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Full Report

Recovery in Mental Health Services

Recovery based human rights indicators in mental health services

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Introduction

Following the enactment of the Americans with Disabilities Act (National Council on Disability, 1990) and the United Nations' Convention on the Rights of Persons with Disabilities (UNCRPD; United Nations, 2006) the acknowledgment of the rights of individuals with mental health problems has evolved into a subject of widespread public debate. The CRPD focuses on essential principles for persons with mental health problems such as eradicating coercion and paternalism and moving from institution to community-based care. The elimination of all forms of coercion is explicitly stated in articles such as 5 (equality and non-discrimination), 14 (liberty and security of the person), and 15 (freedom from torture or cruel, inhuman or degrading treatment or punishment); while supporting individual autonomy is a recurring theme throughout the convention, clearly emphasised in articles 12 (equal recognition before the law), 19 (living independently and being included in the community), 21 (freedom of expression and opinion, and access to information), and 25 (health).

Building upon this international framework, endeavours to implement rights-based mental health projects have proliferated (Porsdam Mann et al., 2016). Previously widely unquestioned coercive practices are now being scrutinised, leading to a surge in studies focused on identifying effective methods to reduce or eliminate them (Goulet et al., 2017; Oostermeijer et al., 2021; Scanlan, 2010; Stewart et al., 2010). Similarly, intervention models that advocate for a paradigm shift from merely addressing symptoms to actively supporting the overall recovery journey of service users, with a strong emphasis on their participation, have transitioned from being on the fringes to becoming mainstream. Notably, approaches like Recovery, which emphasise personalised care tailored to help individuals achieve their fullest potential by fostering resilience and community integration, have gained widespread acceptance and recognition (Pincus et al., 2017). A prime example of the influence of these advancements is the World Health Organisation's (2012, 2021) proactive response with the

publication of a series of guidance and technical packages on the promotion of person-centred and rights-based approaches within community mental health services.

However, despite the generalised acceptance of the so called ‘rights framework’ by most mental health services administrations around the world, this has happened with certain reservations. Numerous professional associations (e.g. Spanish Society of Psychiatry, 2020) and legislators (e.g. Alexandrov & Schuck, 2021) have raised questions concerning the boundaries of the CRPD, particularly in relation to its Article 12, which addresses equal recognition before the law, and its implications for professional competencies. One of the primary arguments is that a stringent interpretation of the CRPD could hinder professionals from implementing involuntary interventions aimed at saving the lives of individuals who pose a risk to themselves or others due to their psychopathology (Alexandrov & Schuck, 2021; Appelbaum, 2019; Freeman et al., 2015; Spanish Society of Psychiatry, 2020). From a range of critical perspectives, including those of clinicians, academics, and advocacy groups, it is argued that merely allowing these measures encourages their extensive application. This is evidenced by the fact that professionals who more frequently utilise such measures tend to provide more justifications for their use (Molewijk et al., 2017). In addition, these voices contend that relying solely on an ethical perspective, as previously upheld by major psychiatric organisations, falls short in providing the necessary accountability for accomplishing the elimination of coercion in mental health care (Lewis & Callard, 2017). Furthermore, a commonly raised concern is that the principles of seemingly rights-based approaches like Recovery have been distorted. This distortion is observed in numerous organisations through the use of strength-based concepts for outreach while maintaining deficit-based practices internally (Howell, 2012; Rose, 2014; Thomas, 2016). Alarmingly, certain types of coercion such as compulsory community treatment, have been even rationalised as a means to facilitate the path to recovery (Eiroa-Orosa & Rowe, 2017).

Beyond the ongoing public debates, everyday professional experiences also highlight a pervasive symbolic validation of coercive and paternalistic practices (Mckeown et al., 2019). Concurrently, the practical implementation of rights-based approaches remains elusive for many professionals who genuinely aspire to work in more supportive ways. Therefore, it is essential to equip individuals and organisations with the necessary tools to embark on the path of transforming their practices.

Actions aimed at transforming mental health systems and their evaluation

There are two main axes of transformation. One focuses on reducing the use of coercive measures, and the other, more global, on the implementation of the Recovery model. Both, in turn, operate at various levels of action and evaluation: from the training of professionals to the transformation of the entire system.

Reducing coercion

Regarding the analysis of the effectiveness of specific interventions to reduce coercion, a systematic review of interventions aimed at reducing mechanical restraints found that cognitive milieu therapies, combined intervention programmes, and the implementation of person-centred care programmes are the most likely to reduce the frequency of restraints (Bak et al., 2012).

Three systematic reviews evaluate interventions aimed at reducing both seclusion and restraint. The earliest in terms of chronological coverage (Stewart et al., 2010) consisted of 36 studies published between 1975 and 2007. According to the authors, the key components include new restraint or seclusion policies, staffing changes, staff training, case review procedures, and crisis management initiatives. An important element identified by the authors

is that, in some cases, reductions in the use of restraints were due to an increase in the use of seclusion, or vice versa.

The second review (Scanlan, 2010) examined 29 studies published between 1996 and 2008 and derived a model of seven strategies: (i) policy/leadership changes; (ii) review committees and post-incident debriefing; (iii) data use; (iv) training; (v) user and family involvement; (vi) increased staff ratios/crisis response teams; and (vii) programme elements/changes.

The third systematic review (Goulet et al., 2017) analyses more recent studies (2010-15), including evaluations of the 'Six Core Strategies to Reduce the Use of Seclusion and Restraint' (National Technical Assistance Center, 2005) and Safewards (Bowers, 2014), identifying six key components in the programmes: 1) leadership, 2) training, 3) post-seclusion and/or restraint review, 4) patient involvement, 5) preventative tools, and 6) therapeutic environment.

Regarding the evaluation of these projects, unlike recovery training programs, the measured variables are related to the effective reduction of coercion, understood as the number of instances it is applied or the individuals subjected to it. However, on some occasions, psychometric tools such as the Staff Attitude to Coercion Scale (SACS; Husum et al., 2008) have been used.

Training practitioners in the Recovery model

Regarding the impact of training activities focused on transmitting the content and values of the Recovery model, the results of several systematic reviews (Campbell & Gallagher, 2007; Gee et al., 2017; Jackson-Blott et al., 2019; Sreeram et al., 2021) and the meta-analysis conducted by our research group (Eiroa-Orosa & García-Mieres, 2019) illustrate that Recovery training for mental health professionals has a clear influence on their beliefs and attitudes,

whereas the effect on practices is less clear and highly heterogeneous. Table 1 presents a compilation of the instruments used in these studies to measure the beliefs, attitudes and behaviours of the professionals.

It is important to note that most studies that have measured behavioural variables have done so within the context of large-scale projects such as REFOCUS (Slade et al., 2015) and GetREAL (Killaspy et al., 2015). This raises the question of whether it is possible to go beyond changing beliefs and attitudes to achieve a transformation in practices, even with sufficient investment of resources.

Qualitative analysis of participant narratives from Recovery training activities within integrated projects (Bhanbhro et al., 2016; Leamy et al., 2014; Lean et al., 2015) provides insight to reflect on this question. Some studies examine the tensions between 'top-down' changes led by management teams and 'bottom-up' changes initiated by teams on the ground. In the large-scale projects mentioned, although the intention was to initiate bottom-up organisational change, it became evident that professionals involved had serious doubts about the existence of institutional commitment to achieving tangible changes.

This links with other concepts already addressed in smaller projects with significant participant involvement, such as hope and autonomy. Some large-scale projects attempt to systematise and implement changes that had previously occurred in highly engaged, transformative settings. As with the achievements of other social movements, when systematising grassroots processes and accounting for the unique characteristics of each context, certain contradictions arise. One such challenge is the difficulty of replicating the intrinsic motivation that organically emerges. This seems to occur in a context where institutions send mixed messages. On the one hand, they allocate funds to transformation projects, but on the other, they fail to provide genuine support for changes to occur and be sustained.

Table 1. Measures of beliefs, attitudes and practices towards mental health service users.

Measure	Applies to	Constructs measured	Reference
Custodial Mental Illness Ideology Scale	Mental health professionals	Custodial and humanistic ideologies	(Gilbert & Levinson, 1956; Rogers et al., 1958)
Opinions about Mental Illness Scale	Mental health professionals	Public stigma	(Cohen & Struening, 1962)
Community Attitudes towards the Mentally Ill Scale	General public	Public stigma	(Taylor & Dear, 1981)
ATP-30: Attitudes towards psychiatry	Mental health professionals	Attitudes towards the psychiatry specialty	(Burra et al., 1982)
Perceived Devaluation and Discrimination Scale	General public / mental health service users	Public stigma	(Link et al., 1987)
Affective Reaction Scale	General public	Public stigma	(Penn et al., 1994, 1999)
Dangerousness Scale	General public	Public stigma	(Penn et al., 1994, 1999)
'Changing minds' questionnaire	General public	Public stigma	(Crisp et al., 2000)
RAQ-7: Recovery attitudes questionnaire	Mental health professionals	Recovery attitudes	(Borkin et al., 2000)
Professionals' Beliefs, Goals and Practices in Psychiatric Rehabilitation	Mental health professionals	Recovery practice	(Casper et al., 2002)
Medical Condition Regard Scale	Medical students	Professional stigma	(Christison et al., 2002)
Attribution Questionnaire	General public	Public stigma	(Corrigan et al., 2003)
ISMI: Internalised stigma of mental illness	Mental health service users	Public stigma	(Ritsher et al., 2003)
Recovery-Oriented Practices Index (ROPI)	Mental health professionals	Recovery practice	(Mancini & Finnerty, 2005)

Measure	Applies to	Constructs measured	Reference
Recovery Self-Assessment	Mental health institutions (professionals, service users and relatives)	Recovery practice	(Barbic et al., 2015; Kidd et al., 2011; O'Connell et al., 2005; Salyers, Tsai, et al., 2007)
RKI: Recovery knowledge inventory	Mental health professionals	Recovery knowledge	(Bedregal et al., 2006)
Implicit Stigma (Implicit Association Test)	General public/Mental health professionals	Public/professional stigma	(Teachman et al., 2006) (Drake et al., 2018; Stull et al., 2017)
Integrated Dual Disorders Treatment Model Knowledge Scale	Mental health professionals	Recovery knowledge	(Salyers, Rollins, et al., 2007)
The Project GREAT Recovery Knowledge Measure - Recovery Attitudinal Pre-Post Survey	Mental health professionals	Recovery knowledge	(Mabe & Fenley, 2008)
Mental Health Knowledge Schedule	General public	Public stigma	(Evans-lacko et al., 2010)
Mental Illness: Clinicians' Attitudes (MICA) Scale	Health professionals	Professional stigma	(Gabbidon et al., 2013; Kassam et al., 2010)
Police Contact Experience Scale	Police officers	Professional stigma	(Watson et al., 2010)
Reported and Intended Behaviour Scale (RIBS)	General public	Public stigma	(Evans-Lacko et al., 2011)
Quality Indicator for Rehabilitative Care (QuIRC)	Mental health professionals	Recovery practice	(Killaspy et al., 2011)

Measure	Applies to	Constructs measured	Reference
OMS-HC: Opening Minds Stigma Scale for Health Care Providers	Primary care professionals	Professional stigma	(Kassam et al., 2012)
Consumer Optimism Scale	Mental health professionals	Professional optimism	(Salyers, Rollins, et al., 2007)
Provider Expectations for Recovery Scale	Mental health professionals	Professional optimism for recovery	(Salyers et al., 2013)
PAREM: Attitude questionnaire developed by psychiatric investigations and education centre	Mental health students	Professional stigma	(Esen Danacı et al., 2016)
Strengths Model Attitudes Questionnaire (SMAQ)	Mental health professionals	Recovery practice	(Deane et al., 2018)
Beliefs and Attitudes towards Mental Health Service Users' Rights Scale (BAMHS)	Mental health professionals	Beliefs and attitudes.	(Eiroa-Orosa & Limiñana-Bravo, 2019)
WHO QualityRights© training measure	Mental health professionals	Knowledge, attitudes and practices.	(Moro et al., 2024)

Measuring System-Wide Transformations Towards Recovery-Oriented Practices

As we have seen, much of the literature focuses on change methodologies (primarily training) or on the reduction of coercion, regardless of the specific change methodology implemented. A third focus of the literature relates to the extent to which mental healthcare facilities adhere to the Recovery model on a broader scale. These tools have been used both in a static way, to assess the degree of adherence to the model, and dynamically, particularly to evaluate the level of change after implementing transformation programmes.

These tools began to be developed at the onset of the Recovery model's emergence in the early nineties. In fact, the legendary activist Judi Chamberlin, who at the time was working at Boston University, contributed to the first review on this topic (Campbell-Orde et al., 2005). Since then, tools designed to assess the recovery orientation of services have continued to be developed. These tools have been reviewed and evaluated in the literature (Leamy et al., 2023; Manser et al., 2018; Williams et al., 2012), sometimes alongside others designed to measure individuals' levels of recovery (Burgess et al., 2011; Penas et al., 2019).

For the purposes of the analyses presented in this report, we have primarily relied on the review by Leamy and collaborators (2023), not only because it is the most recent but also because it is the most comprehensive in terms of selection criteria. The study reviews instruments measuring the recovery orientation of mental health services and also mental health professionals' knowledge, beliefs and attitudes towards recovery. It aimed to update a review by Williams and colleagues (2012). The researchers analysed whether new measures addressed knowledge gaps identified in the earlier review, specifically regarding psychometric properties and how recovery is conceptualised. Fourteen instruments were identified, with ten meeting the eligibility criteria. Two new instruments were highlighted:

INSPIRE: Measures staff support for personal recovery, rated by service users.

RECOLLECT: A fidelity measure for Recovery Colleges.

Six measures from the earlier review were included due to additional validation, such as the Recovery Self-Assessment (RSA) and the Recovery Enhancing Environment (REE). Five new instruments were introduced, focusing on staff recovery knowledge, attitudes, recovery-promoting relationships, and competencies. The main characteristics of the ten instruments that met inclusion criteria were:

- INSPIRE: Assesses staff support for recovery across five dimensions (e.g., identity, meaning).
- RECOLLECT: Evaluates the fidelity of Recovery Colleges.
- RSA: Measures recovery-supporting practices, available in multiple versions.
- REE: Assesses organisational climate and recovery elements with a large number of items.
- ROSA: An adaptation of RSA for staff evaluation.
- RKI: Staff-rated measure focusing on recovery knowledge.
- RAQ: Staff-rated measure of attitudes toward recovery.
- ARQ: Culturally adapted for Hong Kong, emphasizing family involvement and social ties.
- PERS: Assesses staff expectations about recovery outcomes for service users.
- RPRS: Measures the recovery-promoting competence of mental health providers.

Despite some advancements, the study concludes that there is still no gold-standard instrument for measuring the recovery orientation of mental health services. The authors call for a new, psychometrically valid, and easy-to-use measure grounded in a robust recovery framework.

Objective

Given the gaps identified in the literature analysed and the needs expressed by Mental Health Europe, the objective of this study is to examine whether the commonly used definitions and tools for measuring the recovery orientation of mental health services adhere to the principles of the UNCRPD.

Method

To meet our objectives, we have conducted two scoping reviews, and an analysis of surveys collected specifically for this project.

The scoping reviews examine definitions and instruments related to recovery orientation in mental health services. It systematically compiles and evaluates various conceptualisations and measurement tools used across different contexts to assess recovery, with a particular emphasis on integrating these definitions with human rights principles outlined in the UNCRPD. To synthesise this information effectively, we conducted a content analysis of both definitions and measurement tools. Regarding definitions, we present a comparative overview of key definitions and conceptualisations of recovery from mental health challenges, as articulated by various national, regional and organisational bodies. In this context, recovery refers to the personal process of living a meaningful, self-directed life despite the ongoing presence of distress. Regarding the instruments, a range of instruments used to measure recovery orientation in mental health services were examined, including the Recovery Enhancing Environment Measure (REE), the AACP Recovery Oriented Service Evaluation (AACP-ROSE), the Recovery Oriented Systems Indicators Measure (ROSI), the Recovery Self-Assessment (RSA), the Recovery Oriented Practices Index (ROPI), the Recovery Promoting Relationship Scale (RPRS), the Recovery Promotion Fidelity Scale (RPFS) and the Recovery-Oriented Services Assessment (ROSA). These tools vary in terms of the dimensions they assess, the respondents involved (e.g., service users, providers, family members), and the specific aspects of recovery they measure, such as hope, empowerment, and the protection of human rights. In terms of content analysis, we examined all included definitions of recovery and assessed their alignment with specific articles of the UNCRPD.

Literature Search Strategy and Eligibility Criteria

The research method was developed in three phases, using different search strategies and criteria depending on whether it is a search for definitions of recovery, a search for instruments that evaluate recovery-oriented services, or a content analysis of the definitions and their alignment with the articles of the UNCRPD.

Definitions of Recovery

Regarding recovery definitions, the search strategy utilised Google and Google Scholar. The search terms used were a combination of keywords related to 'recovery' and 'recovery definitions.' Boolean operators (AND, OR) were utilised to refine the search ('Recovery' AND 'Mental' AND 'Health') and capture the most relevant definitions, adhering to the following inclusion and exclusion criteria.

Inclusion Criteria:

1. The definition presented an original approach, framework, or understanding of the recovery process.
2. The definition could be precise and theory-based, identifying components of recovery from mental health challenges.
3. The definition was part of a published review or formal policy document issued by a state, provincial, or national authority.
4. The definition was accessible in the English language.

Exclusion Criteria:

1. Definitions that exclusively examined recovery as a particular process, without considering the concept in its entirety.
2. Definitions that exclusively examined clinical recovery.
3. Definitions that could not be found in any official, institutional document or reviews.

Recovery- orientation of mental health services measures

Regarding measurement tools, the research method was designed to identify relevant reviews that assess recovery-oriented measures in mental health services. Each instrument was then searched for using its acronym and original title (e.g., 'Recovery Self-Assessment' RSA). All articles that incorporated the measures were reviewed, without any limitations on publication dates, which allowed both key foundational research and more recent findings to be included. This approach provided a comprehensive analysis of the progression of recovery concepts and the development of evaluation tools over time. The study utilised Scopus and Google Scholar to gather a wide range of both academic and grey literature.

Inclusion criteria:

1. Measures assessing the recovery orientation of services.
2. The instrument must provide quantitative data to ensure measurable outcomes.
3. The tool must be written in English.
4. At least one related psychometric validation paper should be available for review.
5. The instrument must be accessible without cost.

Exclusion criteria:

1. Instruments assessing clinical recovery or personal recovery.
2. Instruments assessing mental health professionals' knowledge, beliefs or attitudes towards recovery (in contrast with Leamy et al., 2023 who also included these types of measures in their review).

Content analysis

In addition to compiling definitions and instruments, the study also conducted a content analysis to examine how these recovery definitions align with the principles of the UNCRPD.

Specifically, the analysis focused on Articles 5 through 33 of the UNCRPD, excluding Articles 1 through 4, which outline the convention's purposes and general obligations.

On the one hand, each definition was analysed with each article of the CRPD from article 5 onwards. This involved finding common themes between the definitions and the content of the articles and marking the article that was relevant to each definition (understanding that a definition may represent more than one article). On the other hand, each instrument was analysed with each article of the CRPD from article 5. At this point, the same method was followed as with the content analysis of the definitions.

Survey

Survey Design

A qualitative survey was designed to explore mental health organisations' approaches to recovery, with a particular focus on the integration of human rights principles in recovery practices. The survey consisted of six open-ended questions, aiming to capture respondents' perspectives and practices on recovery, as well as their understanding and use of human rights-based frameworks in mental health care. The questions were designed to encourage detailed responses that could provide insight into organisational practices and definitions related to recovery.

The survey questions were as follows:

1. **What definition of recovery do you use in your organisation?**

This question aimed to capture the formal or operational definition of recovery utilised by the organisation, providing context on how recovery is framed within their practice.

2. **Do you know of any alternative definitions of recovery, especially those emphasizing human rights?**

This question sought to understand respondents' awareness of different conceptualisations of recovery, particularly those that align with human rights approaches, such as autonomy, dignity, and non-discrimination.

3. **Can you elaborate on your recovery practices, especially if they apply and integrate human rights?**

This question invited participants to describe the specific recovery interventions they use, focusing on whether and how these practices incorporate human rights principles, such as shared decision-making or respect for patient autonomy.

4. **How do you assess the compliance of your recovery practices with human rights principles?**

Respondents were asked to explain any methods or tools used to ensure that their recovery practices adhere to human rights standards, including any assessment frameworks or evaluations they may employ.

5. **Do you know of any human rights' compliant recovery practices?**

This question sought examples of practices that the organisation recognises as compliant with human rights, aiming to gather specific case studies or interventions that align with international human rights frameworks.

6. **Do you use or know of any model of human rights-based indicators that can be useful to assess recovery in mental health?**

This question aimed to identify whether organisations use or are aware of any indicators or measurement tools that assess the integration of human rights principles within their recovery practices.

Participants

Participants in this survey were mental health professionals and organisational representatives from the Mental Health Europe (MHE) network, an organisation dedicated to the promotion of mental health and human rights across Europe. The survey targeted those working in mental health services with a stated interest or practice in integrating human rights into recovery frameworks.

Data Collection

The survey was distributed by email within the MHE network and shared via LinkedIn, ensuring a broad reach among professionals and stakeholders.

Data Analysis

Responses were analysed using qualitative content analysis. The answers were coded into thematic categories based on recurring concepts related to recovery, human rights integration, and compliance assessment. Thematic analysis was employed to identify key patterns and insights that illustrate the diversity of approaches to recovery across different organisations, with particular attention paid to the use of human rights-based frameworks and indicators.

Results

Definitions of Recovery

The scoping review identified seven distinct definitions of recovery, compiled in Table 2 from sources across different levels of governance—organisational, national, and regional. It also includes whether the definition involved participation from stakeholders such as service users. The definitions date from 1993 to 2023 and vary in scope and emphasis but share core principles detailed below.

Personal growth

Anthony's definition (Anthony, 1993) comes from the USA and is the oldest and most widely used definition in scientific literature on recovery. This definition focuses heavily on internal changes—such as attitudes, values, and roles—that enable individuals to achieve personal growth and satisfaction and highlights individual empowerment, centring recovery on the person's ability to develop and evolve, even in the presence of mental health issues.

Self-management and autonomy

In contrast, the Scottish Recovery Network's definition (Brown & Kandikirira, 2010) emphasises the importance of personal control and autonomy in the recovery process. It stresses that individuals can live meaningful and satisfying lives despite ongoing symptoms, with recovery being defined by each person's own decisions and self-management. Similarly, the NICE Institute in the United Kingdom (National Institute for Health and Care Excellence, 2011) adds that recovery means different things to different people, underscoring the subjectivity and individuality of the process.

SAMHSA's (Substance Abuse and Mental Health Services Administration, 2012) introduces a more structured view of recovery, describing it as a process where individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. This definition comes from the USA and places significant importance on self-management and goal setting, focusing on personal agency and the ability to take control of one's health and future.

Connecting with the community

The Australian Government's definition (Australian Health Ministers Advisory Council & Ahmac, 2013) expands the scope of recovery to include social dimensions, emphasizing the

importance of community integration. It suggests that recovery involves creating and living a meaningful life within a community of choice, highlighting the relational aspects of recovery. This approach places a greater focus on social connections and the ability to make autonomous choices about where and how to live.

Supports and resources

The Mental Health Commission of Canada (Mental Health Commission of Canada, 2014) adds further depth by emphasizing the strength-based approach to recovery. It highlights the importance of building on individual, family, cultural, and community strengths, reflecting a holistic view of recovery that considers a wider network of support systems. Recovery is seen as a journey supported not only by the individual but by collective and cultural resources.

Human Rights

Finally, the Government of Catalonia's (Generalitat de Catalunya, 2023) definition introduces a strong focus on human rights, particularly emphasizing the protection of legal and human rights. This definition integrates both subjective aspects, such as emotional well-being, and objective aspects, like legal capacity and rights protection. It recognises that the process is not only about personal empowerment but also about ensuring that individuals have the legal and societal support needed to fully exercise their rights.

Table 2

Attributes of recovery definitions

Definition	Organisation	Year	Level	Participatory
A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life, even within the limitations caused by illness.	Centre for Psychiatric Rehabilitation at Boston University, Boston, Massachusetts (Anthony, 1993)	1993	Organisation	Yes
Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life.	Scottish Recovery Network (Brown & Kandikirira, 2010)	2007	Organisation	Yes
Recovery is a personal, individual process and it means different things to different people. It is often about being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms.	NICE - United Kingdom (National Institute for Health and Care Excellence, 2011)	2011	Country	N/A
A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.	SAMHSA (Substance Abuse and Mental Health Services Administration, 2012)	2012	Country	Yes
Being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.	Australian Government Department of Health (Australian Health Ministers Advisory Council, 2013)	2013	Country	N/A
Refers to living a satisfying, hopeful, and contributing life, even when a person may be experiencing ongoing symptoms of a mental health problem or illness. Recovery journeys build on individual, family,	Mental Health Commission of Canada (Mental Health Commission of Canada, 2014)	2014	Country	N/A

cultural, and community strengths and can be supported by many types of services, supports and treatments.				
Recovery involves, from the perspective of a person with a mental health issue, a whole range of subjective and objective aspects in its approach, such as hope, empowerment, the protection of human rights, as well as promoting a positive culture of care (considering expectations, strengths, and interests).	Government of Catalonia (Generalitat de Catalunya, 2023)	2023	Region	Yes

Note: Levels: Organisation, Region, Country, International. Participation implies that the definition has been consulted with stakeholders.

Recovery-Oriented Measures

Regarding the instruments, eight distinct recovery measurement instruments were compiled (see Table 3). Table 3 includes the full instrument title, acronym, original validation study, number of items, subscales assessed, and the respondents who complete the assessments (e.g., service users, providers, administrators). A range of recovery-focused domains is covered, such as organisational climate, individual recovery markers, peer support and individualisation of services, consumer governance, and provider competencies. Several are completed by service users themselves, while others gather perspectives from providers, family members, or organisational leaders.

From the USA

The Recovery Enhancing Environment Measure REE (Ridgway et al., 2004) is one of the most comprehensive instruments, containing 166 items (20 compulsory) that assess both organisational and individual recovery processes. It emphasises a holistic approach, covering stages of recovery and markers for both service users and organisations.

In contrast, the Recovery Self-Assessment RSA (O'Connell et al., 2005) is more streamlined, with 80 items (36 compulsory) and a strong focus on the consumer perspective. It evaluates the extent to which services align with recovery-oriented principles across five subscales. Its emphasis on capturing feedback from multiple respondent groups ensures that recovery orientation is assessed from a variety of perspectives.

Regarding to the Recovery Oriented Systems Indicators (ROSI) measure (Dumont et al., 2005) takes a more systemic approach, with 23 items spread across six subscales. The ROSI highlights the importance of creating a supportive infrastructure that fosters recovery, suggesting that recovery cannot be achieved through individual efforts alone but must be supported by system-wide changes.

The AACP Recovery Oriented Service Evaluation (Sowers, 2005) assesses recovery orientation through 46 items across three subscales, capturing input from service users, providers, and administrators to assess both policy and practice in recovery-oriented services. Like the ROSI, it takes a more organisational view. This multi-perspective assessment reflects a value for inclusive evaluation.

About the Recovery Promoting Relationship Scale RPRS (Russinova et al., 2006), it stands out from other instruments due to its focus on the competencies of service providers. With 24 items distributed across three subscales, this measure places significant value on the therapeutic relationship and the provider's role in promoting recovery.

Respecting the Recovery Oriented Practices Index ROPI (Mancini, A.D., & Finnerty, 2005) consists of 20 items and assesses eight subscales. This measure combines elements of individual recovery and systemic recovery support, bridging the gap between personal needs and organisational practices.

The Recovery Promotion Fidelity Scale (Armstrong & Steffen, 2009), is a relatively brief instrument with 12 items across five subscales. The RPFS places a strong emphasis on collaborative practices and self-determination, aligning with values of shared decision-making and empowerment. It highlights the importance of peer support as a central component of recovery.

From the United Kingdom

Lastly, the Recovery-Oriented Services Assessment ROSA (Lodge et al., 2018), is another measure with 15 items, assessing five subscales. The ROSA underscores the importance of rights-based approaches in recovery, reflecting values of human rights, dignity, and respect. Its focus on involvement and recovery education for service users aligns with modern principles of empowerment and self-advocacy in recovery.

Table 3

Attributes of recovery orientation instruments

Title	Acronym	First validation reference	Items	Dimensions measured	Completed by
Recovery Enhancing Environment Measure	REE	(Ridgway, 2005)	166 (20 compulsory)	Organisational (4 subscales) and individual recovery (3 subscales: stage of recovery, recovery markers, and special needs)	Service users
AACP Recovery Oriented Service Evaluation	AACP-ROSE	(Sowers, 2005)	46	4 Subscales: administration, treatment, supports, and organisational culture	Service users, service providers, family members and administrators
Recovery Oriented Systems Indicators Measure	ROSI	(Dumont et al., 2005)	23	6 Subscales: peer support, choice, staffing ratios, system culture and orientation, consumer inclusion in governance, and coercion	Service users and services providers
Recovery Self-Assessment	RSA	(O'Connell et al., 2005)	80 (36 compulsory)	5 Subscales (life goals, involvement, diversity of treatment options, choice, individually tailored services)	Directors, service users, services providers, family members
Recovery Oriented Practices Index	ROPI	(Mancini, A.D., &	20	8 Subscales (meeting basic needs, comprehensive services, customisation and choice, consumer involvement/participation, network	Independent assessors

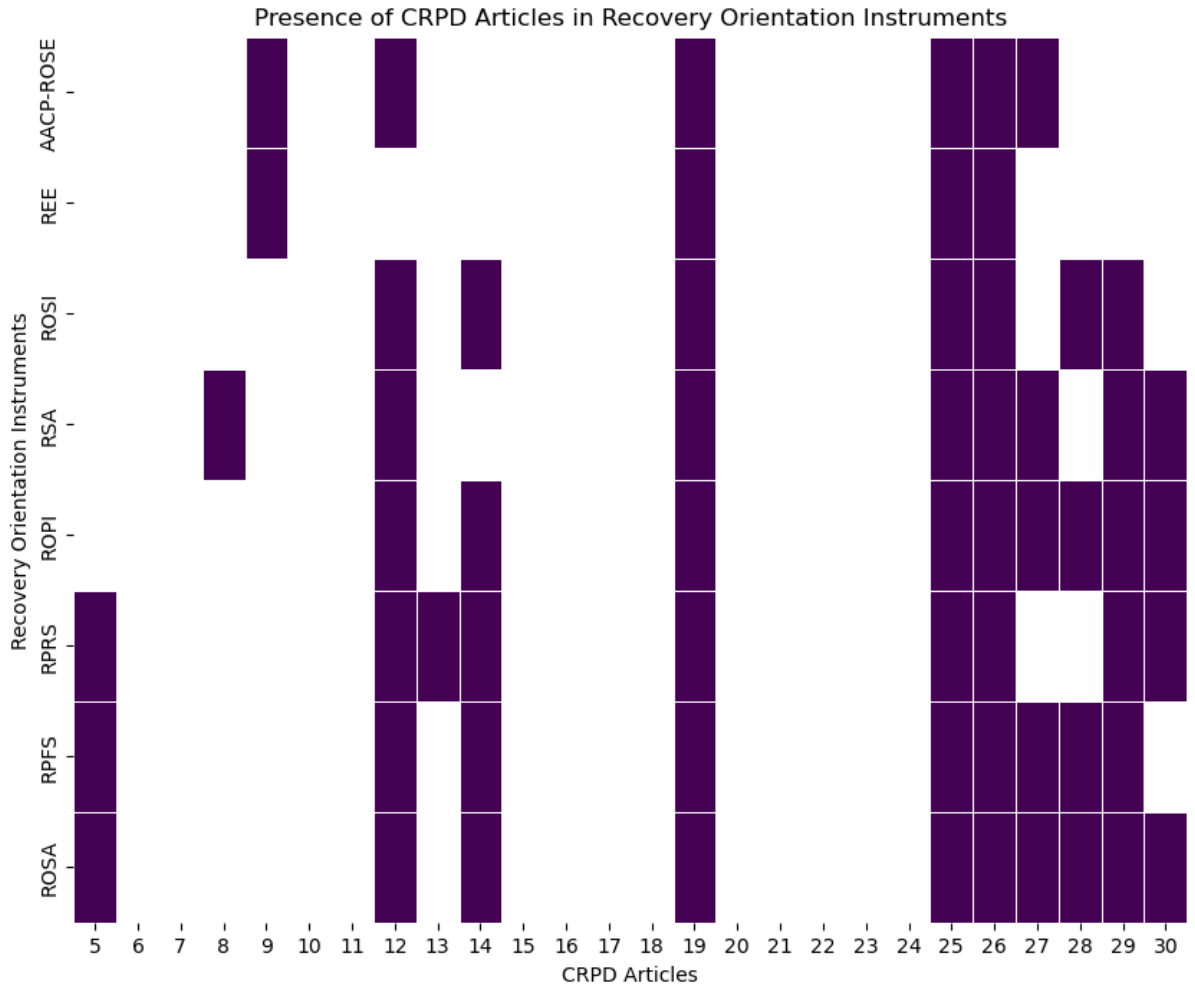
		Finnerty, 2005)		supports/community integration, strengths-based approach, client source of control/self-determination, and recovery focus)	
Recovery Promoting Relationship Scale	RPRS	(Russinova et al., 2006)	24	Providers' competencies (3 subscales: hopefulness, empowerment and self-acceptance)	Service providers
Recovery Promotion Fidelity Scale	RPFS	(Armstrong & Steffen, 2009)	12	5 domains (collaboration, participation and acceptance, self-determination and peer support, quality improvement and development)	Independent assessors
Recovery-Oriented Services Assessment	ROSA	(Lodge et al., 2018)	15	5 Subscales (service user involvement and recovery education, life goals vs. symptom management, individualised and person-centred care, rights and respect and diversity of treatment options)	Service users and services providers

Content Analysis

The content analysis examined how various recovery definitions and measures align with specific articles of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), with Articles 12, 19, 25 and 26 being the most frequently mentioned in the definitions. Articles that met three occurrences or less (adding definitions and instruments) have not been considered in the report due to their lack of representativeness. Figures 1 and 2 show the results of the analysis.

Figure 1. Graphical representation of the content analysis of recovery definitions

Figure 2. Graphical representation of the content analysis of recovery orientation instruments



Article 5: Equality and Non-Discrimination

Article 5 emphasises equality before the law and equal protection and benefit of the law without discrimination. The Recovery-Oriented Services Assessment (ROSA) promotes recovery-oriented services that are equitable and inclusive, ensuring that all individuals receive fair treatment and have equal access to mental health services, consistent with the UNCRPD's commitment to non-discrimination. In a similar way, the Recovery Promotion Fidelity Scale (RPFS) evaluates how well mental health services adhere to practices that ensure equal treatment, non-discrimination, and equity in care. Lastly, the Recovery Promoting Relationship Scale (RPRS) aligns with this by promoting relationships in mental health care that are free

from discrimination and that recognise and value the individuality of each person, thus supporting equal and fair treatment in care.

Article 12: Legal Capacity

Article 12, which guarantees the right to equal recognition before the law and the exercise of legal capacity, was one of the most frequently referenced in the recovery definitions. Interestingly, regarding the instruments, articles 12 and 14 were often discussed together, reflecting the link between legal capacity and coercion. Coercion, as highlighted in the definitions of recovery, inherently denies people their legal capacity, particularly in mental health contexts where involuntary treatment may be common. However, no definition of recovery makes special mention of the content of Article 14, concerning the liberty and security of the person.

However, there was a noticeable gap in linking Article 12 with Article 13, which focuses on access to justice. Despite their close connection—legal capacity being a prerequisite for meaningful access to justice—Article 13 was mentioned far less frequently both in definitions and instruments. In fact, there are no definitions including this point and only the Recovery Promoting Relationship Scale (RPRS) takes it into account. This gap suggests a potential oversight, where the full implications of legal capacity on broader legal rights, such as access to justice, were not fully explored.

Article 19: The Right to Independent Living

Article 19, which advocates for the right to live independently and be included in the community, was another frequently discussed topic both in definitions and instruments. This article was often connected to Article 12, as many individuals who are institutionalised are frequently deprived of both their legal capacity and the right to live freely in the community.

Institutionalisation significantly limits individuals' ability to exercise their legal rights and make independent decisions, underscoring the need for recovery-oriented services that actively support independent living.

All the definitions and instruments suggested that recovery-oriented services should actively support independent living, emphasizing the importance of creating systems that promote community integration.

Articles 25 and 26: Health and Rehabilitation

Articles 25 and 26 cover the right to health and rehabilitation. All recovery definitions and instruments are based on these articles and emphasise the need for mental health services to offer holistic, person-centred care that supports not only physical and mental well-being but also broader aspects of recovery, such as community participation and social inclusion.

Article 27: Work and Employment

The ROSA, ROPI, RSA and RPFS instruments evaluate recovery-oriented services that include support for employment as a key part of recovery, aligning with the CRPD's emphasis on employment as a critical component of full societal participation and economic independence.

Article 28: Adequate Standard of Living and Social Protection

The RPFS, ROPI, ROSA and ROSI promote practices that ensure individuals have access to necessary supports that contribute to their well-being and recovery, aligning with the social protection goals and adequate living standards of the CRPD.

Article 29: Participation in Political and Public Life

The RPFS and RPRS support practices that empower individuals to be actively involved in their own care decisions and advocate for their rights, reflecting Article 29's emphasis on inclusive participation and the importance of self-advocacy and leadership in recovery.

The ROSA, ROPI, RSA and ROSI promote recovery-oriented services that empower individuals to participate in decision-making processes within mental health care settings and in the broader community, reflecting Article 29's emphasis on civic engagement and political participation.

Article 30: Participation in Cultural Life, Recreation, Leisure, and Sport

The ROSA, the RSA, the ROPI and the RPRS align with this article by evaluating mental health services that encourage and support individuals' participation in a wide range of community and cultural activities, which is important for social inclusion and personal fulfilment.

Regarding definitions, those that are most aligned with Article 30 of the CRPD are definitions of Anthony, Australian Government Department of Health, Mental Health Commission of Canada and Government of Catalonia.

Survey results

We received 9 replies to the call for participation, four of them from Mental Health Europe Members. Respondents represented a wide geographical distribution, with participants from Italy, the United Kingdom, Slovenia, and Spain among those who provided information. All respondents providing information indicated a willingness to participate in follow-up interviews.

Definitions of Recovery

Participants' definitions of recovery varied, reflecting both traditional and human rights-oriented approaches. Several organisations emphasised personal recovery, viewing it as an individualised process where the person determines the goals and outcomes of their recovery. This approach aligns with a person-centred model, as illustrated by one respondent, who described recovery as 'a process where the person defines what recovery means for them.' Emphasising its dynamic nature, another participant noted that their organisation defines recovery as an ongoing journey, moving away from illness-focused definitions.

A minority of respondents also highlighted the need for alternative definitions of recovery that integrate human rights principles. These participants recognised a shift from purely clinical definitions towards a more holistic understanding, which includes social inclusion, empowerment, and the right to self-determination.

Integration of Human Rights in Recovery Practices

When asked to elaborate on how recovery practices integrate human rights, several participants provided detailed descriptions of their approaches. Many respondents cited practices aimed at promoting autonomy and self-determination, such as involving service users in shared decision-making processes. For example, one organisation reported using advance directives to allow service users to plan their care during times of crisis, ensuring that their wishes are respected even when they are unable to make decisions independently.

Some participants also emphasised the importance of non-coercive practices in mental health care, stressing that recovery should be voluntary and respect individuals' rights to refuse treatment. Moreover, the use of peer support was frequently mentioned as a human rights-compliant practice, with respondents stating that peer workers play a vital role in empowering individuals and reinforcing the notion of recovery as a right rather than a clinical goal.

Assessment of Human Rights Compliance

Regarding the assessment of compliance with human rights principles, most organisations reported informal mechanisms rather than structured evaluation tools. Several participants acknowledged the need for more systematic monitoring of human rights adherence within their recovery practices. One organisation mentioned using feedback from service users as a method to ensure their practices align with human rights standards, while others referred to periodic reviews of their policies to ensure consistency with international frameworks, such as the UNCRPD.

However, a few respondents expressed uncertainty about how to effectively measure compliance, indicating a gap in the availability of human rights-based indicators that could guide organisations in assessing their recovery practices more rigorously.

Discussion

This report provides a detailed analysis of recovery definitions, recovery-oriented measures, and the views of different actors on the integration of human rights in recovery practices. The scoping review identified seven distinct definitions of recovery from various sources, including organisational, national, and regional levels. These definitions emphasise personal growth, self-management, autonomy, community integration, and the protection of human rights. Notably, the definitions from the Government of Catalonia and the Mental Health Commission of Canada highlight the importance of legal and human rights in the recovery

process. The report also reviews eight distinct recovery measurement instruments. These instruments assess various domains, including organisational climate, individual recovery indicators, peer support implementation, and the individualisation of services. The content analysis examines how these instruments align with specific articles of the UNCRPD, identifying gaps and areas for improvement. For instance, while many instruments address Articles 12 (legal capacity) and 19 (independent living), there is a noticeable gap in addressing Article 13 (access to justice). Survey results provide insights into how mental health organisations define recovery and integrate human rights into their practices. Participants' definitions of recovery varied, with some emphasising personal recovery as an individualised process and others highlighting the need for a more holistic understanding that includes social inclusion and empowerment. Many organisations reported using practices aimed at promoting autonomy and self-determination, such as involving service users in shared decision-making processes and using advance directives. However, most organisations reported informal mechanisms for assessing compliance with human rights principles, indicating a need for more systematic monitoring and the development of human rights-based indicators.

The analysis of existing definitions of recovery in the mental health field reveals significant challenges and opportunities for progress. Despite numerous efforts by governments and international organisations to define recovery, it remains difficult to reach a clear consensus on its meaning. The need for a broader and more inclusive definition of recovery could ensure the protection of human rights and promote a community-based approach with equitable access to guaranteed resources and support systems. Therefore, a recommended definition of recovery could combine elements of the definitions provided by the Government of Catalonia and the Mental Health Commission of Canada, as these are the definitions that best fit the principles promoted by the UNCRPD placing greatest emphasis on the protection of human rights. This combined definition would emphasise recovery as a multidimensional process that empowers

individuals to live a fulfilling, hopeful, and meaningful life, even in the presence of ongoing mental health challenges. Specifically, the definition should remark recovery as a process rooted in the strengths of individuals, families, cultures, and communities, and would entail not only personal empowerment but also the protection, respect, and guarantee of human rights. It should also highlight the importance of a positive care culture that considers individual expectations, strengths, and aspirations. Additionally, this redefined concept of recovery should acknowledge the critical role of providing access to a diverse range of services, supports, and treatments, while ensuring that the autonomy and dignity of individuals are upheld. In light of these considerations, we propose the following definition of recovery:

'Recovery is a process that empowers people to live full and meaningful lives, even with mental health challenges, based on protecting, respecting and guaranteeing their human rights. This process builds on individual, family and community strengths, and promotes equitable access to resources and supports that respect the autonomy and dignity of each person on an equal basis with others.'

According to our results, current recovery orientation instruments not fully encompass all the human rights considerations outlined in the UNCRPD. While existing instruments provide a solid foundation, they may not fully capture the breadth of human rights advocacy. Nevertheless, these instruments can serve as minimum standards, offering a starting point for developing more comprehensive tools. However, the development of a new instrument is warranted to ensure comprehensive and comparable measurement of recovery in mental health services. This new tool should fully integrate the principles of the UNCRPD, covering all relevant articles such as legal capacity, non-discrimination, and the right to independent living. By incorporating indicators that account for intersecting vulnerabilities—such as gender, socio-economic status, ethnicity, age, sexual orientation, etc.—this tool could offer a more comprehensive understanding of recovery. The creation of new indicators could potentially

revolutionise the field by providing a more holistic and nuanced understanding of recovery, ensuring that all aspects of human rights are adequately addressed.

To establish a minimum framework for assessing recovery-oriented practices we have chosen the best from the existing measurements after a detailed evaluation of the contents and properties of each of the eight analysed in this report. We have selected REE, ROSA, AACP-ROSE, and ROPI after a careful evaluation of their applicability in the European context for evaluating the recovery orientation of institutions. REE focuses on service users, providing a comprehensive assessment of both organisational and individual recovery processes. ROSA is suitable for contrasting different views and integrates mental health services with broader societal factors, such as access to affordable education. AACP-ROSE is valuable for gathering perspectives from service users, providers, family members, and administrators, offering the possibility of a balance between their different visions of recovery-oriented services. ROPI is ideal for evaluations conducted by independent assessors. The RSA has been left out, as ROSA is a short version derived from it developed through a mixed participatory and psychometric process, resulting in a more precise and effective instrument. ROSI has been excluded because it mixes the evaluation of mental health services with societal issues, including for instance access to affordable housing or education. RPRS is too relationship-centred, as it is completed by people receiving services from a specific provider. RPFS is only useful for studies focused on organisations undergoing recovery implementation and is not valid if recovery has not been started or if it is already implemented.

For organisations working to improve mental health systems and promote the adoption of the UNCRPD, such as Mental Health Europe, a recommended approach to supporting the use or development of instruments to measure recovery would involve consistent advocacy for the integration of human rights principles in mental health services while also raising awareness

about the importance of measuring recovery in line with the UNCRPD among policy makers, practitioners, service users and the general public.

It is crucial for governments and policymakers to invest in capacity-building initiatives for mental health professionals, enhancing their understanding and use of recovery measurement tools. Supporting research and development efforts to create new instruments or improve existing ones, including funding research projects and collaborating with academic institutions, is essential. Another crucial step is to ensure that recovery measurement is included in national and international mental health policies and frameworks. Building partnerships with organisations, both within and outside the mental health sector to leverage resources and expertise for developing and implementing recovery measurement tools is also essential.

Table 4

Selected subscales from recovery orientation instruments

Title	Acronym	Length	Rationale
Service users			
Recovery Enhancing Environment Measure	REE	Importance (23 items), Experience (23 triple items which develop the experience of the former 23), Organisational Climate (14 items).	Useful for studies focused on the perspectives of service users. In addition to the 46 items addressing organisational aspects, there is a 24-item subscale on personal recovery and 4 items on employment, which may be relevant to administer depending on the context.
Service users and services providers			
Recovery-Oriented Services Assessment	ROSA	15 items (whole scale)	ROSA is suitable for contrasting different perspectives and is more concise than both the AACP-ROSE and the longer version of the RSA.
Service users, service providers, family members and administrators			
AACP Recovery Oriented Service Evaluation	AACP-ROSE	46 items (whole scale).	Comprehensive yet more concise than the RSA, making it suitable for contrasting different perspectives in a straightforward manner.
Independent assessors			
Recovery Oriented Practices Index	ROPI	22 items (whole scale)	Valuable tool for evaluations conducted by independent assessors.

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Mental Health Europe is the largest independent network organisation representing people with mental health problems, their supporters, care professionals, service providers and human rights experts in the field of mental health across Europe. Its vision is to strive for a Europe where everyone's mental health and wellbeing flourishes across their life course. Together with members and partners, Mental Health Europe leads in advancing a human right, community-based, recovery-oriented, and psychosocial approach to mental health and wellbeing for all.

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