More awareness and promotion of good mental health is essential[6]. For example, there is a need for education on mental health in collaboration with schools[7], something that has been largely ignored. Teaching on physical health is a normal part of our educational system, but this has not been the case for mental health.

Negative attitudes lead to late recognition and acceptance of mental health problems among those affected, resulting in seeking help only when these problems begin to escalate[5]. The period between the occurrence of first symptoms and related suffering until first contact with services can take up to several years. However, the first contact with health care services of a young person with mental health problems is often formally registered as the starting point of his/her journey. Mental health care professionals may thereby not always realize what journey an individual has already travelled at that point, and the amount of courage needed to step into the clinic for that first clinical assessment. Perhaps because of our focus on a medical approach of diagnosis and treatment, we may have given too little attention to the steps a young person has to make prior to reaching professional services.

To enhance early intervention, improving the accessibility of services for young people should be even higher on the agenda than it already is. McGorry et al[1] mention co-design, peer involvement and soft entry as key elements for youth mental health services, and peer support as a valuable innovation. However, peer or youth volunteer support is mainly proposed as an alternative to professional care in low-income settings or described as a strategy to cope with the shortage of mental health care professionals in general. We would like to emphasize the value of peer support and youth volunteers on their own, not only as a cheap alternative but as a crucial ingredient for lowering the threshold to seek help and facilitate disclosure of difficult topics, including suicidality and sexual abuse. Peer support results in improvements on both quantitative and qualitative measures of recovery[8], and peers represent an essential source of support for young people with mental health problems. Of course, there are some critical conditions for optimal implementation of peer support, including a clear role description of peer workers and non-peer staff, and sufficient training and supervision[8].

When implemented well, peer support is one of the most promising elements that can increase the accessibility of youth mental health services. As McGorry et al[1] point out, easy accessibility will not only attract young people with emerging mental disorders, but also young people with severe or chronic mental health problems not yet receiving appropriate help. To be able to serve young people in all stages of mental ill-health, well-organized and professionally supervised peer support should be thoroughly aligned with a broad spectrum of mental health care services.

As it may not be feasible to have this entire spectrum of services available at every youth walk-in centre, and possibly not desirable in terms of creating soft entry, we would rather speak of "first-stop" than "one-stop" shops. Deciding what services should be available on site, and who should be collaborative partners, is best done at a regional level, after close consideration of local available services and needs of young people in that specific area.

More research – qualitative as well as quantitative – into the value of peer support for accessibility and effectiveness of youth mental health services is needed. Moreover, increasing awareness amongst professionals and a change of (working) attitudes is necessary. Thus, not only the system has to change, but also our attitudes as people working in the system. In order to do this, we do need input from young people themselves, to help us make the necessary changes and see things we did not see before.

Finally, cross-domain, multidisciplinary approaches in designing integrated easy-access youth mental health services should be embraced, involving available social and educational resources. Mental health problems in young people often coexist with problems in other domains[9]. This requires collaboration with and learning from other professionals.

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Bridging between youth psychiatry and child and adolescent psychiatry

Most adults who develop a psychiatric disorder already met criteria for a diagnosis in childhood or adolescent years[1]. In addition, an early onset of psychiatric disorders is associated with greater chronicity and complexity of later psychopathology[1]. These epidemiological findings are transforming the way we study and tackle psychiatric disorders. Research and clinical practice are increasingly moving away from models prioritizing fully established, late-stage disorders to instead address their risk factors and early manifestations. Investment in prevention and early intervention for psychiatric disorders in childhood and adolescent years may achieve the greatest returns by reducing distress and impairment at key developmental stages, pro-

moting well-being and productivity over the life course – similarly to what has been proposed for education[2]. This cultural shift has promoted renewed interest in child and adolescent psychiatry and in youth psychiatry (aka early intervention psychiatry).

The disciplines of child and adolescent psychiatry and youth psychiatry have emerged from different traditions, which are in many ways complementary and could be helpfully integrated. In particular, youth psychiatry originated from work in psychosis. Inspired by the neurodevelopmental model of psychosis, youth psychiatry has challenged the traditional system of care, focused on adult patients with chronic conditions. Instead, it has championed a novel system, focused on preventing or mitigating the onset of psychosis in adolescents and young adults through early intervention. Building on the success of the early intervention psychosis services, youth psychiatry now seeks to apply this model to address common mental disorders, including anxiety and depression[3]. The current attempts to apply the early intervention psychosis model to common mental disorders highlight both opportunities and challenges in supporting young people's mental health.

A central feature of youth psychiatry is the focus on "the transitional developmental stage from puberty to independent adulthood, which extends approximately from 12 to 25 years"[3]. This focus is justified by the early onset of psychopathology. It is also justified by the need to smooth the often-problematic transition of affected young people from child and adolescent mental health services (CAMHS) to adult services, typically set at 18 years. This age cut-off for service provision is in part related to differences in existing legal frameworks, commissioning arrangements, and educational pathways for the work with young people aged below or above 18 years. However, the cut-off produces a major bottleneck for service delivery, right at the time when young people face key personal transitions into higher education and/or employment. Some young people disengage from adult services because these are not developmentally appropriate. Other young people are not accepted by adult services because these prioritize patients who have already accumulated significant impairment.

The relaxation of the upper age cut-off championed by youth psychiatry offers a potential solution. In fact, many CAMHS have been attempting to implement this solution and increase their upper age limit beyond the 18-year cut-off, with varied results. In addition to the inertia of legal frameworks and commissioning arrangements, an important challenge to implementation has been the need to build up adequate clinical competencies, to prepare the workforce to respond to the wide range of developmental needs from childhood to young adult life. Indeed, the focus on youth psychiatry should not lead to overlook the importance of the care provided to younger, pre-pubertal populations, which is essential to ensure that prevalent psychiatric disorders with very early onset (e.g., anxiety disorders, behavioural problems) are treated timely, and that preventive interventions can effectively target early risk factors for later psychopathology[4,5].

Another important feature of youth psychiatry is its increasing focus on transdiagnostic psychopathology. This transdiagnostic focus has emerged from the epidemiological evidence that psychopathology repeatedly shifts among different successive disorders over the life course[1]. The clinical implications of this evidence are that over-reliance on diagnosis-specific clinical protocols is unhelpful[1] and that service provision should be restructured around other criteria, for example clinical staging[3].

Transdiagnostic models are also increasingly popular in child and adolescent psychiatry, for example to understand and address the consequences of childhood trauma[5]. Nevertheless, the implementation of these models presents important theoretical and practical challenges. Staging models are well established for psychosis and are increasingly emerging for bipolar, depressive and anxiety disorders[4]. However, staging models for truly cross-cutting, transdiagnostic constructs are still underdeveloped. In addition, development and empirical testing of transdiagnostic interventions are also in their infancy[6]. Establishing the validity and utility of these alternative models of psychopathology, therefore, requires further investigation prior to their widespread clinical implementation[7].

A third key feature of youth psychiatry is its focus on improving access to services. Youth psychiatry has promoted a "soft-entry" approach. Young people can self-refer to services, without the requirement for severity or impairment criteria, and access non-specialist, often peer-led support for mental health or psychosocial concerns. This approach has greatly benefited from co-design with young people, a positive-psychology ethos focused on strength building, and the development of technological/digital solutions. These services are less stigmatizing and more engaging for young people and have gained popularity worldwide[3], including in the UK (e.g., the Fund the Hubs campaign supported by the leading mental health charities Mind and YoungMinds). By removing barriers to care access and working with the voluntary sector, youth psychiatry has championed new ways to address the vast demand for youth mental health support.

However, the implementation of this "soft-entry" approach presents important challenges. To begin with, one must consider the present financial landscape. The grossly inadequate funding for CAMHS has been straining the ability to meet the raising demands from young people and their families, often limiting the focus of clinical work to only the most severe and risky cases. While the focus on prevention and early intervention in primary care can have a positive impact on the many young people with sub-threshold mental health problems[4], it is important to ensure that a "soft-entry" approach can work along with, and not in competition with, CAMHS, to avoid further reduction in the treatment opportunities for young people with established psychiatric disorders. Furthermore, the implementation of a "soft-entry" approach will require a more in-depth evaluation of its safety, effectiveness and cost-effectiveness, in the same way novel interventions have been evaluated in CAMHS[3,4].

In sum, there is much to gain from greater collaboration between child and adolescent psychiatry and youth psychiatry. The enthusiasm of early intervention services and the experience of CAMHS could drive

a significant evolution in the mental health care provided to young people.

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Youth mental health care in a context of large-scale collective stress

The accelerating pace of technological and societal changes continues to impose unprecedented levels of challenges to mankind, and young people often bear the foremost impact. As well described by McGorry et al[1], globalization, climate change and technology are suggested to have incurred detectable burdens on youth mental health, and the COVID-19 pandemic has significantly added to this.

Among the different societies undergoing such challenges, Hong Kong represents a notable example where the COVID-19 pandemic coincided with social tensions, protests and unrest. The cumulative effects of these population-level stressors is only beginning to be recognized[2,3]. Symptoms of post-traumatic stress disorder (PTSD), depression and anxiety interact over time in complex manners, with the continuous unfolding of population-level distressing events aggravating outcomes. Available data suggest that the mental health of young people is being disproportionately affected[3].

In the wake of unforeseen population events, timely mental health initiatives are often unavailable. During the initial stages of an unexpected situation, interventions and research often struggle to re-orientate from their ongoing endeavours to attend to the new scenario, especially when the latter is unprecedented. There is also a "wait and see" mindset along with a hopeful anticipation that the stressor would be time-limited. As events evolve, the sense of fear and lack of trust can become another major impediment to early engagement and help-seeking.

In Hong Kong, the situation necessitated the rapid launching of simple yet engaging mental health self-help tools. A youth-friendly, locally-adapted and personalized tool was thus developed (Flow Tool, https://www.psychiatry.hku.hk/flow.html), in both Cantonese and English[2]. In-depth feedback from local young people during its development period ensured that the language and style of the tool could offer a "safe space" for feelings to be articulated. Meanwhile, discussions with clinical and research teams secured its capacity to capture sufficient information for offering individualized advice. Upon completion of the tool, areas of self-help were given to those with lower distress levels, and pathways to professional help-seeking (both online and in-person) were suggested for those with higher symptom levels. To minimize concerns about data privacy (which were particularly pronounced during crisis situations and among young people), the tool was anonymous.

Since its launch, over 70,000 responses have been gathered. Youth-friendliness, respect for confidentiality, and freedom of choice were considered to be crucial elements in successfully engaging young people who may not seek help otherwise. Data from the tool revealed high levels of depressive and PTSD symptoms as a result of the cumulative effects of COVID-19 pandemic, social unrest, and individual stressful life events[3]. Rumination about external events was identified as an important mediator between stress events and distress[3].

In the wake of intense ongoing population-level stress, interpreting heightened mental distress as an increase in "mental disorder" prevalence requires caution. The language of "symptom networks" as "reactions" to external "stressors"[4], with the possibility of transitions not only into "disorders", but also "post-traumatic growth"[5], may provide a more positive framework to support young people in distress. Particularly in a life stage of growing uncertainties and need for security, using a language which emphasizes not only intrinsic vulnerabilities but also the role of extrinsic factors, as well as the potential of the young person to regain control, can be important in instilling senses of agency and hope.

A safe physical space is particularly important during periods of uncertainty. In a city where space is difficult to come by, a new project where community "hubs" were designed for, and with, young people with mental distress was launched (*LevelMind*, https://www.levelmind.hk)[6]. As access to hubs was impeded by waves of COVID-19 pandemic, it became clear that additional online interventional services with high accessibility were needed. A free, anonymous online psychiatrist advisory service has since been launched (*headwind*, https://www.youthmentalhealth.hku.hk) and regularly serves over 100 individuals (mostly young people) every month to date.

To ensure that these initiatives are serving their intended purposes, timely evaluation is needed. Yet, the unforeseeable developments of population-level stress pose new challenges to the process of evaluation, where a significantly reduced turn-around time is demanded. In the context of limited time and resources, reverting to the simple measures of "pre" and "post" effects may be tempting. This should, however, be treated with caution, as the rapid evolution of societal stressors is expected to trig-