CHIME in practice: a qualitative exploration of CHIME framework training experiences and outcomes for service users and mental health professionals

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Abstract

Purpose – *This study aims to explore the experiences and outcomes associated with participating in a brief training course based on the CHIME (Connectedness, Hope and Optimism, Identity, Meaning of Life and Empowerment) Framework among service users and mental health care professionals (MHPs).*

Design/methodology/approach – *The authors used a focus group discussion approach to evaluate the outcomes of a brief four-hour CHIME Framework training. The study sample consisted of eight individuals (four service users and four mental health professionals) who completed the training and provided consent to participate in the interview. The study applied thematic analysis to identify key themes related to participants' experiences and outcomes.*

Findings – *The authors identified five main themes based on participants' experiences and outcomes of the CHIME Framework training: the meaning of recovery, relationships that support recovery, co-production, recovery and empowerment and barriers to recovery.*

Research limitations/implications – *This study is limited by its small sample size and the qualitative design of the research, which restricts the generalizability of the findings and emphasizes their exploratory nature. Future studies should aim to expand the sample size and enhance participant diversity, particularly with regard to gender representation, to strengthen the robustness of the results. Moreover, quantitative or longitudinal research designs are recommended to establish the causal relationship between the CHIME Framework training and the participant's meaningful engagement in mental health practice and recovery processes.*

Practical implications – *Addressing the knowledge deficit among mental health staff and service users regarding the integration of a recovery-oriented approach into mental health practice has the potential to enhance overall well-being, improve mental health literacy and reduce stigma for both groups.*

Originality/value – *This qualitative work explored the role of the outcomes of CHIME Framework training within a mental health center and the effect this training might have on the MHPs and service users. The findings contribute to the growing body of knowledge on recovery-oriented approaches in mental health practice, making it relevant and significant for clinical practice.*

Keywords *CHIME Framework, Mental Health, Recovery Model, Service Users, Mental Health Professionals, Experiences*

Paper type *Research paper*

Introduction

In recent years, recovery has received increasing attention in medical contexts, particularly within mental health programs. The focus has been on developing interventions that promote service users' recovery from somatic or mental health challenges (Kellmann *et al.*, 2023). Recovery has been defined in various ways across different contexts. In medical settings, it is often described as an ongoing healing process aimed at achieving a higher degree of

wellness (Onken *et al.*, 2007). The concept of recovery encompasses a person's ability to pursue hopes and goals and lead a meaningful, self-determined life despite ongoing mental health challenges (Davidson and Roe, 2007).

Psychiatrist William Anthony's widely used definition states that recovery is "a deeply personal, unique process of change in attitude, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and constructive life despite the limitations caused by mental health experiences" (Anthony, 1993). This recovery movement shifts away from the traditional deficit-focused model (pathogenetic) toward empowerment, resilience and hope (Davidson and Roe, 2007; National Center on Substance Abuse and Child Welfare, 2012). Despite calls for reform, biomedical views of recovery still prevail among mental health professionals (Moreta *et al.*, 2016) and the provision of recovery-oriented services remains sporadic (Boutillier *et al.*, 2014; Perkins and Slade, 2012; Pincus *et al.*, 2016; Tse *et al.*, 2013).

Recovery-oriented practice approaches extend beyond addressing mental health challenges, aiming instead to empower individuals throughout their recovery journey (McGregor *et al.*, 2014). From a mental health-care perspective, the effectiveness of care is measured not only by clinical outcomes but also by the subjective experiences of individuals receiving care. Recovery training programs within mental health centers focus on empowering service users through collaborative efforts with staff, emphasizing the importance of tailoring care to individual needs (McPherson *et al.*, 2021).

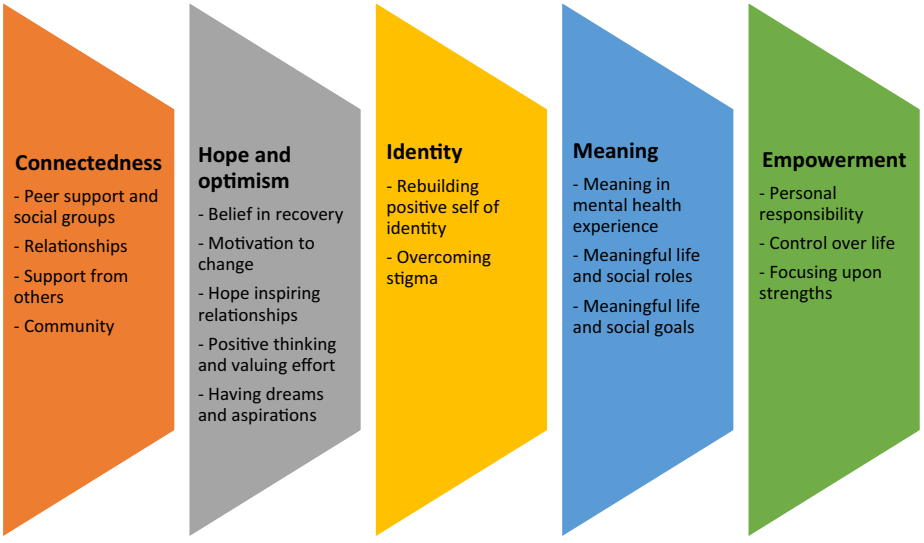
Key values in recovery-oriented practice include fostering respectful, collaborative relationships and emphasizing hope, self-determination, meaning and purpose (Farkas *et al.*, 2005). MHPs need to shift from a position of expertise and authority to one in which they provide coaching toward the goals of service users (Slade, 2012). These practices aim to build support that facilitates recovery and well-being and the professional's belief in understanding recovery (Bird *et al.*, 2014; Wood and Alsawy, 2017; Van Weeghel *et al.*, 2019; Gyamfi *et al.*, 2022).

One prominent framework developed to guide recovery-oriented practices is the CHIME Framework – an acronym for Connectedness, Hope and Optimism, Identity, Meaning in Life and Empowerment. Developed by Leamy *et al.* (2011) through a systematic review of 87 articles, the CHIME framework provides a comprehensive depiction of the recovery process and is widely recognized for its utility in mental health care (Brijnath, 2015). Figure 1 illustrates the CHIME Framework's components, which serve as a foundational reference for recovery-oriented practice.

The CHIME Framework has been widely adopted in mental health services to promote recovery-oriented practices. Its principles are often used to train MHPs and engage service users, aiming to enhance positive outcomes for both groups. Evidence demonstrates that CHIME fosters recovery by emphasizing connectedness, hope, identity, meaning and empowerment (Hine *et al.*, 2023; Salkeld *et al.*, 2012). However, implementing these principles consistently across diverse settings presents challenges (Poon *et al.*, 2024). Peer support and specialized training have been shown to promote CHIME principles, yet service users and carers often report gaps in comprehensive support (Zeng and Chung, 2020). In addition, staff may grasp recovery concepts but still require practical tools and adaptations, such as the CHIME Secure framework to address challenges in specialized contexts like forensic or supported accommodation settings (Kvia *et al.*, 2020; McPherson *et al.*, 2021; Senneseth *et al.*, 2021). While several studies have evaluated recovery training experiences and outcomes for MHPs, showing improvements in recovery-oriented knowledge, attitudes and competencies, there is limited evidence addressing service user and service-level outcomes (Jackson-Blott *et al.*, 2019; Lau and Hutchinson, 2021).

This qualitative study seeks to address this gap by exploring the experiences and outcomes of service users and MHPs following CHIME-based recovery training.

Figure 1 CHIME Framework for personal recovery



Source(s): Authors' own work

By examining the perspectives of both groups, the study aims to bridge the gap between theoretical frameworks and practical applications, contributing to the growing body of evidence on recovery-oriented practices.

Methods

Study design

We used a qualitative research design, as it allows for a detailed analysis of events or situations from an expert perspective to deepen understanding (Braun and Clarke, 2006). The research team consisted of mental health staff, researchers and service users who contributed to the design, conduct and interpretation of the study. The involvement of key stakeholders in addressing relevant issues aligns with participatory research approaches. This approach has several advantages: it optimizes decision-making, improves access to information on effectiveness, enhances understanding of complex issues and creates opportunities for shared learning and reflection. As a result, it increases transparency and lends greater authenticity to the qualitative findings (Mackenzie *et al.*, 2012).

Setting and context

We conducted CHIME Framework training sessions for five cohorts of MHPs and service users at a mental health care center from September 2022 to June 2023. Each cohort had an average of 15 participants, including service users, peer workers and social workers. The sessions were conducted by two staff members of the Recovery College Guetersloh-OWL (AZ and JO).

Established in 2019, Recovery College Guetersloh-OWL offers co-productive educational programs aimed at empowering individuals to independently manage mental health challenges while promoting well-being and emotional development. These programs are uniquely designed using a co-production model, in which course content is collaboratively developed and delivered by individuals with lived experience of mental health challenges,

alongside professionals with specialized training in mental health care (e.g. psychiatric nurses and therapists). This approach integrates experiential knowledge and clinical expertise, contributing to a holistic learning environment that supports personal recovery and resilience.

Intervention

The CHIME Framework training was a half-day session lasting four hours. It used a blended learning approach that incorporated interactive presentations, group discussions and role-playing activities to enhance engagement and deepen understanding (see Table 1). The sessions were cofacilitated by a mental health professional and an individual with lived experience, ensuring a comprehensive perspective that integrated both theoretical knowledge and real-world recovery experiences.

Participants

We recruited four service users and four mental health staff members to participate in the study. Participants were required to meet the following inclusion criteria: they had to be at least 18 years old, capable of providing informed consent and have completed the CHIME Framework training. Exclusion criteria included being under 18 years of age, lacking the

Table 1 The CHIME Framework training plan

Time	*Topic*	*Method*	*Presenter*	*Duration*
09:00	Introduction and welcome	Plenary session	AZ, JO	30 min
09:30	Introduction to recovery	Presentation		10 min
09:40	Identity with exercise:	Presentation	JO	10
	Draw a hand – describe yourself.	Individual exercise		10
	Discussion: What was easy, what was difficult?	Exchange in pairs Plenary session		10
	What does this mean for service users and mental health staff?			
10:10	Hope and optimism:	Presentation	AZ	20
	Film: Yacouba Sawadogo – the man who stopped the desert	Film		
	Association: What do you associate with hope and optimism?	Plenary session		
	Discussion: How can hope and optimism be conveyed in mental health practice?			
10:30	Break			15
10:45	Meaning in life:	Presentation	AZ, JO	20
	What gives service users a sense of meaning in life?	Plenary Session		
	How do you support service users find meaning in life?			
11:05	Connection	Presentation	AZ, JO	15
	Introduction to connection and relationships between service users and mental health professionals	Group work Plenary session		20 30
	Exercise: Exchange in small groups			
	Discussion			
12:15	Break			15
12:30	Empowerment and practical transfer	Presentation	AZ, JO	
	Introduction to empowerment	Plenary session		
	Discussion: Empowerment and recovery process			
13:15	Closing feedback from the participants			
13:30	*End*			

Source(s): Authors' own work

capacity to provide informed consent or not having participated in the CHIME Framework training. Invitations to participate were distributed through post and telephone, with support from the mental health center staff.

Questionnaire and data collection

The study team developed the interview guidelines (see Table 2), which were informed by the experiences of the team and the existing literature on recovery and recovery-oriented work. The team was composed of six members from the Recovery College Guetersloh-OWL, which included two trained professionals and four staff members with lived experience of mental health challenges. Pilot interviews were conducted prior to the main data collection to refine the methodology.

Measures

The study team used focus group discussions (FGDs) as the primary qualitative data collection method. The FGDs allowed for in-depth exploration of participants' perceptions, learning experiences and the applicability of the CHIME Framework in practice. The focus group interview was conducted in December 2023 and lasted approximately 45 min. The discussion was facilitated by a researcher with a PhD and five years of experience in qualitative interviewing. The facilitator was a neutral party who was not involved in delivering the training. The interview was audio-recorded and transcribed *verbatim*, with all identifying information removed to ensure confidentiality. The transcripts were subsequently processed using AmberScript software (AmberScript, 2024) to manage, organize and analyze the data.

Data analysis

We performed inductive thematic analysis following the six-step process outlined by Braun and Clarke (2006) to identify both semantic and latent themes within the data. The analysis aimed to explore the main themes emerging from participants' accounts without any prior theoretical assumptions (Braun and Clarke, 2006).

The research team first familiarized themselves with the data and generated initial codes (steps 1 and 2). Patterns were then identified to capture initial thoughts on potential themes (steps 3 and 4), which were discussed collaboratively within the team. Coding was deemed complete once the team agreed that no further themes could be identified

Table 2 Interview guide

Questions	*Aspect*
Question 1: You have all participated in the CHIME Framework recovery training; what were your main reasons for deciding to participate in the training?	Motivation
– Is this your first CHIME Framework recovery training?	
Question 2: Can you talk about your experiences with the CHIME Framework recovery training?	Experience
– Have you experienced any changes after the CHIME Framework recovery training? If yes, could you explain?	
Question 3: Were there any obstacles that prevented you from participating in the CHIME Framework recovery training?	Challenges
Question 4: Mental challenges are widespread in our society; could you, based on your knowledge and experiences, explain your opinion on recovery and the possibilities to support it?	Knowledge
If you believe they could be supported, could you tell us how?	

Source(s): Authors' own work

(Llewellyn-Beardsley *et al.*, 2019). Subsequently, we reviewed the identified themes based on team feedback (step 4).

Ethical considerations

All participants signed and received a copy of the consent form and were informed that they could withdraw from the study at any time. No identifying information was used in reporting the findings.

All data described in the survey were analyzed and processed following internationally applicable ethics regulations, in compliance with national law and adhering to the Declaration of Helsinki of 1975 (revised version).

Results

Eight participants took part in focus group interviews, which consisted of a single discussion lasting approximately one hour. Participants ranged in age from 31 to 66 years (M = 45.2 years) and included four MHPs and four service users, comprising five females and three males. Sociodemographic details are presented in Table 3.

All participants completed the CHIME Framework Recovery training, providing a common foundation for the discussions. From the focus group interview, five overarching themes were identified, reflecting the participants' experiences and outcomes (see Figure 2).

Themes

Meaning of recovery. Both mental health professionals (MHPs) and service users reported that the training broadened their perspective on the meaning of recovery. They shared that recovery goes beyond merely managing symptoms; instead, it is a personal journey centered on growth, hope and empowerment. This journey enables individuals to discover a sense of purpose, harness their personal strengths and make informed choices that foster resilience and enhance overall well-being. However, experiences and interpretations of recovery varied among both service users and MHPs, influenced by their unique

Table 3 Sociodemographic information of participants

Gender	n(%)
Male	3(37.5%)
Female	5(62.5%)
Age in years	
31	2
38	1
42	1
46	1
53	1
55	1
66	1
Participants roles in the mental health center	
Social workers	3
Peer workers	1
Service users	4
Educational level	
Vocational education	3(37.5%)
University degree	5(62.5%)
Years of experience in the mental health center (SD)	
Staff	4.7 years
Users with lived experience in mental health conditions	2.5 years

Source(s): Authors' own work

Figure 2 Five thematic domains and outcomes

Source(s): Authors' own work

perspectives and subjective experiences. This highlights the deep personal and subjective nature of recovery. Here is a perspective from one of the service users:

> It is about not just preaching the principles of recovery but truly living them. Instead of just talking about them, one should actively embody and implement them. This approach often goes beyond the understanding that it would simply mean more work and instead shows how easy it is to adopt and practice this mindset. (Service User R2)

The MHPs also emphasized that the training helped them understand the critical role of recognizing and embodying recovery, acknowledging its value in fostering a supportive and empowering environment. Here is a perspective from the MHPs:

> I think it is a double-edged sword, and that is why it is important for everyone to engage with the concept of recovery [. . .] (MHP R2).

Relationships that support recovery. Participants reported that the training helped them reflect on the importance of the relationship between service users and MHPs, emphasizing its critical role in supporting recovery within mental health centers. They described the relationship as essential for fostering safety, trust and a sense of belonging, which are fundamental elements for healing and personal growth. Here is a perspective from one of the MHPs:

> For me, it remains important that we do not talk about each other, but rather with each other. This kind of communication has already brought about a change in my thinking. (MHP R3)

Service users reported that the training helped them understand the value of peer support in the recovery process. They shared that relationships with others in the training who had faced similar challenges helped reduce feelings of isolation and stigma, while also providing a sense of validation and hope. This shared experience fostered a supportive environment where individuals felt understood and empowered in their recovery journey. Here is a perspective from one of the service users:

> Having someone who truly understands my struggles because they have been there too makes all the difference. To me, peer support is not just encouragement, it is proof that recovery is possible. (Service User R4)

Empowerment. During the training, we explored how service users perceive empowerment in the recovery process. Participants shared that the process involves overcoming personal challenges, healing from past mental health struggles and gaining the strength to bring about positive changes in their lives. A key takeaway was that, with the right support, individuals are able to engage in self-reflection, cultivate resilience and reclaim their sense of agency. This enables them to rebuild confidence and develop the necessary skills to thrive in various aspects of their lives. One of the service users shared her perspective, shedding light on empowerment:

> I find my own path and develop my strategies. Even if someone else may perceive them as pathological or strange, they are exactly right for me. (Service User R4)

The MHPs shared that the training broadened their understanding of how empowerment plays a crucial role in the recovery process. Particularly, the significance of the collaborative effort between service users and their support systems.

In addition, the MHPs underscored that empowerment through education, therapy and fostering autonomy and self-efficacy is vital. These elements, they noted, are intertwined and essential for encouraging individuals to actively participate in their healing journey. This, in turn, helps build their confidence, resilience and ability to thrive as they regain control over their lives. Here is a perspective from one of the MHPs:

> One of the most important aspects I have internalized from this recovery training, which has greatly influenced my work and my life in general, is that everyone has their path. No one has the right to interfere in another's affairs. (MHP R3)

Barriers to recovery. The service users reported that the training helped them reflect on some of the challenges they face during the recovery process, particularly highlighting areas where the service utilization is not fully conducive to their healing.

They described two primary barriers to recovery. The first barrier was the nature of their mental health conditions, which often led to a heavy reliance on medication, leaving limited opportunities to explore other treatment alternatives. The second barrier was systemic issues within mental health services, including strained relationships with staff, fluctuating staff assignments and the inability to effectively address individual needs.

Some service users voiced concerns about the overemphasis on medication as the primary approach to managing difficult days. They reported that other meaningful activities, such as therapy or engaging in personal hobbies, were sometimes overlooked in favor of relying solely on medications. One service user shared this perspective:

> The attitude that those affected are experts in their matters still has not sunk in for many. I have been thinking all this time about how to change that. (Service User R2)

MHPs reported systemic barriers within mental health services that hindered effective care delivery. These included understaffing, which led to high caseloads and staff burnout, as well as rigid policies that imposed bureaucratic restrictions, limiting flexibility in treatment approaches and service delivery. In addition, service users often express mistrust toward

institutions, driven by past negative experiences or systemic discrimination, further complicating efforts to build therapeutic relationships and provide person-centered care. One of the MHPs shared this perspective:

> [. . .] it always sounds so simple, but it is also challenging to endure in our role as mental health staff, especially when you see someone endangering themselves, or when someone stops taking medication [. . .] (MHP R5).

Participants shared that the training helped them reflect on mental health stigma. Service users and MHPs reported that the training broadened their knowledge and altered their attitudes toward stigma. They explained that societal stigma often arises from widespread misconceptions about mental health challenges, leading to feelings of shame and discrimination. These negative perceptions make it harder for individuals to seek support and openly discuss their struggles.

Within the mental health center, some service users also reported feeling stigmatized by the MHPs or other service users, which further impacted their self-esteem and engagement in treatment. One service user shared his experience, shedding light on how stigmatizing attitudes can hinder personal growth:

> The attitude that theoretically learned knowledge is more valuable than personally experienced knowledge is widespread. However, the question remains, how can such an attitude be changed? (Service User R4)

MHPs emphasized the importance of creating inclusive environments, combating stigma through education and promoting empathy and understanding:

> I find it so unreal to judge people. (MHP R3)

Involvement and Coproduction. Both service users and MHPs emphasized the critical need for greater participation and coproduction within mental health centers. Service users particularly highlighted the importance of being actively involved in decision-making about their care plans. They stressed that it was essential for their preferences to be considered and for them to have a voice in the process.

Service users further shared that when they felt heard and respected in their care decisions This not only improved their sense of agency but also contributed to better engagement in their recovery journey. Their involvement in shaping their care plans was seen as a key factor in promoting empowerment and a more holistic approach to mental health. Here is a perspective from one of the service users:

> More involvement of those affected is promoted, and I have now been given the opportunity to have a small part-time job. I also see myself to some extent as an ambassador in this process. (Service User R3)

MHPs also recognized the numerous benefits of co-production in improving treatment outcomes. During the training, they highlighted how collaborative approaches, where service users are actively involved in their care decisions, help foster trust and promote a sense of ownership and empowerment. MHPs emphasized that involving service users in the decision-making process contributes to more effective, person-centered care, which is essential for improving the overall well-being of individuals accessing mental health services. Here is a perspective from one of the MHPs:

> I have changed my language. Previously, I used to say I was 'caring for' the client. Now, I talk about 'accompanying' the client and working together. (MHP R1)

Discussion

This qualitative program evaluation explored the subjective experiences and outcomes of a brief CHIME Framework training program for service users and mental health staff in a mental health center. The findings highlight the reciprocal influence of recovery training on both

groups, offering insight into shared recovery journeys and emphasizing areas of alignment and improvement. Integrated into the CHIME Framework (Connectedness, Hope, Identity, Meaning in Life and Empowerment) (Leamy *et al.*, 2011), these insights underscore the importance of collaborative and recovery-focused approaches to care (Hungerford and Fox, 2013).

Participants emphasized recovery as a deeply personal and dynamic process. For service users, caring and trusting relationships with staff were instrumental in fostering personal growth and confidence, aligning with previous research on the importance of trust, meaningful engagement and collaborative decision-making in recovery (Wood and Alsawy, 2017; Lau and Hutchinson, 2021). Staff members also experienced a personal transformation, reporting a renewed sense of purpose and fulfillment in their work by witnessing service users' resilience and progress.

Service users initially described feelings of disconnection, isolation and a lack of purpose. However, the recovery training facilitated reconnection with themselves, others and their values, helping them rediscover meaning and purpose. Many participants highlighted the role of community and peer support in creating a sense of belonging and validation, which further motivated them toward health and well-being. This experience of connection and meaning highlights recovery as a process of growth and resilience for both staff and service users (Hine *et al.*, 2023; Salkeld *et al.*, 2012; Senneseth *et al.*, 2021).

Positive interpersonal relationships between service users and staff were central to the recovery process. The training enhanced these relationships, fostering stronger partnerships, mutual respect and shared understanding. Staff reported improved skills in supporting service users and creating an empowering environment. These findings echo the work of Salkeld *et al.* (2012), which demonstrated that CHIME Framework training could drive lasting changes in professional identities and working relationships, strengthening collaboration and empathy in mental health settings. In addition, therapeutic relationship between service users and MHPs have consistently been found to be significant for positive outcomes (Martin *et al.*, 2000) across various care settings (Priebe and McCabe, 2008; Salkeld *et al.*, 2012). Service users often report that their relationship with health-care providers is the most important component of care (Johansson and Eklund, 2003), along with their active engagement in the recovery process (Kirsh and Tate, 2006; Dixon *et al.*, 2016).

Empowerment emerged as a key outcome of recovery training. Service users gained self-awareness, confidence and coping strategies, enabling greater autonomy and engagement in their recovery journey. For staff, the training enhanced their capacity to foster an empowering environment through collaborative decision-making and individualized care. By promoting empowerment, the training cultivated a culture where individuals feel valued, supported and motivated to actively participate in their care (Hine *et al.*, 2023; Salkeld *et al.*, 2012).

Despite the positive outcomes, participants identified persistent barriers. Staff reported challenges in implementing recovery-focused approaches due to organizational resistance, limited resources and entrenched practices that prioritize standardization over personalization. Service users faced societal stigma, limited access to community support and relapse triggers, which often perpetuated feelings of helplessness. Communication gaps between staff and service users also hindered progress. Addressing these barriers requires systemic changes, resource allocation and efforts to dismantle rigid practices that impede recovery-focused care (Nakanishi *et al.*, 2021; Senneseth *et al.*, 2021).

Stigma emerged as a significant obstacle for both staff and service users. While service users experienced discrimination in employment, housing and social settings, staff encountered stigma within professional circles, which limited their ability to advocate for recovery-oriented practices. These findings reinforce the need for ongoing education, advocacy and community engagement to challenge societal biases and foster an inclusive culture that promotes acceptance and support (Clarke *et al.*, 2013; Gee *et al.*, 2015; Amsalem *et al.*, 2018).

Enhanced involvement and coproduction were key outcomes of the training. Staff embraced collaborative decision-making, actively integrating service users' perspectives

into care planning and program development. Service users reported feeling empowered and valued through their participation, which strengthened trust and mutual respect. This approach aligns with the CHIME Framework's emphasis on empowerment and connectedness, fostering personalized care and improving satisfaction for both groups. Ultimately, coproduction nurtures a culture of shared responsibility and partnership, enriching the recovery experience in mental health-care centers.

Limitations/strengths of the study

This study is limited by its small sample size and qualitative design, which restricts the generalizability of the findings and highlights their exploratory nature. However, it is one of the few studies to evaluate the experiences and outcomes of CHIME Framework recovery training for both mental health practitioners (MHPs) and service users. While some studies have assessed recovery training experiences and outcomes for MHPs, showing improvements in recovery-oriented knowledge, attitudes and competencies, there remains limited evidence on outcomes at the service user and service levels (Jackson-Blott *et al.*, 2019; Lau and Hutchinson, 2021). A notable strength of this study is the active involvement of service users in the research design and participatory data collection processes, which ensures the inclusion of key stakeholders' perspective.

The findings offer valuable implications for the design and support of mental health centers, contributing to the growing body of research on individual recovery and recovery-oriented practices. Understanding the subjective experiences of service users and MHPs is critical for developing effective care strategies and fostering collaborative, recovery-oriented environments.

Future research should address the limitations of this study by expanding the sample size and enhancing participant diversity, particularly with respect to gender representation, to strengthen the robustness and generalizability of the findings. Moreover, using quantitative and longitudinal research designs is recommended to establish causal relationships between CHIME Framework training and participants' meaningful engagement in mental health practice and recovery processes.

Implications for policy and clinical practice

The practical implications of a study on recovery training for both mental health professionals (MHPs) and service users are both extensive and transformative. This type of training fosters collaboration and cultivates a recovery-focused mindset by promoting mutual understanding, dismantling power imbalances and integrating lived experiences into mental health care practices.

Positive outcomes from such a study could encourage mental health centers to enhance recovery-oriented practices, develop innovative training programs and enact meaningful policy reforms. Moreover, it could lead to a strategic reallocation of resources, prioritizing effective training initiatives and fostering greater participation of service users in their own recovery journeys.

Conclusion

Recent qualitative research explored the experiences and outcomes of CHIME Framework training for both mental health professionals (MHPs) and service users within a mental health center. The findings revealed that recovery-focused training for both groups not only benefits individuals but also fosters a shift toward recovery-oriented organizational practices.

In summary, the study highlights the crucial role of recovery training for MHPs and service users in cultivating a collaborative, recovery-focused approach to mental health care practices.

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Further reading

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