二零零三年七月七日
討論文件

立法會福利事務委員會

執行家庭服務檢討建議中期報告

目的

本文件旨在告知委員有關執行家庭服務檢討建議中期報告的結果及建議，以及社會福利署（下稱「社署」）就顧問團提出的初步檢討結果及建議所作回應，並徵詢委員對重整現有家庭服務中心／輔導單位的意見。

背景

2. 委員於二零零零年六月十二日、二零零一年三月十二日及二零零一年七月九日的會議上，共討論三份有關家庭服務檢討的文件。在這些會議上，我們匯報由香港大學（下稱「港大」）進行的家庭服務檢討的進展、港大在二零零一年五月提交名爲「迎接挑戰：強化家庭」報告（下稱「報告」）的結果和建議，以及社署對顧問團所作建議的回應。有關報告亦已提交社會福利諮詢委員會和婦女事務委員會，並獲得各委員積極支持。

家庭服務現時的問題所在及推行新的服務模式的需要

3. 本港社會的傳統家庭結構和功能正急劇受到削弱，而社會、經濟及人口方面的變化使這個情況更爲嚴重，以致家庭問題和需要漸趨複雜。面對這種情況，現時以處理個案和補救性質爲主的家庭服務，並未能應付家庭不斷轉變的需要。

4. 報告提出的建議之一，是推行一項嶄新的服務模式 — 綜合家庭服務中心。每個中心將設有家庭資源組、家庭支援組和家庭輔導組，提供一系列的預防、支援和補救服務。新模式將以「方便使用」、「及早識別」、「整合服務」和「伙伴關係」四個原則爲服務基礎。此外，顧問亦建議現有服務可按六個發展模式漸進至綜合家庭服務中心。

5. 在落實新的綜合家庭服務中心模式方面，委員通過社署建議的推行策略，即以由下而上、循序漸進的方式，推行爲期兩年並附設評估研究的綜合家庭服務中心試驗計劃。評估研究的目的，是確定這項新服務模式及其各項發展模式的成效和實施上的安排，以推薦一個最具成本效益的模式供日後採用。港大在進行檢討期間充分顯示出工作熱誠和能力，實在是最適合跟進報告的建議，因此社署已再委託港大由二零零一年四月起進行爲期兩年的試驗計劃評估研究。

6. 我們已根據港大顧問團的建議，成立執行家庭服務檢討

建議工作小組(下稱「工作小組」),成員包括衞生福利及食物局、社署、社會福利諮詢委員會、香港社會服務聯會(下稱「社聯」)和非政府機構的代表,以及一名獨立的社會人士,就推行綜合家庭服務中心試驗計劃提供意見。工作小組在二零零二年一月選出了 15 項綜合家庭服務中心試驗計劃,並定於二零零二年四月至二零零四年三月的兩年內推行。計劃包括一項設於全新服務地域範圍(即東涌)的新計劃、兩項由現時的家庭服務中心自行轉型、四項由有關家庭服務中心與同一服務機構的其他社區服務單位合併而成,而有八項是由家庭服務中心與另一機構的社區服務單位以策略性聯盟方式組成。

評估綜合家庭服務中心試驗計劃:顧問團的研究結果及建議

7. 顧問團採用了多管齊下的方式進行評估研究,即從多個不同來源收集資料,這些來源包括使用者資料系統、服務資料統計、業務計劃以及試驗計劃每半年提交一次的自我評估報告、顧問團的觀察和報告、根據不同模式的試驗計劃,與有關主要服務機構/人士進行焦點小組討論、與試驗計劃使用者和服務伙伴進行焦點小組討論,以及揀選若干使用者進行個案研究。

8. 工作小組於二零零三年五月七日就顧問團提交的中期報告進行討論。有關報告現載於附件 1,以供委員參閱。顧問團的初步研究結果及建議要點,載列如下。

綜合家庭服務中心使用者

9. 從服務使用者的資料及使用者焦點小組得知，綜合家庭服務中心的使用者大部分是新來港定居人士、失去配偶支援的人士、長者及綜合社會保障援助受助人。這些服務使用者面對的問題，主要環繞個人、家庭、環境或處境及人際關係。而他們要求綜合家庭服務中心提供的協助，包括輔導服務、住宿援助、長者日間／住宿照顧服務及經濟援助。由於試辦的綜合家庭服務中心是以弱勢社羣爲對象及照顧他們的需要，這個定位已證明是正確的方向。

綜合家庭服務中心的不同模式及其成效

10. 一如家庭服務檢討報告所預期，策略性聯盟是最易於推行而又最現成的模式，原因是這個模式讓不同機構屬下的兩個服務單位在專業上互相補足，而又無須在實際環境、人手及活動計劃各方面有太大改動。這或可說明何以在 15 個試驗計劃中，八個都採用策略性聯盟這個模式。不過，顧問團認爲以策略性聯盟模式推行試驗計劃的機構，需要花上頗長時間去減少彼此的分歧，並且注意到機構在重新調配員工和共用預算方面有相當困難。事實上，這類中心的服務使用者有部分並未留意到中心是由伙伴機構共同提供服務。在有些試驗計劃，綜合家庭服務中心的服務統計數字只是兩間伙伴單位的數字加起來，而兩者所提供的服務計劃明顯互不相關。

11. 設於全新服務地域範圍（即東涌新市鎮）的試驗計劃，

其優點在於同一機構內的不同服務單位可以爲不同對象組別提供綜合的服務，這樣既不會令員工產生抗拒，亦有助有效溝通。不過，這個模式只能於新發展地區推行，而這種情況可說絕無僅有。

12. 至於合併模式，顧問團認爲不同服務單位透過重新調配員工進行合作的方式較爲有效，能夠充分利用現時家庭個案工作者、小組及社區工作者的專長。不過，亦有人關注到把服務單位合併，將削弱社區爲本計劃的獨特性和原本功能。舉例說，社區中心的社工認爲社區工作的傳統使命會備受衝擊，而他們的社區工作方式和服務方針，例如組織地區居民建立力量和爭取權益的情況將會大幅減少。

13. 至於自行轉型模式，顧問團觀察到傳統的個案工作者可能需要較長時間去掌握籌辦小組和計劃的技巧及把傳統工作方式多元化，加入較多以社區爲本的手法。

14. 總括來說，顧問團認爲合併模式是較具成本效益的方法，可充分利用現有單位的資源和專長，而採用自行轉型的模式則需要確保個案工作者充分掌握所需的社區和小組工作技巧。另一方面，一如上文第 10 段所述，策略性聯盟的模式存在不少缺點，顧問團並不鼓勵採用。

成立綜合家庭服務中心

15. 初步結果顯示，綜合家庭服務中心相對於傳統的家庭服

務中心，更能方便使用和提供更有效的家庭服務。正面的成效包括服務更易使用、能爲亟需援助的家庭提供外展服務、提供一籃子綜合的服務、改善與地區團體和機構的伙伴關係、提高使用者的參與及滿意程度等。再者，採用甄別個案的工具亦能有效轉介使用者接受不同層面的服務，以切合需要。鑑於綜合家庭服務中心能夠取得良好成果，及獲得業界一致認同是行之有效的模式，因此，顧問團建議盡早籌備成立綜合家庭服務中心，並建議一所典型的綜合家庭服務中心應具備下列的結構：

(a) 清晰而獨立的服務地域範圍，服務人口 100 000 至 150 000 名；
(b) 最少有 12 至 14 名社會工作者；以及
(c) 靈活調配三個服務單位的社會工作者。

未來路向

16. 社署充分同意綜合家庭服務中心的服務模式比傳統的家庭服務中心更加可取，因爲綜合家庭服務中心的服務時間較長，更能方便使用者，而且能以綜合方式提供連貫的服務，使用者的滿意和參與程度亦有所提高。有關我們就顧問團建議的回應及日後工作的要點，現臚列如下。

籌備重整工作

17. 由於事實已證明綜合家庭服務中心模式取得理想成

效，加上福利界都一致認爲是一個較可取的服務模式，我們現時便可着手籌備重整的工作，例如物色適合的單位等，而無需留待二零零四年三月評估研究完成後才開始，以便家庭服務可以作出更佳部署，應付因家庭凝聚力日漸式微而增加的需求。因此，我們應爭取時間盡快改善現有的家庭服務。況且，在現時財政緊絀的情況下，重整服務亦可確保以更具成本效益的方式運用現有資源。

重整家庭服務的準則

18. 在重整家庭服務方面，我們已考慮到顧問團的建議以及福利界有需要在財政緊絀的情況下，提高服務效率以節省開支。以下是重整服務的主導準則：

(a) 由於綜合家庭服務中心是較妥善的服務模式，我們的目標是把現時所有家庭服務中心轉型成爲綜合家庭服務中心，而不是局部重整服務，讓部分家庭服務中心以傳統模式營辦。因此，全部設有家庭個案工作者單位／個案工作者／輔導單位[1] 的機構均會納入重整工作的範圍；

(b) 家庭服務中心應採用合併或自行轉型的方式進行重整。策略性聯盟並非可取的模式，而我們亦不會

[1] 在非政府機構營辦的家庭服務中心／輔導單位，一個家庭個案工作者單位設有0.125名社會工作主任、0.5名助理社會工作主任、0.25名高級社會工作助理、0.25名社會工作助理、0.125名助理文書主任、0.125名打字員和0.125名辦公室助理員。而社署方面，個案工作者包括擔任中心主任／臨床督導主任的社會工作主任、助理社會工作主任、高級社會工作助理和社會工作助理。

考慮局部整合服務單位；

(c) 現時家庭個案工作者單位／個案工作者／輔導單位的資源分配情況，並未顧及地區隨着時間而有所轉變的需求。在重整服務時，我們會考慮重新分配全港的整體資源，以填補服務不足之處和防止資源重疊；

(d) 家庭服務中心／輔導單位如沒有足夠資源組成綜合家庭服務中心，可獲許匯集其他家庭服務的資源，包括家庭生活教育單位、家務指導服務、家庭支援及資源中心、新來港定居人士服務中心和單親中心。由於四間新來港定居人士服務中心和五間單親中心都只是有時限的服務，故匯集這方面的資源只屬暫時安排。此外，我們在重整服務時亦須提高效率以節省開支；以及

(e) 除上文(d)項的措施外，如有關的非政府機構作出要求，我們亦可考慮匯集家庭服務範圍以外的資源，例如社區中心、家庭支援網絡隊、兒童及青年中心、鄰舍層面社區發展計劃等。

預期的成效

19. 目前，全港有 66 間家庭服務中心／綜合家庭服務中心合共提供 192 個非政府機構家庭個案工作者單位和 598 名社署家庭個案工作者，所涉開支估計爲每年 4.72 億元。視乎政府爲回復收支平衡的整體目標所要求的節省開支水平，我們計劃一如上文第 18(d)及(e)段所述及視情況而定，重新調配這些資源以成立綜

合家庭服務中心，並匯集其他家庭服務資源或這些服務以外的資源。日後設立的綜合家庭服務中心特色如下：

(a) 一間綜合家庭服務中心須包括三部分，即家庭資源組、家庭支援組和家庭輔導組。一所這類的中心應同時提供一系列的預防、支援和補救服務，包括家庭生活教育、爲新來港定居人士和單親家長提供的服務、防止自殺服務等。

(b) 由於綜合家庭服務中心不再如以往般以個案工作爲主，因此可更平均和合理地分配資源。每個地區綜合家庭服務中心數目的多寡，將視乎多項綜合的因素而定，例如人口（每間中心會爲 100 000 至 150 000 人口提供服務）、地區需要及附件 2 所載的各項社會指標。

(c) 有別於現時社署和非政府機構家庭服務中心在重疊的服務地域範圍一同提供服務的做法，我們會爲日後設立的綜合家庭服務中心釐定清晰的地域範圍，不會出現服務重疊。不過，由於社署的社會工作者須肩負特殊的職責，遇有適宜由社署處理的情況，例如法定個案（須予照顧或保護的個案、僱員賠償個案、監護個案等）和其他個案（如涉及社會福利署署長法團的個案、可能需要接受照顧或保護的被遺棄兒童），即使有關個案是在非政府機構所營辦綜合家庭服務中心的地域範圍，仍會交由社署提供所需服務。

(d) 每間綜合家庭服務中心除設有一名主任外，亦會有最少 12 至 14 名社會工作者（家庭輔導組有 4 至 6

名工作者、家庭支援組有 6 名，而家庭資源組則有 2 名）。不過，部分中心或會有較大編制，視乎上文第 19(b)段所述的各種綜合因素而定。

(e) 家庭服務至今仍是社署的核心工作，因此，社署／非政府機構營辦綜合家庭服務中心的比例會與現時的比例大致相若。換言之，社署會營辦約三分之二的綜合家庭服務中心，而非政府機構則營辦三分之一。不過，社署與非政府機構之間以至非政府機構之間可能會在有需要時，對調部分服務單位或調換服務資源。

(f) 隨着鄰舍層面的社區服務單位（例如青少年及長者服務單位）的功能擴大，我們預期綜合家庭服務中心與這些單位的協調和合作會進一步加強。屆時，綜合家庭服務中心或會僅接收經這些單位採用顧問團制訂的甄別及評估工具轉介的個案，提供深切輔導。

(g) 雖然所有綜合家庭服務中心主要會採用全面和多元化的服務模式，我們仍可能會從同一區域的角度考慮，讓某些區域的個別家庭服務中心提供專門化服務，以切合地區的特色和需要及配合有關機構的特點。詳情會交由同一區域的綜合家庭服務中心共同擬訂。

對財政的影響

20. 在財政緊絀的環境下，透過匯集資源並以協調和符合成本效益的方式整合服務，整項重整工作預計可因提高效率而節省

開支。不過，我們仍需動用若干非經常開支，以設立新服務單位、裝修現有的服務中心以及添置家具和設備等，因而或需尋求獎券基金的撥款。新擬訂的綜合家庭服務中心面積分配表已獲得政府當局通過，以物色可採用多專業介入方式（而非傳統的個案工作方式）提供服務的新單位／重置單位。

諮詢

21. 工作小組已在二零零三年五月七日的會議上，就顧問團提交的初步結果和建議以及社署的回應，進行討論。小組成員均同意綜合家庭服務中心是提供家庭服務的未來路向。此外，小組亦建議現時便應着手爲這項改變做好準備，而不應留待二零零四年三月完成評估研究的最後結果後才開始。

22. 社署聯同顧問團在二零零三年六月二日爲業界舉行簡報會。與會者提出，希望就較爲可取的綜合家庭服務中心模式（即合併和自行轉型而非策略性聯盟）及最低人手需求提供證明，而顧問團已在會上加以解答。另一關注事項是綜合家庭服務中心能否接手提供現有的一些專門服務，例如新來港定居人士服務中心和單親中心。顧問團指出，爲單親家長和新來港人士提供的服務，應是綜合家庭服務中心的重點工作之一，而事實上，有關的試驗計劃正爲不少單親家長和新來港人士服務。至於社區中心的工作者擔心成立綜合家庭服務中心將有損他們的獨特性，顧問團強調把家庭服務中心與社區中心合併能夠以更具成本效益的方式運用資源，而合併與否將由有關機構自行決定。

23. 業界尤其是目前提供家庭服務的非政府機構，對有關計劃的回應一直相當正面。但於社署在二零零三年六月二十六日社會福利諮詢委員會會議上就重整計劃諮詢意見前數天內，諮詢委員會收到社聯、香港社會工作人員協會及一羣未有表明身分的社福界工作者提交立場書，表達他們對中期報告和社署建議的重整計劃的意見。他們的關注和主要要求現概述如下：

(a) 應待爲期兩年的評估研究全面完成後，才就計劃的推行作出任何決定。與此同時，顧問團應覆檢更多數據及服務統計數字，以便得出更多以實據爲本的研究結果，支持其建議，例如綜合家庭服務中心日後的人手需求、策略性聯盟模式並不可取，以及局部綜合模式並非有效方式等；

(b) 重整過程中應向各有關方面進行更多諮詢；

(c) 爲新來港人士和單親家長等弱勢社羣提供的服務及社區發展服務，均不應予以取代；

(d) 應容許目前並無營辦家庭服務中心的非政府機構設立綜合家庭服務中心；

(e) 社署應考慮讓轄下的家庭服務中心脫離政府編制，改由非政府機構營辦；以及

(f) 提高效率以節省開支的課題應獨立個別考慮，不應納入是次重整工作之中。

24. 社會福利諮詢委員會的委員支持設立綜合家庭服務中心這一方向，並同意我們應盡快改善服務。與此同時，他們建議就業界在溝通和員工士氣方面的關注，包括因匯集資源而令員工

憂慮到裁員的問題，應進一步徵詢非政府機構的意見，務使各方面能衷誠合作，確保重整工作能順利進行。

25. 社署澄清，無意即時要全面落實執行重整計劃。我們計劃現時作出準備而非留待二零零四年三月評估研究完成後才開始，是基於非政府機構營辦者的正面回應以及工作小組的建議。社署了解到業界對重整計劃的關注，並已向社會福利諮詢委員會保證，不會在評估研究完成前，強制非政府機構接受落實計劃的時間表。然而，由於綜合家庭服務中心的模式已證實要比傳統的家庭服務中心優勝，社署已決定全力推行綜合家庭服務中心的模式，因此將開始着手籌備把社署轄下的家庭服務中心（現時佔全港總數的三分之二）自行轉型，或與家庭支援及資源中心合併，藉此讓家庭服務中心重整爲綜合家庭服務中心。社會福利諮詢委員會對這個做法表示支持。我們希望，我們的經驗會有助業界認識重整計劃對改善服務的好處。

其他事宜

26. 社署會繼續在二零零三至零四年度爲業界提供培訓支援，以便爲順利過渡至綜合家庭服務中心作好準備，並讓業界同工掌握到這項改變所需要的知識和技巧。我們已計劃開辦與管理有關的課程，包括「領導才能」、「建立團隊」、「推動改革」、「計劃設計」及「市場推廣和服務策劃」，並計劃開辦課程講授如何處理亟需援助家庭及舉辦小組計劃所需的知識和技巧，有關課程可供 500 名員工報讀。

27. 在計劃重整綜合家庭服務中心的同時，我們亦會把服務使用者資訊系統擴展至非政府機構，以便透過該資訊系統把所有的綜合家庭服務中心聯繫起來。

徵詢意見

28. 請各委員閱悉家庭服務檢討的進展，並就建議的重整計劃提供意見。

社會福利署
二零零三年七月

Annex 1

New Frontiers for Family Services

Interim Report on

The Implementation of Family Services Review

Restricted Circulation

The Consultant Team
Department of Social Work and Social Administration
The University of Hong Kong
May 2003

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Abbreviations

ASWO	Assistant Social Work Officer
CSSA	Comprehensive Social Security Assistance
C&Y C/S	Children and Youth Centre/Service
DECC	District Elderly Community Centre
ICYSC	Integrated Children and Youth Services Centre
IFSC	Integrated Family Service Centre
FLE	Family Life Education
FLEO	Family Life Education Officer
FCPSU	Family and Child Protective Services Unit
FCU	Family Counselling Unit
FSU	Family Support Unit
FRU	Family Resource Unit
FSA	Funding and Service Agreement
FSC	Family Services Centre
FSNT	Family Support Networking Team
FSRC	Family Support and Resource Centre
MCHC	Maternal and Child Health Centre
NGO	Non-Governmental Organization
NEC	Neighbourhood Elderly Centre
SWO	Social Work Officer
UIS	User Information System
SIS	Service Information System
SSA	Social Security Assistance
SWD	Social Welfare Department

Executive Summary

According to the Report on the Review of Family Services, Pilot Projects were established to verify the effectiveness of the service model of Integrated Family Service Centers (IFSCs). The Social Welfare Department has commissioned the HKU consultant team to carry out an independent in-built evaluative study on the 15 pilot projects from April 2002 to March 2004. This Interim Report, based on the initial findings, serves to assess the performance of the pilot projects after one year of their implementation, and identify key issues to inform further planning.

Based on a pluralistic approach to evaluation, this study derived information from a variety of sources, namely the user information system, Statistical Information System, business plan and half-yearly self-assessment reports submitted by pilot projects, observations and reports by HKU consultants, focus groups with key stakeholders according to formation modes, focus groups with stakeholders, including users and service partners from each projects, and selected user case studies.

Summary of Findings and Recommendations

1. According to the formation mode, the 15 pilot projects comprised a completely purposefully-designed greenfield, two projects formed by self-transformation of existing family service centers, eight projects formed by having strategic alliance between family service centers of an agency and community-based service of another agency, and four projects formed by merging FSC with community-based service managed by the same agency. In merging and strategic alliance modes, some projects involved only partial integration – only part of the service units (family service center and community-based service) were involved in the formation of the pilot projects. Pilot projects also varied according to their target population sizes and staff provisions.

2. In general, a typical pilot project user is a female adult, with no job, and poor education. There is also a high proportion of new arrivals, people without spouses, older persons, and social security recipients. As such, pilot projects have been targeting vulnerable populations.

3. Evidence suggests that IFSCs can provide a more open, user-friendly, responsive, accessible, and integrated service to users. Now IFSCs render a wide continuum of family and children programs, ranging from clinical case and group intervention, training and educational classes, supportive groups, to family-oriented social activities and child care programs. The use of the screening form and assessment tools has provided an objective and standardized instrument to determine the level of risk and the service needs, as well as the service intervention required. Based on user satisfaction surveys, performance ratings, and focus groups, pilot project users were extremely satisfied with the service offered.

4. During the first year of implementation, social workers had to face a tremendous amount of workload – preparing for the formation, learning and using the new screening form and assessment tools, and the user information system, and launching service promotion campaigns. Teamwork has found to be vital in facing the new administrative and program demands of IFSC.

5. After a year of implementation, the management and program structure of pilot projects have become more mature and institutionalized. The interfacing between the IFSC units has become more smooth and effective. There are strong commitments and initiatives from both

IFSC operators and social workers to translate IFSC principles into practice. Indeed, the establishment of IFSC requires a profound cultural shift among social workers, shifting from the traditional casework dominated approach to a more diversified, multi-level and community-based intervention.

6. Overall, the greenfield, merging and self-transformation modes represent a more effective approach to facilitate the interfacing amongst the three IFSC units. In specific, social workers can be deployed cutting across two to three IFSC units, and inter-unit referrals can be more effective. In the strategic alliance mode, because of the fundamental differences between the culture and practice of the two partnered agencies, collaboration in the form of redeployment of staff and shared budgeting would be limited. Because of the traditional limited experiences of social workers in conventional FSCs in carrying out community-based programs and supportive groups, the family support unit and the family resource unit of the self-transformation mode would take a longer time to develop. Partnership between family service center and community-based service can achieve synergy to develop a new service mode more responsive to community and family needs. Because partial integration can create confusion in service operation and amongst users and community partners, merging of two service units to form an IFSC in the future should involve the two whole units.

7. There should be a clear division of responsibility between IFSC and other family-related community-based services and centers dealing with family and individual crisis. Being more neighborhood-based and easily accessible, IFSC can take up more responsibility in providing services targeting vulnerable populations, such as the new arrivals, single parents, and people with suicidal risk.

8. Because of the clear consensus in the field that IFSC has been accepted as an effective mode of family service, preparation for the establishment of IFSC should be made as early as possible.

9. Each IFSC should have a clear and independent service boundary, serving residents residing in a defined geographical area. Without a rigid provision based on population size, an IFSC should cover a population ranged from 100,000 to 150,000 people. The actual provision should be determined by the district needs and demands for family services. In each district of the District Social Welfare Office, selected SWD IFSC(s) should be responsible for statutory cases. Otherwise, there should be no difference in operation between a SWD IFSC and a NGO IFSC.

10. Likewise, there should not be a rigid standardized staff provision for each IFSC. Based on the experiences of the pilot projects, an efficient IFSC operation should have a minimum of 12 to 14 social workers, and about half of them should be in the family support unit. Noteworthy is the fact that the deployment of social workers in each IFSC units should be dynamic and flexible, responding to changing community needs and demands.

11. The establishment of IFSCs covering all the districts requires the pooling of existing resources to support the transformation. In the formation process, the merging of family service center with community-based service represents a more cost-effective way to maximize existing resources and expertise, whereas the use of strategic alliance in the formation of IFSC should be discouraged. The use of self-transformation mode has to ensure that traditional caseworkers are equipped adequately with the required community and group work skills.

12. In the process of forming IFSC, there will be strategic rationalization, close down, reshuffling, reallocation and merging of existing services, the restructuring of service has to be carefully planned and executed with extensive consultation. There will be innumerable resistance and barriers to overcome, structural as well as cultural. The integration of services represents the need to advance a more important mission and goals of a new program – the rebirth of a new program with a new mission, rather than the death of a conventional program.

1. Introduction

Background

1. The Review of Family Services, commissioned by the Social Welfare Department (SWD) to The University of Hong Kong (HKU) consultancy team, was completed in May 2001. *(See Appendix II for the list of recommendations)* The recommendations of the Report *Meeting the Challenge: Strengthening Families* were fully endorsed by the Administration. According to the findings of the Review, traditional family services were segmented, inward-looking and remedial, with over-emphasis on the use of individualized casework methods. One of the recommendations made by the consultants was the formation of Integrated Family Service Centers (IFSCs) to meet the changing and multiple needs of families. Furthermore, the effectiveness of the ideal model of an IFSC should be verified through pilot projects. The design and implementation of IFSC pilot projects has provided a profound challenge to policy-makers, administrators, practitioners and the HKU consultants.

2. The Social Welfare Department has commissioned the Department of Social Work and Social Administration, The University of Hong Kong to carry out an independent in-built evaluative study on all the pilot projects from April 2002 to March 2004. After their implementation, pilot projects have to participate in the evaluative programs and activities designed by the HKU consultant team throughout the two-year duration. This Interim Report, based on initial findings, serves to assess the performance of IFSCs in the first year of implementation and identify key issues to inform further planning. This report summarizes the work carried out by the 15 IFSC pilot projects from their establishment in April 2002 to March 2003 – how they were formed; what kinds of programs were provided; who were the users and what were their presenting problems; what were the staffing arrangement involved; and what were their initial impacts. Based on these initial findings, this Report examines the issues involved in the future formation and implementation of IFSCs.

3. The main objectives of the evaluation project are:

a) To assess the effectiveness of the new service delivery model, i.e., IFSC, in meeting the needs of families in the community, in achieving the early identification of families with problems, in reaching out to hard-to-reach at risk families, in strengthening families, and in developing community resources;
b) To set a benchmark level in relation to an IFSC so as to form a reference point for the future Funding and Service Agreement;
c) To explore the cost-effectiveness and implementation arrangements of the different modes of transforming existing Family Services Centers into IFSCs; and
d) To recommend the most-cost-effective approach, or how the different modes can be further modified.

4. The Working Group on the Implementation of the Family Services Review, with representatives from the Health, Welfare and Food Bureau, SWD, Social Welfare Advisory Committee, the HKCSS, NGOs and an independent member of the community, has been set up to monitor the implementation of the pilot projects.

The Design and Implementation of IFSC Pilot Projects

5. Needs of families are multi-faceted. Service design has to be user-friendly and proactive to target at-risk families. Needs and problems of at risk families have to be addressed by a mix of services delivered preferably by a single program, or a single agency. Facing

fragmented services, inter-service and inter-agency collaboration is required and seen as solution to the complexity of social needs. The purpose of an IFSC is to meet the multifarious needs of individuals and families in the community. The specific objectives of the IFSC are:[1]

a) to provide a comprehensive range of preventive, developmental, supportive and remedial services to enhance the physical, psychological, intellectual and social functions of individuals and families;
b) to preserve and strengthen family as a unit, support and enhance family functioning and development of its members, facilitate social and interpersonal relationship among individuals and families, and build up a supportive and caring community to facilitate betterment of life; and
c) to identify problems early, and to provide early intervention to support and assist people in disadvantaged circumstances (e.g., families in trouble, children and youth at risk, etc.) so as to help them cope with life crises, regain self-resilience and restore their normal functioning.

6. In formulating this service delivery model, the four principles of "accessibility", "early identification", "integration" and "partnership" are to be adopted. These guiding principles are now the driving force behind IFSC pilot project initiatives and implementation. The design of each IFSC should comprise three components, namely Family Resource Unit (FRU), Family Support Unit (FSU) and Family Counseling Unit (FCU). This continuum of integrated services provides a combination of preventive, empowerment, supportive and remedial functions. Overall, the IFSC spirit is: "strengthening families: child-centered, family-focused and community-based."

7. The Review Report recommended that there are different modes for the formation of IFSC pilot projects. These modes include greenfield (completely new and specifically-designed project), self-transformation (formed by transforming the FSC itself), strategic alliance (formed by the partnership between the FSC and the community-based program of two separate agencies), and merging (formed by the merging of FSC and the community-based program of the same agency). The effectiveness of these different modes of pilot projects should be verified through pilot projects.

IFSC Rationales

8. All program evaluation demands to be theory-based.[2] The core theory underlying the IFSC is to strengthen family support.[3] Notwithstanding the current confusion and ambiguity over this term, family support has been seen as the foremost approach to child and family welfare. Warren describes:[4]

> *Family support practice means providing social support networks for children and their families within a range of formal and informal organizations, thus avoiding social exclusion.*

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[1] Social Welfare Department. *Funding and Service Agreement – Integrated Family Service Center.*

[2] C. Weiss, "Theory-based evaluation: past, present and future," in D. Rog and D. Fournier (eds.). *Progress and Future Directions in Evaluation: Perspective on Theory, Practice and Methods* (Jossey-Bass Publishers, 1997).

[3] Pinkerton, J. et al. *Family Support – linking project evaluation to policy analysis* (Aldershot: Ashgate, 2000); Walton, W. et al., (eds.), *Balancing family centered services and child well-being: exploring issues in policy, practice, theory and research* (New York: Columbia University Press, 2001); Canavan, J. et al. *Family support direction from diversity* (London: Jessica Kingsley Publishers, 2000); Kilpatrick, A. and T. Holland, *Working with Families, an integrative model by level of need* (Boston: Allen and Bacon, 1999); Gardner, R. *Supporting Families: child protection in the community*(John, Wiley and Sons, Ltd., 2003).

[4] Warren, C. "Family Support and Empowerment," in Cannon, C. and Warren, C. (eds.), *Child Protection and Family Support* (London: Routledge, 1997).

Committing to the principle of early identification, the key feature of IFSC is the support unit which emphasizes on providing supportive services targeting families in early difficulties with the risk of breakdown, rather than taking remedial and rescue actions later. The support unit, based on evidence-based need assessment, strengthens the social network of the at-risk families through the development of self-help groups, networking the users to volunteers and carers, time-limited or brief casework, provision of employment, social and family management skill training, practical material and service support, such as housing, home help, child care and finance. Referrals to the FCU are based on the results of the screening form and assessment tools devised by the HKU consultants (Chapter Five). It is expected that the need for clinical services can be systematically formulated, assessed and standardized.

9. In short, the design of IFSC also emphasizes the following approaches:[5]

a) Strength oriented – intervention designed to reinforce the strengths, capacity and assets of the individual, family or community.
b) Changing community conditions – intervention also considers the need to change environmental and community conditions that affect healthy development of children and families.
c) Bottom up initiatives – projects should have the flexibility to initiate creative programs addressing to local needs.
d) Comprehensive services – through partnerships and service integration, complicated and multiple family problems can be met as far as possible in a single service organization or a single service program. This is to avoid services being too categorical and specialized.
e) Strengthening informal services – importance of providing family support from the natural support social network, volunteers, and social capital of mutual-help groups.

10. Overall, this evaluation project has to offer robust evidence that IFSCs can achieve their objectives in providing accessible, preventive and supportive, integrated and coordinated services.

Formation of Pilot IFSC

11. A pilot project vetting committee, comprising SWD, NGO and Social Welfare Advisory Committee representatives, was set up to select promising pilot projects. In each district, the DSWO had been involved in consulting local SWD and NGO service units in the formulation and nomination of IFSC proposals. After reviewing all the proposals submitted, the Committee recommended 14 IFSC pilot projects to the Working Group on the Implementation of Family Service Review in January 2002. Together with the Tung Chung "greenfield" Project, there were altogether 15 IFSC pilot projects.

12. According to their modes of formation, the 15 pilot projects comprised:

a) A new specially-designed and developed IFSC – greenfield
b) Two IFSCs formed by self-transformation of existing FSC
c) Eight IFSCs formed by having Strategic Alliance between FSC of an agency and the community-based services of another agency.
d) Four IFSCs formed by merging FSC with community-based programs managed by the same agency.

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[5] J. Connell and A. Kubisch, "Community Approaches to improving Outcomes for Urban Children, Youth and Families: Current Trends and Future Directions," in A. Booth and A. Crouter (eds.), *Does it Take a Village? Community Effects on Children, Adolescents, and Families* (Mahwah, NJ: Lawrence Erlbaum Associates, Publishers, 2001).

13. In essence, the pilot projects varied according to their mode of formation. Among the different modes of formation, some were formed by self-transformation or merging of existing FSCs; and some through merging or strategic alliance between FSC and community-based services. Community-based services included community centers, Children and Youth Centers (C&YC), and Integrated Children and Youth Service Centers (ICYSC). Some were formed and administered by a single agency, while others were established jointly involving two agencies. In the strategic alliance mode, partnership could be created between two NGOs, or between SWD and NGO. In addition to the variation of modes, pilot projects also varied in a number of aspects:

a) Except greenfield, all pilot projects had a clearly defined geographical service boundaries, serving a target population ranged from 80,000 to 400,000. The majority of them served a population size of around 100,000 people.
b) There was no standardized staff provision. The total number of social workers involved in each project ranged from 8 to 31 social workers. Also, the distribution of social workers between the three IFSC units varied from project to project. The number of social workers assigned to the FCU ranged from 3 to 10 social workers.
c) In some pilot projects involving strategic alliance and merging, only parts of the original units were involved in the formation of the new pilot projects. In effect, a new pilot project would be in co-existence with another FSC or community-based service operated by the same agency within the district. In some cases, some social workers would be involved partially in the new pilot project.

14. The variations of pilot project design and format reflect the need to test out the effectiveness of the different operational modes and have more bottom-up initiatives. Simply put, variations can facilitate more program learning for the future institutionalization of IFSC.

Evaluation and Methodology

15. The implementation of the IFSC pilot projects would require the evaluation of their functions, roles and cost-effectiveness. The major tasks of the consultants are to address the need for accountability – what are the outcomes of IFSCs and how IFSC objectives are achieved. In other words, evaluation has to find out whether IFSC works or not. Equally important, this is also a formative evaluation which emphasizes on program learning and development. The evaluation serves to guide the future development and re-structuring of family services in Hong Kong. Specifically, the evaluation needs to work out how IFSC design can be implemented – how existing family services can move to form IFSCs.

16. Given the complication of the pilot project design, it is not feasible to evaluate their effectiveness based on a controlled experimental design.[6] Instead, based on a pragmatic evaluation paradigm, it stresses a practical, problem-solving orientation to program evaluation. In adopting the emerging pragmatic and postmodernist approaches to evaluation, the role of consultants is to facilitate interpretative dialogue among the program stakeholders, attains consensus among the stakeholders about the program's values and outcomes, and incorporates into their roles the concepts of internal program evaluation and formative feedback.[7]

17. Based on a pluralistic approach to evaluation, this research study employed a mix of

[6] Pilot projects vary in designs, emphasis, staffing and delivery structure, and they do not have an established mode of operation. It is therefore not feasible to employ a rigid experimental design to test pre- and post- intervention outcomes, supplemented with controlled groups. The role of the consultants cannot be fully independent and detached, and they act as partners to IFSCs.

[7] Schalock,, R., *Outcome-based Evaluation* (New York: Kluwer Academic, 2001), p. 15.

qualitative and qualitative data, derived from a variety of sources and stakeholders. The major tasks of the consultant team before the implementation of the pilot projects in April 2002 included the establishment of a core information requirement data set for program evaluation, comparison of performance and program learning. The task group formed with representatives from the consultant team, SWD, HKCSS and NGOs formulated a new set of User Information System forms, Statistical Information System, screening and assessment tools, and outcome indicators. Overall, the core service information for evaluation came from:

a) User Information System (UIS)
b) Statistical Information System (SIS)
c) Business plan and half-yearly self-assessment reports from pilot projects
d) Observations and reports by consultants on pilot projects
e) Focus groups with key stakeholders according the formation modes
f) Focus groups with stakeholders from each pilot project (users, and other stakeholders)
g) Selected users' case studies from each pilot project
h) Clinical measurements

18. The UIS was established to gather information on user profiles, the type of services provided, and the nature of program participation. Pilot projects had to submit relevant information to the Consultant Team on a quarterly basis. The UIS was designed to answer the following questions:

a) What were the socio-economic characteristics of the service users?
b) What were their presenting problems?
c) What types of assistance were requested by them?
d) What kind of service did they receive?
e) How did they move through the program?
f) What user changes could be observed?

These questions, which were basic to the inquiry into IFSC pilot project operations, provided the framework for analysis. Analysis was performed on the data collected from the 15 pilot projects between April and December, 2002. These initial experiences, in the form of empirical data, could keep track on the development of all the pilot projects as a whole and each individual pilot project in specific. More importantly, the data could enable the comparison between projects and between different formation modes.

19. Collected by the SWD, the SIS comprised monthly service input, output and service outcome statistics. Pilot projects had to provide service output information related to the service standards prescribed in the Funding and Service Agreements. The FSA comprised 12 core outputs and 6 complementary outputs (*see appendix III*). Since each pilot project had its own unique staff provision and target population size, the requirement level of each output item for each project was different. In addition, pilot projects had to provide information on outcome indicators, designed by the HKU Consultants. These outcome indicators included:

a) enhanced social support
b) enhanced knowledge of community resources
c) enhanced problem solving capacity
d) user satisfaction level
e) target problem rating

These outcome indicators were based on self-assessment by users after the termination of the services. They focused on the users' perceived effectiveness and improvements due to social work intervention. The SIS data for analysis in this Report was collected between April –

December 2002.

20. Another set of evaluation instrument adopted to document case movement due to intervention in pilot projects was the clinical measurements. It was based on the pre- and post-measurement on changes in the severity of symptoms and risk factors. Two main problem areas were selected by the HKU consultant team and endorsed by the Task Group on Assessment Forms and Outcome Indicators. They were "child behavioral problems" and "spousal conflict and violence", adapted from the Child Behavioral Checklist and Revised Conflict Tactics Scales respectively. Ten cases from each project were required as the subjects of the study. Each case would then be assessed within two periods (1 October to 31 December 2002 and 1 October to 31 December 2003) to document changes after receiving services from the pilot project. Each pilot project could select to work on one of the two areas during the assessment period.

21. Each pilot project had been assigned with a HKU consultant. After initial familiarization visits, each consultant had to work closely with the pilot project team through regular visits and meetings with the staff members. In each pilot project, the consultant had conducted focus groups with service users between September and October 2002, and key stakeholders (community partners of pilot projects) in December 2002. A total of 15 focus groups with users and another 15 focus groups with stakeholders were held. The consultant was also responsible for reviewing selected users' cases from each pilot project. Between October 2002 and July 2003, the consultant would review the selected cases at three-month intervals to keep track on their progress and their pattern of service utilization. Four cases had been selected from each project, with two cases randomly selected and another two cases nominated by the pilot project operator. Two of the cases should come from the FCU, and the other two from FSU.

22. To collect information from the pilot projects based on the formation modes, two separate focus groups were organized for frontline social workers from the two groups of formation modes, namely the merging/ self-transformation/ greenfield and the strategic alliances in July 2002. Similar focus groups were also organized for supervisors from the two groups in November 2002. These focus groups collected views from social workers and supervisors on the operation of the pilot projects according to formation modes.

23. Each pilot project had to submit to the HKU consultant team a self-assessment report every six months. The self-assessment report would include a review of the developments on the transformation process, business plans, good practices, difficulties encountered, and future strategies.

24. The screening and assessment forms were designed to provide a uniform, timely and accurate instrument to identify the need for counseling services of the principal user. Based the results of the assessment, users could be channeled to the appropriate level and type of intervention. Data for the months of June to September 2002 was used for the psychometric testing. For details of the operations and analysis, please refer to Chapter Five.

25. To facilitate the social workers to learn about the design of IFSC, and the data entry for the UIS, screening and assessment tools, and clinical measurements, a series of orientation meetings and training workshops were organized.

26. In essence, the consultant team has maintained a close collaboration with pilot project operators in order to understand their good practices and difficulties encountered. After the publication of the Interim Report, emphasis of the consultant team will be put on the consultation with the stakeholders on the future development of IFSC.

Outline of Chapters

27. Chapter One provides the background and formation of the IFSC pilot projects, and outlines the evaluation methodology involved. Chapter Two describes the implementation of the pilot projects by providing the socio-economic profile of the users and the program outputs. The operation of the pilot projects according to the formation mode is presented in Chapter Three. Chapter Four summarizes the performance of these pilot projects based on the outcome indicators. Chapter Five describes the feasibility of the screening and assessment forms in details. In the concluding chapter, major issues involved in the future development of IFSC are explored.

2. Implementation of IFSC Pilot Projects

Introduction

1. User and service information on pilot projects was derived from three major sources. The User Information System (UIS) and the Statistical Information System (SIS) provided quantitative figures on the user background and service outputs. Both the UIS and SIS included data from April to December 2002. The half-yearly (April-September 2002) self-assessment reports from project operators and focus groups with project staff and stakeholders provided qualitative views on the process of establishing and institutionalizing IFSC pilot projects.

User Profile

2. According to the UIS, the average age of a new user in the pilot projects was 44.9 years. About 55.4% of the new users were aged 21 to 50. The average age of users in each project ranged from 35 to 50 years old. In general, users in FCU were younger than those of FSU. Their average ages were 37 and 53 respectively. The age differences between the units reflected the arrangement that more cases involving older persons who required supportive and material assistance had been directed to the FSU.

3. In terms of accommodations, some 52.3% of the FSU and FCU users lived in public housing, while 36.3% in private housing. In employment, 29% of them were employed (full-time, 22.9%; part-time, 4.9%; self-employed, 1.2%), 21.6% were retirees, 19.6% were homemakers and 19.3% were unemployed. As such, people without employment - unemployed, retirees, and homemakers constituted the majority of the project users. The proportion of people without employment varied from project to project, ranging from 21% to 79%. A higher proportion of FSU users (78.7%) than the FCU users (64.1%) were without employment. Again, figures showed that there were more retirees in the FSU.

4. In education, almost one-third of the users (30%) had attained primary school education or below, and almost one-fifth (17%) did not receive formal education. Almost three-fifths (59.6%) of the FSU users had education below primary education, as compared to 35.6% of the FCU.

5. About two-thirds (65.6%) of the users were female. Two-fifths (40%) of the users were either CSSA recipients (30.9%) or SSA recipients (9.1%). Among the new users, 45.9% of them were not born in Hong Kong. Some 11.7% of them had arrived in Hong Kong for less than 7 years. Noteworthy is the fact that some pilot projects had a much higher proportion of new users (26-28%) classified as new arrivals. Some 44% of the users were married. Those widowed, divorced or separated constituted 30.9%. Presumably, many of them were single parents or single elderly women.[8] The proportion of this target group (widowed, divorced or separated) ranged from 12.9% to 40.1% in different projects. Again, these groups of people were more represented in the FSU (38.8%) than in FCU (23.7%).

6. In general, a typical pilot project user is a female adult, with no job, and poor education.

[8] The statistics did not have detailed breakdown according to sex and the proportion of the divorced and separated people with children.

There is a high proportion of new arrivals, people without spouses, and social security recipients. There are more female and elderly persons in the FSU than in the FCU. There are some distinctive differences in user profiles between projects. Differences may reflect the special features of the target community and the special foci of the projects.

Presenting Problems and Services Requested

7. Presenting problems of new users included: personal/ individual problems, 56.9%; family problems, 56.1%; circumstantial/ situational problems, 44.6%; and interpersonal problems, 3.2%. On average, each user reported 1.6 problems. Problems relating to individuals, families and situation, oftentimes, were interrelated and multi-faceted. As expected, FSU had a higher proportion of circumstantial/ situational problems than FCU (52.5% and 36.8% respectively), whereas FCU had a substantially higher proportion of family problems than FSU (79.3% and 31.7%). The distribution of presenting problem between the units reflects the differences in the major functions of the units. Again, there were substantial variations among projects in the type of user's main problems. Two pilot projects had the proportion of personal/ individual problems and family problems around 90%, while two projects had the proportion at around 55%. In general, pilot projects involving NGO FSCs would have the proportion at around 80 to 90%. For those projects involving SWD FSCs, the proportion was usually around 70%. For circumstantial or situational problems, the differences between projects ranged from the minimum of 1% to the maximum of 40.7%.

8. For assistance requested, the most frequently requested item was counseling (61.8%), followed by accommodation (16.3%), day or residential care services for elderly (12%), and financial assistance (11.4%). The pattern reflected the mixed functions of family services, which included both the provision of intangible clinical intervention and tangible services and referrals. Among the projects, the proportion of users requesting for counseling could range from 12.4% to 100%. Again, the variations of problem natures and assistance requested among pilot projects would partly reflect the traditional differences between the functions of SWD and NGO FSCs and partly the community characteristics. As expected, the majority of the users in FCU (85.5%) would request for counseling services, as compared to 37.8% in FSU. As expected, more users in the FSU would seek tangible assistance. FSU users seeking assistance in accommodations, day or residential care services for the elderly, and finance were 21.9%, 23.4% and 13.8% respectively. The proportions of FCU users seeking similar assistance were 10.8%, 1.1% and 9% respectively.

9. Similar to the information obtained through the UIS, users of pilot projects attending focus groups organized by the HKU consultant team represented a wide variety of background – single parents, parents with children with behavioral problems, couples with marital conflicts, people with emotional problems, low-income families, CSSA recipients, and older people. Some were facing acute problems of financial difficulties and emotional stress. Some were lack of social support. Others would seek referrals for other social services, such as care and attention homes and compassionate housing. In some affluent districts, such as Central and Western District, there were middle class users. Most of them had been using the services for over a year. New comers, who used the services after the pilot projects were formed, were rare. From the self-assessment reports, some projects also engaged with South Asians, people with mental health problems and suicidal risks.

10. On the whole, users learned about the service from a variety of sources, including posters, leaflets, friends, newspapers, outreaching campaigns, RTHK educational program series, and teachers. Some were referred by staff members in clinics, children and youth centers, and hotline services. Others were identified by social workers through participation in social and

group activities, such as the after school projects and tutorial classes for children. Most of them lived nearby the centers. Not surprisingly, a common concern of the users was the need to respect privacy and keep confidentiality. They indicated that stigmatization in conventional FSCs had deterred many people from using the services.

IFSC Programs and Services Rendered

11. According to the IFSC design, IFSC provides a continuum of services with preventive, developmental, educational, supportive, empowerment and remedial functions through the three major components, namely FRU, FSU and FCU. The functions and examples of program activities are:

a) Family Resource Unit: The FRU provides open and universal services to all families with drop-in services, helplines, public enquiry, interest classes, newsletters, information giving, family life education and marital enhancement talks and courses, educational groups or programs, mutual help groups, recreational activities, skills training, volunteer development, needs surveys, social networking and outreaching through home visits, exhibition and street stalls, after school care service, and social issues concern groups. The main objective is to disseminate family resources to enhance the functioning of families.
b) Family Support Unit: The FSU provides service support to vulnerable individuals or families or those who are at risk or in disadvantaged circumstances. Support services include parenting and family management training, referrals for other complementary services, caregiver support, support groups, referrals for assistance, family aide, and brief counseling. The main objective is to render timely support services to prevent further deterioration of individual or family problem. Often, these programs would target at risk families such as the new arrivals, low-income families, single parents, families facing financial crisis, older people waiting for residential placements, and ethnic minorities.
c) Family Counseling Unit: The FCU provides intensive counseling, therapeutic groups and crisis intervention to individuals or families in crisis. Their problems include depression, emotional difficulties, victims of domestic violence (battered spouses and children), families at the risk of marital breakdown. The main objective is to assist individuals or families to regain self-resilience, to preserve family solidarity and prevent occurrence of family breakdown and traumatic tragedies.

FCU Outputs

12. According to the SIS, the total number of cases in the FCU of all the pilot projects had declined by 24.6%, from 6,481 in April 2002 to 4,889 in December 2002. The caseloads of pilot projects in the end of December 2002 ranged from the highest of 811 cases to the lowest of 106 cases. As expected, those projects with a higher target population and more social workers assigned to FCUs would have a higher number of cases. These projects usually involved SWD FSCs which had a bigger FCU and a larger target population size.

13. Looking into the caseloads of each projects, six projects showed slight decreases, while five projects showed more substantial reduction. In one of the projects, the caseload between April and December 2002, had decreased by three times. Another three projects showed slight increases. For the "greenfield" project, being a completely new project, caseloads had been accumulating. The increase in the caseloads was three-fold within the assessment period.

14. Overall, the number of new cases among all the projects opened each month has declined from 431 in April 2002 to only 249 in December 2002. Only two projects showed a clear trend of gradual increases in the number of new cases opened each month. The majority of

the other projects showed either stabilizing numbers or declining numbers of new cases received each month. Evidently, after nine months of implementation, new case intakes in the FCU have been stabilized, and there is no clear indication that the demands are mounting. In other words, proactive publicity of pilot projects has not created a mounting number of service requests in the long run. Another explanation for the decreasing number of new cases may due to the fact that pilot projects have begun to adopt more multi-level intervention approach, such as brief counseling and supportive groups other than intensive counseling. The growing experiences in the use of the screening form and assessment tools have also contributed to more users being directed to the FSU for brief counseling.

15. After rigorous case reviews, the majority of the projects had closed a large number of cases, or transferred them to the FSU for brief counseling in the beginning months. However, in recent months, the number of cases closed each month had dropped. Indeed, the total number of cases closed each month has declined by 54%, from 542 cases in April 2002 (506 cases in August 2002) to 251 cases in December 2002. It is expected that the number of cases closed each month will be more stabilized in the future.

16. Noteworthy is the fact that even though the caseloads had been on the decline, a closer look at some of the pilot projects reveals the fact that the caseload per social worker in the FCU remains high. By dividing the monthly average caseloads in the FSC in each project by the number of social workers in FCU, the caseloads ranged from 24.4 to 120.5 cases per social worker. Two projects which adopt a specialized sub-team approach, did not have defined numbers of social workers in FCU. But assuming the 1/2 to 1/3 of the team members would be allocated to the FCU, the caseloads of these two projects would be considered as low among the pilot projects. The average caseload in 13 projects was around 69.39 cases per social worker. Not surprisingly, the greenfield project, which was only beginning to build up its caseload and was serving a relatively smaller population, had the lowest caseload per social worker. On the whole, those projects self-transformed from SWD FSC or with the former SWD FSCs as the FCU tended to have higher caseloads than those projects with NGO FSCs. The issue was complicated by the fact that the former types of projects tend to serve a larger target population.

17. The number of social workers assigned to FCU varied from 2.5 to 10 social workers. To keep the caseloads to a reasonable size of 40-50 cases per social worker, some projects, such as those with SWD FSCs may have to reduce their target population size, while other projects may have to increase the number of social workers assigned to FCUs. Excluding the two projects adopting a specialized team mode, there were six projects with only 2.5 to 4 social workers in the FCUs. It is unreasonable to have a FCU of this size. There is room to expand the size of the FCU team, either by redeploying social workers from the FSU and FRU, or simply by expanding the size of the team. For the projects with SWD FSCs, serving a population size of around 300,000, there are rooms to reduce its service boundary coverage. It is unreasonable to have caseload per social worker over 100. According to the FSA, it is expected that the caseload size should be maintained at around 40 to 50.

Table 1: Pilot Project FCU Caseload per Social Worker

Project	Number of Social Worker in FCU	Average Caseload per social worker (Apr.-Dec., 2002)	Average Caseload per social worker (Dec, 2002)
A	5 (14)	58.7	47.0
B	3 (12)	24.4	35.3
C	? (10)	-	-
D	? (10)	-	-
E	4 (8)	58.3	57.5

F	7 (23)	70.2	70.1
G	7 (14)	120.5	115.9
H	2.5 (7)	49.5	53.6
I	4 (8)	76.0	80.0
J	10 (31)	86.6	58.6
K	5 (14)	62.0	60.8
L	5 (15)	75.0	76.4
M	3 (9)	52.5	53.0
N	6 (15.5)	68.4	65.7
O	4 (12)	99.97	99.0

( ) Total number of social workers in the pilot project

18. Because the case duration only included the period after April 2002, without taking into consideration of the period before this date, therefore, figures available did not reflect the actual overall case duration. In particular, pilot projects had reviewed vigorously on their former FSC cases for continuous assistance. As mentioned before, pilot projects tended to close a much higher number of cases in the early months after their formation. As expected, the average duration of the cases was only 4 months.

19. In a similar vein, some projects tended to close a higher number of intensive cases in the beginning months, but most of the projects showed a smaller number of intensive cases closed in recent months. The pattern of intensive case closure varied significantly between projects, and tended to fluctuate widely in different months. According to the UIS on terminated cases, the average number of sessions for intensive counseling was 4.86. Variations among projects ranged from 3.1 sessions to 22 sessions per case.

20. In reviewing the statistics on therapeutic groups, it was clear that most of the projects had hardly used therapeutic groups in the beginning months. In the beginning, there might be some confusion on the definition on therapeutic groups. For example, a project included career planning programs for adolescents as therapeutic groups. In summary, only one project had consistently operated therapeutic groups monthly. Some projects had only begun to use therapeutic groups in recent months. In the last three months, six projects had no therapeutic groups at all. The under-utilization of therapeutic groups might reflect the lack of expertise in this area, rather than the lack of needs. On average, group size was small, with only 8 to10 persons.

FSU Outputs

21. The total number of supportive and brief cases had increased by 55%, from 2,598 in April 2002 to 4,033 in December 2002. On the whole, those projects involving SWD FSCs had much higher supportive and brief caseload numbers and caseload turnovers than those with NGO FSCs. It might reflect the traditional differences in case nature between SWD and NGO FSCs. Nevertheless, those projects involving NGO FSCs showed increasing number of supportive and brief caseloads. The increasing number of brief and supportive cases in FSU indicated the growing importance of FSU in the pilot projects. More importantly, those projects with NGO FSCs were beginning to take up more brief and supportive cases. There should be a trend of convergence in the case nature between projects with SWD and NGO FSCs as the FCU.

22. Among terminated cases receiving brief counseling services, the average number of sessions received was 3.57 sessions. Variations between projects were significant, ranging from the lowest average of 2.86 sessions to the highest average of 13.5 sessions. According to the SIS explanation, brief counseling should normally be completed in less than 8 sessions within 4

months.

23. In terms of supportive groups, they were not popular in the beginning months. The pattern of use varied from projects to projects. Some showed increased utilization, with two to three groups each month in recent months, while others had become less frequent in using supportive groups.

24. Even worse, mutual help groups were less popular than supportive groups. Five projects had no mutual help groups in the last several months within the assessment period. The rest had only one group in December 2002. On the whole, mutual help and supportive groups were larger in size than therapeutic groups. The average group size was around 10 to12 persons.

25. The average number of FSU sessions per terminated cases (brief counseling, mutual help groups, training by family aide, and support group) was 3.64. The average number of sessions among projects varied from the lowest of 2.93 sessions to the highest of 16 sessions.

FRU Outputs

26. There was a clear trend of increasing use of educational and developmental groups, particularly during the summer and Christmas holidays. The average group size was 12 to15 persons. In general, those projects involving community centers tended to have higher numbers of educational and developmental groups. Again, educational and developmental programs had increased significantly from 133 programs with 8,014 participants in April 2002 to 214 programs with 10,876 participants in December 2002. Average number of participants in programs was around 50-60 participants. In view of the thriving numbers of educational and developmental programs and participants, there is a need to benchmark the optimal level of service outputs in the FRU in the future.

27. Drop-in center attendance increased slightly from 24,771 persons in April 2002 to 29,592 persons in December 2002. However, some projects had their drop-in attendance increased significantly, while others showed declining attendance. In general, projects involving community centers, greenfield and children and youth centers had a higher attendance than those projects involving the self-transformation of FSCs. The traditions of having drop-in facilities had enabled these projects to have a large number of drop-in attendance, particularly during summer and Christmas holidays.

28. The number of volunteers involved had more than doubled, from 1,745 persons in April 2002 to 3,768 in December 2002. In particular, those projects involving community centers could recruit a much higher number of volunteers. In terms of users turn volunteers, five projects showed obvious difficulties in achieving the objectives. The number of users turned volunteers did not co-relate with the number of volunteers recruited. Those with much higher numbers of volunteers recruited might have relatively very little users involved, while those with a much smaller volunteer pool might show more success in turning users into volunteers. Some projects comprising community centers showed poor results in turning users into volunteers. There were more planned efforts to develop volunteers and to involve users in volunteering work. But the outcomes had been uneven and not particularly impressive. Perhaps some projects had not been fully aware of the desirability of using volunteers and turning them into users, while others would find volunteer development work time-consuming. FRU is usually responsible for general volunteer development and management, while FSU and FCU have direct contact with users. The effective conversion of users into volunteers exemplifies the close interfacing between the IFSC units.

Table 2: Numbers of Registered Volunteers and Users Registered as Volunteers

Project	Average Monthly Registered Volunteers	Total No. of Users Registered as Volunteers
A	267.0	3
B	142.7	29
C	290.3	54
D	93.0	12
E	109.9	62
F	225.8	34
G	76.1	42
H	129.1	105
I	56.1	34
J	276	81
K	106.7	43
L	177.2	1
M	206.9	43
N	756.6	73
O	249.6	13

29. The total number of cases connected through outreaching or networking efforts increased from 317 cases in April 2002 to 797 cases in December 2002. The increasing numbers might reflect the more active use of outreaching efforts and the increasing experiences of social workers in identifying needy families. In outreaching and networking efforts, variations in strategies were found. Some had strengthened linkages with schools, some with nurseries and kindergartens, and others with Maternal & Child Health Centres (MCHC). Six projects did not involve a membership system. Six projects had after school care projects, and two projects had occasional child care programs.

30. According to the UIS between April and December 2002, a review of 1,686 users showed that a total of 103 educational or development program sessions; 108 educational or developmental group sessions; 3,298 brief counseling sessions; 83 training sessions by family aide; 16 mutual help group sessions; 136 support group sessions, 6,375 intensive counseling sessions; and 217 therapeutic group sessions were provided. Intensive and brief counseling remained the most common service received. Only a small number of users would use groups and educational/ developmental services.

31. In summary, there were evidently deliberate attempts to develop more group services, including therapeutic, supportive and developmental groups. Service statistics showed that more group programs had been used. But on the whole, the impression is that the use of groups has room for improvements. The main barrier may be due to the lack of professional expertise in running supportive groups. In other words, the FSU is only evolving and needs further consolidation. Overall, there are significant variations in program outputs between projects. At this stage, it is still difficult to have an exact account on the variations. They may be due to differences in community characteristics, nature of users in SWD-NGO, and strategies employed by pilot project operators.

Interfacing between IFSC Units

32. Family problems are becoming more complicated and inter-related. Financial pressures due to economic recession have in many ways contributed to relationship breakdown in families. Coupled with the increased publicity and intensive service marketing, demands on family services have evidently been escalating. The central feature IFSC pilot project design is

to provide a continuum of services comprising preventive, supportive and clinical services. Admittedly, pilot projects have not introduced any new intervention technology. All along, FSCs have provided individualized counseling services, while most community-based services rendered supportive and developmental services. The innovative concept of IFSC pilot project is to bring these services together under one center.

33. The effectiveness of IFSC pilot projects depends on how these units can complement each other in operations. FRU can, through its outreaching efforts and universal social activities, connect and identify users with the needs. Users with the need for counseling would be assessed by the screening form. The FSU would provide emotional and material support to at-risk populations, so that their situation would not deteriorate further and need clinical intervention. Besides individualized clinical intervention, users in FCU with similar needs can be grouped together to participate in therapeutic groups. An example of therapeutic group is on anger control training groups for those with the risk of committing child abuse. These users after having their crisis settled in the FCU would require some supportive and training services from the FSU. In effect, cases, such as those involving the application of care and attention homes and compassionate rehousing would be handled by the FSU. According to the UIS, it is evident that users at the FSU receive mainly brief counseling, supportive group, mutual help group, and family aide services. At the FCU level, the main service input is individual counseling, complemented sometimes by therapeutic groups.

34. At times, users coming to IFSC pilot projects would still expect to receive individualized counseling services, and would therefore be reluctant to be referred to the supportive unit for group services and brief counseling. According to some social workers, users might be confused on the need for referrals between units, and to be handled by different social workers or even different agencies in the case of projects involving strategic alliance. In practice, some IFSC projects might have the same social workers taking up counseling cases at the FCU and supportive groups in the FSU. Some projects formed specialized teams, with each team comprising the three IFSC units. Thus social workers in each team could move along with their cases between units. In other projects, social workers might escort users to use the services provided by the other units.

35. Moreover, there are times where supportive groups might not be readily available for users from FCU because of insufficient number of users with similar needs. FCU users might have to wait for a while in order to receive supportive group services. In a way, IFSC pilot projects might have to extend its service network to other IFSCs or other community-based services in the district for group service recruitment. On the whole, users expressed satisfaction with the supportive and resource-providing services. Particularly, participation in volunteering services had improved their self-image and sense of contribution.

36. Most key stakeholders also found that the pilot projects had become more user-friendly, with people coming to the center not solely for their problems, but also a place to chat, meet people, relax, learn, and share with other people. Focus groups on users carried out by the consultant teams and by individual projects also showed satisfaction with the wider range of integrated services now provided by IFSC pilot projects. For effective interfacing between the units, intensive formal and informal communication between the units is needed.
A user described the IFSC services:

> *I think IFSC is a one-stop service, which provides services in different spots in the community. There are case, group and program activities for children. It is a convenient service which can provide more choices for people in need. For instance, after the termination with the counseling service, a user may still need to participate in supportive groups, where he or she can meet others with similar needs. There are more children-*

oriented activities in IFSCs now.

Another user described how she perceived the inter-relation between services:

Participation in groups depends on individual needs. When one has a really serious personal problem, individual counseling is more useful than groups. After some time of receiving individual counseling, the immediate problems may become more settled, then, it may be better to be involved in group services. When I sought help to resolve my marital problems, I have tried both individual counseling and supportive groups.

37. According to the UIS, information on inter-unit movements revealed that a total of 43 (2.6%) and 54 (3.2%) of the 1,686 reviewed cases had been transferred from FSU to FCU, and from FCU to FSU respectively. However, it was reported that many pilot projects had failed to provide information in this area. In terms of services provided by FRU among terminated cases, the number of cases reported to receive FRU input was small. For those reported cases, each user received an average of 3.47 program sessions from FRU. Revealing from these figures, the actual collaboration between the units has been still limited and uneven. The use of educational or developmental programs and groups, and mutual help group sessions had been unevenly reported.

Interfacing with other Services

38. Interfacing with other services might take many forms. The most common format was to make referrals to other agencies for services and assistance. According to the UIS, among the 1,686 reviewed cases between April-December 2002, a total of 754 referrals had been made. A breakdown of the referrals indicated that 12.1% were for financial assistance, 10.4% for residential services; 9.3% for support services; and 7.5% for housing assistance; and 5.5% for specialized services. Again, the proportion of cases required referrals varied from 0% (no referral had been made) to 68.2%. Variations may attribute to the differences in the nature of cases.

39. Through focus groups with other stakeholders, community partnerships of IFSC pilot projects varied from project to project. They included nursery, schools (teachers, principals, school social workers and school counselors), District Council members, Parent-Teacher Association representatives, and other services (SWD special units and FSNT, District Elderly Community Centers (DECC) and Neighborhood Elderly Centers (NEC), Rehabilitation Services, Street Sleeper Projects, Outreaching Youth Services, FLE projects), volunteers, religious organizations, community organizations (Mutual Aid Committees, women's organizations), medical doctors and psychiatrists and MCHCs and other service units of IFSC pilot project operators. Among these partners, schools and nurseries were more popular.

40. IFSC pilot projects could receive referrals from these networks of community partners. Many of these partners also expressed appreciation that IFSCs pilot projects facilitated users to understand and use their services. Others community-based services (youth outreaching service, FSNT) even though not joining with the FSC to form IFSC pilot projects, could still function as the FRU, by connecting IFSCs to families in needs; and as FSU, by running supportive groups for IFSCs.

41. Many of these partners had been working with the FSCs before the formation of IFSCs. These stakeholders in general praised the one-stop services provided by pilot projects, with improved flexibility, accessibility (extension of office hours) and publicity of the service, particularly with the reduction of stigmatization and labeling effects (more people coming for educational talks). They were impressed by the wider range of services provided (supportive

group services, preventive programs, and community support programs), thriving volunteer support and involvement, responsiveness in receiving referrals, family focus on linking parents and children together, strengthened collaboration with schools and elderly services. Some of them expressed the awareness that IFSC pilot projects had escalating workload and insufficient resources, particularly in the availability of space for programs. On the other hand, some stakeholders claimed that some social workers in IFSCs were still very much dominated by the casework paradigm. Some also indicated that IFSC pilot projects had reduced provisions in social and recreational activities as compare with other community-based services. There existed some confusion over the IFSC pilot project service boundaries which may be different from the services before the IFSC formation. Others expected IFSCs to be more aggressive in service promotion and community relations. On the whole, their image on family service centers had improved significantly.

42. Evidently there are similar services provided by other service providers and community organizations within the IFSC pilot project service boundaries. For those government subvented family-oriented services, such as School Social Work, Medical Social Services, District Elderly Community Centre and Neighbourhood Elderly Centre, C&YS, they now have provisions to provide supportive and counseling services. The issues of division of responsibility in providing the services and under what circumstances, cases are referred to IFSC have to be settled to avoid overloading IFSCs and service duplications. On the other hand, many pilot projects have provided neighborhood-based integrated services to special target groups, such as single parents and new arrivals. The division of responsibilities between future IFSCs and those special-target services, such as the Single Parent Centres and Post-Migration Projects has to be worked out. If the outreaching work can be carried out by the FRU of the IFSC, there should also be a clear division of responsibility between IFSC and Family Support and Networking Team (FSNT).

43. At times, pilot projects have to refer cases to specialized services. For cases involving child abuse and battered spouses, they have to be referred to the Family and Child Protection Service Unit of SWD. For those urgent cases involving suicide risk, they may have to be referred to the Samaritans Befrienders; those involving mental health, Community Mental Health Link and private psychiatrists; those involving family crisis, the Family Crisis Support Center. Often times, after the crisis is over, these cases may have to come back to IFSC for supportive and educational services. However, statistics indicated that the use of these specialized services has been limited. Even though there are guidelines available, some social workers still expressed uncertainties about how and when to make referrals for specialist services. On the other hand, many community organizations also provide a wide variety of social and recreational activities and services for specific target groups. IFSCs have to maximize this input from the community.

44. In view of the fact that the average number of other stakeholders attending the focus groups was around 5 persons (range between 3 and 8 persons), it is evident that there is still room for the IFSC to develop and widen community partnerships.

45. On the whole, IFSCs have become an integral part of the social welfare service network in the district, seeking active integration with services for the older people, the disabled, youth and children. They serve a variety of families in needs – single parents with limited social support, children with behavioral problems, people with mental health problems, new arrivals with adjustment difficulties, marital conflicts, and families with financial difficulties. In essence, IFSC, being family oriented, has no age limitation and no rigid eligibility requirements for services. But it does not mean that they have to be responsible for all the family-related problems.

Summary

46. The establishment and the restructuring processes present a distinctive challenge for policy makers and family service providers to translate the IFSC design into practice. On the whole, the selection and formation of IFSC pilot projects have been smooth. After one year of implementation, IFSC operators and social workers have been enthusiastic and positive about the outcomes of the pilot projects. There is clear evidence that projects have identified the direction to become "child-centered, family-focused, and community-based", and fully espouse the guiding principles of facilitating user accessibility, service integration, early identification of needs and intervention and community partnerships.

47. The service targets of IFSC are vulnerable individuals and families coming from a variety of background. They include women, old age, the unemployed, and low-income families, usually with poor education. Many of them tend to be new arrivals, single parents, divorcees, and recipients of CSSA or SSA.

48. On the whole, the workload of FCU has been stabilizing, but caseload per social workers has been particularly high with some units due to many factors (high target population size and small number of social workers in FCU). The use of the screening tool has differentiated cases which require intensive and clinical intervention from those requiring supportive services. Evidence showed that users of FCU tended to indicate the predominance of family problems and counseling requests, whereas those of FSU tended to be more situational and would require tangible service support and assistance. On the one hand, different types of cases may be placed in different units for relevant services. On the other hand, users can receive complementary services simultaneously from all the service units. Evidence indicates that the interfacing between units mainly focuses on the provision of supportive and mutual help groups by FSU to users in FCU. More importantly, the development of the FSU requires further consolidation, as the use of supportive groups has been limited. More likely the FRU has played a key role in identifying needy families and individuals and also provided a more open and non-stigmatized image to the community. On the whole, interfacing between units has to be further strengthened.

49. There are significant variations and disparities of program input and output between projects. Variations can be attributed to different staff size, agency tradition, values and program strategies, target population size, and community characteristics. But variations would also reflect the different adjustment processes experienced by the projects to mobilize resources to face the demand for integrated services. Some projects are more adaptable than others in the institutionalization of the IFSC programs.

50. Particularly in the early months, IFSC social workers have to face a tremendous amount of workload – preparing for the transformation or conversion, publicizing the new pilot projects, and learning to use the forms (screening forms, assessment tools, UIS and SIS). In preparing for the new projects, intensive communication is required to work out the administrative and program structures – staff distribution, staff responsibilities, collaboration between units, and new programs. Under the new IFSC mode, there is a higher requirement on teamwork. More importantly, in shifting from a conventional and narrowly-focused FSC operation to the new practice, most social workers now have to use a wider scope of intervention, demanding more skills and knowledge support. Meanwhile there is a concern among some social workers that the multi-skilled and generic approach of IFSC may impede the development of specialization and advanced professional practice. All in all, the demands on social workers have been heavy. Invariably, some social workers are more ready to adapt to changes than others.

3. Pilot Project Operations according to Formation Modes

Introduction

1. IFSC pilot projects have been established by four types of mode, namely self-transformation, merging, strategic alliance and greenfield. Merging and strategic alliance modes involve the combination of a FSC with another community-based service, such as community center and children and youth services. In preparing for the new projects, staff members have to work together to formulate common project vision, understand the FSA requirement, clarify the division of work, define project service boundaries, delineate operational structure, and establish the information system. There is a need to formulate the business plan which includes publicity, community need assessment, program plans, and staff training support. More often, these tasks have been planned and implemented through the establishment of sub-teams. First and foremost, social workers should have a thorough understanding and acceptance of the mission and operational principles of IFSC.

Merging Mode

2. The IFSC pilot projects were formed by merging the FSC with either the Community Center or Family Support and Resource Center (FSRC), or the C&YS operated by the same agency within the district. In some projects, the pilot project team may include the Family Life Education Officer (FLEO).

3. In forming the new team, pilot projects operators had to prepare staff members for the transformation. The planning of the new center included making decisions and arrangements on the governance structure, work teams, division of work, opening hours, program strategy, and necessary renovation work. Similar to other modes, staff members had to learn to use the new screening tool and recording system through attending training workshops organized by the HKU consultants and in-service training classes for other team members. The merging of the two units usually necessitated huge administrative arrangements, including supervision, duty rosters, work procedures, financial system, and secretarial support. Orientations had to be arranged if there were new staff members involved after merging. For those staff members who showed resistance or difficulties in coping with the changes, they might have to be transferred to other units.

4. After merging, some pilot projects (particularly for those involving SWD FSCs) would review their cases vigorously. Based on a thorough assessment of needs, some cases would be terminated; some would be transferred to the FSU for supportive services; and others would continue to receive intensive counseling in the FCU.

5. In forming the different IFSC units, the pilot projects would try to retain the expertise of the social workers involved. For examples, FLEO would be deployed in the FRU and focused on providing parenting talks; community and youth workers, as well as those less experienced counselors would be deployed to provide group and brief counseling services in the FSU, or involved in outreaching work, volunteer development and mass programs in the FRU; experienced counselors from the former FSC would be deployed in FCU for providing intensive counseling and therapeutic groups. For those projects involving two SWOs, the usual arrangement was for one of them acting as the clinical supervisor, while the other one as the overall project supervisor. The provision of clinical supervisor would definitely enhance the quality of clinical supervision and support to social workers involved in intensive counseling.

6. In most cases, experienced counselors would remain to provide intensive clinical intervention in the FCU. At times, they might run therapeutic and treatment groups. Some former FSC caseworkers might have to be transferred to the FSU to provide brief counseling, supportive and mutual help groups. There were special project teams which required the mixing of staff members from the different units.

7. Relatively speaking, the work nature of the merging mode pilot project might not involve profound changes and adjustments. Yet the merging mode implied that a new and irreversible "family" identity was required, and all staff members had to be committed to the objectives and principles of IFSC. In specific, social workers from community centers might have the feelings that by merging the community center together with the FSC, the traditional mission of community work might be eroded. A self-assessment report described:

> *FSU and FRU social workers come from a community center which belongs to community development service. Community workers are mostly devoted to their services with heavy enthusiasm and often with a life outlook that seeks for individual rights and structural changes. This orientation makes their identification with the new commitment more difficult. Some workers may feel that the family service orientation may betray their original commitment.*

8. Inevitably, there would be tensions between different types of social workers after merging. The tension was vividly and frankly described in a self-assessment report:

> *Life outlook and intervention skills are enormously different between community workers and counseling workers. In the past six months, quite a lot of time and energy were spent on communication and consensus building among staff coming from the two centers, and I don't think we can term the process smooth and positive at all. Working closely together for the same goal is what we strive for but not easy to achieve at the present stage.*
>
> *We believe, in order for the new IFSC to be successful, it is an ideal for staff to address themselves, no matter in what unit, as "family worker". However, it is difficult to achieve this in the present stage. It has become a rather sensitive and political issue as community workers may feel that they have surrendered their service to another field, while the counseling workers may feel that their field of service is being intruded by workers who don't share their concern and mission.*

9. From the perspective of the supervisor of the pilot project, the need to develop a common identity as "family social worker" was considered difficult to achieve in a short time. In particular, community workers were largely satisfied with their existing mode of operation, and did not feel the need to become an integral part of family service. They might feel threatened if they had to cut back some of their traditional community work practice approaches, such as organizing local residents for empowerment and advocacy.

10. In some pilot projects, mounting workload could also induce resentment among staff members. Some social workers would be reluctant to take up additional duties assigned. Youth workers, on the other hand, seemed to be more acceptable to the change, and would welcome the more family-oriented approach to youth and children work. The only reservation was that pilot projects would involve less interest classes, recreational activities and support to schools. In fact, integrated children and youth centers have already adopted such a program direction already.

11. In the merging mode, the interfacing and deployment of staff between IFSC units could be more flexible, particularly in developing joint projects targeting new emerging social issues. In some projects, FCU counselors would be involved in running supportive groups, while some

social workers in FSU could be involved in providing intensive counseling. New and innovative projects focusing on specific problems (sex and mental health) or target groups (men, new arrivals, and single parents) could be introduced by mobilizing staff members with different expertise and from different units. In other words, the number of social workers assigned to each IFSC units might not be rigidly fixed. Instead, social workers might be flexibly deployed in different units according to community and user needs.

12. Two pilot IFSC projects, because of the merging arrangements, could allocate their staff members to form specialized sub-teams. One project had their sub-teams based on different targets, namely children, adolescents and adults. Each team, with 4 to 5 staff members each, comprised the three core IFSC units. Accordingly, the social workers might become more generic, with tasks involving the three levels of work prescribed by the IFSC design. It was also claimed that the team would consist social workers with different levels of expertise and experiences. The arrangement would facilitate mutual learning. Accordingly, the requirement for referrals between IFSC units would not be necessary. There would be other project teams which would cut across the main sub-teams.

13. The other project formed sub-teams according to different task foci, namely teams on counseling service, families with special needs, families in transition, volunteer services and networking and outreaching. Each team would comprise the work of the two IFSC units. Each social worker had to join at least two sub-teams based on their expertise and workload. Then coordinators of each sub-team would form together as the steering group. The group was responsible for strategic planning, service coordination and monitoring of the programs. Noteworthy is the fact that these projects currently have relatively low intensive counseling caseloads. This may signify their effective use of multi-level intervention, rather than putting the traditional emphasis mainly on providing intensive counseling.

14. Overall, there was a practice of redeployment or exchange of staff members between the different units, so as to encourage staff members to have a wider exposure, and facilitate mutual understanding. In other cases, social workers in FCU had to be involved in providing supportive groups in the FSU. In one of the pilot projects, those FLE social workers in the FSU could take up counseling cases, with strong clinical supervision from the supervisor. In another project, the original management structure was to keep the two SWO supervisors from the two merging units together in the new pilot project. After a year or so, the joint supervision mode was replaced by having one supervisor only. Social workers from different units were encouraged to work together or team up in special joint projects, e.g., on the needs of new arrival families, sex education, and reaching out visits. In essence, the merging mode would facilitate the flexible and creative redeployment of social workers.

Greenfield Mode

15. As a completely new project in a new settlement area, the greenfield pilot project was set up comprising family, children and youth, and elderly services. It had a small yet gradually increasing target population. Because the community was a new settlement with a small population and the project was completely new, it required a longer period of time to build up its community image and user populations. In the early months, the project launched widespread publicity through distributing service leaflets, setting up publicity banners, visits to community leaders, and developing linkages with other services. Mutual help among residents was encouraged through the development of volunteer groups and programs facilitating community adaptation. Counseling services and family life education were provided to parents in day nurseries, after-school projects, drop-in centers, and youth targets in the outreaching services.

16. The strength of the "comprehensive" integrative team was that the three IFSC units could effectively serve the different target groups, notably parents, children and youth, and elderly. Services could cut across the traditional boundaries between different services for different age groups. There were vigorous efforts to strengthen the community support at the level of the FRU and FSU. Overall the communication between IFSC units was more effective. There were no historical factors and traditions that the project had to follow. Staff members had been fully expected to work in an integrative and generic approach. In this way, staff resistance to change would be minimal, and they would be more acceptable to new challenges.

17. However, the limitation was the capacity to provide intensive clinical intervention in the FCU. With a small FCU and a small caseload, it had to struggle to seek stronger clinical supervision for counseling social workers in handling intensive counseling, therapeutic groups and crisis management.

Self-Transformation Mode

18. Self-transformation mode was achieved through the merging or expansion of the existing FSCs. It meant that the pilot projects would comprise social workers working mainly in conventional FSCs before, and their expertise would be primarily in casework and counseling practice. Usually equipped with limited group and program practice experiences, the foremost challenge facing pilot projects of self-transformation mode was to develop the FSU and FRU. These units were basically new to conventional FSCs. The development of FSU and FRU was often handicapped by the lack of premises for program activities and social workers with the relevant skills, as well as the dominating tradition of using casework methods. One of the projects was able to set up a new center in a commercial complex. The new center was specially-designed for the IFSC purpose. In most cases, the self-transformation of FSCs usually has to locate a new project site, as most conventional FSCs may not have adequate space and facilities. In particular, many existing FSCs are located in office buildings which are definitely not suitable for IFSC operation.

19. In fact, the budget allocations for pilot projects in self-transformation mode might not include sufficient funding support for groups and program expenses. Pilot project had to seek additional allocations for program expenses. Social workers expressed a sense of anxiety in the use of groups and programs. Training and supervisory support were found to be important to turn social workers into multi-skilled practitioners. The issue was how to allocate the FSC social workers to the different IFSC units. Usually, the most experienced counselors would be retained in the FCU, while those with less experiences and social work assistants would be assigned to work in FSU and FRU. Anyway, most social workers in the self-transformation mode lacked working experiences and skills required in FSU and FRU.

20. Operationally, social workers would be divided into staff teams in charge of publicity and special target groups. In one of the pilot projects, the FSU and FRU comprised the case team and program team. The case team was mainly in charge of brief counseling, while the program team focused on group, programs and publicity services.

A self-assessment report commented:

The establishment of the IFSC through the merging and transformation of ex-FSCs was a project of enormous scale and complexity. It involved tremendous administrative work and posed challenges on staff members' readiness for change and the skills they have to adjust to the new working environment.

21. According to the experiences of the pilot projects, they took several months for the FSU and FRU to be in full operation. In setting up the FSU and FRU, the pilot projects had to

review all the existing cases for different services – case termination; referral to other services; continuous services for intensive counseling in the FCU; and brief counseling and supportive groups in the FSU. Service statistics indicated that the number of supportive and mutual help groups, drop-in attendance, outreaching numbers, and volunteers in projects of self-transformation mode were relatively low, particularly in the beginning months. Nevertheless, figures showed that the situation had been improving. These projects had tried to establish strong partnerships with children and youth services and community-based services (FLE, ICYSC, FSRC and FSNT) in the district which could play a "strategic alliance" role as the FRU. These partnered services could actively make outreaching efforts to identify needy families for referrals to the IFSC project.

22. In merging FSCs together to self-transform into the IFSCs, two pilot projects served a much larger population size (300,000 to 400,000 people). Coupled with a relatively belated development of the FSU, the FCUs were overloaded with cases seeking individualized counseling. The caseloads of these two pilot projects were exceptionally high. The use of group services was largely limited. In particular, social workers expressed the feeling of inadequacy in running groups, and more time would be needed for preparation and training. The development of volunteers was only evolving, not to mention the conversion of users into volunteers. Without adequate experiences in developing volunteers, volunteer management would be a formidable challenge to IFSC formed through self-transformation.

23. Overall, self-transformation mode usually involves a longer time period to establish and institutionalize the FSU and FRU. Social workers have to learn new skills and to become more community-oriented. Even though there are already training programs provided at all levels, it has to take some time for the practice of group work be institutionalized, and for the social workers involved to have the competency to deliver group work services.

Strategic Alliances

24. Strategic alliance provided a convenient and ready-made mode to achieve the formation of IFSC with the minimal need to re-structure the service units involved. Presumably, there was no suitable agency in the district which could either has the resources and readiness to self-transform itself or to merge its FSC with a community-based service to form an IFSC. Accordingly, an IFSC was formed through the establishment of a strategic partnership between the two different service units operated by two different agencies. The special and complementary expertise of the two services could be brought together. Through exchanges of resources and collaboration, an integrative service, comprising the three IFSC units could be formed.

25. More specifically, the counseling expertise of the FSC provided by an agency could be combined together with the supportive and resource expertise of the community-based service provided by another agency. In one of the pilot projects, the expertise of a NGO on marital counseling, family life education and therapeutic groups was tapped by becoming an integral part of the FCU in the strategic alliance. By pooling two FSCs operated by two different agencies together to form the FCU, there was a division of responsibility according to case nature. Based on the traditional expertise, an agency would be responsible for the cases involving marital relationships, while the other agency would take care of the statutory and other types of cases. In forming a strategic alliance, the resources of both services, including staff, premises and facilities could be shared to enhance the capacity of the pilot project without the need to inject new resources. Historically, since both services had their own community networks, the formation could further strengthen and extend the accessibility of the pilot project. A new and specifically-designed FSA had enabled the two partnered agencies to work closely together.

26. In the establishment of the pilot projects, the original FSC would become the FCU and the partnered community-based service would naturally be the FRU. Oftentimes, both services would share the work of the FSU. In specific, both partnered agencies would be providing supportive and mutual help groups, as well as brief counseling. In one of the projects, the formation of a strategic alliance involved the re-prioritization of services. The volunteering group which was formerly attached to the FSC of an agency had been transferred to the youth center operated by the partnered agency. The volunteering group now became part of the FRU. In another example, the FSC which had become the FCU would cease to run supportive groups for the new arrivals. New arrival users would be referred to the partnered agency for supportive groups.

27. To make preparation for the strategic alliance, partnered agencies involved:

a) The renovation of drop-in areas, the improvement of play room facilities (traditional FSCs usually did not have these provisions), and the provision of interview rooms in the community-based services.
b) Communication between social workers of the two agencies to work out the collaboration mode through retreat, orientation, and joint meetings.
c) Operationalization of the collaborative structure – intake, screening and referral procedures, and joint user membership.
d) Joint planning on division of responsibilities, publicity (official opening, pamphlets, presentation to the district council), outreaching mode, community relations and networking with other community partners, development of volunteers (recruiting and training volunteers and motivating users to become volunteers), setting up of a hotline, assessment of community and family needs.
e) Regular meetings for planning, initiating, implementing and monitoring new projects, such as introducing new mutual help, supportive and therapeutic groups, common information management system.

28. There were tremendous administrative issues to be tackled with, such as the differences in policies and practices in membership system, program fee charges, and referral procedures. In strategic alliance, because of the fundamental differences between the culture and practices between the two agencies and the two services, it would take time for the agencies to reduce their differences. First and foremost, the redeployment of staff and shared budgeting would be difficult under the strategic alliance mode. Some projects would set up a coordinating committee to facilitate planning and implementation. Without a unitary governance system under the same leadership, joint planning and decisions would be based on mutually-agreeable coordination and negotiated consensus under a dual-administrative structure. One project operator expressed the concern that it might have difficulties to respond to its headquarters' initiatives if the partnered agency could not share the priority.

29. Against these limitations, interfacing between IFSC units would be limited to case referrals, occasional joint activities and shared administrative duties. The collaboration between the two units was often further handicapped by the physical separation between the two centers. Inter-unit referrals involving two separated centers, not within walking distance, would be difficult. Some projects had developed the escort service in which the FCU social workers would personally take their users to the FSU of the partnered agencies for supportive group services. The arrangement was to ensure that the users would not drop out from the intervention processes. Indeed, some projects had expressed difficulties in persuading users to use the services of the partnered agency. It was reported that in some strategic alliance projects, there was a tendency for the partnered agencies to retain the cases, instead of making appropriate referrals to FCU or FSU. Indeed, some projects admitted that the interfacing between the IFSC units had been limited.

30. Focus groups with users found that users were still segmented. For them, they came from different service centers rather than from different IFSC units. Many of them even were not aware of the existence of the partnered agencies, not to mention using the integrative service units of IFSC. Admittedly, it was still difficult to develop a common "user identity" on the two separate agencies. In particular, both partnered agencies might still have other types of services operating in the same premises and in the same district. Users might find the identity of the project confusing. Without a common identity, users might be difficult to receive the benefits of integrated services.

31. In operations, some agencies with the FSC might try to evolve themselves to form the three IFSC units. In specific, the FSC would begin to provide brief counseling and supportive groups, as well as developmental and mass programs. As a result, service statistics on users in each IFSC units were the aggregates of the figures from the two partnered agencies. In fact, the programs offered in the FSU and the FRU in the two partnered agencies were apparently unrelated.

32. However, the two partnered agencies could achieve some synergy through exchange of resources and sharing of experiences. For examples, social workers in the community-based service could learn from the counselors of the FSC on how to carry out brief counseling. In return, community-based service social workers could assist the FSC social workers in volunteer management. There might be joint projects on specific working targets, such as new arrivals, single parents, and the unemployed; and on specific issues, such as mental health and parenting. These projects might also involve teams comprising members from the two partnered agencies. So far, these exchanges were perceived to be beneficial to both service units.

33. Formed by putting together two operating agencies and two different services, there are a variety of inherent cultural and operating issues which have to be resolved. It usually takes a rather long process of intensive communication, mutual sharing, and negotiation to resolve the differences in administrative procedures, resource commitment, and agency philosophy, and promote a common operational framework for IFSC. Thus, the formation and adjustment process of the IFSC formed under strategic alliance usually requires a longer time to build up an effective operation. Even under matured operation, more efforts have to be committed by the project to maintain effective communication and sustain the operation. Therefore, an effective strategic alliance IFSC mode would require a high degree of mutual trust between the partnered agencies. They have to make joint decisions based on mutual adjustment, compromise, and consensus.

34. The basically independent governance and operational budget of the strategic alliance would not facilitate the full exchanges of staff and resources. The most common difficulty involved was the physical distance between the partnered centers. Physical distance, often not within 5 to10 minutes of walking distance, means that the interfacing and collaboration between the IFSC units would be difficult. Even inter-unit referrals would have barriers. Social workers in youth services admitted that they had shifted their work focus from young people to become more family and children oriented, and general recreational and social activities for young people had been reduced. But on the whole, the full integration of the program under the IFSC mode was still difficult. The demand on youth and community workers to adopt a "family social worker image" in a strategic alliance mode is not strong, as compared to the merging mode. More often, the community and youth workers of the partnered agencies would perceive that they are only playing a supportive role in the pilot projects.

Interfacing with Community-based Services

35. In a way, the design of IFSC is to turn a conventional FSC into a community-based program. In other words, community-based services would be incorporated into a FSC to form an IFSC. The outcome is that FSCs have become more children centered and community-based, while community-based services have become more family-oriented. Now in IFSC, as compare with conventional FSC, there are more program activities on parenting, family support programs and outreaching services. In essence, individualized counseling is no longer the dominating form of practice in these pilot projects. As compared with other community-based services, IFSCs have a strong clinical component which provides treatment and clinical intervention on family and individual problems. The needs of young people and children are interpreted in the context of the family as a whole. Pilot projects have more services for adults and family, as compared with other traditional children and youth centers. After becoming family-focused, their community linkages have been widened. Referrals can be received from other government departments and services for counseling and supportive services. In particularly, pilot projects now have a more specific, usually smaller service boundaries, and can be more neighborhood-focused in their delivery of services.

36. For those IFSC pilot projects formed by teaming up with youth services (either through merging or strategic alliance), there was a tendency for more child focused programs on parenting and parent-child relationships, and learning and behavioral difficulties of children. On the other hand, some parent users had expressed the concern that they would not like their children to mix with those "deviant" young people attached to youth centers. IFSC would provide a more appropriate place for programs targeting parents and children. After forming partnership to become pilot projects, community-based services would invariably provide less recreational and social activities, such as interest groups and mass programs. There is also a higher awareness and sensitivity to the needs of the vulnerable families and populations.

Summary

37. Based on the UIS and the SIS, there is no clear evidence to indicate that there is a clear difference in terms of the nature of users and programs offered between the different formation modes. Merging, greenfield and self-transformation modes, being operated under the same agency and usually in the same premises, would have more flexibility in enhancing interfacing between the IFSC units. The communication between the three IFSC units in these pilot projects would be more effective. Needless to say, the merging and greenfield modes would facilitate more effective and prompt referrals between IFSC units, whereas there would be invariably administrative and geographical barriers between the two partnered agencies in the strategic alliance mode. The operation of strategic alliance has been also plagued by the lack of unified administrative leadership for more flexible redeployment of staff and use of resources.

38. On the whole, the adoption of the greenfield mode is difficult because there is hardly any new community where a single agency can be allocated to operate all the inter-related social welfare services. Merging and self-transformation would involve fundamental changes in the agency and service structures. It would involve re-shuffling of services between districts and allocation of new resources. Strategic alliance would involve less administrative and program changes to the IFSC providers. But the inherent difficulties in the governance structure would restrict the optimal interfacing between the IFSC units. Yet the strategic alliance mode can enable the formation of IFSC projects with minimum requirement for substantial re-structuring.

39. In strategic alliance and merging mode, the formation of some pilot projects has not involved completely the FSC and the community-based service. Therefore there is sometimes

confusion in reporting service statistics and projecting a clear IFSC project image. Users may also be confused by the provision of two similar services by the same agency within the same service building. In some projects, some social workers have been partially allocated to the IFSC projects. The real impact of IFSC pilot projects may be difficult to stand out. In the future, such an arrangement should not be supported.

4. Pilot Project Performance

Introduction

1. IFSC pilot projects are required to demonstrate their progress and success in meeting the needs of families. It is therefore important to compile and document the measurable outcomes as well as the qualitative views from stakeholders on the performance of these pilot projects.

2. Three quantitative methods: user satisfaction survey, target problem rating, and pre- and post- clinical measurements have been used to indicate the performance and effectiveness of IFSC intervention. For clinical measurements, the data collection process has not yet completed. Here in this Interim Report, only the preliminary results of user satisfaction surveys and target problem rating from April 2002 to December 2002 would be used to illustrate the IFSC outcomes.

General Improvements

3. Most pilot projects claimed that, being more neighborhood-based with a defined target population and equipped with a more dynamic working team, they could be more responsive to community needs. The services provided have become more versatile and non-stigmatized. With the improvement of community relations and networks, more referrals for assistance had been coming from government departments, professionals, community organizations and service agencies. Meanwhile, more proactive outreaching and publicity work had also widened the accessibility of pilot projects to make contact with families in needs and in crisis. First and foremost, pilot projects, with the flexibility provided, could design specific services for specific target populations according to community needs. For examples, some pilot projects might have special focus on the work of single parents, some on new arrivals, and others on older people. One of the projects claimed to have 20% of their caseloads involving single parents.

4. In promoting accessibility, most projects had extended opening hours and holiday services. Renovated and improved facilities included drop-in corners, toy corners or play rooms, reading corners, kitchens, snack shops, internet computers, activity rooms and audio-visual rooms. They served to create a non-stigmatized and user-friendly environment. In promoting the awareness of the services, most projects handed out service leaflets, put up publicity banners and sent out promotion letters. Several projects had established hotline, service website (on-line booking and enrolment system and information), and newsletters on service information.

5. For early identification of needs, many of the pilot projects used mobile enquiry counters and publicity stalls, community need surveys, home-visits, and crisis intervention to identify community and family needs. In launching the pilot projects, many projects involved official kick off ceremonies and presentations in district councils to publicize the projects. Furthermore, mass educational and developmental programs (carnivals, FLE courses and talks, and sports days) provided a more open and non-stigmatized community image. A project emphasized on the training of receptionists to identify needs of users. Some projects had professional social workers in charge of the drop-in centers to identify families and individuals in needs. A project also provided training to teachers on early identification of children with behavioral problems.

6. In establishing community partnership, most projects had established working

relationship with nurseries, MCHCs, hospitals, community organizations, religious groups, and government departments. The referral networks of the pilot projects had been strengthened as more partnered organizations showed more understanding of the work of IFSC. Partnership with volunteers had been emphasized. A project had introduced a computerized data-base system to register and manage volunteers. Volunteers supported through training would be deployed in the delivery of services (peer counselors and tutors), escort services, child minding and publicity (design and distributing leaflets). There was a deliberate attempt to convert users into volunteers. Community partnership also enabled pilot projects to seek additional resources from the community. With the introduction of more community programs, many pilot projects now could seek sponsorship from a variety of funding sources, such as the district council, Parent-education Fund, private corporations, and charity funds.

7. In achieving service integration, projects had set up a number of special work teams and provided a continuum of services to tackle the multi-faceted needs of families. Under the IFSC design, users could receive different levels of service intervention and could also exercise their choice in the use of services.

Case Progress as Assessed by Social Workers

8. According to the UIS, based on the information from 1,580 cases, four-fifths (80%) were assessed by the social workers to show improvements in the main problems worked with at the time of review; 19.5% with no change; and 0.5% with situation deteriorated. In terms of overall case progress, 85.6% of the cases were claimed by the social workers to have progress. Among the terminated and transfer-out cases recorded in the UIS, 83.9% of the cases were considered to have had the care plan completed. Reasons for case closure included: goal achieved (61.6%); unwilling to continue (8%); transferred to FSC (5.3%); situational factors (4.5%); transferred to another FSC unit (3.6%); and unknown or other reasons (13.1%)

9. In sum, according to the assessment of the social workers, the majority of the cases showed improvements. Among the cases closed, a slight majority of them had the goals achieved.

User Satisfaction

Perceived Performance by Users in Focus Groups

10. In the focus groups, most users appreciated the prompt and sincere assistance offered. Their needs had been largely met. They expressed satisfaction that registration to become users had been simplified. For many of them, IFSCs became more accessible. A user remarked that the conventional FSC was just like a clinic. For an IFSC, it seemed that any body could just walk into the center. IFSCs, as compared with the former FSCs, had more space and facilities. They appreciated the provisions of computer stations, drop-in corners, play corners, kitchens, reading rooms, and activity rooms. Instead of having problems to be solved by the centers, some users claimed that they came to the centers to learn and develop themselves. Besides coming to IFSC for specific program activities, they could also look for resources and someone to talk to.

11. They perceived that IFSCs could provide a variety of services, with little stigma attached. They found that the service were more responsive, with shorter waiting time, extended opening hours, responsive telephone replies, and better information provided. Many of them were delighted to have more parent-child programs. Some expressed satisfaction by becoming volunteers in the centers and had participated more actively in program delivery.

12. However, for some users of the former community-based programs which had now become IFSC partners, they expressed the concern that the provisions of recreational and social activities, such as picnics and interest classes had significantly been reduced. For some users living outside the service boundaries of IFSCs, they expressed concern that being district-focused, they could no longer received services from IFSC. For some IFSCs, the location left much to be desired. Users found that some center locations were not conspicuous and convenient. In particular, for those IFSC involving strategic alliance where the distance between the two partnered centers was significant, users had expressed difficulties in using the two centers simultaneously. To facilitate accessibility, the choice of location for future IFSC needs to be very careful.

13. One of the users has a strong view about the need to improve the attitudes of the receptionists. Indeed, the quality and training of receptionist and the reception process is paramount in social services. They are often the first persons of contact between the service and the users.[9] Overall, users were mostly impressed by the friendliness, trustworthiness and sincerity of the social workers, particularly their commitment to confidentiality.

14. All users of IFSC pilot projects in FCU and FSU, including those receiving counseling, group and program services, have to complete the user satisfaction forms. Users are requested to assess performance on the following areas:

a) Overall satisfaction toward the service and intervention
b) Return for service again if necessary
c) Improvements in four competency areas: problem solving capacity, knowledge on community resources, support system, and resolve presenting problems.
d) Satisfaction toward counseling and group services
e) Performance of the social workers in terms of understanding the needs and showing concern.

Perceived Performance in User Satisfaction Surveys

15. Based on the 1,963 forms received, the overall ratings by users on the services were good. The average score for all the items were close to or higher than 4 on the five-point scale (Score 5 represents the best rating). Some 98% of the users also indicated that they would use the service again if they need it. In terms of overall satisfaction, the mean score was 4.2. Even though all the average scores on the assessed performance were around "4", the relatively higher score items were improvements in problem-solving capacity and meeting the tangible needs, whereas the relatively lower score items were improvement in knowledge on community resources and strengthening the supportive system. Among these protective factors, social workers may have to pay more attention to the use of external community resources and supportive system.

16. In terms of approaches, users were slightly more satisfied with counseling service than group services, even though both these scores were above four. The scores may reflect the competencies of social workers in counseling and the preferences of users to individualized approaches.

17. In evaluating the attitudes of the social workers, the scores were extremely high. Users expressed the strong feelings that social workers had showed genuine concern and understanding to their needs. On the whole, users were largely satisfied with the services, and

[9] A. Hall. *The Point of Entry: A Study of Client Perception in the Social Services* (London: Allen and Unwin, 1974).

variations between projects were small.

Target Problem Rating

18. All users receiving counseling services at FCU and FSU are required to fill in the Target Problem Rating Forms. In the Forms, users would assess their improvements in their core problem conditions due to social work intervention. A user would first give a baseline rating before he or she receives the counseling service. Then he or she would make another rating at a six-month interval or when the case is closed. From April 2002 to December 2002, 3,089 cases had completed the baseline ratings, and 1,612 had the second ratings. Some 88.5% of the cases in the second ratings had terminated their services.

19. Perceived main problems include finance, emotion, adjustment to old age, housing, and parenting difficulty. Among them, emotional and mental health problems (28.3%) were more common, followed by parenting and child care issues (27.3%), financial difficulties (20.1%), marital relationship (20%), adjustment in old age (16.6%), and housing (16.5%). There were a small proportion of cases relating to illness, disability, suicide risks, gambling, unwed mothers, care and protection, employment, domestic violence. Again, the problem nature reflected a mix of tangible and intangible needs. Some 50% of the respondents had listed two types of problems and another 14% indicated three major problems. Accordingly, two-thirds of the users recognized that their problems were multi-faceted.

20. In terms of the extent the problems is alleviated, each user is required to rate the severity of the problems periodically. The problem ratings at the time of case intake formed the baseline for comparison. In comparing the baseline with the second ratings, the three listed problems of users showed significant improvements. On a five-point scale, the average differences between the first and second ratings on the three major problems were 2.16, 2.02 and 1.99. According to the perception of the users, their problems had been alleviated after social work intervention.

Funding and Service Agreements

21. FSA includes output standards to be achieved by the pilot projects within a year. In this Interim Report, the calculation is based on the average figures from 9 months. In other words, pilot projects can fall short of some requirements now, but can still be able to fulfill the FSA requirements if there are some changes in the service statistics in the last quarter. In reviewing the performance of pilot projects according to the FSA, all projects had fulfilled the requirements in the number of intensive counseling cases and number of intensive counseling cases closed with agreed plan completed, and the number of new case through outreach or networking efforts. Excluding the greenfield project, the average number of intensive counseling cases was 160% above the average benchmarked level. In fact, all the projects had a higher level of caseloads than the FSA requirements.

22. The majority of the projects, with the exception of 1 to 2 projects, could fulfill the requirements in educational or developmental programs, number of drop-in, and number of volunteers. On the other hand, the majority of projects (11 to 12 projects) were under-achieved in the number of therapeutic groups and the number of new or reactivated cases receiving brief counseling or supportive casework services. About half of the projects failed to attend the required levels in number of mutual help groups, and 40% in supportive groups. About one-third also did not achieve the requirements in the number of educational or developmental groups.

23. Pilot projects, on the whole, can accomplish the requirements on the number of

intensive counseling cases and the number of intensive counseling cases closed with agreed plan completed. But as mentioned in Chapter Two, the use of various types of groups (therapeutic, supportive and mutual help groups) has been fair. The number of new or reactivated cases receiving brief counseling or supportive casework services has been largely under-achieved. In a sense, the figures may reflect the situation that the FSU has not been fully established yet. Moreover, the agreed levels of these performance standards have to be reviewed and adjusted accordingly to benchmark and standardize the performance of the future IFSC.

Summary

24. Taken together, the pilot projects showed remarkable achievements in most areas. They have provided a more accessible service, achieved early identification of needs, promoted community partnership and enhanced service integration. From the perspectives of users, stakeholders and social workers, the IFSC pilot projects represent a more versatile, pro-active, user-friendly, and responsive service, tackling the multi-faceted needs of families. In short, they are echoing the IFSC spirit of "strengthening families: child-centered, family-focused and community-based."

5. IFSC Screening and Assessment Forms

Background

1. The Family Service Review completed in 2001 indicated that the family service centers in Hong Kong used different systems of user needs assessment, and the usefulness of such systems were seldom monitored. This made comparison amongst centers very difficult, and comprehensive service planning impossible. It was recommended that some screening and assessment forms tailored for the IFSC service format be designed to provide a uniform, timely and accurate identification of the principal users' needs for casework services, and channel these users to the appropriate levels and types of intervention. The forms are expected to be culturally appropriate, sensitive, practical and cost-effective in administration and interpretation, and robust in basic psychometric properties like validity, reliability, and stability in factor structure. They should be supported by an effective User and Service Information System so that the massive data generated can facilitate policy and service planning, research on service evaluation and comparison, and eventually service improvement.

2. A Task Group comprising members of the HKU Consultancy Team, and representatives from SWD, HKCSS and the NGOs was formed to develop the necessary forms for use by all IFSC pilot projects. The IFSC Screening Form and the Case Assessment Form were developed. Before the formal operation of the IFSC pilot projects, relevant IFSC staff was trained in the administration, scoring and interpretation of such forms. To avoid probable mistakes in the initial set up period (April and May), data for the months of June to September 2002 (following the maximum period of usable data criteria) and July to September (following a quarterly unit criteria) were used for the current analysis and report. The result patterns of the two sets of data were very consistent.

The Screening Form *(Appendix IV)*

3. The Screening form was referenced on some overseas scales but underwent major revisions by the Task Group. It can be considered as an indigenously developed instrument to screen casework service needs as expressed by the principal service users. It was designed to be a brief and behaviorally-oriented tool to maximize efficiency and accuracy in early assessment. According to focus group reports by the supervisors and the frontline workers, the form was found to be easy to administer, score and interpret. It was considered very helpful by social workers with IT and community work background, and less so by experienced caseworkers who might prefer to assess cases along selected practice theories and models.

4. Demographic characteristics of the respondents: Screening score was available for 1145 cases for the period between June and September, and 878 cases for the period between July and September. Around 80% of the respondents were service users, and the remaining 20% were referrers. 40% of them were not born in Hong Kong. The male:female ratio was roughly 3:8. Most referrers were the identified client's parents or children. Most learnt about the service themselves (43%) or from SWD (15%). Around 75% reported no prior experience of seeking help from social services.

5. Problems reported and services sought: The first three most commonly reported reasons for help seeking were: housing problem, emotional problem, and child discipline problems. The services with the largest demand were counseling (54%), housing arrangements (12%), followed

by day or residential services for the elderly (9%) and financial assistance and unemployment (10%).

6. Validity: Qualitative means and quantitative means were used to establish the validity of the form. Qualitative means included focus group interviews and project case studies. Quantitative means included exploratory and confirmatory factor analyses to assess the factor structure and stability of the form and its subscales. The information should address issues on how well the form facilitated case assignment, how well it matched the results of the workers' clinical judgment, and how consistent was the information collected from the Screening Form and the Case Assessment form.

a) For both periods, most supervisors and frontline workers were comfortable to allocate most of the cases according to the proposed cutoff points.
b) Around 16% of the cases with FCU scores were assigned to FSU. Around 2.4% of the cases with FSU score were assigned to FCU. These occurred when the supervisors predicted more serious problems than those presented at intake (e.g. new arrival cases might have child care and other concerns even when mild problems were reported at intake). Only 1 or 2 users not endorsing any of the shaded items were assigned to FCU. The findings indicate that the supervisors had exercised discretion in case allocation at the rate of 1 amongst 6 cases, and they normally shifted the cases from FCU to FSU.
c) In focus group and individual communications with the supervisors, it was reported that discretion overriding the cutoff-point guide was exercised for the following reasons: to reduce the FCU workload, maximize the FSU functions and to match the teams' expertise and user needs.
d) The most commonly endorsed problems: For both periods, ratings by the respondent or user and the social worker consistently indicated that the most commonly endorsed problems were feeling depressed, financially strained, problems with sleeping, feels stressed and having health problems. The least endorsed items included perceiving unusual voices directed to self, self-mutilation behavior, substance dependence, problem gambling and perceiving figures not accessible to other people, and suspected children abuse. The pattern was consistent with gross pattern of demands for family services
e) User-worker rating discrepancy: for both periods, the users endorsed higher mean total scores than the workers for both principal and non-principal items, and the difference was significant according to paired-sample t-test results. This indicated that the users tended to report greater problem severity than that assessed by the social workers. The high positive correlation and consistent direction of discrepancy suggest the possibility of deleting either the user or the worker ratings to reduce the workload. But some IFSCs colleagues preferred to keep the worker's column and use it as the intake assessment.
f) Exploratory Factor Analysis: it was performed separately for user and worker scores to first explore how many factors can be identified within all items. This was a prior step to the confirmation of the importance of each item in different areas. All items (except items 50 and 51 which were the "others" items) were included in the analysis. The results for users and workers' data for both periods showed that the items could be grouped into 11 factors. All of the factors were identified by the scree plot (a plot of eigenvalues) as having acceptably high eigenvalues (the variance in a set of items explained by a factor).
g) Confirmatory Factor Analysis: it was conducted to confirm if the items loaded adequately on the preconceived dimensions. For the period between July and September, the clusters of user items explained 10.883% to 35.681% of the variance (Factor 4 and Factor 5 respectively); whereas the groups of worker items explained 11.956% to 34.165% of the variance (Factor 4 and Factor 5 respectively). The patterns of results for both user and worker items were identical. For the period between June and September,

the clusters of user items explained 10.851% to 34.687% of the variance (Factor 4 and Factor 1 respectively); whereas the groups of worker items explained 11.506% to 35.344% of the variance (Factor 4 and Factor 1 respectively). The patterns of results for both user and worker items were also identical.

h) Correlation with the Case Assessment Form results: correlations on major dimensions of the forms were performed for the periods June to September (N=841) and July to September (N=584). The positive correlations supported the concurrent validity of both forms. Actual correlations ranged from 0.42 to 0.57, indicating that the forms overlapped in their functions but were not identical in their coverage.

7. Internal reliability: The Alpha and the Split-half approaches were used to test the internal reliability of the form to eliminate problematic items and to reduce the length of the form. The results obtained from both users and workers were consistently similar. For both periods, the Cronbach Alpha for the items grouped along preconceived dimensions ranged from 0.4 to 0.7, and Guttman split half results ranged from 0.2 to 0.8. These indicate an acceptable degree of reliability for most dimensions (except for the "behavior" dimension). Furthermore, the length of some of the dimensions can be reduced without seriously affecting the reliability (except the "behavior' and "interpersonal" dimensions). The results of reliability analyses for both periods suggest the same set of items to be deleted in each area in order to attain the highest reliability.

Other Comments

8. Some supervisors opined that the five dimensions covered in the form have omitted statutory cases and situational, environmental and external aspects that challenged the users (e.g. social support for the aged and minors; housing issues). The two "others" items at the end of the form did not give the reported problems due significance in subsequent analysis.

Case Assessment Form

9. Quantitative and qualitative data were collected and processed to determine the usefulness of the form designed for in-depth exploration of the case needs at individual and familial levels.

10. Validity: The results of confirmatory factor analysis demonstrated that for the period between July and September, the various groupings of items explained 12.13% to 35.05% of the variance (Circumstantial/situational dimension and interpersonal dimension respectively). For the period between June and September, the groupings explained 10 to 31.60% of the variance (Personal/individual and interpersonal respectively).

11. Internal reliability: For both periods, the values of the Cronbach Alphas were sufficiently large (ranging from 0.5 to 0.7) to indicate an acceptable degree of reliability for the respective dimensions. The results of Split-half reliability (ranged from 0.2 to 0.7) also suggested that the length of most of the dimensions could be reduced without seriously affecting the reliability (except the "personal/individual" and "circumstantial/situational" dimensions).

12. Most workers found the form time-consuming in completion, and not cost-effective in providing insightful information on the cases. Most supervisors used it as a quick reference on the case problem, significant issue in the past year and case plan. It was also used to counter check with the presenting problem/Target Problem Rating of users on understanding the case. Some used it for case progress review.

13. Some supervisors suggested removing the form altogether to reduce staff workload.

Recommendations on the Forms

14. A Task Group meeting was held in early April to consider available evidence and views on the forms and to make relevant recommendations on how the forms should be amended and used. The following were recommended:

a) The principle of using identical assessment instruments for the IFSCs should be upheld to facilitate service communication, comparison and planning.
b) The Screening Form should be amended and kept while the Case Assessment Form can be used at the discretion of individual projects. But no more quantitative data collection and analysis exercise will be conducted during the pilot study period.
c) For the Screening Form, only amendments functional to immediate service improvement should be introduced. Other changes (e.g. deletion of items threatening the internal validity of the form) can be postponed until the completion of the pilot study. There should be on-going consultation with the pilot project staff regarding specific improvements on the Screening Form.
d) Starting from 1.5.2003, the Screening Form should be amended as follows:
    i) To reduce unwarranted referrals to FCU service, the number of shaded items should be reduced (refer to Appendix III for the amended forms). The cutoff point should be maintained.
    ii) Items should be added to capture information on the statutory cases and those requesting for residential placements and other tangible services.
    iii) Individual projects can decide if they require their workers to complete the section on worker's ratings.

6. Implications: The Way Forward

Introduction

1. Family is the most fundamental social institution. Its malfunction contributes to most social ills, such as poverty, delinquency, domestic abuse, mental health, and social exclusion. Yet family is also considered as a welfare resource, tackling and preventing social ills. Families are regarded as resources to their own members, to other families, to programs, and to communities. It is the basic intervention unit cutting across problems of elderly, adult, youth, women and children. In terms of problem nature, family-centered intervention can address issues related to employment, education, poverty, mental health, children development, social exclusion, and care of the sick, disabled and aged. There is a resurgence of interests to strengthen families.[10]

2. Changing socio-economic conditions (economic recession and erosion of the family institution) have placed more families and children at risk. Family needs are complicated and critical. Risk factors are interrelated. They cannot be addressed effectively by a single field, service, program and profession in isolation. The Administration and the field have fully endorsed the concept of IFSC. The two-year IFSC pilot projects serve to provide program learning to develop cost-effective ways to introduce and operate IFSCs. This Interim Report, based on initial findings, summarizes the processes of IFSC formation and explores future strategies for the conversion of existing FSCs into IFSCs. After reviewing what is happening to these pilot projects in the first year after their implementation in the foregoing chapters, this Final Chapter examines the implications and explores key issues for the future of IFSC.

3. Initial findings show that IFSCs have provided a more open, user-friendly and integrated services to users. There are more outreaching and pro-active initiatives to facilitate accessibility. Referrals from the community and between different units of IFSC have been effective, with minimum delay. Now IFSCs provide a wide continuum of family and children programs, ranging from clinical case and group intervention, training and educational classes, supportive groups, to family-oriented social activities and child care programs. Indisputably, integrated interventions are more effective than single and segmented interventions. First and foremost, the FSU and FRU have strengthened the preventive work of family services through early identification of and intervention on at risk and vulnerable families. The use of the screening form and assessment tools has provided an objective and standardized instrument to determine the level of risks and the service needs.

4. After a year of implementation – making continuous adjustment and fine-tuning, all IFSC pilot projects have settled down and have developed on-going programs. So far the operation of all the projects has been improving, with the management and program structure becoming more mature and institutionalized. There is no project showing sign of breakdown or mal-function. All in all, IFSC pilot projects, formed through different modes, have been effectively established. Most of the projects have shown enthusiasm and commitments to carry on the IFSCs after the completion of the two-year pilot projects period.

5. Social workers have gradually adjusted to all the relatively time-consuming yet

[10] K. Briar-Lawson. *Family-centered Policies and Practices: International Implications* (New York: Columbia University Press, 2001).

inevitable administrative and evaluative requirements of UIS, service information system, screening and assessment system, and case assessment. Admittedly, shifting from the traditional practice of casework dominated approach to a more diversified and community-based intervention will require active learning and adjustment from social workers – a profound paradigm shift.

6. Through strengthened publicity, widened community network, and proactive service marketing, there may be escalating demands for IFSC services in the short-term. But service statistics show that in the long-term, service demands on IFSC have been stabilized. The flexible and creative redeployment of social workers and the inter-facing between IFSC units have somehow moderated the traditional heavy demands on intensive counseling services. Still some of pilot projects have exceptionally high caseload per social worker.

7. The operation of IFSC also requires social workers to be more versatile and multi-skilled. Therefore, social workers have to be prepared for the increases both in workloads and task demands. Pilot project supervisors reported that some social workers were more ready to support the change, while some others were hesitant in shifting toward the new practice. For examples, youth workers in general welcomed the more family orientation and focus of their intervention. Some former FSC social workers on the one hand supported the more multi-level intervention approach, and on the other hand, would show anxiety to use group and program services. For some community workers, they had expressed reservations over the erosion of their work identity after merging. Nevertheless, social workers, on the whole, have been supporting and adapting to the change.

Effectiveness of IFSC

8. In operation, the FRU serves to reach out to users with the needs, and strengthen the referral networks in the community. FSU can identify families at risk, achieve early intervention to provide family support and practical assistance to strengthen family capacity and resilience to cope with problems, and can also provide complementary services to users receiving clinical intervention. Based on the assessment of needs by the screening form and assessment tools, the FCU serves to provide remedial in-depth clinical intervention. The effectiveness of IFSC hinges on how these units can interface with each other to achieve synergy.

9. In terms of interfacing between the three closely inter-related core IFSC units, most users and social workers have found the arrangements positive. Technically, some users may prefer to stay with the same social worker while they are being referred from one unit to another unit, or receiving services from more than one unit. To be sure, users are bound to show resistance for change after they have established a trustful relationship with the social workers. Inter-unit referrals have been more effective in the greenfield, merging and self-transformation modes than those in the strategic alliances. For those pilot projects which deploy social workers cutting across two to three IFSC units, or use specialized teams covering the three IFSC core functions, the need for inter-unit referrals would be reduced. Referrals between units can be arranged flexibly to address the needs and expectations of the users. Notwithstanding the need for flexibility and creativity, the experiences of these different practice modes have to be further investigated. On the other hand, referrals would be administratively more difficult in the strategic alliances because they involve two separate agencies, especially when the location of the two agencies is far apart.

10. Some users may prefer to have one-to-one individualized counseling, and would be reluctant to participate in groups. However, in the focus groups with users, some users expressed satisfaction with group programs, where they could share feelings, learn skills and

receive support. There may be delays in referring users to use group services because of the lack of cases of similar nature.

11. Overall, the initial findings from IFSC indicate that IFSC is a more user-friendly and effective mode of family service than the conventional FSCs. From the perspective of IFSC providers, practitioners, users and key stakeholders, they all endorse the benefits of IFSC in promoting accessibility, early identification, partnership and integration. Even though it is still too early to have a conclusive documentation on the cost-effectiveness of IFSC, preliminary findings indicate that the achievements of IFSC include:

a) improved accessibility through having better opening hours, rigorous publicity and marketing of services, improved facilities for utilization.
b) improved publicity and the ability to reach out to at risk families and with a wider community network for referrals.
c) provided a package of integrated services, so that users' need can be met within the same center.
d) improved partnerships with community organizations and agencies.
e) improved user participation, particularly in providing volunteering services.
f) the use of screening and assessment tools to determine the risk level and need for intensive counseling has effectively referred users to different and appropriate levels of services. Tools have apparently reduced the caseloads in the FCU. With the exception of one pilot project with still over 100 cases per social worker, around 9 projects have a caseload per social worker at around 50-60 cases. This level of caseloads represents a reduction from those in conventional FSCs. With a smaller caseload, social workers can devote more time to families with the need for clinical intervention. The FSU which provides supportive services, including supportive group, skill training programs and brief counseling can enhance family capacity to handle their own problems.
g) Based on user satisfaction surveys, performance ratings, and focus groups, pilot projects users were largely satisfied with the service offered.

12. Based on these compelling reasons and the feedback from all pilot project operators, it is clear that IFSC should become the dominant form of family service, and all existing FSCs should be converted into IFSCs.[11] In view of the general consensus and readiness, preparation for the re-engineering of the FSC should begin immediately. At this stage, there should be planning on how to proceed with the transformation and re-engineering process, and what are the resources required to support the conversion process. More importantly, given the lack of new resources, where will the necessary resources come from.

Learning from IFSC Pilot Projects with Different Formation Modes

13. Overall, the forming of IFSCs through merging of FSC and community-based services, and greenfield show better use of resources and expertise. Collaboration between the different units through re-deployment of staff can be more effective, and the existing expertise of family caseworkers and group and community workers can be maximized. Yet there is the concern that merging of the units would lead to the erosion of the identity and the original functions of the community-based programs.

[11] The reply from 9 NGO pilot project operators in a survey carried out by the HKCSS showed that they were positive on the formation of IFSCs. They accepted that IFSC can provide a more comprehensive, diversified and integrated services.

14. The greenfield project involves the integration of family, children and youth and elderly services in a completely new settlement area. Services can cut across the traditional boundaries between different services for different age groups. There are no historical factors and traditions that the project has to follow. Staff members have been fully expected to work in an integrative and generic approach. Because there is no foreseeable new community like Tung Chung, the greenfield project is difficult to reduplicate in another community.

15. The self-transformation of existing FSC is possible either in a FSC with sufficient number of social workers to cover all the IFSC functions or by merging of two existing FSCs. The self-transformation mode shows difficulties for traditional caseworkers to diversify their conventional practice immediately to incorporate a more community-oriented approach. Their repertoire of skill and knowledge may be too specialized yet narrow to cover the demands of IFSC. It will take more time for social workers to make the adjustment. Programs of the FSU and FRU offered by self-transformation mode IFSCs show limited variety as compare with other IFSC modes. For examples, their service statistics in drop-in attendance, mobilization of volunteers and outreaching efforts are usually lower than those of the other modes. Furthermore, the location and premises of current FSCs are usually not suitable and adequate for IFSC operation. Self-transformation mode would therefore require the location of new premises, specially designed for IFSC.

16. The strategic alliance mode shows inevitable difficulties in overcoming communication barriers because of differences in physical location, organizational policy and staff loyalty. In the process of forming the IFSC, the partners have to devote enormous effort to facilitate mutual understanding, resolve differences, and build up an acceptable governance system. In some strategic alliances, they would develop the three units in each center themselves, and inter-agency cooperation limits to case referrals and occasional joint programs. Users in focus groups showed little awareness of the existence of the other IFSC partner. Nevertheless, strategic alliance mode can tap the existing expertise and specialization of different agencies and staff resources. In forming the alliance, they can systematically exchange resources and collaborate together to achieve objectives which they cannot do so before. The awareness of interdependency keeps the partners together.

17. For those pilot projects involving partial integration (only part of the FSC or community-based service was involved in the formation of the IFSC pilot project), evidence suggested that the arrangement would create confusion to users, staff members and community partners. In the formation of future IFSCs, integration through merging should be complete, with a clear family-oriented and independent service identity. There should not be in co-existence of two similar and overlapping service units operated by the same agency within the same service boundaries.

Learning from the Partnerships with Community-based Services

18. According to the Report on the Review of Family Services, community-based programs had to handle the individual family and individual problems themselves, or referred them to FSC. Referrals had not been particularly effective, and had not been followed up closely. Strategic alliance and merging between FSC and community-based services would ensure more prompt and responsive referrals. After becoming an integral part of IFSC, the community-based programs in fact show no dramatic transformation in operation. Most of their programs remain the same, but their focus now has been more on family and children problems. The formation of IFSC has increased their awareness of their needs. Being more family and children oriented, there are more family related programs, supported with social workers specialized in handling individual casework and more outreaching and publicity work. Because of the lower priority,

programs for general recreational needs have been reduced accordingly.

19. On the other hand, the formation of IFSC through partnership with community-based services has induced a larger impact on the operation of FSC. The partnership can be a catalyst to facilitate the change amongst the conventional caseworkers to become more district-based and outward-looking, with more outreaching and proactive services. They have to adopt different approaches to complement their conventional individualized casework intervention. In a way, the demand for the cultural change of these social workers has been substantial.

20. Overall, an IFSC is now operating like a typical children and youth center or a mini-community center. The drop-in center, the resource library, the kitchen, membership system, and other social programs have improved the social image of the family service center and facilitated accessibility. On the other hand, community-based services have been better provided with social workers to work on the social, psychological and practical needs of vulnerable families and individuals. In a way, they have become more family-oriented and incorporated the task of family services. The experiences amongst pilot projects on partnership between FSC and community-based services showed that synergy can be achieved. Therefore in the future formation and development of IFSCs, there are rooms for family service to seek more joined-up actions with community-based services. Collaborations can be in the form of strategic alliance, merging, and partnership. Areas of collaboration include the use of premises, staffing, and joint programs.

21. On the whole, children and youth services show more readiness to become family-oriented and be IFSC partner than community center, mainly because children and youth services have already adopted the need to be family-oriented, diversified service approaches, and incorporated individualized counseling service. Community-based programs can effectively perform the function of FRU and FSU, complementary to the service provided by FCU.

22. For community-based services, the functions of the SWD Group Work Unit in each district has been re-focused and re-structured into the FSRC. In addition, the FSNTs have already acted as the outreaching arm of FSCs. As an integral part of the family service, they should be incorporated into IFSCs in the future. NGO community center facilities have a long tradition of providing community building and social welfare services in the districts. They have already built up a strong social and partnership network in the districts. As such, they can be an excellent partner in the formation of IFSCs. Admittedly, community workers have expressed genuine concern whether the mandate of providing advocacy and community building service can be maintained if community centers are merged with FSC to form IFSC. Their perception is that the transformation would reduce the scope of the work of community centers. However, community workers have to understand that the nature of family service has already undergone radical transformation. The partnership between community work and family service can bring a new service mode more responsive to community and family needs.

Interfacing with Other Services

23. With the strengthening of the task of family counseling in other services, such as elderly services, school social work, post-migration projects, single-parent centers, and integrated children and youth services centers (ICYSC), the role and target of IFSC should be clarified. IFSC often received case referrals from these services which are supposed to provide family counseling and support programs themselves. The use of the newly developed screening form and assessment tools may be used to determine the needs for case referrals from these services to IFSCs. Based on the results of the assessment, IFSC would only receive referrals from other community-based services with proven need for intensive counseling. As such, social workers

in these community-based services may have to learn the use of the screening form and assessment tools. Furthermore, the relationship between IFSC and specialized units such as FCPSU, Family Crisis Support Center and Suicide Crisis Intervention Center should be clarified too. The functions of these "crisis centers" are for short-term crisis intervention. When the situation of the users has become stabilized, they can be referred to IFSCs, which is more accessible and with multi-level intervention, for more long-term follow-up treatment and supportive services.

24. With the strengthening of the work with at-risk families in IFSCs, the need for specialized services for specific vulnerable groups, such as new arrivals and single parents may be reduced. IFSC can provide a more accessible support service, with less stigmatized image for these vulnerable targets. In fact service statistics of pilot projects have already indicated that they have developed specialized services for these vulnerable targets.

25. In response to the needs of the community, some form of specializations within IFSCs can be further explored. These specializations can represent certain professional or service expertise covering a wider district, for example within the service boundary of the District Social Welfare Office. Specializations may be in service with statutory requirements, new arrivals, mental health problems, single parent support, and suicide prevention.

Planning for the IFSC Transformation

26. In planning for the IFSC transformation, key issues to be addressed include:

a) How to extend the coverage of IFSC to cover all the population?
b) What are the staff provisions?
c) How IFSC can be introduced?

IFSC Provisions

27. Traditionally, each family service operator can have their own service boundaries, and some FSCs do not have geographical service boundary at all. Historically, both SWD and NGOs family service centers have independent service boundaries. SWD provides two-third of the FSCs which cover all the districts. For large NGOs family service providers, such as Caritas – Hong Kong and Hong Kong Family Welfare Society, they have their own service boundaries covering all the districts in Hong Kong as well. For small NGOs, some have specific geographical boundaries while others can serve the whole Hong Kong population with no specific service boundaries.

28. To avoid the overlap of services, each IFSC should cover a defined geographical district with a defined population. In other words, each IFSC should primarily serve residents residing within a defined service boundary. There are currently a total of 66 FSCs and IFSCs in Hong Kong. In principle, each center should cover a geographical area with a population of around 100,000 people. Since population-based planning for service provisions has been abandoned, no new service provisions should be strictly based on population size. Therefore, IFSC should be flexibly established in each district within a population range of 100,000 to 150,000, in response to the district needs and different demands for family services, as reflected by some selected social indicators. In preparing for the establishment of IFSC in each district, relevant parties, including SWD headquarters, District Social Welfare Office and NGOs should work out the service boundaries, number of IFSC required, and the operators.

29. In each DSWO district, selected SWD IFSC(s) should be responsible for statutory cases

and receiving special case referrals which would most suitably be handled by SWD IFSCs. In the future, with the exception of special statutory duties, a SWD IFSC should be of no difference in operation from a NGO IFSC. Since the premises of most traditional family service centers are no longer suitable for the enhanced functions of IFSC, new premises for IFSCs have to be located.

Staff Provisions

30. Besides a defined geographical boundary, each IFSC should have a minimum staff provision of at least 12-14 social workers and a supervisor. The staffing standard represents a minimum level, reflecting the basic need to have a sufficient number of social workers to carry out the IFSC functions at each level. Furthermore, there should be room for each IFSC to have additional manpower through partnership with other services and in response to specialized district needs. In view of the enhanced functions and responsibilities of IFSCs, an IFSC would need a proposed staffing structure as follows:

a) 1 Supervisor
b) FCU – 4-6 counselors
c) FSU – 6 group workers and brief counselors
d) FRU – 2 community and group workers.

31. Through merging service units together, some pilot projects may have more than one SWO supervisors. The common arrangement is for one supervisor acting as the overall administrator, while the other(s) as the clinical supervisor(s). In the future provision, there is no need to have a clinical supervisor for every IFSC, particularly in a standard IFSC. In the case of an IFSC with enhanced functions, involving the merging of FSC with a community-based service, for example, ICYSC, the supervisory structure should require further examinations. Anyway, IFSC operators can have the discretion to establish its own supervisory structure.

32. Based on the experiences of the pilot projects, it is unrealistic to have a FCU with less than 3 counselors. The workload per social workers in FCU remains high. With the target population set at 100,000 to 150,000, an IFSC should have a minimum of 4 to 6 social workers involved in intensive counseling. For pilot projects serving a population size of over 300,000 people, their number of FCU social workers can be reduced after the reduction of the target population. For those pilot projects serving a smaller population size, they have to increase their staff provision in the FCU. There should be room for the IFSC social workers to develop therapeutic groups.

33. Strengthening families is central to the IFSC mission. Therefore the consolidation of the FSU is vital to the whole IFSC operations. Most pilot projects have devoted more than half to one-third of their manpower to FSU. Therefore the FSU should constitute at least half of the total staff provisions, i.e., 6 social workers. In particular, the development of supportive groups and brief counseling has to be further strengthened in the future IFSC.

34. Amongst some pilot projects, the FSU and FRU are mixed together under the same team of social workers. At this level, an IFSC can strengthen its community referral networks through forming partnerships with other community-based services and community organizations which can then constitute the "FRU" of the IFSC. For outreaching, developmental programs and volunteer development, there should be a minimum of 2 social workers involved.

35. Based on the experiences from the pilot projects, the allocation of staff between FCU and FSU can be flexible and dynamic, according to changing work demands and user

requirements. For example, if there is a sudden surge of cases in need of clinical counseling, more social workers may be deployed from the FSU to take up the cases in the FCU, and vice versa.

Establishing IFSCs

36. To convert existing FSCs into IFSCs and enable each IFSC to cover a defined geographical district, the re-engineering process will be complicated and require wholehearted support from all the sectors involved. During the formation process, it will be inevitable for some service units to be closed down, reshuffled, re-located to other areas, or merged with other units. In principle, IFSC should be formed either by merging of FSCs with community-based programs or merging of FSCs (self-transformation). Community-based services include community centers and ICYSC. First and foremost, merging should be complete and partial integration cannot be accepted. Strategic alliance should be discouraged.

37. The crux of the problem is how to secure resources necessary to support the transformation and re-engineering process. Presumably, there will be no new resources to support the formation. Therefore, resources can only be come from the rationalization of existing services, particularly those community-based services. The Administration should review the availability of resources for supporting the formation of IFSCs. Those services with similar functions to IFSCs can be pooled together to form IFSCs. They may include – FSRC, FSNT, FLE, Family Aide, Single-Parent Centers, Post-Migration Centers, Community Centers and C&Y centers.

38. Traditionally, services are segmented according to funding modes and categorical programs. A more user-centered approach will require a more integrated service mode which put different social workers together. Merging, reallocation, and close down of services may induce a feeling of loss and displacement to social workers in family services and community-based programs. Therefore, future re-structuring has to be carefully planned and executed with extensive consultation. We have to remind ourselves that the point for mergers and re-structuring is not to make people happy, but to advance a more important mission and goals of a new program – the rebirth of a new program with a new mission, rather than the death of a conventional program. There is an old saying that "ships are safe in port, but that is not why they are built."[12]

Remaining Tasks

39. Between now and the publication of the Final Report in April 2004, the remaining tasks of the HKU Consultant Team include:

a) monitoring of the information from UIS, Service Statistics, and FSA to document the performance of pilot projects and different IFSC modes.
b) seeking close consultation with IFSC providers and key stakeholders on the operation of IFSC pilot projects through focus groups to document the effectiveness of IFSC.
c) benchmarking on the outcome and output levels of IFSC.
d) revising and finalizing the screening and assessment tools for IFSC
e) formulating the outcome indicators and user satisfaction form and the family welfare index
f) completing the case assessments study to document the effectiveness of IFSC.

[12] D, McCormick, *Non-profit Mergers: The Power of Successful Partnerships* (Aspen Publishers, 2001).

Looking into the Future

40. The task to re-structure services to promote integration and rationalization can be a monumental endeavor and presents tough challenge for policy makers and family service providers. In undertaking this task, there are innumerable resistance, obstacles and barriers to overcome, structural as well as cultural. There will be challenges to corporate and professional cultures, centering on increasing work demands and the sense of loss and displacement service providers and social workers may feel. Success will depend on how the policy-makers can advance the cause and legitimacy of change. As McCormick remarked on the experiences of achieving mergers between NGOs:[13]

> *To succeed, mergers must be carefully planned and professionally executed. The case for change must be made forcefully, and the needs and interests of all parties taken into account through out the process. It is simply not possible to satisfy everyone, but reasonable people will be persuaded by reasonable arguments. Throughout the process, it is important to remember that the point of mergers is not to make people happy, but to advance the mission and the goals of an organization. Ultimately, this is the yardstick by which organizational change must be measured.*

[13] D, McCormick, *Non-profit Mergers: The Power of Successful Partnerships* (Aspen Publishers, 2001).

Appendix I: Consultant Team Members

Team Leader	Dr. Joe Leung
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	Dr. Debbie Lam
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	Dr. Daniel Wong
Project Coordinator	Miss May Chung
Research Assistant	Mr. Wong Wing Leung
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Appendix II: Family Services Review Recommendations

Objective 1:
To identify needs of families and prioritize target groups for provision of services, and recommend appropriate level of intervention corresponding to the levels of needs of service users.

Recommendation 1
The Consultant Team recommends that family service programmes remain focused on providing remedial and protective services to families in crisis, involving the risk of human life, domestic violence and child abuse.

Recommendation 2
The Consultant Team recommends that family service programmes be more focused to early identification and early intervention, targeting those at-risk families involving various risk factors.

Recommendation 3
The Consultant Team recommends that family service programmes, in partnership with other family-oriented programmes, develop specialized and cost-effective service for families at risk, and/or in crisis.

Objective 2:
To review the roles and functions, mode of service delivery, service standards and staffing structure of these services and the effectiveness in meeting the changing needs of the community.

Recommendation 4
The Consultant Team recommends that FSCs adopt a more proactive approach, diversify its helping strategy, initiate preventive and early identification approaches, and develop strategic alliances with key partners.

Recommendation 5
With the support of an effective user and service information system, collaboration between FSCs and other family-oriented welfare programmes, namely MSS, SSW service, probation service, and specialized units will be more efficient. A case manager in charge of the planning, implementing, monitoring and evaluation of the cases is recommended.

Recommendation 6
The Consultant Team recommends that FLE should become an integral part of the programme team of FSC, IT, C&YC, or FARC. FLE programmes should be closely integrated with other approaches, such as brief counselling, guidance and support groups. More attention should be directed towards the needs of vulnerable families. FLE programmes and activities should be provided in all family-oriented programmes whether or not they have FLE provisions.

Recommendation 7
The Consultant Team recommends that FLERC be expanded to develop more centralized evidence-based programme packages for the use of all front-line social workers and other professionals. FLERC should continue to coordinate territory-wide thematic FLE publicity.

Recommendation 8
The Consultant Team recommends that alternative modes of delivering the function of SSWP be explored in the face of the changing functions of the FSC.

Recommendation 9
The Consultant Team recommends that the family aide service be an integral part of a FSC. In supporting family service programmes, targeting at-risk families, the responsibility of FA can be extended beyond in-home training to include group training in practical skills on parenting and home management.

Recommendation 10
The Consultant Team recommends that the function of FARC in providing family support needs to be further strengthened. Its partnership with FSC should be formalized and institutionalized. More NGO community centres should be encouraged to establish FARCs.

Recommendation 11
The Consultant Team recommends the termination of the FCDRC while the centre should focus on its caregiver support function.

Recommendation 12
The Consultant Team recommends that all FSCs, should specifically target vulnerable families. There is no need for Family Education to stand alone as a specialized project. In the future, resources for FE should be absorbed into the re-structured FSCs. PMC and SPC, however, need to be reviewed at the end of the contract to see whether they should be integrated into the IFSC or to operate as specialized units.

Objective 3:
To propose whether changes to the current mode of service delivery are necessary and to develop practical, cost-effective, coordinated and integrated service delivery mode and approach with detailed options and recommendations.

Recommendation 13
The Consultant Team recommends six modes for FSCs and other family-related welfare programmes to formulate their own service development strategy in line with district needs and plans to evolve towards the ideal model.

Recommendation 14
The Consultant Team recommends that the effectiveness of the ideal model of an integrated family service centre should be verified through pilot projects.

Recommendation 15
The Consultant Team recommends the establishment of the Working Group on Implementation of Family Services Review to oversee the implementation of the recommendations of the Consultancy Study, which includes the steering of the pilot projects.

Recommendation 16
The Consultant Team recommends that through coordination and consultation between family service providers by DSWO at the district level, the SWD and NGO service units could initiate to form IFSCs. The proposed projects should be put forward by DSWO to the Working Group on Implementation of the Family Services Review for review and selection. The pilot projects should be located in areas of high social need.

Recommendation 17
The Consultant Team recommends the SWD commission a research team to evaluate the effectiveness of the integrated FSC through pilot projects.

Objective 4:
To review the scope of service, geographical locations, and planning ratios for these services, and propose new planning ratios for new integrated facilities where appropriate.

Recommendation 18
The Consultant Team recommends that in the future, service planning should be based on objective indicators of community needs.

Objective 5:
To examine the need for developing assessment tools in the context of Hong Kong situation, and recommend on appropriate tools to be developed.

Recommendation 19
The Consultant Team recommends that a task group on assessment and its operationalization, through the pilot project be established, comprising representatives from the SWD, NGOs and academics to follow up the work on the development of the assessment system and relevant tools.

Objective 6:
To develop outcome measures for family services.

Recommendation 20
The Consultant Team recommends that a task group on outcome measures be established, comprising representatives from SWD, NGOs and academics to work on the outcome indicators, with special reference to FSA in pilot projects.

Recommendation 21
The Consultant Team recommends that a standardized user satisfaction survey system be implemented in all FSCs, and a centralized mechanism be installed to compile and review the data regularly.

Objective 7:
To develop a long-term strategy and map out future direction for providing family services.

Recommendation 22
The Consultant Team recommends that the direction of family services is "Strengthening Families: Child-centred, Family-focused & Community-based."

Recommendation 23
The Consultant Team recommends that the Government strengthen its leadership and

planning mechanisms at both the central and district levels.

Objective 8:
To draw up implementation plans for the final recommendations.

Recommendation 24
The Consultant Team recommends the implementation schedules as described in Chapter Seven.

Other Recommendations

Recommendation 25
The Consultant Team recommends that the Government develop a user and service information system, facilitating programme improvements, the development of service partnerships and case management, as well as learning at the district and central levels.

Recommendation 26
The Consultant Team notes the need for a more vigorous and centralized marketing strategies on family services, providing sound and publicly accessible information to citizen and service users about their options and rights.

Recommendation 27
The Consultant Team recommends that training needs for the new modes of family service delivery should be identified and training support be provided. Opportunities for sharing of good practices should be promoted.

Appendix III: Funding and Service Agreement-Statistical Information System

SIS Form

SWD Form B26/T/AIFSC
May 2002
DSWO : Southern District

Integrated Family Service Centre (IFSC)

(to be submitted in duplicate to A(F)2 of Family and Child Welfare Branch, one copy each to Service Performance Section and concerned DSWO on or before 10th of each month)

Name of Unit : _____

Month/Year : _____

A. **Statistics on Output Standards** (Output Standards 13 – 18 are applicable only to those IFSCs operating the specific services.)

Output Standard 1 : Number of intensive counselling cases (Note 1)

(Agreed Level : _____monthly average)

OS1 = (v) of the following table in a year ÷ 12

i. No. of cases b/f from last month	
ii. No. of new/transferred in cases	
iii. No. of reactivated cases	
iv. No. of cases closed/transferred out	
v. No. of cases at the end of the month (i.e. i + ii + iii - iv)	

Output Standard 2 : Number of intensive counselling cases closed with agreed plan completed

(Agreed Level : ____ per year)

OS 2 = of the following table in a year

No. of cases closed with agreed plan completed	

Note 1 : **Intensive counselling cases** refer to cases assessed by screening form to be in need of intensive counselling.

Output Standard 3 : Number of therapeutic groups (Note 2)

(Agreed Level : _____ per year)

OS 3 = (i) of the following table in a year

i. No. of groups completed	
ii No. of participants in the groups	
iii No. of new participants	

Output Standard 4: Number of new and reactivated cases receiving brief counselling/ supportive casework services (note 3)

(Agreed Level: _____per year)

OS4 = Σ (iv) of the following table in a year

	Brief Counselling	Supportive Casework	Total
i No. of cases b/f from last month			
ii No. of new cases			
iii No. of reactivated cases			
iv No. of new and reactivated cases (i.e. ii + iii)			
v No. of closed/transferred out cases			
vi No. of cases at the end of the month (i.e. i + iv - v)			

Output Standard 5 : Number of support groups (Note 4)

(Agreed Level : _____ per year)

OS 5 = (i) of the following table in a year

i. No. of groups completed	
ii. No. of participants in the groups	
iii. No. of new participants	

Note 2 : **Therapeutic groups** refer to groups which are formed to facilitate intensive group counselling. Each group should preferably have 6 or more members and at least 4 sessions.

Note 3 : **Cases receiving brief counselling/supportive casework services** refer to services provided to individuals and families assessed by screening form to be in need of brief counselling or casework services. Brief counselling cases should normally be completed in less than 8 sessions (excludes mere information giving service) in 4 months. Supportive casework services refer to services rendered to individuals that require longer-term casework care. New cases include transferred in cases.

Note 4 : **Support groups** refer to groups which are formed with the purpose of providing emotional support and sharing of life experience by members. Each group should preferably have 6 or more members and at least 4 sessions. Target members are vulnerable/at-risk individuals and families.

Output Standard 6 : Number of mutual-help groups (Note 5)

(Agreed Level : _____ per year)

OS 6 = of the following table in a year

No. of new groups formed	

Output Standard 7 : Number of educational/developmental groups (Note 6)

(Agreed Level : _____ per year)

OS 7 = (i) of the following table in a year

i. No. of groups completed	
ii. No. of participants in the groups	
iii. No. of new participants	

Output Standard 8 : Number of educational/developmental programmes (Note 7)

(Agreed Level : _____ per year)

OS 8 = (i) of the following table in a year

i. No. of programmes completed	
ii. No. of participants in the programmes	

Note 5 : **Mutual-help groups** refer to groups which are formed with the purpose of providing mutual aid and support among members to cope with daily needs/problems. Members have high degree of independence and the need for worker's intervention is limited.

Note 6 : **Educational/developmental groups** refer to groups which are formed with purposeful intervention to enhance members' personal growth, social skills and healthy relationship with family members, peers, colleagues, etc. Each group should preferably have 6 or more members and at least 4 sessions. Target participants are the general public.

Note 7 : **Educational/developmental programmes** refer to programmes with educational elements to enhance participants' personal growth, social skills and healthy relationship with family members, peers and colleagues, etc. Target participants are the general public.

Output Standard 9 : Number of drop-in (Note 8)

(Agreed Level : _____per year)

OS 9 = of the following table in a year

No. of drop-in	

Output Standard 10 : Number of volunteers

(Agreed Level : ____ monthly average)

OS 10 = (iv) of the following table in a year ÷ 12

i. No. of volunteers b/f. from last month	
ii. No. of volunteers newly registered	
iii. No. of volunteers de-registered	
iv. No. of volunteers registered at the end of the month (i.e. i + ii – iii)	
v. No. of service users newly registered as volunteers	

Output Standard 11 : Number of volunteer hours performed

(Agreed Level : _____ per year)

OS 11 = of the following table in a year

No. of volunteer hours performed	

Output Standard 12 : Number of new cases (individuals/families) engaged in centre services (Note 9) through outreaching and networking efforts

(Agreed Level : ____ per year)

OS 12 = of the following table in a year

No. of new cases engaged in centre services	

Note 8 : **Drop-in** : excludes service users of groups/programmes/counselling services

Note 9 : **Centre services** include all services in the centre except drop-in and enquiries.

Output Standard 13 : Number of cases with training programmes conducted by Family Aide

(Agreed Level : ____ per year;

OS 13 = (i) + Σ (iv) of the following table in a year

i.	No. of cases as at 1st April	(enter once in April only)
ii.	No. of new cases	
iii.	No. of reactivated cases	
Iv	No. of new and reactivated cases (i.e. ii + iii)	

Output Standard 14 : Number of cases with training programmes completed as planned by Family Aide

(Agreed Level : ____ per year)

OS 14 = of the following table in a year

No. of cases with training programme completed	

Output Standard 15 : Number of training hours of Family Aide

(Agreed Level : ____ per year)

OS 15 = (iii) of the following table in a year

i. No. of hours spent by FA for individual training programmes	
ii. No. of hours spent by FA for group training programmes	
iii. Total no. of training hours (i.e. i. + ii)	

Output Standard 16 : Number of new and renewed members

(Agreed Level : ____ per year)

OS 16 = of the following table in a year

	Aged 14 or below(Children)		Aged 15 to 24 (Youth)		Aged 25 to 59 (Adult)		Aged 60 & above (Elderly)		Total No. of members	
Sex / Members	M	F	M	F	M	F	M	F	M	F
No. of new and renewed members										

Output Standard 17 : Number of children enrolled in After School Care Programme

(Agreed Level : _____ monthly average)

OS17 = of the following table in a year ÷ 12

No. of children enrolled in After School Care Programme	

Output Standard 18 : Number of attendance in occasional child care service

(Agreed Level : _____ per year)

OS 18 = of the following table in a year

No. of attendance in occasional child care service in the month	

B. Statistics on Outcome Standards

(For outcome standards 1-4, please compile information from users satisfaction survey. For outcome standard 5, please compile information from target problem rating)

Outcome Standard 1: Service users indicating satisfaction after receiving IFSC service

(Agreed Level : %)

OS 1 = (iii) of the following table in a year ÷ 12

i. No. of users indicating satisfaction after receiving IFSC service	
ii. No. of terminated cases	
iii. Percentage of users indicating satisfaction after receiving IFSC service (i.e. i/ii x 100%)	

Outcome Standard 2 : Service users with enhanced problem solving capacity

(Agreed Level : %)

OS 2 = (iii) of the following table in a year ÷ 12

i. No. of users with enhanced problem solving capacity	

ii. No. of terminated cases – no. of returns indicating "NA" in the user satisfaction survey	
iii. Percentage of users with enhanced problem solving capacity (i.e. i/ii x100%)	

Outcome Standard 3 : Service users with enhanced knowledge of community resources

(Agreed level : %)

OS 3 = (iii) of the following table in a year ÷ 12

i. No. of users with enhanced knowledge of community resources	
ii. No. of terminated cases – no. of returns indicating "NA" in the user satisfaction survey	
iii. Percentage of users with enhanced knowledge of community resources (i.e. i/ii x100%)	

Outcome Standard 4 : Service users with enhanced support network

(Agreed Level: %)

OS 4 = (iii) of the following table in a year ÷ 12

i. No. of users with enhanced support network	
ii. No. of terminated cases – no. of returns indicating "NA" in the user satisfaction survey	
iii. Percentage of users with enhanced support network (i.e. i/ii x 100%)	

Outcome Standard 5 : Service users with perceived improvement in the main problem

(Agreed Level : %)

OS 5 = (iii) of the following table in a year ÷ 12

i. No. of users with perceived improvement in the main problem	
ii. No. of terminated cases	
iii. Percentage of users with perceived improvement (i.e. i/ii x100%)	

C. Supplementary Information: Number of enquiries/information giving

i. No. of enquiries/information giving (on site)	
ii. No. of enquiries/information giving (by phone/hotline)	
iii. Total no. of enquiries/information giving (i.e. i + ii)	

D. Staff Statistics (as at end of period)

(Please provide full particulars when you are completing this form for the first month of the financial year, and whenever there are staff changes. If staff statistics remain the same as the preceding month, please put a ✓ in this box ☐ .

Service Unit	Rank	Post	Establishment	Strength	Vacancy	Remarks
			Total			

Prepared by : _____

Name : _____

Post : _____

Tel. No. : _____

Date : _____

Appendix IV: Screening Form and Assessment Tools

服務申請者初步評估表 (IFSC Case Screening Form)[14]

中心:_____
服務使用者編號:_____

請圈出你認爲適當的選擇，及在空白欄上填寫有關資料。

第一部份 A: 當事人 / 轉介者

1. 1 當事人 → 請由第 8 題開始作答

   2 轉介者 → 請繼續回答以下問題

第二部份 B: 轉介者的資料

2. 姓名：_____ **3. 性別：** 1 **男** 2 **女** **4. 年齡：**_____

5. 聯絡電話：_____ **6. 地址：**_____

7. 與當事人關係：_____

第三部份: 求助原因

8. UIS 編碼 [15] ( ) _____

第四部份: 當事人資料

9. 姓名：_____ **10. 性別：** 1 **男** 2 **女** **11. 出生日期：**_____

12. 婚姻狀況： 1 **未婚** 2 **同居** 3 **已婚** 4 **分居** 5 **離婚** 6 **喪偶**

13. 居港年期： 1 **自出世** 2 **自**_____**年** **14. 地址：**_____

_____ **15. 聯絡電話：**_____

16.職業：_____

17. 如何得知此服務 / 轉介來源? UIS 編碼 ( )

18. 使用社會服務的記錄

   1 **沒有**

   2 **曾經有： (請註明中心、服務及何時)**_____

   3 **現仍有接受服務: (請註明中心、服務)**_____

19. 希望在本中心得到甚麼服務: UIS 編碼 ( )_____

---

[14] *表格需由專業社工填寫*

[15] *參照 UIS 編碼*

第五部份：行爲量表 [16]

在過往**三個月**內，你 / 當事人曾否.....

#	項目描述	A 當事人					B 社工 (有需要時填) (當事人/轉介者) [17]					註明 (舉例)
	註：以下有陰影的部份爲重點問題，請圈出認爲適當的嚴重程度	沒有	有		不知道	不適用	沒有	有		不知道	不適用	
			不嚴重	嚴重				不嚴重	嚴重			
	生理方面											
20.	睡眠有困難?	0	1	2	8	9	0	1	2	8	9	
21.	胃口出現問題?	0	1	2	8	9	0	1	2	8	9	
22.	健康出現問題?	0	1	2	8	9	0	1	2	8	9	
23.	記憶力方面出現問題?	0	1	2	8	9	0	1	2	8	9	
	行爲習慣方面											
24.	出現飲酒過量問題?	0	1	2	8	9	0	1	2	8	9	
25.	出現藥物、毒品、酒精飲品依賴等問題?	0	1	2	8	9	0	1	2	8	9	
26.	出現沉迷賭博問題?	0	1	2	8	9	0	1	2	8	9	
27.	工作/學習注意力出現問題?	0	1	2	8	9	0	1	2	8	9	
	精神方面											
28.	有奇怪或令人困擾的思想?	0	1	2	8	9	0	1	2	8	9	
29.	聽到奇怪的聲音對你說話?	0	1	2	8	9	0	1	2	8	9	
30.	見到別人看不見的奇怪影像?	0	1	2	8	9	0	1	2	8	9	
31.	覺得有人傷害你?	0	1	2	8	9	0	1	2	8	9	
32.	感到抑鬱以致影響日常生活?	0	1	2	8	9	0	1	2	8	9	
33.	感到恐懼、焦慮以致影響日常生活?	0	1	2	8	9	0	1	2	8	9	
34.	想襲擊其他人?	0	1	2	8	9	0	1	2	8	9	
35.	有結束自己的生命念頭?	0	1	2	8	9	0	1	2	8	9	
36.	曾有自毀行爲 (如"界"手, 割脈)	0	1	2	8	9	0	1	2	8	9	
	人際關係方面											
37.	經歷感情/婚姻關係變化	0	1	2	8	9	0	1	2	8	9	
38.	經歷感情/婚姻暴力/虐待事件	0	1	2	8	9	0	1	2	8	9	
39.	經歷感情/婚姻受第三者困擾	0	1	2	8	9	0	1	2	8	9	
40	覺得子女難以管教	0	1	2	8	9	0	1	2	8	9	
41	覺得子女被虐待	0	1	2	8	9	0	1	2	8	9	
42	與父母相處出現問題	0	1	2	8	9	0	1	2	8	9	
43	與朋友/同事相處有問題	0	1	2	8	9	0	1	2	8	9	
44	與兄弟姊妹相處出現問題	0	1	2	8	9	0	1	2	8	9	
45	姻親相處有問題	0	1	2	8	9	0	1	2	8	9	
46	經歷親人/朋友去世與哀傷	0	1	2	8	9	0	1	2	8	9	

---

[16]填表社工請向申請者作如下解說：「填答本問卷，爲了解閣下過往三個月可能面對的各方面問題。請盡量小心並準確地回答每個項目。答案並沒有對錯之分，你對現況的主觀感覺才最重要。」

[17] 刪去不適用者

#	項目描述	A 當事人					B 社工 (有需要時填) (當事人/轉介者)					註明 (舉例)
註：以下有陰影的部份爲重點問題		沒有	有		不知道	不適用	沒有	有		不知道	不適用	
			不嚴重	嚴重				不嚴重	嚴重			
	工作/學業方面/其他											
47	學業上有困難	0	1	2	8	9	0	1	2	8	9	
48	工作不穩定	0	1	2	8	9	0	1	2	8	9	
49	有經濟困難/壓力	0	1	2	8	9	0	1	2	8	9	
50	缺乏照顧/支援	0	1	2	8	9	0	1	2	8	9	
51	其他	0	1	2	8	9	0	1	2	8	9	
		52	*53*	*54*	*55*	*56*	*57*	*58*	*59*	*60*	*61*	
	總分數[18]： (無須加"不知道"及 "不適用"的分數)	*62.重點問題：____分* *63.非重點問題：____分*					*64.重點問題：____分* *65.非重點問題：____分*					

第六部份：初步評估社工之建議及行動

66. 申請者是否願意接受服務?
    1 願意　　2 不願意
67. 如不願意，跟進工作是：_____
68. 建議服務：
    1 **FRU**　　2 **FSU(個案)**　　3 **FSU (其他)**　　4 **FCU**
    5 其他服務(如醫生、法律、心理服務)_____　　6 諮詢，不需跟進
69. 備註(如組名、課程名、或其他註釋)：_____
0. 已採取的行動：_____

填表社工：_____　　評估日期：_____

第七部份：主任批註

中心主任：_____　　批閱日期：_____

請提供以下服務：

1 **FRU** _____

2 **FSU (個案)**_____

3 **FSU (其他)**_____

4 **FCU** _____

5 其他服務(如醫生、法律、心理服務)_____

6 諮詢，不需跟進

個案委派給：_____

[18] *Criteria for consideration on service recommendation:*
If user's scores and worker's scores are different, take the higher scores
0-4 → FRU /FSU (group)
5-12 → FSU (brief counselling/supportive casework)
13 and above or circling of any shaded items → FCU

個案問題評估表[19] (IFSC Case Assessment Form) *(有需要時填)*

User Reference No.:_____ Assessment Worker:_____ Date of Form Completion:_____	Supervisor's Signature:_____ Date:_____ Supervisor's Remarks:_____

第一部份： 服務使用者資料

1. 服務使用者姓名：_____

第二部份：個案問題評估(Problem Rating Scale).

Code[20]	1. 個人方面	請註明問題	請按當事人最受困擾程度圈出評分，最少困擾爲"0"，最受困擾爲"5"， 不適用爲 "9"						
101	情緒問題		0	1	2	3	4	5	9
102	行爲問題		0	1	2	3	4	5	9
103	精神健康/懷疑精神病		0	1	2	3	4	5	9
104	精神病		0	1	2	3	4	5	9
105	自殺傾向/行爲		0	1	2	3	4	5	9
106	性格問題		0	1	2	3	4	5	9
107	上癮(酒/毒癮/賭博...)		0	1	2	3	4	5	9
108	身體疾病		0	1	2	3	4	5	9
109	適應問題(聾)		0	1	2	3	4	5	9
110	適應問題(盲)		0	1	2	3	4	5	9
111	適應問題(多重身體殘障)		0	1	2	3	4	5	9
112	適應問題(其他身體殘障)		0	1	2	3	4	5	9
113	適應問題(智障)		0	1	2	3	4	5	9
114	適應問題(學習困難)		0	1	2	3	4	5	9
115	適應問題(多重缺憾)		0	1	2	3	4	5	9
116	老年適應		0	1	2	3	4	5	9
117	其他人生階段適應		0	1	2	3	4	5	9
118	性別角色		0	1	2	3	4	5	9
119	未婚懷孕		0	1	2	3	4	5	9
120	學習		0	1	2	3	4	5	9
121	職業		0	1	2	3	4	5	9
122	失蹤少女/男孩		0	1	2	3	4	5	9
199	其他		0	1	2	3	4	5	9

[19]評估問題時，要顧及使用者個人、家庭及環境等各個層面；此外，亦要適當地作出調整，以配合使用者的理解能力、反應程度及情緒狀態。應採用並列舉各種評估問題的方法，包括將問題量化、深入探討問題，以及由直接或間接來源獲取消息等。 (評估對象有甚麼問題? 有甚麼觸發因素，促使使用者在現階段尋求協助)? 會否對自己、他人或財產構成危機？問題的急切性及嚴重性如何？使用者如何詮釋問題？社工認爲這些詮釋有沒有問題？使用者曾經嘗試甚麼方法去處理問題？結果如何？使用者認爲問題的出現與自己有甚麼關係？使用者對家庭服務社工有何期望？使用者認爲自己及家庭是否具備一些強項或資源？最接近使用者的社會環境中，有沒有一些優勢。資源或威脅？)

[20] 參照 UIS 編碼

2. 家庭方面 A. 夫婦		請註明問題	請按當事人最受困擾程度圈出評分，最少困擾爲 "0"，最受困擾爲"5"，不適用爲 "9"						
201	分居及離婚		0	1	2	3	4	5	9
202	婚外情		0	1	2	3	4	5	9
203	關係問題		0	1	2	3	4	5	9
204	管教困難		0	1	2	3	4	5	9
205	分開教養(離異夫婦)		0	1	2	3	4	5	9
206	兩代關係		0	1	2	3	4	5	9
207	孩子照顧安排		0	1	2	3	4	5	9
C. 其他家庭關係									
208	父母與成年子女		0	1	2	3	4	5	9
209	兄弟姊妹		0	1	2	3	4	5	9
210	姻親		0	1	2	3	4	5	9
211	孩子紛爭		0	1	2	3	4	5	9
212	虐兒		0	1	2	3	4	5	9
213	配偶虐待		0	1	2	3	4	5	9
214	老年虐待		0	1	2	3	4	5	9
215	其他家庭暴力		0	1	2	3	4	5	9
299	其他		0	1	2	3	4	5	9
3. 人際關係									
301	拍拖與戀愛(包括同性與異性戀)		0	1	2	3	4	5	9
302	同事關係		0	1	2	3	4	5	9
303	朋輩關係		0	1	2	3	4	5	9
304	與同屋/鄰居關係		0	1	2	3	4	5	9
399	其他人際關係		0	1	2	3	4	5	9
4. 處境 / 情況									
401	經濟困難		0	1	2	3	4	5	9
402	失業/就業不足		0	1	2	3	4	5	9
403	房屋		0	1	2	3	4	5	9
404	親人去世/疾病		0	1	2	3	4	5	9
405	創傷		0	1	2	3	4	5	9
406	遺棄		0	1	2	3	4	5	9
407	精神健康條例(MHO)監管		0	1	2	3	4	5	9
408	精神健康條例管轄資產		0	1	2	3	4	5	9
409	僱員賠償		0	1	2	3	4	5	9
410	綜援金受助人的受委人		0	1	2	3	4	5	9
411	被遺棄孩子		0	1	2	3	4	5	9
412	社會福利署監管		0	1	2	3	4	5	9
499	其他處境 / 情況困難		0	1	2	3	4	5	9
		各項總數：							

個案問題評估表[19] (IFSC Case Assessment Form) *(有需要時填)*

User Reference No.:_____ Assessment Worker:_____ Date of Form Completion:_____	Supervisor's Signature:_____ Date:_____ Supervisor's Remarks:_____

第一部份： 服務使用者資料

1. 服務使用者姓名：_____

第二部份：個案問題評估(**Problem Rating Scale**).

Code[20]	1. 個人方面	請註明問題	請按當事人最受困擾程度圈出評分，最少困擾爲"0"，最受困擾爲"5"， 不適用爲 "9"						
101	情緒問題		0	1	2	3	4	5	9
102	行爲問題		0	1	2	3	4	5	9
103	精神健康/懷疑精神病		0	1	2	3	4	5	9
104	精神病		0	1	2	3	4	5	9
105	自殺傾向/行爲		0	1	2	3	4	5	9
106	性格問題		0	1	2	3	4	5	9
107	上癮(酒/毒癮/賭博...)		0	1	2	3	4	5	9
108	身體疾病		0	1	2	3	4	5	9
109	適應問題(聾)		0	1	2	3	4	5	9
110	適應問題(盲)		0	1	2	3	4	5	9
111	適應問題(多重身體殘障)		0	1	2	3	4	5	9
112	適應問題(其他身體殘障)		0	1	2	3	4	5	9
113	適應問題(智障)		0	1	2	3	4	5	9
114	適應問題(學習困難)		0	1	2	3	4	5	9
115	適應問題(多重缺憾)		0	1	2	3	4	5	9
116	老年適應		0	1	2	3	4	5	9
117	其他人生階段適應		0	1	2	3	4	5	9
118	性別角色		0	1	2	3	4	5	9
119	未婚懷孕		0	1	2	3	4	5	9
120	學習		0	1	2	3	4	5	9
121	職業		0	1	2	3	4	5	9
122	失蹤少女/男孩		0	1	2	3	4	5	9
199	其他		0	1	2	3	4	5	9

[19]評估問題時，要顧及使用者個人、家庭及環境等各個層面；此外，亦要適當地作出調整，以配合使用者的理解能力、反應程度及情緒狀態。應採用並列舉各種評估問題的方法，包括將問題量化、深入探討問題，以及由直接或間接來源獲取消息等。 (評估對象有甚麼問題? 有甚麼觸發因素，促使使用者在現階段尋求協助)? 會否對自己、他人或財產構成危機？問題的急切性及嚴重性如何？使用者如何詮釋問題？社工認爲這些詮釋有沒有問題？使用者曾經嘗試甚麼方法去處理問題？結果如何？使用者認爲問題的出現與自己有甚麼關係？使用者對家庭服務社工有何期望？使用者認爲自己及家庭是否具備一些強項或資源？最接近使用者的社會環境中，有沒有一些優勢。資源或威脅？)

[20] 參照 UIS 編碼

第三部份：一年內生活事故[21]

過往一年之內，服務使用者經歷重要事件 (請圈出合適項目)

1 主要支援系統有問題 _____

2 社會環境出現問題 _____

3 學業問題 _____

4 工作問題 _____

5 住屋問題 _____

6 經濟問題 _____

7 難以獲得醫療服務 _____

8 涉及法律訴訟 _____

9 其他心理與環境的問題 _____

第四部份：其他評估 （請列明）

_____

_____

第五部份：支援系統

主要社會支援 (可選多於一項及加上註明):

1 配偶_____

2 子女_____

3 親戚_____

4 朋友_____

5 同事_____

6 專業人士_____

7 其他 (請註明)_____

第六部份：個案家庭圖

第七部份：結論

1. 主要問題：UIS 編碼 (　　)_____

2. 次要問題：UIS 編碼(　　)_____

3. 要求得到服務：UIS 編碼 (　　)_____

4. 跟進服務計劃：

_____

_____

[21] American Psychiatric Association (4th edition). (2000). Diagnostic and Statistical Manual of Mental Disorders IV-TR. Washington D.C.: American Psychiatric Association.

問題評量表 (IFSC Target Problem Rating Form)

服務使用者姓名 ：_____

服務使用者編號 ：_____

*請刪去不適用者	填表日期 _____	*第一次 / 檔案終結 檢討日期 _____	*第二次 / 檔案終結 檢討日期 _____	*第三次 / 檔案終結 檢討日期 _____	*第四次 / 檔案終結 檢討日期 _____
請填寫 3 個你認爲最困擾你的問題。	困擾程度 (0 分---5 分，0 分爲不困擾，5 分爲非常困擾)				
1.					
2.					
3.					

綜合家庭服務使用者調查問卷

這份問卷的目的是收集意見，作爲改善機構服務質素之用。請填上最能代表你意見的答案。 這是保密，你的意見不會被公開，也不會影響你所接受的服務。希望你可以用 5 分鐘時間來填寫， 交回我們。 多謝合作！

見:_____

For Official Use Only
服務使用者編號:_____

請圈出以下你認爲滿意的程度，不適用者，請圈不適用

1. 整體成效

非常不同意 非常同意 不適用

0 1 2 3 4 5

1. 整體來說，我滿意所接受的綜合家庭服務 — 0 1 2 3 4 5 9
2. 綜合家庭服務能增進我解決問題的能力 — 0 1 2 3 4 5 9
3. 綜合家庭服務能提高我對社區資源的認識 — 0 1 2 3 4 5 9
4. 綜合家庭服務能加強我的支援系統 — 0 1 2 3 4 5 9
5. 綜合家庭服務能幫助及解決我生活的實質需要(如:申請房屋、老人宿舍、綜援等) — 0 1 2 3 4 5 9
6. 若我再需要協助，會再使用綜合家庭服務 — ☐ 會 ☐ 不會

2. 服務質素

0 1 2 3 4 5 9

1. 輔導服務能滿足我的需要 — 0 1 2 3 4 5 9
2. 小組服務能滿足我的需要

3. 社工表現

0 1 2 3 4 5

1. 社工會關心我 — 0 1 2 3 4 5
2. 社工能明白我的需要
3. 其他意

Appendix V: Calendar of Events

Date	Activities
March 02	-12/3: Mtg with pilot project providers (1) (Orientation) -22/3: Working group endorsement -26/3: Mtg with pilot projects (Training 1) am and 27/3: Mtg with pilot projects (Training 2) pm
2002 April – June (3 months): Initiation Phase	
April-June	-Consultant team meeting -Quarterly report on User and Service Information -1/4: Pilot project commences -UIS, screening and assessment forms, user survey and data entry in use -Joint-mode meeting **-Project visits by Consultants (monthly)**
2002 July – December (6 months): First Interim	
July-August	Mode-specific Sharing -Mode A -Mode B
	Training for Data Entry System
September	Clinical Measurements – Training
	1st Quarterly Report on UIS
	Submission of 1st Self Assessment Report
	Focus Group – Users (1)
October - December	Clinical Measurements – 1st Measurement
October	Joint-Mode Seminar
	Case Study (1)
November	Focus Group – (Social Workers) -Mode A -Mode B
	Focus Group – (Supervisors)
	Focus Group – (Stakeholders)
December	Meeting with Non-Pilot Projects
2003 January – June: Second Interim	
January – February	2nd Quarterly Report on UIS
January	Case Study -1st Review
March – April	Submission of Self-Assessment Report
April	Focus Group -Users
May-June	IFSC Annual Conference
	Interim Report from Consultant
2003 July – December: Third Interim	
July – August	3rd Quarterly Report on UIS
July	Case Study -1st Review
September	Focus Group – Users
	Submission of Self-Assessment Report
October – December	Clinical Measurements – 2nd Time Measurement
October	Case Study -2nd Review

November-December	Focus Group – (Workers) -Mode A -Mode B
	Focus Group – (Supervisors)
	Focus Group – (Stakeholders)
2004 January – March (3 months): Round-off Phase	
Jan – Feb	-Quarterly report on USI
March-April	-Meeting with pilot projects -Submission of Self-assessment Report
May-June	-Submission of Consultant Final Report -Sharing session with the field

十項主要社會指標所反映的十三區概況

附件2

地區 / 社會指標	分配比重	中西區/離島區	東區及灣仔	南區	觀塘	黃大仙及西貢	九龍城	深水埗	油尖旺	沙田	大埔及北區	元朗	荃灣及葵青	屯門	整體數字
人口 *1		364,800	752,800	283,200	583,300	827,100	369,100	347,600	260,000	636,500	602,800	542,600	777,200	526,000	6,873,000
佔總數的百分比	10	5%	11%	4%	8%	12%	5%	5%	4%	9%	9%	8%	11%	8%	100%
所得分數		0.5	1.1	0.4	0.8	1.2	0.5	0.5	0.4	0.9	0.9	0.8	1.1	0.8	10
正處理的個案 *2		1,354	3,057	578	3,045	2,773	1,266	1,787	1,283	1,950	1,536	1,595	3,247	2,568	26,039
佔總數的百分比	10	5%	12%	2%	12%	11%	5%	7%	5%	7%	6%	6%	12%	10%	100%
所得分數		0.5	1.2	0.2	1.2	1.1	0.5	0.7	0.5	0.7	0.6	0.6	1.2	1.0	10
虐待兒童 *3		3	7	6	12	20	5	5	8	10	16	16	14	16	138
佔總數的百分比	10	2%	5%	4%	9%	14%	4%	4%	6%	7%	12%	12%	10%	12%	100%
所得分數		0.2	0.5	0.4	0.9	1.4	0.4	0.4	0.6	0.7	1.2	1.2	1.0	1.2	10
虐待配偶 *4		55	117	38	86	159	58	67	55	75	151	161	143	264	1,429
佔總數的百分比	10	4%	8%	3%	6%	11%	4%	5%	4%	5%	11%	11%	10%	18%	100%
所得分數		0.4	0.8	0.3	0.6	1.1	0.4	0.5	0.4	0.5	1.1	1.1	1.0	1.8	10
新來港定居人士 *5		838	1,734	556	2,083	2,278	1,083	1,952	1,241	1,318	1,571	1,416	2,348	1,343	19,761
佔總數的百分比	10	4%	9%	3%	11%	12%	5%	10%	6%	7%	8%	7%	12%	7%	100%
所得分數		0.4	0.9	0.3	1.1	1.2	0.5	1.0	0.6	0.7	0.8	0.7	1.2	0.7	10
青少年罪行 *6		378	426	0	572	223	208	240	483	491	731	549	704	461	5,466
佔總數的百分比	10	7%	8%	0%	10%	4%	4%	4%	9%	9%	13%	10%	13%	8%	100%
所得分數		0.7	0.8	0.0	1.0	0.4	0.4	0.4	0.9	0.9	1.3	1.0	1.3	0.8	10
單親家庭 *7		816	1,975	807	3,297	3,811	1,790	2,691	1,618	2,442	3,707	4,281	3,575	3,411	34,221
佔總數的百分比	10	2%	6%	2%	10%	11%	5%	8%	5%	7%	11%	13%	10%	10%	100%
所得分數		0.2	0.6	0.2	1.0	1.1	0.5	0.8	0.5	0.7	1.1	1.3	1.0	1.0	10
低收入 *8		474	697	292	1,244	1,590	481	839	311	744	855	1,136	1,603	687	10,953
佔總數的百分比	10	4%	6%	3%	11%	15%	4%	8%	3%	7%	8%	10%	15%	6%	100%
所得分數		0.4	0.6	0.3	1.1	1.5	0.4	0.8	0.3	0.7	0.8	1.0	1.5	0.6	10
失業 *9		1,414	2,360	594	4,236	4,945	2,266	4,450	4,395	2,297	3,359	4,745	4,561	3,569	43,191
佔總數的百分比	10	3%	5%	1%	10%	11%	5%	10%	10%	5%	8%	11%	11%	8%	100%
所得分數		0.3	0.5	0.1	1.0	1.1	0.5	1.0	1.0	0.5	0.8	1.1	1.1	0.8	10
低教育程度人士*10		65,800	151,804	75,348	165,145	207,632	82,597	103,437	69,955	136,174	141,106	103,192	194,813	117,718	1,614,721
佔總數的百分比	10	4%	9%	5%	10%	13%	5%	6%	4%	8%	9%	6%	12%	7%	100%
所得分數		0.4	0.9	0.5	1.0	1.3	0.5	0.6	0.4	0.8	0.9	0.6	1.2	0.7	10
所得總分	**100**	**4.2**	**8.0**	**2.7**	**9.7**	**11.4**	**4.7**	**6.7**	**5.6**	**7.3**	**9.3**	**9.4**	**11.6**	**9.5**	**100.0**

*1 香港特別行政區規劃署《人口分佈推算2002-2011》中的2003年居港人口推算數字
*2 社署和非政府機構營辦的家庭服務中心及綜合家庭服務中心在截至2003年3月31日正處理的個案，包括涉及情緒問題、婚姻及親子關係問題的個案
*3 2002年10月至12月的新舉報個案
*4 2002年10月至2003年3月的新舉報個案
*5 民政事務總署進行的內地新來港定居人士問卷調查中，填寫二零零二年七月至二零零三年三月內地新來港定居人士調查問卷的新來港定居人士數目
*6 香港警務處刑事部統計組的香港罪案統計數字中所載由二零零二年十月至二零零三年三月期間的少年及青少年罪犯人數（南區和將軍澳區的有關個案，分別納入西區和觀塘區的組別。地區是指罪案的案發地點，而不是違法者居住的地方。）
*7 截至2003年3月31日的單親家庭綜援個案數目
*8 截至2003年3月31日的低收入綜援個案數目
*9 截至2003年3月31日的失業綜援個案數目
*10 2001年未受過教育或者只有小學或以下程度教育的人口（政府統計處《2001年人口及住戶統計數字》-- 按區議會地區劃分）