The Hong Kong Council of Social Service
Submission to The Student Mental Health Support Scheme Task Force
Model Analysis and Recommendation

Introduction

The paper aims at giving an account of the effectiveness of the Student Mental Health Support Scheme (SMHSS) with reference to the Evaluation Study released in March 2021 and the feedback from social work practitioners who participated in the scheme. According to the Evaluation Study[1], the outcome on students was not that impressive. Decrease in depressive and anxiety symptoms were statistically significant among the cases known to Child and Adolescent Mental Health Service of the Hospital Authority (CAMHS) but not for non-CAMHS cases. While parents' rating on the severity of psychopathologies reported fewer cases in the clinical range after six months of intervention, teacher' rating remained largely unchanged.

To begin, an analysis of the current SMHSS Model will be provided, followed by recommendations on possible modifications and additional services required to strengthen tier 2 support for students. Major issues of the current model will be discussed, including: 1) underestimation of tier 2 service needs and under-resourced plan, 2) comprehensive support only for CAMHs students but not school-referred students, 3) insufficient medical intervention for school-referred non-CAMHS students, 4) high refusal rate suggesting that the model is not student-centered, and 5) violation of agreed understanding of multi-disciplinary collaboration if schools are to assume the primary and independent role of supporting students with mental health problems via skill transfer.

To tackle the issues above and maximize resources to provide sustainable support for students, it is proposed to build a more student-centered SMHSS model by: 1) prioritizing school-referred students with clinical pathologies (on the severe end of tier 2) as the target, 2) strengthening medical intervention to a level comparable to CAMHS, 3) transforming the school-based platform to a mobile multi-disciplinary team supporting schools in the community, and 4) replacing annual screening exercise by raising teachers' and parents' mental health awareness and fostering self-help among students. To serve those on the milder end of tier 2, enriching community-based youth-friendly mental health support for students with sub-clinical pathologies should also be considered.

A. Major issues of the current SMHSS Model

1 Underestimation of the wide spectrum of tier 2 service needs and under-resourced plan

The SMHSS is positioned to provide tier 2 support for students with mental health needs at school, including medical treatment, social care and education support, to help them stay in productive education, continue to grow and develop like their peers in families and community, while having their mental health issues and learning disabilities attended to and addressed.

Before the introduction of SMHSS, there was no tier 2 support service for children and young people and it may be difficult to estimate the actual service need. According to the Mental Health Review Report[2], the target groups of tier 2 and corresponding objectives of intervention are as follows:

(a) *Children and young people with moderate to severe mental health problems attending Tier-3 services and whose conditions are stabilized with progress:* to provide ongoing management and support and to ensure smooth transition of care and support services.

[1] Dr. Lai, Kelly. pp. 31-32, *Evaluation Study - Phase 3 of Student Mental Health Support Scheme*.
[2] FHB (2017). pp 89-90, *Mental Health Review Report*.

(b) *Children and young people whose behaviours and/ or emotional difficulties are progressively affecting their psychological, social and educational function and have placed them at risk of developing more complex mental health problems:* to minimize negative impacts and prevent escalation to more serious problems through structured and targeted assessment and intervention.

In operation, SMHSS handles four main types of cases from three sources:

i	From CAMHS:	CAMHS students with diagnosed psychiatric disorders and with mental health problems or medication concerns requiring multi-disciplinary input
ii	From school referral:	Non-CAMHS students but identified to have mental health problems
iii	From annual screening:	Students with clinical anxiety and/or depressive mood problems (i.e., those with highly elevated scores)
iv	From annual screening:	Students with sub-clinical anxiety and/or depressive mood symptoms (i.e., those with elevated scores)

The Evaluation Study found that the degree of psychopathologies of school-referred students were similar to CAMHS students[3]. At the same time, students screened with highly elevated scores are also expected to have clinical level of psychopathologies[4]. Only those students screened with elevated scores are having mental health symptoms below the clinical range.

Though SMHSS is designed and resourced to support a wide spectrum of tier 2 needs (including those at risk of developing more complex mental health problems), in reality its capacity was drawn to serve primarily those at the severe end of Tier 2. A distribution of cases served by types (Appendix 1) shows that 74% of cases handled by SMHSS during the first three phases are in the clinical range and only 26% are sub-clinical. **Such resource allocation may not be expected of SMHSS yet reflects the actual service need. To maximize impact with limited resources, SMHSS should be refocused to address the greatest and most urgent need.**

2 Comprehensive support only for CAMHs students but not school-referred students

Out of the mentioned four types of students served by SMHSS, **school social workers and their school counterparts are most concerned and expect SMHSS to prioritize support for school-referred students -- those not known to CAMHS but identified to have mental health problems**. As stated in the Evaluation Study, "…schools were concerned about their emotional states, school attendance problems, behavioral problems and study stress…"[5]. It was found that the level of severity of psychopathologies of school-referred students were similar to that of students already known to CAMHS. Given these students were having their functioning progressively affected and yet not known to CAMHS (only 20% were known to mental health professionals in the private sector), schools, social workers and parents felt the pressing need for SMHSS to provide timely and accessible medical assessment and care to them.

The SMHSS, on the contrary, only provides limited support to the school-referred students. The Operations Guideline stated that comprehensive support[6] will be provided to the CAMHS

[3] Dr. Lai, Kelly. pp. 29, *Evaluation Study - Phase 3 of Student Mental Health Support Scheme*.
[4] Dr. Lai, Kelly. pp. 42, *Evaluation Study - Phase 3 of Student Mental Health Support Scheme*.
[5] Dr. Lai, Kelly. pp. 29, *Evaluation Study - Phase 3 of Student Mental Health Support Scheme*.
[6] including multi-disciplinary assessment and intervention, formulation of care plan and regular review and monitoring

students, while only support on a need basis[7] and/ or advice and support to teachers and/or social workers[8] would be provided to school-referred students. As learned from school social workers, **there were many incidents that school-referred students were rejected by APN for inclusion into SMHSS**. The exclusion reasons were either not clearly explained or not in line with the Operations Guideline[9]. For example, some students were rejected due to "not having imminent danger" or "disruption in class was not severe", while some were rejected because of "having high risk" etc.

For students screened with highly elevated scores, social workers reflected an unclear and inconsistent handling by SMHSS. According to the operation guidelines, for students identified and screened with clinical anxiety and/or depressive mood problems, the ASWO/psychiatric nurse will inform the school coordinator and/or the school social worker who would follow the regular student selection process, i.e. the Multi-disciplinary Team will review the students' profiles and jointly determine the suitability of these students to join the SMHSS. However, with substantial number of students screened with needs (many of whom were not known to teachers or social workers prior to the test), unclear division of roles and criteria for acceptance into SMHSS, many students end up having no support. **Annual screening without follow up for cases identified with need is unacceptable**.

3 Insufficient medical intervention for school referred non-CAMHS students

Regarding the impact of SMHSS in terms of student outcomes, the Evaluation Study revealed that the decrease in depressive and anxiety symptoms were statistically significant among CAMHS cases but not for non-CAMHS cases[10]. **This calls into question the adequacy of support given by SMHSS alone for students with clinical pathologies yet unknown to CAMHS.** Without sufficient medical intervention (i.e., at least at a level comparable to CAMHS), it remains uncertain whether improved outcomes for these students could be brought about by SMHSS.

As stated in the Evaluation Study, 16-20% of school-referred students served by SMHSS needed referral to CAMHS and some of them accessed the service via A&E[11]. "Many of these (students) had their first CAMHS assessment within the school year, which means that they were considered urgent cases." As for students screened with highly elevated scores, they have already exhibited clinical anxiety and/or depressive mood problems. **Social workers and parents were disappointed that consultation with psychiatrist for clinical assessment, or even referral to CAMHS for timely service was not covered by SMHSS.**

4 High refusal rate suggests that the model is not student-centered

Starting from 2018/19 school year, schools are requested to conduct an annual screening, supported by the service of CAMcom, to facilitate early identification and intervention for students with mental health needs under SMHSS. **According to the Evaluation Study[12],**

[7] Including multi-disciplinary assessment and intervention, formulation of care plan, liaison with the corresponding clinical team and review and monitoring

[8] in managing the students, e.g. advice for service matching respective to students' needs (provided on need basis)

[9] The Operations Guideline (para. 14) stated that "Students with deterioration in functioning and/or students that the school has much concern or problem in managing them in school settings may accord higher priority to be referred to SMHSS."

[10] Dr. Lai, Kelly (2021). pp. 31, *Evaluation Study - Phase 3 of Student Mental Health Support Scheme*.

[11] Dr. Lai, Kelly (2021). pp. 29, *Evaluation Study - Phase 3 of Student Mental Health Support Scheme*.

[12] Dr. Lai, Kelly (2021). pp. 24, *Evaluation Study - Phase 3 of Student Mental Health Support Scheme.*

among those having highly elevated scores and needing follow-up, only 37% of students[13] were followed up successfully. Among those having elevated scores, the overall service uptake rate is 61. 5%[14].

The high refusal rate deserves our attention. The Evaluation Study[15] attributed this to stigmatization and proposed organizing psycho-educational talks to encourage more students to receive intervention. Whether and how far could talks and information provision achieve de-stigmatization is subject to review, at the same time **the following setup may deter students from joining SMHSS:**

4.1 A non-student-centered annual screening mechanism:

According to the SMHSS Operations Guideline, ASWOs, psychiatric nurses and supporting staff of HA will coordinate with participating schools' personnel and school social worker to conduct annual screening exercise to students of a selected form. All students of the selected form (for secondary schools) and parents/guardians of students of the selected form (for primary schools) are invited to participate. Unlike in clinical setting, students were not given explanation by a trusted medical professional about the purpose and data use of the screening before doing it, not to mention the consequence of various results. Besides, there is no mentioning in the Operations Guideline that consent from students or parents/guardians are required for the screening exercise. In practice, some schools only informed parents/guardians about the screening exercise without giving them an option not to join. Thus, the exercise may be perceived as coercive.

As adolescents are relatively more concerned about their choice and autonomy, it is not surprising to see a higher proportion of students from secondary schools rejecting service as compared to the rate of service decline in primary schools. While the purpose for early identification of running annual screening exercise at schools should be acknowledged, **it is important to take note that an across-the-board approach to screening where students' choice and autonomy is not respected may lead to counter-productive results.**

4.2 A non-student-centered school-based intervention platform:

It was reported by school social workers that **some students who were recommended to join the SMHSS rejected the service because they did not prefer their mental health needs to be known by so many parties**, including their attending school, government bureau/departments, non-governmental organizations, and the commissioned institution for the purpose of evaluation of the SMHSS. This can be substantiated by the results of the "Awareness and Stigma Questionnaire" which was used as part of the evaluation for the SMHSS at the pilot stage[16].

Many students who joined the scheme **were found to be unwilling to let the school know about their mental health problems (53.9%) as shown in the pre-test, and many of these concerns remained as indicated in the post-test.** Over **30% of respondents in both pre and post-tests agreed that they were afraid that they would be discriminated against if their teachers knew that they had mental health problems.** Worries about bullying by other students were even more considerable. **40.4% of respondents in the pre-test agreed that they would become the target of bullying if their schoolmates knew that they had mental health problems. In the post-test, 50% of the respondents reported this worry.**

---

[13] 67% of primary school cases accepted the assistance offered by SMHSS whereas only 34% of secondary school cases gave consent for follow-up service under SMHSS.

[14] The percentages of primary school cases and secondary school cases agreeing to accept assistance are 52% and 63% respectively.

[15] Dr. Lai, Kelly (2021). pp. 64, *Evaluation Study - Phase 3 of Student Mental Health Support Scheme*.

[16] Dr. Lai, Kelly (2019). pp. 63, 64 & 74, *Student Mental Health Support Scheme – Final Report*.

With reference to the results of "Satisfaction Questionnaires"[17], some students reported they did not feel they could trust their school. Some specifically gave a reason that they did not prefer their medical records to be known by the Hospital Authority. Others were hesitant to have their mental health needs known to the school.

The above-mentioned findings from the evaluation of pilot stage suggests a concern about **trust and stigmatization**. Even those who had joined the SMHSS reported such worries, it is not hard to imagine that those who rejected to join might have a higher level of worries about trust and stigmatization in the school setting. School social workers concurred that students and parents remained highly concerned about stigma and privacy in considering whether to receive SMHSS service.

5 Violation of the agreed understanding of multi-disciplinary collaboration if schools are to assume the primary and independent role of supporting students with mental health problems via skill transfer

5.1 What made the SMHSS appealing to school personnel in the first place was the injection of medical components into the school context to support cases with deteriorating functioning in multiple dimensions. According to the Mental Health Review Report, "one of the functions of tier 2 is to provide more structured assessment for children and young people whose behaviours and/or emotional difficulties are progressively affecting their psychological, social and educational function, and have placed them at risk of developing more complex mental health problems", and that tier 2 intervention "include medical treatment, social care (such as rehabilitation services and other services to look after the general welfare of the child and the family) and education support"[18]. The objective of SMHSS stated in the first report of the evaluation study[19] for the pilot stage was "to assist in the assessment and formulation of multi-disciplinary care and support plans". It is clear that contribution of the unique expertise of the medical, social work and educational professionals are required.

5.2 While it's unclear why there is no clear mentioning of the objectives of SMHSS in the operation guidelines, as the scheme unfolded, another objective, i.e., to achieve skill transfer and capacity building in schools in the long run, emerged in the second evaluation report[20]. Such skill transfer and capacity building in schools with a view to making the schools assume the primary responsibility to support students requiring tier 2 intervention is a clear violation of the above-mentioned understanding and agreement on multidisciplinary collaboration. Any changes to SMHSS indicating a deviation from this understanding and agreement are unacceptable without prior and thorough consultation of medical, social work and educational professionals.

5.3 The notion of skill transfer also reflects a possible misunderstanding of the role and expertise of social work and educational professionals. To reiterate, each professional involved in the SMHSS platform should contribute their different and unique expertise to make the collaboration and hence intervention effective. Medical treatment, even in the form of group intervention or individual counselling, serves medical purpose and should not be rendered by non-medical professionals. Social work profession, on the other hand, render both micro and macro interventions to enable students with mental health needs to sustain

[17] Dr. Lai, Kelly (2019). pp. 78 & 85, *Student Mental Health Support Scheme – Final Report*.
[18] FHB (2017). pp. 90, *Mental Health Review Report*.
[19] Dr. Lai, Kelly (2019). pp. 2-3, *Student Mental Health Support Scheme – Final Report*.
[20] Dr. Lai, Kelly (2021). pp. 2, *Evaluation Study - Phase 3 of Student Mental Health Support Scheme*.

meaningful participation in school and community. On a micro level, social workers enhance students' personal development (self-acceptance, identity development, meaning making especially of adverse life experiences, resilience building, etc.), interpersonal relationships, social integration and functioning, community participation and empowerment, as well as support their family or carers to better understand their conditions, and access community resources to address their welfare needs. On the macro level, social work professionals address the social determinants of mental health, and are positioned to combat social inequalities, social exclusion and discrimination.

As social workers have their unique role to play, it is inappropriate to ask them to get trained to render treatment on behalf of the medical professionals who can then assume a more consultative role as recommended in the evaluation report. The medical role of healthcare professionals in delivering tier 2 support under the SMHSS is irreplaceable.

B. Recommendations to ensure sustainable support for students

As learned from school social workers participating in SMHSS, shortage of professionals deployed by the Hospital Authority including clinical psychologists (CP), advanced practice nurses (APN) and assistant social work officers (ASWO) for SMHSS had been seen in many schools in the past 6 months. With core professional positions vacant, service delivery had been seriously impeded. Hong Kong has been facing healthcare manpower shortage. According to the "Healthcare Manpower Projection 2020" with base year at 2017 conducted by FHB, there will be a continuous shortage of doctors into the long term in the light of the projection of healthcare needs regarding demographic changes. The projected shortfall of doctors in 2030 and 2040 will be 1 610 and 1 949 respectively.[21] Further development of the SMHSS must consider such context to ensure sustainable support for students.

As learned from the implementation of SMHSS in the past few years, there is substantial demand for mental health support from youth yet many of them are not known to public psychiatric services. The presence of such unmet needs in the community was partly due to the inadequate provision of psychiatric service in Hong Kong. In 2020, 390 psychiatric doctors (5.2 per 100,000 population) were working in the Hospital Authority[22], representing a shortage of 255 psychiatrists for the whole population as compared to WHO high-income countries (with median rate of psychiatrist at 8.6 per 100,000 population[23]). Besides, as noted in the Mental Health Review Report[24], youth's engagement of mental health services is often the poorest among all age groups.

In the long term, increase in psychiatrists serving the population, as well as new and youth-friendly ways of delivering mental health service are essential. **As in the short to medium term, maximizing the resources allocated for SMHSS to address the most urgent and severe needs identified is deemed an ethical and pragmatic choice.**

---

[21] https://www.fhb.gov.hk/en/press_and_publications/otherinfo/210500_amendments_mro/index.html

[22] LCQ10: Mental health services. https://www.info.gov.hk/gia/general/202104/28/P2021042800469.htm

[23] WHO (2021). pp 65, *Mental Health Atlas 2020.* http://apps.who.int/iris/bitstream/handle/10665/178879/9789241565011_eng.pdf?sequence=1

[24] FHB (2017). pp 78, *Mental Health Review Report*.

1. Reforming the SMHSS Model

1.1 Target Group: prioritizing school-referred students with clinical pathologies (on the severe end of tier 2)

Sufficient medical intervention is indispensable for cases within the clinical range. School social workers participating in SMHSS also reflected that the **input of medical professionals was found to be most beneficial for students with moderate mental health problems yet unknown to HA**. Specifically, we recommend change in the target group as follows:

1. **prioritizing school-referred cases;**
2. **limiting target group to students with clinical pathologies (on the severe end of tier 2);**
3. **excluding students with sub-clinical pathologies (on the milder end of tier 2).**

Operationally, this means the highest priority for support by SMHSS would be accorded to school-referred non-CAMHS students who have been assessed as having clinical pathologies, as well as students screened with clinical anxiety and/or depressive mood problems (those with highly-elevated scores) though annual screening is not recommended (to be elaborated in Recommendation 1.4). CAMHS students would be supported on need basis (e.g. with medication concerns or need for multi-disciplinary support at school). This would ensure youths identified with clinical mental health problems at school would be given timely support.

1.2 Strengthening medical intervention to a level comparable to CAMHS

To ensure SMHSS to bring about improvement in students' outcomes, we must address insufficiency of medical intervention for **students with clinical pathologies yet unknown to CAMHS** by adding the following to SMHSS:

- **Provision of prompt assessment and treatment by psychiatrist.** Medical intervention at a level comparable to CAMHS should be provided for non-CAMHS cases. Timely assessment and treatment (including medication as appropriate) by psychiatrists should be included to complement those conducted by clinical psychologists, as well as information on symptoms and medications offered by APN. This could be provided by CAMHS or by way of financial subsidy for accessing private psychiatric services. These students may need psychiatric follow up for some time so the out-patient treatment service should be provided by CAMHS in the long term.
- **Pathway for stepping up to tier 3 care as appropriate.** If student is assessed by psychiatrist as in need of tier 3 service, direct pathway for stepping up and smooth transition to relevant support should be provided as part of SMHSS.

1.3 A student-centered model: transforming the school-based platform to a mobile multi-disciplinary team supporting schools in community

Theoretically, the current school-based platform allows multi-disciplinary professionals to work together physically inside schools where students with mental health needs are supported by a team working around them. Yet, this mode of collaboration could deter students screened with mental health problems or symptoms from joining the SMHSS as they prefer their mental health needs to be kept confidential or restricted to sometimes just the school social worker. It also requires students receive service under the gaze of others at school. Moreover, medical professionals need to spend their valuable professional hours on travelling to attend case conference and render assessment and treatment in school.

Hence, to make the model more student-centered, it is recommended that the mode of

multi-disciplinary collaboration be changed from a school-based platform to a mobile team working directly with schools in the community. Like the REACH Model of Care in Singapore[25], a multi-disciplinary team comprising medical doctors, psychologists, social workers and psychiatric nurses should be formed under each cluster of Hospital Authority, and linked directly with schools in the same cluster. **Serving the whole cluster with a large team is more cost-effective** as manpower can be flexibly deployed according to the distribution of service recipients among schools.

This mode of collaboration will achieve the three objectives below:

a. To provide consultancy service to schools in the cluster via a helpline directed to the designated members of the multi-disciplinary team;

b. To provide assessment and medical treatment for students with mental health problems or symptoms referred by the school social workers at a place preferred by the students (i.e. at school, at home or at a local community centre);

c. To provide a direct pathway for stepping up to tier 3 care for students in need.

Most importantly, **the proposed model is more student-centered** and directly addresses the issues of trust and stigmatization to reduce the possibility of service refusal. Information on students' mental health needs is kept restricted to the mobile multi-disciplinary teams and the school social workers. Students' mental health needs will be known to the school on a need-to-know basis (e.g. additional support or accommodation from the school is required) with students' consent in advance. Students have a choice on where to receive services giving them more autonomy to protect their privacy.

1.4 Replacing annual screening exercise by raising teachers' and parents' mental health awareness and fostering self-help among students

The current SMHSS Model relies on annual screening to achieve early identification of students with mental health needs yet there are substantial drawbacks as mentioned. **It is recommended that two other early identification strategies be adopted to replace the annual screening to minimize perceived coercion and intrusion and hence reduce barriers for students in need to access services:**

a. **Raising teachers' and parents' awareness on mental health:** Medical professionals to provide psycho-educational talk for teachers and parents to enrich their knowledge on mental health, their role in being a protective factor to youth mental health, identify those with mental health problems, and shape appropriate response to cater for the needs of youth with mental health concerns. Also, medical professionals are in a better position to advise the schools on the importance of accommodation for students with mental health problems.

b. **Fostering self-help among students:** Self-help is empowering as young people can have greater control of their own destiny. Social work professionals, such as those from Integrated Community Centre for Mental Wellness (ICCMW), are good at engaging young people and well placed to enhance students' sensitivity on their mental health needs and that of their peers, and to build their repertoire of self-help strategies. Community resources such as Headwind, a website designed by the Department of Psychiatry of The University of Hong Kong to provide resources on mental health knowledge, self-administered assessment tools and online support platform, can be shared with students through a youth friendly, bottom up or snowball approach.

[25] Lim, C.G.; Loh, H., Renjan, V.;Tan, J.; Fung, D. (2017). *Child Community Mental Health Srevices in Asia Pacific and Singapore's REACH Model*. Brain Science, 2017, 7, 126.

2 Enriching community-based youth-friendly mental health support for students with sub-clinical pathologies (the milder end of Tier 2)

2.1 With the proposed refocusing of SMHSS to support students with clinical pathologies, those on the milder end of tier 2 could be supported by self-help resources and community-based youth-friendly mental health service. These could address youths' concern for privacy and autonomy in help seeking and provide an engagement and intervention platform for youths who are willing to take further steps in understanding their mental health conditions and exploring different kinds of support and enrichment programs.

2.2 Various community-based youth mental health initiatives have been tried out by NGOs. One recent example is LevelMind@JC, where eight youth mental wellness hubs have been set up as stigma-free 'third spaces' to provide preventive interventions to youth between the age of 12 and 24. The service model is co-designed by NGOs and the Department of Psychiatry of the University of Hong Kong. Youths are also engaged in the design of the physical set up, user journeys and service model of the hubs, as to address barriers for youth to access mental health service (namely stigmatization, preference for informal and less medical settings, and lack of appeal of traditional/ adult-based service). Social workers at these hubs have been equipped with youth mental health knowledge and psycho-social interventions for youths to enhance personal development and interpersonal relationships through various approaches. Services provided by these hubs include universal preventive interventions for all youths (such as exercise and fitness programs, horticulture, expressive arts and all kinds of wellness improvement programs), selective preventive interventions for youths at risk, as well as indicated preventive interventions for distressed youths displaying symptoms of mental health problems (such as mindfulness, cognitive therapy, etc.). Early assessment, referral for specialist care and ongoing case collaboration is also provided for users in need. "Youthful" marketing and communications strategies are also adopted.

2.3 LevelMind@JC is a time-limited project that will end in October 2023, the Government can refer to its experience and formulate policy on the establishment of a community-based youth-friendly mental wellness platform providing Tier-1 and Tier-2 (below clinical range) services. Currently, Integrated Community Centre for Mental Wellness (ICCMW) is a subvented community-based welfare service for people with mental health needs with an extremely diverse target group (ranging from secondary students to elderly people with various types and severity of mental health problems). They have the software (skilled professionals and practice experience in serving the severe end of Tier 2 and Tier 3) but not the hardware (a well-designed physical space to cater for youth needs) to play the role of a youth-friendly mental wellness hub. On another hand, the Integrated Children and Youth Service Centre have youth-friendly hardware but catering a wide range of needs of children and youth aged 6 to 24. The staff may need some training to consolidate their knowledge on youth mental health and experience on providing psychosocial support to those on the milder end of Tier 2.

13 May 2022

END

Appendix 1

Distribution of cases handled by SMHSS during the first three phases

Categories of Tier-2 Target Groups	Referral Source	Types of Students	No. of cases served			Severity of mental health problems
			Phases 1 & 2 (2016/17 & 2017/18)	Phase 3 (2018/19)	Total	
(a) Children and young people with **moderate to severe** mental health problems attending Tier-3 services and whose conditions are **stabilized** with progress	i. CAMHS	Known to CAMHS with diagnosed psychiatric disorders and with mental health problems or medication concerns requiring multi-disciplinary input	107	182	289 (39%)	**Clinical (Subtotal: 551, 74%)**
(b) Children and young people whose behaviours and/ or emotional difficulties are progressively affecting their psychological, social and educational function and have placed them **at risk of developing more complex mental health problems**	ii. School	Not known to CAMHS but identified to have mental health problems	39[26]	169	208 (28%)	
	iii. Annual Screening	With clinical anxiety and/or depressive mood problems (i.e. those with highly-elevated scores)	N. A.	54	54 (7%)	
	iv. Annual Screening	With subclinical anxiety and/or depressive mood symptoms (i.e. those with elevated scores)	N. A.	198	198 (26%)	**Sub-clinical (Subtotal: 198, 26%)**
		Total	146	603	749	

[26] According to the Evaluation Report of the Pilot SMHSS (Dr. Kelly Lai, 2019), screening questionnaires including CBCL, TRF and YSR were rated by students' parents, teachers and students themselves respectively as an indication of severity and types of psychopathologies. The results showed that non-HA CAMHS students were rated to be more problematic by both parents and teachers than students known to HA CAMHS.