Developing the Youth Mental Health Clinic in Hong Kong: refocus and revisit of clinical practice for youth in the new millennium

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Introduction

Scientific Revolution and Age of Enlightenment paved the way to subsequent blooming of medicine and humanity, catalysing the emergence of modern psychiatry.[1] Across the nineteenth century, conceptualisation and analysis of psychopathology and psychiatric disorders were progressively based on philosophy, psychoanalysis, and neurology. The twentieth century marked the new era of social psychiatry and biological psychiatry. When it comes to the development of subspecialties within psychiatry, for example, in child and adolescent psychiatry, the initial impetus was out of the growing social and medical needs of people after the World Wars, with Kanner and Rutter as the leading figures across the Atlantic.[2] The emergence of a medical subspecialty or a new clinical subject depends on the disease development, specific needs in societies, level and degree of differentiation of the medical knowledge and skills concerned, progression of science and technology, as well as expectation from patients, caregivers, citizens, policy makers and fund-holders.

Need for youth mental health

The operational definition for the age range of youth is from 15 to 24 years,[3,4] which encompasses puberty, adolescence, and youth adulthood, when the youth need to fulfil stage-specific developmental tasks, ranging from self-development, identity exploration, personality formation, socialisation, transition to actualisation as 'emerging adults'.[5] It is also a period of active and differential development of the brain, which explains the emotionality, impulsivity and sensitivity commonly experienced in adolescence.[6] Moreover, epidemiological research revealed that 75% of people with mental disorders have onset before the age of 24 years,[7] with potential chronicity of mental health issues in later life.[8] However, only a small proportion of people with diagnosable mental disorders receive appropriate treatment.[9]

The development of youth mental health was incubated across the millennium when mental health workers across the globe observed the noticeable gap between child and adolescent psychiatry and general adult psychiatry,[10] the high service attrition rate,[11] and youth's increasing reluctance to seek help.[12] Subsequently, international declaration[13] and large-scale youth mental health community projects[14] were launched with specific paradigm shifts.[15] For example, 'headspace' is Australia's innovation in youth mental healthcare model as a national network of youth mental health centres.[16] Aiming at prevention and early intervention, the Department of Psychiatry of the University of Hong Kong has developed different initiatives in youth mental health, ranging from online, community to campus mental health services,[17] including LevelMind@JC project.[18]

To account for the specific causes of this recent global concern, different challenging and even unprecedented environmental factors are emerging across the millennium, spanning across psycho-socio-biological-cultural areas and impacting mental health of young people at both global and local levels. These factors include impact of digitalisation to mind, self, and mental health,[19] COVID-19-related impact upon the developing youth such as disrupted socio-emotional-cognitive development,[20] as well as paradigm-shifting ideological changes such as post-structuralism.[21] They can eventually evolve into different predisposing factors, precipitating factors, and perpetuating factors in the possible progression of psychiatric disorders in the young generations.

An epidemiological study by the Chinese University of Hong Kong in 2023 revealed that 25% of children and adolescents in Hong Kong were diagnosable with at least one form of mental disorder in the past year.[22] More alarmingly, the recent years have also witnessed the increasing trend of suicide in children and youth, with the suicide rate for those under the age of 15 years at historical high of 1.7 per 100 000 people and that for those between age of 15 and 24 years rising to 9.3 per 100 000 people.[23] In the first 11 months of 2023, Education Bureau reported a worrying number of 31 suspected student suicides,[24] which had a surge in the beginning of the current academic year when possible isolation-related youth developmental

disruptions had to undergo reality testing. However, delays in initial treatment contact are a substantial cause of the larger problem of unmet need and interventions are needed to decrease these delays.[25] Therefore, a timely revisit and refocus of the theory-based and evidence-based research, service planning, and clinical practice in the youth clinical population in Hong Kong is warranted.

When it comes to the area of clinical medicine, advocacy for the establishment of youth psychiatry has been pioneered by the College of Psychiatrists of Ireland by establishing the Faculty of Youth and Student Psychiatry[26] as well as the Royal Australian and New Zealand College of Psychiatrists by forming a special division of youth psychiatry.[27] In Hong Kong, the current demarcation of clinical divisions in psychiatry is mainly based on the conventional system in the United Kingdom, with the legal adult age of 18 years as the dividing line between the child and adolescent psychiatry and the general adult psychiatry.[28] With a view to timely address the unique clinical need of young adults in transition in Hong Kong, the Youth Mental Health Clinic in Hospital Authority was set up at Queen Mary Hospital under general adult psychiatry in November 2022. The target patients are in the age range of 18 to 25 years known as transitional age youth (TAY),[29] who are at the final stage of brain maturation, experiencing relatively unprotected environmental stressors and undergoing multi-faceted transitions into adulthood.

Model of the Youth Mental Health Clinic

This Youth Mental Health Clinic consists of two outpatient clinic sessions in the Western Psychiatric Centre. It aims at early intervention for the distressed youth and exploration of the specific clinical practice in youth mental health. As a timely pilot measure to address the imminent need without delay, it has been set up within the existing resources, with flexible adaptations from the existing generic system.

The current pilot initiative mainly focuses on young adults with non-psychotic mental disorders because young patients with psychosis are already under care by the territory-wide psychiatric service known as EASY (Early Assessment Service for Young People with Psychosis). The inclusion criteria for the patients include: (1) age 18 to 25 years, (2) diagnoses of non-psychotic mental disorders, including depression, anxiety disorders, mixed anxiety and depressive disorder, adjustment disorder, obsessive-compulsive disorder, and stress-related psychiatric disorders including post-traumatic stress disorder. The exclusion criteria include: (1) patients with moderate or severe learning disability, (2) patients with main presentations of neurodevelopmental disorders (such as attention deficit-hyperactivity disorder and autistic spectrum disorder), (3) patients with active psychosis, and (4) patients with active substance abuse problems. The outcome pathways include: (1) recovery with no need for follow-up, (2) referral to the IMHP (Integrated Mental Health Programme) in general outpatient clinic, and (3) referral to substance abuse clinic, EASY, and learning disability services, as appropriate. Multidisciplinary collaboration with clinical psychologists, medical social workers, occupational therapists, and community psychiatric service would be advocated to support the youth of different needs in the community during their transitions in life.

In the current patient cohort, the common diagnoses include mixed anxiety and depressive disorder, adjustment disorder, depressive disorder, anxiety disorder, bipolar affective disorder, and obsessive-compulsive disorder. Comorbid conditions include possible prodrome of psychosis, alcohol abuse, features of attention deficit-hyperactivity disorder and autistic spectrum disorder, as well as personality issues.

Youth-oriented clinical practice

For clinical assessment, the familiarisation to youth culture, pop culture, and digital culture by psychiatrists can facilitate effective communication and open sharing of the youth who might be reluctant to seek help.[12] This kind of proactive and empathetic reaching out and active understanding of the youth facilitates further engagement, trust, and therapeutic alliance, which would enhance the clinical outcome.[30] Despite the inevitable generational gap,[31] our intention to understand and help would facilitate them to disclose their issues for further management as their reliable adult figure.[32] The exploration and analysis of pre-existing and upcoming psycho-socio-biological-cultural factors, conceptualised under the framework of predisposing, perpetuating, precipitating, and protective factors, would require a longitudinal, ongoing, multi-source, and theory-driven approach. In particular, a development- and system-informed approach, involving exploration of individual temperament and neurodevelopment, early experience and trauma, parenting style, attachment, and personal development, as well as interaction with significant others and the environment, is necessary to reveal the root of the issues.[33] The use of specific constructs in framing the clinical issues, namely the gene environment interaction,[34] stress vulnerability model,[35] developmental stage perspective,[36] and early brain differential development and maturation model,[37] would be helpful to guide the youth to conceptualise, organise, and make sense of their distress and confusion. The active and collaborative formulation and review of aetiologies and clinical issues with the distressed young patients would also help them to recall, understand, and grasp their experiences in the clinical context, which can empower them to manage their difficulties and diseases with better sense of mastery. At times, it can be difficult to differentiate between definite psychiatric symptoms and variations of normal phenomenon, while missing proper psychiatric diagnosis and treatment in distressed youth mistaken as undergoing adolescent turmoil is undesirable.[38] Moreover, it is not always easy to differentiate in the developing youth between stress-reactive disorders such as adjustment disorder and more endogenous disorders

such as depressive disorder. Accurate clinical judgment enables effective clinical management. In addition, atypical presentation of psychiatric disorders is not uncommon in young patients undergoing psycho-pathogenesis and developing psychiatric symptoms in their early development in the context of the theory of heterotrophic continuity[39] or the concept of transdiagnostic presentation.[40] Diagnostic instability[41] is also observed, especially in the conversion of depressive disorder to bipolar affective disorder, which poses further difficulty in pharmacological management. Therefore, accurate and dynamic assessment of the complex and evolving issues in the youth would require youth-orientated engagement, theory-informed and collaborative assessment and formulation, timely identification of pathological manifestation, accurate differentiation of reactive and endogenous presentations, tolerance of symptom atypicality and diagnostic uncertainty, and active revision of aetiologies, diagnosis, and formulation.

Among the commonest stressors in TAY, academic issues can cause stress in two extreme ways. For the high-achievers, there would be the chronic hypervigilance to achieve excellence especially when associated with a background of anxious-prone and perfectionistic personality traits.[42] For the youth who have marginal academic performance, they would be distressed especially when worrying about school dropout. The work adjustment difficulties in TAY might range from the issues of sleep-wake cycle, work schedule, work habit, work-life balance, beliefs and expectation, as well as meaning of life. For relationship issues, with pre-existing social difficulties such as social anxiety and autistic traits, increased social confrontation and demand would be a stressful time to them. Cyberbullying is increasingly bothering the youth.[43] Romantic issues especially in the digital world would present novel challenges.[44] Parental separation with subsequent complicated family extension might influence adversely in the separation and individuation process of the youth.[45] Practical issues like finance and accommodation difficulties are vital issues for their survival, especially for the underprivileged youth.

The recent trend of self-harm, suicidal attempts, and completed suicide among young people has alarmed mental health workers of different disciplines.[46] Classical theories in self-harm and suicide studies might no longer suffice to account for the contemporary issues. Ideological and identity changes across the millennium, along with the progressive dominance of the digital world, might potentiate their early exposure to age-inappropriate information, premature formation of values, and subsequently possible premature closure to real-world experiences. When confronted with stressors, these subtle youth issues might precipitate into premature existential crises and even reckless behaviours, which would require timely research, prevention and intervention.

The mainstay of clinical management for the youth would be early intervention to prevent avoidable chronic complications.[47] Disengagement and treatment compliance issues in youth would be hindering clinical progress,[48] which could be related to insight issue, indiscriminate information, reluctance, and ambivalence. Therefore, in order to facilitate a sustainable and engaging treatment process, an informative, interactive, and non-judgmental approach would be necessary to establish therapeutic alliance. When pharmacological treatment is indicated, early drug treatment commencement and active review of efficacy and adverse effects are necessary to improve mental condition and reduce complications. In particular, they would have concern for adverse effect of weight gain, as self-image is of utmost importance among youth, especially in a digital age of social media filled with selfies.[49] Moreover, adverse effect of oversedation would be relevant for them, who would usually need to stay alert for daytime studies or works, or social life over internet in midnight. Active monitor and avoidance of iatrogenic benzodiazepine dependence is also important to avoid lifelong adverse effect. For psychosocial interventions, it is essential to involve the youth and collaborate with multidisciplinary colleagues to achieve synergism, proactive management of stressors, and patient empowerment. The high digital literacy of the youth would be an advantage for implementing simplified and effective psychological intervention such as in IAPT (Improving Access to Psychological Therapies)[50] in the digital platforms. A systematic review and meta-analysis showed that computerised cognitive behavioural therapy showed efficacy for reducing anxiety and depressive symptoms in adolescents and young adults, compared with passive controls.[51] Treatment resistance in youth, apart from psychopathological factors, might be related to more profound issues (for example, underlying features of personality disorder, substance abuse, neurodevelopmental issues, or undisclosed traumatic events) and warrant continuous review in the course of clinical management. Remission of symptoms, reduction of personal distress, improvement of quality of life, and improvement of functioning are the targeted treatment outcomes, while full remission should be attempted to prevent potential chronicity of psychiatric issues if possible. Relapse prevention would aim at preventing possible recurrence of disease, through identification and management of early warning signs, mitigation of modifiable risk factors such as substance abuse as well as enhancement of protective factors such as resilience, community integration, and healthy lifestyle. As digital natives, post-millennial youth tend to be independent, altruistic, and knowledgeable; digital platforms such as 'headwind'[52] would be strategic sites to promote personal growth, self-care, and peer support.

Regarding psychiatric rehabilitation, among students, academic stress can be a major stressor or a result of psychiatric disorders. A close collaboration with school with clear assessment and delineation of issues and roles as well as a proactive and gradual approach would help the students readjust to their learning and education. In the community, the territory-wide youth hubs in LevelMind@JC can support distressed youth and improve their mental

Table. Tips on clinical practice in youth mental health ('Youth For MEDICS')[45,55-59]

Youth orientation: Youth-oriented clinical practice is always important to facilitate timely and effective communication, engagement, and management. A proactive understanding of youth and digital culture would be necessary, which would benefit the establishment of therapeutic alliance. Engagement with the distressed youth would require proactive, sincere, and explicit approach, while empathy would require active and mutual cultivation between doctors and young patients in the midst of inevitable generational differences. The youth should always be offered the opportunity to be seen on their own in order to respect their autonomy, while parents and significant others would be seen for collateral information, support, and management. The ultimate goal for establishing a therapeutic partnership with young patients would lead to empowerment in their recovery journey. A development-informed, neuropsychiatry-informed, culture-sensitive, youth-focused, and empathetic approach is necessary for the distressed youth who are fulfilling various developmental tasks, undergoing differential and active brain development, as well as facing different novel environmental changes and adversities, in the background of individual resilience and vulnerabilities. Their participation and feedback would be valuable to refine the clinical practice. If further service development is feasible, comfortable environment such as clinic design with greenery, outreach service in youthful places such as nature or café and designated youth-friendly staff are important elements to sustain engagement with youth in the community.
Formulation and assessment: In a 'glocalised' era,[55] a contextualised and culture-sensitive approach in assessment and formulation is necessary to understand individual and collective meaning of symptoms, stressors, vulnerabilities, aetiological formulations, and subsequent management. It would require contextualisation as well as multidisciplinary assessment and formulation to engage young patients in understanding the psychopathology, organising their issues, undergoing systematic management, as well as making sense of their stressful experience.
Management: In view of their higher mental health literacy probably due to digital information and peer sharing,[56] it is a good practice to engage the youth as our collaborating partners in their management. Similar to other age groups, immediate management would include assessment of any immediate risks to self or others, as well as any risk of neglect or abuse. Potential crises like school dropout or work discontinuation should not be overlooked. Timely collaboration with stakeholders including schools and community partners can help anticipate young patients' difficulties for timely and concerted management to avoid preventable stressors and complications. For treatment strategy, if the young people are indicated for pharmacological treatment, early drug treatment commencement and active review of efficacy and side-effects are necessary, aiming at co-ordination and synergism with psychosocial interventions. For short-term management, symptom reduction, disease remission, function restoration, distress relief, therapeutic alliance formation, stress management, and realistic resilience building would be the focuses according to the clinical condition. For long-term management, relapse prevention, rehabilitation, personal growth, and community integration would be essential for the young patients to develop and sustain a fulfilled and meaningful life. Strength-weakness analysis, empowerment, goal setting, and motivation enhancement would be useful strategies, which would aim at internalised and personalised changes in the young patients in the course of individuation and identity development.
Ethics and privacy considerations: The post-millennial youth, as digital natives, tend to mature earlier but might have longer dependency on own families than the previous generations, with possible ambivalent separation and individuation from their families.[45] Requests for personal privacy and expression of self-preference are common and should be respected, based on medico-legal considerations, 'need-to-know principle', and confidentiality principle.
Diversity: In the millennium of diversity,[57] respect should always be paid to the variations between youth, including gender issue, sexual orientation, as well as cultural, ethnic, and linguistic backgrounds.
Inspiration and resilience: Inspiring the developing youth to explore their own way and develop their own resilience in the midst of distress and adversities should be encouraged with optimism in view of the potential neuroplasticity and growing resilience in young people.
Culture building: A youth culture of wellbeing and resilience should be promoted in schools, universities, workplace, and communities to recognise and actualise their abilities and potentials while balancing their expectations and equipping them with survival skills in order to lead an independent, connected, and meaningful life.
Support: The mutual support of peers in the road of recovery would be the mainstay for the youth with advocacy of self-sufficiency, empowerment, and peer networking,[58] while mentoring by trustworthy adults would help the youth adapt and transform the experiences of the past for their own generations.[59]

health and socialisation, similar to therapeutic communities with guidance.[18] Engagement in art and cultural activities would improve stress coping and mental health for youth. Music, which is youth-friendly, can improve their wellbeing and socialisation.[53] Physical exercise has proven efficacy in improving mental health at a molecular level.[54] Realistic integration into daily activities is the key to success.

The practical tips in the clinical practice for youth mental health are summarised in the Table.[45,55-59]

Way forward

The next step in the development of the subject and service of youth mental health would be to consolidate and review the pilot experience for further understanding, service planning, and resource allocation. Ongoing discussion among stakeholders including psychiatrists, mental health professionals, patients, youth, public and private healthcare sectors, universities, policy makers, and fundholders would be necessary to deliberate youth-oriented service models. Personalised psychiatry approach,[60,61] translational research,[62] and precision medicine,[63] together with multidisciplinary collaboration and youth participation, would be the future direction of clinical development in youth mental health.

Contributors

All authors designed the study, acquired the data, analysed the data, drafted the manuscript, and critically revised the manuscript for important intellectual content. All authors had full access to the data, contributed to the study, approved the final version for publication, and take responsibility for its accuracy and integrity.

Conflicts of interest

All authors have disclosed no conflicts of interest.

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Data availability

All data generated or analysed during the present study are available from the corresponding author on reasonable request.

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