP on *each* item prior to discussing their ratings with other team members. The procedure for a PET member to complete the FACIT Score Sheet involves the following steps:

- 1) Assemble all relevant information including interview notes, field notes, documentation provided prior to the FACIT scoring.
- 2) Review all relevant material, highlighting information that can be used in particular ratings.
- 3) Go through each FACIT rating making a decision on the level assigned on the basis of the totality of the evidence available. For ratings which are difficult it is suggested that the team member again review evidence, and consider in some depth 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 represents the item.
- 4) Total ratings where the FACIT Score Sheet indicates.

The Conciliation Process

The process used to bring PET members and designated DMH representative together to create common rating is known as conciliation and will be done by teleconference after the site visit. Rather than relying on simple averaging of responses from team members, conciliation involves team members in a dialogue with the intention of reaching a joint decision on each particular rating. The procedure for the PET members to complete the conciliation involves the following steps:

- 1) Review independent ratings.

- 2) If there is a discrepancy, refer to the FACIT Score Sheet to help understand the issues intended to be rated under the specific item.
- 3) Share all information used by each team member that was used in arriving at their individual decisions.
- 4) Arrive at a joint decision about the appropriate rating for the COSP on the particular item.
- 5) Total common ratings where the FACIT Score Sheet indicates.

Special Scoring Problems

1) Information is inadequate or not available

- a) Team members should attempt to rate the COSP on *every* item of the FACIT. In some cases, however, they may feel that they do not have adequate information in order to rate a particular item. There may be several reasons for the lack of information, each of which might lead to its own specific remedy:
 - b) During the FACIT evaluation, the team neglected to collect certain information or ask certain questions. In this case, the team should attempt, as possible and appropriate, to contact a member of the COSP and gather additional information prior to the initial scoring of FACIT items.
 - c) An item on the FACIT Score Sheet is not applicable to the program. A team member may feel that a particular item is not applicable to the COSP. In this case, it would be appropriate to make a notation (N/A) in the area in which the rating is required, including a brief explanation of why the item is not applicable. *No score is recorded.*
 - d) The team did not collect any evidence related to an item on the FACIT Score Sheet because the CIs being rated are not demonstrated within the COSP. This is distinct from the previous situation. If the practices are not in evidence because the COSP has not focused on these CIs, but they are applicable to program, they would be given a score of 1 or 0. *If the item rating 1 indicates that the practice is not demonstrated within the COSP, then score a 1 for this item. However, if the item rating 1 does not include the absence of the particular practice, then score a 0.* It is incumbent that the FACIT team member rules out all other alternatives before assigning a score of 0.
- 2) Actual item rating appears to be in between two scores

- a) There may also be times when the true rating for a particular item will fall somewhere between two of the item ratings that are described in the FACIT. After a sufficient level of careful assessment as to whether the item falls more easily into one rating than the other, *if the team member is still in doubt, assign the lower of the two values.*
- b) The highest rating of each item should be reserved for a COSP that clearly meets or exceeds the criteria for that rating. *In no case should a partial score or fraction of a rating point be assigned.*

3) Substantial disagreement between raters

In some rare instances, PET members may have substantial disagreement about the rating of an item and no resolution is apparent. In this situation, team members are instructed to attempt to conciliate the rating to the point that each of them has expressed fully the rationale for the disagreement. At the point at which it is clear that there is not going to be a meeting of the minds on a rating, each member is asked to write out his/her justification for the rating, and both of these ratings (along with the justifications) are to be sent to Dr. Campbell to make a final decision. Obviously, it is most helpful for those who have participated in the actual evaluation to make final determinations about the ratings, rather than parties who have not participated, so PET members are urged to conciliate and to arrive at common agreements whenever possible.

Data Entry

In order for individual FACIT results to be compared overtime and reports prepared, DMH will be entering all FACIT scores into an Excel program which will be able to generate bar graphs for each region, including all domains and CIs.



Using the FACIT for COSP Quality Improvement

As a COSP develops a quality improvement system, COSP leaders, a quality improvement team at the COSP, and staff and program members will weave the FACIT into the fabric of their daily routines. Fidelity assessments give consumers a window into the work done every day at the COSP and help to tailor staff training using selected sections of the COS Evidence-based Practices KIT. Outcomes studies and consumer satisfaction survey may be added at the COSP level to enhance the quality improvement process. A webinar on Using the FACIT for COSP Quality Improvement has been developed and will be broadcast during this training to COSP providers to introduce the concept and process of continuous Quality Improvement. A manual is also forthcoming to be distributed to Missouri COSPs.

At some point, you may wonder how a COSP was able to operate without a Continuous Quality Improvement (CQI) process as staff, members, and the public come to view the FACIT as an essential component of well-implemented evidence-based practices.

Create reports from your assessments

In response to FACIT results, a quality improvement team at a COSP should write a report explaining the scores received by the COSP. A template for this report has been developed to help the Quality Team in performing this task. In general, the template includes:

- Strengths and weakness of the COSP program,
- An interpretation of the results of the assessment, and
- Suggested recommendations to help the COSP improve.

This report should be informative, factual, and constructive. The quality team should start with simple, easy-to-read reports based on the template provided. Then the quality team should let experience and staff and member feedback determine what additional information is needed. The quality team can design their report to give information about selected peer practices, program domains (structure, environment, belief system, peer support, education, advocacy), or outcomes. They may also want to report on the COSP as a whole using overall scores.

Compare assessment scores over time

After first time CIs fidelity is assessed with the FACIT, the quality improvement program at the COSP should establish a program baseline or starting point for efforts to become an evidence-based peer practice. Subsequent assessments can then be compared to both the National FACIT Benchmark and the COSP baseline to track improvements.

The National FACIT Benchmark represents the aggregated FACIT scores from the eight COSPs that were selected to participate in the COSP Multisite Research Initiative. Since these COSPs are geographically diverse, represent multiple program models, and met the federal criteria for a consumer-run program, their aggregated FACIT scores are a useful standard to gauge individual program performance.

Use tables and graphs to understand FACIT data

It is often useful in a report to provide a visual representation of a program’s progress over time. We recommend that the quality team use the graphs and tables designed for FACIT results available in the Excel spreadsheet provided with this Kit (See *FACIT Workbook Users’ Guide*). For an example, see *Figure 1.* for a representation of the results of the first COSP assessment of program structure and the individual peer practices within that domain.

When a COSP shows greater fidelity over time, the bar graph will display it as well. See *Figure 2.* for a representation of the results of three annual COSP assessments of program structure and the individual peer practices within that domain over time. *Figure 3* shows the COSP scores in all program domains for three years of annual assessments.

Another feature of graphing assessment scores is to visually compare your COSP to the National FACIT Benchmark. This can be seen in *Figure 1.*, *Figure 2.*, and *Figure 3.*

Figure1. Fidelity: Baseline Assessment

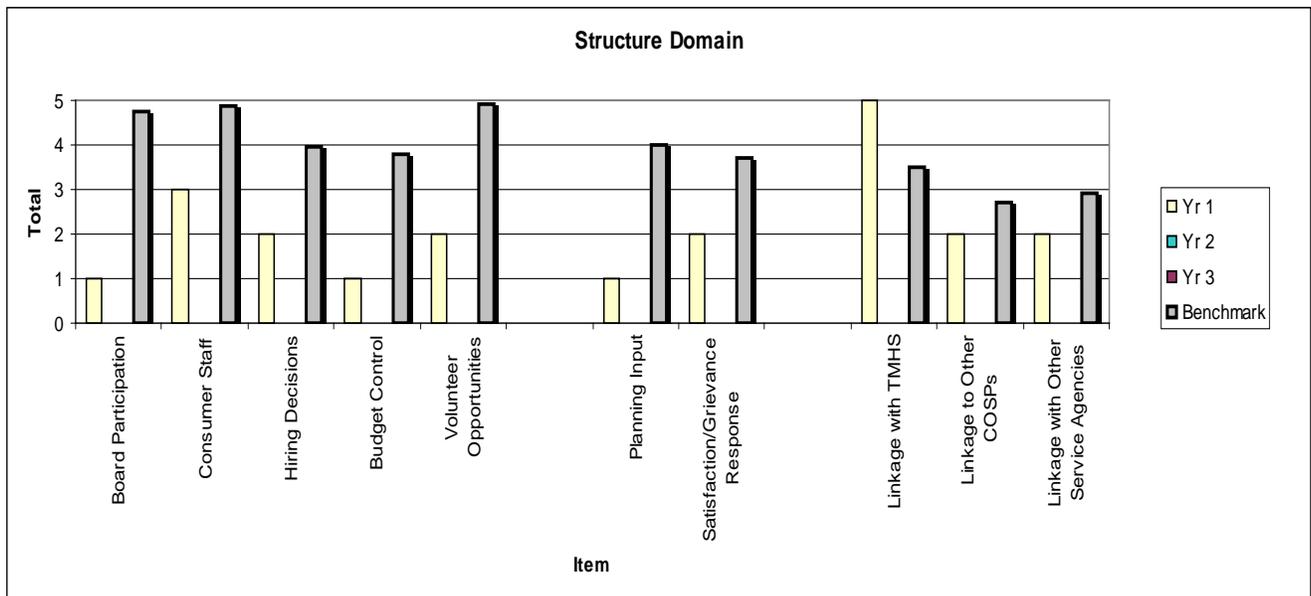


Figure 2. Fidelity: Over Time

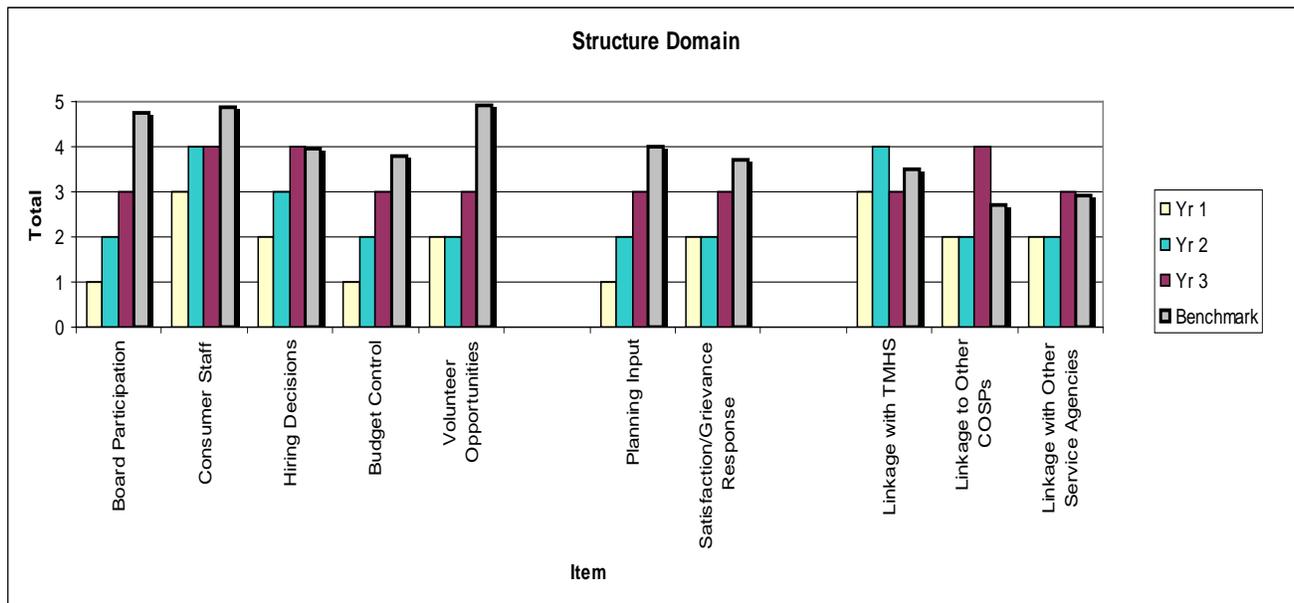
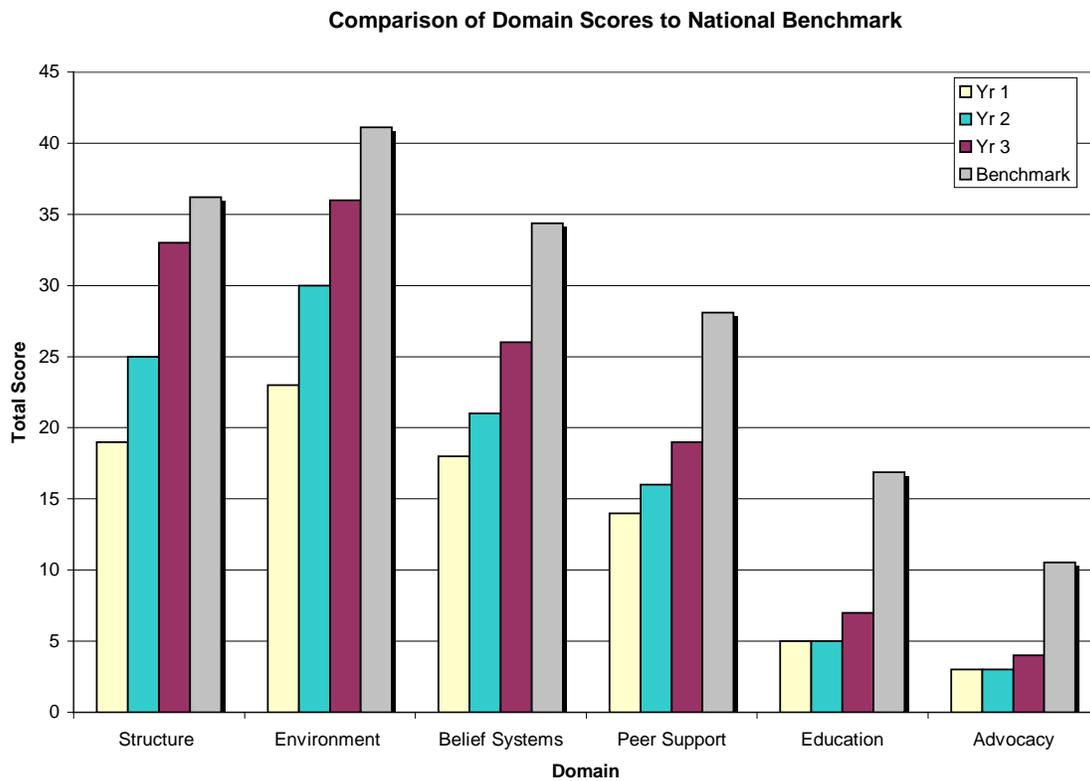


Figure 3. Fidelity of All Domains Over Time

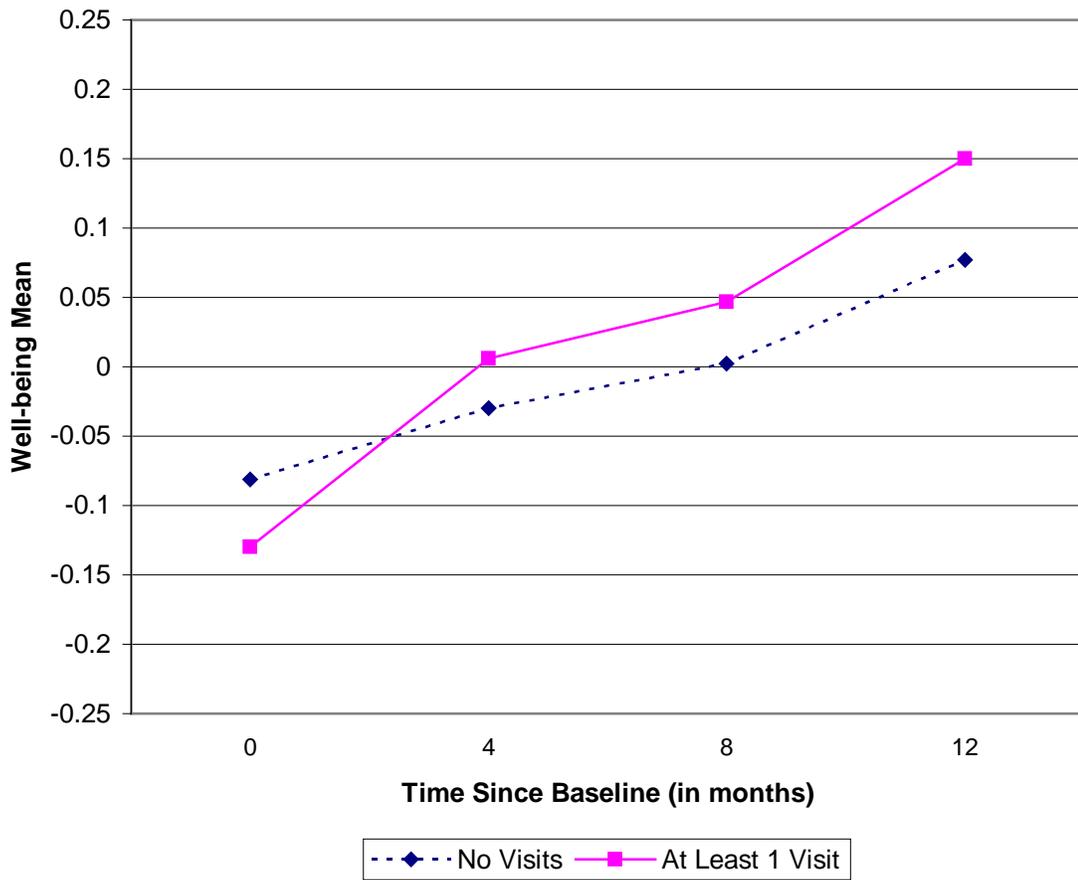


There are multiple ways to display outcome data. However, most outcome data are dependent on sophisticated analyses and will probably require support and consultation to “crunch the numbers” and produce the reports.

A longitudinal plot is one example of an efficient and informative way to display participation or outcome data for more than two successive periods. They are powerful feedback tools because they permit a long-range perspective on participation and outcome. You can use a longitudinal plot for a consumer, a specific EBP or an entire program. A single plot can also contain longitudinal data for multiple consumers or programs for comparison. They enable a meaningful evaluation of the success of a program, and they provide a basis for setting goals for future performance.

In *Figure 4* the level of well-being is compared among consumers who were invited to attend one of the eight COSPs that participated in the COSP Multisite study. One group visited at least one time and the other never visited the COSP for the 12 month period under study. The longitudinal plot shows that greater participation in a COSP (more than one visit) leads to greater well-being outcomes.

Figure 4. Well-Being Means for Engagement in a COSP



Sharing FACIT Results

The single factor that will most likely determine the success of a quality improvement program is the ability to give useful and timely feedback to COSP members and staff. Therefore, its worth is in converting data into information. For information to influence practice, it must be understandable and meaningful. In addition, the quality improvement program must tailor the information to suit the needs of staff and members and be available to answer their questions.

After each assessment, the COSP should dedicate time during a general members' meeting staff meeting to discuss the results. Overall, quality improvement data can motivate people and stimulate changes in behavior by building trust and creating hope and enthusiasm. Therefore, numbers reflective of above average or exceptional performance should trigger recognition, compliments, or other rewards. Data reflecting below average performance should provoke a search for underlying reasons and should generate strategies that offer the promise of improvement. The COSP should also report FACIT results to their advisory board or board of directors and seek their feedback.

Since the FACIT is correlated with the training materials found in the COS Evidence-based Practices KIT in the chapter *Training in COSPs*, the fidelity scores should help point the COSP to where improvements can be made and guide the COSP in developing a training program. Subsequent assessments would indicate if the training program is successful.

By sharing the COSP fidelity and outcome reports, the quality improvement team can help create a learning organization characterized by adaptive responses to information that aims to improve COSP operations and member outcomes.

Further, by sharing evaluation information about a COSP with vested members of the community, representatives from the mental health authority, and local consumer and family advocates it may gain greater support and respect within the continuum of community care.

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