HR-FaCT Scoring Sheet & Codebook

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HR-FaCT Scoring Sheet (FACT Sheet)

Use this page as the summary output for each intervention/program rated. Attach Section A-E evidence pages as needed.

Intervention / Program name	
Setting / site	
Population	
Rater type	□ Research rater □ Program/practice rater
Evidence sources used	List documents/interviews/observations and dates.
Date rated	
Rater initials	

Output 1 - Classification

Is it harm reduction?	**□ Yes □ No □ Mixed / harm reduction components only**
Domains (B1-B9)	List domains + intensity (0-3)
Notes on exclusions (A1)	List any YES flags and mitigation/context.

Output 2 - Fidelity

Score	**Value (0-4)**
CFS (Core fidelity)	
OFS (Operations)	
OAS (Outcomes)	
OFI (Overall Fidelity Index)	

Fidelity label	

Recommended reporting sentence (copy/paste)

"Using HR-FaCT v1.0, the intervention was classified as [harm reduction / not harm reduction / mixed] with domain targets [list domains + intensity]. Fidelity was [high/moderate/low/not aligned] **(CFS=[x.xx], OFS=[x.xx], OAS=[x.xx], OFI=[x.xx]**, based on [evidence sources].

HR-FaCT Codebook

Use this codebook to keep ratings consistent across raters and sites. When in doubt, score lower and document why.

General anchors (0-4)

0	1	2	3	4
Opposite / punitive / absent	Token / informal / rare	Partial / inconsistent	Mostly present with gaps	Embedded in policy + practice

C-section anchors (Core fidelity)

C1. Autonomy & self-determination

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	Goals are staff-defined; participant choices overridden; abstinence required as the only acceptable goal.	Some goal choice exists, but options are constrained (e.g., "treatment compliance" dominates). Goal-setting inconsistently documented.	Participant-led goals are explicit and routinely revisited; non-abstinence goals are acceptable; choices are respected without penalty.

C2. Voluntariness / low-barrier access

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	Multiple prerequisites/eligibility hurdles; missed appointments lead to loss of access; limited hours/locations.	Some low-barrier elements (walk-in or outreach) but inconsistent availability or hidden requirements.	Access is truly low-barrier: walk-in/same-day and/or outreach; minimal paperwork; flexible hours/locations; no unnecessary gatekeeping.

C3. Non-coercion & non-punitive response

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	Use triggers sanctions, discharge, or loss of services; no safety planning; coercive pressure tactics are evident.	Some supportive response exists, but punitive consequences still occur or policies are unclear/inconsistently applied.	Continued use prompts support and safety planning (not punishment); continuity of care is protected; no abandonment.

C4. Pragmatism & risk reduction orientation

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	Messaging centers moral/disciplinary compliance; outcomes are framed as "good vs bad behavior."	Risk reduction is present but secondary to behavior elimination; mixed messaging across staff/materials.	Primary orientation is harm mitigation (overdose, infection, injury, housing instability); pragmatic options offered and normalized.

C5. Dignity & non-stigmatizing practice

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	Shame-based language/policies (e.g., "dirty/clean" framing); participant experience is minimized or blamed.	Respectful interactions occur, but stigmatizing language/policies persist or are not addressed system-wide.	Policies, language, and interactions consistently communicate respect; stigma is actively avoided and corrected.

C6. Trauma-responsive & safety-enhancing

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	Practices increase re-traumatization risk (forced disclosure, public shaming, coercive monitoring). Safety is not prioritized.	Some trauma-informed practices exist (de-escalation, referrals) but choice/control is inconsistent.	Choice, control, and safety are systematically built into service delivery; staff use trauma-responsive strategies and avoid re-traumatization.

C7. Equity & structural awareness

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	No acknowledgement of structural drivers; policies reproduce inequities (e.g., inflexible requirements).	Some equity awareness (translations/partnerships) but limited adaptation or inconsistent implementation.	Structural drivers are explicitly recognized and addressed through design (access strategies, partnerships, tailored outreach, policy awareness).

C8. Participant voice / lived expertise embedded

Score	0-1 (low)	2-3 (mid)	4 (high)

Anchor	No lived expertise involvement; participant feedback is absent or ignored.	Consultation occurs (surveys, advisory input) but not clearly influential in decisions.	Lived/living expertise has meaningful roles (design, delivery, evaluation, governance) with real decision-making power.

D-section anchors (Operations)

D1. Access & engagement

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	Appointment-only; high paperwork; limited contact options; no outreach/mobile capacity.	Some flexible access (walk-ins, outreach) but inconsistent or limited coverage.	Multiple engagement pathways: walk-in/same-day, outreach/mobile, flexible contact, minimal paperwork.

D2. Service integration & warm handoffs

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	Referrals are passive (flyers/lists) with no follow-up or care coordination.	Some active linkage (calls, occasional accompaniment) but not routine.	Warm handoffs are standard: direct scheduling, accompaniment, shared care plans, closed-loop follow-up.

D3. Safety planning & overdose education

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	No overdose education or safety planning; naloxone not offered; content not tailored to local supply.	Education exists but not systematic (offered to some, not all) or lacks tailoring (e.g., fentanyl/xylazine).	Systematic overdose risk assessment + naloxone + individualized safer use planning; tailored education to local supply risk.

D4. Continuity of care

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	Services end abruptly; discharge without transition; loss of essentials (naloxone/supplies).	Some transition support, but gaps occur and responsibilities are unclear.	No abandonment: transitions include plans, maintained

			essentials, and re-engagement pathways.

D5. Workforce competence & supervision

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	No training expectations; supervision reinforces punitive approaches; high drift from harm reduction principles.	Training occurs but is sporadic; supervision addresses principles inconsistently.	Training and supervision are routine, documented, and reinforce harm reduction + MI/trauma-responsive practice.

D6. Cultural humility & community fit

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	One-size-fits-all; limited community partnership; services mismatch local context.	Some tailoring and partnerships, but limited depth/consistency.	Deep community fit: language/cultural tailoring, trusted partnerships, iterative adaptation based on community feedback.

E-section anchors (Outcomes)

E1. Primary outcomes match harm reduction aims

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	Only abstinence/compliance outcomes; harm endpoints not tracked.	Some harm outcomes included but secondary or inconsistently reported.	Primary outcomes reflect harm reduction aims (overdose, infection, safety, housing, QoL, engagement).

E2. Participant-centered outcomes included

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	No participant-defined outcomes; satisfaction/experience not measured.	Some participant measures (satisfaction) but limited depth or inconsistent use.	Participant-centered measures are standard (goal attainment, perceived safety, client-defined progress).

E3. Abstinence not treated as only success

Score	0-1 (low)	2-3 (mid)	4 (high)
Anchor	Abstinence framed as the only success; non-abstinence outcomes devalued.	Mixed framing: abstinence emphasized but alternative outcomes acknowledged.	Abstinence (if tracked) is one possible outcome among many; reporting avoids moralized endpoints.

NR guidance

Use NR when: the information is not reported, is too vague to score, or is contradictory without enough detail to resolve. Document the missing element as a reporting gap.