STUDY GUIDE

European Society of Child and Adolescent Psychiatry (ESCAP) practical guidance for clinicians and mental health services regarding child to adult mental health service transitions and managed discharge at the service boundary.

European Society of Child and Adolescent Psychiatry (ESCAP) · 2026

ESCAP Clinical Guidance on Mental Health Service Transitions: A Comprehensive Study Guide

This study guide provides a detailed synthesis of the European Society for Child and Adolescent Psychiatry (ESCAP) clinical guidance regarding the transition of young people from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS). The guidance is designed to promote safe, timely, and appropriate passage across care settings through structured practices and service-level improvements.

Part 1: Core Concepts and Clinical Framework

The ESCAP guidance is divided into two primary sections: Part 1 focuses on clinical practices and the temporal trajectory of transition, while Part 2 addresses service-level management and improvement.

The Six Domains of Transition Practice

The transition process is categorized into six key stages for clinicians, beginning approximately six months before the service boundary.

Stage	Focus Area	Key Actions
I	**Transition Planning**	Early initiation (6 months prior), multidisciplinary team engagement, and active involvement of the young person and caregivers.
II	**Transition Decision-making**	Evaluating ongoing treatment needs and readiness using tools like the TRAM; prioritizing severe mental illness for AMHS.
III	**Transition Preparation**	Educating about AMHS, promoting autonomy, closing the CAMHS relationship, and developing contingency plans for delays.
IV	**Continuity of Care**	Fostering collaboration between services, ensuring detailed handovers, and joint meetings between CAMHS and AMHS clinicians.
V	**Care after Transition**	Providing enhanced support for the first three months in AMHS, maintaining clinician consistency, and evaluating outcomes via TROM.
VI	**Managed Discharge**	For those not entering AMHS: developing care plans, psychoeducation, medication management, and coordinating with primary care (GPs).

Key Principles of Effective Transition

- **Start Early:** Planning should initiate at least six months before the boundary for service users in care for over 12 months.
- **Person-Centered and Holistic:** Support must be tailored to the individual's maturity, cognitive abilities, and life context (education, housing, relationships), rather than just chronological age.
- **Shared Decision-Making:** Young people should have choices and control over their care, with their preferences respected regarding destination services and the involvement of family.
- **Information Fidelity:** Providing written syntheses of diagnoses, treatment histories, and clear definitions of medical terms in accessible formats.

Transition Tools and Assessments

The guidance emphasizes the use of validated standardized tools to ensure objective decision-making and outcome tracking:

- **TRAM (Transition Readiness and Appropriateness Measure):** A multidimensional tool incorporating perspectives from the youth, parent, and clinician to evaluate psychopathology severity and transition readiness.
- **TROM (Transition Outcome Measure):** Used 4–6 months post-transition to assess the impact of the move on mental health outcomes.
- **OYOF-TES/EOC (On Your Own Feet Scales):** Used to capture the experiences of young people and caregivers to identify service gaps.

Part 2: Service Level Improvements and Advocacy

For mental health care leaders and managers, the guidance outlines systemic requirements to support successful transitions:

- **Resource Allocation:** Ensuring budgets cover transition coordinators, joint clinics, and the use of evaluation tools.
- **Co-Design:** Actively involving young people in service design to ensure environments are "youth-friendly" (e.g., providing free Wi-Fi, comfortable communal spaces, and accessible locations).
- **Inter-Service Collaboration:** Establishing shared responsibility between CAMHS and AMHS. This includes joint training for clinicians from both sectors to ensure consistency in care delivery.
- **Protocols and Monitoring:** Implementing local transition protocols and establishing systems to identify young people reaching the age limit 6–12 months in advance.

Short-Answer Practice Questions

1. **At what point should transition planning ideally begin?**
   - *Answer:* Approximately six months before the service boundary, particularly for those who have been in care for over 12 months.
2. **What are the five domains assessed by the TRAM tool?**
   - *Answer:* Diagnosis and symptom severity, risk factors, functional ability, psychosocial situation, and engagement/insight.
3. **Which specific mental health conditions should be prioritized for transition to AMHS?**
   - *Answer:* Severe conditions such as psychosis, bipolar disorder, severe depression, anxiety, PTSD, personality disorders, eating disorders, and psychiatric disorders with comorbidities (e.g., type-1 diabetes).
4. **How can clinician consistency be maintained during the early stages of AMHS care?**
   - *Answer:* By ensuring the same clinician sees the young person for at least the first two appointments (or 3–4 if weekly support is required) to build rapport and reduce anxiety.
5. **What is the recommended follow-up period for evaluating the impact of a transition?**
   - *Answer:* Within 4–6 months of the transition, using a tool such as the TROM.
6. **What should be included in the "written synthesis" provided to a young person during information sharing?**
   - *Answer:* A diagnosis summary, key developmental/social/clinical factors, strengths, prognostic considerations, treatment history, and details about potential new services and clinical teams.

Essay Prompts for Deeper Exploration

1. **The Role of Autonomy in Transitional Care:** Discuss how the shift from family-centered care in CAMHS to person-centered care in AMHS impacts the young person. How does the ESCAP guidance suggest clinicians balance youth autonomy with the potential need for caregiver involvement?
2. **Managed Discharge vs. AMHS Transition:** Analyze the core elements of a "managed discharge" for young people who do not qualify for AMHS. Why is primary care (GP) coordination and community resource linkage critical in preventing a "cliff-edge" of care?
3. **Systemic Barriers and Service Improvement:** Evaluate the challenges mentioned in the guidance regarding different European healthcare models. How can service managers use the Part 2 recommendations to address issues like rigid age boundaries and resource constraints?
4. **Methodological Rigor and PPI:** Examine the four-stage development process of the ESCAP guidance. Discuss the importance and the identified limitations of Patient and Public Involvement (PPI) in creating clinical standards for youth mental health.

Glossary of Important Terms

- **AMHS:** Adult Mental Health Services.
- **CAMHS:** Child and Adolescent Mental Health Services.
- **ESCAP:** European Society for Child and Adolescent Psychiatry.
- **MILESTONE Consortium:** A collaborative network focused on European transitional care policies and research (2014–2019) that provided the foundational knowledge for the guidance.
- **Multidisciplinary Team:** A group of care providers from various specialties (e.g., nurses, psychiatrists, social workers) who collaborate on transition planning.
- **OYOF-TES / OYOF-EOC:** On Your Own Feet – Transition Experiences Scale and End of Care version; tools used to capture service user and parent feedback on the transition process.
- **PPI (Patient and Public Involvement):** The active involvement of service users (young people) and their families in the research and development of clinical guidance.
- **Step-down Services:** Less intensive support options provided to young people who show improvement but still require monitoring or community-based resources after leaving CAMHS.
- **TRAM (Transition Readiness and Appropriateness Measure):** A standardized tool used to assess if a young person is ready for and requires a transition to adult services.
- **TROM (Transition Outcome Measure):** A tool designed to evaluate the mental health outcomes and impact of the transition process several months after it has occurred.