

**ASSESSING THE RECOVERY- COMMITMENT
OF YOUR MENTAL HEALTH SERVICE:**

**A USER'S GUIDE FOR THE
DEVELOPING RECOVERY ENHANCING
ENVIRONMENTS MEASURE (DREEM)**

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INTRODUCTION TO RECOVERY AND TO THE RECOVERY ENHANCING ENVIRONMENT MEASURE

What is mental health recovery?

Mental health recovery is a complex process. The following definition (Ridgway, 1999) is drawn from first person accounts or autobiographies:

Mental health recovery is an on-going journey of healing and transformation that involves:

- 1) reclaiming a sense of meaning, hope and a positive sense of self
- 2) managing one's mental health to reduce the impact of distressing symptoms or experiences and achieve a higher level of wellness; and,
- 3) reclaiming roles beyond being a user of services in the mental health system.

Recovery is influencing mental health services around the world and is significantly advanced by current UK Government policy as highlighted in the publication 'The Journey to Recovery.' That summarises the policies contained in *Modernising Mental Health Services; The National Service Framework for Mental Health* and the chapter on mental health in *the NHS Plan* that include:

- involving people who use services and their informal carers in the planning and delivery of care
- delivering high quality treatment and care:
 - which is known to be effective and acceptable
 - that is well suited to those who use it and is non-discriminatory
 - that is accessible, so that help can be obtained when and where it is needed
- promoting the safety of people who use services and that of their informal carers, staff and the wider public
- offering choices that promote independence
- services that are well co-ordinated between all staff and agencies
- delivering continuity of care for as long as it is needed
- empowering and supporting staff
- services that are properly accountable to the public, people who use services and their informal carers

This emphasis on quality effective treatment and care for people who use services; on partnerships and collaboration and more recently the report from the Social Exclusion unit (June, 2004) and the NIMHE Guiding Statement on Recovery (December, 2004), are an excellent policy framework for implementing mental health services approaches that are highly individualised, and oriented toward recovery.

In the United States the Surgeon General's (1999) recommended that all mental health systems promote recovery. The Federal Centre for Mental Health Services (CMHS) has adopted "building resilience and facilitating recovery" as its mission. The President's New Freedom Commission on Mental Health (2003) makes mental health recovery a central concern and recommends transforming mental health care so that each person with prolonged psychiatric disorders has a personal recovery plan. Each State has a Recovery Plan, and mental health systems are much more 'consumer'-driven. The Blueprint for Mental Health Services in New Zealand (1998) and

2nd Mental Health Plan (2004) adopt mental health recovery as the main goal of all mental health services.

Given this, there is an urgent need to find ways of enabling services to approach the development of recovery facilitating services. The DREEM begins to achieve this.

What is the DREEM?

The Recovery Enhancing Environment Measure (REE) is a self-report instrument that gathers information/data about mental health recovery from people who receive mental health services. The REE asks people where they are in their 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 service on three activities associated with each of these elements. They also rate the service on factors in the system that promote resilience. Open-ended questions encourage people to share the wisdom they have gained on their recovery journey, and to say how they think staff and systems could be more supportive of their recovery.

Who should use the DREEM?

The REE was designed to be used by:

- Mental health systems including regional and local mental health services;
- Large and small independent sector organisations providing mental health services;
- Free standing multi-service mental health agencies;
- Any service or system whose mission is to comprehensively serve people with mental health problems.

REE studies should be undertaken by services that already operate from the basis of mental health recovery, or that have made a firm commitment to shift the delivery of services to a recovery-orientation. Large mental health systems that want to ensure that each element of their service promotes recovery can use the DREEM to gather information/data across the system, establish some performance standards, and plan system transformation. Large systems can assess a number of services at one time and they can collect data at several points in time, to compare how they perform with other services in the system, and they can use REE data to track performance improvements over time.

People in recovery can also learn from completing the DREEM. Some of the people with mental health problems who were involved in developing the REE said the survey made them feel good about themselves and their recovery; that filling out the survey was educational and that the REE helped them think about their recovery and decide what they wanted to work on next. Some people said that they had never heard of mental health recovery, and did not even know that recovery was possible, until they responded to the REE survey. Some people said they discovered mental health recovery, and the fact that they were *already in recovery*, by completing the REE!

Why is the information attained from the DREEM useful?

The mental health field is undergoing a change in the way we think about peoples' experiences of mental distress, the principles that guide systems and services and the way we serve people. The shift to a recovery orientation actually began more than a decade ago. New national policies in the US and New Zealand began to demand that local systems make this shift. Important national reports in the US like the Surgeon General's Report on Mental Health (1999) and the President's New Freedom Commission (2003) and Blueprint for Mental Health Services in New Zealand (1998) and 2nd Mental Health Plan (2004) support the idea that mental health recovery should become the main goal of all mental health services. A focus on user-defined outcomes is likely to be adopted in many services in England as part of 'putting the user at the centre of everything we do' and a move to outcomes measurement.

Many mental health services are interested in "putting recovery on the ground" and are actively seeking the knowledge and research tools they need in order to move recovery from an ideal vision into an everyday reality. Despite the many innovations taking place in local services and systems the mental health field currently lacks a fully developed model for recovery-oriented practice. The lack of well-conceptualized, well-designed, and psychometrically sound measurement tools also leaves mental health managers and clinicians at a loss when they attempt to systematically determine whether their service promotes or impedes recovery. The DREEM helps fill the gap in the knowledge base on what services can do to support recovery.

The REE may be said to represent a new generation of recovery measures. After a thorough review of the research instruments that were available or under development, internationally known consumer leader and recovery researcher, Patricia E. Deegan, Ph.D. described the REE as "A quantum leap beyond every other measure currently available in the field." The DREEM is unique because it gathers information on personal mental health recovery and the elements that people feel are important to their recovery; staff activities, and an organisational climate that encourages resilience.

The Recovery Enhancing Environment measure (REE) was designed to provide mental health services with answers to questions such as:

- *Where are the people we serve on their personal journeys of recovery?*
- *What elements are important to address in a recovery-oriented mental health system?*
- *What recovery-facilitating practices are already in place in our service or system?*
- *How well are we currently facilitating peoples' potential for resilience and recovery?*
- *What aspects of the environment need to change to better support people's natural capacities for healing, rebound, growth and thriving?*

How can agencies and systems use the findings of an REE study?

Data from the REE can be used to:

- Educate staff and people who use services about mental health recovery
- Orient services towards recovery

- Target specific service innovations and efforts to change organisations
- Assess the impacts that programme change/different recovery facilitating supports have on personal recovery
- Compare the performance of agencies and services
- Support on-going quality improvement

In fact, a few service directors have used the REE instrument to focus discussion, reframe policies and to retrain staff, even before they gathered any data. They said the ideas contained in the REE survey helped them to ground their ideas about recovery in very practical ways. They then used the data they gathered from the people they serve to celebrate the things they already did well and to make decisions about specific next steps they wanted to take to improve the services, supports and organisational climate that their service offers.

An “Ideal Way” to use the Recovery Enhancing Environment Measure

Ideally, groups will use the REE as a tool that helps them target change through mutual learning, creative problem-solving, ‘dreaming together’, strategic planning and on-going innovation. No magic bullet or single way of “doing recovery” exists. A progressive mental health service or system will seek many ways to enhance the potential for recovery in the people they serve. An REE study should be only one of many efforts in an on-going process of personal and organisational transformation. We don’t know everything there is to know about mental health recovery, or about the services and supports that can best facilitate personal recovery, at this point in time. But we can make a commitment to keep learning more and make important changes based on what we know right now. Some progressive leaders talk about mental health *services and systems recovering or being “in recovery”* and say that services and systems need to take on the work of recovery, just as individuals do the work of their own personal recovery. This concept of recovery and resilience in relation to organisations is highlighted by the Local Authority Recovery Programme run from the Office of the Deputy Prime Minister.

REE data can help an organisation to learn, to change, and to grow into a recovery orientation in ways that make sense to the people involved. Change should be tailored to the organisations’ existing resources and strengths and must address the challenges and constraints that exist in the particular environment as well. Positive change can happen in many ways. Moving toward a recovery orientation might mean changing the way staff are trained, making innovations in programming, the appointment of skilled staff with lived experiences of recovery and recognising expertise by experience, becoming a more trauma-sensitive service, creating new ways for people to identify and use their personal strengths. We also envisage: increasing user of service input into quality assurance effort, making the service more welcoming, and increasing attention to people’s circles of support, including the opportunities available for mutual self-help and peer support. There are a host of potential reforms that REE findings can suggest.

Ideally, a service or agency would conduct an REE study by setting up a steering committee made up of people who use services, peer leaders,

evaluators, providers and other stakeholders. The committee would plan the study and oversee the collection of data. The group would analyse the data, and, together, interpret the findings. The group would then work together to set some clear priorities and plan concrete things that the service would commit to doing to move the system forward.

The dream behind the DREEM was that it would serve as a useful tool in a process of organisational transformation that fully involves users of mental health services at every stage along with LIT (Local Implementation Team), PCT, Trust and other commissioning, planning and provider boards, service staff etc.

REE data are only helpful if they are used to focus innovation and lead to positive change – and the very best efforts empower everyone involved by taking place through small groups of people working together!

The DREEM is one among many ways of learning more about recovery and listening to people who use mental health services more carefully and more fully. REE data can be used along with other methods, such as holding focus groups, and involving councils of people who use services or user of service advisory group members on the service's board of directors. Services or agencies can also collect user satisfaction data and find ways to gather and use on-going feedback on outcomes that are important to people in recovery such as the Ohio service user outcomes tool adapted by members of NIMHE's Experts by Experience group.

BACKGROUND OF THE DREEM

Why was the DREEM developed?

People have always recovered from mental illness, even though the mental health system and mental health professions have not operated from a recovery orientation. As long ago as 1838 in England, John Perceval published his narrative of his experience of psychosis and his recovery. Since then many personal narratives of recovery from mental illness have been written. Recent professional interest in recovery was mainly stimulated by a leading figure in psychiatric rehabilitation, Bill Anthony, who in 1993 declared that recovery provided a new guiding vision for mental health service delivery (Anthony, 1993). In 1998 New Zealand published its Blueprint for Mental Health Services and in 1999, the Surgeon General of the United States recommended that all mental health systems become recovery-oriented. Nevertheless, little direct guidance is available at this time about what mental health recovery entails and what constitutes a recovery-oriented mental health system. Very few research tools have been designed to help services assess their recovery-commitment, either from the perspective of the personal recovery of the people they serve or from the perspective of the supports that the service provides. The Recovery Enhancing Environment Measure (REE) was designed to help fill this knowledge gap.

Several other recovery measures have been created since the DREEM was first designed in 1999. But, as yet, no other psychometrically tested measure

is available that looks at personal recovery *and* at mental health services and organisational climate at the same time.

The primary goal of the DREEM is to create a sound, useful and comprehensive measure that helps services to learn about recovery and to assess the extent to which users of service judge that the services' staff, offerings and organisational climate support their recovery.

What steps were used to design and test the REE?

The contents of the measure were developed based on:

- An examination of first person accounts of the process of mental health recovery and the services and supports people say enhance their recovery;
- A review of emerging practices that promote recovery drawn from an informal literature review, workshop descriptions and progressive services; and,
- A literature review of factors that facilitate resilience or rebound from adversity in general (Ridgway, 2004).

Who developed the REE?

The DREEM was designed by Priscilla Ridgway who has both personal and professional experience with mental health recovery. She has worked in the field of mental health for more than 30 years. Her work includes serving as a psychiatric aide, a case manager, an advocate and ombudsman for more than 300 inpatients in a State hospital, and the programme administrator of a supported housing programme.

The DREEM was edited for use in England by Piers Allott, NIMHE (National Institute for Mental Health in England) Fellow for Recovery and Peter Higginson who as part of his journey assists with editing, writing and teaching academic style at the School of Health, University of Wolverhampton. This edited version has aimed to bring the DREEM into an English linguistic and policy context and reduce the length and complexity of the original explanatory text to make it more accessible to a wider English audience.

DECIDING TO USE THE DREEM

Why, When and How should the DREEM be used?

The DREEM can be used as an assessment and service/agency self-study, or as an aspect of on-going service evaluation and service improvement efforts.

- Services that are just beginning to embrace a recovery orientation can use the DREEM to gather information to make decisions about the changes they want to make. They can track the impact of movement toward a recovery orientation by gathering more DREEM data across time.
- Services that have already made a significant investment in creating a recovery-committed service can use the DREEM to see what they are doing well, and where further work is needed to improve their service.

- Services that want to assess the impact of specific changes can track improvement of people who use services before and after the introduction of a new recovery facilitating approach or support. To do this they can use portions of the DREEM (involvement in the recovery process and recovery markers) to assess change over time. To do this, they administer these sections before a specific therapeutic activity takes place to gather baseline data, and then gather data again at least twice more after the activity takes place.
- Researchers can use the DREEM to learn more about recovery by looking at the interaction between changes in the environment and changes in outcomes for users of service. To do such a study they can use the DREEM alone, or use it along with other measures that assess other important domains such as level of functioning, symptoms and perceived quality of life.
- Mental health commissioners and large mental health service providers may want to use the DREEM to identify how services are performing as recovery-enhancing settings. They can use DREEM data to target in-depth training or quality enhancement efforts to the services whose performance indicates the need for improvement.

METHODS

How should a DREEM study be conducted, and by whom?

The DREEM is completed by people who use mental health services. A self-report measure for people who use services was developed because two important values of mental health recovery are “self-determination” and that “recovery-oriented services are driven by people who use services” (see National Service Framework for Mental Health and the NHS Plan as well as the New Freedom Commission for Mental Health, 2004). The experiences and expectations of people who use services have been found to be most relevant to the outcomes for people who use services in other person/environment research (for example Coultin, Holland & Fitch, 1984 and Ohio Department of Mental Health, 1999). The DREEM is based on the idea *that the person in recovery is the primary expert in understanding his or her own recovery, and must have both the right and the opportunity to make choices and to have a voice in saying what is important to him or her.* DREEM studies provide people who use services with a structured opportunity to say what is important to them, to share their experience, to have their opinions heard, and to influence the creation of recovery oriented mental health services and systems.

- The DREEM can be self-administered or it can be conducted as a personal interview.
- The DREEM can be completed person-by-person, or administered in a group.
- The DREEM was field tested as a mail-out survey, but the response rate was quite low (13.6%). The survey *may* perform adequately as a mail-out survey *if* the level of literacy of respondents is high *and* people think the data will be used immediately to improve their service *and* if they receive some sort of an honorarium for completing and returning the survey.

- For populations whose first language is not English or people with lower levels of literacy, a trained interviewer in the person's first language or someone assisting with the study should administer the questionnaire as a personal interview, or be available to read or explain any parts of the questionnaire that an individual finds difficult. The person administering the survey and/or a helper can answer any questions anyone has about language or content.
- If the survey is conducted as a personal interview, the interviewer should be trained. Interviewers should be taught the basics of confidentiality, values and ethics, interviewing, and should be given a script or suggestions for introducing the survey. Training can include having the interviewer complete the survey, having the interviewer conduct an interview under supervision, or audiotape an interview and then having the interview assessed by a skilled interviewer. People who use mental health services can be good DREEM interviewers. Having peer interviewers can increase service recipients' willingness to give answers that reflect their genuine opinions. It is important to employ and train enough interviewers. Keep in mind that some first-time interviewers may choose to do very few interviews, while others may do many more. Some people conduct a certain number of interviews and then reach the point where their earnings have an impact on the level of their benefits. Employing a user-run service to conduct interviews or to take on an entire DREEM study is an option in some areas. Existing user-focused monitoring teams may well find this a useful tool to monitor the recovery commitment of the services they monitor.
- Using care managers or other direct service staff to conduct one-to-one DREEM interviews is **not** appropriate. The study assesses the behaviour of staff and, in part, represents an evaluation of the service. Using service staff as interviewers would strongly *bias* the findings. People generally rate providers of services more highly, or with more satisfaction than is warranted when providers ask for feedback directly. [In truth, people often rate mental health services more highly than they really view them, even in anonymous surveys]. This happens because there is a power differential between people who use services and staff; users of service rely on the helper and don't want to offend them; some people feel they must be appreciative of any help they receive; and there are other social factors that create a positive response bias.
- Because the questionnaire is a long one, people should be given a chance to take one or more breaks when they are involved in a one-to-one interview, and efforts should be made to make the experience a comfortable and pleasant one.
- Offering an honorarium to people who complete the DREEM is good practice, if it is at all possible. A few people may choose not to accept an honorarium for providing their opinions on a survey. Sometimes people are given something other than a cash payment that is worthwhile, such as shopping vouchers, to encourage and acknowledge the worth of their participation. If cash is used as an honorarium, adequate control over the money is important, and double checks that the survey has been completed will ensure the quality of the study process.
- Ethical guidelines should be followed in conducting an DREEM study. Some agencies have to use formal *informed consent procedures*, or follow

local ethical committee guidelines, when they conduct a study like the DREEM.

- Data should be gathered in a way that always protects peoples' confidentiality. Information that specifically identifies an individual should not be requested or included on the DREEM form. The only exception to this rule occurs in a study with a "repeated measures" design, when data is gathered several times from the same person. In that case, a unique client identifier can be created and used on the survey, but, the crossover to personal names should be kept confidential.
- The DREEM survey should always be conducted in a manner that is completely voluntary. People should not be asked or required to complete the DREEM survey if they do not wish to do so. They should be able to skip any particular questions or to stop answering questions before they complete the survey, if they choose to do so.

Completing the DREEM

This document can be completed as a simple checklist. Data collected must be entered by hand, and we have not yet created an electronic format to enter and analyse the data, so such a programme would have to be created.

We kept track of how long it took for people to complete the DREEM. The questionnaire takes about 25 minutes to complete when self-administered. On the outside, some people have taken as long as an hour and thirty minutes to complete an DREEM in a personal interview, including breaks, and one person needed an hour and ten minutes to complete the DREEM.

Who should be asked to respond to the DREEM and how should they be sampled and contacted?

The DREEM was designed to be answered by people with mental health problems, who have extensive involvement with the mental health system and are subject to the Care Programme Approach (CPA). It was not designed to be used to gather data from short-term users of mental health services, or from people in acute crisis, nor is it formulated for use in child or adolescent populations or with older people who experience dementia.

A service may decide to invite all people who use services to complete an DREEM. One field test showed that about 50% of all service recipients will participate if repeatedly invited to complete an DREEM interview, and an honorarium is offered.

DREEM FINDINGS, AND INTERPRETING THE DREEM DATA

What have we learned so far about recovery and recovery enhancing practice from the field tests of the DREEM?

The findings of the combined pilots show that:

- People are able to place themselves within a particular stage of recovery. Over half of the people we surveyed say they are in an active phase of recovery; more than 1 in 4 are not yet in recovery; a few are experiencing

setback; and some view themselves as already fully recovered, but as having to maintain their gains.

- Many respondents have one or more specific status/needs. As other studies have shown, trauma (52%) and the double trouble of drug and alcohol problems (41%) have a high co-occurrence among those diagnosed with mental illness. People generally view having their specific needs status or ethnic and racial diversity addressed as being important to their mental health recovery.
- Almost all people can identify at least a few indicators of recovery in their lives, and most are able to claim several markers of personal recovery.
- Recovery markers have performed well as a measure of change over time in allied research using subscales of the DREEM to study the impact of a form of supported education. Such research shows that people gain ground or attain more markers of recovery, concurrent with, or in part due to, exposure to recovery-enhancing programming.
- Mental health recovery is a multi-dimensional process. All of the elements of recovery tested, with the exception of one, were viewed as important or very important to personal recovery. The one exception was intimacy and sexuality that was rated as falling midway between “agree” and “not sure.”
- The top ten “most important” elements of recovery involve having hope, having one’s rights respected and upheld, having one’s basic needs met (e.g. for income, housing and healthcare), having a sense of meaning in life, improving one’s general health and wellness, being able to self-manage symptoms and distressing experiences, having positive relationships, having a sense of control over important decisions and a sense of empowerment, having a positive sense of one’s identity beyond one’s mental health problem, and taking on new challenges that move one out of one’s comfort zone.
- Resilience-enhancing characteristics within the organisational climate were all rated as important or very important to mental health recovery.
- There is sufficient variance in how people answer the DREEM to make the findings interesting. People don’t just pick a particular response and answer in the same way throughout the survey. People differentiate between the importance of elements and staff performance on the recovery elements, and vary their responses across the items.

DREEM data can differentiate services that perform well from those that perform less well on the basis of significant differences in the overall rating of service performance.

How are DREEM data analysed and scored?

Each major section of the DREEM is handled as a separate scale. Data from particular sections of the DREEM can also be viewed in interaction with other DREEM subscale data, as described below.

Demographic Data

“A few questions about you” is the title of the first section. This section contains demographics and length of service data. These data are analysed and reported as group data. Individual-level data are not collected. Descriptive statistics (percentages in each category) are summarized and

reported for all respondents by age group, gender, ethnic and racial background and service user history (total length of service). The Specific Needs section described later also contains some additional demographic data.

When importance ratings of the recovery elements (discussed below) were analysed by ethnic and racial group status, we found that diverse groups have differing profiles on what constitutes the most important recovery elements.

Stage of Recovery

“Your involvement in the recovery process” is the title of the next section. Involvement in the recovery process is analyzed as a single question. Respondents are asked to tick only one answer (although not every respondent followed these instructions).

These categories are related to Prochaska and colleagues’ (1994) theory concerning stages of change. These investigators found that important changes in health-related behaviour, from the decision to wear safety belts to the choice to quit smoking or reduce drinking, take place in stages. In simplified terms, a person commonly passes through stages of:

- Pre-contemplation (in which one does not know, or does not recognize, that one has a problem, or lacks knowledge or information);
- Contemplation (in which one is gathering information, thinking about choices, and how and whether one may wish to make a change);
- Preparation (in which one is actively making plans or getting ready to change);
- Action (in which one begins to do things differently, and achieves behavioural change);
- Maintenance (in which one has undertaken change, and attained the state one seeks, but has to keep working to maintain one’s gains);
- Setback (in this stage, one returns to earlier behaviour, and loses some of one’s earlier gains).

The DREEM has questions related to each stage in the Prochaska model. The first three questions relate to the pre-contemplation stage, and the rest are aligned with the remaining stages in obvious ways.

We didn’t know if people could or would place themselves within these theorized phases of the recovery process. In the field tests of the DREEM, we found that users of mental health services were able to place themselves in one of the stages of recovery, and that each of the hypothesized stages of the recovery process was claimed by some people. A few people ticked more than one answer, and in those few instances, we coded them as falling into the highest level of involvement, or stage, out of the categories that they ticked.

To simplify the findings further, we collapsed the first five responses into a “pre-recovery” phase that includes people in the pre-contemplation and planning phases. We found 26% of service recipients say they are in the pre-recovery phase, most (58%) say they are in an active phase of recovery, and

some, (12%), consider themselves to be fully recovered and working to maintain their gains. A smaller proportion of respondents (4%) say they are in a setback phase of their recovery - they chose the response: "I was actively moving toward recovery, but now I'm not because..." [space is left for them to write in an answer].

First person accounts of recovery often describe recovery as a nonlinear process and indicate that the experience of **setback** is common. Our data found a relatively small proportion of people in a setback phase at a given point in time. We wanted to know more about the experience of setback, so we left space for people to explain why they were no longer actively in recovery. While we have very little data to date, it seems that setback is associated with loss of hope that recovery is possible, interpersonal problems, loss of supports and return of severely distressing symptoms and experiences.

We also found that stages of recovery are associated with differences in the number of recovery markers people claim at a given point in time. People in each phase of recovery had, on average, different numbers of recovery markers. People in a pre-recovery phase had fewer recovery markers than did people in active recovery, people who rated themselves as fully recovered had even more recovery markers, but people in a setback phase had the fewest recovery markers of all the groups. Some of these differences were statistically significant. These data lend credibility to the idea that stages of change, as measured by phase of recovery, is a meaningful concept.

The mental health field currently lacks a well-developed set of practices associated with stages of recovery. Thinking through and creating specific resources and approaches for people in various stages of recovery has worked well in integrated double trouble/dual diagnosis treatment. We are just beginning to think of mental health recovery as a stage-based process, and will need to work out and test practice implications.

Elements of Recovery

The next section of the DREEM, which is the largest, includes 24 recovery elements that were identified in first person accounts, the literature base on recovery, and in emerging recovery practice seen in progressive services. The 24 elements are:

1. Having a positive sense of identity beyond one's mental illness
2. Having a sense of meaning in life
3. Having hope
4. Having up-to-date knowledge about psychiatric treatment and the most effective treatments [best practice]
5. Self-management of symptoms and avoiding relapse [self-regulation]
6. Improving general health and wellness
7. Being an active user of services and directing one's own treatment [self-determination/self-direction]
8. Having one's rights respected and upheld
9. Mutual self-help/peer support
10. Being involved in meaningful activities

11. Being involved in, and a part of, the larger community [community integration/Social Inclusion]
12. Having positive relationships [social support]
13. Identifying and building on personal strengths
14. Developing new skills
15. Having one's basic needs met
16. Having a sense of control over one's life and feeling empowered [self-agency]
17. Spirituality
18. Taking on and succeeding in normal social roles
19. Challenging stigma and discrimination
20. Taking on new challenges and moving out of one's comfort zone
21. Having positive role models
22. Having assistance when in crisis
23. Intimacy and sexuality
24. Having helpers who really care about you and your recovery

The response scale

This section is the first to introduce the response scale that people use to answer most of the questions in the remaining sections of the DREEM.

- The scale is a 5-point Likert-type scale that ranges from Strongly Agree=1, Agree=2, Neutral/Not Sure=3, Disagree=4, to Strong Disagree=5.
- All of the questions of the DREEM are ***stated positively***, so no reverse scoring is required.
- On every section of the DREEM it is important to recognize that ***lower scores represent higher or more positive ratings and higher scores represent lower or less positive rating.***

Importance Ratings for Recovery Elements

The first set of data involves the ratings respondents provide about how important each of the 24 recovery elements are to their personal recovery. These data are analyzed in two ways 1) as the average of the sum of all scores (overall average score of all 24 importance ratings for all respondents) and 2) as the average of the ratings of importance for each of the 24 elements.

All means can range from 1 (highest possible rating) to 5 (lowest possible rating). If everyone who responded to the questionnaire were to answer "strongly agree" that an element is important to their recovery, the mean would be a perfect "1", whereas, if every person said they "*strongly disagreed*" that the element was important, the mean would be a perfect "5". Of course "perfect" agreement is never found! All the recovery elements were rated as falling between 'important to recovery' (agree) or 'very important to recovery' (strongly agree) in the field tests, with the exception of one element, intimacy and sexuality, which fell between important and the 'neutral/don't know' rating.

Staff or Service Performance

The second set of data in the elements of recovery section concerns rating of **service performance**. Three recovery practices are used to anchor each of the 24 recovery elements, so there are a total of 72 separate performance ratings. The specific data can be examined to assess how staff perform on each of the activities, by looking at the mean for all respondents, and the range of responses.

These data can be examined to identify the most highly rated and least highly rated elements of service performance as assessed by the people served.

- The most highly rated areas (those areas of performance with the lowest mean scores) can be identified, and celebrated as areas where service practices are rated relatively well.
- The lowest rated staff activities (those subscales with the highest mean scores) can be examined and plans made for staff training or service improvements that will increase the service's performance in enhancing their recovery practice.

If you want to use the DREEM as a measure of change in the recovery-orientation of the service over time, you can administer it more than once. You can set targets for the kinds of scores you want to see your service achieve, or try to exceed either the national norm or the top scores achieved to date.

Assessing the “Performance Gap”

Another way to look at scores is to examine the relationship between the ratings of the *importance of each recovery element and the ratings of the service's performance* associated with that element. This provides a kind of test of the “performance gap”, assuming that services should be rated most highly on those elements of practice that are considered most important to personal recovery. So far the field test data reveal that a “performance gap” does exist for both higher and lower performing services. This data implies there is room for growth and improvement in how fully and how well services implement recovery-enhancing practice.

Specific Needs/Status

The next section concerns specific needs or status. This section is the only one that contains “skip questions”. This format was intended to ensure that only those people/respondents who fall into a given specific status or specific needs group would answer questions about the service's performance on that issue. The specific needs areas the DREEM assesses include respect for personal culture [including ethnic or racial diversity]; having mental health problems and substance misuse [dual diagnoses/double trouble]; having a history of trauma [sexual and physical abuse]; sexual orientation; and being a parent.

The same 5 point Likert-type scale we described above is used to assess the degree to which people think having their specific needs/status addressed is important to their recovery. Just like in the elements of recovery section, there

are three service performance questions for each specific needs/status, and this data is analysed in a manner similar to the elements of recovery section.

Data from this section can help us to understand how important issues of diversity and recovery overlap, and to see how services are performing in situations where people are on dual journeys of recovery (trauma recovery and mental health recovery, dual recovery from mental health problems and drugs and/or alcohol). Our findings show that many people do have issues of dual recovery, and that people view having assistance with regard to their specific status and needs as important to their recovery.

Organisational Climate

The ***Organisational Climate*** section is handled as a separate subscale. The first 12 of the items on this subscale are aspects or qualities of the social environment that have been identified as important in the promotion of resilience, or the ability to rebound from adversity, in general. The final two items were added; these items have to do with gathering and using feedback from people who use services. Having a mental health service that seeks and incorporates user of service feedback is important because of the increasing emphasis on having the needs, input, and satisfaction of people in recovery drive mental health service development.

The DREEM field tests found that an extremely high proportion of respondents say that the resilience-engendering aspects of an organizational climate are important to their mental health recovery. In the revised DREEM, people simply rate their service on each of the resilience-enhancing factors using the same 5 point Likert-type scale, that ranges from 1=strongly agree to 5=strongly disagree we used in the other segments. The average rating for all respondents on all the organisational climate factors is used to create a summary score for the service, as was done on the other subscales.

Recovery Markers

The last quantitative section of the DREEM gathers data on recovery markers. While it is often said that recovery is different for each person, we thought there were many common elements. A wide variety of recovery markers are included in the DREEM:

- Most of these markers represent *intermediate outcomes*, or process factors, such as whether people feel motivated, and whether they see themselves as growing or learning new things.
- A future-orientation (a factor that is related to recovery and to resilience in the research) is measured by having goals one is working towards, having hope, and having things to look forward to in life.
- Something akin to sense of self-agency as measured by whether the person believes he can make positive changes in his life, and is using his/her personal strengths, skills and talents.
- A few of the markers such as “I feel alert and alive” came from other studies that asked people how they knew mental health recovery was taking place in their lives.
- Some of the markers have to do with how people see themselves (positive self-concept).

- Others have to do with quality of life issues, such as health status symptom control, and the adequacy of resources and basic supports people have, such as having safe housing and enough income.
- Some have to do with the connections people have to others, or social support;
- Still others have to do with functioning in ordinary social roles, such as working, and going to college or university.

No one of these markers “is recovery”, but, taken together, these markers outline much that has been described as facilitative of recovery. The recovery markers can also be viewed as a kind of assessment of **unmet need**, by examining the data on the proportion of respondents who *did not* say that a given marker was true for them right now. For example, if 60% answered that they were in good physical health, then 40% of the people answering the survey are experiencing less than good physical health; if 40% say that they have at least one close mutual give and take relationship, then 60% are without this important source of social support. The group that is working to understand the implications of the DREEM findings, in such a case, may wish to target interventions that could increase the proportion of service participants that achieve a particular marker (e.g. increase the service emphasis on health and wellness if a high proportion have inadequate physical health; address the need for social network intervention or improve access to opportunities for mutual self-help and peer support if people lack others to turn to, etc.).

Predominant themes from the open-ended questions

The following predominant themes were identified when we analysed the first 3 open-ended questions:

Question 1. What can mental health services and staff do to support people with mental health problems in their recovery?

- Listen
- Treat people as people; see them as unique individuals who deserve respect and who have dignity
- Build hope; be supportive and encouraging
- Have desirable characteristics as helpers
- Provide services that are appropriate to the needs of the individual
- Be available, and provide ready access to services

Question 2: What lessons have you learned so far on your journey of recovery?

- To be actively involved in my recovery
- To believe in myself
- To have hope
- To learn to keep learning
- Treatment is important
- How to pace myself, and to have persistence
- That I am not alone

- To get back into life

Question 3: What advice would you give to someone just starting out on a journey of recovery?

- Pace yourself
- Have hope
- Believe in yourself
- Know you are not alone
- Take responsibility for yourself, your condition, and your recovery
- Accept that you have a problem/psychiatric condition/mental illness/and get good help
- Don't give up on your life

CONCLUSIONS

A study using the DREEM requires a significant investment of time and resources, but these are well spent if the data is used to identify priorities for service development and to set specific targets for transforming mental health agencies and services.

DREEM is one of several tools that can help us move toward fulfilling the vision put forth in the National Service Framework, NIMHE statement on Values and 10 Essential Shared Capabilities (2004) that all mental health systems assume a recovery orientation, and that recovery is possible for everyone.



Recovery Enhancing Environment Measure (DREEM) UK Version 1

This questionnaire explores the process of recovery from mental illness, and the services and supports that people who use mental health services say help them achieve recovery. While **recovery is always a personal process based on self-responsibility/self-agency**, there are many things mental health services can do to support your progress or hold you back. This questionnaire looks at your personal experience of recovery, and the services and supports that are available to you.

Your answers to these questions will be confidential. This means your personal answers will stay secret. Your name will never be asked. Please do not write your name in the booklet. This study is completely voluntary. You can skip any questions that you do not wish to answer. Other people who use services have said that the questionnaire is very interesting and they enjoyed completing it. The survey takes about 25 minutes to complete. Be sure to read the guidance below before you begin to answer.

Guidance:

1. This is **not a test**. There are no 'wrong' or 'right' answers in this survey. Answer each question based on your personal opinions and beliefs.
2. All of the questions should be answered by marking one of the answer spaces that best fits your opinion or situation. If you don't find an answer that fits exactly, use one that comes closest. If any question does not apply to you, or you are not sure of what it means, just leave it blank.

[For more information contact:](#)

THANK YOU FOR YOUR TIME AND ANSWERS!!!!

A FEW QUESTIONS ABOUT YOU

1. What age group are you in (tick your current age group)?

- 18-25
- 26-35
- 36-45
- 46-55
- 56-65
- 65 and over

2. What is your gender?

- Male
- Female

3. How would you describe your ethnicity?

- White British
- White & Caribbean
- Indian
- Other Asian
- Other black
- Irish
- White & African
- Pakastani
- Caribbean
- Chinese
- Other white
- Other mixed
- Bangladeshi
- African
- Other
- Not stated

4. In total, how long have you received any form of mental health services?

- Less than 1 year
- 1 year or more but less than 5 years
- Between 5 and 10 years
- More than 10 years

YOUR INVOLVEMENT IN THE RECOVERY PROCESS

Which of the following statements is most true for you? (Please read through all the questions and tick only the one that applies best to you)

- I have never heard of, or thought about, recovery from mental illness/distress
- I do not believe I have any need to recover from mental illness/distress
- I have not had the time to really consider recovery.
- I've been thinking about recovery, but haven't decided to begin 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 mental illness/distress.
- I was actively moving toward recovery, but now I'm not because:
.....

- I feel that I am fully in recovery and my journey is continuing.
- I feel that I am fully recovered; I just have to maintain my gains.

- Other (please specify).....

For the rest of the questions in this survey, answer only about what you experience in:

.....
(name of the mental health service or agency e.g. Three Rivers Mental Health Trust, Middle Wallop PCT, River View Mental Health Team, Babling Brook Day Centre)

If no service is listed above, think about the mental health service you use the most and the staff of the service. Write the name of the service in the line above. Answer each of the following questions keeping the particular service in mind.

What kind of services are you currently receiving (tick all that apply)

- self-help or user-run services
- culturally specific services
- clubhouse
- day care services (health)
- day care services (social care)
- residential service
- hospital inpatient service
- primary care team (nurse or GP)
- care management/key worker
- community mental health team
- assertive outreach team
- home treatment/crisis resolution team
- psychotherapy/talking therapies/counselling
- medications/medication management
- employment services
- supported housing
- supported education
- direct payments
- other (please describe).....

ELEMENTS OF RECOVERY AND RECOVERY ENHANCING SERVICES

For each of the following questions you should circle one of the answers:

SA – If you *strongly agree* with the statement

A – If you *agree* with the statement

N – If you are *not sure*, or neither agree or disagree, or you are *neutral*.

D – If you *disagree* with the statement.

SD – If you *strongly disagree* with the statement

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. Having a positive sense of personal identity beyond my diagnosis/mental illness/distress is important to my recovery	SA	A	N	D	SD
a) Staff view me as more than a “case” or diagnosis; they want to know me as a person	SA	A	N	D	SD
b) The service offers individualized services to meet my unique needs.	SA	A	N	D	SD
c) Staff treat me as a whole person with a body, mind, emotions, important relationships and spirit.	SA	A	N	D	SD
2. Having a sense of meaning in life is important to my recovery.	SA	A	N	D	SD
a) Staff help me make sense out of what is happening in my life.	SA	A	N	D	SD
b) Staff ask me what is meaningful to me.	SA	A	N	D	SD
c) This service encourages me to do things that give my life meaning.	SA	A	N	D	SD
3. Having hope is important to my recovery.	SA	A	N	D	SD
a) Staff believe I have a positive future.	SA	A	N	D	SD
b) Staff encourage me to feel hopeful again when I’m discouraged or have a setback.	SA	A	N	D	SD
c) Staff tell me most people do recover from mental health problems over time	SA	A	N	D	SD
4. Having up-to-date knowledge about mental disorders and the most effective treatments is important to my recovery.	SA	A	N	D	SD
a) Staff teach me about my mental disorder and symptoms.	SA	A	N	D	SD
b) The service provides me with up-to-date information about effective treatments.	SA	A	N	D	SD
c) Staff give me enough information about my treatment options and their risks and benefits, for me to give informed consent for treatment.	SA	A	N	D	SD

5. Being able to self-manage symptoms/distressing experiences and avoid setbacks is important to my recovery.	SA	A	N	D	SD
a) This service helps me to identify and monitor triggers/early warning signs.	SA	A	N	D	SD
b) This service helps me develop personalized coping skills so I can manage stress well.	SA	A	N	D	SD
c) This service teaches me ways to self-monitor and self-control psychiatric symptoms.	SA	A	N	D	SD
6. Improving my general health and wellness is important to my recovery.	SA	A	N	D	SD
a) Staff pay careful attention to my physical health.	SA	A	N	D	SD
b) This service encourages me to achieve higher levels of wellness.	SA	A	N	D	SD
c) This service offers wellness programming such as nutrition, movement and relaxation.	SA	A	N	D	SD
7. Being active in directing my own recovery is important to my recovery.	SA	A	N	D	SD
a) Staff assist me to explore options and set my own personal goals.	SA	A	N	D	SD
b) Staff treat me as a responsible partner in decision making.	SA	A	N	D	SD
c) I direct my own treatments in this service.	SA	A	N	D	SD
8. Having my rights respected and upheld is important to my recovery.	SA	A	N	D	SD
a) Staff inform me of my rights.	SA	A	N	D	SD
b) There is a clear complaints policy and procedure if any of my rights are violated.	SA	A	N	D	SD
c) Staff uphold my rights.	SA	A	N	D	SD
9. Mutual self-help/peer support is important to my recovery.	SA	A	N	D	SD
a) This service encourages users of service to help and support one another.	SA	A	N	D	SD
b) Self-help groups and peer support opportunities are available in this service.	SA	A	N	D	SD
c) This service actively links me to self-help groups and self-help resources in the community.	SA	A	N	D	SD

10. Being involved in personally meaningful activities is important to my recovery.	SA	A	N	D	SD
a) Staff encourage me to get involved in meaningful activities of my choice.	SA	A	N	D	SD
b) Service activities are meaningful to me.	SA	A	N	D	SD
c) The service assists me to become involved in personally meaningful activities (such as working, furthering my education, creativity).	SA	A	N	D	SD
11. Being involved in, and part of, the larger community is important to my recovery.	SA	A	N	D	SD
a) Staff help me find and use community resources.	SA	A	N	D	SD
b) Staff help me gain individualized supports so I can live, learn and work in the community.	SA	A	N	D	SD
c) I don't feel cut-off from the "real world" in this service.	SA	A	N	D	SD
12. Having positive relationships is important to my recovery.	SA	A	N	D	SD
a) Staff assist me in having positive relationships with my peers.	SA	A	N	D	SD
b) Staff support me in building or rebuilding positive relationships with family members and friends of my choice.	SA	A	N	D	SD
c) Staff assist me in forming friendships with people outside the mental health system.	SA	A	N	D	SD
13. Identifying and building on my own personal strengths is important to my recovery.	SA	A	N	D	SD
a) Staff recognize and focus on my positive attributes and talents.	SA	A	N	D	SD
b) Staff help me explore my dreams, values and goals.	SA	A	N	D	SD
c) Staff link me to opportunities and resources that build on and reflect my strengths.	SA	A	N	D	SD
14. Developing new skills is important to my recovery.	SA	A	N	D	SD
a) Staff help me assess how I am functioning and identify skills I need to develop.	SA	A	N	D	SD
b) This service teaches me the skills I want and need.	SA	A	N	D	SD
c) This service connects me to places and people who help me build important skills.	SA	A	N	D	SD

15. Having my basic needs met is important to my recovery.	SA	A	N	D	SD
a) This service assists me to get a basic income and/or benefits.	SA	A	N	D	SD
b) This service helps me get decent, affordable housing of my choosing.	SA	A	N	D	SD
c) This service helps me gain access to the full range of health care supports.	SA	A	N	D	SD
16. Having a sense of control over my life and feeling empowered is important to my recovery.	SA	A	N	D	SD
a) Staff encourage and support my sense of empowerment.	SA	A	N	D	SD
b) Staff assist me to gain or maintain control over important decisions in my life.	SA	A	N	D	SD
c) Staff do not try to maintain power and control over me.	SA	A	N	D	SD
17. Spirituality is important to my recovery.	SA	A	N	D	SD
a) Staff ask me about my spiritual beliefs.	SA	A	N	D	SD
b) Staff help me to connect with spiritual resources and groups, if I so desire.	SA	A	N	D	SD
c) Staff encourage me to explore spiritual practices such as prayer or meditation that can support well-being.	SA	A	N	D	SD
18. Taking on, and succeeding in, ordinary social roles is important to my recovery.	SA	A	N	D	SD
a) Staff offer to help me to get a real job and succeed as an employee.	SA	A	N	D	SD
b) Staff offer to assist me to return to college or University and be a successful student.	SA	A	N	D	SD
c) Staff offer to help me get housing and be a successful tenant or home owner.	SA	A	N	D	SD
19. Challenging stigma and discrimination is important to my recovery.	SA	A	N	D	SD
a) This service helps me overcome internalized stigma (feeling badly about myself because of my label of mental illness/distress).	SA	A	N	D	SD
b) This service raises my awareness of the negative impact of stigma and discrimination.	SA	A	N	D	SD
c) This service teaches me to be an effective self-advocate for my civil, human and personal rights.	SA	A	N	D	SD

20. Taking on new challenges and moving out of my comfort zone is important to my recovery.	SA	A	N	D	SD
a) Staff encourage me to take on new challenges.	SA	A	N	D	SD
b) I feel supported when I try new things that seemed out of my reach before.	SA	A	N	D	SD
c) Staff encourage me to stretch myself and grow.	SA	A	N	D	SD
21. Having positive role models is important to my recovery.	SA	A	N	D	SD
a) This service employs people who are positive role models of recovery.	SA	A	N	D	SD
b) Staff help me learn from others who are successfully in recovery (e.g. recovery narratives from users of service, internet sites, visiting speakers, mentors etc.).	SA	A	N	D	SD
c) I have opportunities to become a staff member or role model in the service, if I choose.	SA	A	N	D	SD
22. Having assistance when I am in crisis is important to my recovery.	SA	A	N	D	SD
a) This service has help available immediately if I am in crisis.	SA	A	N	D	SD
b) Staff stand by me through hard times, they help me see setbacks are a part of recovery.	SA	A	N	D	SD
c) This service has good options if I am in crisis that help me avoid compulsory treatment and hospital admission.	SA	A	N	D	SD
23. Intimacy and sexuality are important to my recovery.	SA	A	N	D	SD
a) This service supports me in forming and succeeding in intimate relationships.	SA	A	N	D	SD
b) This service adequately addresses my sexuality.	SA	A	N	D	SD
c) This service provides me with information on sexuality, such as safe sex, and medication side effects and sexuality.	SA	A	N	D	SD
Having helpers who really care about me and my recovery is important to my recovery.	SA	A	N	D	SD
a) The staff here really listen to me.	SA	A	N	D	SD
b) Staff here spend enough quality time with me on activities that promote my recovery.	SA	A	N	D	SD
c) Staff encourage, motivate and support me to move toward recovery.	SA	A	N	D	SD

SPECIFIC NEEDS

These questions relate to specific issues and groups of people. If you are not a member of the specific needs group being asked about, place a tick mark beside the question and go onto the next question.

- __1. If you do not want to complete this section on culture, race and ethnicity, please tick and go on to the next question. All groups of people have a cultural background and we therefore would value your responses to this section.**

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

- __2. If you do not have both mental illness/distress and substance misuse problems (double trouble/dual diagnosis) tick here and skip to question 3.**

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

- __3. If you do not have a history of abuse and/or trauma tick here and skip to question 4.**

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

__4. If you are not lesbian, gay, or bi-sexual put a tick here and go to question 5.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Having support for my sexual orientation is important to my recovery.	SA	A	N	D	SD
d) Staff of this service are not homophobic (very negative about gay, lesbian or bi-sexual people).	SA	A	N	D	SD
e) Staff of this service are respectful to me as a lesbian, gay or bi-sexual person.	SA	A	N	D	SD
f) Staff deal effectively with issues of sexual preference.	SA	A	N	D	SD

__5. If you are not a parent with children put a tick here and go to the next section.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Having support as a parent is important to my recovery.	SA	A	N	D	SD
a) Staff support me in my role as a parent.	SA	A	N	D	SD
b) Staff assist me to be an effective parent.	SA	A	N	D	SD
c) Staff help me to uphold my rights in custody disputes.	SA	A	N	D	SD

ORGANISATIONAL CLIMATE

Circle the answer that best describes whether your organisation has the quality we are asking about. These qualities support resilience/recovery or the ability to rebound from adversity.

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 N – If you are not sure , or neither agree or disagree, or you are neutral . D – If you disagree with the statement. SD – If you strongly disagree with the statement					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. The service promotes learning, thriving and growth.	SA	A	N	D	SD
2. The service is a hopeful environment that promotes positive expectations.	SA	A	N	D	SD
3. The service is inspiring and encouraging.	SA	A	N	D	SD
4. Staff of this service are caring and compassionate.	SA	A	N	D	SD
5. The service has enough resources to meet peoples' needs.	SA	A	N	D	SD
6. The service provides opportunities for meaningful participation and contribution.	SA	A	N	D	SD
7. The service helps people feel valued, respected and powerful.	SA	A	N	D	SD
8. The service helps people to feel connected to others in positive ways.	SA	A	N	D	SD
9. The service is safe and attractive.	SA	A	N	D	SD
10. All levels of staff are welcoming.	SA	A	N	D	SD
11. There are creative and interesting things going on in the service.	SA	A	N	D	SD
12. The service provides real choices, desirable options, and opportunities.	SA	A	N	D	SD
13. The service asks for feedback from people who use services.	SA	A	N	D	SD
14. The service makes changes based on the satisfaction ratings of people who use services.	SA	A	N	D	SD

RECOVERY MARKERS

For each of the following questions you should circle one of these answers that is true for you now.

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 N – If you are not sure , or neither agree or disagree, or you are neutral . D – If you disagree with the statement. SD – If you strongly disagree with the statement					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. My living situation is safe and feels like home to me.	SA	A	N	D	SD
2. I have trusted people I can turn to for help.	SA	A	N	D	SD
3. I have at least one close mutual (give-and-take) relationship.	SA	A	N	D	SD
4. I am involved in personally meaningful productive activities.	SA	A	N	D	SD
5. My distressing symptoms are under control.	SA	A	N	D	SD
6. I have enough income to meet my needs.	SA	A	N	D	SD
7. I'm not working, but see myself working within 6 months.	SA	A	N	D	SD
8. I am learning new things that are important to me.	SA	A	N	D	SD
9. I am in good physical health.	SA	A	N	D	SD
10. I have a positive spiritual life/connection to a higher power.	SA	A	N	D	SD
11. I like and respect myself.	SA	A	N	D	SD
12. I'm using my personal strengths, skills and talents.	SA	A	N	D	SD
13. I have goals I am working to achieve.	SA	A	N	D	SD
14. I have reasons to get out of bed in the morning.	SA	A	N	D	SD
15. I have more good days than bad.	SA	A	N	D	SD
16. I have a decent quality of life.	SA	A	N	D	SD
17. I control the important decisions in my life.	SA	A	N	D	SD
18. I contribute to my community.	SA	A	N	D	SD
19. I am growing as a person.	SA	A	N	D	SD

20. I have a sense of belonging.	SA	A	N	D	SD
21. I feel alert and alive.	SA	A	N	D	SD
22. I feel hopeful about my future.	SA	A	N	D	SD
23. I am able to deal with stress.	SA	A	N	D	SD
24. I believe I can make positive changes in my life.	SA	A	N	D	SD
Tick the box that is true for you now				YES	NO
25. I am working part time (less than 37 hours a week)					
26. I am working full time (37 or more hours per week).					
27. I attend college, university or other educational programme.					
28. I am not in paid employment and am happy with my life.					

FINAL QUESTIONS

1. What are one or two of the most important things a mental health service and its staff can do to support people with mental health problems in their mental health recovery?

.....
.....
.....
.....

2. What are one or two of the most important things you have learned so far on your journey of recovery?

.....
.....
.....
.....

3. What are one or two things you would want to say to a person who is just beginning his or her journey of recovery from mental health problems?

.....
.....
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4. Are there any other comments or ideas that could improve the service that you want to include in the survey?

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THANK YOU!