

# An Example of a Model for Practicing Community Mental Health Nursing: “Recovery”

## *Toplum Ruh Sağlığı Hemşireliğinde Uygulamaya Yönelik Bir Model Örneği: “Recovery”*

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### Öz

Ülkemizde açılmış olan toplum ruh sağlığı merkezlerinde, ruhsal bozukluğu olan hastalara sunulacak olan hizmetlerle ilgili bazı belirsizlikler bulunmaktadır. Bu merkezlerde çalışanların dörtte birini hemşireler oluşturur. Bu sunulan hizmetlerin kalitesini etkileyebilmesi açısından önemli bir rakamdır. Sunulan hizmet kalitesini artırılmasında düzenli eğitime alınacak hemşirelerin alanda uygulayabilecekleri modellere gereksinimleri vardır. Bu anlamda “Recovery” model olarak toplum ruh sağlığı hizmetlerinin temel felsefesi olan bireyi merkeze alan yapısına oldukça uygun bir modeldir. Bu çalışmada “Recovery” modeli tanımlanarak, toplum ruh sağlığı merkezlerinde çalışan hemşireler için tedavi ve bakımda model olarak uygulanmasının tartışılması amaçlanmıştır.

**Anahtar sözcükler:** Toplum ruh sağlığı, psikiyatri hemşireleri, iyileşme.

### Abstract

There are some uncertainties about the services that will be offered to patients with mental disorders in the community mental health centers opened in our country. One-fourth of the employees in these centers are nurses. This is an important figure that could affect the quality of the services offered. In order to improve the quality of the services offered, nurses need models that can be applied in the field. In this sense, “Recovery” model, is a model that is quite suitable for the community mental health services which centers the individual as a part of its basic philosophy. The aim of this study is to define the “Recovery” model and to discuss it as model for the treatment and maintenance of patients by nurses working in community mental health centers.

**Key words:** Community mental health, psychiatry nurses, Recovery.

IN THE "NATIONAL MENTAL HEALTH ACTION PLAN (2011-2023)" published by the Turkish Ministry of Health in 2011, the primary purpose was to create a service network so that mental health services could be delivered to the individuals with better quality. An action plan has been prepared in line with this goal and the aim of establishing a patient-centered approach in the treatment and care of individuals with mental illness, community-based mental health service model, has been

settled in Turkey (Sağlık Bakanlığı 2011). Community mental health centers constitute the core of the community-based mental health service model. For the first time in Turkey, the Bolu Community Mental Health Center has been implemented in 2008 (Ensari 2011). Although many community mental health centers have been opened in our country since then, research on the functioning of the centers and the services offered has been quite inadequate (). Although a small number of studies have been going on since the first community mental health center, it is still unclear which service individuals will receive and how and by whom (Bilge et al. 2016, Icel et al. 2016, Söğütü et al. 2017).

Bilge and colleagues (2016) in their research on the functioning of these centers, they found that one-fourth of the employees were nurses. This figure is important for the potential effectiveness of nurses working in these centres in bringing the promised services to individuals with mental illness. In summary, it can be interpreted as supporting the nurses working in the field with in-service trainings to bring the centers functional with the training programs would be implemented at a certain time organized by the Ministry of Health in the field of mental health of the community. After this interpretation, another step to be taken is to determine and implement which models are suitable for community mental health centers in relation to treatment and care in psychiatric nursing.

One of the most important models that can be applied in community mental health centers is the recovery model that contains individual-centered elements. These elements are hope, the right to self-determination, the ability to make sense/purpose, the potential to create awareness/awareness, and the ability to negotiate. These elements also include interaction with others, for example with relatives of the individual and mental health workers. These interactions help an individual to play an active role in making decisions about himself, negotiate when necessary, create a meaning his/her life, and create a goal for him/her (Onken et al. 2002). In this sense, the basic philosophy of community-based mental health services in Recovery model is to achieve the goal of "protecting the well-being of patients by performing regular follow-up and treatment in their neighborhood, preventing attacks, reducing hospitalization and providing rehabilitation of patients to society" (Bag 2012).

In this study, it was aimed to define the Recovery model and discuss whether it can be used as a model for treatment and care for nurses working in community mental health centers in the field of mental health and psychiatry nursing.

## Recovery Model

Recovery model, which has been increasingly used over the last two decades, includes several approaches focused on individualized treatment, emphasizing the autonomy and subjectivity of individuals with mental disorders (Winter et al. 2015). "What are the requirements for individuals with mental disorders to have a high quality of life?" he seeks answers to his question. In this way, it selects a way to alleviate symptoms and to treat the cause, also known as preventative treatment. In a sense, there is a different expectation from the expectations of classical psychiatric treatment. Defining Recovery will be useful for better understanding the model and for using it in the application areas.

## ***Definition***

Even in the psychosocial context from which he received his source, Recovery can not be clearly defined. The different definitions made up to day-time have only an emphasis on different aspects of Recovery (Winter et al., 2015). For example, Anthony (1993) defines the term Recovery as "Recovery, attitudes are the process of deep personal and individual change in values, emotions, goals, skills and roles".

Recovery is a way for an individual with mental disorders to lead a hopeful and constructive life. Recovery is a new task in the life of an individual and a reintroduction of life as the destructive effect of psychiatric illness continues in the individual (Onken et al. 2007). The concept of "process" in the attempt to identify Recovery is often encountered and is the journey of the intended individual to recovery. Here, it can be said that recovery is a kind of psychological resilience. Some authors describe recovery as a non-linear process (Anthony 1993, Onken et al. 2007). According to them, the individual can go forward in the Recovery, that is, they can experience a process towards recovery, and vice versa. Raph (2004) defines recovery as "the spiritual journey of individuals with mental disorders in a spiral model that can advance both backwards and forwards in accessing health from one phase to another". Orken and his colleagues (2007) stated that there was a variety of Recovery understanding and stated that the distinction should be made between them.; "the recovery process that occurs with the elimination of symptoms, clinical improvement and despite the continuous/permanent symptoms of the disease, the patient's self-feeling can survive alone despite the symptoms, that describes as personal improvement. The term discussed here is personal Recovery (Davidson 2010).

Systematic and methodological reviews usually comes from English-speaking countries. The Recovery movement was defined as an expression of the so-called "post Psychiatry" approach (Bracken and Thomas 2001). As can be understood from the above definitions, Recovery has a very complex structure that includes different theories as a concept. While this complex structure is being adapted to different languages, it causes problems in translation of the language. With regard to this issue, Knuf et al. (2007) complains that the Recovery word, which stands for improvement and development, is not the only word that Recovery fully satisfies as a concept, describing in its own language German as improvement and / or recovery of health. Similarly in Turkish the Recovery word has many meanings such as "to get rid of", "to be good", "to recover", "to get rid of the disease", "to recover" and "to find" (Recovery 2017). The term recover is also used to refer to the struggle of psychiatric patients against self-labeling (Shulz and Zuaboni 2012). For this reason, translation "Recovery" into Turkish was considered to be inappropriate in terms of both meaning of the word as well as understanding of the model and it was decided that the original would be more suitable to use in this paper.

## ***Historical Development of Model***

The emergence of the model is associated with the fact that in the 1980s, self-help groups began to question the idea that mental health and disorders were not curable. These groups preferred to use the term "Recovery" instead of psychiatric patients in order to be their own determinant of their lives (Deegan, 1988). Contrary to classical psychiatric practices, "psychiatric services are no longer intended to reduce or eliminate

symptoms of illness". Since the 1990s, treatment goals have focused on helping individuals with mental disorders to improve their livelihoods and quality of life, to participate in society more effectively, and to have the right to self-determination (Vereinte Nationen 2006). In this model for example it has clearly been stated that a chronic disease does not interfere with the life of the community, and the focus is not only reducing the symptoms of chronic disease, but also contributing to a high quality of life in the community with functional participation. In addition, the elimination or struggle of obstacles such as despair, personal responsibility, exclusion from society and poverty constitutes part of the model.

The model's supporters state that Recovery is a dynamic process in which the experiences of individuals with mental illness and personal biographies are meant to be integrated into care and treatment (Deegan 1988, Amering and Schmolke 2012). This approach has been decisive in the planning and shaping of psychiatric services in United Kingdom, Ireland, particularly Scotland, New Zealand and in many states of the United States (Amering and Schmolke, 2012). Dammann (2014) stated the impressive factors in the development of the concept as such; in particular consumer behaviors including criticisms of individuals with mental health disorders and services related to their relatives, the development of community-based treatment and care approaches in social psychiatry, patient rights and patient autonomy have become increasingly important and reflect on the law, combating labeling, criticizing only psychopharmacological treatment, the adoption of the triple (patient, patient and health staff) dialogue approach, the quality of life in chronic illnesses, the opening of the concept of resilience, change in behavioral therapies (self control and management in psychotic patients), Seligman's "learned helplessness" and attention-grabbing (mindfulness) and exotic-oriented approaches to empowering spirituality originating in the Far East.

### ***Elements of Recovery Model***

Although there are many attempts to identify the elements that constitute the recovery, there is no consensus on the issue yet (Dammann 2014). For example, Onken and his colleagues (2007) talk about the existence of individual and individual motivation factors in recovery. They defined them as hope, the right to self-determination, the meaning of life, the awareness and the potential. These include interaction with others (family, friends and health workers). These interactions help or hinder the ability to reach the individual's hopes and to act in the direction of his or her own determination, to negotiate when necessary, and to create meaning and purpose in life seeking. (Onken et al. 2002). The element of hope, an indispensable part of recovery's concept, means that the individual tries and makes changes in ways in addition to new goals in the fight against disease (such as finding meaning in different areas of life through spirituality). With the possibility of a positive change here, it brings together the condition of taking control of the life that is upset with the diagnosis of the disease that is taken by the individual independently and actively involved in the healing process. In summary, recovery is a holistic approach that encourages participation in social life. All elements that can be called the quality of life of an individual must be included in the process (for example, the environment of the profession, the neighborhood or the place where he / she resides). Zuaboni et al. (2012) and Dammann (2014) describe the hope, meaning

and function of some of the elements of the recovery, namely control, self-determination, personal growth.

They pointed out the factors necessary to achieve all of these as dialogue based on mutual respect, acceptance that each person has individual characteristics, demanding calm and peace instead of power struggle, reducing damage and encouraging the patient to take responsibility for himself/herself.

Recovery, which can also be called recovery of something, is a complex journey that penetrates the life of an individual who does not follow a specific multi-dimensional sequence. All elements related to Recovery are interactions and initiatives between the individual and society (Onken et al., 2007).

### *Functioning of Model*

In a paradigm shift in the treatment and care of mental disorders, the Recovery model supports improvements such as positive attitudes towards the patient and confidence building, as opposed to the concept that the individual with mental disorders is untreatable and only accompanied. This trend towards Recovery has already moved into practice in the UK, New Zealand and Canada as a health policy. In the work of the model, that is to say in the Recovery-oriented work, regular team supervisors, workshops formed by the tripartite dialogue approach and discussion groups in which continuous exchange of views were made. It was aimed to increase self-awareness, self-efficacy and self-respect by motivating and motivating the patient to turn to individual power sources. Even in long-term psychiatric patients with continuous hospitalization stories, it was observed that positive results were obtained with Recovery-oriented studies (Schrack and Amering 2007). What has been done here is to awaken the hope of the healing of the patient so that he can discover new ways to make his life a meaningful life for himself. The purpose of the therapeutic relationship is to make a joint decision by meeting with the patient's experiences and viewpoint. Another change is the optimal functioning of the model to develop resistance to stigmatization in the patient (anti-stigma) (Sibitz 2013).

**Table 1. Recovery model (NHS 2008)**

<b>Modules</b>	
Module 1	Understanding Recovery
Module 2	Gain insight to develop a recovery-oriented initiative
Module 3	Self-control
Module 4	Individual-specific support
Module 5	Responsibility and risk sharing
Module 6	Participation in social life

The Recovery Learning Material (NHS Scotland 2008) was created in collaboration with the National Health Service (NHS), the Scottish Recovery Network (SRN) and the National Education for Scotland (NES). This improved material focuses on the international research literature on recovery and the findings from various sources as well as patient experiences. The generated training material "Recovery in Practice" assists the nursing staff in guiding and developing their skills in support of Recovery-oriented work as well as other members of the team working on the field. At the same time, Recovery-oriented achievements in patient relatives and peer group work are

enhanced (NHS 2008). "Application Recovery" is a modular structure (Figure 1). Each module can be handled and applied alone. It is recommended to follow the first three modules in order. Each module is created in a similar way. Below you will find brief information on the six modules.

Module 1: Understanding Recovery; It examines the recovery approach more deeply. The main purpose here is to understand what each individual on the team means to the recovery in the recovery journey of the patient.

Module 2: Gain insight to develop a recovery-oriented initiative; how individual values, opinions, experiences are used in a useful form on the basis of Recovery Orientation in professional relations. In psychiatry units, the definition of professional work is examined in daily work, and the ways to work in constructive and productive work are defined.

Module 3: Self-control; composes center in Recovery. The topics examined here are; peer support, self-care, self-control barriers in psychiatric institutions, and roles that professionals can play to overcome these obstacles.

Module 4: Individual specific support; individual-centered work. All planned initiatives are made person-specific in the Recovery process.

Module 5: Responsibility and risk sharing; an important element in Recovery . Here risk taking is examined in different ways.

Module 6: Participation in social life; the importance of being social and how to adopt an inclusive approach to this issue.

Recovery approach necessitates the individualization of any point of focus (especially in the fourth of the modules created). It is important to raise awareness about the patient's subjective aspects, religious and spiritual life plans. This issue is often neglected (Dammann 2014). At this point, there are many interaction points with anthropological and psychotherapy based psychiatry (Viktor Frankl, Maslov's basic needs hierarchy, Rogers speech therapy, neopsychoanalytic psychosis psychotherapy). Jaspers (1913), in his book "General Psychopathology", deepens the distinction between "understanding" and "expressed" and states that the subjective reflection of the sick patient spiritual world must be centralized individually. For example, individual pharmacotherapy has become a necessity for both the psychiatric services and the recovery movement today. Dammann (2014) emphasizes that each module will have a different validity in practice, and says that for specialist nurses working in the field of psychiatry, especially modules 3 and 4 contain a number of concrete indicators to work with and assess the patient (self-control, such as helping to make decision-making skills and individual plans on their own.

## Measuring Tools Enhanced for Model

The measurement tools for Recovery reflect the scope and feature of the approach that is still evolving. Recovery's emphasis on the concept of treatment and care that highlights the individual and the process-oriented individual values and goals-is meaningful for the newly developed measurement tools (Slade 2012). In summary, the cooperation between researchers and non-researchers with their own experience and the participation of stakeholders are preconditions for the development of measuring instruments in this field.

Many of the rapidly growing activities of Recovery-related scientific research can be found at [www.power2u.org](http://www.power2u.org). The most commonly used measurement tools are; The Recovery Assessment Scale (Corrigan et al., 1999), the Recovery Process Inventory (Jerrell et al., 2006), and the Recovery Attitudes Questionnaire (RAQ-the Recovery Assessment Scale) Borkin et al., 2000), Recovery Stages (STORI - The Stages of Recovery Instrument (Andresen et al., 2006) and Recovery Forms Questionnaire (RSQ - the Recovery Style Questionnaire (Drayton et al 1998). The brief information on measurement tools are as follows;

1. Recovery Assessment Scale (RAS): The scale, developed as part of a research project, has 41 items (Corrigan et al., 1999). Short forms are also used. Five factors were found in the analysis. These are; personal confidence and hope, requesting help, goal and achievement orientation, do not trust others and unable to control symptoms of disease.
2. Recovery Process Inventory (RPI): It consists of 22 questions (Jerrell et al., 2006). There are six factors, fear and despair, attachment to others, dual relationships, living home, hope and self-care.
3. STORI -The Stages of Recovery Instrument): It measures various phases related to the recovery process (Andresen et al., 2006). As a result of the analyzes made, the existence of five universes has been determined. These are; psychological moratorium (withdrawal, loss, despair), awarenessn (nothing is lost, it is possible to maintain a happy life), preparation (identifying strengths and weaknesses in terms of recovery, starting to work on skills and abilities for Recovery), reconstruction (positive self esteem, goal setting, taking control of your own life) and growth (fully experiencing life, creating individual goals, combating disease, psychological stability, positive self-esteem) (Andresen et al., 2006)..
4. Recovery Attitudes Questionnaire (RAQ): It consists of 7 items. It has two factors named as "Recovery is possible and requires believing" and "recovery is difficult. It differs among people "(Borkin et al., 2000).
5. Recovery Style Questionnaire (RSQ):A 39-point scale was developed to measure Recovery in psychotic patients. As a result of the analyzes, four improvement styles were found. These are; integration, mixed picture where integration is predominant, mixed picture where stiffness is dominant and stiffness (Drayton et al., 1998).

## **Application of Recovery Model to Community Mental Health**

Since community mental Health studies in Turkey do not have a history like in the United States and Europe, there has not been enough scientific data in Turkey except for a few research articles on the subject. It is obvious that moving recovery model to application areas will cause difficulties in discussing it. In addition, community mental health and practices can be understood as the institutions where community aid organizations and the team working in the field provide treatment and care services that focus on collaboration between patient and patient relatives. This understanding prevents the desired level of community mental health services (Eikmeier et al. 2017). In spite of these obstacles, the Recovery Movement from English-speaking countries over the past decade has become more and more important in the provision of mental health services

in German-speaking countries, and the main point is that the approach to reducing the symptoms of disease has started to be abandoned. The aim of the model is to develop a meaningful, hopeful and self-determined life with a positive identity and social role (Self Recovery), by removing the patient from ongoing symptoms or disturbances and from patient role limitations (Amering and Schmolke 2012).

Bilge et al. (2016) found that a quarter of the employees were formed by a nurse group in their profile studies on Community Mental Health Centers. It would not be wrong to say that the group has played an important role in the quality of the services offered at these centers and will continue to play in the future. As a matter of fact, Zuabonu and Schulz (2013) define Recovery as an opportunity for the development of psychiatric nursing. According to them, the use of Recovery psychiatry in treatment and care by nurses in the field of practice is an opportunity to present patients with a "conceptual framework of a multi-faceted professional". Zuaboni et al. (2012) stated that Recovery model has a qualified conceptual structure that can be used by various professional professionals for patients against psychiatric care for years.

Community mental health centers provide effective treatments for patients with chronic mental disorders to improve their individual function within the framework of the community mental health model, provide psycho-social support services, follow-up and treatment environments, overlap with the recovery vision, where services are required to be offered (içel et al., 2016). Anthony (1993) says that with every service offered to the individual in the recovery-oriented mental health system, the individual's inability to work and the inability to perform the role of the individual in society have become disadvantaged because of the failure of the individual's function, and the situation of limiting the individual's opportunities has been examined.

The preconditions for moving the recovery model to the application areas of community mental health services are the patient's participation in the treatment, the right to self-determination and the opposition to discrimination. According to Knuf and Brides (2008), some professional behaviors are needed to function in individuals with mental health disorders. The current improvement in the patient is that he believes in the current power that may be useful and in no way enter into an additional power demonstration.

The main point in recovery applications is the ability to establish relationships that are formed within the framework of respect that the patient is really interested in, recognized as an individual, and whose experience is taken seriously. Although the approach requires close proximity to the patient, the relationship between the individuals should be established between "overloaded" and "completely released" in the study with recovery, paying attention to the need for countertransmission. Kelly and Gamble (2005) indicate that there are major differences between health workers and patients in terms of treatment and care goals. While patient individuals demanded free decision-making, access, legal representation, and self-help, psychiatric institutions were stuck in approaches focused on monitoring the patient's individual's treatment on the main axis and on the structuring of daily life. It is recommended that nurses communicate more with their patients and their relatives in order to address the differences between them and this form of communication.

It is questioned here whether the Recovery model is actually a new model for Milieu therapy for the nurse working in the community mental health field. It is important



for milieu therapy to provide patient involvement, to build mutual trust, to take care of what is happening in the outside world, to daily activities, and to everyone's mindset. It was structured according to the needs of the institution with its therapy, reflective, protective, ie a kind of artificial family. The expected changes for the patient individual and team members are as follows. Patients say that treatment has become much more exhausting for them, and above all, it is a greater personal responsibility. At the same time, however, they define themselves as bringing greater benefits than their old counterparts. Patients may feel that they are "less" in control of the team members, ie the patients have moved into a more effective position ("Patients start to tell us what to do about them (Burr et al. 2013)." Conclusion: Of course, this power struggle should be monitored and the time the anarchic elements begin to increase should be carefully followed. However, it is also explained that after the first stage of motivation, patients (service users) exhibit "more passivity and a tendency to be under the influence of others" (Burr et al., 2013). The changing near distance in the communication with the patient must be questioned repeatedly and critically. For example, patients with a personality disorder need a different "professional distance" than people who have a psychosis or addiction disorder. Recovery as a general attitude is a process that contributes to the development of health care workers, only partially, in a multidisciplinary team (eg special therapists or art therapists may play an inhibiting role in this development, as they exhibit different behaviors). A common groundwork is the time-consuming process of getting support at every level. Recovery should not be allowed to mean that players on the team are left idle. In group interviews with patients, it should be questioned what effect the patient has on the Weekly plan of the service concept, which is organized as autonomous and gives the patient the right to speak (Delaney 2009).

Amering and Schmolke (2007) report that health professionals generally expect compliance with ill patients. This compliance process is defined as a situation in which patients show unconditional co-operation and do not need to be asked for their opinions in taking decisions. For example, in the decision-making phase of a psychiatrist who recommends medication, the patient may want to be active about which medication may be better for him. Because the sick individual is an expert in his or her recognition. There is a need for a participatory model in order for the expert role of the patient to be involved. This means both trials dialogue treatment agreements for both the psychiatrist and the patient wanting to write the pills and new roles such as participant decision making. The triologue, that is, the triple dialogue, is a condition that means that the patient and the patient are closely connected with the health personnel. In this sense, organized psychosis seminars serve to realize these meetings. In the process of moving the recovery movement to the application areas, the focal point was psychosis patients. For this reason, the community mental health team members may think that this approach is not suitable for patients who do not have psychosis diagnosis. However, research has also shown that Recovery has positive findings in use in other non-psychotic clinical populations (Couturier and Lock 2006, Friesen 2007, Sass 2009, Katsakou et al 2012, Daley 2013, Slade et al 2014).

Schrank and Amering (2007) say that in Recovery, hope is a personal belief. According to them, hope expresses the individual's commitment to being healthy. Recovery is not to frustrate the individual's intent or to meddle in a futile attempt. On the contrary, it should not be forgotten that it is always possible to improve because most of the

mental health disorders do not anticipate disease progression (Amerin and Schmolke (2007), but it is almost impossible for the individual to return to the level of functionality before the disease has developed, the recovery model is able to integrate the patient into the life of this experience in the future (as an individual who is diagnosed with schizophrenia hears the other person talking on the radio during the psychosis). The experience of the patient should not be suppressed, but rather the environment should be established for the patient to speak, as well as the changes that occur with psychosis. Thus, the aim here is not to reach the pre-disease state or pre-experience situation, but rather to examine the experience. It should also be noted that the explanatory models, especially those made by patients, are likely to affect the course of the disease. Such models are useful for showing how the experience from the patient's own perspective can be explained and how they will deal with it.

Individuals with mental disorders go through different stages of recovery. Individual stages do not develop linearly nor support each other's mutual functionality (Amering & Schmolke 2007). Moving this approach to practice is also desirable for other team members. The idea that the Recovery model will only be implemented by a nurse is as misguided as "it can be intervened if the problems are identified with the elements of medical development (with specific disorders, treatment manuals, psychiatric books)". Here, contrary to the situation, besides the nurse, other team members (such as expert psychiatrists and psychologists) need to recognize the new concepts of social psychiatry. If this is the case and the approach is only carried out by the nurses in the field of practice, the patient may be damaged. This process, as often seen in psychiatry and psychotherapy, can lead to an unnecessary power struggle within the team, which causes the patient to have problems in understanding his own illness.

Recovery is not even fully defined by its implementers. The model is not primarily a theory or a specific initiative. It is the personal journey that an individual makes towards a specific goal determined by the individual in his / her life (Farkas 2007). It would not be wrong to say that Recovery is more than orientation to remission. Dammann (2014) stated that in the studies related to recovery, the model is an approach that helps individuals with mental problems to learn their own lives as much as possible despite their limitations and problems. It means that it is a controversial issue whether this approach will undertake the role of healing in this process. A review by Davidson (2010) found that adult patients were trying to preserve their normative role as much as possible despite mental disorders.

The approach is to rename the old nursing interventions, albeit in part. For example, by analyzing patients' leisure behavior, attempts are sought to ensure that health workers can communicate with patients more effectively in order to prevent them from being socially isolated. In the Recovery approach, "individual centeredness" (establishment of the patient's living spaces, ensuring continuity, multidisciplinary and dynamic process) is shared with modern, social psychiatry care philosophy. Prior to the recovery approach, expert nurses prioritised mutual respect and valuing the other side as the basic elements in their nursing initiatives. This attitude in the past coincides with the fact that the model takes the individual to the forefront and makes the decisions taken effective. Delaney (1997) recommends giving up Milieu therapy in psychiatric care and defining concrete individual interventions. Recovery is currently in the research phase, so Anthony (1993) says that Recovery should be considered as a supportive approach

rather than an alternative to treatment. For the Recovery approach that attaches importance to team work, ways should be developed where different perspectives can be integrated for the same purpose. In the future, more concrete initiatives should be developed and explored in the context of the recovery process and the resulting results.

Recovery is the way of life and the attitude and process to protect it. Psychiatric nurses can help to implement recovery-oriented treatment and care vision in all areas of the psychiatric treatment and care system. It may be possible for this team to combine their roles and methods of working with recovery approach with their expertise and reflect them into practice. In the guidelines issued on community mental health centers, the team members working in these centers (2011) are responsible for giving psychoeducation to patients and their relatives. Recovery, which also means struggling with the conditions that prevent the patient from continuing his / her daily life with illness and disease, should be among the treatment and care practices recommended for psychoeducation as well..

## Conclusion

Recovery is understood as a positive change (Lang 2015), in spite of the limitations of the person with mental disability, to assist in personal development, to become self-confident and independent. First and foremost, it is important to believe that Recovery can help the process. Later, in the individual healing process, resistance must be gained through, for example, recognizing their strengths and weaknesses, understanding their illness and therapeutic options, improving their ability to cope, or socializing (Schrank and Amering 2007, Slade et al 2011). Here the empowerment of the individual is ensured by activating appropriate resources and actively supporting the search for support (Lang et al. 2015).

It has been found that being active in the social field increases the quality of life and self-esteem of the individual (Corrigan et al. 1999). For this reason, in order to support these processes, healing-oriented approaches should be a part of the therapeutic approach to the patient with mental disorders in our country, as in some countries.

Recovery approach is likely to contribute to the development of mental health and psychiatric nursing practices by focusing on the available resources of the individual with a mental disorder and improving the patient nurse relationship. As a result, Recovery can be summarized as nursing therapy in which the acute conditions of the disease are alleviated and / or the individual improves life satisfaction by adapting to the situation in question. Community mental health services have advantages such as "socialization of the individual without being centered on the disease" in bringing this approach to the application areas. The implementation of Recovery will be possible through regular in-service training for other team members to support a new perspective on community mental health practice and target areas.

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No conflict of interest is declared related to this article.

**Submission date:** January 7, 2018 - **Accepted:** January 29, 2018

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