

GUIDELINE

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Transitions for youth and young adults with eating disorders and/or other mental health conditions: a Canadian guideline

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Abstract

Background Eating disorders (EDs) are severe mental illnesses with high rates of mortality, morbidity, and reduced quality of life. Their onset occurs during adolescence and early adulthood, coinciding with the critical transition from pediatric to adult care. To address the lack of guidelines to support ED transitions in Canada, this study developed evidence-based guideline recommendations.

Methods Scoping review methodology was employed using comprehensive searches across seven databases, supplemented by forward and backward citation chaining to identify records on youth and young adults (YYAs) (16–25 years) with EDs and/or mental health conditions transitioning from pediatric to adult care. The Grading of Recommendations Assessment, Development, and Evaluation approach was used to evaluate the quality of the evidence for applicable studies. Using a modified Delphi method, the evidence was reviewed by a guideline development panel and consensus was achieved in a single round of voting.

Results After de-duplication, 14,350 records from all sources were screened, with 1817 studies undergoing full-text review. A total of 419 studies were included. Of these, 199 were primary research studies which fell under one or more

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of the following categories: descriptive (n = 86), qualitative (n = 75), predictors (n = 48), transition interventions (n = 21), measurement tools (n = 8), and key outcomes (n = 3). The certainty of the evidence for specific interventions and tools was generally low.

Recommendations The panel issued strong recommendations for integrated, collaborative transition approaches involving YYAs, families, and providers, and for the use of the Transition Readiness Assessment Questionnaire (TRAQ) to support transition planning. Additional recommendations are included, with an emphasis on future research focused on long-term outcomes such as care continuity and treatment retention.

Conclusion This research addressed the absence of a cohesive approach to transitions for YYAs experiencing EDs and/or mental health conditions, highlighting evidence variability and the need for a unified approach. These guidelines propose actionable steps for improving care transitions for YYAs with EDs and/or mental health conditions by promoting collaborative care models, prioritizing outcome-focused research, and using measurement tools.

Keywords Transition, Eating disorders, Interdisciplinary care, Mental illness, Interventions, Key outcomes, Measurement tools, Clinical practice guidelines, Guideline development panel, Youth, Emerging adults

Plain English summary

Young people with eating disorders (EDs) and/or other mental health conditions often face challenges when moving from pediatric to adult care, both in mental health and physical health realms. This transition typically occurs during adolescence or early adulthood which is a critical developmental period when continuation of care and support is essential. In Canada, there are no clear guidelines to help navigate this process. To address this gap, our team developed six recommendations based on a comprehensive scoping review of existing research. In these recommendations, we emphasize the importance of a collaborative approach that involves young people, families, and health-care providers to ensure continuity and coordination of their care during the transition. In addition, research should prioritize the study of long-term outcomes, such as whether young people stay in treatment, leave early, or achieve successful transitions. Tools like the Transition Readiness Assessment Questionnaire (TRAQ) can help assess how prepared someone is for this change, but these tools need more testing to ensure they work well for people with EDs. These guidelines aim to improve care during this transition and to ensure that young people with EDs and/or other mental health conditions are prepared and supported as they move into adult healthcare services.

Introduction

Eating disorders (EDs) are serious psychiatric illnesses associated with significant medical complications and elevated mortality rates [1–6]. Notably, EDs have the second-highest mortality rate of all psychiatric illnesses [1], driven by medical consequences and suicide [3, 7, 8]. Lifetime prevalence estimates among females range from 0.6 to 2.0% for Anorexia Nervosa (AN) and 1.2–4.6% for Bulimia Nervosa (BN) [9–11]. EDs often emerge in adolescence and continue into adulthood [12, 13], with many young people requiring a transfer from pediatric care [5, 6, 13] to adult care [3, 14]. The term “pediatric to adult care” encompasses a variety of related services, such as Child and Adolescent Mental Health Services (CAMHS), Child and Adolescent Eating Disorder Services (CAEDS), Adult Mental Health Services (AMHS), and Adult Eating Disorder Services (AEDS) as well as transition clinics, specialized programs, and coordinated care pathways found in countries such as Canada, the United States, the United Kingdom, Australia, and various European nations.

Transitions for youth and young adults (YYAs) with EDs are often poorly executed [14], resulting in delayed or discontinued care. We define YYAs as ages 16–25 to align with developmental science and transitional care literature, recognizing this period as a critical window for health system navigation and evolving needs in ED and psychiatric treatment [15, 16]. Qualitative research highlights these transition difficulties. One study found that YYAs aged 16–25 with prior pediatric ED treatment exhibited lower self-esteem and greater fears of maturity when assessed in adult ED services compared to peers without pediatric treatment [17], suggesting that transition interventions should foster autonomy. Other studies note that healthcare providers often lack the knowledge, skills, and confidence to effectively support YYAs with EDs and their families through this transition [14]. Despite growing awareness, few effective transition solutions or interventions for YYAs with EDs have been identified. Given the limited research on ED-specific transitions, this guideline draws on broader mental health literature, recognizing that EDs are a

subset of mental health disorders and share overlapping challenges in care transitions.

National organizations have published general guidelines to support healthcare transitions of YYAs. Guidelines from the National Institute for Care Excellence in the United Kingdom recommended: (1) co-designing transition processes, policies, and materials; (2) transition planning that is early, strengths-based, youth-centred, and developmentally-appropriate; (3) collaboration between pediatric and adult systems; and (4) robust information sharing and transfer [18]. The Canadian Association for Paediatric Health Centres issued healthcare transition guidelines emphasized rigorous data collection and evaluation to support youth with special healthcare needs [19]. While useful, these guidelines remain general and do not address nuances and complexities specific to EDs.

First, the medical complications that accompany EDs require coordination between physical and mental healthcare providers [13, 14, 20] and involvement of primary care providers to ensure continuity of care [21–23]. Second, developmentally-appropriate involvement of parents is critical in supporting YYAs as they navigate transitions [24], especially given the use of Family-Based Treatment (FBT) in pediatric care. Third, ED behaviours reduce motivation to change [25] and recognition of the need for continued adult treatment; this lack of insight requires a tailored transition approach especially for those early in their ED.

Best practices for transitioning YYAs with EDs have been developed in the United Kingdom [26–28]. No evidence-based clinical practice guidelines exist for pediatric to adult ED care. We conducted a scoping review and shared findings with a national team of researchers, providers, decision makers, people with lived experience, and families to reach consensus on evidence-informed guidelines for the transition from pediatric to adult care for YYAs with EDs and/or other mental health conditions.

Methods

Using a scoping review of the literature, we synthesized available evidence to arrive at practice recommendations for transitioning YYAs with EDs and/or other mental health conditions. Using this evidence, we used a modified Delphi Method, a consensus-based approach, to generate the guidelines with multiple partners across Canada [29].

Scoping review methods

Scoping reviews differ from systematic reviews and meta-analyses by allowing the inclusion of diverse study designs [30], which is essential given the limited

controlled research on transitions in ED care. The rationale for using scoping review methodology includes the ability to include, synthesize, and rate the quality of quantitative, qualitative, and mixed methods evidence relevant to our goals; the allowance for intentional stakeholder engagement at the outset of the guideline development process; and the ability to generate recommendations for new lines of inquiry in transition of care which can be pursued following the achievement of the present project's goals [31].

The scoping review was guided by the question: What is the extent, range, and nature of the literature on the transition from pediatric to adult care among YYAs (aged 16–25) with EDs and/or other mental health conditions? Registered with Open Science Framework, the review followed the PRISMA-ScR checklist [32] and employed the Arksey and O'Malley framework [33] with adaptations from the Joanna Briggs Institute Manual for Evidence Synthesis [34].

To address the anticipated scarcity of ED-specific transition literature, we incorporated broader mental health research to better inform improvements in the ED field. We included records in any language about the transition from pediatric to adult care for YYAs with mental health disorders, including EDs [35], and excluded those focused on developmental disorders (e.g., autism spectrum disorder, intellectual disabilities) and physical conditions. Although transition research in other chronic conditions (e.g., diabetes) offers valuable insights, this review was limited to mental health due to its distinct challenges and growing condition-specific evidence base. Broader cross-condition reviews are available and offer helpful context [36–39]. Treatment modifications unrelated to care transitions were also excluded, as the review focused on system- and program-level interventions to support care transitions rather than treatment-specific adaptations. Records of any language were eligible for inclusion.

The search strategy was adapted from Cleverley et al. [40] developed in consultation with a health service librarian (co-author NB). The search strategy was implemented in March 2023 across seven electronic databases that were selected based upon published methodological guidelines for optimal search engines for reviews on health outcomes: these included Medline, CINAHL, Embase, Emcare, PsycInfo, Cochrane Database SR, and CENTRAL. The search included all languages and covered records dating back to 1980. To ensure comprehensive coverage, database searches were supplemented by forward citation chaining (i.e., the tracking of articles published after the database search (up to April 2024) that cited any of the included records), backward citation chaining (i.e., conducting a thorough hand search

of reference lists from the included records), and conference abstract searches (i.e., reviewing abstracts from the International Conference on Eating Disorders and Eating Disorders Research Society over the past ten years). Two blinded reviewers performed title and abstract screening, and the full-text screening was done in duplicate by two reviewers. The search was not extended beyond May 2024 because a defined cutoff was necessary to align with the guideline development process and panel meeting which occurred on May 31, 2024. Additional steps following the panel meeting were essential to produce a robust guideline—such as editing the recommendations after input from the panel meeting, followed by a round of voting by the panel, then refining and writing the entire guideline. This was followed by external review and editing of the guideline, then by final approval of the document by the guideline panel.

Data extraction

Due to the unanticipated large number of studies captured in the review, records were grouped into primary studies ($n=199$) and other records ($n=220$). The primary studies were used to form the basis of the recommendations. Data were extracted from the primary studies using a standardized chart template to gather key information from each study (e.g., country, sample description). These findings were reported in a narrative summary in the Results section below and are described in detail in Supplemental File 1. Other records included reviews (i.e., literature, narrative, scoping, systematic), commentaries, and protocols, among others, are also listed within the Supplemental File 1. To aid with the organization of the data, studies were sorted into one or more of the following categories:

Primary research studies

- **Descriptive Studies:** Studies that describe challenges, patterns, and characteristics of transition experiences. These are typically cross-sectional studies using chart reviews or questionnaires.
- **Qualitative Literature:** Studies that explore transition experiences, barriers, facilitators, and recommendations from the perspectives of patients, parents, or healthcare providers using qualitative methods.
- **Predictors of Transition:** Studies that identify moderators, characteristics, or factors associated with transition-relevant outcomes. These are typically secondary data analyses.
- **Transition Interventions:** Studies evaluating interventions designed to support YYAs transitioning from pediatric to adult care, including program evaluations and clinical trials.

- **Measurement Tools:** Studies assessing the development, psychometric properties, or implementation of questionnaires, surveys, or other instruments used to measure transition-related outcomes, such as readiness for transition.
- **Key Transition Outcomes:** Consensus-based studies in which participants identify and define important transition outcomes using rigorous methods.

Other studies

- **Reviews:** Scoping, systematic, literature, or narrative reviews centred on the transition from pediatric to adult care for YYAs.
- **Commentaries:** Editorials, opinion pieces, or call-to-action papers discussing challenges and proposed solutions for improving transitions from pediatric to adult care.
- **Grey Literature:** Clinical guidelines, policy reports, oral presentations, published abstracts, or other documents that are used within healthcare or research communities.
- **Book Chapters:** Textbook chapters or full books discussing transitions from pediatric to adult mental health care.
- **Protocols:** Records outlining planned research studies, including interventions, qualitative studies, mixed-methods studies, or reviews focused on transition care.

Certainty assessment

Certainty assessment for eligible studies was completed using the Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) approach [41]. Eligible studies included an intervention or a diagnostic/measurement instrument, and included outcome data. Evidence was categorized into very low, low, moderate or high certainty evidence based on elements of risk of bias, inconsistency, indirectness, and imprecision, with randomized controlled trials (RCTs) generally starting at high certainty and rated lower if serious threats to research rigor were present. Non-randomized studies started at low certainty and were rated up or down based on these elements for intervention studies [42]. For measurement tools, the GRADE approach for diagnostic tests was used where cohort or correlational studies can be rated high quality and rated downward for concern with bias, inconsistency, indirectness, and imprecision [43].

Guideline development

Guideline development occurred through consensus discussions. Conflicts of interest were managed by disclosure and discussion, if needed. The core research team reviewed and synthesized evidence summaries, formulated practice recommendations based on the scoping review, drafted the guidelines, and limited biases that could impact the guideline development process. The guideline development panel (hereafter referred to as the panel) included members with previous experience participating in the development of adolescent ED guidelines including YYAs with lived experience, caregivers of such youth, and clinicians. The panel reviewed the evidence from the scoping review and discussed: (i) strengths and limitations of the evidence base (high or low certainty evidence); (ii) whether the interpretation of the evidence put forward aligned with recommendations; and, (iii) consideration of the generalizability of the studies and whether the evidence aligned with values and preferences of the multiple stakeholder groups represented in the panel. Alternative interpretations and suggestions for further research were discussed when the panel met on May 31, 2024.

Group consensus on strength of recommendations was obtained using a modified Delphi method [44], with voting on recommendations by all panel members, using Qualtrics following the panel meeting. For a recommendation to be accepted, at least 70% of the panel were required to identify the recommendation as weak or strong and approve generally of the wording of the recommendation [45]. Consensus was reached after one round of voting.

External review

Following consensus by the panel, we disseminated the draft guidelines to various national and international stakeholders for review. As suggested in the literature on guideline development [44, 46], we invited review from clinical and research experts in pediatric and adult EDs, methodological experts in practice guideline development, through our partners and knowledge users. Fidelity checks using the *Appraisal of Guidelines, Research, and Evaluation (AGREE II)* [47] were completed by five reviewers [48, 49]. Following this external review, each panel member received a summary of the comments and suggested changes, as well as the full manuscript to approve prior to submission for publication.

Results

Included studies

See Fig. 1 for the full PRISMA diagram. Database searches yielded 14,517 records; after removing 280 duplicates, 14,237 unique records remained. An

additional 113 records were identified through forward citation chaining ($n=30$), backward citation chaining ($n=77$), and conference abstract searches ($n=6$), for a total of 14,350 screened by title and abstract. Of these, 12,502 were excluded because they were not relevant to the main question about care transitions for individuals with EDs and/or other mental health conditions. The remaining 1817 underwent full-text review, though 31 could not be retrieved. Of the full-texts assessed, 1398 were excluded due to ineligibility ($n=1314$; not focused on transitions [$n=1011$], not on eligible mental health conditions [$n=304$], or not on youth aged ≤ 25 [$n=18$]), duplication ($n=49$), inability to translate ($n=9$), or being corrections to previously published articles (e.g., errata, authorship amendments, or paper corrections) ($n=7$). Ultimately, 419 records were included in the review: 199 primary research studies and 220 other studies. Study categorizations are available in Supplemental File 1.

Scoping review

The 199 primary studies were organized into six content areas (described above), with study details (i.e., populations, key findings) provided in Tables 1–7 in Supplemental File 1 to support transparency and interpretation. Studies relevant to multiple areas were cross-referenced across evidence tables.

The 220 non-primary research included 57 reviews, 91 commentaries, 47 grey literature reports, 12 books or chapters, and 18 study protocols (see Tables 8–12, Supplemental File 1), with only a minority focusing on YYAs with EDs.

Descriptive studies

Eighty-six papers described challenges in transitioning YYAs with mental health conditions to adult care, including six focused specifically on EDs (Table 2, Supplemental File 1). Broadly, youth requiring continued mental health treatment often experienced disruptions or discontinuation of care [50, 51]. Reported transition rates to adult services among adolescents identified as needing ongoing support ranged from 16 to 50% [52–58]. Referrals post-discharge included family doctors, other specialized mental health services, or continued care within child and adolescent mental health services (CAMHS) [55, 56, 59, 60].

Among the six ED-specific studies, findings underscored variability in service engagement and outcomes. Arcelus et al. found that only 27.7% of young adults referred to a specialist adult ED service had prior CAMHS involvement [17]. Gilsbach et al. reported that nearly 60% of youth with AN remained under CAMHS, often living at home and relying on family doctors [61]. McClelland et al. showed that 68.3% of pediatric ED

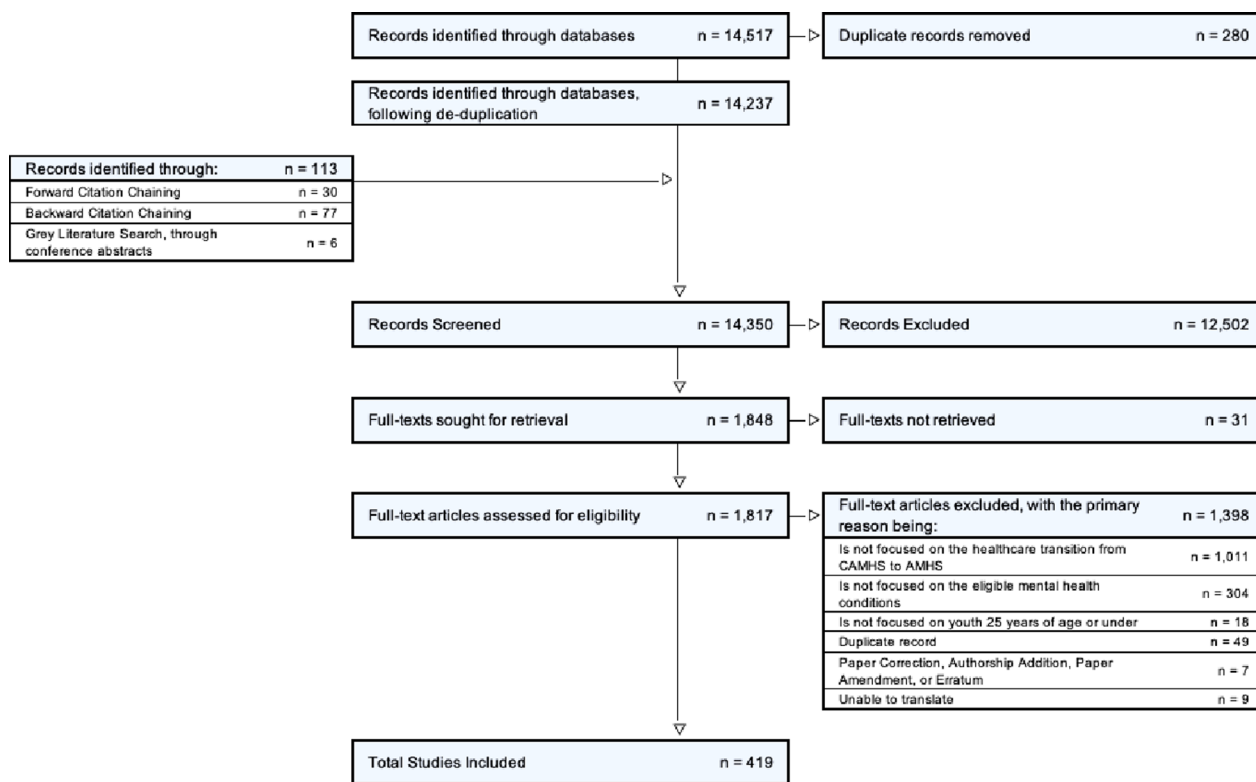


Fig. 1 PRISMA Diagram

patients received no adult mental health treatment, with only 10.8% directly transitioning to adult ED services [62]. Similarly, Steinegger et al. found most youth exiting a Canadian pediatric ED program reached weight restoration, did not require clinical continuation of ED care as an adult, and were transferred to their primary care provider or community mental health services [63]. Someshwar et al., reported that while most adolescent medicine programs offered ED care, only 44% had formal transition protocols, with barriers including insurance issues and reluctance to leave pediatric care [64]. Winston et al. noted that while most UK ED services enforced fixed transition age limits, only 31 of 38 services allowed for flexible timing based on individual needs [65]; 21 services discharged youth who did not meet adult service criteria. Together, these studies reveal considerable inconsistency in transition practices and highlight gaps in continuity of care for youth with EDs.

Qualitative literature

Of 75 qualitative studies, 60 explored general mental health transitions and 15 focused on EDs (Table 3, Supplemental File 1). Common themes across general mental health included the need for personalizing care [16, 66], the importance of measuring transition readiness [67,

68], managing expectations [69, 70], and systemic barriers to care continuity, such as rigid age limits [71–73], communication breakdowns between child and adult services [74–77], inadequate adult care [78, 79], and financial strain [80, 81].

ED-specific qualitative studies highlighted the need to maintain caregiver involvement [14, 82–84], transitioning based on developmental stage rather than age [61, 85], and addressing different treatment cultures between child and adult services [86]. These studies emphasized the emotional toll of transition [87–89], the need for information sharing [24, 90, 91], and medical monitoring during transition [85, 92].

Predictors of transition

Forty-eight studies explored predictors of transition outcomes, including five on EDs (Table 4, Supplemental File 1). Predictors were sorted into seven categories: demographic, clinical, service use, health behaviours, program-specific, environmental, and system-level.

Demographically, females reported higher transition readiness [93] and were more likely to regain and retain healthcare insurance coverage after losing it [94]. In contrast, males experienced higher rates of care discontinuity and mental health-related hospitalizations in young

adulthood [95]. Race was another factor associated with accessing care [96], with ethnic minority youth being less likely to use services at age 18 compared to White youth [97]. Additionally, White youth in the U.S. with mental health problems and healthcare insurance coverage were more likely to use outpatient services than ethnic minority youth. [98]

Clinical factors included diagnosis severity and comorbidities; youth with severe mental health conditions, like schizophrenia and psychosis, were more likely to transition successfully to adult care [99, 100], while youth with emotional and neurodevelopmental disorders faced greater transition challenges [60, 101]. Comorbid conditions, including personality disorders and substance use disorders, were linked to higher transition readiness [93, 102]. Medication use, especially for youth with a history of inpatient admissions or psychosis, also predicted better transition outcomes [52, 103].

Prior service use was another factor associated with transition success. Youth with prior psychiatric admissions or previous service use were more likely to continue care into young adulthood [52, 99, 104]. Longer stays in CAMHS and enduring diagnoses were linked to higher referral rates to adult mental health services (AMHS) [103, 105].

Health behaviors, including preparedness, knowledge, and engagement, also play crucial roles in transition success. Youth with greater healthcare knowledge, self-efficacy, and strong communication with healthcare providers demonstrated better transition outcome, especially when they perceived a need for continued treatment, felt prepared, actively engaged in services and had support through parent engagement and continuity of care [50, 99, 100, 106–108]. Youth with histories of trauma or abuse were less prepared to manage their mental health, despite being more likely to use counseling or medication services [106].

Programs that collaborated with other programs, demonstrated cultural competence, and offered a range of services (such as those with structured, personalized transition plans and family doctor support) were associated with better continuity of care and more successful transitions [96, 107, 109].

Environmental factors, such as living situation and welfare involvement, were significant predictors. A sample of American youth living in rural areas, particularly those in foster care or receiving Supplemental Security Income, were at a higher risk for transition difficulties and were less likely to be insured or enrolled in healthcare insurance coverage, complicating their transition [110]. Youth living with parents or involved in child protection services were more likely to transition to adult care [71]. Similarly, youth who were not in employment, education,

or training were more likely to be referred to adult mental health services [111].

Lastly, system-level factors such as insurance coverage played a critical role, with youth from higher socioeconomic backgrounds and those covered by public or private insurance experiencing greater continuity of care and access to mental health services in young adulthood [112, 113].

The five ED-specific studies highlighted distinct transition patterns. Stagi et al. found that, compared to other mental health conditions, youth with EDs were less likely to transition from pediatric to adult care and more likely to seek private over public care [114, 115]. Shorter pediatric care duration was associated with increased dropout risk from adult services [57, 58]. Older age and greater pediatric ED service use predicted continued ED treatment into adulthood [62].

Transition interventions

Twenty-one studies focused on interventions designed to support transitions from pediatric to adult care, with one study including participants with EDs (Table 5, Supplemental File 1).

Provider-facing interventions Five interventions, reported across seven papers, were designed to build capacity among clinicians to support successful transitions—none of which were ED-specific. Online training programs, such as the Promoting Positive Pathways to Adulthood and ProTransition, were associated with improvements in provider competencies and knowledge, though baseline proficiency in transition psychiatry was moderate [116–118]. Interdisciplinary models and blended-learning approaches improved provider comfort with communication, attitudes toward transition care, and openness to practice change [119, 120]. Peer Support Worker (PSW) models were also positively received, empowering young people and caregivers, promoting hopeful transitions, and improving staff attitudes over time [121, 122]; while PSWs reported mental health benefits from their role, adequate supervision was necessary to mitigate workload pressures [122].

Youth-facing interventions Fifteen studies evaluated interventions designed to support youth with various mental health conditions and their families during the transition to adult services. Multicomponent interventions combining structured planning, readiness assessments, care coordination, and collaboration across pediatric and adult services (such as Managed Transition, Youth Transition Project, and “The Protocol”) showed promise in improving service access and mental health outcomes [123–127]. These interventions often led to higher transi-

tion rates (22–94%), reduced wait times post-discharge, and high participant satisfaction. Group-based sessions, early joint assessments, and system navigation supports contributed to youths' perceived increases in independence and engagement [128, 129]. Additionally, conceptual or early-stage models—including liaison psychiatry teams, short-term transition workers, care frameworks, and applied theatre (i.e., arts-based interventions)—were proposed to enhance self-advocacy, reduce stigma, and ensure continuity, though they require further evaluation [130–133].

Only one study focused on a youth-facing intervention specific for EDs. This small Canadian study assessed a co-designed, five-component program offering flexible transition support [134]. Ten adolescents and their parents could select from: (1) a virtual youth-to-youth session, attended only by youth, led by a young adult who had transitioned from pediatric to adult ED care, sharing their experience and answering questions; (2) a parent-to-parent virtual session, attended only by parents, led by two parents whose children had transitioned to adult ED care or private therapy, discussing their experiences and strategies for supporting adolescent healthcare responsibility; (3) a transition meeting with their pediatric therapist accompanied by a video about the adult program; (4) a family doctor communication guide; and, (5) a digital navigation guide to support planning and understanding of adult ED or mental health care options. On average, participants completed 75% of the components and found them convenient and helpful. Parents reported reduced guilt. However, feasibility was limited (33% recruitment, 68% retention rate), and by-post intervention, only three of ten adolescents transitioned to interim supports (e.g., their family doctor, a private therapist), with none accessing specialist adult treatment.

Measurement tools

Eight studies examined tools assessing transition readiness and processes among YYAs [67, 93, 135–140], though none focused specifically on EDs (Table 6, Supplemental File 1). Common readiness tools included the Transition Readiness Assessment Questionnaire (TRAQ) [67, 93, 135], the Transition Readiness and Appropriateness Measure (TRAM) [136, 138] and the Readiness Assessment of Independence for Specialty Encounters (RAISE) [140]. The Health Care Transition Index [137] and the Transition Service Provider Competency Scale (TSPCS) [139] were used to evaluate the transition process and provider competencies.

The TRAQ—a 20-item tool assessing transition preparedness, self-management, and disease-related knowledge in youth with chronic conditions—was evaluated in three Canadian studies. Allemang et al. found that youth with

mental health comorbidities (as opposed to having physical health conditions alone) had higher readiness scores [93]. However, their mixed-methods study highlighted the limitations of the TRAQ when applied with the complex and nuanced comorbid youth population [67]. Cleverley et al. confirmed the TRAQ's factor structure and criterion validity in youth accessing outpatient mental health services [135]. The TRAM, validated across eight European countries demonstrated good internal consistency and a well-defined factor structure [138]. In Austrian youth receiving CAMHS, TRAM scores correlated strongly with identity development, linking health identity to greater transition readiness [136]. The RAISE tool was supported by a clinical expert panel for assessing medical independence across developmental stages, emphasizing its relevance and potential to guide education on medical independence and improve transition outcomes [140].

Regarding transition processes, McManus et al. used the Health Care Transition Index to track implementation of six core transition elements across primary care sites, noting improvements in policy adoption and youth transition rates [137]. Sellmaier et al. developed and validated the TSPCS—a reliable measure of provider confidence in delivering culturally responsive, youth-led transition services—with higher competencies reported among younger and more experienced providers [139].

Key transition outcomes

Three studies focused on key transition outcomes for youth with mental health conditions [141–143]; none addressed EDs (Table 7, Supplemental Table 1). Suris et al. employed a Delphi method with international adolescent health experts to distill 34 key elements into six essential and 11 very important ones, including coordination between pediatric and adult professionals, starting transition planning at an early age, and seeing adolescents alone during consultations. From 32 indicators, one was deemed essential (patient not lost-to-follow-up) and seven very important, such as attending adult care visits and number of ER visits for routine care in the past year.

Brewer et al., using a mixed-methods approach, identified six key areas: access to and availability of care, care coordination between specialists and primary care providers, immunization rates, primary care integration, models for improving doctor-patient relationships, and training parents or teens as advocates for their care [141]; care coordination and integration with primary care providers were ranked as the highest priorities.

Cleverley et al. built upon these findings in a follow-up Delphi study with clinicians, administrators, caregivers, and youth to delineate components of effective transitions among the same six categories [142]. Key elements

included a logbook to track completion of transition steps and the youth six months post-transfer to confirm transition. Most of the components emphasized the importance of collaboration among all stakeholders and a youth-centered process.

Certainty assessment

The Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) was used to evaluate the certainty of the evidence for studies amenable to this approach [41]. This included studies reporting on outcomes for YYAs who were transitioning out of pediatric care in which a transition intervention or measurement tool was evaluated.

Transition interventions

In terms of transition interventions, seven reports existed that were amenable to GRADE assessment (See Tables 1, 2, 3, 4, 5, 6, 7). The transition interventions were largely multi-faceted and varied in approach, so they could not be amalgamated. Outcomes included the proportion of YYAs who successfully transitioned to adult care, intervention satisfaction, and feasibility, among others. One study was an RCT demonstrating high certainty of evidence [123], and the other six studies were rated as low certainty [125–128, 134, 144].

Measurement tools

In terms of measurement tools, there was one high quality study validating the TRAQ [135]. This study was rated as high quality as it used a cohort design and included a large sample size consisting of the population of interest (youth in mental health services) (Table 8).

Two studies evaluated the validity of the TRAM compared to other transition measures [136, 138]. The quality of these studies was rated as moderate as the studies were cross-sectional in nature and used different reference standards for comparison of transition readiness (Table 9).

Recommendations

1. Transition interventions

- (A) **STRONG RECOMMENDATION:** Transition interventions, models, and/or initiatives for YYAs with eating disorders and/or mental health conditions that include an integrated and collaborative care approach are strongly recommended to support continuity of care in transitions from pediatric to adult care.

Qualifying statements

Although specific key components of effective transitions, such as assessing readiness, awareness of available resources, a navigator for accessing adult care, and involving family need to be further studied in clinical settings, the general premise of continuity of care is strongly supported by research evidence. Additionally, transitions in care from pediatric to adult care should consider developmental stage and age rather than relying solely on chronological age criteria. Further research is required to evaluate the feasibility and acceptability of specific existing transition interventions aiming to better address the needs of transitioning YYAs. Distinctions between transitions in mental health care and those related to EDs also warrant prioritized research attention, due to the unique and complex medical requirements of individuals with EDs alongside the mental health needs of this population, necessitating a paramount focus on and integration of both medical and mental health management during the transition process. Transition interventions should also consider the unique nutritional needs specific to YYAs with EDs. Current interventions often lack input from individuals with lived experience and are often tested among those who can readily access treatment and participate in research. Future research efforts should emphasize the inclusion of individuals with lived experience in the design, development, and implementation of transition interventions. Importantly, these interventions should be rigorously tested among marginalized and equity-deserving groups.

Key evidence

The interventions captured in the key supporting evidence included the Youth Transition Project [125], the “Protocol” [126], the Crisalide Project [144], Managed Transition [123], and two other transition interventions that did not have a specific name [127, 128]. Although these reports varied widely in terms of study design and intervention content and format, a common thread uniting them was their emphasis on collaboration between all members involved to support transitions: pediatric and adult care providers, parents, and youth. Only one transition intervention for adolescents and parents with EDs existed in the eligible studies [134]. This underscores the need for continued progress on transition interventions in the field of EDs, to better address the unique needs of these youth during transition.

2. Measurement tools

- (A) **STRONG RECOMMENDATION:** The Transition Readiness Assessment Questionnaire (TRAQ) is strongly recommended to assess transition readiness

Table 1 Transition intervention—*managed transition*

Certainty assessment							Impact	Certainty	Importance
Nº of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations			
Outcome: PROPORTION OF SUCCESSFUL TRANSITION TO ADULT CARE (%)									
1	RCT	Not serious	Not serious	Not serious	Not serious	None	One RCT (Singh et al., 2023) assessed a transition intervention called Managed Transition (n = 552) against Usual Care (n = 243) on the outcome of successful transition to adult care. @ More participants in the MT group transitioned to adult care (28.2% vs. 22.1%)	⊕⊕⊕⊕ HIGH	CRITICAL
Outcome: GENERAL HEALTH AND SOCIAL FUNCTIONING									
1	RCT	Not serious	Not serious	Not serious	Not serious	None	One RCT (Singh et al., 2023) assessed a transition intervention called Managed Transition (n = 552) against Usual Care (n = 243) on the outcome of general health and social functioning, assessed using the mean Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) score at 15 months. @ The mean score at 15 months was 8.63 (SD = 6.00) for the MT group and 8.82 (SD = 6.25) for the UC group	⊕⊕⊕⊕ HIGH	CRITICAL

RCT Randomized Controlled Trial

Bibliography: Singh et al. 2023 [123]

among YYAs, particularly those with mental health concerns and requires further study for those with eating disorders.

Qualifying statements

The Transition Readiness Assessment Questionnaire (TRAQ) provides important insights for clinicians into the self-management skills of YYAs during transition. The tool is widely used across multiple sectors (e.g.,

healthcare and post-secondary education contexts), cross-culturally, and has been translated in multiple languages, including English, French, Spanish, Japanese, German, and Turkish. However, TRAQ has not yet been evaluated in YYAs with EDs. Additionally, there is limited validation of the TRAQ within ED and equity-owed groups. Adaptations of the TRAQ may be necessary to apply the tool effectively to youth with EDs, address the needs of parents and/or caregivers (who can also complete the TRAQ if youth are unable to), and consider

Table 2 Transition intervention—youth transition project


Certainty assessment							Impact	Certainty	Importance
No of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations			
Outcome: PROPORTION OF SUCCESSFUL TRANSITION TO ADULT CARE (%)									
1	Cohort	Very serious ^{a,b}	Not serious	Not serious	Not serious	None	One single-group prospective cohort study assessed a transition intervention called Youth Transition Project on the proportion of successful transition to adult care. Of 215 youth, 127 youth (59.1%) were transitioned to adult care	⊕○○ LOW	IMPORTANT

^a No control condition

^b No randomization

Bibliography: Cappelli 2014 [125]

Table 3 Transition intervention—“the protocol”

Certainty assessment		Impact					Certainty	Importance
No of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations		
Outcome: PROPORTION OF SUCCESSFUL TRANSITION TO ADULT CARE (%)								
1	Case Control	Serious ^a	Not serious	Not serious	Not serious	None	 LOW One Case control study (Gatta et al., 2021) assessed a transition intervention called “ The Protocol ” (n=49) against a matched control group (n=46) on the proportion of successful transition to adult care. The proportion of successful transition to adult care was 93.9% (46/49) for “The Protocol” group, and 54.3% (25/46) for the control group	

^a No randomization

Bibliography: Gatta et al. 2021 [126]

Table 4 Transition intervention—the *Crisalide Project – TSMREE/CSM 17–19*

Certainty assessment		Impact					Certainty	Importance
No of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations		
1	Cohort	Very serious ^{a,b}	Not serious	Not serious	Not serious	None	One cohort study (Grasso et al., 2022) assessed a transition intervention called “Crisalide Project – TSMREE/CSM 17–19” on the proportion of successful transition to adult care. Of 46 youth in the sample, 35 (76%) were taken over by the Community Mental Health Centre (CSM)—an adult service	

^a No control condition

^b No randomization

Bibliography: Grasso et al. 2022 [144]

the broader psychosocial context of transitions, such as transitions to post-secondary education or other health-care settings, as well as changes in family and peer relationships.

Key evidence

Three Canadian studies provide key evidence supporting the TRAQ’s utility in assessing transition readiness among youth with mental health concerns [67, 93, 135]. Allemang et al.’s first study demonstrated higher TRAQ scores among youth with mental health comorbidities, indicating its relevance for this population [93]. Allemang et al.’s second study emphasized the limitations of generic scales like the TRAQ in fully capturing the nuanced needs of youth with co-occurring chronic health and mental health conditions, suggesting areas for further development [67]. Cleverley et al.’s psychometric evaluation provides high quality evidence, confirming the TRAQ’s strong validity and reliability in mental health settings, while identifying gaps in its applicability to specific subscales [135]. Together, these studies validate the TRAQ as a measure of transition readiness among youth with mental health conditions, while also identifying its limitations, areas for improvement, and the need for further research, particularly in its application to youth with complex needs.

- (B) WEAK RECOMMENDATION: The Transition Readiness and Appropriateness Measure (TRAM) may be reasonable measurement tool for assessing transition among YYAs experiencing mental health symptoms and requires more study for those with eating disorders.

Qualifying statements

The Managing the Link and Strengthening Transition from Child to Adult Mental Healthcare in Europe (MILESTONE), funded by the European Union, presents a model to assess the readiness of transition for young people. Central to this model is the Transition Readiness and Appropriateness Measure (TRAM), which evaluates whether transition is appropriate for a young person who is approaching their transfer boundary in the pediatric system, and whether they are ready for the transition [138]. However, the tool does not assess the youths’ readiness to self-manage their own eating and recovery. The TRAM is currently employed in the MILESTONE cluster RCT as a part of the study’s efforts to inform *Managed Transition* in the intervention arm [123]. To adopt a holistic approach, the tool aims to capture all essential information for facilitating the transition from Child

Table 5 Transition Intervention—multi-component transition intervention

Certainty assessment		Impact				Certainty	Importance
No of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	
1	Cohort	Serious ^a	Not serious	Not serious	Not serious	None	One cohort study (Khan et al., 2022) compared the proportion of successful transition to adult care between a planned transition group and a normal transfer group. @100% of the planned transition group and 77.8% of the transfer group engaged with adult care during a 6-month period
							⊕⊕⊕⊕ LOW IMPORTANT

^a No randomization

Bibliography: Khan et al. 2022 [127]

Table 6 Transition Intervention—a six-week Transition Group

Certainty assessment							Impact	Certainty	Importance
Nº of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations			
Outcomes: SATISFACTION WITH THE TRANSITION INTERVENTION									
1	Open Trial	Very serious ^{a,b}	Not serious	Not serious	Not serious	None	One single group open trial evaluated a transition group for emerging young adults using the Client Satisfaction Questionnaire (CSQ-8).@Youth and parents rated a high level of satisfaction with the program (Youth M = 26.86 ± 2.03, Parent M = 28.57 ± 3.10)	⊕⊕○○ LOW	IMPORTANT
Outcomes: CHANGE IN HEALTH KNOWLEDGE									
1	Open Trial	Very serious ^{a,b}	Not serious	Not serious	Not serious	None	Youth perceived an increase in health knowledge upon completion of the program (entry M = 2.00 ± 0.82 vs. exit M = 2.86 ± 1.07, t(8) = -3.29, P < 0.0)	⊕⊕○○ LOW	IMPORTANT

^a No control condition

^b No randomization

Bibliography: King et al. 2017 [128]

Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) (e.g., symptoms, overall illness, overall disruption, risk factors, factors affecting symptoms, health system factors, barriers to functioning, and other life changes) [138]. Inclusively, the assessment process involves not only clinicians, but also includes the input of young people and their caregivers. Moreover, TRAM’s web-based nature allows for remote completion using developmentally appropriate interfaces, which can contribute to potential global accessibility [138]. Nevertheless, challenges in locating the TRAM publicly raise concerns about its ease of implementation.


Key evidence

Two papers support the TRAM’s utility in assessing transition readiness [136, 138]. Santosh et al., as part of the MILESTONE project, employed a comprehensive approach including an expert panel, focus groups, cohort study, and nested clustered RCT [138]. The TRAM demonstrated strong internal consistency, moderate reliability, a well-defined factor structure, good construct

validity, and conceptual overlap with established instruments. In another cross-sectional study involving 42 adolescents and young adults, Kunczicky et al. identified significant correlations between identity development and both transition readiness and transition needs [136]. Taken together, these studies confirm the TRAM’s applicability as a robust standardized measurement tool that can facilitate tailored transition plans for youth seeking continuation of their mental health care.

- (C) WEAK RECOMMENDATION: The Readiness Assessment of Independence for Specialty Encounters (RAISE) may be a reasonable measurement tool for assessing patient autonomy and self-management among YYAs with mental health disorders undergoing transition care and requires more study in those with eating disorders.

Table 7 Transition intervention—multi-component transition intervention for youth and caregivers

Certainty assessment		Impact					Certainty	Importance
N ^o of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations		
Outcome: INTERVENTION FEASIBILITY AND ACCEPTABILITY								
1	Prospective Cohort	Very serious ^{ab}	not Serious	Not serious	Not serious	None	 LOW One prospective cohort study assessed a five-component transition intervention on its feasibility and acceptability (Nicula et al., 2023). @Participants completed 75% of the required components on average and found the intervention convenient helpful, with parents reporting reduced guilt post-intervention. However, feasibility was limited, with a 33% recruitment rate, a 68% retention rate, and only three adolescents transitioning to interim supports—none entering specialist adult treatment	

^a No control condition

^b No randomization

Bibliography: Nicula et al. 2023 [134]

Table 8 Measurement Tool—*Transition Readiness Assessment Questionnaire (TRAQ)*

Certainty assessment		Impact				Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	
Outcome: TRANSITION READINESS							
1	Cohort	Not serious	Not serious	Not serious	Not serious	None	This study assessed the validity of the Transition Readiness Assessment Questionnaire (TRAQ) . @The study involved 237 youth receiving outpatient mental health treatment. In terms of factor structure, the TRAQ had adequate fit after applying modification indices. The measure was found to have adequate internal consistency for overall scale (alpha coefficient = 0.88), adequate internal consistency for three subscales (MM = 0.76, AK = 0.79, TP = 0.82), and less than adequate internal consistency for two subscales (TKI = 0.65, MDA = 0.51). Regarding convergent validity, small correlations with IDEAS and DERS subscales were found, and correlations remained after holding age constant. Lastly, regarding criterion validity, the mean overall TRAQ 5.0 score was significantly higher for those who had discussed a transition or referral to AMHS with their clinical team than those who had not had this discussion

Bibliography: Cleverley et al. 2023 [135]

Table 9 Measurement Tool—the *Transition Readiness and Appropriateness Measure (TRAM)*

Certainty assessment		Impact				Certainty	Importance
Nº of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	
Outcomes: TRANSITION READINESS							
2	Cross sectional	Serious	Not serious	Not serious	Not serious	None	<p>A significant correlation was found between identity development and transition readiness ($r = 0.431, p < 0.01$), with a stronger correlation observed in relation to transition needs ($r = 0.821, p < 0.01$)($n = 42$) [136] @</p> <p>The TRAM had low-to-moderate correlations when compared with other established instruments (e.g., HoNOSCA, CGI-S, SLOF) [138]</p>

Bibliography: Santosh et al. 2020 [138], Kunzicky et al. 2024 [136]

Qualifying statements

The Readiness Assessment of Independence for Specialty Encounters (RAISE) Tool is an instrument designed to guide clinicians in assessing and facilitating patients' progression towards autonomy and self-management, specifically in the context of chronic conditions [140]. However, the tool does not assess the youths' readiness to self-manage their own eating and recovery. The RAISE Tool consists of key features such as: starting evaluation from the time of diagnosis (early as birth), includes identification of contextual psychosocial factors that may necessitate remediation in order to master skills, and does not rely on self-report, but is rather a guideline tool for providers. The RAISE Tool encompasses a spectrum of nine age-based scales, from birth through young adulthood (21 years old), where healthcare providers evaluate patients' skills directly, ensuring a thorough assessment process.

Key evidence

The supporting evidence includes one study by Shanske et al., which utilized an expert panel design focusing on youth with chronic illness [140]. Experts evaluated the tool to be relevant, clear, and appropriate for various stages of development. The age-based scales of the tool demonstrated content validity, with the retained items meeting the established criteria.

3. Transition outcomes

- (A) **STRONG RECOMMENDATION:** Prioritizing research efforts focused on understanding long-term outcomes of YYAs with eating disorders and/or mental health disorders following transition from pediatric to adult care is strongly recommended.

Qualifying statements

Examining long-term outcomes can provide valuable insights into how transitional care practices affect the overall well-being and functioning of individuals as they progress through various stages of care. However, it is important to recognize that the effectiveness and generalizability of these research efforts may be influenced by factors such as the heterogeneity of mental health disorders, variations in healthcare systems, and differences in demographic and socio-economic contexts. Therefore, future research should be designed to account for these variables to ensure robust and applicable findings. Of note, most existing quantitative work is focused on other mental health disorders and not specifically on EDs.

Key evidence

There are two studies that explicitly support this recommendation: an international Delphi study by Suris et al. [143] and one Canadian Delphi study led by Cleverley et al. [142]. Both studies identified tracking and monitoring as an avenue to assess transition outcomes, such as identifying whether the patient was lost-to-follow-up or if they reached adult care 3–6 months after transfer [142, 143, 145]. Cleverley et al. specified that the person most responsible for the transition should contact the youth and family (if appropriate) to confirm transfer to adult mental health services [142]. Specifically, Suris et al. noted the importance of assessing disease severity over time [143]. Ultimately, these studies emphasize the need to monitor and assess post-transition success and long-term impacts.

- (B) **STRONG RECOMMENDATION:** Evaluating acceptance, transfer, leaving treatment, and discharge rates of individuals with eating disorders and/or mental health conditions transitioning from pediatric to adult care may improve the understanding of the transition process and help identify factors influencing an effective transition.

Qualifying statements

Evaluating these outcomes should be considered amidst current evidence on barriers to transitions in care for youth (e.g., geographic accessibility of adult services at the time of transition). Broadening the scope of transition outcomes beyond mental health care (e.g., in post-secondary education or other healthcare contexts) would be beneficial for exploring service access for diverse groups of YYAs (e.g., equity-owed groups) undergoing transitions. Prioritizing a shift in focus from solely diagnostic/symptomology outcomes to functional and developmental outcomes during the transition is essential. It is also important to define indicators of successful transitions and to examine these indicators at the point of transfer from the perspectives of YYAs, caregivers, and providers. Current evidence on transition outcomes often overlooks facilitators of the transition process (e.g., hope and optimism) and variables important to lived experience. More research is needed to discern the impact of these facilitators on acceptance, discharge, transfer, and drop-out rates. Additionally, more research is needed to identify potential mediators (e.g., maturation fears, self-esteem, self-efficacy, and autonomy) of transition outcome. Wide-spread, standard implementation of these outcomes would help to capture the state and success of transitions of YYAs at any point of time and would allow

for the identification of factors that influence transition success.

Key evidence

The supporting evidence includes findings gathered from two studies focused on identifying key priorities, outcomes, and indicators of transition [142, 143]. Suris et al. emphasized the importance of tracking patients' engagement with care post-transition, with indicators such as "patient not lost to follow-up," "attending scheduled visits in adult care," and "timely completion of the first adult care visit" [143]. Cleverley et al. highlighted the need for transition readiness assessments and structured planning to monitor the completion of transfer steps [142], while also underscoring the value of tracking transition outcomes and maintaining continuity of care.

Discussion

We conducted a scoping review to examine the literature on transitions from pediatric to adult care for YYAs with EDs and/or other mental health conditions, aiming to synthesize evidence to inform guideline development. Findings were shared with a Canadian panel of researchers, clinicians, individuals with lived experience, and caregivers who, through a modified Delphi method, reached consensus on six recommendations to guide this transition.

Our review identified six primary research areas. Three—descriptive studies, qualitative studies, and predictors of transition studies—did not directly inform the recommendations but were essential in framing the current landscape. These studies emphasized persistent barriers to seamless transitions, including poor coordination between pediatric and adult services, limited information sharing, and abrupt, age-based transfers. They also highlighted the emotional, practical, and relational burdens experienced by YYAs and their caregivers. Delays and disruptions in care during this transition can lead to worsening of the overall mental condition of the patients and to the need for more intensive and costly interventions, such as inpatient or day treatment services [146, 147]. Current research does not adequately explore the unique and intersecting medical, nutritional, and psychological needs of YYAs with EDs who simultaneously navigate physical and mental health challenges.

Although counterintuitive, several studies reported that youth with higher comorbidity often demonstrate greater transition readiness [52, 93, 99, 100, 102, 103]. This is thought to occur because these patients receive increased clinical attention, more structured support, and to more opportunities to practice self-management skills and system navigation [93]. Greater transition

readiness among youth with higher comorbidity may also reflect their likely increased levels of distress.

The risk is that YYAs with less visible or severe needs before transition may be overlooked until their condition worsens, delaying essential transition planning. To avoid this, transition support should be offered proactively and universally, ensuring all youth are prepared well before crises occur and in advance of transition.

The three remaining content areas—transition interventions, measurement tools, and key outcomes—formed the basis of our guideline recommendations. Only one intervention was developed explicitly for individuals with EDs, but was not found to be feasible due to low recruitment and retention rates, both falling below pre-established feasibility thresholds [134]. Other interventions developed for broader mental health populations often encountered logistical and cultural barriers, impeding their successful implementation and effectiveness. Age-based transfers remain the norm, despite the well-established fact that developmental readiness varies widely and is shaped by structural and economic influences. Although the evidence base for ED-specific and mental health-related transition interventions remained limited, there was strong consensus across the panel for an integrated, collaborative approach to care transitions for YYA with EDs and/or mental health conditions. This recommendation advises that gaps in care be eliminated or minimized by planning transitions early and jointly between pediatric and adult providers, with strategies such as information sharing, joint clinical meetings, or an overlap in care between pediatric and adult providers.

The panel also endorsed the use of transition readiness measurement tools. A strong recommendation was made for the TRAQ, with weak recommendations made for the TRAM and RAISE. While critiques of tools like TRAM and RAISE often focus on their limited assessment of youth self-management, this may reflect a broader systemic shift from the family-centered ethos of pediatric care to the individual focus of adult services. For youth with complex or chronic EDs, this transition may expose gaps in adult systems rather than flaws in the tools themselves.

Lastly, the panel called for research to capture key transition outcomes. This includes not only short-term indicators, such as acceptance, transfer, and discharge rates, but also long-term outcomes.

Several findings diverged from expectations. Although caregiver involvement was frequently cited as essential in the qualitative research, no transition interventions were designed to directly support caregivers. The transition process often lacks adequate preparation and does not consider the shared experiences of YYAs and their families. Furthermore, the shift from pediatric to adult care

is frequently misunderstood by YYAs and their families, with a move from a family-centered to a patient-centered approach, which potentially leads to their disengagement and inadequate support during this transition.

Best practice guidelines recommend that transition preparation begin early, be guided by the individual's developmental and familial needs rather than rigid age thresholds, and should focus on building self-management skills through regular meetings well before the actual transfer from pediatric services [18, 148]. A personalized transition plan can help youth with EDs incrementally gain advocacy, decision-making, and self-management skills [149]. To establish developmentally-appropriate transition plans, a theoretically-driven approach to transition, such as the Socio-Ecological Model of Readiness to Transition (SMART), has been suggested [150]. The SMART model may influence the development and testing of interventions aimed to facilitate pre- and post-transition processes for both youth with EDs and their caregivers.

Our review also revealed limited research centering equity-owed groups. Few studies focused on or even reported data related to Indigenous, racialized, gender-diverse, economically-marginalized, and disabled youth. This gap is especially concerning given previous research that socioeconomic status, gender, ethnicity, and race influence transition readiness [151–154]. In the spirit of Truth and Reconciliation [155], we argue that transition research involving Indigenous YYAs must explicitly recognize the ongoing impacts of colonization, genocide, and intergenerational trauma. To date, none of the studies were primarily focused on examining or explicitly centering the voices of Indigenous youth and their families, though one study included two Indigenous participants in their research [24].

More broadly, the limited diversity in the patient samples across the transition literature raises concerns that current interventions and outcomes are currently understood primarily through a Western and Eurocentric perspective. Future research on transitions in care for YYAs with EDs and/or other mental health conditions must prioritize an intersectional and equity lens to avoid recreating and perpetuating inequities.

Implications

This scoping review contributes new insights by compiling and critically examining the fragmented body of research on transitions for YYAs with EDs and/or other mental health conditions. The resulting guideline advances the field by offering actionable, consensus-based recommendations that reflect both the empirical

literature and the lived experiences of affected youth and caregivers.

One key implication is the need to reframe transition readiness not as an individual trait but as a product of systemic preparation and coordinated care. Our findings challenge current models that emphasize youth self-management without accounting for systemic gaps or structural inequities and call for early, personalized, and developmentally-appropriate transition planning.

This study also raises challenges for health policy and service delivery. Existing interventions often assume uniform developmental timelines and stable access to care. However, as our findings underscore, transitions occur within unequal systems shaped by colonial histories, economic disadvantage, and institutional bias. Without deliberate efforts to design inclusive, equity-informed interventions, transition policies may inadvertently exacerbate disparities.

Finally, our work holds relevance for public health practice by identifying the key elements of effective transitions (e.g., joint care, information continuity, readiness assessment) and offering a roadmap for system-level reform. Future care models should be co-developed with youth and families and tailored to the specific needs of marginalized groups.

Strengths and limitations

This guideline was developed through a rigorous and transparent process. Strengths include a comprehensive scoping review that incorporated both peer-reviewed and grey literature, the use of GRADE to evaluate the certainty of the evidence when applicable, a diverse and representative GDP, external review by international experts. To enhance transparency, we included tables summarizing GRADE assessments to help readers appraise evidence certainty. While group differences may seem subtle, the grading highlights study rigor and informs confidence in findings. These tables complement the narrative synthesis and were critical for guiding recommendations. All identified literature in the scoping review informed the recommendations.

Despite these strengths, several limitations remain. The research to date is limited in addressing the transition needs of individuals with EDs, highlighting a gap in the application of general transition interventions to this group. There is also considerable variability in the evidence base regarding effective transition strategies, and the lack of a cohesive approach limits the ability to generalize findings universally. There is a commitment to update the guidelines in five years-time, hoping further research will be completed to add to the content of our guidelines.

Additionally, we focused on treatment-related outcomes selected a priori based on their expected availability. Functional outcomes such as education, employment, and relationships were rarely reported and thus not included. This limits the scope of our findings, and future research should consider these broader outcome measures.

Another limitation of this study is that, while the scoping review design allowed for a broader evidence base, it does not permit pooled effect estimates or meta-analysis. This limits direct comparisons between transition approaches. However, given the early stage of research in this area, a scoping review design was appropriate and necessary to map the landscape. In the future, as more evidence on transition interventions becomes available, we recommend conducting a systematic review to pool data on patient-important outcomes and evaluate the effectiveness of these interventions.

Future directions

Several priorities emerged from this review and guideline. Future research should focus on developing and evaluating ED-specific transition interventions, ideally incorporating both medical and psychological supports and considering cultural and logistical challenges. More effective caregiver and family involvement are crucial in future intervention design, acknowledging their critical role in transition. Additionally, prioritizing research on long-term outcomes following the transition from pediatric to adult care is necessary, including acceptance, transfer, leaving treatment early, and discharge rates. Existing tools and interventions should be tested and adapted for the unique developmental, medical, and relational needs of youth with EDs. The experiences of underrepresented and equity-owed groups, including Indigenous, racialized, gender-diverse YYAs, should be centred in future research. Intersectional and anti-colonial frameworks should be implemented in future research to ensure that transition policies and practices do not replicate systemic inequities. Of note, this review focused on system- and program-level transition interventions, not on treatment adaptations for YYAs with EDs (e.g., Family-Based Treatment for Transition-Age Youth), which remain an important area of research. Future research should explore how evolving clinical care needs of YYAs with EDs (e.g., evolving supervision needs, target weight definitions, medical monitoring), ideally through co-designed, mixed-method evaluations. Addressing these gaps will help to improve the transition experience for YYAs with EDs and enhance overall care continuity.

Conclusion

In summary, these guidelines aim to direct further attention to the issue of transition for YYAs with EDs and/or other mental health conditions. Implementation of these guidelines will require investment from stakeholders and policymakers to overcome systematic barriers. Providers in pediatric and adult systems need to collaborate more closely to minimize gaps in care. Administrators and policymakers must allocate resources to support transition readiness assessment and planning across both systems. Furthermore, research funding agencies should devote resources to capture transition-related data and develop feasible, evidence-based interventions tailored to this population. Taken together, we are confident that these efforts can result in significant improvements in care for YYAs and their caregivers during the transition from pediatric to adult services.

Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s40337-025-01343-6>.

Additional file 1 (DOCX 540 KB)

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Author contributions

GD and JC conceptualized and designed the study. NB developed the search strategy. Data screening, extraction, and grouping were conducted by AK, MA, MN, MS, JL, CW, SS, ADA, CB, and HV. MN, GD, JC, AK, MA, MS, and JL contributed to drafting the manuscript. Members of the guideline panel and survey voters included MK, CM, NL, JS, KA, AB, AT, AL, AF, BA, CF, DK, ET, GM, HS, JS, JC, JT, JG, KD, JH, KB, KS, LI, LB, MB, ML, MJ, NO, SS, SG, SM, SF, WP, WS, AM, LW, SI, MN, HV, SJ, EL, MF, CS, TL, JG, AL, NJ, SP, MP, ZP, and KG. All authors read and approved the final manuscript.

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Availability of data and materials

The methods for the scoping review that informed this guideline are detailed within the article. Interested researchers may contact the corresponding authors to request further information on the article selection pathway, including how studies progressed from initial identification to inclusion. Data related to the voting outcomes and individual insights of members of the guideline development panel are not available.

Declarations

Ethics approval and consent to participate

This manuscript does not report on or involve the use of any animal or human data or tissue. Ethics approval is not applicable.

Competing interests

The authors declare no competing interests.

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