



A MILESTONE study of youth service transitions in Europe

See [Articles](#) page 944

The transfer between services for children and adults falls at a particularly vulnerable time, coincides with multiple other transitions, and is reputedly “poorly planned, executed and experienced”.¹⁻³ Suzanne E Gerritsen and colleagues⁴ study challenges this orthodoxy. They recruited 763 young people from 39 Child and Adolescent Mental Health Services (CAMHS) across eight European countries, who were within 1 year younger than or less than 3 months older than the CAMHS maximum age.⁴ Young people, their parents, and clinicians completed interviews and questionnaires at 9, 15, and 24 months after the baseline assessment. Only a third of young people and parents reported ongoing problems in the clinical range at baseline, whereas a similar proportion (40.6%) stopped using mental health services. Most young people’s mental health improved over follow up according to self-report, or were stable by parental account; although 5.3% had a clinically relevant increase in self-reported problems. Participants no longer attending mental health services were no more likely to visit general practitioners or emergency departments than those attending CAMHS or Adult Mental Health Services (AMHS), whereas there were no significant baseline differences in mental health whether participants stayed in CAMHS, transitioned to AMHS, returned to care, or left services. Notably, the mental health of most young adults who left services did not deteriorate. Sadly, the study did not present data on support from family, education, the third sector, or social care, which qualitative studies suggest can have a substantial effect on mental health.^{2,5} Future research should have a broader perspective to identify where the additional burden of care might fall.

This is a MILESTONE study⁴ in more than just name. These findings challenge transition literature, which suggest considerable unmet need and distress.² Few previous studies have prospectively followed up participants; collected mental health data from young people, carers, and clinicians; or followed up young people for over 1 year post-transition.² Most literature relies on retrospective case-note review, and critical appraisal tools applied by systematic review methods would be assessed as methodologically weak. This assessment is both harsh and, in relation to studying transition, incorrect. Administrative records

are less susceptible to selection bias due to eligibility or loss to follow up.² Gerritsen and colleagues⁴ should be congratulated on the high retention in their cohort, but nearly half of those initially assessed were deemed ineligible, and less than a quarter of those deemed eligible were successfully recruited.⁴ For example, 16.3% were considered too unwell to approach, which might have skewed the participants towards higher levels of function. Although a huge achievement, the study population is small and scattered across 39 services within eight countries, which brings into question how generalisable these results are as well as reducing statistical power. The study provides a much greater depth of information than administrative records could, but linkage to health, education, and social care records for longer term follow up would enhance the findings.

Only 19.6% of the MILESTONE cohort transitioned to AMHS, which is a similar finding to other quantitative studies.^{2,4} These results suggest that it should not be assumed that all young people attending CAMHS necessarily require transition. Both clinical practice and future research should start with a thorough assessment as young people approach the upper age limit to establish whether ongoing clinical care is required.^{2,5,6} The most common reasons for not transitioning include the young person or family disengaging from care or referral, which emphasises the need for discussion about current and future care.^{1,2,5}

Gerritsen and colleagues⁴ reported that 26.8% of their participants remained in CAMHS; a quarter of whom still attended CAMHS after 2 years.⁴ Similarly, half of the 13.0% who returned to care went back to CAMHS. Given the fluctuating nature of many mental health conditions, some flexibility in the CAMHS upper age limit to allow interventions to be completed is desirable. Continuation for as long as 2 years, however, has obvious implications for CAMHS capacity. The predictors of continuing or return to care were indicators of severity or ongoing need (severe mental illness, suicidal ideation or behaviour, and psychotropic medication), which imply that the young adults with the most need for care do access services, as reported by previous work,^{1,2,5} and increases confidence in the more novel results from this study.⁴

Gerritsen and colleagues⁴ have made an important contribution, but currently there is no evidence on how best to support young adults who require ongoing mental health services, particularly in relation to potential interventions.² Transition should promote the ability to function in everyday life rather than merely transferring clinical responsibility. A scoping review by Cleverley and colleagues⁷ identified six essential components for optimal transition; the use of transition protocols, tracking of young people approaching transition age, transition readiness, transition planning, transfer of care, and continuity of care. In addition to incorporating these components into clinical practice, future research should assess these elements, as well as evaluate young people's mental health and cost benefits.

We declare no competing interests.

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A death by any other name: substance-induced or substance-related mortality



Tomáš Formánek and colleagues have used the Czech national registers to shed light on the contribution of alcohol and substance use disorders to the risk of mortality following a range of physical health conditions.¹ The scope is impressive, and while the general results of increased mortality are unsurprising, the magnitude of 10–40 life-years lost for most of the physical health conditions they investigated is both compelling and concerning.

Some of this excess mortality can be attributed directly to the use of alcohol and other substances. Direct negative effects have been observed for alcohol and other substances on most organ systems, including the heart, liver, and pancreas.² However, several other factors also contribute to the excess mortality. Of the WHO-defined major risk factors for early mortality, tobacco smoking and sedentary lifestyle are overrepresented in populations with substance misuse.^{3,4} Living in deprived areas, living under poor conditions, and social isolation have been linked to excess mortality, and such situations are common for people with substance misuse.^{5,6} Substance misuse is further associated with prejudice and

stigma, reducing the likelihood of seeking medical care and of receiving adequate care once contact has been established. Finally, it is also likely that both common and severe mental illness have a role in the excess mortality.

The study by Formánek and colleagues clearly indicates that something needs to be done. The question becomes what can be done and how. Seeing as so many different factors can increase the risk, a stepped approach is probably necessary. The first step will be prevention through legislation, which requires political will. For many years, alcohol has become less socially acceptable; for example it is no longer considered appropriate to drink in workplaces. Continuing this move away from alcohol consumption being perceived as normal may be an important path, and public alcohol advertisement or sponsorships of sporting teams should be banned. In this light, the increasing normalisation of cannabis use is of concern.⁷

Focus on what drives the initiation and continued misuse of substances is very important. Early detection and help for those on a path to misuse are important

See [Articles](#) page 957