

The Convention on the Rights of Persons with Disabilities Adherence Scale (CRPDAS): Development and Psychometric Validation of a Clinician-Level Measure of Rights-Based Practice

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Abstract

Purpose

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) has reshaped mental health care, emphasizing autonomy, non-coercion, and community inclusion. However, empirical assessments of CRPD implementation have focused on policy and institutional levels, with no validated instruments at the clinician level. This study aimed to develop and validate the CRPD Adherence Scale (CRPDAS), a self-report measure of mental health professionals' (MHPs) adherence to CRPD principles.

Methods

The CRPDAS was developed by adapting standards and illustrative examples from the WHO QualityRights framework into clinician-level self-report items. The scale was administered to a multidisciplinary sample of Israeli MHPs (N = 341). Factor structure was examined using exploratory and confirmatory factor analyses. Reliability was assessed using Cronbach's α , and construct validity was assessed using intercorrelations among subscales and associations with demographic and professional variables.

Results

Analyses supported a two-factor structure: Patient Autonomy (7 items; $\alpha = 0.71$) and Personal Liberty and Community Inclusion (7 items; $\alpha = 0.77$; inpatient subsample, $n = 96$). Confirmatory factor analyses indicated excellent model fit. The factors were strongly correlated ($r = 0.70$, $p < 0.001$), and a second-order model supported a higher-order construct. Specialists reported higher adherence than interns. Autonomy scores were higher in private settings and increased with age.

Conclusions

The CRPDAS is a psychometrically sound instrument for assessing CRPD implementation at the clinician level. Its use may identify implementation gaps and inform targeted training and policy efforts. Further research should examine applicability across settings and populations.

Introduction

The United Nations Convention on the Rights of Persons with Disabilities (CRPD), adopted in 2006, represents a paradigmatic shift in the conceptualization of disability within a human rights framework, positioning individuals with physical and mental impairments as active rights-holders [1, 2]. In particular, it seeks to eliminate barriers to social, political, economic, and legal participation and to respect their inherent dignity and autonomy [3, 4], moving from models of guardianship and paternalistic decision-

making to a model of supported decision-making [5, 6]. To date, 193 countries have signed and ratified the CRPD, thereby endorsing its legally binding framework, incorporating its principles into national legislation [3, 5], and committing to support implementation in practice [1].

In the context of mental health care, the CRPD raises substantial ethical and clinical challenges for mental health professionals (MHPs), particularly with regard to involuntary care, freedom of movement, community inclusion, and autonomy, i.e., the freedom to make one's choices [6, 7]. These issues are reflected in several specific, core CRPD articles, among them: the right to exercise legal capacity and the right to personal liberty and security (Articles 12 and 14, respectively); freedom from torture or cruel, inhuman or degrading treatment or punishment, and from exploitation, violence and abuse (Articles 15 and 16, respectively); the right to live independently and be included in the community (Article 19); the right to the enjoyment of the highest attainable standard of physical and mental health (Article 25); and the right to an adequate standard of living (Article 28) [4].

In recent years, international efforts have underscored the urgent need to address human rights violations and to transform mental health care services accordingly [7–9]. Although progress has been made, substantial evidence indicates that such violations persist worldwide, as well as in Israel [7, 10–12], including involuntary hospitalization and forced treatment [9].

Research on CRPD implementation has predominantly focused on the macro level. In 2017, the WHO used the QualityRights Toolkit to evaluate adherence to CRPD standards of care in institutions for adults with psychosocial and intellectual disabilities across selected European countries [4]. Subsequent studies have examined CRPD adherence at the institutional level in psychiatric hospitals and facilities (e.g., hospital regulations, hospitalization conditions, use of coercive measures) [13, 14], as well as at the national legislative level [7, 15].

To date, no validated instruments have specifically assessed the extent to which MHPs implement CRPD principles in their routine clinical practice. This represents a critical gap, as the translation of human rights frameworks into practice ultimately depends on clinicians' behaviors, attitudes, and interactions with patients. The present study aims to address this gap by developing and validating the *CRPD Adherence Scale (CRPDAS)*, a self-report measure designed to assess clinicians' adherence to CRPD principles in everyday practice. The scale was adapted from the standards and illustrative examples derived from the WHO QualityRights framework [4]. We examined the psychometric properties of the Hebrew version of the CRPDAS, including its factor structure, reliability, and validity, as well as its associations with demographic and professional characteristics among Israeli mental health professionals.

Method

Participants

The study included 341 MHPs practicing in Israel. Demographic and professional characteristics of the participants are presented in Table 1. The mean age of participants was 46.31 years ($SD = 12.04$), and the mean years of experience was 15.83 years ($SD = 12.80$). Most participants were female (73.5%). The sample was multidisciplinary, comprising psychiatrists (36.2%, $n = 123$), psychologists (22.6%, $n = 77$), social workers (19.4%, $n = 66$), and other allied mental health professionals (21.8%, $n = 74$; e.g., art therapists, occupational therapists, psychiatric nurses, and clinical criminologists). Participants worked across a range of settings, including public clinics (46.3%), psychiatric hospital departments (32.3%), private practice (16.1%), and other settings (5.3%).

Procedure

The study was conducted as part of a broader project promoting a human-rights-based approach to mental health care in Israel. An online questionnaire was distributed between May and October of 2024 via multiple professional channels, including the mailing lists of major Israeli professional unions and associations, healthcare organizations, and relevant social media groups. This multi-channel recruitment strategy was intended to maximize reach and increase participation across a broad range of professional backgrounds and service settings. Participants were also encouraged to share the survey with colleagues to increase reach. Participation was voluntary and anonymous, and all respondents provided electronic informed consent prior to participation. The study was approved by the Shalvata Institutional Review Board (IRB; SHA-0012-23).

Development of the CRPDAS Scale

The CRPD Adherence Scale (CRPDAS) is a self-report instrument designed to evaluate MHPs' implementation of CRPD principles in clinical practice. Questionnaire items were adapted from the WHO QualityRights framework, as operationalized in prior applications assessing mental health facilities' compliance with CRPD human rights standards [4, 16].

In the original WHO framework, CRPD articles are translated into a set of corresponding standards, each accompanied by illustrative examples and observable criteria for their implementation in practice. To develop the CRPDAS, the research team systematically reviewed these standards and examples to identify those applicable and relevant to the work of individual clinicians. Standards pertaining primarily to institutional policy, administrative procedures, environmental conditions, or hospitalization settings were excluded. In contrast, standards reflecting clinicians' day-to-day conduct and decision-making were retained.

Selected standards and examples were reformulated into items describing clinicians' behavior in practice, which respondents rated according to the frequency with which they engage in each behavior. For example, the standard "Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises." was adapted to "Utilizes alternative, non-restrictive methods for dealing

with crisis situations.” A detailed description of the item selection and adaptation process is provided in Appendix 1.

All items were rated on a five-point Likert scale ranging from 1 (never) to 5 (always), with an additional “not relevant” option. For statistical analyses, response categories were collapsed into a three-point scale (1 = low, 2 = moderate, 3 = high) to reduce skewness and ensure adequate variability. Higher scores indicate greater adherence to CRPD principles.

A pilot version of the questionnaire was reviewed by 15 MHPs from diverse disciplines and service settings, who provided feedback on item clarity, relevance, and appropriateness. This process supported face validity and informed minor revisions to the item wording.

The CRPDAS was designed to include two subscales reflecting distinct domains of rights-based practice. Items specific to inpatient settings were administered only to respondents working in psychiatric departments and were omitted from those in community or private settings. Subsequent item analysis and factor validation supported a two-factor structure: (1) Patient Autonomy (7 items), applicable to all respondents, capturing the implementation of practices related to informed consent, shared decision-making, respect for patients’ preferences, and access to information; and (2) Personal Liberty and Community Inclusion (7 items), validated for MHPs in inpatient settings ($n = 96$), capturing implementation of practices related to freedom from coercion or restraint, the exercise of legal capacity, and independent and community living.

Measures

In addition to the CRPDAS, participants completed a questionnaire assessing demographic and professional characteristics. Demographic variables included gender, age, marital status, number of children, socioeconomic status, religion, and educational level. Professional variables included primary discipline, level of expertise (e.g., intern or specialist), years of experience, and primary workplace setting (e.g., public clinic, psychiatric hospital, or private sector).

Statistical analysis

Data were analyzed using SPSS version 30 and Mplus version 8.1.3. Prior to analysis, data were screened for missing or “not relevant” responses. Respondents who omitted more than 50% of the items within a subscale were excluded, and items with more than 50% missing values were removed. To minimize data loss and reduce bias, remaining missing values were handled using full information maximum likelihood (FIML) [17].

Exploratory factor analyses (EFA) were conducted separately for each conceptual section to identify the underlying factor structure. Sampling adequacy was assessed using the Kaiser–Meyer–Olkin (KMO) measure and Bartlett’s test of sphericity. Items with low loadings or cross-loadings were excluded during the exploratory phase, resulting in two final subscales, each with seven items.

Confirmatory factor analyses (CFA) were conducted using Mplus to validate the unidimensional structure of each subscale. Model fit was evaluated using the chi-square statistic (χ^2), Comparative Fit Index (CFI), Tucker–Lewis Index (TLI), Root Mean Square Error of Approximation (RMSEA) with a 90% confidence interval, and the Standardized Root Mean Square Residual (SRMR). Acceptable model fit was defined as CFI and TLI $\geq .95$, and RMSEA and SRMR $\leq .06$ [18].

To test whether the two subscales reflect a single higher-order construct, a second-order CFA was conducted among respondents who completed both subscales ($n = 96$; i.e., inpatient-setting MHP subsample). To ensure robust parameter estimation given the relatively small subsample size, a Bayesian estimator was employed using the Gibbs sampling algorithm with 50,000 iterations [19].

Internal consistency reliability was assessed using Cronbach's α . Construct validity was evaluated through intercorrelations between the subscales and group comparisons (t-tests and one-way ANOVAs) across demographic and professional characteristics.

Table 1
Demographic and professional characteristics of the study
sample (N = 341).

Gender	n (%)	Mean (SD)
Male	89 (26.5)	
Female	247 (73.5)	
Education		
BA	36 (10.6)	
MA	164 (48.1)	
MD and/or PhD	141 (41.3)	
Income		
Below average	39 (11.4)	
Average	67 (19.6)	
Above average	253 (68.9)	
Age		46.31 (12.04)
≤ 30	23 (6.7)	
31–40	104 (30.5)	
41–50	100 (29.3)	
51–60	71 (20.8)	
61≤	43 (12.6)	
Professional sector		
Psychiatrists	123 (36.2)	
Psychologists	77 (22.6)	
Social workers	66 (19.4)	
Other*	74 (21.8)	
Level of expertise**		
Intern	53 (26.8)	
Specialist	145 (73.2)	
Experience (years)		15.83 (12.80)

Gender	n (%)	Mean (SD)
Primary workplace setting		
Public clinic	158 (46.3)	
Psychiatric hospital department	110 (32.3)	
Private clinic	55 (16.1)	
Other [§]	18 (5.3)	

* Including psychiatric nurses, art therapists, occupational therapists, and clinical criminologists.

** Only for the relevant professions in Israel: psychiatry and psychology.

§ Including General hospital, nursing home, rehabilitation center, and supportive housing.

Results

Exploratory factor analyses

Exploratory factor analyses (EFA) were conducted separately for the two CRPDAS subscales using the recoded three-point response scale. Items with low loadings or cross-loadings were excluded, resulting in two unidimensional subscales, each comprising seven items.

For the Patient Autonomy subscale ($N = 337$), sampling adequacy was supported ($KMO = .75$; Bartlett's $\chi^2 = 401.80, p < .001$). A single factor emerged (eigenvalue = 2.36), accounting for 26.2% of the variance. Factor loadings ranged from .40 to .72.

For the Personal Liberty and Community Inclusion subscale ($n = 96$), KMO was .72 and Bartlett's test was significant ($\chi^2 = 94.98, p < .001$). One factor emerged (eigenvalue = 2.32), explaining 33.1% of the variance, with factor loadings ranging from .43 to .68. Factor loadings for all retained items are presented in Table 2.

Internal consistency was satisfactory (Cronbach's $\alpha = .71$ for Patient Autonomy; $\alpha = .77$ for Personal Liberty and Community Inclusion).

Confirmatory factor analyses

Confirmatory factor analyses (CFA) were conducted to validate the factor structure identified for each subscale. Standardized factor loadings are presented in Table 2.

For the Patient Autonomy subscale, model fit was excellent: $\chi^2(13) = 16.72, p = .212, CFI = .990, TLI = .984, RMSEA = 0.029$, and SRMR = 0.034. Standardized factor loadings ranged from .33 to .78.

For the Personal Liberty and Community Inclusion subscale, model fit was excellent: $\chi^2(12) = 13.77, p = .316, CFI = .986, TLI = .975, RMSEA = 0.039$, and SRMR = 0.044. Standardized factor loadings ranged from .43 to .76.

Descriptive item characteristics and response patterns

Table 3 presents descriptive statistics for all 14 items in the final two-factor model. Across both subscales, items demonstrated adequate variability, with item means ranging from 1.55 to 2.78 (*SDs* ranging from 0.48 to 0.90).

The highest endorsement was observed for maintaining medical confidentiality (80.5% reporting high adherence), followed by supporting patients' ability to maintain contact with people outside the hospitalization facility (66.7%). The lowest endorsement rates were observed for informing patients about their right to access medical records (20.2%), informing them about their right to consult another specialist (23.6%), and investing efforts to integrate patients into work or studies during hospitalization (24.1%).

Intercorrelations and validity evidence

Bivariate correlations indicated a strong positive association between the two subscales ($r = .702, p < .001$). A paired-samples *t*-test showed that the Patient Autonomy subscale had a significantly higher mean score than the Personal Liberty and Community Inclusion subscale (mean difference = 0.14, $t(95) = 3.53, p < .001$).

Second-order confirmatory model

A second-order confirmatory factor analysis was conducted among the subsample of MHPs working in inpatient settings ($n = 96$) who completed both subscales. A total adherence score was calculated as the mean of all 14 items.

The Bayesian model demonstrated an acceptable fit: the posterior predictive *p*-value (PPP) was .066, and the 95% confidence interval for the difference between the observed and replicated χ^2 values included zero (95% CI [-9.44, 72.62]). Incremental fit indices were also within satisfactory ranges ($CFI = .937, TLI = .929$).

Both first-order factors loaded strongly and significantly on the higher-order CRPD Adherence factor ($\lambda = .87$ for Patient Autonomy; $\lambda = .87$ for Personal Liberty and Community Inclusion).

Group comparisons and construct validity

Construct validity was examined through differences in CRPDAS scores across demographic and professional characteristics (Table 4).

Specialists reported higher adherence scores than interns on both subscales: Patient Autonomy ($M = 2.38$ vs. 2.16 ; $F = 11.99$, $p < .001$, $\eta^2 = .058$) and Personal Liberty and Community Inclusion ($M = 2.18$ vs. 1.78 ; $F = 6.32$, $p < .05$, $\eta^2 = .116$).

Workplace setting was also associated with adherence to patient autonomy, with higher scores reported by clinicians in private practice ($M = 2.52$) compared to public clinics ($M = 2.36$) and psychiatric hospitals ($M = 2.29$; $F = 3.84$, $p < .01$, $\eta^2 = .033$). Adherence to patient autonomy was also positively correlated with age ($r = .19$, $p < .001$).

Table 2
Standardized factor loadings for the final two-factor model of the CRPD Adherence Scale.

Item*	EFA	CFA
Factor 1 (n = 337)		
1	.55	.49
2	.61	.57
3	.41	.37
4	.52	.56
5	.40	.33
6	.72	.78
7	.55	.43
Factor 2 (n = 96)		
1	.56	.61
2	.61	.76
3	.61	.51
4	.68	.52
5	.51	.52
6	.59	.61
7	.43	.43

*All items loaded significantly ($p < .001$) on their respective factors.

EFA = Exploratory factor analyses; CFA = Confirmatory factor analyses

Table 3
Descriptive statistics for the final two-factor model of the CRPD Adherence Scale (N = 341).

Item	(%) HIGH	Mean	SD
Factor 1: Patient Autonomy (n = 337)			
1. Ensures that patients' preferences regarding continuation of treatment and/or rehabilitation are clarified	64.9	2.57	0.64
2. Makes every effort to conduct a shared decision-making process with patients	56.7	2.50	0.61
3. Informs patients that they have the right to access their medical records	20.2	1.55	0.81
4. Acts according to the principle that every patient can integrate into the community, regardless of the degree of disability	48.1	2.34	0.71
5. Ensures that patients are aware of the medications they receive, their purpose, and side effects	45.9	2.22	0.81
6. Ensures that the treatment or rehabilitation plan is developed together with the patients	55.2	2.45	0.67
7. Maintains medical confidentiality and discretion regarding patients	80.5	2.78	0.48
Factor 2: Personal Liberty and Community Inclusion (n = 96)			
1. Utilizes alternative, non-restrictive methods for dealing with crisis situations	40.0	2.28	0.76
2. Discusses with patients various de-escalation methods and strives to consider their preferences	39.6	2.12	0.81
3. Makes efforts to find community housing arrangements for patients	41.5	2.15	0.82
4. Invests efforts to integrate patients into work or studies during hospitalization	24.1	1.77	0.82
5. Acts to fulfill patients' right to vote in elections (general or municipal)	46.8	2.13	0.90
6. Informs patients about their right to consult another specialist regarding their treatment	23.6	1.73	0.82
7. Believes that every patient should be allowed to maintain contact with people outside the hospitalization facility without restriction	66.7	2.55	0.70

Table 4
Group score differences and demographic correlations for CRPDAS subscales (N = 341)

Gender	Patient Autonomy	Personal Liberty and Community Inclusion
	F = 0.98	F = 0.46
Male	2.32 (0.47)	2.06 (0.58)
Female	2.37 (0.41)	2.14 (0.53)
Education	F = 1.55	F = 1.01
BA	2.48 (0.40)	2.19 (0.62)
MA	2.34 (0.39)	2.17 (0.54)
MD and/or PhD	2.35 (0.44)	2.02 (0.47)
Income	F = 0.23	F = 0.33
Below average	2.32 (0.33)	2.00 (0.56)
Average	2.37 (0.44)	2.07 (0.60)
Above average	2.36 (0.42)	2.14 (0.52)
Professional Sector	F = 1.71	F = 0.49
Psychiatrists	2.35 (0.44)	2.06 (0.54)
Social workers	2.35 (0.39)	2.08 (0.61)
Psychologists	3.00 (0.36)	2.23 (0.67)
Other	2.54 (0.44)	2.19 (0.48)
Level of expertise	F = 11.99***, $\eta^2_p = .058$	F = 6.32*, $\eta^2_p = .116$
Intern	2.16 (0.34)	1.78 (0.47)
Specialist	2.38 (0.42)	2.18 (0.55)
Main Workplace Setting	F = 3.84**, $\eta^2_p = .033$	
Public clinic	2.36 (0.38)	-
Psychiatric hospital department	2.29 (0.48)	2.11 (0.54)
Private clinic	2.52 (0.36)	-
Other	2.31 (0.39)	-
*** p<.001, ** p<.01, * p<.05		

Gender	Patient Autonomy	Personal Liberty and Community Inclusion
	F = 0.98	F = 0.46
Age	r = .19***, n = 337	r = .18, n = 96
*** p<.001, ** p<.01, * p<.05		

Discussion

The present study aimed to validate the CRPDAS, a newly developed scale designed to assess the extent to which MHPs implement CRPD principles in clinical practice. The findings supported a two-factor structure, with both subscales demonstrating acceptable internal consistency and excellent model fit in confirmatory analyses. A second-order model further indicated a unified higher-order construct of CRPD adherence.

The factor analysis suggests that CRPD adherence comprises two interrelated domains – Patient Autonomy and Personal Liberty and Community Inclusion – each corresponding to key CRPD domains identified by the WHO as central to mental health legislation and clinical guidance [20, 21]. Although the subscales were moderately to highly correlated, their significantly different mean scores indicate that they capture related but distinct aspects of rights-based practice.

The Patient Autonomy subscale captures practices enacted primarily within the clinician–patient interaction, including informed consent, legal capacity, and shared decision-making, corresponding mainly to Articles 12 and 14 of the CRPD [20]. The Personal Liberty and Community Inclusion subscale reflects practices related to freedom from inhumane or degrading treatment (Articles 15 and 16) and community inclusion (Article 19) [20]. These practices are particularly relevant in inpatient settings and are shaped not only by clinicians’ attitudes but also by structural factors such as institutional policies, staffing levels, and interdisciplinary coordination [13, 21]. Maintaining this dual structure may therefore be important, as it allows testing the hypothesis that different domains are shaped by different forces – individual and systemic – and supports the development of interventions targeted at the specific barriers relevant to each aspect of rights-based practice.

Despite these distinctions, the confirmation of the second-order model indicates that both subscales converge to reflect a unified underlying construct of overall CRPD adherence. A total adherence score may be empirically valuable for screening or examining the effects of intervention programs, but it is also theoretically important: it underscores the synergistic nature of rights-based practice, in which shared decision-making, community-based care, and coercion reduction mutually reinforce one another [6, 22]

Construct validity was further supported by associations with professional characteristics. Specialists reported higher adherence than interns, and adherence to patient autonomy was positively associated

with age. These findings correspond to previous studies, which found that older and more experienced professionals reported higher levels of knowledge regarding professional ethical codes [23] and the human rights legal framework [24–25].

Workplace setting was also associated with adherence, with clinicians in private practice reporting higher scores on the Patient Autonomy subscale than those in public clinics or psychiatric hospitals. This pattern may be in line with known differences in patient characteristics, where inpatient care typically involves patients with more complex or acute diagnoses [26], and with structural differences, in which private settings typically allow for longer sessions and greater flexibility, facilitating a patient-centered dialogue [13, 27].

These findings have several important implications. First, the CRPDAS addresses a critical measurement gap by shifting the focus from legislative or institutional evaluation tools to a micro-level assessment tool of individual clinical practice. By operationalizing abstract legal principles into concrete behaviors, the CRPDAS offers a practical tool for researchers, clinical leaders, and policymakers to screen for implementation gaps and identify specific training needs. Furthermore, the scale's capacity to distinguish between adherence to patients' autonomy and personal liberty allows for the design of differential interventions that may require focusing on ethical education for the former and systemic resource allocation for the latter.

Although the study has several strengths, including its solid theoretical grounding in the WHO QualityRights Toolkit [4, 16] and the inclusion of a multidisciplinary sample spanning various sectors, it also has several limitations. First, reliance on self-report measures may have introduced social desirability bias, potentially inflating adherence scores given the topic's ethical sensitivity. Second, the voluntary nature of study recruitment raises the possibility of selection bias, where professionals with a pre-existing commitment to human rights may have been more inclined to participate. Third, the sample size for the inpatient subscale was relatively small ($n = 96$), necessitating replication in larger hospital-based samples to ensure the stability of the Personal Liberty and Community Inclusion subscale. Finally, as the tool was validated in Hebrew within the Israeli context, further cross-cultural validation is required to establish its applicability across languages and healthcare systems.

Notwithstanding these limitations, our findings support the utility of the CRPDAS as a measure of rights-based clinical practice and highlight its potential relevance for both research and clinical applications. By operationalizing CRPD principles into measurable behaviors, this instrument may help inform evidence-based strategies to reduce coercion and promote patient autonomy, thereby narrowing the gap between the promise of the CRPD and everyday practice in mental health care.

Abbreviations

CRPD

Convention on the Rights of Persons with Disabilities

CRPDAS

Convention on the Rights of Persons with Disabilities Adherence Scale

MHPs

Mental health professionals

WHO

World Health Organization

Declarations

Ethics approval and consent to participate

The study was approved by the Shalvata Institutional Review Board (IRB; SHA-0012-23). All participants provided informed consent to participate in the study.

Consent for publication

Not applicable.

Availability of data and materials

The datasets generated and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing Interests

The authors declare that they have no competing interests.

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Authors' contributions

IL conceived the study, supervised the development of the questionnaire, data collection and data analysis, and critically revised the manuscript. YH contributed to the development of the questionnaire, was responsible for distributing and collecting data, conducted the statistical analyses, and drafted the initial manuscript. YM contributed to the development of the study concept and its translation into a research framework with clinical and methodological applications. All authors reviewed and approved the final manuscript.

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