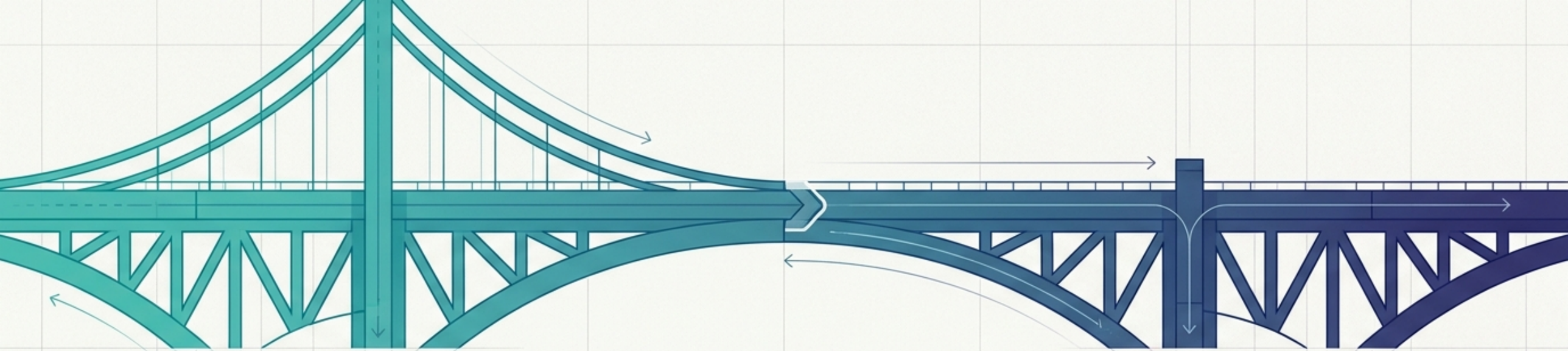
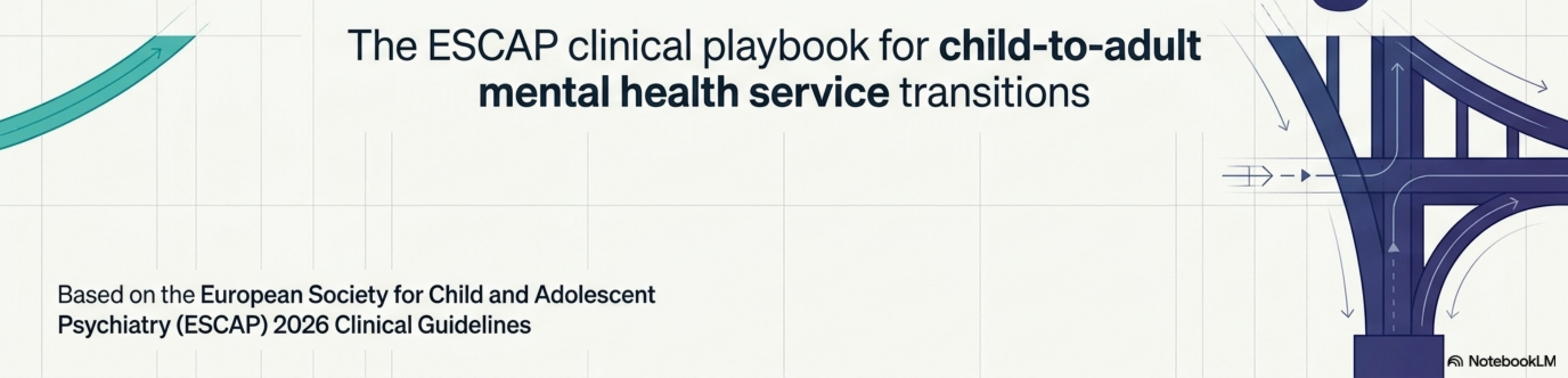


The Continuous Bridge

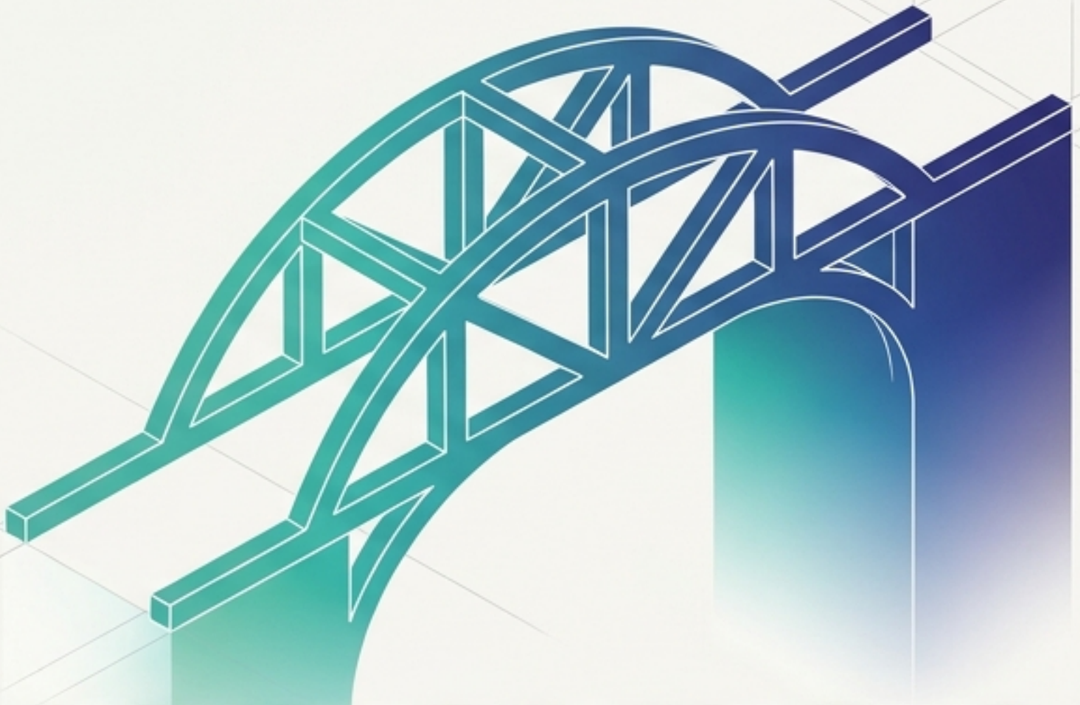
The ESCAP clinical playbook for **child-to-adult mental health service** transitions



Based on the **European Society for Child and Adolescent Psychiatry (ESCAP) 2026 Clinical Guidelines**

THE MENTAL HEALTH SERVICE BOUNDARY IS HISTORICALLY A CLIFF EDGE, LEADING TO DISRUPTED CARE AND HEIGHTENED RISK FOR YOUNG PEOPLE.

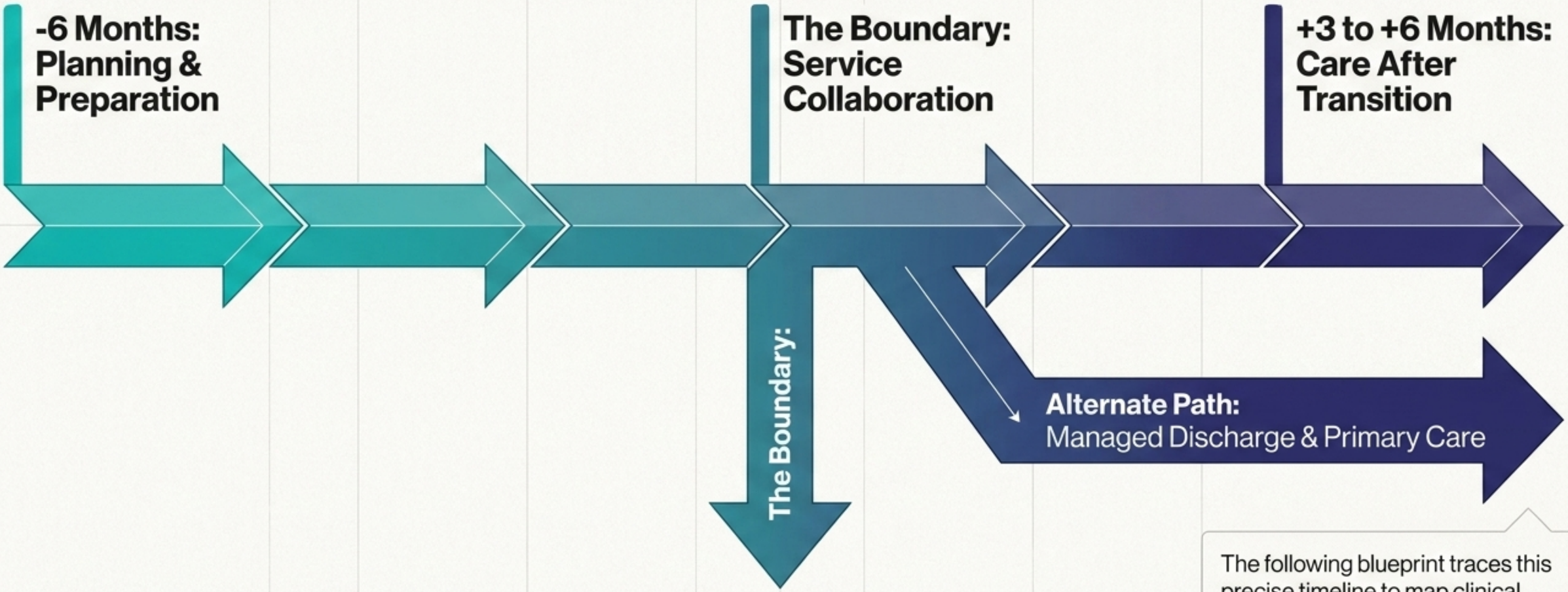
The current system presents an abrupt cessation of services, lacking continuity and coordination, which dramatically increases vulnerability and the likelihood of negative outcomes for adolescents reaching the service age limit.



TRANSITION IS NOT A HANDOVER; IT IS A PROCESS OF PLANNED CONTINUITY. THIS BLUEPRINT MAPS THE EXACT CLINICAL ACTIONS AND MANAGERIAL SUPPORT SYSTEMS REQUIRED TO BUILD A CONTINUOUS BRIDGE ACROSS THE CAMHS-TO-AMHS BOUNDARY.

The proposed framework establishes a guided, multi-stage journey with shared responsibility, overlapping support, and clear clinical protocols, ensuring a seamless, supported, and effective transfer of care, minimizlng risk and promoting long-term stability.

The Master Blueprint: Mapping the Clinical Journey



The following blueprint traces this precise timeline to map clinical interventions at every step.

Initiating the Blueprint: The 6-Month Mark

Start Early

Initiate planning at least 6 months before the service boundary for patients in care over 12 months.

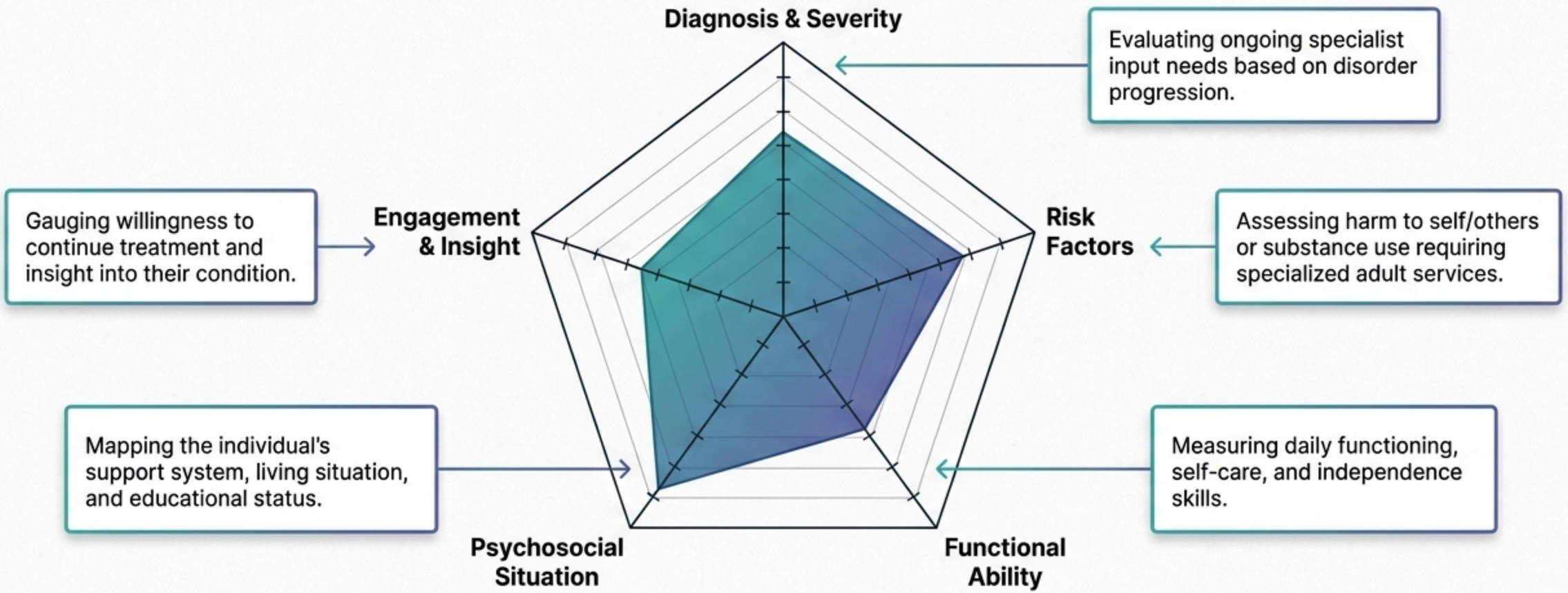
The Coordinator

Allocate a specific person in the existing care team (e.g., a nurse) as the single point of contact to coordinate care and navigate the system.

The Multidisci-plinary Team

Engage a broad range of care providers, taking a holistic perspective that includes education, housing, health, and legal circumstances.

The 6-Month Mark: The TRAM Readiness Radar

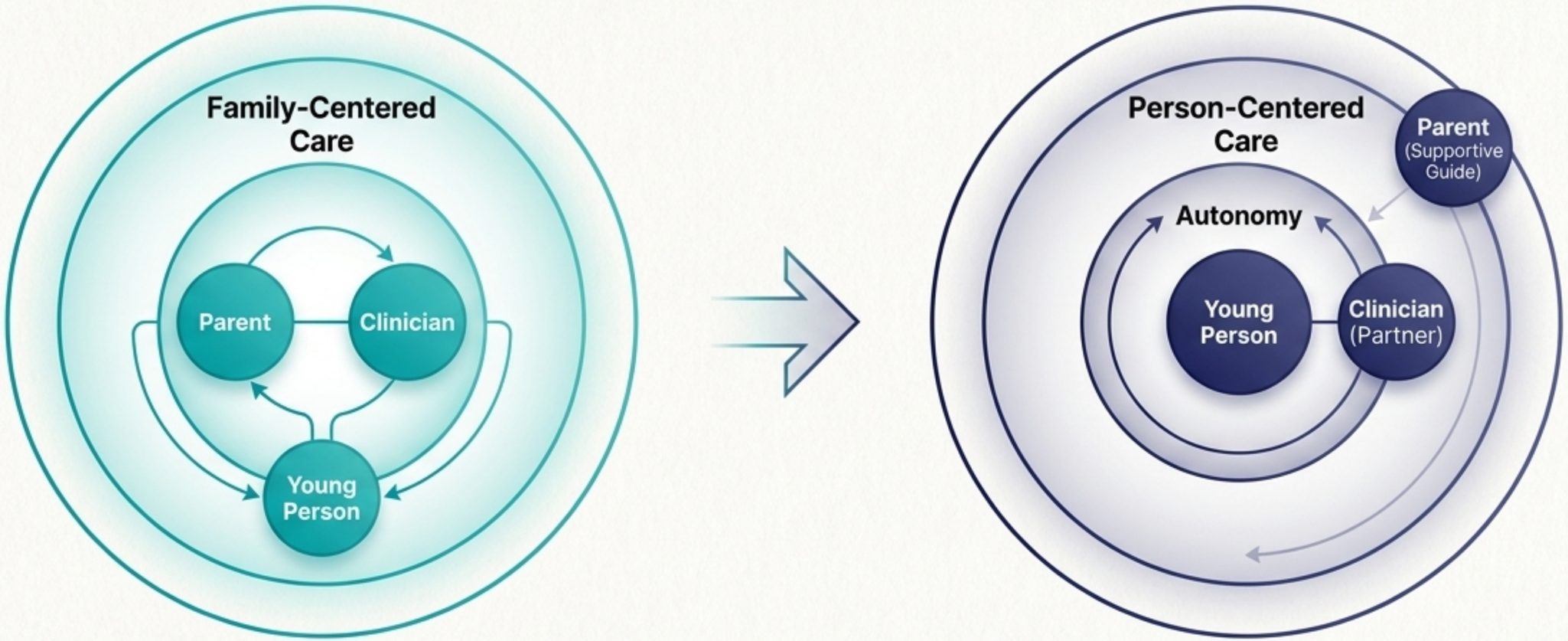


Takeaway: Assessing the overall level of impairment and risk takes priority over diagnosis alone.

The 6-Month Mark: The Destination Decision Matrix

Transition to AMHS (Specialist Care)	Managed Discharge (Primary & Community Care)
Profile: Severe conditions (psychosis, bipolar, severe depression/PTSD, eating disorders, complex comorbidities like type-1 diabetes).	**Profile:** Show improvement in mental health, lower impairment, symptom stability.
Needs: Requires specialist medication management, high suicide/self-harm risk management.	**Needs:** Less intensive support, routine medication management.
Action: Prioritize for full transition to Adult Mental Health Services.	**Action:** Step-down services, time-limited follow-ups, referral to GP or voluntary sector.

The 3-Month Mark: The Shift in the Care Paradigm



Key Actions: Prepare parents for this shift. Support options for parents to attend the first AMHS appointment, while developing alternative plans if the young person prefers independent engagement.

The 3-Month Mark: The Comprehensive Handover Toolkit

Diagnosis & Formulation

Clear written synthesis, acknowledging any evolving uncertainties.

Development & Strengths

Complete history of personal and environmental resources.

Medication History

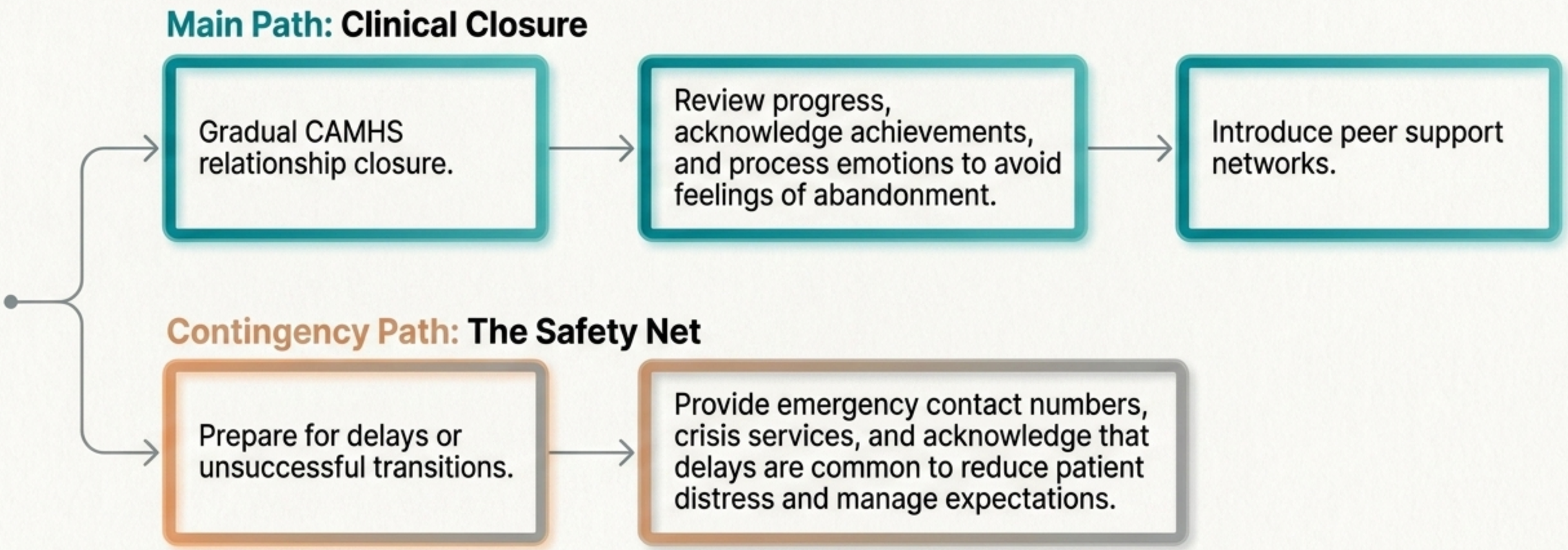
Prescriptions, efficacy, and treatment history.

Accessible Records

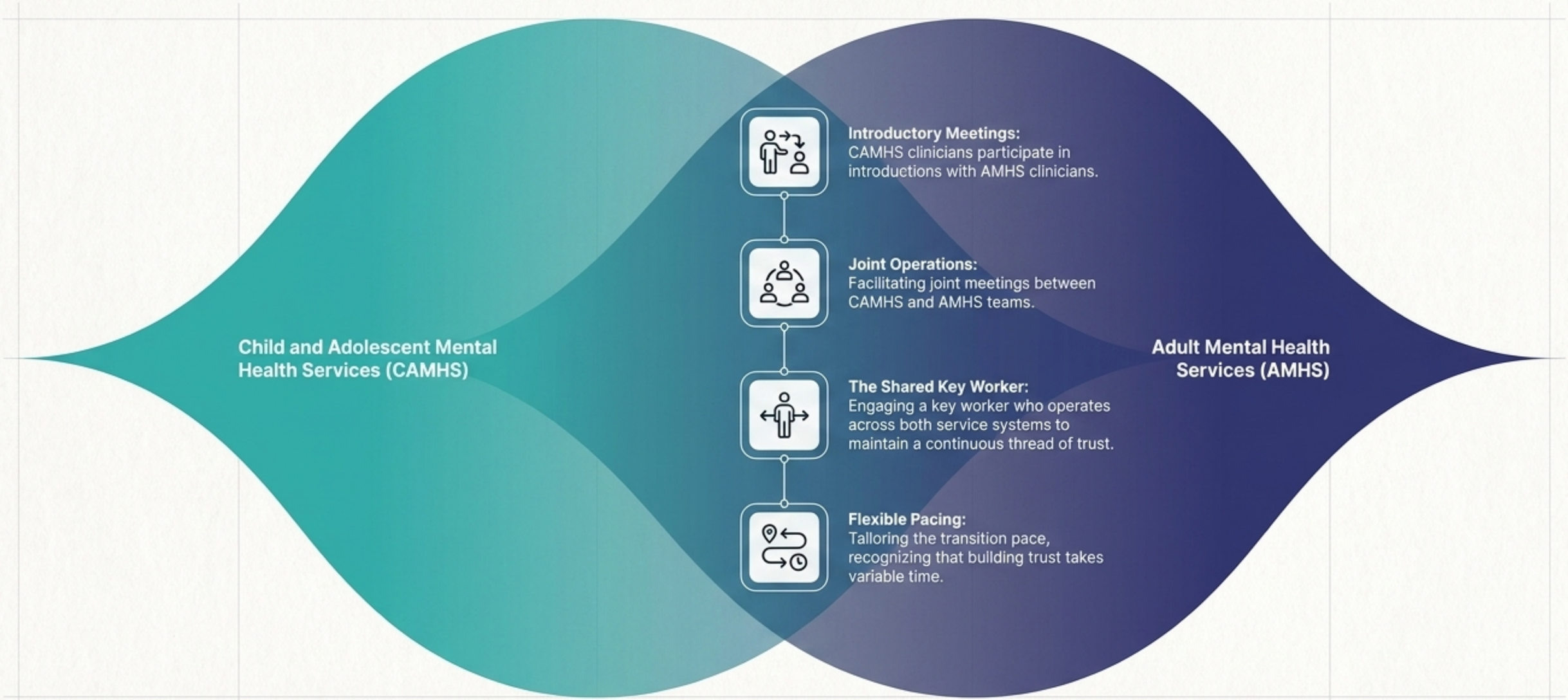
Provide the young person with a secure, patient-held communication booklet or digital record for their first AMHS appointment.

Information must be accessible, age-appropriate, and explain differences between child and adult services.

The 1-Month Mark: Closure, Contingencies, and Peer Support



The Boundary: Inter-Service Collaboration



Alternate Path: The Managed Discharge Pathway

Psychoeducation & Self-Management

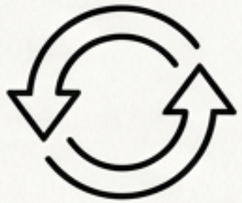
Age-appropriate symptom trackers and apps.

Medication Handover

Clear agreement on who prescribes (e.g., GP), treatment duration, and deprescribing guidance.

Primary & Community Integration

Active, ‘warm’ introductions to GP, peer groups, and vocational training (no passive leaflet dropping).



Rapid Re-entry & Crisis

Clear pathways established for re-accessing mental health services rapidly if symptoms relapse.

The +3 Month Mark: Landing in AMHS and Securing Engagement

The Pre-requisite

Ensure at least one AMHS appointment occurs before final CAMHS discharge.

Clinician Consistency Rule

The exact same AMHS clinician **MUST** see the young person for the first 2 appointments (extend to 3-4 if weekly support is needed) to build rapport and lower anxiety.

Proactive Follow-up

AMHS must actively pursue and follow up with young people who disengage within the first 3 months post-transition.

Environment Note: Physical spaces must be youth-friendly (WIFI, cozy spaces, digital communication options).

The +6 Month Mark: Closing the Loop and Measuring Impact

The Process

At 4 to 6 months post-transition, conduct a comprehensive evaluation of mental health outcomes.

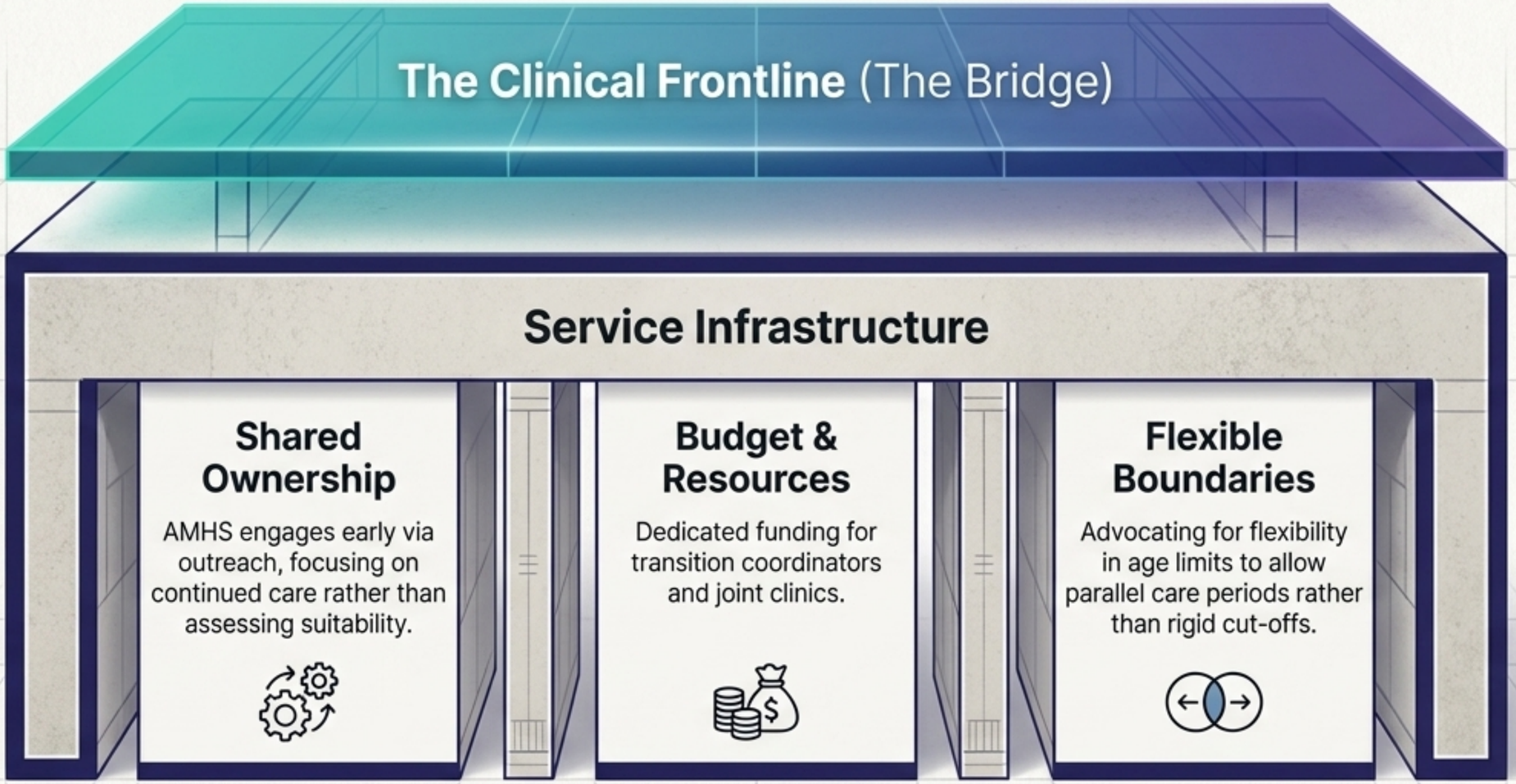
The Tool

Utilize the Transition Outcome Measure (TROM) to match the initial TRAM assessment.

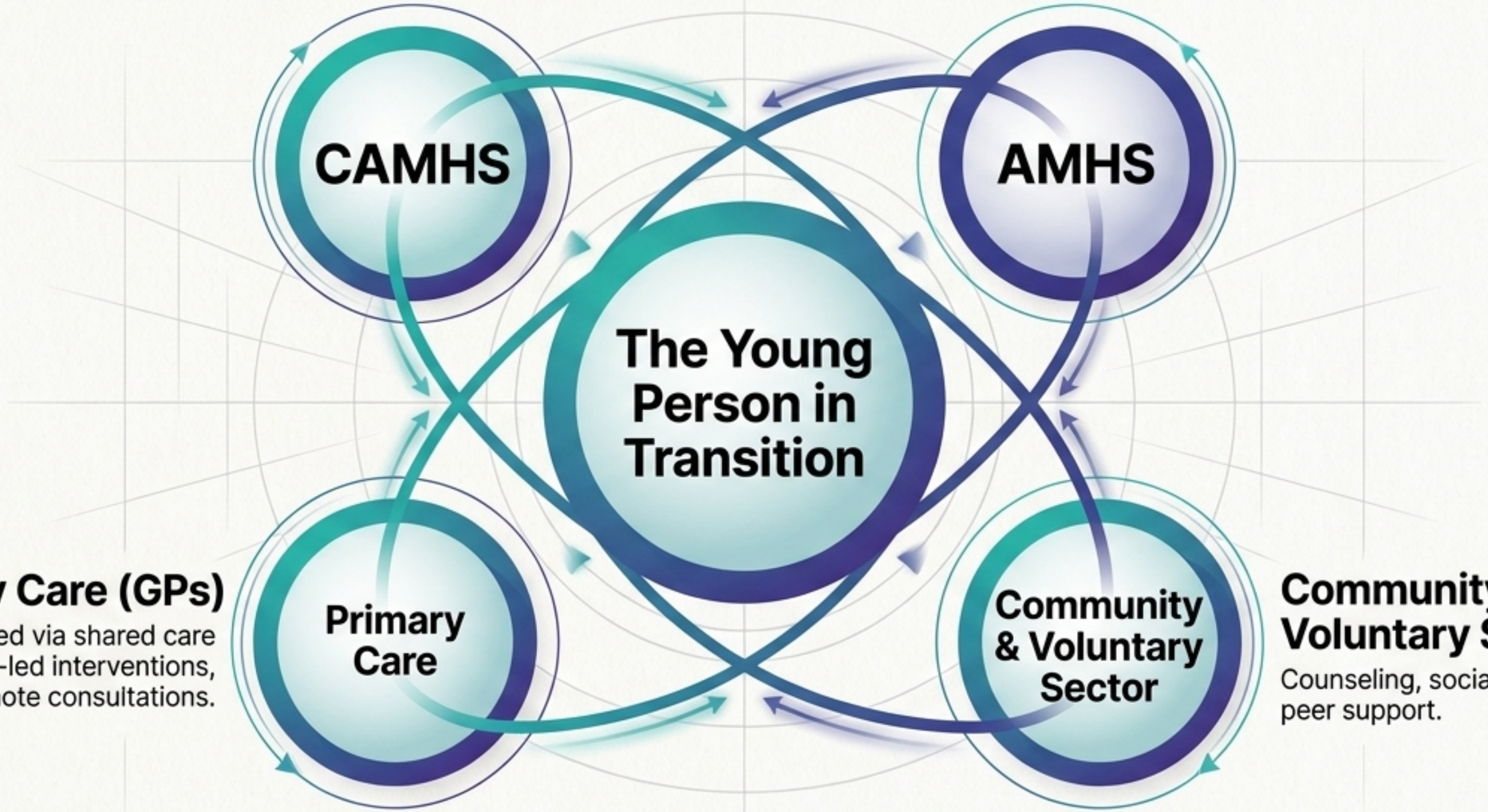
The Goal

Assess the transition from multiple perspectives to ensure the young person has stabilized in their new care environment.

The Manager's Engine: Building the Backstage Blueprint



The Connected Ecosystem of Care



Primary Care (GPs)
Integrated via shared care models, nurse-led interventions, and digital remote consultations.

Community & Voluntary Sector
Counseling, social services, peer support.

System Action: Service directories must be actively maintained and updated to eliminate referral friction between these spheres.

Co-Design and Continuous Refinement

Co-Design with Youth

Actively involve young people and families in designing youth-friendly, developmentally appropriate services.

Standardized Feedback Tools

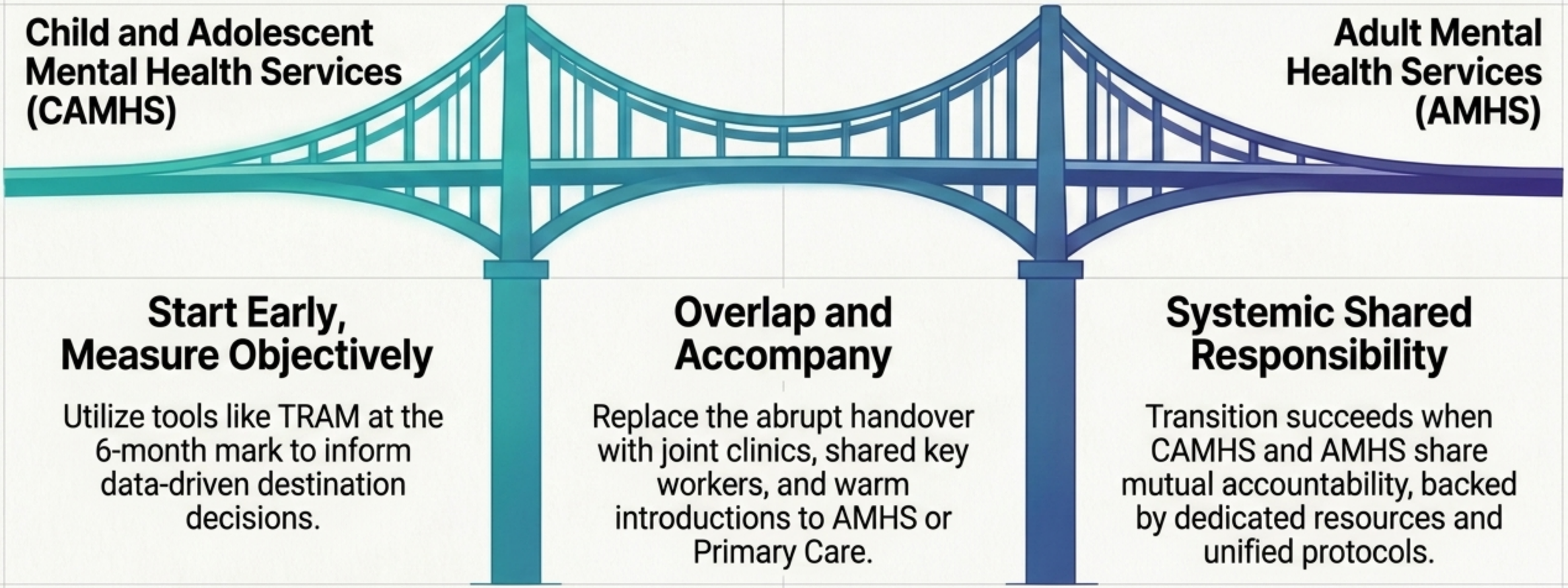
Equip clinicians to systematically capture service user experience at 6 months post-transition using validated tools:

- **OYOF-TES** (On Your Own Feet - Transition Experiences Scale)
- **OYOF-EOC** (End of Care version)

Takeaway: Use this data for ongoing policy reform and funding advocacy to address rigid timelines and waiting lists.

The Completed Bridge

Child and Adolescent Mental Health Services (CAMHS)



Adult Mental Health Services (AMHS)

Start Early, Measure Objectively

Utilize tools like TRAM at the 6-month mark to inform data-driven destination decisions.

Overlap and Accompany

Replace the abrupt handover with joint clinics, shared key workers, and warm introductions to AMHS or Primary Care.

Systemic Shared Responsibility

Transition succeeds when CAMHS and AMHS share mutual accountability, backed by dedicated resources and unified protocols.

Transition is not an administrative discharge—it is a critical therapeutic intervention.