

Development of a recovery oriented mental health care programme for nurses in Botswana

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Thesis layout

The research project “**Development of a recovery-oriented mental health care programme for nurses in Botswana**” was conceptualised and conducted by the PhD candidate Kebope Mongie Kealeboga. She was under the supervision and mentorship of Prof Eva Manyedi and Prof Salaminah Moloko-Phiri. The supervisors guided the research project.

Section 1: Overview of the study

This study followed an article format and report on the developed recovery-oriented mental health care programme for nurses working in (ROMHP) in Botswana

Section 2: 6 Manuscripts

Recovery-oriented programmes to support the recovery approach in mental health in Africa: Findings of PhD: A scoping review (*Published in The Open Nursing Journal*)

Assessment of nurses’ knowledge of a recovery-oriented mental health care approach using the Recovery Knowledge Inventory: Findings from a developing country (*To be submitted for publication*)

Perceptions of nurses working in mental health services regarding the recovery-oriented mental health care approach: Empirical Research Qualitative. (*Published in Nursing Open Journal*)

Nurses’ perceptions on how recovery-oriented mental health care can be developed and implemented. (*Published in Nursing Research and Practice Journal*)

Development of a conceptual framework for a recovery-oriented mental health programme for nurses in Botswana (*To be submitted for publication*)

Recovery-oriented mental health care programme for nurses in Botswana (*To be submitted for publication*)

Section 3: Conclusions, Limitations and Recommendations

Appendices

Declaration

I, Kebope Mongie Kealeboga, student ID number **37551906**, declare that “**Recovery-oriented mental health care programme for nurses in Botswana**” is my original work, and I am submitting it for a degree of Doctor of Philosophy in the School of Nursing Science, Faculty of Health Sciences at the Mafikeng Campus of the North-West University, and I have acknowledged all the sources used in this work.



28.11.2023

Signature

Date

Kebope Mongie Kealeboga (PhD Candidate)

This thesis on **Recovery-oriented mental health care programme for nurses in Botswana** has been read and approved for submission in article format at the Mafikeng Campus of the North-West University by:



28.11.2023

Prof. M.E. Manyedi (Promoter)

Date



20/03/2024

Prof. S. Moloko-Phiri (Co-Promoter)

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Abstract

Mental health issues and mental illness are a global burden, and many people continue to be affected by the responsibility of mental illness directly and indirectly. Therefore, researchers and mental health experts continuously make efforts to deal with mental health issues and support people living with mental illnesses. One such move is the adoption of the recovery-oriented mental health care services, which is more evident in most Western countries. However, Africa is left behind in adopting more evidence-based mental health programmes. In addition, most countries are still operating with none or old mental health policies. Therefore, this study was conducted to develop and validate a recovery-oriented mental health care programme for nurses working in mental health facilities in Botswana. The study received ethical clearance from the North-West University Research Ethics committee and the Ministry of Health and Ethics committee.

The study adopted a convergent mixed-method approach, and it was conducted in three phases; the empirical, development and validation. Phase one included the situational analysis, which involved the quantitative and qualitative phases of the scoping review. The scoping review was conducted to find out the origins of the recovery-oriented mental health care problems and where they have been mostly implemented in the hope of finding gaps for further research. The quantitative phase used the Recovery Knowledge Inventory (RKI) scale to assess the knowledge of nurses working in mental health facilities of recovery. Finally, the qualitative phase explored and described the nurses' views of recovery, focusing on how they view the meaning of recovery and how a recovery-oriented mental health care programme for Botswana can be developed and implemented.

The findings of phase one of the study were classified according to the Practice Oriented Theory of Dickoff, James and Wildenbach and concept classification was used to develop the conceptual framework for the programme in phase two. Phase three used the developed conceptual framework to develop the programme. The programme showed the involvement of all stakeholders, such as government, mental health facility managers, health care workers, people living with mental illness, community leaders, traditional healers, herbalists, and spiritualists, as necessary to a functional recovery-oriented mental health care programme. In addition, the stakeholders viewed having funds, qualified mental healthcare experts, and policies and standards in place as elements that can facilitate the recovery programme.

The developed programme was validated by a health specialist who saw it as relevant for the setting, believed it could boost the recovery of people with mental illness, and recommended it for use. The programme adds to the literature on recovery-oriented practice in Africa.

Keywords: Mental illness, Recovery, Recovery-oriented mental health care approach and recovery-oriented mental health care programmes.

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List of abbreviations

APA:	American Psychiatric Association
CARe:	Comprehensive Approach to Rehabilitation
ACT:	Assertive Community Treatment
HF:	Housing First
ICN:	International Council of Nurses
ISMHU:	Intermediate Stay Mental Health Unit
MHS:	Mental Health Services
MMAT:	Mixed Methods Appraisal Tool
MoHW:	Ministry of Health and Wellness
NWU-HREC:	NuMIQ and North-West University Health Research Ethics Committee
ODR:	Opening Doors to Recovery
PCP:	Person Centered Therapy
RKI:	Recovery Knowledge Inventory
PARC:	Prevention and Recovery Care
PCCP:	Person Centered Care Planning
PRISMA:	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
ROMHCA:	Recovery oriented mental health care approach
ROMHCP:	Recovery oriented mental health care programme
ROP:	Recovery-Oriented practice
SMI:	Serious mental illness
SOP:	Standard of operation
WHO:	World Health Organisation

WRAP: Wellness Recovery Action Plan

SECTION ONE: OVERVIEW OF THE STUDY

1.1 Introduction

This study details the developed recovery-oriented mental health care programme (ROMHP) for nurses working in Botswana. Recovery is a relatively familiar term for disease diagnosis and prognosis in health and healing literature. Recently, the term has drawn interest from mental health professionals and researchers in the field as they try to align it with the recovery of patients from mental illness (International Mental Health Collaborating Network, 2020:1). This study explored how nurses in Botswana perceived recovery-oriented mental health care approach to the care of clients with a diagnosis of mental illness. Based on their perceptions and with the help of the literature, a Recovery Oriented Mental Health Care Programme (ROMHCP) for nurses in Botswana was developed. This chapter outlines the background, problem statement, research objectives and questions, theoretical assumptions, methodological assumptions, research methodology, ethical considerations, thesis layout and conclusion.

1.2 Background and rationale for the study

Recovery-oriented mental health care approach (ROMHCA) is the provision of person-centred care which ensures individuals live a meaningful life through the inspiration of hope, collaboration, engagement, and family involvement in their care as they recover from mental illness (World Health Organisation (WHO), 2019:19). The areas of practice that support the ROMHCA conceptualise it as mental health facilities whose primary role is to support patient initiatives in their care (Jacobs, 2018:118). Furthermore, the importance of family support and significant others, including patient empowerment, are paramount in ROMHCA (Kealeboga et al., 2023: 8; Department of Health Australia, 2013:15). The ROMHCA calls for providing clients care that is full of hope for the future and, most importantly, recognising that patients' recovery is a personal journey and it is not the same for all (Shera & Ramon, 2013:17; Tse *et al.*, 2013:155).

The ROMHCA was influenced by the discovery of psychotropic drugs, giving hope to those diagnosed with mental illness and those caring for them (Leamy et al., 2011:445). Following the discovery of the psychotropic drugs regime, many patients worldwide were deinstitutionalised and reintegrated into communities upon the realisation that symptom remission could be possible if patients took their treatment as prescribed (Bilir, 2018:564). The deinstitutionalisation of patients was adopted in order to facilitate holistic recovery of patients as they would be cared for in a familiar environment (WHO, 2014:17). Research evidence suggests that being cared for in a family gives clients a sense of belonging and promotes recovery (WHO, 2014:17). In addition, patients enjoy equal opportunities in the society.

According to Slade and Longden (2015:10), evidence indicating that people diagnosed with mental illness can recover also emerged. Similarly, mental health consumers started openly critiquing the biomedical model care approach for people diagnosed with mental illness. In addition, the biomedical approach, which has been used to manage patients diagnosed with mental illness, has been criticised because it seems dehumanising, service-oriented, oppressive, stigmatising and robs people of their rights (Kwok, 2014:129).

Researchers and individuals who considered themselves recovered started advocating a client-centred and recovery-oriented mental health service delivery (Anthony, 1993:533; Deegan, 1988:16). Additionally, mental health consumer advocates and researchers working from Western countries such as the United States of America, the United Kingdom, New Zealand, Australia developed an interest in the mental health recovery concept (Tse *et al.*, 2011:155). However, to date, there is not yet a universally acceptable definition of recovery due to individualistic descriptions of the term by clients and theoretical conceptualisation of the term by different professionals in the mental health field (Dell *et al.*, 2020:21; Gilbert *et al.*, 2013)

Although there is an acknowledgement of a lack of agreement on what recovery entails for mental illness, the term has gained popularity. It is used by mental health professionals daily when discussing patients among themselves. As a mental health nurse specialist and a lecturer at the University of Botswana, the researcher has personally witnessed it in her interaction with nurses in the mental health field. Moreover, various countries, particularly the Anglophone communities such as the United Kingdom, Northern Ireland, North America, Europe, New Zealand and Australia, have aligned their policies and strategies with principles embedded in the mental health recovery concept (Gilbert *et al.*, 2013:2; Parkin, 2016:24; Slade *et al.*, 2014:12).

The United Kingdom (UK) originated a no health without mental health strategy (Parkin, 2016:24). The strategy has six objectives, including one which states that people with mental health problems will recover. In 2008, the Australian government adopted the recovery concepts (Department of Health, 2009:22). The policy envisions "a mental health system that enables recovery and detects illness early and ensures that all Australians with mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community". Moreover, the American government adopted the New Freedom Commission on Mental Health report commissioned by their president that positioned recovery as a cornerstone of federal mental health policy (New Freedom Commission 2003:1).

Asian countries, particularly China and Hong Kong, have also embraced the ROMHCA pioneered by Western communities. However, a literature review on the possibility of ROMHCA in Hong Kong revealed that adopting recovery as the best practice in mental health in Asian countries was more of a

theory than practice. It is believed that the paternalistic nature of the Asian governments, especially China, is responsible for the slow progress in the successful implementation of recovery-oriented mental health programmes (Siu *et al.*, 2016:2). This suggests that the Chinese government does not fully support the recovery concept even though the policy endorses it. On the other hand, Arab countries are still restructuring their mental health services to embrace the ROMHCA through the help of the WHO to align their mental health policies to best practices that promote recovery principles (Habhab, 2018:4).

In Africa, ROMHCA services still need to be applied (Bila, 2019:344). Most African countries still need mental health policies (Maiga & Eaton, 2014:71). The lack of policies alone may imply that mental health matters and management remain less prioritised in Africa and, therefore, still need to catch up in implementing the latest treatment modalities. A survey of the mental health care services of five Francophone African countries in West Africa, Benin, Burkina Faso, Côte d'Ivoire, Niger and Togo, by Maiga and Eaton (2014:71) showed that there were signs that the mental health systems were still under-resourced although there was still hope. Only Benin had a mental health policy in place among the five countries, even though it has not yet been fully endorsed. Since ROMHCA is generally new in most countries, especially in Western African countries, one can assume that it is yet to be adopted because several do not even have mental health policies. Traditionally, treatment modalities are aligned with the biomedical approach as procedures to care are more on symptom remission and overuse of traditional medicine.

Similarly, in Southern Africa, ROMHCA in mental health is not yet implemented. A reflection on mental health policy and legislature development and implementation in Malawi showed that the lack of mental health policy compounds the country's mental health service delivery. It is more dependent on the biomedical model approach in the treatment of patients (Chorwe-Sungani, 2015:35). These findings are consistent with the report of a study conducted in South Africa, which concluded that there was a general lack of knowledge towards ROMHCA and the biomedical model remained dominant in mental health services (Bila, 2019:17). The study further indicated that traditional beliefs significantly influenced the way mental health care is provided in the country. In Botswana, ROMHCA is unknown and therefore has not yet been implemented. The care of people with a diagnosis of mental illness is mainly focused on symptom management (Sidandi *et al.*, 2011:67). Findings of a study from Botswana indicated that patients sought help from traditional doctors before visiting a mental health facility (Seloilwe & Thupayagale-Tshweneyagae, 2007:173).

Although there are apparent differences in mental health policy development and implementation in Africa as compared to the Western countries, the individualistic nature of mental illness recovery conceptualised by these Western communities has been found to be challenging to mental health care professionals in terms of translating evidence-based practice into clinical practice (Le Boutillier *et al.*,

2015:2; Slade et al., 2014:12). In order to address these challenges, frameworks, programmes, and guidelines have been developed to guide practice (Department of Health, 2009:22; Leamy et al., 2011:449). Most available recovery-oriented mental health programmes (ROMHCP) or models were developed from research from developed countries. The University Of Wollongong Illawarra Institute Of Mental Health developed the Collaborative Recovery Model (BRM) in Australia in 2006. The model aims to assist people living with a diagnosis of mental illness. It is built on the principle that ROMHCA mainly includes recognising recovery as an individual process and appreciating the role of the client support system. The model was built using the available literature on recovery, service user involvement and the positive contribution of psychology to human behaviour (University Of Wollongong Illawarra Institute Of Mental Health, 2020:2).

The Recovery Focus (REFOCUS) programme is an intervention programme that was developed following several studies which were geared towards supporting mental health services to be recovery-oriented. The REFOCUS intervention manual comprises strategies for recovery (Bird *et al.*, 2014:2). This REFOCUS intervention programme originated in England. The primary purpose of the REFOCUS programme was to pave the way for community mental health service to be recovery-oriented through the promotion of working relationships between staff and mental health service users (Bird & Slade, 2012:2). The other primary focus of the REFOCUS intervention was to change the staff attitude and behaviour towards supporting the personal recovery of people undergoing recovery from mental illness. Therefore, the REFOCUS intervention's emphasis is more on staff's understanding of the values attached to patients' treatment, strengths, and goals as they go through their recovery.

All efforts to understand what recovery should constitute have been made through programmes and policies. However, despite this effort, there is still a lack of universal acceptance of what recovery-oriented mental health care should entail among mental health professionals (Gilburt et al., 2013:2; Slade et al., 2014:12). Literature has mined two broad parallel definitions of recovery; clinical based and person/client based (Dell et al., 2020:2). The two definitions are parallel, but their interdependence cannot be ignored.

The clinical definition of recovery assumes that mental illness is a physical disorder, just like any other medical condition whose diagnosis is based on mechanical tests. Historically, biomedical interpretation of disease has assumed that mental health conditions, like any other diseases, can be diagnosed, labelled, and treatment approaches should target symptoms (Lebowitz & Appelbaum, 2019: 555). As a result, more emphasis is put on clinical diagnosis by a psychiatrist, compliance with treatment, and remission of symptoms. Moreover, it is expertly opinionated rather than considering the client's views (Kwok, 2014:129). The form of recovery where the emphasis is on symptom

remission is seen by many as the focus of most psychiatric settings worldwide, especially in Africa (Kwok, 2014:131; WHO, 2014:12).

The person/client-centred definition of recovery is underpinned by the belief that a person diagnosed with mental illness can master the challenges posed by the illness and successfully re-establish a sense of purpose and drive to live, love, work, and participate fully in society despite the diagnosis (Rennick-Egglestone, Callard et al. 2018:2; Department of Health, 2013:17). This implies that recovery is focused on not only symptom reduction but also the improvement of quality of life of the individuals undergoing recovery. Notably, the person-centred approach model of recovery does not emphasise the need for pharmacological treatment for recovery to take place (Slade & Longden, 2015:8). To support this observation, the review of literature on characteristics of recovery indicated that 97% of reviewed studies showed recovery could occur without professional intervention (Leamy et al., 2011:448). This evidence suggests recovery from mental illness depends on treatment from mental health facilities and the commitment to recovery from those diagnosed with mental illness (Slade & Longden, 2015:8).

This study adopted the most well-accepted definition of recovery in recovery research, which is aligned with the person-centred approach (WHO, 2019:3, Callard et al., 2018:2). “Recovery is about regaining control of their identity and life, having hope for their life and living a life that has meaning for them whether that be through work, relationships, spirituality, community engagement or some or all of these.” Within this framework, recovery does not mean “being cured” or “being normal”, instead, it is about gaining or recapturing meaning and purpose in life and being empowered to live a self-directed/determined and autonomous life, despite any emotional distress that a person may have lived through or is currently experiencing” (WHO, 2019:3). This definition implies that recovery from mental illness entails more than adhering to treatment but a recognition that even without a cure there is still life. Recovery is recognised as a personal journey and is believed to happen with or without medication (Jacob, 2015:119). The significant tenets of recovery identified by patients and researchers on recovery research are hope and optimism for the future, finding meaning in life, empowerment, and, most of all, taking responsibility for own recovery (Lavalley & Poole, 2010:279).

Critiques believe that the recovery concept and programmes could have a more Western influence, as evidenced by more consumer advocates emanating from the Anglophone world with indigenous people having little say (Lavalle & Poole, 2010:272; Slade *et al.*, 2014:17). Additionally, ROMHCP originates and have been conducted from the western countries (Kealeboga et al., 2023a: 10). Therefore, according to Lavalle and Poole (2010:272), there is a need for the recovery concepts to consider the cultural aspect of African people as it can enrich this approach of care to people diagnosed with mental illness.

Similarly, a special report in 2014 by multi-international pro-recovery researchers from the United States of America, England, Australia, New Zealand, Canada, Austria, and Hong Kong calls for a more culturally tailored ROMHCP (Slade *et al.*, 2014:17). Furthermore, a more current systematic review and meta-analysis literature reported that most of the ROMHCA are from Europe, United States of America, Canada, Australia, New Zealand, and Netherlands and has been utilised in those countries (Eiroa-Orosa & Garcia-Miers, 2019:724).

There is a consensus in the literature that singles out the cultural competence of the care provider as an essential aspect when it comes to the provision of mental health care to diverse communities (Habhab, 2018:4; Rice & Harris, 2021:e65). It is believed that therapists who are more culturally sensitive are more likely to give positive results than those who are not (Rice & Harris, 2021: e65). This belief is emphasised by a call by WHO for research and collaboration on ROMHCA it should be also informed by culture (Campos *et al.*, 2017:312).

The Africans believe more in their culture, and it is well documented in the literature that people with a diagnosis of mental illness usually seek help from traditional doctors before seeking clinical health care (Abo *et al.*, 2019: 109; Bila, 2019:17). In Botswana, the trend is that people first consult traditional doctors before they can seek clinical health care, and the assumption is that health workers are aware of this pattern (Abo *et al.*, 2019; Seloilwe & Tshweneyage, 2007:173). Therefore, the focus of this study was healthcare workers and, to be precise, nurses as they primarily receive the patients in most mental health facilities due to the high numbers in the healthcare sector in Botswana (Sidandi *et al.*, 2011:67). It is critical to understand how they appreciate recovery-oriented mental health approaches in mental health and what they think a recovery-oriented mental health care approach should entail. Therefore, developing and validating a ROMHCP for nurses in Botswana informed by indigenous data is imperative.

1.3 Problem statement

Context plays a significant role in interpreting disease and its management by particular individuals within different countries (Alves & Oliveira, 2018:184). In light of this view, Slade *et al.* (2014:17) emphasised the need for contextualising ROMHCPs. In addition, these authors recognised the importance of culture and infrastructure, such as budget, as crucial in how countries from the low and middle class might conceptualise ROMHCS and therefore advocate recovery-oriented mental health care approaches that are contextualised.

In Africa, the ROMHCA is yet to be unpacked following a call from Western countries that there is a need for recovery programmes and models to be contextualised, especially from a non-western cultural perspective (Slade *et al.*, 2014:17). Most African countries such as Benin, Burkina Faso, Côte

d'Ivoire, and Niger are still without mental health policies and recovery principles are not implemented even though deinstitutionalisation took place in some countries (Maiga & Eaton, 2014:71). Botswana is no exception with regards to lack of ROMHCA to support mentally compromised patients. According to WHO (2014:16), African low-middle-income countries still highly rely on institutionalising the patients despite evidence supporting the best mental health treatment approaches and the more recent ROMHCA. The same report recommends that mental health professionals be trained to accommodate change and adopt innovative and evidence-based treatment modalities that have proven to work, such as the recovery approach, hence this ROMHCP (WHO, 2014:31).

In Botswana, nurses are the leading mental health care providers due to a shortage of psychiatrists, an observation common in most African countries and the world at large (Becker *et al.*, 2019). The ratio of psychiatrists to a patient is approximately 1:9200, therefore making it difficult for psychiatrists to service patients timeously. Therefore, psychiatric mental health nurses or general nurses on admission are the first carers to assist most patients on arrival. Therefore, psychiatric mental health nurses are Botswana's pillar of mental health services (Sidandi *et al.*, 2011:67).

Nurses, in their daily interactions with clients, talk about "recovery," which the researcher has witnessed during her follow-up of students as their facilitator when they are attached to the hospital for their clinical practicums. However, the attachment to the meaning of recovery when they care for their clients is mainly on symptom reduction and compliance to treatment. Therefore, there is a need to explore nurses' understanding of the new approaches to care for clients with mental illness, mainly the recovery approach in mental health. Healthcare workers have attributed the failure to implement a recovery-oriented mental health care approach to a lack of knowledge of what it entails, a lack of support from management, and a lack of teamwork in mental health (Brooke-Sumner *et al.*, 2016:4).

This study focuses on nurses caring for clients with mental illness, both psychiatric mental health nurses and general nurses because they play a critical role in the recovery of patients as they are always the first and last contacts of patients in any healthcare setting. Furthermore, since nurses interact more with patients, it is assumed that if nurses know the best practices in mental health, the patients are likely to receive improved care. Therefore, it is paramount to explore and describe how nurses caring for clients with mental illness understand the meaning of recovery in the context of mental health. Most importantly, with the help of literature, develop a ROMHCP for possible transformation to recovery-oriented mental health care.

1.4 Research aim

The study aimed to develop and validate a recovery-oriented mental health care programme for nurses working in mental health care services in Botswana.

To achieve the purpose of the study, the following questions were asked:

1.4.1 Research Question(s)

1.4.1.1 Phase 1: Empirical Phase

- **Step 1:** What is the available literature review of recovery-oriented mental health care programmes?
- **Step 2:** What is the knowledge of nurses working in Botswana mental health services regarding the recovery-oriented mental health care approach?
- **Step 3:** What are the perceptions of nurses working in mental health services regarding the recovery-oriented mental health care approach?
- **Step 4:** What should a recovery-oriented mental health care programme for nurses working in mental health care services in Botswana entail?

1.4.1.2 Phase 2: Development Phase

- **Step 1:** How can a conceptual framework for a recovery-oriented mental health care programme for nurses working in mental health care services in Botswana be developed?
- **Step 2:** How can a recovery-oriented mental health care programme for nurses in mental health care services in Botswana be developed?

1.4.1.3 Phase 3: Validation Phase

- What will be the outcome of the validation of a recovery-oriented mental health care programme for nurses in the mental health care services in Botswana?

1.5. Significance of the study

To date, no study has addressed ROMHCA in Botswana. Additionally, no recovery-oriented mental health care programme has ever been developed to help guide mental health nurses in their care delivery in Botswana. The study aimed to develop and validate a ROMHCP for nurses working with people with mental health conditions in Botswana. The study's recommendations could provide the policymakers with more information on the ROMHCA, making it a baseline for developing appropriate in-service education for nurses in the mental health care field. It may also close the gap in the ROMHCA literature in Africa and Botswana when caring for clients with mental illness.

1.6. Paradigmatic perspective

A paradigmatic perspective is how the researcher views and understands research (DeCarlo, 2020:1). According to Cresswell and Poth (2018:64), the pragmatism approach does not commit to a single form of reaching reality but looks at many ways of seeking the truth using many data collection approaches. This study's paradigmatic perspectives are meta-theoretical, theoretical, and methodological assumptions.

1.6.1. Meta-theoretic assumptions

According to Allana and Clark (2018), meta-theoretic assumptions refer to broad claims that underpin research and practice. It is more like the broader claim the researcher has about the nature of reality. The researcher's view of reality influenced the meta-theoretical assumptions of this research. The researcher's view of reality is discussed under ontology, epistemology, and methodology.

1.6.1.1. Ontology

Ontology is how the researcher views nature (Polit & Beck, 2018:9). The researcher believes that reality is relative and is subjected to many interpretations and therefore calls for multiple research perspectives to conclude it. Consequently, the researcher used a mixed methods approach to establish reality in this study.

1.6.1.2. Epistemology

Epistemology is the relationship between the researcher and the study participants (Polit & Beck, 2018:9). The researcher suggests that reality can be both observable and subjective to interpretations. Therefore, it is vital to use different research approaches to conclude what reality is. Therefore, the researcher interacted with the participants in their settings as they described how they conceptualised recovery in mental health.

1.6.1.3. Methodology

Research methodology describes and explains the research design and methods of gaining knowledge on a particular problem (Brink *et al.*, 2018; 187). Since the researcher believes that multiple realities exist, this study adopted a mixed methods approach to develop and validate a recovery-oriented mental health care programme using qualitative and quantitative methods to collect data. According to Schoonenboom and Johnson (2017: 108), "Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research

approaches (e. g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration.”

1.6.2. Theoretical assumptions

Theoretical assumptions for this research include a central theoretical argument and conceptual definitions of significant concepts used.

1.6.2.1. Central Theoretical Argument

The study explored recovery in mental health and developed a ROMHCP for nurses working in mental health care facilities in Botswana. The study was underpinned by Person-Centred Therapy (PCT) developed by Carl Rogers. Rogers proposed that human beings are "trustworthy, resourceful, capable and self-understanding and self-directed, able to make constructive changes and able to live effective and productive lives" (Corey, 2013:164). It implies that each individual has resources within themselves to achieve any desired goals, aspirations, self-directed behaviours, and attitudes. That can be achieved provided a facilitative and psychologically enabling environment is provided for such growth to blossom. He further asserts that a genuine, caring, non-judgemental, and supportive therapist can contribute significantly to clients' health and well-being. The PCT rejects the notion that the therapist knows it all during therapy but emphasises establishing a good therapeutic relationship between client and therapist, which can facilitate self-awareness and lead to a self-directed behavioural change in clients (Corey, 2013:164).

According to the PCT, there are three central attributes of therapists that, if practised effectively, can facilitate the self-growth of clients undergoing therapy, and they are: congruence or genuineness, unconditional positive regard, and accurate empathetic understanding. A therapist who is authentic, empathetic, and accepting can potentially catalyse clients to change their attitudes towards their illnesses and find resources within themselves to move towards their growth (Halter, 2018:32)

The main focus of the person-centred approach is the person undergoing therapy but not the problem that the person presents. The therapist's role is to provide a conducive environment for clients as they move towards self-discovery and actualisation (Corey, 2013:165). Understanding problems from the client's perspective, as they are the ones experiencing it can be instrumental to the establishment of a good nurse-client relationship (Halter, 2018:26). According to the PCT, this can be achieved if nurses display an attitude of acceptance, warmth, respect, and support towards their clients.

In this study, the researcher aimed to develop a recovery-oriented mental health care programme that is entrenched in the values in line with the PCT care proposed by Carl Rogers. The theory informs the base for conceptual definitions of the study terms, the development of the conceptual framework and

the programme. Through the developed conceptual framework that mapped the study from the literature and the merged results of the mixed method study, a ROMHCP was developed. The ROMHCP is based on the PCT's humanistic nature, as Carl Rogers proposed. A client centred ROMHCP for Botswana nurses will facilitate care provision that supports clients' personal growth and promotes participation and decision-making as they recover from mental illness (Eiroa-Orosa & Garcia-Mieres, 2019:725).

1.6.2.2. Conceptual definitions

The major concepts defined for this study are mental illness, recovery, recovery-oriented care, recovery principles, mental health recovery-oriented care programme, recovery-oriented mental health care approach, psychiatric mental health nurse, nurse, mentally ill patients, and psychiatric mental health facility.

Mental illness

According to American Psychiatric Association (2021:1), mental illness refers collectively to all diagnosable mental disorders and health conditions involving significant changes in thinking, emotion and/or behaviour, including distress and problems functioning in social work and family activities. For this study, mental illness is conceptualised as a collection of diagnosable mental health disorders that have the potential to heal as long as the mental health facilities provide the right therapeutic environment that is client centred.

Recovery

According to WHO (2019:3), "Recovery is about regaining control of their identity and life, having hope for their life and living a life that has meaning for them whether that be through work, relationships, spirituality, community engagement or some or all of these." Within this framework, recovery does not mean "being cured" or "being normal", rather, it is about gaining or recapturing meaning and purpose in life and being empowered to live a self-directed/determined and autonomous life despite any emotional distress that a person may have lived through or is currently experiencing." According to the definition, recovery does not necessarily mean a cure for the mental illness but living a meaningful life even when presenting with debilitating signs and symptoms of mental illness. In this study, recovery means living positively in spite of a diagnosis of mental illness, performing the activities of daily living and participating in family, work and community activities without being hindered by the effects of the mental illness.

Recovery-oriented mental health care approach

According to WHO (2019:19), ROMHCP is the provision of person-centred care which focuses on facilitating a meaningful individual life through the inspiration of hope, collaboration, engagement, and family involvement in their care as they recover from mental illness. For this study, recovery-oriented mental health care is defined as the provision of mental health services that are customer driven, hopeful, support clients' autonomy, are collaborative and are entrenched on the principle that all patients with mental illness can recover.

Recovery principles

The recovery principles are described as hope and optimism for the future, finding meaning in life, empowerment, and, most of all, taking responsibility for own recovery (O'Keeffe *et al.*, 2018). For this study, recovery principles mean providing an environment that supports patients' recovery, which includes listening to patients and offering alternative treatments, patient engagement, facilitating hope and providing holistic care by mental health care facilities.

Recovery-oriented mental health care programme

The recovery-oriented mental health care programme for this study is a structured and empirically developed programme that teaches and guides the implementation of ROMHCP in Botswana. The programme will be entrenched in the principles that support recovery-oriented care.

Psychiatric mental health nurse

According to American Psychiatric Nurses Association (APA) (2021:1), psychiatric mental health nurses are registered nurses qualified to work with individuals, families, groups, and communities to assess and address their mental health needs. Psychiatric mental health nurses also assess, diagnose, and treat people presenting with mental health problems. For this study, a psychiatric mental health nurse is a nurse who has undergone at least two years of post-basic training in the care and management of clients with a diagnosis of mental illness.

Nurse

According to the International Council of Nurses (ICN) (2021:1), a nurse "is a person who has completed a program of basic, generalised nursing education and is authorised by the appropriate regulatory authority to practice nursing in his/her country." For this study, a nurse is defined as any person who has undergone basic training in nursing education for at least three years, has a minimum of a diploma in nursing, has been caring for clients diagnosed with mental illness for a minimum of three years and is licensed by Botswana Midwifery and Nursing Council to practice as such.

Mentally ill patient

According to the Mental Disorders Act of Botswana (1971:3), a mentally ill patient is "a mentally disordered or defective person or person concerning whom proceedings are considered necessary to determine whether or not he is suffering from a mental disorder or defect." For this study, a person with a diagnosis of mental illness means an individual receiving care be it psychotropic drugs or psychological services in a psychiatric mental health facility and is fully capable of utilising resources within himself with the help of a nurse to better his/her life situation following a diagnosis of a mental illness.

Psychiatric mental health care facility

According to Mental Disorders Act of Botswana (1971:3), a psychiatric mental health care facility means "a mental hospital or other place which is prescribed as an institution or place for the reception, medical treatment and detention of persons suffering from mental disorder or defect." Therefore, for this study, a psychiatric mental health facility is a place where a client with mental illness receives psychiatric mental health care, be it inpatient or outpatient care in Botswana.

1.7. Research Methodology

A research methodology is the process through which a researcher intent to conduct the study. Sileyew (2019) describe the research methodology as a path through which researchers conduct their studies. The process entails formulation of the research problems, objectives, analysis and presentation of the results. This section gives a brief outline of the study design, research methods, study context, population, sampling technique and sample size, eligibility and exclusion criteria, data collection and analyses, quality of data, trustworthiness, and ethical considerations.

1.7.1. Study design

The study utilised a convergent parallel mixed method approach whereby both qualitative and quantitative data were collected and analysed in a single study (Creswell, 2015:219). This method involved the once-off collection of quantitative and qualitative data (QUAN+QUAL) at the same time, but analysis of the data was done separately (Cresswell, 2015:38; Polit & Beck, 2018:585). The two results were merged and interpreted as an outcome of the study. According to Creswell (2013:8), mixed methods research is commonly used in the health sciences. It involves collecting quantitative and qualitative data to answer research questions because of the healthcare profession's complex health problems. The results were analysed separately but concurrently. The findings from the two sets of data were compared and integrated. The data collected from the two methods complemented

each other and enhanced a clearer understanding of how nurses in Botswana understand the recovery-oriented mental health care approach in mental health.

The study was conducted in three phases: The empirical phase, the development phase, and the validation phase. Table 1 below summarises the study approach.

1.7.1. Phases of research

Table 1: Phases of the research			
Empirical phase	Scoping Review		
	Item	Quantitative	Qualitative
	Design	Cross-sectional descriptive survey	Contextual and descriptive
	Study context	Nurses working in 5 mental health facilities (One referral hospital and four units offering mental health services to 4 different main Districts across Botswana)	Nurses working in 5 mental health facilities (One referral hospital and four units offering mental health services to 4 different main Districts across Botswana)
	Population	Nurses working in mental health facilities (N=242)	Nurses working in mental health facilities (N=242)
	Sampling	non-probability convenient	Purposive
	Sample size	n=(152)	n=(30)
	Data collection methods	Self-administered questionnaire	Structured interview guide in Focused Group Discussions (FDGs), which were audiotaped
	Data analysis	(SPSS) version 27. Descriptive and comparative statistics, t-tests, crosstabs,	Transcriptions Content analysis Coding and Core-coding
	Rigor	Cronbach's Alpha for reliability, Confirmatory Factor Analysis (CFA) for validity,	Trustworthiness was assured through credibility, transferability, dependability, authenticity, and confirmability.
Phase 2 Development Phase	The development stage started with the development of a conceptual framework. The conceptual framework was developed using concept classification proposed by Dickoff, James and Wiedenbach (1968:422). The emerging concepts in phase one of the study and some constructs of the health belief model were identified and classified according to Dickoff <i>et al.</i> (1968:422). They formed the foundation of the researcher's thinking map. The six aspects of the practice theory by Dickoff <i>et al.</i> (1968:422) are agent, recipient, context, terminus or endpoint, procedure, and dynamics (1968:422). The six aspects of practice theory and illustration questions were used to operationalise the emerging concepts from phase one.		
	The programme was developed based on the conceptual framework that was developed based on the classified concepts of Dickoff <i>et al.</i> (1968:422) at step 1 of phase 2. It was further classified using Chinn and Kramer's (2008:235) six components. These are (1) an overview of the programme, (2) the purpose of the programme, (3) the structure consisting of assumptions on which the programme is		

	based, (4) concepts definition and (5) relationship statements.
Validation Phase	The programme was validated using eDelphi, technique.

1.8. Ethical considerations

The North-West University Health Research Ethics Committee (NWU-HREC) No: NWU-00306-21-S1 and Ministry of Health Botswana REF NO: HPDME 13/18/1 approved and cleared the study. Furthermore, the study was granted permissions by the institutional ethics review boards of all the participating hospitals. The participants were assured of protection and anonymity as no names were used on the questionnaires and transcribed data. In addition, the patients were told that they could choose not to participate in the study, and they will not be penalised for doing so. All the participants gave written and verbal consent to participate in the study. The data was stored in a locked computer protected password and only the researchers had access to it. The audio recordings were destroyed once the data were transcribed.

1.9. Thesis layout

Section 1: Overview of the study

This study report on the developed recovery-oriented mental health care programme for nurses working in (ROMHP) in Botswana.

Section 2: Manuscripts

Recovery-oriented programmes to support the recovery approach in mental health in Africa: Findings of PhD: a scoping review (*Published in The Open Nursing Journal*)

Assessment of nurses' knowledge of a recovery-oriented mental health care approach using the Recovery Knowledge Inventory: Findings from a developing country (*To be submitted for publication at Journal of Clinical Nursing*)

Perceptions of nurses working in mental health services regarding the recovery-oriented mental health care approach: Empirical Research Qualitative. (*Published in Nursing Open Journal*)

Nurses' perceptions on how recovery-oriented mental health care can be developed and implemented. (*Published in Nursing Research and Practice*)

Development of a conceptual framework for a recovery-oriented mental health programme for nurses in Botswana (*To be submitted for publication*)

Recovery-oriented mental health care programme for nurses in Botswana (*To be submitted for publication*)

Section 3: Conclusions, Limitations and Recommendations

1.10. Conclusion

The section described the outline, covered the introduction, background and rationale for the study, problem statement, research aim, research objectives, the significance of the study, paradigmatic perspective, theoretical perspective, conceptual definitions, research methodology, ethical considerations, and thesis layout.

1.11. References

- Abbo, C., & Odokonyero, R. & Ovuga, E. (2019). A narrative analysis of the link between modern medicine and traditional medicine in Africa: a case of mental health in Uganda. *Brain Research Bulletin*, 145, 109-116.
- Allana, S., & Clark, A. (2018). Applying Meta-Theory to Qualitative and Mixed-Methods Research: A Discussion of Critical Realism and Heart Failure Disease Management Interventions Research. *International Journal of Qualitative Methods*, 17(1).
<https://doi.org/10.1177/1609406918790042>
- Alves, S.A.A. & de Oliveira, M.L.B. 2018. Sociocultural aspects of health and disease and their pragmatic impact. *J Hum Growth Dev*, 2018; 28(2):183-188.
<http://dx.doi.org/10.7322/jhgd.147236>
- Americana Psychiatric Nurse Association. 2021 *Psychiatric Mental Health Nurse*. <https://www.apna.org/i4a/pages/index.cfm?pageid=3292> Date of access: 03 Mar 2021.
- Becker, T.D., Ho-Foster, A.R., Poku, O.B., Marobela, S., Mehta, H., Cao, D.T.X., ... Yang, L.H. 2019. "Its When the Trees Bloosom": Expalanatory Beliefs, Stigma and Mental Illness in the Context of HIV in Botswana. *Qualitative Health Research*, 1-15.
<https://doi.org/10.1177/104973231982752>
- Bila, N.J. 2019. Social workers' perspectives on the recovery-oriented mental health practice in Tshwane, South Africa. *Social Work in Mental Health*, 17(3):344-363.
DOI: [10.1080/15332985.2018.1554547](https://doi.org/10.1080/15332985.2018.1554547)
- Bilir, M.K. 2018. Deinstitutionalisation in Mental Health Policy: from Institutional-Based to Community- Based Mental Healthcare Services. *Hacettepe Journal of Health Administration*, 21(3): 563-576.
- Bird, V. & Slade, M. 2012. *REFOCUS: Researching recovery* <https://www.scottishrecovery.net/resource/refocus-researching-recovery/> Date of access: 02 Jul 2020.

Lebowitz, M.S. & Appelbaum, P.S. 2019. tBiomedical Explanations of Psychopathology and Their Implications for Attitudes Beliefs About Mental Disorders. *The Annual Review of Clinical Psychology*, 15, 555-557. <https://doi.org/10.1146/annurev-clinpsy-050718-095416>

Brink, H., van der Walt, C., & Van Rensburg, G. (2018). *Fundamentals of research methodology for health care professionals*. 4th ed, Juta & Company, Capetown, South Africa.

Brooke-Sumner, C., Lundi, C. Selohilwe, O. & Petersen, I. 2016. Community-based psychosocial rehabilitation for schizophrenia service users in the North-West province of South Africa: A formative study. *Social Work in Mental Health*, 15(3):248-283. <https://doi-org.nwulib.nwu.ac.za/10.1080/15332985.2016.1220439>

Cambridge Dictionary. 2021. *Meaning of validation in English*.
<https://dictionary.cambridge.org/dictionary/english/validation> Date of access: 13 Sept 2021.

Campos, R. T. O., Costab, M., Pereira, M.B., Riccia, E.C., Giselli da Silva Tavares Enesa, G.D. T., Leidy Janetha, L., ... & Davidson, L. 2017. Recovery, citizenship, and psychosocial rehabilitation: A dialogue between Brazilian and American mental health care approaches. *American Journal of Psychiatric Rehabilitation*, 20(3):11-326 <https://doi.org/10.1080/15487768.2017.1338071>

Chinn, P.L., & Kramer, M.K. (2012). *Integrated Theory & Knowledge Development in Nursing*. 9th Edition. St Louis: Elsevier-Mosby.

Chorwe-Sungani, G., Namelo, M., Chiona, V. & Nyirongo, D. 2015. The Views of Family Members about Nursing Care of Psychiatric Patients Admitted at a Mental Hospital in Malawi. *Open Journal of Nursing*, 5:181-188.

Corey, G. 2013. *Theory and practice of counselling and psychotherapy*. 9th Edition, United States of America Cengage.

Creswell, J. W. 2013. *Qualitative enquiry and research Design: Choosing among five approaches* 3rd Edition. Thousand Oaks, CA: SAGE.

Creswell J. W. 2015. *A Concise Introduction to Mixed Methods of Research*. 8th Edition. Thousand Oaks, CA: SAGE.

Creswell J. W. & Poth, C.N. 2018. *Qualitative Inquiry Research Design: Choosing among the five approaches*. 15th Edition, Thousand Oaks, CA:SAGE.

Decarlo, M. Scientific Inquiry in Social Work.

2020. <https://scientificinquiryinsocialwork.pressbooks.com/chapter/6-2-paradigms-theories-and-how-they-shape-a-researchers-approach/> Date of access: 09 July 2020.

Department of Health. Australian Government. 2013. A national framework for recovery-oriented mental health services: Guide for practitioners and providers. Commonwealth of Australia

Department of Health (Australia). 2021. *Recovery Oriented Service Delivery*. <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-recovgde-toc~mental-pubs-n-recovgde-5#:~:text=Recovery-oriented%20mental%20health> Date of access: 24 Jan 2021.

Dickoff, J., James, P. & Wiedenbach, E. (1968). Theory in practice discipline part Nursing Research, 17 (5): 415-435.

Eiroa-Orosa, F. J. & Garcia-Miers, H. 2019. A Systematic Review and Meta-analysis of Recovery Educational Interventions for Mental Health Professionals. *Administration and Policy in Mental Health and Mental Health Services Research*, 46:724-752.

Gilburt, H., Slade, M., Bird, V., Oduola, S., Tom, K.J. & Craig, T. K.J. 2013. Promoting recovery-oriented practice in mental health services: a quasi-experimental mixed-methods study. *BMC Psychiatry*, 13:167.

Habhab, N. 2018. *The Perceived Barriers and Facilitators of Therapeutic Work with Arab Clients: Examining therapists' attitudes towards stigma and recovery from mental illness*. Wayne State University Dissertations. (Dissertation-PhD). https://digitalcommons.wayne.edu/oa_dissertations

Halter, M.J. 2018. *Varcropolis' foundations of psychiatric-mental health nursing: a clinical Approach*. 8th Edition. Canada: Elsevier Inc.

International Council of Nurses. 2021. *Nursing Definitions*. <https://www.icn.ch/nursing-policy/nursing-definitions>

Jacob, S. 2013. Recovery Model of Mental Illness: A Complementary Approach to Psychiatric Care. *Indian Journal of Psychological Medicine*, 37(2):117-119.

Kealeboga, K.M., Manyedi, E.M. & Moloko-Phiri, S. (2023b). Nurses' Perception on How Recovery-Oriented Mental Health Care Can be Developed and Implemented. *Nursing Research and Practice*, 2023, Article ID 2404420, 1-11. <https://doi.org/10.1155/2023/4504420>

Kwok, C. F. 2014. Beyond the clinical model of recovery: recovery of a Chinese immigrant woman with bipolar disorder. *East Asian Archives of Psychiatry*, 24:129-133.

Lavallee, L. F. & Poole, J. M. 2010. Beyond Recovery: Colonization, Health and Healing for Indigenous People in Canada. *International Journal of Mental Health and Addiction*, 8(2):271-281.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J. & Slade, M. 2011. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199(6):445-452.

Maiga, D.D. & Eaton, J. 2014. A survey of the mental healthcare systems in five Francophone countries in West Africa: Benin, Burkina Faso, Côte d'Ivoire, Niger and Togo. *International Psychiatry*, 11(30):69-72.

Mental Disorders Act of Botswana (1971:3). Government printers. Gaborone

Mental Health Collaborating Network (IMHCN). 2020. *What is Recovery?* <https://imhcn.org/bibliography/recovery-an-introduction/recovery-general/> Date of access: 22 Apr 2021.

Mongie, K.K., Eva, M. & Salamina, M. 2023a. Recovery Oriented Programmes to Support the Recovery Approach to Mental Health in Africa. Findings of PhD: A Scoping Review. *The Open Nursing Journal*, 17, e1874434622302140. [10.2174/18744346-v17-230223-2022-152](https://doi.org/10.2174/18744346-v17-230223-2022-152)

New Freedom Commission on Mental Health.

2016. Achieving the Promise: *Transforming Mental Health Care in America. Final Report*. <https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf> Date of access: 03 Aug 2020.

O’Keeffe, D., Sheridan, A., Kelly, A., Doyle., R., Madigan, K., Lawlor, ...Clarke, M. 2018. ‘Recovery’ in the Real World: Service User Experiences of Mental Health Service Use and Recommendations for Change 20 Years on from a First Episode Psychosis. *Adm Policy Ment Health*, 45, 635–648. <https://doi.org/10.1007/s10488-018-0851-4>

Parkin, S. 2016. Salutogenesis: Contextualising place and space in the policies and politics of recovery from drug dependence. *International Journal of Drug Policy*, 33:21-26.

Pincus, H.A., Spaeth-Rublee, B., Sara, G., Goldner, E. M., Prince, P.N., Ramanuj, P., Gaebel, W., ... Ramanuj, P. 2016. A review of mental health recovery programs in selected industrialised countries. *International Journal of Mental Health Systems*, 10(73). DOI 10.1186/s13033-016-0104-4.

Polit, D.N. & Beck, C. T. 2018. *Nursing research: Generating and assessing evidence for nursing practice*, 10th Edition, Philadelphia: Wolters Kluwer.

Rice, A.N. & Harris, S. C. 2021. Issues of cultural competence in mental health care, *Journal of the American Pharmacists Association*, 61, 1, e65-e68.
<https://doi.org/10.1016/j.japh.2020.10.015>.

Seloilwe, E.S. & Thupayagale-Tshweneyagae, G. 2007. Community mental health care in Botswana: approaches and opportunities. *International Council of Nurses*

Sidandi, P., Opondo, P & Sebonetse, T. 2011. Mental health in Botswana. *BJPsych International*, 8(3):66-68.

Siu, B. W. M., Tsang, M.M.Y., Lee, V.C.K., Liu, A.C.Y., Tse, S., Luk., ... & Leung, Y.L. 2016. Pathway to mental health recovery: a qualitative and quantitative study on the needs of Chinese psychiatric inpatients. *BMC Psychiatry*, 16:236.

Jilcha Sileyew, K. (2020). *Research Design and Methodology*. IntechOpen. doi: 10.5772/intechopen.85731

Slade, M., Amering, A., Farkas, M., Hamilton, B., O'Hagan, M., Graham, P., ... & Whitley, R. 2014. Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems *World Psychiatry*, 13(1):12-20. Doi: [10.1002/wps.20084](https://doi.org/10.1002/wps.20084).

Slade, M. & Longden, E. 2015. Empirical evidence about recovery and mental health. *BMC Psychiatry*, 15 (285) DOI 10.1186/s12888-015-0678-4 Date of access: 30 June 2020.

Schoonenboom. J & Johnson. R.B. 2017. How to Construct a Mixed Methods Research Design. *Kolner Z Soz Sozpsychol*, 69 (Suppl 2):107-131. doi: 10.1007/s11577-017-0454-1.

Sue, S., Zane, N., Nagayama, G.C. & Berger, L.K. 2009. The Case for Cultural Competency in Psychotherapeutic Interventions. *Annu Rev Psychol*, 60:525-548.

Tse, S., Siu, B.W.M. & Kan, A. 2013. Can recovery-oriented Mental Health Services be created in Hong Kong? Struggles and Strategies. *Adm Policy Ment Health*, 40:155-158.

University of Wollongong Ilawarra Institute of Mental Health. 2020. *Collaborative Recovery Model*. <https://www.scottishrecovery.net/resource/refocus-researching-recovery/> Date of access: 20 Dec 2020.

World Bank. 2017. *Poor mental health, an obstacle to development in Latin America* <https://www.worldbank.org/en/news/feature/2015/07/13/bad-mental-health-obstacle-development-latin-america> Date of access: 01 Jul 2020.

World Health Organisation, 2019. *Recovery practise for mental health and well-being: WHO Quality Rights Specialised Training Course guide*. Geneva
<https://apps.who.int/iris/bitstream/handle/10665/329602/9789241516747-eng.pdf> Date of access: 10 Sept 2021

World Health Organization. 2014. *Social determinants of health*. https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf?sequence=1 Date of access: 01 Jul 2020.

SECTION 2: MANUSCRIPTS

Appendix 1: Author guidelines: The Open Nursing Journal

Aims and scope

The Open Nursing Journal is an Open Access online journal, which publishes Research, Reviews and Letter articles in the field of Nursing, aiming at providing the most complete and reliable source of information on current developments in the field.

Each peer-reviewed article that is published in a Bentham *OPEN* Journal is universally and freely accessible *via* the Internet in an easily readable and printable PDF format.

Manuscript preparation

The manuscript should be written in English in a clear, direct and active style. All pages must be numbered sequentially, facilitating in the reviewing and editing of the manuscript.

Manuscripts Published:

The journal accepts original research articles, review/mini-review articles and letters written in English. Single topic/thematic issues may also be considered for publication.

Manuscript Length:

Research Articles:

Research articles should be of 4000-6000 words with 75 or more references excluding figures, structures, photographs, schemes, tables, etc.

Review Articles:

The length of a published comprehensive review article is from 35000 to 40000 words with 100 or more references excluding figures, structures, photographs, schemes, tables etc.

Systematic Reviews:

Systematic Reviews include systematic updates in review protocols, methods, research and results from all relevant fields for any studies and updates on already published issues. The total number of words for a published systematic review is from 35000 to 40000 words with 100 or more references excluding figures, structures, photographs, schemes, tables etc. Systematic reviews and meta-analyses must be reported according to PRISMA guidelines; (www.prisma-statement.org).

Letter Articles:

Letters should be 3000-6000 words with 40 or more references excluding figures, structures, photographs, schemes, tables, etc.

Randomized Drug Clinical Trial Studies:

Trial studies should be 1500 to 4000 words with 50 or more references excluding figures, structures, photographs, schemes, tables etc.

Book Reviews:

This journal publishes open access reviews on recently published books (both print and electronic) relevant to the journal. Publishers and authors of books are invited to contact our book reviews editor at tonursj@benthamopen.net with book review requests. All submitted books will be reviewed by an independent expert in the field. No page charges will be levied to authors for the publication of book reviews.

Editorials:

Editorials are short papers on important topics related to the journal. The total number of words in an editorial should not exceed 1000, and it should contain only 10-15 references. An abstract is not required.

Commentaries:

Commentaries present an analysis by scientists on different important issues related to the publications in the journal. Commentaries should contain less than 3000 words, including the abstract, main text, references, and figure legends. However, an abstract is not necessary.

Perspectives:

A perspective should provide a short overview of a research topic relevant to the field. We do not expect a systematic literature review, instead some brief details about how the evidence searched is presented, including primary and secondary sources. The length of a published perspective ranges from 1500 to 1800 words with 20 or more references excluding figures, structures, photographs, schemes, tables, etc.

Conference Proceedings:

For proposals to publish conference proceedings in this journal, please contact us at email: proceedings@benthamopen.net.

Supplement/Thematic Issues:

Manuscript sections for papers

Manuscripts submitted for research and review articles in the respective journal should be divided into the following sections:

Title:

The title should be precise and brief and must not be more than 120 characters. Authors should avoid the use of non-standard abbreviations and question marks in titles. The title must be written in title case except for articles, conjunctions and prepositions.

As recommended by the Reporting guidelines information about the study should be a part of the title (particularly for randomized or clinical trials, systematic reviews and meta analyses).

Authors should also provide a short 'running title'. Title, running title, by line correspondent footnote and key words should be written as presented in the original manuscript.

Title Page:

Title page should include paper title, author(s) full name and affiliation, corresponding author(s) names complete affiliation/address, along with phone, fax and email.

Structured Abstract:

The abstract of an article should be its clear, concise and accurate summary, having no more than 250 words, and including the explicit sub-headings (as in-line or run-in headings in bold). Use of abbreviations should be avoided and the references should not be cited in the abstract. All the original research articles, systematic reviews and meta analyses must be accompanied with a structured abstract. Ideally, each abstract should include the following sub-headings, but these may vary according to requirements of the article: background, objective, methods, results, implications for nursing and the conclusion. The headings can vary, but must state the purpose of the study, details of the participants, measurements, methods, main findings and conclusion. The clinical trial studies should have the registration number at the end of the study. And lastly 6 to 8 the key words:

6 to 8 keywords must be provided. Choose important and relevant keywords that researchers in your field will be searching for so that your paper will appear in a database search. The

keywords should be contained in the title and they should appear several times in the article. In biomedical fields, MeSH terms are a good ‘common vocabulary’ source to draw keywords from <https://www.nlm.nih.gov/mesh/meshhome.html>.

Main text

Text Organization:

The main text should begin on a separate page and should be divided into title page, abstract and the main text. The text may be subdivided further according to the areas to be discussed, which should be followed by the List of Abbreviations (if any), Conflict of Interest, Acknowledgements and Reference sections. For review, the manuscript should be divided into title page, abstract and the main text. The text may be subdivided further according to the areas to be discussed, which should be followed by the Acknowledgements and Reference sections. The Review Article should mention any previous important recent and old reviews in the field and contain a comprehensive discussion starting with the general background of the field. It should then go on to discuss the salient features of recent developments. The authors should avoid presenting material which has already been published in a previous review. The authors are advised to present and discuss their observations in brief.

For Research Articles the manuscript should begin with the title page and abstract followed by the main text, which must be structured into separate sections as Introduction, Materials and Methods, Results, Discussion, Implications for Nursing, Conclusion, Ethics Approval and Consent to Participate, Human and Animal Rights, Conflict of Interest, Acknowledgements and References.

All randomized clinical trials must include a flow diagram and authors should provide a completed randomized trial checklist (see CONSORT Flow Diagram and Checklist; www.consort-statement.org) and a trial protocol.

For case reports, the authors should follow the CARE guidelines. The CARE checklist should be submitted as a separate file.

The manuscript style must be uniform throughout the text and 10 pt Times New Roman fonts should be used. The full term for an abbreviation should precede its first appearance in the text unless it is a standard unit of measurement. The reference numbers should be given in square brackets in the text. Italics should be used for Binomial names of organisms (Genus and Species), for emphasis and for unfamiliar words or phrases. Non-assimilated words from Latin or other languages should also be italicized e.g. *per se*, *et al.*, etc.

Section Headings:

Section headings should be numbered sequentially, left aligned and have the first letter capitalized, starting with the introduction. Sub-section headings however, should be in lower-case and italicized with their initials capitalized. They should be numbered as 1.1, 1.2, etc.

Introduction:

The Introduction section should include the background and aims of the research in a comprehensive manner.

Materials and methods:

This section provides details of the methodology used along with information on any previous efforts with corresponding references. Any details for further modifications and research should be included. Sufficient details should be provided to the reader about the

original data source in order to enable the analysis, appropriateness and verification of the results reported in the study.

It is important for the Method Section should be sufficiently detailed in respect of the data presented, and the results produced from it. This section should include all the information and protocol gathered for the study at the time when it was being written. If the study is funded or financially supported by an organization to conduct the research, then it should be mentioned in the Method Section. Methods must be result-oriented. The statement regarding the approval by an independent local, regional or national review committee (e.g. name of ethic committee and institutional review board) should be part of the Methods Section.

Experimental:

Repeated information should not be reported in the text of an article. A calculation section must include experimental data, facts and practical development from a theoretical perspective.

Results:

The important and main findings of the study should come first in the Results Section. The tables, figures and references should be given in sequence to emphasize the important information or observations related to the research. The repetition of data in tables and figures should be avoided. Results should be precise.

Discussion:

This should explore the significance of the results of the work, and present reproducible procedure. Extensive citations and discussion of published literature should be avoided.

The Results and discussions may be presented individually or combined in a single section with short and informative headings.

Conclusion:

A small paragraph summarizing the contents of the article, presenting the final outcome of the research or proposing further study on the subject, may be given at the end of the article under the Conclusion section.

Funding:

The authors need to declare the funding sources of their manuscripts clearly by providing the name of the funding agency or financial support along with allotted grant/award number in round brackets (if applied), for instance, “This work was financially supported by [Name of the funding agency] (Grant number XXX).

Similarly, if a paper does not have any specific funding source, and is part of the employment of the authors, then the name of the employer will be required. Authors will have to clearly state that the funder was involved in writing, editing, approval, or decision to publish the article.

Greek Symbols and Special Characters:

Greek symbols and special characters often undergo formatting changes and get corrupted or lost during preparation of manuscript for publication. To ensure that all special characters used are embedded in the text these special characters should be inserted as a symbol but should not be a result of any format styling (Symbol font face) otherwise they will be lost during conversion to PDF/XML.

Authors are encouraged to consult reporting guidelines. These guidelines provide a set of recommendations comprising a list of items relevant to their specific research design. All

kinds of measurements should be reported only in International System of Units (SI). Chemical equations, chemical names, mathematical usage, unit of measurements, chemical and physical quantity & units must conform to SI and Chemical Abstracts or IUPAC.

List of Abbreviations:

If abbreviations are used in the text either they should be defined in the text where first used, or a list of abbreviations should be provided.

Registration of Systematic Reviews:

Bentham OPEN supports retrospective registration of systematic reviews, in a suitable registry (such as PROSPERO). The registered systematic review must include the registration number as the last line of the manuscript abstract.

Appendices:

In case there is a need to present lengthy, but essential methodological details, use appendices, which can be a part of the article. An appendix must not exceed three pages (Times New Roman, 10 point fonts, 900 max. words per page). The information should be provided in a condensed form, ruling out the need of full sentences. A single appendix should be titled APPENDIX, while more than one can be titled APPENDIX A, APPENDIX B, and so on.

Supportive/Supplementary Material (if any):

We do encourage to append supportive material, for example a PowerPoint file containing a talk about the study, a PowerPoint file containing additional screenshots, a Word, RTF, or PDF document showing the original instrument(s) used, a video, or the original data (SAS/SPSS files, Excel files, Access Db files etc.) provided it is inevitable or endorsed by the journal's Editor.

Published/reproduced material should not be included unless you have obtained written permission from the copyright holder, which must be forwarded to the Editorial Office in case of acceptance of your article for publication.

Supportive/Supplementary material intended for publication must be numbered and referred to in the manuscript but should not be a part of the submitted paper. In-text citations as well as a section with the heading "Supportive/Supplementary Material" before the "References" section should be provided. Here, list all Supportive/Supplementary Material and include a brief caption line for each file describing its contents.

Any additional files will be linked into the final published article in the form supplied by the author, but will not be displayed within the paper. They will be made available in exactly the same form as originally provided only on our Web site. Please also make sure that each additional file is a single table, figure or movie (please do not upload linked worksheets or PDF files larger than one sheet). Supportive/Supplementary material must be provided in a single zipped file not larger than 4 MB.

Authors must clearly indicate if these files are not for publication but meant for the reviewers'/editors' perusal only.

Research ethics and policies

Conflict of interest

Authors

All potential conflicts of interest (competing interests) that could have a direct or indirect influence on the work must be disclosed by the authors. Even if an author does not have a

conflict, disclosing affiliations and interests allows for a more comprehensive and open approach, which leads to a more accurate and objective evaluation of the work. Conflicts of interest, whether genuine or imagined, are a perspective to which the readers are entitled.

The publication of a conflict statement in the article itself, as well as the submission of the conflict disclosure form, is required for all types of papers. It is not necessarily the case that a monetary relationship with examination support or funding for counseling work is inappropriate. Even if the authors do not have any conflict of interest, they still need to provide a confirmation statement in their manuscripts, i.e., “The author(s) confirm(s) that there is no conflict of interest related to the manuscript.”

The following are some examples of potential conflicts of interest that are directly or indirectly related to the research:

Financial competing interests include (but are not limited to):

Type of support/grant number

Institutional Conflicts of Interest

Funds received by the author

Funds received by the institution

Travel allowances for the research

Funds received for article preparation and reviewing

Funds for conducting review activities

Support provided for article writing assistance, for drugs, equipment, etc

Paid lectures

Pending fund or grant

Financial conflicts of interest can be personal as well as institutional. Personal conflict of interest occurs when a contributor involved in the publication process either receives an amount of money or expects to receive some financial help (including any other financial benefits such as patents or stocks, gifts or services) that may impact the work related to a specific publication. More importantly, in academic research, such financial relationships can lead to institutional conflicts of interest (COIs) because the economic interests of the institution or institutional representatives may unsuitably affect the decision-making process.

An institutional conflict of interest arises in a situation when financial interests of an institution or any institutional official (e.g., investments held by the university in a company) have the potential to unduly influence the research conducted by its employees or students, or pose an unacceptable risk to human subjects. Such conflicts usually arise in a state of affairs where a research project directly offers assistance or a benefit to an external entity via evaluation, validation, trial or test of an invention, product, drug, service or technology, and the institution holds a financial interest with the external entity. Such financial interests incorporate, but are not limited to, receipt of licensing payments or royalties from the external entity, or ownership interest with the external entity. When human subjects are involved in any research project, and the institution supports such a financial interest, the conflict of interest is speculated to be unreasonable.

Non-financial competing interests include (but are not limited to):

In addition, interests other than monetary and any funding (non-financial interests) should be declared if they are relevant to readers. Personal relationships or conflicting interests directly

or indirectly related to research, as well as professional interests or personal opinions that may impact your research, are examples of these.

Intellectual property, in basic terms, refers to any intangible property that is the result of creativity, such as patents, copyrights, etc. Similarly, this section seeks to know about copyright and patent (licensed patent, pending or issued) and any payment received for intellectual property, such as:

Patent

Licensed Patent

Issued Patent

Pending Patent

Royalties

Licensee

Remarks

Disclosure statement

All conflict of interest disclosure forms are collected by the corresponding author. It is sufficient for the corresponding author to sign the disclosure form on behalf of all authors in author collaborations when legal agreements for representation allow it. The templates of the form can be found [here](#).

Acknowledgements:

All individuals listed as authors must have contributed substantially to the design, performance, analysis, or reporting of the work and are required to indicate their specific contribution. Anyone (individual/company/institution) who has substantially contributed to the study for important intellectual content, or was involved in the in drafting or revising the manuscript must also be acknowledged.

Guest or honorary authorship based solely on position (e.g. research supervisor, departmental head) is discouraged

The specific requirements for authorship have been defined by the International Committee of Medical Journal Editors (www.icmje.org). Examples of authors' contributions are: 'designed research/study', 'performed research/study', 'contributed important reagents', 'collected data', 'analyzed data', 'wrote paper' etc. This information must be included in the submitted manuscript as a separate paragraph under the heading 'Acknowledgements'. The corresponding author is responsible for obtaining permission from all co-authors for the submission of any version of the manuscript and for any changes in the authorship.

Graduate students' research section

Publishing from post-graduate studies is an essential requirement for students. Research has very little value unless it is disseminated. Supervisors expect it, and examiners are likely to look favourably on students' work where they can show it has contributed to literature and debate in the field.

In order to help post-graduate research students, get their work published, we are introducing a post-graduate students' research section to The Open Nursing Journal. We will accept a maximum of 20 submissions annually from post-graduate students, provided that their supervisor(s) are listed as co-authors on the submitted manuscripts. This can be from MSc, PhD or other post-graduate programmes (but not post-doctoral work), and we anticipate international relevance in these submissions. Whilst we expect most submissions to be from

current students, we will accept submissions from post-graduate studies up to one year after degrees have been awarded.

References

References should be submitted preferably in the ACS or Vancouver style. All references must be complete and accurate. The reference numbers must be finalized and the bibliography must be fully formatted before submission.

The references should be relevant to the study and should refer to the original research sources. Self-citation and self-interest should be avoided by the authors, editors and peer-reviewers.

See below few examples of references listed in the ACS and Vancouver Style:

ACS Style

In ACS style, all references should be numbered sequentially [in square brackets] in the text and listed in the same numerical order in the reference section. Superscript in the in-text citations and reference section should be avoided.

[6] National Library of Medicine. Specialized Information Services: Toxicology and Environmental Health. sis.nlm.nih.gov/Tox/ToxMain.html (Accessed May 23, 2004).

Patent

[7] Hoch, J.A.; Huang, S. Screening methods for the identification of novel antibiotics. U.S. Patent 6,043,045, March 28, 2000.

Thesis

[8] Mackel, H. Capturing the Spectra of Silicon Solar Cells. PhD Thesis, The Australian National University: Canberra, December 2004.

E-citations

[9] Citations for articles/material published exclusively online or in open access (free-to-view), must contain the accurate Web addresses (URLs) at the end of the reference(s), except those posted on an author's Web site (unless editorially essential), e.g. 'Reference: Available from: URL'.

Some important points to remember

All authors must be cited and there should be no use of the phrase et al.

Date of access should be provided for online citations.

Punctuation should be properly applied as mentioned in the examples given above.

Abstracts, unpublished data and personal communications (which can only be included if prior permission has been obtained) should not be given in the references section. The details may however appear in the footnotes.

The authors are encouraged to use a recent version of EndNote (version 5 and above) or Reference Manager (version 10) when formatting their reference list, as this allows references to be automatically extracted.

Vancouver Style

In Vancouver style, all references should be numbered sequentially [in square brackets] in the text and listed in the same numerical order in the reference section. Punctuation should be properly applied as mentioned in the examples given above.

Reference Lists

Different reference formats have different rules for citation. See below for some common format examples

Manuscript one: Recovery-oriented programmes to support the recovery approach in mental health in Africa: Findings of PhD a scoping review (Published)

Title page

The Open Nursing Journal, Vol.17, March 2023, page e187443462303280. DOI: 10.2174/18744346-v17-230223-2022-152

**Recovery-oriented programmes to support the recovery approach in mental health in Africa:
Findings of PhD a scoping review**

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Abstract

Background

Recovery-oriented mental health care approach in the care of clients with mental illness is advocated for by researchers in the field of mental health and people living with a diagnosis of mental illness. Most developed countries are implementing the recovery-oriented approach in mental health facilities to care for people with a diagnosis of mental illness. However, Africa is left behind in implementing and adopting such a model of care.

Objective

The objective of the review was to explore and describe the global literature on recovery-oriented mental health care programmes on where they originate, their implementation and effectiveness, as well as identify gaps in the literature for further research.

Methods

The scoping review utilised a refined framework of Arskey and O'Mally (2005) by Levac et al. (Levac, Colquhoun, & O'Brien, 2010). Different databases were systematically searched, and The PRISMA Flow Chart was used to select the articles included in the review.

Results

The results indicated that most recovery-oriented programmes are developed in well-developed Western countries. No programme that addresses recovery in mental health was found in Africa.

Implications for Nursing

Nurses need to understand and implement the latest treatment modalities in mental health practice, and recovery-oriented care is one such practice.

Conclusion

The recovery-oriented approach in the care of people with a diagnosis of mental illness has shown that it has the potential to improve their well-being. Therefore this calls for Africa to develop its recovery-oriented programmes aligned with the budget and informed by the local context.

Keywords: Mental health, Mental illness, Recovery, Recovery-oriented mental health care programme, recovery approach, Recovery programme

Introduction

The recovery-oriented approach to care in mental health is now under implementation in various western high-income countries [1, 2]. The approach came to light following evidence that people presenting with severe mental illness can recover and live productive lives [3]. However, the definition of recovery remains challenging as it is described from multiple individuals' and researchers' perspectives. There seems to be some individuality or, more to say, personal experience attached to some definitions of recovery from mental illness [4, 5]. A common observation in the definitions of recovery points to it as being a unique personal journey which is more than symptom remission [6]. The most common acceptable definition of recovery is by [7] who defines recovery as

“a deeply personal, unique process of changing one’s attitudes, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.” Nevertheless, there is still no agreement on the definition of recovery, and researchers call for a standard definition acceptable to all [5, 8,]. The review conceptualised recovery as being able to live positive with a diagnosis of mental illness, performing the activities of daily living and participating in family, work and community activities without being hindered by the effects of mental illness. It will entail being happy and enjoying life without being trapped by the effects of having a mental illness. According to the Victorian Department of Health 2011 as cited in [9], recovery-oriented mental health care provides client-centred care in an environment that fosters optimism and hope, which is facilitated by a caring and respectful staff.

Most western countries are implementing a recovery-oriented mental health care approach to caring for people with a diagnosis of mental illness [5, 10, 11]. However, due to the lack of a standardised definition of what recovery should entail, the implementation remains a challenge [2, 5]. Therefore, researchers have come up with programmes, frameworks, guidelines and visions for their mental health settings to address implementation challenges [2]. However, the contexts and the subjects of the studies that have led to the development of such programmes and frameworks have come under question as it seems like they were all developed in high-income countries [12, 11].

Research points to a monoculture of recovery as more programmes are conceptualised from the personal descriptions of individuals and consumer movements from recovered clients from high-income communities [12, 11]. Furthermore, [12] say that recovery can be said to be the "thing" of western cultures and more medically advanced mental health set-ups. Therefore, the need to recognise indigenous people and tailor culture-specific recovery programmes or frameworks for it to be effective. Recovery-oriented approach to the care of people with mental illness is practised in the United States of America, New Zealand, Australia, Canada and the United Kingdom. All these countries are classified as high-income countries [13]. A special report in 2014 by multi-national pro-recovery researchers from various countries called for more culturally tailored recovery programmes which are more resource and service contextual [11].

Most African countries are still without mental health policies, and recovery principles are not implemented even though deinstitutionalisation took place in some countries [14]. Also, recovery-oriented mental health services are still not yet known [15]. Sub-Saharan Africa remains one of the poorest areas and has a wide gap in mental health resources for its people [14]. The lack of policies alone may imply that mental health issues and management continue to remain less prioritised in Africa. Therefore, that hampers the implementation of the latest treatment modalities approaches in

mental health, such as recovery-oriented mental health care [16]. Botswana is a country in sub-Saharan Africa categorised as a middle-income country [17]. Currently, the care of people with a diagnosis of mental illness in Botswana is under the influence of the biomedical approach through psychotropic drugs. Nurses are the primary mental health care providers in Botswana due to the shortage of psychiatrists, an observation common in most African countries and the world [18]. There are approximately 0.29 psychiatrists per 100 000 people in Botswana which makes it difficult for psychiatrists to see all patients on arrival [19]. Therefore, most patients on arrival at mental health facilities are first attended to by psychiatric mental health nurses or general nurses. Psychiatric mental health nurses are the pillar of mental health services in Botswana. Currently, to the best of the researcher's knowledge, no policy, guidelines, or programme addresses recovery-oriented mental health care principles. Botswana operates with one referral mental hospital south of Botswana and four psychiatric units attached to four general hospitals [19].

Methods

The scoping review aimed to explore the global literature on recovery-oriented mental health care programmes. It focuses on what recovery-oriented mental health care programmes are, how they have been implemented globally, the challenges of their implementation, the effectiveness of programmes based on the context of development and implementation and identifying gaps in the literature for further research. The review focused on how the studies were conducted, paying attention to the population and the findings. The scoping review served as a framework to access the types of evidence available on the subject as well as identify knowledge gaps [20]. The review utilised the refined framework of [21] which was refined by [22]. The following steps of the framework were used to structure the scoping review: identification of the research question and the relevant studies or objectives, inclusion and exclusion criteria, search for evidence, selection of evidence (relevant studies), extraction of evidence, chart of the data, collation, summary, and report of the results.

Identification of the research question/or objectives

The main aim of this scoping review was to explore existing literature on recovery-oriented mental health programmes by looking at what it is, how it is implemented, the challenges of their implementation, the effectiveness of programmes, and identifying gaps in the literature for further research. The review addressed the following specific objectives:

- Describe recovery-oriented mental health approaches
- Describe how recovery-oriented mental health care programmes have been implemented.
- Identify challenges in the implementation of recovery-oriented mental health programmes
- Describe the effectiveness of recovery-oriented mental health programmes

- Describe the adoption and implementation of recovery-oriented mental health approaches in sub-Saharan Africa and Botswana

The review answers the following questions:

- What literature is available on mental health-related recovery-oriented programmes?
- How are the recovery-oriented mental health care programmes being implemented?
- What are the challenges of implementing recovery-oriented mental health care programmes?
- How effective are the recovery-oriented mental health care programmes?
- How have the recovery-oriented mental health care programmes been adopted and implemented in Sub-Sahara Africa?

Inclusion and exclusion criteria

The studies were selected based on the formulated inclusion and exclusion criteria. All peer-reviewed studies from January 2010 to April 2022 and published in English were included in the study. The selected studies were on the implementation of mental health/illness recovery programmes, evaluation of recovery programmes, the effectiveness of recovery programmes and validation of the recovery programme. Studies that focused only on substance use and selected narcotics use and rehabilitation only without a diagnosis of mental illness were excluded as the study intended to find the effectiveness of already existing programmes on recovery from mental illness. The study protocols were also excluded as they did not fit the purpose of the review.

Inclusion criteria

All peer-reviewed papers published in 2010 broadly addressed the study's objectives. Reports, summits or conference reports with well-elaborated recovery-oriented mental health frameworks/guidelines or visions.

All the studies and reports should be in English to be included.

Exclusion criteria

All peer-reviewed studies published before 2010 on recovery programmes and frameworks/guidelines.

All studies with mental health programmes that do not address recovery-oriented mental health care approach

All studies not published in the English language

Search strategy

The following electronic databases were searched to answer the research question: Sabinet, Medline, PubMed Academic Search, Cinahl, PsychARTICLES, and Psych Info). In addition, reference lists of the included articles in the significant articles were also searched. Keywords of relevant studies and the Medical Subject Headings (MeSH) terms such as "mental health recovery, mental illness, mental health, mental health intervention programme were used. This review's string/Boolean search terms included mental health AND recovery approach AND recovery programmes. The review included all study designs to select articles. Copies of all articles that meet or appear to meet the inclusion criteria were obtained. Then two reviewers, the researcher and the research assistant, independently scrutinised the retrieved studies from databases to determine their eligibility for inclusion in the study.

Search strategy for PubMed

The search was conducted between February 2022 to April 2022 and the string/Boolean search terms mental health AND recovery approach AND recovery programmes were used. An initial search produced 296 articles. The articles were loaded on to Endnote X9 software reference 82 articles remained after duplicates were removed. The remaining articles were then combined with other articles to make one data set of studies.

Study selection

The first stage involved independent title selection of articles from the proposed databases by the two reviewers to determine their eligibility. The identified articles were uploaded to Endnote X9 software reference, and duplicates were removed. The two reviewers then independently screened the identified abstracts and full-text studies to determine whether to include them. The University Librarian was contacted for assistance in locating articles and contacting the authors through emails for studies without full texts. Any discrepancy that arose between the reviewers was addressed. (See Fig 1 PRISMA Flow Chart).

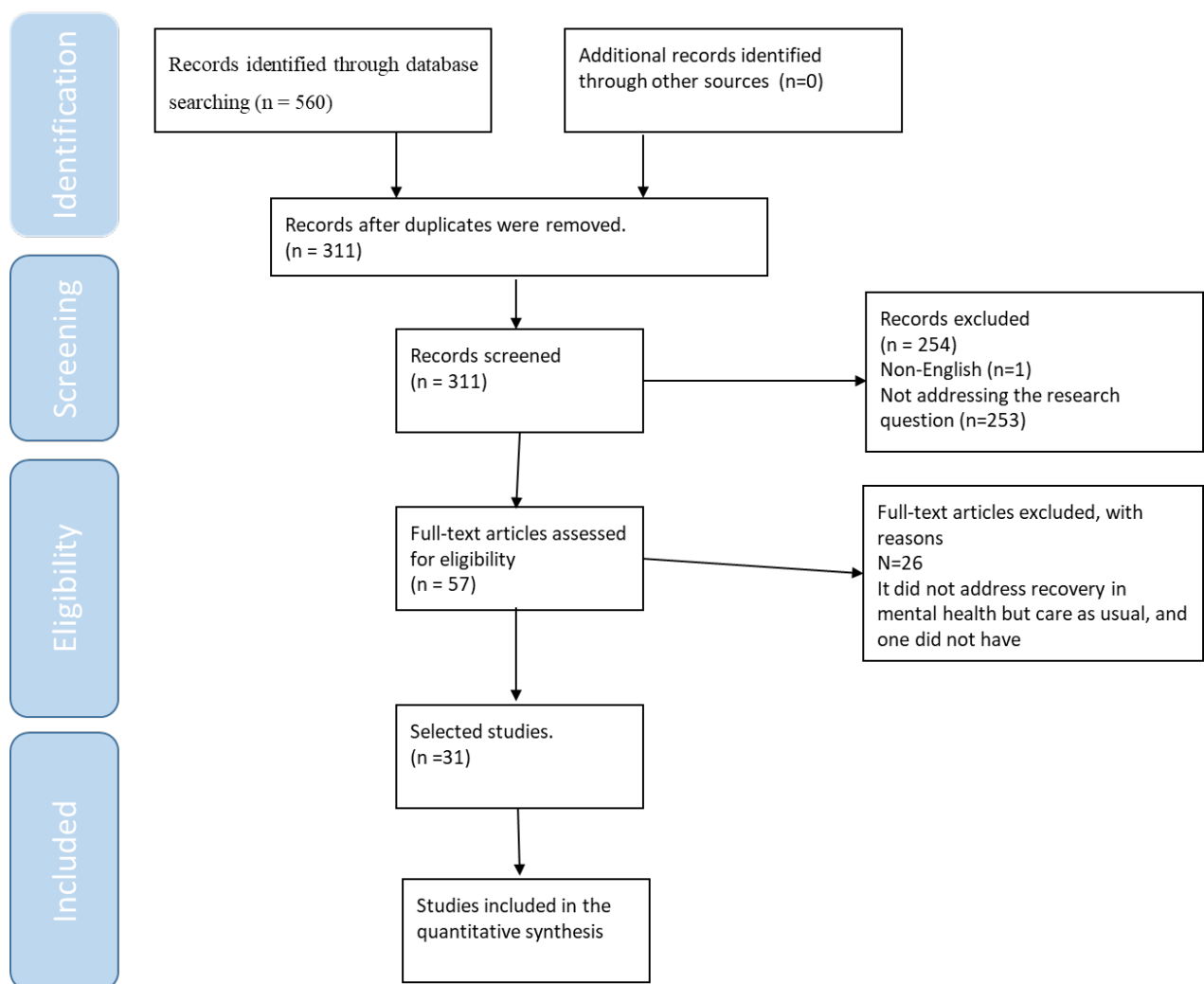
Data extraction

A data charting form was developed from all the studies included, looking at the inclusion criteria. The researcher and the research assistant independently extracted the information that included the author, intervention, setting, design, aim, significant findings and other relevant information such as the origin and challenges of implementing the recovery-oriented approach. All the reasons for excluding studies are reported.

Quality appraisal

A Mixed Methods Appraisal Tool (MMAT) version of 2018 was used to appraise the quality of the included studies independently by the two reviewers [23]. Any discrepancies were solved, and a consensus was reached. MMAT assessed the eligibility of the included studies by looking at the study aim, target participants, study design, data collection and analysis, ethical issues and study presentations. All the studies were rated on a scale of 50 to 100. Those who scored 50 to 65 were viewed as good quality, and those who scored more than 66-100 were considered to be very good. Table 3 shows the summary of the included studies.

Fig 1 PRISMA Flow Chart 2009 showing illustration screening process of studies



The PRISMA flow diagram above summarises the search and screening processes used to select the articles. 31 articles met the inclusion criteria (see figure 1). A literature search was conducted, and 560 studies were identified through different databases. Ebscohost 68, (Cinahl (14), Academic Search (21), APA Psych Infor (24), Medline (6), APA Psych Article (3), SABINET (196) and PubMed 296.

After combining and removing all the duplicates, including one article written in French, 311 articles remained. The reviewers scrutinised the remaining articles' titles and abstracts and removed 254 articles that did not address the broader research question. 57 articles remained. Furthermore, 26 were removed after going through the full text of the remaining articles as they did not focus on the recovery approach of people with serious mental illness, and 31 remained.

Data synthesis and analysis

The results were analysed using content analysis. As a research method, content analysis systematically and objectively describes and quantifies phenomena [24]. The review results were manually coded and presented in a narrative format (Table 1).

Table 1 showing the summary of included studies

Author s	Intervention	Setting	Design	Populatio n	Aim	Major findings	Any important informatio n
26	Meaning of recovery and Applicability of Wellness Recovery Action Plan WRAP (workshops)	Japanese Canadian s living in Canada metropol itan city	Qualitative explorative	First- generatio n older Japanese- speaking Canadians with mental illness N=8	To explores whether the Well-ness Recovery Action Plan (WRAP), a recovery-based programme, is applicable to Japanese- Canadian older adults t	-WRAP helpful - Recovery helpful in finding self-worth. -Be positive and hopeful -Advocate for their rights	Origin USA Conducted Canada
41	Recovery Guide for you-RG in inpatient care.	Inpatient s wards in Sweden	Mixed method	Staff member working in 14 Sweden inpatients units	To investigate the implementation of RG intervention in Inpatient Mental Health services (MHS) settings in order to improve quality of care	-All perceived RG to be legitimate, right and acceptable - potential to provide staff with vital information on recovery -Staff can integrate information into clients' plan of care	Origin: Sweden Conducted: Sweden Challenges Lack of resources, anticipated increased workload, lack of motivation (all

							resolved)
48	GetReal	Selected mental health Units in England	Qualitative Case study analysis	Existing data from 19 Units that took Part in the (RCT)in the Rehabilitation Effectiveness	To explore factors associated with variation between sustaining recovery-oriented practice during the GetReal intervention	Positive signs to sustain long-term Recovery-Oriented practice (ROP)	Origin: UK Conducted: UK Challenges -Have change agent or champion - Managerial support - organisational structures
47	Training in Comprehensive Approach to Rehabilitation (CARE) Methodology for people with Mental illness	National supported housing alliance in the Netherlands	Cluster Randomised Controlled Trial	Three Organizations for sheltered and supported housing in the Netherlands 893 clients	To investigate the effectiveness of CARE by means of training staff of methodology on personal recovery of clients with mental illness	-No difference in both groups -Quality of life improved in both groups	Origin: Netherlands Conducted: Netherlands Challenges Small sample size
52	Person Centered Care Planning (PCCP)	Permanent supportive housing sites from a recovery-oriented, community-	Qualitative explorative study	Staff and tenants of permanent supportive housing from a recovery oriented community based organizations	understand multiple stakeholder perspectives implementing a recovery-oriented approach to service planning in supportive housing programs serving people with lived experience of mental illnesses	-Service plan served as institutional reminder to staff and service users -Users and implementers viewed the service as rigid -Plan is seen as obligatory and does not cater to the individual needs of users	Origin: USA Conducted: USA Challenges: Rigid requirements undermine the provision of recovery-oriented care

31	Self-Direction program For people living with mental illness	One State in USA offering Self-Directed Program	Qualitative explorative –Content analysis	Former and present participants of Self-Directed Program	Explore the participants ‘experiences of Self-Direction Program	-Positive relation between Self-direction and recovery - recovery seen as dynamic and interrelated	Origin: USA Conducted: USA
42	Illness Management and Recovery (IMR)	Danish Community services	Randomized assessor-blinded multi-center clinical trial	People with schizophrenia and bipolar diagnoses participated	The aim of this randomized trial was to investigate the effects of the IMR program compared with treatment as usual in Danish patients with schizophrenia or bipolar disorder.	-No significance was found on the functioning, symptoms, substance abuse or service utilization in those who were in the program compared to control group	Origin: USA Conducted: Denmark
54	Art Therapy Project	Australian Secure extended care Unit Australia	Qualitative descriptive design	Consumers in rural Australia of an art therapy project and nurse managers and therapists in recovery-oriented rehabilitation programs	1. Explore the experiences of consumers who participated in the project 2. Examine the views of nurse managers and art therapists on recovery oriented rehabilitation programs in the context of Making Precious Things	-Consumers found the experience helpful -service managers and art therapists supported the program but there were systematic barriers to implementation	Origin: Australia Conducted: Australia Challenges Biomedical model Loss of clinical experts Lack of understanding of recovery-oriented care
40	Critical time intervention-task shifting (CTI-TS)	Brazil and Chile	Secondary Qualitative data analysis	Existing Data collected as part of a larger study that evaluated the pilot	Analyses of users’ perspectives and experiences regarding the implementation of these adaptations in	-Results shows adoption are promising -Users expressed promising use of community mental health intervention	Origin: UK Conducted: Brazil/Chile Challenges Stigma towards peers Mental health

				CTI-TS study in Brazil & Chile	Brazil and Chile		stigma
39	Patient engagement	A mental healthcare organization in Montreal (Quebec, Canada)	Qualitative single case study	Service users Committee Managers Executive managers Researchers Project managers Administrators	Shed light on patient engagement in mental health, more specific, the implementation of a structure for patient engagement on a strategic organizational Level	-led to improved patient partner participation -reduced stigma within the organisational committee	Origin: USA Conducted: Canada Challenges Resistance towards patient participation and the existence of stigma
28	Intervention The Steps to Recovery (STR)	Mental health Facilities within Tess Esk and Wear Valleys NHS Foundation (TEWV) caring for older people with mental illnesses	Prospective cohort repeated- measure	Older people with mental illnesses with TEWV mental health facilities	Evaluation of group-based intervention for older individuals receiving mental health services	-100% evaluated the STR group as having a positive effect on their recovery -reported improved mental wellbeing and recovery	Origin: UK Conducted: UK Challenges Structured programmes
44	Prevention and Recovery Care (PARC)	Victoria , Australia	A purpose- designed survey (mixed methods)	Managers of the 19 selected TARC facilities in Victoria N=19	Describe and the 19PARC services operating in Victoria	-emerging evidence that PARCs are providing recovery-oriented services that offer consumers autonomy and social inclusion, which future studies may find links to a	Origin: Australia Conducted: Australia Challenges Variation in funding, content and quality of care

						positive consumer experience.	
53	Intermediate Stay Mental Health Unit (ISMHU) 6 weeks intervention, implemented within an Integrated Recovery-Oriented Model (IRM)	Newcastle, Australia (ISMHU)	Mixed methods	Admitted clients at an Intermediate Stay Mental Health Unit (ISMHU) and train	Evaluation of the program and on the establishment of ISMHU and implementation of IRM, Characterise the admitted patients and quantify recovery needs and priorities on admission and any changes during admission	-Clients improved in symptoms and functioning from admission to discharge -Clients valued model of care, holistic approach, educational sessions, family and career involvement and the environment	Origin: Australia Conducted: Australia
5	The intervention comprised four full-day workshops and an in-team half-day session on supporting recovery	mental health services & community-based and in-patient rehabilitation adult mental health teams for the inner-city London	A quasi-experimental design	staff of 22 multidisciplinary community and rehabilitation teams providing mental health services	Evaluation of the implementation of recovery-orientated practice through training across a system of mental Health services.	Changes in staff approach to care, included a holistic care approach to care -Shift from focusing on maintenance to improved mental health and outcomes -Utilization of recovery-related terminology	Origin: UK Conducted: UK Challenges Resources More staff and funding Skilled experts in recovery
45	Evaluation of PARC by service users, careers, and staff	Residential Mental Health Recovery Service in North Queensland	Participatory research	Staff, service users, and careers of residential mental health	Evaluation of a residential Mental health Service using a newly developed framework	staff supported and valued -PAR is recovery focused -Consumers felt supported to come up with their own	Origin: Australia Conducted: Australia

		nd, Australia		service		recovery plans	
51	Wellness Recovery Action Planning (WRAP) educational programme	Multiple sites in Ireland	Mixed method approach Pre and post	People with personal experience of mental health problems, practitioners in mental health facilities and carers and family members of people with mental problems Who participated in WRAP programme	To evaluate the effects of WRAP	All had high degree of knowledge pre and post -Attitudes towards recovery was good pre even positive post -Participants agreed with WRAP beliefs on recovery. Beliefs on WRAP increased more after intervention -Confidence in applying WRAP skills increased -All felt that they can teach others WRAP beliefs	Origin: USA Conducted: Ireland
36	Therapeutic horticulture' (TH) within Mental Health Recovery Programme	Mental Health Recovery Program (MHRP) using TH to support people with mental health problems in the recovery process.	Mixed methods: four semi-structured focus group interviews	People with a diagnosis of mental health problems in a community-based setting participating	Evaluate the impact of a mental health recovery programme that used therapeutic horticulture as an intervention to reduce social inclusion and improve engagement for people with mental health problems.	Improvement in mental health social networks and relationships -Development of new skills, others were employed as confidence -Self-esteem and skills improved -Improvement in mental health wellbeing	Origin: UK Conducted: UK

56	Assertive Community Treatment (ACT) program Standard Case-Management Program and served as a control group	Suwon Mental Health Center Korea	Pre and post comparative evaluation study	Individuals with a diagnosis of mental illness at the Suwon Mental Health Center	To evaluate the effect of an Assertive Community Treatment (ACT) program on psychiatric symptoms, global functioning, life satisfaction, and recovery-promoting relationships among Individuals with mental illness.	-ACT reduction in severity of symptoms but not significantly greater than the control group -ACT showed significant increase GAF –No difference in life satisfaction	Origin: USA Conducted: Korea
32	‘Housing First’ approach Vs Treatment as Usual group	Existing data of in-depth qualitative interviews of participants from the Toronto, Ontario site of the ‘At Home/chez Soi’ Project	Data analysis of existing qualitative data using constant comparative methods (RCT)	Existing data from participants from the Toronto, Ontario site of the ‘At Home/chez Soi’ Project.(At Home/chez Soi’ study	Explores perspectives on hopes for recovery and the role of housing on these hopes from the perspective of homeless adults experiencing mental illness	-Many associated recovery to starting over -housed was key to recovery, first step to rebuilding their lives *improvement in health and well-being, Physical health, sleep improved *improved emotional being & maintaining relationships	Origin: USA Conducted: Canada
34	Consumer-run mental health services	Open Arms (a pseudonym) is a Consumer-run mental health centre.	Modified ethnographic study and semi-structured interviews	Open Arms members—with multiple admissions with bipolar and psychosis.	To learn what is distinctive about consumer-run services-e.g how they might strengthen personal capacity for social integration and	-support is of one another is important -Members are accountable for one another -members well connected. Relationships are authentic -Center helps	Origin: USA Conducted: USA

				Both staff and users	to explore how the development of these capacities might promote recovery	members in their recovery	
43	Auto videography	Mental Health Association of South-eastern Pennsylvania (MHASP)	Randomised trial based on participatory research model	People with serious Mental illness who completed a recovery-oriented programme at (MHASP)	Assess whether Autovideography was feasible method to use with mental health consumers and its benefits	-intervention facilitated recovery through self-reflection -Reciprocity and advocacy of others with MI -videos viewed as powerful tools for education	Origin: USA Conducted: USA
46	Social Point” program-Social inclusion activities	Mental health care services in Moderna - Social Point USA	A cross-sectional design-comparative study	People with non-affective psychosis who participated in social inclusion programme	Whether social interventions offered by Social Point have better outcomes for on areas of personal and social recovery especially areas of self-esteem , self-stigma and perceived quality of life	-Intervention group showed lesser impairment in areas of physical and social functioning -Internalised stigma and quality of life was better in the waiting list group	Origin: USA Conducted: USA Challenges Internalized stigma experience d by the intervention group
49	Illness Management and recovery (IMR) for people with serious MI integrated in Assertive Community Treatment(A	Assertive Community Treatment (ACT) in two States USA	A small-scale cluster randomized controlled design	Eight ACT teams and four from each state with no prior training in IMR (101 people with serious	Feasibility of implementing IMR within ACT and its effectiveness	Promising evidence to implement IMR within ACT	Origin: USA Conducted: USA

CT			mental illness					
50	Illness Management and recovery (IMR) for people with serious MI integrated in Assertive Community Treatment(ACCT)	11 ACT that implemented ACT	Qualitative study Semi structured interviews	- service users -staff in 11 ACT teams	Assess feasibility, advantages/disadvantages and factors that hinder or facilitate the implementation of IMR with ACT team	Service users and staff benefitted - Staff and users felt IMR in ACT improved recovery focus of users -Users expressed good personal outcomes in terms of managing symptoms and understanding their condition -Staff improved clinical skills -Facilitated building of relationships among staff and users -peer support	Origin: USA Conducted: USA Challenges included clients symptoms, and competing normal day duties for staff vs IMR teaching	
29	Medication-free treatment programme in Bergen, Western Norway	Mental health services in Health	Qualitative descriptive study	People with psychosis registered as patients in one of two district psychiatric centers for	Investigate the experiences of recovery following new treatment options and choices	Offered clients to have treatment options -improved interpersonal relations between users and staff -Communication improved	Origin: Norway Conducted: Norway Challenges lack of rights in treatment choice for clients - sharing of information by therapists poor	
37	Recovery Camp	Adventure camp in	Descriptive phenomenological	People with mental	How program has contributed to the recovery	Participants felt empowered to -live fulfilling life	Origin: Australia Conducted:	

Australia	approach	illness who attend a Recovery camp Program	of the participants	-confidence to socialise -Improved relationship with self and others -Improved participation	Australia
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35	Opening Doors to Recovery. (ODR)	Southeast Georgia	Longitudinal study – semi Structured interview of number participants 6 months after implementation	New community-based, recovery-oriented “community navigation” program (Consumers, Navigators, mental professionals and all involved in designing and implementing the programme)	Conduct an initial program evaluation of ODR and its community navigation services	Hopes and strength, Good collaboration among stakeholders noted in running the programme -garnered support for implementation -relationships facilitated implementation -Consumers felt supported - Leadership fully supported the programme	Origin: USA Conducted: USA Challenges Slow implementation, insufficient housing, lack of fidelity across teams, peers feel devalued
55	Assertive Community treatment (ACT)	Participants included staff and consumers on two ACT teams (selected from certified ACT teams in	Mixed methods comparative methods	2 ACT teams 2 rated low and 2 high in provision of recovery oriented services Staff and consumers of	Identify, within one state, extremes of recovery orientation and used multiple methods to examine how teams differed	The high-recovery-oriented team had greater consumer involvement in treatment planning, which showed evidenced language supportive of consumer strengths self-directed goals -high-recovery-oriented team had	Origin: USA Conducted: USA

		Indiana.		mental health services		consumers on medication monitoring -More family involvement in the care of clients	
33	Treatment in Supportive Housing	Supportive-housing organization that participated in a larger National Institute of Mental Health-	longitudinal qualitative design -In-depth interviews	Staff (case managers) of supportive-housing organization that participated in a larger National Institute of Mental Health-	To examine how frontline providers enact their case management roles with consumers living in supportive housing	- Treatment centers on adherence to medication & insight and viewed as key to recovery. Those without insight of their illness were viewed as challenging. Consumers should take treatment for life noncompliance viewed as not housing ready	Origin: USA Conducted: USA
30	Housing First (HF) program-with ACT	Housing first for people with SMI and homeless Lille, Marseille , Paris and Toulouse France	Randomised controlled trial	Homeless people with SMI in selected sites from Lille, Marseille, Paris and Toulouse France	The effectiveness of housing first in reducing the hospital and emergency use	-Intervention showed Reduced hospital stay, -housing stability, quality of life but not on other health related outcomes like substance abuse and dependency	Origin: USA Conducted France
38	Partners in Recovery (PIR) Australia	Nepean Blue Mountains Consortium	program logic model (PLM) mixed method	Clients and carers, program management, staff of the Consortium, and other partners and	To evaluate the program two years after implementation	Staff -management open and transparent -Client and careers agreed that the staff was engaging them -All agreed that service offered clear meaningful recovery program that is understood by all - improved collaboration,	Origin: Australia Conducted: Australia Challenges Lack of understanding on what PIR Lack of facilitators in

agencies, and clinical, allied health, and other service providers.	communication, clear referral channels among the team -all seemed to understand the recovery approaches and its language	implement ation, lack of peer engageme nt
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Characteristics of included studies

Of the included studies, 15 were conducted on patients. They involved exposing or enrolling patients in a programme and, in the end, evaluating its effectiveness. Eight of these studies involved a comparative study where a particular programme that enrolled mental health users was compared against another or to those that were taking regular treatment. Three studies were conducted on staff members or others, and they involved training staff on a recovery programme, implementation and evaluation at the end. Four studies were conducted on the staff, patients, families and other mental health stakeholders. The remaining nine (9) studies involved implementing a recovery programme at the facility level and its evaluation by the combination of staff and patients or families or, in other studies, all of which made 31 studies.

The results are based on the review's objectives, which were to describe the recovery-oriented mental health approaches, recovery-oriented mental health care programmes, the effectiveness of the recovery programmes and their challenges and the recovery-oriented programmes in sub-Saharan Africa. The results are summarised as follows: Recovery-oriented programmes, recovery-oriented mental health approaches, effectiveness and challenges of recovery-oriented programmes and recovery orientation approach in Sub-Sahara Africa.

Theme 1 Recovery-oriented mental health programmes.

Most of the studies selected were conducted in the United States of America (11), UK (4), Australia (5), Canada (2), Sweden (1), Ireland (1), Denmark (1), Netherlands (1), Portugal (1), South Korea (1), Norway (1), France (1) and Chile and Brazil (1). The mental health recovery programmes utilised in the studies selected mainly originated from Western Countries, as per table 2 below.

Table 2 Recovery Programmes and their origins

Country	Programme
United State of America	Wellness Recovery Action Planning educational programme (WRAP), Self-Direction programme, Illness Management and Recovery (IMR) for people with serious mental illness, person-centred Care Planning (PCCP), Self-Direction program For people living with mental illness, Art Therapy Project, Assertive Community Treatment (ACT) programme, 'Housing First' approach, Consumer-run mental health services, Auto videography, Social Point" program-Social inclusion activities, Opening Doors to Recovery (ODR), Housing First (HF) program- with ACT, Pathways Housing First within the ACT.
Australia	Recovery Camp, Prevention and Recovery Care (PARC), Partners in Recovery
United Kingdom	Therapeutic Horticulture (TH) within Mental Health Recovery Programme, GetReal, Critical time intervention-task shifting (CTI-TS), Patient engagement, Intervention The Steps to Recovery (STR), Intermediate Stay Mental Health Unit (ISMHU) intervention, implemented within an Integrated Recovery Oriented Model (IRM), Four full-day workshops and in-team half-day session on supporting recovery.
Sweden	Recovery Guide for you-RG in inpatient care.
Netherlands	Training in Comprehensive Approach to Rehabilitation (CARE)

Theme 2: Recovery-oriented mental health approaches

The recovery-oriented mental health approaches are reported from the perspectives of the patients, peers and staff members on what they believe recovery from mental illness entails.

Sub-theme 2.1 Description of recovery

Recovery is often understood differently by staff and patients.

2.1.1 Patients' perspectives

Six (6) studies involved enrolling clients in a recovery-oriented programme followed by its evaluation. 2 studies focused on skills improvement, the importance of self-care, self-management skills, fostering hope, and the value of peer support and emphasis on personal recovery. A study by [25] used the Wellness Recovery Action Plan (WRAP) programme to find out the meaning of recovery for older Japanese-speaking Canadians with a diagnosis of mental illness. The study further sought to establish the applicability of the programme to them. WRAP is a framework health care workers use to learn more about mental illness and how to manage it from a recovery-oriented approach. Also, individuals with mental illness could use it to learn more about their condition and how to take control of their life. It is a tool that individuals can use to gain insight into and control

their mental illness to facilitate their recovery process [26]. It can be tailor-made to the needs of a specific target group. The findings indicated that the clients felt that WRAP was helpful to them. They reported that they learnt a lot about themselves, felt hopeful for the future, and valued peer support in their recovery process despite having a diagnosis of mental illness. They felt empowered to negotiate things essential in their recovery that were not only focused on medication. Another study utilised the Steps to Recovery Programme (STR) on older people with mental illness health facilities [27]. STR programme is a group intervention where people with mental illness were provided with information about mental illness and recovery, including goals of recovery, hope for recovery, personal skills and maintaining relationships. Participants reported improved mental health and well-being. They valued the support and having relationships as vital to their recovery. They embraced the recovery concept as vital in their recovery process.

One intervention study utilised a Medication Free Programme (MFP) to demonstrate that people with serious mental illness can recover even without medication [28]. MFP is a programme whereby clients are offered alternative treatments other than psychotropic drugs to manage their mental health problems. Clients were given a choice to take medications or not. The study was conducted in Norway and aimed to describe users' experience of their recovery process on a medication-free intervention. The results demonstrated that clients valued having choices on treatment as crucial to their recovery process. There was a general improved interpersonal relationship between clients and health care workers. In addition, the channels of communication between clients and staff improved.

Furthermore, two studies involved the intervention of self-determination involving people with mental illnesses enrolled on government-sponsored recovery programmes to empower them with accommodation and monetary budget to determine how they will manage their recovery process. One study involved an intervention whereby people with mental illness were provided with housing as part of their recovery in France [29]. Another involved people being given money to control their budget based on their recovery goals and plans [30]. The results demonstrated that people with mental illness view self-determination as part of their recovery process. The study by [30] indicated general improvement in the quality of life of people with mental illness following allocation of a house to stay in, a general reduction in hospital stay and improved self-esteem. The Croft and Parish study indicated that participants could meet their daily basic needs, which resulted in better clinical outcomes. The clients were able to use the money to seek the help of social workers and psychologists for better symptom management. Most clients worked towards their employment goals as they used the money to buy resources such as computers. They felt a sense of belongings as they could afford to pay for memberships in social clubs.

Another study compared the effectiveness of Housing First against treatment as usual in the recovery of people with serious mental illness in Canada [31]. HF is a recovery-oriented mental health service

intervention that uses government funds in the USA to build and allocate homeless people with mental illness houses as part of their treatment plan. Participants viewed having a house as an integral part of their recovery than homelessness. Participants reported general improvement in mental health, emotional and physical well-being, and relationships. In addition, owning a house brought a sense of hope for recovery and the future.

2.1.2 Staff perspective and peers' perspectives

[32] conducted a study to find out the perspectives of case managers on the role of medication on clients with severe mental illness in supported housing recovery programmes and how their personal beliefs influence treatment options for them. The findings reveal that the case managers of the housing programme found the treatment to be integral to the recovery of clients, and some suggested that it should be taken for life. In addition, treatment adherence was used as a sign of being house ready. Generally, case managers viewed clients who did not have insight into their illness as challenging to deal with and were not prioritised for housing.

Of the 31 included studies, two (2) involved peer-supported recovery-oriented care. [343] conducted a study to learn about consumer-run facilities' recovery features. Consumer-run facilities are mental health settings that are staffed and run by people who are users of mental health services. The peers are on government payrolls. The study utilised a modified ethnographic method and was conducted over ten (10) months. The results indicated that the staff and the users felt accountable for the welfare of each other. There was a sense of belonging and authentic connectedness among the staff and users. The staff and users often accompanied each other on job hunting, socialisation activities and community involvement. There was also accountability in the management of symptoms as they watched each other and monitored any signs of relapse. It could be said that recovery focused on support on relationships, employment, symptoms management and general accountability of each other's welfare in a non-judgemental setting.

Another study that involved peer support was the evaluation of an Open Doors to Recovery (ODR) programme by [34]. ODR is a mental health recovery-oriented programme run by peers, social workers, and other mental health stakeholders such as multiple community partners and community navigators. The programme's main aim was to help the service users in their recovery programme. All those involved took part in the evaluation. The participants viewed the programme as helpful to their recovery. It brought the mental health personnel, service users, peers and community navigators closer to the central goal of helping clients recover. However, the significant weaknesses were slow implementation, lack of community and clinical services support, insufficient resources and devaluation of peers by clients and the community.

2.3 Facilitators of recovery

Two (2) intervention studies involved patient engagement in a recovery programme to improve client recovery through team building and collaboration. One utilised Therapeutic Horticulture [35]. TH is where people with mental illness were involved in a gardening project to facilitate their recovery. The participants reported having confidence in themselves, improved social networks and relationships, developed new skills, and improved mental health and well-being. Another study utilised a recovery camp programme to improve collaboration and teamwork among people with mental health problems in Australia [36]. The clients reported improved self-confidence and relationships with themselves and others and felt empowered. The study demonstrated the potential for Recovery Camp as a facilitator for the recovery clients with mental illness.

Further, two studies, one from Canada Patient Engagement (PE) and another from Australia Partners in Recovery (PIR), were conducted to demonstrate patient engagement in a recovery-oriented approach. Patient engagement facilitates recovery and reduces stigma towards people with mental illness. PE, just like PIR, entails the involvement of service users, clients, peers and careers of people with mental illness in the decision-making and daily running of mental health services. The two studies evaluated the effectiveness of patients and their partners in strategic committees and organisational functioning of the facilities as they fostered to have an inclusive environment that supports the recovery of patients [37, 38]. The two studies reported improved collaboration between staff and patients following patient engagement. Trankel and Reath's study reported that the PIR program was recovery-oriented and more engaging for patients, families and peers. There was an improved understanding of the recovery principles and approaches. The staff and everyone involved seemed to understand the recovery process, and management supported the programme. Elwards and others' study reported that managerial support and strong leadership were instrumental in implementing patient engagement programmes.

One patient study demonstrated the value of support by adapting the Critical Time programme in Brazil and Chile [39]. The intervention aimed to integrate people with mental illness in the community transiting from homeless shelters through the help of a paired community mental health worker and a peer support worker in Brazil and Chile. The participants valued the support from the mental health peer workers as they believed they helped them to integrate back into the community. In addition, the participants identified with the paired workers more than regular mental health professionals. A minor setback was that some participants and their families were stigmatising peer workers as they could see that they were having symptoms of mental illness. Nevertheless, the intervention was welcomed by many, and they felt it could continue.

In Sweden [40] conducted a study intended to find the feasibility of implementing a recovery programme (Recovery Guide for you (RG)) for mental health staff. RG is a booklet with information which describes the recovery process touching on topics such as views on recovery, guidelines for the provision of recovery and treatment plans in the recovery approach. The staff perceived RG booklet to be legitimate and acceptable. The staff could transfer knowledge gained to the care plans of the clients. The results of applicability of RG were acceptable.

Theme 3: Effectiveness and challenges of recovery-oriented programmes

About 3 studies evaluated the effectiveness of the recovery programmes on patients with mental illness in their recovery process, focusing on their illness management and general well-being. [41] utilised a randomised assessor-blinded multisite clinical trial on Illness Management Recovery (IMR) to compare it with treatment as usual on 200 people with mental illness. IMR is a curriculum-based intervention based on topics that explain what mental illness is from the context of the recovery approach. It focuses on symptom management, coping with stress, promoting healthy life struggles, reducing relapses, promoting healthy lifestyles and encouraging personal recovery. The results showed no difference between the intervention and the control group. Another study by [42] introduced, implemented and evaluated the use of videography on clients with serious mental illness following graduation from a recovery-oriented programme. The study used a randomised controlled trial on 27 participants who were randomised into two groups, one group provided with videos to document their recovery process and the other serving as control. The findings revealed that videography was feasible for people with mental illness. The video offered participants a self-reflection on their fears, hopes for the future and recovery goals. The videos were also educative as they provided information about living with a diagnosis of mental illness. Videos have the potential to advocate for people with mental illness as they reflect on their needs, such as accommodation and equal treatment in society. The intervention was feasible and had the potential to be used in individual and group therapy sessions for people with mental illnesses.

One programme developed and evaluated for its effectiveness is PARC. PARC are residential recovery-oriented facilities that help people with mental illness from recurrent back-and-forth hospital admissions. The facility utilises a clinical model and recovery-oriented approach. [43] compared the services offered to a PARC facility in Australia on its operations and functionality, including resources. The managers of each facility were interviewed to solicit their views on the study's objective. The results indicated that all the facilities provide services in line with the Australian policies on recovery-oriented care. However, the facilities differed in structure and resources, and the services provided were contextualised to the community's needs and how the staff understood the recovery approach. Overall the programme was found to be promising in providing recovery-oriented care. [44] also evaluated another PARC facility in Australia on services users, carers and staff. The

participants evaluated PARC as a functional recovery-focused model. The clients valued and appreciated the care provided by the staff.

Furthermore, the clients felt supported by all in the facility. Lastly, the staff reported feeling valued and appreciated by the clients. Overall, the programme was appreciated by all the participants.

One programme implemented on patients compared the effectiveness of a social inclusion programme intervention against treatment as a usual approach to the recovery of patients [45]. The social inclusion programme promotes the social participation of clients with mental illness by engaging them in community activities such as volunteerism, leisure engagement, mental health awareness campaigns and general promotion of mental health matters. Those in the social inclusion programme showed a high level of functionality, increased self-esteem, and reduced internalised stigma. The study provided evidence of the usefulness of social inclusion programmes in the recovery of patients.

Two (2) included studies that evaluated the effectiveness of the recovery programmes on staff. [46] investigated the effectiveness of the CARE methodology programme by training staff on managing mental illness. CARE approach to recovery involves improving the quality of life of people with a diagnosis of mental illness. It is built on reinforcing clients' strengths, improving connectedness with the client's environment, and helping them access their daily wishes. The investigation used RCT to compare two housing-supported facilities; one where the staff received CARE methodology training and the control, which continues treatment as usual. The results showed improvement in clients' quality of life after being cared for by staff who have undergone training.

[5] developed, implemented and evaluated a training workshop on staff across mental health facilities in London. The workshop comprised of a four-day classroom set-up workshop, covering information on what constitutes recovery, and care planning from users' perspectives based on recovery principles underpinned by the role of hope and clients' personal goals. The results indicated a buy-in to the training evidenced by good attendance, staff provided care reflective of recovery, the staff instilled hope in the clients, and they took ownership of the programme implementation. Generally, staff felt empowered to implement a recovery approach for service users. Another study by [47] evaluated the GeTREAL staff training recovery programme using realistic evaluation principles. The GeTREAL programme aimed to improve the staff's confidence and skills in caring for clients with mental illness. The results indicated that the staff were welcoming to the programme, happy to see the clients improving, trying new things with clients, and generally feeling empowered. However, the challenges experienced were lack of support and other resources to implement the programme.

Other intervention programmes evaluated the effectiveness of programmes on different stakeholders in mental health facilities. For instance, [48] used a small-scale cluster RTC to assess the feasibility of

implementing Illness Management Recovery (IMR) within ACT teams in two states in America. One team was just an ACT, and the intervention was ACT+IMR. The results showed the feasibility of implementing IMR within the ACT. Another study that implemented the feasibility of IMR within ACT was conducted by [49]. The study utilised qualitative methods to solicit views on the implementation, staff training and barriers to implementation. The findings revealed that IMR enhanced the recovery goals of ACT. Clients' symptom management improved, and they understood their illnesses better. The staff reported improved skills in a recovery-oriented approach. The significant challenges were that it took a long time to learn and implement the IMR. There was also a general competition between work as usual with the implementation of IMR. Moreover, the staff were challenged by the service users' symptoms when implementing IMR.

In Ireland, [50] conducted a mixed method pre and post-study that evaluated the effectiveness of 2 and 5 days on the WRAP programme on service users, their families and staff. The evaluation focused on the knowledge, attitudes and skills of using the WRAP programme following the intervention. All participants showed a high level of knowledge gained pre and post-training, resulting in improved attitudes and skills. In addition, all the participants had confidence in the implementation of WRAP, and they all felt that they could train others on the programme.

Other studies provided evidence of implementing recovery in mental health facilities. A study by [51] sought an understanding of the multiple stakeholders involved in a recovery-oriented approach to service planning in a supported housing programme. The service plan uses a person-centred care planning approach that focuses on the client's individual needs and goals. It is based on a strength model that is collaborative and inclusive. The aim was to understand the multiple stakeholders' perspectives in implementing service planning in supportive housing. There was a consensus from programme planners and users that implementation rules are rigid as they do not support the recipients' goals. The services remind everyone of the institutional plans and one size all model of care, which they believe is not recovery-oriented. A rigid organisational culture and lack of sponsor for the programme was seen as significant challenge to the programme implementation.

[52] evaluated the Intermediate Stay Mental Health Unit (ISMHN) services using multiple methods. The (ISMHN) in Australia is an Integrated Recovery Model concept. ISMHN is a 20 beds unit providing non-acute care to address the recovery needs of people with mental illness for a maximum of 6 weeks. They aim to provide remediation, reconnection and improve the overall quality of life. The programme is person-centred and embedded in the principles of recovery. The clients showed improvement in symptom management and functionality. Patients appreciated the services they received from the staff and valued the holistic and patient-supported approach.

Another study in Australia implemented and evaluated the use of ART therapy in a secure mental health facility [53]. The study sought the views of the managers, art therapists' and patients on the use of Art therapy following the intervention. All participants reported that the intervention was beneficial. Patients gained participatory skills, cooperation, teamwork and self-confidence. There was a general sense of belonging and relaxation experienced by service users who were in the programme, and they wanted more of the programme. Some challenges experienced included a general lack of support in implementing the recovery approaches from the managers, such as using the biomedical approach. In addition, there was also a lack of funds for the programme.

Two studies compared the effectiveness of two recovery-oriented facilities. [54] used an observational survey to compare the effectiveness of a high and low recovery orientation programme. Assertive Community Treatment (ACT) teams comprise a community-based group of mental health practitioners that facilitates patient recovery in a team approach. ACT teams' goals are person-centred and encourage the achievement of individualised client goals. The results indicated the same findings on illness management, hope for future optimism and general overall satisfaction. The highly rated recovery-oriented ACT team showed greater client involvement in their care. The evidence is supportive that ACT teams are recovery-oriented.

[55] also conducted a study comparing ACT teams' effectiveness and standard case management, which served as a control. The two approaches were compared on psychiatric symptoms of clients, global functioning, life satisfaction and recovery promotion among individuals with mental illness. ACT teams' service users showed a significant reduction in symptoms and global functioning. There was no difference in life satisfaction. ACT teams were found to be more supportive of the recovery approach compared to the control group.

Theme 4: Recovery orientation approach in Sub-Saharan Africa

No study on recovery-oriented programmes in the care of mental illness was found in Africa in the literature search that was conducted. Most studies on this search were from the USA, Australia, UK, Brazil and Europe.

Discussion

The review aimed to explore the literature on recovery-orientated programmes in mental health in the Sub-Saharan context. Furthermore, it intended to bring to light mental health recovery-oriented programmes available, their origins, effectiveness and challenges of implementing them. Unfortunately, no recovery-oriented mental health programmes were found in sub-Saharan Africa. In recent years, recovery in mental health and mental illness has been shaped by the experiences of those undergoing it. In addition, recovery is described as more of a process that goes beyond the cure of

symptoms and the personal experiences of an individual shape it. Therefore, attempts have been made to support people with mental illness to make their recovery process as smooth, personal and fulfilling as much as possible. This has been done by developing mental health recovery programmes geared towards supporting people with mental illness as they walk through their recovery process.

The review found 31 research articles on mental health recovery programmes that intended to improve the recovery of clients with mental illness. The studies also intended to improve the knowledge level of staff working in mental health facilities and families of people with mental illness, as they are instrumental in clients' recovery through their care and support. The majority of studies included in this study were from the USA (33.3%), Australia (18.18%), Canada (6.45), UK (12.90%), Europe (22.58%), South Korea (3.22%) and Brazil and Chile (3.22%). Most recovery-oriented programmes originated from Western countries, and none was identified in Africa. The results indicate the implementation of different programmes across countries, and other programmes that originated in the USA were tested and implemented in other countries with some modifications. Most recovery programmes were developed and implemented in different settings and countries. This is suggestive that recovery programmes are contextualised according to the needs of the communities in different countries.

The findings indicate that although the implementation of recovery programmes met some challenges across countries, the programmes significantly improved the general well-being and quality of people with mental illness. Studies have described what recovery from mental illness means and the factors that facilitate it. They described having a sense of belonging, connection through different channels, community participation, house ownership, hope, and a general feeling of being in control of their life as essential steps and facilitators of their recovery. Literature in recovery studies has consistently pointed to patient empowerment, self-determination, connectedness, having hope for the future and living a life that is personally fulfilling with or without symptoms of mental illness as factors that are essential in the recovery of people with SMI [56, 57]. On the other hand, some staff have alluded that good patients' insight about their illness and the use of medication adherence as essential ingredients for the recovery of clients with mental illness. In addition, others have suggested that people with mental illness must take treatment for life once diagnosed with mental illness. Insight involves processes of awareness or recognition of signs and symptoms of illness and attribution or explanations about the cause or source of these signs and symptoms [58]. In addition, insight includes the recognition by a person with a mental illness diagnosis of a need to take and adhere to treatment as prescribed [59]. Studies on health care workers' perceptions of insight and mental health recovery attached having good insight as the first step in recovery from mental illness. They believed that if clients had good insight, they would comply with the treatment, which could greatly facilitate their recovery [60]. Studies have found a link between insight and adherence to the treatment of clients [61,

62]. An editorial by [63] categorised insight as a critical factor in clinical psychiatry. It could facilitate clients' willingness to take treatment, leading to better clinical outcomes for their mental illness. Therefore, adherence to medication by patients should be part of the treatment plan for clients with mental illness [64]. On the other hand, it is argued that medication is just one of the facilitators of recovery, as people with a mental illness can recover with or without it [65]. This argument is fostered by the perspective that encourages the care approach in mental health that looks beyond an individual's symptoms, focuses on capacitating resilience, and offers patients support [3].

Facilitators of recovery in this review have been identified from the perspective of the service users, staff, and mental health peers. The values of support from families, peers, staff and other mental health workers are paramount to the service users in their recovery. The education provided to the service users, staff and their families was instrumental in helping the individuals deal better with their mental illness. The staff could also give improved care to the service users following the skills gained from the educational programmes they attended. This finding highlights the value clients attach to receiving care from peer-run mental health facilities.

Peers are the users of mental health services. They offered the clients non-judgemental mental health care, giving them a sense of hope through the shared array of activities they did for and with the clients. This included being accountable for one another, accompanying each other in employment seeking endeavours and patient engagement through community participation. As a result, clients felt more at home with a peer-run facility. The result is indicative that there was a general buy-in to implementing peer-run facilities recovery programmes. This could be so because most Western countries have policies that support the recovery approach [5, 10, 11, 66]. Most studies on intervention and evaluation of programmes for patients and staff have found significant improvements. However, two studies did not find any change or difference when the mental health recovery programmes were compared with treatment-as-usual programmes. It could have alluded that most facilities, especially in Western countries, view themselves as offering holistic, integrated care and not as different from the recovery approach [67]. Other factors could be that most countries have endorsed the recovery approach, making it difficult to differentiate from care as usual [66, 68, 69]. In one study, a suggestion was made that sample size could be the reason for a failure to see the difference when the programmes were compared with treatment as usual.

In implementing the recovery, even though they showed that they worked for people with mental illness, they also faced some challenges. Most of them had problems with funding and a shortage of staff to implement. Additionally, other facilities reported a lack of understanding of the recovery approach and how to differentiate it from the usual practice. Organisational policies and regulations were also rigid, and staff were bent on the existing rules to provide patient care than implementing the recovery approach. As a result, the staff were torn between their routine work and implementing the

recovery approach. Furthermore, there were indications that mental health peer workers were stigmatised by professional mental health care workers and the community when doing their job. Findings are supported by [70] in their study on the challenges of adopting recovery-oriented practices in specialised mental health care. The study identified factors such as rigidity of mental health personnel towards recovery approach, existing policies, the disease model prevention and cure perspective of managing illnesses and legal dilemmas of practice as challenging implementation of the recovery-oriented approach. As a result, the study recommended that if adopting a recovery-oriented approach, there must be a change in policies and existing management protocols of patient care and a change in mental health professionals' mindset. Despite all these challenges, the recovery programmes showed promising results that they are essential in managing people with mental illness, and there is a need for them to be contextualised.

Limitations of the study

The study provided a broader perspective on the recovery approach and how it is implemented in people with mental illness. However, the review is limited as it did not consider the design used to conduct the study since it was not the aim of the study. In addition, the review was limited to articles found and included at the time of selection of the studies. No studies in Sub-Saharan Africa described implementing a recovery-oriented mental health care programme when selecting articles were found.

Conclusion

The studies indicated that the recovery approach in mental health is very relevant for people with mental illness. Recovery programmes tailor-made to the context of the communities can help people with mental illness in their recovery process. Africa needs to develop or adopt and adapt recovery programmes that are aligned with their context.

The objective of the review was to explore the global literature on recovery-oriented mental health care programmes on where they originate, their implementation and effectiveness, as well as identify gaps in the literature for further research.

List of abbreviations

MMAT: Mixed Methods Appraisal Tool

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses

Author's contributions

All authors contributed in this manuscript submitted for review. KMK conceptualised the manuscript as part of her PhD study. The two study supervisors ME and PMS provided guidance and the final critical revisions and editing of the manuscript. All the authors proof read the article before submission.

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The authors declare no conflict of interest

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References

1. Andresen, R.; Oades, L.; Caputi, P. The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry.*, **2003**, 37, 568-594.
2. Leamy, M.; Bird, V.; Le Boutillier, C.; Williams, J.; Slade, M. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry.*, **2011**, 199 (6) 445-452.
3. Jacob, J.S. Recovery Model of Mental Illness: A Complementary Approach to Psychiatric Care. *Indian Journal of Psychological Medicine.*, **2015**, 37 (2) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4418239/pdf/IJPsyM-37-117.pdf> (Accessed August 24, **2022**).
4. Dell, N.A.; Long, C.; Mancini, M.A. 2020 Models of Recovery in Mental Illness: Protocol for an Overview of Systematic Reviews and Qualitative MetaSyntheses. *Social Science Protocols.*, 2020, 1-9. <http://dx.doi.org/10.7565/ssp.2020.2805>
5. Gilburt, H.; Slade, M.; Oduola, S.; Craig, T. K.J. Promoting recovery-orientated practice in mental health service: a quasi-experimental mixed-methods study. *BMC Psychiatry.*, **2013**, 13,167.
6. Whitley, Palmer & Gunn, (2015:951) Recovery from severe mental illness. *CMAJ*, **2015**, 187 (13).
7. Anthony, W. Recovery from mental illness: the guiding vision of the mental health services in the 1990s. *Psychosocial Rehabilitation Journal.*, **1993**, 4, 11-23.
8. Collier, E. Confusion of recovery: one solution. *International Journal of Mental Health.*, **2010**, 19, 16-21.
9. Australian Department of Health. Online. *Recovery Oriented Service Delivery*. **2021**. <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-recovgde-toc~mental-pubs-n-recovgde-5#:~:text=Recovery-oriented%20mental%20health> (Accessed January 24 2021).
10. Parkin, S.. Salutogenesis: Contextualising place and space in the policies and politics of recovery from drug dependence. *International Journal of Drug Policy*, **2016**, 33:21-26.
11. Slade, M.; Amering, M.; Farkas, M.; Hamilton, B.; O'Hagan, M. et al. Uses and abuse of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry.*, **2014**, 13:1.
12. Lavalley, L. F.; Poole, M. Beyond Recovery: Colonisation, Health and Healing for Indigenous People In Canada., *Int J Ment Health Addiction*, 2009, 8: 271-281.
13. World Bank Indicators Data Base, World Bank (2015), Gross Domestic Products GDP data source. <http://data.worldbank.org/data-catalogue/world-development-indicators> (Accessed March 14, **2015**).
14. Maiga, D.D.; Eaton, J. A survey of the mental healthcare systems in five Francophone countries in West Africa: Benin, Burkina Faso, Côte d'Ivoire, Niger and Togo *International Psychiatry.*, **2014**, 11(30): 69-72
15. Bila, N.J. Social workers' perspectives on the recovery oriented mental health practice in Tshwane, South Africa. *Social Work in Mental Health.*, **2019**, 17(3) 344-363, DOI: 10.1080/15332985.2018.1554547

16. Chorwe-Sungani, G.; Namelo, M.; Chiona, V.; Nyirongo, D. The Views of Family Members about Nursing Care of Psychiatric Patients Admitted at a Mental Hospital in Malawi. *Open Journal of Nursing*, **2015**, 5:181-188.
17. World Population Review. *Middle Income Countries* 2022. <https://worldpopulationreview.com/country-rankings/middle-income-countries>
18. Hinga, B.W. *Examining mental health policies in Botswana*. **2021**. <https://borgenproject.org/mental-health-in-botswana/> (Assessed September 08, 2022)
19. Maphisa, M. Mental health legislation in Botswana. *BJPSYCH INTERNATIONAL*, **2018**, doi:10.1192/bji.2018.24
20. Munn, Z.; Peters, M.D.; Stern, C.; Tufanaru, C.; McArthur, A.; Aromataris, E. Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Medical Research Methodology*, **2018**, 18, 143 <https://doi.org/10.1186/s12874-018-0611-x>
21. Arksey, H.; O'Malley, L. Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology: Theory and Practice*, **2005**, 8, 1, 19-32.
22. Levac, D.; Colquhoun, H.; O'Brien, K. Scoping studies: advancing the methodology. *Implementation Science*, **2010**, 5, 1, 69
23. Hong, Q.N.; Pluye, P.; Fàbregues, S.; Bartlett, G.; Boardman, F.; Cargo, M.; Dagenais, P.; Gagnon, M.; Griffiths, F.; Nicolau, B.; O'Cathain, A.; Rousseau, M.; Vedel, I. *MIXED METHODS APPRAISAL TOOL (MMAT) VERSION 2018 User guide*. Department of family Medicine, **2018**,
24. (Elo, S.; Kaariainen, M.; Kanste, O.; Polkki, T.; Utriainen, K.; Kyngas, H. Qualitative Content Analysis: A Focus on Trustworthiness. *SAGE Open*, 2014, 4: 1-10, DOI: 10.1177/2158244014522633
25. Matsuoka, A. K. Ethnic/Racial Minority Older Adults and Recovery: Integrating Stories of Resilience and Hope in Social Work. *British Journal of Social Work*, **2015**, 45 (1), i135-i152.
26. Copeland, M.E. *Wellness Recovery Action Plan*. **2002**, USA: Peach Press
27. Flaherty-Jones, G. M.; Carne, A. S.; Dexter-Smith, S. The Steps to Recovery Program: Evaluation of a Group-Based Intervention for Older Individuals Receiving Mental Health Services. *Psychiatric Rehabilitation Journal*, **2016**, 39, (1), 68 -70.
28. Oedegaard, C. H.; Davidson, L.; Stige, B.; Veseth, M.; Blindheim, A.; Garvik, L et al., It means so much for me to have a choice”: a qualitative study providing first person perspectives on medication-free treatment in mental health care. *BMC Psychiatry*, **2020**, 20:399
29. Tinland, A.; Loubière, S.; Boucekine, M.; Boyer, L.; Fond, G.; Girard, V.; Auquier, P. Effectiveness of a housing support team intervention with a recovery-oriented approach on hospital and emergency department use by homeless people with severe mental illness: a randomised controlled trial. *Epidemiology and Psychiatric Sciences*, **2020**, 29, e169, 1–11. <https://doi.org/10.1017/>
30. Croft, B.; Isvan, N.; Parish, S.L.; Mahoney, K.J. Housing and Employment Outcomes for Mental Health Self-Direction Participants. *Psychiatric Services in Advance*, **2016**, doi: 10.1176/appi.ps.201700057
31. Kirst, M.; Zerger, S.; Wise Harris, D.; Plenert, E.; Stergiopoulos, V. The promise of recovery: narratives of hope among homeless individuals with mental illness participating in a Housing First randomised controlled trial in Toronto, Canada. *BMJ Open*, **2014**, 4: e004379. doi:10.1136/ bmjopen-2013-004379

32. Stanhope, V.; Choy-Brown, M.; Tiderington, E.; Henwood, B. F.; Padgett, D. K. Case Manager Perspectives on the Role of Treatment in Supportive Housing for People with Severe Mental Illness. *Soc Social Work Res.*, **2016**, 7(3): 507–525. doi:10.1086/687986.
33. Lewis, S. E.; Hopper, K.; Healion, E. Partners in Recovery: Social Support and Accountability in a Consumer-Run Mental Health Center. *Psychiatric Services.*, **2012**, 63(1).
34. Reed, T. A.; Broussard, B.; Moore, A.; Smith, K. J.; Compton, M. T. Community Navigation to Reduce Institutional Recidivism and Promote Recovery: Initial Evaluation of Opening Doors to Recovery in Southeast Georgia. *Psychiatr Q.*, **2014**, 85:25–33 DOI 10.1007/s11126-013-9267-1
35. Howarth, M.; Rogers, M.; Withnell, N.; McQuarrie, C. Growing spaces: an evaluation of the mental health recovery programme using mixed methods. *Journal of Research in Nursing.*, **2018**, 23(6) 476–489.
36. Picton, C.; Patterson, C.; Moxham, L.; Taylor, E.; Perlman, D.; Brighton, R.; Heffernan, T. Empowerment: The experience of Recovery Camp for people living with a mental illness. 25 *Collegian.*, **2018**, 113–118 DOI:<https://doi.org/10.1016/j.colegn.2017.04.005>
37. Trankle, S. A.; & Reath, J. Partners in recovery: an early phase evaluation of an Australian mental health initiative using program logic and thematic analysis. *BMC Health Services Research.*, **2019**, 19:524 <https://doi.org/10.1186/s12913-019-4360-2>
38. Ewalds Mulliez, A. P.; Pomey, M. P.; Bordeleau, J.; Desbiens, F.; Pelletier, J. F. A voice for the patients: Evaluation of the implementation of a strategic organisational committee for patient engagement in mental health. *PLoS ONE.*, **2018**, 13(10): e0205173. <https://doi.org/10.1371/journal.pone.0205173>
39. Dev, S.; Kankan, T.; Blasco, D.; Le, P. D.; Agrest, M.; Dishy, G.; Mascayano, F.; Schilling, S.; Jorguera, M.J.; Dahl, C.; Cavalcanti, M.A.; Price, L.; Yang, L.H.; Susser, E. S. Implementation of a pilot community-based psychosocial intervention for patients with psychoses in Chile and Brazil: a comparative analysis of users' perspectives. *Global Mental Health.*, **2021**, 8 (15), 1–9. <https://doi.org/10.1017/gmh.2021.10>
40. Bejerholm, U.; Allaskog, C.; Andersson, J.; Nordström, L.; Roe, D. Implementation of the Recovery Guide in inpatient mental health services in Sweden—A process evaluation study. *Health Expectations.*, **2022**, 1-13.
41. Dalum, H. S.; Waldemar, A. K.; Korsbek, L.; Hjorthøj, C.; Mikkelsen, J. H.; Thomsen, K.; Kistrup, K.; Olander, M.; Lindschou, J.; Nordentoft, M.; Eplov, L. F. Illness management and recovery: Clinical outcomes of a randomised clinical trial in community mental health centers. *PLoS ONE.*, **2018**, 13 (4) e0194027. <https://doi.org/10.1371/journal.pone.0194027>
42. Linz, S.; Hanrahan, N. P.; DeCesaris, M.; Petros, R.; Solomon, P. Clinical Use of an Autovideography Intervention to Support Recovery in Individuals with Severe Mental Illness. *Journal of Psychosocial Nursing.*, **2016**, 54, (5).
43. Fletcher, J.; Brophy, L.; Killaspy, H.; Ennals, P.; Hamilton, B.; Collister, L.; Hall, T. Prevention and Recovery Care Services in Australia: Describing the Role and Function of Sub-Acute Recovery-Based Residential Mental Health Services in Victoria. *Frontiers in Psychiatry.*, 2019, 10.
44. Hyeres, M.; Kinchin, I.; Whatley, E.; Brophy, L.; Jago, J.; Wintzloff, T.; Morton, S.; Mosby, V.; Gopalkrishnan, N.; Tsey, K. Evaluation of a residential mental health recovery service in north Queensland. *Front. Public Health.*, **2018**, 6:123. <https://doi.org/10.3389/fpubh.2018.00123>

45. Mazzi, F.; Baccari, F.; Mungai, F.; Ciambellini, M.; Brescancin, L.; Starace, F. Effectiveness of a social inclusion program in people with non-affective psychosis. *BMC Psychiatry*, **2018**, 18:179.
46. Bitter, N.; Roeg, D.; van Assen, M.; van Nieuwenhuizen, C.; van Weeghel, J. How effective is the comprehensive approach to rehabilitation (CARE) methodology? A cluster randomised controlled trial. *BMC Psychiatry*, **2017**, 17:396 DOI 10.1186/s12888-017-1565-y
47. Bhanbhro, S.; Gee, M.; Cook, S.; Marston, L.; Lean, M.; Killaspy, H. Recovery-based staff training intervention within mental health rehabilitation units: a two-stage analysis using realistic evaluation principles and framework approach. *BMC Psychiatry*, **2016**, 16:292 DOI 10.1186/s12888-016-0999-y
48. Monroe-DeVita, M.; Morse, G.; Mueser, K. T.; McHugo, G. J.; Xie, H.; Hallgren, K. A.; Peterson, R.; Miller, J.; Akiba, C.; York, M.; Gingerich, S.; Stiles, B. Implementing Illness Management and Recovery Within Assertive Community Treatment: A Pilot Trial of Feasibility and Effectiveness. *Psychiatr Serv.*, **2018**, 69(5): 562–571 doi:10.1176/appi.ps.201700124.
49. Morse, G.; Monroe-DeVita, M.; York, M. M.; Peterson, R.; Miller, J.; Hughes, M. et al., Implementing Illness Management and Recovery within Assertive Community Treatment Teams: A Qualitative Study. *Psychiatr Rehabil J.*, **2020**, 43 (2): 121–131. doi:10.1037/prj0000387.
50. Higgins, A.; Callaghan, P.; deVries, J.; Keogh, B.; Morrissey, J.; Nash, M.; Ryan, A.; Gibels, H.; Cater, T. Evaluation of mental health recovery and Wellness Recovery Action Planning education in Ireland: a mixed methods pre–post evaluation. *Journal of Advanced Nursing*, **2012**, 68 (11), 2418–28 doi: 10.1111/j.1365-2648.2011.05937.x.
51. Choy-Brown, M.; Hamovitch, E. K.; Cuervo, C.; Stanhope, V. I Have My Own Lease—So Why the Service Plan Again? Perspectives on Service Planning in Supportive Housing. *Psychiatric Rehabilitation Journal*, **2016**, 39, 4, 313–320
52. Frost, B. G.; Turrell, M.; Sly, K. A.; Lewin, T. J.; Conrad, A. M.; Johnston, S., et al., Implementation of a recovery-oriented model in a sub-acute Intermediate Stay Mental Health Unit (ISMHU). *BMC Health Services Research*, **2017**, 17:2 DOI 10.1186/s12913-016-1939-8
53. De Vecchi, N.; Kenny, A.; Kidd, S. Stakeholder views on a recovery-oriented psychiatric rehabilitation art therapy program in a rural Australian mental health service: a qualitative description. *International Journal of Mental Health Systems*, **2015**, 9:11 DOI 10.1186/s13033-015-0005-y
54. Salyers, M. P.; Stull, L. G.; Rollins, A. L.; McGrew, J. H.; Hicks, L. J.; Thomas, D.; Strieter, D. Measuring the Recovery Orientation of Assertive Community Treatment. *Journal of the American Psychiatric Nurses Association*, **2013**, 19 (3) 117–128
55. Kim, T.; Jeong, J.; Kim, Y.; Kim, Y.; Seo, H.; Hong, S. Fifteen-month follow up of an assertive community treatment program for chronic patients with mental illness. *BMC Health Services Research*, **2015**, 15 (388) DOI 10.1186/s12913-015-1058-y
56. Ngo, H.; Ennals, P.; Turut, S.; Geelhoed, E.; Celenza, A.; 4 Step-up, step-down mental health care service: evidence from Western Australia’s first – a mixed-method cohort study. *BMC Psychiatry*, **2014**, <https://doi.org/10.1186/s12888-020-02609->
57. Lietz, C.A.; Lacasse, J.R.; Hayes, M.J.; Cheung, J. Source: 161-188 *Journal of the Society for Social Work*, **2014**, 5 (2).
58. Chaudhury, S.; Das, P.R.; Murthy, P.S.; Soren, S.; Bakhla, A. K.; Subodh, K. Insight in Psychiatry: A review. *Universal Research Journal of Medical Sciences*, **2014**, 01, (01).

59. Buchman-Wildbauma, T.; Váradic, E.; Schmelowszky, A.; Griffithse, M.D.; Zsolt Demetrovics, Z.; Urbánb, R. (2020). Targeting the problem of treatment non-adherence among mentally ill patients: The impact of loss, grief and stigma. *Psychiatry Research.*, **2020**, doi: <https://doi.org/10.1016/j.psychres.2020.113140>
60. Roncero, C.; Szerman, N.; Terán, A.; Pino, C.; Vázquez, J.M.; Velasco, E., García-Dorado, M.; Casas, M. Professionals' perception on the management of patients with dual disorders. *Dovepress Journal: Patient Preference and Adherence.*, **2016**, 10, 1855-1868
61. Bitter, I.; Feher, L.; Tenyi, T.; Czobor, P. Treatment adherence and insight in schizophrenia. *Psychiatr Hung*, **2015**, 30 (1): 18-26.
62. Novick, D.; Montgomery, W.; Treuer, T.; Aguado, J.; Kraemer, S.; Haro, J.P. Relationship of insight with medication adherence and the impact on outcomes in patient with schizophrenia and bipolar disorder: results from a 1-year European outpatient observational study. *BMC Psychiatry.*, **2015**, 15:189 DOI 10.1186/s12888-015-0560-4
63. Reddy, M.S. Insight and psychosis. *Indian JPsychol Med.*, **2015**, 37:257-60.
64. Kauppi, K.; Hatonen, H.; Adams, C.; Valimaki, M. Perceptions of treatment adherence among people with mental health problems and health care professionals. *Journal of Advanced Nursing.*, **2015**, 71(4).
65. Baker, P.J; Buchanan-Baker, P. Mental health nursing and the politics of recovery: a global reflection. *Arch Psychiatr Nurs.*, **2011**, 5, 350-8 doi: 10.1016/j.apnu.2011.03.009.
66. Presidential New Freedom Commission. Achieving the Promise: Transforming Mental Health Care in America. **2003**, <https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm> (Accessed September 08, 2022).
67. Le Boutillier, C.; Chevalier, A.; Lawrence, V.; Leamy, M.; Bird, V.J.; Macpherson, R., et al., Staff understanding of recovery-orientated mental health practice: a systematic review and narrative synthesis. *Implementation Science.*, **2015**,10:87, <https://DOI.10.1186/s13012-015-0275-4>
68. Australian Health Ministers' Advisory Council. *A National framework for recovery-oriented mental health services: policy and theory*. Canberra: Commonwealth of Australia; **2013**
from: <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-recovpol>. (Accessed September 08, 2022).
69. Mental Health Commission of Canada. Guidelines for Recovery-Oriented Practice. **2015**. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/MHCC_RecoveryGuidelines_ENG_0.pdf (Accessed September 08, 2022).
70. Ørjasæter, K.B. & Almvik, A. Challenges in Adopting Recovery-oriented Practices in Specialized Mental Health Care: “How Far Should Self-Determination Go; Should One be Allowed to Perish?”. *J. Psychosoc. Rehabil. Ment. Health*, **2022**, <https://doi.org/10.1007/s40737-022-00276-6>

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5. Results

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Manuscript Two: Assessment of nurses' knowledge of a recovery-oriented mental health care approach using the Recovery Knowledge Inventory: Findings from a developing country (To be submitted for publication)

Title page

Manuscript 2: Assessment of nurses' knowledge of a recovery-oriented mental health care approach using the Recovery Knowledge Inventory: Findings from a developing country (To be submitted for publication at Journal of clinical nursing)

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Abstract

The recovery-oriented mental health approach has been widely embraced and became a new hope for mental health services. Nevertheless, a common meaning of ‘recovery’ still has to be established in order to create a similar understanding of the term among mental health professionals. Nonetheless, the Recovery Knowledge Inventory (RKI) tool has been widely used to measure recovery in different countries.

Aim

To assess nurses' knowledge of a recovery-oriented mental health care approach using the Knowledge Recovery Inventory.

Methods

The study utilised a cross-sectional quantitative design. One hundred and forty-nine nurses consented to participate in the study. Data were analysed using the Statistical Software for Statistical Package for the Social Sciences (SPSS) version 27. Cronbach's Alpha was used to test the reliability of the variables used in the study. Some variables that would compromise the overall reliability of the questionnaire were excluded. Following the reliability test, exploratory factor analysis (EFA) was used to explore the possibility of factors describing recovery-oriented mental health care.

Results

After some validity and reliability test and adjustment, the RKI was valid and reliable and offered insight into how participants perceived recovery. The findings confirmed that nurses in this study lacked knowledge of the recovery approach in mental health.

Conclusion

There is evident lack of knowledge of the recovery approach among the participants. Based on the findings, the researcher recommends a launching of the recovery-oriented interventions to close the knowledge gap.

Key words: Recovery, Recovery Knowledge Inventory, Recovery-oriented mental health approach

Introduction

The Recovery-oriented mental health care approach emerged from Western countries as a new vision and beacon of hope for the mental health service as it sets a trajectory for recovery (Mongie et al 2023a). However, the meaning of recovery in the context of mental illness is still being mulled, it is difficult to find the meaning of recovery that applies to all as there is an element of personal touch and experience is attached to the meaning of recovery (Dell et al, 2020). That could allude to the recovery concept as viewed from the lens of publications of the personal accounts of consumers and mental health users on how they cope and live with mental illness (Kwok, 2014).

Nevertheless, the most common and widely cited contextualised definition of recovery is “a way of living a satisfying, hopeful, and contributing life even with limitations of the illness' (Anthony, 2003). It entails individuals living and doing things that bring them joy despite being diagnosed with mental illness. The definition is said to have a personal touch because recovery is different for all those diagnosed with mental illness. Others view it as a process of self-discovery following a diagnosis of mental illness (Davidson et al., 2005). Individuals with a mental illness diagnosis realise that it is impossible to return to a premorbid state but thrive in the possibility of living as long as they can with the condition.

Several governments and mental health services of well-developed Western countries have adopted the recovery concept (New Freedom Commission on Mental Health, 2016; Australian Department of Health, 2021). A scoping review by Mongie et al. (2023a) indicates that incidences from various studies have shown the effectiveness of recovery-oriented mental health care for people with mental illness. For instance, people with mental illness have shown tremendous changes in their lives, such as improved quality of life, reduced hospital stays, community participation, and improved self-image and esteem. Many clients value the recovery approach as a management of mental illness (Flaherty-Jones et al., 2016; Bitter et al., 2017; Frost et al., 2017). Despite the positive outcomes associated with recovery-oriented mental health care, there is still no clear and shared definition of recovery in mental health.

In order to have an improved understanding of recovery-oriented approach and possibly to practice it better, different tools have been developed to measure the health workers' understanding of the recovery concept. One such instrument is the Recovery Knowledge Inventory scale (RKI). The tool was developed in the United States of America (USA) by Bedregal et al. (2006). The RKI measures the healthcare workers' and patients' attitudes towards the recovery-oriented mental healthcare approach. In addition, the tool has been used to assess healthcare workers' knowledge of the recovery-oriented approach, with the hope of identifying their training needs in the understanding and implementation of the concept (Bedregal et al., 2006). The tool consists of 20 items based on the

principal component analysis and feedback from stakeholders on what should constitute recovery. The RKI has four parts on recovery which are roles and responsibilities in recovery, nonlinearity of the recovery process, the roles of self-definition and peers in recovery, and expectations regarding recovery (Bedregal et al., 2006). Items of the RKI are rated on a 1 to 5 Likert scale format with 1 representing strongly disagree and 5 strongly agree.

The RKI has been adopted and used in various studies to measure healthcare workers' knowledge of recovery-oriented approaches and has been found to be effective. Wilrycx et al. (2012) from the Netherlands used the Dutch 14 version of RKI (0.80) to assess the general knowledge of 210 health professionals who consented to participate in their study following a recovery intervention programme over time. The results showed an improvement in the knowledge of recovery of participants. In Italy, Giusti et al. (2021) assessed the effectiveness of a short personal recovery training programme for mental health professionals using the RKI. The results indicated that the recovery knowledge of participants improved, as indicated in their RKI score.

In Norway, Egeland and colleagues (2021) validated the adapted RKI in mental health workers and measured their attitudes and knowledge towards recovery. They translated RKI to Norwegian and tested it on a sample of 317 mental health care workers. Despite the challenges with the scale's psychometric properties, the RKI offered insights into how the participants understood recovery-oriented care. Their results showed a general need for more knowledge of the recovery-oriented approach when compared to other countries such as the United Kingdom. To account for the difference, the authors suggested that Norway was still in the early stages of the recovery approach and had not yet dedicated national programmes to it.

The recovery-oriented approach to mental health services in Africa is yet to be fully accepted. A scoping review by Mongie et al. (2023) indicates that Africa is still lacking in terms of policy, adoption and implementation of the recovery-oriented approach in mental health care services. In South Africa, the recovery approach in mental health was adopted at policy level and is yet to be translated into mental health service (Department of Health, South Africa, 2013). A study by Bila (2019) from South Africa, indicated a general lack of awareness on the recovery-oriented approach for mental illness.

As a neighbour to South Africa, Botswana is a country in southern Africa whose mental health services are still dominated by biomedical orientations. The country is serviced by only one main mental health referral hospital. Most of the mental health personnel who run mental health services across the country are nurses (Sidandi et al., 2011). In order to progress and adopt best practices in mental health care, Botswana should adopt the recovery-oriented approach for improved patient care. In order to do that, there was need to assess the knowledge of nurses on the recovery oriented using

the RKI. The study's intention was not to validate the RKI scale but to understand how nurses, as most mental health care workers in the country, understand the recovery-oriented care approach. The RKI was thus adopted to meet the purpose of the study, which was to assess nurses' knowledge of a recovery-oriented mental health care approach using the RKI.

Methods

This study was part of a large convergent parallel mixed method study conducted to solicit the views of nurses working in mental health facilities in Botswana about the recovery-oriented mental health care approach to developing a recovery-oriented mental health care programme for nurses in Botswana. This researcher used cross sectional quantitative methods and used RKI to collect data.

Context

According to Stremersch et al. (2023), a context is the "setting in which a phenomenon is studied". The study was conducted in four mental health facilities in Botswana. Among the four facilities was the only referral hospital in Botswana's south-eastern part. The referral hospital is a 300 beds facility offering outpatient and inpatient services to public members. The other three sites were mental health units attached to the district hospitals: one in the far Northeast of Botswana, one in Southwest Botswana, and one in the North-West of Botswana. Each of the three mental health units has a bed capacity of 10 to 15 patients, and they primarily serve as holding bays for patients in transit to the referral hospital.

Population and sample

A study population is the population of interest in a particular area that exhibits qualities that the researchers intend to study (Majid, 2018). For this study, the entire population of nurses in the five study sites was 242. Of the 242, only 76 nurses were qualified in mental health nursing, the rest were general nurses. A total of 152 questionnaires and consent forms were returned as the author distributed more questions than the estimated sample size. Using the RAOSOFT sample calculator and based on the confidence level of 95% and margin of error of 5% a sample, the sample size was calculated at 149. Three participants did not meet the inclusion criteria, which stated that one should be a nurse, should have worked in the mental health facility for at least three years providing direct care to people with mental illness and have a minimum diploma in nursing.

Data collection

Following clearance from the hospitals to conduct the study, first, the researcher identified a gatekeeper in each participating facility, the nurse in charge, and notified them of the study. However, due to the ongoing pandemic of Covid-19, the researcher informed the gatekeepers about the research

through email and later through a meeting on Microsoft Teams. The researcher explained the study's intended purpose and expectations to the mediators, who then shared it with the potential participants in all targeted facilities. The questionnaires were sent to the study sites through the courier services since the study was conducted during Covid-19 pandemic. A data collection questionnaire was distributed and administered to all five study sites through the help of the mediator and the independent person to all the nurses who consented to participate. Unfortunately, respondents in one site did not consent to participate despite receiving approval for the study. The facility whose nurses did not agree to participate in the research had only 11 nurses, thus making up 4.5% of the targeted population.

The data collection tool was divided into two parts: the demographic variables and RKI. The RKI has four structures for recovery, which are roles and responsibilities in recovery, nonlinearity of the recovery process, the roles of self-definition and peers in recovery, and expectations regarding recovery (Bedregal et al., 2006). Items of the RKI were rated on a 1 to 5 Likert scale format with 1 representing strongly disagree and 5 strongly agree. In addition, nurses were asked to rate their agreement with the statement on recovery concepts. RKI was administered in English as all nurses have undergone training in English, and the official language in the workplace in Botswana is English. The researchers were given permission to use the instrument by the developers.

Data analysis

According to Polit and Beck (2018), data analysis involves reviewing, coding, and logging data into statistical software packages for analysis. Quantitative data from the demographic variable and the RKI (Annexure 3) were analysed using the Statistical Software for Statistical Package for the Social Sciences (SPSS) version 27. The researcher used tables to present the participants' biographic profiles. Cronbach's Alpha was used to test the reliability of the variables used in the study. Some variables that could jeopardise the overall reliability of the questionnaire were excluded. Following the reliability test, exploratory factor analysis (EFA) was used to explore the possibility of factors describing recovery-oriented mental health care for nurses in Botswana. Following EFA, some constructs were identified, while other variables were analysed individually. For the constructs that were identified, Confirmatory Factor Analysis (CFA) was used to confirm the validity of those constructs. Following CFA, clustered bar charts were used to present the participants' responses per construct. This assisted in exploring and describing the nurses' understanding of the concept of recovery-oriented mental health care in Botswana. In addition, correlation analysis was used to determine the relationship between the constructs identified through EFA and CFA. The statistician was consulted during the data analysis phase to verify the results and authenticate them.

Reliability of RKI

Table 1. Reliability test for internal consistency of RKI

	Cronbach's Alpha	N of Items
Roles and responsibilities of recovery	.538	7
Nonlinearity of recovery	.663	4
The role of self-definition and peers in recovery	.693	4
Expectations regarding recovery	.394	2

A Cronbach Alpha of at least 0.6 indicates that the variables in a construct exhibit acceptable internal consistency (Al-Metwali et al., 2021), and they can be regarded as measuring the same construct. From the table above, the items in the constructs on 'Nonlinearity of recovery' and 'The role of self-definition and peers in recovery' have acceptable internal consistency. It was regarded as measuring the same constructs, which means that we can compute an aggregate score from them to represent the participants' responses for these constructs. However, this acceptable reliability was achieved after removing the item "NLR13_Symptom management is the first step towards recovery from mental illness/substance abuse" from the Nonlinearity of the recovery construct and the item "RSP18_All professionals should encourage clients to take risks in the pursuit of recovery" from The role of self-definition and peers in recovery construct. These items were found to be jeopardising the internal consistency of these constructs based on the reliability test statistic of "Cronbach's Alpha if Item Deleted".

For the constructs on Roles and responsibilities of recovery and Expectations regarding recovery, the items in these constructs did not show acceptable internal consistency since the Cronbach's Alpha values for these constructs are less than the acceptable minimum of 0.6. Also, the "Cronbach's Alpha if Item Deleted" statistics did not suggest removing any items to improve the alpha values for these constructs. As such, the items in these constructs were not regarded as measuring the same constructs, and we report the results per item and not per construct since the items do not measure the same constructs.

Validity of RKI

When doing research, it is crucial that the data collected is high quality and represents the study participants. Validity is the degree to which the research instrument accurately measures what it

intends to measure (Brink et al., 2018). Construct validity was used to assess the validity of RKI. According to Flake *et al.* (2017), construct validity describes the extent to which an instrument accurately measures what it is intended to measure within a particular context. RKI was used to assess the nurses' knowledge of recovery-oriented care. All the questions of RKI assess nurses' knowledge of recovery-oriented care.

Table 2. Construct validity test results

Factor1	Estimate	Std.Err	z-value	P-value	Std.lv	Std.all
RRR1	0.645	0.153	4.222	0.000	0.645	0.447
RRR2	0.338	0.123	2.751	0.006	0.338	0.322
RRR3	0.473	0.130	3.637	0.000	0.473	0.412
RRR4	0.342	0.133	2.567	0.010	0.342	0.307
RRR5	0.528	0.126	4.174	0.000	0.528	0.450
RRR6	0.505	0.159	3.174	0.002	0.505	0.382
RRR7	0.382	0.132	2.901	0.004	0.382	0.314
Factor2						
NLR8	0.531	0.083	6.395	0.000	0.531	0.571
NLR9	0.377	0.066	5.741	0.000	0.377	0.512
NLR10	0.328	0.047	6.955	0.000	0.328	0.599
NLR11	0.442	0.057	7.717	0.000	0.442	0.675
NLR13	0.235	0.074	3.166	0.002	0.235	0.296
Factor3						
RSP14	0.339	0.058	5.845	0.000	0.339	0.524
RSP15	0.488	0.062	7.859	0.000	0.488	0.671
RSP16	0.375	0.064	5.830	0.000	0.375	0.519
RSP17	0.559	0.070	7.999	0.000	0.559	0.684
RSP18	0.290	0.102	2.849	0.004	0.290	0.263
Factor4						
ER19	0.667	0.253	2.639	0.008	0.667	0.553
ER20	0.472	0.186	2.540	0.011	0.472	0.447

The construct validity test, which was performed using confirmatory factor analysis (CFAO), led to the removal of NLR12 from Factor 2 (Nonlinearity of Recovery) since it was found not to belong to this construct significantly (it had a p-value of 0.144 which is greater than the significance level of 0.05). Therefore, the table above was founded by re-running CFA after removing NLR12. The results show that all the p-values of the items are significant at 5% significance (p-values < 0.05). The findings confirm that each of the items significantly belongs to their respective constructs. As such, the constructs are valid. Table 3 presents the fit indices.

Table 3. CFA results-Goodness of fit indices

	Comparative Fit Index (CFI)	Non-Normed Fit Index (NNFI)	Root mean square error of approximation (RMSEA)	standardised root mean square residual (SRMR)
Author's model	0.766	0.725	0.065	0.077
Benchmark (Hooper et al., 2008)	At least 0.9	At least 0.95	Less than 0.08	Less than 0.08

Table 3 shows that based on the Absolute Fit Indices (RMSE and SRMR), which measure how well the model fits the data compared to no model at all, and the model fits well. However, the Incremental Fit Indices (CFI and TFI), which compare the fitted model to a baseline model, indicate that the fitted CFA model does not fit the data well. These opposing results may be due to a small dataset used in this study which is known to affect the SRMR and NNFI (Hooper et al., 2008). The interpretation of the constructs should be done with caution since the indices do not agree with the construct validity. These results may also be related to why some of the constructs' items were inconsistent based on the reliability test results in Table 1.

Ethical considerations

North-West University NuMIQ Scientific Research Committee granted the Ethical approval to conduct the study and then further cleared by the Faculty of Health Research Ethics Committee (NWU-HREC); *Ethics number NWU-00306-21-A1*. The researcher used ethical approval from the HREC to obtain permission from the Ministry of Health and Wellness Research and Ethics Committee in Botswana REF NO: HPDME 13/18/1 and goodwill permissions from the participating hospitals. The participants were informed about the purpose of the study, and they all signed a consent form to participate. Codes were used to protect the identity of individuals.

Results and Discussion of the Study

Demographic variables of participants and occupational attributes

Table 4: Demographic variables of participants

		N=152	
		n	%
		[Mean]	[SD]
Gender	Female	81	53.3
	Male	71	46.7
Occupation	Nurse	131	86.2
	Nurse manager	21	13.8
Age		[38.21]	[6.721]
Educational background	Diploma in Nursing	121	79.6
	Degree in Nursing	24	15.8
	Master's Degree in Nursing	7	4.6
Work status	General nurse	84	55.3
	Psychiatric mental health nurse	68	44.7
Department	Out Patient Department	62	40.8
	Psychiatric ward	90	59.2
Experience working in a mental health facility		[7.60]	[3.917]

Discussion

A total of 152 questionnaires were received from the participants for analysis. Only three (3) questionnaires did not meet the criteria for inclusion and therefore were excluded. An existing tool, RKI, was used to assess the nurses' knowledge of recovery in mental health care. Data were presented using bar charts.

This section will start with a description of the demographic variables followed by the respondents' perceptions on the Roles and Responsibilities of Recovery, Nonlinearity of Recovery, The roles of Self-Determination and Peers in Recovery, Expectations Regarding Recovery, and the conclusion.

The demographic variables of participants

A greater percentage of the respondents in this study were females (53.3%); their male counterparts comprised the remaining 46.7%. Only 13.8% of the respondents were nurse managers; the rest worked as support staff. In addition, most nurses had a diploma in general nursing, 15.8% had a degree in nursing, and only 4.6% had a master's degree qualification. Most respondents were working as general nurses without a qualification in mental health, only 44.7% were qualified in mental health.

Botswana's mental health care facilities are staffed with psychiatric mental health nurses and general nurses. Botswana, like other countries, continues to experience a shortage of mental health personnel (Sidandi *et al.*, 2011). Therefore, general, and psychiatric mental health nurses are deployed in mental health facilities and are responsible for taking care of people with SMI.

Perception of the nurses on the roles and responsibility of recovery.

This construct of the RKI had seven items; "Only people who are clinically stable should be involved in making decisions about their care.", "Recovery from mental illness is achieved by following a set of procedures.", "It is the responsibility of professionals to protect their clients against possible disappointments.", "The idea of recovery is relevant for those who have completed or are close to completing active treatment.", "People with mental illness/ substance abuse should not be burdened with the responsibility of everyday life.", "People receiving psychiatric/substance abuse treatment are unlikely to be able to decide their own treatment and rehabilitation goals." Each item under this construct was interpreted individually since the seven variables did not show an acceptable internal consistency and implied that they could not be reported as a construct. Table 5 summarises the participants' responses for each of these items.

Table 5: The nurses' perceptions of the roles and responsibilities of recovery.

	n	%
Strongly disagree	26	17
Only people who are clinically stable should be involved in making decisions about their care.	44	29
Disagree	13	9
Uncertain	36	24
Agree	33	22
Strongly agree	7	5
Recovery in serious mental illness/substance abuse is achieved by following a prescribed set of procedures.	11	7
Strongly disagree	5	3
Disagree	74	49
Uncertain	55	36
Agree	10	7
Strongly agree	11	7
It is the responsibility of professionals to protect their clients against possible failures and disappointments.	21	14
Disagree	61	40
Uncertain	49	32
Agree	7	5
Strongly agree	32	21
The idea of recovery is most relevant for those people who have completed, or are close to completing, active treatment.	17	11
Strongly disagree	74	49
Disagree	22	14
Uncertain	38	25
Agree	63	41
Strongly agree	14	9
People with mental illness/substance abuse should not be burdened with the responsibilities of everyday life.	31	20
Disagree	6	4
Uncertain	27	18
Agree	53	35
Strongly agree	7	5
People receiving psychiatric/substance abuse treatment are unlikely to be able to decide their own treatment and rehabilitation goals.	50	33
Strongly disagree	15	10
Disagree	31	21
Uncertain	58	38
Agree	24	16
Strongly agree	26	17
Recovery is not as relevant for those who are actively psychotic or abusing substances.	12	8

Only people who are clinically stable should be involved in making decisions about their care.

Nurses in this study had varying thoughts about the statement, "Only people who are clinically stable should be involved in making decisions about their care." 17% strongly disagreed, 29% disagreed

with the statement, and 22% strongly agreed or agreed (22%). 9% of the respondents were undecided. The findings of this study showed inconclusive results concerning the statement. However, findings from a similar study in Japan by Chiba *et al.* (2017) were conclusive that only clinically stable people should be involved in decisions about their care. On the other hand, respondents of a study from Norway (Egeland *et al.*, 2021) strongly disagreed with the statement. Recovery concepts emphasise that recovery can occur with or without symptoms. Everyone can participate in their recovery process if supported and given choices to lead their recovery process (Winsper *et al.*, 2020). In addition, Jacob (2015), in a commentary, observed that people with SMI may not have control of their symptoms. However, it could be possible for them to take control of their lives if they were given opportunities just like any member of society. The results indicated that respondents of this study could not decide whether people with symptoms of mental illness should or should not decide on their treatment.

Recovery from mental illness is achieved by following a set of procedures.

Most nurses in this study (84.9%) strongly agreed (36%) and agreed that recovery from mental illness could be achieved by following a set of procedures. Only 5% strongly disagreed, and 7% disagreed with the statement, and 3% were uncertain. These results confirm that respondents in this study had a poor orientation to the recovery approach, as the majority believed that one should follow prescribed activities to recover. Similar findings were established in a study by Egeland *et al.* (2021), whose respondents agreed that to recover from SMI, they should follow a set of procedures. On the other hand, respondents from a study in Japan disagreed with the statement that for one to recover from SMI, one should follow a set of prescribed procedures. The respondents in this study lacked orientation to recovery. The recovery approach in mental health is self-defined and an individualised process that is experienced differently by each person, and no prescription is followed (Jacob, 2015; Winsper *et al.*, 2020)

It is the responsibility of professionals to protect their clients against possible disappointments.

Seventy two percent (72.3%) of the respondents strongly agreed, forty percent (40%) agreed and thirty two percent (32%) that professionals' responsibility is to protect their clients against possible disappointments. Fourteen percent (14%) of the respondents were uncertain, seven (7%) strongly disagreed, and seven (7%) disagreed with the statement. The respondent believed that people with SMI should be responsible for their recovery and in charge of their recovery process. However, respondents in the study from Japan and Norway disagreed (Egeland *et al.*, 2021: 6; Chiba *et al.*, 2017). Recovery from mental illness is a personal journey, and people with SMI should take a central role in their recovery process (Chiba *et al.*, 2017). Very often, health professionals and family members of people with a diagnosis of SMI tend to have questionable approaches and overprotective tendencies towards clients' abilities (Jacob, 2015). Recovery principles talk about looking beyond

those barriers and looking at individuals with a diagnosis of SMI as people with the potential to set and achieve their recovery goal (Egeland et al., 2021). This belief is consistent with the person-centred approach by Carl Rogers that each individual can grow and achieve their desires provided they are cared for in a nurturing environment (Corey, 2013).

The idea of recovery is relevant for those who have completed or are close to completing active treatment.

Nurses in this study agreed (49%) and strongly agreed (14%), making (63.2%) that the idea of recovery is relevant for those who have completed or are close to completing active treatment. While 21% disagreed and 5% strongly disagreed with the statement. Eleven percent (11%) of the respondents were uncertain of whether recovery is relevant for those who have completed or are close to completing active treatment. However, these findings suggest that respondents in this study consider recovery possible only for people who are taking or have taken their treatment. This assumption shows respondents' low orientation to recovery concepts since the recovery approach advocates recovery possibility for all people with SMI, with or without treatment. A similar thinking pattern was noted in the research findings from Norway (Egeland et al., 2021). On the other hand, a study in Japan offered a differing view as the respondents disagreed with the statement (Chiba et al., 2017). Therefore, showing a good orientation to recovery concepts on this item.

People with mental illness/ substance abuse should not be burdened with the responsibility of everyday life.

The majority of the respondents in the study (65%) showed some orientation to recovery on this concept of recovery as they strongly disagreed (25%) and disagreed (41%) that people with mental illness/ substance abuse should not be burdened with the responsibility of everyday life. Twenty percent (20%) of the respondents agreed, and four (4%) strongly agreed with the statement. Nine (9%) of the respondents were uncertain. The findings of studies from Japan and Norway agree with the results of this study (Chiba et al., 2017; Egeland et al., 2021). These findings suggest that respondents in this study believe that people with serious mental illness should live an everyday life just like everyone in society. This belief supports the recovery approach that people with SMI should be engaged in societal activities and live everyday life like any other member of society. A systematic review on patient engagement to improve the quality of clients' care by Bombard et al. (2018) indicated that engagement of people with SMI in everyday activities improved their self-esteem, and they felt empowered. Healthcare professionals and society need to appreciate the potential of people with a diagnosis of SMI separate from their problems (Jacob, 2015). Through that, society will realise that people with SMI should also be engaged in everyday societal activities without being judged for their personal growth and well-being.

People receiving psychiatric/substance abuse treatment are unlikely to be able to decide their own treatment and rehabilitation goals.

Fifty two percent (52.7%) strongly disagreed, eighteen percent (18%) agreed and thirty-eight (38%) disagreed that people receiving psychiatric/substance abuse treatment are unlikely to decide their own treatment and rehabilitation goals, while 17% agreed and 8% strongly agreed. To support this finding, respondents from the studies in Norway and Japan (Egeland et al., 2021: 6; Chiba et al., 2017) disagreed or strongly disagreed with the same statement. This finding was suggestive that respondents in this study had a high orientation to the recovery approach principle that people with serious mental illness are capable of taking care of themselves and hence can also set their own recovery goals. This finding concurs with Self-Determination, which purports that all individuals strive for growth and well-being and will do great if given support and encouragement (Mancini, 2008). Therefore, health professionals should see beyond the illness of the client. Furthermore, they must not underestimate the power of self-determination of individuals under their care. Recovery involves seeing beyond the clients' problems and fostering a sense of purpose and growth in them (Jacob, 2015).

Recovery is not as relevant for those actively psychotic or abusing substances.

More than half of the respondents (58.9%) strongly disagreed (21%) and 18% agreed, while 38% disagreed with the statement that recovery is not relevant for those who are actively psychotic or abusing substances, while 17% agreed and 8% strongly agreed with the statement. Sixteen (16 %) of the respondents were uncertain about the statement. The results showed some variations in opinion, but they suggested that most nurses in this study had a good orientation to recovery since recovery is regarded relevant for all people with SMI. It is believed that everyone, as per client-centred therapy, has inherent qualities that can facilitate their recovery (Mancini: 2008). Findings from studies in Japan and Norway concur with the results of this study (Egeland: Most interventions in the recovery literature aim to improve the client's symptoms and functionality. Leendertse et al. (2021) recommended that health professionals look beyond symptom management and foster a sense of hope, belief, empowerment, and meaningful life in patients. Studies on patients' narratives of recovery have shown that they have described recovery as having a meaningful life, social functionality, and hope despite having mental illness symptoms (Ngo et al., 2020; Lietz et al., 2014).

Perception of Nurses on the Nonlinearity of Recovery

This construct of the RKI was treated as measuring the same thing as its items and were found to be consistent after removing NLR 12 and NLR 13, based on the reliability test for the construct. Since the items in the construct are internally consistent with each other within this construct, the results are

presented for the construct and not for each item of the construct which was done for the construct on the perception of the nurses on the roles and responsibility of recovery.

Table 6 Perception of Nurses of the Nonlinearity of Recovery

	n	%	
Nonlinearity of Recovery	Strongly disagree	0	0%
	Disagree	1	1%
	Uncertain	4	3%
	Agree	67	44%
	Strongly agree	80	53%

Most respondents strongly agreed (53%) and 44% agreed making 97% with the Nonlinearity of recovery. This implies that respondents in this study perceived recovery to be associated with a person with a diagnosis of mental illness making gradual steps forwards, not backward, and complying with treatment to reduce the symptoms as instrumental to recovery. It also suggests that nurses in this study believed that the severity of clients' symptoms would determine expectations about the patient's recovery. Finally, the finding suggested that participants in this study lacked knowledge of what recovery constitutes as a recovery approach and believed that everyone diagnosed with SMI could recover with or without treatment.

In a study from Australia by Hungerford et al. (2014), the perception of the recovery approach using RKI on mental health care practitioners in a mental health unit recovery-oriented mental health care approach did not agree with the Nonlinearity of recovery. The results indicated a low mean score of 2.94 on the construct nonlinearity of recovery. This finding confirmed that the participants viewed recovery as an individualised process and did not follow a linear pattern. Australia is one of the countries that have embraced the concept of recovery, and the Government has developed and implemented recovery in mental health settings (Commonwealth Australia, 2009). This could be the reason why the staff did not agree with the Nonlinearity of recovery as the participants had received training on the implementation of recovery-oriented services.

Roles of self-determination and peers in recovery.

Based on the reliability test for the construct, the items in the construct are internally consistent with each other, therefore; the results are presented for the construct and not for each item of the construct which was done for the construct on the perception of the nurses on the roles and responsibility of recovery.

Table 7: Perception of Nurses of the Role of Self-determination and peers in Recovery

	n	%	
The roles of self-definition and peers in recovery	Strongly disagree	0	0%
	Disagree	1	1%
	Uncertain	6	4%
	Agree	68	45%
	Strongly agree	77	51%

Respondents in this study strongly agreed (51%) and 45% agreed making 96% that self-determination and peers were vital in the recovery of people with a diagnosis of mental illness. The findings are corroborated by Hungerford et al. (2013) from Australia and Egeland et al. (2021) from Norway. The findings underscore the importance of the support of significant others and self-determination in the recovery process of individuals with SMI. According to Mancini (2008), research on self-determination has identified three critical factors necessary for human motivation and well-being: autonomy, competence, and relationships. The self-determination theory postulates that individuals strive for growth and well-being when supported and further purports that individuals have inherent qualities to meet those needs (Mancini, 2008). According to Jacob (2015), "The environment, which provides for personal growth, developing resilience to stress and adversity and allows people to develop cultural and spiritual perspectives is also crucial. Being believed in, listened to and understood by families, friends and health and social service personnel are very helpful to people on the road to recovery." Recovery-oriented mental health facilities have been associated with better patient recovery outcomes (Gamieldeen, 2021; Monroe-DeVita et al., 2018).

Nurses' Expectations on Recovery

Each item under this construct was interpreted individually since the four items did not show an acceptable internal consistency based on the reliability test. This implies that they cannot be reported as a construct, and the results for these items are reported individually as it was done for the construct on the perception of the nurses on the roles and responsibility of recovery. Table 8 summarise the participants' responses for each of these items.

Table 8: Nurses' Expectations on recovery

		n	%
Not everyone is capable of actively participating in the recovery process	Strongly disagree	15	10%
	Disagree	34	23%
	Uncertain	23	15%
	Agree	61	40%
	Strongly agree	18	12%
It is often harmful to have too high expectations for clients.	Strongly disagree	7	5%
	Disagree	19	13%
	Uncertain	21	14%
	Agree	77	51%
	Strongly agree	27	18%

Most respondents in this study strongly agreed (12%) and agreed (40%), with a combined score of 52% with the statement that not everyone is capable of actively participating in the recovery process. Twenty-three (23%) disagreed, and 10% strongly agreed with the statement. Fifteen (15%) of the respondents were uncertain of whether everybody is capable of participating in the recovery process. On the other hand, 18% strongly agreed, and 51% agreed that it is often harmful to have too high expectations for clients. 15% disagreed, and 5% strongly disagreed with the statement. Fourteen (14%) of the respondents were uncertain of the statement.

For example, 52.3% agreed with the item that not everyone is capable of participating in the recovery process, and 64.9% agreed with the view that it is often too harmful to have high expectations for clients. The recovery approach is based on the person-centred approach and supports individualised care. Healthcare professionals must see the individuals beyond their diagnosis and focus on their strengths and potential (Lietz et al., 2014: 000). Expectations about recovery between clients and patients differ. In most cases, healthcare workers expect clients to comply with their treatment and set realistic goals for their recovery, looking at the signs and symptoms of their mental illness (Stanhope et al., 2016). On the other hand, patients are to believing that support, hope, encouragement, and independent living are instrumental to their recovery (Lewis et al., 2012). Moreover, findings of a

study from Ghana in community-based facilities viewed medications, participation in the community activities and finding jobs as facilitators of clients' recovery (Gyamfi et al., 2020).

Conclusion

This study's respondents lacked knowledge of the recovery-oriented mental health approach, they put more emphasis on medication and adherence for people with mental illness to recover. They also believed that health professionals should take responsibility and make treatment decisions on the mental illness patients' healthcare recovery goals under their care. There was also a view that recovery is only relevant to those who have completed or are on treatment. These findings contradict with the recovery principles of the self-centredness approach and the value of self-determination. The recovery-oriented mental health care approach encourages individuals with mental illness to decide their treatment goals because it has been proven to increase their self-esteem and improve their general well-being.

Recovery was also viewed as a linear process. However, different people have described recovery as a multidimensional process. Therefore, patient plans should be individualised due to the nonlinearity of recovery. On the other hand, there were some positive views on the recovery-oriented approach from the participants. For instance, the participants agreed that patient engagement was essential in recovery. However, the findings suggested that nurses in this study lacked knowledge of the recovery approach in mental health care, underscoring the need for a recovery-oriented mental health care programme to be developed and implemented.

Relevance for clinical practice

Nurses form the backbone of the mental health practice in Botswana. Consequently, they must understand the latest developments in mental health practice, such as recovery-oriented practice. The study offered insights into how nurses understand recovery, the knowledge would help policymakers develop appropriate training programs. In addition, patients deserve to be cared for by competent and knowledgeable mental health care personnel, therefore, nurses need to stay abreast of the therapeutic advancements available in mental health care.

Data availability

The data supporting the results of this study have not been made available by the authors in any format.

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References

Al-Metwali, B. Z., Al-Jumaili, A. A., Al-Alag, Z. A. & Sorofan, B. (2021). Exploring the acceptance of COVID-19 vaccine among healthcare workers and general population using health belief model. *Journal of Evaluation in Clinical Practice*, 27, 1112-1122.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11-23. doi:10.1037/h0095655

Australian Department of Health. (2021). *Recovery Oriented Service Delivery*. Accessed from <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-recovgde-toc~mental-pubs-n-recovgde-5#:~:text=Recovery-oriented%20mental%20health> Date of access: 24 Jan 2021.

Australian Health Ministers' Advisory Council. (2013). A national framework for recovery-oriented mental health services: Guide for practitioners and providers. Commonwealth of Australia. <https://www.health.gov.au/sites/default/files/documents/2021/04/a-national-framework-for-recovery-oriented-mental-health-services-guide-for-practitioners-and-providers.pdf> Accessed 14 May 2023

Bedregal, L. E., O'Connell, M., & Davidson, L. (2006). The Recovery Knowledge Inventory: assessment of mental health staff knowledge and attitudes about recovery. *Psychiatric rehabilitation journal*, 30(2), 96-103.

Bila, N.J. (2019). Social workers' perspectives on the recovery-oriented mental health practice in Tshwane, South Africa. *Social Work in Mental Health*. 17(3) 344-363, DOI: 10.1080/15332985.2018.1554547

Bitter, N., Roeg, D., van Assen, M., van Nieuwenhuizen, C. & van Weeghel, J. (2017). How effective is the comprehensive approach to rehabilitation (CARE) methodology? A cluster randomised controlled trial. *BMC Psychiatry*, 17(1): 396. <http://dx.doi.org/10.1186/s12888-017-1565-y>

Brink, H., van der Walt, C., & Van Rensburg, G. (2018). *Fundamentals of research methodology for health care professionals*. 4th ed, Juta & Company, Capetown, South Africa.

Bombard, Y., Baker, G.R., Orlando, E., Fancott, C., Bhatia, P., Casalino, S. & Onate, K. (2018). Engaging patients to improve quality of care: a systematic review. *Implement Sci*, 26; 13(1):98, doi: 10.1186/s13012-018-0784-z

Chiba, R., Umeda, M., Goto, K., Miyamoto, Y., Yamaguchi, S. & Kawakami, N. (2017). The property of the Japanese version of the Recovery Knowledge Inventory (RKI) among mental health service providers: a cross-sectional study. *Int J Ment Health Syst*, 11:71. doi: 10.1186/s13033-017-0178-7.

Corey, G. (2013). *Theory and Practice of Counselling and Psychotherapy*. 9th ed, Belmont, CA, United States of America. Brooks/Cole,

Davidson, L., O'Connell, M. J., Tondora, J., Lawless, M., & Evans, A. C. (2005). Recovery in serious mental illness: A new wine or just a new bottle? *Professional Psychology: Research and Practice*, 36(5), 480-487.

Dell, N.A., Long, C. & Mancini, M.A. (2020). Models of recovery in mental illness. *Social Science Protocols*, 3: 1-9.

Department of Health (2013). *National Mental Health Policy Framework and Strategic Plan 2013–2020*. South African Department of Health, Gauteng. (2013) <https://www.health.gov.za/wp-content/uploads/2020/11/National-Mental-Health-Policy-Framework-and-Strategic-Plan-2013-2020.pdf> accessed 14 May 2023

Egeland, K.M., Benth, J.S. & [Heiervang](#), K.S. (2021). Recovery-oriented care: mental health workers' attitudes towards recovery from mental illness. *Scandinavian Journal of Caring Sciences*, 35, (3), 998-1005.

Flaherty-Jones GM, Carne AS, Dexter-Smith S. (2016). The steps to recovery program: Evaluation of a group-based intervention for older individuals receiving mental health services. *Psychiatr Rehabil J*, 39(1): 68-70. <http://dx.doi.org/10.1037/prj0000159>

Flake, J. K., Davidson, I. J., Wong, O. & Pek, J. 2022. *Construct validity and the validity of replication studies: A systematic review*. <https://doi.org/10.1037/amp0001006>

Frost, B.G., Turrell, M., Sly, K. A., Lewin, T.J., Conrad, A.M., Johnston, S., Tirupati, S. et al. (2017). Implementation of a recovery-oriented model in a sub-acute Intermediate Stay Mental Health Unit (ISMHU). *BMC Health Serv Res*, 17(1): 2. <http://dx.doi.org/10.1186/s12913-016-1939-8>

Giusti, L., Ussorio, D., Salza, A., Casacchia, M. & Roncone, R. (2022). Easier Said Than Done: The Challenge to Teach “Personal Recovery” to Mental Health Professionals Through a Short, Targeted and Structured Training Programme. *Community Mental Health Journal*, 58:1014–1023 <https://doi.org/10.1007/s10597-021-00910-w>

Gamielien, F., Galvaan, R., Myers, B. & Sorsdahl, K. (2020). Exploration of recovery of people living with severe mental illness (SMI) in low-income and middle-income countries (LMIC): a scoping review protocol. *BMJ Open*; 10: e032912. Doi: 10.1136/ bmjopen-2019-032912.

Gyamfi, N., Bhullar, N., Islam, M.S. and Usher, K. (2020). Knowledge and attitudes of mental health professionals and students regarding recovery: a systematic review. *BMC Psychiatry*, 20:355 <https://doi.org/10.1186/s12888-020-02768-w>

Hungerford, C., & Kench, P. (2013). The perceptions of health professionals of the implementation of recovery-oriented health services: A case study analysis. *Journal of Mental Health Training, Education and Practice*, 8(4), 208–218, <https://doi.org/doi:10.1108/JMHTEP-04-2012-0005>

Hooper, D., Coughlan, J. & Mullen, M. (2008). *Evaluating model fit: a synthesis of the structural equation modelling literature*. 7th European Conference on research methodology for business and management studies, 195-200.

Jacob, J.S. (2015). Recovery Model of Mental Illness: A Complementary Approach to Psychiatric Care. *Indian Journal of Psychological Medicine*, 37 (2) Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4418239/pdf/IJPsyM-37-117.pdf>, Accessed 24 Aug, 2022.

Kealeboga, K.M., Manyedi, E. & Moloko-Phiri, S. (2023). Recovery-oriented Programmes to Support the Recovery Approach to Mental Health in Africa: Findings of PhD: A Scoping Review. *The Open Journal of Nursing*. 17, DOI: 10.2174/18744346-v17-230223-2022-152, e18744346230214

Kwok, C. F. (2014). Beyond the clinical model of recovery: recovery of a Chinese immigrant woman with bipolar disorder. *East Asian Archives of Psychiatry*, 24, 129-133.

Lietz, C.A., Lacasse, J.R., Hayes, M.J. & Cheung, J. (2014). The role of services in mental health recovery: A qualitative examination of service experiences among individuals diagnosed with serious mental illness. *J Soc*, 5(2), 161-88.

Lewis, S.E., Hopper, K. & Healion, E. (2012). Partners in Recovery: Social Support and Accountability in a Consumer-Run Mental Health Center. *Psychiatric Services*. 63 (1)

Majid, U. (2018). Research Fundamentals: Study Design, Population, and Sample Size. *URNCSST Journal*, 2 (1), 1-7 DOI Link: <https://doi.org/10.26685/urncst.16>

Mongie, K.K., Eva, M. & Salamina, M. 2023a. Recovery Oriented Programms to Support the Recovery Approach to Mental Health in Africa. Findings of PhD: A Scoping Review. *The Open Nursing Journal*, 17, e1874434622302140. [10.2174/18744346-v17-230223-2022-152](https://doi.org/10.2174/18744346-v17-230223-2022-152)

Monroe-DeVita, M., Morse, G., Mueser, K. T., Gregory, G., Xie, H., Hallgren, K.A. *et al.* (2018). Implementing illness management and recovery within assertive community treatment: A pilot trial of feasibility and effectiveness. *Psychiatr Serv*, 69(5): 562-71. <http://dx.doi.org/10.1176/appi.ps.201700124>

New Freedom Commission on Mental Health. (2016). Achieving the Promise: *Transforming Mental Health Care in America. Final Report*. <https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf> Date of access: 03 Aug 2020.

Ngo, H., Ennals, P., Turut, S., Geelhoed, E. & Celenza, A. (2014). 4 Step-up, stepdown mental health care service: Evidence from Western Australia's first-a mixed-method cohort study. *BMC Psychiatry*, 20(1): 214. <http://dx.doi.org/10.1186/s12888-020-02609->

Parker, J.S. (2012). Developing the philosophy of recovery in South African mental health services. *Afr J Psychiatry*, 15, 17-419, doi: [10.4314/ajpsy.v15i6.51](https://doi.org/10.4314/ajpsy.v15i6.51)

Polit, D.N. & Beck, C. T. (2018). *Nursing research: Generating and assessing evidence for nursing practice*, 10th ed. Philadelphia. Wolters Kluwer.

Slade, M. (2009). 100 ways to support recovery: a guide for mental health professionals, *Rethink Recovery Series 2009*: v(1).

Sidandi, P., Opondo, P & Sebonetse, T. (2011). Mental health in Botswana. *BJPsych International*, 8(3):66-68.

Stanhope, V., Choy-Brown, M., Tiderington, E., Henwood, B.F. & Padgett, D.K. (2016). Case manager perspectives on the role of treatment in supportive housing for people with severe mental illness. *J Soc Social Work Res*, 7(3): 507-25. <http://dx.doi.org/10.1086/687986>

Stremmer, S., Gonzalez, J., Valenti, A. & Villanueva, A. (2023). The value of context-specific studies for marketing. *Journal of the Academy of Marketing Science*, 51:50–65. <https://doi.org/10.1007/s11747-022-00872-9>

Wilrycx, G.K.M.L., M.A., Croon, M.A., van den Broek, A.H.S. & Ch. van Nieuwenhuizen, C.H. (2012). Mental Health Recovery: Evaluation of a Recovery-Oriented Training Program. *The Scientific World Journal*, Article ID 820846, 8 doi:10.1100/2012/820846.

Winsper, C., Crawford-Docherty, A., Weich, S., Sarah-Jane Fenton, S., & Singh, S.P. (2020). How do recovery-oriented interventions contribute to personal mental health recovery? A systematic review and logic model. *Clinical Psychology Review*, 76. <https://doi.org/10.1016/j.cpr.2020.101815>

Appendix 3: Author Guidelines: Nursing Open

General submission information

We are delighted you are choosing to submit to Nursing Open. While we cannot provide any assurance of acceptance, we can say that following all of the following guidelines very carefully and asking any questions you might have along the way to this email address: Nursingopen@wiley.com

Nursing Open now offers Free Format submission for a simplified and streamlined submission process.

Statements relating to our ethics and integrity policies, which may include any of the following (Why are these important?

We need to uphold rigorous ethical standards for the research we consider for publication):

data availability statement

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Please see the details below on what to include in your title page and main document. Your manuscript may be returned to you if you do not submit all the required information.

Important: the journal operates a double-blind peer review policy. Please anonymize your manuscript and supply a separate title page file.

Authorship

All listed authors are to have contributed to the manuscript substantially, agreed to the order in which the author names appear, and agreed to the final submitted version. Review Wiley's editorial standards and see the ICJME description of authorship criteria.

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This journal requires ORCID. Refer to Wiley's resources on ORCID.

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This journal uses American Psychological Association (APA) Reference Style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter. All references must be in English.

Manuscript preparation

TITLE PAGE

The title page is to be submitted separately from all other files and must include the following as applicable:

1) a. A brief informative title (maximum 20 words) containing as many of the keywords for your submission as possible. Do not use country names or abbreviations in the title.

b. Craft your title with great thought and care for readability and maximum search discoverability (see Wiley's best practice SEO tips).

c. We require that you include the article type name at the end of the full article title as appropriate and applicable. Do not include the article type name in the title for Brief Reports, Commentary, Editorial, or Letter to the Editor. The article type name does not count towards the 20-word maximum.

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5) Insert all the declarations regarding conflicts of interest from all authors here. Include what they are if any, or if there are none for each author.

6) Corresponding author's contact email address and telephone number.7. Twitter handles for all authors and their affiliated school/university/organization if available; note these may not be included if a handle is not appropriate in a professional setting.8. The number of References for Clinical Trials, Empirical Research Mixed Methods, Empirical Research Qualitative, Empirical Research Qualitative, or Feasibility submissions permitted are shown in the Article Type chart as 25 or less. If more than 25 references are included address why here.

7) Conflict of Interest Statement

8) Acknowledgments

Acknowledgments, including all funding sources. The corresponding author is responsible for obtaining in writing permission for individual acknowledgements for those persons and their names to be included, for including the funding sources for all authors, and for the accuracy of funder designations. If in doubt, check the Open Funder Registry for the correct nomenclature. Include information from all authors specifying any sources of funding (institutional, private and corporate financial support) for the work reported in their paper. Include the name of the funding organization(s) and the grant number. If there was no funding, use this wording: "This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors." (NB: this does not apply to protocols). Name any suppliers of materials and their location (town, state/county, country) included if appropriate. This information will be included in the published article.

Confirm that any data utilised in the submitted manuscript have been lawfully acquired in accordance with The Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from Their Utilization to the Convention on Biological Diversity. State that the relevant fieldwork permission was obtained and list the permit numbers.

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The Journal uses a double-blind peer review process. ensure that all identifying information such as author names and affiliations, acknowledgements or explicit mentions of author institution in the text are on the title page and not in the main text file. It is not possible to anonymize trial registration entries. Reviewers will be able to view who conducted the trial when making essential checks of the registration entry.

For all article types except Brief Reports, Letter to the Editor, and Editorial the main text file to include the following information and/or headers:

Repeat the brief informative title (maximum 20 words) you included on the title page here.

The full names of the authors (last name in CAPITALS) including institutional affiliations where the work was conducted (maximum of three per author) and a footnote for the author's present address if different from where the work was conducted.

Abstract:

The abstract format for all article types is structured, except these article types do not include abstracts: Brief Report, Letter to the Editor, and Editorial.

Structured Abstract Format

300 words maximum.

b. No abbreviations.

c. Do not report p values, confidence intervals and other statistical parameters.

INCLUDE THE FOLLOWING HEADERS IN ABSTRACTS:

Aim(s) (of the paper, simply state 'To...')

Design

Keywords (You will be able to choose keywords when you begin the submission process, and you can select up to ten).

Review Methods

Data Sources (Include search dates)

Results (If statistical component is not minor e.g. more than basic descriptive statistics)

Conclusion

Implications for the profession and/or patient care

Impact (Addressing:)

What problem did the study address?

What were the main findings?

Where and on whom will the research have an impact?

Reporting Method: State here that you have adhered to relevant EQUATOR guidelines and name the reporting method.

Patient or Public Contribution: Include a paragraph that details how patients, service users, caregivers or members of the public were involved in your study. This may be the design or conduct of the study, analysis or interpretation of the data, or in the preparation of the manuscript.

OR

Include a statement at the end of the abstract titled "No Patient or Public Contribution" if such details are not necessary or don't apply to your work and state why. Your paper will be unsubmitted and returned to you if this section is not included.

MAIN TEXT HEADINGS

Introduction

Background

The study : Aims and objectives, Technical terminologies used to describe the aim if any, Method/ Methodology, Design, validity and reliability, sampling and recruitment, quality appraisal, sampling and recruitment, sample size and power, population and sample, inclusion and exclusion criteria, data sources/collection, data analysis, ethical considerations, findings, participants, Discussion, Strengths and limitations of the work, recommendations for further researchs and conclusion.

Date of Submission: 20 February 2023

Manuscript 3: Perceptions of nurses working in mental health services regarding the recovery-oriented care approach: Empirical Research Qualitative (*Published in Nursing Open Journal*)

Title page

Nursing Open Journal, Vol. 10, Issues 11, 2023, page 7348-7359, <https://doi.org/10.1002/nop2.1989>

Perceptions of nurses working in mental health services regarding the recovery-oriented care approach: Empirical Research Qualitative (Accepted for publication at Nurisng Open Journal)

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Abstract

Background

The recovery-oriented care approach in mental health is recognised as the vision for mental health. People with a diagnosis of mental illness value the support and the individualistic approach emphasised in the recovery-oriented mental health care approach as they believe it facilitates their recovery. However, as a developing country, Botswana has a long way to go in terms of availing mental health care resources to people with mental illness, let alone adopting new mental health approaches such as recovery.

Aim

The study aimed to explore and describe the perceptions of nurses working in mental health care facilities of recovery-oriented mental health care.

Methods

Four mental health facilities from Botswana consented to participate in the study. A descriptive qualitative approach was utilised to explore nurses' views on how they perceive recovery from mental illness. Thirty nurses participated in the focus group discussions across the four study sites. All participants consented to participate and to be recorded. Thematic analysis was used for this study.

Results

Three main themes were identified in participants' perceptions of a recovery-oriented care mental health: Recovery from mental illness is possible, the Meaning of recovery from mental illness and Factors facilitating recovery from mental illness.

Public contribution

The study offers a perspective into how nurses perceive recovery-oriented approaches from a developing country and add to the gap existing in recovery-oriented mental health care approach from the African context.

Keywords

Botswana, Mental health, Mental illness, Recovery

Introduction

Recovery-oriented mental health care approach is regarded as the new vision and hope for people with a diagnosis of mental illness (Anthony, 1993; Mental Health Commission of Canada, 2009). The approach came to light following advocacy from consumers and researchers in the mental health field upon the realisation that people with a diagnosis of mental illness can recover and live meaningful lives (Bilir, 2018). The recovery-oriented care provides person-centred care modelled on self-determinism, hope, autonomy, and empowerment (WHO, 2019). The model puts a person with a mental illness at the centre and in control of their illness. Most studies view the recovery approach in mental health as supporting, encouraging, inclusive and instrumental in facilitating recovery from mental illness (Matsuoka, 2015; 2016; Oedegaard et al., 2020; Tinland et al., 2020). The meaning of recovery in the context of the recovery-oriented mental health care approach mental health is described from both personal and clinical perspectives.

Personal recovery is conceptualised as living and enjoying life despite having symptoms of mental illness. It is the ability of an individual diagnosed with mental illness to live positively and satisfactorily, fulfilling much as possible with symptoms of mental illness (Bejerholm & Roe, 2019). The approach does not emphasise complete control of symptoms but focuses on a person taking control of the mental illness through resiliency and self-determination. In contrast, clinical recovery focuses on the total control and remission of symptoms to the point that the premorbid status of functionality is reached (Van Eck et al., 2018). More emphasis on clinical recovery is on diagnosis, treatment, and mental illness control with psychotropic drugs. This view of recovery is not in line with the recovery approach in mental health. There is a belief that recovery can happen with or without medication. Instead, in the recovery approach, more emphasis is on mental health facilities to find ways of facilitating that people with mental illnesses achieve their recovery goals and live a long-lasting, satisfying life.

People with a diagnosis of mental illness can recover, provided they are supported. Multiple factors contribute to individuals' recovery from mental illness, including personal and other related factors such as mental health personnel, mental health facility and family and peer support (Iseselo & Ambikie, 2020). The personal related factors that can facilitate the client's recovery from mental illness include the inherent factors that are peculiar to the individual. These include self-awareness, self-motivation and the drive of the individual to want to achieve something. In addition, insight is also one of the critical intrinsic factors that facilitate the recovery of an individual with a diagnosis of mental illness. According to the online Cambridge Dictionary, 2022, insight is "the ability to have a clear, deep, and sometimes sudden understanding of a complicated problem or situation." Patients who have insight into the cause of and management of their mental disorders are more likely to take treatment, adhere to it, and follow other recommendations from the health care personnel, including

other significant people involved in their care, in facilitating their recovery (Bitter, et al., 2015; Novick et al., 2015).

The other facilitators of recovery from mental illness are staff, facility and significant others. Mental health personnel who are well trained in mental health and have the right attitude to the care of clients with mental illness are critical in caring for and recovering clients. For a facility to be deemed recovery-oriented, it should have relevant staff with qualifications in mental health. The staff should have training in implementing a recovery-oriented mental health care approach to facilitate clients' Recovery (Chang et al., 2021). Furthermore, the staff should be embrative and be willing to accept that people with a diagnosis of mental illness can recover and be ready to support them in their recovery.

Familial and peer support is also influential in helping people with a diagnosis of mental health problems. Findings from Tanzania and Malawi have indicated that family support; such as giving patients love, housing, and financial and emotional support, is critical in the recovery of patients with mental illness (Chorwe-Sungani et al., 2015; Iseselo & Ambikie, 2020). Peer support has also proven to be beneficial in assisting people with a diagnosis of mental illness to recover. Peers are people with a mental illness diagnosis who deem themselves to have recovered from mental illness. Mead et al. (2021) define a peer as "*an equal*, someone with whom one shares demographic or social similarities, whereas *support*, refers to "the kind of deeply felt empathy, encouragement, and assistance that people with shared experiences can offer one another within a reciprocal relationship." There is a belief that peers are in a better place to offer advice and support to people with a mental illness diagnosis as they have gone through the process and can guide them without judgement (Shalaby & Agyapong, 2020). A literature review on peer support in mental health showed a general improvement in the quality of life of clients and a reduction in hospitalisations (Shalaby & Agyapong, 2020). On the contrary, the same study identified challenges of engaging peers, including self-stigma and societal stigma, low pay structure and role confusion. Nevertheless, the study emphasised the importance of peer support in supporting people with mental illness and therefore recommends a way forward of mitigating challenges experienced by peers and engaging them in the care of people with mental illness.

Most of the recovery-oriented programmes are developed and implemented in some western countries (Jørgensen, et al., 2023; Kealeboga et al., 2023), alluded that recovery-oriented approach in more visibly practiced in some Western countries. A scoping review by Kealeboga et al. (2023) indicated that the recovery-oriented approach is yet to be fully embraced by African countries and there is a need for Africa to develop and implement the recovery-oriented programmes which are informed by the local findings. In addition, WHO (2022) recommends mental health intervention that are backed by evidenced based practice. Botswana, like other African countries has not yet implemented the

recovery approach and still operates with a biomedical orientation to treatment of people with mental illness (Gamieldien et al., 2023). Most people with mental illness are admitted to psychiatric mental health units for inpatient care and the community mental health services are not operational. On the other hand, health-seeking behaviour of people in Botswana are influenced by their cultural beliefs and people mostly seek help from their traditional healers, spiritualists and herbalist before seeking help with mental health issues (Seloilwe, & Thupayagale-Tshweneyagae, 2007). In addition, the stigma and discrimination attached to mental illness prevent people from seeking help when sick (American Psychiatric Association, n.d). A study by Becker et al. (2019) from Botswana on the explanatory beliefs of stigma and mental illness in the context of HIV in Botswana among adults associated the cause of mental illness with witchcraft. The study recommended integrating the support of peers, traditional healers and other rehabilitative models that support recovery-oriented care.

Even though, Becker et al. (2019) made a recommendation for Botswana's mental health services to be recovery-oriented, the country faces challenges in implementing programmes in mental health services due to a lack of resources, such as a staff shortage and funds (Sidandi et al., 2011). The psychiatrists and other multidisciplinary team members are found at the only referral hospital and mainly service other small mental health units on a rotational basis (Opono et al., 2020). Psychiatric mental health nurses and general nurses are the majority of health personnel offering mental health services and run most mental health facilities (Becker et al., 2019). Nurses as the majority of the mental health personnel in the country, should understand latest developments in mental health care such the recovery-oriented approaches in mental health.

Therefore, the paper sought to explore the perceptions of nurses working in mental health facilities on their understanding of recovery in the context of mental health. To the researcher's knowledge, no study has been conducted in Botswana that sought the nurses' views on how they perceive recovery from mental illness.

Purpose

The study aimed to explore the nurses' perceptions of recovery-oriented care. Focusing on the central questions:

1. What are the nurses' descriptions of recovery?
2. What factors facilitate recovery from mental illness?

Research Design

This study utilised a qualitative approach to explore and describe nurses' views on how they perceive recovery from mental illness. Qualitative methods were chosen as help to gather in-depth data to understand contextual meaning about a phenomenon of interest (Hamilton & Finley, 2019).

Study context

The study was conducted in Botswana's primary referral psychiatric hospital and 3 district hospitals with psychiatric units attached to them. The only referral psychiatric hospital is about 70 kilometres from Gaborone, and it has a capacity of about 300 beds. The hospital has four (4) psychiatrists, psychologists (3), psychiatric mental health nurses (31), general nurses (149), social workers (4) and hospital attendants (61). Most of the health personnel in the hospital are general nurses and psychiatric mental health nurses.

The other sites are hospitals with psychiatric units, each with a bed capacity of about 20 patients. They serve mainly as holding bays for patients in transit to the only psychiatric referral hospital. The units are staffed by psychiatric mental health nurses, general nurses, one visiting psychologist, and a social worker from the main hospital. The three sites had a total of 39 nurses combined which made a total of 219 nurses.

Population and sample

The target population for this study was all nurses caring for people with a diagnosis of mental illness in all the four study sites (219). Nurses with at least a diploma in general nursing and three years of experience caring for people with mental illness were purposively selected to participate in the study. A total of 30 nurses consented to participate in the four focus group discussions (FGDs) in 4 study sites.

Data collection

Once permission to conduct the study was granted by the Ministry of Health and Wellness Botswana and the participating hospitals, recruitment of the study participants commenced. The mediator and independent person facilitated signing of the consent forms for those who agreed to participate in the study. At the time of data collection, covid-19 was still a problem, and virtual platforms were used as participating hospitals had emphasised the need to adhere to Covid-19 disease prevention protocols. As a result, the study participants and the researcher signed a virtual consent form. The signed consent form was sent to the researcher by an independent person via email and courier services. K.M.K conducted a PhD student conducted Four (4) FGDs through Microsoft Teams in the four sites whose participants consented to participate in the study. K.M.K has experience in qualitative methods and

has previous experience of conducting interviews through her previous published work in qualitative research methods. FGDs were used since they have the advantage of collecting data perceptions, beliefs or experiences from a group of 5 to 8 people with the same qualities needed by the study simultaneously and they are not time consuming (Center for Disease and Prevention, (2018). The participants used a mix of local language and English to answer the questions. Two FGDs had seven (7) participants, and the other two had eight (8) participants, each making a total of 30. Each FGD took at least 60 to 80 minutes due to connectivity issues. Before starting each interview, participants consented verbally to participate in the study and to be recorded. Researchers utilised open-ended questions and communication techniques such as probing, exploring and seeking clarification to explore how nurses understand the concept of recovery in mental health. Digital voice and field notes were used for data accuracy. The researcher summarised each FGD at the end, and other members affirmed to ensure member checking. Saturation was reached when it became obvious that the groups were not generating any new information (Saunders et al., 2018). Data saturation was reached at FGD three, but the researcher went ahead to conduct the last FDG to confirm the themes. The participants were each compensated with two hundred pula (P200.00) (\$12) for the data they used to participate in the study. None of the participants was exposed to Covid-19.

Data analysis

Recorded interviews were transcribed verbatim. Data were analysed using Tesch's (in Creswell, 2013:198) eight steps, which allows data to be reduced into themes and categories. The process was done for all the scripts, which saw new codes and categories emerge. Summary of the analyses:

- From the transcribed data, the researcher K.M.K read the transcribed scripts to make sense of them.
- K.M.K then pick one interesting, transcribed script and search for underlying meaning from it and jotted notes on the side.
- K.M.K then repeated the process for all the transcripts and grouped similar ideas into columns.
- Once the ideas are grouped together, the researcher took the completed list and revisit the data. Abbreviations were used to code the topics and put them next to the text that represent that particular code. This help to see if any new codes and categories will emerged.
- Descriptive words were used to name the topics and group them into categories. At this stage topics that related were grouped together to reduce the number of topics.
- The researcher made a final naming of each category, and they were arranged into codes alphabetically.
- Data was assembled according to a category it belongs to for preliminary analysis.
- Recoding was done to complete the process.

The process was completed by K.M.K and an independent co-coder experienced in qualitative methods. Afterwards, a meeting was organised to discuss the themes and categories and a consensus was reached on the naming of the themes and sub themes.

Measures to ensure trustworthiness.

The researcher ensured credibility through prolonged engagement, persistent observation, triangulation, and member checking. A co-coder, well-experienced in qualitative research identified through the help of study supervisors, was engaged. To ensure transferability, the researcher gave a thick description of the context. It includes the participants' demographic details, a description of the settings and a description of direct quotes from the focus group discussions. The researcher ensured dependability through an audit inquiry. The research process is well documented in detail to allow the readers to determine the extent to which I was followed. Confirmability was assured through an audit trail. The researcher developed an audit trail document or checklist that would allow an external observer to assess the data's authenticity. The researcher followed the research process thoroughly. Lastly, the study captured detailed descriptions of the context and the co-coder to ensure authenticity.

Ethical considerations

The Ethical approval to conduct the study was granted North-West University Health Research Ethics Committee (NWU-HREG) then further cleared by the Ministry of Health and Wellness Botswana REF NO: HPDME 13/18/1 and the goodwill permissions from the participating hospitals. The participants were informed of their rights and told that participation was voluntary and that they could leave the study without penalty. Codes like P0 to P8 were used to ensure anonymity.

Results and discussion

Demographic variables of participants

Participants' age ranged from 26 to 53 years. Only 3 (10%) of the participants had a degree in nursing, 2 (6.66%) had a Master of Nursing, and the remaining 25 (83.3%) had a diploma in nursing qualification. In addition, 14 (46.66%) nurses had an additional qualification of diploma in psychiatric mental health nursing and the rest were general nurses. 2 (6.65%) of the participants were nurse managers. The highest years of experience working in a mental health facility was 13 years, and the minimum was four years.

Themes and sub-themes

Data analysis identified three themes; 'Recovery from mental illness is possible.' Meaning of Recovery from mental illness.', and 'Factors facilitating recovery from mental illness'. The subthemes follow the themes.

Table 1: Showing themes and subthemes.

Theme	Subthemes
- Recovery from mental illness is possible	Recovery is possible and depends on the type of mental illness
- Meaning of recovery from mental illness	Reduction of mental illness symptoms
	Treatment and adherence
	Functionality and living a meaningful life
	Regaining insight into their mental state
Factors facilitating recovery from mental illness	
Patient-related factors	Patient-related factors
	Having insight, acceptance of diagnosis and self and treatment
	Adherence to medication
Staff-related factors	Qualified and skilled healthcare workers
	The ability to see each patient individually and set up treatment modalities accordingly
	Giving unconditional support and acting in the best interest of patients
	Instillation of hope for the future
	Creating a safe environment for patients to recover
Facility-Related Factors	Having more qualified and skilled mental health personnel
	Functional multidisciplinary team
	Provision of a holistic care
Support from significant others	Support from family

Theme 1: Recovery from mental illness is possible.

Participants in this study believed that clients with a diagnosis of mental illness could recover, and their recovery would depend on the type and severity of mental illness (Table 1). For debilitating conditions like schizophrenia, clients could only stabilise from them. They said:

L, P4: "Yes, I think it is possible to recover, and it is happening. It depends on the type of mental illness the person has."

F, P6: "We have different mental illnesses, and recovery will depend on the patient's illness."

Other Participants mentioned that recovery is possible, but only stability can be reached for some conditions.

L, P0: "It will depend on the medical condition, say schizophrenia. It is hard for somebody to recover, but they do stabilise."

One participant mentioned that a patient could recover, and the chance of relapses with conditions like schizophrenia is very high.

L, P2: "With schizophrenic disorders, it is possible to recover though we know the chances of relapse are high."

Theme 2: Meaning of recovery from mental illness

The participant further described the meaning of recovery in the context of mental health. As a result, four sub-themes emerged on what recovery constitutes; 1) functionality and living a meaningful life, 2) regaining insight into their mental state, 3) treatment and adherence, and 4) the ability to differentiate right from wrong.

2.1 Reduction of mental illness symptoms

The participants in this study contextualised recovery as reducing the patients' symptoms for them to say recovery has taken place.

One participant said:

M, P3: 'Recovery is when we don't see abnormal symptoms in the patients.'

2.2 Treatment and adherence

Participants believed that for an individual with a diagnosis of mental illness to be considered to have recovered, they should take their treatment and adhere to it.

One stated that:

F, P7: 'Some conditions are because of chemical imbalances, and only treatment can help eliminate the signs and symptoms.'

F, P5: 'Other conditions are chronic, and patients cannot stay alone without treatment. For example, schizophrenia is a chronic condition and needs treatment to control the symptoms.'

On adherence to treatment, some stated that:

L, P1: 'I think patients should adhere to their treatment. Adherence is the key. If they adhere and they accept their mental condition.'

2.3 Functionality and living a meaningful life

Participants in this study viewed the ability to function and participate in society as a form of recovery from mental illness. In addition, they believed that if patients could think and make decisions for themselves, they could be considered recovered. Most importantly, they viewed having hope for the future as a critical drive in clients' recovery.

One participant mentioned being able to participate in everyday activities as having recovered from mental illness.

F, P1: 'Being back to the state where they can rationalise the situation and contribute in the society, participate in daily activities, and come up with suggestions on things which we think make sense.'

Others mentioned the ability to contribute to the community and have a sense of hope as they recover from mental illness. They stated that:

M, P5: 'When the client can contribute to the community with or without mental health issues. That individual has hope in life and have a purpose in life.'

2.4 Regaining insight into their mental state

In addition to taking medication and adhering to it, other participants felt that an individual was considered to have recovered from mental illness if they had insight into their illness.

They said:

M, P6: 'I believe recovery is when the client can see the difference in themselves.'

The participants mentioned that the insight should include understanding their conditions and the importance of medication adherence.

They said:

L, P4: 'They should have full or partial insight, understand their problem, and adhere to all the necessary treatment to recover.'

Theme 3: Factors facilitating recovery of clients from mental illness

Participants identified factors that can facilitate the recovery from mental illness as 1) patient-related factors, 2) staff-related factors, 3) facility-related factors, and 4) support from family and the community.

3.1 Patient-related factors

Patient-related factors include all the activities controlled by the individual to facilitate their recovery, and they involve inherent qualities such as will and desire to overcome the problem. Others involve readiness to comply with accepting and following the health workers' prescriptions and protocols. The participants in this study believed that people with a diagnosis of mental illness could facilitate their recovery. Two sub-themes emerged from the findings: 1) having insight, and 2) acceptance of the diagnosis, self and their treatment and adhering to it.

3.1.1 Having insight, acceptance of diagnosis and self and treatment

Participants believed that an individual should have an insight into what they are going through. For example, individuals diagnosed with mental illness should accept that they are sick and need help. They should also accept that they need help and be willing to accept the recommended intervention.

There was a general belief that clients with a diagnosis of mental illness should own their recovery process. They said:

F, P2: 'It should start with themselves accepting that they need help.'

S, P1: 'I strongly believe that for one to recover, they must first accept that they need help.'

In addition to accepting themselves, participants expressed that people with mental illness should accept their diagnosis and treatment.

They stated that:

M, P1: 'It should come from the individual by accepting that they are mentally ill, need to learn about their condition, and accept that they need treatment.'

L, P2: 'If you accept yourself, you as well see the importance of treatment, and in process, the patient can take care of themselves.'

3.1.2 Adherence to medication

There was a strong belief that to recover from mental illness; one must take treatment and adhere to it. The treatment was more associated with the use of psychotropic drugs.

This is what they said:

F, P3: 'One of the most important things is the medication and the readiness of the patient to receive it.'

L, P1: 'I think patients should adhere to their treatment. Adherence is the key.'

3.2 Staff-related factors

Participants in this study believed that patients' recovery could be facilitated by having qualified and skilled healthcare workers. The staff should be able to see each client as an individual and use suitable treatment modalities, give unconditional support in the best interest of patients, instil hope and create a safe environment for patients to recover.

3.2.1 Qualified and skilled healthcare workers

The participants in this study emphasised the importance of qualified mental health staff and the presence of a multidisciplinary team as facilitators of recovery from mental illness.

There was a general belief that trained and skilled mental health personnel could better facilitate the recovery process of people with mental illness. They stated that:

F, P4: 'In most cases, when they come in, they are unstable-minded. We should welcome them in an environment that is welcoming and client-centred. We should also use the multidisciplinary team approach to help the clients to recover.'

L, P6: 'The health workers should possess the right qualifications that will enable them to function and care for patients better.'

3.2.2 The ability to see each patient individually and set up treatment modalities accordingly.

One participant believed patients should be treated as individuals and have personalised care.

The participant said:

M, P7: 'Recovery-oriented approach, in my view, will include the understanding that each person is unique and should be supported to make their own choices in their recovery plan. This means that you cannot have patients towards same recovery plan; they should be treated as individuals and uniquely because people respond differently and uniquely to treatment.'

3.2.3 Giving unconditional support and acting in the best interest of patients

The participants felt that clients could recover if the staff fully supported patients. In addition, they believed that patients should be cared for with love, respect and the right positive attitudes that a mental health nurse practitioner should possess, such as being non-judgemental, empathetic, listening and accommodating to all clients. The right attitude towards patient care, such as love, empathy, non-judgemental attitude, support, respect and the instillation of hope, is essential to the recovery from mental illness.

One participant said:

M, P5: "One can recover from most mental illnesses depending on the support they get from health care workers and the family."

In addition, participants expressed support through views of respecting the client and treating them as one of them. These factors are fundamental to the recovery of patients as this can boost their self-esteem and improve their recovery.

One stated that:

L, P6: 'They should be sensitive and respectful to each patient and treat them with dignity.'

Lastly, the staff emphasised the need for staff to have good personal attributes such as love, warmth and patience when caring for patients, as that could facilitate their recovery.

This is what they said:

S, P1: 'Each individual is unique, and we should be able to support them with their choices, have an ear to listen and treat them with respect.'

M, P7: 'How the nurse portrays themselves to the patients can also facilitate recovery. Particularly with being empathetic to mentally ill clients. Empathy is one of the nurse's qualities that can help clients feel better about themselves.'

3.2.4 Instillation of hope for the future

The results also indicated that the participants felt that clients should be cared for with hope. Participants stated that staff should instil positivity in people with mental illness to facilitate recovery.

One participant stated that:

S, P4: 'A relevant approach to therapy will help client recover. They should not be judged or looked at as being jugged. We should instill hope and positivity in them to help to recover.'

3.2.5 Creating a safe environment for patients to recover

In addition to the instillation of hope, the participants in this study believed that for the staff to facilitate better recovery of clients with a diagnosis of mental illness, they should provide a safe environment for them. Participants associated clients' safety with providing quality care by competent, knowledgeable and qualified mental health personnel. The provision of care should be in a therapeutic and not punitive environment.

This is what they said:

F, P2: 'We need to have that warm environment and necessary equipment for the mentally ill. We should show them that they are people. We should feed them properly and take care of them in a calming environment and handle them by trained staff.'

L, P0: 'The Environment should facilitate recovery not as if they are being punished.'

3.3 Facility-Related Factors

Participants believed that a mental health facility could facilitate the recovery of people with a diagnosis of mental illness if it has; 1) more qualified and skilled mental health personnel, 2) a functional multidisciplinary team, and 3) provide holistic care.

3.3.1 Having more qualified and skilled mental health personnel

There was a general view that a facility staffed with trained mental health personnel could better facilitate the recovery of clients with a diagnosis of mental illness.

They stated that:

S, P2: 'I believe we should have competent personnel in mental health facilities from all areas of mental health. These include mental health nurses, psychiatrists, psychologists and other mental health personnel.'

3.3.2 Functional multidisciplinary team

The participants not only expressed the need to have the right staff but also the need for a facility to have a functional multidisciplinary team.

They stated that:

M, P6: 'Multidisciplinary professions can help the clients recover. It is not about the treatment, but the support from other professions that we know can be part of the client's recovery.'

3.3.3 Provision of a holistic care

The participants further indicated that mental health facilities should cater for the spiritual well-being of clients by so doing providing holistic care. Mental health facilities are considered to be providing clients with holistic care. However, participants in this study felt that clients in Botswana's mental health settings are not provided with holistic care, so they felt that more should be done.

They stated that:

F, P7: 'Holistic care, the support from the family, the medications and a lot of things are needed to get maximum recovery or 100% recovery.'

M, P7: 'The spiritual aspect is very important in recovery. The hospitals should respect the spirituality of patients. You know patients can want their pastors and traditional healers to see them and I think the hospitals should allow that. Facilities can have policies that regulate at what level patients engage in spirituality.'

3.4 Support from significant others

Lastly, there was a strong emphasis for the facilities to involve patients' families in their care for support. Participants identified that family support was crucial to clients' recovery from mental illness.

3.4.1 Support from family

Support from family members was seen as necessary in recovering people with mental illness. They stated that:

M, P5: 'For most mental illnesses one can recover depending on the support they get from the care of the health care workers and from the family.'

M, P6: 'The support from the family is very vital when it comes to taking care of a mentally ill client.'

Discussion

This study explored and described nurses' perceptions regarding recovery-oriented mental health care programmes. The findings revealed three themes; *'Recovery from mental illness is possible.'* *Meaning of Recovery from mental illness.'*, *'Factors facilitating recovery from mental illness and Implementation of the recovery-oriented mental health care programme.'*

Participants in this study believed that clients with a diagnosis of mental illness could recover, and their recovery would depend on the type and severity of mental illness. This result supports the findings of Tse et al., (2013) and Bitter et al. (2020). When asked what Recovery from SMI for clients will mean, the participants in this study strongly felt that it would mean living a meaningful life, managing symptoms, taking and adhering to treatment, having normal functionality, having the ability to distinguish wrong and right, having insight, and most importantly having hope for the future. Similar findings were found in a study by Stanhope et al. (2016) where adherence to medication was viewed as central to recovery from mental illness.

Studies on clients' perspectives of recovery agree with the findings of this study on attaching recovery from mental illness to having a meaningful life, functionality and hope for the future. In addition, clients identified having meaningful relationships and general improvement in well-being as necessary in their recovery (Kirst et al., 2019). These findings are further supported by Matsuoka (2015), where clients reported being hopeful for the future after participating in a recovery-oriented mental health programme in Canada. Recovery-oriented principles emphasise living a meaningful life and having hope for the future despite the effects of a debilitating mental illness as essential to the recovery of individuals with SMI (Keet et al., 2019; Victorian Department of Health 2011 as cited in Australian Department of Health 2021:1 online).

On the other hand, clients in other studies seemed to disagree that medication is integral to their recovery process as they believe it is just one ingredient that facilitates recovery, as one can recover with or without treatment (Jacob, 2015). A study by Oedegaard et al. (2020) on medication-free treatment interventions indicated that patients offered alternative treatment instead of psychotropic drugs improved in general well-being and valued the importance of having choices as treatment options as it facilitated their recovery. Participants in this study also identified regaining insight into the illness or situation as recovery from mental illness. In support of these findings, participants in a study by Stanhope et al. (2016)'s believed clients should have insight into their condition to recover. A commentary on making sense of personal recovery from mental illness by Lim (2017) described the process of recovery as starting with self-discovery, which they believe individuals with a mental illness can utilise to rebuild themselves despite the debilitating effects of illness. The findings suggest that for recovery to occur, one should have insight, which alone could ignite the hope essential for their recovery process.

Participants in this study further expressed their views of factors which they believed could facilitate the recovery of people with mental illness. They mentioned patient, staff, facility, family and peer-related factors. For patient-related factors that facilitate recovery from serious mental illness, participants mentioned having insight and taking and adhering to medication. The importance of patients' adherence and insight has already been emphasised (Garcia-Cabeza, et al., 2018). Furthermore, findings from Hyder et al. (2021) on compliance and insight in patients with schizophrenia indicated that patients who lacked insight into their diagnosis were more likely to have poor compliance and, therefore, less likely to benefit from the medication. Adherence to medication such as clozapine was found to be influential in good sleeping patterns and reduced auditory hallucinations (Kaar et al., 2019). This finding may help us understand that those taking medications improve their decision-making skills and ensure that they accept their mental condition.

The participants in this study indicated the importance of a qualified, multidisciplinary team in caring for people with mental illness. They indicated that people with mental illness should be cared for by

health personnel with professional training in mental health. In support of this study's findings, Piat et al. (2021) indicated that staff with the proper knowledge of the latest field development could facilitate patients' recovery. Their study indicated the importance of training new staff to familiarise themselves with new procedures in mental health care provision.

The current study results demonstrate the importance of individualising patient care. Participants expressed that each client is treated as an individual when providing care. The study findings align with that of Coffey et al. (2019), which found that all individuals need individualised treatment care plans to facilitate their recovery. The SAMHSA (2022) recognises recovery as an individual process to reaffirm this finding. As such, each client should be treated individually and have personalised care plans. Therefore, as mental health care workers, it is essential not to apply a size fits all plan of care to patients and to assess each client individually and come up with their recovery plan.

The study findings highlighted the importance of supporting people with mental illness. There was a consensus that if clients were supported, they could recover. The support included treating the patient with respect and conveying an accepting attitude to accord them the self-esteem and dignity they desire. In addition, the qualities of a health care worker were seen as essential as facilitating recovery of clients. The results are supported by findings of (Iseselo & Ambikile, 2020; Moudatsou, et al., 2020; Piat et al., 2021).

Participants in this study believed that people with mental illness should be encouraged and instilled with hope to facilitate their recovery. Therefore, the staff should encourage positivity in the clients under their care. This study's findings support Sari et al. (2021)'s findings that patients with schizophrenia who were hopeful were more likely to recover than those who did not. In addition, a concept paper by Park and Chen (2016) identified that instilling hope in an individual gives them the sense to want to live and find a purpose to fulfil in life. The Park and Chen study further emphasised that having hope motivates an individual with mental illness to try and engage more in their recovery process with a purpose. Furthermore, Acharya and Agius (2017) emphasised that hope is a catalyst for an individual to want to change and recover. Therefore, the instillation of hope in clients can be a recipe for clients' recovery in a mental health facility.

The study participants also believed that a safe and very conducive environment is instrumental for clients' recovery. Participants viewed safety as the physical structure and competency level of staff. Patients should have the assurance that they are being cared for by skilled multidisciplinary mental health care personnel. The results are in line with other findings where patients identified the staff qualities such as abilities of health care personnel to diagnose and treat problems as instrumental in their recovery (Lietz et al., 2014; Keet et al., 2017; Iseselo & Ambikile, 2020; Boden et al., 2021) and being empathetic caring and displaying a non-judgemental attitude as fundamental to recovery

(White, 2022; Piat et al. 2021). However, the mental health care facilities in Botswana are staffed with health workers with and without training in mental health care training. For instance, most facilities have more general nurses than psychiatric mental health nurses and more general doctors due to the shortage of staff trained in mental health care. Therefore, there is a need to train more mental health staff to care for clients with confidence.

This study also viewed a holistic approach to care as essential in recovering people with mental illness. A holistic approach is a provision of care underpinned by biological, psychological, social, cultural and even spiritual aspects of a client's world. It entails providing care that aims to provide care that addresses the physical, mental and social needs of individuals. In their study, Yusuf et al. (2019) developed a comprehensive, holistic care model based on the nurses' perception of what should be. The results indicated that holistic care included a client's biological, psychological, social, cultural and spiritual spheres. The spiritual needs of clients are often left unattended as more focus in most mental health settings is on the biological, psychological and social aspects; therefore, the participants in this study recommended that the spiritual realm be included in clients' care plans.

This paper also highlighted the importance of family and peer support for people with mental illness. Support for clients with a diagnosis of mental illness as necessary for their recovery (WHO, 2014). Furthermore, findings from a consumer-run mental health facility indicated that clients who utilised the services felt a sense of belonging and support. Additionally, they felt offered non-judgmental care (Lewis, Hopper, & Healion, 2012). Similar results were found in the study by Reed et al. (2014) which indicated peers were instrumental in meeting the client's therapeutic goals of people with mental illness. A literature review (Shalaby & Agyapong, 2019) on peer support in mental health also indicated an increase in the running and advocacy of peer-run mental health facilities due to the benefits of connectedness clients feel with peer support.

Lessons learned.

Nurses in this study offered a perspective on what recovery from mental illness entails. It also became apparent that they attributed recovery from mental illness to taking and adhering to medications. However, the recovery-oriented approach does not emphasise medication adherence. Instead, people diagnosed with serious mental illness find what works for them and live happily with or without medication. Therefore, nurses would need to be fully oriented to the recovery-oriented mental health care approach as applied in mental health.

Recommendations

Nurses in this study offered a perspective on what recovery from mental illness entails. It also became apparent that they attributed recovery from mental illness to taking and adhering to medications.

However, the recovery-oriented approach does not emphasise medication adherence. Instead, people diagnosed with serious mental illness find what works for them and live happily with or without medication. Therefore, nurses would need to be fully oriented to the recovery-oriented mental health care approach as applied in mental health.

Limitations of the study

The study is the first to report on the nurses' perceptions of recovery-oriented care in Botswana. The study provides insights into how nurses believe people with mental illness can be supported during recovery. However, the study findings are limited to the views of nurses who participated and cannot be generalised to all nurses in Botswana.

Conclusion

The recovery-oriented care approach has shown its value through numerous study findings by people diagnosed with mental illness for its support and client-centeredness. Participants in the study believed that people diagnosed with mental illness could recover, and they identified the inherent patient and other factors such as staff, family and peers as crucial in the care of clients with mental illness. The results could inform the development of mental health interventions and policies for mental health services in the country and contribute to the larger base of research on mental health interventions from developing countries.

References

- American Psychiatric Association. (n.d). *Stigma, Prejudice and Discrimination against People with Mental Illness*. <https://www.psychiatry.org/patients-families/stigma-and-discrimination>
- Anthony, W.A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosoc Rehabil J*. 16(4):11.
- Acharya, T. & Agius, M. (2017). The importance of hope against other factors in the recovery of mental illness. *Psychiatria Danubina*, 29, (3), 619-622.
- Becker, T.D., Ho-Foster, A.R., Poku, O.B., Marobela, S., Mehta, H., Cao, D.T.X., et al. (2019). “It’s When the Trees Blossom” Explanatory Beliefs, Stigma, and Mental Illness in the Context of HIV in Botswana. *Qualitative Health Research*, 1-15.
- Bejholm, U. & Roe, D. (2019). Personal recovery with positive psychiatry. *Nordic Journal of Psychiatry*. 72 (6), 420-430. <https://doi.org/10.108039488.2018.1492015>
- Bilir, M.K. 2018. Deinstitutionalisation in Mental Health Policy: from Institutional-Based to Community- Based Mental Healthcare Services. *Hacettepe Journal of Health Administration*, 21(3): 563-576.
- Bitter, I., Feher, L., Tenyi, T. & Czobor, P. (2015). Treatment adherence and insight in schizophrenia. *Psychiatr Hung*, 30 (1): 18-26.
- Bitter, N., Roeg, D., van Nieuwenhuizen., & van Weeghel. (2020). Recovery in Supported Accommodations: A Scoping Review and Synthesis of Interventions for People with Severe Mental Illness. *Community Mental Health Journal*, 56:1053–1076. <https://doi.org/10.1007/s10597-020-00561-3>
- Bjornestad, J., Kristina O. Lavik., Larry Davidson, Hjeltne, A., Moltu, C. & Veseth, M. (2020). Antipsychotic treatment – a systematic literature review and meta-analysis of qualitative studies. *JOURNAL OF MENTAL HEALTH*. 2020, 29(5), 513–523. <https://doi.org/10.1080/09638237.2019.1581352>
- Boden, M., Smith, C.A. & Trafton, J.A. (2021). Investigation of population-based mental health staffing and efficiency-based mental health productivity using an information-theoretic approach. *PLoS ONE*, 16(8): e0256268.
- Booyesen, D., Mahe-Poyo, P. & Grant, G. 2021. The experiences and perceptions of mental health service provision at a primary health centre in the Eastern Cape. *South African Journal of Psychiatry*, (27), a1641, DOI: <https://doi.org/10.4102/sajpsychiatry.v27i0.1641>
- Cambridge Dictionary (Online), (2022). Insight. Available from: <https://dictionary.cambridge.org/dictionary/english/insight>. Retrieved 04 October 2022
- Chang, Y., Chang, L., Hsu, & Huang, M. (2021). Professional perspectives on providing recovery-oriented services in Taiwan: a qualitative study. *BMC Psychiatry*, 21-154, <https://doi.org/10.1186/s12888-021-03152-y>
- Chorwe-Sungani, G., Namelo, M., Chiona, V. & Nyirongo, D. 2015. The Views of Family Members about Nursing Care of Psychiatric Patients Admitted at a Mental Hospital in Malawi. *Open Journal of Nursing*, 5:181-188.
- Coffey, M., Hannigan, B., Barlow, S., Cartwright, M., Cohen, R., Faulkner, A., Jones, A. & Simpson, A. (2019). *BMC Psychiatry*, 19:115,
- Creswell, J. W. 2013. *Qualitative enquiry and research Design: Choosing among five approaches* 3th Edition. Thousand Oaks, CA: SAGE.
- Dou, L., Hu, L., Zhang, N., Cutler, H., Wang, Y. & Li, S. (2020) Factors Associated with Medication Adherence Among Patients with Severe Mental Disorders in China: A Propensity Score Matching Study; V2020:14 Pages 1329—1339 DOI <https://doi.org/10.2147/PPA.S255934>.
- Van Eck, Burger, Vellinga, Schirmbeck & de Haan, (2018). The Relationship Between Clinical and Personal Recovery in Patients With Schizophrenia Spectrum Disorders: A Systematic Review and Meta-analysis. *Schizophrenia Bulletin*, V44, (3), 631–642, <https://doi.org/10.1093/schbul/sbx088>.

- Garcia-Cabeza, I., Victor, F., Epifanio, M.M. & de Portugal E. (2018). Relationship Between Insight, Adherence and Disability in the Diagnose of Paranoid Schizophrenia. *J Ment Health Clin Psychol*, 2(6): 6-10.
- Hyder, S., Monga, A., Paisari, P. & KUnjumooidee, R.R. (2022). *Indian Journal of Neurosciences* 2022; 8 (1):50–56.
- Gilburt, H., Slade, M., Bird, V., Oduola, S., Tom, K.J. & Craig, T. K.J. 2013. Promoting recovery-oriented practice in mental health services: a quasi-experimental mixed-methods study. *BMC Psychiatry*, 13:167.
- Hamilton, A.B. & Finley, E.P. (2019). Qualitative methods in implementation research: an introduction. *Psychiatry Res*, 280(112516). <https://doi.org/10.1016/j.psychres.2019.112516>
- Iseselo, M.K. & Ambikile J.S. (2020). Promoting Recovery in Mental Illness: The Perspectives of Patients, Caregivers, and Community Members in Dar es Salaam, Tanzania. *Hindawi Psychiatry Journal*, V(2020), Article ID 3607414, <https://doi.org/10.1155/2020/3607414>
- Jusuf, A., Fitriyarsi, R., Tristiana, R.D., Endang, H., Nihayati., Ahsan, & Suprajitno (2019). Development of Holistic Nursing Care Model for Mental Disorder Patients Care in Indonesia. *Indian Journal of Public Health Research & Development*, 10(8)
- Keet, R., de Vetten-Mc Mahon, M., Shields-Zeeman, L., Ruud, T., van Weeghel, J., Mulder, C. L., et al. (2019). Recovery for all in the community; position paper on principles and key elements of community-based mental health care. *BMC Psychiatry*. <https://doi.org/10.1186/s12888-019-2162-z>.
- Kaar, S.J., Gobjila, C., Butler., E., Henderson & Howes, O.D. (2019). Making decisions about antipsychotics: a qualitative study of patient experience and the development of a decision aid. *BMC Psychiatry*, 19:309.
- Kirst, M.; Zerger, S.; Wise Harris, D.; Plenert, E.; Stergiopoulos, V. The promise of recovery: narratives of hope among homeless individuals with mental illness participating in a Housing First randomised controlled trial in Toronto, Canada. *BMJ Open*, 2014, 4: e004379. doi:10.1136/bmjopen-2013-004379
- Lewis, S.E., Hopper, K. & Healion, E. (2012). Partners in Recovery: Social Support and Accountability in a Consumer-Run Mental Health Center. *Psychiatric Services*. (63) 1
- Lietz, C.A.; Lacasse, J.R., Hayes, M.J. Cheung, J. Source (2014). *Journal of the Society for Social Work*, 2014, 5 (2), 161-188.
- Lim MW, Remington G, Lee J. Personal Recovery in Serious Mental Illness: Making Sense of the Concept. (2017). *Ann Acad Med Singap*, 46(1):29-31. PMID: 28182815.
- Maiga, D.D. & Eaton, J. 2014. A survey of the mental healthcare systems in five Francophone countries in West Africa: Benin, Burkina Faso, Côte d'Ivoire, Niger and Togo. *International Psychiatry*, 11(30):69-72.
- Mead, S., Hilton, D. & Curtis, L. (2021). Peer support: a theoretical perspective. *Psychiatr Rehabil J*. 25(2):134–41. doi: 10.1037/h0095032.
- Mental Health Commission of Canada. Toward recovery & well-being (2021). *A framework for a mental health strategy for Canada*. 2009 Draft for public discussion.
- Matsuoka, A. K. (2015). Ethnic/Racial Minority Older Adults and Recovery: Integrating Stories of Resilience and Hope in Social Work. *British Journal of Social Work*, 45 (1), i135–i152.
- Moudatsou, M., Stavropoulou, A., Philalithis, A. & Koukouli, S. (2020). The Role of Empathy in Health and Social Care Professionals. *Healthcare (Basel)*. *PubMed*, 8(1):26. doi: 10.3390/healthcare8010026.
- Muhorakeye, O. & Biracyaza, E. (2021). Exploring Barriers to Mental Health Services Utilization at Kabutare District Hospital of Rwanda: Perspectives from Patients. *Front. Psychol., Health Psychology*, <https://doi.org/10.3389/fpsyg.2021.638377>
- Novick, D., Montgomery, W., Treuer, T., Aguado, J., Kraemer, S. & Haro, J.P. (2015). Relationship of insight with medication adherence and the impact on outcomes in patient with schizophrenia and bipolar disorder: results from a 1-year European outpatient observational study. *BMC Psychiatry*, 15:189 DOI 10.1186/s12888-015-0560-4

- Oedegaard, C. H., Davidson, L., Stige, B., Veseth, M., Blindheim, A., Garvik, L. M. S. et al. (2020). It means so much for me to have a choice”: a qualitative study providing first person perspectives on medication-free treatment in mental health care. *BMC Psychiatry*, 20:399.
- Opondo, P.R., Olashore, A.A., Molebatsi, K., Othieno, C.J. & Ayugi, J.O. (2020). Mental health research in Botswana: a semi-systematic scoping review. *J Int Med Res*, 48(10):300060520966458. doi: 10.1177/0300060520966458.
- Park, J & Chen, R.K (2016). Positive Psychology and Hope as Means to Recovery from Mental Illness. *Journal of Applied Rehabilitation Counseling*, 47 (2).
- Piet, M., Wainwright, M., Sofouli, E., Vachon, B., Deslauriers, T., Prefontaine, C., & Frati, F., (2021). Factors influencing the implementation of mental health recovery into services: a systematic mixed studies review. *Systematic Reviews*, 10:134, <https://doi.org/10.1186/s13643-021-01646-0>
- Radez, J., Reardon, T., Creswell, C., Lawrence, P.J., Evdoka Burton, G. & Polly Waite, P. (2021). Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. *European Child & Adolescent Psychiatry*, 30:183–211 <https://doi.org/10.1007/s00787-019-01469-4>
- Reed, T. A., Broussard, B., Moore, A., Smith, K. J., & Compton, M.T. (2014). Community Navigation to Reduce Institutional Recidivism and Promote Recovery: Initial Evaluation of Opening Doors to Recovery in Southeast Georgia. *Psychiatr Q.*, 85:25–33 DOI 10.1007/s11126-013-9267-1
- Sidandi, P., Opondo, P & Sebonetse, T. 2011. Mental health in Botswana. *BJPsych international*, 8(3):66-68.
- Siu, B. W. M., Tsang, M.M.Y., Lee, V.C.K., Liu, A.C.Y., Tse, S., Luk., & Leung, Y.L. 2016. Pathway to mental health recovery: a qualitative and quantitative study on the needs of Chinese psychiatric inpatients. *BMC Psychiatry*, 16:236.
- Salaheddin, K & Mason, B. (2016). Identifying barriers to mental health help-seeking among young adults in the UK: a cross-sectional survey. *British Journal of General Practice*, 66 (651): e686-e692. DOI: <https://doi.org/10.3399/bjgp16X687313>
- Seloilwe, E.S. & Thupayagale-Tshweneyagae, G. 2007. Community mental health care in Botswana: approaches and opportunities. *International Council of Nurses* (2007).
- Slade, M., Amering, A., Farkas, M., Hamilton, B., O'Hagan, M. & Graham, et al., (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems *World Psychiatry*, 13(1):12-20. Doi: 10.1002/wps.20084.
- Sari, S. P., Agustin, M., Wijayanti, D., Sarjana, W., Afrikhah, U. & Choe, K. (2021). Mediating Effect of Hope on the Relationship between Depression and Recovery in Persons With Schizophrenia. *Front. Psychiatry*, <https://doi.org/10.3389/fpsyt.2021.62758>
- Stangl, A. L., Earnshaw, V.A., Logie, C.H., van Brakel, W., Simbay., C., Barre, I. et al (2019). The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Med* 17, 31. <https://doi.org/10.1186/s12916-019-1271-3>
- Substance Abuse and Mental Health Service Administration, (2022). *10 guiding principles of recovery*. Available from: <https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf> Accessed: 22 September 2022.
- Subu, M.A., Wati, D.F., Netrida, N., Priscilla, V., Dias, J.M., Abraham, S. et al. (2021). Types of stigma experienced by patients with mental illness and mental health nurses in Indonesia: a qualitative content analysis. *Int J Ment Health Syst* 15, 77. <https://doi.org/10.1186/s13033-021-00502-x>
- Shalaby, R. & Agyapong, V. (2020). Peer Support in Mental Health: Literature Review. *JMIR mental health*, 7(6), e15572. <https://doi.org/10.2196/15572>
- Stanhope, V., Choy-Brown, M., Tiderington, E., Henwood, B. F., & Padgett, D. K. (2016). Case Manager Perspectives on the Role of Treatment in Supportive Housing for People with Severe Mental Illness. *Soc Social Work Res*, 7(3): 507–525. doi:10.1086/687986.
- Tinland, A., Loubière, S., Boucekine, M., Boyer, L., Fond, G., Girard, V., & Auquier, P. (2020). Effectiveness of a housing support team intervention with a recovery-oriented approach on hospital and emergency department use by homeless people with severe mental illness: a

- randomised controlled trial. *Epidemiology and Psychiatric Sciences*, 29, e169, 1–11.
<https://doi.org/10.1017/>
- World Health Organization. 2014. *Social determinants of health*.
[https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf?sequence=](https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf?sequence=1)
1 Date of access: 01 July 2020.
- World Health Organisation, 2019. *Recovery practise for mental health and well-being: WHO Quality Rights Specialised training Course*

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Manuscript 4: Nurses' perceptions on how recovery-oriented mental health care can be developed and implemented. (*Published in Nursing Research and Practice Journal*).

Title page

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Nurses' perceptions on how recovery-oriented mental health care can be developed and implemented.

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ABSTRACT

Aim

This study explored how nurses working in in-patient mental health units perceived the development and implementation of a recovery-oriented mental health care programme.

Background

The recovery-oriented mental health care approach in mental health is regarded as the future of mental health services and has been implemented in different countries worldwide. However, regarding developing and implementing the recovery approach, Africa appears to have been left behind by the rest of the continents.

Design

The study used a qualitative approach to describe how a recovery-oriented mental health care approach could be developed.

Methods

Thirty nurses who worked in Botswana's four in-patient mental health facilities consented and voluntarily participated in the study. Data were collected from February to mid-March 2022 through online focus group discussions and analysed using thematic analysis. The COREQ checklist was used to report the findings.

Results

Two main themes emerged:

- Developing and implementing a recovery-oriented mental health care programme is possible.
- Certain elements are required to develop and implement ROMHCP.

Conclusions

The participants believed that people diagnosed with mental illness could recover from the illness and suggested how it could be achieved. They also contended that the programme's success would lie mainly with multi-sectoral support from policymakers, facilities, hospital personnel, patients, and the community.

Clinical relevance

The recovery-oriented mental health care programme has the potential to benefit people with mental illness in the country. Additionally, it would allow nurses to improve their knowledge and skills in managing mental illnesses.

Patient or public contribution

The patients and the general public did not contribute to the study's concept, design, and outcomes. However, the nurses working in mental health facilities volunteered to participate in the study.

What does this paper contribute to the clinical community?

The paper has the potential to:

- Contribute to the transformation of mental health care in Botswana to recovery-oriented.
- Reduce the scarcity of literature on developing and implementing recovery-oriented mental health care programmes in Botswana.

Introduction

Mental health services, notably the community based, from certain Western high-income countries have embraced the recovery-oriented mental health care approach (ROMHCA) as a new dimension for mental health departments when treating people diagnosed with mental illness (Mental Health Association in New Jersey, 2023 online; New Freedom Commission on Mental Health, 2016; Slade et al., 2014). The recovery vision entails rethinking and reforming the current mental health care practice, whose approach is predominantly biomedical, to a person-centred approach in providing care to people with mental illness. The biomedical approach in mental health positions the cause of mental illness to brain disorders, thus relating the cause of mental illness to biological abnormalities in an individual and, therefore, one will need pharmacological interventions (Deacon, 2013). Doing so has led to shifting to the ROMHCA. The ROMHCA recognises the individuality of a person diagnosed with a mental illness. It is entrenched in the principles of self-determination, empowerment, citizenship, love, connectedness, respect, and the installation of hope for the future of people with mental illness (Frost et al., 2017; O'Keeffe et al., 2018). In this model, the patient drives their recovery process.

There is no common understanding of what mental health constitutes. Anthony (2003) gives the most popular and widely accepted definition. He explains recovery as living a gratifying life notwithstanding being de-capacitated by the symptoms of mental illness. Ørjasæter et al. (2022) also describe recovery as a multifaceted process through which individuals with mental illness live satisfying and fulfilling lives like any other citizen. This definition validates the personal nature that people attribute to recovery. Literature has revealed that the person-centeredness of recovery alone highlights the need for individualised care plans for people with mental illness (Jacob, 2015; Coffey et al., 2019).

Intervention programmes have been developed to facilitate the ROMHCA. For instance, in the United States of America, Copeland (2002) developed a Wellness Recovery Action Plan (WRAP) programme to teach healthcare workers and people with mental illness how to live with and manage mental illness. WRAP is a framework healthcare workers use to learn more about mental illness and how to manage it from a recovery-oriented approach and it has been proven to improve the general well-being of people with mental illness (Matsuoka, 2015). In England, Bird et al. (2014) developed a REFOCUS intervention to improve the working relationships between the staff and patients. A REFOCUS is an intervention focusing on activities promoting recovery and recovery working practices and relationships among staff for them to connect better with patients (Slade et al., 2015). In addition, it coaches staff to understand mental health users' values and treatment preferences to support them in a better recovery process (Slade et al., 2015).

Flaherty-Jones, Carne and Dexter-Smith (2018) developed a Steps to Recovery Programme (STR) in Australia to improve mental illness by providing information, including instilling hope for the future by providing people with mental illness skills on managing mental illnesses. In Ireland, a psychoeducation programme called EOLAS (Irish for Knowledge) was developed in collaboration with peers, family members and healthcare workers to help support people with psychosis and their caregivers. (Higgins et al., 2020). The EOLAS is delivered in a manual format and teaches people about psychosis focusing on the biopsychosocial model, relapse prevention and how families can support patients. (Higgins et al., 2020; O'Sullivan et al., 2023). The programme improved the understanding of recovery and communication between healthcare workers and other stakeholders (Higgins et al., 2020). An e-version of EOLAS has been implemented following the covid-19 pandemic it has shown that it was feasible to use and effective. (O'Sullivan et al., 2023). The findings support

the usefulness of digital platforms to deliver health education interventions to support people with mental illness (Batchelor et al., 2022, Strand et al., 2022).

The effectiveness of ROMHCPs is well documented in the literature (Salberg et al., 2022; Stanhope, 2016; Odegaard et al., 2020; Tinland et al., 2020). However, evidence from the literature indicates that the implementation of these programmes is from mainly high-income countries, mainly from the West (Lavallee & Poole, 2010; Slade et al., 2014; Eiroa-Orosa & Garcia-Miers, 2019; Kealeboga et al., 2023). Other regions, such as Asia and South America, have adopted the ROMHCA despite challenges such as poor implementation (Chang et al., 2021; Siu et al., 2016). Africa is still behind in delivering mental health care services, let alone adopting recovery-oriented mental health care services. Studies from Africa have indicated that the delivery of mental health care services is hampered by a lack of mental health policy, overreliance on biomedical approaches and a general lack of knowledge about recovery-oriented mental health care (Chorwe-Sungai, 2015; Brooke-Sumner et al., 2016; Bila, 2019).

The ROMHCA in Botswana has not yet been implemented and uses the biomedical approach, which does little for people with mental illness at the community level but to admit them to mental health institutions (Becker et al., 2019). The country operates only one psychiatric hospital, Sbrana Psychiatric Hospital (SPH), with a bed capacity of 300 patients. The provision of mental health care is through the Mental Health Policy of 2003, which serves as a reference for integrating mental health into general health care (Opondo et al., 2020). SPH is backed by eight mental health units, all with a bed capacity of 10 to 15 patients. There are 11 psychiatrists in the country, and most are based in private practice. Only two are based at SPH. Psychiatric mental health nurses operate most mental health services with the help of general nurses (Modie-Moroka, 2019; Becker et al., 2019).

With the increasing evidence from international studies on the effectiveness of recovery-oriented mental health services (Reed et al., 2014; Tinland et al., 2020; Kealeboga et al., 2023), Botswana should also position itself to implement the latest evidence-based care approaches in mental health to support people with mental illness in the community. Following admission, patients are discharged to their families without proper preparation to reintegrate them into society. The mental health service continues to face a shortage of mental health care personnel. Nurses are the leading providers of mental health care and mostly see patients first on arrival at mental health facilities (Sidandi et al., 2011). The

researchers, who are mental health nurse specialists, have observed that “Nurses talk about Recovery” in their daily interactions with patients. The meaning attached to recovery is mainly symptom reduction and compliance with treatment. The recovery-oriented practice goes beyond symptom reduction and treatment adherence but calls for patient-centred care (Jacob, 2015).

Nurses in Botswana must devise or participate in developing interventions to improve the care of people diagnosed with mental illness. Brooke-Sumner et al. (2016) from South Africa have attributed the failure of health workers to implement recovery-oriented mental health services to a lack of understanding and involvement of mental healthcare personnel. In addition, a review of how recovery is understood among ethnic minorities by Sofouli (2021) concluded that more work should be done on policy so that cultural minorities can access culturally tailored interventions to address their needs. Therefore, this calls for developing interventions informed by findings from the localised data context to accommodate the uniqueness of different communities. To our knowledge, no study has been conducted in Botswana that solicited nurses' views on how ROMHCP can be developed and implemented. Since most mental health care professionals in Botswana are nurses, eliciting their views on developing a ROMHCP is essential. Thus, the purpose of the study was to explore and describe how nurses working in four in-patient mental health units in Botswana perceived the development and implementation of a recovery-oriented mental care programme for Botswana.

Methodology

Design

This qualitative study explored nurses' views on developing a recovery-oriented approach. The qualitative method investigates people in their locality and emphasises how study participants experience and interpret phenomena (Daniel, 2016). Therefore, the design was appropriate since it described the contextual meaning of the participants of how a recovery-oriented mental health care programme could be developed and implemented. This study focused on the following questions and further probing statements from participants to find more meaning in their responses. The study participants were nurses working in mental health facilities with at least 3 years of experience. It was believed that the participants would be able to use their experience to provide information about the following objective:

1. What are your views on developing a recovery-oriented programme for Botswana?
2. How could a recovery-oriented mental health care programme be developed and implemented?

Context

The study was conducted in Botswana in four sites offering in-patient mental health care to people with mental illness. Among the four sites was the country's only mental health referral hospital in south-eastern Botswana, in Lobatse. The other three sites are psychiatric units attached to district hospitals. Of the three sites, one was in the far North-West of Botswana Maun, one in Central North East Botswana Francistown and the last in the South West of Botswana, in Molepolole. The three mental health units provide care to clients daily, with a bed capacity of 10 to 15 patients each. However, since they are small units, most of their patients are referred to the main psychiatric hospital, which has a bed capacity of 300.

Population and sample

The study's population was all the nurses in the four sites actively treating patients with mental illness for at least three years. Thirty-two nurses were purposively selected out of 149 who consented to participate in the study. All the selected nurses consented to participate in the Focus Group Discussions (FGD). The number of FGDs was determined by data saturation.

Data collection

Data were collected through online FGDs with nurses with at least three years of experience treating people diagnosed with mental health challenges. Microsoft Teams was used to conduct the FGDs since data was collected during the active phase of the covid-19 pandemic to conduct the FGDs. Two FGDs had seven participants and the other two had 8. According to Nyumba et al. (2017), six to eight people are ideal for FGDs. The FGDs were preferred for this study due to their ability to produce an interactive atmosphere that allows participants to produce diverse information quickly from multiple participants (Krueger & Casey, 2015). One FGD was conducted per site, and in total, four FGD were conducted across the four sites.

The steps to recruit nurses, study participants are described below. Through and identified mediator and independent person in each facility, meetings were set, and the purpose of the study was explained to potential participants following the study advertisement. Then each

potential participant was given information about the study and a consent form by an independent person. The nurses who eventually consented to participate voluntarily provided their phone numbers to the researcher through the help of an independent person. All participants consented to be virtually and audio recorded. K.M.K., a lecturer and a mental health nurse specialist, conducted the FGDs. K.M.K, a PhD student, had undergone training in qualitative data collection methods and had conducted qualitative interviews as a lead investigator in one study before conducting the interviews. K.M.K. was also supervised by two study supervisors experienced in qualitative research methods.

The FGDS were conducted in a private, secure place, and as participants participated from their homes. The interviewer used an interview guide pilot tested with participants from one mental health unit that was not part of the study. The pilot test offered insight into probing to get rich responses. FGDs were conducted in English and Setswana, the local language, allowing participants to express themselves in the language they felt comfortable in. However, English remains Botswana's official language in workplaces. Besides, all the nurses have undergone intensive training in English. The FGDs lasted between 60 to 80 minutes. The interviewer researchers took notes as the participants expressed their views, summarised each interview and shared the summary with the participants to validate the content during the interview.

Data saturation was reached at FGD number three, although the researcher went on to complete the last FDG to confirm the recurring themes. According to Hennink et al. (2019), data saturation refers to a point at which issues become repetitive to the point of redundancy. Furthermore, Saunders et al. (2018) conceptualise data saturation as “a matter of identifying redundancy in the data, with no necessary reference linked to these data; saturation appears to be distinct from formal data analysis”. As such, in this study, at the end of the third FGD, it became clear that no new data were identified, confirming that data saturation had been reached. Therefore, the fourth FGD was conducted to confirm the themes.

Data analysis

Data were analysed using Tesch's eight steps of data analysis (Creswell, 2013) as it provides a detailed eight-step guideline for organising unstructured data. First, the interviewer transcribed visual recordings. The interviewer masked the participants' names to ensure confidentiality by using P0 to P8. Following the data transcription, the researcher (K.M.K.) read all the data carefully to make sense of the transcribed data and notes. Some notes were

scribbled on the side of the script. At this point, the researcher generated and wrote topics on the margin of the script. A similar process of note-writing was completed for all of the scripts. Then, similar ideas and topics were grouped into columns. Once the ideas were grouped, the researcher took the completed list and revisited the data. Abbreviations were used to code the topics and put them next to the text representing that particular code. That exercise helped to tell if any new codes and categories emerged. The researcher used descriptive words to name and group the topics into categories. At this stage, related topics were grouped to reduce the number of topics. The researchers labelled each category and arranged the codes alphabetically. Data were assembled according to a category it belonged to for preliminary analysis. The repeating data informed the grouping of categories, and irrelevant data were discarded. The researcher then sent raw data to the co-coder for an independent analysis. The co-coder is an experienced mental health specialist qualitative researcher identified and recommended by the study's supervisors.

Subsequently, a meeting was set to discuss the themes and categories, and a consensus was reached. The results were further discussed with the study's participants to ensure that the emerging themes reflected the study context. A virtual meeting was held with participants - nurses in each site through Microsoft Teams to validate the themes. The participants validated the themes orally and confirmed the descriptions of the sites by raising their hands to confirm that they represented what had been said during the interviews. In addition, the study's supervisors, professors E.M. and S.M., together with experienced qualitative nursing researchers, also checked, validated, and confirmed the themes.

Measures to ensure trustworthiness.

To ensure the trustworthiness of this qualitative study, the researchers demonstrated thoroughness in credibility, transferability, dependability, authenticity, and confirmability (Polit & Beck, 2017). Credibility was ensured through triangulation and visual recording of the FGDs. Researcher triangulation was achieved by reviewing the visual recordings and comparing them with the emerging themes and sub-themes. In addition, credibility was further ensured through prolonged engagement with the study's participants. To achieve that, the interviewer took time, for example, to meet and set an appointment with participants for the FGDs to form and strengthen relationships to build rapport. In addition, the researcher had one virtual meeting with the study's participants to validate the themes and sub-themes (member-checking). For transferability, the researchers gave a thick description of the

context, the study participants, and quotes from the participants. Authenticity was ensured by giving a complete description of the study context and engaging the co-coder to verify the themes. Finally, the researchers documented a detailed description of the research process to ensure dependability and confirmability. Moreover, the research supervisors, EM and SM, monitored the research process throughout data collection and analysis to ensure confirmability. The study was reported based on the COnsolidated criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007).

Ethical considerations

Fleming and Zegwaard (2018) posits that all human research must be approved prior to data collection to protect the participants and demonstrate good research conduct. Therefore, North-West University Health Research Ethics Committee (NWU-HREC) No: NWU-00306-21-S1 cleared and approved the study. Following clearance from MoHW Botswana REF NO: HPDME 13/18/1, all the participating hospitals gave the researcher goodwill permission to conduct the study. The participants were given information about the study and voluntarily consented to participate. The researcher used codes to protect the anonymity of all those who participated. All participants consented to the virtual recording of the data collection procedure.

Results

Thirty nurses participated in the FDGs. The age of participants ranged from 26 to 53 years. Twenty-five nurses (83.3%) had a diploma in nursing, fourteen (n=14) (46.66%) had a diploma in psychiatric mental health nursing, three (n=3) (10%) had a degree in Nursing, and two (n=2) (6.66%) had a master's degree in nursing qualification. Only two 2 (6.66%) nurses were nurse managers. The average experience of working in mental health facilities ranged from 4 to 13 years. All the nurses had more than three years of experience working directly with patients diagnosed with mental illness.

Themes and subthemes

Table 1: showing how a recovery-oriented mental health care programme can be developed and implemented.

Theme	Sub Themes	Categories
1. Development of a recovery-oriented mental health care programme is possible.	1.1 Implementation of recovery-oriented mental health care is possible if it's supported.	- Recovery is possible and achievable. - Prioritise mental health initiatives - Provide funding for mental health.
2. Elements needed to develop and implement recovery-oriented mental health care programmes.	2.1 Having proper policies and up-to-date guidelines and SOPs within and between facilities	- Having policies in place - Have a consistent standard of operations - Develop guidelines to support the implementation of a recovery programme
	2.2 The inclusion of external stakeholders in the recovery plan of patients	- Provision of holistic care in mental health services - Include pastors, traditional healers, herbalists, Spiritual healers - Have policies on the inclusion and regulation of spiritual care
	2.3. The importance of after-care	- Have proper discharge and follow-up policies - Have proper linkages in the community for continuity of care
	2.4. Education among the community and the patients themselves (psychoeducation) and stigma eradication	- Develop educational programmes for mental health awareness - Provide education to patients, families, community/society, nurses, and other healthcare workers on mental health issues - Training plan of nurses on the recovery-oriented mental health care approach - Provide education to society and cultural leaders on mental health issues and cultural misconceptions about mental illness

Participants indicated that Botswana's recovery-oriented mental health care programme could be developed and implemented. Table includes 1 themes: a) 'Developing and implementing of a recovery-oriented mental health care programme'; b) "Elements needed to develop a recovery-oriented mental health care program"; and c) Elements needed to implement recovery-oriented mental health care programmes.

Theme 1 Development and implementation of a recovery-oriented mental health care programme

1.1 Implementation of recovery-oriented mental health care is possible if it is supported.

Participants believed that it was possible for Botswana's mental health facilities to implement the recovery-oriented mental health care programme.

F, P4: "I believe this is all possible if we can all come on board, from family, community and leadership levels and prioritise mental illnesses or mental health services as much as we prioritise other health services. So, it can be achieved if we can all come on board."

In addition, the participants indicated that mental health recovery-oriented care could be developed and implemented if prioritised and well-funded. However, there was a belief that that could only be possible if there was support from the government, hospital managers and the community.

L, P0: "Yes, it is possible to have a mental health programme in our country, provided mental health is prioritised and supported by the top management."

S, P1: "I believe it can happen with support."

Theme 2 Elements needed to develop and implement recovery-oriented mental health care programmes

Participants in this study believed that a recovery-oriented mental health care programme could be developed and implemented and suggested how this could be done. They suggested the following sub-themes on how a recovery programme could be implemented. 'Having appropriate policies and up-to-date guidelines and SOPs within and between facilities, including external stakeholders (e.g. pastors, traditional healers) in the recovery plan, the importance of after-care, psychoeducation for the community, patients and stigma eradication regarding mental illness in communities.

2.1. Proper policies, up-to-date guidelines, and standard of operations procedures (SOPs) within and between facilities

The participants felt that for a recovery-oriented mental health care programme to be successful, there must be appropriate policies, guidelines, and standards of SOPs to guide its development and implementation. They stated:

L, P5: I believe there should be a team in place that can measure whether care rendered to clients is as per the standards according to our SOPs. I believe commitment to quality care in all facilities should be a priority.

M, P6: There must be detailed guidelines on how the client will be assisted starting from admission until discharge.

2.2. Inclusion of external stakeholders (e.g., pastors, traditional healers) in the recovery plan

The participants also felt that external stakeholders such as herbalists, traditional doctors and spiritual leaders should be involved in implementing the mental health care programme. Health involves restoring health from all the client's biopsychosocial sphere, including the spiritual needs often left unattended in mental health, as already discussed. They suggested that policies could be developed and implemented to assess the involvement of external stakeholders.

F, P1: "I will give an example if patients want to be seen by a herbalist, spiritualist or traditional doctor in the hospital, there should be assistance to provide holistic care. Someone from the spiritual perspective can pray for them. All stakeholders must come on board to make the patient's recovery possible."

M, P7: "Spirituality is very important in the recovery of patients. Hospitals should respect the spirituality of patients. Wards and facilities can have policies that regulate at what level patients engage in spirituality."

2.3. The importance of after-care

Furthermore, the results also indicated that the participants felt that the programme should have after-care and follow-up programmes to cater for the clients once they get discharged from mental health facilities. In addition, there should be a link between the hospital and the community to receive the patients and continuity of care.

S, P4: *“It is possible to achieve full recovery of this client by ensuring there are linkages or continuity in the community. If they get discharged from a hospital, there should be continuity of care or after-care to support the patients.”*

L, P3: *“Sometimes we find that the patients are just discharged into the society without notifying the local clinics of their whereabouts. We must have proper discharge procedures that link the patients to the clinics where they are discharged.”*

In addition, one participant emphasised the need for a follow-up plan following the discharge of patients from mental health facilities. For example, the current set-up in Botswana needs a better-defined follow-up plan following the discharge of patients from the hospital.

S, P2: *“When we discharge patients, there is no follow-up until we see the patient upon readmission. We need personnel that can do follow-ups of patients.”*

2.4 Psychoeducation for the community, patients and stigma eradication regarding mental illness

Furthermore, there was a great emphasis on implementing a recovery-oriented mental health care programme with a strong psychoeducation programme targeting individuals, families, and the community at large on issues of mental health and stigma eradication. They further indicated the need to target the cultural misconceptions about mental illness and its causes by involving cultural leaders in the psychoeducation interventions as they greatly influence the community members.

M, P1: *The health care workers should do thorough psychoeducation to the individual, the family and community. Psychoeducation can include many things regarding the diagnosis that can help the individual and what to expect.”*

L, P3: *“First, teach the clients and the family about the condition so that the patient can accept themselves and the family accepts the client. That can happen if there is education about the patient's condition and treatment.”*

The participants also felt that psychoeducation should be extended to community leaders because of their critical societal roles. There was a belief that because of their influence, they could help dispel the myths and stereotypes that are normally associated with mental illness due to their influence.

S, P4: *“Our cultural leaders must be on the same page with modern health. Clients relapse because of the myths surrounding mental health.”*

S, P2: *“There is a way that culture perceives mental illness. We can reach cultural leaders and the community and teach them how culture and mental illness intersect.”*

The issue of stigma towards mental illness also came very strongly. Participants felt that for our setting to be recovery-oriented, issues of stigma must be dealt with.

L, P3: *“The patient should know about the stigma in society. Sometimes we need to understand that stigma is one of the factors that contribute to patients rejecting treatment. The patient can sometimes commit suicide because of stigma.”*

Participants also believed that cultural perspectives and myths surrounding the cause of mental illness influence how patients with a diagnosis of mental illness deal with and facilitate their recovery process.

F, P4: *“We still have setbacks regarding mental health issues because of our belief systems. People still hold that mental illness comes as a result of witchcraft. Some believe that you have done something bad to another person and they're trying to fix you. A lot of people have got people with mental illness in their communities and in their families but still fail to accept that mental illness can happen to anyone.”*

Discussion

The study explored how nurses working in four in-patient mental health units in Botswana perceived the development and implementation of a recovery-oriented mental care programme for Botswana. The study used an explorative, descriptive qualitative method and FGDs to collect data on nurses' views on the phenomenon.

Participants in this study believed that developing and implementing a recovery-oriented mental health care programme could be possible for Botswana nurses to guide the care of people diagnosed with mental illness. The participants further believed that the programme's success could be realised if all stakeholders came on board in support of the programme. Similar findings were reported in a study from Indonesia by Nurhayati et al. (2019), where stakeholders indicated that a mental health community recovery program could be applied in community settings. On the other hand, they averred that the care of people diagnosed with

mental illness is still addressed through hospital admissions, where medication is the preferred choice treatment.

On the important elements in facilitating the development of a recovery-oriented mental health care programme, the participants in this study highlighted the importance of having proper policies and guidelines on the proposed programme. In addition, they underscored the need for mental health interventions to be prioritised in terms of funding. The same findings were established in a study by Nurhayati et al. (2019). Participants indicated that there must be supporting policies on the recovery programs and the availability of funds to ensure their success. A lack of funds for mental health initiatives was reported in a study from Taiwan by (Chang et al. 2021). In the study, staff proposed more resources in implementing recovery-oriented mental health services.

It is crucial for countries implementing a recovery-oriented mental health approach to have proper guidelines and policies to guide its implementation (New Freedom Commission, 2003; Parkin, 2016; Gilburt et al., 2013; Slade et al., 2014). Policies are effective in enforcing what is on paper. For example, staff and peer workers expressed concern about implementing recovery-oriented care in an organisation that does not support it in terms of having policies and procedures in place (Piat et al, 2021). They contended that such a care project was unlikely to succeed. However, nurses in this study believed that the programme could be developed. Nonetheless, the implementation would require policies, procedures, and standards in place.

Other views on essential elements in developing the recovery-oriented mental health care programme were the involvement of other stakeholders such as traditional doctors, herbalists, and spiritualists. According to studies conducted in South Africa and Botswana, people diagnosed with mental illness usually seek help from traditional doctors, herbalists and spiritual healers before they can resort to modern health (Bila, 2019; Okafor et al., 2022; Seloilwe & Thupayagale-Tshweneyagae, 2007). In concurrence, nurses in this study suggested that mental health facilities should provide for the spiritual needs of clients in a mental health facility. Participants suggested that patients' spiritual needs could be provided for by having spiritualists, herbalists, and traditional doctors in the facilities to avoid situations where clients might end up overusing the prescriptions they might get from such services, which may be fatal. One participant suggested that the facilities could develop

guidelines on how spiritual care could be incorporated and regulated into the mental health services in Botswana.

The importance of after-care, proper follow-up, and planned home of patients was mentioned by participants as essential in implementing the programme. Participants expressed the need for proper discharge and follow-up channels following discharge from the mental health care facility. To corroborate this study's findings, patients in a study conducted in Norway highlighted the importance of follow-up plans for continuity of care (Biringer et al., 2017). In addition, the participants in the same study suggested that follow-up plans should be communicated on time, flexible and include the service users and their families. Findings from Indonesia from a study by Nurhayati et al. (2019) also back the study as stakeholders in their study emphasised that home visits were essential to support the recovery of people diagnosed with mental illness. In Botswana, mental health service has a discharge and follow-up plan; however, when patients are discharged, they are not followed and reintegrated into the community. There is a need for this gap to be closed, and that could be achieved through developing a functional recovery-oriented mental health programme.

Some recovery-oriented-mental health care programmes are after-care programmes that help facilitate patients' recovery and reintegration into the community following discharge from a mental healthcare facility (Fletcher et al., 2019; Frost et al., 2017). Being cared for in a community set-up has been demonstrated to be effective in helping patients recover from mental illness. Fletcher et al. (2019) evaluated the effectiveness of residential recovery-oriented facilities that helped people with severe mental illness from recidivism in Australia. The services effectively provided community contextualised care that aligned with the recovery principles of empowerment and inclusion in line with the Australian mental health policies of a recovery-oriented approach. In addition, the services were well appreciated by clients as they felt they were supported and valued by staff. The findings were further supported by Heyeres et al. (2018), as their study also indicated that residential facilities were recovery-focused and complied with the recovery policies set by their government. The findings on the importance of community mental health services in caring for people diagnosed with mental illness could be why nurses in this study felt there should be after-care and follow-up in place.

Lastly, the participants raised the importance of a functional and practical programme. In their view, the programme should have a psychoeducation programme targeting the staff, the

patients, families, and the community. Participants felt a general lack of awareness about mental illness and mental health issues. In addition, stigma towards mental illness and cultural misconceptions about the causes and management of mental illness could hinder the successful implementation of the programme. Similar views were echoed in a study from Tanzania, which reported a general lack of awareness of mental illness and its causes in the community (Iseselo & Ambikile, 2020).

Furthermore, caregivers in the same study indicated that the community needed to be educated on handling people with mental health problems. The findings are further supported by findings of a study from Taiwan where health workers expressed the need for families and public health education on mental health issues with the hope that once the public is informed, they could be a stigma reduction and hence better understanding leading to the better outcomes for patients (Chang et al., 2021). Moreso, the Taiwanese study emphasised the need for health professionals to be educated on the recovery-oriented mental health approach to enhance their competencies and confidence in caring for clients with mental illness.

A study from Botswana on beliefs on the cause of HIV and mental illness by Becker et al. (2019) associated the cause of mental illness with witchcraft. The study further indicated that people diagnosed with mental illness were viewed negatively as dangerous, untrustworthy and discriminated against in the workplace. The study recommended training and public sensitisation on mental health issues to align rehabilitation services to a recovery-oriented care approach. Additionally, a meta-synthesis on the beliefs and perceptions about mental health issues by Choudhry et al. (2016) associated mental illness with punishment from God. The authors recommended that mental health services develop clinical interventions to address cultural beliefs by encouraging dialogue with traditional leaders and developing strategies for involving them.

In the same vein, the participants in this study suggested that a recovery-oriented mental health care programme should include a psychoeducation training component for people with mental illness, families and mental health care personnel on stigma in mental illness. Moreover, a systematic review by Wagas et al. (2020) on interventions to reduce stigma in higher education indicated that psychoeducation programmes successfully reduced the self and public stigma of students with mental health problems.

These findings, therefore, emphasise the need to educate the community on mental health issues to dispel stigma and misconceptions about mental illness. Thus, a recovery-oriented mental health care programme developed for Botswana should be inclusive and consider elements such as funding, a training plan, the interplay of different stakeholders and a strong psychoeducation programme to improve its effectiveness.

Conclusion

This study is a preliminary exploration of factors that could enhance the development and implementation of mental health recovery in Botswana. The study is the first of its kind to be conducted in Botswana. It provides insight into how nurses in four in-patient units perceive the implantation of a recovery-oriented approach in mental health services. The study suggested essential factors for consideration for the success of the approach, including the development of mental health policies that support the recovery-oriented approach; revising hospital admission, discharge and follow-up plans for people diagnosed with mental illness; revitalising the community mental health services; involvement of other stakeholders such as traditional leaders, herbalists, traditional healers, and spiritualists. In addition, the nurses recommended developing health education programmes to reduce the stigmatisation of mentally ill patients in the community. Besides, other influential people such as community cultural leaders such as chiefs and ward men would be targeted for inclusion in the programme. They would help change people's perceptions towards the causes and management of mental illnesses.

Recommendations

Mental health problems remain a burden and a significant public health concern. Unfortunately, mental health programmes remain the least funded among health programmes, especially in low and middle-income countries (Liese et al., 2019). For example, in Botswana, mental health still operates under 1% of the national health budget. Participants in the study recommended that the programme could be developed and implemented if it received funding, involved multiple stakeholders and had a psychoeducation programme targeting all the major stakeholders, community leaders, mental health personnel, and the patient's families. In a meeting hosted by WHO in conjunction with the World Bank Group in 2016, Global Mental Health included mental health as one of the Sustainable Development Goals. That underscores the need to prioritise mental health and well-being at all ages (Liese

et al., 2019). In order to meet the goal, mental health initiatives should be prioritised in terms of funding.

Relevance to clinical practice

The recovery-oriented mental health care programme has the potential to benefit people with mental illness in the country. In addition, it would allow nurses to improve their knowledge and skills in managing mental illnesses. Findings might also inspire policy change in Botswana and other countries with limited resources as they move to adopt the recovery-oriented approach and guide its implementation.

Data availability

Data for this study can be made available upon reasonable request.

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Conflict of interest

The authors declare no conflict of interest.

References

- Anthony, W.A. (1993). Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4).
- Batchelor, R., Gulshan, S., Shritharan, H., Williams, E., Henderson, C., Gillard, S., Woodham, L.A. et al. (2022). J Med Internet Res, 24(2):e27781. doi: [10.2196/27781](https://doi.org/10.2196/27781)
- Becker, T.D., Ho-Foster, A.R., Poku, O.B., Marobela, S., Mehta, H., Cao, D.T.X., et al. (2019). "It's When the Trees Blossom" Explanatory Beliefs, Stigma, and Mental Illness in the Context of HIV in Botswana. *Qualitative Health Research*, 1-15.
- Bila, N.J. (2019). Social workers' perspectives on the recovery-oriented mental health practice in Tshwane, South Africa *Social Work in Mental Health*, 17 (3) 344-363, DOI: 10.1080/15332985.2018.1554547.
- Bird, V. & Slade, M. 2014. *REFOCUS: Researching recovery*. Accessed from <https://www.scottishrecovery.net/resource/refocus-researching-recovery/> Date of access: 02 Jul 2020.
- Biringer, E., Hartveit, M., Sundfør, B., Ruud, T. & Borg, M. (2017). Continuity of care as experienced by mental health service users - a qualitative study. *BMC Health Serv Res*, 17, <https://doi.org/10.1186/s12913-017-2719-9>
- Brooke-Sumner, C., Lundi, C., Selohilwe, O. & Petersen, I. (2016). Community-based psychosocial rehabilitation for schizophrenia service users in the North West province of South Africa: A formative study. *Social Work in Mental Health*, 15:3 [https://doi-org.nwulib.nwu.ac.za/10.1080/15332985.2016.1220439](https://doi.org.nwulib.nwu.ac.za/10.1080/15332985.2016.1220439)
- Chang, Y., Chang, L.H., Hsu, S.T. & Huang, M. (2021). Professional perspectives on providing recovery-oriented services in Taiwan: a qualitative study. *BMC Psychiatry*, 21, 154 <https://doi.org/10.1186/s12888-021-03152-y>
- Choudhry, F. R., Mani, V., Ming, L. C., & Khan, T. M. (2016). Beliefs and perception about mental health issues: a meta-synthesis. *Neuropsychiatric disease and treatment*, 12, 2807–2818. <https://doi.org/10.2147/NDT.S111543>
- Coffey, M., Hannigan, B., Barlow, S., Cartwright, M., Faulkner, A., Jones, A. et al. (2019). Recovery-focused mental health care planning and coordination in acute in-patient mental health settings: a cross-national comparative mixed methods study. *BMC Psychiatry*, 19, 115 <https://doi.org/10.1186/s12888-019-2094-7>
- Copeland, M.E. (2002). *Wellness Recovery Action Plan*. USA: Peach Press

- Chorwe-Sungani, G., Namelo, M., Chiona, V. & Nyirongo, D. (2015). The Views of Family Members about Nursing Care of Psychiatric Patients Admitted at a Mental Hospital in Malawi. *Open Journal of Nursing*, 5:181-188.
- Creswell, J. W. (2013). *Qualitative enquiry and research Design: Choosing among five approaches*. 3rd Edition Thousand Oaks, CA: SAGE.
- Daniel, E. (2016). The Usefulness of Qualitative and Quantitative Approaches and Methods in Researching Problem-Solving Ability in Science Education Curriculum. *Journal of Education and Practice*, 7, (15).
- Deacon, B.J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research, *Clinical Psychology Review*, 33 (7), pp 846-861, <https://doi.org/10.1016/j.cpr.2012.09.007>.
- Eiroa-Orosa, F. J. & Garcia-Miers, H. (2019). A Systematic Review and Meta-analysis of Recovery Educational Interventions for Mental Health Professionals. *Administration and Policy in Mental Health and Mental Health Services Research*, 46:724-752.
- Flaherty-Jones, G. M., Carne, A. S. & Dexter-Smith, S. (2016). The Steps to Recovery Program: Evaluation of a Group-Based Intervention for Older Individuals Receiving Mental Health Services. *Psychiatric Rehabilitation Journal*, 39, (1), 68 -70.
- Fleming, J. & Zegwaard. K. (2018). Methodologies, methods and ethical considerations for conducting research in work-integrated learning. *International Journal of Work-Integrated Learning, Special Issue*, 19(3), 205-213.
- Fletcher, J., Brophy, L., Killaspy, H., Ennals, P., Hamilton, B., Collister, L. et al (2019). Prevention and Recovery Care Services in Australia: Describing the Role and Function of Sub-Acute Recovery-Based Residential Mental Health Services in Victoria. *Frontiers in Psychiatry*, 2019, 10: 735
- Frost, B. G., Tirupati, S., Johnston, S., Turrell, M., Lewin, T. J., Sly, K. A., & Conrad, A. M. (2017). An Integrated Recovery-oriented Model (IRM) for mental health services: evolution and challenges. *BMC psychiatry*, 17(1), 22. <https://doi.org/10.1186/s12888-016-1164-3>
- Gilburt, H., Slade, M., Oduola, S. & Craig, T. K.J. (2013). Promoting recovery-orientated practice in mental health service: a quasi-experimental mixed-methods study. *BMC Psychiatry*, 13,167.
- Hennink, M.M., Kiaser, B.N. Weber, M.B. (2019). What Influences Saturation? Estimating Sample Sizes in Focus Group Research. *Qual Health Res*, 2019, 29(10), 1483–1496, doi:10.1177/1049732318821692.

- Iseselo, M.K. & Ambikile J.S. (2020). Promoting Recovery in Mental Illness: The Perspectives of Patients, Caregivers, and Community Members in Dar es Salaam, Tanzania. *Hindawi Psychiatry Journal*, V(2020), Article ID 3607414, <https://doi.org/10.1155/2020/3607414>
- Jacob, J.S. (2015). Recovery Model of Mental Illness: A Complementary Approach to Psychiatric Care. *Indian Journal of Psychological Medicine*, 37 (2) Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4418239/pdf/IJPsyM-37-117.pdf>, Accessed August 24, 2022.
- Higgins, A., Downes, C., Monahan, M., Hevey, D., Boyd, F., Cusack, N., & Gibbons, P. (2020). Evaluation of a co-facilitated information and learning programme for service users: The EOLAS programme. *Irish Journal of Psychological Medicine*, 37(2), 89-98. doi:10.1017/ipm.2019.32
- Hyerer, M., Kinchin, I., Whatley, E., Brophy, L., Jago, J., Wintzloff, T. et al. (2018) Evaluation of a residential mental health recovery service in north Queensland, *Front Public Health*, 6:123, <https://doi.org/10.3389/fpubh.2018.00123>
- Kealeboga, K.M., Manyedi, E.M. & Moloko-Phiri, S. (2023). Recovery-oriented Programmes to Support the Recovery Approach to Mental Health in Africa: Findings of PhD: A Scoping Review. *The Open Journal Nursing*, V(17) DOI: [10.2174/18744346-v17-230223-2022-152](https://doi.org/10.2174/18744346-v17-230223-2022-152), 2023
- Krueger, R., & Casey, M. (2015). *Focus groups: A practical guide for applied research*. 5th ed. Thousand Oaks, CA: Sage.
- Lavallee, L. F. & Poole, J. M. 2010. Beyond Recovery: Colonization, Health and Healing for Indigenous People in Canada. *International Journal of Mental Health and Addiction*, 8(2), 271-281.
- Liese, B.H., Gribble, R.S.F. & Marisha, N. & Wickremsinhe, M.N. (2019). International funding for mental health: a review of the last decade. *International Health*, V (11), 5.
- Lewis, S. E., Hopper, K. & Healion, E. (2012). Partners in Recovery: Social Support and Accountability in a Consumer-Run Mental Health Center. *Psychiatric Services*, 63 (1).
- Maiga, D.D. & Eaton, J. (2014). A survey of the mental healthcare systems in five Francophone countries in West Africa: Benin, Burkina Faso, Côte d'Ivoire, Niger and Togo *International Psychiatry*, 11(30): 69-72.
- Matsuoka, A. K. (2015). Ethnic/Racial Minority Older Adults and Recovery: Integrating Stories of Resilience and Hope in Social Work. *British Journal of Social Work*, 45 (1), i135–i152.
- Mental Health Association in New Jersey (2023). *Public Policy Statement Introduction to a new vision for mental health services based on wellness and recovery*. Government Affairs

Department Available from: https://www.mhanj.org/content/uploads/2022/07/New-Vision-for-MH-Services-Based-on-Wellness-Recovery_Policy-Paper.pdf

Modie-Moroka, T. (2016). *A Historical Evolution of Mental Health Services in Botswana*.

https://www.researchgate.net/publication/318837827_A_historical_evolution_of_mental_health_services_in_Botswana_Past_and_present

New Freedom Commission on Mental Health (2016). *Achieving the Promise: Transforming Mental Health Care in America Final Report*

<https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf> Date of access: 03 Aug 2020.

Nurhayati, G.E., Kusumah, R.B. & Murwasuminar, B. (2019). The experiences of stakeholders in supporting the implementation of the mental health community recovery program in West Java Province Indonesia. *Belitung Nursing Journal*, 5(6), 225-233

<https://belitungraya.org/BRP/index.php/bnj/index>

Nyumba, T. O, Wilson, K., Derrick, C.J., & Nibedita Mukherjee, N. (2017). The use of focus group discussion methodology: Insights from two decades of application in conservation. *Methods Ecol*, 9.

Oedegaard, C. H., Davidson, L., Stige, B., Veseth, M., Blindheim, A., Garvik, L et al. (2020). It means so much for me to have a choice": a qualitative study providing first person perspectives on medication-free treatment in mental health care. *BMC Psychiatry*, 20:399.

Okafor, I.P., Oyewale, D.V., Ohazurike, C. & Ogunyemi, A.O. (2022). Role of traditional beliefs in the knowledge and perceptions of mental health and illness amongst rural-dwelling women in western Nigeria. *Afr J Prim Health Care Fam Med*, 29,14(1):e1-e8.

<https://doi.org/10.4102/phcfm.v14i1.3547>.

O'Keeffe, D., Sheridan, A., Kelly, A. Doyle, R., Madigan, K., Lawlor E. et al. (2018) 'Recovery' in the Real World: Service User Experiences of Mental Health Service Use and Recommendations for Change 20 Years on from a First Episode Psychosis. *Adm Policy Ment Health*, 45, 635–648, <https://doi.org/10.1007/s10488-018-0851-4>

Opondo, P.R., Olashore, A.A., Molebatsi, K., Othieno, C.J. & Ayugi, J.O. (2020). Mental health research in Botswana: a semi-systemic review. *Journal of International Medical Research*, 48(10) 1-16, DOI: 10.1177/0300060520966458

Ørjasæter, K.B. & Almvik, A. (2022). Challenges in Adopting Recovery-oriented Practices in Specialized Mental Health Care: “How Far Should Self-Determination Go; Should One be Allowed to Perish?” *J. Psychosoc. Rehabil. Ment. Health*, 9, 395–407.

<https://doi.org/10.1007/s40737-022-00276-6>

- O' Sullivan, K., Downes, C., Monahan, M., Morrissey, J., Byrne, G., Farrell, G et al. (2023). Operationalising a Recovery-Oriented Support and Information Programme Online: The EOLAS Programme. *Int. J. Environ. Res. Public Health*, 20(5), 4417. <https://doi.org/10.3390/ijerph20054417>
- Parkin, S. (2016). Salutogenesis: Contextualising place and space in the policies and politics of recovery from drug dependence. *International Journal of Drug Policy*, 33. 21-26.
- Piat, M., Wainwright, M., Sofouli, E., Vachon, B., Deslauriers, T., Prefontaine, C. et al. (2021). Factors influencing the implementation of mental health recovery into services: a systematic mixed studies review. *Systematic Reviews*, 10:134, <https://doi.org/10.1186/s13643-021-01646-0>
- Polit, D.N. and Beck, C. T. (2017). *Nursing research: Generating and assessing evidence for nursing practice*, 10th ed Philadelphia. Wolters Kluwer.
- Reed, T.A., Broussard, B., Moore, A., Smith, K.J. & Compton, M.T. (2014). Community navigation to reduce institutional recidivism and promote recovery: Initial evaluation of opening doors to recovery in Southeast Georgia. *Psychiatr Q*, 85(1): 25-33. <http://dx.doi.org/10.1007/s11126-013-9267-1>
- Salberg, J., Ekselius, L., Hursti, T. & Oster, C. (2022). *International Journal of Mental Health Nursing*, 31, 731–742. doi: 10.1111/inm.12995
- Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B (2018). Saturation in qualitative research: exploring its conceptualisation and operationalisation. *Quality & quantity*, 52, 1893-1907.
- Seloilwe, E.S. & Thupayagale-Tshweneyagae, G. (2007). Community mental health care in Botswana: approaches and opportunities. *International Council of Nurses* (2007).
- Sidandi, P., Opondo, P. & Tidimane, S. (2011). Mental health in Botswana. *Int Psychiatry*. 2011, 8(3):66-68.
- Siu, B. W. M., Tsang, M.M.Y., Lee. V.C.K., Liu, A.C.Y., Tse, S., Luk. et al. (2016). Pathway to mental health recovery: a qualitative and quantitative study on the needs of Chinese psychiatric in-patients. *BMC Psychiatry*, 16,236.
- Slade, M., Amering, A., Farkas, M., Hamilton, B., O'Hagan, M., Graham et al. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13(1).12-20. Doi: 10.1002/wps.20084.
- Slade, M., Bird, V., Le Boutillier, C., Farkas, M., Grey, B., Larsen, J. et al. (2015). Development of the REFOCUS intervention to increase mental health team support for personal recovery. *Br J Psychiatry*, 207(6):544-50. doi: 10.1192/bjp.bp.114.155978.

- Sofouli, E. (2021), "Cross-cultural conceptualisation and implementation of recovery in mental health: a literature review". *Mental Health and Social Inclusion*, 25 (1), 32-
<https://doi.org/10.1108/MHSI-08-2020-0057>
- Stanhope, V., Choy-Brown, M., Tiderington, E., Henwood, B. F. & Padgett, D. K. (2016). Case Manager Perspectives on the Role of Treatment in Supportive Housing for People with Severe Mental Illness. *Soc Social Work Res*, 7(3): 507–525. doi:10.1086/687986.
- Strand, M., Eng, L.S. & Gammon, D. (Combining online and offline peer support groups in community mental health care settings: a qualitative study of service users' experiences. *Int J Ment Health Syst*, 14(39). <https://doi.org/10.1186/s13033-020-00370-x>
- Tinland, A., Loubière, S., Boucekine, M., Boyer, L., Fond, G. & Girard, V. (2020). Effectiveness of a housing support team intervention with a recovery-oriented approach on hospital and emergency department use by homeless people with severe mental illness: a randomised controlled trial. *Epidemiology and Psychiatric Sciences*, 2020, 29, e169, 1–11,
<https://doi.org/10.1017/>
- Tong, A., Sainsbury, S. & Craig, J (2007) Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups, *International Journal for Quality in Health Care*, Volume 19, Issue 6, December 2007, Pages 349-357
<https://doi.org/10.1093/intqhc/mzm042>
- Waqas, A., Malik, S., Fida, A., Abbas, N., Mian, N., Miryala, S. et al (2020). Interventions to Reduce Stigma Related to Mental Illnesses in Educational Institutes: a Systematic Review. *The Psychiatric quarterly*, 91(3), 887-903 <https://doi.org/10.1007/s11126-020-09751-4>

Manuscript Five: Development of a conceptual framework for a recovery-oriented mental health programme for nurses in Botswana (To be submitted for publication).

Title page

Development of a conceptual framework for a recovery-oriented mental health programme for nurses in Botswana (To be submitted for publication).

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ABSTRACT

The study aimed to develop a conceptual framework for the recovery-oriented mental health care programme for nurses working in mental health facilities in Botswana. First, a situational analysis was conducted to gather information. That involved conducting the scoping review on the origins of the recovery-oriented mental health care programmes. It was followed by phase two of the study, which included an assessment of nurses' knowledge of recovery-oriented practice using the Recovery Knowledge Inventory scale (RKI) and the nurses' perceptions of recovery and how recovery-oriented mental health care for nurses in Botswana could be developed and implemented. Concepts emerging from the situational analysis were classified using Dickoff et al. (1968) concept classification. Finally, the identified concepts that informed the developed conceptual framework were identified.

Keywords

Botswana, Mental health, Mental illness, Recovery, Recovery-oriented mental health care programme

Introduction

The struggle with mental health continues to be a global challenge. It is estimated that over one billion people worldwide have mental health-related disorders (Arias, Saxena, & Verguet, 2022). In addition, those living with mental illnesses have to endure stigmatisation and discrimination associated with mental illness diagnosis (Kenny et al., 2018; Webber et al., 2014). As a result, such people disdain mental health services despite having mental health issues (Radez et al., 2021). Nevertheless, in recent years, people living with mental illness have been given hope through the recovery-oriented mental health approach. This approach shifts attention from psychotropic drugs to client-focused mental health services (Leamy et al., 2011; Whitley et al., 2015). The recovery approach proposes that people with mental illnesses can recover and live a meaningful life. Thus, recovery is conceptualised as the ability of people to live as happily as they can be, enjoy life and contribute to society with or without symptoms of mental illness (Jacob, 2015).

Anthony (2003) has described recovery as regaining control of one's life, having hope and living life that is meaningful to the individual through connections at work, relationships, spirituality, community engagement or some or all of these areas. Within the recovery framework, recovery does not mean "being cured" or "being normal", instead, it is about gaining or recapturing meaning and purpose in life and being empowered to live a self-directed/determined and autonomous life, despite any emotional distress that a person may have lived through or is currently experiencing. Recovery principles do not emphasise adherence to medication but rather the rediscovery of self, following a

diagnosis of mental illness and living a happy and fulfilling life within the parameters of one's illness (Jacob, 2015).

There is an element of individualism on how recovery is perceived since it was born from the consumer and advocates who viewed themselves as having recovered from mental illness (Davidson, 2016). Following this, many researchers in the field of mental illness have embraced the recovery concept, and many have started advocating it (Anthony, 1993; Deegan, 1988; Slade et al., 2014). Studies reveal that recovery is possible, and can be achieved (Davidson, 2016; Mongie et al., 2023a). Researchers have developed recovery-oriented mental health programmes to facilitate the recovery process of people with mental illness. Numerous programmes such as REFOCUS (Gilburt et al., 2013), Wellness Recovery Action Planning educational programme (WRAP) (Copeland, 2002), Prevention and Recovery Care (PARC) (Fletcher et al., 2019), and Recovery Guide for you in inpatient care (RG) (Bejerholm, 2022) have been developed and utilised to facilitate the recovery of people with mental illness. Most of these programmes have been embraced by people with mental illness and the staff in mental health facilities in terms of their usefulness in helping them recover from their mental illnesses.

Most ROMHCP have been developed from intervention studies from Western countries. A scoping review on recovery-oriented healthcare programmes to support mental health services in Africa by Mongie et al. (2023) confirms that most recovery programmes are from the United States of America, the United Kingdom, Sweden, and the wealthiest western countries. According to the same review, no recovery-oriented programme was identified in Africa. The findings support previous findings that reveal that the recovery concept in mental health has more western influence since it originates from the West (Lavalle & Poole, 2010; Slade et al., 2014). In light of this revelation, there is need to develop a recovery-oriented programme for nurses working in mental health facilities in Botswana to close the gap. Botswana is a low-middle-income country in Southern Africa with a population of 2.4 million people (Statistics Botswana, 2022). It has one main referral psychiatric mental health facility, supported by eight mental health units attached to district hospitals to care for people with mental illnesses. At the moment, the biomedical approach dominates mental health services in Botswana. People with mental illness are mostly institutionalised and managed by first controlling their symptoms with psychotropic drugs and subsequently discharged back to their families to continue with their monthly treatments.

There is need for Botswana to transition to more medically advanced evidence-based practices such as the recovery-oriented mental health approach to care for people with mental health issues and illnesses. In a study conducted by Kealeboga et al. (2023) (Unpublished), participants recommended that the time has come for Botswana's mental health care facilities to embrace and develop a recovery-oriented programme. The same participants highlighted the need to involve multiple

stakeholders such as family, peer and managerial support, training of health workers, funding and community psycho-education in promoting the recovery-oriented programme.

In order to develop a recovery-oriented mental health programme, there was need to first develop a conceptual framework to guide the development process. “A conceptual framework is a structure which the researcher believes can best explain the natural progression of the phenomenon to be studied” (Camp, 2001 as cited by Adom, Hussein & Agym, 2018: 439). It is a map through which a researcher visualises and puts their thinking into perspective. In addition, the conceptual framework has been compared to the foundation of a house through which all the structures take off (Grant & Osanloo, 2013). Therefore, to develop the programme, the researcher had to deduce the conceptual framework from the empirical phase of the study as a foundational base for the programme.

Methodology

The research methodology followed to develop the conceptual framework is described below:

Research design

The situational analysis was utilised to gather information to develop the conceptual framework. Situational analysis “involves a systematic collection and study of health and demographic data, study findings and other contextual information in order to identify and understand the specific health issue to be addressed” (Martin et al., 2016). Situational analysis is important as it gives the researcher comprehensive data from different methodological perspectives that can help map and understand a phenomenon of interest. For this study, this included the scoping review on ROMHCP to support mental health services in Africa. Kealeboga et al., (2023a) converged results of the mixed methods on the assessment of nurses’ knowledge of recovery using the Recovery Knowledge Inventory (RKI) (Kealeboga et al., 2003b unpublished), and nurses' perceptions of what recovery is and how a recovery-oriented mental health care programme can be developed (Kealeboga et al, 2023cd). The situational analysis was critical as it provided the idea of how the developed programme was informed by different methodological perspectives and by the intended recipients of the proposed activity (Kalender, 2016). The data were further classified using the survey list of Practice Oriented Theory of Dickoff *et al.* (1968:422).

Research setting

The conceptual framework was developed for the nurses working in mental health facilities in Botswana. Botswana operates with one psychiatric mental hospital and eight mental health units attached to the district hospitals across the country (Becker, et al., 2019). A vast area of Botswana is a desert, forcing the mental health services to concentrate on the railway line, with only one located in

the far north-west of Botswana as it harbours most of the population (Sidandi et al., 2011). The study utilised the referral hospital (Sbrana Psychiatric Hospital) and three mental health units: one in the North-West, one in the North East and one in the South-West of Botswana. Participants in one study site did not consent to participate in the study. All the facilities had both inpatient and outpatient provision of care to people with mental illness. The small mental health units are operated mainly by psychiatric mental health nurses, and they are offered support services by visiting psychiatrists and psychologists. Sbrana psychiatric Hospital offers inpatient and outpatient mental health services. It is staffed with 2 psychiatrists and is also supported by 4 psychiatrists from the University of Botswana, Faculty of medicine. Other staff members include 31 psychiatric mental health nurses, 149 general nurses, 8 medical doctors, occupational health therapists, 4 social workers and 58 mental health attendants (Sbrana Psychiatric Hospital Annual Report, 2021).

Data collection

Data were collected through the scoping review, questionnaires, and focus group discussions. The scoping review was conducted to explore the global literature on recovery-oriented mental health care programmes, on where they originate, their implementation and effectiveness. Besides, it was conducted to identify gaps in the literature for further research (Kealeboga et al., 2023). The Recovery Knowledge Inventory (RKI) was used to assess the nurses' knowledge of a recovery-oriented mental health care approach. Lastly, focus group discussions were used to explore perceptions of nurses working in mental health services regarding the recovery-oriented mental health care approach and nurses' perceptions on how recovery-oriented mental health care can be developed and implemented (Kealeboga et al., 2023d).

Data analysis

Different tools were used to analyse data from the empirical findings. For the scoping review, data were analysed using narratives and thematised to create meaning. Descriptive and comparative statistics were used to assess the nurses' recovery knowledge and to analyse data. Finally, data from the focus group discussions were analyzed using the Tesch (in Creswell, 2014) method of qualitative analysis.

Ethical considerations

The researcher followed all protocols needed to conduct research where human beings are the participants of data collection. The North-West University Ethics Committee No: NWU-00306-21-S1 and the Botswana Ministry of Health and Wellness REF NO: HPDME 13/18/1 granted permission to develop the conceptual framework for the recovery-oriented mental health care programme. All the

hospitals that consented to participate in the study gave the study goodwill permission for data to be collected. All the participants who gave data consented and did that voluntarily and willingly.

Trustworthiness

Trustworthiness was assured through credibility, transferability, dependability, authenticity, and confirmability. In order to ensure the credibility of data, triangulation of data was done. The researcher used multiple methods to collect data during the empirical phase of the study. The scoping review, the use of RKI to assess nurses' knowledge of how they understood recovery and the focus group discussions to collect data on how nurses perceived recovery, including how they believed recovery-oriented mental health care could be implemented. Transferability was ensured through thick descriptions of the research methodology followed when the conceptual framework for the recovery-oriented mental health programme was developed. Dependability was assured through the triangulation of different data collection methods to develop the conceptual framework.

Results

The results of the study are presented according to the phases of the research: the scoping review, the assessment of nurses' knowledge of recovery using the Recovery Knowledge Inventory (RKI), and the perception of nurses of what recovery is and how a recovery-oriented mental health care programme can be developed formed.

Table 1: showing the results of the scoping review.

Themes	Subthemes	Categories
Recovery-oriented mental health care programmes	Most recovery-oriented mental health programmes were from Western High-income countries	United States of America (11), UK (4), Australia (5), Canada (2), Sweden (1), Ireland (1), Denmark (1), Netherlands (1), Portugal (1), South Korea (1), Norway (1), France (1) and Chile and Brazil (1).
	No programme was identified from the African context	NIL
Recovery-oriented mental health approaches	Description of recovery	
	- Patients' perspectives	- Learning about self - Hope for the future - having relationships - Medication free - Self-determination - improved self-confidence - Societal engagement
	- Staff perspective and peers' perspectives	- Adherence to treatment - Insight into condition - symptom management
	- Facilitators of recovery	- Support from peer - empowerment (money, houses, participation) - Non-judgemental staff and community - Funding for recovery approach initiatives - social activities - employment - Support from staff - Stigma reduction - collaboration (staff, families, peers and patients) - better understanding of recovery
Effectiveness of recovery-oriented programmes	Effective	- most effective - offer hope - goal-oriented - non-judgemental - educational
	Not effective	- time consuming - not understood - competes with normal day duties
The recovery-oriented approach in Sub-Saharan Africa	No programme was found addressing recovery in the Sub-Saharan region	

**Kealeboga et al. (2023)

Table 2: showing nurses' understanding of a recovery approach using RKI

Theme	Subtheme	Categories
Roles and Responsibilities of Recovery	-recovery is achieved by following a set of procedures -Professionals should protect patients from disappointments -Recovery is possible for those who follow treatment -people with mental illness should engage in everyday activities -Patients should decide on their treatment -recovery is relevant for all people with mental illness	-Treatment is essential -adherence and compliance to treatment - Value of engagement in daily activities by clients - decision making by clients -all people should decide on their recovery journey
Non-Linearity of Recovery	-Recovery is not a linear process	-compliance with treatment
Roles of self-determination and peers in recovery	-Importance of self-determination and peers are important in recovery	-Value Family support -Value peer support -Self-determination to achieve goals
Expectations regarding recovery	Expectations about recovery are important	-Be realistic about goals of recovery

Table 3: showing results of the nurses' perception of a recovery-oriented mental health care approach

Theme	Sub Themes	Categories
Recovery from mental illness is possible	- Possible - Depends on the condition	-Recovery is possible
Meaning of recovery from mental illness	Functionality and living a meaningful life	-Function in the society -Make decisions -Hope for future -Participate in daily activities
	Regaining insight into their mental state,	-Have insight into the condition -acceptance of the diagnosis -Acceptance of treatment
	Treatment and adherence	-adherence to treatment
	Reduction of mental illness symptoms	-no symptoms
Factors facilitating recovery of clients from mental illness	Patient-related factors,	-Desire to overcome illness -Compliance with treatment -Acceptance of the diagnosis -Adherence to medication
	Staff-related factors,	- Competency (Qualified staff) - give unconditional support to clients - Instil hope - Qualities (empathy, listening skills, respect, love, caring and treating each client as an individual) -Provide a safe environment
	Facility-related factors	- More qualified and skilled mental health personnel, - Functional multidisciplinary team, - Provide holistic care.
	Support from significant others	-Family support -Peer support

Table 4: showing how a recovery-oriented mental health care programme can be developed and implemented

Theme	Sub Themes	Categories
Development and implementation of a recovery-oriented mental health care programme are possible.	Implementation of recovery-oriented mental health care is possible.	-recovery is possible and achievable
Measures needed to develop and implement recovery-oriented mental health care programmes.	Having proper policies and up-to-date guidelines and SOPs within and between facilities)	- Policies - Standard of operations - Developed guidelines
	The inclusion of external stakeholders in the recovery plan	- Pastors, - Traditional healers) - Herbalists - Spiritual healers - Community leaders
	The importance of after-care	- Follow-up plans - Home visits
	Education among the community and the patients themselves (psychoeducation),	- Patients - Families - Community/society - Nurses - Healthcare providers
	Dealing with stigma in the community (views on the origins of mental illness in communities	- deal with myths about mental illness - education on stigma - awareness
	Funding and recognition of mental health initiatives.	-Funding

Table 5: Integrated results from the empirical phase of the study

Theme	Subthemes
Recovery is possible	Recovery is possible and achievable
Meaning of recovery	Function in the society Make decisions Hope for future Participate in daily activities Have insight into condition Acceptance of the diagnosis Acceptance of treatment Adherence to treatment Self-confidence Medication free
Factors facilitating recovery from serious mental illness	Patient-related factors
	- Insight acceptance of diagnosis, themselves, and their treatment - Adherence to medication
	Staff related factors
	Qualified and skilled healthcare workers
	Provide individualised care
	Give unconditional support and act in the best interest of patients.
	Instillation of hope for the future
	Creating a safe environment for patients to recover
	Qualities of professional psychiatric mental health nurses
	Facility related factors
	More qualified and skilled mental health personnel
	Functional multidisciplinary team
	Provision of a holistic care
Provision of support	Support from the mental health care personnel
	Support from the family and peers
	Community support
Implementation of the recovery-oriented mental health care programme	Implementation of recovery-oriented care mental health approach is possible
	Proper policies, up-to-date guidelines and
	SOPs within and between facilities
	The inclusion of external stakeholders (e.g., pastors, traditional healers) in the recovery plan
	The importance of after-care
	Education among the community and the patients themselves (psychoeducation)
	Dealing with stigma in the community (views on the origins of mental illness in communities)
	Funding and recognition of mental health initiatives

From the integrated results, a conceptual framework for the study was developed.

The conceptual framework of the study

According to Chin and Krammer (2011:174), a conceptual framework is like a map that graphically depicts the phenomenon under study. It has been conceptualised to depict a foundation which aims to give a logical structure that portrays the ideas and relationships that connect the study. It is more like the backbone of the study. The conceptual framework shows the interrelatedness of concepts and variables and how they communicate in a study. Grant and Oonsloo, (2013) compare a conceptual framework to a house's foundation since researchers use it to structure their research problems.

The merged results, the scoping literature review results, the PCT and the general literature on recovery were used to develop the conceptual framework for this study. The empirical phase of the study answered the questions:

- What is the available literature review of recovery-oriented mental health care programmes?
- What is the knowledge of nurses working in Botswana mental health services regarding the recovery-oriented mental health care approach?
- What are the perceptions of nurses working in mental health services regarding the recovery-oriented mental health care approach?
- What should a recovery-oriented mental health care programme for nurses working in mental health care services in Botswana entail?

The conceptual framework was developed using concept classification by Dickoff, James and Wiedenbach (1968:422). The emerging concepts in phase one of the study were identified and classified according to Dickoff et al. (1968:422) and formed the researcher's thinking map. The six aspects of the practice theory by Dickoff et al. (1968:422) are agent, recipient, context, dynamics, procedures and terminus.

Agents are all the individuals who will oversee the implementation of the programme. They included all nurses caring for the client with mental illness and managing mental health facilities.

Context: Includes where the care of clients with a diagnosis of mental illness takes place. It includes mental health facilities and other clinics providing care to people with mental illness. The context will also include the Ministry of Health as the country's regulator and funder of health care. The Mental disorders Act of 1969 and the Mental Health Policy of 2003 will also serve as a base as they regulate the care of people with mental illness.

Dynamics: This includes all factors that will enforce the effectiveness of a recovery-oriented mental health care programme in Botswana. These include qualified mental health personnel, a

multidisciplinary team, funds, policies and standards in mental health, psychoeducation, training plans for health care workers, programmes, and other multiple stakeholders such as traditional doctors, herbalists and spiritual healers.

Recipient includes all the patients receiving care from the mental health facilities, which will benefit from the care the agents provide. These also include the nurses and other health care personnel in the mental health facilities that will benefit from a recovery-oriented mental health care programme.

The terminus or end point includes the purpose of the proposed programme at the end. For this study, the end product is a developed recovery-oriented programme that has the potential to benefit the mental health care facilities in Botswana.

Procedure: includes all the activities that would make the recovery-oriented mental healthcare programme successful. The dynamics are a psycho-education programme, multidisciplinary team approach, programme funding, management and government support, after-care programmes, a collaboration of all stakeholders, communication, and recognition of societal mental health initiatives.

The programme was developed based on the scoping review results, mixed methods findings on nurses' understanding of the recovery in mental health results and the conceptual framework. Furthermore, the programme was validated by mental health experts using the e-Delphi method.

Carl Rogers's Client-centred therapy, which assumes that "trustworthy, resourceful, capable and self-understanding and self-directed, able to make constructive changes and able to live effective and productive lives" Corey (2013), underpinned the study. Each individual has resources within themselves to achieve self-directed goals and reach an optimum level of functioning. An assumption that everyone can achieve what they desire if the environment is favourable and supportive is made. From the assumption, mental health facilities that are customer focused and staffed with supportive and non-judgemental personnel are likely to facilitate the recovery of people with mental illness. The emphasis is on the mental health personnel's ability to understand clients' problems from their perspectives as they are experiencing them.

Figure 1 below shows the researcher's thinking map. It shows how the agents, through their skills and critical thinking, manipulate the context to provide a nurturing environment (as assumed by Carl Rogers), to provide a therapeutic environment suitable for recovering people with mental illness. The thinking map also shows the overall outcome of factors that, according to Carl Rogers, such as support, non-judgmental attitudes towards people with mental illness and caring when emphasised and practised in a mental facility, have the potential to facilitate the recovery of patients with mental illness.

See the conceptual framework on the page below.

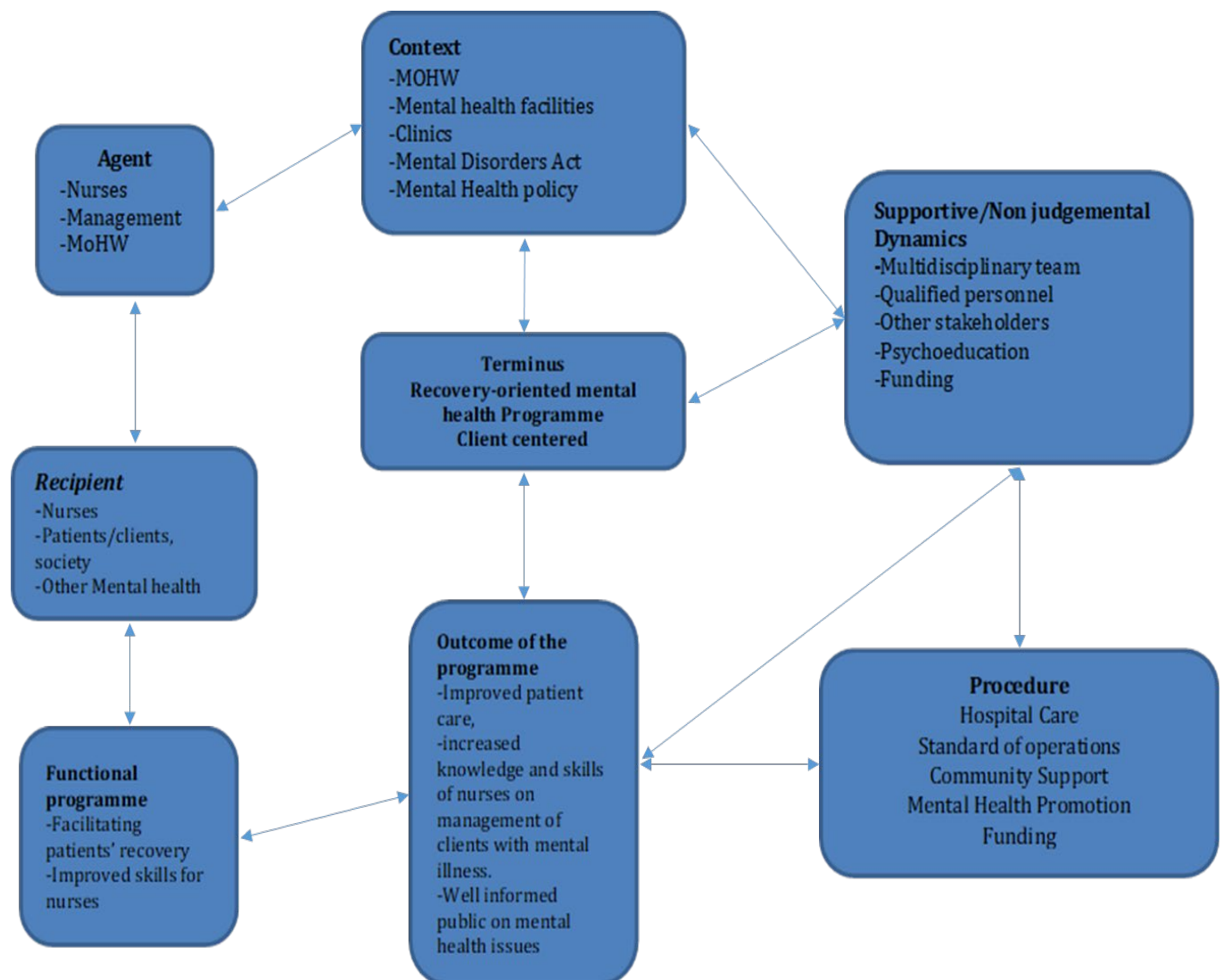


Fig 1: a conceptual framework for a recovery-oriented oriented programme for nurses working in Botswana. Kealeboga et al., (2023)

Description of the concepts as applied to the conceptual framework development.

Agents

According to Dickoff et al. (1968), an agent is a person who is instrumental in the planning, implementation, monitoring, and evaluation that is fundamental to the success of the recovery-oriented mental health care programme and therefore they should be part of the conceptual framework. The agent has a big responsibility of deciding who performs what activity and why. In most cases, it is possible to have more than one agent. For this study, the agents included the Ministry of Health, management in the mental health facilities and the nurses.

Ministry of Health

The Ministry of Health hold the key to the successful planning and implementation of health programmes in Botswana as that is where the health resources are distributed. The MoH Botswana must prioritise the mental health needs of the country and accommodate new management approaches proposed in all health-related fields. In Botswana, mental health continues to receive a low budget (Seloilwe & Tshweneyagae-Thupayagale, 2007). For the programme to be successful and effective, the MoH must start recognising the problems created by mental illness and give them the attention they deserve. That would include policy changes, standards, and allocation of funds to execute the mental health agendas, which include developing, adopting, and implementing new mental health management programmes such as the recovery-oriented mental health approaches. Sustainability and effectiveness of the programmes are largely dependent on the support from the regulators and funders.

Management in the mental health facilities

The successful implementation of programmes depends mainly on the acceptability and the reception the facility management gives to them. It also depends on how willing and receptive the management is, to change. One of the essential things that the study participants expressed is the lack of support for mental health initiatives. All the managers need to understand the context of the recovery-oriented mental health approach to mental health. There should be training of the managers in different facilities to have a common understanding of the recovery-oriented mental health care approach so that they can also embrace it and understand its overall intent. Lack of management support has hampered mental health programme implementation (De Vecchi, Kenny, & Kidd, 2015). On the contrary, where there is support, patients are more likely to benefit from the programmes (Hyeres et al., 2018).

Nurses

Nurses are the drivers of recovery-oriented mental health programmes they are majority of mental health personnel in Botswana (Becker et al., 2019). It is, therefore, crucial for them to have the necessary skills in the care and management of people with mental illness for the recovery-oriented mental health programme to be functional and effective. The participants in a study by Kealeboga et al. (2023b unpublished) highlighted the need for mental health care personnel to possess attitudinal and interpersonal skills such as unconditional positive regard, warmth, acceptance, and a non-judgmental approach to the care of clients with mental illness. These are the building blocks of the client-centred therapy of Carl Rogers that have proven to be central to the recovery of people with mental illness if practised and reinforced in a mental health facility (Corey, 2013). In addition, nurses should be the drivers of change for the recovery-oriented programme to be successful. That would

include learning on their part to better equip themselves with the recovery-oriented mental health care approach skills and how to disseminate the same information learnt to facilitate adoption, understanding and buy-in of the programme.

Context

The context of the conceptual framework includes all the mental health facilities where the care of people with mental illness takes place. In order to support recovery, mental health facilities should be very supportive and equipped with resources that facilitate recovery. That includes being staffed with personnel that possess proper qualifications, having a functional multidisciplinary team involving both the patients and their families, as well as other stakeholders such as traditional doctors, herbalists and spirituals in the care of people with mental illness. Recovery from mental illness is a personal journey (Jacob, 215). Participants in this study expressed the need to involve different mental health professionals and stakeholders in caring for people with mental illness. They have recommended having spiritualists and traditional doctors in mental health facilities. By so doing, the patients could access care under the same facility.

Recipients

The recipients are the people who have direct or indirect benefits from the action the agents perform. For this programme, the recipients are the patients, nurses, and the community at large. The patients are the primary recipients of a successful and functional recovery-oriented mental health care programme as they are likely to receive better and improved care. The nurses working in mental health facilities are also recipients because they will learn new approaches of managing people with mental illness. For the recovery-oriented approach to be implemented, there has to be a shift from the traditional, everyday approach to managing mental illnesses in a more recovery-oriented one. Healthcare workers will need to be oriented to the recovery approach through formal and informal education for them to be able to implement the care. The community will also benefit from the psycho-education programme on mental health, targeting the stigma and misconceptions about mental illness. It is anticipated that with a structured psycho-education programme, society will have improved knowledge about mental illness. These procedures will be conducted at the facility and community levels.

Procedures

The procedures are all activities that must be performed to ensure the success of the programme. The procedures for the programme include the activities carried out at the facility and community levels. The procedures include community linkages, peer support/support group, admission and discharge plans, referrals channels, funding, psycho-education programmes, training plan, functional

multidisciplinary team, family involvement, client involvement, key stakeholders, (dikgosi) traditional and religious leaders, and community participation.

Facility level

The procedures that need to be performed in order to have a practical and functional recovery-oriented programme at the facility level include having a functional multidisciplinary team, structured patient care activities, involvement of clients, families and other external stakeholders such as peers, traditional doctors, herbalists and spiritualists. Having staff with a relevant qualification qualified in mental health is fundamental in the ROMHCA (Iseselo & Ambikile, 2020). Support from family members, peers and health workers are also paramount to the recovery programme. Participants in a study conducted by Kealeboga et al. (2003), one informed the development of this conceptual framework (table 3 & 4), highlighted the importance of involving families and other stakeholders in the care of people with mental illness something that is well supported by the literature in facilitating the recovery of people with mental illness (Lewis, Hopper, & Healion, 2012; Reed, Broussard, Moore, Smith, and Compton, 2014). In addition, a facility should have a funded training plan since the new approach to care will care for people to acquire new skills, which will require further training for the implementers.

Standard of operations

For the programme to be successful, there must be policies in place that support its adoption and implementation. The move is essential as it will avoid competing interests as there are already policies supporting how Botswana manages mental illnesses. In addition, there should be proper admission and guideline policies on admission, discharge and follow-up, referral channels, after-care and community linkages following discharge and integration into the community. Currently, the country faces a circle of admission and readmission of patients to mental health facilities as there are no active community mental health services to guide the reintegration of clients back into the community and their families following discharge. The policies would facilitate the integration of clients back into the community following proper guidelines.

Community Support

Community support is integral to successfully reintegrating clients into society following discharge from a mental health facility (Iseselo & Ambikile, 2020). Properly planned, run, and coordinated community structure should help patients reintegrate into the community. That will include a functional programme of peer, family and community leaders support groups that support the patients. In addition, person-centred community support focuses on enhancing the community's healthcare experience and harnessing the healthcare systems' compassion, empathy, and professionalism. Thus,

the honest assessment and introspection of an organisation can be achieved through empathising with the community.

Mental Health Promotion

A functional ROMHCP would have substantial health promotion activities to improve the general knowledge at the facility and societal levels. That will include having a psycho-education programme run by stakeholders from the facility and community levels. Psycho-education programmes can potentially improve people's knowledge of mental health issues and the problems surrounding the stigma towards mental illness. For example, a study by Becker et al. (2019) has associated the cause of mental illness with witchcraft. These are the stereotypes that the psycho-education programme can disillusion if well implemented.

Funding

The success of every programme depends on funding. Botswana government should prioritise funding mental health initiatives. Currently, all mental health activities are allocated fewer funds; therefore, very little is done for people with mental illnesses. Nothing is done for clients at community level regarding reintegration of the people back into the community due to lack of funds.

Monitoring and evaluation activities.

Monitoring and evaluation form the fundamental goals of every programme. Patients, nurses, and the community should constantly give feedback about the programme and where changes could be made. Engaging the community on issues pertaining to health shows the belief in people's potential to discover and suggest solutions to their problems. Besides, this is consistent with client-centred ideals. Nurses and the Ministry of Health and wellness Mental Health Unit should monitor the implementation and coordination of the programme for it to be successful. Things should be done in a planned and orderly manner for them to be successful.

Dynamics

The dynamics are like the fuel or the energy that would drive the success of the programmes (Dickoff et al. 1968:435). The developed recovery-oriented mental health programme would require commitment and from all involved to make it successful. The dynamics below are recommended for an effective and functional recovery-oriented mental health care programme for nurses in Botswana.

Person-Centred Approach

The tenets of patient-centred therapy would be the central energy of the programme. Carl Rogers (Corey, 2013) emphasises the facility's ability to provide non-judgmental, genuine, and supportive care to clients based on the belief that each client can facilitate recovery. Every client has the potential to recover, provided the system believes in them and supports them. The facilitation of the support can be achieved through having a ROMHCP that provides support to the community to attain better health, to strive toward self-realisation, self-determination, and fulfilment. Lastly, it calls for providing care to clients by well-trained and skilled mental health professionals that possess interpersonal qualities such as love, empathy, genuineness, and compassion for people with mental illness. These qualities align with the person-centred approach advocated by Carl Rogers to facilitate the recovery of people with mental illness.

Functional multidisciplinary team (MDT)

For the programme to be effective and functional, there should be an MDT comprising all the mental health personnel with decision-making powers in the care of the clients. The participants reiterated that currently, there is no functional MDT in place to care for people with mental illness holistically (Table 3 and 4). Therefore, they have recommended that a recovery-oriented mental health programme should have policies requiring each facility to have an MDT in place and procedure guidelines of operations. A mental health facility with a functional MDT has the potential to facilitate patient recovery better as there is more accountability and ownership of clients' care.

Funding and recognition

In addition, funding and recognition of all mental health initiatives by the government and all management in all mental health facilities is required. Currently, mental health services in Botswana are underfunded. So there has to be some improvement in that regard. On the other hand, health workers need to recognise the recovery-oriented programme. Evidence confirms that the recovery-oriented approach competes with treatment, as usual, the biomedical approach. Some health workers have indicated that the approach is time-consuming (Higgins, 2012), others still believe in the biomedical model (Gamieldien, 2022), while others think they already offer recovery-oriented care. Policy change and education on the recovery-oriented approach will improve the programme's buy-in and adoption.

Policy change

For a programme to be functional, it will require developing and implementing policies that align with it to facilitate buy-in from all involved in the care of people with mental illness. Unfortunately,

Botswana mental health services operate with old mental health policies of 1969 and 2003, respectively. Therefore, there is a need to realign the policies and standards governing the implementation of mental health services in the country to the latest evidenced-based mental health management approaches, such as recovery-oriented ones.

Involvement of all stakeholders

The programme should include all the stakeholders, from the government level, facility, patients, families, peers, and community leaders, religious and traditional doctors, for it to be effective. Participants in this study reflected on the need for all stakeholders to be involved for the recovery of clients to be enhanced. They highlighted the need for patients to be involved in decision-making about their care. They recommended that clients should be exposed to several choices by being provided with the spiritual care within the facilities.

Training plan

There is need to have a mindset shift and acquisition of new knowledge and skills for a programme to be successful. That can be achieved through having a funded training plan in place and having the right staff in place. The majority of health personnel possess general health qualifications. Most nurses and doctors possess a general qualification, while only a handful are mental health personnel. The participants recommended that for people with mental illness to be better facilitated with their recovery, the mental health facilities should be staffed with mental health personnel that will care for the client with confidence, empathy and love, the qualities which are emphasised by the person Centred therapy by Carl Rogers (Corey, 2013).

The study's findings confirmed that the participants recommended the programme to include all the mental health stakeholders, including other external stakeholders such as traditional leaders and religious leaders, to be effective. They have indicated the need for policy change and funding for mental health initiatives.

Terminus

The terminus is the end point of the activity (Dickoff et al. 1968:442). For this study, the end product is a recovery-oriented mental health care programme for nurses in Botswana. The programme has the potential to benefit the mental health care facilities in Botswana in terms of implementation of care and acquisition of new knowledge and skills by nurses and other health care workers caring for people with mental illness.

Conclusion

The conceptual framework for the recovery-oriented mental health care programme was developed using the practice Oriented Theory of Dickoff et al. (1968) and some concepts of the client-centred theory of Carl Rogers. The conceptual framework formed the basis for developing a recovery-oriented mental health care programme for nurses working in mental health care facilities in Botswana.

References

- Adom, D., Hussen, E.K. & Agym, J. A. (2018). Theoretical and conceptual framework: Mandatory ingredients of a quality research. *International Journal of Scientific research*, (7)1, 93.98.
- Anthony, W.A. 1993. Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4).
- Arias, D., Saxena, S. & Verguet, S. 2022. Quantifying the global burden of mental disorders and their economic value. *Eclinicalmedicine*, 54, 101675.
- Bejerholm U, Allaskog C, Andersson J, Nordström L, Roe D. (2022). Implementation of the recovery guide in inpatient mental health services in Sweden-A process evaluation study. *Health Expect*, 25(4): 1405-17.
- Copeland, M.E. (2002). *Wellness Recovery Action Plan*. USA: Peach Press
- Corey, 2013. *Theory and Practice of Counselling and Psychotherapy*. 9th Edition, Brooks/Cole, USA.
- Deegan, P.E. 1988. "Recovery: the lived experience of rehabilitation". *Psychosocial Rehabilitation Journal*, 11(4):11-19.
- Davidson, L. (2016). The Recovery Movement: Implications For Mental Health Care And Enabling People To Participate Fully In Life. *HEALTH AFFAIRS*, 35, 6: 1091–1097, <https://doi.org/10.1377/hlthaff.2016.0153>
- De Vecchi, N., Kenny, A. & Kidd, S. (2015). Stakeholder views on a recovery-oriented psychiatric rehabilitation art therapy program in a rural Australian mental health service: a qualitative description. *Int J Ment Health Syst*, 9(1): 11. [http://dx.doi.org/10.1186/s13033-](http://dx.doi.org/10.1186/s13033-2015-0015-0)
- Kidd, 2015
- Dickoff, J., James, P. & Wiedenbach, E. (1968). *Theory in practice discipline part 1. Nursing Research*, 17 (5): 415-435.
- Fletcher, J., Brophy, L., Killaspy, H., Ennals, P., Hamilton, B., Collister, L. et al (2019). Prevention and Recovery Care Services in Australia: Describing the Role and Function of Sub-Acute Recovery-Based Residential Mental Health Services in Victoria. *Frontiers in Psychiatry*, 2019, 10: 735
- Gamielien, F., Galvaan, R., Myers, B. & Sorsdahl, K. (2022). Service Providers perspectives on personal recovery from severe mental illness in Capetown, South Africa: A qualitative study. *Community Mental Health Journal*, 58:955–966 <https://doi.org/10.1007/s10597-021-00904-8>
- Gilburt, H., Slade, M., Oduola, S. & Craig, T. K.J. (2013). Promoting recovery-orientated practice in mental health service: a quasi-experimental mixed-methods study. *BMC Psychiatry*, 13,167.
- Grant, C. & Osanloo, A. (2013). Understanding, selecting and integrating a theoretical framework in dissertation research: creating the blue print for your "House" *Administrative issues Journal, Connecting Education, Practice and Research*, 4, (2).
- Iseselo, M.K. and Ambikile J.S. 2020. Promoting Recovery in Mental Illness: The Perspectives of Patients, Caregivers, and Community Members in Dar es Salaam, Tanzania. *Hindawi Psychiatry Journal*, Volume (2020), Article ID 3607414, <https://doi.org/10.1155/2020/3607414>
- Jacob K. S. (2015). Recovery model of mental illness: a complementary approach to psychiatric care. *Indian journal of psychological medicine*, 37(2), 117–119. <https://doi.org/10.4103/0253-7176.155605>
- Kalender, J. (2016). Situational analysis as a framework for interdisciplinary research in the social sciences. *Human Affairs*, 26 (340-355). DOI: 10.1515/humaff-2016-0029

- Mongie, K.K., Eva, M.E. & Salamina, M.S. (2023). Recovery-oriented programmes to support the recovery approach to mental health in Africa: Findings of PhD: a scoping review. *The Open Journal of Nursing*, 17
- Kenny, A., Bizumic, B. & Griffiths, K.M. (2018). The Prejudice towards People with Mental Illness (PPMI) scale: structure and validity. *BMC Psychiatry* 18, 293.
<https://doi.org/10.1186/s12888-018-1871-z>
- Lavallee, L. F. & Poole, J. M. 2010. Beyond Recovery: Colonization, Health and Healing for Indigenous People in Canada. *International Journal of Mental Health and Addiction*, 8(2):271-281.
- Martin, W., Pauly, B., & MacDonald, M. (2016). Situational Analysis for Complex Systems: Methodological Development in Public Health Research. *AIMS public health*, 3(1), 94–109.
<https://doi.org/10.3934/publichealth.2016.1.94>
- Sbrana Psychiatric Hospital Annual Report, (2021). *Annual Report*. Ministry of Health Botswana
- Seloilwe, E. S., and Thupayagale-Tshweneagae, G. 2007. Community mental health care in Botswana: Approaches and opportunities. *International Nursing Review*, 54, 173– 178.
doi:10.1111/j.1466-7657.2007. 00525.x
- Sidandi, P., Opondo, P and Sebonetse, T. 2011. Mental health in Botswana. *BJPsych international*, 8(3)
- Slade, M., Amering, A., Farkas, M., Hamilton, B., O'Hagan, M., Graham, P., ... & Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13(1).12-20. Doi: 10.1002/wps.20084.
- Statistics Botswana, (2022). *2022 population sensors*. Available from
<https://www.statsbots.org.bw/census-2022> Accessed 14 March 2023
- Webber, M., Corker, E., Hamilton, S., Weeks, C., Pinfold, V., Rose, D., Thornicroft, G., & Henderson, C. (2014). Discrimination against people with severe mental illness and their access to social capital: findings from the Viewpoint survey. *Epidemiology and Psychiatric Sciences*, 23, 155–165, doi:10.1017/S2045796013000243
- Whitley, R., Palmer, V. & Gunn, J. (2015). Recovery from severe mental illness. *Canadian Medical Association Journal*. 187, 951-952

Manuscript six: Recovery-oriented mental health care programme for nurses in Botswana (*To be submitted for publication*)

Title page

Recovery-oriented mental health care programme for nurses in Botswana (*To be submitted for publication*)

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Abstract

The study aimed to develop a recovery-oriented mental health programme for nurses in Botswana. The programme was developed based on the conceptual framework developed. The conceptual framework was informed by the Practice theory of Dickof et al. (1968) and further developed based on the components of a model by Chinn and Kramer. These are (1) an overview of the programme, (2) the purpose of the programme, (3) the structure consisting of assumptions on which the programme is based, (4) concepts definition and (5) relationship statements. The North-West University and the Ministry of Health and Wellness, Botswana, granted permission to conduct the study. All the participating hospitals gave the study goodwill permission for the study to be conducted. All participants voluntarily consented to participate in the study, and the collected data informed the development of the conceptual framework. The study results indicated that a functional programme should have funding, policies and procedures in place, functional multidisciplinary teams,

involvement of all stakeholders, and operate within a client-centred environment. Experts in the mental health field validated the programme and recommended it for adoption and implementation in mental health facilities. The study adds to the scarce literature on recovery programmes in Africa.

Keywords: Botswana, Conceptual framework, Programme, Recovery oriented mental health care Programme

Introduction

Recent literature on the care of patients with mental illness contends that mental health services should provide patient-centred care (Kwok, 2014, Slade & Longden, 2015). The patient-centred care approach entails providing individualised care that is patient-driven and client-centred. The option to provide patient-centred care came after the critics of the biomedical approach felt that the biomedical approach was expert opinionated and oppressive to people with mental illness (Kwok, 2014; Australian Health Ministries Advisory Council, 2013). They thus entreated healthcare facilities to provide respectful care to patients. Moreover, the biomedical model approach of care to people with mental illness puts more emphasis on reducing symptoms and neglect the lived experience of the person diagnosed with mental illness (Gamielien et al., 2022). Patient-driven care is characterised by recognising and respecting the contribution of people with mental illness during their care. Client-centred care is embedded in the recovery-oriented mental health care approach (ROMHCA). The ROMHCA recognises that recovery from mental illness is an individual-led process and is possible. It also emphasises that recovery is better understood by a person undergoing recovery hence the need to allow them to lead their own recovery process.

In order to understand ROMHCA, first, there is need to describe how recovery is understood in the context of this approach. There is no definite definition of recovery, but there is some agreement among researchers that it entails finding meaning and purpose in life, living a fulfilling life and having hope for the future despite having debilitating symptoms of mental illness (Anthony, 2003; Slade et al., 2009; Jacob, 2015). People who have personal experiences of mental illness take centre stage in understanding and contextualising recovery (Australian Health Ministries Advisory Council, 2013). It recognises the ability of the individual with a mental illness to participate, enjoy life and be happy as one can be with or without symptoms of mental illness.

To facilitate the recovery of people with mental illness, recovery-oriented mental health programmes (ROMHCP) have been developed. ROMHCP is a mental health intervention that supports recovery and understanding of health care needs of a person with mental illness from their perspective. It is built on the tenets of the client-centred theory by Carl Rogers that values an individual's individuality. It emphasises that patients can facilitate their recovery process (Corey, 2013). Therefore, the patient's

needs and wants are prioritised when the patient's care plans are developed. Most ROMHCP programmes have been adopted and implemented in Western countries (Australian Health Ministries Advisory Council, 2013). A scoping review by Kealeboga et al. (2023) on the originality of recovery-oriented mental health care programmes did not find any such programme in Africa. South Africa is the only country that has embraced the recovery approach through the mental health policy (Department of Health, South Africa, 2013-2020).

However, in Botswana, studies by Becker et al. (2021) and Kealeboga et al. (2023) have confirmed that the country has not adopted the recovery approach. The mental health services in Botswana are underfunded, an observation common in other African countries (Seloilwe & Thupayagale, 2007; Iseselo & Ambikile, 2017; Department of Health, South Africa, 2013-2020). Lack of funding has rendered some mental health strategies such as integrating patients back into the community, ineffective (Becker et al., 2019). Consequently, the Botswana mental health care delivery system mainly operates through the lens of the biomedical orientation. Most people with mental illnesses are cared for in the only referral mental health facility, Sbrana Psychiatric Hospital, supported by other mental health units attached to the main district hospitals (World Health Organisation, 2015; Seloilwe & Thupayagale, 2007).

Sbrana Psychiatric Hospital is located in a small town called Lobatse in the south-East of Botswana and serves as the only referral hospital in the country. Its staff comprises 4 psychiatrists, 31 psychiatric mental health nurses, 149 general nurses, 3 psychologists, 4 social workers, 6 occupational therapists and 58 mental health attendants. The hospital is supported by mental health units attached to major district hospitals nationwide. They serve as temporary holding bays for patients in transit to Sbrana Psychiatric Hospital and are operated mainly by nurses supported by visiting psychiatrists and psychologists (Seloilwe & Thupayagale, 2007; Becker et al., 2019). Most of the staff in the hospital are nurses, a situation prevalent in most healthcare settings due to severe shortages of mental health personnel, especially psychiatrists (Sidandi, Opondo & Sebonetse, 2011; WHO, 2014). Thus, the need for nurses to familiarise with the latest developments in the care of people with mental illness, in this case, the ROMHCA.

An exploration of nurses' perception of recovery by Kealeboga et al. (2023c) (unpublished) from Botswana established that recovery from mental illness is possible, provided the patients are supported. In addition, the findings confirm that participants feel the need for the country to develop its ROMHCP to facilitate the care of people with mental illness. In addition, the recommendations of a study on explanatory beliefs, stigma, and mental illness in the context of HIV in Botswana, by Becker et al. (2019) point to the need to provide care that addresses local context, such as beliefs and recognises the value of peer support. Based on this background, the study sought to develop a ROMHCP informed by local context for nurses in mental health care facilities.

Methodology

The study sought to develop a recovery-oriented mental health programme for nurses in Botswana. For this study, the programme was developed based on the conceptual framework based on the classified concepts of Dickoff *et al.* (1968:422) at step 1 of phase 2. The programme was classified components of a model by Chinn and Kramer (2008:235). These are (1) an overview of the programme, (2) the purpose of the programme, (3) the structure consisting of assumptions on which the programme is based, (4) concepts definition and (5) relationship statements. Permission to conduct the study was granted by the North-West University and the Ministry of Health and Wellness, Botswana. All the participating hospitals gave the study good will permission for the study to be conducted. All participants voluntarily consented to participate in the study and the collected data informed the development of the conceptual framework.

Results

From the results of the mixed methods study, a conceptual framework was developed. The conceptual framework depicts the interrelatedness of the concepts and how they will be interpreted to inform the development of the programme.

The programme

The programme was developed based on the conceptual framework which was developed from the findings of a scoping review on the origins of the recovery-oriented mental health care programmes. The mixed methods study sought to mine the nurses' knowledge and perception on the recovery-oriented mental health care approaches and how recovery can be developed and implemented. According to Kealeboga *et al.* (2023), a functional recovery-oriented programme should have proper funding, policies, and involvement of all stakeholders, such as the mental health care personnel, Ministry of Health and Wellness, patients, families, community leaders, traditional healers, herbalists, and spiritualists. In addition, the programme should be run by qualified mental health personnel with a proper multidisciplinary team.

To support these findings, a study by Becker *et al.* (2019) from Botswana also urged mental health services to provide contextual care paying attention to the cultural needs, beliefs and respect of people undergoing care. In addition, patients who have been cared for in facilities that are recovery-oriented have reported tremendous improvement in their self-esteem and general mental well-being (Picton *et al.*, 2018). Besides, they have understood their mental illness better and better managed their symptoms (Frost *et al.*, 2017). Moreover, they have felt valued and supported (Howarth, 2018). Lastly, they appreciate the opportunity to be involved in their care plans (Dev *et al.*, 2021). The conceptual framework was therefore deemed appropriate to inform the development of ROMHCP.

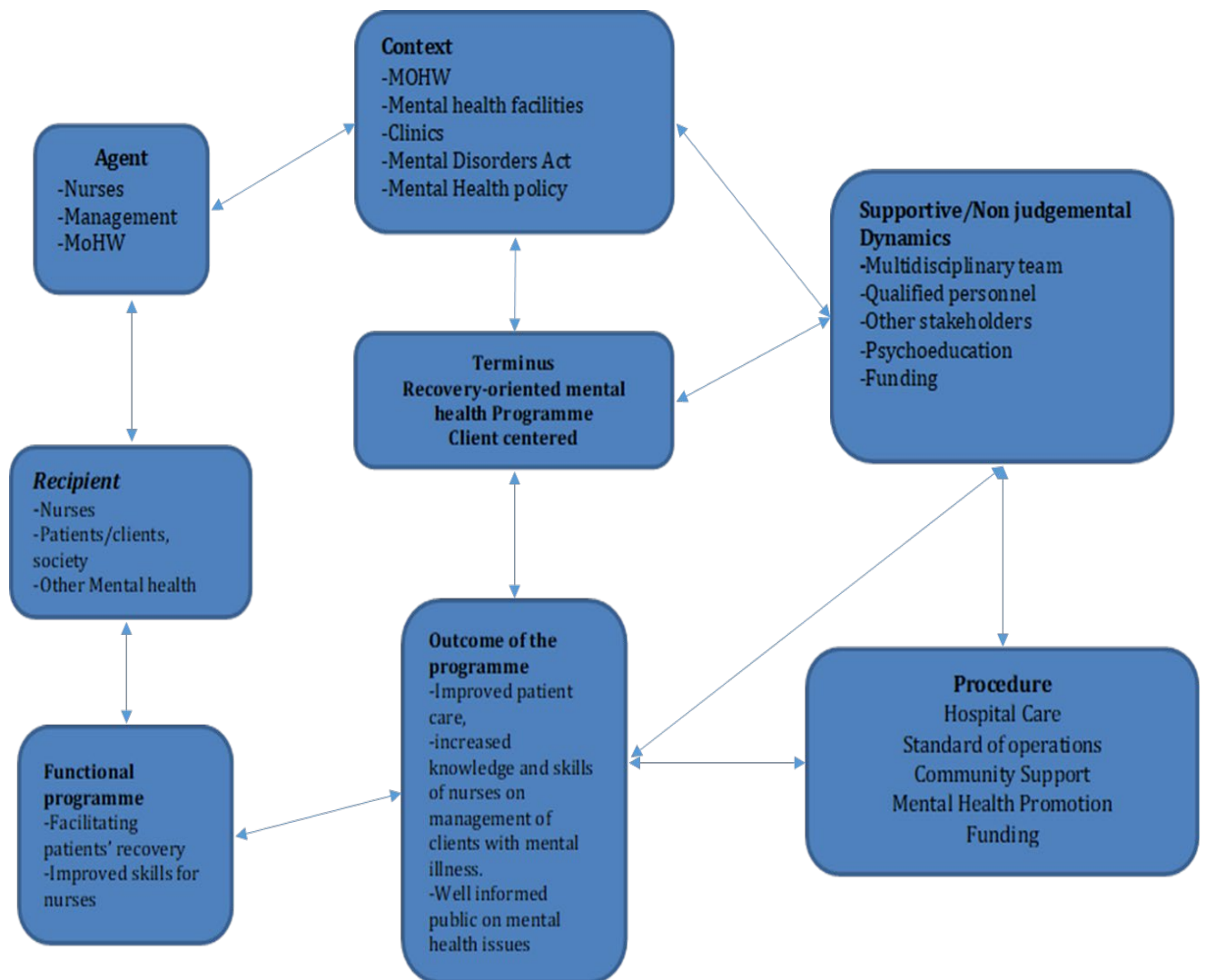


Fig 1: a conceptual framework for a recovery-oriented oriented programme for nurses working in Botswana. Kealeboga et al., (2023)

Overview of the programme

The recovery-oriented mental health care programme is a patient-centred approach model of care based on the premise that each patient can recover if they are provided with the necessary tools such as support, love, and a nurturing environment staffed by skilled mental health personnel. The participants in this study by Kealeboga et al. (2023cd) indicated the need for Botswana to have a mental health programme that guides the implementation and provision of mental health care to people with mental illness. The developed programme is based on the person-centred therapy by Carl Rogers and the empirical findings of this study that recommended factors to be considered to have an effective and functional recovery-oriented mental health care programme for nurses in Botswana.

The purpose of the programme

The programme's purpose is best understood if the implementers know its intended purpose (Chinn & Kramer, 2012:185). This programme will serve as a frame of reference for mental health services and the nurses to transform mental health services in Botswana to be recovery oriented.

The structure

The programme structure gives a form or picture of how concepts relate within it (Chinn and Kramer, 2012:191). The programme's structure will include assumptions, concept definitions, relationship statements and the nature of the structure.

Assumptions on which the programme

The assumption of the recovery-oriented programme is underpinned by the Person-Centred Therapy proposed by Carl Rogers. It assumes that all human beings have the potential to grow and self-actualise as long as they are provided with an environment that facilitates growth (Corey, 2013). The growth and self-actualisation, that is, recovery as experienced and led by the client, can be achieved, and are based on the following assumptions about the programme:

- The recovery-oriented mental health care programme for nurses has the potential to facilitate the recovery of people with mental illness, if it is funded and recognised by the government, lawmakers and decision-makers at the facility and community levels.
- If the context is favourable and supportive, all the patients can achieve full or partial recovery as defined by each patient looking at what recovery from mental illness will mean for them.
- If the healthcare workers accept and treat all the clients with love, have empathy and treat them as individuals, they are likely to facilitate their recovery from mental illness.
- The effectiveness of the recovery-oriented mental health care programme depends on the interplay and commitment of multi-stakeholders and their involvement in caring for people with mental illness.
- People with mental illness are the primary stakeholders, and they should be recognised as such in the recovery-oriented mental health programme.

Concepts definition

Concepts for this programme were classified based on Person-Centred Therapy by Carl Rogers and the evidence from the empirical phase of the study mainly on how nurses perceived recovery from mental illness and the development of the recovery-oriented mental health care programme. The concepts have been classified according to Dickoff *et al.* (1968).

Relationship statements of the programme

- For the programme to be functional and practical, it must be supported by the context, including the Ministry of Health and Wellness, mental health facilities and the community.
- The agents (Nurses, Ministry of health and wellness, and other mental health care practitioners) should be embrative, committed, and critical in pushing and implementing the mandated programme.
- The recipients of this programme are the patients, nurses, and other members of the health team.
- The energy source of the programme is the interpersonal qualities of the multidisciplinary team and other factors such as a functional multidisciplinary team, qualified personnel, involvement of other stakeholders, having a psycho-education programme and training plan and having Supportive policies and funding.
- A functional programme will likely influence clients' recovery from mental illness as it will serve as a frame of reference for implementation and monitoring for nurses, management, and other healthcare team members.
- If procedures were established and implemented at ministerial, hospital and community levels, the country would provide improved care to clients. The procedures include the establishment of community liaison/linkages, peer support/support group, admission and discharge plan, referral channel, funding, psycho-education programmes, training plan, functional multidisciplinary team, family involvement, client involvement and other key stakeholders such as traditional healers, herbalists and spiritualists, and community key stakeholders, Dikgosi (Traditional leaders) and religious leaders.
- Overall, the patients are the primary recipients of the programme, therefore, they should be listened to, respected, and accommodated as they recover from mental illness. People with mental illness should have a say in their treatment plan.
- The programme is underpinned by client-centred therapy, which recognises that every client can recover and assume self-actualisation provided a nurturing, supportive and enabling environment is provided to them. The assumption is that the recovery-oriented mental health care programme can provide an environment for people with mental illness to facilitate their recovery process.

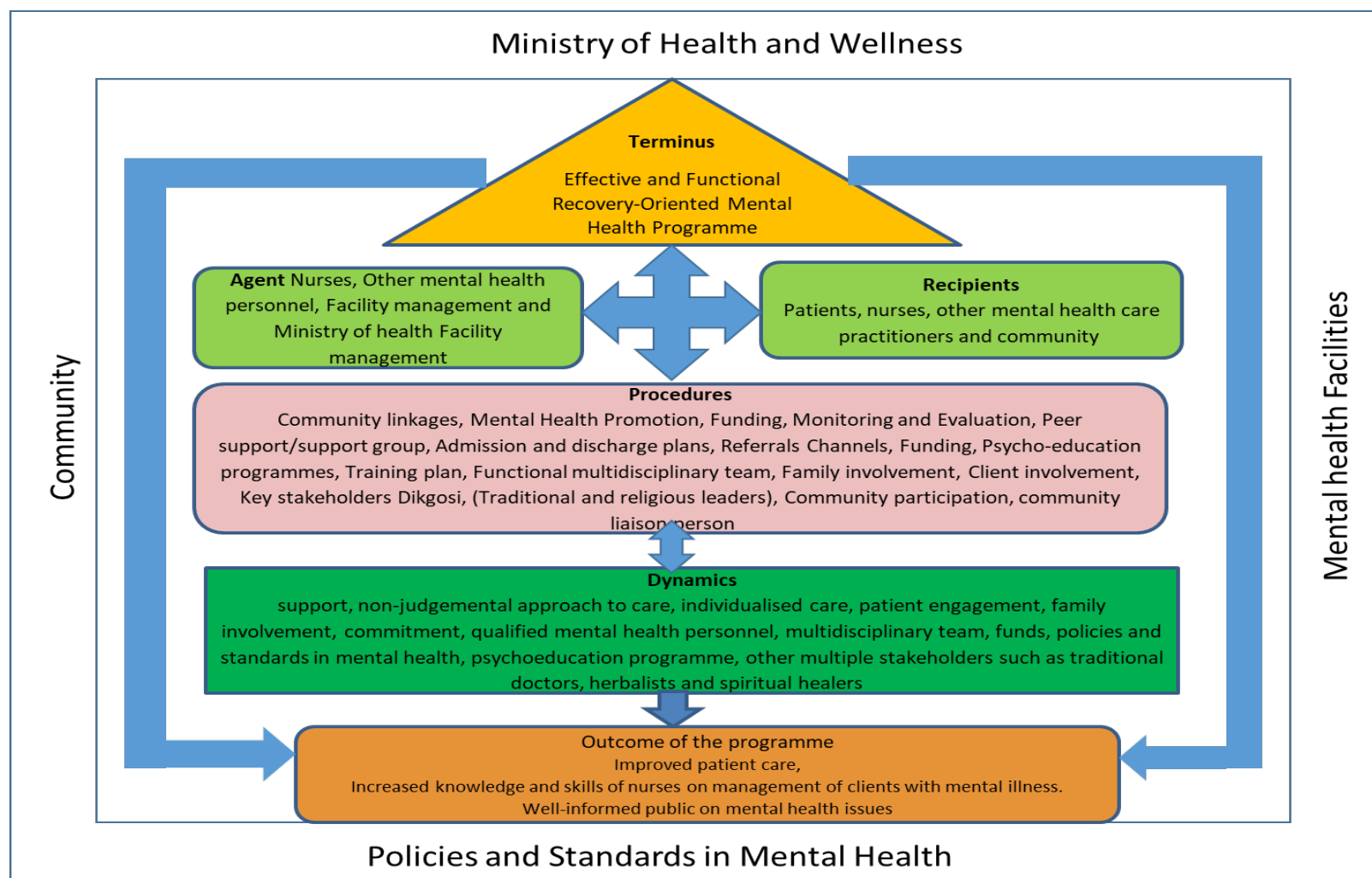


Figure 2: The recovery-oriented mental health programme for nurses in Botswana

Interpretation of the programme

The diagram depicts the summary of the programme in a picture format.

- The outer layer represents the context where the care of people with mental illness will occur. For example, mental illness patients are cared for in mental health facilities, family settings, and the community. Favourable policies and standard procedures in mental health facilities that support recovery will influence its implementation.
- The topmost triangle represents a functional recovery-oriented mental health care programme.
- The agents are the programme's primary drivers, and their buy-in and support may influence the success of its adoption and implementation.
- Patients, nurses, other mental health care practitioners and the community are the primary recipients of the programme, with patients being the primary recipients.
- Implementing the procedures may lead to a successful, functional, and effective programme.
- The arrows represent the inter-relationship between the concepts. For example, successfully implementing one concept may lead to a better outcome for the other.
- The outer thick blue arrows represent the likely benefit of a functional and effective recovery-oriented mental health care programme: improved patient care and increased knowledge and skills of nurses and other mental health care practitioners in managing clients with mental illness.

Programme Validation

The programme was validated by mental health experts using the e-Delphi method. E- Delphi involves sending of questionnaire or programme to an expert panel to seek validation (Skulmoski, & Hartman, 2007). The e-Delphi method of research validation is mostly used when clarity is needed on a particular problem, and it stops when a consensus is reached. The experts mulled over the developed programme until they reached a consensus. A 4 steps e-Delphi technique by Msibi, et al. (2018) was used to appraise the programme as follows:

Phase 1 preparatory phase.

Through the help of the Learning Management System (LMS), the researcher developed an online platform that was a centre point where the programme was validated and appraised. The learning management used to validate the programme was a Padlet platform. A Padlet is an online digital notice board. All the mental health experts who consented to participate in the programme validation were sent the Padlet link to comment on the programme.

The programme validation was part of the study, so the North-West University Health Research Ethics Committee and the Ministry of Health and Wellness cleared it. Following clearance from the

ethics committee of different hospitals for the study to be conducted, the researcher developed an invitation letter inviting the experts to participate in the programme's validation process. It was then sent to 9 mental health experts from different District Management Teams to validate the programme. In addition, the letter explained the purpose of the programme validation, and those willing to participate in the validation process consented. The experts were chosen based on their experience of caring for people with mental illness. Seven consented to validate the programme and participated in the LMS validation platform. The experts had a range of 14 to 35 years of experience in caring for people with mental illness. The researcher moderated the LMS platform. The researcher developed a guide that was followed to validate and appraise the programme.

Phase 2 Exploratory phase

The draft of the developed mental health programme was uploaded on the LMS discussion forum for the experts to comment on. The experts validated the programme using the guide which answered questions: how easy is it to understand is the programme?, How relevant is the programme?, How doable is the programme?, How accessible can the programme be? And the experts were asked for recommendations and additions. The experts were given two weeks to give input on the developed programme.

Phase 3 Consensus phase

The experts agreed that the programme was understandable, doable, could be accessible, and they all recommended it.

All the participants who consented to validate the programme commented that the programme is understandable. In addition, they believed that the programme would be accessible to all the stakeholders and can serve as a point of reference. This is what some of the said;

J. G. "It is easy to understand."

In addition, the participants agreed that the programme was doable and recommended it for adoption.

E.N. "The programme is very much doable because it can be used anywhere in the community etc, and because it contains important information which could benefit the nurses."

All the participants believed that the programme could be feasible and they strongly recommended it to policy makers.

O.T "Programme to be recommended to policy makers."

W.G “The programme is comprehensive and addresses all facets of the problem for use by policymakers.”

No adjustments were made to the programme since all the experts who validated the programme did not recommend it. Instead, they saw the programme as something that could work for all healthcare workers in Botswana should it be adopted. Following the experts validation, another expert (study supervisor) helped with the programme's final organisation.

Conclusion

The ROMHCP programme was developed for mental health nurses working in mental health facilities. The programme will be recommended for implementation in mental health facilities as it can serve as a frame of reference for applying the ROMHCP programme in Botswana. The ROMHCP can facilitate improved care for people with mental illness and help the health care workers, mostly nurses, gain knowledge and hone their skills in caring for people with mental illness. Through the programme, all stakeholders can participate in patient care.

References

- Anthony, W.A. (1993). Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4).
- Australian Health Ministries Advisory Council, (2013). A national Framework for recovery-oriented mental health services. Commonwealth of Australia, (2013).
<https://www.health.gov.au/sites/default/files/documents/2021/04/a-national-framework-for-recovery-oriented-mental-health-services-guide-for-practitioners-and-providers.pdf> Accessed 14 March 2023
- Becker, T.D., Ho-Foster, A.R., Poku, O.B., Marobela, S., Mehta, H., Cao, D.T.X., et al. (2019). “It’s When the Trees Blossom” Explanatory Beliefs, Stigma, and Mental Illness in the Context of HIV in Botswana. *Qualitative Health Research*, 1-15.
- Chinn, P.L., and Kramer, M.K. (2012). *Integrated Theory & Knowledge Development in Nursing*. 9 th Edition. St Louis: Elsevier-Mosby
- Corey, G. (2013). *Theory and practice of counselling and psychotherapy*. 9th Edition, United States of America Cenveo,
- Deptment of Health, South Africa. National Health Policy Framework and Strategic Plan 2013-2020 (2013).<https://www.safmh.org/wp-content/uploads/2020/09/National-Mental-Health-Policy-Framework-2013-2020.pdf> accessed on 14 March 2023
- Dev, S., Kankan, T., Blasco, D., Le, P. D., Agrest, M., Dishy, G., Mascayano, F., Schlling, S., Jorguera, MJ., Dahl, C., Cavalcanti, M.A., Price, L., Yang, L.H., Susser, E. S. (2021). Implementation of a pilot community-based psychosocial intervention for patients with psychoses in Chile and Brazil: a comparative analysis of users’ perspectives. *Global Mental Health*, 8 (15), 1–9. <https://doi.org/10.1017/gmh.2021.10>
- Dickoff, J., James,P., & Wiedenbach, E. (1968). Theory in practice discipline part 1. *Nursing Research*, 17 (5): 415-435.
- Frost, B. G., Turrell, M., Sly, K. A., Lewin, T. J., Conrad, A. M. & Johnston, S. (2017). Implementation of a recovery-oriented model in a sub-acute Intermediate Stay Mental Health Unit (ISMHU). *BMC Health Services Research.*, 17:2 DOI 10.1186/s12913-016-1939-8

- Gamielidien, F., Galvaan, R., Myers, B. & Sorsdahl, K. (2022). Service Providers perspectives on personal recovery from severe mental illness in Capetown, South Africa: A qualitative study. *Community Mental Health Journal*, 58:955–966 <https://doi.org/10.1007/s10597-021-00904-8>
- Grant, C. & Osanloo, A. (2013). Understanding, selecting and integrating a theoretical framework in dissertation research: creating the blue print for your “House” *Administrative issues Journal, Connecting Education, Practice and Research*, Vol, 4, (2).
- Howarth, M., Rogers, M., Withnell, N. & McQuarrie, C. (2018). Growing spaces: an evaluation of the mental health recovery programme using mixed methods. *Journal of Research in Nursing*, 23(6) 476–489
- Iseselo, M.K. & Ambikile J.S. (2020). Promoting Recovery in Mental Illness: The Perspectives of Patients, Caregivers, and Community Members in Dar es Salaam, Tanzania. *Hindawi Psychiatry Journal*, Volume (2020), Article ID 3607414, <https://doi.org/10.1155/2020/3607414>
- Jacob, S. (2013). Recovery Model of Mental Illness: A Complementary Approach to Psychiatric Care. *Indian Journal of Psychological Medicine*, 37(2):117-119.
- Kealeboga, K.M., Manyedi, and Moloko-Phiri, S. (2023a). Recovery-oriented programmes to support the recovery approach to mental health in Africa: Findings of PhD: a scoping review. *The Open Journal of Nursing*.
- Kealeboga, K.M., Manyedi, and Moloko-Phiri, S. (2023). Assessment of nurses’ knowledge of a recovery-oriented mental health care approach using the Recovery Knowledge Inventory: Findings from a developing country (Unpublished)
- Leamy, M.; Bird, V.; Le Boutillier, C.; Williams, J.; Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199 (6) 445-452.
- Msibi, P.N., Mogale, R.S., De Wal, L & Ncobo, N. (2018). Using e-Delphi to formulate and appraise the guidelines for women’s health concerns at a coal mine: A case study. *Curationis*, 41(1) 2223-6279 DOI: 10.2975/30.2006.96.103.
- Picton, C., Patterson, C., Moxham, L., Taylor, E., Perlman, D., Brighton, R., et al... (2018). Empowerment: The experience of Recovery Camp for people living with a mental illness. 25 *Collegian*, 113–118 DOI:<https://doi.org/10.1016/j.colegn.2017.04.005>

- Radez, J., Reardon, T., Creswell, C., Lawrence, P.J., Evdoka Burton, G. P. & Waite, P. (2021). Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. *European Child & Adolescent Psychiatry*, 30:183–211 <https://doi.org/10.1007/s00787-019-01469-4>
- Skulmoski, G.T. & Hartman, F.T. (2007). The Delphi Method for Graduate Research, *Journal of Information Technology Education*, Vol, 6, Available from <http://www.jite.org/documents/Vol6/JITEv6p001-021Skulmoski212.pdf> Date of access: 27 Nov 2020.
- Sidandi, P., Opondo, P. & Sebonetse, T. (2011). Mental health in Botswana. *BJPsych international*, 8(3):66-68.
- Seloilwe, E. S. & Thupayagale-Tshweneagae, G. 2007. Community mental health care in Botswana: Approaches and opportunities. *International Nursing Review*, 54, 173– 178. doi:10.1111/j.1466-7657.2007. 00525.x
- World Health Organisation, (2014). *Mental Health Atlas*. Geneva. https://apps.who.int/iris/bitstream/handle/10665/178879/9789241565011_eng.pdf accessed 14 March 2023.

SECTION 3: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS FOR THE RECOVERY-ORIENTED MENTAL HEALTH CARE PROGRAMME FOR NURSES IN BOTSWANA

Introduction

The previous sections consisted of six manuscripts, out of which one has been published in an accredited peer-reviewed international journal, two are under review, and the last three will be submitted for publication in accredited peer-reviewed journals. This section of the study covers the conclusion, recommendations, and limitations.

Conclusions

The conclusions were based on the phases and objectives of the study and were summarised as per the findings of the research.

The study's overall purpose was to develop a recovery-oriented mental health programme for nurses working in mental health facilities in Botswana. The purpose of the study was accomplished since a programme was developed and validated by experts in the mental health field. Below are the conclusions based on the objectives and the findings of the research as detailed in manuscripts one to six.

Manuscript 1: Review the existing literature on recovery-oriented mental health care programmes using a scoping review approach.

A scoping review (manuscript 1) was conducted to explore the global literature on recovery-oriented mental health care programmes. The focus was on the origins, where the programmes have been implemented and identifying the gaps for further research. The results indicated that most of the recovery-oriented mental health care programmes were from certain high-income Western countries. Though the recovery-oriented mental health care programmes are from high-income Western countries, the evidence from the included studies indicated that most programmes benefitted people with mental illness. There was a generally improved physical and mental health well-being of people enrolled in the programmes. People with mental illness who were enrolled in the programmes felt good about themselves, their self-esteem improved, had improved skills of managing their mental illness, and appreciated the mental health care services more. Although there were generally positive results in implementing the programmes, some challenges, such as lack of support from management, resistance to the new approach and lack of funding for the programmes, were experienced in some programmes.

The researcher established that Africa has procrastinated the implementation of the recovery-oriented mental health care approach. The researcher therefore recommended that Africa, especially Sub-Saharan, should initiate and implement context-based mental health care programmes.

Manuscript 2: To assess the nurses' knowledge of the concept of mental health recovery-oriented care in Botswana

The manuscript aimed to assess the nurses' knowledge of the recovery-oriented mental health care approach using an existing Recovery Knowledge Inventory (RKI) instrument. RKI is an existing tool used to assess the perception of nurses and patients towards the recovery approach in mental health care. The tool consists of section A which collects the biographic information about the participants, and 20 items that describe the attributes of recovery. The participants evaluated the items on a scale showing their agreement and / or disagreement with them. Generally, most nurses agree that for recovery to be achieved, patients should follow a set of prescribed procedures, health professionals should protect their clients against disappointments, and that the patients who have or are close to completing treatment may recover.

On the other hand, they strongly disagreed or disagreed that people with mental illness should not be burdened with everyday life, recovery is not relevant for those who are actively psychotic or abusing substances, and people receiving psychiatric/substance abuse are unlikely to decide their own treatment and rehabilitation goals. In addition, the participants agreed that the severity of the client's symptoms would determine the expectations about recovery. Moreover, the participants agreed that medication and adherence to treatment are essential for recovery. The participants showed lack of knowledge of the recovery-oriented mental health care approach. The findings confirmed the need for them to be oriented in the recovery-oriented care approach. The findings therefore underscore the need for the recovery-oriented mental health care approach to be developed for nurses working in mental health facilities in Botswana.

To explore and describe the perceptions of nurses working in mental health services regarding the concept of mental health recovery programmes in Botswana. The study aimed to explore the perceptions of nurses working in mental health care facilities of recovery-oriented mental health care. This phase used qualitative methods and focus group discussions to collect data. The data were presented in themes and subthemes. Two manuscripts were crafted from this phase. Manuscript 3 and 4.

Manuscript 3: Perceptions of nurses working in mental health services regarding the recovery-oriented care approach: findings from Africa.

Three main themes; Recovery from mental illness is possible, Meaning of recovery from mental illness, Factors facilitating recovery from mental illness, and Implementation of the recovery-oriented mental health care programme emerged from the study. The participants believed that recovery from mental illness was possible. Recovery was described as functioning in society and living a meaningful life, regaining insight into their mental illness, taking, and adhering to treatment and being able to differentiate wrong from right. The participants identified factors that could facilitate the recovery of a client with mental illness as personal, staff and other related factors. Personal factors were categorised as activities that could be performed by an individual undergoing recovery to help themselves in the recovery journey. They included acceptance of the diagnosis and recognising the need and acceptance of treatment with anti-psychotropic drugs. The staff-

related factors that could facilitate recovery included the staff qualifications of those rendering care and the core qualities of the health care workers such as having warmth, empathy, listening ear, giving support, instilling hope in patients, and creating a safe environment for patients under their care. The other factors that could facilitate recovery included the resources within health facilities, such as having a functional multidisciplinary team, having skilled personnel and the provision of holistic care where the services of other stakeholders, such as traditional doctors and spirituals are available within the facilities. Finally, the involvement of families and other support systems, such as friends and peers, were viewed as potential mediators of recovery of patients. The study offered insight into elements necessary to facilitate the recovery of people with mental illness and how it could be enabled.

Manuscript 4: Nurses' Perceptions on How Recovery-Oriented Mental Health Care can be Developed and Implemented

The intent was to explore the nurse's perceptions on how a recovery-oriented mental healthcare programme could be developed and implemented for mental healthcare nurses in Botswana. Findings indicated that developing and implementing a recovery-oriented mental health care programme was possible. Two themes were identified: i) The development and implementation of a recovery-oriented mental health care programme are possible ii) Certain elements are required to develop and implement recovery-oriented mental health care programmes. Participants believed that a recovery-oriented mental health care programme could be developed and implemented, and it would require funding and commitment from management for it to be successful. In addition to that, they mentioned elements that they believed could be considered for the programme to be developed and implemented. Some of the considerations could be appropriate policies to guide the development and implementation, inclusion of other stakeholders such as patients, families, traditional leaders, traditional doctors, herbalist for it to be successful. Moreover, having a psycho-education programme in place and the importance of aftercare and follow up plans could also boost the programme. Overall, the results indicated the need for the programme to be developed and implemented in Botswana.

Manuscript 5: Development of a conceptual framework for a recovery-oriented mental health programme for nurses in Botswana

The study utilised the findings of the scoping review on ROMHCP to support mental health services in Africa (Kealeboga et al., 2023a), converged results of the mixed method on the assessment of nurses' knowledge of recovery using the Recovery Knowledge Inventory (RKI) (Kealeboga et al. 2003b unpublished), Nurses' perceptions on recovery and how a recovery-oriented mental health care programme can be developed (Kealeboga et al., 2023cd), to develop the conceptual framework for the study. Data were further classified using the survey list of Practice Oriented Theory of Dickoff *et al.* (1968:422) to develop the conceptual framework. The conceptual framework formed the base of the developed recovery-oriented mental health care programme for nurses working in mental health facilities in Botswana.

Manuscript 6: Recovery-oriented mental health care programme for Nurses in Botswana

The conceptual framework formed the base of the developed recovery-oriented mental health care programme for nurses in Botswana. The programme was validated by experts in mental health, from academic to clinical practices. They all agreed that the programme was understandable and relevant as it covered all areas that would promote caring for people with mental illnesses and mental health problems. The experts also believed the programme could be adopted and shared with all the stakeholders in mental health practice. The programme is very comprehensive, and should be adopted, it has the potential to transform the mental health services in Botswana, as the mental health care services are predominantly inpatient care.

Overall Conclusion

A recovery-oriented mental health care programme was developed for nurses working in Botswana. The mental health care experts validated the programme, found it understandable, feasible, and doable, and recommended it for adoption and implementation in the country. For the programme to be effective, there is need for all the stakeholders to understand and adopt it. All programmes need resources for them to be effective. The mental health professions, mainly the nurses, should understand the programme. Firstly, there should be capacity building to capacitate the government officials, hospital management, mental health personnel, families of people living with mental illness, and other stakeholders, such as spiritual and traditional doctors, on what recovery approach to lobby-in support and buy-in of the programme. This could be done through workshops and seminars. As the most critical healthcare workers in the country's mental healthcare facilities, nurses are expected to be in the forefront of the campaign to sell the programme.

The programme will need processes and procedures, such as developing policies and standards, to facilitate its adoption and implementation. In addition, the survival of each programme relies primarily on funding and allocating more resources. The government should prioritise the funding of the country's mental health initiatives. All stakeholders should come on board to make the programme a success.

Limitations

The researcher achieved the overall purpose of developing a recovery-oriented mental health care programme for nurses working in mental health facilities. However, some limitations are noted as follows:

Scoping review

The scoping review's aim to document the origins and how the recovery programme has been implemented globally was achieved. However, it was only limited to the selected studies. Some important articles might have been omitted. In addition, the reviewers, the researcher, and the assistant had no experience conducting scoping. Mistakes such as selecting and including articles that were not supposed to be included might have

been made on the way. Nevertheless, the research has been published in an accredited international journal, and it provided insight that informed the development of the programme.

Nurses' perception of recovery and how recovery-mental health care programme can be developed and implemented.

The focus group discussions (FGDs) were used to collect data from the participants in the four selected sites. A few nurses consented to participate as it was during the peak of covid-19, and they were not easily accessible. Some participants did not want to be recorded. Therefore, their wishes were respected. Two sites had 8 participants, and the other two had seven participants each. Prospective participants from one site did not consent to participate. The researcher collected information from the participants through Microsoft Teams. Some interruptions due to network connectivity sometimes disturbed the flow of the conversations. Due to the small sample size for the qualitative phase, the results cannot be generalised to Botswana's mental health facilities. Nevertheless, the objective of the qualitative phase was met, as the nurses' inputs informed the development of the programme, which was validated and deemed applicable to Botswana's setting by mental health experts.

Recommendations

Currently, Botswana has no mental health programme for mental health services. Therefore, the developed recovery-oriented mental health care programme is recommended for adoption since it can potentially guide mental health care services in the country. The focus areas are:

Practice

The programme should be effective within an enabling context as the client-centred therapy purported. The context for this programme is the mental health facilities in both primary and tertiary settings. The environment should have facilities that accelerate healing and growth. These include mental health services that are spacious and free of hazards. The environment should also be staffed with trained mental health specialists to support people with mental health problems. In addition, the environment should provide holistic care and be embrative of the patients' needs. Finally, mental health facilities should form partnerships with the patients, families and all the stakeholders to create an environment that will promote the recovery of people with mental illness and mental health problems.

For the programme to be effective, all the stakeholders will need to come on board. The stakeholders include:

The government

The government is the main funder of all programmes in Botswana. Therefore, it should avail the funds to promote the agenda of the programme. In addition, more funds should be availed for staff training about the programme so that they can understand and roll it to the other stakeholders.

Non-Government Organisations

Non-governmental organisations (NGOs) play a crucial role in preventing mental illness and promoting mental health in Botswana. This programme should also be extended to NGOs to enable them to collaborate with the mental health facilities in the implementation of the programme.

Nurses and other mental health care professionals

Nurses and other mental health care professionals should be at the forefront of adopting and implementing the programme. In addition, they should be at the forefront of developing policies and standards to guide the programme's implementation. On the other hand, health workers and nurses should be educated on the recovery approach to convey the message to communities. The government should invest money into educating the nurses on how to run the programme.

Involvement of other stakeholders

All the stakeholders should be involved. There should also be proper guidelines on the extent to which other stakeholders, such as traditional doctors and herbalists, should be involved in the programme.

Furthermore, the programme should involve the patients and their families. There should be community ownership for it to be successful. Mental illness is still facing stigma and discrimination globally. Therefore, the involvement of everyone would go a long way in helping deal with such stereotypes and, in the process, facilitate the programme's success.

Education

The programme should be recommended to educators in health care for adoption. The recovery-oriented mental health care approach is not implemented in Botswana partly due to lack of knowledge on what it entails and how it should be implemented. The researcher intends to unveil the programme to mental health workers through workshops to build capacity for the recovery approach. The researcher will target mental health professionals, especially nursing schools and the referral hospital. In addition, the thesis will be made available to all the hospitals for easy referral and guidance.

The education of the programme will also be directed to the people living with mental illness, their families, and the community at large. The programme should be inclusive, the patients should take centre stage in their recovery process and own it. Furthermore, the families and caregivers of people with mental illness should also be involved in their care and thus be capacitated. Consequently, a psycho-education programme would be developed targeting the patients and families, teaching the recovery programme and the importance of forming partners with health care providers.

Education should also target community leaders. Community leaders are influential people who have the potential to influence those who look up to them. There is a need for the teachings to be extended to them so

that they can reach out to their different community members. Other major stakeholders in mental health care are the herbalist, traditional doctors, and the spiritual leaders. One recommendation from the participants was the provision of holistic care. The current set-up of mental health services in Botswana excludes spirituality in mental health. People with mental illness should be given choices, especially when admitted. There should be designated areas in the hospital where they can go for their spiritual consultation. For current health and the spiritual realm in mental health to work in synergy, they should all be educated on the programme's aims.

Research

Since this research was the first of its kind in Botswana, more research should be conducted in the same area and disseminated for it to reach the intended audience, such as the policymakers. The findings of the scoping review have been published in an international nursing journal. Other manuscripts have been submitted for possible publication in peer-reviewed journals. More research should be conducted on the recovery programme. For instance, the programme should be implemented and evaluated for effectiveness as a pilot study in the sites that participated in the study. Following that, national research targeting most facilities offering mental health services should be conducted for representation and buy-in. Generally, there is scarcity of research in the mental health field in Botswana. That could be why mental health initiatives are side-lined in the country in terms of funding and support. Programmes are generally supported based on the evidence generated to back their usefulness. Therefore, more research has to be done to close this gap.

Summary

A recovery-oriented mental health care programme was developed and validated by experts in mental health for its usefulness and applicability. The programme is built on the tenet that every individual has the potential for maximal growth and self-actualisation, provided the environment is conducive for such growth to materialise. Therefore, if adopted and implemented, the programme can transform the mental health care services in Botswana to provide patient-centred care. The programme has the components that made the experts who validated it believe it could be feasible and recommended it for adoption and implementation for better recovery of patients and mental health care users in Botswana. Nonetheless, more research should be conducted on recovery and other mental health-related research to push mental health initiatives in the country and increase the profession's recognition in terms of support and funding from policymakers.

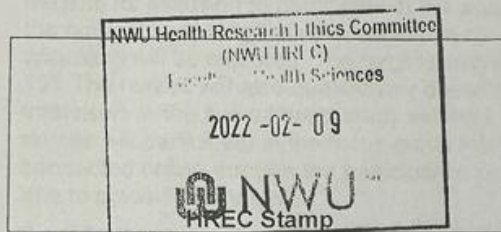
References

- Dickoff, J., James, P. & Wiedenbach, E. 1968. Theory in a practice discipline: Part I. Practice Oriented Theory. *Nursing research*, 17(5), 415-434.
- Kealeboga, K.M., Manyedi, and Moloko-Phiri, S. 2023. Recovery-oriented programmes to support the recovery approach to mental health in Africa: Findings of PhD: a scoping review. *The Open Journal Of Nursing*, 17, DOI: 10.2174/18744346-v17-230223-2022-152, 2023

Kealeboga, K.M., Manyedi, and Moloko-Phiri, S. 2023. Assessment of nurses' knowledge of a recovery-oriented mental health care approach using the Recovery Knowledge Inventory: Findings from a developing country (Unpublished)

APPENDICES

Appendix 5: Consent form



TITLE OF THE RESEARCH STUDY: Development of a mental health care recovery programme for nurses in Botswana

ETHICS REFERENCE NUMBERS: NWU-00306-21-A1

PRINCIPAL INVESTIGATORS: Prof Eva Manyedi

POST GRADUATE STUDENT: Kebope Mongie Kealeboga

ADDRESS: P O Box 21289 Gaborone Botswana

CONTACT NUMBER: +267 71769627

You are being invited to take part in a **research study** that forms part of my PhD studies in Nursing. The study is undertaken to develop and validate a recovery oriented mental health care programme for nurses in Botswana.

Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participation. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00306-21-A1)** and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

1 What is this research study all about?

The study intends to develop a recovery oriented mental health care programme for nurses caring for the mentally ill in Botswana. This study will be conducted at 5 study sites in Botswana which are providing services to people with mental illness. Nurses caring for people with mental illness with at least three years of experience will be eligible for inclusion to participate in this study. Through an existing questionnaire, the nurses' knowledge of what constitute recovery oriented mental health care approach will be explored. The target sample for the quantitative views of nurses is 151. The nurses will also qualitatively describe recovery through a focus group interviews in the five different study settings. At least eight purposively selected nurses will participate in the focus group interviews. The focus groups will be conducted online through the participants' preferred online communication platform due to covid-19 pandemic.

2 Why have you been invited to participate?

1. *You have been invited to be part of this research because you are a nurse and have at least three years of experience taking care of clients with mental illness.*
2. *You also fit the research because you have worked in your facility caring for the mentally ill for at least 2 years*
3. *You will not be able to take part in this research if you have not taken care of the clients with mental illness for 3 years*

3 What will be expected of you?

- *You will be expected to answer a questionnaire and participate in focus group interview virtually.*
- *Sign a consent form after 4 days if you agree to participate in this study*

4 Will you gain anything from taking part in this research?

- *There is no direct gain from participating in the study*
- *The potential gains of the study is for health care system as the recovery programme will greatly improve the knowledge of the nurses caring for the mentally ill'*
- *The patients will also benefit from the care provided by the knowledgeable nurses.*

5 Are there risks involved in you taking part in this research and what will be done to prevent them?

There is potential for participants to express frustration and anger towards the way the system disregard the care of the mentally ill. There is likely to be feeling of helplessness from study participants since they don't have control, over the way things are done at national level especially budgetary allocation of resources to mental health in the country. A psychologist will be on standby to address any issues that might arise during the interview. Participating in this study will accord participants to air what is happening in the system and that alone can give them psychological relieve. There is a potential for covid-19 infection and measures will be put in place to protect participants as per level of Covid-19 alertness. Online communication platforms will be utilised for focus group interviews. The

questionnaire will be shared with participants by email. Some questionnaires will be sent to the independent person for easy distribution to study participants and it will be sent back through email or WhatsApp. The researcher will provide the participants with data for focus group discussions.

6 How will we protect your confidentiality and who will see your findings?

Anonymity of participant will be protected by using codes on the questionnaires instead of names. Your privacy will be respected by conducting the interview in a secure private place and protecting the identity of the participants throughout the research process. Your results will be kept confidential. Only the researchers, supervisors of the study, co-coder and transcriber will be able to look at your findings. Findings will be kept safe by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. (As soon as data has been transcribed it will be deleted from the recorders.) Data will be stored for 5 years.

What will happen with the findings or samples?

The findings of this study will only be used for this study.

How will you know about the results of this research?

We will give you the results of this research when the project is completed through publication in a recognised research journal.

Will you be paid to take part in this study and are there any costs for you?

This study is funded by the graduate student and you will not be paid to take part in the study since the study is not funded by any grant or any donors. There will be no travel expenses as the interviews will be conducted online. The questionnaires will be emailed directly to you or they will be sent via WhatsApp. Others will be sent to the independence person for easy distribution via email. The researcher will provide study participants with data for virtual focus group interviews. Therefore there will be no costs involved for you, if you do take part in this study.

Is there anything else that you should know or do?

- You can contact Kebope Mongie Kealeboga at +267 71769627 or Professor Manyedi at 0027 82 202 0424 if you have any further questions or have any problems.
- You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

Declaration by participant

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

You can consent by putting X on Yes bellow or if you are comfortable sign bellow.

Signed at (place) on (date)
20....

Yes No

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (name) declare that:

- I clearly and in detail explained the information in this document to
.....
- I did/did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Appendix 6: Data collection tool (RKI) including demographic information of participants.

Introduction

My name is Kebope Mongie Kealeboga would be collecting information from you for the study about development of a mental health care recovery programme for nurses in Botswana as you consented. Please feel free to share as much as you can. There is no right or wrong response. Ethics approval for this research has been sought from NuMIQ Scientific Committee, Faculty of Health Research Ethics Committee (HREC), Ministry of Health and Wellness Research and Ethics Committee in Botswana and the institutional review board. Participation in this study is voluntary and you are free to withdraw at any time without any negative implications. Confidentiality will be assured by using codes instead of names.

Section A. Demographic information

Sex:

Age:

Occupation

Educational background:

Doctoral:

Masters:

Bachelor's Degree in Nursing

Diploma in Psychiatric nursing:

Diploma in General nursing:

Other qualifications in nursing:

Experience working in mental health facility:

Work status:

Department:

Section B

The instrument provides knowledge of recovery in mental health. There are 21 statements that ask you to strongly agree, disagree, uncertain, agree or strongly disagree by putting x next to the item that best represents your choice.

Recovery Knowledge Inventory Tool

No	Items	Strongly disagree	Disagree	uncertain	Agree	Strongly disagree
	Roles and Responsibility of Recovery					
1	Only people who are clinically stable should be involved in making decisions about their care.					
2	Recovery in serious mental illness/substance abuse is achieved by following a prescribed set of procedures.					
3	It is the responsibility of professionals to protect their clients against possible failures and disappointments.					
4	The idea of recovery is most relevant for those people who have completed, or are close to completing, active treatment.					
5	People with mental illness/substance abuse should not be burdened with the responsibilities of everyday life.					
6	People receiving psychiatric/substance abuse treatment are unlikely to be able to decide their own treatment and rehabilitation goals.					
7	Recovery is not as relevant for those who are actively psychotic or abusing substances.					
	Non-Linearity of Recovery					
8	Recovery is characterized by a person making gradual steps forward without major steps back.					
9	Expectations and hope for recovery should be adjusted according to the severity of a person's illness/condition.					
10	The more a person complies with treatment, the more likely he/she is to recover.					
11	Symptom reduction is an essential component of recovery.					
12	There is little that professionals can do to help a person recover if he/she is not ready to accept his/her illness/ condition or need for					

	treatment					
13	Symptom management is the first step towards recovery from mental illness/substance abuse.					
	The roles of self-definition and peers in recovery					
14	The pursuit of hobbies and leisure activities is important for recovery.					
15	Other people who have a serious mental illness or are recovering from substance abuse can be as instrumental to a person's recovery as mental health professionals.					
16	The concept of recovery is equally relevant to all phases of treatment					
17	Defining who one is apart from his/her illness/condition, is an essential component of recovery.					
18	All professionals should encourage clients to take risks in the pursuit of recovery.					
	Expectations regarding recovery					
19	Not everyone is capable of actively participating in the recovery process					
20	It is often harmful to have too high of expectations for clients.					

(Adopted from Bredgal, O'Connell and Larry, 2006)

Appendix 7: Permission to use recovery inventory scale

The screenshot shows an Outlook application window titled "Re: Permission to use RKI 20 item scale - Message (HTML)". The interface includes a ribbon with "FILE" and "MESSAGE" tabs, and a toolbar with various actions like Ignore, Delete, Reply, Forward, Meeting, Move, Rules, Assign, Mark, Categorize, Follow Up, Find, and Zoom. The email header shows the subject "Re: Permission to use RKI 20 item scale" and the sender "Davidson, Larry <larry.davidson@yale.edu>". The email body contains the following text:

To: Kebope Kealeboga
Cc: luis bedregal

Re: Permission to use RKI 20 item scale

You replied to this message on 27/04/2021 22:06.
Click here to download pictures. To help protect your privacy, Outlook prevented automatic download of some pictures in this message.

Bing Maps

You may certainly have our approval to use the tool, it is free and available to the public. Should you need any assistance with scoring or interpreting it, I would suggest contacting its first author, Dr. Luis Bedregal, who is copied above. Best wishes for your studies and your thesis.

Larry

--

Larry Davidson, Ph.D.
Professor of Psychiatry and Director
Program for Recovery and Community Health
School of Medicine, Yale University
(<http://medicine.yale.edu/psychiatry/prch/>)

Senior Policy Advisor
Connecticut Department of Mental Health and Addiction Services
(<http://www.ct.gov/dmhas/site/default.asp>)

Director

Davidson, Larry No items

The Windows taskbar at the bottom shows the search bar, taskbar icons, and system tray with the date 27/04/2021 and time 22:09.

23/05/2023

To whom it may concern

Dear Sir/ Madam,

RE: Proof of Statistical Consultation

This serves to confirm that Kebope Mongie Kealeboga (37551906) who is a PhD candidate perusing a study titled "Development of a recovery-oriented mental health care programme for nurses in Botswana" consulted with me pertaining the Statistical soundness of her work in my capacity as a Statistician.

I confirm that the statistical methodology and analyses used in this study have addressed address all the objectives of the study, the results are valid and reliable, and may be published in an academic journal.

Yours sincerely,

**Prof Volition
Montshiwa**

Digitally signed by
Prof Volition
Montshiwa
Date: 2023.05.23
11:04:33 +02'00'

PhD in Statistics (2016) tlhavolmon@gmail.com

Appendix 9: Interview Schedule English

Introduction

My name is Kebope Mongie Kealeboga I would be interviewing you for the study about development of a mental health care recovery programme for nurses in Botswana as you consented. Please feel free to share as much as you can. There is no right or wrong response. This research has sought ethics approval from NuMIQ Scientific Committee, Faculty of Health Research Ethics Committee (HREC), Ministry of Health and Wellness Research and Ethics Committee in Botswana and the institutional review board. Participation in this study is voluntary and anyone is free to withdraw at any time. Confidentiality will be assured by using codes instead of names i.e N1 and N2 to represent participants.

If you have any questions you can contact the following:

13. You can contact Kebope Mongie Kealeboga at +267 71769627 or Professor Manyedi at 0027 82 202 0424 if you have any further questions or have any problems.
14. You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
15. You can also contact Office of Research and Development at University of Botswana on 355-2900, E-mail: research.ethics@ub.ac.bw , Telefax: [+267] 395-7573.
16. You will receive a copy of this information and consent form for your own purposes.

Questions

1. How do you perceive recovery from mental illness?
2. What does recovery in mental illness entail?
3. How would you describe a person who has recovered from mental illness?
4. How would you describe a recovery oriented mental health care service?
5. What do you suggest should a recovery-oriented mental health programme for Botswana entail?

Appendix 10: Letters to seek permission to conduct the study from various institutions

To Whom It May Concern

IRB Committees

I am a doctoral student at NorthWest University, and I am currently a PhD in nursing under the supervision of Professors Manyedi and Moloko-Phiri. The title of my study is **Development of a recovery-oriented mental health care programme for Nurses in Botswana**. I am working as a lecturer at the University of Botswana School of Nursing. The study has been approved by North-West University Health Research Ethics Committee (NWU-HREC). No: NWU-00306-21-S1. My participants for this study are nurses. My mode of interaction with nurses will involve minimal to no physical contact. I anticipate collecting data mid February 2022.

Thank you for your cooperation.

Kebope Mongie Kealeboga

Cell: 71769627

Thank you in advance.

Annixture 11: Permission to conduct the study from various institutions

PRIVATE BAG 0038
GABORONE
BOTSWANA
REFERENCE:



REPUBLIC OF BOTSWANA
MINISTRY OF HEALTH AND WELLNESS

TEL: (+267) 363 2500
FAX: (+267) 391 0647
TELEGRAMS: RABONGAKA
TELEX: 2816 CARE BO

REFERENCE NO: HPDME 13/18/1

09 December 2021

Health Research and Development Division

Notification of IRB Review: **New application**

Kebope Mongie Kealeboga
P O Box 21289
Gaborone

Dear Kebope Mongie Kealeboga

**PROTOCOL TITLE: DEVELOPMENT OF A RECOVERY ORIENTED MENTAL
HEALTH CARE PROGRAMME FOR NURSES IN BOTSWANA**

HRU Approval Date:	9 th December 2021
HRU Expiration Date:	8 th December 2022
HRU Review Type:	Expedited Review
HRU Review Determination:	Approved
Risk Determination:	Minimal risk

Thank you for submitting new application for the above referenced protocol. Permission is granted to conduct the study.

This permit does not however give you authority to collect data from the selected sites without prior approval from the management. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

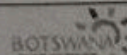
Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health and Wellness within 3 months of completion of the study. Approval is for academic fulfillment only. Copies should also be submitted to all other relevant authorities.

Continuing Review

In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol's expiration date. The Continuing Review Form can be obtained from the Health Research Division Office (HRDD), Office No. 7A.7 or Ministry of Health website:

Vision: A Healthy Nation by 2036.

Values: *Botho, Equity, Wellness, Customer Focus, Teamwork, Accountability*



www.moh.gov.bw or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: kgmmotlhanka@gov.bw As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form

Amendments

During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 7A 7 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: kgmmotlhanka@gov.bw . In addition submit three copies of an updated version of your original protocol application showing all proposed changes in bold or "track changes".

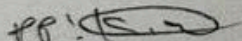
Reporting

Other events which must be reported promptly in writing to the HRDC include:

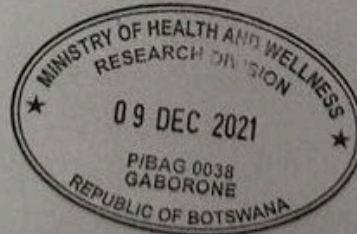
- Suspension or termination of the protocol by you or the grantor
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

If you have any questions please do not hesitate to contact Mr. K. Motlhanka at kgmmotlhanka@gov.bw, Tel +267-3632751. Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours sincerely

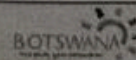

Dr. P. Masokwane

for **/PERMANENT SECRETARY**



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Values: Botho, Equity, Timeliness, Customer Focus, Teamwork, Accountability



Telephone: 4611000/4630333
Telegrams: Ngaka
Fax: 4600664



Sekgoma Memorial Hospital
P O Box 120
Serowe, Botswana

REF: SDHMT 6/6/4 I

24 January 2022

Kebope Mongie Kealeboga
P.O. Box 21289
GABORONE

Dear Kebope Mongie Kealeboga,

**RE: PERMISSION TO CONDUCT STUDY ON TITLED DEVELOPMENT OF
A RECOVERY ORIENTED MENTAL HEALTH CARE PROGRAMME FOR
NURSE IN BOTSWANA**

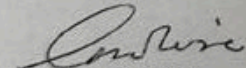
This communiqué serves to inform you that permission is granted to conduct the study.

The permit allow you to conduct the study as illustrated in your protocol, consent from identified individual ought to be obtained at all times during the study.

Ms Rabosoma has being informed to assist you during this study.

Thank you.

Yours faithfully

A handwritten signature in dark ink, appearing to read 'G.C. Moloise'.

Dr G.C. Moloise
ACTING REGIONAL COORDINATOR

TELEPHONE: 5332100/5305500
TELEFAX: 5332174
REFERENCE:



REPUBLIC OF BOTSWANA

SBRANA PSYCHIATRIC HOSPITAL
Private Bag 30
LOBATSE

SPH 4/2/2 III (32)

13 January 2022

Kebope Kealeboga
University of Botswana School of Nursing
Private Bag 00712
Gaborone

Dear Madam

REQUEST FOR RECRUITMENT OF STUDY PARTICIPANTS

The above subject matter refers;

This correspondence serves to respond to your request dated 10 January 2022 on the above subject.

Your request has been acceded to.

Please contact the Research Committee Chairperson (Ms R. Nyambe) to facilitate your research at Sbrana Psychiatric Hospital.

Thank you.

Yours faithfully

.....
Dr J. M. Shama

HOSPITAL SUPERINTENDENT I

TELEPHONE: 5908000
FAX: 5915065
TELEGRAM: NGAKA
REFERENCE:



SCOTTISH LIVINGSTONE HOSPITAL
PRIVATE BAG 001
MOLEPOLOLE

TO: Ms Kebope Mongle Kealeboga
P.O Box 21289
Gaborone

11 January 2022

**PERMISSION TO CONDUCT RESEARCH: DEVELOPMENT OF A RECOVERY
ORIENTED MENTAL HEALTH PROGRAMME FOR NURSES IN BOTSWANA.**

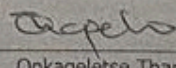
This serves to inform you that the ethics committee reviewed and approved your request referenced above.

We also note that Health Research and Development Division has reviewed and approved your proposal.

Please ensure that:

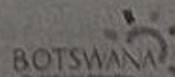
1. The information collected be treated in an ethical manner i.e. confidentiality must be maintained.
2. Participants consent must be sought before conducting study and detailed explanation of the study is given to participants so that they can make informed choice.
3. Necessary arrangements are in place to avoid interference with staff coverage at their work stations.
4. Please share the research findings with our District Health Management Team at the end of your project.


Dr. Jacques Tshimbalanga
Chairperson – Research Committee


Onkageletse Thapelo
Secretary – Research Committee



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Values: Botho, Equity, Timeliness, Customer Focus, Teamwork



NYANGABGWE HOSPITAL
PRIVATE BAG 127
FRANCISTOWN



TEL: (267) 2411000
FAX: (267) 2416706

14TH JANUARY 2022

Researcher: KEOPE MONGIE KEALEBOGA

NORTH WEST UNIVERSITY

Study Title: DEVELOPMENT OF A RECOVERY ORIENTED MENTAL HEALTH CARE PROGRAMME FOR NURSES IN BOTSWANA

Application Type: Initial Submission

Site: Nyangabgwe Referral Hospital

Date of Approval: 14TH JANUARY 2022

Expiration date: 14TH JANUARY 2023

The Institutional Review Board (Research and Ethics Committee) for Human Subjects Research for Nyangabgwe Hospital is pleased to inform you that your request to conduct a research study has been approved.

- You will not change any aspect of your research without permission from the Nyangabgwe Hospital IRB. The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Research and ethics board for consideration and approval.
- You need to report any unforeseen circumstances including the termination of the study.
- You must allow Nyangabgwe Hospital IRB access to the study at any time for purposes of auditing.
- At the end of the study you should give Nyangabgwe Hospital IRB a hard copy and soft copy of your report.
- The permit does not however give you authority to collect data from the selected sites without prior approval from management and relevant heads of departments. Consent from the identified individuals should be obtained at all times.
- Please note that in this COVID-19 times all health and safety precautions must be adhered to.

Wishing you success in your study

Yours Sincerely

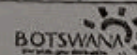
A handwritten signature in black ink, appearing to be 'M. Tyreman', is written over a horizontal line.

Dr. M. Tyreman

For: Chairperson Nyangabgwe Hospital IRB Committee



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Values: Botho, Equity, Timeliness, Customer Focus, Teamwork, Accountability*



Appendix 12: Request letter for language editing

Dear Dr Sibanda

I am a doctoral student at North-West University, Mafikeng Campus. I am currently persuing a PhD in nursing under the supervision of Professors Manyedi and Moloko-Phiri. The title of my study is **Development of a recovery-oriented mental health care programme for Nurses in Botswana. One of the requiremnts is for ths study to undergo Englisng editing.** The study supervisors have read and approved the study for final editing. Attached with this request is the research project.

Thank you in advance.

.....

Kebope Mongie Kealeboga

Student

.....

Study promoter

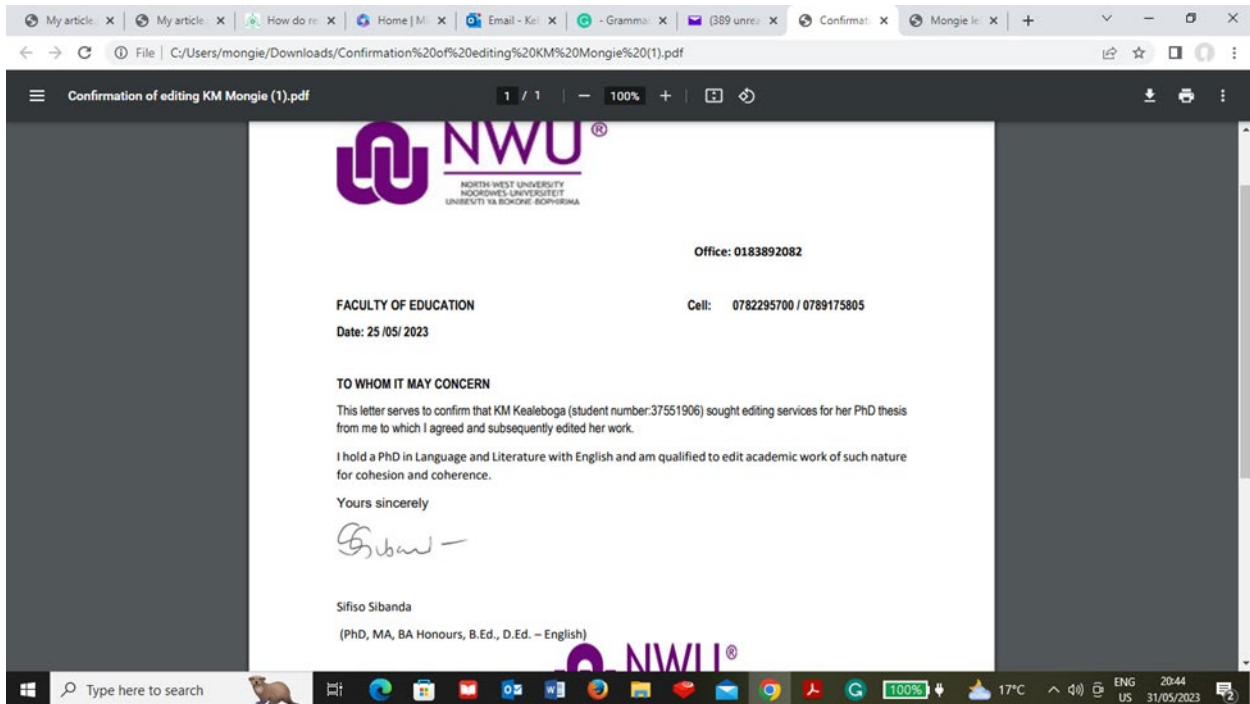
Prof. M.E Manyedi

.....

Co-promoter

Prof. Moloko Phiri

Appendix 13: Acceptance of editing from the editor





Office: 0183892082

FACULTY OF EDUCATION

Cell: 0782295700 / 0789175805

Date: 19/05/2023

TO WHOM IT MAY CONCERN

CERTIFICATE OF EDITING

I, Sifiso Sibanda, confirm and certify that I have read and edited the entire dissertation: *Development of a recovery oriented mental health care programme for nurses in Botswana* by KM Kealeboga, Student number: 37551906 submitted in fulfilment of the requirements for the degree *Doctor of Nursing Science (PhD)* at the North-West University, which was supervised and co-supervised by Professors E Manyedi and S Phiri-Maloko of the North-West University.

I hold a PhD in Language and Literature with English and am qualified to edit academic work of such nature for cohesion and coherence.

The views and research procedures detailed and expressed in the dissertation remain those of the researcher/s.

Yours sincerely

Sifiso Sibanda

(PhD, MA, BA Honours, B.Ed., D.Ed. – English)



Appendix 15: Proof of co-coding



Appendix 16: Form of validation of the programme by the experts

Programme validation guide

Recovery-oriented mental health care programme for nurses in Botswana

Names:

Gender:

Qualification:

Years of experience in your field:

Questions	Comments
How easy to understand is the programme	
How relevant is the programme	
How feasible/doable is the programme	
How accessible is the programme	
Recommendations/additions	

Appendix 17: Consent form for validation of the developed recovery-oriented mental health care programme for nurses in Botswana

Consent to participate in the validation of the Recovery oriented mental health care programme for nurses in Botswana

I ----- hereby consent to voluntarily participate in the validation of a developed programme: **Recovery oriented mental health care programme for nurses in Botswana.**

I understand that my participation is voluntary and that I have the right to decide whether or not to participate in the validation of the programme. I also have the right to withdraw from the research anytime I so wish, to refuse to give information or to ask for clarification about the purpose of validation process. I also understand that the results of the validation will be included in the findings of the final research, study publication and research conferences.

My name will be code and my identity won't be revealed in the report and published articles. The results are solely for the purpose of this study.

I have read this consent form and voluntarily give consent to participate in this validation process

Participant's signature: ----- Date: -----

Researcher's signature: ----- Date: -----

Appendix 18: Programme validation on padlet learning management system

The screenshot shows a Padlet board titled "Programme validation" with a background color of light purple. The board contains several cards:

- Validation By J.S**: A card with a table titled "Programme validation guide" and a "DOCX" icon.
- Programme validation EN**: A card with a table titled "Programme validation guide" and a "DOCX" icon.
- Programme validation by W.G**: A card with a table titled "Programme validation guide" and a "DOCX" icon.
- Programme validation guide**: A card with a table titled "Programme validation guide" and a "DOCX" icon.
- O.T Community Mental Health Nurse Specialist**: A card with a table titled "Programme validation guide" and a "DOCX" icon.
- Programme validation guide**: A card with a table titled "Programme validation guide" and a "DOCX" icon.
- Programme validation guide**: A card with a table titled "Programme validation guide" and a "DOCX" icon.
- Good day. Welcome to the pallet. You see this page because you consented to be part of this programme validation process. Kindly look at the programme and use the guideline provided to validate it. Thank you**: A text card.
- Programme for validation**: A card with a table titled "Programme for validation" and a "DOCX" icon.

The bottom of the screenshot shows the Windows taskbar with the search bar, taskbar icons, and system tray information (43% battery, 25°C, ENG UK, 18:48, 06/05/2023).

Appendix 19: Example of participant response on programme validation

Programme validation guide

Recovery-oriented mental health care programme for nurses in Botswana

Names: E. N

Gender: Female

Qualification: Phd -psych mental health nurse

Years of experience in your field: 35yrs

Questions	Comments
How easy to understand is the programme	The framework is clear and easy to read, and follows a stet-by-step process
How relevant is the programme	The programme is very relevant as it gives adequate and comprehensive information on how different health care providers could manage mental illness hence improving the quality of care
How feasible/doable is the programme	The programme is very much doable because it can be used anywhere in the community etc, and because it contains important information which could benefit the nurses
How accessible is the Programme	The framework can be accessed by different stakeholders at different contexts as outlined in the framework
Recommendations/Additions	The programme can be adopted by different stakeholders

Appendix 20: Example of focus group Discussion

TITLE	DEVELOPMENT OF RECOVERY ORIENTED MENTAL HEALTH CARE PROGRAMME
NO PARTICIPANTS	7
DATE	12 April 2022
Researcher	My name is Ms Kealeboga. I am a student at North-West University South Africa. I'm currently doing PhD, and I'm doing a project entitled Development of a recovery-oriented mental health care programme for nurses in Botswana. Erica very. You are here because you consented to be part of the study. The study has been approved by the University of Northwest Ethics Committee as well as the Ministry of Health and Wellness in Botswana Ethics Committee and participating hospitals' Ethics Committee. Your participation in this study is voluntary, and you are free to withdraw anytime you feel like without any penalty. Confidentiality will be assured as we transcribe data we will be coding your names. So you will be called P1 to P7. So this interview will be recorded for accuracy only. The recordings will be accessed by the researchers only. Do we all agree to be here and to be recorded? Can I hear you? One by one
Participants	P1, P2, P3, P4, P5, P6, P7, all agree
Researcher	OK Thank you very much for being part of this interview and like I said, be free. You can use both Setswana and English. There's no wrong or correct answer in this interview. Every opinion is highly welcome, but I would appreciate it if we could communicate in English, but you are welcome to speak in any language between the two that you are Ok with. So like I said, this is a follow-up of the questionnaires that we did, and we are just going to explore further the concept of recovery in mental health; maybe to start, I just want you to briefly explain how you perceive recovery from mental illness. And before I go further, let me emphasize the importance of our opinions. So how do you perceive recovery from mental illness?
P1	OK. To me, Recovery....I think it comes or it can mean different things. For instance, for other people, it may mean they no longer have symptoms of their mental conditions. Uh oh, and for others, it will mean that they are managing these symptoms and now regaining control of their life even though the mental illness is still there, and now they may be learning new ways to live the life they want, still having the illness.
Researcher	P 2
P2	Ok thank you. To me, when it comes to recovery in mental health, it means that an individual is able to cope with presenting symptoms and is able to cope with life situations and that individual is able to go and give back to the community and live a meaningful life despite the presence of the symptoms or anything, but as long as the individual is able to cope and live a meaningful life and is able to give back to the community. That is recovery to me. And it might come being on a clinical recovery or psychological recovery. Clinical recovery is when an individual is coping with those symptoms and psychological recovery is when now an individual is able to cope and find happiness and find that meaningful life.
Researcher	P3
P3	Thank you. To me recovery is when there is reduction in symptoms. A person is able to

	cope and be it fully functional and be able to live better life. That's how I understand recovery
Researcher	Yes P4
P4	Ok my submission here is that, remember we receive this client who comes in unstable, psychotic and with this other positive symptoms. Recovery to me will mean we have to strive to get this client to an optimal level of functioning and that doesn't necessarily focus on the client we need to also focus on the environment where the client is coming from. That means recovery will include other stakeholders the support system for this client to fully function on his own together with the support of those who support him.
RESEARCHER	Researcher P5
P5	OK, recovery in mental health to me generally means somebody is able to carry out the day-to-day activities despite having a mental illness. Symptoms have generally subsided and somebody is able to carry on with their normal life. With all the other aspects of mental, meaning the physical, the psychological aspect and they able to carry on with their duties
RESEARCHER	OK, I'm. We have all spoken our minds on this one. And maybe just to probe a bit, somebody talked about recovery being regaining control of ones life. Regaining control of somebody's life? Can we unpack it further? What does that mean? Regaining control of one's life. Can we elaborate on that?
P6	I think for that now the patient becomes functional. Therefore, he or she can be able to pursue his life dream despite having the condition so the client will be able to cope. The client will be able to contribute in the community. I do understand to that extent.
Researcher	Yes P2
P2	OK. Thank you for me. For me regaining one's life means going back to a premorbid state for example one might be a breadwinner. One might be working during the time that he gets that diagnosis, and at that particular time is not able to go back to work because of the state of mental health. And now when we talk of recovery that individual is going back to work despite being a mentally ill client or individual, is able to give back to the same family as the breadwinner, is able to give back to the community like before the diagnosis. So going back to the premorbid situation, despite the presentation or the diagnosis that she or he is having.
Researcher	Yes P5
P5	Regaining one's life taking control of one's life, to me, I will say mental illness the way it manifests, it kind of takes over somebody. You lose control to it. So when you recover, you are able to control everything. You are able to be bigger than the mental illness, meaning that you able to do normal day to day activities. Just like going back to work. You are able to be present wherever you are and able to think for yourself.
Researcher	Researcher P1
P1	And. Um, um, like regaining control like they have just said, being able to create and live a meaningful life and also be able to contribute to the community with the mental health issues, with or without the mental health issues. So you get back to normal. You now find hope, you are able to now have good self-esteem and you're able and now you have this

	sense of purpose and meaning in your life.
Researcher	OK P7 The system kicked you out. We are trying to understand recovery from the context of nurses from in this area. So the speakers were saying recovery will entail regaining Control of one's life. So we're trying to unpack that. What does that mean? Regaining ones life and living a meaningful life, we're trying to understand that better. Maybe we can make your personal contribution on that.
P7	Yeah, Like they have said, gaining control of one life is speaking to the fact with mental illness that one can actually at one point loose life skills that they had soft and hard skills. They may loose insight. They may disconnect due to mental illness and then recovery then will mean that the person regains whatever skill or self-concept that they have had lost in the process of morbidity.
Researcher	OK. Having said that, Is it possible to recover from mental illness and elaborate further on that? Is it something that can be realized for our clients?
P7	Well, let me start. Yah it is actually possible to recover. With the use of treatment modalities that are available, that facilitate restoration of health, client who are having mental illness and conditions are able to get back to where they were or somewhere closer to where they were before their onset of illness. That is what I mean when I said it's possible to recover and it's something that can be achieved.
Researcher	Researcher: Yes P4
P4	OK. Uum my understanding is that for one to regain self I belief we should focus more on to getting this person on the psychosocial and the financial aspects to be fully functional. Nurses should work with the client to fully develop positive outlook towards life. And again it is possible to achieve full recovery of this client by making sure there are linkages or continuity let's say they get discharged from a hospital so they should be continuity of care or after care and the clients are provided with support. For example, we need places where clients can further access support say in counseling or any therapy at their own environment. If we get these things in place that can further facilitate the full recovery of patients and I believe it can be something that can be achieved. Yes it is possible to get a full recovery.
Researcher	Is it possible to help cover. Can I hear P2?
P2	Oh yes, I believe it is very possible, And maybe just to take a moment to distinguish this two. I believe we tend to use cure and recovery interchangeably, but there is a difference between the two. Because when you talk of cure you know we talk about the entire elimination of the disease or the illness. So with mental illness mostly especially severe condition, you are able to recover and if it takes a lot, it takes some aspect for an individual to get to the state of recovery. Naming two or three of them. Psychotherapy Interventions they can do help, how they do contribute to one's recovery. Psychopharmacological interventions, do also contribute to an individual recovery and also the social or the support system, because we tend to, after recovery when the patient was in inpatient like we are in XX we admit an individual, that individual, reaches a state of recovery, We discharge that individual to join the community. Are we assisting to see if there is a support system outside because if there is no support system there is that possibility for that individual now to go back out of recovery state. So to me, it is, yes, it is possible to recover and it takes such things for individual to recover.

Researcher	Can I hear P5
P5	P5 With me, I believe that there are different levels of recovery. There is one who can fully recover and then there is another other patients that can just recover to be just functional. So with a different management and recovery I think everybody can reach their level of recovery. You have to make an individualized care plan for people to recover. No one size fits all.
Researcher	Can we hear the views of P7
P7	I want to believe that as humans we perceive recovery in different ways. To some when we mean recovery, we mean aiming to be symptom free while others might mean being able to manage your mental illness and continue with the day-to-day life activities. But I also believe that it is possible to recover provided the patient has been rightfully diagnosed and they have accessed the right support and also having the insight that this the reason why I have to take this is because I'm suffering from mental illness with the right self-management techniques and treatments works be it, psychotherapy and you are more likely to feel confident and manage them and can fully recover either being symptom free or just being able to control to avoid cases of relapses and stuff.
Researcher	OK. Is there anyone who want to add?
P2	Oh OK well. I think one other aspect is holistic approach to helping the individual. Because mental health doesn't only mean you addressing your cognitive ability and mental. But also what about physical illness? Or what about those social? What about your area environment.? So holistic approach will also help us for individuals to reach their recovery?
Researcher	To probe further. What will it take for one to cover? As a newly diagnosed person with mental illness what will take for this person to recover? Let's hear P4
P4	I think for this person to fully recover like you just mentioned, Sometimes in most cases they come with social problems that affect how they judge and perceive their life so if we can put this client to a state to start looking at life with positivity I want to belief that they will eventually recover and be able to correct how they perceive life generally. A relevant approach to therapy will help client recover. They should not be judged or looked at as being juggled. We should instill hope and positivity in them to help to recover.
Researcher.	I see P1
P1	Like I just mentioned earlier as an individual maybe who has been newly diagnosed with mental illness for me to be able to recover, I need to be in a position to have insight that I have a problem and I'm not well and therefore I need to be helped to take the right precautions. Because if say I'm diagnosed with mental illness and my belief is that I am well, I mean I have a denial that maybe I have bipolar, therefore I will not see the need for me to take medication because I feel I am fine. That will lead to frequent relapses. But if I acknowledge to have the insight that I have a problem and I need to be help. It now becomes easy for health care workers to plan and assist such individual. So, I strongly believe that for one to recover they have to first accept that they need help. Other than that, the individual will just be in circles.
Researcher	Thank you. P2 any additions
P2	Yes, I will agree with the previous speaker become it takes insight because with insight it will lead to commitment unto self-care. That individual is able to adhere to treatment. If interventions are psychopharmaceutic interventions and that individual will be committed

	to psychotherapy interventions. And again, I believe it needs somebody who can be assertive because out there we still faced with stigma and we need individual who can stand against Sigma who will stand against the environment outside so that individuals can recover and maintain recovery. Like we said on the definition of the recovery. One is able to cope with life situations. So such situations when they come and individuals should have the stability to be assertive and stand against them and that individuals can be able to maintain the state of recovery.
Researcher	Thank you. Can I hear P3
P3	Hello. Yeah, like I have said before it is possible to recover when the person is aware that they have a problem. And that's when they'll be able to take it upon themselves. And also they should be aware of the possible triggers of their problem. Yeah. So that's they will be able to comply. It starts with an acceptance that you have a problem and it's possible to recover. And that's when you can be able to take part in your health by complying.
Researcher	What does it takes to recover any additions? P7
P7	OK. Well. The intrinsic factor that a person need to have to facilitate recovery is the self, insight. Its start with the person undergoing recovery. As somebody has mentioned yes we have stigma and it is brought by people judging and it's upon the individual to be open minded. You know sometimes because of stigma we want to close ourselves out of this issues of mental health and that is what is going to stand in front of my recovery. I don't want to accept that I can have mental illness or Mental health issues can affect you, so as an individual it takes you being open minded to embrace and accept and be teachable such that you can absorb the knowledge that can dispel the stigma that you may have such that you can have the insight, that you may be lacking at being instilled and that is what is going to facilitate you being able to take the responsibility of your recovery.
Researcher	OK, now that we have seen the possibility of recovery, and we have described it. How will we then describe a recovery oriented mental health facility? And giving an example of our facilities here what will you want to see to say the facility is supporting recovery?
P4	We should be having processes as to how client are going to receive their care and try to avoid fragmented services towards clients because clients always appear to be tossed up and down. For example in the last two months you have seen clients having to appear to be all over because we don't have a functional rehabilitation. The clients are regularly put on different confusing care. The institutions should be in a better position to support recovery. We tend to lack linkage with other stake holders and even if we have linkages it is not sufficient to address the client needs. The rate at which clients are readmitted it shows that clients are not supported outside the hospital. The institution needs to do a lot by reaching other stakeholders on the grounds and getting them on board on the needs of the clients. That could help curb the readmissions that the mental health facilities are experiencing. The health facility should clarify processes of aftercare that can cater for better recovery.
Researcher	How would you describe a recovery oriented care
P5	Like I said, earlier on in Sbrana. We need to start making individualized plans for patients, individualized plans in terms of management, and the recovery and the after care. Because currently in our facility we just manage symptoms, manage the patient and then they kind of stabilize and when they stabilize, we send them back home. iln 2-3 days the patients come back. They have relapsed. It means that we are lacking somewhere in our recovery

	plan we need to start focusing so much on the issue of aftercare because, we are currently just doing enough when the patient is an inpatient. But whatever happens out there once the patient leaves the facility does not care. That has to be incorporated in our care. So our facility should do more. Thank you.
Researcher	Can you add something P3
P3	Yes, like they have already mentioned a facility should adopt a holistic approach that is to cater for all the needs of the clients, and it also should incorporate the support system that is the family since after hospitalization the patients will be going to the families. There should be sensitization or raising awareness on mental illness. It should be the patient, And the support system and the community at large. That's when we can say the facility is oriented on recovery.
Researcher	Yes P2
P2	Oh yes, I'm. Just to add on what they have said. I believe we should have competent personnel in mental health facilities from all areas of mental health. We are talking mental health nurses, psychiatrists, psychologists and other mental health personnel not as it is the case. Let's have competent staff that can give proper diagnosis. Let's have the right personnel in mental health facilities. It is not enough to fill the hospital with people, but the question is are they qualified to be in a mental health facility. The facility should have an educational model which teaches about life after hospitalization. The model should also focus on support. What should be the person's support system? What will be the aftercare? Lastly there should be ongoing monitoring and evaluation looking at the issues of readmission and staff. We need to research these issues and find out the problems.
Researcher:	Can we hear from others we are quiet P7
P7	Thank you. I would like to say a facility is recovery oriented when we have a multidisciplinary approach and most of the time we think of mental health and recovery like within the hospital, but yet we are the same people who are talking about recovery beyond the hospital and mental health It's broad and it's encompassing a lot of factors of people's lives. And if we are to say for a facility to be recovery-oriented, it needs to tailor-made and like prepare the patient to be autonomous such that they are able to go forward after the hospital stay or aftercare to be able to own their recovery. But then. You also have the other aspects of life that influence mental health. Like the spiritual aspect, if we have the culture, we have to take that into consideration. And if it means for us to be recovery oriented, it means we have to have a setting where in preparation for recovery which we all, I think we appreciate that we prepare for recovery from the time we diagnose, we meet you to the first time, We connect with you. We form that relationship we are building up to recovery from that time I think we should also engage the people that can help us in the spiritual aspect, the cultural traditional healers we need them there. Then we can have them to facilitate recovery such that from the time the person transition from the hospital All their needs have been addressed and they can actually go back to the society and function fully to the level to where its optimal which is the objective of recovery
Researcher	Yes P1
P1	I think the multidisciplinary team Is the best way when we bear in our mind that each individual is unique and we should be able to support them with their choices, and we should also be in a position as the health professionals to be able to have an ear to listen to, treat them with respect. And dignity. And with this, I think it's easy for them to instill

	hope for those who were hopeless and to be able to help them help self-identity. But like they've already mentioned, multidisciplinary approach and also we should include community participation. We should sensitize in schools and do follow-ups throughout so that when they leave they are able to face and we would minimize the frequent admissions.
Researcher	Is there anyone who wants to add? You have said a lot of things. What is it that you think should be in place? You keep stating patients should be given appropriate care and what would be the appropriate care? What will appropriate care entail? So I want you to unpack some of the things that you have said. Some are saying we are giving fragmented care can we explain further all that.
P5	P 5 Yeah. We need after care facilities. I believe it is time we have halfway homes to cater for patients after care. We need supportive homes where people can go and get help on daily basis to receive the care.
Researcher	One talked about the hospital having competent staff. One might ask are we not having competent staff.
P1	I want to believe that on that one competent staff Would mean those who are specially trained to look up for clients with a diagnosis of mental illness 'because right now I want to believe that when you get to our referral hospital, you find that there will be a psychiatric nurse, there would be a general nurse. But they are both nurses yes, but they're not trained the same way. I think in that way.
Researcher	Yes P7
P7	That's one of competent I think it can also speak to further training 'because like, yes, I could be a nurse, I could be a psychiatric nurse, but they are so many specialties and subspecialties and specialties in psychiatry, and you find that most of the time we are there with our diploma training all our lives we are there saving this clients with no platform whatsoever for development and growth that can empower us and actually to help us help this client better. So Beyond having psychiatric nurses and nurses we need personnel who are actually specialized in the fields that are critical in mental health, because that actually plays a very vital role in quality care at the end of the day. Thank you
Researcher	Do you want to add P2
P2	OK. Yes, I'm yes, like the previous speaker was saying, yes we are mental nurses, but still, we can just go and do further studies. Most of us we are diploma holders. We need forensic mental health nurses or all these other subspecialties in psychiatric nursing. That can help us to come up with a proper diagnosis. To be competitive entails a lot and education is one of them.
Researcher	How can the help health care (nurses) workers facilitate the recovery of patients
P4	Ok I believe as a psychiatric nurse being able to collect history that can help you to come with a good nursing care plan. You should be in a position to involve the client and other stakeholders in the care of the patient so that you can give the client quality care.
Researcher	Yes P6
P6	It take back to the issue of competency. If nurses are competent enough with the right skills they will be able to come up with relevant management for patients.
Researcher	Another question is how can the health care in this case the nurses? How can they help or how can they facilitate recover of vision
P7	OK, our role in patient is actually placing us very well to facilitate recovery through the

	education we give them. The collaboration and advocacy that we do on behalf of the clients can facilitate recovery. You know the activities that we do with clients on a day-to-day basis during nursing care or during daily interactions can actually facilitate recovery. The other important aspect that I think we have at our disposal to facilitate recovery is the therapeutic use of self which actually gives us an opportunity for clients to kind of learn from us without us trying, and then that actually can actually facilitate recovery. Thank you
Researcher	Yes P1
P1	Um. We should also be in a position to listen to our clients when they talk about their values and concerns and fears, be like they already mentioned, be able to advocate for them, we help them and their family to understand their treatment options and, we should also make them to understand the end life care decisions that they make
researcher	Yes P5
P5	When it comes to recovery as much as I agreed with the confidence, but I also believe that the systems and processes that are in place in that facility should also allow the nurses to be able to contribute and do their part in facilitating recovery of patients. Because when you come to our facilities nurses are more on the back seat. The psychiatrist, doctors, psychologists and social workers are the ones at the fore of care. They are the ones who get to shine when it comes to patient care in mental health and nurses are the sidelines. I think maybe the hospital needs to change the systems and the processes that allow nurses to do more.
Researcher	Yes P2
P2	OK. Thank you. One thing that I would like to mention here is that the mental health facilities should take in to cognizant the welfare of the staff. There should be some form of therapy for nurses caring for the client. Also as nurses our role should be well defined. We should be seen to be doing enough for our patients. We should advocate we should be the link the patients and the multidisciplinary team. The nurse's role in a multidisciplinary team should be well defined. We should, as nurses apply what we learnt in classes. Our role is not seen and we are swallowed by other disciplines in mental health. Let's also be seen to contribute to the care of the patients.
Researcher	May be just so we come into the end of our interview, maybe just to summarize, what are your views of a recovery oriented health care programmes? Do you think it's something that we can have? What are your views? Is it possible to have a recovery-oriented programme for nurses in Botswana?
P1	Yes, I think, uh. It is something that is possible but I want to believe it's going to take time for us to get there first and foremost. When we look into our mental health, the multidisciplinary team is not as active as like other countries. We are still lagging. So I want to believe that it can be. Possible if we get to see how we review a lot of things and make it happen.
Research	Can we elaborate on things that need to be done
P1	May be to review the mental health policies 'because if you get to look into it now. We are still operating with the old mental health policies and also maybe just to benchmark onto how other people are doing things.
Researchers:	How can it be achieved?

P5	P5 Okay I assume I think this is something which is possible to have a ROMHCP for example our government need to have some processes that empower nurses to do more. For example nurses can establish nursing homes run by psychiatric nurses.
P1	Yes its possible. If we can have the full support on the programme of mental health from the ministry down coming down to the facility then to the community, we can do it. Ministry should provide facilities with the trained staff. We have few trained personnel in mental health in Botswana. Empower nurses to do more in patient care. For instance we have only one school training offering diploma level in Botswana. Upgrade qualification of diploma holding nurses. Review policies to attend patients holistically. I belief it can happen with support. Look at other programmes like HIV programme because they are supported they are doing well. If the same energy given to such programmes are given to mental health recovery programme we can see it start and succeed.
Researcher	Before you leave can you give a summary on what you want to see in the programme?
P2	Let's take an example when we discharge clients there is no follow up until we see the individual when they are readmitted again. We need personnel that can do follow ups of patients. Let's have more campaigns on mental health supported by the mental health facilities. Let's have more people in the community preaching mental health.
P5	Yes it is possible to have it her. We need, like, a political will, like people were saying the mental health has to be prioritized. We still need the government to see that mental health is an issue. We need to sensitize the community. Everybody has to know how to handle clients with mental illness. To know that it is a problem that affects all of us, like I was saying.
P6	Thank you. And and just lastly, maybe just to add on to what they're saying is they were just talking and just thought one we've been saying mental health recovery, mental health recovery, but it seems like we are only concentrating on the elderly. If you look in the issue, yeah, right now. Nowadays we don't even have child health psychiatrists. We don't even have where we take a 11 year old if, say, they come early substance abuse or their suicidal. So I think such things also should be looked into so that when we talk mental health It's broad. We don't just say mental health talking about someone who is older 18 and above.
P7	Thank you. It's actually attainable and uh, what we can do, it starts with us, I think mental health personnel. Uh, we are the people who should bring the mental health issues to the table so that they can be in the agenda and the policies can be informed and influenced in favor of it. So I think we how we can actually influence policies I mean as practitioners. We need to not only advocate for our client, but we need to also advocate and actually advocate for our profession. We know what we want to achieve. We need to be able to broadly talk about mental health issues and make sure that somebody who needs to make decision and make policies and decide is listening
Researcher	Earlier on you talked about holistic care and you also talked about the issues of culture. So how do they fit in in our programme? Do you think it's something that we can consider?
P2	I believe that there are a lot contributing factors that facilitate recovery. Somebody earlier mentioned culture, spirituality and religion. There is a way that culture perceive mental illness. We can reach leaders of culture, we can reach people and teach them how culture

	and mental illness come together. We should teach our religious leaders out mental illness.
P7	I will like to infer on the issue of culture and religion and how they come to play on the issues of recovery. I think what we need to also understand is that one of the challenges that we have in mental health is the conflict of cultural practices, mental health and modern care. And then the stigma that is still into our cultural and past experiences where if we were to have in our recovery process where we can harmonies this two. Where we can have where modern care is coming together with cultural and spiritual practices to talk together and dispel the myths and educate each other where the three can work together in harmony. Such that at the end of the day come together so that at the end of the day our clients are not forced to go and do their cultural practices behind closed doors where they do things that can do them harm. We can have where if we can find where in our facilities we can have our traditional healers or spiritual leaders who works with the medical personnel and think that can work for clients. That can also help alleviate the stigma. All stake holders can come together and help clients holistically.
P5	We need holistic approach. Like I said we should incorporate mental health in the school health. Education system should also touch on mental health issues from primary schools. Our adolescents are just there and floating they are lost they don't know where to go. So I think we should incorporate mental health at school level. Thank you
Researcher	P4
P4	Let me touch on the issue of culture I want to belief that its important that our cultural leaders should be on the same page with the modern health. You know the clients relapse because of the myth surroundings mental health. Our cultural leaders need to have frequent interactions with them so that they also get to understand better the components of mental health. You know people listen to their leaders.
Researcher	Research: Any other comments
P2	I think we should also benchmark. Let's benchmark from other programmes and see how they do things. We have a Traditional leaders Association (Dingaka Association). Let's get them to explain to us how they understand mental health issues and see how they think they can come in. I believe that they have a role to play in the recovery programme.
Researcher	I don't see any hand, we are almost at the end can someone sum up our discussion. Is there anyone who can sum up our discussion
P7	In summary we have appreciated that Recovery Oriented Mental Health care Programme is attainable, its achievable it's doable it needs us to put our resources together and mobilize for it. It needs for us to have advocacy for empowering practitioners to effectively deliver services that are geared at promoting recovery. It also looks at the client to say client has Ownership, responsibility accountability unto their recovery. And then it does not end at the hospital it looks at the client after the discharge at their own settings. There is need for policy change. There is need for a review of policies and the mental health act. This will not help only practitioners but it will also help improve the care of the patients. Thank you
Researcher	Is there anyone who will like to add...Since I am not seeing any hand. We have come to the end of this interview. Let me thank you all for participating in this focus group discussion. Like I said your names will not appear in any of our transcriptions that's why we used P1 to P8. The data will only be accessed by the researchers only. Recording like I said is just for data accuracy only. Let me thank you and have a blessed night.

All	Thank you
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9 February 2022

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the North-West University Health Research Ethics Committee (NWU-HREC) on 09/02/2022, the NWU-HREC hereby approves your study as indicated below. This implies that the NWU-HREC grants its permission that, provided the general conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Development of a recovery oriented mental health care programme for nurses in Botswana

Principal Investigator/Study Supervisor/Researcher: Prof ME Manyedi

Student: KM Kealeboga – 37551906

Ethics number:

N	W	U	-	0	0	3	0	6	-	2	1	-	A	1
Institution			Study Number						Year		Status			

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation;
A = Authorisation

Application Type: Single study

Commencement date: 09/02/2022

Expiry date: 28/02/2023

Risk:

Minimal

Approval of the study is provided for a year, after which continuation of the study is dependent on receipt and review of an annual monitoring report and the concomitant issuing of a letter of continuation. A monitoring report is due at the end of February annually until completion of the study.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:

- The principal investigator/study supervisor/researcher must report in the prescribed format to the NWU-HREC:
 - Annually on the monitoring of the study, whereby a letter of continuation will be provided annually, and upon completion of the study; and
 - without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.
- The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the principal investigator/study supervisor/researcher must apply for approval of these amendments at the NWU-HREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.
- Annually a number of studies may be randomly selected for active monitoring.
- The date of approval indicates the first date that the study may be started.
- In the interest of ethical responsibility, the NWU-HREC reserves the right to:
 - request access to any information or data at any time during the course or after completion of the study;
 - to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.

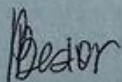
- withdraw or postpone approval if:
 - any unethical principles or practices of the study are revealed or suspected;
 - it becomes apparent that any relevant information was withheld from the NWU-HREC or that information has been false or misrepresented;
 - submission of the annual monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and/or
 - new institutional rules, national legislation or international conventions deem it necessary.
- NWU-HREC can be contacted for further information via Ethics-HRECApplied@nwu.ac.za or 018 299 1206

Special conditions of the research approval due to the COVID-19 pandemic:

Please note: Due to the nature of the study i.e. (online collection of both quantitative and qualitative data via a convergent mixed method design, from nurses within the public health system in Botswana), this study will be able to proceed during the current alert level, following receipt of the approval letter. No additional COVID-19 restrictions have been placed on the study except that the researcher must ensure that before proceeding with the study that all research team members have reviewed the North-West University COVID-19 Occupational Health and Safety Standard Operating Procedure.

The NWU-HREC would like to remain at your service and wishes you well with your study. Please do not hesitate to contact the NWU-HREC for any further enquiries or requests for assistance.

Yours sincerely,



Digitally signed by
Prof Petra Bester
Date: 2022.02.11
12:57:39 +02'00'

Chairperson NWU-HREC