Secondary Prevention for Mental health problems of children and adolescents under COVID

G05

Table 1
Trends of mental health symptoms in Hong Kong adult population.

	2016 (N = 4036)	2017 (N = 4054)	April 2020 (N = 1501)
Stress level			
Mean (SD)	5.61 (2.86)	5.85 (2.90)	7.2[illegible] (2.12)
Crude β (95% CI)	0 [reference]	−0.03 (−0.25, 0.18)	1.80 ([illegible], 2.01)[b]
Adjusted β (95% CI)[a]	0 [reference]	0.48 (0.16, 0.74)	1.72 (1.52, 1.92)[b]
Anxiety			
No. (%)	456 (11.3)	377 (9.3)	237 (15.8)
Crude OR (95% CI)	1 [reference]	0.92 (0.80, 1.07)	1.45 ([illegible], 1.72)[b]
Adjusted OR (95% CI)[a]	1 [reference]	1.17 (0.96, 1.44)	1.42 (1.19, 1.70)[b]
Depression			
No. (%)	291 (7.2)	255 (6.3)	221 (14.8)
Crude OR (95% CI)	1 [reference]	0.95 (0.80, 1.13)	2.13 ([illegible], 2.57)[b]
Adjusted OR (95% CI)[a]	1 [reference]	1.20 (0.94, 1.53)	2.07 (1.71, 2.51)[b]
Unhappiness			
No. (%)	476 (11.8)	469 (11.6)	354 (23.6)
Crude OR (95% CI)	1 [reference]	0.98 (0.86, 1.12)	2.32 ([illegible], 2.70)[b]
Adjusted OR (95% CI)[a]	1 [reference]	1.14 (0.94, 1.38)	2.27 (1.95, 2.65)[b]

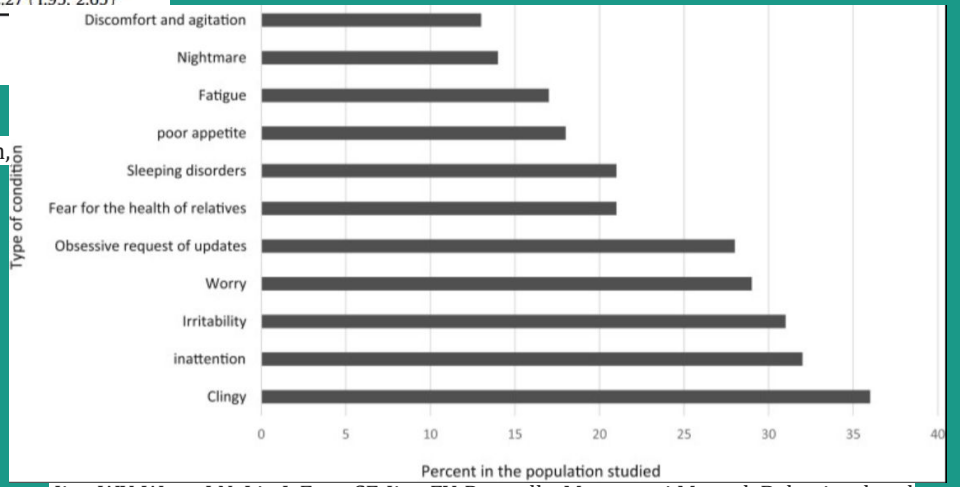
Abbreviations: β, regression coefficient; OR, odds ratio.
[a] Adjusting for sex, age, marital status and education attainment.
[b] $P < 0.001$.

Trends of mental health symptoms in Hong Kong adult population
Sheng Zhi Zhao, Janet Yuen Ha Wong, Tzu Tsun Luk, Abraham Ka Chung Wai, Tai Hing Lam, Man Ping Wang, Mental health crisis under COVID-19 pandemic in Hong Kong, China, International Journal of Infectious Diseases,, Volume 100, 2020, Pages 431-433

The stress level and prevalence of anxiety and depressive symptoms and subjective unhappiness greatly increased during the COVID-19 outbreak.

Compared with 2016, the proportion of unhappiness and depressive symptoms doubled.

A recent study conducted in China screened children and adolescents for behavioral and emotional distress due to the Covid-19 pandemic. Clinginess, distraction, irritability, and fear that family members can contract the deadly disease were the most common behavioral problems identified.



Jiao WY, Wang LN, Liu J, Fang SF, Jiao FY, Pettoello-Mantovani M, et al. Behavioral and Emotional Disorders in Children during the COVID-19 Epidemic. *J Pediatr.* 2020

Risk factors

1. Parents: parental stress
    a. Job insecurity, unemployment
    b. How parents and caregivers respond to behavioural problems
    c. Additional role of educators to facilitate instruction that is assigned by teachers
2. School: school closure
    a. Unable to identify & report signs of abuse
        i. Study from previous financial recessions, natural disasters, and outbreaks like the Ebola outbreak in West Africa from 2014-2016, revealed **increased rates of child abuse, neglect, and exploitation**
        ii. Recent reports from Hubei province, China, that **police report of domestic violence** was increased to more than triple during the lockdown in February 2020, from 47 last years to 162 this year
        iii. Children with histories of previous trauma, have had any mental +/- physical health problems, parents who are divorced/separated or incarcerated, parents who have mental/chronic physical health problems
    b. Increased screentime
        i. Sensationalism
        ii. Sreading misinformation
        iii. Cyber bullying, harmful content

Secondary prevention is...

- **Screening to identify diseases in the earliest stages** before the onset of signs and symptoms according to *At Work, Issue 80, Spring 2015: Institute for Work & Health, Toronto*
- Aims to reduce the impact of a disease or injury that has already occurred
- How?
    - Detect and treat disease or injury as soon as possible to halt or slow its progress
    - Encourage personal strategies to prevent reinjury or recurrence
    - Implement programs to return people to normal functioning
- Examples include:
- regular exams and screening tests to detect disease in its earliest stages (e.g. mammograms to detect breast cancer)

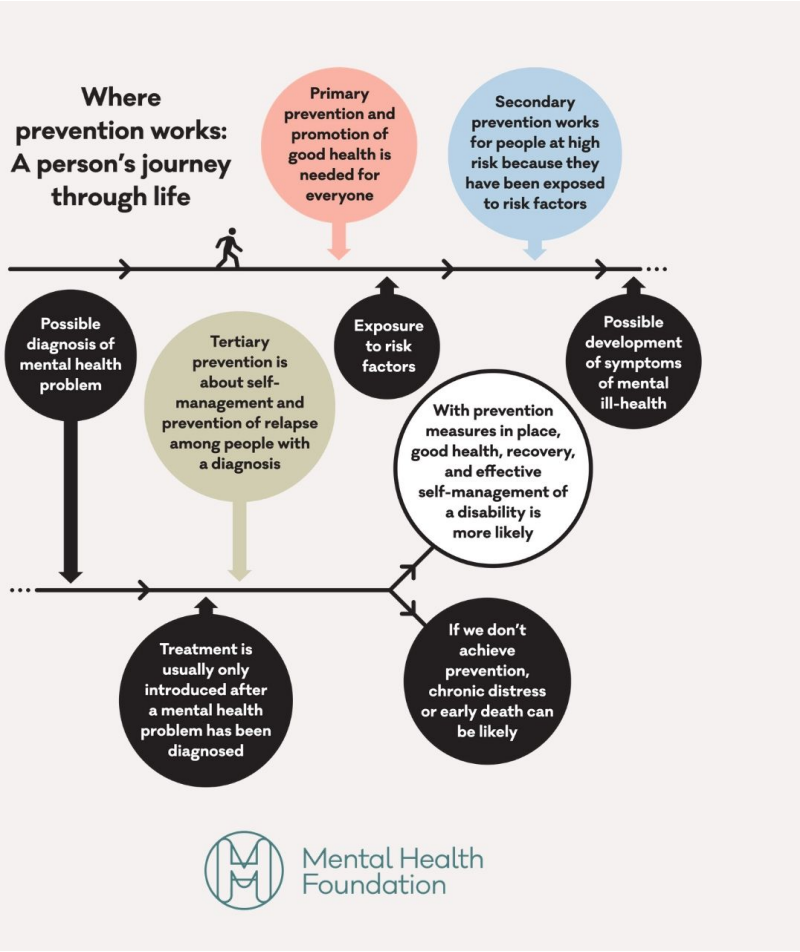


Table 2
Trends of mental health symptoms by sex, age, and education in Hong Kong adult population.

	Adjusted OR/ β (95% CI)[a]						
	Sex		Age groups		Education attainment		
	Male	Female	18–59 years	60+ years	Primary or below	Secondary	Tertiary
Stress level							
2016	0 [reference]	0 [reference]	0 [reference]	0 [reference]	0 [reference]	0 [reference]	0 [reference]
2017	0.07 (−0.27, 0.41)	0.11 (−0.15, 0.37)	−0.44 (−0.85, −0.02)[a]	0.03 (−0.27, 0.32)	−0.07 (−0.58, 0.43)	−0.10 (−0.47, 0.26)	−0.29 (−0.72, 0.14)
2020	1.53 (1.21, 1.85)[d]	1.77 (1.51, 2.04)[d]	0.84 (0.54, 1.14)[d]	2.40 (2.12, 2.67)[d]	2.78 (2.28, 3.27)[d]	1.83 (1.54, 2.12)[d]	0.82 (0.46, 1.18)[d]
Interaction	0.54		<0.001		<0.001		
Anxiety							
2016	1 [reference]	1 [reference]	1 [reference]	1 [reference]	1 [reference]	1 [reference]	1 [reference]
2017	0.95 (0.74, 1.22)	1.01 (0.84, 1.21)	0.76 (0.57, 1.00)	1.06 (0.84, 1.33)	1.13 (0.79, 1.61)	0.85 (0.64, 1.13)	0.80 (0.59, 1.10)
2020	1.44 (1.09, 1.90)[b]	1.36 (1.08, 1.72)[c]	1.09 (0.77, 1.39)	1.88 (1.46, 2.45)[d]	1.58 (1.00, 2.49)[b]	1.39 (1.08, 1.78)[c]	1.28 (0.93, 1.76)
Interaction	0.79		0.006		0.99		
Depression							
2016	1 [reference]	1 [reference]	1 [reference]	1 [reference]	1 [reference]	1 [reference]	1 [reference]
2017	0.95 (0.71, 1.26)	1.06 (0.85, 1.33)	0.73 (0.53, 1.01)	1.25 (0.95, 1.65)	1.08 (0.72, 1.62)	1.00 (0.72, 1.38)	0.87 (0.59, 1.28)
2020	1.88 (1.39, 2.53)[d]	2.13 (1.65, 2.74)[d]	1.68 (1.30, 2.18)[d]	2.54 (1.90, 3.40)[d]	1.97 (1.23, 3.18)[d]	1.92 (1.46, 2.53)[d]	2.09 (1.47, 2.95)[d]
Interaction	0.72		0.12		0.92		
Unhappiness							
2016	1 [reference]	1 [reference]	1 [reference]	1 [reference]	1 [reference]	1 [reference]	1 [reference]
2017	1.01 (0.81, 1.25)	1.01 (0.85, 1.20)	0.92 (0.69, 1.21)	1.05 (0.86, 1.28)	0.99 (0.74, 1.33)	1.05 (0.82, 1.35)	0.90 (0.66, 1.24)
2020	2.18 (1.73, 2.74)[d]	2.31 (1.88, 2.83)[d]	2.09 (1.67, 2.62)[d]	2.47 (2.00, 3.04)[d]	2.09 (1.48, 2.97)[d]	2.20 (1.78, 2.73)[d]	2.44 (1.82, 3.28)[d]
Interaction	0.94		0.086		0.85		

Abbreviations: β, regression coefficient; OR, odds ratio.
[a] Adjusting for sex, age, education level, and marital status.
[b] $P < 0.05$.
[c] $P < 0.01$.
[d] $P < 0.001$.

Subgroup analyses by sex, age, and education showed that respondents who were older (aged 60+) tend to show a larger increase in all mental health outcomes. The overall stress level and all mental health outcomes are generally more dominant in older respondents, regardless of time periods. The increases in stress level were significantly larger among older and less educated respondents.

Current screening method: Questionnaire

Anxiety related: **Generalized Anxiety Disorder (GAD-7)**

在過去兩個星期，你有多經常受以下問題困擾？（請選擇你的答案）	完全沒有	幾天	一半或以上的天數	超過近乎每天
	0	1	2	3
1. 感到緊張、不安或煩躁	○	○	○	○
2. 無法停止或控制憂慮	○	○	○	○
3. 過份憂慮不同的事情	○	○	○	○
4. 難以放鬆	○	○	○	○
5. 心緒不寧以至坐立不安	○	○	○	○
6. 容易心煩或易怒	○	○	○	
7. 感到害怕，就像要發生可怕的事情	○	○	○	

0-4: 無焦慮
5-9: 輕度焦慮
10-14: 中度焦慮
15-21: 重度焦慮

DSM-V

Criteria for Diagnosing GAD

When assessing for GAD, clinical professionals are looking for the following:

1. The presence of excessive anxiety and worry about a variety of topics, events, or activities. Worry occurs more often than not for at least six months and is clearly excessive.
2. The worry is experienced as very challenging to control. The worry in both adults and children may easily shift from one topic to another.
3. The anxiety and worry are accompanied by at least three of the following physical or cognitive symptoms (In children, only one of these symptoms is necessary for a diagnosis of GAD):
   - Edginess or restlessness
   - Tiring easily; more fatigued than usual
   - Impaired concentration or feeling as though the mind goes blank
   - Irritability (which may or may not be observable to others)
   - Increased muscle aches or soreness
   - Difficulty sleeping (due to trouble falling asleep or staying asleep, restlessness at night, or unsatisfying sleep)

Spitzer R.L., Kroenke, K., Williams, J.B.W., & Lowe, B. (2006) *A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7 Arch Intern Med. 66:1092-1097*. Retrieved from http://www.phqscreeners.com/pdfs/03_GAD-7/GAD7_Traditional%20Chinese%20for%20Hong%20Kong.pdf

Mnemonic for MDD:
SIG-E-CAPS

- **S**leep changes
- **I**nterest loss
- **G**uilt
- **E**nergy loss
- **C**oncentration difficulties
- **A**ppetite loss
- **P**sychomotor (agitation)
- **S**uicidal thoughts

Current screening method: Questionnaire

Distress and Depression Related: **Patient Health Questionnaire (PHQ-9)**

在過去兩個星期，有多少時候您受到以下任何問題所困擾？	完全沒有	幾天	一半以上 的天數	幾乎每天
	0	1	2	3
1 做事時提不起勁或沒有樂趣	○	○	○	○
2 感到心情低落、沮喪或絕望	○	○	○	○
3 入睡困難、睡不安穩或睡眠過多	○	○	○	○
4 感覺疲倦或沒有活力	○	○	○	○
5 食慾不振或吃太多	○	○	○	○
6 覺得自己很糟 —或覺得自己很失敗，或讓自己或家人失望	○	○	○	○
7 對事物專注有困難， 例如閱讀報紙或看電視時	○	○	○	○
8 動作或說話速度緩慢到別人已經察覺， 或正好相反—煩躁或坐立不安、動來動去的 情況更勝於平常	○	○	○	○
9 有不如死掉或用某種方式傷害自己的念頭	○	○	○	○

0-4: 無抑鬱
5-9: 輕度抑鬱
10-14: 中度抑鬱
15-19: 嚴重抑鬱
20-17: 重度抑鬱

Based on:

TABLE 1 DSM-5 criteria for major depressive disorder and persistent depressive disorder

Major depressive disorder (in children and adolescents, mood can be irritable)

5 or more of 9 symptoms (including at least 1 of depressed mood and loss of interest or pleasure) in the same 2-week period; each of these symptoms represents a change from previous functioning

- Depressed mood (subjective or observed)
- Loss of interest or pleasure
- Change in weight or appetite
- Insomnia or hypersomnia
- Psychomotor retardation or agitation (observed)
- Loss of energy or fatigue
- Worthlessness or guilt
- Impaired concentration or indecisiveness
- Thoughts of death or suicidal ideation or suicide attempt

Persistent depressive disorder (in children and adolescents, mood can be irritable and duration must be 1 year or longer)

Depressed mood for most of the day, for more days than not, for 2 years or longer

Presence of 2 or more of the following during the same period

- Poor appetite or overeating
- Insomnia or hypersomnia
- Low energy or fatigue
- Low self-esteem
- Impaired concentration or indecisiveness
- Hopelessness

Never without symptoms for more than 2 months

Table 1: DSM-5 criteria for major depressive disorder and persistent d...

Kroenke K, Spitzer RL, Williams JB (September 2001). "The PHQ-9: validity of a brief depression severity measure". *Journal of General Internal Medicine*. **16** (9): 606–613. doi:10.1046/j.1525-1497.2001.016009606.x. PMC 1495268. PMID 11556941.

Current screening method: Questionnaire

Other questionnaires:

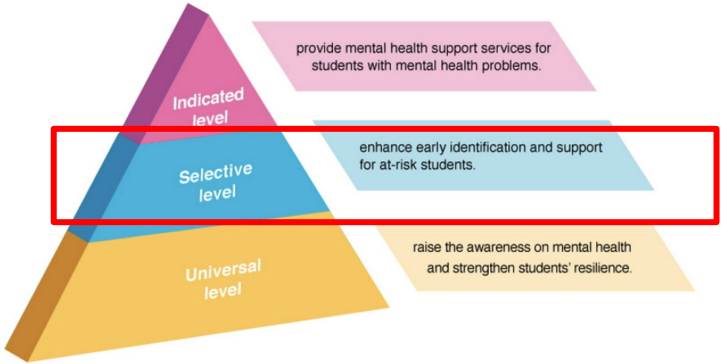
- **Eating Attitude Related:** Eating Attitude Test (EAT-26)
- **Insomnia Related:** Insomnia Severity Index (ISI)
- **Sleep Pattern Related:** Morning Eveningness Questionnaire (MEQ)

Advantages	Limitations
• Able to recognize individuals with early symptoms and signs of mental health problems (facilitates diagnosis, assess symptoms severity) • Well established and accepted (with validation by research papers) • Can be administered by clinician, through telephone, or self-administered by patients themselves (easily assessable on the internet)	• Passive: More active distributions in order to reach more potential individuals that might have early symptoms and signs of mental health problems • Honesty: Subjects may make the more socially acceptable answer rather than being truthful • Introspective ability: Subjects may not be able to assess themselves accurately

Current screening method:
Early identification by observation from teachers and parents

Education for teachers: *what trainings are provided?*

- mental health@school provided by Education Bureau
  - **three-tier support model**: universal → selective → indicated
- professional development of teachers (specific for secondary prevention)
  - **"structured training for teachers"**
    - a program for primary and secondary schools teachers
    - 3-day elementary training for teachers at large + 5-day in-depth training for designated staff
    - aim: to raise teachers' awareness of mental health and to enhance their professional knowledge and skills to identify and spport students with mental health needs
  - "professional development of teachers on detecting and supporting students with suicidal risks"
    - examples: "Gatekeeper Training", "Seminar on Prevention of Student Self-harm and Suicide"



"selective level" = enhance early identification and support for at risk students

Bureau, E. (n.d.). Student Mental Health Information Online. Student Mental Health Information Online - PD on Detecting and Supporting Students with Suicidal Risks. Retrieved May 13, 2022, from https://mentalhealth.edb.gov.hk/en/professional-development-of-teachers/pd-on-detecting-and-supporting-students-with-suicidal-risks.html

Current screening method:
Early identification by observation from teachers and parents

Education for teachers: *what are the roles of teachers in secondary prevention of mental health problems in students?*

- teachers should be alert to specific signs indicating possible mental health problems → early detection → report to designated staff
  - declining grades which are not in line with students' usual performance
  - frequent / long term absenteeism
  - failure to focus on school work and routine tasks
  - emotional / behavioral problems over a sustained period of time
  - fatigue and tireness over a long period of time
  - irritable, emotional ups and downs
  - social withdrawal / isolation
- home-school communication by annual end-of-year meetings, looking into medical history of children (voluntary basis)

pros	cons
before COVID students spend most times in school → better observation on students behavioral changes + school performance → early identification	less face-to-face interaction and less time spent between teachers and students ⇒ observation is less reliable
professionally trained to equip with skills for spotting early signs and symptoms as trainings are mandatory	questionable feasibility due to high student-to-teacher ratio & questionable ability due to lack of transparency in assessments

How schools can help students with mental health problems. (n.d.). Retrieved May 13, 2022, from https://mentalhealth.edb.gov.hk/uploads/mh/content/document/ENG_Guidelines%20to%20help%20MI%20students__20200717.pdf

Current screening method:
Early identification by observation from teachers and parents

education for parents: *what trainings are provided? what are the main problems?*

- educational talks → identification / suppport / management of mood disorders
  - provided by universities e.g. The Education University of Hong Kong / Educational Bureau
- articles and information on how to spot mental illnesses in kids
  - provided by Student Health Service / NGOs e.g. Mind Hong Kong
- Problems:
  - parents have an impotant role especially during COVID BUT mental health education for parents is provided on a voluntary basis + lacking promotion
    - COVID → more time spent at home + most parents need to work-from-home → responsbility for spotting signs and symptoms in children ↑
    - COVID → ↓ social life in children + ↑ stress from online learning → problem developed at home rather than at school → signs first to be noticed by parents
  - a lack of reporting system for parents even if they can spot mental problems in their children *(vs teachers must report to the school if students express suicidal thoughts → handled by social workers / psychologists)*

current distribution of screening tools

social workers in school/ community

one social worker for each school policy 

→ around 34 NGOs operate stationing school social work service for more than 460 secondary schools in HK

distribution of mental health related questionnaire for screening/ brief treatment/ referral to clinical pscyhologist or psychiatrist

able to conduct both active (e.g. talks) and passive (e.g. consultation) screening

- difficult to reach the students during class suspension
- ineffective talks or activities

health care professionals

GP, OPD of psychiatrist/ clinical psychologists 

- more accurate screening results e.g. more proactive approach by asking risk factors/ family history
- quicker medical intervention

- long waiting time for patients to seek help i.e. average 1.6yr waiting time for children/ adolescents psychiatric specialist clinic
- mental illness stigma → afraid of bias
- unable to identify the problems by children/ adolescents themselves → will not reach for mental health support
- high cost: private sector HKD$800-3000

current distribution of screening tools

student health service

P1-S6 students are given an annual health assessment at a Student Health Service Centre which includes psychological health assessment

annual check; free; reliable health care professionals involved

- attendence: 65% of the enrolled students attend their section
- fail to involve the parents: many students were not accompanied by their parents when attending the sessions → too young to understand and convey the messages to their parents
- insufficient follow-up actions and inadequate communication with organisations referred

HEALTH PROGRAMMES AT STUDENT HEALTH SERVICE CENTRE　　學生健康服務中心服務計劃

Activity 活動項目 / Grade 級別		P1 小一	P2 小二	P3 小三	P4 小四	P5 小五	P6 小六	S1 中一	S2 中二	S3 中三	S4 中四	S5 中五	S6 中六
Body Weight & Height Measurement	體重及身高量度	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Blood Pressure Measurement	血壓量度					✓		✓		✓		✓	
Vision 視力 – Visual Acuity Test	視力測試	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vision 視力 – Stereopsis Test	立體視覺測試	✓											
Vision 視力 – Colour Vision Test	色覺測試						✓						
Hearing Test	聽覺測試	✓	If indicated 按情況需要						✓	If indicated 按情況需要			
Checking of Immunisation Status	免疫接種核對							✓	✓	✓	✓	✓	✓
History Taking	病歷記錄	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physical Examination	身體檢查	✓		If indicated 按情況需要		✓		✓		✓		✓	
Growth/Pubertal Development Assessment (may include examination of external genitalia/ secondary sexual characteristics)	發育/青春期評估 (或需檢查外生殖器/第二性徵)	If indicated 按情況需要											
Spinal Assessment	脊柱評估	Age 10 or above and if indicated 10 歲或以上及按情況需要				✓		✓		✓	If indicated 按情況需要		
Health Assessment Questionnaire 健康評估問卷 – For Student	學生填表				✓		✓		✓		✓		✓
Health Assessment Questionnaire 健康評估問卷 – For Parent	家長填表		✓		✓		✓						
Individual Health Counselling	個別健康輔導	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Group Health Talk	健康講座	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Laboratory Test & Other Investigations	化驗及其他檢驗	If indicated 按情況需要											
Prescription/ Referral / Follow-up*	處方/轉介/跟進*	If indicated 按情況需要											
Child Health Record Updating	兒童健康記錄填寫	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Key:　P – Primary 小學　　S – Secondary 中學

* 如有需要，若學生健康服務未能透過提供的電話號碼致電家長 / 監護人，本服務或會透過學校聯絡家長 / 監護人。

* If necessary, Student Health Service (SHS) may seek support from school to contact parents / guardians if they could not be reached by the given phone number.

(StdHS May 2020)

Proposed screening program

Who should be in charge of screening?
= multidisciplinary!

- Parents & teachers
- Social workers & counsellors
- Doctors (e.g. psychiatrists, GP)
- Allied health (e.g. CP, MSW)
- NGOs
- Online resources

⇒ raise awareness about importance of mental health particulary under COVID & educate on screening tools

General screening

- Distribute questionnaires (PHQ-9 & GAD-7) to all primary and secondary school students
- Organize more workshops & training for teachers & parents → increase awareness about mental health in COVID-19 → early identification of affected students
- Refer to health care professionals & social workers for affected cases

Proposed screening program

Focused screening for high risk targets

- Adolescents with pre-existing mental health problems, comorbidities, learning disabilities, or family Hx of mental health disorders
  - Rely on healthcare professionals involved in the case for more detailed & frequent screening
- Adolescents with poor financial background
  - Low income families, poor living environment, lack of family/ social support network
  - Cooperate with social welfare department & volunteers who have already built rapport with them → regular screening & promote awareness

Others: Screening by NGOs

- Online counselling services (anonymous chat) by NGOs for teenagers with mental health problems
  - For emotional support + suicide prevention
  - E.g. HeartlineHK, Open Up, Counseline (MHAHK), Nite Cat online, uTouch, Chatpoint, Caritas Inifinity Teens Cyber Youth Support Team
- Educate volunteers about significance of mental health disorders among teens & introduce relevant screening tools → advocate for early screening
- Refer to psychiatrists & CP
- Online self help resources: education + self diagnosis + personal strategies to prevent recurrence + seek help

Education for volunteers

current education provided: e.g. *Harmony House* - (1) Basic training (4 sessions) (2) Advance training (2 sessions) (3) Hotline Service Manual

risk stratification

- volunteers on online platforms can be educated to ask questions based on PHQ-9 questionnaire → act accordingly to the scores
- from ≥ 10 → recommend seeking professional help / continuous annonymous counselling as they wish
- from ≥20 → refer to partnered psychiatrists / ask professionals to handle the calls or texts

other actions

- identify emergency situation: suicidal intention/ self-harm
- provide clear information on where/ who to approach for further help
- provide platform or resources for self-help e.g. *Shall We Talk, Social Welfare Department Psycho-education information Hub for Combatting the Novel Coronavirus*
- emotional support: give suitable suggestions based on the educated received

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0 – 4	None-minimal	None
5 – 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 – 19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: A new depression diagnostic and severity measure. *Psychiatric Annals, 32*(9), 509–515. https://doi.org/10.3928/0048-5713-20020901-06

https://shallwetalk.hk/zh/news/mental-health-of-work-from-home-amid-covid-19-pandemic/

S tudent-centred | M entorship-based | A ssured Knowledge Acquisition | R obust Clinical Teaching | T eaching Ethics and Professionalism

Medical Curriculum Integration

- Currently in the MED5 curriculum, Pediatrics and Psychiatry are 2 separate modules and overlaps fall outside the curriculum, so what can be done to minimize this overlap so that medical students have the right training to tackle children/adolescent mental health?
- Current arrangement: 1 week attachment to child and adolescent psychiatry
    - The 1 week only compose of 1 OPD and optional child team ward round
- Important as a secondary prevention as future healthcare professionals regardless of the specialty students decide to enter

What we propose in addition to the current curriculum

1. **Tutorials** on walking medical students through cases of which children mental health was compromised due to various reasons including covid, cyberbullying, e.t.c
2. Conducting a **thorough analysis** of the family background, to allow medical students to identify the risk factors of early signs and symptoms of mental health issues.
3. Adding to the **FFU project extension on child psychiatric health** and recognizing early signs of mental health distress in children
4. Learn to **recognize patterns** based on CMS and other case studies on predictors of children's future backgrounds and recongize pattern of abuse (divorced families, child abuse…)
5. Adopt an **interdisciplinary approach** by learning with nursing, social work, psychology students to have a holistic approach towards mental health

Mandatory mental health first aid class for medical students

Current practice in CUHK

- Faculty wellness team
- Apply on voluntary basis
- Certificate issued by the Hong Kong Mental Health Association and Mental Health First Aid International upon passing the exam

**Under COVID situation …

➢ Class resumption in August 2020
➢ Online lectures + face-to-face training & exam

Content of the course

1. Lecture topics
   - Adolescent development
   - Depression
   - Suicide
   - Anxiety
   - Panic attack
   - Substance misuse
   - Bipolar
   - Eating disorder
2. Soft skills practice session – “ALGEE”
3. Examination

Mandatory mental health first aid class for medical students

Course impacts

- Improve mental health literacy
- Ability to recognize relevant signs & symptoms of mental health problems
- Ability to respond to peers with mental health problems

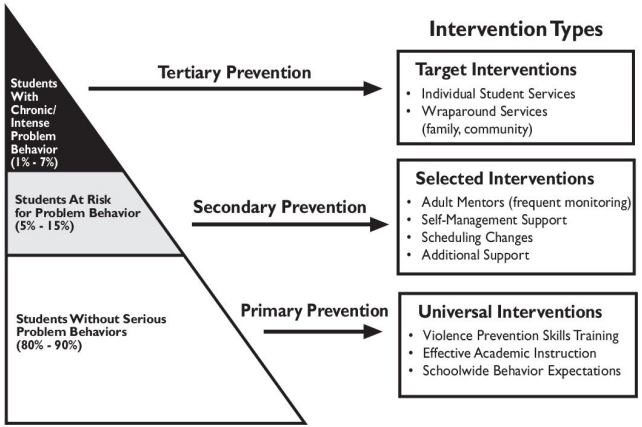
Making it mandatory to medical students …

- ➢ Passive screening tool on peers level → support network
- ➢ Knowledge & confidence equipped to recognize mental health issues in adolescent friends[1] → early intervention
- ➢ Facilitates interdisciplinary treatment approach for future patients
- ➢ Both online & face-to-face tailored courses have shown similar results[2]

1. Davies, E., Beever, E., & Glazebrook, C. (2018). A pilot randomised controlled study of the Mental Health First Aid eLearning course with UK medical students. *BMC Medical Education*, *18*(1). doi: 10.1186/s12909-018-1154-x
2. Bond, K., Jorm, A., Kitchener, B., & Reavley, N. (2015). Mental health first aid training for Australian medical and nursing students: an evaluation study. *BMC Psychology*, *3*(1). doi: 10.1186/s40359-015-0069-0

Conclusion and evaluation: Integrating mental health into society's practice

1. Incorporation of primary vs. secondary vs. tertiary preventions
   - Primary: educational program, health campaigns
   - Secondary: regular checkups, screening tests
   - Tertiary: rehabilitation programs, support groups
2. Cooperation in a **multidisciplinary manner,** concerning the patient in a holistic manner
   - An effort made by groups of individuals, playing different role in helping those in need: primary care providers, educators, government, NGOs
3. Difficulties in screening, such as internet, norms, culture and lack of **self-awareness and self-confidence**
   - Depression deemed as socially inacceptable, connoted with weakness and attention-seeking



Walker, Hill M. and Mark R. Shinn. "Structuring School-Based Interventions to Achieve Integrated Primary, Secondary, and Tertiary Prevention Goals for Safe and Effective Schools." (2002).

Conclusion and evaluation:
What it means for us medical students at this stage

1. Broaden our perspectives and focuses in history taking and medical consultations
   - Psychosocial, economical aspects
   - Family and environmental factors
2. Appreciate the **complexity of different identities and narratives** of our patients
   - HK as a multi-cultural city: gender diversity, LGBTIQ+, low-income groups, ethnic minorities, preexisiting disorders, substance abuse disorders
   - Our values determine the metrics by which we measure ourselves and others
   - Avoid over-reliance on clinical predictor models and personal experiences
3. Create a holistic **whole person undersanding** and **patient-centered management**
   - Limited consultation time with stress and distraction increases the vulnerability to unintentional biases and missed diagnoses
   - Divorcing the mind from body and dehumanizing the patient is rather harmful under all circumstances