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Developing an Effective and Implementable Mental Health Nursing Model: A Review of Theoretical Foundations, Recovery-Oriented Practice, and Contextual Adaptation

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A R T I C L E I N F O

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A B S T R A C T

Mental health nursing draws on multiple theoretical traditions and practice models, yet no single framework adequately addresses the relational, clinical, recovery, cultural, and implementation demands of contemporary care. This qualitative literature review critically synthesizes recent evidence on major mental health nursing theories and models and identifies components that can support a more effective and practically implementable model. Peer-reviewed literature published mainly between 2020 and 2026 was selected purposively and iteratively, with emphasis on interpersonal, adaptation, self-care, human caring, biopsychosocial, cognitive-behavioural, trauma-informed, recovery-oriented, person-centred, and community-based approaches. Thematic and integrative synthesis shows that the strongest contemporary architecture is not a stand-alone grand theory but a layered configuration combining a therapeutic relationship, person-centred shared decision making, recovery orientation, evidence-informed intervention selection, cultural responsiveness, and continuity across institutional and community settings. Its implementation depends on workforce competence, supervision, organizational leadership, interprofessional collaboration, service-user and family participation, adequate resources, and policy support. Evidence from Indonesia further indicates that family roles, stigma, regional service inequality, spirituality, and community resources must be incorporated into model design rather than treated as secondary contextual variables

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INTRODUCTION

Mental health conditions constitute a major and persistent component of global disease burden. Before the COVID-19 pandemic, mental disorders already accounted for substantial years lived with disability worldwide, while the pandemic was associated with marked increases in the prevalence and burden of depressive and anxiety disorders. This growing burden has intensified the need for mental health services that are accessible, person-centred, evidence-informed, and capable of supporting not only symptom stabilization but also functional recovery, social participation, and long-term well-being (COVID-19 Mental Disorders Collaborators, 2021; GBD 2019 Mental Disorders Collaborators, 2022).

Within this landscape, mental health nurses occupy a strategically important position because they provide sustained contact across inpatient, outpatient, primary-care, and community settings. Their roles encompass assessment, therapeutic communication, psychoeducation, medication support, crisis management, physical-health monitoring, family engagement, recovery facilitation, and coordination of care. Yet contemporary evidence indicates that the mental health nursing workforce remains underutilized in many systems and that its clinical identity and full scope of capability are not always clearly operationalized. This makes the development of coherent nursing models particularly important for translating professional competencies into consistent and measurable care processes (Hurley et al., 2022).

A central challenge is that psychiatric and mental health nursing draws on multiple theoretical traditions and practice models, including interpersonal, adaptation, self-care, holistic caring, stress-and-coping, psychodynamic, cognitive-behavioural, biopsychosocial, recovery-oriented, and community-based perspectives. The diversity of these frameworks is intellectually valuable, but in practice it can create fragmentation when theoretical concepts are not translated into clear decision pathways, intervention priorities, and outcome criteria. Contemporary studies continue to show that the therapeutic nurse-patient relationship is a core mechanism through which mental health nursing interventions become meaningful and effective, while also demonstrating that such relationships require deliberate organizational and professional support rather than relying on individual intuition alone (Hartley et al., 2020; Coelho et al., 2021; Tolosa-Merlos et al., 2023).

At the same time, the dominant direction of contemporary mental health care has shifted toward recovery-oriented, person-centred, trauma-sensitive, and culturally responsive practice. Recovery-oriented nursing emphasizes hope, autonomy, shared decision-making, personal meaning, social participation, and the recognition that recovery is not reducible to symptom remission. However, implementation studies show that recovery principles can be difficult to embed in routine care when services remain strongly biomedical, risk-dominated, hierarchical, or insufficiently resourced. Training, leadership, co-design with service users, reflective practice, and changes in ward or organizational culture are therefore as important as the theoretical model itself (Solomon, Sutton and McKenna, 2021; Nardella et al., 2021; Salberg et al., 2022; Sreeram, Cross and Townsin, 2023).

These findings create an important distinction between a model that is theoretically attractive and a model that is actually implementable. An effective mental health nursing model should contribute to therapeutic alliance, safety, symptom management, recovery, self-management, quality of life, dignity, and continuity of care. An implementable model must additionally be understandable to frontline nurses, compatible with available staffing and competencies, adaptable across clinical and community settings, culturally responsive, measurable through practical indicators, and sufficiently flexible to accommodate individual variation. Consequently, the question is no longer merely which classical theory is conceptually strongest, but how the most useful elements of established theories and contemporary evidence can be integrated into a model that is clinically actionable and context-sensitive (Nardella et al., 2021; Salberg et al., 2022; Tolosa-Merlos et al., 2023).

The implementation problem is particularly relevant in Indonesia, where mental health nursing is delivered across psychiatric hospitals, general hospitals, primary health centres, villages, and home-based or community programmes. Indonesian studies have documented the importance of community mental health nursing in rural settings, the emerging but uneven understanding of recovery among nurses, and the persistence of cultural, organizational, educational, and service-access barriers. Research from Eastern Indonesia indicates that recovery is recognized by mental health nurses as involving meaningful life and social reintegration, yet the concept remains relatively new in some practice contexts. Other Indonesian evidence highlights mixed perceptions of mental illness among mental health nurses and the need for continuing education, while community-based integrated services still face limitations related to workforce availability, privacy, medicine continuity, psychoeducation, and stigma (Kadar, Andriani and Tandi, 2020; Tasijawa et al., 2021; Kusumawaty, Yunike and Upoyo, 2023; Marthoenis et al., 2023).

Accordingly, there is a strong rationale for moving beyond a descriptive catalogue of mental health nursing theories toward a critical comparison of what each model contributes, where each model is limited, and which components can be combined into a more effective and feasible practice architecture. Such a synthesis is expected to help bridge theory and implementation by identifying the clinical mechanisms, relational principles, contextual requirements, and operational criteria that should be retained when developing an integrative model of mental health nursing. The resulting framework should be relevant to both institutional and community care and should remain sensitive to cultural diversity and resource variation.

Research Questions

1. RQ1. What conceptual principles, clinical mechanisms, strengths, and limitations characterize the major theories and models currently relevant to mental health nursing practice?
2. RQ2. Which combination of theoretical elements and implementation criteria can support the development of an effective, person-centred,

recovery-oriented, culturally responsive, and practically implementable mental health nursing model across inpatient and community settings?

Objectives

This article aims to critically synthesize the conceptual foundations and contemporary evidence associated with major mental health nursing theories and practice models; compare their relative strengths, limitations, and implementation requirements; and identify the core components and criteria needed to develop a more integrated model that is both clinically effective and feasible in real-world settings. Particular attention is given to therapeutic relationships, recovery orientation, holistic and biopsychosocial assessment, self-management, coping, community integration, cultural responsiveness, and implementation conditions that are relevant to diverse health systems, including Indonesia.

LITERATURE REVIEW

Mental Health Nursing as a Theory-Informed Discipline

Mental health nursing is a distinctive field of professional practice in which clinical reasoning is inseparable from relational, ethical, behavioural, social, and contextual dimensions of care. Contemporary mental health nurses work across acute inpatient units, community services, primary care, rehabilitation, crisis response, and integrated physical-mental health settings. Their contribution includes therapeutic engagement, assessment, psychoeducation, risk management, support for self-management, coordination of care, and advocacy for recovery and social inclusion. The breadth of these roles means that practice cannot be reduced to symptom monitoring or the implementation of medical treatment plans; it requires conceptual frameworks that explain how nurses understand the person, the environment, health, and the nursing response to distress (Hurley et al., 2022; Jones et al., 2023).

Nursing theories and conceptual models therefore perform two related functions. First, they provide disciplinary language for identifying what nurses assess and why particular interventions are selected. Second, they connect observable clinical problems with mechanisms such as adaptation, interpersonal processes, self-care capacity, coping, caring, recovery, or person-environment interaction. Theory-guided practice is not an alternative to evidence-based practice; rather, it offers an interpretive structure within which empirical evidence can be translated into coherent nursing decisions. Recent discussions of nursing theory-guided practice emphasize the continuing relevance of explicit conceptual foundations in maintaining professional identity, strengthening clinical reasoning, and making nursing contributions visible and evaluable (Turkel et al., 2021; Jones et al., 2023).

From Grand Nursing Theories to Practice Models in Mental Health Care

The theoretical landscape of mental health nursing is pluralistic. Grand nursing theories such as Roy's Adaptation Model, Orem's Self-Care Deficit Nursing Theory, Watson's Human Caring Theory, and Peplau's interpersonal tradition provide broad accounts of human functioning and nursing action. In contrast, practice models such as cognitive-behavioural, biopsychosocial, trauma-informed, recovery-oriented, and community-based approaches are generally more proximal to clinical decision making. These categories should not be treated as mutually exclusive. A grand theory may specify the nurse's philosophical orientation, while a practice model may guide the assessment and intervention sequence used for a particular problem or setting.

This distinction is especially important in mental health care because effectiveness depends on matching the conceptual level of a model to the clinical task. A highly abstract theory may offer a strong account of personhood and nursing purpose but require operational translation before it can guide day-to-day care. Conversely, a narrowly defined intervention model may be highly implementable but insufficient to address spiritual needs, social determinants, identity, family relationships, or long-term recovery. An effective and implementable mental health nursing model therefore requires theoretical coherence together with practical specificity, measurable processes, and adaptability to setting and culture (Callis, 2020; Yip, 2021; Ahn and Yi, 2022).

Peplau's Interpersonal Tradition and the Therapeutic Relationship

The interpersonal tradition associated with Hildegard Peplau remains particularly influential because the nurse-patient relationship itself is treated as a therapeutic medium. The central proposition is that nursing is not merely a sequence of tasks performed for a patient; it is a purposeful interpersonal process in which communication, mutual understanding, role clarification, collaboration, and progressive autonomy can contribute to recovery. Contemporary evidence strongly supports the continuing importance of this relational core. A systematic review found that the therapeutic alliance is fundamental to positive mental health care, although the evidence for specific interventions designed to strengthen that alliance remains methodologically uneven (Hartley et al., 2020).

Recent research has further operationalized the therapeutic relationship as an assessable component of mental health nursing practice. Coelho et al. (2021) developed the Therapeutic Relationship Assessment Scale-Nurse, reflecting the need to make relational quality measurable rather than leaving it as an implicit professional value. Participatory action research in acute mental health units likewise showed that deliberate efforts to place the therapeutic relationship at the centre of nursing practice can reshape routines, professional reflection, and team culture (Tolosa-Merlos et al., 2023). These findings support a contemporary interpretation of Peplau's tradition: relational competence is both a theoretical foundation and an implementation requirement for any mental health nursing model.

The limitation of an exclusively interpersonal perspective is that a high-quality relationship does not by itself resolve all determinants of mental distress. Biological vulnerability, poverty, trauma, family conflict, housing insecurity,

culture, medication effects, and service fragmentation may require interventions extending beyond the dyadic nurse-patient relationship. Thus, the interpersonal model is best understood as a core relational mechanism that should be integrated with broader adaptive, behavioural, social, and recovery-oriented frameworks.

Roy's Adaptation Model and Stress-Coping Perspectives

Roy's Adaptation Model conceptualizes the person as an adaptive system responding to internal and external stimuli through multiple modes of functioning. In mental health nursing, this perspective is useful because psychological distress frequently involves disrupted adaptation to loss, role transition, chronic illness, trauma, interpersonal conflict, or environmental stress. The model encourages nurses to assess not only symptoms but also the person's physiological responses, self-concept, role functioning, and interdependence. Contemporary applications of Roy's model continue to demonstrate its value as a structured framework for organizing nursing assessment and intervention, including in contexts characterized by stress, uncertainty, and disrupted coping (Callis, 2020).

Stress-and-coping perspectives complement the adaptation model by focusing on the dynamic appraisal of demands and the strategies used to manage them. In mental health care, coping is not a fixed trait but a process that can be strengthened through psychoeducation, problem solving, emotional regulation, social support, and environmental modification. Cognitive-behavioural approaches provide one operational route for such work because they target interactions among cognition, emotion, behaviour, and avoidance. Recent reviews describe continued development of CBT techniques and technologies for mental health and stress-related disorders, including digitally supported formats and transdiagnostic applications (Nakao, Shirotsuki and Sugaya, 2021).

The principal strength of adaptation and coping frameworks is their capacity to convert complex stress responses into assessable domains and modifiable processes. Their limitation is the risk of locating adaptation primarily within the individual if environmental injustice, coercive service structures, cultural conflict, or structural disadvantage are not simultaneously examined. For this reason, an integrative model should treat adaptation as a person-environment process rather than as an expectation that the patient simply adjust to adverse circumstances.

Orem's Self-Care Deficit Theory: Autonomy, Agency, and Supported Self-Management

Orem's Self-Care Deficit Nursing Theory is particularly relevant to mental health nursing because many psychiatric conditions affect motivation, executive functioning, sleep, nutrition, medication management, hygiene, social participation, and help-seeking. The theory distinguishes between self-care demands, the person's capacity to meet those demands, and nursing systems required when a self-care deficit occurs. Contemporary theory-based practice literature continues to emphasize the usefulness of Orem's framework for

organizing nursing interventions around self-care agency and progressively reducing unnecessary dependence (Yip, 2021).

In mental health care, a self-care orientation can support recovery by linking nursing interventions to practical capabilities required for community living. Review work on self-care nursing interventions for people with mental disorders has highlighted the relevance of self-care frameworks to psychiatric rehabilitation and community functioning (Usami and Ishitobi, 2020). The model is therefore compatible with psychoeducation, relapse prevention, medication self-management, sleep and activity routines, coping plans, and shared goal setting.

However, autonomy should not be interpreted as individual responsibility detached from context. Severe symptoms, cognitive impairment, trauma, poverty, stigma, and limited access to services may constrain self-care agency. An ethically sound application of Orem's theory therefore requires supported autonomy: nurses help the person develop capabilities while also modifying environmental barriers and mobilizing family, community, and interprofessional resources when necessary.

Watson's Human Caring Theory and Holistic Mental Health Nursing

Watson's Human Caring Theory provides a philosophical counterbalance to approaches that risk reducing mental health care to risk control, symptom checklists, or technical interventions. It foregrounds human dignity, presence, compassion, relational authenticity, meaning, and the moral quality of caring encounters. Recent scholarship has continued to extend caring science by connecting it with resilience, psychology, and neuroscience, illustrating how caring theory can inform strategies for maintaining connection, hope, self-awareness, and resilience under conditions of adversity (Wei, Hardin and Watson, 2021).

Evidence from nursing education also suggests that caring-theory-based programmes can influence coping and anxiety, supporting the proposition that caring frameworks can be translated into structured interventions rather than remaining purely philosophical (Durgun Ozan et al., 2020). In mental health nursing, this orientation is especially relevant when service users experience shame, stigma, fear, coercion, or loss of identity. The nurse's presence and recognition of personhood may be clinically significant because they shape trust, willingness to disclose distress, treatment engagement, and the perceived safety of care.

The main challenge is operationalization. Concepts such as presence, compassion, and holistic caring can become rhetorically attractive but difficult to evaluate if they are not linked to observable practices and outcomes. Consequently, a contemporary model should translate caring principles into measurable behaviours such as respectful communication, shared decision making, continuity, validation of lived experience, culturally safe engagement, and active protection of dignity.

Biopsychosocial, Cognitive-Behavioural, and Trauma-Informed Models

The biopsychosocial model remains influential because it resists single-cause explanations of mental disorder and directs attention to interactions among biological processes, psychological mechanisms, and social conditions. Contemporary discussion has reaffirmed the model's importance in mental health while also highlighting the need to apply it with sufficient specificity rather than using it as a generic statement that 'everything matters' (Porter, 2020). For nursing, the model is valuable because it aligns with comprehensive assessment: medication effects and physical health can be considered alongside cognition, emotion, relationships, housing, work, family functioning, stigma, and social support.

The cognitive-behavioural model adds greater intervention specificity. It proposes that maladaptive patterns of interpretation, avoidance, safety behaviour, and reinforcement can maintain distress and can be modified through structured psychological strategies. Although formal psychotherapy may require advanced competence and scope-of-practice considerations, mental health nurses commonly use CBT-informed techniques such as behavioural activation, coping-skills coaching, graded exposure principles, problem solving, and relapse planning. Current literature supports the continued evolution of CBT for stress-related and mental health conditions while emphasizing the value of technology-assisted and individualized delivery (Nakao, Shirotsuki and Sugaya, 2021).

Trauma-informed care adds another essential lens by asking not only what symptoms are present but also what adverse experiences may have shaped distress and how services themselves may recreate powerlessness or threat. Research among psychiatric hospital nurses demonstrates both the relevance of trauma-informed principles and variation in staff attitudes toward their application (Cilia Vincenti, Grech and Scerri, 2022). Trauma-informed nursing therefore requires safety, transparency, collaboration, choice, attention to triggers, and avoidance of unnecessary coercion. These principles are highly compatible with person-centred and recovery-oriented care and should be incorporated into any contemporary integrative model.

Recovery-Oriented and Person-Centred Mental Health Nursing

Recovery-oriented care represents one of the most important shifts in contemporary mental health services. Rather than defining success exclusively as symptom remission, recovery-oriented nursing emphasizes a meaningful life, identity, hope, agency, social participation, and the person's own goals even when symptoms persist. Studies of mental health nurses in acute settings show that recovery-oriented practice involves creating therapeutic spaces, advocating for service users, supporting ownership of recovery, and negotiating organizational barriers that may privilege risk management over participation (Solomon, Sutton and McKenna, 2021; Lim, Wynaden and Heslop, 2021; Derblom et al., 2025).

Implementation evidence also shows that recovery principles do not become routine practice simply because they are endorsed in policy. Education, co-designed resources, supportive leadership, and cultural change are needed to improve nurses' knowledge and the consistency of recovery-oriented care

(Nardella et al., 2021; Salberg et al., 2022). A quantitative narrative review similarly found that recovery-focused interventions can improve knowledge and attitudes among mental health professionals, although implementation remains variable (Sreeram, Cross and Townsin, 2021).

Person-centred care overlaps with recovery but adds explicit emphasis on dignity, rights, preferences, and partnership in decision making. Research with mental health nurses has identified moral sensitivity and professional competence as important factors associated with person-centred practice, especially in restrictive inpatient environments where autonomy may be compromised (Ahn and Yi, 2022; Byrne, Baldwin and Harvey, 2020). Accordingly, an effective nursing model should treat the patient not as a passive recipient of expert decisions but as a partner whose goals, values, and lived experience shape care planning.

Cultural Sensitivity, Community Orientation, and the Indonesian Context

Mental health nursing models cannot be assumed to transfer unchanged across cultural and service contexts. Recovery, autonomy, family responsibility, spirituality, stigma, and help-seeking can have different meanings across societies. Matsuoka (2021) demonstrated that culturally sensitive recovery-oriented community psychiatric nursing requires reflective awareness of professional culture, dialogue with clients, support for self-management, teamwork, and maintenance of relationships with significant others. A later model-development study translated these principles into a more explicit culturally sensitive recovery-oriented nursing care model for community practice (Matsuoka, 2023).

The need for contextualization is particularly salient in Indonesia, where mental health services span hospital, primary-care, family, and community arrangements and where access and workforce distribution vary substantially. Research in rural Indonesia has shown the distinctive challenges and practices of mental health nursing outside highly resourced specialist settings (Kadar, Andriani and Tandi, 2020). Indonesian studies have also documented nurses' perspectives on recovery from schizophrenia and highlighted the importance of family, social reintegration, and context-sensitive understandings of recovery (Tasijawa et al., 2021).

Consequently, implementability should be treated as a theoretical criterion rather than a logistical afterthought. A model that requires highly specialized resources, long consultation times, or assumptions about individual autonomy that do not fit local care structures may be difficult to sustain. A context-sensitive model should specify which elements are core and non-negotiable—such as dignity, therapeutic engagement, safety, and shared goals—and which elements can be adapted to family structures, service resources, culture, and community capacity.

Toward an Integrative Framework for Evaluating Mental Health Nursing Models

The reviewed theories and models are best viewed as complementary rather than as competitors for a single universal solution. Peplau contributes the relational mechanism; Roy and stress-coping perspectives explain adaptation; Orem foregrounds self-care agency; Watson emphasizes caring and human dignity; the biopsychosocial model broadens causal assessment; CBT increases intervention specificity; trauma-informed care protects safety and reduces re-traumatization; and recovery-oriented, person-centred, culturally sensitive approaches ensure that care remains aligned with the person's life goals, rights, and context. Their overlap suggests that contemporary mental health nursing requires a layered model rather than exclusive adherence to one theoretical tradition.

the purposes of this article, five criteria provide a conceptual basis for evaluating which elements are most effective and implementable. The first is clinical relevance: the model must guide assessment and interventions for common mental health problems. The second is relational and ethical quality: it must strengthen therapeutic alliance, dignity, autonomy, and safety. The third is recovery utility: it must enhance agency, self-management, hope, social participation, and personally meaningful outcomes. The fourth is implementation feasibility: roles, competencies, workflow, training requirements, and outcomes must be sufficiently explicit for routine use. The fifth is contextual adaptability: the model must function across inpatient and community settings and allow culturally responsive modification without losing its core principles (Hartley et al., 2020; Ahn and Yi, 2022; Hurley et al., 2022; Matsuoka, 2023).

This integrative framework provides the conceptual bridge to the Results and Discussion section. Rather than asking which classical theory is universally 'best', the more clinically relevant question is which combination of mechanisms can be assembled into a coherent model that is simultaneously evidence-informed, person-centred, recovery-oriented, culturally responsive, and feasible within real nursing systems. This framing also directly supports the research questions stated in the Introduction and provides criteria for the later comparative synthesis of mental health nursing models.

METHODOLOGY

This article employed a qualitative literature review (QLR) with a narrative-integrative orientation to examine how major mental health nursing theories and care models can inform the development of an effective and implementable contemporary framework. The QLR approach was selected because the article seeks conceptual interpretation, comparison, and synthesis across heterogeneous theoretical, empirical, and practice-oriented literature rather than an exhaustive estimate of intervention effects. Accordingly, this study is not a systematic literature review: it did not use PRISMA-based exhaustive screening, protocol registration, formal risk-of-bias scoring, or meta-analysis. Instead, methodological rigor was pursued through explicit research questions, transparent conceptual boundaries, critical comparison, and integrative synthesis, consistent with contemporary guidance on narrative, integrative, and state-of-the-art reviewing (Elsbach and van Knippenberg, 2020; Barry, Merkebu and Varpio, 2022; Sukhera, 2022).

Relevant literature was identified purposively and iteratively, with emphasis on peer-reviewed journal articles published from 2020 to 2026 in English or Indonesian and directly relevant to mental health nursing theory, therapeutic relationships, recovery-oriented and person-centred care, self-care, adaptation and coping, holistic caring, cognitive-behavioural approaches, biopsychosocial perspectives, trauma-informed care, cultural responsiveness, and community mental health nursing. Searches were guided by combinations of these concepts with terms such as mental health nursing, psychiatric nursing, nursing theory, nursing model, recovery, implementation, and therapeutic relationship. Priority was given to reputable journals and to records whose bibliographic identity could be verified through publisher pages, DOI links, or indexed database records. Classical theories developed before 2020 were retained as conceptual anchors only when their contemporary relevance could be supported by recent peer-reviewed literature. This purposive strategy is compatible with integrative reviewing, which allows different forms of relevant evidence to be brought together in order to generate a coherent conceptual understanding rather than a narrowly delimited pooled effect estimate (Lubbe, ten Ham-Baloyi and Smit, 2020; Elsbach and van Knippenberg, 2020).

The selected literature was analysed through qualitative thematic comparison and integrative synthesis. Evidence was first organized according to the principal theoretical and practice traditions addressed in the article and was then compared across five analytic criteria derived from the literature review: clinical relevance, relational and ethical quality, recovery utility, implementation feasibility, and contextual adaptability. Attention was given not only to the claimed strengths of each model but also to its limitations, implementation requirements, and suitability across inpatient, primary-care, family, and community contexts. The final synthesis therefore sought patterns of complementarity across theories rather than selecting a single universally superior model, and it was used to construct the analytical bridge between the research questions and the Results and Discussion section. This interpretive procedure follows the logic of contemporary narrative and integrative reviews,

in which critical categorization and synthesis are used to develop a reasoned account of the state of knowledge and its practical implications (Barry, Merkebu and Varpio, 2022; Sukhera, 2022).

RESULTS AND DISCUSSION

Overview of Thematic Findings

The qualitative synthesis indicates that contemporary mental health nursing is best understood as a pluralistic field in which multiple theoretical traditions address different dimensions of the same clinical reality. Across the reviewed literature, five recurring functions can be distinguished: establishing a therapeutic relationship, supporting adaptation and self-management, applying structured evidence-based interventions, enabling personal recovery and shared decision making, and connecting care with family, community, and culture. These functions overlap but are not interchangeable. The evidence therefore supports a model-development strategy based on complementary mechanisms rather than on replacing one established theory with another (Hurley et al., 2022; Jones et al., 2023; Dickens et al., 2023; Wangel et al., 2024).

A second major finding is that effectiveness and implementability cannot be treated as separate questions. A theoretically sophisticated model may have limited clinical value if nurses lack time, supervision, organizational support, or the competencies required to translate it into daily practice. Conversely, highly pragmatic interventions may become fragmented if they are not anchored in a coherent nursing philosophy and a person-centred account of recovery. Recent implementation studies consistently show that organizational culture, leadership, training, role clarity, and service-user involvement influence whether recovery-oriented and evidence-based approaches become embedded in routine care (Lorien, Blunden and Madsen, 2020; Nardella et al., 2021; Salberg et al., 2022; Ezeruigbo, 2023; Lorien et al., 2024).

Figure 1 Synthesizes These Findings Into a Conceptual Framework that Links Theoretical Foundations, Core Nursing Processes, Implementation Enablers, and Desired Outcomes.



Figure 1. Conceptual Framework for Developing Effective and Implementable Mental Health Nursing Models
Source: Author Synthesis Based on the Reviewed Literature

As illustrated in Figure 1, theoretical foundations alone do not generate outcomes. They shape the core nursing processes through which care is delivered, while implementation enablers determine whether those processes can be sustained in real-world services. The resulting model should therefore be evidence-informed, person-centred, recovery-oriented, culturally responsive, and contextually adaptable. This framing directly addresses the practical problem identified in the source manuscript: the task is not to identify a universally superior model, but to determine which theoretical components are most useful, for whom, in which setting, and under what organizational conditions (Ahn and Yi, 2022; Matsuoka, 2023; Lee, Jang and Sun, 2024).

Comparative Contributions of Major Theories and Models

Peplau's interpersonal tradition provides the strongest conceptual foundation for the relational core of mental health nursing. Contemporary studies continue to show that the therapeutic relationship is not merely a desirable communication style but a mechanism through which assessment, engagement, risk discussion, adherence, and therapeutic work become possible. Systematic and qualitative evidence indicates that alliance quality is strengthened by trust, shared goals, reflective practice, and consistent interpersonal engagement, while discrepancies between nurse and patient perceptions can emerge early in admission and should be actively explored (Hartley et al., 2020; Coelho et al., 2021; Tolosa-Merlos et al., 2023; El-Abidi et al., 2024).

Roy's adaptation perspective, Orem's self-care approach, and Watson's human caring theory contribute different but complementary lenses. Adaptation theory helps nurses understand how stressors, coping resources, and environmental demands shape behavioural and emotional responses; self-care theory highlights agency, supported independence, and the capacity to manage everyday health needs; and human caring theory protects dignity, meaning, compassion, and the relational-spiritual dimensions that may otherwise be neglected in highly medicalized environments. Their principal limitation is not lack of conceptual value, but the challenge of translating broad constructs into observable interventions, measurable outcomes, and reproducible care processes (Callis, 2020; Durgun Ozan et al., 2020; Wei, Hardin and Watson, 2021; Yip, 2021). The biopsychosocial, cognitive-behavioural, and trauma-informed traditions make the model more clinically operational. The biopsychosocial perspective widens assessment beyond symptoms to interacting biological, psychological, social, and contextual determinants. Cognitive-behavioural approaches provide structured techniques for modifying maladaptive cognitions, behaviours, avoidance, and coping patterns, while trauma-informed care reframes safety, trust, choice, collaboration, and avoidance of retraumatization as essential conditions of care. Reviews of nurse-delivered interventions show that nurses can deliver therapeutically meaningful structured interventions, although the evidence base remains heterogeneous and requires stronger trials, fidelity assessment, and clearer specification of nursing-specific mechanisms (Porter,

2020; Nakao, Shirotsuki and Sugaya, 2021; Nizum et al., 2020; Goddard, Jones and Etcher, 2022; Dickens et al., 2023).

Recovery-oriented and community-based models add a crucial longitudinal and social dimension. They shift the endpoint of care from symptom control alone toward hope, agency, social participation, meaningful life roles, shared decision making, and continuity across service settings. Evidence from inpatient and community services shows that recovery-oriented practice can be implemented, but usually requires sustained organizational commitment, staff development, service-user involvement, and cultural adaptation. This is especially relevant in Southeast Asia, where family, spirituality, communality, stigma, and local understandings of autonomy can strongly influence recovery trajectories (Lorien, Blunden and Madsen, 2020; Matsuoka, 2021; Murwasuminar, Munro and Recoche, 2023; Thongsalab, Yunibhand and Uthis, 2023; Matsuoka, Marumoto and Horikawa, 2024).

Figure 2 compares the major models according to their central focus, strengths, limitations, and implementation requirements, making their complementarities and trade-offs explicit

Figure 2. Comparison of Major Mental Health Nursing Models

Key focus, strengths, limitations, and implementation considerations

Model	Key Focus	Main Strengths	Key Limitations	Implementation Considerations
Peplau's Interpersonal Theory	Therapeutic relationship	Trust, communication, patient engagement	Requires high interpersonal skills	Training, supervision, manageable workload
Roy's Adaptation Model	Adaptation to stressors	Holistic and flexible framework	Complex assessment process	Nursing assessment tools, contextual adaptation
Orem's Self-Care Theory	Self-care agency	Empowers independence	May be challenging in severe mental illness	Gradual and supported self-care interventions
Watson's Human Caring	Holistic caring and dignity	Strengthens humanistic care	Abstract concepts, harder to measure	Organizational culture and reflective practice
Cognitive Behavioural Nursing	Thoughts, emotions and behaviour	Evidence-based, structured interventions	Requires specific training	Integration into routine practice
Recovery-Oriented Model	Hope, autonomy and meaningful life	Person-centred and empowering	Cultural and organizational barriers	Training, policy support, service user involvement
Community-Based Model	Community integration	Improves access and social inclusion	Resource and workforce constraints	Cross-sector collaboration and sustainable funding

Figure 2. Comparison of Major Mental Health Nursing Models
Source: Author Synthesis Based on the Reviewed Literature

Figure 2 shows why model selection should be purpose-driven rather than ideological. Therapeutic-interpersonal approaches are indispensable where engagement and trust are weak; adaptation and self-care models are especially useful when the objective is coping, rehabilitation, and autonomy; cognitive-behavioural and trauma-informed approaches increase intervention specificity and safety; and recovery- and community-oriented models are essential when the desired outcomes include empowerment, continuity, and social inclusion. An effective nursing model therefore needs a stable conceptual core while remaining sufficiently modular to accommodate differences in acuity, diagnosis, setting, culture, and available resources (Aoki, 2020; Gurtner et al., 2021; Matsuoka, 2023; Wangel et al., 2024).

Therapeutic Relationship, Person-Centredness, and Shared Decision Making

The therapeutic relationship emerged as the most cross-cutting mechanism in the literature. It underpins assessment, de-escalation, shared decision making, psychoeducation, recovery planning, and the delivery of structured psychological interventions. Participatory and observational studies in acute mental health settings show that relationship quality depends on more than individual warmth; it is shaped by time, continuity, communication practices, reflective capacity, and the degree to which goals and tasks are negotiated with the service user (Hartley et al., 2020; Tolosa-Merlos et al., 2023; El-Abidi et al., 2024; Wangel et al., 2024).

Person-centred care strengthens this relational mechanism by positioning the service user as an active participant rather than a passive recipient. Mental health nurses' empathy, teamwork, professional competence, and work environment are associated with stronger person-centred practice, while shared decision making can reduce traditional power asymmetries by making preferences, information, deliberation, and follow-up explicit. Nevertheless, the evidence for shared decision-making interventions remains mixed, and implementation is constrained when services prioritize risk control, time efficiency, or professional authority over collaborative processes (Ahn and Yi, 2022; Aoki et al., 2022; Gurtner et al., 2021; Lee, Jang and Sun, 2024).

Evidence of Effectiveness and the Limits of a Single-Model Strategy

The contemporary evidence base does not support a simple claim that one mental health nursing model is superior across all outcomes. A systematic review of randomized controlled trials of nurse-delivered mental health interventions found evidence of benefit in some domains but also highlighted the limited quantity, heterogeneity, and risk of bias of available trials, particularly for outcomes central to personal recovery. Likewise, reviews of nurse-delivered interventions for anxiety show that nurses can effectively deliver structured therapeutic interventions, but intervention content, intensity, and training requirements vary substantially (Amaral et al., 2022; Dickens et al., 2023).

This limitation is important because different models target different causal pathways and outcomes. A therapeutic alliance model may improve engagement and trust without directly changing symptom scores; a self-care model may improve functioning and autonomy; trauma-informed care may reduce distress and retraumatization; recovery-oriented practice may improve agency and participation; and community-based care may strengthen continuity and social inclusion. Evaluating all models using only symptom reduction would therefore underestimate clinically meaningful outcomes such as dignity, empowerment, quality of life, self-management, shared decision making, and social participation (Nizum et al., 2020; Solomon, Sutton and McKenna, 2021; Sreeram, Cross and Townsin, 2021; Thongsalab, Yunibhand and Uthis, 2023).

The strongest interpretation of the available literature is thus one of conditional effectiveness: a model is effective when its mechanisms fit the needs of the person, the intended outcome, and the care setting, and when the organization can deliver it with adequate fidelity. This interpretation is consistent

with the repeated finding that recovery-oriented and trauma-informed programmes can be feasible and acceptable but require training, supervision, organizational change, and sustained implementation rather than one-off educational initiatives (Wilson et al., 2021; Salberg et al., 2022; Cilia Vincenti, Grech and Scerri, 2022; Lorien et al., 2024).

Implementation Feasibility: From Theory to Routine Practice

Implementation feasibility emerged as a decisive criterion for model development. Barriers repeatedly identified across studies include inadequate staffing and time, limited training, unclear professional roles, fragmented policies, competing organizational priorities, risk-dominant cultures, and insufficient access to supervision. Evidence-based practice can be positively valued by psychiatric nurses while still being implemented at a low level when organizational readiness is weak. The implication is that implementation failure should not automatically be interpreted as theoretical failure; in many cases, the barrier lies in the service environment rather than in the underlying model (Lorien, Blunden and Madsen, 2020; Hurley et al., 2022; Ezeruigbo, 2023).

Facilitators show a corresponding multi-level pattern. Effective implementation is strengthened by leadership commitment, staff education, reflective practice, multidisciplinary collaboration, service-user co-design, and clear alignment between clinical protocols and recovery-oriented values. Trauma-informed initiatives also emphasize the need for system-level safety and workforce resilience, because nurses cannot consistently provide trauma-sensitive care in environments that themselves generate chronic stress, coercion, or moral distress (Wilson et al., 2021; Macedo et al., 2022; Wheeler, 2022; Goddard, Jones and Etcher, 2022).

Figure 3 summarizes the principal barriers and facilitators that determine whether a mental health nursing model can move from theoretical endorsement to sustainable clinical implementation.



Figure 3. Barriers and Facilitators for Implementing Mental Health Nursing Models. Source: Author Synthesis Based on the Reviewed Literature

Figure 3 underscores that implementation is an ecosystem property rather than an individual nurse responsibility. Training is necessary but insufficient if staffing, leadership, policy, supervision, and interprofessional coordination remain misaligned. Conversely, supportive organizational conditions can increase the practical value of existing models without requiring constant introduction of new frameworks. This supports an implementation strategy focused on strengthening the environment in which nursing models operate, rather than treating model adoption as a stand-alone educational exercise (Nardella et al., 2021; Salberg et al., 2022; Ezeruigbo, 2023; Lorien et al., 2024).

Cultural Responsiveness, Community Orientation, and the Indonesian Context

Cultural responsiveness is especially important when models developed in high-income Western settings are applied in Indonesia or other Southeast Asian contexts. Recovery may be interpreted through family obligations, spirituality, social belonging, stigma, and communal identity rather than solely through individual autonomy. A Southeast Asian systematic review found that connection, hope, meaning, identity, spirituality, family involvement, and community participation are central to recovery, while stigma, limited knowledge, unemployment, and weak continuity of care can obstruct empowerment (Murwasuminar, Munro and Recoche, 2023).

Indonesian evidence reinforces the need for contextual adaptation. Studies of rural mental health nursing, schizophrenia recovery, community-based services, and nurses' perceptions of mental illness indicate persistent challenges related to service availability, stigma, role expectations, and integration between clinical and community support. These findings argue against direct transplantation of a single foreign model and support co-designed approaches that align person-centred and recovery-oriented principles with local family structures, community resources, and cultural meanings of illness and recovery (Kadar, Andriani and Tandi, 2020; Tasijawa et al., 2021; Kusumawaty, Yunike and Upoyo, 2023; Marthoenis et al., 2023).

Recent work on culturally sensitive recovery-oriented nursing offers a useful direction because it combines universal recovery principles with explicit attention to cultural context. Community psychiatric nurses using such a model reported the importance of reflecting on professional values, tailoring practice to individual circumstances, and promoting empowerment through interaction, while also encountering tensions between risk management and recovery. For Indonesia, this suggests that cultural adaptation should be treated as a core design process, not as a final adjustment after a model has already been developed (Matsuoka, 2021; Matsuoka, 2023; Matsuoka, Marumoto and Horikawa, 2024).

Selecting the Most Effective and Implementable Approach

The five evaluation criteria proposed in the Literature Review provide a practical basis for model selection. First, clinical relevance asks whether a model helps nurses assess needs and choose interventions for the target population. Second, relational and ethical quality examines whether the model protects dignity, therapeutic alliance, autonomy, and safety. Third, recovery utility evaluates whether it strengthens hope, agency, self-management, participation, and meaningful life roles. Fourth, implementation feasibility addresses training demands, workload, organizational fit, resources, and measurability. Fifth, contextual adaptability assesses whether the model can be modified for local culture, service configuration, family involvement, and community resources (Ahn and Yi, 2022; Matsuoka, 2023; Hurley et al., 2022; Lee, Jang and Sun, 2024). Applying these criteria leads to a consistent conclusion: no single existing theory satisfies all five domains at the same level. Peplau is strongest as a relational foundation; Roy and Orem contribute adaptation and self-management; Watson strengthens humanistic and ethical orientation; cognitive-behavioural approaches provide intervention structure; trauma-informed care strengthens safety; and recovery/community models provide direction for autonomy, participation, continuity, and social inclusion. The most effective and implementable model is therefore likely to be integrative, with a small number of clearly specified components rather than an accumulation of every available theory (Hartley et al., 2020; Yip, 2021; Wei, Hardin and Watson, 2021; Dickens et al., 2023; Thongsalab, Yunibhand and Uthis, 2023).

Toward an Integrated and Contextually Adapted Mental Health Nursing Model

The synthesis supports a layered model with four interacting elements. The first layer is the therapeutic-relational foundation, emphasizing trust, respectful communication, shared goals, and person-centred engagement. The second layer is individualized clinical formulation, integrating biopsychosocial assessment, adaptation and coping, self-care capacity, trauma history, and current risk. The third layer is intervention selection, drawing on recovery-oriented practice, psychoeducation, cognitive-behavioural techniques, self-management support, family engagement, and community linkage according to identified needs. The fourth layer is the implementation environment, including training, supervision, workforce capacity, policy alignment, data systems, and continuous evaluation (Gurtner et al., 2021; Nardella et al., 2021; Wheeler, 2022; Lorien et al., 2024).

The model should be designed as a flexible practice architecture rather than a rigid protocol. Standardization is useful for core principles, documentation, safety processes, and minimum competencies, but personalization is required for goals, intervention mix, family involvement, cultural meaning, and the pace of recovery. This balance is particularly important in mental health nursing, where service users may move between acute crisis, stabilization, rehabilitation, and community recovery, and where the relative importance of safety, autonomy, coping, and social participation changes over

time (Aoki, 2020; Matsuoka, 2023; Scheirich, Maguire and Daffern, 2024; El-Abidi et al., 2024).

Figure 4 presents a research-driven pathway for developing, testing, refining, and scaling such an integrated model in a way that preserves theoretical coherence while responding to local conditions.



Figure 4. Pathway to an Integrated and Contextually Adapted Mental Health Nursing Model
Source: Author Synthesis Based on The Reviewed Literature.

Figure 4 emphasizes that model development should be iterative. Evidence synthesis should be followed by integration of complementary mechanisms, explicit implementation planning, pilot testing, evaluation, and refinement before scale-up. Continuous learning is essential because an effective model in one institution may need adaptation in another because of differences in staffing, service-user characteristics, community resources, and organizational culture. The pathway also provides a practical research agenda: effectiveness and implementation should be evaluated together rather than sequentially, with clinical, recovery, implementation, equity, and patient-experience outcomes measured in parallel (Lorien, Blunden and Madsen, 2020; Barry, Merkebu and Varpio, 2022; Matsuoka, Marumoto and Horikawa, 2024).

Synthesis and Answers to the Research Questions

In response to RQ1, the major mental health nursing theories and models are characterized by distinct conceptual strengths and mechanisms. Interpersonal theory explains how therapeutic relationships create the conditions for engagement and change; adaptation and coping perspectives explain responses to stressors; self-care theory foregrounds agency and supported independence; human caring theory protects dignity and holistic meaning;

biopsychosocial and cognitive-behavioural models increase explanatory and intervention specificity; trauma-informed care strengthens safety; and recovery/community models extend the focus toward autonomy, social participation, culture, and continuity. Their limitations arise mainly from differences in abstraction, intervention specificity, measurement, resource requirements, and fit with particular clinical contexts (Callis, 2020; Wei, Hardin and Watson, 2021; Hartley et al., 2020; Nakao, Shirotsuki and Sugaya, 2021; Wilson et al., 2021; Thongsalab, Yunibhand and Uthis, 2023).

RQ1 is therefore answered not by identifying a single dominant model, but by recognizing that different models illuminate different dimensions of mental health nursing practice. The contemporary literature supports a core architecture in which the therapeutic relationship remains foundational, person-centred and recovery-oriented principles determine the direction of care, biopsychosocial and trauma-informed assessment improve clinical formulation, and structured interventions are selected according to patient needs and evidence. This architecture is compatible with both acute inpatient and community care, but its emphasis must change according to acuity and context (Hurley et al., 2022; Wangel et al., 2024; El-Abidi et al., 2024).

In response to RQ2, the most promising basis for an effective and implementable model is an integrative configuration rather than a new stand-alone grand theory. The proposed configuration combines six essential properties: a strong therapeutic relationship; person-centred shared decision making; recovery orientation; evidence-informed intervention selection; cultural responsiveness; and community continuity. These properties require implementation enablers including workforce development, supervision, leadership, interprofessional collaboration, organizational readiness, and service-user participation (Aoki et al., 2022; Ezeruigbo, 2023; Lee, Jang and Sun, 2024; Lorien et al., 2024).

For Indonesia, RQ2 also requires explicit contextualization. The model should be co-designed with nurses, service users, families, and community stakeholders; tested in both hospital and community services; and adapted to regional differences in workforce, resources, stigma, family roles, and cultural or spiritual interpretations of mental illness. Effectiveness should be evaluated using multidimensional outcomes that include symptoms, functioning, personal recovery, quality of life, therapeutic alliance, self-management, service experience, continuity of care, and equity. Such an approach would make the model both scientifically defensible and practically relevant to the health-system context in which it is intended to operate (Kadar, Andriani and Tandi, 2020; Murwasuminar, Munro and Recoche, 2023; Marthoenis et al., 2023; Matsuoka, Marumoto and Horikawa, 2024).

CONCLUSIONS AND RECOMMENDATIONS

Mental health nursing requires theoretical guidance, but the contemporary evidence does not support the search for one universally superior model. The principal theories and practice models address different dimensions of care: therapeutic relationship, adaptation, self-care, humanistic caring, biopsychosocial formulation, structured psychological intervention, trauma sensitivity, recovery, and community participation. Their greatest value emerges when these contributions are treated as complementary and organized around clearly defined clinical purposes rather than used as isolated or competing doctrines.

The review indicates that an effective mental health nursing model should place the therapeutic relationship at its core and combine it with person-centred shared decision making, recovery orientation, evidence-informed intervention selection, cultural responsiveness, and continuity across hospital and community settings. This combination offers a stronger basis for responding to the complex and changing needs of people experiencing mental illness than a model focused exclusively on symptoms, risk management, or a single theoretical tradition. It also preserves nursing's distinctive contribution by integrating relational, functional, psychosocial, ethical, and community dimensions of care.

Implementability is equally important. Training nurses in a model will have limited effect if staffing, supervision, leadership, organizational culture, policies, and service structures do not support the intended practice. The evidence reviewed here therefore suggests that model development should include an explicit implementation architecture comprising workforce competencies, reflective supervision, interprofessional collaboration, service-user and family involvement, adequate resources, data systems, and continuous evaluation. In this sense, the effectiveness of a nursing model is partly a property of the service system in which it is embedded.

For Indonesia, the implications are particularly significant. Mental health nursing models should be culturally and organizationally adapted rather than transferred unchanged from other health systems. Family participation, spirituality, stigma, regional inequality, community resources, and the availability of specialist nurses need to be incorporated into model design and evaluation. An integrated model should therefore be developed through co-design with service users, nurses, families, educators, managers, and community partners, followed by phased testing across inpatient, primary-care, and community mental health settings.

Future research should move beyond descriptive endorsement of theories and test clearly specified model components using hybrid effectiveness-implementation designs. Studies should compare alternative combinations of relational, recovery-oriented, trauma-informed, self-management, and community components; examine mechanisms of change; evaluate cost and workforce implications; and include outcomes such as therapeutic alliance, personal recovery, functioning, quality of life, shared decision making, continuity, and equity. Longitudinal and multicentre research in low- and middle-income settings is especially needed to determine which components are

transferable, which require cultural adaptation, and how integrated mental health nursing models can be sustained at scale.

FURTHER STUDY

This study still has limitations, so further research is needed on the topic of Developing an Effective and Implementable Mental Health Nursing Model: A Review of Theoretical Foundations, Recovery-Oriented Practice, and Contextual Adaptation to improve this study and provide more insights for the authors and readers.

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