own place and secure employment seems an unrealizable goal. Given this, a sense of meaning and purpose is important for us to engender in our politics and society, to offer a new Hero's Journey to young people. If one wanted to take a Keynesian approach to mental health, investing economically in young people to carry out volunteering and altruistic acts may have a benefit on their mental health, while at the same time contributing to create more equal and inclusive societies[6].

A final point I want to make is the importance of co-production and having young people at the centre of mental health service developments. Many of us are aiming to move from participation and involvement to full equal co-production with those with lived experience of mental ill-health. Epistemic injustice is a term developed from feminist philosophy to describe someone's capacity as a knower being devalued or ignored due to factors such as gender, class or ethnicity. Young people with mental ill-health may be treated unjustly for multiple reasons[7] (age, health, gender, ethnicity, social class) and, given the benefits they can bring to us in their knowledge of services and their personal experience, it is crucial for us all to do what we can to minimize injustice and scaffold and support full democratic and equal production. A first step towards this can be charting such injustices in real clinical and research contexts and developing steps to mitigate them.

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Meeting the challenges of the new frontier of youth mental health care

Youth mental health (YMH) services are mental health's new frontier, buoyed by the widespread implementation of early intervention in psychosis services[1]. McGorry et al[2] provide an excellent account of YMH services across many high-income countries. Here we focus on the key challenges that need to be addressed for the future success of these services.

While the key principles of prevention/early intervention, youth and family participation, community engagement, stigma-free open access, choice and empowerment, and research and evaluation should guide future YMH services, it is unlikely that any one service model will meet these objectives across variations of local social, political, economic and cultural circumstances.

An enhanced primary YMH service is a most welcome innovation. However, an entirely new system parallel to any existing services may neither be feasible nor advisable in many jurisdictions. It will be prudent to incorporate existing resources in each community into the new system. Given the large variation in the way different communities transform their YMH services, testing adherence to the key principles will be necessary in evaluating their effectiveness. Producing evidence for the effectiveness of new YMH services, designed to address different levels of severity of all mental disorders, is more complex than was the case for early intervention in psychosis services, but nonetheless essential.

The primary objective of providing unencumbered stigma-free access to youth experiencing all levels of mental health distress needs to be balanced by the ability of the service to address priority needs of those with existing or emerging mental disorders. Assumed that the practice of a diagnosis-based entry for mental health services is undesirable, the question of what is a "case" in the proposed open access service has to be answered. Determining "caseness" may involve a combination of measures of youth-reported subjective distress and perception of mental health problems with clinical and functional impairments observed by the clinician[3] .

To achieve a valid and reliable definition of a YMH "case" will require carefully designed prospective studies comparing different thresholds for dimensions of distress, symptoms and functioning with currently used diagnostic categories. This becomes particularly relevant considering reports of a recent explosion of YMH problems during the COVID-19 pandemic[4]. This increase in youth distress is not necessarily indicative of a sustained increase in the incidence and prevalence of mental disorders[5]. Much of this distress is likely related to specific problems of economy (jobs, training) and a forced breakdown in social relationships.

Such widespread increase in youth distress may not be best served exclusively within the structure of even newly designed mental health services. The resulting increased workload may produce a negative impact on the already well-known delay in treatment of highly prevalent mental disorders. The front-line open door of the new YMH services providing rapid access to initial assessment must be backed by timely access to specialized mental health services and specific interventions (e.g., psychotherapies) for a range of mental disorders.

To make this core mission clear, we will need to confront the epistemic issues related to mental health/disorders/wellness or other new terms that continue to come into use. For example, some YMH services are set up as wellness centres, although

they provide services for those with mental disorders. Such terminology is likely to be confusing to the potential consumer, given the varied meanings attached to the expression "mental wellness"[6].

The considerable overlap in the age at onset of substance abuse and mental disorders in youth, and the resulting long-term association between the two[7], creates one more challenge. The new YMH services must be equipped to both assess and treat emerging as well as established substance abuse problems. While heavy use of alcohol and cannabis is transient among many young people, it may also be harbinger of later abuse and dependence. There is indeed an opportunity for effective prevention of substance abuse problems among heavy users through relatively brief, non-invasive, and effective interventions, some of which can be provided online[8]. Including substance use services on an equal footing with those for mental disorders will require a more complex infrastructure, staffing, training and evaluation than what seems to be the case currently. Last, but not least, the epidemic of opioid abuse and the tragically high mortality associated with it remain largely absent from YMH service narratives, with some exceptions[9]. Mental health services for these highly vulnerable youth will need to be connected to other interventions and systems of care currently in place for opioid abuse, so that youth can navigate between different aspects of care for these deadly problems.

There is an implicit agreement that the new YMH services are designed for the age group of 12-25, based on the high incidence of mental health and addiction disorders during this period and the assumption that child psychiatric services are more adequately provided for the 0-12 year period. However, there is little empirical evidence to support the specific age range for which an entirely new system of care is being built, and issues of continuity with the age groups before and after should be addressed. Among those under 12 years of age, a substantial proportion present with developmental disorders, making them particularly vulnerable to future mental disorders. The new YMH services must be deeply connected with the system of care for developmental disorders and ensure the same unencumbered access for these youth as for those without prior developmental problems. At the other end of the age spectrum, most major disorders are likely to persist beyond 25 years of age and, therefore, need both episodic as well as continuous care of the highest quality. Shifting transition from 18 to 25 may postpone the problem, but not solve it[3].

In summary, in setting up the new YMH system in multiple jurisdictions, some key issues need to be addressed, including connections with existing services, extending the transformation of service to the age period before and beyond 12-25 years, and providing equally weighted services to those with substance use disorders and pre-existing developmental disorders. The key principles underlying these services must guide an evaluation of a variety of methods of service delivery, as one model is unlikely to fit all circumstances and jurisdictions. Such evaluation will require innovative designs, as traditional randomized controlled studies will be difficult to conduct and we cannot hold back the progress that is already taking place.

It would be prudent, even if not popular, to clearly define the boundaries of mental health and disorders to be able to serve those with the greatest needs. This will require research into different definitions of "caseness", matched by provision of care appropriate to the stage and level of an existing or an emerging disorder. It is unlikely that YMH services can address all forms of distress in youth, the origin of and solution to some of which may be outside the field of health. This is likely to be particularly the case for the greatest proportion of youth on the planet who live in low- or middle-income countries, where poverty, political oppression, gross human rights violations, gender discrimination and violence, often resulting from post-colonial legacies, are major sources of distress.

In the context of these environments, the current models of YMH services are not only unlikely to be workable but may be grossly inappropriate. Much of the globe will need to find its own solution to problems of youth, including mental and addiction disorders, using its own unique assets, but still able to incorporate the key principles generated from the current wave of YMH services discussed in this Forum.

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Implementing 21st century "end-to-end" and technology-enhanced care for young people

The advent of health services specifically designed for young people with emerging anxiety, mood or psychotic disorders is the most appropriate response to the peak age of onset of these disorders, the evidence favouring early intervention, and the problems with access to clinical care[1]. The primary goal of these services is to provide an attractive "front door" that engages youth at risk of progression to major disorders. The available data suggest that they are largely fulfilling this basic purpose[1].

While health service innovations alone are unlikely to reduce population-level disease burden, it remains the principal