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Cross-cultural adaptation of the recovery self-assessment instrument (RSA–R) person in recovery version to Brazilian Portuguese (Pt/Br)

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Abstract

Purpose – *The Recovery Self-Assessment (RSA–R) in Revised Version is an instrument designed to assess the degree to which mental health programs and services implement recovery-oriented practices. The purpose of this paper is to conduct a cross-cultural adaptation of the RSA–R instrument for use in local mental health services in the city of Campinas, State of São Paulo, Brazil.*

Design/methodology/approach – *This method for cross-cultural adaptation of the instrument included a series of iterative steps including preparation, translation, back translation, harmonization, expert evaluation, focus groups, in-depth interviews, expert opinion and pilot study.*

Findings – *A multi-rater assessment of the equivalence of content between the original RSA–R and the translated version revealed that each of the 32 items achieved at least 88% agreement in terms of equivalency. A multi-step harmonization process revealed additional suggestions for improvements in readability, comprehension and applicability to Brazilian context. An expert in youth and adult education provided additional stylistic recommendations. Combined, this iterative approach to cross-cultural translation resulted in an adapted version of the instrument that was well understood, culturally appropriate and adequate for further verification of psychometric properties.*

Originality/value – *The recovery process in Brazil and in the USA has culturally determined differences in terms of the way mental disorders are understood, diagnosed and treated. Moreover, there are different notions of what constitutes desirable results of recovery, health care and welfare. At the present time, there are few, if any, available cross-cultural instruments to assess the recovery-orientation of services between Brazil and the USA.*

Keywords *Mental health, Health services evaluation, Methods, Questionnaire, Mental health recovery*

Paper type *Research paper*

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Introduction

Choosing an instrument for assessing subjective phenomena is not simple, given the potential for ambiguity, multi-dimensionality and varied meanings within and across populations. Not only should an instrument demonstrate adequate reliability and validity, but it must demonstrate these attributes specific to the population with which it is being used. This is especially important when adapting an instrument for use in a country and/or language that differs from the country/language of origin (Wild *et al.*, 2005; Beaton *et al.*, 2007; de Faria Mota and de Mattos Pimenta, 2007).

Consensus-Based Standards for the Selection of Health Measurement Instruments (COSMIN) improved this field of study, through consensus among notorious researchers,

who developed a checklist, containing standards to assess the quality of method in studies on properties of measurement. This is very suitable for instruments that measure multidimensional constructions and complex phenomena (Mokkink *et al.*, 2010).

Mental health recovery is one such example of complex, subjective phenomena. Recovery neither corresponds to the remission of symptoms nor is understood as a final product or a static result (Deegan, 1988). It is usually defined as a process, a daily challenge and a rediscovery of hope, personal trust, social participation and control about life itself (Deegan, 1988; Mead and Copeland, 2000).

In Brazil, the evaluation of public mental health services is challenged by the lack of indicators that have been identified and used to assess development of services. Thus, there are few Brazilian studies that evaluate results in a consistent way (Dantas and Oda, 2014). Adapting an instrument that has been validated and used in different settings/cultures is one way to create a common language and a set of indicators that can be used to compare differences across settings, cultures and countries.

The purpose of this study was to develop a cross-culturally valid instrument that can be used to evaluate the orientation of services for the practice of recovery, from the perspective of the service user, in the city of Campinas, state of São Paulo, Brazil. We aimed at having a translation that could grasp the meaning, ensuring the conceptual equivalence of the instrument, rather than just a merely literal translation (Hambleton, 2001; Wild *et al.*, 2005).

To this end, we selected the Recovery Self-Assessment – Revised Version (RSA–R), which was developed by Dr Maria O'Connell and colleagues at the Yale Program for Recovery and Community Health. The RSA–R aims to assess the degree to which health-care programs and services implement practices supportive of an individual's process of recovery from the perspective of multiple stakeholders (O'Connell *et al.*, 2005; Salyers and Tsemberis, 2007).

The version of RSA – R (service-users') consists of 32 items (affirmative sentences), with the possibility of choosing among five possible answers, ranging from number 1 (Strongly disagree) to number 5 (Strongly agree), constituting a five-point Likert scale and two more choices: Don't know (D/K) and Not applicable (N/A). Sentences are grouped into six domains described as follows: Domain 1 (Life Goals); Domain 2 (Involvement); Domain 3 (Diversity of Treatment Options); Domain 4 (Choice); Domain 5 (Individually tailored Services); Domain 6 (two-item about Inviting Environment) (O'Connell *et al.*, 2005; Davidson *et al.*, 2007).

Methods

Setting. This research is part of a larger project titled: Recovery: Instrumentos para sua aferição na realidade brasileira [Recovery: Instruments for measuring it within the Brazilian reality], approved by the Research Ethics Committee (CEP) with opinion no. 60826616.6.0000.5404, in March 2017. The study took place in the Psychosocial Care Network (RAPS, in Portuguese) in the city of Campinas, which has an important role in the Brazilian Psychiatric Reform movement. The RAPS comprised Sociability Centers and Cooperatives (Cecos), Centers for Workshops on Income Generation (NOT), Psychosocial Support Centers (CAPS 24 h) and Psychosocial Support Centers for Addiction of Alcohol and Other Drugs (CAPS AD 24 h).

Procedures. An essential step in the cross-translation of measures involves re- orientating the overall construct and items to the reality of the new culture (Wild *et al.*, 2005; Beaton *et al.*, 2007). This is done through a series of iterative steps involving preparation, translation, back translation, harmonization and evaluation, which are presented in Table 1 and described in detail below.

Table 1 Description of the steps of the qualitative method for cross-cultural adaptation

Steps	*Actions*	*Occurrence in this study*
1. Preparation	Meetings and bibliographical survey	4 meetings
2. Harmonization	Evaluation of the process and changes in the instrument	7 harmonizations
3. Translation and back translation	Translation and Back Translation of the RSA–R instrument version	1 translation and 1 back translation
4. Experts' evaluation	Evaluation per instrument equivalence	5 experts
5. Focus groups (FGs)	Application of the translated instrument for the stakeholders	3 FGs – 10 participants in each group
6. Interviews	Instrument about illness experience and recovery processes	10 interviews with participants of the FGs
7. Expert opinion	Meetings with Dr. Maria O'Connell	2 meetings
8. Pilot study	Application of the instrument thus developed to a pilot study	2 pilot studies, 11 participants in total

Findings

Step 1. Preparation

According to the handbook for cross-cultural translations and adaptations of the International Society for Pharmacoeconomics and Outcomes Research (ISPOR) (Wild *et al.*, 2005), the first step for instrument translations should be the direct contact with the authors, to submit the request for permission to use, with an appropriate proposal of how the study intends to validate the instrument (Wild *et al.*, 2005).

After receiving permission from Dr O'Connell to conduct a translation of the RSA–R, we conducted a bibliographic review on the RSA–R instrument, and found cross-cultural adaptations and validations made by authors from other countries (Tsai *et al.*, 2010; Ye *et al.*, 2013; Zuaboni *et al.*, 2015; Bola *et al.*, 2016) and its use (Kidd *et al.*, 2010, 2011; Tsai and Salyers, 2010; Mak *et al.*, 2017) in different contexts.

After the bibliographic review, we took the RSA–R to the working group (WG recovery) whose participants were service-users and researchers (Dimov and Ricci, 2016) of the interfaces group (this group was created in 2004, to establish an interdisciplinary field between public health and mental health. This group has always had masters, doctoral students and the participation/collaboration of stakeholders from the Association of Family Members, Users and Friends of Mental Health – AFLORE).

We performed one first free translation of the instrument and opened the discussion to get closer to the service-users' understanding. This experience favored a first process of reflection and more horizontal-like knowledge, in which we could go through the story of each member, talk and hear the stories of life and recovery, and to discuss sentences and words of the instrument (Nascimento *et al.*, 2017). We stored the users' information, reflections and suggestions in our research field diary. The participation of service-users as researchers is a recent tendency, not only in Brazil but also in countries such as Australia, Canada, the USA, the UK and New Zealand (Dimov and Ricci, 2016).

Step 2. Harmonizations

Harmonization or revision, although omitted as a technique in some guidelines, is one of the main techniques in the process of cross-cultural adaptation. Harmonization seeks to enhance the validity of translations and adaptations by grouping, in a more reliable way, the data. In each step of the harmonization process, products of translations are compared with the original version (Wild *et al.*, 2005). Harmonizations are conducted in between each of the remaining steps of cross-cultural adaptation.

Step 3. Translation and back translation

The initial translation from English to Portuguese was made by a bilingual and independent translator. The research team provided the translator with information about the construct of recovery and the objectives of the present study. The translated version (Pt-Br) was then made available to another independent, bilingual translator, native in English, without knowledge of the basic concepts, study objectives or original instrument (Wild *et al.*, 2005; Beaton *et al.*, 2007). This person conducted a "back translation" of the instrument from Portuguese to English, which was compared to the original instrument.

This comparison, conducted by specialists, focused on semantic equivalence, identifying discrepancies in both versions and reconciling items (Wild *et al.*, 2005; Silva *et al.*, 2012).

Step 4. Consensus of experts

The experts' evaluation is a fundamental part of the process of cross-cultural adaptation of instruments, because the first version of the translated instrument is revised with the knowledge of the language, comprising cultural aspects and evaluating words, sentences and instructions that are appropriate for the new context (Wild *et al.*, 2005; Gorenstein *et al.*, 2016).

We selected five experts from our prior knowledge about them in other research and invited them by letter sent by email. All experts had had experience in the mental health field, a graduate degree, were bilingual, independent from the research team and were paid for their work (Beaton *et al.*, 2007; Alexandre and Coluci, 2011; Gorenstein *et al.*, 2016). All experts were professionals in mental services graduated and post graduated in the areas of mental health and public health, with fluency in English and lived in English-speaking countries for more than one year.

Experts rated each item for semantic and idiomatic equivalence between the original English version and the Portuguese translation using a six-point Likert scale (ranging from 0 to 5, with 0 being "no equivalence" and 5 being "perfect equivalence"). They also provided suggestions for additional translations and general guidelines of the instrument (Wild *et al.*, 2005; Alexandre and Coluci, 2011; Gorenstein *et al.*, 2016).

We entered expert ratings into Microsoft Excel, calculated scores and conducted descriptive statistics (Pedroso *et al.*, 2009). All translated items achieved expert consensus on semantic and idiomatic equivalence with the original RSA–R above 88% agreement. To consider the relevance and weighting of sentences, each should have validation above 80% (Gorenstein *et al.*, 2016).

Next, we began a second process of harmonization focusing on appropriateness of words for Brazilian culture and social contexts. This second round of harmonization led to:

- the replacement of the words "program – *programa*" and "agency – *agência*" with the word "service – *serviço*";
- replacement of the words "team - *grupo*" and "workers – *trabalhadores*" with "staff – *equipe*"; and
- replacement of the words "meetings – *reuniões*" and "management committee – *comitê gestor*," to "local councils - *conselho local*" and "assemblies - *assembleias*", respectively.

These changes are coherent with the Brazilian culture and recommended in the RAPS guidelines.

Step 5. Focus groups

The inclusion of stakeholders in the process of cross-cultural adaptation of instruments aids in the understanding of complex phenomena (Wild *et al.*, 2005; Beaton *et al.*, 2007).

We selected participants by contacting the coordinators of all the services in the RAPS – Campinas. The coordinators and service workers indicated names and telephone numbers of people who could be interested in participating in the research, after previous notices in assemblies, conversation circles, groups and workshops. In total, they meaning 40 service users. We contacted 25 and 10 agreed to participate.

Hence, the instrument version was adjusted with the support of FGs conducted with RAPS users, who received incentives of transport and a meal on the meeting days, held at the university.

Three audio-recorded focus groups were conducted with a total of ten users. Each focus group lasted about 90 min and were led by a rapporteur. An additional observer/researcher was present to register nonverbal communications and parallel conversations (Miranda *et al.*, 2008). Following the review of general guidelines for focus groups and recordings, each item in the instrument was read aloud to the group.

For this step, there were six men and four women, with the age's average of 50.1 years, ranging from 33 to 71 years, seven were single with some elementary school education, six Catholic and four evangelical and seven black people. Only one participant of the focus group was employed, as a stockist in a supermarket, and two people had no income source, being financially dependent on their families. The participation to Service were 6 at a CECO – Coexisting Centers, 2 at the NOT – Workshop Center for income generation and one at a CAPS - Center for Psychosocial Care.

In the first focus group, participants were able to work through only the first domain of the RSA–R (Life Goals). Participants felt that the items were fairly long and some words required clarification. Prior to holding the second focus group, the research team met to re-evaluate the process, and it was decided that we would perform a third harmonization of the instrument. We replaced the words "service/institution" with "service", simplified sentences and clarified sentences that seemed distant from the daily lives of the participants (such as groups of mutual help, or possibility of discharge from treatment).

In the second focus group with the same people, most participants reported an improvement in comprehension and readability of the statements. They further recommended replacing the word "encouraged" with "motivated" and standardized the words "work/job" only to "work". The participants preferred the use of the present tense for the statements.

They also recommended splitting two items into separate items, as they addressed distinct realities for the service users. Item 17 addressed work and employment (work can be any remunerated activity, and employment brought with it the issue of registration for an employment record card); and sentence 21 described self-help groups and associations defending of rights (distinct situations in Brazilian reality).

After making these changes, we held a third and final focus group and conducted a pre-pilot administration of the instrument. These data confirmed our impressions that it was still necessary to improve instructions of the scale, to briefly describe what recovery is (considering the Recovery instrument), and to repeat words of the points of the scale in each sentence, making it visually easier for participants to choose which options they have in each item.

In Table 2, we illustrate the format of the fifth harmonization with our suggestions for the instructive header of RSA–R (Pt-Br).

During the focus groups, we also noticed some similarities and differences regarding what each one really understood about their recovery process and whether there was something more to say besides the described sentences, but we could not deepen the content. Thus, we decided to take one more step in this adaptation process, in which we explored the individual experience of the process of illness and recovery of FG users through interviews.

Table 2 Instructive header for RSA – R (Pt-Br) after the fifth harmonization

Title	Instrument for evaluating mental health services in Brazil regarding recovery: person in recovery version
What is recovery?	We understand "recovery" as your possibility of dealing with your own illness and treatment, aiming at a meaningful life for you. Thus, recovery can be: accepting illness, dealing with symptoms, regaining hope, having control and responsibility for your own life, exercising citizenship, engaging in activities that matter to you, establishing relationships with people that assist you and overcome prejudice
Instruction to answer the sentences	We invite you to answer this instrument Guidelines for filling out: There are no "right" or "wrong" answers; you should answer based on your experience in this mental health service, in such a way to sincerely express your feelings Each sentence corresponds to actions that may happen in this service You should mark with an "X" only one alternative per sentence. You should choose the closest alternative to what happens in this service

Step 6. Interviews

We conducted in-depth interviews with the same ten service-users from Step 5 to understand aspects related to recovery and create narratives from the first-person experience of illness. We followed the McGill *Illness Narrative Interview* (MINI) model (Leal *et al.*, 2016).

Interviews were conducted in August 2017. The mean duration of each interview was 1 h. Interviews were recorded and transcribed for the analyses. Data were analyzed following the phenomenological interpretative method: Initial Forecast and description of data based on Phenomenological Reduction; Grouping and Design of units of meaning. Units were grouped and named as follows:

- People remembered signs of illness before access to health care.
- People were informed they had a mental illness and were provided with treatment and support.
- People experienced improvements in their condition, both in terms of what led them to seek health care and in broader aspects of their lives.
- Recovery transcended the disease/treatment paradigm, having a broader and more positive impact on peoples' lives as a whole.

During interviews and analyses, we perceived that everyone could describe their illness processes, how were their first experiences and the bodily and social dimensions of such. The first sensations of the illness experience were devastating, leading to isolation of social, working and family life.

Affective bonds were broken or strongly shaken, deepening isolation and loneliness during the first experiences of illness. However, during narratives people began to report they have found some means that helped them in the first steps of recovery.

Some people sought health-care services with the aid of friends and family. The journey was not simple, and there was much suffering, because before seeking help, they went through the acceptance that something was wrong, and several people close to them corroborated this need.

During the process of this experience, changes starts to happen. We can recognize through their statements that recovery begins, new meanings are given to the experience, hope is strongly regained and the treatment, which before seemed difficult to accept (by stigma and moral issues), was recognized as part of the recovery process, re-establishing control in their lives and everyday self-confidence.

Treatment, individual efforts and re-establishing social bonds drive recovery, because they assist in the processes of self-confidence, hope and search for new projects (work, dating) or in resuming activities that have become fragile in the process of illness (taking the initiative to leave, relationship with relatives, for instance). Returning to work, new achievements, such as study, and new social roles begin to emerge as real possibilities in the lives of people with severe mental disorders.

Through these narratives, we learned that the meaning of the word "recovery", to our participants, was similar to the notion of recovery discussed in other countries. Recovery can be a continuous journey; getting a job or going back to school; strengthening friendships and relationships; participating more actively in community life; and/or redefining the meaning of an experience based on hope and optimism for the future (Deegan, 1996; Davidson, 2003; Davidson *et al.*, 2005; Assis *et al.*, 2013). Thus, we concluded, it is possible to evaluate this construct in Brazilian services through instruments such as the RSA–R.

Step 7. Expert opinion

The next step in our harmonization process was to consult with the developer of the initial instrument, Dr. O'Connell, from the Yale University Program for Recovery and Community Health. We discussed some of the difficulties our service users had with the instrument (i.e. the five-point scale, unfamiliarity with certain terms, degree of literacy required, relevance of certain items to the Brazilian context and difficulties with the self-administered format) and together reviewed and refined each item, the instructions and the response options.

Despite recognizing the socio-educational differences of the North American and Brazilian population, Dr O'Connell recommended that we keep the scale as close as possible to the original scale during the pilot phase and to test the self-administration format with the revisions made. We were able to align some words, such as the literal translation of "agency" or "program," which did not make sense to our context, and we opted to write "services" in all sentences, considering the translation that is closer to our reality, but which was not distant from the original. We opted to maintain one sentence addressing the topic of work (instead of adding an item pertaining to "employment") and separated the item addressing local "assemblies" and "councils" from the item on "self-help groups".

Overall, Dr O'Connell agreed that the modifications in the sentences and suppression of the examples did not impact the general construct of the instrument. After all consensuses, we proceeded to the last step of the qualitative method for cross-cultural adaptation of instruments: the pilot-study phase.

Step 8. Pilot study

The pilot study is often considered the final step in the process of cross-cultural adaptation of instruments. It can be quantitative or qualitative and requires more than one application of the pre-final version to a target-audience sample. It may be followed by an interview with the participants shortly after administration to assess the respondent's cognitive understanding of the whole of the instrument (Beaton *et al.*, 2007).

Interviews during pilot studies can help researchers better adapt the sentences of the instrument, and this technique is increasingly used as a research tool (Collins, 2003). Interviews can also help to ensure qualitative validity of the instrument during the adaptation. Such interviews are also called "communicative validation" or "confirmability" (Denzin and Lincoln, 2011; de Paiva Júnior *et al.*, 2011).

We conducted our first pilot study with six service users, who were invited to participate by us or a staff member. We applied the same inclusion criteria as the focus groups, but with a different group of people to avoid analytical bias. There were four men and one woman, with

mean age of 44.2 years, ranging from 36 to 57 years. Most were single with some elementary school education, self-employed and black ethnicity (Table 3).

After presenting an overview of the research, reviewing confidentiality and obtaining informed consent, we asked participants to complete the instrument. It should be noted that some questioned whether their answers could harm them, so we also offered assurances of data privacy and confidentiality, and assurance that information would not result in loss of social benefits or access to the services.

Upon completion, in post-administration interviews, we asked participants to explain, one by one, their responses to each item of the scale. From this explanation, we identified terms misunderstood by the participants, asked for suggestions of which word could be simpler and/or more applicable to the target population and sought to identify culturally relevant situations that could assist in the provision of examples or general reformulation of sentences (Beaton *et al.*, 2007; Bandeira *et al.*, 2009).

During the administration of the instrument and in the subsequent interviews, it became clear that further modifications were required – both in terms of the response scale and the complexity of some of the word choices. Factors that seemed to influence the ability to understand and complete the RSA–R that we needed to consider included prolonged use of psychotropic medications and other psychoactive substances, low education level, low visual acuity and chronicity of illness (Onocko Campos *et al.*, 2017).

Following the initial pilot administration of the instrument and interviews, the research team met and decided that to adapt the instrument as close as possible to the linguistic and interpretative reality of mental health in Brazil, we needed to secure the consultation services of an expert in public education of young people and adults. For this role, we hired a teacher who had 26 years of experience as a specialist in youth and adult education, as well as experience with mental health in the classroom by the partnership of the Municipal Foundation for Education of Campinas (*Fundação Municipal para a Educação de Campinas* – Fumec) with Sociability Centers and Cooperatives (Cecos) of the city.

Our consultant, who was familiar with the instrument and our study objectives, was given tables that contained the original English version, the version presented to the participants in first pilot study, and the pre-harmonized suggestions. We met over the course of three meetings in which we read each statement aloud. She offered recommendations for simplifying the statements, ideas for reorganizing sentence structure and provided alternative word choices (Table 4).

After adjusting almost all of the items, our consultant then offered recommendations for revisions to the instructions and suggested that we insert colored objective figures below the worded response options, to reflect the subjective gradation of the phenomena.

In Figure 1, we present the format of the scale suggested by the expert

After incorporating her suggestions into a sixth harmonized version, we returned to the field in December 2017 for a second pilot study. We followed the same procedures as implemented in the first pilot study.

Six service users participated in the second pilot study. There were six men with mean age of 49.2 years, ranging from 33 to 58 years. Most were single, Catholic, with some elementary school education and self-employed. Completion of the instrument took between 10 and 20 min. Although two claimed they knew how to read and write, they had difficulty in reading and needed our support to answer and record their choices.

In the post-instrument interviews, participants in the second pilot study seemed to have a much greater understanding of the instructions and items, but still struggled with the scale gradation. Two sentences still presented problems, more due to the lack of experience in

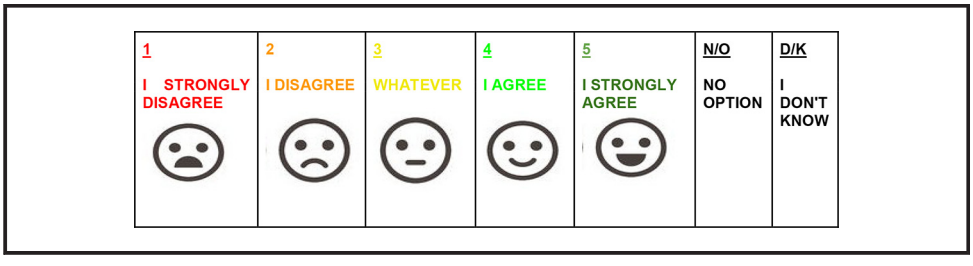
Table 3 Profile of users participating in the pilot study 01

User/ inserted service	*Sex*	*Ethnicity/ color*	*Age (years)*	*Marital status*	*Education level*	*Religion*	*Occupation/ Profession*	*Income source*
01/ CAPS AD 24 h	F	Black	38	Married	ES	Catholic	Housekeeper	None
02/ CAPS AD 24 h	M	Mixed-race	39	Single	HS	Evangelical	Self-employed/ painter	Works as a painter
03/ CAPS AD 24 h	M	Black	57	single	SES	Catholic	Self-employed/ construction worker	Works in constructions
04/ CAPS AD 24 h	M	White	36	Divorced	SES	Evangelical	Self-employed/ unemployed	Social aid
05/ CAPS AD 24 h	M	Mixed-race	51	Single	ES	None	Trader	Disability compensation

Table 4 Some examples about recommendations of the expert in popular education

Original version	*Pilot 1*	*Change suggested popular education*	*Pilot 2*
2. The physical space of this program (e.g., the lobby, waiting rooms, etc.) Feels inviting and dignified	*2. O espaço físico deste serviço me parece acolhedor, agradável, limpo e organizado.* *The physical space in this service seems to me welcoming, pleasant, clean and organized	*2. Este ambiente é agradável e limpo.* *This physical space is nice and clean	*2. Este ambiente é agradável e limpo.* *This physical space is nice and clean
This program offers specific services that fit my unique culture and life Experiences	*13. Este serviço oferece atividades específicas que respeitam às minhas raízes culturais e religiosas* *This service offers specific activities, which respect my cultural and religious roots	*13. A equipe oferece atividades que respeitam a minha raça, religião e meu modo de vida.* *The staff offers activities that respect my race, religion and my way of life	*13. A equipe oferece atividades que respeitam a minha raça e religião.* *The staff offers activities that respect my race and religion

Figure 1 Caption inserted in the instrument RSA–R Person in recovery version



practices that should be routine in Brazilian public services, such as local health councils and self-help groups, which are still not widespread in the country.

We met again for the final harmonization of the instrument before a second workshop with Dr O'Connell and validation of the instrument. At this step, we had 33 sentences (one was added because of the division of a sentence that comprised two distinct events in our culture), with the most sensitive 1–5 Likert scale, now colored to facilitate access for people with low education level.

In the second workshop with Dr O'Connell, held in December 2017, we presented the seventh and final harmonized version of the instrument and discussed the possibility of using an interview administration format, rather than self-administration format. Even with the improvements made to the instrument, there is still a considerable proportion of the Brazilian population who cannot read or interpret text. Our main purpose was to include as many people as possible in the evaluative process of the services, although knowing that this had the risk of bias on the part of the interviewer applying the instrument.

Dr O'Connell understood our intention and authorized this change to the Brazilian reality, aware of our commitment to create an instruction manual for applying the instrument. Our results from the second pilot and final harmonization process show that the adapted version of the instrument was well understood and appropriate for verification of psychometric properties. The final version is attached to the end of this paper (see Appendix).

Conclusion

The procedure of cross-cultural adaptation of the RSA–R instrument (person in recovery version) was followed according to what is recommended in literature. Analysis by the

working group, expert committee and the focus groups showed that the items are relevant to Brazilian culture.

We included the additional step of conducting in-depth interviews to more fully understand the recovery process and secured the participation of a teacher who specialized in people's education to ensure the instrument was sensitive to local cultural needs.

Paying attention to privacy during data collection and the assurance that information would not result in loss of social benefits or access to the service were important, because some service-users questioned whether their answers could harm them. The notion of health as a right and evaluation as an implied for the improvement in access to health care seems not to be part of the daily lives of some Brazilians. Thus, we also corroborate and stimulate discussions about assessments of results concerning processes of recovery in mental health services in Brazil.

Considering these results, new studies are being conducted to evaluate the psychometric properties of the instrument, in terms of reliability and validity, to enable its use in Brazil, and will be the subject of future publication.

We expect that the challenges described in the cross-cultural adaptation of the RSA–R, along with a presentation of our methods to overcome them, promotes further research on cross-cultural adaptations of measures of recovery, centered on the experience of people in treatment.

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Appendix

Attachment

Versão para Validação

RECUPERAÇÃO É ENFRENTAR A DOENÇA, OS SINTOMAS E O TRATAMENTO, VIVENDO UMA VIDA SIGNIFICATIVA, RENOVANDO A ESPERANÇA, TENDO CONTROLE E RESPONSABILIDADE PELA PRÓPRIA VIDA, EXERCENDO A CIDADANIA, ESTANDO ENVOLVIDO EM ATIVIDADES IMPORTANTES E SE RELACIONANDO COM OUTRAS PESSOAS QUE TE FAZEM BEM.

CONVIDAMOS VOCÊ A RESPONDER ESTE INSTRUMENTO.

ORIENTAÇÕES PARA O PREENCHIMENTO:

- CADA FRASE DIZ COISAS SOBRE ESTE SERVIÇO;
- VOCÊ DEVE RESPONDER DE ACORDO COM SUA EXPERIÊNCIA;
- ESCOLHAUMA ALTERNATIVA PARA CADA FRASE;

LEGENDA APRESENTADA PARA O PESQUISADO PELO ENTREVISTADOR COMO UMA RÉGUA						
NÃO CONCORDO MESMO 	NÃO CONCORDO 	TANTO FAZ 	CONCORDO 	CONCORDO MUITO 	N/A NÃO TEM AQUI	N/S NÃO SEI

Nome do participante:

Número:

FRASES							
1. A EQUIPE TE RECEBE BEM.	1	2	3	4	5	N/A	N/S
2. ESTE AMBIENTE É AGRADÁVEL E LIMPO.	1	2	3	4	5	N/A	N/S
3. A EQUIPE TE AJUDA A TER ESPERANÇA NA SUA RECUPERAÇÃO.	1	2	3	4	5	N/A	N/S
4. VOCÊ PODE TROCAR DE MÉDICO E DE OUTRO PROFISSIONAL SE VOCÊ QUISER.	1	2	3	4	5	N/A	N/S
5. VOCÊ PODE VER SEU PRONTUÁRIO.	1	2	3	4	5	N/A	N/S
6. A EQUIPE**NÃO** TE OBRIGA A FAZER O QUE ELES QUEREM.	1	2	3	4	5	N/A	N/S
7. A EQUIPE ACREDITA QUE VOCÊ PODE SE RECUPERAR.	1	2	3	4	5	N/A	N/S
8. A EQUIPE ACREDITA QUE VOCÊ PODE ENFRENTAR SEUS SINTOMAS.	1	2	3	4	5	N/A	N/S
9. A EQUIPE ACREDITA QUE VOCÊ PODE TOMAR DECISÕES COMO ESCOLHER AMIGOS, COM QUEM MORAR E OUTRAS COISAS.	1	2	3	4	5	N/A	N/S
10. A EQUIPE TE ESCUTA E RESPEITA AS SUAS DECISÕES SOBRE SEU TRATAMENTO.	1	2	3	4	5	N/A	N/S
11. A EQUIPE TE PERGUNTA SOBRE SEUS INTERESSES E COISAS QUE VOCÊ GOSTARIA DE FAZER NA CIDADE.	1	2	3	4	5	N/A	N/S
12. A EQUIPE TE AJUDA A EXPERIMENTAR COISAS NOVAS.	1	2	3	4	5	N/A	N/S
13. A EQUIPE OFERECE ATIVIDADES QUE RESPEITAM A SUA RAÇA, RELIGIÃO E SEU MODO DE VIDA.	1	2	3	4	5	N/A	N/S
14. QUANDO VOCÊ QUER, VOCÊ PODE DISCUTIR SOBRE AS SUAS NECESSIDADES E INTERESSES RELIGIOSOS.	1	2	3	4	5	N/A	N/S
15. QUANDO VOCÊ QUER, VOCÊ PODE DISCUTIR SOBRE AS SUAS NECESSIDADES E INTERESSES SEXUAIS.	1	2	3	4	5	N/A	N/S

(*continued*)

16. A EQUIPE TE AJUDA A PLANEJAR SUA VIDA, ALÉM DO TRATAMENTO.	1	2	3	4	5	N/A	N/S
17. A EQUIPE TE AJUDA A PROCURAR TRABALHO.	1	2	3	4	5	N/A	N/S
18. A EQUIPE TE AJUDA A PARTICIPAR DE ATIVIDADES FÍSICAS, RELIGIOSAS, ESCOLARES E DE LAZER.	1	2	3	4	5	N/A	N/S
19. A EQUIPE FACILITA A PARTICIPAÇÃO DAS PESSOAS IMPORTANTES PARA VOCÊ NO SEU TRATAMENTO.	1	2	3	4	5	N/A	N/S
20. A EQUIPE TE APRESENTA PESSOAS QUE PODEM SER EXEMPLOS DE RECUPERAÇÃO.	1	2	3	4	5	N/A	N/S
21 A) A EQUIPE TE AJUDA A PARTICIPAR DE GRUPOS DE APOIO FEITO POR PACIENTES.	1	2	3	4	5	N/A	N/S
21 B) A EQUIPE TE AJUDA A PARTICIPAR DE GRUPOS E ASSOCIAÇÕES EM DEFESA DOS SEUS DIREITOS.	1	2	3	4	5	N/A	N/S
22. A EQUIPE TE AJUDA A COLABORAR COM A SUA COMUNIDADE.	1	2	3	4	5	N/A	N/S
23. A EQUIPE TE CONVIDA A AJUDAR NA CRIAÇÃO DE NOVOS GRUPOS E OFICINAS.	1	2	3	4	5	N/A	N/S
24. VOCÊ É CONVIDADO A AVALIAR OS TRABALHADORES E AS ATIVIDADES DESTE SERVIÇO.	1	2	3	4	5	N/A	N/S
25. VOCÊ É CONVIDADO A PARTICIPAR DOS CONSELHOS LOCAIS DE SAÚDE E ASSEMBLEIAS.	1	2	3	4	5	N/A	N/S
26. A EQUIPE CONVERSA COM VOCÊ SOBRE O QUE É NECESSÁRIO PARA TERMINAR O TRATAMENTO.	1	2	3	4	5	N/A	N/S
27. A EQUIPE ACOMPANHA AS SUAS CONQUISTAS.	1	2	3	4	5	N/A	N/S
28. A EQUIPE TE AJUDA A ALCANÇAR NOVAS CONQUISTAS.	1	2	3	4	5	N/A	N/S
29. VOCÊ PODE DAR CURSOS E OFICINAS PARA A EQUIPE.	1	2	3	4	5	N/A	N/S
30. A EQUIPE ESCUTA E RESPONDE ÀS SUAS EXPERIÊNCIAS PESSOAIS, SEUS INTERESSES E PREOCUPAÇÕES.	1	2	3	4	5	N/A	N/S
31. A EQUIPE SABE SOBRE GRUPOS E ATIVIDADES INTERESSANTES PARA VOCÊ.	1	2	3	4	5	N/A	N/S
32. A EQUIPE TEM VARIEDADE DE RAÇA, RELIGIÃO E DE OPÇÃO SEXUAL.	1	2	3	4	5	N/A	N/S

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