One ring to rule them all: Applications of the CHIME framework of mental health recovery

Robert Hurst*, Lisa Ogilvie, Ije Asike, Andrew Voyce and Jerome Carson

Abstract. Jerome. The CHIME Model has become the dominant model of mental health recovery. The model has been grounded in the lived experience literature of people recovering from mental health problems. Four of the components were first articulated by Australian researchers. These were Hope, Identity, Meaning and Empowerment. English researchers added Connection, thus forming the acronym CHIME. In this paper we show how we have added to this basic model. Robert and Jerome were the first to describe C-CHIME, with the C reflecting Creativity. This was also Jerome's experience in mental health services, that often those people who recovered most, had creative talents, such as photography, artistic skills, filmmaking, or poetry. Lisa and Jerome discovered that a critical element in recovering from addiction was the concept of Growth. For someone to give up an all-consuming addiction, something needs to replace this in their lives. This could be education or developing a new career. Ije found that there were additional critical elements in her recovery from lupus. She felt that Pain, Acceptance, Adaptation and again Growth, were key in addition to the core elements of CHIME. Andrew Voyce briefly describes his own long journey of recovery that took place over a 20-year period. He illustrates how CHIME can be harnessed to explain his own recovery. Finally, we look at how practitioners might apply the CHIME model and its variants in their clinical practice. We note the lack of an assessment that might just guide this process, but which could also serve as an outcome measure.

Keywords: mental health recovery; addiction recovery; lupus; recovery narratives; CHIME framework

Correspondence: R.Hurst@bolton.ac.uk

Date of acceptance: 14th May 2025
Date of first online publication: 6th January 2026

***Robert Hurst** is an Associate Lecturer in the School of Psychology at the University of Greater Manchester. He is a registered person-centered counsellor. Robert's main research interests are creativity, positive psychology, mental health recovery, autoethnography, and bereavement. Orcid: https://orcid.org/0000-0002-0054-6703

Dr Lisa Ogilvie is a visiting research fellow at the University of Greater Manchester, and a qualified counsellor and chartered psychologist working for a drug and alcohol treatment centre. Her specialist area of research and practise is addiction recovery, in particular realising the pluralistic advancement of positive psychology in this field. Lisa is also interested in narrative research, exploring the lived experience of addiction and recovery, to which end she curates a series of addiction recovery stories for the Emerald journal *Advances in Dual Diagnosis*. Orcid: https://orcid.org/0000-0001-7718-052X

Ijeabalum Asike is a PhD student at the University of Greater Manchester. She is a qualified Psychotherapist and has a private practice. Ijeabalum's research is focused on the Lived experience of Black people with Lupus. She also has lupus and is investigating the factors that enable people with lupus to flourish. She has adapted the CHIME framework to include factors such as Pain, Acceptance, Adaptation, and Growth (PAAG). This is called PAAG-CHIME. Orcid: 0009-0003-8200-8136

Dr Andrew Voyce was awarded an Honorary Doctorate in Social Science from the University of Greater Manchester in 2024. He graduated without a degree from Reading University, obtained two Bachelor's degrees from the Open University and has a Master's degree in Social Policy from the University of Brighton. He supports mental health recovery and is an activist through his website AndrewVoyce2.com. He advocates for better mental health awareness through lecturing and Mental Health First Aid and The Langford Centre's Patients Council. He has an interest in autoethnography, alienation and 1960s youth culture, and has published a number of academic articles. His Orcid number is 0000-0001-8705-3161.

Jerome Carson is Professor of Psychology at the University of Greater Manchester. His interest in recovery from mental health problems largely developed in 2006 when he worked for the South London and Maudsley NHS Foundation Trust. While he now works as an academic he retains his interest in recovery and also applications of the CHIME model. Orcid: https://orcid.org/0000-0002-7596-116X

Introduction to the CHIME framework (Robert Hurst)

Few frameworks of mental health recovery can be said to have had an impact comparable to that of the CHIME framework in the last decade. Connectedness, Hope and optimism, Identity, Meaning in life, and Empowerment are the five factors which make up CHIME. This article seeks to outline CHIME to readers, before exploring recent additional factors that have been considered by researchers as possible expansions to the framework. Lived experience is shared, to try and illustrate the real-life validity of CHIME, before discussing potential future directions.

At the turn of the 21st century, Positive Psychology emerged as a significant new strand of the discipline of Psychology (Seligman and Csikszentmihalyi, 2000), as scholars considered whether it was time to focus on human strengths and wellbeing rather than deficit and suffering. It was in this climate that the recovery movement, where practice was to be better-informed by service user input, was coming to the fore (Davidson, 2016). Decisions by commissioners and sweeping changes across mental health care services made it clear that the biomedical model was no longer in vogue – the recovery movement was here to stay (Thornton and Lucas, 2011). Indeed, it is now something recommended internationally by the World Health Organization (WHO, 2021).

Research trends indicate that academia is following suit, and it was from this milieu of work into recovery that CHIME emerged. Leamy et al. (2011) conducted a systematic review of models and conceptualisations of personal mental health recovery (Davidson and Roe, 2007). Building on the work of Andresen et al. (2003), the team synthesised 97 research papers, identifying the five factors that make up the CHIME framework as being key recovery processes. They suggested that it is these processes that support positive recovery, that services and practitioners should strive to ensure that their care covers these five factors.

Connectedness in recovery could refer to being part of a community, relationships, support from other, and peer/support groups. **Hope and optimism** may include belief in the possibility of change, positive thinking and valuing success, having dreams and aspirations, and being motivated to change. The dimension of **identity** in this framework pertains to rebuilding or redefining a positive sense of identity after mental health difficulties, and overcoming any associated stigma. **Meaning in life** refers to finding meaning in mental health experiences, having meaningful social roles and goals, rebuilding life, finding an acceptable quality of life, and having a sense of spirituality. Finally, the **empowerment** dimension involves a sense of control over life, a focus on strengths, and appropriate personal responsibility.

CHIME is a conceptual framework (Hare-Duke et al., 2023), in that unlike a linear stage model or collection of assorted ideas, the five factors form an interlinked network that together provide an understanding of a phenomena (Jabareen, 2009), in this case, personal mental health recovery. It was designed to be accessible to non-academic publications and across disciplines (Hare-Duke et al., 2023), which

may have played a part in the success of the framework. The original paper alone has almost 3,500 citations as of March 2025. But researchers found themselves asking 'Is this enough?'. Are there blind spots in the framework, dimensions to recovery that are not covered by the five processes? Can CHIME be applied to other recovery processes away from the broad domain of personal mental health recovery?

In the remainder of this paper, three researchers (Robert Hurst, Lisa Ogilvie and Ije Asike) will detail their own recent adaptations of the CHIME framework, before Andrew Voyce reviews it directly against his lived experiences of mental health recovery. Finally, CHIME and recent additions to the framework are discussed, with future directions considered.

C-CHIME (Robert Hurst)

My introduction to the CHIME framework came from Professor Jerome Carson. It was the height of lockdown, and we found ourselves looking for something to write. Jerome proposed that we look at *Remarkable Lives*, a series of first-hand narrative accounts that he had been curating for almost a decade (e.g., McManus and Carson, 2019), through the lens of the CHIME framework. Little did we know where this work would lead us.

There were 36 *Remarkable Lives* papers published at this point, each one written by somebody who had been on a mental health recovery journey. These were all people with whom Jerome had crossed paths, including as Professor of Psychology. Therefore, to aid the analysis the papers were split into two groups, students, and non-students.

We first examined each of the student accounts. Initial reads were looking to map these accounts onto the five recovery processes of the CHIME framework. However, we were also reading for any inductive themes that came from the text. After this work was published (Hurst and Carson, 2021), we began working on the non-student accounts (Hurst et al., 2022). Across both papers, we found that of the 36 mental health recovery accounts, all five CHIME processes could be mapped onto 35 of them. The account that did not fully map onto CHIME mapped onto four out of five of the dimensions. To us, this indicated that CHIME was indeed a valid way to examine the recovery journey that people embark upon with their mental health. However, amongst the inductive findings that arose from the text along the way was creativity.

Creativity has been defined in various ways throughout the course of history, by various fields (Ford and Harris, 1992). Often, definitions focus on the importance of the creative output having value (Andreasen, 2006) or originality (Treffert, 1989), placing the decision on whether something is creative in the hands of cultural gatekeepers and experts rather than grounding it in the mind of the individual.

Psychology has not been immune to this seemingly sociological definition, with Csikszentmihalyi (1997) suggesting that a person whose work is not recognised within their lifetime would only become creative many years after their death when their output is recognised as noteworthy. The absurdity of this has been critiqued (Weisberg, 2015), with a suggestion that some scholars become distracted by what is created, rather than the internal psychological process of creativity (Walia, 2019).

Historically, when examining creativity and mental health, much research has fallen into the trap of studying the 'mad genius' hypothesis (Pickover, 1998). This is ultimately a 'chicken and egg' scenario where anachronistic 'diagnoses' are applied to long-dead historical figures such as Vincent van Gogh (Nettle, 2001), who have no right of reply. Fortunately, more and more in recent years scholars have turned to attempting to understand the ways that creativity can improve psychological wellbeing. Indeed, there is generally found to be a significant correlation between positive affect and creativity (Amabile et al., 2005). That was the direction that we decided to take after finding that each of the 36 first-hand account of the recovery narratives that we examined had some element of creativity present. We posited that perhaps creativity was a forgotten factor in recovery and argued that the CHIME framework may need to be expanded to C-CHIME to incorporate creativity (Carson and Hurst, 2021).

To begin investigating the link between mental health recovery and creativity, we turned to interpretative phenomenological analysis (IPA), as we felt that this would allow us to utilise authentic lived experience (Smith, 2017) in a bottom-up approach to generating knowledge (Reid et al., 2005), in line with CHIME origins as a conceptual framework trying to be in touch with the phenomena of mental health recovery. Five participants were recruited using purposive sampling, to ensure that they would be able to contribute relevant and rich data (Smith and Osborn, 2003). While the study was not one aiming to establish cause-and-effect or evaluate correlations, the analysis of the interviews brought out three themes: Creativity as an **internal process** that is instinctive, engaging and cathartic, which can aid with **sense-making** of chaotic experiences, allowing meaning to be imbued in creations and found in the creations of others, with **social** implications such as pressures, contextual conditions and the possibility of escapism from surroundings into creativity.

While this was the main finding of the work, we also looked to attempt to map creativity onto the conceptual framework of CHIME, arguing that it cannot be subsumed within one of the five existing recovery processes, and that it interacts with each of these.

A person may find that they improve their **connectedness** by sharing their creative works, or discussing creations that they enjoy with other (music, books, etc.).

One might use creativity as a mode of fostering a positive mindset within their recovery, of generation **hope and optimism for the future**.

Creativity is a way by which people might express their **identity**, it can allow

them to tell their story of who they are on their own terms (very much in line with the philosophy of personal recovery).

Somebody on a recovery journey may find **meaning in life** from creating something, or from immersing themselves and deepening their understanding of self through creative works.

Finally, the act of being creative can bring a sense of control, and leave a person feeling a sense of **empowerment**, that they might influence the world around them, and in catharsis discover creativity as a tool by which they can proactively alter the course of their recovery journey.

This piece of research ultimately led to the publication of a book (Hurst et al., 2024), co-authored by me, Andrew Voyce (who you will hear from shortly), and Professor Jerome Carson. In it, we outline a working psychological definition of creativity, which we hope will aid readers in understanding how this often-ephemeral concept might tangibly play a role in the lives of people on a mental health recovery journey. While a further evidence base is needed, we also state the case for the addition of creativity to CHIME to form C-CHIME. From our research, it seems clear to us. People use creativity in all kinds of ways throughout their everyday life, and when harnessed, it can be a powerful tool for good, it can save lives. As such, we aim to try to give the 'forgotten factor' of recovery a platform.

The G-CHIME Model (Lisa Ogilvie)

In recognising the need to adapt the CHIME model for individuals in addiction recovery, the following question arose, 'Why did the components of the existing model fail to adequately address the needs of this population?' Previous research helped provide the answer to this, when it was proposed that some of the difficulties experienced by people in recovery from substance use disorder (SUD) could be understood in the context of their difficult life experiences and expressed as a need to further advance one or more of the components of CHIME (Dekkers et al., 2020). Given that recovery-oriented systems focus on strength and ability, not deficit, by extension this led to the conceptualisation of G-CHIME, where a component for growth was introduced. In effect, reframing difficulty as an opportunity for development. Further supporting this, when addiction is regarded as a traumatic experience, the meaningful role that post traumatic growth can have in the transition from addiction to recovery, and protracted recovery, thereafter, stresses the potential utility of growth as a distinct component within the model (Ogilvie and Carson, 2022a).

Before operationalising G-CHIME, each of its dimensions were theoretically evaluated 'a priori' using apposite works on addiction recovery, not just more generalised mental health recovery (Ogilvie and Carson, 2023a). This not only upheld

the position of the original five dimensions in the model but also emphasised the theoretical synergy with addiction recovery and second wave positive psychology, a psychological discipline that acknowledges overcoming adverse experiences and managing negative emotions, as fundamental to growth and wellbeing (Ivtzan et al., 2015). Carried on by what was read as a persuasive theoretical basis (Ogilvie and Carson, 2025), the G-CHIME model became the focus of a number of research projects in order to garner evidence for its validity in explaining the dimensions of a successful addiction recovery (Ogilvie and Carson, 2025).

Researching addiction recovery, and thus G-CHIME, meant studying a singularity that is person-driven, subjective, and can be achieved via many pathways (SAMHSA, 2012). It is understandable therefore that addiction recovery as an area of study has been criticised for being overly general and becoming meaningless when too many factors that contribute to it are considered (Davidson et al., 2021). An added complication is that recovery extends beyond the individual and distinct outcome, making some aspects difficult to report, observe, and measure empirically, for example evaluating the effect of support groups and external relationships, or understanding how finding meaning through experience has impacted recovery in different individuals. For these reasons, van Weeghel *et al.* (2019) recommended that a mixed methods research approach using both quantitative and qualitative methods be used to track progress and allow for a richer source of data to evaluate both process and outcome. This was deemed appropriate for G-CHIME, firstly to demonstrate how its components were evident in recovery narratives, and secondly to show that interventions directed at the same components were able to affect wellbeing, recovery capital and flourishing.

The qualitative branch of the G-CHIME research adopted a narrative analytical methodology using first-hand accounts of addiction recovery. Thus far 21 studies have been conducted, each using the same methodology and taking G-CHIME to be the connecting theory. In these studies, the participants ages ranged from 19 to 70, included a mix of males and females, and as a group were representative of an internationally diverse population, where the participants were known to reside or be born in one of seven different countries (Ogilvie and Carson, 2023a). As a collected work, this allowed for conclusions to be drawn such that addiction recovery is a ubiquitous process which is explainable by the G-CHIME model. The quantitative aspect of the study was concerned with outcome and saw a programme of work known as positive addiction recovery therapy (PART) developed and delivered to 30 participants in a pilot study (Ogilvie and Carson, 2022b), and then a further 35 in a replication and follow-up study (Ogilvie and Carson, 2023c). The PART programme delivered a series of workshops which included interventions targeted at developing the components of G-CHIME in those participating. Validated measures for recovery capital, wellbeing and flourishing were used pre and post programme delivery to assess the participants' recovery outcomes. The results showed statistically significant improvements in all measures in the pilot, which was then substantiated

as transferable to another group in the replication and follow-up study. In deciding to adopt this mixed methods approach, evidence of the efficacy of the G-CHIME in addiction recovery has been demonstrated against recovery as a process and by factors that contribute to it as a measurable outcome.

As mentioned, the G-CHIME model captures components important to a successful addiction recovery. However, it is self-restricting to assume that this cannot be enhanced to further improve recovery outcomes. In fact, to not do so would oppose the ideology of the nascent third wave positive psychology, where progressive research is not limited to existing concepts and previously adopted procedures (van Zyl and Salanova, 2021). Consequently, it was considered important that interventions based on ancillary theory that could be advantageous to the success of addiction recovery but do not represent an independent component, could be accommodated within the model. To give an example, positive psychology's values in action (VIA) character strengths model (VIA Institute on Character, 2025) was incorporated into the PART programme, where separate research provided evidence that the use of this model was of benefit to people in addiction recovery (Ogilvie, 2022a; Ogilvie and Carson, 2023b). Such theoretical expansion falls under what has been defined as G-CHIME+, the G-CHIME model with intervention flexibility that can strengthen recovery to aid long-term outcomes by including a fast track for complimentary intervention integration.

PAAG-CHIME (Ije Asike)

The PAAG-CHIME model was inspired by an autoethnographic account of my lived experience with lupus. My narrative used self-reflection and literature to analyse my journey with lupus. This journey illustrated my struggles and my path to recovery and coping with the condition. The acronym PAAG, which means Pain, Acceptance, Adaptation and Growth, was added to the CHIME framework to explain a possible path to recovery from lupus. Recovery, in this case, does not mean the absence of disease. It means the possibility of living and thriving despite the disease. Moreover, recovery is both a process and a journey. The person deciding to make the trip starts from an unpleasant place of brokenness and pain. The pain of lupus goes beyond the physical pain you get on your skin but goes into the psyche because the pain depicts grief, loss, and trauma. In this section of this paper, I will reflect on the prospective development of the PAAG-CHIME model in the recovery process of a lupus sufferer.

Lupus is characterised by the excessive production of antibodies, complex immune dispositions and heterogenous clinical manifestations that can lead to death (Deng et al., 2013; Lucas, 2021; Rees et al., 2016). Whilst people can be genetically predisposed to lupus, environmental, sociodemographic and sociocultural factors can contribute to the development of the disease (Borchers et al., 2010). Likewise,

women of childbearing age (15-44 years) are more affected than men (Fav and Petri, 2019; Petri, 2002; Yen and Singh, 2018). The ethnic disparity shows that women from Black, Asian, and Hispanic ethnicities tend to develop severe manifestations with a higher mortality rate compared to their White counterparts (Dall'Era et al., 2017; Fava and Petri, 2019; Izmirly et al., 2021; Rees et al., 2016; Sun et al., 2021; Ugarte-Gil et al., 2022; Yen and Singh, 2018).

However, despite the evident ethnic disparity in severity and symptomatic experience, pain is a common theme that cuts through the lupus lived experience (Pisetsky et al., 2021). Several studies have linked pain in lupus with musculoskeletal pain, characterized by joint tenderness, stiffness and swelling (Franco et al., 2014; Hochberg, 1997; Petri et al., 2012). The pain engulfs the individual not just from a physiological perspective but psychologically. On my bad days, I have experienced '*pain from the crown of my head to the sole of my feet*' (Asike, 2024). This also includes the mental and emotional distress that accompanies the disease's complexities. Life never remains the same. A strong and independent adult becomes hopelessly dependent. Studies with narrative accounts have described participants' experience with pains not just from symptoms, and side effects from treatment but also from social misunderstanding due to the invisible nature or unpredictability of the illness (Case et al., 2021; Colmenares-Roa et al., 2023; Hale et al., 2015).

Larsen et al. (2018) described the unpredictable nature and impact of lupus as an '*existential rearrangement of life*'. It disrupts what one perceives as their life path. It feels like a pause or stop to the motion called life, which is confusing and overwhelming for the person. It comes with a great sense of loss that the body is incapable of completing basic daily tasks. In most cases, people tend to grieve the life they used to have before lupus (Bea, 2022; Dunkin, 2023). Energy dies, and what is left is pain and fatigue. I always felt like a young soul trapped in an old person's body. It embodies the emotional struggles of grief. At the start, I had a sense of denial: 'Nothing is wrong with me, I can beat this'. Then I was angry when I discovered I could not beat this like the normal flu. Nonetheless, I realised that to survive, I needed to concede defeat and accept the disease.

Accepting is always tough because it comes with many struggles and requires letting go. The existential consequences of living with lupus, like most chronic diseases, are sudden and enormous. Therefore, the acceptance process should be slow and accompanied by empathy and compassion. One needs to succumb to weakness to gradually build strength. Angel and Halling (2023) describe acceptance as a *'place that one arrives and not something one can make happen'*. In accepting the new version of self, one can see the possibilities of this new self. It enables mindfulness, to be present and not wrapped up in the past or terrified by future uncertainties. I accept the good days and the bad days. I had to adapt my life to the condition. This meant accepting the use of walking aids, home adaptation, specific utensils, avoiding the sun and using sun cream irrespective of ethnic background, and adherence to medical treatments (Asike, 2024).

Furthermore, adaptation requires letting go of the stigma of being labelled disabled. One needs to adapt to the change they experience in their body and befriend this new body and life to cope. However, some exceed the level of coping to growth and thriving. That does not mean the struggles of the disease are over. It just means that pain and suffering may have redefined a path of purpose and meaning. The process of pain, acceptance and adaptation enabled a shift from '*What I cannot do to what I can do*' (Asike, 2024; Avvenuti et al., 2016). A path of rediscovery that was paved by uncomfortable and continuously painful circumstances. Growth is a path never envisioned when pain and suffering are proceeding. My autoethnographic narrations highlighted the role of faith, resilience, hope, optimism, and posttraumatic growth in the path to recovery (Asike, 2024).

This ties in with the elements of CHIME as it reflected a sense of connection to family (son and mother) and church community, reducing isolation. Faith, infused hope, and optimism to envision a productive life that enables family sustainability and career progress. A sense of identity and not being defined by the constraints of lupus. I can find meaning in the little perks of life, such as spending time with family and not in the hospital. This process has enabled a deeper reflection on life, which has led to a sense of gratitude, meaning, and purpose. A journey that started in pain has become empowering by creating a career path in counselling and enabling research and prospective development of the PAAG-CHIME model as a recovery process for people with lupus and other chronic illnesses.

A lived experience perspective on how the CHIME framework worked for me (Andrew Voyce)

Recovery in my mental health journey has happened to me at two major points in my life. The first recovery journey lasted about five years at a time when contemporary recovery practice was unknown. The second, and continuing, journey has lasted thirty-four years as 2025 begins.

A key element of my recovery is that antipsychotic medication has worked for me. It does not have a therapeutic effect for everyone who has, like me, a psychotic condition. However, the five-year recovery in the early 1980's meant that along with the antipsychotic effect of medication by injection in the buttock, there was a side effect of extreme sedation. So, as multiple times previously with this arrangement, as soon as I could escape supervision to have the medication, I did so, with the result of a relapse into psychosis, homelessness, and criminality. My present recovery journey has lasted so long because I am compliant with medication by tablet, which has acceptable side-effects, and which enables me to lead a financially independent lifestyle through employment into my 70's. This has meant no inpatient time, no arrests, and no periods of homelessness. Some of this experience is documented in

'Side Effects' and 'The Durham Light,' e-books on my website (Voyce, n.d.).

However much suitable medication has enabled my recovery journey, that alone would probably not be enough to sustain me. I have built a life as is suggested by Repper and Perkins (2003), who state that recovery is not a cure. Anthony (1993) concurs, that recovery from mental illness is possible even if symptoms are not 'cured'. My symptoms are managed, I take medication, and I have maintained a recovery journey.

What I make of life with controlled symptoms is echoed in the model of recovery in CHIME from the Scottish Recovery Network (n.d.). I relate to **Connection** in that I meet others through my work life, my academic life, in the social housing scheme where I live, and I even count the relations I have with shop staff where I buy my essentials. I may have a lot of screen time in my work activities, but this is often to have a positive collaboration or two-way process when delivering a talk or lecture, and this I value. Along with many others with a severe mental health condition, I have experienced estrangement and stigma in my family relations. However, part of my recovery is the re-building of connections I had with family members. Although I have lost all my parents' generation, I have been able to have meaningful conversations to reconcile the past to some extent. With my generation I have regular contact with cousins online and for special events, this is most heartening, and I find acceptance, non-judgemental dialogue, and invitations to partake socially. I am delighted to be in touch with my niece in Australia. Probably the most important therapeutic connection I have is with my counsellor. My thirty-four-year current recovery journey has been accompanied by regular counselling, as recommended by documents such as from the Department of Health (2011). I began counselling at the time of the Health of the Nation programme of John Major's government in 1992, and it is a regular connection where I can discuss and broach an overview of my activities. It is an invaluable space where I can offload concerns when I have nowhere else to discuss issues. It is confidential and I am happy with my counsellor's credentials. It is part of my wellbeing regime.

I have **Hope** and optimism. Not so much for specific goals, as to be a way of life. The longer my recovery journey continues, the stronger is my belief that it will carry on, which is a source of hope. As my familiarity with tasks and my acceptance at work and scholarly activities goes on, so my confidence is maintained. I am optimistic that I can take on tasks that require a degree of familiarity and competence.

Identity for me is a key to recovery, beyond the stability that therapeutic medication and talking therapies bring. Identity beyond that of mental patient, vagrant, and petty criminal. I have been able to handle challenges which in previous times would have led me to psychosis, homelessness, and associated brushes with the law. Although there are still many situations where I am best with people who have a knowledge of mental health, old-fashioned attitudes to mental illness prevail to 'other' or exclude someone different. So, I am happy to be able to have a different conversation to build on, as someone not defined by mental health issues. There are

increasingly times when I can be open as well, with diminishing stigma in mass media and increasing acknowledgement of the difficulties many have in common, with their challenges.

I have to say that much of what I have built up gives me a **Meaningful life**. I now have experience as a peer support worker, where my lived experience has enabled me to share the journeys of others who find themselves in the mental health system. Perhaps one of the most personally meaningful activities I complete, is to make books of other people's narratives. This can be especially impactful when making a print book has coincided with a step-down in security or a discharge from inpatient care.

I do feel **Empowered** to know that I have come from places of extreme jeopardy and have achieved an honorary Doctorate in Social Science. I look to the future and learn from experience. It has been especially empowering, therapeutic, and cathartic, to write my own personal narrative and to recognise former false beliefs as just that, false beliefs. I can select the issues which are important for me, where I need to have a voice.

Discussion (Robert Hurst)

Thus far this paper has introduced readers to the CHIME framework, examined three proposed extensions from three different areas of recovery (mental health, addiction, and lupus), and finally grounded how the framework can be applied to a person's lived experience, in Andrew Voyce's own words. This final section will seek to explore further impacts and implications of CHIME, and ask the question, where next?

Firstly, it is important to look at the real-world application of this conceptual framework. The most significant attempt to apply CHIME was a staff intervention called 'REFOCUS'. The aim of this was to educate staff on CHIME as five recovery processes, which they could keep in mind during their practice in mental health services (Slade et al., 2015b). Users of these services qualitatively reported experiencing benefits after REFOCUS had been delivered to staff, and staff displayed a higher level of recovery-oriented behaviour (Slade et al., 2015a). However, quantitative metrics for the initial study showed no significant difference between pre- and post-intervention recovery measures. A follow-up study in Australia, which saw adjustments made on the initial REFOCUS programme to be locally relevant, found a significant but small quantitative improvement in service users' recovery measures (Meadows et al., 2019). The use of CHIME as a tool for mental health professionals was also examined by Piat et al. (2017), who used the framework as a conversation starter to highlight to staff how these processes that may not be obvious could in fact be important to service users.

As Lisa Ogilvie discussed above, her work on the G-CHIME adaptation led to

the development of a therapeutic intervention, Positive Addiction Recovery Therapy (Ogilvie and Carson, 2022). This demonstrates clearly how the principles of the CHIME framework can be applied in a direct therapeutic intervention, in this case with addiction recovery. This raises a question. Why has something similar not developed to work with individuals on a mental health recovery journey? This is a major drawback for all of CHIME's influence and near-omnipresence in recovery literature, there is yet to develop a method of directly applying the theories and the five processes with service users.

Lisa and Ije's work also calls into question the focus of CHIME as purely mental health recovery based. Is CHIME rather a broad-spectrum framework of recovery, that can be enhanced with refinements to accommodate the needs of particular groups, especially marginalised or complex ones? Could CHIME be a base upon which to build, or is it transdiagnostic (Lases et al., 2024). Lisa and Ije are not alone in raising these questions, with Jagfield et al. (2021) extending CHIME to be a better fit with service users who have a diagnosis of bipolar disorder – their POETIC framework adds tensions as a part of the recovery process. This approach to intersectionality and marginalised groups is in line with the nascent Third Wave of Positive Psychology (Lomas et al., 2021), while POETIC's focus on tensions alongside more positive factors in recovery embodies Paul Wong's Positive Psychology 2.0 (Wong, 2011).

While no measure has been directly developed using the CHIME framework, Penas et al. (2020) mapped a section of the existing Recovery Enhancing Environment (REE) measure onto the CHIME recovery processes. Using input from recovery experts, this work suggests that the REE Scale can be used to gather a personal recovery index, based on the five recovery processes of CHIME. This vastly expands the potential for quantitative CHIME research, with researchers having at their disposal a single 24-item measure to investigate elements of or interactions with CHIME, rather than needing to source measures for each of the five processes, or create a brand-new measure from scratch. This could aid in investigating a further key question around CHIME – is it 'proven'?

With the initial work being based on systematic reviews, or being top-down, there is perhaps a need for CHIME to return to service users and try to ground the understanding of the five dimensions in lived experience. A mixture of qualitative and quantitative methods could be deployed to further strengthen evidence bases, and ensure that over a decade on from its inception, the model is still fully relevant to those on a recovery journey. The cultural contextuality of CHIME could also be further investigated. While some researchers posit that CHIME is applicable across cultures (Hare-Duke et al., 2023), others suggest that the framework requires adaptation for use depending on cultural context and populations of use (van Weeghel et al., 2019). While CHIME was developed from the beginning with the intent of being relevant to a diverse range of cultures (Leamy et al., 2011), and it has been found to be reliable in both Anglophone (Slade et al., 2012) and non-Anglophone countries

(Apostolopoulou et al., 2020), the question still remains of how cross-cultural and universal it is. If CHIME were entirely universal, where is the CHIME intervention? Brijnath (2015) found that the five CHIME dimensions were interpreted differently by people from different cultures. Is this a strength of the framework (in that each dimension can be adapted by the individual to suit their meaning), or a limitation?

Ultimately, further work is needed across the board to keep furthering the relevance and applicability of CHIME. What other forms of recovery could this framework be utilised in understanding? How could CHIME be applied to people on recovery journeys, how can the theory be efficiently put into practice? Regarding the work of Robert, Lisa and Ije, can each of these CHIME extensions be further validated? What lies next for these models, and how relevant are they to those in recovery? These are all questions that demand answers. By bringing together a range of research into CHIME, we hope to leave readers interested to learn more for themselves, and to potentially aid us in contributing to this knowledge. CHIME has proven itself to be a relatable concept to many people on a recovery journey. It has also shown itself to be favoured by researchers. Yet, it is not perfect. We are only at the beginning. More is still to come!

Conclusions (Jerome Carson)

The CHIME model has established itself as the dominant model in the field of mental health recovery. In this paper we explained how our own research had led to us developing C-CHIME for mental health, incorporating creativity. Research with people in addiction recovery led us to proposing the G-CHIME variation, where 'G' represented growth, which we feel is essential if people are to move beyond their lives in addiction. A more complex variation of CHIME was needed to appreciate recovery from lupus. This model, PAAG-CHIME, looked at pain, acceptance, adaptation, and growth. This last model is still in need of empirical validation. Research to establish this is currently underway. Andrew Voyce then described how the CHIME model applied to his own mental health recovery, offering his own personal testimony. Social workers and their students will find CHIME and its variants to be helpful in their client work. They can also apply the model to their own working lives. If we consider the basic CHIME model, Connection is vital in terms of work with supervisors and clients. Connections with clients can be the most rewarding, though line management and peer support are also critical. Hope is a much under-valued aspect of the role. Often the social worker must encourage hope in their clients, whose lives may have led them to lose hope. Developing the Identity of being a social worker is part of the socialisation process for students. You become a social worker, a profession with responsibilities enshrined in law and despite much media criticism, especially around the 'minefield' of childcare, it remains a highly valued

profession. The work of social workers brings them into contact with some of the most disadvantaged groups in our society. This is work imbued with Meaning. Finally, as social workers develop their skills sets and experience, they become Empowered. The CHIME model and its variants do indeed have much to offer social work.

References

Amabile, T. M., Barsade, S. G., Mueller, J. S. and Staw, B. M. (2005) Affect and creativity at work. *Administrative Science Quarterly*, 50, 3, 367-403.

Andreasen, N. C. (2006) *The creative brain: The science of genius*. Plume.

Andresen, R., Oades, L. and Caputi, P. (2003) The experience of recovery from schizophrenia: Towards an empirically validated stage model. *Australian & New Zealand Journal of Psychiatry*, 37, 5, 586-594.

Angel, S., and Halling, S. (2024) Uses and abuses of the concept of acceptance in rehabilitation and recovery. *The Humanistic Psychologist*, *52,* 4, 341–352. https://doi.org/10.1037/hum0000341

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

Apostolopoulou, A., Stylianidis, S., Issari, P., Chondros, P., Alexiadou, A., Belekou, P., Giannou, C., Karali, K., Foi, V., and Tzaferou, F. (2020) Experiences of recovery in EPAPSY's community residential facilities and the five CHIME concepts: A qualitative inquiry. *Frontiers in Psychiatry*, 11, 24.

Asike, I. (2024) The shackles of lupus, and the redefining path of faith and positive psychology. In, A. Grant and J. Carson (Eds.), *Autoethnographies in Psychology and Mental Health*. Routledge.

Avvenuti, G., Baiardini, I., and Giardini, A. (2016) Optimism's explicative role for chronic diseases. *Frontiers in Psychology*, 7, 295. https://doi.org/10.3389/fpsyg.2016.00295

Bea, M. (2022) *How it Feels to Experience the Grief of Losing the Old You*. Lupus.Net. https://lupus.net/living/grief-old-self

Borchers, A. T., Naguwa, S. M., Shoenfeld, Y., and Gershwin, M. E. (2010) The geoepidemiology of systemic lupus erythematosus. *Autoimmunity Reviews*, *9,* 5, A277–A287. https://doi.org/10.1016/j.autrev.2009.12.008

Brijnath, B. (2015) Applying the CHIME recovery framework in two culturally diverse Australian communities: Qualitative results. *International Journal of Social Psychiatry*, *61,* 7, 660-667.

Carson, J. and Hurst, R. (2021) Mental health nursing and recovery: The C-CHIME model. *British Journal of Mental Health Nursing*, 10, 2, 1-3.

Case, S., Sinnette, C., Phillip, C., Grosgogeat, C., Costenbader, K. H., Leatherwood, C., Feldman, C. H., and Son, M. B. (2021) Patient experiences and strategies for coping with SLE: A qualitative study. *Lupus*, *30,* 9, 1405–1414. https://doi.org/10.1177/09612033211016097

Colmenares-Roa, T., Gastelum-Strozzi, A., Crosley, E., Fuentes-Silva, Y., Reategui-Sokolova, C., Elera-Fitzcarrald, C., Ibañez, S., Cairoli, E., Pons-Estel, B. A., Drenkard, C., and Peláez-Ballestas, I. (2023) Digital narratives of living with lupus: Lived experiences and meanings for Latin American and Latino patients and their families. *Arthritis Care & Research*, *75,* 3, 540–549. https://doi.org/10.1002/acr.24870

Csikszentmihalyi, M. (1997) *Creativity: The Psychology of Discovery and Invention*. Harper Collins.

Dall'Era, M., Cisternas, M. G., Snipes, K., Herrinton, L. J., Gordon, C., and Helmick, C. G. (2017). The incidence and prevalence of systemic lupus erythematosus in San Francisco County, California: The California Lupus Surveillance Project. *Arthritis & Rheumatology*, *69,* 10, 1996–2005. https://doi.org/10.1002/art.40191

Davidson, L. and Roe, D. (2007) Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16, 459–470.

Davidson, L., Rowe, M., Bellamy, C., and Delphin-Rittmon, M. (2021) Recovery-oriented systems of care: A perspective on the past, present, and future. *Alcohol Research: Current Reviews, 41,* 1, DOI: 10.35946/arcr.v41.1.09.

Davidson, L. (2016) The recovery movement: Implications for mental health care and enabling people to participate fully in life. *Health Affairs*, 35, 6, 1091-1097.

Department of Health (2011) *Talking Therapies: A Four-year Plan of Action* available at: https://assets.publishing.service.gov.uk/media/5a7cdd6fed915d7c849adb5d/dh_123985.pdf accessed 22.12.24

Dekkers, A., Vos, S., and Vanderplasschen, W. (2020) Personal recovery depends on NA unity: An exploratory study on recovery-supportive elements in Narcotics Anonymous Flanders. *Substance Abuse Treatment, Prevention, and Policy, 15,* 1, 53.

Deng, Y., Hahn, B. H., and Tsao, B. P. (2013) Systemic lupus erythematosus. In, D. Rimoin, R. Pyeritz, & B. Korf (Eds.), *Emery and Rimoin's Principles and Practice of Medical Genetics (Sixth Edition)* (pp. 1–22). Academic Press. https://doi.org/10.1016/B978-0-12-383834-6.00081-1

Dunkin, M. A. (2023) *Lupus and Mental Health Concerns*. WebMD. https://www.webmd.com/lupus/psychosocial-aspects-lupus

Fava, A., and Petri, M. (2019) Systemic lupus erythematosus: Diagnosis and clinical management. *Journal of Autoimmunity*, *96*, 1–13. https://doi.org/10.1016/j.jaut.2018.11.001

Ford, D. Y. and Harris, J. J. (1992) The elusive definition of creativity. *The Journal of Creative Behavior*, 26, 3, 186–198.

Franco, M. D., Guzzo, M. P., Spinelli, F. R., Atzeni, F., Sarzi-Puttini, P., Conti, F., and Iannuccelli, C. (2014) Pain and systemic lupus erythematosus. *Reumatismo*, *66*(1), Article 1. https://doi.org/10.4081/reumatismo.2014.762

Hale, E. D., Radvanski, D. C., and Hassett, A. L. (2015). The man-in-the-moon face: A qualitative study of body image, self-image and medication use in systemic lupus erythematosus: Table 1. *Rheumatology*, *54*(7), 1220–1225. https://doi.org/10.1093/rheumatology/keu448

Hare-Duke, L., Charles, A., Slade, M., Rennick-Egglestone, S., Dys, A. and Bijdevaate, D.

(2023) Systematic review and citation content analysis of the CHIME framework for mental health recovery processes: Recommendations for developing influential conceptual frameworks. *Journal of Recovery in Mental Health*, 6, 1, 38.

Hochberg, M. C. (1997) Updating the American College of Rheumatology revised criteria for the classification of systemic lupus erythematosus. *Arthritis & Rheumatism*, *40*(9), 1725–1725. https://doi.org/10.1002/art.1780400928

Hurst, R. & Carson, J. (2021) For whom the bell CHIMEs: A synthesis of remarkable student lives. *Mental Health and Social Inclusion*, 25, 2, 195-207.

Hurst, R., Carson, J., Shahama, A., Kay, H., Nabb, C. and Prescott, J. (2022) Remarkable recoveries: An interpretation of recovery narratives using the CHIME model. *Mental Health and Social Inclusion*, 26, 2, 175-190.

Hurst, R., Voyce, A., & Carson, J. (2024). *Creative Mental Health Recovery: An Approach to Healing*. Routledge.

Ivtzan, I., Lomas, T., Hefferon, K., and Worth, P. (2015). *Second Wave Positive Psychology: Embracing the Dark Side of Life*. Abingdon: Routledge.

Izmirly, P. M., Parton, H., Wang, L., McCune, W. J., Lim, S. S., Drenkard, C., Ferucci, E. D., Dall'Era, M., Gordon, C., Helmick, C. G., and Somers, E. C. (2021). Prevalence of systemic lupus erythematosus in the United States: Estimates from a meta-analysis of the Centers for Disease Control and Prevention National Lupus Registries. *Arthritis & Rheumatology*, *73,* 6, 991–996. https://doi.org/10.1002/art.41632

Jabareen, Y. (2009) Building a conceptual framework: Philosophy, definitions, and procedure. *International Journal of Qualitative Methods*, 8, 4, 49-62.

Jagfeld, G., Lobban, F., Marshall, P. and Jones, S. H. (2021) Personal recovery in bipolar disorder: Systematic review and 'best fit' framework synthesis of qualitative evidence–a POETIC adaptation of CHIME. *Journal of Affective Disorders*, 292, 375-385.

Larsen, J. L., Hall, E. O. C., Jacobsen, S., and Birkelund, R. (2018) The existential experience of everyday life with systemic lupus erythematosus. *Journal of Advanced Nursing*, *74,* 5, 1170–1179. https://doi.org/10.1111/jan.13525

Lases, M. N., Bruins, J., Scheepers, F. E., Van Sambeek, N., Ng, F., Rennick-Egglestone, S. ... and Castelein, S. (2024) Is personal recovery a transdiagnostic concept? Testing the fit of the CHIME framework using narrative experiences. *Journal of Mental Health*, online, 1-9.

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

Lomas, T., Waters, L., Williams, P., Oades, L. G. and Kern, M. L. (2021) Third wave positive psychology: Broadening towards complexity. *The Journal of Positive Psychology*, 16, 5, 660-674.

Lucas, K. (2021) A narrative review of systemic lupus erythematosus. *Lupus Open Access,* 6, 2, e111.

McManus, J. and Carson, J. (2019) Remarkable Lives: John McManus in conversation with Jerome Carson. *Mental Health and Social Inclusion*, 23, 4, 156-161.

Meadows, G., Brophy, L., Shawyer, F., Enticott, J. C., Fossey, E., Thornton, C. D., Weller, P. J.,

Wilson-Evered, E., Edan, V. and Slade, M. (2019) REFOCUS-PULSAR recovery-oriented practice training in specialist mental health care: A stepped-wedge cluster randomised controlled trial. *The Lancet Psychiatry*, 6, 2, 103-114.

Nettle, D. (2001) *Strong Imagination: Madness, Creativity and Human Nature*. Oxford University Press.

Ogilvie, L. (2022) The values in action character strengths model in addiction recovery: A case study. *Advances in Dual Diagnosis, 15,* 3, 177-186.

Ogilvie, L., and Carson, J. (2022a) Trauma, stages of change and post traumatic growth in addiction: A new synthesis. *Journal of Substance Use, 27,* 2, 122-127.

Ogilvie, L., and Carson, J. (2022b) Positive addiction recovery therapy: A pilot study. *Advances in Dual Diagnosis, 15,* 4, 196-207.

Ogilvie, L., and Carson, J. (2023a) *Stories of Addiction Recovery: The G-CHIME Model.* Leeds: Emerald Points.

Ogilvie, L., and Carson, J. (2023b) The values in action character strengths model: A resource for people in addiction recovery. *Advances in Dual Diagnosis, 16,* 3, 152-158.

Ogilvie, L., and Carson, J. (2023c) Positive addiction recovery therapy: A replication and follow-up study. *Advances in Dual Diagnosis, 16,* 4, 227-241.

Ogilvie, L., and Carson, J. (2025) *Positive Psychology for Addiction: Theory, Research and Application.* Leeds: Emerald.

Penas, P., Uriarte, J. J., Gorbeña, S., Moreno-Calvete, M. C., Ridgway, P. and Iraurgi, I. (2020) Psychometric adequacy of recovery enhancing environment (REE) measure: CHIME framework as a theory base for a recovery measure. *Frontiers in Psychiatry*, 11, 595.

Petri, M., Orbai, A.-M., Alarcón, G. S., Gordon, C., Merrill, J. T., Fortin, P. R., Bruce, I. N., Isenberg, D., Wallace, D. J., Nived, O., Sturfelt, G., Ramsey-Goldman, R., Bae, S.-C., Hanly, J. G., Sánchez-Guerrero, J., Clarke, A., Aranow, C., Manzi, S., Urowitz, M., … and Magder, L. S. (2012) Derivation and validation of the Systemic Lupus International Collaborating Clinics classification criteria for systemic lupus erythematosus. *Arthritis & Rheumatism*, *64,* 8, 2677–2686. https://doi.org/10.1002/art.34473

Piat, M., Seida, K. and Sabetti, J. (2017) Understanding everyday life and mental health recovery through CHIME. *Mental Health and Social Inclusion*, 21, 5, 271-279.

Pickover, C. A. (1998) *Strange Brains and Genius: The Secret Lives of Eccentric Scientists and Madmen.* Plenum Press.

Pisetsky, D. S., Eudy, A. M., Clowse, M. E. B., and Rogers, J. L. (2021) The categorization of pain in systemic lupus erythematosus. *Rheumatic Disease Clinics of North America*, *47,* 2, 215–228. https://doi.org/10.1016/j.rdc.2020.12.004

Rees, F., Doherty, M., Grainge, M. J., Lanyon, P., Davenport, G., and Zhang, W. (2016) Mortality in systemic lupus erythematosus in the United Kingdom 1999–2012. *Rheumatology*, *55,* 5, 854–860. https://doi.org/10.1093/rheumatology/kev424

Reid, K., Flowers, P., and Larkin, M. (2005) Exploring lived experience. *The Psychologist*, 18, 1, 20-23.

Repper, J and Perkins, R (2003) *Social Inclusion and Recovery* Edinburgh, Balliere Tindall.

SAMHSA. (2012) *SAMHSA's working definition of recovery: 10 guiding principles of recovery.*

Retrieved January 2025, from SAMHSA: https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf

Scottish Recovery Network (n.d.) available at: https://scottishrecovery.net/lets-talk-recovery/ accessed 22.12.24

Seligman, M. E. and Csikszentmihalyi, M. (2000) Positive psychology: An introduction. *American Psychologist,* 55, 1, 5-14.

Slade, M., Bird, V., Clarke, E., Le Boutillier, C., McCrone, P., Macpherson, R., Pesola, F., Wallace, G., Williams, J. & Leamy, M. (2015a) Supporting recovery in patients with psychosis through care by community-based adult mental health teams (REFOCUS): A multisite, cluster, randomised, controlled trial. *The Lancet Psychiatry*, 2, 6, 503-514.

Slade, M., Bird, V., Le Boutillier, C., Farkas, M., Grey, B., Larsen, J., Leamy, M., Oades, L. and Williams, J. (2015b) Development of the REFOCUS intervention to increase mental health team support for personal recovery. *The British Journal of Psychiatry*, 207, 6, 544-550.

Slade, M., Leamy, M., Bacon, F., Janosik, M., Le Boutillier, C., Williams, J., and Bird, V. (2012) International differences in understanding recovery: Systematic review. *Epidemiology and Psychiatric Sciences*, 21, 4, 353-364.

Smith, J. A. and Osborn, M. (2003) Interpretative phenomenological analysis. In, J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* (pp. 51-80). Sage.

Smith, J. A. (2017) Interpretative phenomenological analysis: Getting at lived experience. *The Journal of Positive Psychology*, 12, 3, 303-304.

Sun, K., Eudy, A. M., Criscione-Schreiber, L. G., Sadun, R. E., Rogers, J. L., Doss, J., Corneli, A. L., Bosworth, H. B., and Clowse, M. E. B. (2021) Racial differences in patient-provider communication, patient self-efficacy, and their associations with systemic lupus erythematosus-related damage: A cross-sectional survey. *The Journal of Rheumatology*, *48,* 7, 1022–1028. https://doi.org/10.3899/jrheum.200682

Thornton, T., and Lucas, P. (2011) On the very idea of a recovery model for mental health. *Journal of Medical Ethics*, 37,1, 24-28.

Treffert, D. A. (1989) *Extraordinary People: An Exploration of the Savant Syndrome*. Transworld Publishers.

Ugarte-Gil, M. F., Alarcón, G. S., Seet, A. M., Izadi, Z., Montgomery, A. D., Duarte-García, A., Gilbert, E. L., Valenzuela-Almada, M. O., Wise, L., Sparks, J. A., Hsu, T. Y.-T., D'Silva, K. M., Patel, N. J., Sirotich, E., Liew, J. W., Hausmann, J. S., Sufka, P., Grainger, R., Bhana, S., …and Yazdany, J. (2023) Association between race/ethnicity and COVID-19 outcomes in systemic lupus erythematosus (SLE) Patients from the United States: Data from the COVID-19 Global Rheumatology Alliance. *Arthritis Care & Research*, https://doi.org/10.1002/acr.25039

van Weeghel, J., Van Zelst, C., Boertien, D. and Hasson-Ohayon, I. (2019) Conceptualizations, assessments, and implications of personal recovery in mental illness: A scoping review of systematic reviews and meta-analyses. *Psychiatric Rehabilitation Journal*, 42, 2, 169-181.

van Zyl, L., and Salanova, M. (2021) Editorial: Facilitating the third wave of positive psychology: Perspectives on the future of the discipline. *Frontiers in Psychology, 13*, DOI: 10.3389/fpsyg.2022.963167.

VIA Institute on Character. (2025). *What the Research Says About Character Strengths*. Retrieved from VIA Institute on Character: https://www.viacharacter.org/research/findings

Voyce, A (n.d.) *andrewvoyce2.com* available at https://andrewvoyce2.com/ accessed 22.12.24

Weisberg, R. W. (2015) On the usefulness of 'value' in the definition of creativity. *Creativity Research Journal*, 27, 2, 111-124.

Wong, P. T. (2011) Positive psychology 2.0: Towards a balanced interactive model of the good life. *Canadian Psychology/Psychologie Canadienne*, 52, 2, 69-81.

World Health Organization (2021). *Comprehensive Mental Health Action Plan*. 2013–2030.

Yen, E. Y., and Singh, R. R. (2018) Brief Report: Lupus—An unrecognized leading cause of death in young females: A population-based study using nationwide death certificates, 2000–2015. *Arthritis & Rheumatology*, *70*(8), 1251–1255. https://doi.org/10.1002/art.40512