Journal of Psychiatric and Mental Health Nursing

WILEY

REVIEW ARTICLE OPEN ACCESS

Conceptualisation of Mental Health Recovery by Health Professionals and Students in Southeast Asia: A Qualitative Systematic Review and Meta-Aggregation

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Received: 4 December 2024 | **Revised:** 15 January 2025 | **Accepted:** 5 February 2025

Keywords: international issues | mental health | recovery | staff perceptions | systematic literature reviews

ABSTRACT

Introduction: While the recovery approach is gaining recognition in non-Western countries, it remains underexplored in Southeast Asia. This study addressed this gap by examining how health professionals and students conceptualised recovery, providing insights for enhancing mental health practices.

Aim: To synthesise how health professionals and students in Southeast Asian countries understand mental health recovery.

Methods: A search across CINAHL, MEDLINE, PsycINFO, Scopus, and the Web of Science identified ten qualitative studies (2006–2024). Data extraction, quality appraisal, and synthesis were conducted following the JBI methodology.

Results: The findings highlighted a medically driven and determined return to normal functioning for individuals living with mental illness. This was classified into six categories: return to being a 'normal person', symptom-free status, medication adherence, access to mental health services, living with residual symptoms, and holistic care with a psychosocial focus.

Discussion: Medical-oriented practices have dominated mental health care, creating a power imbalance. Training, education, culture, socioeconomic status, and stigma have shaped the understanding of recovery.

Implications for Practice and Recommendations: Shared decision-making and formal training prioritising lived experiences are vital to reducing power imbalances. A shift towards recovery-oriented approaches is critically needed to enhance mental health practices in Southeast Asia.

1 | Introduction

Different cultures have varied understandings of mental health conditions, leading to diverse interpretations of mental health recovery (Carpenter-Song et al. 2010; Kleinman 2008; Ku and Ha 2021). There has been a paradigm shift in mental health care in many Western nations, including Australia, Canada, the United Kingdom and the United States, moving from purely medical-oriented practices to prioritising recovery-oriented approaches (Chatwiriyaphong et al. 2024; Slade et al. 2012; Wand 2015). The vision of recovery, introduced by William Anthony, highlighted 'a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness' (Anthony 1993, 15).

The concept of recovery has evolved and is considered from various standpoints, including clinical and personal recovery. Clinical recovery is grounded in a medical-oriented

Summary

- What is known on the subject?
  - Recovery-oriented practice is a contemporary framework widely used in mental health services in Western countries (e.g., Australia, Canada, the United Kingdom and the United States).
  - In Southeast Asia, the recovery approach is gaining recognition. Understanding how healthcare professionals and students perceive and implement recovery in this culturally diverse region provides valuable insights for enhancing practices.
- What the paper adds to existing knowledge
  - Mental health care in Southeast Asia remains primarily medically oriented rather than recovery-focused.
  - Socioeconomic factors significantly impact the adoption of recovery models, with a predominant focus on clinical recovery due to limited resources and support systems.
  - Immediate action is needed to integrate a recovery-oriented framework, prioritising lived experiences and personal recovery over clinical outcomes.
- What are the implications for practice?
  - Mental health nurses should reflect on their reliance on the medical model, recognising that recovery is non-linear and shaped by individual contexts and personal goals.
  - Empower individuals with lived experience to lead meaningful lives by focusing on a person-centred approach that includes goal setting, strength-based practices and shared decision-making. Actively engage family members in the recovery journey to foster understanding and support.
  - Formal training and education on personal recovery are crucial, emphasising the importance of lived experiences. Policymakers should develop comprehensive guidelines and policies to formalise recovery-oriented frameworks, prioritising culturally sensitive and person-centred practices.

approach, focusing on clinical outcomes such as symptom reduction and functional improvement (Andresen et al. 2010; van Eck et al. 2017; Ponce-Correa et al. 2023). In contrast, personal recovery is measured by the individual's subjective sense of recovery and life satisfaction (Anthony 2000; Chan et al. 2018). Personal recovery emphasises individuals taking control of their lives and regaining personal and social power, focusing on personal growth rather than fixating on the diagnosis (Wand 2015). Personal recovery focuses on individuals creating new meaning and rebuilding their identity (Saiz et al. 2021). Five key processes are essential for facilitating recovery: connectedness, hope, identity, meaning, and empowerment—CHIME (Leamy et al. 2011). Spirituality and stigma also emerged as significant factors, particularly in minority ethnic groups (Leamy et al. 2011). An umbrella review by van Weeghel et al. (2019) recommended adapting the CHIME framework to reflect cultural and population-specific characteristics, focusing on non-Western countries. Additionally, a qualitative systematic review by Dell et al. (2021), analysing the definition of mental health recovery from the consumer perspective, indicated that recovery involves transforming from a negative to a positive sense of self.

Findings from the 2019 Global Burden of Disease study highlighted a significant increase in the impact of mental health conditions in Asia over the past 30 years (Chen et al. 2024). Mental health disorders are emerging as the eighth leading cause of disease burden within the region (Chen et al. 2024). Most Southeast Asian (ASEAN) countries, except Singapore, are identified as developing nations (World Bank 2021). Southeast Asian countries share similarities in culture, ethnicity, and beliefs, fostering a strong ASEAN identity and cultural awareness (ASEAN 2020). Mental health systems, especially in Southeast Asia, are significantly under-resourced, resulting in considerable treatment gaps, and mental health has not been a health priority (Tan et al. 2023). The severe underfunding of mental health services is a significant barrier to the development of sustainable mental health care, including prevention, promotion and treatment in the region (WHO 2023a). Therefore, the World Health Organisation (WHO) has prioritised improving mental well-being, protecting human rights, and addressing health-related challenges for individuals with mental conditions across Asia (WHO 2023b). As part of its strategic approach, the WHO aims to promote deinstitutionalisation in Southeast Asia by shifting the mental health paradigm to focus on recovery, psychosocial support, and community-based care. This also involves incorporating family members and caregivers into the care process (WHO 2023b).

In line with the WHO's initiatives, the concept of personal recovery and recovery-oriented practice interventions has been gradually introduced into mental health practices in some Asian countries, indicating a growing awareness (Kuek, Raeburn, and Wand, 2023; Khanthavudh et al. 2023). However, a systematic review by Murwasuminar et al. (2023) showed that further research is required to explore the concept of personal recovery among people living with specific diagnosed mental illnesses in Southeast Asia. This gap in the literature highlights the need to understand how recovery is perceived and implemented within this diverse and culturally rich region.

The mental health workforce, such as psychiatrists, nurses, therapists, and social workers, plays a pivotal role in delivering the effectiveness and sustainability of the mental health system and shaping the future of mental health care practices (Australian Government Department of Health and Aged Care 2023; Gabrielsson et al. 2020). Direct interactions with consumers and their understandings about recovery significantly influence their professional practice. Therefore, examining the attitudes of such professionals toward mental health recovery is crucial for gaining valuable insights into current practices and informing the future direction of successfully providing recovery-oriented care (Le Boutillier et al. 2015). In addition, research focused on understanding recovery among mental health professionals and students is gaining momentum, shaping the future of practices and education in the field, and ensuring a workforce prepared to implement recovery-oriented care (Gyamfi et al. 2020). The results of this review have identified gaps in understanding and provide direction for educating current professionals and future students in mental health disciplines. Furthermore, this evidence plays a

pivotal role in guiding policymakers to allocate resources for enhancing recovery-oriented practices through education and intervention development.

1.1 | Aim

This review aimed to synthesise how health professionals and students in Southeast Asian countries understand the concept of mental health recovery.

2 | Methods

This qualitative systematic review followed the Joanna Briggs Institute (JBI) methodology for qualitative synthesis, explicitly utilising a meta-aggregation approach. A qualitative systematic review is a structured process for synthesising primary qualitative studies to understand a specific phenomenon comprehensively. Meta-aggregation preserves the original meaning and context of findings, providing synthesised statements to inform policy or practice recommendations (Lockwood et al. 2024).

The PRISMA 2020 statement (Page et al. 2021) was also used to guide conducting and reporting this review. The review protocol was registered in the PROSPERO International Prospective Register of Systematic Reviews on 20 May 2024 (ID no. CRD42024539957). Primary studies that explored how health professionals and students understand mental health recovery were included. This review used the PIC (Population, phenomena of Interest, and Context) strategy to formulate eligible criteria; details are shown in Table 1.

2.1 | Search Methods

The research team liaised with a research librarian regarding all keywords, databases, and Boolean expressions to ensure optimal rigour. Key search terms were developed using the Population, Phenomena of Interest and Context (PIC) mnemonic (see Supporting Information S1). The search also included a list of 10 Southeast Asian countries (The ASEAN 2024). CINAHL, MEDLINE, PsycINFO, Scopus and Web of Science were searched in May 2024. Reference lists of included papers were scrutinised to identify further studies. Only studies published in English between 2006 and 2024 were included. This timeframe was chosen because it marks the period during which significant research began on mental health professionals' conceptualisation of recovery (Gyamfi et al. 2020).

2.2 | Selection Process

All references obtained from the search were exported to Covidence (www.covidence.org) for de-duplication, title, abstract, and full-text screening. The initial screening of titles and abstracts was conducted independently by three researchers (RC, LM and RB). Any conflicts arising during this stage were resolved through consensus between two researchers, with a third researcher (GK) resolving conflicts if consensus could not be reached. Subsequently, one researcher (RC) conducted the full-text screening, reporting the reasons for any exclusions at this stage. Any uncertainties about the eligibility criteria of individual studies were addressed through discussions among four researchers (LM, RB, GK and RF).

2.3 | Assessment of Methodological Quality

Two researchers (RC and GK) independently appraised each study for methodological rigour, with the consensus reviewed by LM, RB and RF using the Joanna Briggs Institute's (JBI) Critical Appraisal Checklist for Qualitative Research (Lockwood et al. 2015). The critical appraisal results are presented in a table. Data extraction and synthesis were conducted on all studies, regardless of their methodological quality, to provide a comprehensive systematic review of all existing findings (Butler et al. 2016).

2.4 | Data Extraction and Synthesis

The first author (RC) was responsible for completing the data extraction, following the procedures outlined in the JBI Reviewer's Manual (Lockwood et al. 2024). The extracted data included study characteristics such as publication year and authors, country, participants, study methods, data collection methods, and findings. The three steps of meta-aggregation, which are the extraction of findings, the categorisation of findings, and the synthesis of categories into statements, were strictly followed (Lockwood et al. 2024). First, the process of data aggregation was a collaborative effort involving all authors. We independently extracted findings and supporting illustrations from the results sections of the included studies. The credibility of the findings was classified as unequivocal, credible, or unsupported based on the congruence between the findings and their supporting illustrations. Unsupported findings were excluded from subsequent data synthesis. Consequently, one researcher (RC) generated categories by aggregating findings with similar meanings. All researchers reached a consensus on the categories and synthesised findings through discussions to resolve differences and clarify category descriptions.

2.5 | Assessment of Confidence in the Findings

The confidence in synthesised qualitative findings (ConQual score) developed by JBI (Munn et al. 2014) was used to assess the confidence level of the synthesised findings. The scoring system assessed each study's dependability and each finding's credibility by ranging from high to very low. Studies were downgraded for dependability if they did not meet the five criteria in JBI's qualitative research critical appraisal tool (Lockwood et al. 2015). Similarly, findings were downgraded in their credibility rating if not all were considered unequivocal. This process ensured the final synthesised findings could reliably inform healthcare practice recommendations or policy decisions.

TABLE 1 | Inclusion and exclusion criteria.

	Inclusion	Exclusion
Population	• Mental health professionals and allied health professionals: clinical psychologists, psychiatrists, mental health nurses, social workers, occupational therapists, art therapists, paramedics, speech and language therapists, and mental health service managers. • Students: Nursing, psychology, medical, and occupational therapy students, including those in social work programs.	• Consumers of mental health services, caregivers, the general population, and peer support workers.
Phenomena of interest	• The meaning of mental health recovery: Studies that explored their interpretations, concepts, experiences, perceptions, expectations, clinical definitions, and the goals the above population perceived as essential to the recovery process. • Factors influencing mental health recovery: Studies that explored various factors, such as social norms, socio-economic conditions, and mental health practices.	• Studies focusing solely on recovery-oriented practice interventions.
Context	• Studies originating from Southeast Asian countries, encompassing a list of 10 countries including Brunei Darussalam, Burma, Cambodia, Indonesia, Laos, Malaysia, Philippines, Singapore, Thailand, and Vietnam as identified by the Association of Southeast Asian Nations (The ASEAN 2024). • Any mental health care and educational setting, including hospitals, clinics, outpatient and inpatient units, community health centres, and universities.	
Type of study	• Qualitative studies including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research, and feminist research. • The qualitative component of mixed methods studies relevant to the phenomena of interest.	• Quantitative studies only or papers without direct quotes of data.

3 | Results

Overall, 1179 articles were identified through database searching, leaving a remaining 898 articles after duplicate removal in Covidence. After screening the titles and abstracts, 54 full texts were retrieved and screened for eligibility. Ten studies were included in this review. The summary of the screening process is shown in Figure 1.

3.1 | Methodological Quality

In more than half of the included studies, the authors did not state their influence on the research (Q7) and failed to explain their cultural and theoretical perspectives (Q6). Three studies provided unclear descriptions of their philosophical perspectives (Q1). Additionally, two studies did not mention ethical approval (Q9). The overall methodological quality of the included studies is summarised in Table 2.

3.2 | Characteristics of Included Studies

An overview of the included studies is presented in Table 3. All ten included studies were qualitative studies published between 2011 and 2023. As expected, there was an increase in the number of studies in recent years, with eight included studies conducted from 2019 to 2023. The qualitative studies employed various methodological approaches, including a descriptive approach ($n=8$), grounded theory ($n=1$) and phenomenology ($n=1$). They were conducted in a diverse range of locations, including Singapore ($n=5$), Indonesia ($n=3$), Thailand ($n=1$), and Vietnam ($n=1$). Studies were conducted in hospitals ($n=5$), mental health services ($n=2$) and universities ($n=3$). Seven studies were health professionals' views, and three were students' views. The total sample was 144 participants, including 96 health professionals and 48 students. The age range of health professionals was 28–58 years old, with working experience ranging from 8 months to 27 years. Meanwhile, health professional students ranged from 20 to 25 years old. Table 4 shows the number of participants by professional category.

4 | Summary of Review Findings

The overall quality of the studies scored low on ConQual, which is presented in Table 5.

4.1 | Findings on Data Synthesis

The meta-aggregative synthesis of qualitative studies found that health professionals and students in Southeast Asia

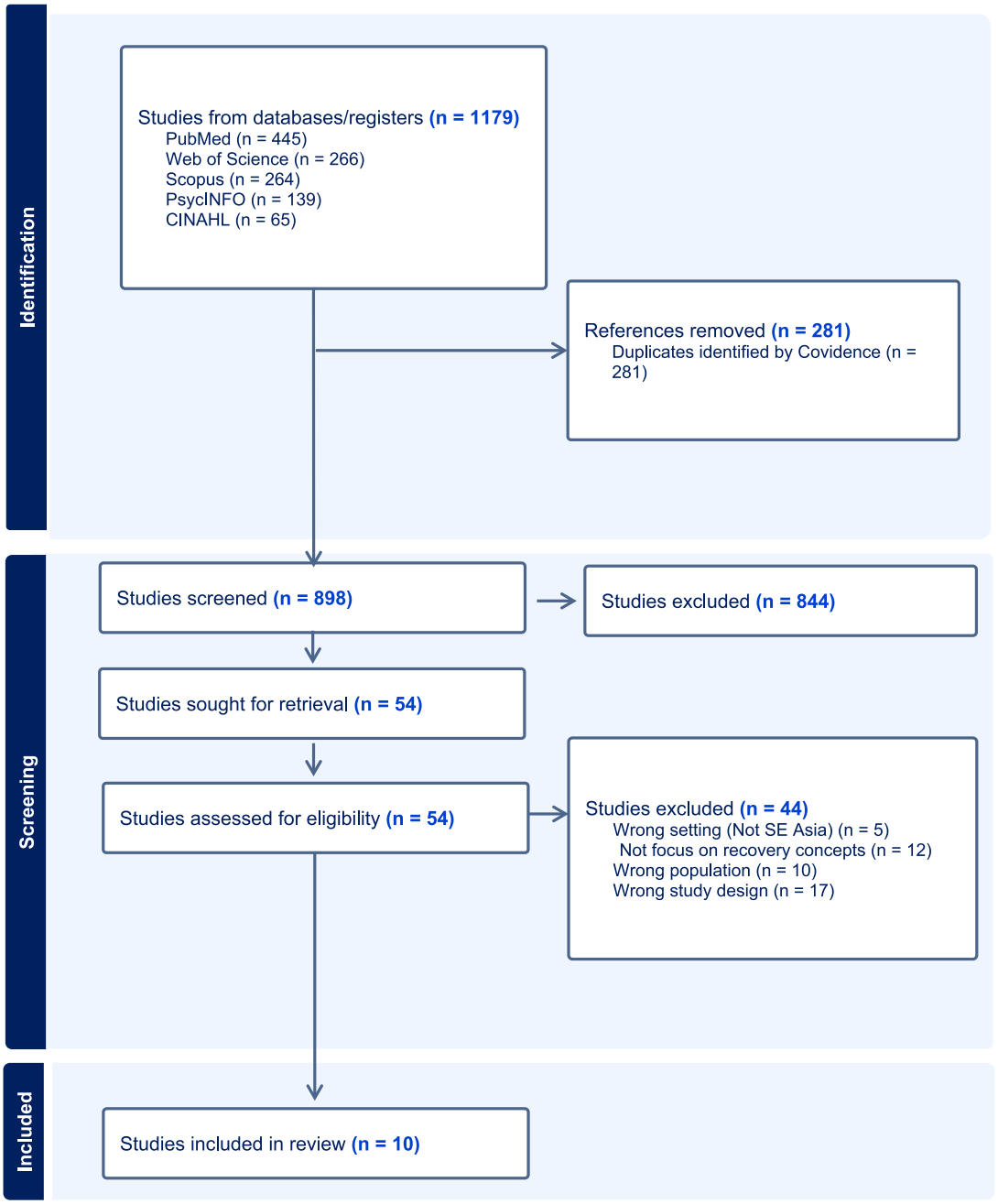

FIGURE 1 | PRISMA flowchart of the study selection process.

understood recovery to be a medically driven and determined return to normal functioning for individuals living with mental illness. Their understanding is comprised of six categories: return to being a 'normal person', symptom-free status, medication adherence, access to mental health services, living with residual symptoms, and holistic care with a psychosocial focus.

The term 'normal' highlights its subjective and contextual nature, as perceptions of 'normalcy' vary across individuals and cultural settings. In this context, 'normal functioning' and 'return to being a normal person' refer to regaining the ability to achieve daily tasks, fulfil responsibilities, and engage in social roles at one's pre-illness baseline, as shaped by societal and cultural expectations. This synthesis highlights the predominantly medical model approach taken by health professionals and students in Southeast Asia. The conceptualisation of recovery has a biomedical orientation whilst also moving toward a person-focused perspective, illustrated by emphasising psychological aspects to define mental health recovery for individuals living with mental illness (Figure 2).

4.1.1 | Category 1: Return to Being a 'Normal Person'

Recovery for people living with mental illness involved restoring the person's ability to perform activities of daily living (ADLs) and responsibilities independently; as they did before the onset

TABLE 2 | Critical appraisal of the included studies.

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Chua et al. (2023)	Y	Y	Y	Y	Y	U	N	Y	Y	Y
Gunasekaran et al. (2022)	U	Y	Y	Y	Y	Y	N	Y	Y	Y
Humphries et al. (2015)	U	Y	Y	Y	Y	Y	N	N	N	Y
Kaewprom et al. (2011)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Kuek et al. (2022)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Kuek, Raeburn, Liang, and Wand (2023)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Kuek, Raeburn, and Wand (2023)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nurjannah et al. (2019)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Ratnawati and Rizaldi (2021)	Y	Y	Y	Y	Y	N	N	Y	N	Y
Tasijawa et al. (2021)	U	Y	Y	Y	Y	N	N	Y	Y	Y
Total (%)	70	100	100	100	100	50	20	90	80	100

Note: Y: yes; U: unclear; N: no.
Q1: Is there congruity between the stated philosophical perspective and the research methodology?
Q2: Is there congruity between the research methodology and the research question or objectives?
Q3: Is there congruity between the research methodology and the methods used to collect data?
Q4: Is there congruity between the research methodology and the representation and analysis of data?
Q5: Is there congruity between the research methodology and the interpretation of results?
Q6: Is there a statement locating the researcher culturally or theoretically?
Q7: Is the influence of the researcher on the research, and vice-versa, addressed?
Q8: Are participants, and their voices, adequately represented?
Q9: Is the research ethical according to current criteria or, for recent studies, is there evidence of ethical approval by an appropriate body?
Q10: Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

of the illness. This was particularly illustrated through medical students' perceptions: "So, recovery, we must first understand what the pre-morbid is" (Kuek et al. 2022, 5). Perspectives from both students and health professionals emphasised the importance of regaining previous levels of functioning, including self-care, duties, and maintaining relationships. A clinical psychologist articulated this view by stating: "Successful recovery will look like, I will say, returning to prior levels of functioning, being able to go back to work, going back to, you know, being in a relationship. So being able to go back to your level of functioning" (Kuek, Raeburn, Liang, and Wand, 2023, 739).

Being a 'normal person' (akin to being recovered) also involved reconnecting to society and engaging appropriately in social interactions. A health professional particularly noted the importance of participating in religious activities: "For Muslims, they can attend Islamic forums or go to the mosque for praying to meet and chat with the neighbours" (Nurjannah et al. 2019, 29).

4.1.2 | Category 2: Symptom-Free Status

Recovery was viewed as being free from clinical symptoms. This perspective emphasised that to recover, a reduction or absence of clinical symptoms, relapses, and readmissions is required. As a health professional stated: "... total recovery is when the patients no longer have to depend on medicine, show no psychological disturbance, and no symptoms of mental disorder." (Nurjannah et al. 2019, 28). Cultural influences regarding financial investment in treatment shaped the perception that mental health recovery should lead to substantial improvements in symptoms and a return to community life free from clinical symptoms. As a psychiatrist explained: "If I spent $2,000 on treatment over one year, for instance, with the medication and doctor's appointments, then chances are the family expects the mood, the depression, to go away, or no more self-harming. Right? Yeah. That is what the culture seems to want" (Kuek, Raeburn, Liang, and Wand, 2023, 739).

4.1.3 | Category 3: Medication Adherence

The studies revealed that medication adherence was perceived to play a crucial role in the recovery from mental illness by reducing symptoms and preventing relapse. A mental health professional voiced this perspective by stating: "Recovery is maintaining medication, that is recovery. As they are back to their 100%, they need medication to sustain them, and that's considered recovery" (Kuek, Raeburn, Liang, and Wand, 2023, 739). Apart from personal responsibility, family were considered essential in managing medication and, as a result, crucial in ensuring recovery. As a psychiatrist stated: "In Ho Chi Minh City, because they are so busy with their job... they forget to prompt patients to take medications or the patients feel so sad and lonely that they drink alcohol..." (Humphries et al. 2015, Sociocultural influences section).

4.1.4 | Category 4: Access to Mental Health Services

When referred to mental health hospitals, which were mostly located in large cities, individuals were believed to have had a

TABLE 3 | Study Characteristics of included papers.

Authors, year, country	Settings	Methodology	Participants, male/female, age range, working experience	Sampling method	Data analysis	Data collection method and date	Findings
Chua et al. (2023) Singapore	University	A Descriptive Qualitative Study	14 nursing undergraduates from Years 1–4. Gender: $F=9/M=5$, Age range: 20–24	Convenience sampling	An inductive thematic approach	Individual face-to-face interviews between October and December 2019.	Three main themes (1) semantics of major terms used in mental health care—where participants provided the description of terminologies used; (2) the meaning of recovery—where participants explained their views on "recovery"; and (3) sources of conceptualisation—where participants explained their conceptual understanding on mental health conditions and recovery.
Kaewprom et al. (2011) Thailand	Two local hospital	A qualitative study	24 RN comprising 19 women and 5 men. Age range: 26–56. The duration of work experience in psychiatric nursing ranged from 3 to 27 years.	A purposive sampling	A thematic analysis	Semi-structured interviews	Four themes were identified: personal facilitators, environmental facilitators, personal barriers, and environmental barriers.
Kuek et al. (2022) Singapore	Singapore-based university	A qualitative descriptive approach	17 medical undergraduates comprised 11 males and 6 females between 21 and 25 years of age. The majority (15) of them were in their fourth year	A purposive sampling.	A thematic analysis	Individual face-to-face interviews from March to July 2021	Four themes were identified: the relationship between mental illnesses and well-being; opinions on mental well-being; understanding of mental illnesses; and perceptions of recovery from mental illnesses.

(Continues)

TABLE 3 | (Continued)

Authors, year, country	Settings	Methodology	Participants, male/female, age range, working experience	Sampling method	Data analysis	Data collection method and date	Findings
Kuek, Raeburn, Liang, and Wand (2023) Singapore	Mental healthcare in Singapore	A constructivist grounded theory study	19 MHP Counsellor =2. Art Therapist =1 Social Worker =1. Nurse =6 Case Manager = 2 Psychiatrist =3 Clinical Psychologist =4 Age range = 27–48 years. Duration of working experience = 7 months –21 years.	A mix of convenience and snowball sampling approaches	A constructive grounded theory approach.	Semi-structured interviews from May 2021 and November 2021.	A single core category, "living in society once more", and three categories, "An ongoing process", "Regaining ability to function in society", and "A normality report card" were identified from our data.
Kuek, Raeburn, and Wand (2023) Singapore	A university in Singapore	A descriptive qualitative exploration	A pre-registration occupational therapy programme. Seventeen undergraduates were recruited (year 1, $n = 5$; year 2, $n = 7$ and year 3, $n = 5$) The participating OT undergraduates comprised 12 females and 5 males, aged between 20 and 25 years.	A purposive sampling.	A thematic analysis	Semi-structured interview guide from June to August 2022.	Two macro themes were discerned: the understanding of mental health conditions and the meanings of recovery. Sub-themes were created under each grouping to describe the data.
Nurjannah et al. (2019) Indonesia	A public health centre and the health department in Yogyakarta province	A qualitative method	12 participants of professional health workers, 2 psychiatrists, 2 psychologists, 2 nurses and 2 doctors from a public health centre, 2 social workers, and 2 officials from the health department in Yogyakarta province. Age range: 33–58. $F = 10$, $/M = 2$. Working experience was 3 years and the maximum was 20 years.	A purposive sampling technique	A thematic analysis	Using in-depth interviews, with a semi-structured questions.	Four themes, namely: definition of recovery, type of recovery, recovery characteristics, and differences in perceptions about recovery.

(Continues)

TABLE 3 | (Continued)

Authors, year, country	Settings	Methodology	Participants, male/female, age range, working experience	Sampling method	Data analysis	Data collection method and date	Findings
Tasijawa et al. (2021) Indonesia	Eight Puskesmas at Buru District, Maluku, Indonesia.	A phenomenological approach	8 nurses; 4 males and 4 females with ages ranging from 24 to 46 years. Working experience: 8 months to 14 years	A purposive sampling	Content analysis model using Colaizzi's method	In-depth interviews from April to May 2020	Five themes were generated, including (i) treat a patient like a brother, (ii) recovery as an unfamiliar term with various meanings, (iii) medication as the primary action but also the main problem, (iv) being recovered if referred to a mental hospital, and (v) ineffective mental health programs.
Gunasekaran et al. (2022) Singapore	Mental health settings in Singapore. Type of setting Public hospitals Educational institutions Volunteer welfare organisations	A qualitative inquiry	17 healthcare professionals Psychiatrist = 4 General Practitioner =1 Psychologist = 2 Nurse = 1 Counsellor = 3 Medical Social Worker = 2 Rehabilitation Manager =1 Pharmacist = 1 Case Manager = 1 Occupational Therapist = 1 $F = 8$/ $M = 9$. Working expereinces from 5 years to 24 years.	Purposive and snowball sampling	The inductive thematic analysis method	Semi-structured interviews from March 2019 to July 2019	The three themes were classified as Micro Factors (e.g., internalised stigma), Meso Factors (e.g., discrimination of people associated with the stigmatised group), and Macro Factors (e.g., structural stigma and stigma within healthcare settings).
Humphries et al. (2015) Vietnam	Five psychiatric facilities	The qualitative approach	15 Vietnamese psychiatrists working in five leading psychiatric facilities.	A purposive snow-balling technique	Thematic content analysis	semi-structured interviews	Three broad domains: access to contemporary treatment; established prognostic indicators; and sociocultural influences.

(Continues)

TABLE 3 | (Continued)

Authors, year, country	Settings	Methodology	Participants, male/female, age range, working experience	Sampling method	Data analysis	Data collection method and date	Findings
Ratnawati and Rizaldi (2021) Indonesia	Jiwo's Mental healthcare post	A qualitative approach	5 Professionals. Midwife = 1 Nurse = 3 Person in charge = 1 $F = 5$	A purposive sampling	Thematic analysis	Semi-structured interviews	Four themes: Knowledge of mental health officers in mental health services, Social support for mental health officers in mental health services, Self-motivation of mental health officers in mental health services, Availability of Mental Health Services

greater chance of experiencing recovery. Participants believed that access to such environments, provided earlier interventions and consistent mental health treatment. As noted by one nurse, this access was seen as essential to increasing the possibility of recovery: "[An] effective transferral system can promote the client's recovery. It helps clients to access mental health services and get treatments promptly, so the client's recovery is developed quickly" (Kaewprom et al. 2011, 325).

However, resources in some countries of Southeast Asia are limited, including choices of medications and service options due to financial considerations. A mental health nurse noted: "Recovery depends on economic factors. Because to take medicine in Ambon (Maluku Islands of Indonseia), it costs money because it is so far" (Tasijawa et al. 2021, 340). Health professionals in this review perceived that some consumers might avoid formal services, seeking traditional treatments within their communities due to their beliefs (Humphries et al. 2015).

4.1.5 | Category 5: Living With Residual Symptoms

Some mental illnesses were considered challenging to achieve what was defined as "total recovery" (sic) (Nurjannah et al. 2019, 29) through a purely medical-oriented approach. People living with mental illness did not necessarily need a return to their baseline level of functioning. As one nursing student noted: "Some symptoms are more stubborn to eradicate, and the person can live with it; I think it's alright" (Chua et al. 2023, 219). This perspective suggested that health professionals felt that individuals living with mental illness may need to accept the presence of residual symptoms. Another psychiatrist stated: "There are some conditions we can treat and that do not return, like certain phobias or anxiety. However, there are chronic conditions where even the best treatments will still leave some symptoms and impacts on your life" (Gunasekaran et al. 2022, 16).

The studies in this SR revealed that clinical recovery in psychotic disorders like schizophrenia is a multifaceted and challenging process, with complete normalisation often deemed unachievable. A mental health nurse explained: "Recovery means all things related to schizophrenic disorder are no longer there or finished. The meaning of completion means you will recover like a normal person; it's not possible" (Tasijawa et al. 2021, 339). Despite the presence of residual symptoms, it was felt that individuals can comprehend the reality of their conditions and lead meaningful lives. As one occupational therapy student explained, "If they don't regain 100% functional capacity, I would still consider that recovery because they can participate in daily living and society" (Kuek, Tan, Tan, et al. 2023, 572).

4.1.6 | Category 6: Holistic Care With a Psychosocial Focus

When describing what mental health recovery means, health professionals and students in Southeast Asia spoke about approaches to care that would better facilitate mental health recovery. This includes being person-centred and providing holistic care. This approach involved focusing on the individual as a whole and addressing their specific needs. As medical

student mentioned: "I guess I would want to know how they view recovery? Yeah, then I can see how our perspectives are different and similar" (Kuek et al. 2022, 6). Participants believed that fostering person-centred care, grounded in kindness and genuineness, was essential for developing a therapeutic relationship. As one mental health nurse stated: "Whatever the task to serve people with mental disorders, I still have to do it sincerely" (Tasijawa et al. 2021, 339). Viewing individuals living with mental illness through a psychological lens, participants considered maintaining well-being and coping with stress as key to recovery. One nursing student voiced: "You can practice mental wellness when you are ill... you need to practice mental wellness to recover" (Chua et al. 2023, 219). Mental wellness involved self-awareness, managing clinical symptoms, and adapting to life changes. As one health professional noted: "He is said to recover when he knows how to control the disease. He knows well when he feels the symptoms recurrence, and he understands how to deal with it. Thus, he is well aware of the symptoms" (Nurjannah et al. 2019, 28). Participants in the studies included in this review recognised that promoting positive mindsets in people living with mental illness involved acceptance of the illness and hope in recovery, which can help in their transformation: "Hope is important for promoting people to recover from their mental illness. It gives them motivation to change [their] behaviours or lifestyle for recovery" (Kaewprom et al. 2011, 325).

There seemed to be a consistent view in the primary studies that recovery required multiple factors, especially biopsychosocial support. One clinician highlighted: "There are three key elements for healing people with mental disorders: the role of the family, the role of the environment, and the role of the health professionals. If these three work together, God willing, recovery will be achieved." (Ratnawati and Rizaldi 2021, 35). Acceptance and support from family members was seen to also assist people with mental illnesses to recover, as indicated by one nurse: "When people feel stressful[sic], they can seek some help from their relatives, who can treat them with love and care (Kaewprom et al. 2011, 325). Acceptance from the community, including the opportunity of being employed, was seen as crucial for people living with mental illness. This was often because people living with mental illness was seen by participants to fear stigmatisation, which was considered an obstacle to recovery, making consumers hesitant to ask for help and to integrate into society. From this perspective, a psychiatrist noted: "All these non-Singaporeans, by that I mean the Westerners, are the ones that self-select to see us. They are not the ones that feel the stigma of getting help" (Gunasekaran et al. 2022, 9).

5 | Discussion

This systematic review synthesised qualitative findings on how health professionals and students in Southeast Asia understood mental health recovery as a medically driven and determined return to normal functioning for individuals living with mental illness. The essence of meaning relating to this synthesised finding was that individuals living with mental illness would return to normal functioning as a result of medical intervention: that they would adhere to medication, access mental health services, and be symptom-free. Adhering to these criteria above means the individual would be considered 'recovered', reflecting the medical model's influence in its synonymousness with cure. While some participants valued personal recovery, the results primarily identified clinical recovery or interventions focused on diagnosis. Health professionals and students emphasised psychological aspects through person-centred care and a holistic approach to define mental health recovery for individuals living with mental illness.

To begin with, the review findings are presented primarily as medically oriented rather than recovery-oriented practices in mental health care settings. This perspective aligns with trends observed in various parts of the world, including the Middle East, Western countries (e.g., Australia, UK, USA, and Europe-wide), and South Africa (Alhamidi and Alyousef 2020; Gamieldien et al. 2022; Le Boutillier et al. 2015). In the context of this review's findings, the medical model perspective is evident as participants in Southeast Asia predominantly focused on a return to normal functioning, heavily reliant on medication adherence and achieving a symptom-free status. This reflects the influence of their clinical experience, which is grounded in the biomedical model (Gamieldien et al. 2022). The Diagnostic and Statistical Manual of Mental Disorders 5 (DSM5) represents the biomedical model approach, aiding mental health professionals in diagnosing and classifying mental disorders (American Psychiatric Association 2013). Training in the medical model provides a structured, systematised approach to diagnosing and treating mental illness. Medically driven care is thought to ensure standardised care and integrates disease-specific pharmacological treatments, improving clinical outcomes (Deacon 2013). This approach views health professionals as the experts on mental illness related knowledge, rather than also recognising the individual's expertise about their own condition.

Additionally, limited resources allocated to primary care result in a focus on managing consumers through psychotropic medication (Docrat et al. 2019). Almost 90% of mental health budgets in Southeast Asia, especially in low- and middle-income countries, are allocated to hospitals in urban areas, resulting in insufficient mental health care services or non-existent community mental health services (Saxena et al. 2011; Pathare et al. 2018). Hospital-based settings often prioritise rapid consumer turnover and crisis-driven practice (Solomon et al. 2021). The limited capacity and lack of resources pose significant challenges to moving toward recovery-oriented care, especially within hospital-based settings (Chatwiriyaphong et al. 2024). Resource constraints in Southeast Asia, particularly the shortage of trained mental health professionals, are contributing to multiple challenges in the transformation of mental health care (WHO 2023c). Recovery-oriented mental health services and shifting from hospital-based to community-based care appear to be better supported in high-income countries (Matsuoka 2021).

Despite medical model dominance, some health professionals and students acknowledged alternative concepts of recovery. Some participants in the primary studies indicated a shift in perspective, recognising that a person could have residual symptoms but still live in society, thus recognising personal recovery as a journey, not a cure. The review's findings in this regard, align with contemporary international mental health practices that emphasise the consumer movement, where recovery is viewed

TABLE 4 | Participants by professional category.

	Number
Health professionals	
Nurses	44 (45.8%)
Psychiatrist	24 (25%)
Psychologist	5 (5.2%)
Counsellor	5 (5.2%)
Social Worker	4 (4.2%)
Case Manager	4 (4.2%)
Doctor	2 (2.1%)
Clinical staff	2 (2.1%)
Midwife	1 (1%)
General practitioner	1 (1%)
Rehabilitation manager	1 (1%)
Pharmacist	1 (1%)
Occupational therapist	1 (1%)
Art therapist	1 (1%)
Total	96
Health professional students	
Medical student	17 (35.4%)
Nursing student	14 (29.2%)
Occupational therapy	17 (35.4%)
Total	48

as a unique and ongoing process (Subandi et al. 2023). Even when clinical symptoms are present, consumers can maintain hope, make choices, take responsibility, and live satisfying and meaningful lives (Anthony 2000; Andresen et al. 2010; Jacob et al. 2015; Damsgaard and Angel 2021). However, the review findings show a discrepancy in understanding between clinical and personal recovery. These findings are consistent with a systematic review by Gyamfi et al. (2020), which examined mental health professionals and students in Europe and English-speaking countries, including Australia, New Zealand, the USA, and Canada. Gyamfi et al. (2020) similarly revealed a lack of clarity regarding understanding the concept of recovery, highlighting confusion between clinical and personal recovery. This suggests that the medical model's influence on the perception of recovery is not unique to Southeast Asia but is also prevalent in other parts of the world. Diverse professional perspectives on mental health recovery can lead to inconsistent treatment methods, disparate models of care, and reduced overall effectiveness of the mental health system. Therefore, a clear and consistent understanding of 'recovery' is essential. Training and education are therefore crucial in ensuring all professionals have a shared understanding of recovery (Roberts and Boardman 2014).

The current review highlights the psychological aspects of person-centred care and illustrates the need for a holistic approach to defining mental health recovery for individuals living with mental illness. For example, a holistic approach involves tailoring care to meet each individual's specific needs and considering other aspects of consumers life. This holistic concept aligns with the global movement toward value-based, person-centred care in education and practice (McCormack et al. 2015; WHO 2015). Nevertheless, the findings of the current review could have been more evident, particularly regarding consumer involvement in their care. Shared decision-making, which involves health professionals and consumers equally, promotes person-centred care over authoritative models (Dixon et al. 2016). In many Western countries, consumer participation in health professional education and mental health services is documented in policy which expects active involvement and research demonstrating its benefits in improving understanding and effectiveness in addressing mental health needs (Arblaster et al. 2015; Byrne et al. 2016; Happell et al. 2019; Jørgensen et al. 2023). Focusing on the value of expert-by-experience involvement is essential to improving mental health practices in Southeast Asia, with such an approach demonstrating recognition of individuals' subjective experiences as experts and individual ownership of their recovery journey (Fisher 2023). However, transforming mental health practice will be challenging if the medical model, including the biopsychosocial (BPS) model, remains dominant. The BPS model provides a comprehensive framework for understanding and treating mental health conditions and likely influences training and education, shaping perspectives on recovery. While it values personalised, individual-centred care and support and encourages the involvement of various professionals in a multidisciplinary manner (Tripathi et al. 2019), it is often initiated by healthcare professionals who see themselves as experts in mental illness-related knowledge. This can sometimes lead to an emphasis on the medical aspects of care. As a result, health professionals views may not fully acknowledge individual experiences or recognise consumers as experts in their recovery journeys. Therefore, organisational policies should emphasise incorporating consumer experiences and expertise into mental health practices.

Cultural backgrounds, values, beliefs, and socioeconomic factors may significantly influence mental illness and stigma outcomes (Kleinman 2008; Potts and Henderson 2020). The perspectives of participants in this current review align with those found in a scoping review by Kuek, Raeburn, and Wand (2023), which indicated that Asians living with mental illness often view recovery as a transformative process with the aim of returning to a pre-illness state. Mental illness is predominantly understood through a biomedical lens, though religious and culturally bound explanations also play a significant role (Kuek, Raeburn, and Wand, 2023). This alignment reveals that Asian populations tend to view mental health recovery through the medical model. Health professionals are likely to, therefore, emphasise biomedical explanations and treatments in their psychoeducation, influencing consumers to adopt similar perspectives. This dynamic can create a feedback loop, reinforcing the biomedical model in professional practice and consumer understanding. The doctor-consumer relationship in Southeast Asia is frequently characterised by one-way interaction, where doctors assume a dominant role as a result of their advanced medical knowledge (Claramita et al. 2011). Cultural norms of respecting hierarchy

TABLE 5 | ConQual summary of findings.

Systematic review title: Conceptualisation of mental health recovery by health professionals and students in Southeast Asia: A qualitative systematic review and meta-aggregation				
Population: Health professionals and students				
Phenomena of interest: The meanings of mental health recovery				
Context: Southeast Asian countries				
Synthesised finding	Type of research	Dependability	Credibility	ConQual score
Medically driven and determined return to normal functioning for the person living with mental illness.	Qualitative	Downgrade 1 level[a]	Downgrade 1 level[b]	Low

[a]Downgraded one level due to common dependability issues across the included primary studies (the majority of studies had no statement locating the researcher and no acknowledgement of their influence on the research).
[b]Downgraded one level due to a mix of 45 unequivocal and 44 equivocal findings.

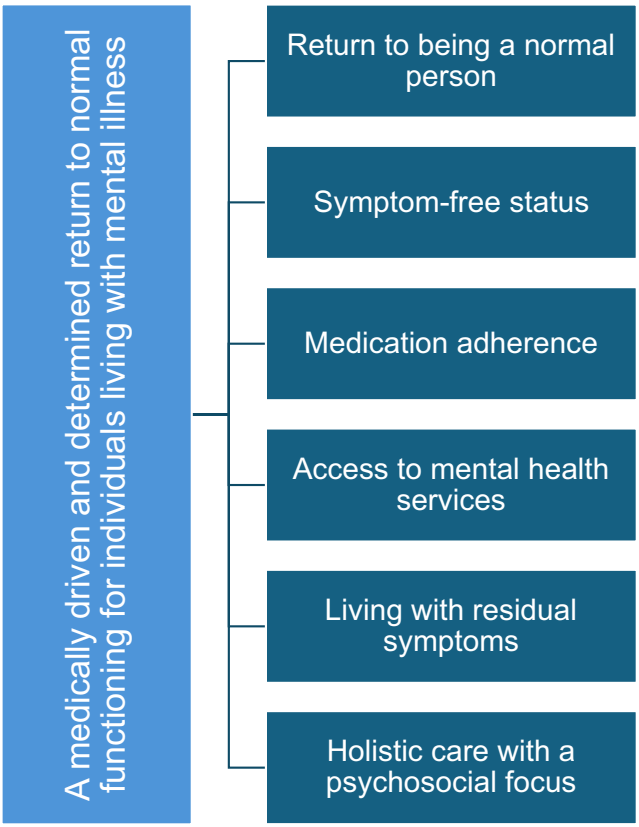

FIGURE 2 | Synthesised findings and categories.

toward elders or individuals of higher social status, including health professionals, can build a power imbalance, causing consumers to feel obligated to follow their doctor's authority without questioning (Claramita et al. 2013). These societal norms cause consumers to rely heavily on their health professionals' expertise and recommendations. Despite some progress toward incorporating personal recovery principles, these concepts remain relatively unfamiliar to many healthcare providers, service users, and families in the Asia region (Khanthavudh et al. 2023; Kuek, Raeburn, and Wand, 2023; Murwasuminar et al. 2023). Transformation of the mental health system in Southeast Asia may begin with educating and training health professionals about personal recovery concepts.

Health professionals and students in the current review identified holistic care as crucial, particularly highlighting the family's role. This aspect is significant for many Asian individuals, where family involvement is critical in their recovery journey (Khanthavudh et al. 2023). People living with mental illness in Southeast Asia generally live with their family members from whom they receive emotional and financial support (Suttajit and Pilakanta 2015). Due to deep-rooted cultural and societal attitudes in Southeast Asia, mental health conditions are often associated with shame and perceived weakness, potentially bringing dishonour to the family (Subramaniam et al. 2017). It is imperative to be aware that specific cultural contexts might influence the stigma connected to mental illness among family members (Yin et al. 2020).

Consequently, mental health conditions are often concealed and not openly discussed, hindering access to help-seeking attitudes toward treatment (Zhang et al. 2019). Cultural stigma contributes to avoiding mental health services and results in untreated mental health conditions. Addressing these cultural barriers involves improving mental health literacy, implementing recovery-oriented practices, and implementing a partnership approach that involves consumers, carers, and the wider community (Gunasekaran et al. 2022; Rathod et al. 2017).

5.1 | Implication for Research and Mental Health Nursing

There is a notable discrepancy in the understanding of clinical recovery and personal recovery within this systematic review study. This knowledge gap highlights the importance of developing and promoting mental health policies focusing on personal recovery and providing formal training for mental healthcare professionals on personal recovery concepts. The provision of training for mental health professionals on mental health recovery, involving collaboration with consumers in designing and delivering the training, can help achieve a shared understanding of mental health recovery (Ibrahim et al. 2022; Happell et al. 2024). Incorporating experts by experience (EBE) into the undergraduate curriculum for health professionals will highlight the unique knowledge and expertise they bring to mental health education through their lived

experiences (Happell et al. 2022). For example, involving consumers in sharing their recovery journeys and experiences receiving mental health services within university or clinical settings enhances learning and understanding. This has also been recognised as a practical approach in mental health nursing and addressing stigmatised attitudes (Bocking et al. 2019). The 'Recovery Camp 'is an example of incorporating experts by experience (EBE). The Recovery Camp positions consumers as integral members of the multidisciplinary team, valuing and respecting their contributions to their care and recovery journey and their impact on multidisciplinary health education (Moxham et al. 2017; Jay et al. 2024). However, there is currently limited interest in this approach in Asian countries (Kang and Joung 2020). Promoting the inclusion of consumer involvement or experts with experience in mental health services can balance power dynamics between health professionals and consumers, leading to positive outcomes and attitudinal changes (Byrne et al. 2012; Happell et al. 2023).

Mental health nurses should critically reflect on their reliance on the predominant medical model and recognise recovery as a personal journey rather than solely focusing on symptom reduction or treatment adherence. In the ASEAN context, where the biomedical model is prevalent, early psychoeducation is crucial to help consumers and their families understand that recovery involves living a meaningful and fulfilling life, not just managing symptoms. Mental health nurses should actively involve families in care plans to understand the consumer's experiences, foster a supportive environment, and reduce stigma. Mental health nurses should develop their understanding of recovery frameworks to enhance their practice. For instance, the Tidal Model emphasises empowerment and a person-centred approach, which is essential for guiding mental health nurses in recovery-oriented care. A key aspect of the Tidal Model is the recognition of consumers' narratives and personal experiences as therapeutic tools, supporting individuals in understanding their journey and finding meaning in their recovery journey (Barker 2001; Bag 2019). Recovery-oriented practice should prioritise individual needs, instil hope, set achievable goals, and empower consumers through shared decision-making in care planning.

Based on the systematic review of 10 qualitative studies published between 2011 and 2023, with a surge from 2019 to 2023, recovery concepts have been introduced more frequently in the region of Asia but only in some countries. These studies in Singapore, Indonesia, Thailand, and Vietnam highlight a gap in understanding the meaning of mental health recovery. Updated research in these countries may be pivotal in designing culturally sensitive mental health programmes and policies that better address the unique needs of these populations. Future research should expand to conduct diverse methodologies, underrepresented areas, and integrate cultural perspectives. To align with WHO guidelines for mental health in Southeast Asia, emphasis should be placed on developing community mental health services, conducting more research and training, and promoting culturally considerate recovery-oriented practices (WHO 2024). It is essential to consider reviewing education, practice, and national policies to highlight recovery-oriented practices, as this could significantly improve mental health care in the region. Future research should focus on developing culturally sensitive recovery-oriented interventions tailored to the unique needs of this region.

5.2 | Limitations

The findings of this qualitative systematic review and meta-aggregation have some limitations. First, the review did not include studies that were not in English, nor did it include conference reports or specific grey literature, indicating a potential lack of insight from some countries and cultures. Relevant papers might have been missed. Secondly, more than half of the included studies did not disclose their influence on the research or explain their cultural and theoretical perspectives, which are critical for assessing the study's transparency and reflexivity (Lockwood et al. 2015). This lack of explanation implies that the research context and framework were insufficiently detailed, potentially affecting the interpretation of the findings (Olmos-Vega et al. 2023). The meta-aggregation method aims to provide generalisable recommendations to guide practitioners and policymakers (Hannes and Lockwood 2011). However, the context-specific and subjective nature of qualitative data limits the generalisability of findings across different settings and populations.

5.3 | Conclusion

This review highlights increasing interest in conceptualising mental health recovery in Southeast Asia, particularly from 2019 to 2023. Notably, most primary studies were conducted in Singapore, a high-income country. Health professionals and students in the region often view mental health recovery as a medically oriented practice. In contrast, others perceive it as a personal process involving living with residual symptoms, with clinical recovery being the dominant perspective. Mental health nurses are encouraged to shift toward recovery-oriented practices that acknowledge individuals' subjective experiences, recognising them as experts in their recovery journey. This approach involves implementing shared decision-making with consumers and their families, empowering individuals to lead meaningful lives, even with ongoing mental health challenges. The findings reveal discrepancies in mental health recovery, indicating a need for further training and education in ASEAN. This study suggests shifting from a purely medical model to a personal recovery approach in line with the WHO Mental Health Action Plan 2020–2023 (WHO 2023b), informing clinical practice and policymaking. Although the transition requires time, shifting is urgent and should begin now.

Acknowledgements

The first author wishes to express deep gratitude to the Ramathibodi School of Nursing, Faculty of Medicine Ramathibodi Hospital, Mahidol University, Thailand, for providing the PhD scholarship. Open access publishing facilitated by University of Wollongong, as part of the Wiley - University of Wollongong agreement via the Council of Australian University Librarians.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.