RECOVERY ENHANCING ENVIRONMENT (REE) MEASURE: MICHIGAN STATEWIDE SUMMARY

FINAL REPORT

Completed in partnership with the Michigan Department of Community Health, Michigan Recovery Council and Advocates for Human Potential

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Executive Summary

Background

In 2008, the Michigan Recovery Council embarked upon a significant systems transformation process to evaluate and improve processes to assure that recovery is the foundation of the service delivery system. The Council recommended that each Community Mental Health Services Program (CMHSP) measure its capacity to support recovery and develop plans for Quality Improvement. The Council and the Michigan Department of Community Health (MDCH) reviewed existing instruments and selected the Recovery Enhancing Environment (REE) measure, developed by consumer-researcher Priscilla Ridgway, Ph.D. MDCH expects that leaders, consumers, staff and stakeholders in the public mental health system will use the results of the REE to implement and improve recovery policy and practices.

Implementation

MDCH contracted with Advocates for Human Potential, Inc. (AHP) to design and assist with implementation of statewide data collection and analysis of the REE. MDCH required each CMHSP to develop an implementation plan to ensure that a representative, unbiased sample of sufficient size was surveyed. MDCH contracted with the Michigan Disability Rights Coalition (MDRC) to employ peer surveyors and data entry staff. The REE was administered to 6,146 adults with serious mental illness served by Michigan's 46 CMHSPs and their contract agencies from March 2009 through August 2010. The successful statewide implementation of the REE was a major accomplishment requiring the coordinated efforts of hundreds of staff, peer surveyors, contractors, and survey participants. Inadequate sample sizes and non-representative samples in most locations resulted in a positive response bias which needs to be kept in mind in interpreting findings.

Findings

Survey results were disseminated to each CMHSP separately, and statewide results are reported in the body of this report. Among the major findings: 58% of respondents were involved in the recovery process (rates varied widely across program types and among CMHSPs). While high ratings were seen for most recovery markers, markers with the lowest rates included "enough income," "good physical health," and "dealing with stress." Programs were rated most highly in "supporting personal identity" and lowest in "meeting basic needs."

Conclusions and Recommendations

Conclusions and recommendations incorporated comments gathered at meetings with the Recovery Council, CMHSP Directors and other stakeholders in September, 2010, at which major statewide findings of the REE were presented. Discussion focused on ways to ensure that CMHSPs used the findings in an inclusive Quality Improvement process that would strengthen recovery as the foundation in the delivery of services and supports for adults with serious mental illness.

1. Introduction

In December 2005, MDCH appointed the Michigan Recovery Council to oversee the department's policy development and implementation of recovery-oriented practices. Comprised of over 75% primary consumers, the Council meets bi-monthly to provide advice and guidance that will support and advance the transformation. Other community stakeholders contribute to the process and participate as Recovery Partners. In 2008, the Council recommended that each Community Mental Health Services Program (CMHSP) measure its current capacity to support recovery and develop plans for Quality Improvement. MDCH, in partnership with the Recovery Council, reviewed a number of existing instruments and selected the Recovery Enhancing Environment (REE) as the tool to be used in Michigan. The REE establishes benchmarks for system transformation and informs stakeholders about how recovery principles are reflected in practice. MDCH expects that leaders, consumers, staff and all stakeholders in the public mental health system will use the results of the REE to implement recovery principles and practices in their service areas.

Michigan REE Project Description

The goals of this project are:

- To educate providers and consumers about recovery and to encourage an orientation to recovery in individual and systems planning
- To assess the extent to which recovery-enhancing elements are incorporated into current practice
- To assess consumer needs to facilitate their movement toward recovery
- To provide summary data based upon REE survey results to local communities to support their plans for transforming the system toward a recovery orientation
- To provide summary data based upon REE survey results to the MDCH and the Michigan Recovery Council to support their plans for transforming the system toward a recovery orientation
- To provide a baseline assessment of the extent to which recovery-enhancing elements are incorporated into current practice, which can be compared to later assessments

What is the Recovery Enhancing Environment Measure (REE)?

The Recovery Enhancing Environment measure (REE) is a paper and pencil self-report survey that collects information about recovery from people who use mental health services. The instrument is made up of several subscales. The REE asks people where they are in the process of mental health recovery, and what markers of recovery they are currently experiencing. People rate the importance of several elements (such as hope, sense of meaning, and wellness) to their personal recovery, and rate the performance of their mental health program on activities associated with each of these elements. The REE asks people if they are members of certain demographic and cultural groups, such as racial minorities, and, if so, they are asked to rate their mental health program on how well it meets their needs in this area.

The survey results show how successful a program is in creating an atmosphere in which recovery can flourish – whether the program has an *environment* that *enhances recovery*. The REE also provides mental health programs and systems with answers to other important questions like:

- *Where are the people we serve on their personal journeys of recovery?*
- *What factors are important to address in a recovery-oriented mental health system?*
- *What recovery-promoting practices are already in place in our programs or system?*
- *Which services and supports are not yet fully developed?*
- *How well do we support people in developing their potential for resilience and recovery?*
- *What aspects of our program or system need to change to better support people's natural capacities for healing and growth?*

The results of the REE can be used to help organizations learn, change, and become more recovery-oriented in ways that make sense to all parties involved. It is meant to be part of an organizational development process that includes all stakeholders in a Continuous Quality Improvement process.

The REE was developed by Priscilla Ridgway, Ph.D., a consumer/researcher and Associate Professor with Yale University's Program for Recovery and Community Health. The REE has been tested and found to be a reliable and valid survey instrument. Reliability refers to the survey's consistency and dependability, and validity refers to the accuracy with which the survey measures the concepts it sets out to measure.

In addition to the original REE survey, Dr. Ridgway created a short form with fewer questions. Based on discussions with the Michigan Recovery Council, she created a new version for Michigan, referred to as the REE-MI, which is shorter than the original REE but includes more questions than the REE-short form. This is the version that was used in the present study.

The REE-MI: A Summary Description

- Demographics

Information is collected about the following elements: age; gender; employment and/or school attendance; race/ethnicity; length of time receiving any mental health service; and whether respondents receive more than one type of mental health service.

- Involvement in the Recovery Process

From a list of nine statements about mental health recovery, respondents are asked to select the one that most accurately represents their current level of involvement in the recovery process.

- Recovery Elements

Ten elements of a recovery-enhancing environment are listed. These elements were identified from first- person accounts, the literature on recovery, and in emerging recovery practices seen in progressive programs. Respondents are asked to rate staff and program performance on each of the elements.

- Special Needs

Respondents are asked to indicate whether they are a member of one or more of five listed sub-populations: an ethnic or racial minority group; persons with substance abuse problems; persons with trauma histories; lesbian, gay, bi-sexual or transgendered individuals; and parents. Respondents who identify with each group are asked to rate staff and program performance on issues related to their special needs as a member of the group.

- Recovery Markers

Beliefs, activities, and descriptions of emotional states that are frequently reported by people in recovery were used to generate 23 statements that indicate progress in recovery, called "recovery markers." Respondents are asked to rate their level of agreement with these statements.

Survey Methodology

MDCH contracted with Advocates for Human Potential (AHP) to design and assist with the implementation of a plan for statewide data collection and analysis of the REE-MI measure. MDCH used its fiscal year (FY) 2009 Program Policy Guidelines (PPG) and the Application for Renewal and Recommitment (ARR) process to require each CMHSP to develop a REE implementation plan, detailing which mental health programs would be surveyed, reporting the size of a representative sample to be surveyed at each program, based on average weekly numbers served, and determining what methods (scheduled groups, individual surveys, intercept interviews in waiting rooms, etc.) would be used to survey each program. [Instructions for developing REE sampling plans and implementation plans are shown in Appendix 1.] The goal of developing the plans was to assure that a representative and unbiased sample of people currently receiving services would be surveyed and that the sample would be of sufficient size to assure reliability of findings. These plans were reviewed by AHP and approved by MDCH. MDCH contracted with the Michigan Disability Rights Coalition to employ consumers as contracted peer surveyors and data entry staff.

Eight program types were included in the REE survey:

- Targeted Case Management/Supports Coordination (TCM/SC)
- Assertive Community Treatment (ACT)
- Psychosocial Rehabilitation (PSR)
- Supported Employment (SE)
- Consumer-run Drop-in Center (DI)
- Medication Clinic (MC)
- Licensed Housing (LH)
- Community Living Services for people living in non-licensed housing (CLS)

In accordance with each CMHSP's approved plan, the REE was administered as a paper and pencil survey to samples of consumers receiving services from eight types of programs funded by MDCH. The survey was carried out by trained peer surveyors funded by MDCH who were assigned to administer the survey in each CMHSP across the state, according to a schedule

approved by MDCH. In addition to training, the surveyors were given a manual of procedures [See Appendix 2]. The survey was translated in Spanish, Hmong and Arabic.

In addition, people who took the survey were offered an additional copy of the Recovery Markers section of the REE [see Appendix 3]. Peer surveyors shared with the person surveyed that the individual markers could be used as part of the person-centered planning process. Surveyors estimated that about 45% of participants took the extra copy of the Recovery Markers.

In summary, MDCH provided extensive guidance, technical assistance and support to CMHSPs in planning and implementing REE data collection, including:

- Detailed instructions and guidance in the PPGs and additional guidance documents for calculating sampling plans, selecting appropriate survey methods for each program type, doing outreach to populations to be sampled, promoting the REE, and developing REE narrative plans and schedules
- Technical assistance through AHP to ensure that REE plans were completed correctly and thoroughly
- Approval of REE plans well in advance of scheduled surveys
- Review of approved plans and additional technical assistance 2-3 weeks prior to scheduled surveys
- Providing REE peer surveyors trained by AHP
- Providing at least $2,000 per CMHSP for refreshments and transportation

2. REE Implementation

Survey Participation

The REE was administered to 6,146 adults with serious mental illness served by Michigan's 46 CMHSPs and their contract agencies, as detailed in Exhibit 2.1. Pilot sites were surveyed in March and April 2009. The general survey began in September 2009, and data collection was completed in August 2010. Between 29 and 1,295 consumers were surveyed per CMHSP, and the average number of respondents per CMHSP was 133.

Variation in sample size was at least in part attributable to variation in CMHSP size; however, CMHSPs also varied in the degree to which they were able to implement the sampling strategy outlined in their REE implementation plans. For each CMHSP, a *percentage of projected samples surveyed* was calculated by dividing the actual number of consumers surveyed by the number given in the sampling plan. These percentages ranged from 23% to 96%. On average, CMHSPs surveyed only 56% of the number of consumers that they had intended to survey. Issues raised by problems with plan implementation and data collection are discussed later in this section.

Exhibit 2.1 below shows statewide response rates by program type. Psychosocial rehabilitation programs had the highest percentage completion of the projected sample—90%. Residential

programs (Licensed Housing) had the lowest completion rate at 33%. These differences likely reflect the relative difficulty of successfully recruiting, providing transportation to, and surveying clients of the different program types. Additionally, it is important to note that most of the programs with higher response rates were those with fixed program sites where consumers did not have to make a special trip to take the survey. This may have facilitated higher participation rates in those programs.

Exhibit 2.1 Planned and Actual Participation

Service	Projected Sample Size	Actual # Surveyed	% Projected Sample Surveyed
Targeted Case Management & Supports Coordination	2,785	1,495	54%
ACT	1,574	732	47%
Psychosocial Rehabilitation	1,057	947	90%
Supported Employment	695	293	42%
Consumer-run Drop-ins	1,029	785	76%
Medication Clinics	2,226	1,410	63%
Licensed Housing	763	250	33%
Community Living Supports	688	234	34%
TOTAL	**10,817**	**6,146**	**57%**

Successes of the REE Implementation Process

It is important to recognize that the successful statewide implementation of the REE with over 6,000 individuals served by 46 CMHSPs was a major accomplishment in itself. It involved complex logistics and required the coordinated efforts of hundreds of staff, consumer surveyors, contractors, and survey participants. Consumer surveyors reported that they felt empowered by their ability to take a leadership role in this process.

Members of the Recovery Council emphasized that this was the first time that large numbers of consumers in Michigan had the opportunity to make their voices heard about their recovery process and the extent to which services are promoting recovery, and that this is an achievement worth celebrating. They also noted that the REE implementation was an excellent opportunity to increase the visibility of people in recovery. In addition, the REE survey effort resulted in a significant amount of new information for use by CMHSPs and their stakeholders in developing and implementing plans to enhance the recovery orientation of the services they provide.

Problems Encountered during Data Collection and Implications for Interpreting Results

Problems were encountered in developing and implementing the REE data collection plans and the implications for interpreting the results. The following discussion is based upon the surveys received from each CMHSP, as well as interviews with REE lead surveyors, CMHSP directors, and REE coordinators in CMHSPs, correspondence with REE coordinators during the plan

development process, and reports from the field during the survey process by REE surveyors and REE coordinators. The problems discussed below were not universal; many CMHSPs were able to implement their REE Plans successfully with minimal problems. However, there were some problems associated with data collection in the majority of CMHSPs.

Interest In and Commitment to Carrying Out the Project

In many CMHSPs, there seemed to be a lack of understanding of the stated purpose of implementing the REE, particularly at the individual program site level. A number of organizations expressed that they already had their own Quality Assurance programs and did not see or understand the need to spend staff resources implementing the REE. The fact that the REE was an instrument to measure recovery and that this is not a part of existing Quality Assurance programs did not seem like a sufficient reason to many CMHSPs to invest time and staff resources in implementing the REE. A number of CMHSPs expressed concern that the REE was costly, and the amount of time that was expected of them in order to properly generate a representative sample and to publicize the survey to staff and consumers was challenging. A small number of REE Coordinators stated that their CMHSPs found the survey process unduly burdensome and did not understand the value of the survey.

Resources and Knowledge

It appears that many CMHSPs did not coordinate sufficient staff resources or have the specific knowledge necessary to develop the required REE implementation plan according to the specifications set out in the PPGs and the additional guidance provided by MDCH. The majority of REE plans submitted had shortcomings that required one or more rounds of technical assistance from AHP and revisions before they could be approved by MDCH. Further, many CMHSPs did not implement their approved REE plans as written. In particular, detailed procedures necessary to ensure that an unbiased, representative sample was recruited at each site were frequently not followed. Some CMHSPs reported that they found these procedures burdensome.

While many CMHSPs successfully promoted the REE, many others did not appear to put sufficient time and resources into ensuring that staff and consumers at all sites understood the purpose of the survey and what was expected of them in the process. This sometimes resulted in staff doing things that interfered with conducting the survey in an unbiased manner. Many sites did not appear to have adequately explained the value of the survey or publicized it to consumers, which likely impacted the turnout for the survey in some sites.

Logistical Issues

The logistics of implementing the survey were interpreted by some as complicated. Tasks included:

- Ensuring representative samples
- Ensuring adequate sample sizes
- Developing and implementing survey schedules across many sites
- Educating management, staff and consumers at each site about the purpose of the REE and the processes involved in carrying out the survey

Many CMHSPs encountered difficulties with these tasks. Some CMHSPs reported feeling that they did not have adequate lead time to do these tasks, and others felt that it took too long to finalize survey dates. MDCH initially needed to replace the contractor responsible for hiring and supervising the REE surveyors and for data entry in the midst of the process, which caused confusion for some CMHSPs. Some CMHSPs reported that weather negatively affected turnout for the survey. Others noted that transportation issues resulted in low turnout.

Generally, REE surveyors reported that REE Coordinators at the CMHSP level were well-prepared for the survey and were easy to work with, although they noted that this was not always true at individual program sites. REE surveyors reported that in many of the sites they visited the rooms available for administering the REE were either not large enough or did not offer privacy. Surveyors also reported that in about 20% of sites, staff did not appear to know that a survey was being held there on the scheduled date. Surveyors also reported that arrangements for translators were often not made in advance.

Specific Challenges Regarding Issues Described Above

These over-arching issues resulted in a number of specific problems with the survey process, including:

- Inadequate sample size in the vast majority of locations. As described in the section on Survey Participation below, on average, only 57% of each CMHSP's projected sample was actually surveyed. Across all CMHSPs, the survey rate ranged from 23% to 96%. Recovery Council members and CMHSP representatives offered some additional possible explanations for small sample sizes, including:
    - People felt empowered to say "no"
    - Too many other surveys were scheduled too close to the REE in some CMHSPs
    - People who were working were not available during scheduled survey times
    - Lack of privacy to take the survey in some locations
    - Concerns about possible retaliation, especially in housing programs
- Non-representative samples. In most locations, it is likely that the consumers surveyed were not representative samples of the population served. This was due to widespread failure to follow the detailed sampling requirements explained in the PPGs and to the fact that there were high rates of refusal to participate in many areas. In many CMHSPs, the sample letters developed by MDCH for CMHSPs to send to program enrollees in order to ensure random representative samples were either modified in ways that did not provide accurate information, or were never sent. In some locations, many of the letters were returned due to outdated addresses, indicating that the programs did not have current information on people using their services.
- In a small number of CMHSPs, there were significant issues that affected the quality of the data collected, including[1]:

[1] This information was reported by peer surveyors who were responsible for collection of the data in each community.

- People with developmental disabilities being surveyed
- Staff being paid an incentive for each consumer they brought in to take the survey
- Staff going into the community looking for consumers who they convinced to come with them to take the survey
- Staff telling consumers they were "too sick" to take the survey
- Staff trying to sit with consumers during the survey and tell them what answers to give
- Staff wanting to allow guardians to take the survey in place of a specific consumer, or to remain in the room while the survey was given
- Staff refusing to allow surveyors to approach consumers in the waiting room
- Consumers being pressured to take the survey to ensure that the minimum per program numbers were surveyed

Implications for Interpreting and Using the Data

Social scientists have long recognized that self-report instruments in areas like satisfaction with services or reports of one's own characteristics tend to have a significant positive response bias.[2],[3] That is, when people are asked to rate their experience with health services or to report on their own state of emotional well-being, their answers tend to be more positive than their actual experience. This is due to a number of factors, including whether the respondent believes a certain answer is considered more desirable than another, and a general inclination to respond in a way that would win social approval. Those being the case, any additional conditions that tend to increase the existing positive response bias are cause for concern in interpreting the findings of a survey such as the REE.

Some of the conditions that tend to increase positive response bias include small sample sizes, non-random samples, and large numbers of refusers. All of these issues were factors in implementing the REE in Michigan. As described earlier and shown in more detail in the section on Survey Participation below, data were collected from just over 50% of the projected sample in most CMHSPs. Further, as described above, in many CMHSPs, the criteria for selecting random, representative samples were not met. Among the issues noted were failure to follow the sampling plan and procedures designed to bring in as many individuals as possible, regardless of whether they were correctly part of the sample. There were large numbers of people who were invited and declined to participate in the REE. Finally, some items on the REE had significant numbers of non-responders. That is, many people who took the survey did not respond to certain questions; for one key item, data were missing from almost 20% of

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[2] Walter R. Gove, WR & and Geerken, MR. Response bias in surveys of mental health: An empirical investigation. A*merican Journal of Sociology*, 82: 6, 1289-1317 (May 1977).

[3] Mazor, KM, Clauser, BE, Field, T., et al. A demonstration of the impact of response bias on the results of patient satisfaction surveys. Health services Research 37:5, 1403-1717 (October 2002).

respondents. In addition, Recovery Council members expressed concern that some consumers, especially those who have been receiving services for decades, have low expectations of programs and the possibility for recovery, which may have resulted in them over-stating their level of satisfaction.

Given all these factors, it is likely that the results of the survey are significantly more positive than they would have been with a data collection process that was more consistent with the original sampling plans.

3. Major Findings

Involvement in the Recovery Process

From a list of nine statements about recovery, respondents were asked to select the statement that most accurately represents their level of involvement in the process of recovery from a mental health problem. Exhibit 3.1 shows the reported level of recovery involvement for all respondents across all CMHSPs and program types.

The response options were grouped into two categories: those representing what was considered to be current involvement in the recovery process, and those representing lack of current involvement in the recovery process. Overall, slightly less than three-fifths of the respondents chose a response option reflecting current involvement in recovery. Respondents who checked *other* were grouped with those who skipped the question for the purposes of this analysis. A high proportion of respondents (19%) skipped this item, and an additional 3% chose *other*. Another look at these data may be found in Appendix 1, which shows the distribution of responses to this item by CMHSP, allowing CMHSPs to compare their results to the results of CMHSPs statewide.

Exhibit 3.1 Involvement in the Recovery Process: All Program Types

Response		% of all participants *N=6,146*
Involved in Recovery	I am actively involved in the process of recovery	39%
	I am committed to recovery & making plans to take action very soon	12%
	I feel that I am fully recovered, I just have to maintain my gains	6%

Not Involved in Recovery	I have never heard of or thought about recovery	7%
	I have been thinking about it but have not decided to move on it yet	5%
	I was actively moving toward recovery but now I am not	3%
	I have not had the time to really consider mental health recovery	3%
	I do not believe I have any need to recover	3%
Missing & Other	No response/missing	19%
	Other	3%
	TOTAL	100%

Exhibit 3.2 shows the reported level of recovery involvement for each program type across all CMHSPs. Of the response options categorized as indicating current involvement, *I am actively involved in the process of recovery* was most frequently cited by respondents. The proportion of respondents choosing this option ranged from 25% in Licensed Housing to 47% in Medication Clinics. Note that the proportion of participants skipping this item ranges from 15% in Medication Clinics to 24% in Licensed Housing and Community Living Supports. As shown at the bottom of Exhibit 3.2, the proportion of respondents involved in recovery overall ranges from 46% in Licensed Housing to 64% in the Medication Clinics.

Exhibit 3.2 Involvement in the Recovery Process by Program Type

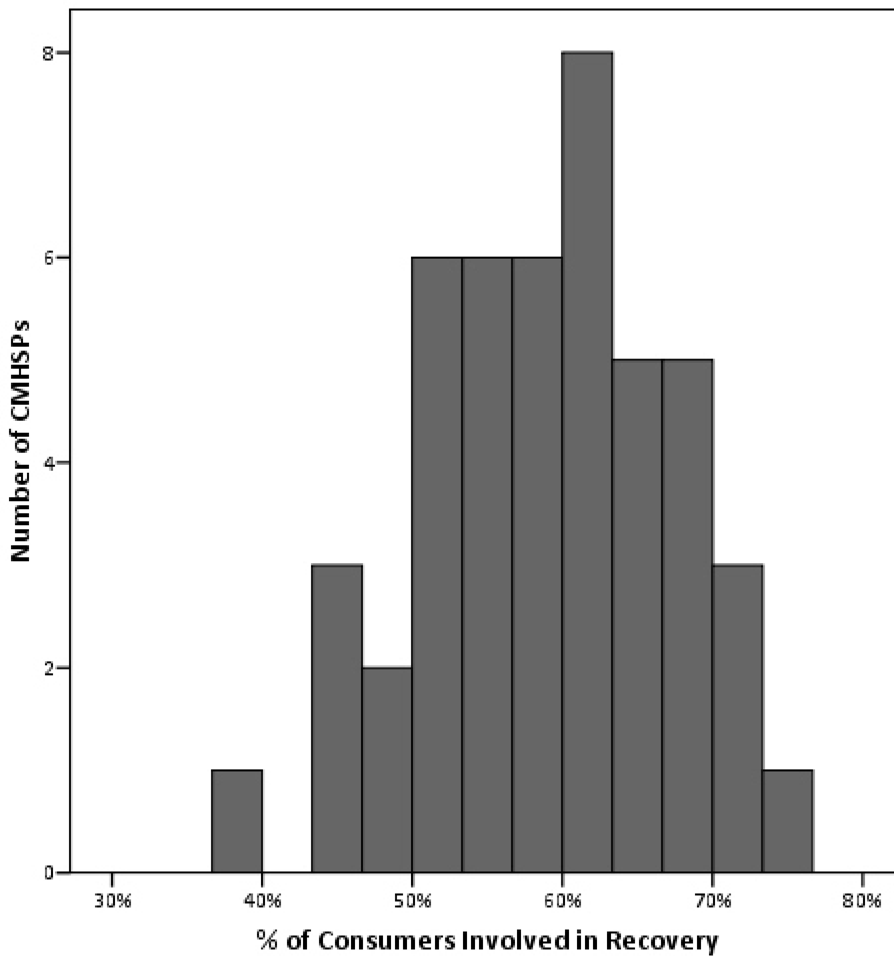
	Response	TCM & SC *N=1,495*	ACT *N=732*	PSR *N=947*	SE *N=293*	DI *N=785*	MC *N=1,410*	LH *N=250*	CLS *N=234*
Involved in Recovery	I am actively involved in the process of recovery	41%	43%	33%	38%	31%	47%	25%	37%
	I am committed to recovery & making plans to take action very soon	12%	12%	13%	16%	14%	13%	10%	10%
	I feel that I am fully recovered, I just have to maintain my gains	5%	7%	9%	6%	7%	5%	11%	4%
Not Involved in Recovery	I have never heard of or thought about recovery	7%	6%	7%	4%	8%	6%	8%	8%
	I have been thinking about it but have not decided to move on it yet	5%	5%	6%	6%	5%	5%	7%	7%
	I was actively moving toward recovery but now I am not	3%	3%	3%	5%	3%	3%	2%	4%
	I do not believe I have any need to recover	2%	2%	3%	4%	4%	2%	4%	2%
	I have not had the time to really consider mental health recovery	3%	2%	3%	2%	2%	3%	5%	3%
Missing & Other	No response/missing	19%	18%	22%	16%	22%	15%	24%	24%
	Other	2%	3%	3%	3%	4%	3%	5%	1%
	TOTAL	100%	100%	100%	100%	100%	100%	100%	100%

Total Proportion Involved in Recovery	59%	62%	54%	60%	52%	64%	46%	51%

TCM & SC=Targeted Case Management/Supports Coordination • ACT=Assertive Community Treatment • PSR=Psychosocial Rehabilitation
SE=Supported Employment • DI=Consumer-run Drop-ins • MC=Medication Clinic • LH=Licensed Housing • CLS=Community Living Supports

The proportion of consumers involved in recovery was calculated for each CMHSP. These proportions varied considerably, ranging from 39% to 74%. The distribution of these proportions is illustrated in Exhibit 3.3. With the exception of the outlying CMHSP with 39% of consumers reporting involvement in recovery, the results are distributed relatively normally around the mean of 59%.

Exhibit 3.3 Involvement in Recovery by CMHSP



Recovery Markers

While recovery is an individualized experience, research has found that some common elements are frequently reported by people about their recovery, such as self-agency, positive self-concept, a future orientation, and connection to others. This information was used to generate 23 statements called "recovery markers."

Respondents were asked to indicate their level of agreement with each statement on a four-point scale (Strongly Agree, Agree, Disagree, Strongly Disagree). Agreement with a higher percentage of recovery marker statements indicates that a person is currently experiencing a

higher level of recovery. Those who indicated that they strongly agreed or agreed with the statement were considered to have endorsed the marker.

Exhibit 3.4 shows the percentage of respondents across all CMHSPs and program types who endorsed each individual recovery marker, ranked from the most frequently endorsed item to the least frequently endorsed item. At least 5,398 consumers responded to each of these items. The distribution of these data by CMHSP is also shown in Appendix 1 to allow CMHSPs to compare their results to the results of CMHSPs statewide.

Exhibit 3.4 Percent of Respondents Endorsing Recovery Markers: All Program Types

Recovery Marker	% Endorsing
Have goals	91%
Can make changes	91%
People I trust	90%
Growing	90%
Learning new things	88%
Reasons to get up	88%
Safe home	87%
Control own decisions	86%
Like/respect self	85%
Spiritual life	85%
Close relationship	84%
Decent quality of life	84%
Using skills	84%
Alert & alive	83%
Hopeful	83%
Sense of belonging	83%
Meaningful activities	82%
Symptoms controlled	80%
More good days than bad	78%
Contribute to community	72%
Deal with stress	69%
Good physical health	68%
Enough income	56%

Exhibit 3.5 shows the most challenging recovery markers (those endorsed by less than 80% of respondents overall) and examines the average percentage of recovery markers endorsed by respondents across program types. There was some variation in these proportions across program types. Respondents from Medication Clinics were least likely to endorse these recovery markers, while respondents from Psychosocial Rehabilitation programs, Consumer-run Drop-ins, and Licensed Housing were most likely to endorse them.

Exhibit 3.5 Percent of Respondents Endorsing Challenging Recovery Markers by Program Type

Recovery Marker	TCM & SC N≥ 1,323	ACT N≥ 635	PSR N≥ 827	SE N≥ 267	DI N≥ 685	MC N≥1,213	LH N≥ 202	CLS N≥ 204
More good days than bad	75%	82%	85%	82%	82%	70%	84%	84%
Contribute to community	68%	71%	80%	75%	82%	66%	77%	72%
Good physical health	65%	69%	75%	73%	73%	60%	73%	67%
Deal with stress	67%	75%	77%	75%	75%	57%	77%	70%
Enough income	55%	62%	68%	50%	57%	44%	64%	63%

Participant Ns in the column headings represent the smallest N within the column. There was little variation in Ns among cells within given columns.

The Chi-square statistic was used to test the relationship between employment status and endorsing the recovery maker of having enough income. Probability of less than or equal to .05 was used at the indicator of significance for this and all subsequent statistical tests in this report. Significant results—including those significant at more stringent probability levels—are uniformly reported as $p \leq .05$. The relationship between employment status and income marker endorsement was significant at .05, and logistic regression analysis revealed that both respondents who were working full-time and those who were working part-time were significantly more likely to endorse the income maker than were those who were unemployed, and those who were working full-time were significantly more likely to endorse the income marker than were those who were working part-time.

Exhibit 3.6 Percent of Respondents Reporting Sufficient Income by Employment Status

Recovery Marker	Not Working N=4,475	Working Part-time N=805	Working Full-time N=228	Overall N=5,508
Enough income	54%	61%	70%	56%

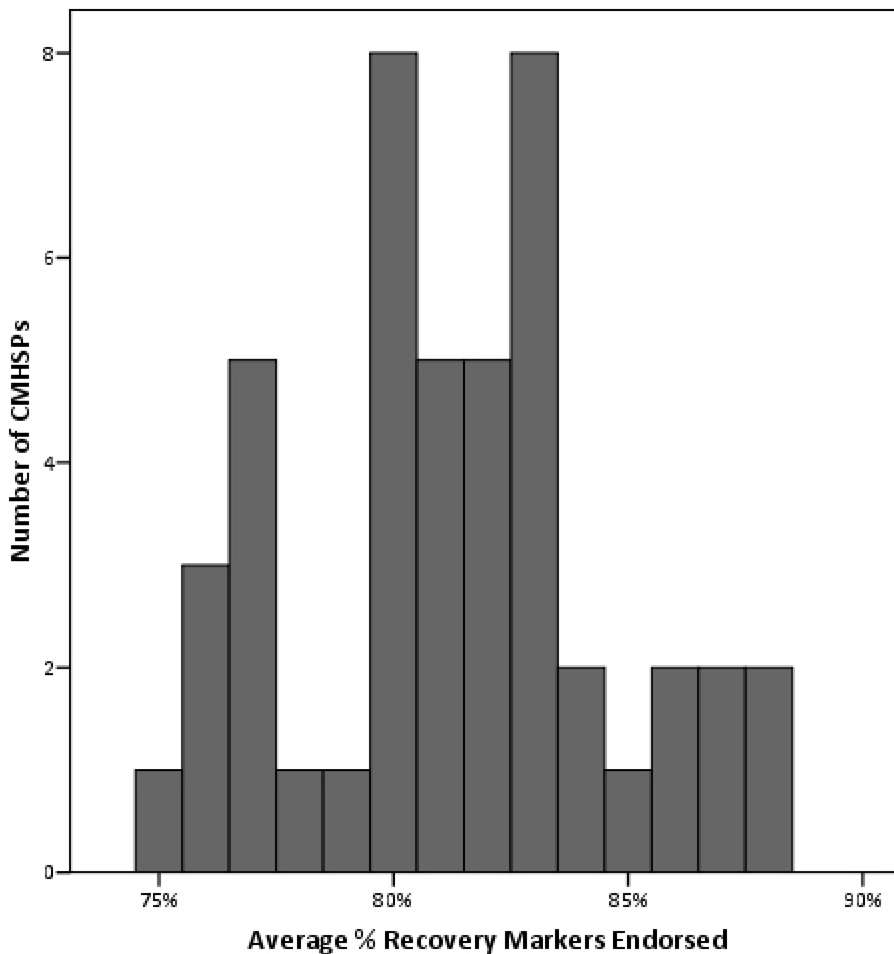
The proportion of recovery markers endorsed was calculated for each participant. Overall and program type-specific averages of these percentages are shown in Exhibit 3.7. Visual inspection suggested that these percentages were not normally distributed, but instead were clustered in the high end of the range (i.e., closer to 100% endorsement). The range of program type means could be described as moderate, ranging from 77% in the Medication Clinics to 87% in Psychosocial Rehabilitation programs. Given the pattern of responses for involvement in recovery, the pattern shown in Exhibit 3.7—with a low mean for the Medication Clinics and a relatively high mean for Licensed Housing—is somewhat surprising. The cross-program distribution of this percentage is also shown in Appendix 1, to allow CMHSPs to compare their results to the results of CMHSPs statewide.

Exhibit 3.7 Average Percent of Recovery Markers Endorsed By Program Type

Program Type	Mean
TCM & SC (N=1,373)	80%
ACT (N=662)	83%
PSR (N=860)	87%
SE (N=275)	84%
DI (N=706)	85%
MC (N=1,276)	77%
LH (N=208)	85%
CLS (N=211)	83%
Overall (N=5,571)	82%

The mean proportion of recovery markers endorsed was calculated for each CMHSP. These means offer a measure of overall rate of marker endorsement within each CMHSP. For example, a mean of 80% indicates that, on average, consumers receiving services from that CMHSP endorsed 80%, or four-fifths, of the 24 recovery markers. These means ranged modestly, from 75% to 88%, with an average of roughly 81%. As shown in Exhibit 3.8, the averages were not distributed normally. The pattern of recovery marker endorsement by CMHSP could also not have been predicted based on the pattern of involvement in recovery by CMHSP. In fact, an attempt to correlate these two proportions revealed no significant relationship.

Exhibit 3.8 Average Percentage of Recovery Markers Endorsed by CMHSP[4]



Predicting Involvement in Recovery

Relationships were tested between involvement in recovery and seven other study variables: program type, proportion of recovery markers endorsed, and the respondent characteristics of age, gender, race, ethnicity, and years receiving services. All of these relationships were statistically significant, except for the relationship between ethnicity and involvement in recovery. Then, a logistic regression model was created to determine whether these individual relationships remained significant when considered simultaneously, and in fact all of them did. Note that participants who did not respond to the involvement in recovery item were dropped from this analysis. As a result, the exhibits in this section show higher proportions of consumers involved in recovery than those shown in the previous section.

[4] Each bar represents the number of CMHSPs with the given mean recovery endorsement rate. For example, one CMHSP had a mean recovery endorsement of 75%, indicating that consumers receiving services from that CMHSP endorsed only about three-quarters of the 24 recovery markers, on average. Three CMHSPs had a mean endorsement of 76%, five had a mean endorsement of 77%, and so on.

Consumers in TCM/SC, ACT, and MCs were all significantly more likely to be involved in recovery than were consumers in the reference group, CLS. The proportion of consumers involved in recovery by program type is shown earlier, in Exhibit 3.2.

As would be expected, consumers endorsing a higher proportion of recovery markers were more likely to be involved in recovery. Among respondents reporting involvement in the recovery process, the mean proportion of recovery markers endorsed was 83%, as opposed to 77% among those not involved in recovery.

Exhibit 3.9 Proportion Recovery Measures Endorsed by Recovery Involvement

	Respondents Involved in Recovery (N=3,360)	Respondents Not Involved in Recovery (N=1,135)
Mean proportion recovery markers endorsed	83%	77%

Respondents 66 years old and older were significantly less likely to report involvement in recovery than those from any other age group. As described in the participant demographics section, respondents were asked to indicate their age using a set of seven age range categories. For this analysis, the highest two age categories (*66-75* and *76 and up*) were combined to create a single larger group.

Exhibit 3.10 Recovery Involvement by Age Group

	18-25 N=371	26-35 N=684	36-45 N=1,069	46-55 N=1,644	56-65 N=795	66 + N=190	Overall N=4,753
Proportion involved in recovery	73%	77%	75%	74%	73%	65%	74%

The relationship between race and engagement in recovery can be attributed to the decreased likelihood of American Indian/Alaskan Native and African American respondents reporting involvement in recovery compared to white respondents. The REE question on race and ethnicity is described in more detail in the demographics section. For this analysis, respondents who had checked more than one race were added to the *other* category, and three categories with very few responses (Asian, Arab Chaldean, and Hawaiian/Pacific Islander) were collapsed into the other category. The full response set is shown in Exhibit 3.23 in the demographics section.

Exhibit 3.11 Recovery Involvement by Race

	AI/AN N=114	African American N=1,034	White N=3,227	Other N=280	Overall N=4,655
Proportion involved in recovery	62%	71%	75%	72%	74%

A somewhat higher proportion of women than men reported involvement in the recovery process. While this difference was not large, it was statistically significant.

Exhibit 3.12 Recovery Involvement by Gender

	Men (N=2,485)	Women (N=2,282)
Proportion involved in recovery	71%	77%

The relationship between length of time receiving services and involvement in recovery is a result of the lower likelihood of consumers who have been receiving services for less than one year reporting involvement in recovery, when compared to all other consumers.

Exhibit 3.13 Recovery Involvement by Length of Time Receiving Services

	<1 yr N=441	≥1 yr, <5 yrs N=1,094	5-10 yrs N=1,075	> 10 yrs N=2,090	Overall N=4,699
Proportion involved in recovery	65%	75%	76%	75%	74%

Recovery Elements

The ten elements of a recovery-enhancing environment that were identified from first person accounts, the literature base on recovery and the emerging recovery practice seen in progressive programs are listed in this section. Respondents were asked to rate staff and agency performance on each of the elements by indicating their level of agreement with three statements related to each element, using a four-point scale (Strongly Agree, Agree, Disagree, and Strongly Disagree). The average of the three sub-questions was calculated to determine the ratings of each of the ten elements.

Exhibit 3.14 shows the ratings of staff and program performance on each of the ten elements across all program types and CMHSPs. Each of these elements represents the responses of at least 5,537 survey participants. The distribution of these data by CMHSP is also shown in Appendix 1, to allow CMHSPs to compare their results to the results of CMHSPs statewide.

Exhibit 3.14 Percent Agree Program Supports Recovery Elements – All Programs

Recovery Element	Overall
Personal identity	92%
Respecting/upholding rights	91%
Hopefulness	90%
Sense of meaning	90%
Empowerment	89%
Self-monitoring	88%
Taking on new challenges	88%
Wellness programming	88%
Building positive relationships	86%
Meeting basic needs	82%

Special Needs/Status

The Special Needs section asks respondents if they have a particular status or are a member of a specific group. Respondents who identify with one of these statuses/groups were asked to rate staff and agency performance on factors related to their special need or status. The groups are:

- Member of ethnic/racial minority group
- Have a substance abuse problem
- Have a history of trauma
- Gay, lesbian, bi-sexual or transgendered
- Is a parent

The next five exhibits show the percentage of respondents identified with a special needs group or status who believes that staff support factors related to their special need or status, by program type. Overall agreement rates ranged from 77% for sexual orientation to 88% for ethnic/racial identity. For a few of the categories, variation across program types could be argued to be expected. For example, agreement rates for trauma recovery and parental role were lowest for Supported Employment programs, but this may reflect the fact that these are not the primary focus of Supported Employment programs. The cross-program distributions of these percentages are also shown in Appendix 1 to allow CMHSPs to compare their results to the results of CMHSPs statewide.

Exhibit 3.15 Percent Agree Program Supports Ethnic/Racial Identity

Program Type	Total %	(N)
TCM & SC	90%	(274)
ACT	84%	(153)
PSR	89%	(210)
SE	88%	(64)
DI	86%	(166)
MC	91%	(222)
LH	89%	(53)
CLS	86%	(43)
Overall	88%	(1,185)

Exhibit 3.16 Percent Agree Program Supports Substance Abuse Recovery

Program Type	Total % (N)
TCM & SC	87% (356)
ACT	90% (235)
PSR	85% (178)
SE	88% (67)
DI	86% (168)
MC	91% (362)
LH	80% (54)
CLS	85% (53)
Overall	88% (1,473)

Exhibit 3.17 Percent Agree Program Supports Trauma Recovery

Program Type	Total % (N)
TCM & SC	86% (521)
ACT	79% (325)
PSR	77% (332)
SE	71% (115)
DI	77% (312)
MC	85% (660)
LH	74% (81)
CLS	78% (101)
Overall	81% (2,552)

Exhibit 3.18 Percent Agree Program Supports Sexual Orientation

Program Type	Total % (N)
TCM & SC	77% (150)
ACT	72% (79)
PSR	71% (95)
SE	74% (35)
DI	84% (86)
MC	83% (136)
LH	77% (26)
CLS	65% (23)
Overall	77% (630)

Exhibit 3.19 Percent Agree Program Supports Parental Role

Program Type	Total % (N)
TCM & SC	83% (620)
ACT	77% (320)
PSR	78% (286)
SE	63% (119)
DI	76% (298)
MC	84% (667)
LH	75% (77)
CLS	79% (72)
Overall	80% (2,459)

Demographics

Information on the following demographic elements was collected:

- Age;
- Gender;
- Employment and/or school attendance;
- Race/ethnicity;
- Length of time receiving any mental health services; and
- Whether respondents receive more than one type of mental health service.

The next six exhibits show data on the demographic elements by program type across CMHSPs.

Respondents were asked to indicate their age using seven age categories. For the purposes of describing the resulting data distribution, the midpoints of the age categories were used to assign specific ages to all respondents. For example, respondents who indicated that they were from 46 to 55 years of age were assigned an age of 50. Using these assigned ages, average ages were calculated. As shown in Exhibit 3.20, the average age across CMHSPs overall was just over 46, with relatively little variation by program type.

Exhibit 3.20 Age of Population Served by Program

Program Type	Mean
TCM & SC (N= 1,455)	47.04
ACT (N= 708)	45.55
PSR (N= 924)	47.09
SE (N= 290)	43.72
DI (N= 764)	47.01
MC (N= 1,393)	44.48
LH (N= 242)	47.88
CLS (N= 227)	48.62
Overall (N= 6,003)	46.21

The overall group of respondents was nearly evenly split by gender (48% were female), with program gender distributions ranging from 41% female (Supported Employment) to 53% female (Medication Clinic).

Exhibit 3.21 Gender of Population Served by Program

Program Type	% Female
TCM & SC	49%
ACT	43%
PSR	46%
SE	41%
DI	46%
MC	53%
LH	43%
CLS	49%
Overall	48%

Respondents were asked to indicate their current employment and education status, and were given the option of indicating that they were both in school and employed. Overall, 14% of respondents were working part-time, 4% were working full-time, and 7% were in school. There is little variation in education status across program types, and the majority of the variation in employment status can be attributed to the relatively high proportions employed in Supported Employment. As it was not possible to distinguish those who skipped the question from those who were neither employed nor in school, the denominator in these proportions equals the total number of people who participated in the REE overall and within each program type.

Exhibit 3.22 Employment/School Status of Population Served by Program

Program Type	Working Part-time	Working Full-time	In School
TCM (N= 1,495)	13%	4%	7%
ACT (N= 732)	8%	3%	7%
PSR (N= 947)	16%	3%	7%
SE (N= 293)	34%	11%	10%
DI (N= 785)	14%	4%	5%
MC (N= 1,410)	12%	4%	9%
LH (N= 250)	12%	5%	6%
CLS (N= 234)	12%	2%	7%
Overall (N=6,146)	14%	4%	7%

Respondents were asked to indicate their race and ethnicity using a series of "check all that apply" options, shown in the column headings in the exhibit below. As a result, percentages may add up to more than 100. Hispanic/Latino was not distinguished as a separate option class (ethnicity). As shown in Exhibit 3.23, nearly 70% of the respondents identified as White or biracial including White, with African American being the second-largest group at 24% overall. Five percent or fewer of respondents identified as partly or entirely Hispanic, Asian, Hawaiian/Pacific Islander, Arab Chaldean, or other. There was relatively little variation across programs.

Exhibit 3.23 Race/Ethnicity of Population Served by Program

Program Type	White	African American	Hispanic/ Latino	Am Indian Alaskan	Asian	Hawaiian Pacific Isln	Arab Chaldean	Other
TCM & SC	70%	24%	2%	4%	1%	0%	1%	2%
ACT	63%	28%	2%	5%	1%	1%	1%	4%
PSR	70%	23%	2%	5%	1%	1%	1%	3%
SE	57%	36%	2%	4%	1%	0%	0%	3%
DI	71%	21%	3%	5%	2%	1%	0%	4%
MC	70%	25%	3%	4%	1%	0%	0%	2%
LH	76%	16%	2%	6%	2%	2%	2%	7%
CLS	81%	10%	5%	7%	0%	1%	0%	2%
Overall	69%	24%	3%	5%	1%	0%	1%	3%

Respondents were also asked to indicate their tenure in mental health services overall. Nearly half of those responding had been receiving services for more than a decade, while 10% reported having begun receiving services within the last year. Medication Clinics had the lowest proportion of consumers in the *> 10 years* group (37%), while Licensed Housing had the highest (56%).

Exhibit 3.24 Length of Time Receiving Any Mental Health Services by Program

Program Type	< 1 yr	At Least 1 yr < 5 yrs	Between 5 and 10 yrs	> 10 yrs
TCM & SC (N= 1,434)	10%	23%	21%	46%
ACT (N= 710)	5%	21%	21%	52%
PSR (N= 905)	7%	17%	25%	52%
SE (N= 286)	8%	28%	24%	41%
DI (N= 730)	11%	20%	23%	45%
MC (N= 1,382)	14%	27%	22%	37%
LH (N= 231)	10%	13%	21%	56%
CLS (N= 219)	6%	26%	23%	46%
Overall (N=5,897)	10%	22%	22%	46%

Overall, nearly two-fifths of those responding reported receiving multiple mental health services. Drop-in program users were the most likely to report receiving other services (55%), while Medication Clinic users were the least likely to do so (23%).

Exhibit 3.25 Percent Receiving More Than One Community Mental Health Service By Program

Program Type	Percent
TCM & SC	33%
ACT	26%
PSR	54%
SE	47%
DI	55%
MC	23%
LH	54%
CLS	54%
Overall	38%

4. Using the REE Findings

The MDCH set forth expectations that CMHSPs would use their REE findings as part of their Quality Improvement activities, with a focus on using the results to enhance the recovery orientation of their services and to increase the involvement of consumers in planning, program development and evaluation.

REE data can help an organization to learn, change, and grow in its recovery orientation in ways that make sense to everyone involved. REE findings can suggest a host of potential change strategies, such as recovery-oriented staff training, program innovations, becoming more trauma-informed, increasing consumer participation in governance and Quality Improvement, increasing opportunities for self-help and peer support, or any other possibilities that make sense given local circumstances and resources.

Specifically, MDCH expects that CMHSPs will:

- Outline an implementation plan to maintain the existing strengths of the recovery environment and to address areas for improvement
- List individuals/organizations to be part of a stakeholder group charged with reviewing the data and working in partnership to develop a strategic planning process
- Describe how data will be shared locally and regionally
- Describe the role of the Improving Practices Leadership Team (IPLT) in the Quality Improvement (QI) process
- Describe how the IPLT will use the REE data in coordination with other projects

MDCH’s expectations included the understanding that each CMHSP would be responsible for interpreting their REE findings and for developing an inclusive process to use the findings as a tool for Quality Improvement. Findings should be shared and discussed with a representative group(s) of consumers, staff, and managers. Different perspectives should be considered in determining the meaning of these findings and the steps that might be considered to further the journey toward a recovery-oriented system. CMHSPs are encouraged to use the REE results as part of an inclusive planning process with active involvement of a significant number of consumers in order to further move their system toward a recovery orientation.

MDCH did not set specific goals associated with REE outcomes. For example, there is no State target for the percentage of persons who report that "I am actively involved in the process of recovery" (See Exhibits 3.1- 3.3). It is the responsibility of each CMHSP to determine whether the reported overall rate (or the rate of any program type) is appropriate and to determine what steps might be taken to improve the rate.

While MDCH did not set specific targets for REE outcomes, they did issue guidance about using the REE data appropriately. The expectations are that CMHSPs will:

- Circulate REE findings only within the explanatory context of the report
- Not selectively report findings
- Not create new tables or figures from the report data

As of September 28, 2010, it appears that most CMHSPs have not yet used the REE findings in a systematic way to address MDCH's expectations. Some CMHSPs said they were waiting until the statewide REE data is available so that they can compare their performance with statewide performance. Others said they had expected more detailed recommendations, tools, and instructions on how to interpret the REE findings and use the data for Quality Improvement.

Complementary Sources of Data on Recovery

MDCH may wish to consider using existing data sources to complement the use of the REE in the future. MDCH has a number of other data collection efforts that may individually and collectively be employed to provide a larger picture on the progress of the public mental health system in promoting recovery (see Exhibit 4.1, below). As a part of its measurement of recovery, the REE includes a set of "markers" for which survey respondents provide self-reports. Data that are conceptually similar are also available in other systems.

The client information system used by the State for the management of Medicaid and other sources of reimbursement for mental health services requires that providers regularly report on demographic, clinical and social characteristics of clients, as well as about services provided to them. This is a major effort that yields a very extensive array of information about all individuals who "touch" the public mental health system each year. These data may be employed to construct "recovery" measures at the CMHSP, provider, and program levels. Exhibit 4.1 below provides some specific examples of data that may be used in this manner.

Exhibit 4.1 Correlation between Existing Data and REE Recovery Markers

Recovery Marker	Existing Data	Performance Measures
Enough Income	Total annual income	Changes from one year to the next
	Minimum wage or more	Changes from one year to the next
	Employment status	Percent of adult consumers who are employed
More good days than bad days Symptoms controlled	Episodes of acute inpatient care	Rates per 1,000 persons enrolled in CMHSP
	Episodes of emergency/crisis care	
Quality of life	Residential living arrangement	Changes from one year to the next
MHSIP client measures	Consumer-rated access, quality and outcomes of services	Changes from one year to the next

The measures in the table above are intended to be suggestive. From our meetings in Michigan, it was clear that there are consumers and evaluation/quality assurance staff with the knowledge and sophistication to develop an excellent group of performance measures that rely on existing data. Because no new data collection is required, the cost of exploring the development of these types of measures is quite reasonable.

No single measure or measurement approach can represent the extent to which a system is showing improvement in recovery. Each will have its strengths, as well as its weaknesses. The REE is a very appropriate measure, although some problems with the instrument and with data collection were identified in the course of this study, as described earlier in this report. Even if these difficulties are addressed, it would still be appropriate to take advantage of existing data and other approaches to better understand each system's success in supporting individual recovery.

Another approach that would require additional effort would be conducting consumer focus groups, ideally facilitated by consumers. In contrast to the REE survey or the use of existing data sources for secondary analysis, this is a qualitative approach to understanding how the system interacts with its clients. Information—unique to each local system—can emerge through the use of these semi-structured discussion groups. Consumers can also receive training to facilitate these groups, to take extensive notes, and to write reports identifying key themes that emerge through this process.

5. Strengths and Weaknesses of the REE as a Measure and of the Study Design

Issues with the REE Instrument

Like all measures, the REE has both strengths and weakness that should be considered when interpreting its results. Chief among its strengths is its strong *face validity*, or the degree to which its items seem to clearly reflect the construct of recovery. This may be directly related to an additional strength of the instrument: its foundation in consumer narratives of their recovery process.[5] Additionally, the REE is unique among recovery instruments in that it measures respondents' involvement in their individual recovery process as well as their impressions of the degree to which their services support that process.[6]

The greatest drawback of the REE is not directly attributable to the measure itself, but to the entire genre of self-report measures of service satisfaction. As discussed in Section 2 above, respondents tend to offer positively-biased answers to this type of survey. In addition to yielding data that paint a more positive picture than may be warranted, this phenomenon reduces the variability of responses, and therefore the ability of the data to support analyses.

While the REE was explicitly designed as a measure of recovery and recovery-enhancing environments, the concept of "recovery" is never defined in the instrument. The measure also relies heavily on abstract concepts that are not defined and uses language that may not be familiar to all respondents (e.g., "psychiatric disability"). Perhaps due to these issues, the response rate for one of the critical items—regarding the respondents' current involvement in the recovery process—was surprisingly low (81%). Given the role that this item played in subsequent analyses, this high proportion of missing data was a limitation. As it is likely that the group who skipped the question differed from the group who answered, any analysis using this item may not reflect the range of experiences of all who participated.

Problems with the Study Design

A major drawback to the study design is that it relied upon staff in 46 different CMHSPs to develop local sampling and implementation plans according to guidelines issued by MDCH, and to successfully implement these plans at the local level. As discussed in Section 2 above, there were significant problems in the data collection process; much of this was due to the wide variability among the CMHSPs in the availability of resources and personnel with the skills and knowledge to develop and implement these plans according to the established criteria. There was also variability in the extent to which CMHSPs publicized the survey and ensured that all procedures for generating a random sample were followed. As a result, it is likely that most of the samples of consumers surveyed were not random, representative samples, which, as

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[5] Ridgway, P. in Campbell-Orde, T., Chamberlin, J., Carpenter, J. & Leff, H.S. (2005). *Measuring the promise: A compendium of recovery measures, Volume II*. Cambridge, MA: The Evaluation Center at Human Services Research Institute.

[6] Campbell-Orde, T., Chamberlin, J., Carpenter, J. & Leff, H.S. (2005). *Measuring the promise: A compendium of recovery measures, Volume II*. Cambridge, MA: The Evaluation Center at Human Services Research Institute.

discussed in Section 2, undermines the validity of the resulting data. Results would likely have been significantly improved had there been an opportunity to do in-depth training for staff at each CMSHP on how to develop and implement sampling plans and ways to increase response rates, but this project did not have the resources to provide this level of training.

The use of the web-based application Survey Monkey as a data entry tool was a problem with the study design and implementation. Survey Monkey is designed as a self-administered survey tool, not primarily as a data entry tool. During the development of the study design, it was anticipated that the survey would be administered in many situations by consumers accessing the survey online. AHP concluded that Survey Monkey was the most effective tool for a situation in which some people would complete the survey online and others would complete paper surveys that would require data entry. However, it was not possible to arrange for consumers to take the survey on the web, although Survey Monkey was used for data entry. Because it was not designed for this purpose, there were difficulties and inefficiencies with this process. In any future use of the REE, a more efficient data entry process would be selected.

Conclusions and Recommendations

The conclusions and recommendations which follow incorporate comments gathered at meetings with the Recovery Council, CMHSP Directors and other stakeholders on September 27 and 28, 2010, at which major statewide findings of the REE were presented. Discussion focused on ways to ensure that CMHSPs used the findings in an inclusive Quality Improvement process that would move the recovery agenda forward and how other data sources could be used to complement and enhance the REE findings.

1. *Successful statewide implementation of the REE was a major accomplishment that focused renewed attention on people in recovery and on the need to continue system transformation activities toward a recovery orientation*. The fact that over 6,000 individuals served by 46 CMHSPs completed the REE was a significant achievement. The process involved complex logistics and required the coordinated efforts of hundreds of staff, consumer surveyors, contractors, and survey participants. It was an important first: an opportunity for consumers across Michigan to voice their opinions about their recovery processes and the extent to which the services they receive promote recovery.

2. *It is crucial that each CMHSP develop and implement an active and inclusive Quality Improvement plan based on their REE findings.* As described in the body of this report, MDCH expects that each CMHSP will:
a) Share the REE findings widely with consumers, staff, administrators and other stakeholders.
b) Convene a group with significant consumer participation to review and interpret their REE findings and determine how best to use the findings to enhance their ability to deliver recovery-oriented services.
c) Develop and implement a Quality Improvement Plan based on this group's deliberations.

At the September, 2010 meeting of CMHSP Directors and other stakeholders, it was reported that some CMHSPs have already begun this process. Activities reported included:

- Sharing information widely with consumers, clinicians, staff, and other stakeholders through newsletters, handouts, meetings
- Holding focus groups to solicit feedback
- Forming speakers' bureau to talk about recovery, share report and get feedback

Interest was expressed at the September, 2010 meeting in:

- Finding ways to voluntarily share REE findings across CMHSPs for benchmarking purposes (MDCH will facilitate this by accepting data-sharing requests);
- Maintaining a statewide recovery focus and ensuring that CMHSPs follow through with developing and implementing QI plans to facilitate recovery;
- Focusing on the need to build consensus at the local level about how the findings should be used and further exploring the meaning of recovery to people who receive services.

3. *MDCH and/or individual CMSHPs may wish to develop and implement strategies to supplement the REE findings with data from other sources.* No single measurement approach can capture all needed information about how to successfully support each individual's recovery. The REE is just one measure; even if the methodological problems were addressed, it will remain imperfect. MDCH and CMHSPs may wish to consider augmenting the REE with additional data elements that are already being collected and can be correlated with some of the items on the REE, such as changes in income, employment, education, and MHSIP indicators. Another important source of information would be focus groups with consumers, ideally facilitated by consumers.

4. *If the REE is repeated in subsequent years – either as a statewide initiative or by individual CMHSPs - it will be important to address the weaknesses of the study design discussed in the report as well as the documented problems in preparing and implementing sampling plans to ensure unbiased, representative samples.* The cost associated with replication would also need to be a consideration.

APPENDICES

1. **Findings: Distributions by CMHSP**
2. **The Recovery Enhancing Environment Measure – Michigan (REE-MI)**
3. **Instructions for Preparing CMHSP REE Sampling and Implementation Plans** [from the FY 2009 Program Policy Guidelines (PPG) and Application for Renewal and Recommitment (ARR)]
4. **REE Surveyors' Manual**

Appendix 1. Findings: Distributions by CMHSP

Generally, the tables in the body of this report show the results of statewide analyses performed without breaking out the responses by CMHSP. For example, Exhibit 3.1 shows that 39% of the 6,146 participants indicated that they were involved in recovery, but the proportion of participants choosing that response within any given CMHSP may have been greater or less than 39%. For many items, there was a fair amount of variation among CMHSPs.

As each CMHSP received a report showing their results, the distribution of CMHSP results for key items may be of interest. The tables that follow show these distributions using the median (the point dividing the body of responses into equal halves) and first and third quartiles (the points dividing the upper and lower halves into quarters). This approach was used because, for many items, results were not distributed normally. This approach also makes it easy to use the tables to compare one CMHSP's results to the statewide findings. For example, using the first exhibit, a CMHSP with 52% of consumers reporting involvement in recovery could see that their results are in the upper half of results for all CMHSPs (because it is above the median of 49%), but not within the upper quarter (because it is below the third quartile of 55%).

While the exhibits that follow are generally aligned with one of the exhibits in the body of the report, Exhibit A.1 is not completely aligned with its counterpart, Exhibit 3.1. For these exhibits, the analysis approach used in the statewide report differed somewhat from that used in the CMHSP reports. Exhibit A.1 uses the approach and formatting of the CMHSP reports to better allow for comparison.

Exhibit A.1 Distribution of CMHSP Results for Involvement in Recovery

Recovery Involvement	*Median*	*First Quartile*	*Third Quartile*	*Min*	*Max*
I have never heard of or thought about recovery	8%	6%	10%	0%	14%
I do not believe I have any need to recover	3%	1%	5%	0%	9%
I have not had the time to really consider mental health recovery	3%	1%	5%	0%	12%
I have been thinking about it but have not decided to move on it yet	7%	4%	8%	0%	15%
I am committed to recovery & making plans to take action very soon	14%	10%	18%	3%	23%
I am actively involved in the process of recovery	49%	44%	55%	29%	79%
I was actively moving toward recovery but now I am not	4%	2%	5%	0%	12%
I feel that I am fully recovered, I just have to maintain my gains	8%	5%	11%	0%	18%

Exhibit A.2 Distribution of CMHSP Results for Endorsement of Recovery Markers

Recovery Marker	*Median*	*First Quartile*	*Third Quartile*	*Min*	*Max*
Have goals	91%	89%	92%	87%	97%
Can make changes	91%	89%	94%	79%	98%
People I trust	90%	87%	93%	79%	99%
Growing	91%	87%	92%	77%	99%
Learning new things	88%	85%	91%	74%	100%
Reasons to get up	87%	85%	90%	76%	96%
Safe home	88%	85%	91%	77%	96%
Control own decisions	86%	83%	87%	77%	92%
Like/respect self	84%	79%	87%	68%	91%
Spiritual life	85%	81%	87%	70%	91%
Close relationship	85%	82%	87%	74%	93%
Decent quality of life	83%	80%	87%	70%	96%
Using skills	84%	81%	86%	72%	94%
Alert & alive	81%	77%	85%	69%	94%
Hopeful	82%	78%	86%	63%	96%
Sense of belonging	82%	78%	86%	64%	93%
Meaningful activities	81%	79%	84%	69%	90%
Symptoms controlled	79%	76%	82%	65%	92%
More good days than bad	78%	74%	81%	64%	90%
Contribute to community	72%	68%	75%	54%	84%
Deal with stress	69%	61%	73%	52%	84%
Good physical health	67%	63%	72%	44%	79%
Enough income	58%	52%	64%	30%	69%

Exhibit A.3 Distribution of CMHSPs' Mean Proportion of Recovery Markers Endorsed

	Median	*First Quartile*	*Third Quartile*	*Min*	*Max*
Mean % of recovery markers endorsed	81%	80%	83%	75%	88%

Exhibit A.4 Distribution of CMHSP Results for Agreement with Recovery Elements

Recovery Element	*Median*	*First Quartile*	*Third Quartile*	*Min*	*Max*
Personal identity	92%	88%	94%	82%	99%
Respecting/upholding rights	92%	90%	95%	79%	97%
Hopefulness	90%	88%	94%	78%	100%
Sense of meaning	90%	88%	94%	77%	100%
Empowerment	90%	87%	93%	76%	100%
Self-monitoring	88%	86%	91%	75%	96%
Taking on new challenges	89%	86%	92%	73%	97%
Wellness programming	88%	84%	91%	69%	97%
Building positive relationships	86%	82%	89%	73%	95%
Meeting basic needs	81%	76%	85%	60%	93%

Exhibit A.5 Distribution of CMHSP Results for Agreement with Special Needs Items

Percent agreeing that...	*Median*	*First Quartile*	*Third Quartile*	*Min*	*Max*
Program supports ethnic/racial identity	86%	83%	97%	50%	100%
Program supports substance abuse recovery	88%	82%	93%	65%	100%
Program supports trauma recovery	82%	77%	88%	61%	95%
Program supports sexual orientation	80%	70%	91%	50%	100%
Program supports parental role	80%	76%	85%	56%	92%

RECOVERY ENHANCING ENVIRONMENT – Michigan (REE-MI)

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This questionnaire explores the process of recovery from psychiatric disability. While **recovery is always a personal process based in self-responsibility**, there are things mental health programs can do to support your progress or hold you back. This questionnaire looks at your experience of recovery, and some of the services and supports that are available to you.

Your answers to these questions will be confidential. This study is completely voluntary. You can skip any questions that you do not wish to answer. Other people who receive mental health service have said that this questionnaire is very interesting, they enjoyed filling it out, and they learned something about their recovery by taking part.

Instructions:

1. This is **not a test**. There are no right answers or wrong answers. Answer each question based upon your personal opinions and beliefs.

2. All of the questions should be answered by marking the <u>one</u> answer that best fits your opinion or situation. If you don't find an answer that fits exactly, use the one that comes closest. If any question does not apply to you, or you are not sure of what it means, leave it blank.

<u>THANK YOU FOR YOUR TIME AND ANSWERS!</u>

For Office Use Only

Data entered ___________________ by ____________________________
date print name

Appendix 2. REE-MI

I. A FEW QUESTIONS ABOUT YOU

1. What age group are you in (Check your current age group)?
   ___18-25
   ___26-35
   ___36-45
   ___46-55
   ___56-65
   ___66-75
   ___76 or older

2. What is your gender?
   ___Male
   ___Female

3. What is your racial or ethnic background?
   ___White
   ___ Black or African American
   ___ Hispanic or Latino
   ___ American Indian or Alaskan Native
   ___ Asian
   ___ Native Hawaiian or other Pacific Islander
   ___ Arab-Chaldean
   ___ Other Category:

4. In total, how long have you received any form of mental health services?
   ___Less than one year
   ___One year or more but less than 5 years
   ___Between 5 and 10 years
   ___More than 10 years

5. Do you currently receive any community mental health services from programs other than this one?
   __ Yes
   __ No

II. YOUR INVOLVEMENT IN THE RECOVERY PROCESS

Which of the following statements is <u>most true</u> for you?

<u>(Check only one)</u>

__ I have never heard of, or thought about, recovery from psychiatric disability.
__ I do not believe I have any need to recover from psychiatric problems.
__ I have not had the time to really consider mental health recovery.
__ I've been thinking about recovery, but haven't decided to move on it yet.
__ I am committed to my recovery, and am making plans to take action very soon.
__ I am actively involved in the process of recovery from psychiatric disability.
__ I was actively moving toward recovery, but now I'm not because:
____
__ I feel that I am fully recovered; I just have to maintain my gains.
__Other (specify) ____

III. ELEMENTS OF RECOVERY AND RECOVERY-ENHANCING

For each of the following questions you should circle **one** of these answers:
SA --If you ***strongly agree*** with the statement.
A --If you ***agree*** with the statement
D --If you ***disagree*** with the statement.
SD --If you ***strongly disagree*** with the statement.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. Having a positive sense of personal identity beyond my psychiatric disorder is important to my recovery.	SA	A	D	SD
a) Staff view me as more than a "case" or a diagnosis; they want to know me as a person.	SA	A	D	SD
b) The program offers individualized services to meet my unique needs.	SA	A	D	SD
c) Staff treat me as a whole person with a body, mind, emotions, important relationships and spirit.	SA	A	D	SD

Appendix 2. REE-MI

	Strongly Agree	Agree	Disagree	Strongly Disagree
2. Having a sense of meaning in life is important to my recovery.	SA	A	D	SD
a) Staff help me make sense out of what is happening in my life.	SA	A	D	SD
b) Staff ask me what is meaningful to me.	SA	A	D	SD
c) This program encourages me do things that give my life meaning.	SA	A	D	SD
3. Having hope is important to my recovery.	SA	A	D	SD
a) Staff believe I have a positive future.	SA	A	D	SD
b) Staff encourage me to feel hopeful again when I'm discouraged or have a setback.	SA	A	D	SD
c) Staff tell me most people do recover from psychiatric problems over time.	SA	A	D	SD
4. Being able to self-manage symptoms and avoid relapse is important to my recovery.	SA	A	D	SD
a) This program helps me identify and monitor triggers/early signs of relapse.	SA	A	D	SD
b) This program helps me develop personalized coping skills so I can manage stress well.	SA	A	D	SD
c) This program teaches me ways to self-monitor and self-control psychiatric symptoms.	SA	A	D	SD

Appendix 2. REE-MI

	Strongly Agree	Agree	Disagree	Strongly Disagree
5. Improving my general health and wellness is important to my recovery.	SA	A	D	SD
a) Staff pay careful attention to my physical health.	SA	A	D	SD
b) This program encourages me to achieve a higher level of wellness.	SA	A	D	SD
c) This program offers wellness programming such as nutrition, movement, relaxation.	SA	A	D	SD
6. Having my rights respected and upheld is important to my recovery.	SA	A	D	SD
a) Staff inform me of my rights.	SA	A	D	SD
b) There is a clear grievance policy if any of my rights are violated.	SA	A	D	SD
c) Staff uphold my rights.	SA	A	D	SD
7. Having positive relationships is important to my recovery.	SA	A	D	SD
a) Staff assist me in having positive relationships with my peers.	SA	A	D	SD
b) Staff support me in building or rebuilding positive relationships with family members.	SA	A	D	SD
c) Staff assist me in forming friendships with people outside the mental health system.	SA	A	D	SD

Appendix 2. REE-MI

	Strongly Agree	Agree	Disagree	Strongly Disagree
8. Having my basic needs met is important to my recovery.	SA	A	D	SD
a) This program assists me to get a basic income and/or benefits.	SA	A	D	SD
b) This program helps me get decent, affordable housing and/or rent subsidies.	SA	A	D	SD
c) This program helps me gain access to health care.	SA	A	D	SD
9. Having a sense of control over my life and feeling empowered is important to my recovery.	SA	A	D	SD
a) Staff encourage and support my sense of empowerment.	SA	A	D	SD
b) Staff assist me to gain or maintain control over important decisions in my life.	SA	A	D	SD
c) Staff **do not** try to maintain power and control over me.	SA	A	D	SD
10. Taking on new challenges and moving out of my comfort zone is important to my recovery.	SA	A	D	SD
a) Staff encourage me to take on new challenges.	SA	A	D	SD
b) I feel supported when I try new things that seemed out of my reach before.	SA	A	D	SD
c) Staff encourage me to stretch myself and grow.	SA	A	D	SD

IV. SPECIAL NEEDS

The next five questions relate only to specific groups of people. If you are NOT a member of the specific group being asked about, answer "no" and go onto the next question.

1. **Are you are a member of an ethnic, racial or cultural minority group?**

   Yes (Please answer questions a-c, below)

   No (Go to question 2)

	Strongly Agree	Agree	Disagree	Strongly Disagree
Having my ethnic & cultural background respected is important to my recovery	**SA**	**A**	**D**	**SD**
a) Staff here are respectful to me as a person of a racial, ethnic, or cultural minority	**SA**	**A**	**D**	**SD**
b) This program understands and supports my cultural values/language/customs.	**SA**	**A**	**D**	**SD**
c) Staff are aware of, and sensitive to my cultural heritage and needs.	**SA**	**A**	**D**	**SD**

2. **Do you have a substance abuse problem?**

   Yes (Please answer questions a-c, below)

   No (Go to question 3)

	Strongly Agree	Agree	Disagree	Strongly Disagree
Having help with alcohol or drug problems is important to my recovery.	**SA**	**A**	**D**	**SD**
a) This program has resources to help me with both alcohol and psychiatric problems.	**SA**	**A**	**D**	**SD**
b) This program has resources to help me with both drug and psychiatric problems.	**SA**	**A**	**D**	**SD**
c) This program links me to self-help groups that deal with dual diagnoses/ substance abuse.	**SA**	**A**	**D**	**SD**

3. Do you have a history of trauma or abuse?

Yes (Please answer questions a-c, below)

No (Go to question 4)

	Strongly Agree	Agree	Disagree	Strongly Disagree
Healing from trauma, including sexual abuse and/or physical abuse, is important to my recovery.	**SA**	**A**	**D**	**SD**
a) This program has resources to help me heal from abuse and/or trauma.	**SA**	**A**	**D**	**SD**
b) It feels safe to open up about abuse or trauma in this program.	**SA**	**A**	**D**	**SD**
c) Staff deal effectively with abuse and trauma.	**SA**	**A**	**D**	**SD**

4. Are you a lesbian, gay, bi-sexual or transgendered person?

Yes (Please answer questions a-c, below)

No (Go to question 5)

	Strongly Agree	Agree	Disagree	Strongly Disagree
Having support for my sexual orientation is important to my recovery.	**SA**	**A**	**D**	**SD**
a) Staff of this program are **not** homophobic (very negative about gay, lesbian, bi-sexual or transgendered people).	**SA**	**A**	**D**	**SD**
b) Staff of the program are respectful to me as a lesbian, gay, bi-sexual or transgendered person.	**SA**	**A**	**D**	**SD**
c) Staff deal effectively with issues of sexual orientation.	**SA**	**A**	**D**	**SD**

5. Are you a parent?

Yes (Please answer questions a-c, below)

No (Go to next section)

	Strongly Agree	Agree	Disagree	Strongly Disagree
Having support as a parent is important to my recovery.	**SA**	**A**	**D**	**SD**
a) Staff support me in my role as parent.	**SA**	**A**	**D**	**SD**

b) Staff assist me to be an effective parent.	SA	A	D	SD
c) Staff help me uphold my rights in custody disputes.	SA	A	D	SD

V. RECOVERY MARKERS –Revised (RM-R)

For each of the following questions, circle the **one** answer that is most true for you right now.

SA --If you ***strongly agree*** with the statement.
A --If you ***agree*** with the statement
D --If you ***disagree*** with the statement.
SD --If you ***strongly disagree*** with the statement.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. My living situation feels like a safe home to me.	SA	A	D	SD
2. I have people I trust whom I can turn to for help.	SA	A	D	SD
3. I have at least one close mutual (give-and-take) relationship.	SA	A	D	SD
4. I am involved in activities I find meaningful.	SA	A	D	SD
5. My psychiatric symptoms are under control.	SA	A	D	SD
6. I have enough income to meet my needs.	SA	A	D	SD
7. I am learning new things that are important to me.	SA	A	D	SD
8. I am in good physical health.	SA	A	D	SD
9. I have a positive spiritual life/connection to a higher power.	SA	A	D	SD
10. I like and respect myself.	SA	A	D	SD
11. I'm using my personal strengths, skills or talents.	SA	A	D	SD
12. I have goals I'm working to achieve.	SA	A	D	SD
13. I have reasons to get out of bed in the morning.	SA	A	D	SD

Appendix 2. REE-MI

	Strongly Agree	Agree	Disagree	Strongly Disagree
14. I have more good days than bad.	**SA**	**A**	**D**	**SD**
15. I have a decent quality of life.	**SA**	**A**	**D**	**SD**
16. I control the important decisions in my life.	**SA**	**A**	**D**	**SD**
17. I contribute to my community.	**SA**	**A**	**D**	**SD**
18. I am growing as a person.	**SA**	**A**	**D**	**SD**
19. I have a sense of belonging.	**SA**	**A**	**D**	**SD**
20. I feel alert and alive.	**SA**	**A**	**D**	**SD**
21. I feel hopeful about my future.	**SA**	**A**	**D**	**SD**
22. I am able to deal with stress.	**SA**	**A**	**D**	**SD**
23. I believe I can make positive changes in my life.	**SA**	**A**	**D**	**SD**
	True	**False**		
24. I'm not working, but see myself working within 6 months.				
25. I am working part time (less than 35 hours a week).				
26. I am working full time (35 or more hours per week).				
27. I am in school.				

RECOVERY ENHANCING ENVIRONMENT MEASURE

Background:
The Recovery Council, in partnership with the Michigan Department of Community Health (MDCH), recommended implementation of the Recovery Enhancing Environment Measure[7] (REE) within each CMHSP and within each contract/provider agency during FY09. The REE is a survey of adults with serious mental illness designed to identify the extent to which recovery-enhancing factors are present within mental health programs and the extent to which individuals receiving services report that they are experiencing recovery.

Project Goals:
- To support a Quality Improvement process for CMHSPs and MDCH.
- To assist providers, consumers and other stakeholders develop a fundamental understanding of the elements of recovery.
- To strengthen recovery-oriented practices in individual service planning, systems planning and service delivery.
- To assess the extent to which recovery-enhancing elements are integrated into current practice for an unbiased, representative sample of programs and individuals.
- To provide summary data for use in developing plans to support and strengthen a recovery-based system of care.
- To provide summary data to MDCH and the Recovery Council to support policy development and technical guidance in the oversight of systems transformation.
- To provide baseline data to measure progress for future assessments.

Project Overview:
Each CMHSP will prepare a narrative plan describing how it will implement REE data collection and will complete the REE Table for the programs it operates. If the CMHSP contracts with outside agencies for programs, the REE Table will also be completed by each contract agency (detailed instructions follow).

These plans will be reviewed for completeness and feasibility by MDCH, and additions or corrections may be requested before the plan is approved. MDCH has contracted with Advocates for Human Potential (AHP) to assist the department and CMHSPs in implementing the REE. Two CMHSPs have volunteered to implement the survey in January 2009. MDCH will begin scheduling the remaining CMHSPs, first with "early adopter" volunteers, and the remainder as plans are approved and CMHSPs are ready to implement the survey.

Data will be collected from representative samples of adults with serious mental illness who have received certain services for 90 days or longer. Data collection will occur in phases according to a schedule to be developed in consultation with MDCH. Procedure codes identifying the programs to be surveyed are listed in the REE Table. Data collection will be facilitated by consumer surveyors who will be trained by AHP.

[7] A revised short form of the REE, called the REE-MI, will be used in Michigan.

Surveyors will provide instructions, hand out surveys, answer questions from survey participants, read survey questions aloud if requested, and enter the data online (except where participants take the survey online). Consumer surveyors will be interviewed, selected and employed through the Michigan Recovery Center of Excellence (MRCE) as independent contractual staff. The MRCE will serve as the REE Logistics Coordinating agency (referred to later in this document).

Services for adults with serious mental illness included in REE implementation:

- Targeted case management
- Supports Coordination
- Assertive Community Treatment
- Psychosocial Rehabilitation
- Supported employment
- Consumer-run Drop Ins
- Medication clinics
- Group homes serving people diagnosed with serious mental illness
- People living in non-licensed housing who receive Community Living Supports

CMHSP/Contract Agency Responsibilities:
Each CMHSP will provide MDCH and its contractors for this project with the name and contact information of an individual responsible for putting the approved REE Implementation Plan into practice within the CMHSP. This person's responsibilities will include:

- Contact each contract agency to explain REE implementation and get the name of a contact person responsible for REE logistics at each contract agency and program site to be surveyed.
- Ensure that each CMHSP program site has a contact person responsible for REE logistics.
- Facilitate the surveyor's work with each program site by providing them with all needed contact information, directions, introductions, and other necessary information.
- Coordinate with contract agency and program site contacts to ensure that the approved sampling plan is carried out accurately in each program to be surveyed.
- Coordinate with contract agency and program site contacts to establish contact with the consumer surveyor(s) assigned to each program and have an initial planning and scheduling call or meeting with the surveyor(s).
- Ensure that the contract agency and program site contacts arrange for mutually-convenient times for the survey to be conducted in each program.
- Ensure that the contract agency and program site contacts are equipped to respond to questions or requests for clarification or assistance from surveyors.
- Coordinate with contract agency and program site contacts to arrange for appropriately-sized private space at each site for survey administration and access to a photocopier for the surveyor.

Consumer Surveyors:
To ensure that conflict of interest issues are addressed and that a trained surveyor group is assembled, MDCH and MRCE will handle the selection and assignment of surveyors. They will review applications of potential surveyors, hire surveyors, coordinate trainings to be provided by AHP, assign surveyors to programs, and reimburse surveyors for their time, and travel-related expenses.. CMHSPs may recommend primary consumers to be surveyors.

- Conflicts of Interest:
- To ensure that there are no conflicts of interest between surveyors and CMHSPs or provider organizations, the following criteria will be strictly observed:
- Surveyors may not be current or former employees of the CMHSP or of the contract agency operating the program in which the survey is being administered.
- Surveyors may not administer the survey in programs run by organizations from which they currently or formerly received services.

Consumer Surveyors' Responsibilities:
- Keep AHP contact information readily available in the event that there is a need to ask questions regarding REE data collection or web-based data entry.
- Establish contact with the designated contact person responsible for implementing the REE at each program to which the surveyor is assigned.
- Keep that person's full name and contact information during the administration of surveys.
- Hold an initial planning/scheduling call or meeting with the designated contact person to ensure that all parties are clear about when and where the surveyors will be responsible for conducting the survey.
- Keep all scheduled appointments to conduct the survey. If an emergency makes it impossible to keep a scheduled appointment, the designated contact person and the REE Logistics Coordinating agency must be contacted as soon as possible so that the appointment can be rescheduled or another surveyor assigned.
- Arrive at each scheduled site at least 30 minutes before the scheduled start time to ensure that the room is set up and needed supplies and/or equipment are set up.
- Bring sufficient pencils and paper copies of the survey to each site.
- Bring sufficient extra copies of the Recovery markers section of the survey so participants can make copies of that section to take with them.
- Contact the designated contact person and/or REE Logistics Coordinating agency if problems are encountered or questions during the survey process.
- Keep all completed paper surveys in a safe place before entering the data online, and return completed surveys to the REE Logistics Coordinating agency for secure storage in compliance with HIPAA rules and regulations.

Instructions for Completing the Table and Plan Narrative:

Each CMHSP will complete the REE Table and develop a narrative plan, to be approved by MDCH, for implementing the REE within the CMHSP and in its contract and provider agencies. If you have questions, please call 1-866-931-4817 to receive technical assistance from the MDCH contractor, AHP. Please indicate that you are calling about the "Michigan REE Survey Implementation Plan development."

TABLE:

1. In the REE Table, complete Part 1 by providing the name, address, telephone number and email address of the person who will be responsible for implementing the REE for the CMHSP.

If the CMHSP has contract agencies, Parts 2 and 3 of the REE Table must be completed separately for **each** contract agency.

2. In the REE Table, Part 3, identify all services from column 1 (as identified by the procedure codes provided in column 2) that are offered by your CMHSP or contract agency. Enter the name of each local program on the respective line in column 3. It is important that a unique local program name be entered in this column. Enter the name, phone number and email address of the contact site for each local program in column 4. If you do not provide services of the type shown on any line, please cross that line out.

3. For each program listed in column 3, attach a brief narrative description of how the survey will be administered. There are a number of considerations to be taken into account, depending on the nature of the service, which will determine the most efficient method for administering the REE. Several illustrative examples are presented below. Please choose the one most appropriate to the program and enter the corresponding letter code in column 5 of the REE Table.

   Survey methods:

   A. The preferred method is for the REE to be administered in person to the selected sample of program enrollees in a group. If there are sufficient computers available on-site for consumers to enter their own responses online after a group introduction to the instrument by the surveyor, this will be an acceptable method of data collection. Each program will be assigned a unique link to the survey. In other cases, the survey will be administered in a paper/pencil version, with the surveyor collecting the completed surveys and doing the data entry later. This method would work in programs where the entire sample is present at one time, such as Psychosocial Rehabilitation programs. Whenever feasible, this would involve selecting the sample as soon as people arrive at the program, and doing the group introduction and REE administration as soon as the entire sample is present. (See 4, below, for discussion of sampling methods.)

B. A variation of this method could be used in cases in which less than the entire sample is present at one time. For example, if people from one part of the county attend a Drop-in Center only on Monday, Wednesday and Friday, while people from another area attend only on Tuesday and Thursday, it would not be possible to get a representative sample by administering the survey only on a Monday. In such cases, half the sample would be chosen and administered the survey on Monday, and the other half would be chosen and administered the survey on Tuesday.

C. Another variation could be used for programs which do not have a fixed program site, such as ACT teams or supported employment programs. In this instance, the people in the sample would be identified and would be provided transportation to a central site for the survey to be administered.

D. In programs where people are at the program site only for brief appointments, such as medication clinics or targeted case management, the survey would be administered individually or to small groups of people while they are waiting for appointments or after they finish with their appointments. This method would require survey administrators to explain the instrument to individuals or small groups sequentially, and to remain onsite until they had administered surveys to the entire sample.

E. To facilitate access to survey participation in situations in which options A-D described above would be difficult or for individuals within the selected sample who would prefer a non-group administered survey, online access to the survey will be made available to consumers who were part of the selected sample in each program. The surveyor will give participants the survey link assigned to the program, along with written instructions. A trained surveyor will be available for questions through a toll-free number staffed by the MRCE.

F. In situations in which none of the suggested methods described above are feasible, please describe an alternate method for administering the survey. Please describe how you will ensure that those surveyed receive an adequate explanation of the survey process; how they will have questions answered; how data will be entered, and how confidentiality and accountability will be ensured.

4. For each service listed in the REE Table, Part 3, calculate the number of individuals that will serve as an unbiased representative survey sample for this program. This number can be calculated using a sampling methodology; three types of sampling methods are described below. If none of these methods is appropriate for the program, please describe an alternative sampling method that will result in the necessary sample size.

<u>Examples of Sampling Methods</u>: For each program, calculate the sample size using the appropriate sampling method. Enter the average weekly number served in column 6, and the size of the sample in column 7.

For programs serving five or fewer people weekly, the following rule will be used:

If a CMHSP or contract agency operates only one such program of any given type, the program will not be surveyed. However, if the CMHSP or contract agency operates two or more programs of the same type, each serving 5 or fewer people weekly, a sample may be constructed by inviting all these individuals to a central location to be surveyed (up to a maximum of 25 people). Each of these programs must be listed separately in column 3, and the survey method for these multi-program surveys should be described in the narrative plan.

a. For services with a fixed program site and 25 or fewer average weekly number served, the sample is <u>everyone</u> served during the sample week.

b. For services with a fixed program site and 26 or more average weekly number served, the sample is the first 25 served in the sample week. In order to ensure that the sample size is reached, people should be asked to participate in the order in which they arrive, until there are 25 positive responses.

c. For services without a fixed program site (i.e., ACT teams), sample the 25 or more clients living closest to the program site where the survey will be administered. In order to ensure that the sample size is reached, people should be asked to participate until there are 25 positive responses. If the program serves fewer than 25 individuals weekly, the sample is <u>everyone</u> served during the sample week.

d. Other (please describe in plan narrative).

5. Completion of Data Collection. When data collection is completed, each CMHSP and contract agency will be asked to complete a revised REE Table showing how the final sample was developed. During data collection, the number of persons who decline to complete the survey will also be tracked separately.

REE Table: PLAN FOR ADMINISTERING THE RECOVERY ENHANCING ENVIRONMENT MEASURE

Part 1. Responsibility for Administering the REE in the CMHSP

CMHSP name: ____

Name of person responsible for overseeing REE implementation: ___________________________

Address____

Telephone ______________________________ Email ______________________________

Part 2. Responsibility for Administering the REE in Contract Agencies

[Skip if CMHSP directly administers **all** its programs. Otherwise, complete Parts 2 and 3 for **each** contract agency.]
In addition, provide the name and contact information of an on-site contact person for each local program surveyed in Part 3, column 4.

Contract Agency name: ____

Name of person responsible for overseeing REE implementation: ___________________________

Address____

Telephone ______________________________ Email ______________________________

Part 3. Sampling Plan for Administering the REE in the CMHSP or Contract Agency

1. Service	2. Procedure code	3. Local program name	4. Local program contact person: name, phone, email	5. Survey Method	6. Avg. weekly number served	7. Sample size
Targeted case management	T1017					
Supports Coordination	T1016					
Assertive Community Treatment	H0039					

1. Service	2. Procedure code	3. Local program name	4. Local program contact person: name, phone, email	5. Survey Method	6. Avg. weekly number served	7. Sample size
Psychosocial Rehabilitation	H2030					
Supported employment	H2023					
Consumer-run Drop Ins	H0023					
Medication clinics	H2010 90862 H0034					
Licensed specialized residential or licensed general residential (AFC) home residents who receive Community Living Supports	QI element 8.6 or 8.8 **And** receive H2015 or H2016					
Residents of non-licensed housing programs who receive Community Living Supports	H2015 or H2016					
TOTAL to be surveyed						

PLAN NARRATIVE TO ACCOMPANY REE TABLE.

1. Describe how the survey will be administered in each service listed in Part 3, column 3. If it is necessary to vary from the sample survey methods described above for any program, please indicate below how the CMHSP proposes to assure a representative, unbiased sample of service participants.
2. Identify primary consumers in the CMHSP area who are interested and demonstrate the qualifications in the section below.
3. Identify the number of surveys to be conducted at a central site, described in Item C on page 5. Mental health block grant funding will be made available to assist with these meetings. Total funding available will be dependent on the plan and discussion with MDCH.

Michigan REE Consumer Surveyor Position Requirements
Part-time surveyors who are current or former consumers of mental health services are sought to administer the Recovery Enhancing Environment-Michigan (REE-MI) instrument in each CMHSP throughout the state.

Surveyors will receive training about how to introduce and administer the REE, as well as a survey implementation manual from the MDCH contractor, AHP. A toll-free number to call for assistance will also be made available. Surveyors will introduce and administer the REE to consumers, typically in group settings in a pare/pencil format. The survey will also be available in an online version. Surveyors will be responsible for entering data online from pencil/paper surveys. A more detailed description of surveyor tasks is available in the document "Mutual Responsibilities of CMHC/Agency Contacts and Consumer Surveyors" and will be used for review and discussion as part of the surveyor selection process.

Required and demonstrated skills:

- Experience using the internet and ability to do accurate data entry on a computer.
- Speak comfortably before groups of consumers.
- Communicate clearly with consumer groups and individuals about the purposes for completing the survey, how the data will be used, confidentiality of data, and instructions for survey completion (training and script will be provided).
- Work effectively one-on-one with individuals who may have difficulty reading the survey, who have questions, or who request support in the survey process.
- Work collaboratively with the REE contact at each program to be surveyed.
- Able to keep scheduled appointments, maintain accurate records, and complete required paperwork.

Required Characteristics:

- Familiarity with and support of recovery concepts and principles. Must be a current or former consumer of mental health services: for example, surveyors may be peer support specialists, members or staff of Drop-In Centers or other consumer-run programs, independent contractors, and/or other current or former consumers. However, surveyors may not conduct surveys in programs or organizations where they work or receive services

Recovery Enhancing Environment Measure (REE) – Michigan

Surveyors' Manual

Section 1. Overview

What is the Recovery Enhancing Environment Measure (REE)?

The Recovery Enhancing Environment Measure, called the REE for short, is a paper and pencil survey that collects information about recovery from people who use mental health services. People who take the survey are asked to rate the importance of several elements to their personal recovery, such as hope, having a sense of meaning, and wellness. They are then asked to rate how well their mental health program performs activities linked with each of these elements. The REE asks people whether they are members of certain groups, such as racial minorities or parents. If they are, they are asked to rate their mental health program on how well it meets their needs in this area. The REE also asks people where they are in the process of recovery from mental health problems and what signs of recovery they currently experience.

The results of the survey show how successful a program is in creating an atmosphere in which recovery can flourish – whether the program has an *environment* that *enhances recovery*. The REE also provides mental health programs and systems with answers to other important questions like:

- *Where are the people we serve on their personal journeys of recovery?*
- *What factors are important to address in a recovery-oriented mental health system?*
- *What practices that promote recovery are already in place in our program or system? Which services and supports are not yet fully developed?*
- *How well do we help people develop their potential for resilience and recovery?*
- *What aspects of our program or system need to change to better support people's natural capacities for healing and growth?*

The results of the REE can be used to help organizations learn, change, and become more recovery-oriented in ways that make sense to the people involved. It is meant to be part of an organizational development process that includes all stakeholders, not just a one-time event.

The survey instrument was developed by Priscilla Ridgway, PhD. She is a researcher who identifies as a mental health consumer and is an Associate Professor in the Department of Psychiatry at Yale University. She works at the Yale Program for Recovery and Community Health, where she conducts research, training and system-level consultation.

The REE has been tested and found to be a reliable and valid survey instrument. Reliability refers to the survey's consistency and dependability, and validity refers to the accuracy with which the survey measures the concepts it sets out to measure.

In addition to the original survey, Dr. Ridgway has created a REE-short form, which has fewer questions than the original REE instrument. Based on discussions with the Michigan Recovery Council, she created a new version for Michigan, referred to as the **REE-MI**, which is shorter than the original REE but includes more questions than the REE-short form. This is the version that will be used in Michigan **(Appendix A)**.

How is the REE Being Used in Michigan?

The Michigan Department of Community Health (MDCH) has contracted with Advocates for Human Potential (AHP) to design and implement a plan for statewide data collection and analysis of the REE measure. As noted, the REE has been adapted for Michigan and the version being used is called the REE-MI.

The goals of this project are:

- To educate providers and consumers about recovery and to encourage an orientation to recovery in individual and systems planning
- To assess the extent to which recovery-enhancing elements are incorporated into current practice
- To assess consumer needs to facilitate their movement toward recovery
- To provide summary data based upon REE survey results to local communities to support their plans for transforming the system toward a recovery orientation
- To provide summary data based upon REE survey results to the Michigan Department of Community Health and the Michigan Recovery Council to support their plans for transforming the system toward a recovery orientation
- To provide a baseline assessment of the extent to which recovery-enhancing elements are incorporated into current practice, which can be compared to later assessments

To meet these goals, the REE will be administered to a representative sample of consumers receiving services from certain types of programs funded by MDCH. The survey will be carried out in each Community Mental Health Service Program (CMHSP) across the state during 2009, according to a schedule determined by MDCH.

The **types of programs that will be surveyed** are:

- Targeted case management/ Supports Coordination
- Assertive Community Treatment
- Psychosocial Rehabilitation
- Supported employment
- Consumer-run Drop Ins
- Medication clinics

- Group homes serving people diagnosed with serious mental illness
- People living in non-licensed housing who receive Community Living Supports

Surveyors
The REE will be administered by peer surveyors who are current or former recipients of mental health services. AHP will train the surveyors. In many cases, the REE will be completed in group settings. The surveyor will read an introductory statement to consumers who will complete pencil and paper surveys and return them to the surveyor. The surveyor will be available to answer questions or to read survey questions to people who ask for this kind of help. In some situations, the REE may be administered using other methods, such as individually to people in waiting rooms in clinics. Surveyors may not administer the REE in programs where they are or have been employed or receive(d) services.

CMHSPs and REE Implementation Plans
Each CMHSP will submit a REE Implementation Plan for MDCH approval. The plan shows which programs will be surveyed, how many people will be surveyed at each program, and how the CMHSP will ensure that a representative sample of consumers will be surveyed in each program. The REE Plan describes which survey methods – group, individual, or some other method – will be used in each program. The plan also explains how the CMHSP will deploy trained peer surveyors, who will work under contract with the Michigan Disability Right Coalition (MDRC).

REE Implementation Logistics Coordination: MDRC

The Michigan Disabilities Rights Coalition (MDRC) has been contracted by MDCH to recruit, contract with, supervise, deploy, and coordinate the activities of peer surveyors who will administer the REE in each CMHSP. MDRC's responsibilities include:

Recruiting/Hiring/Supervision:
- Recruit and hire individuals who meet all the criteria in the REE Peer Surveyor position description.
- Recruit and hire data entry staff.
- Ensure that all surveyors are trained using the Advocates for Human Potential (AHP) training before being deployed to the field.
- Ensure that surveyors are paid according to plan developed by MDCH
- Maintain regular supervisory contact with surveyors.
- Supervise data entry staff.

Deployment to CMHSPs:

- Establish contact with the designated REE implementation person in each CMHSP.
- Review the CMHSP's approved REE Implementation Plan and the survey schedule for each site with the contact person.
- Assign surveyors to administer the REE in specific CMHSPs and at specific programs, ensuring there are no conflicts of interest.
- Ensure that each surveyor has an accurate schedule of their survey assignments and contact information
- Keep an updated, accurate list of the names and contact information of the designated REE contact people in each CMHSP, each contract agency, and each program location where the survey will be done.
- Coordinate with AHP staff as needed
- Provide surveyors with all needed program materials
- Serve as a contact point for CMHSPs and surveyors for questions or concerns about the survey implementation process

Michigan Association of Community Mental Health Boards (MACMHB)

- Arrange lodging for surveyors as needed
- Handle all travel and meal reimbursements
- Ensure that surveyors have access to sufficient hard copies of the REE and enough extra copies of the Recovery Markers section to meet their assignments
- Receive all completed surveys for distribution to individuals who will do the data entry
- Maintain secure filing system for paper surveys following data entry.

CMHSP Responsibilities

The CMHSPs are responsible for making sure that the logistics of administering the REE are carried out smoothly in each CMHC and in each contract agency in its area. The CMHSPs will provide MDCH, AHP, and MDRC with the name and contact information of an individual responsible for putting the CMHSP's approved REE Implementation Plan into practice.

This person's responsibilities will include:
- Ensuring that each program to be surveyed assigns a contact person responsible for making sure that REE implementation goes smoothly. Gather full contact information (phone and email) for each program contact person.
- Ensuring that the approved sampling plan is carried out accurately in each program.
- Establishing contact with MDCH to share the schedule for surveying each program, information on each program contact person, and discussing logistical issues.
- Responding to questions or requests for clarification or assistance from surveyors.

- Facilitating the surveyors' work with each program by providing all needed contact information, directions, introductions, and other necessary information to MDCH.

The REE contact at **each program** to be surveyed will be responsible for:
- Establishing contact with MDCH and/or directly with the consumer surveyor(s) assigned to survey the program.
- Holding an initial planning and scheduling call or meeting with the surveyor(s).
- Responding to questions or requests for clarification or assistance from surveyors.
- Arranging for mutually convenient times for the survey to be conducted at the program.
- Ensuring that the sampling plan is carried out accurately.
- Arranging for appropriately sized private space at each site for survey administration and access to a photocopier for the surveyor.

Surveyors' Responsibilities

The surveyors' responsibilities will include the following tasks, which will be explained in greater detail later in this manual:
- Participate in AHP training.
- Get in touch with the designated REE contact person at each program to which you are assigned and participate in an initial planning/scheduling call or meeting if needed.
- Keep all scheduled appointments to conduct the survey.
- Arrive 30 minutes before the scheduled survey time at each site to ensure that the room has been set up and needed supplies and/or equipment are there.
- Bring sufficient pencils and paper copies of the survey.
- Distribute and collect survey forms.
- Introduce the survey by reading the introductory script.
- Be available to assist people and answer questions.
- Speak to the program's contact person and/or MDRC if problems arise during the survey process.
- Maintain accurate time sheets and travel vouchers
- Keep all completed paper surveys in a safe place and in a provided, sealed envelope labeled with the program's name the completed surveys are sent to MACMHB for data entry.

See APPENDIX B: Michigan REE Implementation: Mutual Responsibilities

Section 2. Survey Basics

As a surveyor, you don't need to be an expert on research and evaluation methods, but it will help you understand your role if you know a few basic things about surveys, how the REE was developed, how information collected through the survey must be handled and why, and how the results will be used.

In a typical survey procedure, there are a number of important steps that must be completed, including:

- development of the survey instrument or questionnaire
- testing and re-testing of the survey for validity and reliability
- collecting data
- recording the collected data and keeping it secure
- analysis of the data and preparation of reports

In this project, your main role in this process will be to:

- collect the data by administering the REE according to your assigned schedule
- keep the data secure by sealing each program's survey forms in a properly labeled envelope, and
- forward the completed survey forms to MDRC for data entry and safekeeping

Development and Testing of the REE

The REE was developed by Priscilla Ridgway, Ph. D., a consumer/researcher. She saw a need for an evaluation tool to measure how well mental health services are promoting recovery, and to what extent people who use mental health services are making progress toward their recovery.

To develop a set of questions that reflected what is known about recovery and mental health, Dr. Ridgway took the following steps:

- Reviewed first-person accounts of the mental health recovery process and the services and supports people say enhance their recovery;
- Reviewed emerging promising practices that promote recovery drawn from an informal literature review, workshop descriptions, and progressive programs; and,
- Conducted a literature review of factors that facilitate resilience, or rebound from adversity, in general

Using these sources, she designed a survey that was reviewed and pre-tested by people in a Consumer-as-Provider training program and by people served in a community support program. Items were revised, dropped, and added based on consumer input. The REE

measure was edited and the format and content were refined based on the input of other researchers.

Two formal field tests were conducted on the REE, involving over 500 people. Statistical tests were done to make sure that the REE was a reliable and valid survey tool. Reliability refers to the survey's consistency and dependability, and validity refers to the accuracy with which the survey measures the concepts it sets out to measure. The REE was revised and finalized based on the findings of the field tests, and the result is what is known as a *standardized survey instrument*.

Ensuring the Integrity of the Survey Process

A *standardized survey instrument* is one that asks the same established list of questions of every person surveyed. It is administered and scored in a consistent manner. Any differences in answers should be directly attributable to differences between respondents (people answering the questions), NOT to differences in the process that produced the answer. Therefore, it's important for the surveyor to follow certain rules to ensure that the survey remains standardized.

In order to maintain the integrity of the survey process using a standardized instrument, each surveyor needs to be aware of the following issues:

- Maintaining confidentiality
- Avoiding conflicts of interest
- Avoiding bias

Maintaining confidentiality

Since you will **not** be gathering the names of people who complete the REE and people must be asked **not** to write their names on the survey form, maintaining confidentiality will not be as complex as it would be if you were collecting identified information. Still, it is important to keep these issues in mind, and you will be required to sign a **Confidentiality and Non-Conflict of Interest Pledge** (Appendix C).

In the introductory script that you will read to people taking the survey, you will instruct people taking the survey NOT to write their names on the forms. If you receive completed surveys that have been marked with names or other identifying information, you must immediately cross out this information to make it unreadable.

If anyone taking the survey verbally reveals any personal information to you in your role as a surveyor, you must not disclose this confidential information to friends, relatives, co-workers or anyone else.

Avoiding conflicts of interest

Conflicts of interest – or even the appearance of conflicts – interfere with the integrity of the survey process. That is why the **Confidentiality and Non-Conflict of Interest Pledge** that you will sign addresses the following issues:

- You cannot not administer the REE in any CMHSP or contract agency in which you are currently or were formerly employed
- You cannot not administer the REE in any programs run by organizations from which you currently or formerly received services

It is important to remember that violating either the confidentiality pledge or the non-conflict of interest pledge will be grounds for dismissal.

Avoiding bias

In survey procedures, "bias" refers to anything that might influence the answers that people give to the survey questions. For instance, if the questions on different copies of the form were worded slightly differently, or if surveyors gave different explanations of the survey procedures to different groups of people, these would be potential sources of bias. This is why standardized surveys have to be administered in the same way, with the same list of questions and the same instructions, no matter who is giving the survey and who is taking it.

As we'll discuss in the next section, we will work hard to avoid sources of bias in implementing the REE in Michigan by:

- Using a prepared script to introduce and explain the REE every time the survey is administered (Appendix D)
- Using a list of standard answers to ***Frequently Asked Questions about the REE*** (Appendix E)
- Being clear about what kind of assistance and support are OK to give people and what kind of assistance could be a source of bias

Section 3. Surveyor Role and Responsibilities

Overview: The Surveyors' Role in Brief

- To introduce and explain the survey to groups or individuals who will complete the REE by reading a prepared script
- To distribute blank copies of the paper survey instrument and collect completed instruments
- To answer questions about the survey instrument but **not** to interpret the meaning of questions
- To make sure survey procedures are followed and that everyone eligible who wants to complete the survey has the opportunity to do so
- To act in a pleasant but professional manner in carrying out these responsibilities, and to refrain from interactions with participants that are outside the scope of the role of surveyor
- Maintain accurate time sheets to be returned to MDRC
- Maintain accurate travel records including mileage and receipts for return to MACMHB
- To keep completed surveys properly labeled and secure until they are sent to MACMHB for data entry and secure storage.

Preparation: Before You Administer the Survey

The Role of the MDRC

Know the name and contact information of your supervisor at the Michigan Disability Right Coalition (MDRC) and your local survey team leader. They will be responsible for:

- o Serving as a liaison between you and the CMHSPs and agencies in which you'll be administering the REE
- o Assigning you to the specific programs you will survey
- o Receiving and processing your time sheets
- o Helping you problem-solve if issues arise while you're doing your work

The Role of MACMHB

- o Receiving and processing your travel expense vouchers
- o Making sure that you have:
  - ✓ the address, contact information, and directions to each program you survey
  - ✓ sufficient copies of the REE survey form
  - ✓ extra copies of the Recovery Markers section for people to keep if they wish
  - ✓ large envelopes labeled with the local contact information for *each* program you survey

- ✓ pre-addressed envelopes to return the survey forms to MACMHB for data entry

Become Familiar with the REE Survey Instrument

While we went over the sections of the REE during your surveyor training, it's important that you read through it several times on your own to make sure you are comfortable and familiar with it before you go out to administer the survey for the first time. Another way to become familiar with what it feels like to complete the REE is to take the survey yourself for practice.

Day-of-the-Survey Activities

Checklist:

- ✓ Arrive at the survey site 30 minutes before the scheduled start time with:
  - The *Day-of-the-Survey Checklist* (Appendix F)
  - Introductory script (Appendix D)
  - A copy of *Frequently Asked Questions about the REE* (Appendix E)
  - Enough blank copies of survey forms for the sample + 5 extra
  - Enough extra Recovery Marker forms for the sample + 5 extra
  - Pencils or pens
  - Local site contact information
  - MDRC contact information

- ✓ Meet the site's contact person; make sure the room has been set up for the survey

- ✓ Distribute survey forms & pencils or pens
  (this applies whether you will be surveying a group, asking people in waiting rooms to complete the REE, or using some other method)

- ✓ Read the introductory script

- ✓ Be available to answer questions or to read survey questions if asked

- ✓ Collect and count returned survey forms

- ✓ Seal the completed forms in an envelope with the name of the program; date & initial it. Keep the envelope in a safe place until it is returned to MACMHB for data entry.

REE Introductory Script

As we discussed earlier, you ***must*** use the prepared script to introduce and explain the REE every time the survey is administered. The reason for this is to eliminate the possibility of bias by making sure that everyone who takes the survey hears the same information. The introductory script is **Appendix D**.

It will be helpful if you ***practice reading the script aloud*** several times before you administer the REE for the first time. If you are familiar with the words and comfortable repeating them aloud, the script will sound more natural to you.

It's important not to paraphrase the script or to change the wording or the sequence of the sentences. Just read it aloud exactly as it is written.

Handling Questions

In your role as surveyor, people who've been asked to participate in the REE may ask you questions. It's important that you answer these questions consistently in order to avoid biasing the survey results.

General Questions

There are two types of questions that you are most likely to be asked. The first type is *general questions about the survey*: what the REE is, who is conducting the survey, why the information is being collected, what will be done with the results.

It's important that you use the same language to answer these questions whenever they are asked, so we have prepared a list of **Frequently Asked Questions about the REE (Appendix E).** Again, don't paraphrase or add anything to the answers – just read them as they are written.

Questions about the Content of the REE

People may ask you to explain what is meant by a question on the REE survey. There are very specific and limited ways that you can address people's questions about the content of the REE.

For any number of reasons, someone may ask for your help in reading a question or may ask you to read all the questions to them aloud. It is perfectly OK for you to provide that kind of help – in fact, it's really part of the job of the surveyor. If this happens in a group

setting, you might suggest that the two of you go to a quiet corner to do this so you don't disturb others.

But if people ask you to explain the meaning of a question or the meaning of a word, you are very limited in what you may say to them. Your options are:

- To read the entire question to them aloud
- Reply with a phrase like "whatever _____ means to you"
- You may answer a "yes-or-no" kind of question. For example, if someone asks "Is yoga a type of wellness programming?" you can answer "yes." (Or if someone asks if a hotdog-eating contest is a type of wellness programming, you can answer "no.") But if someone asks you to give them examples of "wellness programming" beyond what is explained within the question, you cannot give them any suggestions.
- Explain to the questioner that the rules of the survey don't allow you to give them any explanations beyond those described above, and that the reason for this rule is to make sure that everyone who takes the REE survey does so with the same information.

Handling of Completed Survey Forms

Your final responsibility for each survey site is to ensure that all completed surveys forms are collected and that all the forms from the same program are kept together until they are returned for data entry. That's why it's important to seal all the surveys from a program into an envelope labeled with the program's name as soon as you collect all the completed surveys. These envelopes will either be returned to the MDRC supervisor or lead surveyor onsite, or will be mailed back to MACMHB for data entry. MDRC supervisory staff will inform you about what method will be used for each site.

Appendices

Appendix A: Recovery Enhancing Environment Measure- Michigan (REE-MI)
(*Not included here: See Appendix 3 of the larger statewide report document*)
Appendix B: Michigan REE Implementation: Mutual Responsibilities
Appendix C: Confidentiality and Non-Conflict of Interest Pledge
Appendix D: REE-Michigan Introductory Script
Appendix E: Frequently Asked Questions about the REE
Appendix F: REE Day-Of-Survey Checklist

Michigan REE Implementation:
Mutual Responsibilities of CMHSPs, MDCH and its Contractors, and Surveyors

The Recovery Council, in partnership with the Michigan Department of Community Health (MDCH), recommended implementation of the Recovery Enhancing Environment Measure (REE) within each CMHSP and each contract/provider agency during FY09. The REE is a survey of adults with serious mental illness designed to identify the extent to which recovery-enhancing factors are present within mental health programs and the extent to which individuals receiving services report that they are experiencing recovery.

REE implementation will be a complex process engaging a number of parties; this document provides an overview of the roles and responsibilities of the organizations and individuals involved in making REE implementation a success.

MDCH and its Contractors:

- MDCH has requested that each CMHSP submit a REE Implementation Plan for its approval, as described in the PPGs.
- MDCH has contracted with Advocates for Human Potential (AHP) to develop a plan for REE data collection; develop planning, training, and survey materials; to train surveyors; to serve as a resource for CMHSPs during implementation; to receive and analyze data; and to report findings to MDCH and CMHSPs.
- MDCH has contracted with the Michigan Disability Rights Coalition (MDRC) to for recruit, hire, supervise, deploy, and coordinate the activities of consumer surveyors who will implement the REE in each CMHSP. MDRC will also recruit, hire and supervise data entry staff. These responsibilities are explained in detail in the document called "Michigan REE Surveyor Supervision and Logistics Statement of Work."

CMHSP Responsibilities:

Each CMHSP will provide MDCH and its contractors AHP and MDRC with the name and contact information of an individual responsible for putting the approved REE Implementation Plan into practice within the CMHSP. This person's responsibilities will include:

- Contacting each contract agency to explain REE implementation and get the name of a contact person responsible for REE logistics at each contract agency and each program to be surveyed
- Ensuring that each CMHSP-run program has a contact person responsible for REE logistics
- Establishing contact with MDRC, which will be responsible for hiring and deploying surveyors, to ensure that they have all required contact and scheduling information
- Facilitating the surveyor's work with each program site by providing them with all needed contact information, directions, introductions, and other necessary information
- Coordinating with contract agency and program contacts to ensure that the approved sampling plan is carried out accurately in each program to be surveyed

- Coordinating with contract agency and program contacts to establish contact with the consumer surveyor(s) assigned to each program and have an initial planning and scheduling call or meeting with the surveyor(s)
- Ensuring that the contract agency and program contacts arrange for mutually convenient times for the survey to be conducted in each program
- Ensuring that the contract agency and program contacts are equipped to respond to questions or requests for clarification or assistance from surveyors
- Coordinating with contract agency and program contacts to arrange for appropriately-sized private space at each site for survey administration and access to a photocopier for the surveyor.

Surveyors' Responsibilities:
The REE will be administered according to each CMHSP's approved REE Implementation Plan by surveyors who are current or former recipients of mental health services hired by MDRC and trained by AHP. Surveyor's responsibilities will include:

- Participating in AHP training and refer to training manual as needed
- Contacting AHP by email or toll-free phone number if needed for technical support
- Establishing communication with the designated contact person responsible for implementation at each assigned survey site
- Maintaining a list of contact information for contact persons at each assigned survey site
- Participating in an initial planning meeting or conference call with the CMHSP and contact persons to clarify roles, responsibilities, times and locations of survey administration at least two weeks prior to administration
- Keeping all scheduled appointments. If circumstances arise that interfere with the ability to keep scheduled appointments, phone the agency contact person and the MDRC at the earliest opportunity to provide notice and identify an alternative appointment date and time
- Arriving at each survey site at least 30 minutes prior to scheduled administration to ensure that all necessary equipment is available and the room is properly arranged for survey administration
- Bringing a sufficient number of pencils and paper copies of the survey to each site
- Bringing extra copies of the Recovery Markers section of the survey so that participants can take copies with them
- Introducing and administering surveys to groups and individuals in pencil/paper format or on-line via computer link
- Providing direct assistance to individuals who request assistance completing the survey
- Contacting the CMHSP/contract agency contact person or the MDRC if you encounter problems or questions you are unable to answer during the survey process

- Sealing completed paper surveys in the pre-labeled envelope for each specific program and keep them in a safe place until they are forwarded to the MACMHB for data entry and secure storage.

CONFIDENTIALITY AND NON-CONFLICT OF INTEREST PLEDGE
for contracted surveyors administering the REE in Michigan

Confidentiality of personal information

I understand that as a contracted surveyor administering the Recovery Enhancing Environment measure (REE) in Community Mental Health Services Programs (CMHSPs) and provider organizations throughout Michigan, I will NOT routinely collect or have access to confidential personal information about individuals completing the survey.

I will instruct people taking the survey NOT to write their names or any other indentifying information on the survey forms and I will NOT collect or write down the names of people taking the survey. If I receive completed survey instruments that have been marked with names or other identifying information, I will immediately cross out this information to make it unreadable.

If individuals taking the survey verbally reveal any personal information to me during my interactions with them in my role as a surveyor, I will not disclose this confidential information to friends, relatives, co-workers or anyone else.

Non-Conflict of Interest

To ensure that I have no conflicts of interest with CMHSPs or provider organizations in which I will administer the REE, I state that:

- I will not administer the REE in any CMHSP or contract agency in which I am currently or was formerly employed; and
- I will not administer the REE in any programs run by organizations from which I currently or formerly received services.

I have read the above pledges and agree to be bound by them. I understand that violation of these pledges will be grounds for dismissal.

Name: _____________________________ Signature: ____________________________________
(print)

Date: _______________________________

REE – Michigan Introductory Script

Hi, my name is _____________ , I am also a person who has received mental health services. I am here from the Michigan Recovery Council to offer to the chance to take the Recovery Enhancing Environment Survey.

The Michigan Department of Community Health wants to know if the services you receive at __________________ are helping you get the life that you want.

This is an anonymous survey, I am not collecting names so don't write your name on the form. All your answers will be confidential.

The survey is voluntary, you don't have to participate. You can skip any questions, or stop that survey at anytime.

This is not a test. There are no right or wrong answers. We are looking for your opinions and beliefs.

The survey is divided into 5 sections. Each section has the instructions at the top.

Remember, that your answers apply only to the services you receive at ___________________.

If you like, you can fill out an extra copy of the Recovery Markers section to take with you. You can keep this for your own information, or use it in your person centered planning process.

Thank you for taking the time to share your opinions by taking this survey.

Frequently Asked Questions about the REE

(1) What is the REE?

The Recovery Enhancing Environment Measure, called the REE for short, is a survey that collects information about recovery from people who use mental health services. The survey results show how successful a program is in supporting recovery.

(2) What do you mean by "recovery"?

Mental health recovery is a journey of healing and transformation that enables people with mental health problems to live meaningful lives in their chosen communities and strive to achieve their full potential.

(3) Who is conducting the REE survey in Michigan?

The survey is being conducted at the request of the Michigan Recovery Council and the Michigan Department of Community Health. The people administering the survey are people who have received mental health services. They are working on behalf of the Michigan Recovery Council.

(4) Why is this information being collected?

The survey is being done to find out what kind of improvements people who use mental health services think are needed. It is very important that we get the opinions of everyone in order to get useful results. Your input is valuable to us and we need your help.

(5) How was I picked to take this survey?

Your service provider was asked to randomly choose a certain number of people who receive services at this program and ask them if they would agree to take the survey. The surveyors do not have the names of people who take this survey.

(6) How will the results be used?

The results of this study will be used to help policy makers, staff and consumers work together to decide how to improve mental health services in Michigan.

(7) I have a problem at this program with ______. Can you help me?

(note: People may approach you about issues they have the program, with staff, with their housing, medications, or many other issues that are outside your role as a surveyor.)

I'm sorry, but I can't help you with that. I am here only to give the survey. You can talk to <u>(name of on-site program REE contact person)</u> about that.

(8) How do I answer the questions in Section I? (A Few Questions About You)

For each of the five questions in this section, put a check mark next to the **one** answer that best describes yourself.

(9) **How do I answer the questions in Section II?** (Your Involvement In The Recovery Process)

Put a check mark next to the **one** answer that is **most** true for you.

(10) **How do I answer the questions in Section III?** (Elements of Recovery and Recovery-Enhancing Programs)

You'll see that each question has four parts. The first part in bold type is a statement about an issue related to recovery. Under the statement, there are three questions labeled a, b, and c.

For **each** of these questions, circle the **one** answer that reflects your opinion:
SA --If you ***strongly agree*** with the statement.
A --If you ***agree*** with the statement
D --If you ***disagree*** with the statement.
SD --If you ***strongly disagree*** with the statement.

(11) How do I answer the questions in Section IV? (Special Needs)

Each of the questions is to be answered **only** by a specific group - for example, parents or people with trauma histories. If you are NOT a member of the specific group being asked about in the question, answer "no" and go onto the next question.

If you ARE a member of the group being asked about, answer "yes," and then answer **each** of the four parts by circling the **one** answer that reflects your opinion:
SA --If you ***strongly agree*** with the statement.
A --If you ***agree*** with the statement
D --If you ***disagree*** with the statement.
SD --If you ***strongly disagree*** with the statement.

(12) How do I answer questions in Section V? (Recovery Markers)

For questions 1 through 23, circle the **one** answer that reflects your opinion:
SA --If you ***strongly agree*** with the statement.
A --If you ***agree*** with the statement
D --If you ***disagree*** with the statement.
SD --If you ***strongly disagree*** with the statement.

For questions 24 through 27, check **true** if the statement is currently accurate about you, and check **false** if it is not currently accurate for you.

REE: DAY-OF-THE-INTERVIEW CHECKLIST FOR SURVEYORS

- ✓ Arrive at the survey site 30 minutes before the scheduled start time with:

    - o This checklist
    - o Know the name of the program (such as Appleton Clubhouse)
    - o Introductory script
    - o A copy of ***Frequently Asked Questions about the REE*** (Appendix E)
    - o Enough blank copies of survey forms for the sample + 5 extra
    - o Enough extra Recovery Marker forms for the sample + 5 extra
    - o Pencils or pens
    - o Large manila envelopes labeled with program contact information
    - o Local site contact information
    - o MDRC contact information

- ✓ Meet the site's contact person; make sure the room has been set up for the survey

- ✓ Distribute survey forms & pencils
  (this applies whether you will be surveying a group, asking people in waiting rooms to complete the REE, or using some other method)

- ✓ Read the introductory script

- ✓ Be available to answer questions or to read survey questions if asked

- ✓ Collect and count returned survey forms

- ✓ Seal the completed forms in an envelope with the name of the program; date & initial it

- ✓ Keep the sealed envelopes in a safe place until they are collected by the on-site MDRC supervisor or lead surveyor, or are forwarded to MACMHB for data entry and storage.