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Examining the implementation of the patient-centered recovery model in psychiatric nursing

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Examining the Implementation of the Patient-Centered Recovery Model in Psychiatric Nursing

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PUBLIC PRESENTATION

This work was accepted for presentation, in part or in full, at Pi Mu Professional Day on April 12, 2016. It will also be presented at the Nursing Honors Presentation Day on December 15, 2016.

Dedication Page

I would like to dedicate this senior honors project to my advisor Christine Fasching Maphis, who inspired me to switch my major to nursing and helped me solidify my passion for mental health further, and to anyone living with a mental illness, who all deserve the best psychiatric health care and to live successfully in their recovery.

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Recovery Care Model Study Article
"Examining the Implementation of the Patient-Centered Recovery Model in Psychiatric Nursing"

Abstract

The Recovery Care Model is the recommended evidence-based model for delivering holistic, patient-centered care for mental health clients. The model is a more therapeutic approach than the traditional medical model and upholds the ideas that psychiatric clients are more than just their illness, should be respected as unique individuals, and provided with hope and empowerment in their care while being given the opportunity for informed and autonomous decision-making. Although research has shown support for the Recovery Care Model, its implementation has not been fully accomplished in all psychiatric facilities. Of all of the members of the health care team, nurses have the most extensive and prolonged interaction with clients and are strategically positioned to be at the forefront of this shift towards recovery-based services. The aim of this study was to discover whether the Recovery Care Model is being utilized fully in psychiatric nursing care in the Augusta/Rockingham/Staunton community in Virginia. Eight psychiatric nurses and fifteen psychiatric clients provided qualitative and quantitative input regarding the usage of the ten fundamentals of the Recovery Care Model in the acute psychiatric nursing care system via a Qualtrics survey. Of the ten fundamentals, there were three areas of care that were identified as needing improvement including; care that focuses on strengths, is respectful, and includes peer support. From this survey, it appears that the Recovery Care Model is not fully embraced and executed by psychiatric nurses. Education and change in the cultural mindset of psychiatric nurses can help aid in this transition.

Introduction

The Recovery Care Model is the recommended best practice model in caring for mental health patients and has replaced the traditionally employed medical model (Chandley, Cromar-Hayes, Mercer, Clancy, Wilkie, & Thorpe, 2014; Marynowski-Traczyk, Moxham, & Broadbent, 2013; Townsend, 2012). The medical model focuses on uncovering and diagnosing pathology and coming up with a treatment plan that is determined by health professionals (Marynowski-Traczyk et al., 2013). This model of care focuses more on the illness than clients and their personalized needs. It attempts to cure and recognizes success in the cessation of symptoms, usually by medications. On the other hand, the Recovery Model of care is patient-driven, holistic, and hones in on finding a way for clients to live happy, meaningful lives with mental illness rather than allowing it to control them or to dictate their lives (Marynowski-Traczyk et al., 2013). The Recovery Model is a more holistically therapeutic approach than the traditional medical model. It holds that mental health patients are more than just their illness and the illness does not define them (Barber, 2012). As opposed to the medical model, the Recovery Model expands past the patient's medical needs and acknowledges the importance of promoting personal development. Intentions of the recovery mindset encompass successful client integration into society, achieving maximal potential despite having a mental illness, and acknowledging recovery as a journey and not simply a destination (Canmann, 2010; Marynowski-Traczyk et al., 2013; Seed & Torkelson, 2012). It is important to develop the treatment plans and tools that support adherence, but there is more to account for, and the ultimate plan must be tailored to each unique patient's wants and needs.

The United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration developed the ten fundamentals that define the Recovery

Model. The defining components include services that are individualized and patient-centered, patient self-directed, care that is holistic, non-linear and strengths-based and focuses on patient empowerment and responsibility, and the instillation of hope (Seed & Torkelson, 2012; Townsend, 2012). Descriptions of each fundamental are shown in Table 1.

Table 1
Fundamental Descriptions

Fundamental	Definition
Self-Direction	allowing the client to take control of their care and make educated, personal decisions
Individualization/ Patient-Centered	basing care on the unique person behind the illness
Empowerment	giving authority to the client in managing their care and positively impacting them in the search for their place in society
Holistic	considering all facets of the client, not just the physical
Nonlinear	enlightening the client that recovery is not necessarily a smooth journey, but has some setbacks that can be overcome with the focus of continuous growth and experiential learning
Strengths-Based	focusing on the client's abilities and using them to allow the patient to take on new life roles
Peer Support	ensuring that the client has a supportive group where they feel a sense of belonging, which includes family, friends, and support groups specific to his or her condition
Respect	facilitating a client's feeling of acceptance and appreciation from society and others, so that they feel fully integrated despite their mental illness
Responsibility	cultivating patient understanding in the need to manage their self-care, adhere to treatment plans, and effectively cope so that they live a happy and well life
Hope	sending positive messages that the client can successfully overcome obstacles and find personal success in their own recovery journey

All of these fundamentals are key in implementing the Recovery Model and involve both the nurse and patient (Seed & Torkelson, 2012; Townsend, 2012). There is a consensus in the literature to transition towards Recovery Care Model in psychiatric nursing and health care, however, the medical model of care still tends to dictate current nursing practice (Carlyle, Crowe, & Deering, 2012). With this trend in mind, the purpose of this study is to determine whether psychiatric nurses are implementing this best practice model to the fullest.

Literature Review

Throughout the literature, various sources and literature have shown that the Recovery Care Model and its fundamentals are best practice for psychiatric nursing and health care implementation. Multiple studies found that recovery-oriented care is the preferred and best method to successful patient care (Barber, 2012; Chandley et al., 2014; Cromar-Hayes & Chandley, 2015; Gandi & Wai, 2010; Marynowski-Traczyk et al., 2013; McKenna, Furness, Dhital, Park, & Connally, 2014a; McKenna, Furness, Dhital, Park, & Connally, 2014b; McKenna, Furness, Dhital, & Ireland, 2014). Other resources studied certain fundamentals and concluded that the Recovery Care Model produces desirable and long-term benefits for personal recovery in mental illness (Chandley et al., 2014; Gale & Marshall-Lucette, 2012; Gandi & Wai, 2010; Linette, 2011; Matthias, Salyers, Rollins, & Frankel, 2012; Seed & Torkelson, 2012;). Common themes such as collaborative partnerships, therapeutic and holistic care, focusing on the patient and their strengths, and instilling hope and empowerment arose in the studies, and were confirmed to be essential for recovery care (Barber, 2012; Caldwell, Sclafani, Swarbrick, & Piren, 2010; Canmann, 2010; E-Morris, Caldwell, Mecher, Grogan, Judge-Gorny, Patterson,...McQuaide, 2010; Gandi & Wai, 2010; Keeling & McQuarrie, 2014; Kidd, Kenny, & McKinstry, 2014; Linette, 2011; Le Boutillier, Leamy, Bird, Davidson, Williams, & Slade, 2011; Marynowski-Traczyk et al., 2013; Matthias et al., 2012; McKenna et al., 2014; Seed & Torkelson, 2012). With nurse implementation of this model and its components, patients have a better sense of autonomy. Mental health personnel, especially nurses were seen as being imperative in making this shift towards recovery care a reality (Caldwell et al., 2010; Canmann, 2010; E-Morris et al., 2010; Linette, 2011; McKenna et al., 2014b; Seed & Torkelson, 2012). Studies have shown that by empowering patients in the decision-making process and acting as a

supportive and educative partner in care continuity, there is a better chance of patient treatment adherence, effective self-management, and individual recovery (Canmann, 2010; McKenna et al., 2014b; Newman, O'Reilly, Lee, & Kennedy, 2015). By failing to establish a therapeutic relationship with the patient, nurses may be instilling fear, vulnerability, and hopelessness while indirectly enforcing the societal stigmas placed upon them because of their mental condition (Newman et al., 2015). In addition, by focusing solely on the illness and not the person, the patient cannot have successful long-term treatment nor live a meaningful life.

Although research has shown support for the Recovery Model, it has not been fully implemented in all psychiatric facilities (Hungerford & Fox, 2014; McKenna et al., 2014b). Seed & Torkelson (2012) report that the current state of the mental health care system is "fragmented", "inequitable", and stigmatized without any portrayal of hope in recovery. This may be due to nurses spending more time on paperwork, administering medication, and maintaining unit safety than direct patient interaction (Seed & Torkelson, 2012). Carlyle et al. (2012) found that nurses said that the medical model was what they believed in and used most in their practice. Newman et al. (2015) suggest that the lack of implementation could be due to staff resistance or unavailability of resources to educate or enact the model. Steps should be taken to overcome the reasons for non-compliance, and action towards a complete transition to Recovery Care Model implementation needs to occur now. Nurses interact the most with patients and are considered to be at the forefront of this shift. Facilities have attempted to educate their nursing staff in recent years to facilitate this change, but further education is needed (Gale & Marshall-Lucette, 2012; Gilburt, Slade, Bird, Oduola, & Craig, 2013; Hungerford & Fox, 2014; McKenna et al., 2014a). Patients also need education on what to expect from their care and what recovery itself means for them (Knutson, Newberry, & Schaper, 2013). The call to action to make this

transition away from psychiatric care that is based on the medical model to the Recovery Care Model has been sent out, but the answer to the call appears still to be a work in progress.

Methods

Population and Setting

The intended population sample for this study was at least 10 psychiatric nurses and 10 psychiatric clients. Twelve nurses and fifteen clients were contacted. The psychiatric nurses came from facilities in the Augusta County, Rockingham County, and Staunton, Virginia areas. The psychiatric clients were from the community Clubhouses Shenandoah Clubhouse in Staunton, Virginia and Summit House in Harrisonburg, Virginia, and have already been in the acute psychiatric clinical system. Clubhouse participation was voluntary and the clients have been pre-screened by a qualified mental health professional regarding their cognitive, functional, emotional, and psychiatric abilities. Participants were able to understand their treatment and condition, appreciate the benefits of treatment, reason potential risks and benefits of their treatment, and express choice about treatment; therefore, they were deemed competent. Absence of Power of Attorney for the client, assessment by clubhouse staff, and review by a Nurse Practitioner (the study adviser), ensured competency for study participation.

Design

In order to evaluate the status of Recovery Care Model usage in psychiatric nursing care in the area, the perspectives of both psychiatric nurses and clients were obtained. While the findings of this viewpoint comparison cannot generalize the overall practice of all psychiatric nurses given the small sample size and specific target geographic area, they do provide insight into the current status of the transition towards recovery-based care. Similar small-scale studies like this one could be conducted in other areas to build upon the subject matter.

Qualitative and quantitative measures were utilized in a Qualtrics survey to both subject groups. This approach allowed for objective and subjective interpretations of Recovery Care

Model usage. Each subject group had their own “nurse survey” or “client survey” that contained ten Likert scale questions, with each one accounting for one of the ten fundamentals of the Recovery Care Model (Table 2). The nurse survey consisted of an additional eleven qualitative questions that delved deeper into the specific current efforts being made towards or against the model’s use, while the client survey had nine that addressed the same (Table 3). This qualitative portion was intended to enhance data when drawing conclusions about specific fundamentals and general recovery-based care. Clients were asked to answer questions based on past experiences with the nurses in the mental health acute care setting.

Nurses were emailed their survey links and asked to have it completed in a week in order to provide flexibility with their work schedules. Clients were visited by the researcher and one of her advisors at the Clubhouse and given the survey individually on a James Madison University-issued iPad. This method was chosen for the clients in order to give them the privacy to record responses without other client or staff involvement, however, if they had any questions, the researcher and advisor were there to help. Some may say that this could skew data depending on what was asked by the participant and the following answer, but both the researcher and advisor did their best to maintain objectivity when clarifying the question wording.

Table 2

Likert Scale Questions for Client and Nurse Surveys

Recovery Fundamental	Client	Nurse
	On a scale of 0-10 with 0 being not at all, and 10 being all of the time, please choose your response to the following questions	
Self-Direction	Do you feel that your nurse has given you plenty of say personally in making decisions about your treatment plan and goals during your psychiatric care?	You and other health care providers allow adequate client self-determination and autonomy in making treatment and mental health care decisions and goals.
Empowerment	Do you feel like your nurse staff helps facilitate your integration into society outside of your mental health care and positively promotes a higher quality of life?	You provide life meaning and integration of those with mental health illnesses within and outside of the workplace.
Responsibility	Do your nurses provide you with the tools to improve your daily condition self-management?	You adequately educate your clients about all possible treatment options so that they have a solid foundation to make an informed decision about their care and can provide themselves with effective self-care.
Peer Support	Have your nurses given you the chance to share your perspective and listen to the perspectives of others who are experiencing the same mental health conditions?	You allow clients to interact with others with similar conditions or take them to support groups so that they can share experiences and have a support system.
Individualized	Do you feel that your individualized needs are being met by the nurses involved in your care and the facility that you are in?	Your clients' individualized needs are being met in their care in your facility.
Hope	Do your nurses help you feel optimistic and hopeful that you can successfully manage your condition and live a happy and healthy life?	You foster hope in your clients as they are managing an treating their conditions.
Holistic	Do you feel like your nurse considers all aspects of you as a person while providing you care (physical, mental, emotional, etc.)?	You acknowledge the person behind the illness and all facets of him/her during client care rather than solely focusing on treating the illness itself.
Respect	Do you feel like your nurse and care team respect you and act as your advocate?	You act as an advocate for mental health by challenging societal stigma and respecting your clients as people.
Nonlinear	Does your nurse help you continuously grow in your recovery and give you assistance whenever there is a "setback"?	You help your client continuously grow in their recovery and provide assistance whenever there is a setback.
Strengths-Based	Does your nurse ask you about your strengths and use them in your treatment plan?	You ask about your client's strengths and integrate them in their treatment plan.

Table 3
Qualitative Questions for Client and Nurse Surveys

Client	Nurse
How has your nurse helped to give you power in making decisions about your treatment and goals?	What methods do you use to facilitate more client control in their care?
What could your nurse do to give you more power in decision making?	How specifically do you act as an advocate for mental health and challenge societal stigma?
In what ways have your nurses provided you with tools to improve your daily condition self-management?	How do you provide life meaning and integration into society for your clients?
What is your view of recovery?	Provide some examples of how you see the person behind the illness aside from their condition. If you feel that you are unable to look past the illness, how do you think you can?
How do nurses and your treatment team promote the idea of recovery?	What are some examples of ways that you individualize your clients' care?
How do your nurses help you to feel optimistic and hopeful that you can successfully manage your condition and live a happy and healthy life?	How often and in what ways do you allow clients to interact with others with similar mental health conditions so that they can share experiences and have a support system?
What does your nurse do that helps you to feel that you are working in a close partnership towards your recovery?	How do you foster hope in your patients?
What does your nurse do that makes you feel respected and advocated for?	How do you incorporate education into your client care and how effective do you think it is for promoting effective self-care?
How has your nurse helped you personally to facilitate your integration into society outside of your mental health care and positively promote a higher quality of life?	How do you foster growth in your clients in their recovery journey and aid them when they have setbacks? If you do not, how do you think you can improve in this aspect?
	How specifically do you incorporate your client's strengths into their treatment plan?
	What does recovery-based care mean to you?

Ethical Issues

Approval for this study was obtained from the International Review Board of James Madison University on January 29, 2016 under the protocol number 16-0346. Before completing each survey on Qualtrics, nurses and clients were given a consent form explaining the study, risk and benefits, confidentiality, etc. They could not move forward to the survey until they read the form, had all their questions answered, and pressed the certification to consent button. The nurses performed the survey independently In order to ensure understanding in members of the client population who may have struggled with reading, a brief explanation of the Recovery Care Model was performed and then the consent form was read aloud. Each participant was asked if they had any questions or concerns and were assured that they could withdraw from the survey at any moment. Participants supplied no identifiable information except if they were a client or nurse, which depended on the survey taken. The participants were informed that their data would be presented and shared at presentations and in print and assured that there would be no disclosure of information that would identify any specific individuals. Each participant whose information was used in data analysis provided consent. The researcher followed-up with nurses via email and clients via an in-person presentation at the Clubhouses about the results and conclusions in April of 2016.

Data Collection and Analysis

Eight nurses and fifteen clients consented to participation and completed the Qualtrics survey. Although the target number of nurse participants was not reached, the client group exceeded expectations, which provided valuable data from their perspective. Each of the completed surveys had finished quantitative sections, but there were several incomplete qualitative portions. For this study, the cumulative responses to each of the individual Likert

scale questions for each subject group were averaged together to obtain a "fundamental score" in order to compare which fundamentals were perceived to have stronger utilization from each group's standpoint. Then, all of the fundamental averages were added together to get "recovery care model score" for each subject group, so that the perception of recovery care implementation could be compared between the two groups. Finally, the "recovery care model scores" for the nurses and for the clients were averaged to get the cumulative recovery score for Recovery Care Model usage overall.

Qualitative information was not meant to judge whether the model was being used, but acted as an insight to the particular efforts being made for or against its implementation. The qualitative data was generalized and separated into a comparison table displaying what promoted and inhibited recovery care. Particular emphasis was placed on the client perspective since they were the ones receiving care and their experiences could act as a basis for what reaped benefits and what did not. The Recovery Care Model emphasized giving the client a say in their care, and these responses could facilitate a push for further improvement and explain what aspects of the model were being successfully employed.

Results

The data analysis gave insight into which fundamentals appeared to be implemented by psychiatric nurses in practice from both the nurse and client perspective. All of the Likert scale questions were answered by both subject groups, but not all qualitative questions were.

Quantitative Look at Fundamentals and Overall Recovery

Both subject groups expressed that the Recovery Care Model is not being used to its fullest, with clients rating every recovery fundamental usage lower than that from the nurse perspective. Nurses exhibited self-direction, individualization, and responsibility as being the least implemented fundamentals of the ten in the Recovery Care Model. Clients saw strengths-based, peer support, and respect as being the least used in current psychiatric nursing practice. The nurses believed that they successfully applied the fundamentals of holistic, nonlinear, and strengths-based in practice, while clients thought that nurses more successfully executed responsibility, individualization, and hope overall. Two of the three lowest nurse-rated fundamentals were thought to be the highest from the client perspective when observing all ten fundamentals, so nurses were actually doing better than they perceived in implementing individualization and responsibility. Although the average value was still lower for those two fundamentals respectively from the client perspective when comparing it to the numerical average of the nurse group, this trend of greater fundamental application came from observing the fundamentals as a whole within the individual subject groups. Nurses also rated strengths-based as being one of the highest and that was the lowest rated fundamental according to clients. This could be a targeted fundamental to strengthen in order to better implement the ideals of recovery. Table 4 showed a comparison of the input from the two subject groups on each of the ten fundamentals with the lowest ranked being in red and highest ranked being in green.

The input from the Likert scale questions had nurses rating their overall recovery care as 90.78 out of 100 and clients seeing nursing recovery practice as 72.32 out of 100 when averaging all ten of the fundamentals. Clients perceived psychiatric nursing care based on the Recovery Care Model as being implemented to a lesser degree than nurses perceived, which showed a need for improvement for more complete model use.

Table 4
Likert Scale Client and Nurse Survey Question Results

Recovery Fundamental	Nurses (N=8)	Clients (N=15)
Self-Direction	8.75±1.04	6.77 ±3.17
Individualization	8.50±1.41	6.92±3.43
Holistic	9.38±0.52	6.62 ±2.53
Empowerment	9.13±0.99	6.47±3.20
Nonlinear	9.38±0.74	6.69±3.20
Strengths-based	9.38±0.74	6.00±3.55
Peer Support	8.88±1.36	6.31±2.98
Respect	9.13±1.36	6.25±3.41
Responsibility	8.75±1.04	7.46±2.79
Hope	9.50±0.53	6.92±3.42

Qualitative Look at Efforts Made and Not Made Towards Recovery Care

Although qualitative data was not meant to explain the amplitude of Recovery Care Model execution in psychiatric nursing care, it did reveal what nurses and clients believe was and was not being done towards this recovery-based transitional effort. Since strengths-based, peer support, and respect were seen as the weakest implemented fundamentals, results will focus

on current efforts and client inputs on improvement for these fundamentals specifically. For strengths-based, nurses made statements such as:

"Strengths are the building blocks and you must listen to client and observe them to find these"

"Find out what they enjoy and talk about ways that can be continued or expanded"

"Ask about strengths and weaknesses upon admission"

Clients consistently had comments surrounding the importance of active listening, "longer listening", and asking them questions and then subsequently actually listening to their feedback. There were accounts of psychiatric nurses not facilitating any discussion, which is imperative to finding out more about each client's individual story and strengths. For peer support, nurses discussed these initiatives that they encourage in practice to allow client interaction with others with similar mental illnesses and experiences:

"Community clubhouse, NAMI, try as much as possible to allow them to interact with others with similar illness"

"Hospital and off grounds groups"

"Support groups (AA, NA, bipolar support group, etc.)"

"Social times on patient's own time in hospital"

Clients on the other hand did not incorporate any suggestions or comments on the peer support fundamental, which would require further inquiry. Regarding the fundamental component of respect, nurses accounted various diverse ways to implement this fundamental in practice by advocating for clients and combatting public stigma on mental health:

"Take any opportunity to discuss mental illness and that it is a disease, not a choice"

"Provide positive success stories to educate public on advances in care"

"Encourage public support of bills or funds for mental health"

"Listen to misconceptions and educate as needed"

"Be true to yourself and stand up for what you believe in"

From the client viewpoint, there were mixed reviews on respect. Some clients said that nurses did treat them with respect in the acute care setting while some said that no respect was present. Some comments on what they appreciated regarding this fundamental involved nurses:

"Telling me about how I am doing and giving me encouragement"

"Support in good choices"

"Listens to my wants and needs and answers my questions or concerns"

These were ways that nurses could increasingly demonstrate the fundamental of respect for their patients as people aside from their mental illness. Table 5 highlights some of the comments that appeared consistently in the qualitative responses for clients and nurses, these included active listening and providing encouragement and hope.

Table 5

Positive Key Points from Nurse and Client Qualitative Questions

Nurses	Clients
• Inform on resources, options, and opportunities and allow them to make decisions on their own/take control • "If you lose, don't lose the lesson" • Explain in terms they understand and answer their questions • Actively listen to clients not just talk at them, with client at center • **"**Treat the client as you would want the most important person in your life to be treated" • Meaningful conversation and inquiry • Remember everyone is a human being as baseline but with variations • Encourage community participation and offer transition and coping skills • "Acknowledge gains as steps towards their goals and a setback as a new opportunity for growth and assessment for improvement" • Praise them for the successes made • Make education part of most interactions • Tailor to individual and respect as a person • Encourage questions so can help them better understand illness • Acknowledge realness of concerns	• Listen to what we have to say, not just the staff's thoughts • Support us • Allow us to be present in treatment team meetings • Acting as a positive role model with a positive attitude • Help with making goals and give tools to achieve them • Offer continuous encouragement and reminders to stay positive when we are down • "Cooperate with me" and "give me hope"

Despite positive reflections from both subject groups, clients also made statements like "they make you feel miserable", "they don't help me" and "my rights were limited", which further emphasize the need for transition to nursing care that is based on the Recovery Care Model. No system is wholly perfect. By focusing on the essential but less implemented areas highlighted in these results; especially those from the client viewpoint, nurses could learn important information to help propel them closer to that ideal.

Discussion

As mentioned, the aim of this study was to determine whether psychiatric nurses were utilizing the Recovery Care Model to its fullest capacity. This study allowed both nurses and clients to provide input on the ten fundamentals of the model and provided insight into the efforts that have been made towards its usage. There were disparities found between the nurse and client perspectives and improvements need to be made towards achieving optimal recovery-based care in psychiatric nursing. Nurses should focus on delivering care that is strengths-based, includes peer support, and conveys respect. These foundational components of the Recovery Care Model were ranked as least often perceived by clients. Client response in this study ranked self-direction and individualization as most often portrayed in their care. Traditional research had identified these fundamentals as the least commonly utilized (Chandley et al., 2014). Nurses were doing better than perceived in these categories and since the receivers of nursing care see them as being the better-utilized fundamentals, there was evidence of a recovery transition occurring to some degree. Because the Recovery Care Model promotes patient-centeredness, it is imperative to continue progress and improvement in its implementation.

Both nurses and clients provided insight on different actions taken in practice that were reflective of the Recovery Care Model. Improvement was needed in creating active partnerships with patients, conveying mutual respect, and promoting hope. According to the qualitative data gathered, psychiatric nurses identified positive efforts that they were currently implementing in practice to fulfill each of the ten fundamentals of the Recovery Care Model. Despite nurses reporting positive strides in executing fundamentals, the clients did not consistently perceive effective implementation. Active listening to wants and needs, support and positive attitude, encouragement, and cooperation were common client responses to inquiry about what nurses do

to promote their recovery. All of these should be capitalized in nursing practice. It was clear that efforts are being made towards this transition away from the medical model, but more could be done in order to fully implement the Recovery Care Model into nursing practice. It appears that an overall mindset shift of health care personnel to recovery will be necessary in order for complete interdisciplinary usage to occur. Focused and purposeful education will be instrumental in this change. Those who have received this education tend to support using recovery approaches in practice and could be the ambassadors of transformation (Gale & Marshall-Lucette, 2012).

The results of this study mirrored some of others in the nursing literature. Like Caldwell et al. (2010), McKenna et al. (2014a), and McKenna et al. (2014b), results revealed that the shift from medical model to more Recovery Care Model usage in mental health practice was occurring. Similarly, Newman et al.'s (2015) study concluded that despite literary support for implementation of the Recovery Care Model, there were still limitations present that inhibit its full use. After examining the qualitative data from this study, it was clear that nurses were incorporating recovery based principles and that the transition from the medical model to the Recovery Care Model was possible. Slade et al. (2014) recognized this possibility and made recommendations for interventions to facilitate the change. Some of these interventions were mentioned in nurse survey answers like illness management, peer support, and wellness recovery action planning. Education to participant clients on the Recovery Care Model during this study revealed that many of them had never heard of the model, which was noteworthy. This emphasizes the importance of educating clients and not just nurses. In 2013, Knutson's study had a similar conclusion. Although there was some conclusion correlation with other studies, this study differed in that it examined nurse and client perspectives through surveys and input was

sought on each fundamental in the Recovery Care Model individually and together as a complete model.

Conclusion and Implication for Practice

This study enhanced the call to action for conversion from care delivery that is based on the medical model to delivery that is based on the Recovery Care Model in psychiatric nursing. All health care personnel, and nurses in particular, should strive to provide the best possible care for clients. They could do so by strengthening aspects of recovery-based care, inculcating its importance, and not merely hoping or waiting for change to appear without purposeful effort. Although education of health care personnel was seen as vital to changing the culture of psychiatric care, more importantly, nurses need to integrate empathy and an awareness that clients are people and not just the illness that brought them into the care arena. Nurses make a great impact on their client's lives and generally have the greatest amount of interaction time, so it will be essential for them to uphold and promote recovery as much as possible. Recovery Care Model implementation is possible. Enlightenment about the Recovery Care Model and why it is important, combined with a supportive health care system and personnel passionate about patient centered care, can propel its full enactment.

Limitations

This mixed methods study had limitations that inhibit its results from being generalizable to all psychiatric nursing practice. The sample size was small and the data could have been richer with more nurses and client input. Although emails were convenient for nurses for survey links, it was harder to obtain a guaranteed response compared to in-person survey distribution and could attribute to the low sample size. There was some convenience bias of choosing nurses in one of the advisor's psychiatric network, which was easier for data collection purposes. However, requesting participation utilizing a list of all of the nurses in each of the facilities who were randomly selected would have provided better representation and eliminated potential bias. There may have been the possibility of client selection bias since the heads of the clubhouse chose the client participants. Very few out-spoken clients were chosen, which could have been unintentional selection bias. Finally, some study design components could be improved upon in future research. Some clients struggled with the question wording and vocabulary meaning, so this aspect should be simplified in future studies order to meet the needs of the participants. The findings of this study, although smaller in scale, do add some valuable insight to Recovery Care Model implementation by psychiatric nurses.

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PICO Table of Literature

Table 6

PICO Table of Literature

Author, Yr.	LOE	Study Purpose	Sample How was the sample selected? Who was in the sample? How many were in the sample	Intervention If no intervention – say so	Instruments with Validity and Reliability	Results/Findings	Article Conclusion How does the research answer the PICO
Barber, 2012	Level 7, expert opinion	Not a study, but to explain idea of recovery being the newer and better model of care in psych	N/A	N/A	N/A	By promoting recovery and focusing on strengths, decisions, and framing treatment with a hopeful perspective, a client can successfully recover in their mental illness	Recovery is the new medical model and although we should not abandon medical knowledge, we should not focus on the medical treatments as being the end goal, but as part of the recovery journey
Caldwell, Sclafani, Swarbrick, & Piren, 2010	Level 7, expert opinion	Not a study, but the article examines support for recovery, its use in nursing, and offers recommendations for continuing the shift towards recovery	N/A	N/A	N/A	The shift from the medical to recovery model is occurring but needs to place a larger role in mental health care. The supportive partnership between a nurse and client, individualized holistic care, mutual respect, instilling hope, and providing client decision-making are essential	The mental health system does need to transform to implement the recovery model in delivering care and nurses should take charge in this transition.

						in recovery care and success in mental health treatment adherence.	
Canmann, 2010	Level 7, expert opinion (but with study examination)	Not a study, but the article aims to explore the psych nurse role in helping clients manage their mental illness throughout their recovery journey	N/A	N/A	N/A	Recovery plans should encompass the individual's mental and medical needs so that holistic care can be obtained. Nurses need to help nurture the client throughout the journey, act as an educator, and assist in weighing actions and outcomes while allowing for client perceptions and wishes to be heard.	The mental health system needs recovery focused programs and plans and nurses can contribute to this effort through their partnerships with and decision-making support for clients.
Carlyle, Crowe, & Deering, 2012	Level 6, mixed quantitative and qualitative descriptive study	To identify the models that are currently being implemented by mental health nurses in the inpatient and community outpatient settings	48 nurses in acute inpatient, forensic, community mental health, alcohol and drug, rehab, child and adolescent, psych emergency, and eating disorders specialties (27 of them were inpatient, 34 females)	N/A	-questionnaire with a client scenario and questions on six elements from participant perspective (definition/diagnosis, etiology, treatment, role of mental health services, prognosis, nurse's role). For each of the six questions, participants either ranked four	-all models endorsed but medical model lowest one attributed to etiology of client distress -57.1% of nurses said medical model is what was most close to what they believed in -those working in outpatient settings more likely to use interpersonal model of care for treatment required and to contribute to client improvement -those without postgraduate qualifications use medical model with treatment than those with postgraduate	Mental health nurses consider interpersonal and psychodynamic factors to contribute to illness etiology but see the role of mental health services from the medical model perspective. They recommend nurses to adopt models of practice that meets the patients' rather than professional needs, which is not

					models of mental disorder (medical, interpersonal, cognitive and psychotherapeutic conceptualizations) as least or most close to what believe on scale 1-4 or rated them from little relevance to very relevant on 1-4 scale -qualitative section asked "What would be your explanation and interpretation of patient's current problem and what nursing interventions would you provide for the patient?"	-qualitatively attributed etiology to psychodynamic but approached treatment with medical framework	the medical model and is instead more holistic in nature.
Chandley, Cromar-Hayes, Mercer, Clancy, Wilkie, &	Level 6, qualitative study (action-based and research)	To explore the concept and application of recovery in the care and clinical management of	Approximately 20 nurses and 20 patients in a monthly champions focus group	N/A	N/A	-labelling and stigma oppose recovery ideal of inclusion and freedom, but you also do not want to provide false hope -relationships and rapport are crucial in this setting, but	Ultimately, safety and recovery utilization together in care is the most optimal in caring for patients in the high-

Thorpe, 2014		patients detained in one UK high-security hospital				there is also a duty in place to maintain safety -pts must feel safe in order to get anything done and support is key -there is a difference between madness (mental disorder-oriented behavior) and badness which is driven by human dangers and relations/environment help to protect from these violence threats -those in these settings actually can reap the most benefits from recovery care	security mental health institutions. Protective factors, cultural factors, proactive approaches, individual characteristics all influence recovery use.
Cromar-Hayes & Chandley, 2015	Level 6, qualitative action study	To explore how and if the recovery model can be embraced in high secure services.	Focus groups of nurses from two units (mental illness and personality disorders) that were obtained through voluntary consent	53 sessions of reflexive practice group attendance that focused on recovery for nurses (audiotaped)		-raised the issue of what are they recovering from specifically; crime or mental illness -the target pt population may not want recovery because they have nowhere better to go than the hospital -forming relationships is at the focal point of recovery for these pts and collaborating with other healthcare personnel will help the process so it is consistent -hope reduces the risk of harm to self and others but not	Reflective practice is best practice according to participating nurses in this setting and recovery is the direction we should go towards as practitioners.

						false hope -openness and transparency decrease in more secure systems, which is not recovery-oriented -control and power of pts important, but this can be compromised in this setting -nurse's fear can hinder implementation of the recovery model and they stated that they needed to feel secure before they could engage in pt recovery	
E-Morris, Caldwell, Mecher, Grogan, Judge-Gorny, Patterson,... McQuaide, 2010	Level 3, controlled trial (?)	Describe a quality improvement project in the development and implementation of recovery model patient-centeredness in a state psychiatric hospital.	Nurses at a state psychiatric institution	9 month Quality improvement project with 2 phases: establish structure to lay groundwork for accountability and development of mechanism to provide clinical	Surveys at baseline and after implementation measured by SPSS t tests	-Improvement was seen in almost all parts of care, environmental aspects of care, reduced seclusion and restraint incidents -nurses felt that they were more able to focus on pts, be familiar with their meds and behavior, prevent escalation, know pt needs -sustainability will require constant effort, guidance, and support	Shift to the recovery model is possible with commitment from administration and management groups and should be done not only within nursing but among other disciplines to meet client needs. This system improves nursing care for pts and enhances safety and can only occur in a safe environment

				supervision process for staff in their work with clients			
Gale & Marshall-Lucette, 2012 ********	Mixed methods approach (questionnaire and quantitative/qualitative content analysis)	Explore CMHN application of the recovery model, assess their educational needs, and identify the service-education gaps in the development of a mental health care delivery model	23 community mental health nurses, 28 course documents analyzed	Self-efficacy questionnaire on the extent of the continuing professional development curriculum efficacy in meeting educational needs on implementing the recovery model	Questionnaires with 6-point self-efficacy scale for confidence in undertaking recovery care (content validity performed)	-confident in 9 out of 20 items and somewhat confident in 7 items -highest scores in "promoting hope", "assisting access to community activities" -lower scores in "help service users work towards employment options", "ensure stable and safe accommodation" -about 1/3 confident in understanding of model and 70% were confident in ability to incorporate guiding principles in practice -83% confident or somewhat confident in ability to promote hope and 65% were confident in articulating importance of recovery model -over 1/3 were unconfident or somewhat unconfident in helping users dev methods of self-management -only 1 of the 28 documents had "recovery model" in it	There was high overall confidence in principles of the recovery model like the psychological components (eg hope promotion), however, less so when it comes to practical elements (eg social inclusion). Nursing education falls short in giving sufficient training in the recovery model which could explain gaps in practice. The teaching documents showed little evidence of the recovery model from the key word search.

						and "recovery was found 30 times in all documents and "hope" only 2 times and "support" for service users 11 times	
Gandi & Wai, 2010	Level 2, randomized controlled trial (double blind)	To ascertain the impact of Partnership in Coping in mental health recovery with specific objectives to: improve psychological well-being, ensure balanced locus of control, promote a greater degree of self-efficacy.	56 service users at the Federal Neuro-Psychiatric Hospital, Kaduna (schizophrenia, depression, mania, anxiety disorders, drug-induced psychosis) chosen by MH professionals in the center	Partnership in Coping 3 month clinical intervention (experimental group), medical treatment (control group)	Questionnaire (to select research assistants/MH professionals and measuring post-treatment behavior of participants) with the Professional Quality of Life Scale and Mental Health Recovery Measure, which have well-established validity	Partnership in Coping in mental health recovery has a positive and meaningful effect on clients and betters negative impacts from medical model-centered treatment.	Recovery is possible when clients are in a collaborative partnership with support and people to provide skills and knowledge to make change in their lives, and the idea of recovery needs to be at the forefront of our mental health system.
Gilburt, Slade, Bird, Oduola, & Craig, 2013	Level 3, Quasi-experimental design (quantitative care plan audit and qualitative	To evaluate the implementation of recovery-oriented practice through training across a system of mental health services.	342 MH staff from 22 multidisciplinary community and rehab teams from London Boroughs of Lambeth, Lewisham, and Southward	4 full-day workshops and in-team half-day session on supporting recovery	Behavioral intent rated by coding points of action on care plans of random 673 patients (385 intervention, 288 control) before and 3 months after intervention	-Pts in intervention groups had higher incidence of change in topics covered in care plan after MH professional participated in intervention -themes emerged: recovery of individuals and practice (care provision, hope, language, ownership, multidisciplinary) and systemic implementation	Training can have an effective role in making the transition to recovery-oriented practice in mental health care practice both in content of patient's care plan and the attribution of responsibility for

	interviews with participating staff) with non-random intervention allocation					(hierarchy and role definition, training approaches, measures of recovery, resources)	actions.
Hungerford & Fox, 2014 ****	Level 6, Qualitative case study approach for themes	To identify factors that challenge the effective implementation of recovery-oriented services and consider solutions to these challenges.	9 consumers volunteered	Semi-structured open-ended interview and option of individual interview that were audio recorded digitally then transcribed verbatim	Interpretative phenomenological analysis to sort discussion into themes and patterns (done by 2 analysts with comparison for validity)	-3 themes: recovery, challenges to recovery, solutions to these challenges -recovery: majority of participants had understanding of recovery as defined by literature -challenges: consumer fear of change, professional struggle to translate their knowledge of recovery in practice (hands-off), uncertainty with who was responsible for delivering what aspect of the recovery-oriented service, incongruence between recovery and biomedical approaches learned Solutions: ongoing education on recovery for consumers and professionals, use of consumer consultants for peer support in recovery, more	Large-scale shifts can cause resistance and fear, so focused effort and time is needed to implement this model of care effectively and incrementally. We need to go further in education of professionals and consumers on recovery.

						collaboration and cooperation between team/services, LISTEN actively	
Keeling & McQuarrie, 2014	Level 7, expert opinion	To explain a model that would service as one for implementing mental health and wellbeing promotion in practice.	N/A	N/A	N/A	-four parts: collaborative working to identify what the client wants to achieve, prompting the client to engage with statutory and non-statutory services, creativity in approach, conductive and constraining factors to implementation	This model hopes to teach about important principles of mental health and wellbeing promotion in any setting.
Kidd, Kenny, & McKinstry, 2014	Level 6, Action research design (qualitative)	To explore the meaning of recovery to those who provide and receive mental health services.	11 participants recruited from purposive sampling (6 service users, 4 clinicians, 1 carer)	Monthly 2 hour group meeting from August 2012-July 2013 that explored and reflected upon concept of recovery and the services surrounding it	Identifying significant issues from the audiorecordings of the meetings and gathering themes that would be re-read and checked with participants for approval (validity and reliability examined)	-recovery is an ongoing life journey -five themes: finding meaning, an invisible disability, empowerment and agency, connection, the passage of time	Lived experiences perspectives and participatory efforts of the user and provider of care are essential to the transition to recovery-oriented care.
Knutson, Newberry, & Schaper,	Level 4, cohort study	To describe the development of a Recovery	92 psychiatric patients without unpredictable	Recovery Education program	Evaluation slips post-intervention asking	-1% rated poor, 6% fair, 21% good, 37% very good, 35% excellent	Patient teaching about the Recovery Model is an

2013		Education program to promote successful client recovery.	behavior from mania, psychosis, other psychiatric condition nor adolescent)	based off the researchers ' developed version of the recovery model (Gundersen Lutheran's Recovery Model) from January 2009-2010	participants to rate the lesson and how helpful it was to them (examined with t-tests) and an Admission and Discharge Worksheet to evaluate change during hospitalization	-19 patients wrote positive comments about gains from the group -18 patients mentioned learning new information with 6 learning a new skill -helpfulness was mentioned 22 times -17 patients commented on the group connection and shared experience being helpful -significant improvements from admission to discharge	imperative part of psychiatric patient care.
Le Boutillier, Leamy, Bird, Davidson, Williams, & Slade, 2011	Level 5, systematic qualitative review of documents	To identify the key characteristics of recovery-oriented practice based off guidance of current international perspectives and to develop a general conceptual framework to aid in the transition to recovery practice.	30 international documents about recovery-oriented practice from the US, England, Scotland, Republic of Ireland, Denmark, and New Zealand	N/A	Inductive thematic analysis (extraction of data from 2 raters based off established recovery criteria, initial sematic-level analysis by 4 analysts, then interpretive analysis into themes and patterns)	-16 themes: seeing beyond the service user, service user rights, social inclusion, meaningful occupation, recovery vision, workplace support structures, quality improvement, care pathway, workforce planning, individuality, informed choice, peer support, strengths focus, holistic approach, partnerships, inspiring hope Four practice domains: promoting citizenship, organizational commitment, supporting personally defined recovery, working	The conceptual framework from this study can aid in the transition to recovery-oriented practice by clearing up confusion on what constitutes recovery-oriented care.

						relationship	
Linette, 2011	Level 5, review of the literature and discussion of models of practice based off it	To describe how implementation of a recovery-oriented practice nursing model (Nursing as Caring) in a hospital setting caring for those with mental health issues.	335-bed treatment facility in South Florida	Coming up with and implementing Nursing as Caring model of care	Assess knowledge of the leadership team and conducting a literature review to find a model that best meets patient needs, staff education and discussion, interviews with staff/patients/families (these are also part of intervention)	-clarifies the focus of nursing care so that nurses can facilitate recovery and hope -nurses became more aware of how to care in practice and the uniqueness of each patient	No true conclusions were drawn except that the nursing leadership team is excited about the positive effects of implementing this developed caring model.
Marynowski-Traczyk, Moxham, & Broadbent, 2013	Level 5, review of literature	To bring forth a critical discussion about recovery for mental health patients in the Emergency Department.	Scholarly journals and policy documents from academic databases from 1995-2012	N/A	'recovery' AND 'mental health' AND 'consumers', 'recovery' AND mental health' AND 'recovery-oriented', 'recovery' AND 'recovery-oriented' AND 'services' OR 'experienc*' search terms in CINAHL, Medline, Web of	-the needs of the increasing numbers of people with mental illness have to be met in the ER and currently many RNs do not have any formal mental health training -the education that these RNs need to receive should involve not only general psych but also recovery model since best practice -need to uphold the fundamentals of the recovery model in care and treat patients with respect and protect their rights	All clinicians need to be cognizant of the recovery model of care and they need to uphold collaboration with mental health service users in the ED.

					Science	-health care professionals need to truly believe in this model and implement in order to provide optimal care	
Matthias, Salyers, Rollins, & Frankel, 2012	Level 6, observation with qualitative data about shared decision making concept	To explore how decisions are made in mental health care consultations, especially with the degree of shared decision making.	Four providers and 40 consumers with severe mental illness	Observation of 40 medication management appointments	Thematic analysis to characterize decision making process in group discussion and individually	-provider initiated decision making process in most decisions but when consumers did so, they began with a question or concern -complete disagreement rare and negotiation was common -consumers agreed to provider's preference 2/3 of time -if decision was brought up by consumer then disagreement occurred 1/3 of time while never if brought up by provider -if consumer initiated decision making process then their preferences more frequently in the final decision	Shared decision making is not prevalent and interventions allowing consumers to take more initiative while collaborating with providers should be initiated.
McKenna, Furness, Dhital, Park, & Connally, 2014	Level 4, case study	To describe the organizational procedure that allowed the shift to recovery-oriented care in mental health service.	15 staff from a 26-bed adult secure extended-care facility in Victoria, Australia and 4 recovery documents	One-on-one interviews and document analysis (qualitative)	Thematic analysis using inductive approach where data was transcribed with NVivo and continuously read and agreed upon by involved	-four themes: We had this whole paradigm shift that needed to happen; Think recovery, the development of a manualized guide; Stepping out my recovery;" adaptation of the service guide to the secure care context; and developing the culture.	The transition to full recovery implementation is a journey that requires the mental health organizations involved to be committed and have an understanding of

					researchers until themes developed	-you need the right people, education, reflective learning, and leadership	what it entails
McKenna, Furness, Dhital, Park, & Connally, 2014 ***	Level 6, qualitative research	To describe recovery service delivery in a secure in-patient mental health service.	15 staff and consumers and 5 carers in a secure setting in Melbourne, Australia	-Interviews with the consumers and staff with these questions: (a) the consumers' experience of participation in the secure service, (b) what it is about the service framework that is recovery-oriented, (c) how involvement in the service has affected their recovery, and (d) the	Thematic analysis using inductive approach where data was transcribed with NVivo and continuously read and agreed upon by involved researchers until themes developed	-content domains in a "journey toward a life worth living": promoting hope, promoting autonomy and self-determination, meaningful engagement, focusing on strengths, holistic and personalized care, community participation and citizenship, managing risks by taking calculated risks	This case study showed that mental health personnel can take on the challenge to shift towards recovery-focused care, but it is still a work in progress.

				relationship of the recovery-oriented service delivery with the consumer's sense of overall recovery. - focus group with carers			
McKenna, Furness, Dhital, & Ireland, 2014	Level 6, qualitative focus group interviews	To determine the extent to which elements of existing nursing practice resemble the domains of recovery-oriented care and to provide a baseline understanding of practice to prepare for the transition to recovery-oriented care.	12 MH nurses in an older adult acute patient setting and recruited with flyer	Focus group interview asking about current practice relevance to recovery model (culture of hoe, collaborative partnerships, meaningful engagemen	Inductive approach with coding to make categories and relationships from the data and collective agreement on results	-culture of hope: they will set aside therapeutic time to moderate negative attitudes and reinforce the positive and that this is a journey that naturally has short-term setbacks, keep routines -collaborative partnerships: holistic care, emphasizing steps to recovery, family involvement -meaningful engagement: assess the patient and modify approach to meet needs, ask them to share their story and actively listen -autonomy: goal setting and give them control, seek	Recovery-oriented care in this sector is still being developed and change is occurring, and education is imperative to drive this change.

				t, autonomy and self-determination, community participation and citizenship)		compromise for realistic autonomy -community participation: encourage reengagement with daily activities, continuity of care -challenges: hard to frame recovery with deteriorating dementia patient, low staff to high consumer numbers adds pressure, lack of knowledge	
Newman, O'Reilly, Lee, & Kennedy, 2015	Level 5, literature review	To identify what mental health service users experience in their care.	34 papers after searching "mental health service users and relationships" (2008-2012)	N/A	Integrative review and appraised using Critical Appraisal Skills Programmes Checklists	-themes: acknowledging a mental health problem and seeking help, building relationships through participation in care, working towards continuity of care -key areas that impact service users and providers: continuing concerns relating to stigma, the relationship aspects of care, and service users' involvement in care planning and issues -patients experience stigma, lack of service user involvement in care planning process, kindness but not compassion, lack of treatment choice -barriers: resistance to change by staff, lack of resources,	Although there is a call to recovery, there are still limitations and reluctance to its implementation.

						unavailability of services	
Seed & Torkelson, 2012	Level 5, review of the literature	To demonstrate how concepts of Orem's Self-Care Deficit Nursing Theory (SCDNT) are aligned with that of recovery and how it can be used in interventions and research by nurses in acute psychiatric settings to help patients in their recovery journey.	Not stated	N/A	N/A	-SCDNT allows practitioners to help clients develop self-care so that they can overcome an deficits from mental illness -having the tools for good self-care helps the perception of well-being and self-esteem -movement from medical to recovery model requires a culture change in hospitals and SCDNT can help with that	The movement towards recovery necessitates nursing leadership and involvement and is instrumental in making this transition successful.
Slade, Amering, Farkas, Hamilton, O'Hagan, Panther,… & Whitley, 2014	Level 1, clinical practice guidelines	To identify mis-uses of the recovery concept and interventions to combat them.	N/A	N/A (literature review though included interventions that target recovery outcomes, have emerging or established supported empirical evidence	N/A	-abuses: recovery is the latest model; recovery does not apply to "my" patients; services can make people recover through effective treatment; compulsory detention and treatment aid recovery; a recovery orientation means closing services; recovery is about making people independent and normal; and contributing to society happens only after the person is recovered -interventions: peer support workers, advance directives, wellness recovery action	We are starting to understand that the transition to recovery-oriented services is possible and that there are interventions that mental health systems can employ to facilitate this.

				based off experimental investigation)		planning, illness management and recovery, REFOCUS, strengths model, recovery colleges or recovery education programs, individual placement and support, supported housing, and mental health trialogues	