



A non-randomised controlled trial testing the effectiveness of a recovery planning workshop implemented in community mental health services in Spain

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ABSTRACT

This study explores the effectiveness of a 12-session recovery planning workshop designed to train users of community mental health services to draw up their personal recovery plan. We employed a non-randomised controlled trial design with 152 participants, comparing those who participated in the workshop with a control group. The primary outcomes assessed were the stage and level of personal recovery, while secondary outcomes were empowerment, hope, and perceived social support. Change in the recovery stage from baseline to post-intervention was assessed using the McNemar-Bowker test. Separate two-way mixed ANOVA (group $\times$ time) were performed to examine the effects of the recovery planning workshop on both primary and secondary outcomes. Results suggest that participants in the experimental group experienced significant improvements in terms of recovery stage, particularly as regards the number of individuals who, following the intervention, considered themselves unrecoverable (i.e., at the moratorium stage), in comparison with baseline and controls. Changes in the level of recovery and secondary outcomes were not statistically significant when the initial stage of recovery was not taken into account. However, when accounting for the stage of recovery at baseline, significant differences were observed in the level of recovery, empowerment, and hope, highlighting the importance of considering the baseline stage of recovery when evaluating recovery-oriented interventions. These results suggest that the workshop has the potential to promote mental health recovery, empowerment, and hope, while also highlighting the need to assess the initial stage of recovery prior to any intervention so as to properly evaluate its effectiveness.

1. Introduction

The concept of personal recovery in mental health emerged in the 1990s from the narratives of users and survivors of psychiatry (Slade et al., 2008), for whom recovery goes beyond the remission of symptoms and implies living a meaningful and satisfying life, in accordance with one's own preferences and values (Anthony, 1993; SAMHSA, 2011; World Health Organization and United Nations, 2023). Nowadays, the most widely accepted conceptual model of personal recovery is the

CHIME framework (Leamy et al., 2011), the name being an acronym that refers to its dimensions: (a) Connectedness with others and with the community, (b) Hope and optimism about the future, (c) a positive sense of one's own Identity, (d) Meaning and purpose in life, and (e) Empowerment so to have control over one's own life. Understanding personal recovery in this way suggests that the process requires both self-determination (Copeland, 2004; Piltch, 2016) and the exercise of citizenship rights (Pelletier et al., 2015).

The literature that draws on this perspective considers personal

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recovery to be a processual experience (Sommer et al., 2021), that is, as a way of living life rather than a final state to be attained (Slade et al., 2008). This aligns with the fact that when users talk about recovery, they describe both gradual improvements and qualitative leaps in their recovery process, which in the literature have been referred to as stages (Andresen et al., 2003; Baxter and Diehl, 1998; Young and Ensing, 1999). In other words, people in recovery not only improve their level of hope, empowerment, and wellness, but at certain points in the process may come to redefine their identity or the meaning they give to their lives.

Accordingly, there is now a broad consensus that recovery unfolds in a series of stages or phases, although just how many varies across authors. Pettie and Triolo (1999) suggested two phases; Baxter and Diehl (1998), Lapsley et al. (2002), and Young and Ensing (1999) identified three; Davidson and Strauss (1992) and Spaniol et al. (2002) proposed four; and the most popular model, that of Andresen et al. (2003), includes five stages: (1) moratorium, (2) awareness, (3) preparation, (4) rebuilding, and (5) growth.

This five-stage conceptual model has received widespread acceptance (Oades et al., 2008), possibly because it was the first to provide a foundation for the design of psychometric instruments for measuring recovery stages (Andresen et al., 2006, 2007). However, empirical studies aimed at evaluating these stages, conducted in different cultural contexts such as Australia (Andresen, 2007, p. 16), the UK (Weeks et al., 2011), and Spain (Lemos-Giráldez et al., 2015), concluded that a three-stage model provided the best fit to the data, which could be due to an overlap between adjacent stages (Andresen, 2007, p. 16). In this model, the five original stages are collapsed as follows: (1) moratorium, (2) awareness/preparation, and (3) rebuilding/growth.

This conceptualisation of recovery as a process involving stages, and going beyond symptom remission and functionality, has been incorporated by the World Health Organization (WHO). Through its *Quality-Rights* initiative (Funk and Drew, 2020), the WHO is promoting a shift in public mental health policies worldwide, proposing person-centred, community-based, recovery-oriented, and rights-based care (World Health Organization, 2021). Enabling people to manage their mental health difficulties and an increased focus on personalised recovery have thus become key goals of public mental health policies (Hall et al., 2023). This paradigm shift responds to the need to align mental health care with the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2006), especially Article 12, concerning equal recognition before the law (United Nations, 2014). Accordingly, mental health services are responsible for promoting and respecting people's self-determination, allowing users to exercise legal capacity, that is, to make decisions for themselves on all aspects of their lives, including treatment preferences, support needs, and recovery objectives (Funk and Drew, 2020; World Health Organization and United Nations, 2023).

One resource that facilitates self-determination and respect for people's preferences in the recovery process is the use of recovery planning tools, which are considered by the WHO as fundamental for adopting recovery and human rights approaches (World Health Organization, 2019). Recovery planning tools are resources created by users and survivors of psychiatry through the systematization of their recovery experiences, and they are aimed at helping people to develop their own recovery plan, including strategies to promote well-being, prevent or deal with mental health crises, build or rebuild their life project, and learn from their own experience.

The Wellness Recovery Action Plan (Copeland, 1997) was the first recovery planning tool to be published and implemented. This is a practical tool that, through a series of questions organized into sections, helps people to draw up their recovery plan. Following the publication of the Wellness Recovery Action Plan, several other tools with similar objectives have been released.

Since 2015, the "Get Active for Mental Health" program has been implemented in Catalonia (Spain) through collaboration between

mental health service providers and user and family organisations. This program aims to improve the well-being of people with mental health problems and their relatives and help them become active agents in the recovery process (Rojo-Rodes et al., 2019). As part of the Get Active for Mental Health program, taking the Wellness Recovery Action Plan as a model and through a participatory process, a recovery planning tool has been created, which includes two materials.

- (a) the *Manual for recovery and self-management of well-being* (Sampietro and Gavalda-Castet, 2018a) introduces the concept of personal recovery, presents different resources that people often use in their recovery process, and explains how to draw up a recovery plan.
- (b) the *Personal workbook* (Sampietro and Gavalda-Castet, 2018b) is a practical tool designed to help individuals to develop their recovery plans.

As in the Wellness Recovery Action Plan, the Get Active for Mental Health program also offers people the opportunity to learn how to use the recovery planning tool by participating in a recovery planning workshop. Likewise, there are objectives common to both these tools, and the Get Active for Mental Health program workbook follows a similar structure to the Wellness Recovery Action Plan. However, the recovery planning tool of the Get Active for Mental Health program differs insofar as it is adapted to the legal framework, the portfolio of services, and the formal and informal resources available in Catalonia and Spain. Furthermore, it not only explains which resources people can use but also helps them to locate these resources in their local region – for example, by providing access to online search engines that allow people to browse the volunteer network in Catalonia or job offers in the protected market for people with disabilities. In addition, the manual and the workbook are published in open access format (see Sampietro and Gavalda-Castet, 2018a, 2018b, to access these documents). A detailed comparison of similarities and differences between the Wellness Recovery Action Plan and the Get Active for Mental Health recovery planning tool is provided in the [Supplementary Table S1.1](#).

A recent scoping review of studies that have evaluated the implementation of recovery planning tools noted that, among existing tools, the Wellness Recovery Action Plan is the only one to have been widely implemented and evaluated, and most of these studies have been conducted in anglophone countries, with none carried out in Mediterranean or Spanish-speaking countries (Sampietro et al., 2022a). Thus, although some mental health services in Catalonia have already begun to implement the recovery planning workshop of the Get Active for Mental Health program, this workshop has yet to be evaluated.

The purpose of the present research was to address these gaps in knowledge. Following a published protocol (Sampietro et al., 2022b), this article presents the results of a non-randomised controlled trial designed to evaluate the effectiveness of the Get Active for Mental Health recovery planning workshop implemented in community mental health services in Catalonia (Spain). More specifically, we sought to evaluate its effectiveness in improving the stage and level of personal recovery, with this analysis being conducted both with and without the initial stage of recovery as a covariate. We hypothesized that participants in the recovery planning workshop would experience a significant improvement in the variables evaluated, and that this would also be greater than any improvement experienced by control group participants who did not attend the workshop.

2. Method

2.1. Study design

This was a multi-centre, non-randomised controlled trial comparing users of community mental health rehabilitation services who participated in the Get Active for Mental Health recovery planning workshop

with users from the same services who did not. The non-randomised design was chosen to ensure the inclusion of community rehabilitation services based not only in large cities but also in medium-sized and smaller towns. Given that having a minimum of 10 participants was considered a requirement to carry out the workshop in each community rehabilitation service, and that in some centres located in medium-sized and small towns it was difficult to recruit a sufficient number of individuals interested in the study, it was not possible to implement random assignment of participants to groups without jeopardizing the minimum number needed to conduct the workshop.

The stage and level of personal recovery were assessed as primary outcomes. Secondary outcomes included empowerment, hope, and perceived social support, which were selected due to their relevance as core components of the CHIME recovery framework (Leamy et al., 2011). Both primary and secondary outcomes were assessed at baseline (i.e., one-two weeks before starting the workshop) and post-intervention (i.e., one-two weeks after finishing the workshop).

This study was designed and implemented with the participation of a representative from the user and survivor movement as a member of the research team. The trial registration number is ISRCTN11695542.

2.2. Participants

Participants were recruited from 13 community rehabilitation services across 12 towns and cities in Catalonia (Spain). The inclusion criteria were being between 18 and 65 years of age, a commitment to participate in community rehabilitation services activities for at least the duration of the study (i.e., approximately 4 months), and providing signed informed consent. The exclusion criteria were the presence of relevant cognitive impairment, comprehension difficulties, and/or a severe or decompensated somatic disease.

2.3. Setting and interventions

The Get Active for Mental Health recovery planning workshop was delivered in community rehabilitation services across Catalonia (Spain). A community rehabilitation service is a public community mental health service with a remit to accompany people in their recovery process, with a specific focus on promoting functional and personal recovery, strengthening psychosocial skills, and facilitating autonomy and inclusion in the community. Each community rehabilitation service offers a range of services and activities, which may include learning workshops, career guidance and vocational training, sports or artistic activities, and group recreational or cultural activities. Attendance at a community rehabilitation service and participation in its activities are voluntary choices made by users.

For the present study, users in both the control group and the experimental group were participating in the usual community rehabilitation service activities, but only those in the experimental group attended the Get Active for Mental Health recovery planning workshop. The workshop consists of 12 sessions, each lasting 90 min. All sessions include conceptual content, participatory activities, and moments of collective reflection. During the workshop, participants learn the meaning of personal recovery, the importance of self-determination to the recovery process, and how to draw up their personal recovery plan step by step. The recovery plan is organized into six sections: (a) the *Wellness Toolbox*, which includes the daily routines or daily actions that each person can do to promote his/her well-being; (b) the *Maintenance Toolkit*, which sets out all the things that each person should do or avoid doing to reduce the risk of relapse; (c) the *Personal Growth Plan*, which focuses on identifying personal goals and the individual life project, and

what to do to move in that direction; (d) the *Mirror of Relapses*, which is about recognizing the first signs of a personal mental health crisis and how this can be responded to; (e) the *Crisis Plan*, aimed at helping participants to undertake advanced care planning; and (f) the *Learning Agenda*, helping people to systematize their own experience and use it as a source of basic learning to guide the recovery process.

The Get Active for Mental Health recovery planning workshop was implemented by community rehabilitation services professionals who had previously completed a training program. This training covered the concept of personal recovery, the Get Active for Mental Health recovery planning tool, how to support the development of personal recovery plans, and the process for evaluating implementation of the workshop. The Get Active for Mental Health recovery planning workshop also provided trainers with a *Guide for the implementation of workshops* (Sampietro and Gavalda-Castet, 2018c), a support material setting out the learning objectives and the specific contents and participatory activities for each session. In addition, sessions 5 and 10 of the workshop were conducted in collaboration with experts with lived experience in the recovery process (users and survivors), who also served as trainers. Four online follow-up meetings were held between the research team and community rehabilitation services professionals to address questions about the workshop's implementation and to ensure the fidelity of the intervention.

Supplementary Table S1.2 presents the structure and content of each session of the Get Active for Mental Health recovery planning workshop.

2.4. Study outcomes and measurement instruments

2.4.1. Primary outcomes: stage and level of recovery

Self-Identified Stage of Recovery (SISR). The SISR (Andresen, 2007) is a two-part scale. The first part (SISR-A) is a single forced-choice item aimed at determining an individual's stage of recovery. It includes five statements (A to E), each representing one of the five stages of recovery according to the model proposed by Andresen et al. (2003): A: moratorium, B: awareness, C: preparation, D: rebuilding, and E: growth. The second part (SISR-B) is a 4-item scale designed to measure the level of four components of the recovery process: hope (item 1), identity (item 2), meaning (item 3), and responsibility (item 4). The SISR-B uses a 6-point Likert-type scale (1 = Disagree strongly, 6 = Agree strongly). Higher scores correspond to greater levels of recovery. For the present study we used the validated Spanish version of the SISR, which has shown good psychometric properties (Sampietro et al., 2024a). Internal consistency of scale scores in the study sample was good (McDonald's $\omega = 0.82$; Cronbach's $\alpha = .82$).

Maryland Assessment of Recovery Scale (MARS-12). The MARS-12 (Drapalski et al., 2012, 2016; Medoff, 2015) is a 12-item scale that assesses six components of personal recovery, labelled as self-direction/empowerment, holistic, non-linear, strengths-based, responsibility, and hope. Items are rated on a 5-point Likert-type scale (1 = Not at all; 5 = Very much). Higher scores reflect greater levels of recovery. The Spanish version of the MARS-12 has demonstrated good validity and reliability (Balluerka et al., 2024). In the present sample, scores on this scale showed excellent internal consistency (McDonald's $\omega = 0.94$; Cronbach's $\alpha = .93$).

2.4.2. Secondary outcomes: empowerment, hope, and perceived social support

Netherlands Empowerment List (NEL). The NEL (Boevink et al., 2017) is a 40-item scale that assesses six factors of empowerment: confidence and purpose, self-management, connectedness, social support, caring community, and professional help. Items are rated on a 5-point

Likert-type scale (1 = Completely disagree; 5 = Completely agree). Higher scores correspond to more empowerment. A Spanish version of the NEL has recently been published and yields valid and reliable scores for assessing empowerment in Spanish-speaking countries (Sampietro et al., 2024b). In the present sample, the NEL evidenced excellent internal consistency (McDonald's $\omega = 0.95$; Cronbach's $\alpha = .95$).

Dispositional Hope Scale (DHS). The DHS (Snyder et al., 1991) is a 12-item scale that evaluates two subdomains: pathway and agency. Each sub-domain is assessed with four items, and the scale as a whole also includes four filler items (items 3, 5, 7, and 11) that are not scored. Items are rated on a 4-point Likert-type scale (1 = Definitely false; 4 = Definitely true). Higher scores indicate greater levels of hope. The Spanish version of the DHS has shown adequate psychometric properties in terms of validity and reliability (Galiana et al., 2015). In the present sample, scores on the DHS showed excellent internal consistency (McDonald's $\omega = 0.90$; Cronbach's $\alpha = .90$).

Multidimensional Scale of Perceived Social Support (MSPSS). The MSPSS (Zimet et al., 1988, 1990) is a 12-item scale aimed at measuring three sources of social support: family, friends, and significant others. It employs a 7-point Likert-type scale (1 = Very strongly disagree; 7 = Very strongly agree). Higher scores reflect greater levels of perceived social support. The Spanish version of the MSPSS used here has demonstrated good reliability and validity (Ruiz-Jiménez et al., 2017). In the present

sample, scores on the MSPSS exhibited excellent internal consistency (McDonald's $\omega = 0.92$; Cronbach's $\alpha = .92$).

2.5. Procedure

The required sample size of 64 participants per group was determined using a power analysis in G*Power 3.1 (Erdfelder et al., 2009) to detect a small effect size ($f = 0.18$) in a repeated measures ANOVA, with an alpha level of 0.05 and 80 % statistical power. Between January and October 2022, all eligible community rehabilitation service users were invited by professionals from their respective centres to participate in the evaluation study, either as workshop participants or as members of the control group. Those who expressed an interest in taking part were invited to a pre-workshop meeting to address any queries they had about the study objectives and procedures. Informed consent was obtained during this meeting.

A total of 218 participants were initially recruited, but one individual did not sign the informed consent and was therefore excluded. Each participant was then assigned an alphanumeric code by community rehabilitation services professionals to ensure confidentiality and anonymity.

Participants self-selected into the experimental group by choosing to attend the workshop ($n = 117$), or into the control group by choosing not

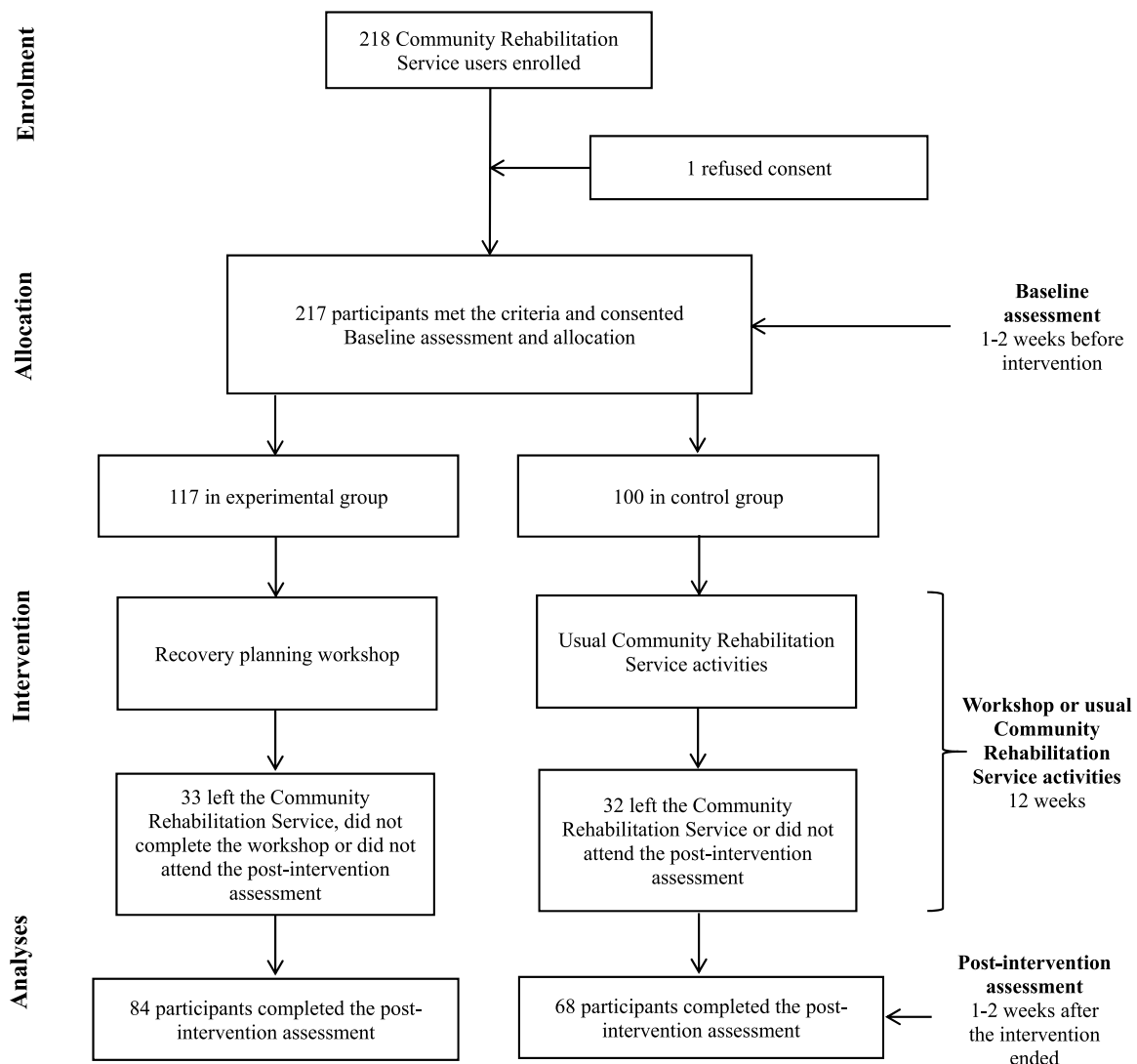


Fig. 1. Flowchart of participant enrolment, group allocation, and assessment schedule in the study.

to attend and continuing attending the regular community rehabilitation service activities ($n = 100$). Baseline data collection was conducted approximately one-two weeks prior to the start of the recovery planning workshop, while post-intervention data were collected about one-two weeks after the workshop concluded. During the study, 65 participants withdrew (33 from the experimental group and 32 from the control group) for various reasons: they ceased to attend the community rehabilitation service, did not complete the workshop, or did not attend the post-intervention evaluation meeting. No significant differences were found in sociodemographic characteristics and in most outcome variables between participants who completed the assessment and those who dropped out, except for empowerment, with completers showing higher levels. For more details, see [Tables S2.1 and S2.2](#) of the [Supplementary Material S2](#).

The final sample consisted of 152 participants: 84 in the experimental group and 68 in the control group. The process of participant enrolment, group allocation, and assessment schedule is summarised in [Fig. 1](#).

Data collection spanned from February 8, 2022 to January 24, 2023. It was carried out by one member of the research team, with the support of one or two professionals in each community rehabilitation service. Participants were asked to complete the scales individually, and also to provide sociodemographic information (age, gender, diagnosis, marital status, living arrangement, education level, and occupational status). Before participants left the setting, the protocols were reviewed to identify any unanswered items, and participants were asked to complete any missing responses. This procedure ensured that no missing data were present in the study.

The study procedures were approved by the Bioethics Committee of the University of Barcelona (Institutional Review Board Number: IRB00003099), as well as by the ethics committees of the service providers that collaborated with the study.

2.6. Statistical analysis

We began by computing descriptive statistics to characterize the sample. To examine baseline differences between groups across the outcome variables, we conducted Mann-Whitney U tests, along with the rank-biserial correlations and their 95 % confidence intervals.

For the SISR-A, the McNemar-Bowker test was conducted separately for the experimental group and control group to examine whether participants' recovery stage changed from baseline to post-intervention. Next, we conducted separate two-way mixed ANOVAs (Group $\times$ Time) to examine the effects of the recovery planning workshop on both level of recovery and secondary outcomes (i.e., empowerment, hope, and perceived social support). The experimental group and control group were treated as the between-subjects factor, and the two time points (baseline and post-intervention) as the within-subjects factor. First, the ANOVA was performed without covariates. Second, the baseline stage of recovery (SISR-A), categorized according to the five-stage conceptual model ([Andresen et al., 2003](#)), was included as a covariate. Finally, the stage of recovery was reclassified using a three-stage model, based on prior empirical evidence ([Andresen, 2007](#); [Lemos-Giráldez et al., 2015](#); [Weeks et al., 2011](#)), and it was included as a covariate. Group $\times$ Time interactions were reported, along with their corresponding effect sizes (η^2). When a significant interaction was identified, post hoc analyses were conducted using Bonferroni-corrected pairwise comparisons and effect size estimates based on Cohen's d , following the method proposed by [Morris \(2008\)](#), were obtained.

All analyses were performed using JASP 0.16.3 ([Love et al., 2019](#)), except for the McNemar-Bowker test, which was computed using SPSS 27, and the calculation of Cohen's d , which was performed using Lenhard and Lenhard's effect size calculator ([Lenhard and Lenhard, 2022](#)). An alpha level of 0.05 was applied across all tests to determine statistical significance.

3. Results

Mean age of participants in the experimental group ($n = 84$; 51.2 % male) was 48.2 years ($SD = 8.7$; range 26–65). The majority were disabled and in receipt of a pension (71.4 %), and the most commonly reported diagnoses were depression (35.7), bipolar disorder (17.9), and schizophrenia (14.3). Participants in the control group ($n = 68$; 60.3 % male) had a mean age of 48.0 years ($SD = 9.8$; range 20–65). As in the experimental group, the majority were disabled and in receipt of a pension (64.7 %), and the most frequently reported diagnoses were schizophrenia (29.4 %), bipolar disorder (23.5 %), and depression (19.1 %). No significant differences were found in sociodemographic characteristics of the experimental group and control group participants. More details on the sociodemographic and clinical characteristics of participants are shown in [Table 1](#).

Results from the Mann-Whitney U test indicated statistically significant baseline differences between groups on the level of recovery. Specifically, the control group scored higher on both measures of the primary outcome, the level of recovery, (SISR-B: $U = 2304.000$, $p = .040$, $r_{rb} = -0.193$, 95 % CI [-0.364, -0.011]; and MARS-12: $U = 2194.000$, $p = .014$, $r_{rb} = -0.232$, CI [-0.398, -0.051]). Baseline differences on the three secondary outcomes were non-significant: empowerment ($U = 2431.500$, $p = .116$, $r_{rb} = -0.149$, CI [-0.323, 0.035]); hope ($U = 2500.000$, $p = .187$, $r_{rb} = -0.125$, CI [-0.301, 0.060]); perceived social support ($U = 2842.500$, $p = .962$, $r_{rb} = -0.005$, CI [-0.188, 0.179]).

Results from application of the McNemar-Bowker test to the stage of recovery data indicated statistically significant differences between baseline and post-intervention stage of recovery for the experimental group ($MB(7) = 24.539$, $p \leq .001$), and non-significant differences in the control group ($MB(7) = 6.533$, $p = .479$). [Fig. 2](#) shows the percentage of participants at each stage of recovery both at baseline and post-intervention in the experimental and control groups.

When comparing the groups in terms of change from baseline to post-intervention without considering the baseline recovery stage as a covariate, no statistically significant differences were found on the primary outcome, the level of recovery (SISR-B: $F(1,150) = 2.54$, $p = .113$, $\eta^2 = 0.003$; and MARS-12: $F(1,150) = 0.64$, $p = .426$, $\eta^2 \leq 0.001$) or on the secondary outcomes: empowerment ($F(1,150) = 0.003$, $p = .958$, $\eta^2 \leq 0.001$), hope ($F(1,150) = 2.05$, $p = .154$, $\eta^2 = 0.002$), and perceived social support ($F(1,150) = 0.30$, $p = .583$, $\eta^2 \leq 0.001$). [Fig. 3](#) presents the baseline and post-intervention level of recovery, empowerment, hope, and perceived social support for the experimental and control groups.

When the baseline five-stage model of recovery was included as a covariate (i.e., stages: moratorium, awareness, preparation, rebuilding, and growth), the results indicated statistically significant differences in the primary outcome, the level of recovery (SISR-B: $F(4,142) = 2.56$, $p = .041$, $\eta^2 = 0.011$, and MARS-12: $F(4,142) = 2.79$, $p = .028$, $\eta^2 = 0.010$). Regarding secondary outcomes, significant differences were also observed for empowerment ($F(4,142) = 2.58$, $p = .040$, $\eta^2 = 0.011$), although not for hope ($F(4,142) = 1.79$, $p = .134$, $\eta^2 = 0.006$) or perceived social support ($F(4,142) = 0.65$, $p = .628$, $\eta^2 = 0.002$). Post hoc analyses indicated statistically significant improvements for participants in the experimental group who were at the awareness stage at baseline: level of recovery (SISR-B mean difference = -3.16 , $t = -5.049$, $P_{\text{bonf}} \leq 0.001$, $d = 0.965$) and hope (mean difference = -3.28 , $t = -3.955$, $P_{\text{bonf}} = 0.023$, $d = 0.683$). These differences were not observed in the control group. Detailed results of the post hoc analyses are presented in [Table 2](#).

Similarly, when the baseline three-stage model of recovery (SISR-A: moratorium, awareness/preparation, and rebuilding/growth) was included as a covariate, statistically significant differences were again observed in the level of recovery (SISR-B: $F(2,146) = 5.32$, $p = .006$, $\eta^2 = 0.012$, and MARS-12: $F(2,146) = 5.86$, $p = .004$, $\eta^2 = 0.011$). There were also significant differences in two secondary outcomes, empowerment ($F(2,146) = 3.73$, $p = .026$, $\eta^2 = 0.008$) and hope ($F(2,146) =$

Table 1
Sociodemographic and clinical characteristics of participants ($n = 152$).

Variable	Experimental	Control	Total
Age			
<i>M (SD)</i>	48.2 (8.7)	48.0 (9.8)	48.1 (9.2)
Range [95 % CI]	26–65 [45.3, 50.1]	20–65 [45.7, 50.4]	20–65
Gender, <i>n (%)</i> [95 % CI]			
Male	43 (51.2) [40.0, 62.3]	42 (60.3) [47.7, 72.0]	84 (55.3)
Female	40 (47.6) [36.6, 58.8]	27 (39.7) [28.0, 52.3]	67 (44.1)
Non-binary	1 (1.2) [0.0, 6.5]		1 (0.6)
Diagnosis ^a , <i>n (%)</i> [95 % CI]			
Depression	30 (35.7) [25.6, 46.9]	13 (19.1) [10.6, 30.5]	43 (28.3)
Bipolar disorder	15 (17.9) [10.4, 27.7]	16 (23.5) [14.1, 35.4]	32 (21.1)
Schizophrenia	12 (14.3) [7.6, 23.6]	20 (29.4) [19.0, 41.7]	31 (20.4)
Personality disorder	13 (15.5) [8.5, 25.0]	7 (10.3) [4.2, 20.1]	20 (13.2)
Schizoaffective disorder	8 (9.5) [4.2, 17.9]	7 (10.3) [4.2, 20.1]	15 (9.9)
Anxiety disorder	10 (11.9) [5.9, 20.8]	4 (5.9) [1.6, 14.4]	14 (9.2)
Obsessive-compulsive disorder	5 (6.0) [2.0, 13.3]	4 (5.9) [1.6, 14.4]	9 (5.9)
Other psychotic disorders (F21–F29, ICD-10)	5 (6.0) [2.0, 13.3]	3 (4.4) [0.9, 12.14]	8 (5.3)
Others (ADHD, ASD, ED, PTSD) ^b	5 (6.0) [2.0, 13.3]	4 (5.9) [1.6, 14.4]	9 (5.9)
Don't know/Not answered	9 (10.7) [5.0, 19.4]	7 (10.3) [4.2, 20.1]	16 (10.5)
Marital status, <i>n (%)</i> [95 % CI]			
Single	37 (44.1) [33.2, 55.3]	40 (58.8) [46.2, 70.6]	77 (50.7)
Married	30 (35.7) [25.6, 46.9]	13 (19.1) [10.6, 30.5]	43 (28.3)
Separated/Divorced	16 (19.0) [11.3, 29.1]	15 (22.1) [12.9, 33.8]	31 (20.4)
Widower	1 (1.2) [0.0, 6.5]		1 (0.6)
Educational level, <i>n (%)</i> [95 % CI]			
Primary education not completed	1 (1.2) [0.0, 6.5]	2 (2.9) [0.4, 10.2]	3 (2.0)
Primary education	27 (32.1) [22.4, 43.2]	26 (38.3) [26.7, 50.8]	53 (34.9)
Secondary education	36 (42.9) [32.1, 54.1]	30 (44.1) [32.1, 56.7]	66 (43.4)
Higher education	20 (23.8) [15.2, 34.3]	10 (14.7) [7.3, 25.4]	30 (19.7)
Living arrangement, <i>n (%)</i> [95 % CI]			
Original family	32 (38.1) [27.7, 49.3]	37 (54.4) [41.9, 66.5]	68 (44.7)
Own family	30 (35.7) [25.6, 46.9]	13 (19.1) [10.6, 30.5]	44 (28.9)
Alone	15 (17.9) [10.4, 27.7]	12 (17.7) [9.5, 28.8]	27 (17.8)
Shared flat	4 (4.7) [1.3, 11.7]	4 (5.9) [1.6, 14.4]	8 (5.3)
Other relatives (grandmother, uncle, etc.)	3 (3.6) [0.7, 10.1]	2 (2.9) [0.4, 10.2]	5 (3.3)
Occupational status ^a , <i>n (%)</i> [95 % CI]			
Disabled (receiving a pension)	60 (71.4) [60.5, 80.8]	44 (64.7) [52.2, 75.9]	104 (68.4)
Unemployed (with benefits)	12 (14.3) [7.6, 23.6]	8 (11.8) [5.2, 21.9]	20 (13.2)
Taking care of own home and family	5 (6.0) [2.0, 13.3]	9 (13.2) [6.2, 23.6]	14 (9.2)
Studying	4 (4.7) [1.3, 11.7]	3 (4.4) [0.9, 12.4]	7 (4.6)
Retired	2 (2.4) [0.3, 8.3]	4 (5.9) [1.6, 14.4]	6 (4.0)
Unemployed (without benefits)	3 (3.6) [0.7, 10.1]	1 (1.5) [0.0, 7.9]	4 (2.6)

Table 1 (continued)

Variable	Experimental	Control	Total
Working	1 (1.2) [0.0, 6.5]	2 (2.9) [0.4, 10.2]	3 (2.0)
Other occupational status ^c	3 (3.6) [0.7, 10.1]	2 (2.9) [0.4, 10.2]	5 (3.3)

^a The categories are not mutually exclusive; people can choose more than one option.

^b ADHD: attention deficit hyperactivity disorder; ASD: autism spectrum disorder; ED: eating disorder; PTSD: post-traumatic stress disorder.

^c Other occupational status: medical sick leave; not in work but with income other than pension or unemployment benefits; not specified.

3.39, $p = .036$, $\eta^2 = 0.005$), although not in perceived social support ($F(2,146) = 0.26$, $p = .772$, $\eta^2 \leq 0.001$). Post hoc analyses revealed significant improvements among experimental group participants who were at the awareness/preparation stage at baseline: level of recovery (SRS-B, mean difference = -2.27 , $t = -5.212$, $P_{\text{bonf}} \leq 0.001$, $d = 0.639$), MARS-12 (mean difference = -5.49 , $t = -4.992$, $P_{\text{bonf}} \leq 0.001$, $d = 0.558$), and hope (mean difference = -2.62 , $t = -4.604$, $P_{\text{bonf}} \leq 0.001$, $d = 0.438$). These differences were not observed in the control group. Individuals who were at either the moratorium or rebuilding/growth stage at baseline did not show statistically significant improvements. Detailed results of the post hoc analyses are presented in Table 3.

4. Discussion

The aim of this study was to conduct a comprehensive evaluation of a recovery planning workshop implemented in the context of community mental health rehabilitation services, using a quasi-experimental design with a control group. When comparing workshop participants with those who did not attend it, differences were observed in the number of participants who transitioned between recovery phases (SISR-A), indicating that workshop participants experienced more substantial changes toward advanced stages of recovery. Particularly notable was the reduction in the number of participants identifying themselves as being at the moratorium stage, where individuals believe that recovery is not possible. This suggests a positive impact of the Get Active for Mental Health recovery planning workshop on the recovery process. However, when the group and time factors were analysed irrespective of the recovery stage at baseline, no significant improvements were found in personal recovery level, as measured by the SISR-B and MARS-12. A similar result was reported by Andresen (2007), who noted that the SISR-B showed a low correlation with the SISR-A. It was suggested that this might be because the SISR-A taps into a unique aspect of recovery (i. e., the stage) that continuous measures are not assessing (Andresen, 2007).

When the baseline five-stage model of recovery was included as a covariate, workshop participants showed greater improvements than controls in both personal recovery and empowerment levels. Moreover, with the baseline three-stage model, these improvements were also accompanied by an increase in hope following participation in the workshop. Effects were particularly notable among participants who, prior to taking part in the workshop, were at the awareness stage (five-stage model) or the awareness/preparation stage (three-stage model). Specifically, these individuals reported improved levels of personal recovery and hope. This suggests that the effect of the recovery planning workshop on recovery varied depending on the participant's stage of recovery at the outset, it being more effective among individuals who believe that progress in the recovery process is possible, but that there is still a long way to go. To our knowledge, this is the first study to consider the recovery stage at baseline as a covariate in the evaluation of an intervention aimed at promoting recovery. Previous studies that used the SISR to evaluate the effectiveness of an intervention did not include

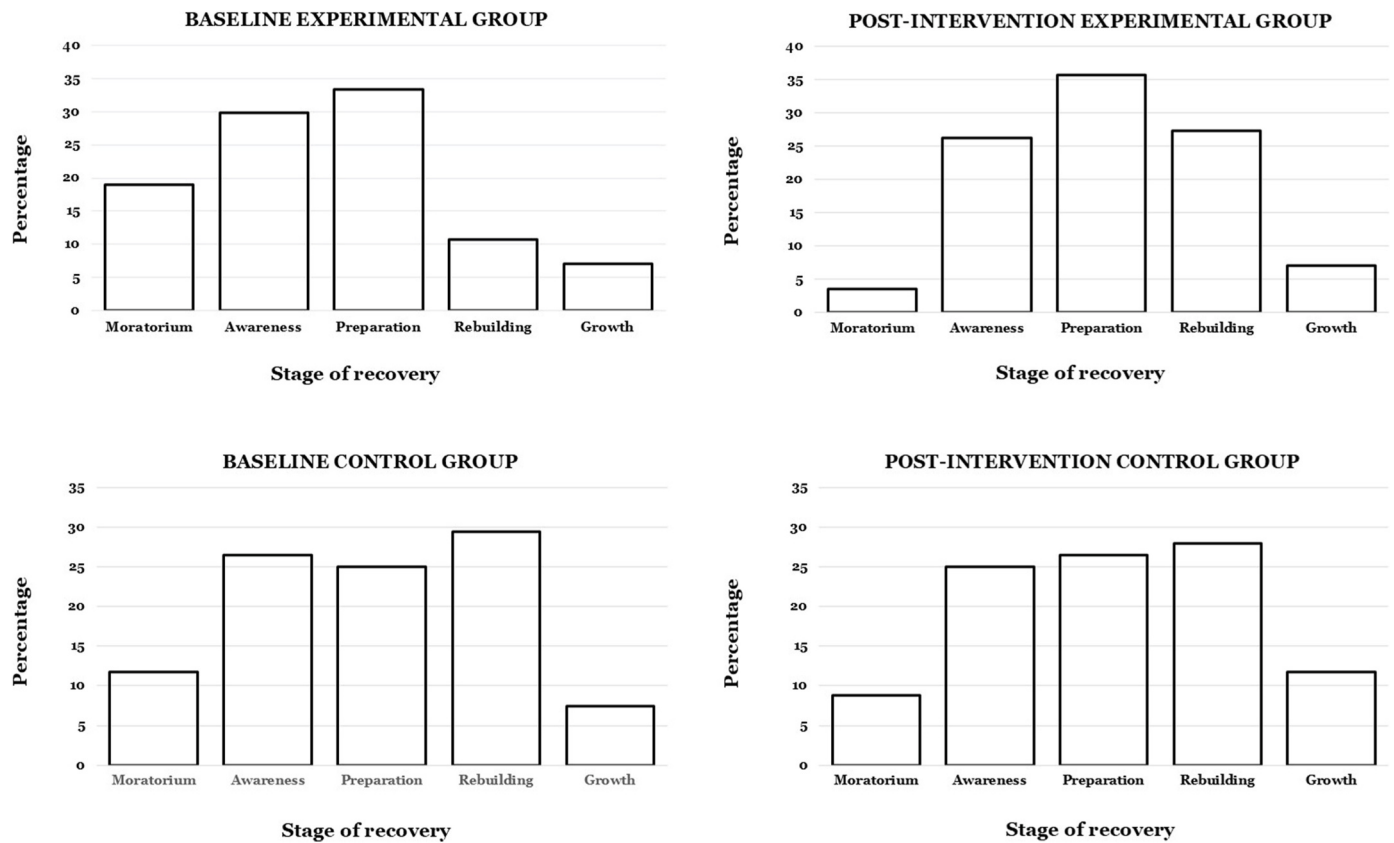


Fig. 2. Percentage of participants at each stage of recovery at baseline and post-intervention in the experimental and control group.

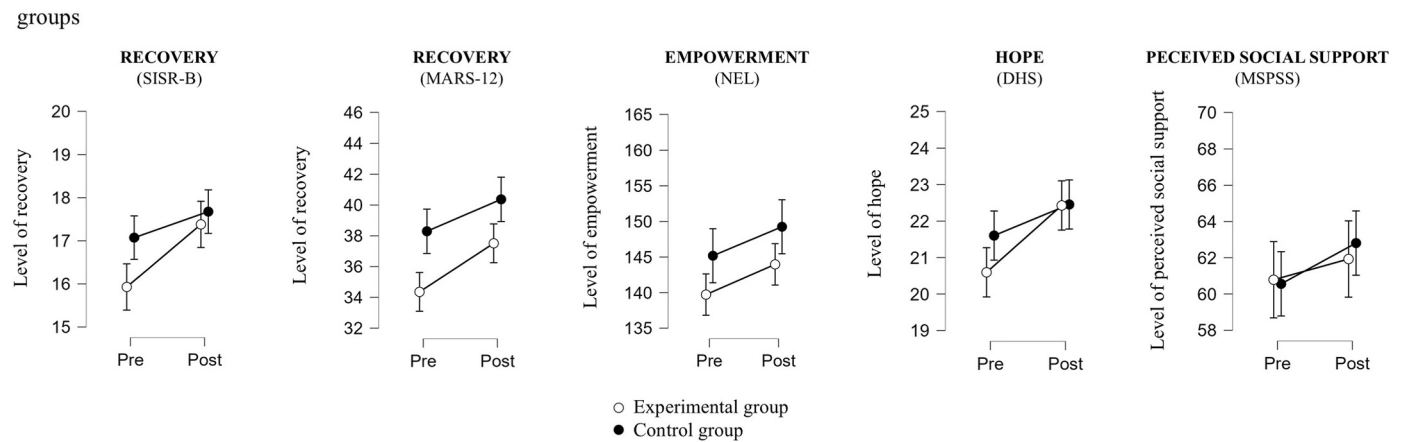


Fig. 3. Baseline and post-intervention level of recovery, empowerment, hope, and perceived social support for the experimental and control group.

the SISR-A, which assesses the stage of recovery. Some studies relied solely on the SISR-B along with other measures of the level of recovery (Chiba et al., 2014), while others either did not include the initial recovery stage as a covariate even when reporting significant post-intervention improvements in recovery level (Rüsch et al., 2019) or found no such improvement (Mitsunaga-Ohmuro and Ohmuro, 2021).

Regarding perceived social support, no improvements were observed in our study sample, most likely because all participants, regardless of whether they attended the workshop or their stage of recovery, had relatively high levels of perceived social support at the outset.

Studies evaluating the effectiveness of the Wellness Recovery Action Plan, a program similar to the Get Active for Mental Health recovery planning workshop, have reported a range of results that appear to depend on the cultural context of implementation (Sampietro et al., 2022a). For example, in the study by Cook et al. (2009) in the USA, high improvement was reported for all variables (i.e., personal recovery, empowerment, hope, and perceived social support), without considering the initial stage of recovery. In a study conducted in China, Mak et al. (2016) found that participants reported a significant increase only in perceived social support, with no improvement in empowerment,

Table 2Post hoc test for the two-way mixed (group $\times$ time) ANOVA with baseline stage of recovery as a covariate and using the five-stage model of recovery.

Outcomes (scale)	Stage at baseline	Pre-intervention		Post-intervention		Mean difference		<i>t</i> -test		<i>d</i> _{ppc2}
		<i>M</i> (<i>SD</i>)		<i>M</i> (<i>SD</i>)						
		Experimental	Control	Experimental	Control	Experimental	Control	Experimental	Control	
Recovery (SISR-B)	1	13.25 (3.44)	11.38 (5.32)	14.13 (3.78)	13.38 (4.21)	−0.88	−2.00	−1.107	−1.789	−0.254
	2	13.60 (3.19)	16.00 (2.38)	16.76 (2.73)	16.39 (3.53)	−2.27	−0.17	−5.212***	−0.321	0.965
	3	17.18 (3.52)	17.83 (2.30)	18.64 (2.74)	17.77 (2.33)	−1.46	0.06	−2.476	0.078	0.498
	4	18.44 (2.35)	18.10 (3.09)	18.44 (2.40)	19.25 (3.08)	0	−1.15	0	−1.643	−0.423
	5	23.17 (0.75)	23.40 (0.89)	21.17 (2.14)	22.60 (1.95)	2.00	0.80	1.565	0.572	−1.464
Recovery (MARS-12)	1	27.06 (8.84)	22.25 (5.90)	26.56 (7.20)	28.50 (10.76)	0.50	−6.25	0.249	−2.201	−0.876
	2	29.32 (6.51)	35.17 (8.06)	35.12 (8.17)	35.11 (10.43)	−5.80	0.06	−3.610	0.029	0.805
	3	36.86 (8.96)	38.00 (5.36)	42.07 (8.30)	40.18 (9.02)	−5.21	−2.18	−3.435	−1.117	0.398
	4	42.11 (6.49)	42.80 (8.15)	42.67 (6.44)	45.90 (9.97)	−0.56	−3.10	−0.207	−1.726	−0.347
	5	51.50 (8.98)	58.20 (4.03)	47.67 (10.44)	56.80 (3.27)	3.83	1.40	1.169	0.390	−0.336
Empowerment (NEL)	1	124.31 (12.81)	108.75 (22.81)	124.44 (12.85)	129.00 (24.54)	−0.13	−20.25	−0.025	−2.885	−1.114
	2	127.32 (16.75)	136.83 (16.84)	140.24 (22.85)	136.94 (19.93)	−12.92	−0.11	−3.254	−0.024	0.759
	3	146.61 (19.64)	150.12 (18.09)	150.39 (19.09)	155.88 (17.26)	−3.79	−5.77	−1.009	−1.197	−0.104
	4	156.67 (12.98)	153.10 (20.82)	155.89 (24.17)	154.95 (34.61)	0.78	−1.85	0.118	−0.417	−0.155
	5	174.83 (13.17)	185.00 (8.19)	163.67 (16.57)	180.60 (4.45)	11.17	4.40	1.378	0.496	−0.599
Hope (DHS)	1	16.25 (5.21)	13.63 (6.28)	17.00 (3.54)	16.38 (6.44)	−0.75	−2.75	−0.723	−1.876	−0.348
	2	17.92 (4.53)	20.44 (5.22)	21.20 (4.85)	20.39 (6.92)	−3.28	0.06	−3.955*	0.057	0.683
	3	23.04 (5.08)	21.88 (5.17)	25.08 (4.20)	22.53 (5.03)	−2.04	−0.65	−2.598	−0.643	0.270
	4	22.78 (4.87)	23.05 (4.77)	24.00 (3.97)	24.55 (5.25)	−1.22	−1.50	−0.884	−1.618	−0.058
	5	28.67 (3.33)	31.80 (0.45)	27.33 (4.27)	31.00 (1.23)	1.33	0.80	0.788	0.431	−0.215
Perceived social support (MSPSS)	1	54.31 (15.50)	55.88 (15.26)	55.25 (13.74)	57.25 (14.46)	−0.94	−1.37	−0.306	−0.317	−0.028
	2	53.64 (16.27)	51.28 (15.76)	59.84 (17.07)	54.22 (18.00)	−6.20	−2.94	−2.528	−1.019	0.202
	3	67.46 (12.94)	63.12 (16.96)	66.61 (10.98)	67.06 (12.83)	0.86	−3.94	0.370	−1.325	−0.321
	4	58.44 (14.02)	63.80 (18.28)	58.00 (17.62)	65.60 (16.26)	0.44	−1.80	0.109	−0.656	−0.139
	5	80.17 (2.93)	79.80 (7.26)	72.50 (12.13)	77.00 (9.54)	7.67	2.80	1.531	0.511	−0.911

Notes: Stage 1: Moratorium, Stage 2: Awareness, Stage 3: Preparation, Stage 4: Rebuilding, Stage 5: Growth.

*d*_{ppc2} Effect Size *d*, computed by difference in pretest-posttest change scores, controlled.

SISR-B: Self-identified stage of recovery – Part B, MARS-12: Maryland Assessment of Recovery Scale, NEL: Netherlands Empowerment List, DHS: Dispositional Hope Scale, MSPSS: Multidimensional Scale of Perceived Social Support.

p* < .05, *p* < .01, ****p* < .001.

hope, self-stigma, social network size, symptom severity or personal recovery. Our results are therefore only partially in line with those reported by Cook et al. (2009), or other similar studies carried out in anglophone countries such as New Zealand (Doughty et al., 2008) or Ireland and the UK (Higgins et al., 2012; O’Keeffe et al., 2016). These differences could be attributed to factors such as the content and design of each recovery program, the cultural context, or the implementation methods used in each study. It should be noted, for instance, that several studies have stressed the importance of peer facilitation in recovery planning workshops (Davidson, 2018; O’Dwyer, 2015; Olney and Emery-Flores, 2017; Sampietro et al., 2022a), insofar as peer facilitators may serve as a model for recovery and increase hope among participants. However, in Catalonia (and Spain as a whole), peer-to-peer programs have yet to be integrated into the portfolio of mental health services. Consequently, peer facilitators participated in only a couple of the workshop sessions featured in the present study.

Our study has some important limitations. First, we were unable to implement a double-blind experimental design, due to service characteristics and our wish to include services from across a range of towns and cities in Catalonia. Second, the absence of follow-up measurements in this study prevents us from determining the temporal stability and durability of the observed effects. Future studies should address this limitation by incorporating follow-up assessments to examine the long-term impact of the intervention. Third, the attrition rate between baseline and post-intervention measures was high (30.0 %), although it was similar in both groups (experimental group and control group).

Notably, participants who dropped out of the study had significantly lower empowerment levels at baseline. Finally, the groups were not matched on stage and level of recovery at baseline: specifically, participants who chose to attend the recovery planning workshop (experimental group) scored significantly worse at baseline on both measures of recovery (SISR-B and MARS-12) than did those in the control group. Notwithstanding these limitations, our study also has some noteworthy strengths. First, it constitutes the first attempt to evaluate a recovery planning tool in a Spanish-speaking or Mediterranean country. In addition, our final sample size was sufficient, according to a priori power analysis (Sampietro et al., 2022b). The sample also comprised individuals from across most of Catalonia who were residents and attending mental health services in both cities and medium-sized and smaller towns, which differ greatly in the formal and informal resources that people can access.

5. Conclusions

Our findings suggest that the Get Active for Mental Health recovery planning workshop is a promising tool for promoting positive changes in personal recovery, empowerment, and hope among users of community mental health services who have begun to take the first steps in their recovery process, that is, those who are at the awareness/preparation stage. In this respect, our study highlights the importance of considering the baseline stage of recovery when evaluating interventions aimed at promoting recovery. Future research should explore the role of peer

Table 3Post hoc test for the two-way mixed (group $\times$ time) ANOVA with baseline stage of recovery as a covariate and using the three-stage model of recovery.

Outcomes (scale)	Stage at baseline	Pre-intervention		Post-intervention		Mean difference		<i>t</i> -test		<i>d</i> _{ppc2}
		<i>M</i> (<i>SD</i>)		<i>M</i> (<i>SD</i>)						
		Experimental	Control	Experimental	Control	Experimental	Control	Experimental	Control	
Recovery (SISR-B)	1	13.25 (3.44)	11.38 (5.32)	14.13 (3.78)	13.38 (4.21)	−0.88	−2.00	−1.107	−1.789	−0.254 0.639 −0.477
	2	15.49 (3.79)	16.89 (2.48)	17.76 (2.87)	17.06 (3.05)	−2.27	−0.17	−5.212***	−0.321	
	3	20.33 (3.02)	19.16 (3.52)	19.53 (2.62)	19.92 (3.16)	0.80	−0.76	0.980	−1.202	
Recovery (MARS-12)	1	27.06 (8.84)	22.25 (5.90)	26.56 (7.20)	28.50 (10.76)	0.50	−6.25	0.250	−2.208	−0.876 0.558 −0.369
	2	33.30 (8.70)	36.54 (6.93)	38.79 (8.88)	37.57 (9.96)	−5.49	−1.03	−4.992***	−0.760	
	3	45.87 (8.69)	45.88 (9.74)	44.67 (8.31)	48.08 (10.02)	1.20	−2.20	0.580	−1.374	
Empowerment (NEL)	1	124.31 (12.81)	108.75 (22.81)	124.44 (12.85)	129.00 (24.54)	−0.13	−20.25	−0.025	−2.876	−1.114 0.316 −0.287
	2	137.51 (20.60)	143.29 (18.47)	145.60 (21.36)	146.14 (20.76)	−8.09	−2.86	−2.959	−0.849	
	3	163.93 (15.59)	159.48 (22.89)	159.00 (21.16)	160.08 (32.58)	4.93	−0.60	0.959	−0.151	
Hope (DHS)	1	16.25 (5.21)	13.63 (6.28)	17.00 (3.54)	16.38 (6.44)	−0.75	−2.75	−0.723	−1.875	−0.348 0.438 −0.157
	2	20.62 (5.43)	21.14 (5.17)	23.25 (4.88)	21.43 (6.08)	−2.62	−0.29	−4.604***	−0.408	
	3	25.13 (5.14)	24.80 (5.55)	25.33 (4.29)	25.84 (5.38)	−0.20	−1.04	−0.187	−1.254	
Perceived Social Support (MSPSS)	1	54.31 (15.50)	55.88 (15.26)	55.25 (13.74)	57.25 (14.46)	−0.94	−1.38	−0.303	−0.315	−0.028 −0.057 −0.254
	2	60.94 (16.05)	57.03 (17.19)	63.42 (14.45)	60.46 (17.79)	−2.47	−3.43	−1.456	−1.642	
	3	67.13 (15.39)	67.00 (17.77)	63.80 (16.85)	67.88 (15.69)	3.33	−0.88	1.045	−0.356	

Notes: Stage 1: Moratorium, Stage 2: Awareness/Preparation, Stage 3: Rebuilding/Growth.

*d*_{ppc2} Effect Size *d*, computed by difference in pretest-posttest change scores, controlled.

SISR-B: Self-identified stage of recovery – Part B, MARS-12: Maryland Assessment of Recovery Scale, NEL: Netherlands Empowerment List, DHS: Dispositional Hope Scale, MSPSS: Multidimensional Scale of Perceived Social Support.

p* < .05, *p* < .01, ****p* < .001.

facilitators in enhancing the effectiveness of recovery planning workshops and their implementation in other settings, such as in-patient psychiatric care.

CRedit authorship contribution statement

Hernán María Sampietro: Writing – original draft, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Georgina Guilerá:** Writing – review & editing, Supervision, Project administration, Methodology, Funding acquisition, Formal analysis, Conceptualization. **Maite Barrios:** Writing – review & editing, Validation, Supervision, Methodology, Formal analysis, Conceptualization. **J. Emilio Rojo:** Writing – review & editing, Visualization, Validation, Supervision, Resources. **Juana Gómez-Benito:** Writing – review & editing, Validation, Supervision, Project administration, Funding acquisition, Conceptualization.

Ethics approval

This study is part of a bigger project entitled “Toward recovery in people diagnosed with a severe mental disorder: Definition, assessment and intervention (RECO-DAI)”. The RECO-DAI project was approved by the Bioethics Committee of the University of Barcelona (CBUB; Institutional Review Board Number: IRB00003099); the Clinical Research Ethics Committee of the FIDMAG - Benito Menni Hospital Sisters (CEIC-FIDMAG; Reference Number PR-2021-24); Medicines Research Ethics Committee of the Pere Virgili Health Research Institute (CEIm-IISPV; Reference Number: 009/2022); Medicines Research Ethics Committee of the Arnau de Vilanova University Hospital (CEIm-HUAV; Reference Number: CEIC-2636); Medicines Research Ethics Committee of the Catalan Health Institute – Lleida (CEIm ICS-Lleida; Reference Number: CEIM-2636); Research Ethics Committee of the Catalan Union of Hospitals Foundation (CEI-FUCH, Reference Number: CEI 21/99); Research Ethics Committee of the Catalan Union of Hospitals Foundation (CEI-FUCH, Reference Number: CEI 22/01); Clinical Research Ethics Committee of the Sant Joan de Déu Foundation (CEIC Fundació SJD; Reference Number: PIC-26-22).

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.socscimed.2025.118483>.

Data availability

Data will be made available on request.

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