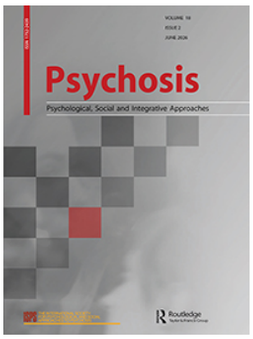

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What recovery-enabling services for psychosis should do: a multi-informant focus group study

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ABSTRACT

Background: Recovery-oriented care is widely promoted but remains difficult to realize in routine psychosis services, particularly in hospital-centered systems. The authors aimed to identify broadly supported service actions to embed recovery principles in daily practice in Flanders, Belgium.

Methods: Twelve focus groups were conducted in two waves with purposively sampled stakeholders: service users ($n = 19$), relatives ($n = 20$), bachelor-level staff ($n = 20$), and MSc/MD-level professionals ($n = 18$). Data were analyzed using reflexive thematic analysis by a four-researcher team.

Results: Analysis yielded 13 action points, emphasizing: (1) warm welcome and caring style; (2) dialogical practice; (3) small-scale, everyday living together; (4) centering the person's trajectory and meaning of experiences; (5) continuity of relationships; (6) patience and pace-matching; (7) involving the social context while safeguarding confidentiality; (8) structural inclusion of peer experts; (9) co-creation and shared decision-making; (10) de-escalation and dialogical crisis work; (11) professional containment of anxiety through supervision and reflective team cultures; (12) shared responsibility rather than rigid procedure enforcement; and (13) community connection and warm handovers. Subgroups differed in emphasis, yet expressed broadly overlapping views.

Conclusions: The actions form a practicable framework for recovery-supporting psychosis care and can inform training, service standards, quality improvement, and policy.

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Introduction

Psychotic disorders are among the most disabling and stigmatizing conditions, posing major challenges for affected individuals, families, communities, and health systems. Services have historically been dominated by hospital-based and biomedical models

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emphasizing symptom stabilization and relapse prevention. While these reduced acute morbidity and improved pharmacological management, they often overlooked psychosocial, existential, and rights-based dimensions of living with psychosis (Davidson et al., 2005; Slade & Longden, 2015).

Over the past three decades, recovery-oriented care has gained momentum as an alternative paradigm, emphasizing personal agency, social inclusion, hope, and meaning in life, extending beyond symptom reduction (Leamy et al., 2011; Stuart et al., 2017). The World Health Organization (2013, 2022) repeatedly endorsed this shift, identifying recovery as a global priority for service transformation.

Conceptual reframing of psychotic disorders consistent with a recovery-oriented perspective has also been proposed. Van Os et al. (2019) argue that psychosis should be viewed as a vulnerability that may precipitate crises but also allows opportunities for resilience. From this perspective, services are best conceived as small-scale healing communities that foster connectedness and social participation, embedded within broader ecosystems that empower families and facilitate collaboration (van Os et al., 2019, 2023).

Despite rhetorical and policy support, implementation in routine practice remains difficult (Morera et al., 2017). Structural barriers include risk-averse policies, workforce shortages, and insufficient investment in community alternatives (Holley et al., 2016; Ørjasæter & Almvik, 2022). Moreover, biomedical organizational cultures often conflict with recovery principles of autonomy, empowerment, and shared decision-making (Bracken et al., 2012; Chisholm et al., 2023; Martinelli & Ruggeri, 2020). Service users frequently report coercion, lack of information, poor communication, and negative ward environments, all of which undermine recovery (Lau & Hutchinson, 2021; Staniszewska et al., 2019).

When implementing recovery-oriented support, professionals, service users, and relatives often hold divergent expectations (Burger et al., 2024; Jørgensen et al., 2024; Lorien et al., 2020). Even when professionals believe they are acting holistically, service users and relatives often do not experience such support, resulting in disappointment (Jørgensen et al., 2024; Kroon et al., 2025; Mekuriaw et al., 2025).

These findings suggest that sustainable implementation requires co-construction between service users, relatives, and professionals (Zomer et al., 2024). However, most studies adopt single-perspective designs (e.g. only service users' perspectives), with few systematically integrating multiple viewpoints.

This study examines what psychosis services should do to implement recovery-oriented support within resource-constrained, highly hospital-focused contexts. With the highest psychiatric bed rate in Europe (139 per 100,000 in Flanders in 2023) and a slow transition toward community-based care (Federal Public Service Health, 2023; Organisation for Economic Co-operation and Development [OECD], 2023), the region of Flanders in Belgium provides a critical context for addressing this question.

Method

A qualitative, exploratory, and participatory design was applied to co-discern key service actions for recovery-supporting psychosis care. Data were collected through focus groups (Kitzinger, 1995; Morgan, 1997). The entire research process was overseen by an expert

panel including representatives from a family-support organization, a peer-led psychosis organization, and academics specializing in psychosis and recovery (Beresford, 2002). Medical ethical approval was granted by the Ethics Committee of Ghent University (protocol number ONZ-2024-0310). The study was assessed for risks related to vulnerable participation. Participants provided written informed consent, retained the right to withdraw, and all data were anonymised.

Four stakeholder groups were targeted: (i) service users, (ii) relatives of people with psychosis vulnerability, (iii) bachelor-level staff (e.g. nurses), and (iv) MSc/MD-level professionals (e.g. psychologists). Purposive sampling ensured inclusion of participants with rich relevant experiential or professional knowledge. Service users and relatives were recruited via three peer-led organizations; professionals through psychiatric hospitals, community mental health centers, and mobile care teams.

A total of 137 individuals were invited; 77 participated: 19 service users, 20 relatives, 20 bachelor-level staff, and 18 MSc/MD-level professionals (39 women, 38 men; aged 22–75 years). All participants were fluent in Dutch. Among professionals, 26 worked in psychiatric hospitals, while 12 were employed in community or outreach teams.

Two waves of focus groups were conducted. Wave 1 (October – December 2024): Following a pilot group with four participants, eight homogeneous focus groups ($n = 63$) were held across two cities (6–8 participants per group). Each session (≈180 minutes) was moderated by two researchers experienced in qualitative methods and psychosis care. Discussions began with the question: "What needs to change in daily service provision to make mental healthcare for people vulnerable to psychosis more recovery-focused?" Participants explored strengths, weaknesses, opportunities, and threats (SWOT framework), first in pairs and then in plenary dialogue.

Wave 2 (February – March 2025): Four heterogeneous focus groups ($n = 14$) brought together service users, relatives, and professionals for member checking. Participants reviewed 11 preliminary themes derived from Wave 1, including illustrative quotes, and were invited to evaluate their completeness, identify gaps, and propose reframing. This wave primarily refined existing themes and did not substantially alter the analytic framework, indicating that the data were sufficiently rich to support the analytic claims made. All sessions were audio-recorded and transcribed verbatim.

Data were analyzed using reflexive thematic analysis (Braun & Clarke, 2021). Four psychologists (PhD student, professor, postdoctoral researcher, senior practitioner) independently coded transcripts for "do's and don'ts" and for supportive versus hindering conditions. Four coding meetings (≈180 minutes each) were held to review codes sequentially, discuss emerging patterns, and construct a shared coding framework. Initial collaboration between two coders yielded 8 overarching themes; cross-validation with the full team expanded these to 11. For each theme, a descriptive synthesis (≈500 words) with quotations was produced to ensure analytic coherence. Wave 2 transcripts were analyzed to assess how participants validated or challenged these themes, leading to 2 additional themes and minor revisions in wording (intermediate lists of themes and syntheses available upon request). Key reflexivity considerations include that all four coders are clinical psychologists who endorse a recovery-oriented paradigm. Three have psychotherapy expertise with psychosis; three have an explicit academic research profile focused on qualitative research and psychoanalysis; two are trained psychoanalysts; and one has extensive experience in residential settings. This shared clinical and theoretical

positioning likely shaped both the focus of the analysis and the interpretive lens through which the data were understood.

To assess the relative importance of each theme for each subgroup and the degree of convergence between researchers, median scores and Mean Absolute Deviation (average of the absolute differences between each rater's score and the median score, with values of ±0.20 indicating low variation and ±0.40–0.50 indicating fair variation) were calculated.

Several measures enhanced rigor. Interviewer triangulation ensured balanced facilitation and reflexive debriefing after each session. Member checking increased credibility and practical validity. Coder triangulation, combining independent coding and team discussion, strengthened dependability and confirmability. Reflexive discussions throughout the process helped researchers recognize and manage preconceptions, while consultation with the external expert panel further enhanced analytic rigor and applicability.

Results

Analysis generated thirteen action points (Table 1). Broad agreement emerged between subgroups regarding what they considered essential, although each emphasized different facets. Table 2 summarizes subgroup priorities and coder convergence.

Offer a warm welcome and a caring style

First encounters with mental health services were described as decisive in shaping trust and willingness to engage. Service users often recalled admissions as abrupt and depersonalizing, marked by administrative formality rather than recognition of their distress. Being received as "patient X" without acknowledgment reinforced feelings of alienation. In contrast, participants valued staff who greeted them warmly, explained procedures, and conveyed calm reassurance. Relatives stressed that they, too, arrived in states of crisis and needed recognition and support rather than bureaucratic hurdles. Professionals indicated that institutional routines and workload sometimes result in rushed intakes, yet they agreed that respectful reception is indispensable for building therapeutic alliances. Recovery begins not with diagnostic categorization but with a human welcome. One user summarized: "*There is a big difference between a caregiver who sits on the edge of the bed with you and talks, and someone who stands there with papers to diagnose you*."

Ensure that experts engage in dialogue

Dialogue emerged as a central vehicle for recovery. Service users emphasized that they did not want to be treated as passive recipients of expertise but as partners in conversations about meaning, experience, and uncertainty. Encounters where professionals listened openly were described as profoundly validating. Medical jargon and distant language were considered alienating. Relatives noted that genuine dialogue prevented them from feeling excluded or dismissed. Professionals reflected that psychiatry's culture often pressures them to provide quick answers, yet recovery requires time for shared exploration. One user stated: "*It's about listening, asking questions, and not assuming what someone needs*." True expertise, participants argued, lies not in prescribing solutions but in sustaining open dialogue. Staff training should thus include therapeutic and

Table 1. Action points for recovery-supporting psychosis care.

Action Point	Illustrative Quotes
Offer a warm welcome and a caring style	POS: "Welcome people, not patients . . . In earlier days, we had a checklist. Now we ask what they need, whether they like something to eat or drink". — Nurse POS: "What makes a connection? Usually, it is a point of commonality; being treated with warmth and humanity" – Relative NEG: "One of the difficult things, is when you are admitted to a closed ward at night. You don't really know where you are; you're brought in by ambulance through a back door, on a stretcher. (. . .) That made me more psychotic". - Service user
Ensure that experts engage in dialogue	POS: "As a caregiver, you ask questions that imply curiosity: Who are you? What do you enjoy doing? In this way, people feel taken seriously". — Nurse POS: "I ended up in seclusion (. . .) the next day the psychiatrist apologized and said 'I'm sorry it hurt you so much, I didn't realize it'". — Service user NEG: "During my second admission, I was diagnosed by a doctor I had never seen (. . .) He had copied what was already in my file, even though a lot had changed compared to my first admission". - Service user
Create major impact through Small-scale living together	POS: "Just sitting with a newspaper in the group (. . .) people experience that as low-threshold". — Nurse POS: "As an outsider, I wouldn't have known who was a patient and who a caregiver. That had to do with clothing". – Service user NEG: "That makes me think of the evolution over the years of having to record more. How much can you actually live among the people? And how much time are you sitting behind your computer?" – Nurse
Place the patient's trajectory and story at the center	POS: "The guiding principle is the human being with desires, who is searching, stuck, and suffering; we lose sight of the individual leading their life". — Psychologist POS: "When you tell someone, 'this is better for you', you create a division. You could instead say, 'I would want this for myself – how is that for you?'" - Psychiatrist NEG: "My daughter never dared to tell her psychosis story, the content of it, to her psychiatrist . . . that is very strange". — Relative
Ensure continuity of care	POS: "Having to share your story over and over again is not easy. Ideally, one should have a team that follows the trajectory, and helps carry it". – Relative POS: "It happens that when people who have ongoing care trajectories are admitted to a ward, staff say: 'We will take over now'. Whereas patients often say: 'I want to continue seeing my outpatient therapist'." - Psychiatrist NEG: "I was following therapies in the day hospital, but I had to wear a cast, so they suggested I be admitted. They didn't tell me I could no longer attend day clinic therapies. They imposed a new structure on me, I was confronted again with new caregivers. That was very disruptive". — Service user
Be patient in times of urgency	POS: "At first, our son absolutely did not want to talk to the psychiatrist. He had paranoid feelings toward her. In the end, she managed to make a connection, by continuing to address him and giving him time". — Relative POS: "Psychosis develops gradually; the search for a quick solution only looks at the tip of the iceberg, not at what is going on beneath". — Service user NEG: "There is enormous time pressure. You have to be seriously civilly disobedient to say: we are going to schedule empty moments to be creative and see what might emerge". - Nurse
Engage with and involve the context	POS: "At moments of crisis, you get pinned down, while they don't know your background. But family and friends can share that. This way, they can gain a broader view of you". – Service user POS: "We ask the question: 'Who can help you tell your story?' But it is the patient who must have the mandate to indicate who that person is, even if these are not always the people we had in mind". - Psychologist NEG: "I wanted more information at the beginning. Not general information, but about our son's condition. Some people are violent, but our son was catatonic, which is completely different. How on earth are you supposed to deal with that?" – Relative

(*Continued*)

Table 1. (Continued).

Action Point	Illustrative Quotes
Involve peer experts	POS: "In my view, it is very important to involve peer workers (. . .) It gives the feeling of not having to face things alone, and of being able to carry something together". — Service user POS: "The presence of a peer expert in a team changes the team's way of speaking. There is less emphasis on the diagnosis, we feel more like fellow participants". — Psychologist NEG: "Very little has changed since the deinstitutionalization of care. As a network representative, I helped evaluate several project proposals concerning psychiatric care, and in half of them there was still no involvement of family, relatives, or peer experts". - Relative
Co-create care	POS: "After my first psychosis, I said I was getting a little better. The psychiatrist then told me that I was actually doing well enough to manage without medication. The fact that I was able to express this, and that it was taken seriously, had an enormously positive impact". – Service user POS: "Patients must allow care to be carried out in dialogue. We sometimes think too much that we are the experts, but patients also sometimes put us in that role. Responsibility must be shared". Nurse NEG: "Sometimes my patients are admitted, but I am never called about them. I regularly say: 'You can invite me for a consultation', but that almost never happens". — Psychiatrist
De-escalate and use dialogical crisis work	POS: "I notice that during an acute crisis a great deal comes to the surface that does not reappear afterward, which is why we must fully focus on the meaning of a crisis". – Psychologist POS: "Our son became psychotic when travelling to Sweden. He was admitted to a closed ward. During the night, someone stayed with him the whole time so that he wasn't placed in isolation. They sat next to him and talked all night about Sweden". - Relative NEG: "I was placed in the isolation cell, where you know you are being filmed and that caregivers are available. Even though I kept shouting that I needed to urinate, no one came, and I wet my pants. (. . .) That is humiliation".— Service user
Contain anxiety and uncertainty professionally	POS: "If you feel fear, you should name it. Say: 'You are scaring me now'. That holds up a mirror, and then someone approaches me as a normal human being, which also makes me clear-headed again". – Service user POS: "Supervision is more important than manpower (. . .) You can have a very large team, but if they are all anxious and there is no consultation, it doesn't work". — Psychologist NEG: "Assistant psychiatrists nowadays arrive on the closed ward, pumped up and resolute: 'I am not afraid'. Then I say: 'That is a big problem'. As caregivers, we must be able to feel when we are afraid". - Psychiatrist
Share responsibility instead of enforcing procedures	POS: "I was in crisis and wanted to go outside, as nature calms me, but the rule says that is not allowed. Still, I asked a nurse, and he allowed it. That gave me freedom". — Service user POS: "I once allowed a mother to sleep at our ward because otherwise her son would have to be placed in isolation. The mother said, 'he will stay calm if I stay with him'. You shouldn't have to go and ask permission for that – you just need to act when it is necessary". – Psychologist NEG: "We had a resident who could only find peace in a car. As a team, we thought about how we could respond to that, and managed to arrange a caravan for her. I thought I should at least inform management, but then the whole plan was blocked". — Nurse

(*Continued*)

Table 1. (Continued).

Action Point	Illustrative Quotes
Connect to society	POS: "When we noticed that the neighborhood was mistrustful of us, we started seeking connection. Once a month the house is open to everyone. In the meantime, Turkish women from the market come to drink coffee, the potato seller brings potatoes, and the Roma come to play music together. (. . .) The image that local people have of our visitors changes: they gain a face, a narrative, and are no longer looked at with suspicion". – Social worker POS: "When we speak about deinstitutionalisation, the first social context is, after all, the family – the household within which one must first regain balance, in order then to be able to follow an autonomous path from that family structure". - Relative NEG: "I found it very difficult to talk about psychosis. Psychosis somehow breaks your connection with reality and severs your social ties. How do you start that conversation and frame what is happening to you at that moment? (**. . .**) I never dared to tell my employer because of the stigma and shame I felt about having had psychosis. I returned to work gradually, but I received very little support in this, which made me hesitant to be transparent". – Service user

POS = example giving positive characterization of the theme; NEG: example illustrating the opposite of the theme.

Table 2. Median ranked importance of recovery-supporting psychosis care action points for four subgroups.

Action Point	Score service users	Score elatives	Score bachelor-level staff	Score Msc/MD - level staff	MAD
Offer a warm welcome and a caring style	1	2	3	4	0,19
Ensure that experts engage in dialogue	1	3	3	3	0,50
Create major impact through Small-scale living together	1,5	4	1,5	3	0,25
Place the patient's trajectory and story at the center	1	3,5	2	3,5	0,25
Ensure continuity of care	1	2	4	3	0,19
Be patient in times of urgency	1	4	3	2	0,19
Engage with and involve the context	3	1	2	4	0,19
Involve peer experts	1	4	2	3	0
Co-create care	1	2,5	3	4	0,44
De-escalate and use dialogical crisis work	1	2	3	4	0
Contain anxiety and uncertainty professionally	2,5	3,5	2	1	0,25
Share responsibility instead of enforcing procedures	3	4	2	1	0
Connect to society	3	2	1	4	0

1 = Highest importance; 4 = Lowest importance. Score = Median across four coders. MAD (Mean Absolute Deviation) = average of the absolute differences between each rater's score and the median score.

communicative skills, and professionals should acknowledge their own fallibility to foster genuine encounters.

Create major impact through small-scale living together

Participants highlighted the humanizing power of everyday interactions. Service users described moments when staff joined them for meals, chatted about music, or walked outside together as deeply supportive. Informal encounters broke down hierarchical barriers and fostered trust. Relatives valued these gestures as restoring dignity, contrasting them with regimented institutional routines that accentuate difference.

Professionals noted that sharing ordinary activities enriched their work and buffered against burnout, though administrative demands often prevented genuine presence. Across groups, the message was clear: recovery thrives in small-scale, relational environments where companionship and ordinariness prevail. As one socio-therapist said, "*A patient once told me, 'I like creative therapy because we talk about normal things – holidays, children's bad grades*.'"

Place the patient's trajectory and story at the center

Service users insisted that their lives could not be understood without their personal narratives. Exclusive focus on symptoms ignored what mattered most. Families observed that meaningful care began when professionals took time to understand life trajectories and contextual struggles. Professionals found that centering personal stories aligned treatment with recovery principles and prevented reduction of the person to a diagnosis. Several participants emphasized acknowledging the meaning of psychotic experiences. Professionals noted they should see themselves as temporary companions who should explicitly value patients' perspectives rather than viewing patients as transient figures in their routines. As one psychologist remarked, "*We must connect with what they need at that moment*".

Ensure continuity of care

Discontinuity of care was a major frustration. Service users described the exhaustion of repeatedly recounting their history to new professionals, undermining trust. Families reported that turnover and fragmented services precipitated relapse. Professionals stressed that rotation policies and sector fragmentation disrupted alliances, even though sustained relationships are vital. In Belgium's system, sequential interventions often cause unintended discontinuity. Participants agreed that patients should be able to rely on familiar professionals throughout their trajectory. As one psychiatrist put it: "*It's not about transferring information; it's about transferring relationships. People must keep talking to those they know*."

Be patient in times of urgency

Service users and relatives valued professionals who listened, explained, and stayed present even amid crises. Professionals admitted that systemic pressures foster haste and standardized responses but recognized that meaningful recovery unfolds gradually. Participants cited examples where patience – remaining calm, allowing silence, revisiting questions – created safety. Families recounted that rushed interventions often alienated their relatives, while slower engagement nurtured trust. Time, participants agreed, should be viewed not as a cost but as an investment in recovery. One socio-therapist reflected, "*Give people the time they need: not needlessly long, not forcibly short. They need time to fall and get back up again*."

Engage with and involve the context

Recovery was perceived as inseparable from one's social environment. Service users acknowledged that family involvement could be ambivalent – supportive yet stressful – but most valued opportunities to include relatives at chosen moments. Families emphasized their pivotal role in recognizing warning signs, sustaining routines, and buffering crises. Professionals observed that involving relatives improved understanding and continuity, though balancing confidentiality remained challenging. Timing was crucial: some preferred early family involvement; others only later. Practices like Open Dialogue, bringing relatives, patients, and professionals together, were cited as inspiring. One relative said, "*In an Open Dialogue meeting you start talking differently and develop a shared language*."

Involve peer experts

Peer experts were regarded as unique contributors to recovery support. Service users described peers as offering hope and credibility that professionals could not provide. Families valued how peers normalized experiences and conveyed that recovery was achievable. Professionals appreciated that peers challenged assumptions, enriched discussions, and introduced perspectives often silenced in hierarchical settings. A user turned peer worker recalled: "*I was able to talk to the head doctor of the hospital where I'd been treated. He was astonished when I described in detail how his staff had treated me during psychosis*." Participants cautioned against tokenism: peer roles must be structurally integrated, fairly compensated, and treated as equal collaborators.

Co-create care

Co-creation – shared decision-making among service users, relatives, and professionals – was considered essential. Users emphasized that their preferences should guide choices about medication, daily routines, and goals. Families valued opportunities to contribute insights without bearing full responsibility. As one relative stated, "*We don't know; doctors don't know. That's why we must search together*". Professionals described co-creation as enriching yet challenging, especially when perspectives diverged on risk, medication, or freedom of movement. The challenge involves integrating professional expertise with patients' lived experiences. Transparent discussion, they agreed, fosters trust. Participants warned against both unilateral professional decisions and overburdening families.

De-escalate and use dialogical crisis work

Crises were described as meaningful moments when hidden struggles surface. Service users recalled small gestures – someone sitting quietly, offering food, or staying through the night – as profoundly stabilizing. In contrast, coercive measures such as isolation or fixation left enduring trauma. One user remarked: "*People think when you're psychotic you don't notice restraint, but you do. You feel everything*."

Relatives provided vivid examples of how calm presence prevented coercion, highlighting that dialogue can replace force. Professionals viewed crises as opportunities for understanding rather than control. Participants stressed the value of post-crisis debriefings and individualized preventive plans co-developed with users and families.

Contain anxiety and uncertainty professionally

Professionals acknowledged that psychosis evokes fear and confusion. Service users valued staff who admitted vulnerability instead of hiding behind authority, interpreting honesty as authentic and trustworthy. Families observed that staff panic often worsened crises. Professionals explained that supervision, intervision, and ethical dialogue were indispensable for managing anxiety without reverting to rigid protocols. Participants agreed that fear must be addressed openly, enabling reflective rather than defensive responses. As one nurse put it, "*Some things are hard to discuss – like fear – but they really should have a place*".

Share responsibility instead of enforcing procedures

Rigid proceduralism was viewed as obstructive to recovery. Service users felt stripped of autonomy when rules were applied mechanically. Families described feeling like outsiders bound by institutional schedules. Professionals recognized that rules serve protective functions but acknowledged their tendency to suppress creativity and connection. A nurse noted, "*Teams must be trusted to think outside the box and given space to experiment*". Participants recounted examples of staff who made small exceptions – allowing a walk outside, letting a parent stay overnight – that transformed trust. Such acts of "creative civil disobedience" showed courage, prioritizing people's needs over bureaucracy. Rules, they concluded, should enable individualized care, not obstruct it.

Connect to society

Finally, participants viewed recovery as extending beyond psychiatric services into the social sphere. Service users described it as regaining valued social roles – through work, study, culture, or relationships – while confronting stigma and shame in disclosure. Families identified themselves as the first social context but felt burdened when services withdrew. Professionals saw themselves as bridge-builders, facilitating warm handovers, supported employment, and community links. Examples included neighborhood projects and inclusive spaces where users participated without being defined by illness. As one psychologist summarized, "*As people say about children – it takes a village to raise a child – it also takes a village to support a vulnerable person*."

Discussion

A first cluster of actions (Themes: #1–3) centers on relationships among professionals, users, and relatives. Warm reception, unconditional respectful contact, and collaborative daily life were considered fundamental to trust and belonging.

Dialogue, mutual recognition, and a willingness to acknowledge mistakes were emphasized as ways to maintain equality and repair ruptures. These findings align with classic conceptions of empathic and thoughtful psychosis care, as articulated in the work of Bleuler (Miller, 2023) and subsequent contributions (Jørgensen et al., 2020; Lorien et al., 2020; Matsuoka, 2021; van Os et al., 2019, 2023), and resonate with Leamy et al.'s (2011) recovery components of connectedness and empowerment. They also echo Slade and Longden's (2015) emphasis on relational trust and everyday cohabitation, often neglected in training (Chisholm et al., 2023).

The first cluster is consistent with previous findings (Matoba et al., 2023; Matsuoka, 2021), and correspond to three of the four dimensions in Staniszewska et al.'s (2019) review of service users' experiences. This cluster also resonates with Leamy et al.'s (2011) recovery processes of connectedness and empowerment, and Slade and Longden's (Slade & Longden, 2015) emphasis on relational trust. The value of small-scale living together is often neglected in training, yet it embodies the equality and attunement most valued by service users (Ørjasæter & Almvik, 2022).

A second emphasis concerns validation of lived experience (Themes: #4,7,8). Participants advocated for systematic inclusion of patient and family perspectives and highlighted the essential role of peer experts as role models and mediators.

This reinforces longstanding calls to embed lived experience in care (Beresford, 2002; Bracken et al., 2012) and aligns with empirical work showing that recovery is co-constructed in everyday interactions requiring collaboration (Burger et al., 2024; Davidson et al., 2005; Kroon et al., 2025). Yet, structural barriers such as risk management frameworks and institutional norms continue to constrain practice (Holley et al., 2016; Lorien et al., 2020; Ørjasæter & Almvik, 2022). Peer experts emerged as crucial mediators of these organizational tensions. Integrating such expertise requires more than symbolic presence: cultural and structural change, supported by intersectoral collaboration, is essential (Jørgensen et al., 2020, 2024; Zomer et al., 2024).

A third cluster (Themes: #4,5,6,9,12) underscores the need for long-term, flexible support. Participants warned against rigid guideline application that may undermine individualized trajectories. Recovery was understood as a shared responsibility of professionals, users, and families, grounded in attentiveness to personal stories and contexts.

These findings resonate with Open Dialogue practices prioritizing sustained interaction over episodic intervention (Seikkula et al., 2006), as well as with Davidson et al.'s (2005) notion of "recovery in" rather than "recovery from" mental illness and Vanheule's (2024) focus on the personal meaning of psychotic experience. Continuity across service sectors was again viewed as essential (Jørgensen et al., 2020, 2024).

A fourth cluster (Themes: #10,11) addresses crisis situations. Participants preferred de-escalation, presence, and relational attunement, noting that coercion was often experienced as traumatic and counterproductive. Professionals recognized their own anxieties during crises and highlighted the need for team support and reflective supervision to avoid defensive or procedural responses.

This reflects Langlands et al. (2008), who stressed relational presence in crisis care, and corresponds with Open Dialogue's crisis strategies (Vanheule, 2024; Seikkula et al., 2006). Menzies Lyth's (1988) theory of anxiety within organizations also supports establishing supervisory structures that transform anxiety into collective care. Supervision and

reflective cultures play a key role in safeguarding recovery-oriented crisis practice (Hornik-Lurie et al., 2018).

Finally, recovery was conceptualized as a socially embedded process (Themes: #7,13). Reintegration into family, community, and society was viewed as essential, with participation in work, education, and leisure considered key to reducing stigma and sustaining recovery.

This perspective is consistent with Anthony's (1993) vision of community-based care and recent frameworks prioritizing citizenship and social participation (Dierinck, 2023; van Os et al., 2023; World Health Organization, 2013, 2022).

Compared with existing recovery models (Martinelli & Ruggeri, 2020; Matoba et al., 2023; Stuart et al., 2017; van Os et al., 2023), this study stands out for integrating multi-informant data across a complete policy region (Flanders, Belgium) and bridging hospital and community settings. The convergence among users, relatives, and professionals strengthens its applicability across care levels. While earlier research revealed divergent stakeholder views (Burger et al., 2024; Kroon et al., 2025), this study found substantial agreement: users prioritized personal relevance, relatives emphasized network inclusion, and professionals highlighted organizational support. All underscored the need for relational, continuous, and socially embedded care. The areas of convergence identified reflect shared priorities within a hospital-centered, recovery-oriented context and should be understood as context-bounded rather than universal claims.

Several limitations should be noted. First, the study explicitly adopts a recovery perspective, which implies that viewpoints not aligned with it were beyond its scope. Future research could examine how including additional stakeholders – such as general practitioners, emergency services, and policymakers – and professionals working from other perspectives (e.g. the medical model) might affect the conclusions. Second, Belgium's strongly clinic-centered care system means that several ideas emerging from our results focus on residential psychosis care, which may be less relevant in countries with predominantly community-based services. Moreover, inpatient populations may differ in contexts with lower bed ratios. Third, conducting the study in Dutch may have excluded non-Dutch-speaking minority groups, limiting diversity. Fourth, participants were not assessed in terms of their level of expertise, intelligence, or education, which might have added further nuance to the conclusions.

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