International Journal of Nursing and Health Care Research

OPEN ACCESS

Carney M, et al. Int J Nurs Health Care Res 8: 1628

www.doi.org/10.29011/2688-9501.101628

www.gavinpublishers.com

GAVIN PUBLISHERS

Review Article

Recovery Concepts in Child and Adolescent Mental Health Services (CAMHS)

Marie Carney[1*], Paul Mahon[2], Mark White[3], Thomas Kearns[3]

[1]Associate Professor of Nursing and Midwifery, Faculty of Nursing and Midwifery, Royal College of Surgeons in Ireland University of Medicine and Health Sciences. Ireland

[2]Operations and Education Manager, Faculty of Nursing and Midwifery, Royal College of Surgeons in Ireland University of Medicine and Health Sciences. Ireland

[3]Executive Dean, Faculty of Nursing and Midwifery, Royal College of Surgeons in Ireland University of Medicine and Health Sciences. Ireland

[3]Consultant and Co-Director Candidate WHO Collaborating Centre, Faculty of Nursing and Midwifery, Royal College of Surgeons in Ireland University of Medicine and Health Sciences. Ireland

***Corresponding Author:** Prof Marie Carney, Associate Professor of Nursing and Midwifery, Faculty of Nursing and Midwifery, Royal College of Surgeons in Ireland University of Medicine and Health Sciences. Ireland.

Citation: Carney M, Mahon P, White M, Kearns T (2025) Recovery Concepts in Child and Adolescent Mental Health Services (CAMHS). Int J Nurs Health Care Res 8: 1628. DOI: 10.29011/2688-9501.101628.

Received Date: 13 March, 2025; **Accepted Date**: 24 March, 2025; **Published Date**: 27 March, 2025

Abstract

Background: Empirical research on the outcomes and psychological mechanisms of recovery in child and adolescents with mental health disorder remains underdeveloped. In its concept state, recovery can be a challenge for clinicians to successfully embed into professional clinically directed treatment. **Aim:** To explore the concepts of recovery in child and adolescent mental health services (CAMHS) and its successful embedding in mental health care delivery. **Methods:** This integrative review explored recovery in CAMHS by utilising Cooper's five stages (1982) [1], with revision, dimensions/project formulation, data collection, evaluation of data for suitability, data analysis, interpretation and presentation of results. **Findings:** Thematic analysis elicited themes designated as necessary to recovery. Themes include the importance of co-production in practice with family, professionals and General Practitioner (GP) care, thus embedding the principles of recovery into care in CAMHS and the challenges to achieving positive outcomes during recovery. Screening assessment tools and patient and professional experiences are explored alongside the barriers and facilitators to navigating recovery in CAMHS, with emphasis on difficulties encountered and outcomes during transitioning from CAMHS to adult mental health services (AMHS). **Application to practice:** Consistent differences exist in care philosophies between CAMHS and AMHS which emphasises client autonomy and individual responsibility. Better understanding of these differences and collaborative planning and service delivery may foster shared approaches to meeting the needs of transitioning youths, and ultimately aid recovery.

Citation: Carney M, Mahon P, White M, Kearns T (2025) Recovery Concepts in Child and Adolescent Mental Health Services (CAMHS). Int J Nurs Health Care Res 8: 1628. DOI: 10.29011/2688-9501.101628.

Keywords: Recovery; CAMHS; Mental health services; Implementation of recovery models.

Background

In mental health services, recovery constitutes a guiding principle that has become central to mental health policies for children and adolescents. Yet, limited models or frameworks exist. Valuing recovery-oriented practice at the interface between mental health services and communities came to the fore in the 1990's [2,3]. Implementing recovery-oriented mental health service was a policy priority in many countries [4]. Other dimensions which may impinge on recovery have come to the fore since then and are explored in this review.

Methods

Aim

To explore the concept of recovery in mental health care and to determine how recovery can be successfully embedded in clinician care in mental health care delivery.

Methods

Cooper's [1] five stage approach, with revision, guided this integrative review: concept/project formulation, data collection, evaluation of data for suitability, data analysis and interpretation and presentation of results.

Concept / project formulation

Recovery models in mental health care emphasises users' right to be involved in key decisions of their care, yet in its concept state, *recovery* can be a challenge for clinicians to successfully embed into clinician directed care/treatments.

Data Collection

The search strategy was recovery in mental health services and recovery models of care. These concepts were operationalised broadly to capture as many relevant articles as possible. Papers published between 2014 and 2024 were included in the search. The search yielded more than 200 papers and 46 were evaluated. Library databases searched included EBSCOHost, PubMed central, Google Scholar, Medline, CINAHL, PsycInfo, and Grey Literature.

Evaluation of data for suitability

The recovery papers that were evaluated were screened against inclusion and exclusion criteria. Articles were included if they met most or all the following criteria: based on empirical research, contained an abstract, written in English and placed emphasis on child and adolescent mental health care and settings.

Data analysis and interpretation

Papers were reviewed for study design, sample approach and sample size, methods used, aims presented, outcomes and relevance and recommendations.

Findings

This review includes published research related to child and adolescent mental health services (CAMHS) nationally and internationally. The research identifies the changes that have taken place since 2014.

Presentation of results

Sample sizes of study populations researched in the papers reviewed ranged from one to 1,000. The majority of studies used designs that were either descriptive-correlational, qualitative, mixed methods, longitudinal, or quasi or true experimental. Thirty percent of papers reviewed used quantitative analysis. Of the papers evaluated, 46 full texts were read and abstracts read for the remainder. The most relevant papers were of Australian, Canadian, United States, United Kingdom, Irish or European origin. Thematic analysis elicited the following themes:

- Frameworks or models of recovery
- Co-production in practice guidance documents
- Embedding the principles of recovery into care
- Recovery in CAMHS and challenges to achieving positive outcomes during recovery
- International evidence to recovery
- Barriers and facilitators to navigating recovery in childhood Obsessive Compulsive Disorder (OCD)
- Early years development Interventions
- Screening and professional assessments tools and interventions
- Community initiatives and public mental health services
- Transitioning from CAMHS to Adult Mental Health Services (AMHS)

Discussion

Frameworks or models of recovery

Two frameworks of note are analysed and presented in this document: the Irish and Australian frameworks. Whilst the Irish framework focus is on quality, the Australian framework is for recovery-oriented mental health services, which provides policy direction to enhance and improve mental health services delivery in Australia. Ireland has adopted a strategic approach to mental health

reform that includes a range of coordinated quality and recovery initiatives. This approach provided a foundation for engaging government, health care organisations, clinicians, service users and carers in developing quality and outcome measurements. This coordinated model involves a range of interconnected initiatives linked to quality and recovery initiatives over time [5,6]. Wellness and wellbeing were introduced to the recovery concept in the Australian mental health recovery framework [7]. Recent studies explored wellness by focusing on self-reliance, self-confidence, respect, and community integration [8].

Co-Production in practice guidance documents

The Co-Production in Practice Guidance [9] is a principle's-based document, developed to support mental health services in the implementation of the National Framework for Recovery in Mental Health (2018-2020), launched in 2017, in Ireland [10]. The Framework strengthens the delivery of a quality person-centred service and provides mental health services with a practical guide to co-production in practice. The principles within the guidance document are reflective of the current mental health quality and safety agenda, mental health legislation and service user expectations and for better governance in the planning, managing, and safety of the services provided. The Health Information and Quality Authority (HIQA) and the Mental Health Commission (MHC) jointly developed standards to set and promote a standard for cohesive, person-centred reviews of incidents [11].

The Health Service Executive (2020) Ireland Framework Document is relevant across all services: CAMHS's, Adult, Psychiatry of Later Life, Community and Voluntary sector services with service users and others in their recovery. The document supports implementation of the National Framework for Recovery in Mental Health (2018-2020) in Ireland by supporting service providers working in co-production with all stakeholders [10,11]. Recovery-orientated services promote working in a holistic and respectful manner where all are valued and acknowledged for their unique experiences. The expertise of service users, family members and service providers are accepted and valued to ensure better recovery outcomes. This document will strengthen the delivery of a quality person-centred service and provide mental health services with a practical guide to co-production in practice (Health Service Executive 2020). Person- centred, value-based health care is also promoted by the Australian centre for value-based health care which supports implementation by experience-based co-design, person-centred value -based health care (VBHC) [12].

Embedding the principles of recovery into care

Empirical research on the outcomes and psychological mechanisms of recovery remains underdeveloped. Recovery models seek to operationalise recovery by improving mental health in children and adolescents with mental health conditions. In mental health services, recovery constitutes a guiding principle that has become central to mental health policies. However, in its concept state, *recovery* can be a challenge for clinicians to successfully embed into clinically focused treatment [13]. Recovery models in mental health care emphasise users' right to be involved in key decisions of their care, including choice of one's primary mental health professional and being able to change a primary mental health professional if desired [14]. Mental health services and programmes throughout Australia have adopted different conceptual models for helping staff to understand personal recovery processes and how they might enable and support personal recovery. Processes involved in personal recovery include finding and maintaining hope by believing in oneself and being optimistic about the future. This is supported by making sense of illness or emotional distress by finding a meaning in life beyond illness and by taking back responsibility and control of illness and distress (Australian Mental Health Recovery Framework 2013)[7].

For mental health practice to become more recovery-oriented, consensus on what constitutes well-functioning recovery involves co-production by patients, practitioners, and researchers [15]. Family centred conversations focussing on how family members can be supportive to each other were explored in a family nursing intervention with young people in Norway [16]. Findings indicate that health care professionals can facilitate a safe environment by talking openly about the experience of living with and managing mental health illness [16]. A study exploring the interrelationship between mental well-being and mental distress in young people indicates that a relationship exists, and that recovery-oriented practice takes place in organisational environments that influence an individual's recovery [4]. The Partners in Recovery Australian programme [17] identifies how changes in unmet needs influence recovery. Open Dialogue, an innovative approach to mental health care with in-patient young adults in Australia emphasises family involvement, flexibility, interdisciplinary and collaboration, yet even though staff members were supportive of Open Dialogue, the focus on economic efficiencies and cost effectiveness hindered progress [18].

Embedding the principles of recovery-oriented practice into care is supported by providing recovery education and training for staff and by promoting active service user engagement [19]. In an Irish study conducted by McSharry and O'Grady [20], coaching was proposed as a mechanism or strategy to make the philosophy of recovery a reality in mental health. However, attempts to identify pathways to health improvement in a community-led empowerment initiative, engaged in the Big Local programme in England, indicates no clear single pathway leading to mental health improvement [21].

Care planning addresses concerns about safety and fragmented community mental health care. These concerns led to the development of the care programme approach in the United Kingdom that requires service users to have a care coordinator, a written care plan which is regularly reviewed, and education and training for staff that is designed to enable personalised, recovery-focused care [2].

Recovery in CAMHS and challenges to achieving positive outcomes during recovery

Few studies have reported recovery outcome metrics for CAMHS. The MHC (2022) explored recovery outcomes from the perspectives of CAMHS and children with enduring mental illness. The focus of CAMHS in the early 2020's was on exploring areas that have now become critical for the mental health of children and adolescents and the services available to them. Adolescent perceptions of the benefit to access highlight the need for more understanding [22]. A study by Gibbons et al. [23] investigated reliable change and recovery rates for treatment as usual, provided by one community CAMHS in the United Kingdom, finding that half of the young people being studied improved on at least one routine outcome measure.

Mental health disorders often develop during childhood and adolescence, causing long term and debilitating impacts at individual and societal levels. Early assessment and evidence-based treatment are necessary to achieve positive mental health outcomes and to avoid long-term care. Technological advances, such as computerised Clinical Decision Support Systems (CDSSs) can support practitioners in providing evidence-based care. However, evidence is limited on its use for CAMHS according to a study conducted in Norway by Røst et al. [24] which presents challenges and opportunities for adapting CDSS design and implementation in CAMHS. These authors identify four components needed before implementing CDSS, namely: supporting collaboration among all stakeholders involved in care; using accurate health data; identifying children with comorbidities and addressing the temporality of patient care. In Ireland, the DSS was introduced in 2016. While previous studies have found that the implementation of CDSS help to improve aspects of medical care, evidence is limited on its use for CAMHS. Attention deficit hyperactivity disorder (ADHD) was the case study example used. The integration of the Individualised Digital Decision Assist System (IDDEAS) in Norway intends to provide improved outcomes for children and adolescents with enduring mental health disorders and as an education tool for CDSS design and implementation [24].

International evidence to recovery

Recovery in CAMHS is not uniform as availability of primary mental health systems, access to care interventions that are amenable to recovery, and transition from CAMHS to AMHS all contribute to recovery in a positive or negative manner [25]. An international study undertaken by Michaud et al. [25] as part of a Horizon 2020-funded project explored the availability and accessibility of primary mental health services for adolescents in 31 European countries. Models of child health were appraised via questionnaires by an expert from each country. Results indicate that all 31 participating countries had some policy or recommendations that met the study aim but that focus and implementation varied. For example, half of the participating countries had recommendations on screening adolescents for mental health issues. A quarter had ambulatory facilities specifically targeting adolescents throughout the whole country. Just over half had a suicide prevention programme. Same-day access to primary care in health emergencies was possible in 21 countries, while nineteen countries had strategies securing accessible mental health care for vulnerable adolescents. Michaud et al. [25] recommend that EU countries should widen the range of policies and recommendations governing the delivery of mental health care to adolescents and to monitor implementation, thus contributing to recovery. Hansen et al. [26] in a study relating to non-obsessive-compulsive anxiety disorders in CAMHS recommend the need for early intervention and assessment, while Stadnick et al. [27] propose that assessment should be implemented within the multidisciplinary team for children with autism. Targeted family intervention for adolescents with social, emotional, and behavioural difficulties attending CAMHS, is recommended by Wynne et al. [28].

Shared decision making in adolescent mental health care was explored by Abrines-Jaume [29]. Linguistics has also been seen to have a role in decision making. The lived experiences of persons with mental illness were explored in Australia and this has led to an elevated level of participation and inclusion of people in mental health services [30]. In assessing linguistics, findings from Bowen et al. [31] indicate that cultural behaviours have the greatest impact on recovery. A US study examining social factors including limited literacy found that even though literacy was not a predictor of recovery, further research should examine the relationship between social supports and literacy [32].

Barriers and facilitators to navigating recovery in childhood OCD

Barriers exist in navigating recovery in many mental health conditions presenting in CAMHS, for example obsessive-compulsive disorder (OCD), autism, anxiety disorder and transition to AMHS [25,27,33,34]. Sravanti et al. [33] examined the barriers and facilitators to recovery in children and adolescents (n = 10) with OCD using a qualitative interview approach. They identified barriers to recovery including an internal lack of awareness, poor motivation to seek treatment and perceived stigma, parental

anxiety and lack of support and inadequate awareness in schools. Facilitators to recovery included determination to be well, self-discipline, having a sense of purpose and external-general awareness, parental and peer support, and positive therapeutic engagement. Their findings underscore the importance of tailored interventions, positive support networks, and cultural sensitivity for successful recovery outcomes.

Early years development Interventions

Mental health disorders often first appear during youth, which justifies targeting treatment services at this age group. Australia has had a substantial increase in youth mental health services since the introduction of the Medicare Better Access scheme and Headspace services (2006-2007) [35]. These author's examined trends in the mental health of Australian youths aged between 12-25 years before and after this time, using available national and state databases. Identified were the use of mental health services per 100,000 population provided under Medicare by GPs, psychiatrists, clinical psychologists, other psychologists and allied health professionals; per capita accessing of Headspace services; and prevalence of psychological distress reported in youth age groups in health surveys in some Australian states (2001-2018). Findings indicate that while there was a substantial increase in use of mental health services since the introduction of these services no significant improvement in youth mental health or reduction in psychological distress occurred.

However, an early intervention addressing CAMHS in Italy found promising results. Poletti et al. [36] identified that early intervention in psychosis (EIP) can reduce severity and prevent illness re-occurring. The 'Reggio Emilia At-Risk Mental States' (ReARMS) protocol was the intervention used. Adolescent participants (n = 125), aged 13-18 years, completed the Comprehensive Assessment of At-Risk Mental States (CAARMS) to investigate the clinical status. Poletti et al. [36] recommend that EIP programmes for adolescents with early psychosis in Italian CAMHS are feasible and are clinically relevant.

Screening and professional assessments tools and interventions

Hollocks et al. [37] evaluated the sensitivity and specificity of the Social Communication Questionnaire (SCQ) as a screening tool for Autism Spectrum Disorder (ASD) in young people referred to in CAMHS in Los Angeles when used in the context of community CAMHS. Seventy-seven young adolescents with suspected ASD were screened using parent- and teacher-reported SCQ's before completing a comprehensive diagnostic assessment. Fifty-seven percent (57%) met criteria for an ASD diagnosis. Results indicate that regardless of informant, SCQ scores did not significantly predict the outcome of the diagnostic assessment, suggesting that the SCQ is not an effective screening tool when used in the context of community CAMHS. ASD is a neurodevelopmental disorder characterised by persistent difficulties in social interaction, communication, and restricted or repetitive patterns of behaviour in children and adolescents [38]. Parent training and family involvement in intervention is a necessary component of effective intervention programmes. However, accessibility of evidence-based interventions (EBIs) for children with ASD remains limited. Levy et al. [38] addressed this gap by examining the efficacy of a digital parent trainer by using e-learning technologies and video feedback, in delivering Pivotal Response Treatment (PRT) with 10 children with ASD, and their parents. The results indicate positive outcomes in the areas of children's communicative behaviours, parental usage, and satisfaction with the digital app, which offered a sense of empowerment in supporting their children. However, limited financial resources and lengthy waitlists, and time commitments have all been cited as obstacles to participation in such programmes [39].

Community initiatives and public mental health services

Patient experience in CAMHS was explored by Crosier and Knightsmith [40] in a study undertaken in England by exploring if one-to-one service provision and timely responses to patients' expressed needs are key components of government plans to improve CAMHS. Despite national level commitments to listening to and acting on the "patient's voice," young people using the service and parents of this group reported not having been invited to participate in patient experience research. This prompted senior policy makers to call for a rethink in relation to the role and value of patient experience research in order to recognize its important and unique contribution to addressing the questions facing services.

General practitioner (GP) satisfaction with specialist CAMHS is often reported as low internationally. Lambert et al. [41] explored GP perceptions of local children's mental health services to understand their experiences of a novel GP- attached Primary Mental Health Worker (PMHW) service in a local community service in the United Kingdom. Nine GPs were interviewed in this study. Most GPs perceived their role to signpost and refer patients with mental health issues to specialist services, rather than offering care directly. However, GPs were unclear as to the criteria for specialist CAMHS referral and the availability of alternate resources, resulting in communication challenges when the GP sought advice and support from the specialist services. While there is need for more training for GPs in supporting children with mental health problems, positive features to this initiative enabled GPs to have informal discussions, seek advice about children, recognise problems earlier and access help more quickly.

A prospectively audited study on referrals was provided by one community CAMHS in the United Kingdom [23]. Baseline outcome data were obtained for 672 (78%) and 744 (77 %) young people. Pre- and post-test for scores were gathered on the Revised Child Anxiety and Depression Scale (RCADS) and the Strengths and Difficulties Questionnaire (SDQ). 174 (59%) and 155 (45.7%) participants. The study aim was to investigate change and recovery rates for treatment as usual in two time periods (2018 and 2019) with children from CAMHS. Total RCADS scores showed 21-25% of participants reliably improved, with 44-49% showing reliable improvement on one or more subscale. On the SDQ, 15.5% and 25% reported reliable improvement on at least one subscale. Findings show that recovery rates ranged from 48 to 51% for youth-completed and 40 to 42% for parent-completed RCADS, indicating that reliable change and recovery on subscale rather than total scores may be a better indication of outcomes.

Another community intervention: The Family-Based Recovery Model by the State of Connecticut Dept. of Children and Families, Yale Child Study Centre and Johns Hopkins University was undertaken by Hanson et al. [42] using a qualitative intervention treatment collaborative model. The study highlights the family-focused practice elements that allow children to remain safely at home with parents who are in treatment. Outcomes suggest that this is a promising practice when this Model is used as collaborations between child protective services and substance use treatment providers that can yield positive results for families with young children.

Transitioning from CAMHS to Adult Mental Health Services (AMHS)

Differences in care philosophies may influence transitions from CAMHS to AMHS that may influence recovery. Mulvale et al. [43] reviewed literature about both care philosophies and influence of care philosophy on transitions. Findings reveal consistent differences in care philosophies between CAMHS (developmental approach, involving families and nurturing) and AMHS (clinical/diagnosis-focus, emphasis on client autonomy and individual responsibility) indicating the need for better understanding to better meet the needs of transitioning youth and support recovery. Pontoni et al. [44] explored factors associated with transition in a cohort of former inpatients (n = 322) of a Children and Adolescents Intensive Treatment Ward (CAITW) and found a transfer rate of 50%. Two years after transition-age CAMHS-AMHS continuity of care was found in 40% and disengagement in 6% of cases. Young adults with a history of psychiatric inpatient admission as children or adolescents have a high rate of transition to AMHS.

Transitioning raises ethical aspects for healthcare professionals, as well as for young people, their parents, and carers. O'Hara et al. [45] conducted focus groups in Croatia, Ireland and the United Kingdom with youth mental health groups and youth representatives with no mental health (MH) remit (n = 111). Perpetuation of stigma, autonomy and decision-making were central themes as both enablers and deterrents of successful transition. The tension between professional (and at times parental) paternalism and young persons' growing autonomy was captured in the themes, particularly autonomy and collaboratively working, which people expect to underpin the transition between CAMHS and AMHS.

Cleverley et al. [34] aimed to identify the core components of interventions that facilitate successful transition to determine the characteristics that support the transition process. A major finding was a significant lack of measurable indicators. This review did identify 26 core components organised within the framework of the six core elements of healthcare transitions. Policy makers, practitioners, and administrators can use the core components to guide decisions about transition programme and intervention content. Future research needs to focus on the development of indicators to evaluate transition programs and interventions.

A further approach to transitioning was undertaken by Signorini et al. [46] in identifying collaboration and involvement of social services supporting young people approaching transition via a survey of 16 European Union countries. Findings indicate that service availability ranges from 3/100,000 social workers working with young people of transition age in Spain to 500/100,000 social workers in Poland, with heterogeneous involvement in youth health care. Community-based residential facilities and services for youth under custodial measures were the most common type of social service involved. In 80% of the surveyed countries, youth protection from abuse/neglect was overall regulated by national protocols or written agreements between mental health and social services, except for the Czech Republic and Greece, where poor or no protocols apply. Findings suggest weakness in youth mental health policymaking at European level and the need for greater inclusion of all stakeholders to inform development. Lack of connection between CAMHS and AMHS has been identified as the major obstacles to transition (93.8%), together with insufficient involvement of stakeholders throughout the process.

Conclusion

Thematic analysis elicited themes designated as necessary to recovery. Themes include the importance of co-production in practice with family, professionals and General Practitioner care, thus embedding the principles of recovery into care in CAMHS and the challenges to achieving positive outcomes during recovery. Findings reveal consistent differences in care philosophies between CAMHS and AMHS. Better understanding of these differences

and collaborative planning and service delivery may foster shared approaches to meeting the needs of transitioning youth and aid recovery. Transitioning raises ethical aspects for healthcare professionals, as well as for young people, their parents, and carers. Transition of young people from CAMHS to AMHS is a complex process. Engaging young people early in making decisions about their future care can enhance trust between the practitioner and the young person and aid their recovery. In addition to diagnosis, several factors (such as moving home, waiting lists and stigma) may need to be considered when considering the direction of future health care. When possible, alternatives to AMHS should be considered if the young person considers these to be a less-stigmatising treatment option. Findings suggest weaknesses in youth mental health policymaking at the European level and indicates the need for greater inclusion of relevant stakeholders to inform the development and implementation of person-centered health-care models. Gathering information on social service provision at the time of mental health services transition at European level is needed to inform services to offer a better coordinated social health care for young people with mental health disorders that supports recovery.

Funding

No funding was obtained in the writing of this study.

Acknowledgement

We acknowledge the support of the RCSI library staff. We also acknowledge the Mental Health Commission for awarding a former *quality framework for mental health services* to the Faculty of Nursing and Midwifery, RCSI which ignited the importance of recovery in mental health systems and led to this study on recovery in CAMHS.

Ethical Approval

Ethical approval was not required for this evidence review as patients or stakeholders were not involved.

Conflict of Interest

None

References

1. Cooper HM (1982) Scientific guidelines for conducting integrative research reviews. Review of Educational Research 52: 291-302.
2. Simpson A, Bannigan B, Coffey M, Barlow S, Cohen R, et al. (2016). Recovery-focused care planning and coordination in England and Wales: a cross-national mixed methods comparative case study. BMC Psychiatry 16: 147.
3. Biringer E, Hartveit M, Sundfør B, Ruud T, Borg M (2017) Continuity of care as experienced by mental health service users - a qualitative study. BMC Health Serv Res 17: 763.
4. Bauer A, Evans-Lacko S, Knapp M (2019) Valuing recovery-oriented practice at the interface between mental health services and communities. The role of organisational characteristics and environments. Int J Soc Psychiatry 65: 136-143.
5. Carney M, Mahon P, Kearns T (2022) National quality framework for mental health services: Evidence Review. Mental Health Commission, Dublin.
6. Farrelly J, Kiernan G, Finnerty S, Stepala P, Costigan D, Carney M., Mahon P, Kearns T. (2023) The National Quality Framework: Driving Excellence in Mental Health Services. Mental Health Commission, Dublin.
7. Commonwealth of Australia (2013) A National Framework for Recovery-Orientated Mental Health Services: Guide for Practitioners and Providers.
8. Drake RE, Wallach MA (2020) Employment is a critical mental health intervention. Epidemiol Psychiatr Sci 5: e178.
9. Health Service Executive (2018) Co-Production in Practice Guidance Document 2018-2020: Supporting 'A National Framework for Recovery in Mental Health 2018-2020. Ireland.
10. Health Service Executive (2017) A National Framework for Recovery in Mental Health: A National Framework for Mental Health Service Providers to Support the Delivery of a Quality, Person-Centred Services 2018-2020.
11. MHC (2020) Judgement Support Framework.
12. Australian Centre for value-based health care (AHHA) (2024). Experience based co-design toolkit for Australia.
13. Khan N, Tracy DK (2021) The challenges and necessity of situating 'illness narratives' in recovery and mental health treatment. BJPsych Bull 46: 77-82.
14. Rioli G, Ferrari S, Henderson C, Vandelli R, Galli G, et al. (2020) Users' choice and change of allocated primary mental health professional in community-based mental health services: A scoping review. Int J Soc Psychiatry 66: 373-381.
15. Bitter N, Roeg D, Van Nieuwenhuizen C, Van Weeghel J (2019) Training professionals in a recovery-oriented methodology: a mixed method evaluation. Scand J Caring Sci 33: 457-466.
16. Aass LK, Skundberg-Kletthagen H, Schrøder A, Moen ØL (2020) Young adults and their families living with mental illness: Evaluation of the usefulness of family-centered support conversations in community mental health care settings. J Fam Nurs 26: 302-314.
17. Hancock N, Scanlan JN, Gillespie JA, Smith-Merry J, Yen I (2018) Partners in recovery program evaluation: Changes in unmet needs and recovery. Aust Health Rev 42: 445-452.
18. Dawson L, River J, McCloughen A, Buus N (2021) 'Should it fit? Yes. Does it fit? No': Exploring the organisational processes of introducing a recovery-oriented approach to mental health in Australian private health care. Health 25: 376-394.
19. Nardella N, Hooper S, Lau R, Hutchinson A (2021) Developing acute care-based mental health nurses' knowledge and skills in providing recovery-orientated care: A mixed methods study. Int J Ment Health Nurs 20: 1170-1182.
20. Mc Sharry P, O' Grady T (2021) How coaching can assist the mental healthcare professional in the operationalization of the recovery approach. Perspect Psychiatr Care 57: 844-851.

21. McGowan VJ, Wistow J, Lewis SJ, Popay J, Bambra C (2019) Pathways to mental health improvement in a community-led area-based empowerment initiative: Evidence from the Big Local 'Communities in Control' study, England. J Public Health 41: 850-857.

22. Tatlow-Golden M, McElvaney R (2015) A bit more understanding: Young adults' views of mental health services in care in Ireland. Children and Youth Services Review 51: 1-9.

23. Gibbons MBC, Gallop R, Thompson D, Gaines A, Rieger A, et al. (2021) Predictors of treatment attendance in cognitive and dynamic therapies for major depressive disorder delivered in a community mental health setting. J Consult Clin Psychol 87: 745-755.

24. Røst TB, Clausen C, Nytrø Ø, Koposov R, Leventhal B, et al. (2020) Local, early, and precise: Designing a clinical decision support system for child and adolescent mental health services. Frontiers in Psychiatry 11: 564205.

25. Michaud P, Visser A, Vervoort J, Kocken P, Reijneveld S, et al. (2020) Availability and accessibility of primary mental health services for adolescents: An overview of national recommendations and services in EU. Eur J Public Health 30: 1127-1133.

26. Hansen BH, Oerbeck B, Skirbekk B, Kristensen H (2016) Non-obsessive-compulsive anxiety disorders in child and adolescent mental health services--Are they underdiagnosed, and how accurate is referral information? Nord J Psychiatry 70: 133-139.

27. Stadnick N, Lau A, Dickson K, Pesanti K, Innes-Gomberg D, et al. (2020) Service use by youth with autism within a system-driven implementation of evidence-based practices in children's mental health services. Autism 24: 2094-2103.

28. Wynne C, Doyle C, Kenny R, Brosnan E, Sharry J (2016) A first-level evaluation of a family intervention for adolescent social, emotional and behavioural difficulties in child and adolescent mental health services. J Child Adolesc Ment Health 28: 33-46.

29. Abrines-Jaume N, Midgley N, Hopkins K, Hoffman J, Martin K, et al. (2014) A qualitative analysis of implementing shared decision making in child and adolescent mental health services in the United Kingdom: Stages and facilitators. Clin Child Psychol Psychiatry 21: 19-31.

30. Piccone J, Moodie K, Sanderson L, Bond M, DeGraeve G (2018) Sharing wisdom II: Integrated care in partnership – Designing youth mental health services in Queensland, Australia. International Journal of Integrated Care 18: 103.

31. Bowen A, Maguire T, Newman-Taylor K (2020) Do recovery outcome measures improve clinical practice? A linguistic analysis of the impact of the Hope, Agency and Opportunity measure in community mental health teams. Perspect Public Health 140: 102-107.

32. Garverich S, Prener CG, Guyer ME, Lincoln AK (2021) What matters: Factors impacting the recovery process among outpatient mental health service users. Psychiatr Rehabil J 44: 77-86.

33. Sravanti L, Madegowda RK, Velusamy AJP, Kommu JVS, Girimaji SC, et al. (2024) Navigating recovery in childhood OCD: A qualitative analysis of barriers and facilitators. Child Adolesc Psychiatry Ment Health 18: 160.

34. Cleverley K, Rowland E, Bennett K, Jeffs L, Gore D (2020) Identifying core components and indicators of successful transitions from child to adult mental health services: A scoping review. Eur Child Adolesc Psychiatry 29: 107-121.

35. Jorm AF, Kitchener BA (2020) Increases in youth mental health services in Australia: Have they had an impact on youth population mental health? Aust N Z J Psychiatry 55: 476-484.

36. Poletti M, Pelizza L, Azzali S, Paterlini F, Garlassi S, et al. (2020) Overcoming the gap between child and adult mental health services: The Reggio Emilia experience in an early intervention in psychosis program. Early Interv Psychiatry 15: 1749-1758.

37. Hollocks MJ, Casson R, White C, Dobson J, Beazley P, et al. (2019) Brief report: An evaluation of the social communication questionnaire as a screening tool for autism spectrum disorder in young people referred to child & adolescent mental health services. J Autism Dev Disord 49: 2618-2623.

38. Levy G, Sagiv-Friedgut K, Cohen Z, Front-Shaham B, Aran A, et al. (2024) Scaling evidence-based practice in autism: A randomized clinical trial of a digital parent trainer in pivotal response treatment. Journal of Psychiatry and Cognitive Behaviour 8: 184.

39. Gengoux GW, Abrams DA, Schuck R, Millan ME, Libove R, et al. (2019) A pivotal response treatment package for children with autism spectrum disorder: An RCT. Pediatrics 144: e20190178.

40. Crosier A, Knightsmith P (2020) Patient experience research in children and young people's mental health services in England: A route to genuine service transformation or just pretty pictures and tasteful color schemes? J Patient Exp 7: 1398-1402.

41. Lambert AK, Doherty AJ, Wilson N, Chauhan U, Mahadevan D (2020) GP perceptions of community-based children's mental health services in Pennine Lancashire: A qualitative study. BJGP Open 4: bjgpopen20X101075.

42. Hanson KE, Duryea ER, Painter M, Vanderploeg JJ, Saul DH (2019) Family-based recovery: An innovative collaboration between community mental health agencies and child protective services to treat families impacted by parental substance use. Child Abuse Review 28: 69-81.

43. Mulvale GM, Nguyen TD, Miatello AM, Embrett MG, Wakefield PA, et al. (2019) Lost in transition or translation? Care philosophies and transitions between child and youth and adult mental health services: a systematic review. J Ment Health 28: 379-388.

44. Pontoni G, Di Pietro E, Neri T, Mattei G, Longo F, et al. (2022) Factors associated with the transition of adolescent inpatients from an intensive residential ward to adult mental health services. Eur Child Adolesc Psychiatry 31: 805-818.

45. O'Hara L, Holme I, Tah P, Franic T, Vrljičak Davidović N, et al. (2020) A cross-cultural qualitative study of the ethical aspects in the transition from child mental health services to adult mental health services. Child Adolesc Ment Health 25: 143-149.

46. Signorini G, Davidovic N, Dieleman G, Franic T, Madan J, et al. (2020) Transitioning from child to adult mental health services: What role for social services? Insights from a European survey. Journal of Children's Services 15: 89-108.