Evaluation Report

Comprehensive Child Development Service (CCDS)

Family Health Service, Department of Health

2007

The Research Team

Dr Shirley SL Leung, Principal Medical Officer, Family Health Service, Department of Health
Dr Cynthia M Leung, Senior Research Officer, Family Health Service, Department of Health
Dr Ruth SM Chan, Research Officer, Family Health Service, Department of Health
Dr TN Lee, Senior Medical Officer, Family Health Service, Department of Health
Dr Patrick Ip, Associate Consultant, Hospital Authority

Acknowledgements

The research team would like to thank the Social Welfare Department and all the non-governmental organizations involved in the Comprehensive Child Development Service (CCDS) for their support of this evaluation exercise, by providing service data and assistance in data collection from clients, participating in focus group discussions and arranging client interviews for the research team. The team is grateful to the midwives and visiting psychiatric nurses of the Hospital Authority for their participation in focus groups / individual interviews and the arrangement of client interviews for the research team. The team would also like to thank Associate Professor Sandra Tsang (Department of Social Work and Social Administration, University of Hong Kong), and Ms Betty Wong (Clinical Psychology student, University of Hong Kong) for facilitating the focus group discussions. Furthermore, the team is indebted to clients of the pilot Maternal and Child Health Centres (MCHCs) and pre-primary educators who kindly shared their experiences of the CCDS with us. Finally, the team would like to express its heartfelt appreciation to all the staff of the pilot MCHCs and research assistants of the Family Health Service for their dedication and hard work as well as their patience and meticulousness in the tedious data collection process. Without their devotion and professionalism, this evaluation would not have been possible.

Table of Contents

Abbreviations

ACC	Ambulatory Care Clinic
A&E	Accident and Emergency department
ARS	Antenatal Record System
BDI	Beck Depression Inventory
CAC	Child Assessment Centre
CAS	Child Assessment Service
CCC	Child Care Centre
CCDS	Comprehensive Child Development Service
CI	Confidence Interval
CMC	Caritas Medical Centre
CMS	Clinical Management System
CP	Community Paediatrician
CPH	Castle Peak Hospital
CSSA	Comprehensive Social Security Assistance
DCC	District Co-ordinating Committee
DCCC	Day Child Care Centre
DH	Department of Health
EMB	Education and Manpower Bureau
EPDS	Edinburgh Postnatal Depression Scale
FCPSU	Family and Child Protection Service Unit
FCU	Family Counselling Unit
FHS	Family Health Service
FRU	Family Resource Unit
FSC	Family Service Centre
FSU	Family Support Unit
GHQ-12	General Health Questionnaire – 12 items
HA	Hospital Authority
HKFWS	Hong Kong Family Welfare Society
HOS	Home Ownership Scheme
HWFB	Health Welfare and Food Bureau
ICHDP	Integrated Child Health and Development Programme
IFSC	Integrated Family Service Centre
ISC	Integrated Services Centre
ISP	Integrated Service Programme
ISS	International Social Service
IUCD	Intrauterine Contraceptive Device
KCH	Kwai Chung Hospital
KEC	Kowloon East Cluster
KG	Kindergarten
KWC	Kowloon West Cluster

KWH	Kwong Wah Hospital
LRT	Light Rail Transit
MCH	Maternal and Child Health
MCHC	Maternal and Child Health Centre
MSW	Medical Social Worker
MTR	Mass Transit Railway
NEP	Non-entitled Person
NGO	Non-governmental Organisation
NTW	New Territories West
NTWC	New Territories West Cluster
O&G	Obstetrics and Gynaecology
OC	Oral Contraceptive
PMH	Princess Margaret Hospital
PND	Postnatal Depression
PRC	Parent Resource Corner
PS-33	Centre for Psychotropic Substance Abusers
PSPS	Private Section Participation Scheme
QEH	Queen Elizabeth Hospital
SARDA	Society for the Aid and Rehabilitation of Drug Abusers
SGA	Small for Gestational Age
SSIG	Semi-structured Interview Guide
SSP	Sham Shui Po
STDS	Sexually Transmitted Diseases
SWD	Social Welfare Department
TKO	Tseung Kwan O
TKO PNR	Tseung Kwan O Po Ning Road
TKOH	Tseung Kwan O Hospital
TM	Tuen Mun
TMH	Tuen Mun Hospital
TMWH	Tuen Mun Wu Hong
Triple P	Positive Parenting Programme
TSW	Tin Shui Wai
UCH	United Christian Hospital
WK	West Kowloon
YFS	Yung Fung Shee
YL	Yuen Long
YO	Yan Oi

List of Tables

List of Figures

Executive Summary

Background

It is widely recognised that the early years of childhood is of great importance to human development. To provide a comprehensive and integrated service to children and their families, a pilot programme on child development was announced in the 2005 policy address. This pilot programme was implemented in phases in four selected communities, namely, Sham Shui Po, Tin Shui Wai, Tseung Kwan O and Tuen Mun, in the name of Comprehensive Child Development Service (CCDS), which commenced in July 2005. The CCDS was a community-based programme aiming to ensure early identification of the varied needs of children and their families and timely referral to appropriate services for intervention. Maternal and Child Health Centres (MCHCs), which provide public health services to over 90% of newborn babies until 5, was used as a platform where services could be delivered through inter-sectoral partnership among government departments and relevant agencies.

Design of the CCDS

The design of the CCDS was based on the theories of help seeking behaviour, and drew on the concepts of the hierarchy of health promotion outcomes (Nutbeam, 1988), dimensions of quality of service (Maxwell, 1992) and assessment of quality in health care (Donabedian, 1988). Guided by the theories of help seeking behaviour, changes in organizational structure and professional practices were introduced to facilitate the identification and referral of clients to various services. It was anticipated that these changes would lead to an improvement in the quality of service, in terms of access, acceptability, equity, effectiveness and efficiency (intermediate outcome), and the well-being of families and children (social and health outcome) would ultimately be improved.

The CCDS components

Built on existing services provided in MCHCs, hospitals of the Hospital Authority (HA), Integrated Family Service Centres (IFSCs) and pre-primary institutions, the pilot CCDS comprised four additional components:

a. Identification and holistic management of at-risk pregnant women - comprehensive assessment would be conducted and holistic management plans developed for at-risk pregnant women identified by health and social service professionals. Midwives from the HA were responsible for service coordination and progress monitoring of these women. After delivery, a visiting community paediatrician would provide follow-up service for their children in MCHCs.
b. Identification and management of mothers with postnatal depression (PND) - postnatal mothers would be routinely screened for PND in MCHCs using the Edinburgh Postnatal Depression Scale (EPDS). Counselling services would be provided by trained MCH

nurses with referral to visiting psychiatric nurses on-site and other specialist and support services where necessary.

c. Identification and management of families with psychosocial needs - in collaboration with the Social Welfare Department (SWD), the Department of Health (DH) had developed an assessment tool for MCH staff to facilitate early identification and referral of families with psychosocial needs. These families would be referred to IFSCs for service. For families who were not yet ready to approach IFSCs for assistance, IFSC staff would meet them at MCHCs or conduct home visits where appropriate.

d. Identification and management of pre-primary children with physical, developmental and behavioural problems - in collaboration with pre-primary institutions, a referral and feedback system was developed to enable pre-primary educators to identify and refer these children to MCHCs for assessment and further assistance.

The evaluation framework and methodology

The evaluation of the pilot CCDS covered both formative and summative aspects. The formative evaluation focused on whether the implementation of the new initiative had been proceeding according to plan and how this had impacted on the quality of health services (i.e. intermediate outcome), as well as identifying the conditions necessary for the successful implementation of the initiative. Both structural (e.g. facilities, staff, and training) and process (e.g. client identification and referral, and service interface) issues were examined. The data collected had been used to inform the improvement and refinement of the programme during the formative period. The summative evaluation aimed to examine whether there were changes in the quality of services, in terms of access, acceptability, equity, effectiveness and efficiency. Quantitative and qualitative data were collected, including service statistics, training evaluation, client outcomes, client and staff feedback, and case progress reports.

Evaluation results

The evaluation attempted to answer the questions: "Did the CCDS work?"; "What worked?" and "Why and how did it work?" The summative evaluation provided answers to the first question as to whether the CCDS could achieve the anticipated improvement in service quality. The formative evaluation provided answers to the latter two questions in terms of the structural and process issues that had contributed to the success or otherwise of the CCDS.

Did the CCDS work?

Highlights

Across the four CCDS components, there was an increase in ***access*** and ***acceptability*** to various health and social services, although there was still room for improvement in the use of the service by pre-primary institutions.

In terms of ***equity,*** through the CCDS, disadvantaged groups such as pregnant women with

regular heroin use, low-income families and children of new arrivals were identified, their needs were assessed and referrals for intervention were made, where appropriate. However, clients who could not turn up at MCHCs personally, such as working parents, were less able to access the service.

There was preliminary information on ***effectiveness***. The available data suggested that the PND screening programme using EPDS was more effective in improving the clients' mental health outcome than the usual practice of clinical assessment. Clients who returned the pre- and post-intervention questionnaires also showed improvement in mental health outcome after social service intervention. However, it was likely that this represented a group of more motivated clients and/or more enthusiastic social workers.

Regarding ***efficiency***, it was anticipated that with problems identified and dealt with effectively at an early stage, it would help save more resource-intensive interventions at a later stage. However, there was no available data to show whether the CCDS could achieve this aim because of the short period of trial.

Details

Details about the four components are presented below:-

a. Identification and holistic management of at-risk pregnant women – different at-risk groups were targeted in different HA clusters, including mothers with illicit drug use and teenage pregnant women. The CCDS had enhanced access by bringing the service to the clients, through collaboration with NGOs, such as in the case of the Integrated Service Programme for heroin users. Clients were highly appreciative of the integrated service, the accepting and caring attitudes of the workers, and their professionalism. Many of the clients were able to make informed decisions on their pregnancy and lifestyle such as contraception, drug use and smoking after intervention.

b. Identification and management of mothers with postnatal depression (PND) – service statistics indicated an increase in the number of clients identified as having probable PND and that referred for MCH nurse counseling, and psychiatric and social services. This suggested an increase in service access. Clients were positive about the services of MCH nurses and visiting psychiatric nurses. However, some clients were still reluctant to accept referral to psychiatrists because of perceived stigma and inconvenience. Preliminary results also indicated better client mental health outcome under EPDS screening, compared with the usual practice of clinical assessment. However, clients who did not personally attend MCHCs were not able to access PND assessment.

c. Identification and management of families with psychosocial needs - this component was set up to target and address the needs of the disadvantaged clients at an early stage. The aim was largely achieved as statistics indicated that most of the clients assessed belonged to this group, and there was an increase in the number of referrals to social services. Around 70% of the clients accepted referral to social services. Clients were appreciative of MCH

nurses' caring and professional attitudes. Most clients found the social workers caring and understanding, though some would like their social workers to show them more concern. Among those who returned the questionnaires, there was also an improvement in their mental health outcome after social service intervention. However, clients who could not personally turn up at MCHCs were unable to access the service.

d. Identification and management of pre-primary children with physical, developmental and behavioural problems – despite direct contact through school letters, there were still a fair number of pre-primary institutions which had not been aware of the CCDS. The number of referrals was not high though those which had used the service were satisfied. Among those children referred by pre-primary institutions, there was a higher proportion of children from new arrival families in comparison with the general population profile. It suggested that the service had facilitated the access of this socially disadvantaged group.

What worked? Why and how did it work?

There were common factors identified to have contributed to the success or otherwise of the CCDS across all components and all communities.

a. Structural issues - arranging psychiatric nurses and social workers to meet clients in MCHCs as appropriate had helped to reduce stigmatization and increase convenience, which were vital in increasing clients' access to psychiatric and social services. Clients' perception of staff competence and professionalism contributed significantly to their confidence in the staff. On the other hand, the lack of privacy during interviews by MCH nurses might have hampered clients' disclosure of personal difficulties. The increased workload, against a background of manpower deficiency due to recruitment difficulties, might have led to higher stress and lower morale for the MCH staff. Furthermore, staff members who lacked a sense of self-efficacy, or those with unrealistic expectation about their roles, experienced more stress and frustration. It was recognized that staff mental well-being/morale could be associated with the quality of service delivered.

b. Process issues - with empathy, a caring attitude, perseverance, and good knowledge of service, health and social workers were able to encourage clients' sharing of personal difficulties and acceptance of referral. Moreover, the provision of an out-reaching and one-stop service was important for enhancing service accessibility to socially disadvantaged groups that were "hard-to-reach". Team spirit and teamwork were essential to enhancing staff sense of competence and boosting morale. As for inter-sectoral collaboration, mutual respect, open communication, responsiveness and flexibility in service delivery, and experience sharing, were instrumental in ensuring that clients receive the most appropriate services.

Recommendations

Many issues identified during the formative stage had been addressed, where possible, to

improve and refine the programme. Based on the experience of the pilot, the following recommendations were considered essential for the successful implementation of the programme and further improvement of service quality.

Issues applicable to all or more than one components:

a. Facilities
   - Sufficient interview rooms should be made available in MCHCs to protect the privacy of clients during interview.
   - Each district should have at least one of its MCHC(s) equipped with a Parent Resource Corner to enable parents to obtain updated information about child/family issues, services and resources.
   - Data management should be computerized to enhance efficiency and to reduce staff workload.
   - A computer platform for information sharing between MCHCs, IFSCs and HA should be actively pursued in order to enhance the effectiveness and efficiency of the referral-feedback systems and tracking of defaulters.

b. Staff
   - Manpower - there should be adequate professional staff to meet the increased workload for down-stream services including developmental assessment and treatment services for children with special needs.
   - Team building – teamwork should be strengthened to boost staff morale and to ensure smooth service implementation.
   - Staff training - to enhance staff competence, training on understanding client psychosocial issues, readiness to change and cultural sensitivity should be provided. MCH nurses should be adequately briefed about their roles in the various CCDS components to reduce stress arising from unrealistic role perception.

c. Procedures - referral procedures and record keeping should be streamlined to reduce workload.

d. Inter-sectoral collaboration - there should be information sharing, mutual visits, case discussion, and more flexible management of service boundary issues to better meet client needs.

e. Continuous evaluation and service quality management - to ensure that interventions are evidence-based and to continuously improve service quality, all service providers should undertake rigorous evaluations and maintain effective quality management mechanisms.

Issues specific to individual components:

a. Identification and management of at-risk pregnant women
   - As regards the discrepancy in service boundaries between MCHC and HA, all parties involved should adopt a flexible approach to best meet clients' needs.

- To provide intervention of sufficient intensity to the most severely disadvantaged client groups and to yield the best results, HA clusters should review the number and the nature of at-risk groups to be targeted.
- The CCDS midwives should consider taking up the role of case manager to better meet clients' needs and monitor their progress.
- To improve service efficiency, the follow-up service for the children of at-risk families, currently provided by the visiting community paediatrician, could be shared by the MCH staff. The community paediatrician could take up the strategic role of overseeing programme development and implementation.

b. Identification and management of mothers with PND
   - The number of visiting sessions by psychiatric nurses should be increased to meet clients' needs and provide ample support to MCH nurses.
   - To reduce the barrier for women with PND to receive psychiatric service, the possibility of arranging visiting psychiatrist, where appropriate, could be explored.
   - To improve efficiency, in the long term, MCH nurses could be expected to take up more of the counselling services while the psychiatric team could focus its efforts on assessing and managing more difficult cases.
   - To include more working mothers in the EPDS screening programme, screening could be advanced to 6 weeks postnatal, when most working women are still on their maternity leave.

c. Identification and management of families with psychosocial needs - to improve working mothers' access to the service, the assessment for psycho-social needs could be performed earlier in the postnatal period.

d. Identification and management of pre-primary children with physical, developmental or family problems - to enhance service utilisation by pre-primary institutions, the coordination work through school development officers of the EMB could be strengthened. Moreover, a training VCD introducing MCHC child health services, the recognition and support of children with developmental needs and the referral and feedback mechanism could be produced and distributed to all pre-primary institutions.

Main limitations of the study

Since the evaluation was based on data collected within a period of between 9 to 15 months after the CCDS had been piloted in the 4 respective communities, only intermediate outcome could be examined. The results should therefore not be interpreted as representing the long-term effectiveness of the CCDS. Besides, there was no control community in the present evaluation.

Due to the time limitation, the summative evaluation was being conducted at the same time as the formative evaluation, i.e. during the formative stage of the programme when it was likely to be fraught with teething problems. It was possible that the results might not be a true

representation of the usefulness of the CCDS.

The way forward

In summary, the early results of the pilot CCDS indicated an improvement in service quality, in the dimensions of access, acceptability, equity and effectiveness. Ongoing evaluation and quality management of the CCDS by all service providers were considered vital for continuous quality improvement. Subject to additional resources, the pilot model is recommended to be rolled out territory-wide so as to benefit more children and their families. The schedule of extension could be prioritized on the basis of the social need as defined by demographic characteristics and the operational preparedness of the various implementing agencies in different districts.

Chapter 1
Background to the Comprehensive Child Development Service (CCDS)

1.1 Background

It is widely recognised that the early years of children is of great importance to their future development (Shonkoff & Phillips, 2000). In Hong Kong, services for pre-primary children and their families are provided by the health, education and social service sectors separately. It is argued that inter-sectoral and inter-agency collaboration is needed to provide comprehensive service that meets the varied needs of pre-primary children and their families. Integration of services is vitally important in pooling multi-disciplinary resources not only to address these needs but also to reduce gaps or overlaps in service provision by the various sectors. It also ensures coherence in service delivery.

In the 2005 Policy Address, it was announced that the Administration will implement a pilot Head Start Programme on Child Development (兒童發展先導計劃) in phases in four selected communities[1], namely, Sham Shui Po (SSP), Tin Shui Wai (TSW), Tseung Kwan O (TKO) and Tuen Mun (TM), to provide comprehensive and timely support to children and their families. The pilot programme was implemented in the name of the CCDS (兒童身心全面發展服務). The Maternal and Child Health Centres (MCHCs) of the Family Health Service (FHS), Department of Health (DH), which provide public health services to over 90% of newborn babies until 5 years of age, was used as a platform where services could be delivered through inter-sectoral partnership among government departments and relevant agencies.

The CCDS was a community-based programme which aimed to ensure early identification of the varied needs of children and their families so that appropriate services could be made available to them in a timely manner. This was to be achieved by augmenting the existing services for children 0-5, through better alignment of the delivery of health, education and social services. Implementation of the CCDS involved inter-disciplinary and inter-sectoral collaboration among government departments and relevant agencies.

To move towards an integrated community-based child-centred and family-oriented service model, the DH, Hospital Authority (HA), Education and Manpower Bureau (EMB), Social Welfare Department (SWD) and non-governmental organisations (NGOs) would cooperate and align their services to improve the interface among healthcare, social and education services at the community level.

1.2 Existing services

The existing services of DH, HA, EMB and SWD relevant to children (0-5 years) and their families are described below.

[1] In this report, the terms “community” and “district” were used interchangeably, although strictly speaking, TKO and TSW were not district council districts.

1.2.1 Maternal and child health (MCH) services in DH

Maternal health (antenatal and postnatal) services

Antenatal checkups were provided for pregnant women. MCHCs operated a comprehensive shared-care programme, in collaboration with the Obstetrics Department of HA hospitals, to monitor the whole pregnancy and delivery process. Educational programmes on pregnancy and birth as well as childcare and parenting related topics were also conducted in the centres.

All women, after delivery, were provided with postnatal checkups and advice on family planning. The health professionals helped postnatal mothers to adapt to changes in life by setting up support groups and experience sharing sessions, as well as providing individual counselling. They also conducted clinical assessment on postnatal mothers to identify postnatal mood problems. Those who required follow-up counselling or psychiatric management would be seen by MCH doctors who would then recommend subsequent management as appropriate. Referrals to social services were arranged if necessary.

Since December 2002, a referral system between the FHS, Family Service Centres (FSCs)/Integrated Family Service Centres (IFSCs) and Medical Social Workers (MSWs) of the HA has been established for pregnant women with psychosocial risk factors, such as teenage pregnancy and substance abuse, to ensure they receive the appropriate health and social services.

Child health services

The core child health service was provided in MCHCs through the "Integrated Child Health and Development Programme" (ICHDP) which adopted a health promotion and disease prevention approach. The ICHDP comprised three components designed to meet the developmental needs of children 0-5 in the physical, cognitive, social and emotional domains in a coordinated way. The three components were:

- **Parenting programme** – parents were equipped with the knowledge and skills to promote all aspects of their children's health and development. The universal parenting programme was for all expectant parents and parents of children 0-5. They would receive anticipatory guidance on childcare and parenting issues which were appropriate to the ages of their children. For parents of children with early signs of behavioural problems or those who encountered difficulties with parenting, an intensive parenting programme, the Positive Parenting Programme (Triple P)[2] was available.
- **Immunization programme** – immunization against nine infectious diseases was provided at intervals as recommended by the Scientific Committee on Vaccine Preventable Diseases of the Centre for Health Protection of DH; and
- **Health and developmental surveillance programme** – health professionals worked in

[2] The Triple P was developed by a group of clinical psychologists from the University of Queensland, Australia. It is a structured behaviour family intervention programme that aims to prevent severe behavioral and, emotional problems in children by enhancing parents' knowledge, skills and confidence in parenting.

partnership with parents in the continual monitoring of health and development of the child through (i) newborn consultation; (ii) growth monitoring; (iii) developmental surveillance; (iv) hearing screening; and (v) vision screening.

Children with significant health problems were referred to relevant specialists in HA hospitals whereas children with developmental problems requiring multidisciplinary assessment and management were referred to the Child Assessment Service (CAS)[3] of DH. Those with family or social problems were referred to social services for follow-up.

1.2.2 Specialty services in HA

In this section, the HA services relevant to children 0 to 5 and their families are described. They include paediatrics, obstetrics and gynaecology as well as psychiatry services.

Paediatrics service

Paediatrics departments offered a comprehensive range of services comprising 24-hour emergency admissions for acute illnesses, in and out-patient services for the assessment and management of common paediatric diseases, long-term treatment and rehabilitation service for chronic illnesses, and assessment and treatment of medical problems.

Within the HA, paediatricians worked in close collaboration with obstetricians to provide comprehensive care to high-risk obstetric patients and attend high-risk deliveries to provide the necessary assessment and resuscitation for the newborn. Moreover, every newborn baby was examined by a paediatrician before being discharged from the hospital. Babies with medical problems or those requiring monitoring were cared for in the special care baby units or neonatal intensive care units.

Children with common paediatric problems were assessed and managed in general paediatric outpatient clinics or as in-patients in the general paediatric ward. Those with complicated conditions were referred to sub-specialty teams for management. Children requiring intensive monitoring and care were managed in paediatric intensive care units. Children with chronic illness were managed in paediatric rehabilitation wards or ambulatory care units.

Obstetrics and gynaecology service

Obstetrics and Gynaecology (O&G) departments provided comprehensive care for pregnant women and specialized in- and out-patient services for women with gynaecological problems.

The antenatal care for low-risk pregnant women was shared with nearby MCHCs while women with more complicated pregnancy were managed by obstetricians at the hospital

[3] CAS serves children aged under 12 years with developmental-behavioural problems or disorders, particularly complex cases requiring multidisciplinary assessment and management. CAS provides comprehensive diagnostic evaluation, rehabilitation prescription, interim child and family support, and review evaluation at critical developmental transition points.

antenatal clinics. Routine ultrasound scan was performed in the antenatal period for ascertaining the gestational age and screening of obstetric abnormalities. Those with increased risk of fetal abnormality were referred for counselling and special prenatal diagnostic procedures. During labour, assessment and necessary interventions such as instrumental delivery and caesarean section were performed by obstetricians. Both the mother and newborn baby were accommodated in the postnatal ward after delivery, where breastfeeding was encouraged and supported. Patients with special problems or operative deliveries were usually followed up at the hospital postnatal clinics while women with low risk and uneventful pregnancy and delivery were followed up at MCHCs.

Psychiatry service

Psychiatry departments provided a comprehensive range of mental health services consisting of general psychiatric in-patient and out-patient services for adults, acute psychiatric care, consultation-liaison service, community psychiatric and rehabilitation care, ambulatory care at clinics and day centres, child and adolescent service and psychogeriatric service.

The scope of in-patient service included psychiatric service for acute illnesses, forensic admission for patients referred by law enforcing bodies or prosecuting agencies and rehabilitation for those undergoing treatment for mental illnesses or detoxification for substance abuse. Consultation-liaison services were provided for Accident and Emergency departments (A&E) and in-patients in general hospitals in the HA. Community psychiatric services, including client/relative hotline service, crisis-intervention skills training and psycho-education programme, were provided by multi-disciplinary teams consisting of psychiatrists, psychiatric nurses, clinical psychologists and social workers. Ambulatory care and training were also provided in psychiatric day hospitals. Furthermore, sub-specialty services were provided for the assessment and intervention of mental health problems in target clients in the child and adolescent as well as geriatric age groups.

1.2.3 Pre-primary services (EMB and SWD)

Pre-primary service in Hong Kong referred to the provision of education and care to young children by kindergartens (KGs) and day child care centres (DCCCs). KGs, registered with the EMB, provided services for children from three to six years of age. DCCCs, which catered for children aged under three, were registered with the SWD.

The aim of pre-primary service was to provide children with a relaxing and pleasurable learning environment to promote a balanced development of the various aspects of a child, such as the social, cognitive, physical, emotional and aesthetic aspects.

In a continuum of service, DCCCs provided services for children aged under three with more focus on care and learning through play and stimulation while for children aged three to six, KGs provided more structured learning so as to meet the needs of different developmental stages of children. Most of the KGs operated on a half-day basis offering upper and lower KG classes

as well as nursery classes. Some KGs operated full-day classes too. DCCCs might provide full-day or half-day services, with most centres providing full-day services.

The majority of the DCCCs were co-located in KGs under the administration and monitoring of the EMB until the children reached the age of six. A Kindergarten and Child Care Centre Fee Remission Scheme was in place to assist parents to pay for the service in part or in full subject to a means test and social needs assessment

The Chief Executive, in his 2006-07 Policy Address, announced a major financial commitment for assisting service providers and parents of children receiving pre-primary education. A series of new initiatives, including the Pre-primary Education Voucher Scheme would be implemented with an aim to ensuring all school-aged children receive affordable and quality pre-primary education.

1.2.4 IFSC services

Following a review of family services in 2000-01 and the evaluative study of 15 pilot projects on IFSC in 2002-04, the SWD re-engineered the then family service centres to form a total of 61 IFSCs (40 operated by SWD and 21 operated by NGOs) in 2004-05.

Each IFSC served a well-defined geographical boundary in order to avoid overlapping of resources. The population served by each IFSC was around 100 000 to 150 000. With "child-centred, family-focused and community-based" as the direction, IFSCs adopted the principles of "accessibility", "early identification", "integration" and "partnership". Each IFSC comprised three components, namely the Family Resource Unit (FRU), Family Support Unit (FSU) and Family Counselling Unit (FCU), and used different intervention methods including casework, groups and programmes to achieve a greater synergy.

With the objective of preserving and strengthening the family as a unit, the IFSC sought to meet the multifarious needs of individuals and families in the community. A continuum of preventive, supportive and remedial services including family life education, parent-child activities, enquiry service, volunteer training, outreaching service, mutual support groups, counselling and referral service for individuals or families in need, etc. were provided with extended hour services.

Medical social services

MSWs were stationed in public hospitals and specialist out-patient clinics to provide timely psycho-social intervention to patients and their families and help them solve or cope with problems arising from illnesses, traumas or disabilities. The services rendered by MSWs included counselling services to patients and their families; formulation of discharge plan and psychosocial assessment for patients; making referral for rehabilitation and community resources for patients and their families; financial/material assistance; collaboration with other medical and allied health professionals (e.g. physiotherapist, occupational therapist etc.) to identify persons in the community who are in need of treatment or rehabilitation services, and provision of

necessary assistance for them; group counselling service and organizing seminars for patients or family members.

1.3 The four communities

1.3.1 Sham Shui Po

SSP was situated at the northwestern part of the Kowloon Peninsula. Being one of the earliest developed districts in Hong Kong, SSP was a densely populated district in the 1950s and 1960s. According to the 2001 Census, the population of SSP was 353 550 (Census and Statistics Department, 2001). The SSP District recorded the lowest median monthly domestic household income ($14 000 in 2001 excluding Marine). It had the highest percentage of elderly (15.7%). New arrivals constituted 9.7% of the population, being the second highest in all districts (Census and Statistics Department, 2002). There were 14 public housing estates and 6 Home Ownership Scheme (HOS)/Private Section Participation Scheme (PSPS) estates (Housing Authority, 2007).

Despite the above portrait of SSP, it should be noted that there were pockets of private residential areas where residents were likely to be more affluent. For example, Mei Foo Sun Chuen was Hong Kong's first large-scale private housing estate. Yau Yat Tsuen was a luxurious residential area which contrasted sharply with other residential areas in the district (Sham Shui Po District Council, 2005).

The West Kowloon (WK) MCHC in SSP started operation in January 2001. It merged with the Cheung Sha Wan MCHC in January 2005. As of July 2005, there were 18 nurses and 3 doctors in WK MCHC. It was one of the busiest MCHCs in the territory with the highest number of new registered child health cases (under the age of one) of 3 584 in 2005.

Regarding specialty services under HA, SSP belonged to the Kowloon West Cluster (KWC). The paediatrics and psychiatry services in SSP were mainly provided by the Caritas Medical Centre (CMC) whereas O&G services were provided by the Kwong Wah Hospital (KWH) and Princess Margaret Hospital (PMH) in the same cluster.

In terms of social service provision, SSP was served by four IFSCs among which two were operated by the SWD and the other two run by NGOs, the Hong Kong Family Welfare Society (HKFWS) and the International Social Service (ISS) Hong Kong Branch.

As far as pre-primary services are concerned, there were 50 pre-primary institutions in the district in 2005.

1.3.2 Tin Shui Wai

TSW New Town was located in the north-western part of the New Territories. Its development began in 1987, starting with the southern part of the new town. Further expansion of the new town into the remaining areas to the north commenced in July 1998. The population of TSW new town was 178 000, according to the 2001 census (Planning Department, 2002). A

Light Rail Transit (LRT) line and new roads linking the new town to the trunk road network provided communication with the Yuen Long (YL) and TM districts and to the urban areas beyond (Civil Engineering and Development Department, 2004). There were 10 public housing estates and 6 HOS/ PSPS estates (Housing Authority, 2007).

TSW was characterized by a large population of children under 14, small nuclear families mainly living in subsidized housing estates, large number of low income families, lone parent families and new arrival families. There was also a relatively large number of child abuse cases in YL district where TSW is situated (Social Welfare Department, 2001).

The TSW MCHC started operation in September 1993. As of January 2006, there were 17 nurses and 2 doctors. The number of new child health cases (under the age of one) registered in 2005 was 2 350.

For the specialty services in HA, TSW belonged to the New Territories West Cluster (NTWC) (see 1.3.3 for description of service provisions).

Regarding social service provisions, there were three IFSCs with one operated by SWD and two by NGOs, the Caritas-Hong Kong and the ISS Hong Kong Branch. There were .47 pre-primary institutions in the district, as of 2005.

1.3.3 Tuen Mun

TM was situated at the western part of the New Territories with a population of 488 831 (Census and Statistics Department, 2001). TM was one of the most densely populated districts, ranking 4th in the 18 districts (Census and Statistics Department, 2001). There were 12 public housing estates, 18 HOS/ PSPS estates (Housing Authority, 2007) and a variety of private flats. TM was connected to the rest of Hong Kong through the TM Road, Castle Peak Road, Route 3 and Ting Kau Bridge. The main public transport facilities were the LRT and West Rail.

There were two MCHCs in TM, namely, Yan Oi (YO) MCHC and Tuen Mun Wu Hong (TMWH) MCHC. YO MCHC started operation in April 1982. As of January 2006, there were 20 nurses and 3 doctors. TMWH MCHC started operation in December 1993. There were 11 nurses, 1 doctor as of January 2006. The number of new registered child health cases (under the age of one) in 2005 were 2 574 and 1 011 respectively for the two centres.

TM district belonged to the NTWC of HA, which served 13% of the population in Hong Kong. Tuen Mun Hospital (TMH) was the acute regional hospital for TM, TSW and YL districts and other northern region of the New Territories West (NTW). Paediatrics and O&G services were provided in TMH while psychiatry service was provided by the Castle Peak Hospital (CPH) and its satellite team in TMH.

For social service provision, there were four IFSCs in TM, three of them were operated by SWD while the other one was operated by NGO, the Caritas–Hong Kong. There were 87 pre-primary institutions in TM in 2005.

1.3.4 Tseung Kwan O

TKO New Town was located in the southern part of Sai Kung District in the South East New Territories. It was however very close to the Metro Area. It included the areas of Tsui Lam, Po Lam, Hang Hau, Town Centre, Tiu Keng Leng, Pak Shing Kok, Siu Chik Sha, Tai Chik Sha and Fat Tong O. The existing population was about 266 000, according to the 2001 census (Planning Department, 2002). There were 8 public housing estates and 18 HOS/PSPS estates (Housing Authority, 2007). Existing external road links to the New Town included Po Lam Road, Tseung Kwan O Tunnel and Hang Hau Road. Apart from roads, external access has been greatly enhanced since 2002 upon completion of the extension of the Mass Transit Railway (MTR) to the New Town.

The Sai Kung District Council started to launch a "Tseung Kwan O - Healthy City" project in collaboration with various voluntary organizations in 1999 to raise public awareness of healthy living and to establish TKO as a healthy and ideal place to live and work in (Sai Kung District Council, 2005).

The Tsueng Kwan O Po Ning Road (TKO PNR) MCHC started operation in March 1997. It has merged with TKO MCHC in January 2005. As of January 2006, there were 21 nurses and 3 doctors. The number of new registered child health cases (under the age of one) in 2005 was 3 372.

Under the HA, the Kowloon East Cluster (KEC) served the population of TKO, Kwun Tong and Sai Kung districts which had an estimated population of 0.95 million. The United Christian Hospital (UCH) and Tseung Kwan O Hospital (TKOH) were two acute general hospitals providing paediatrics and O&G services in the community. The psychiatry service was provided at the outpatient clinic and day hospital of the Yung Fung Shee (YFS) Clinic, which was run by the UCH psychiatry team.

There were three IFSCs serving the TKO community, two operated by SWD and the other one by NGO, the HKFWS. Regarding pre-primary services, there were 58 pre-primary institutions in 2005.

Table 1.1 displays the general information and existing medical and health, social and education services in the four communities. The demographic information of the population in the four communities is presented in Table 1.2 and the client demographic profile in the five MCHCs is shown in Table 1.3.

Table 1.1: Health, social and educational services for pre-primary children and their families in the four pilot CCDS communities

Community	**SSP**	**TSW**	**TM**		**TKO**
Total population	353 550	178 000	488 831		266 000
2006 projected population (0-4)[a]	14 200	12 200	19 100		14 500
MCHC	WK MCHC	TSW MCHC	YO MCHC	TMWH MCHC	TKO PNR MCHC
Manpower strength (professional)[b]	3 doctors and 18 nurses	2 doctors and 17 nurses	3 doctors and 20 nurses	1 doctor and 11 nurses	3 doctors and 21 nurses
New child cases[c]	3 584	2 350	2 574	1 011	3 372
HA cluster	KWC		NTWC		KEC
Obstetrics and paediatrics services	PMH, CMC, KWH		TMH		UCH, TKOH
Psychiatry service	CMC		CPH and satellite team in TMH		YFS psychiatric clinic by UCH team
Social Service					
IFSCs (SWD + NGOs)	4 (2 + 2)	3 (1 + 2)	4 (3 + 1)		3 (2 + 1)
Education (Pre-primary)					
Pre-primary institutions[d]	50	47	87		58

[a] Planning Department (2006)

[b] Manpower strength at the commencement of CCDS (July 2005 for WK and January 2006 for the other MCHCs)

[c] New child cases (under the age of one) in the year 2005

[d] Number of pre-primary institutions as of 2005

Table 1.2: Demographics of the population in the four pilot CCDS communities

	SSP	YL[a]	TM	Sai Kung[a]
No. of households with at least one child aged 0 – 5[b]	13 023	23 949	23 187	17 405
Percentage of households with at least one child aged 0 – 5 AND median domestic household income of $19,999 or below[b]	53% (3)[c]	52% (4)[c]	55% (2)[c]	38% (12)[c]
No. of households with at least one child aged 0 – 5 AND at least one new arrival parent[b]	1 863 (5)[c]	2 321 (2)[c]	1 769 (7)[c]	1 656 (9)[c]
No. of lone parent families with at least one child aged 0 – 5[b]	476 (8)[c]	868 (1)[c]	599 (4)[c]	307 (14)[c]
No. of child abuse cases in 2005[d]	39 (7)[c]	133 (1)[c]	102 (2)[c]	38 (8)[c]
Projected resident population 2005[e]	375 000	551 900	499 300	407 100
Projected resident population 2015[e]	449 200	660 800	513 700	475 000
No. of children 0-5 registered with MCHCs[f]	18 221	12 614	23 065	17 055

[a] TSW and TKO are part of the Yuen Long and Sai Kung districts respectively. There is no separate statistics for the 2 communities.

[b] 2001 Census

[c] Rank order in the 18 districts plus marine (1: highest number)

[d] Based on SWD 2005 figures

[e] Planning Department (2006)

[f] The TSW and TKO figures include TSW and TKO statistics only

Table 1.3: Client demographic profile in the five CCDS MCHCs (2005)[a b]

	WK	TSW	YO	TMWH	TKO
No. of new registered cases	4 212	2 731	2 958	1 207	3 995
Family type					
Nuclear family	1 609 (38.2%)	1 708 (62.5%)	1 392 (47.1%)	784 (65.0%)	620 (15.5%)
Extended family	1 067 (25.3%)	925 (33.9%)	748 (25.3%)	381 (31.6%)	282 (7.1%)
Lone parent family	36 (0.9%)	16 (0.6%)	33 (1.1%)	4 (0.3%)	3 (0.1%)
Residential status					
Both parents Hong Kong permanent residents	1 586 (37.7%)	1 267 (46.4%)	1 465 (49.5%)	763 (63.2%)	2 649 (66.3%)
One or both parent(s) being new arrivals from China[c]	801 (19.0%)	400 (14.7%)	330 (11.1%)	96 (8.0%)	294 (7.4%)
Both parents being two-way permit holders[d]	148 (3.5%)	214 (7.8%)	138 (4.7%)	58 (4.8%)	244 (6.1%)
One parent being Hong Kong permanent resident and one parent being two-way permit holder	715 (17.0%)	487 (17.8%)	534 (18.1%)	207 (17.2%)	453 (11.3%)

Father education					
Form 3 or below	1 589	1 097	1 181	371	1 050
	(37.7%)	(40.2%)	(39.9%)	(30.7%)	(26.3%)
Form 4 or above	2 411	1 524	1 579	802	2 794
	(57.2%)	(55.8%)	(53.4%)	(66.5%)	(69.9%)
Mother education					
Form 3 or below	1 808	1 138	1 228	376	1 171
	(42.9%)	(41.7%)	(41.5%)	(31.2%)	(29.3%)
Form 4 or above	2 356	1 551	1 598	810	2 757
	(55.9%)	(56.8%)	(54.0%)	(67.1%)	(69.0%)
Employment status					
Both parents working	1 246	782	832	486	1 947
	(29.6%)	(28.6%)	(28.1%)	(40.3%)	(48.7%)
One parent working	2 235	1 166	1 310	521	1 375
	(53.1%)	(42.7%)	(44.3%)	(43.2%)	(34.4%)
Neither parent working	287	217	263	73	224
	(6.8%)	(8.0%)	(8.9%)	(6.1%)	(5.6%)

[a] The data included cases transferred from other MCHCs
[b] Percentage not equal to 100% due to the existence of incomplete data
[c] Defined as new arrivals from China who have resided in Hong Kong for 7 years or less
[d] Two-way permit holder: visitor from China

1.4 The committees

At the central level, a CCDS Task Force was set up to steer the initiative and monitor its progress. The Task Force was chaired by the Deputy Secretary (Family and Women), Health Welfare and Food Bureau (HWFB). Members include community leaders, professionals, NGOs and officers from the HWFB, DH, SWD, EMB and HA.

At the district level, CCDS Coordinating Committees (Coordinating Committee) led by DH with representatives from the HA, SWD, and EMB were set up to co-ordinate the implementation of the pilot CCDS in each of the four communities. This provided a platform for the various government departments to discuss and iron out district and frontline issues during the implementation process. The Coordinating Committee also consulted various stakeholders on implementation issues.

References

Census and Statistics Department (2001). *Basic tables for district council statistics*. Hong Kong SAR Government.

Census and Statistics Department (2002). *Thematic report – persons from the mainland having resided in Hong Kong for less than 7 years*. Hong Kong SAR Government.

Civil Engineering and Development Department (2004). *Tin Shui Wai New Town*. Retrieved 1 August, 2006, from http://www.cedd.gov.hk/eng/about/achievements/regional/regi_tinshuiwai.htm)

Housing Authority (2007). *Property location and profile*. Retrieved 16 January, 2007, from http://www.housingauthority.gov.hk.eu/interactivemap/districtmap/0//1-347-3_3_1,00.html

Planning Department (2002). *Tuen Mun*. Retrieved 1 August, 2006, from http://www.pland.gov.hk/press/publication/nt_pamphlet02/tm_html/index_e.html

Planning Department (2006). *Projections of Population Distribution, 2006-2015*. Retrieved 16 January, 2007, from http://www.pland.gov.hk/info_serv/statistic/tables/WGPD_Report_full.pdf

Sai Kung District Council (2005). *District highlights*. Retrieved 1 August, 2006, from http://www.districtcouncils.gov.hk/sk/english/welcome.htm

Sham Shui Po District Council (2005). *District highlights*. Retrieved 1 August, 2006, from http://www.districtcouncils.gov.hk/ssp/english/welcome.htm

Shonkoff, J.P., & Phillips, D.A. (Eds.). (2000). *From Neurons to Neighborhoods – The science of early childhood development*. Washington, D.C: National Academy Press.

Social Welfare Department (2001). *Annual Report.* Hong Kong SAR Government.

Chapter 2
The Design of the CCDS

2.1 Conceptual framework

As mentioned in chapter 1, the CCDS was a community-based programme which aimed to ensure early identification of the varied needs of children and their families and timely referral to appropriate services for management. This was achieved by augmenting the existing service for children 0-5 through better alignment of the delivery of health, education and social services. The design of the CCDS was based on theories on help seeking behaviour, and drew on concepts of hierarchy of health promotion outcomes (Nutbeam, 1998), dimensions of quality of service (Maxwell, 1992) and assessment of quality in health care (Donabedian, 1988). The following is a brief explanation of the relevant theories and concepts.

2.1.1 Theories of help-seeking behaviour

As the aim of CCDS was early identification and referral of children and families with needs to appropriate services for management, one of the prerequisites for its success was the willingness of children and families to accept the referral for appropriate services. The theories of help-seeking behaviour were relevant here as they dealt with factors influencing people's willingness to seek help.

In the help-seeking behaviour literature, especially those in relation to utilization of mental health services, it was recognized that a necessary precursor of any help-seeking behaviour was that people realized they had a problem. Among Chinese people, there might be barriers in admitting that there was a mental health or family problem, because of the "shame" or stigma associated with mental health problems and the reluctance to disclose family problems to outsiders (Leong & Lau, 2001; Fan & Karnilowicz, 2000). Other important elements affecting help-seeking behaviour were the knowledge/awareness of available services and perceived accessibility of service (Leong & Lau, 2001). Finally, outcome expectancy was another important factor affecting help-seeking behaviour. People would not engage in help-seeking behaviour unless they perceived that the action was likely to bring desirable outcomes (Schwarzer, 2002).

2.1.2 Hierarchy of health promotion outcomes

Nutbeam (1998) described three kinds of health promotion actions. Education referred to the creation of opportunities for learning to enhance the individuals' capacity to improve and protect their health. Facilitation referred to the mobilisation of social and material resources for health, in partnership with individuals or social groups. Advocacy referred to actions to overcome structural health barriers taken on behalf of individuals or groups. As a result of these health promotion actions, a hierarchy of health promotion outcomes could be expected:

- **Health promotion outcomes** – these were intervention impact measures including health literacy (e.g. health-related knowledge, attitudes, motivation, knowledge of where to go and what to do to gain access to gain service), social action and influence (e.g. community participation) and healthy public policy and organizational practice (e.g. policies directed towards improving access to service). These represented the more immediate results of health promotion activities (Nutbeam, 1998).
- **Intermediate health outcomes** – these were modifiable determinants of health such as healthy lifestyles (e.g. food choice, physical activity), effective health services (e.g. access to and appropriate use of health services) and healthy environments (e.g. safe

physical environment). These outcomes represented the determinants of health and social outcomes (Nutbeam, 1998).

- **Health and social outcomes** – examples of social outcomes were quality of life, functional independence, equity, and examples of health outcomes were reduced morbidity, disability, and avoidable mortality. This type of outcome was at the top of the hierarchy and was regarded as the end point of health and social intervention (Nutbeam, 1998).

2.1.3 Quality of service

Donabedian (1988) described three aspects of health services under which quality could be assessed:

- **Structure (resources)** referred to the input of resources, tangible or intangible, into the provision of services, such as staff, building and facilities in the former case or staff culture, morale and training in the latter.
- **Process (actions)** referred to what was done to the clients with the resources, which might be clinical (e.g. screening, assessment, management, etc.) or non-clinical (reception service, etc.).
- **Outcome (results)** referred to the results of the activities and the benefits (or otherwise) to clients, which might be described at the individual or population level.

Maxwell (1992) outlined six dimensions of service delivery (p. 171, Box 1):

- **Effectiveness** – was the treatment given the best available in a technical sense, according to those best equipped to judge? What wais their evidence? What was the overall result of the treatment?
- **Acceptability** – how humanely and considerately was this treatment/service delivered? What did the patient think of it? What would an observant third party think of it ("How would I feel if it were my nearest and dearest?") What was the setting like? Were privacy and confidentiality safeguarded?
- **Efficiency** – was the output maximised for a given input or (conversely) was the input minimised for a given level of output? How did the unit cost compare with the unit cost elsewhere for the same treatment/service?
- **Access** – could people get this treatment/service when they needed it? Were there any identifiable barriers to service – for example, distance, inability to pay, waiting lists, and waiting times – or straightforward breakdowns in supply?
- **Equity** – was this patient or group of patients being fairly treated relative to others? Were there any identifiable failings in equity – for example, were some people being dealt with less favourably or less appropriately in their own eyes than others?
- **Relevance** – was the overall pattern and balance of services the best that could be achieved, taking account of the needs and wants of the population as a whole?

Maxwell (1992) argued that quality was multi-dimensional and there might be overlaps (e.g. access and equity) and trade-offs (e.g. equity and efficiency) between the dimensions. Equity and relevance might be more applicable at the population level whereas effectiveness, acceptability, efficiency and access were more useful at the individual level.

In this report, we focused our discussions on the design, implementation and outcome of one specific service, the CCDS. The dimension of relevance, which referred to the overall pattern and balance of service in the population, would therefore not be discussed.

2.1.4 The design of the CCDS

Consequent to community advocacy for government leadership and inter-sectoral

collaboration (health promotion action), a policy initiative to support children and families in need was announced in 2005, and the CCDS was being put in place (health promotion outcome). The design of the CCDS was guided by the theories and research on help-seeking behaviour. It involved changes in organisational structure and processes, including, among others, improvement in information technology and interviewing rooms, staff training to facilitate the identification and referral of clients, protocols to standardize practices, and measures to break down inter-sectoral barriers to achieve integration of services. The intermediate health outcome to be measured was an improvement in the quality of service. It was anticipated that the well-being of families and children (social and health outcome) might ultimately be improved. The design of the CCDS is illustrated in Figure 2.1.

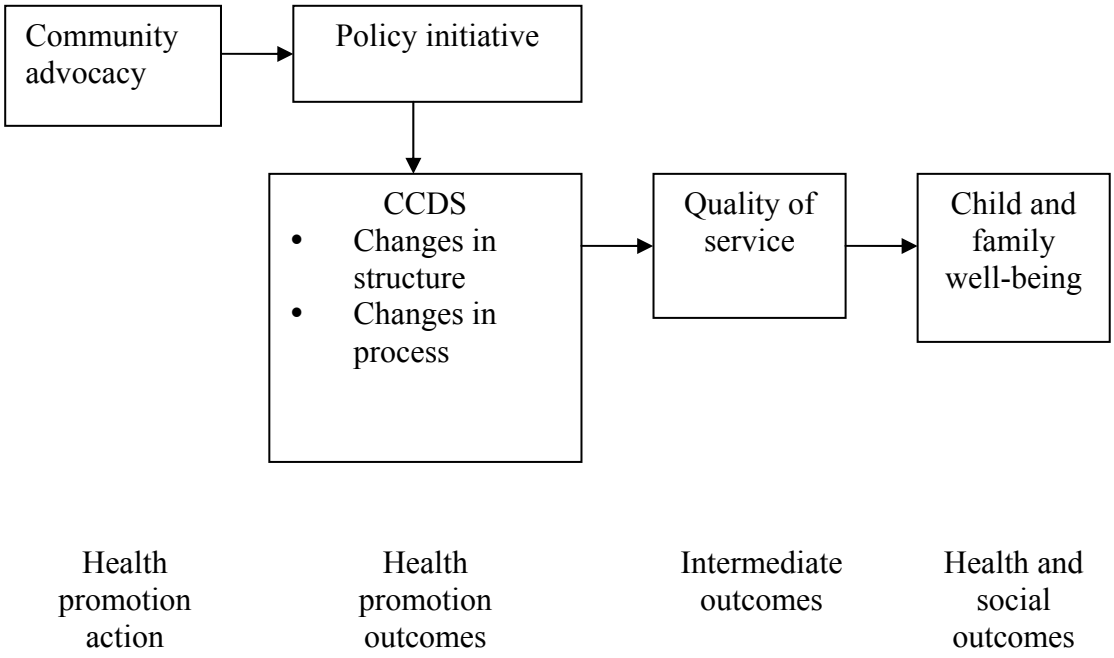


Figure 2.1: The design of the CCDS

2.2 The CCDS components

Built on existing services provided in MCHCs, HA hospitals, IFSCs and pre-primary institutions, the pilot CCDS comprised four additional components. These four components and their implementation schedules are briefly described below, to be followed by detailed description of each component in the subsequent chapters.

2.2.1 Identification and holistic management of at-risk pregnant women

The aim of this component was to address health inequality of the disadvantaged or "hard to reach[4]" groups. Unequal health care might be the result of unequal access due to

[4] "Hard to reach" groups generally refers to those marginalized by poverty, ethnicity and different cultural or behavioural norms (e.g. illicit drug users), whose health status are most affected by inequity or alienation and fails to improve despite the efforts of conventional public health approaches (Carr, Matheson & Tipene-Leach, 2001).

financial, geographical, or cultural barriers. In Hong Kong, MCHC, IFSC and HA services were available territory-wide and conveniently located. The former two services were free of charge, while the latter was highly subsidized for entitled persons, hence there should be minimal financial or geographical barriers to access. However, marginalized groups such as pregnant teenagers, women with substance abuse, etc. did not access the services they needed even without financial and geographical barriers. The component was designed to address the specific needs of these groups.

At-risk pregnant women (e.g. those with substance abuse or mental illness, or teenage and/or lone mothers) would be identified by various health and social service professionals from the DH, HA and SWD/NGOs during the antenatal period. Comprehensive assessment would be conducted and holistic management plans were developed for them. Midwives from the HA were responsible for service coordination and progress monitoring of these women. After delivery, a visiting community paediatrician (CP) would provide follow-up service for their children in MCHCs.

2.2.2 Identification and management of mothers with postnatal depression (PND)

PND affected about 10% of postnatal women. It caused considerable psychological distress to the mother and the family. The cognitive and emotional development of the infant might also be affected and the adverse effects mighty persist into late infancy and early childhood. Early identification and timely intervention might improve the mental health of the mother and family as well as the development of the child.

Under the CCDS, postnatal mothers would be routinely screened for PND in MCHCs by trained nurses, using the Edinburgh Postnatal Depression Scale (EPDS). Depending on their needs, counselling services would be provided to mothers by trained MCH nurses with referral to visiting psychiatric nurses on-site, clinical psychologists or psychiatrists, as appropriate. Other social needs would also be followed up by social services.

2.2.3 Identification and management of families with psychosocial needs

It was well recognized that the development of children was affected by their families and the community. Children from families which were socially marginal or economically deprived, e.g. low-income families, new arrival families, lone-parent families, were more likely to encounter difficulties. To address health inequalities of these groups, in collaboration with the SWD, the DH developed an assessment tool for MCH staff to facilitate their early identification of families with psychosocial needs. Identified families would be followed up by staff of IFSCs. For those not yet ready to approach IFSCs for assistance, IFSC staff would meet them at MCHCs if situation warranted or contact them through home visits to provide assistance.

To provide parents with updated information on child and family related issues and community resources, parent resource corners (PRCs) would be set up in MCHCs[5].

2.2.4 Identification and management of pre-primary children with physical, developmental and behavioural problems

Some developmental and behavioural problems might only become manifest after children had started pre-primary education. In collaboration with child care centres (CCCs) and KGs, a referral and feedback system would be developed to enable pre-primary educators to identify and refer these children to MCHCs for assessment and further assistance in a timely manner.

---

[5] At the time of writing the report, the PRC was only set up at WK MCHC. Information about client satisfaction with the facility is summarised in Appendix 2.1.

2.3 Implementation schedule

The CCDS was first piloted in the WK MCHC in July 2005, and extended to the other four MCHCs in January 2006 (official commencement). The schedule for the full implementation of the various components in the five centres is shown in Table 2.1.

Table 2.1: The schedule for the full implementation of the four components in the four communities

Communities	**SSP**	**TSW**	**TM**		**TKO**
MCHC(s)	WK	TSW	YO	TMWH	TKO
Identification and holistic management of at-risk pregnant women					
	April 2006	May 2006	May 2006	May 2006	Aug 2006
Identification and management of mothers with PND					
Visiting psychiatric nurse	July 2005	Jan 2006	Jan 2006	Jan 2006	Feb 2006
EPDS screening	Jan 2006	Mar 2006	June 2006	Mar 2006	Sept 2006
Identification and management of families with psychosocial needs					
	July 2005	Mar 2006	May 2006	Mar 2006	Apr 2006
Identification and management of pre-primary children with problems					
	July 2005	Jan 2006	Jan 2006	Jan 2006	Jan 2006

References

Carr, J., Matheson, D., & Tipene-Leach, D. (2001). "Hard to reach" populations. In D. Pencheon, C. Guest, D. Melzer, & J.A.M. Gray (Eds.), *Oxford handbook of public health practice*. New York: Oxford University Press.

Donabedian, A. (1988). The quality of care: how can it be assessed? *JAMA, 260*, 1743-8.

Fan, C., & Karnilowicz, W. (2000). Attitudes towards mental illness and knowledge of mental health among the Australian and Chinese community. *Australian Journal of Primary Health-Interchange, 6*(2), 38-48.

Leong, F.T.L., & Lau, A.S.L. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research, 3*, 201-214.

Maxwell, R.J. (1992). Dimensions of quality revisited: from thought to action. *Quality in Health Care, 1*, 171-177.

Nutbeam, D. (1998). Evaluating health promotion – profess, problems and solutions. *Health Promotion International, 13*, 27-44.

Schwarzer, R. (2002). *Modeling health behaviour change: the Health Action Process Approach (HAPA)*. Retrieved 14 February, 2005, from http://userpage.fu-berlin.de/~health/hapa.htm

Appendix 2.1: The PRC

The PRC aimed to provide comprehensive and updated information about child and family related issues and relevant services and resources in the community. Information about childcare and education, child development, parenting, women health, family issue, and services offered by DH, SWD, NGO and EMB, were provided, in the form of pamphlets (Chinese and English) and audio-visual materials. Clients could also access online information on child and family issues.

A client satisfaction survey was conducted with 110 service users in WK MCHC. The majority of the users had secondary education (68%) or above (30%). Most clients spent about 10 to 20 minutes in the PRC. The most common services used by clients are shown in Figure 2.1.1.

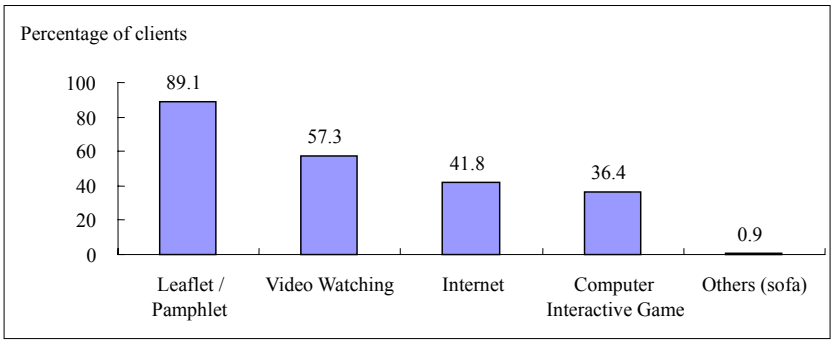


Figure 2.1.1: Services used by clients in the PRC (more than one service could be used by each client)

Clients were positive about the provision of PRC. They used the PRC because of its usefulness and convenience and would recommend it to their relatives or friends. The overall satisfaction rate was about 97% (Figure 2.1.2).

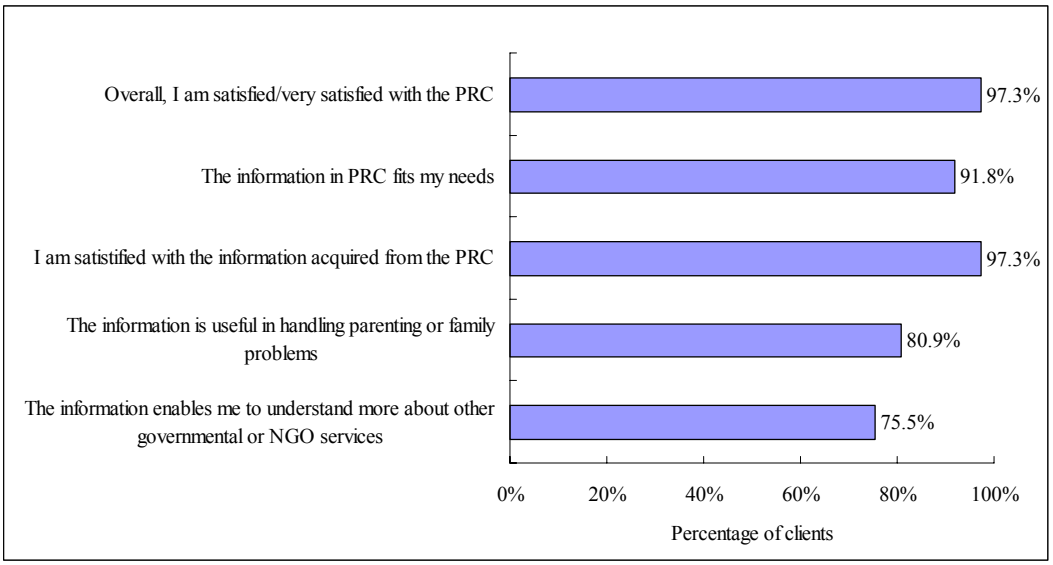


Figure 2.1.2: Client satisfaction with the PRC

Chapter 3
Methodology

3.1 Concepts and terminology in evaluation

3.1.1 Evaluation

According to Last (2001), evaluation was "a process that attempts to determine as systematically and objectively as possible the relevance, effectiveness, and impact of activities in the light of their objectives" (p. 64). Patton (1997) defined programme evaluation as "the systematic collection of information about the activities, characteristics, and outcomes of programmes to make judgments about the programme, improve programme effectiveness, and/or inform decisions about future programming" (p. 23). Both of the above definitions emphasized systematic data collection in order to make judgment on programme effectiveness.

3.1.2 Types of evaluation

One of the most common distinctions in the literature was that between formative and summative evaluation. The purposes of formative evaluation were i) to improve implementation; ii) to solve unanticipated problems, and iii) to make sure that the intervention was proceeding according to plan and the clients were progressing toward desired outcomes (Patton, 1997). The purpose of summative evaluation was to find out whether the objectives of an action had been attained, and focused on the effectiveness of the programme (Patton, 1990).

3.2 Evaluation of the CCDS

The main objective of the CCDS was early identification and referral of children and families in need to appropriate services for management. The programme components focused on the identification and referral mechanism, and making the services more accessible and acceptable, and it was expected that clients would receive services that met their needs.

As the CCDS was a new initiative, the current evaluation included both formative and summative evaluation. The focus of the formative evaluation was on whether implementation of the new initiative had been proceeding according to plan, how this had impacted on the intermediate outcome (quality of health services) and on identification of the conditions necessary for the successful implementation of the initiative. The focus of summative evaluation was on whether there were changes in the intermediate outcome, i.e. the quality of services (See Figure 3.1). Gilliam, Ripple, Zigler and Leiter (2000) pointed out that for new initiatives, there were often teething problems in the beginning and conducting evaluation of social and health outcomes with the first cohorts of clients might not be appropriate.

The pilot commenced officially on the 1st of July 2005 in SSP and on the 1st of January 2006 in TSW, TM and TKO. This evaluation study covered the pilot programme in the 5 MCHCs of the 4 communities, during the period from the 1st of July 2005 to the 30th September 2006.

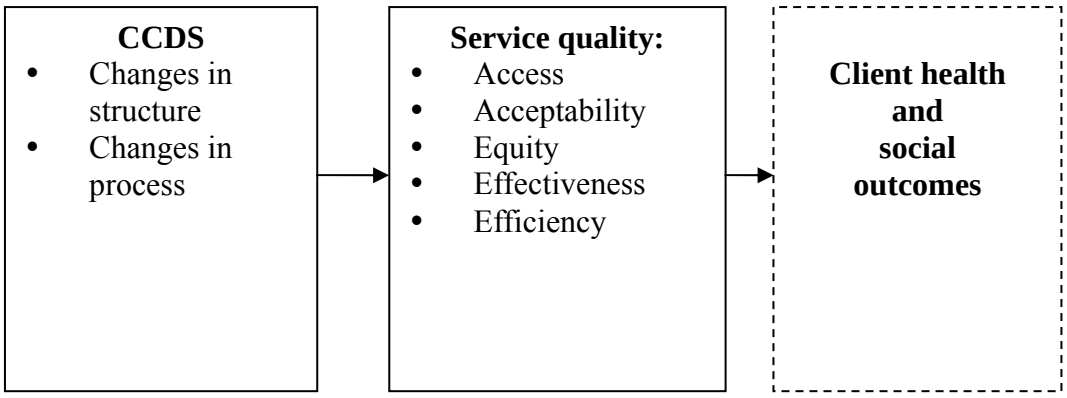


Figure 3.1: Formative and summative evaluation

3.2.1 Dimensions or outcome for evaluation

The various dimensions to be examined under the formative evaluation, and outcome measures for summative evaluation are listed as follows:

Dimensions in the implementation of the CCDS to be examined under formative evaluation included:

- **Structural issues**
  - i) Facilities
  - ii) Staff
  - iii) Training
  - iv) Others
- **Process issues**
  - i) Service interface
  - ii) The identification and referral mechanism
  - iii) Client management
  - iv) Others

Outcome measures (changes in the quality of service) to be examined under summative evaluation included:

- **Access** – change in the number of clients utilizing services
- **Acceptability** – client perception of and satisfaction with the service
- **Equity** – availability of the identification-referral mechanism and services to different sub-groups of the population
- **Effectiveness** – change in the psychosocial well-being of clients
- **Efficiency** – maximizing the output for a given input or vice versa

3.3 Method of data collection

Data were collected using different approaches and from different sources. Details are as follows:

3.3.1 The CCDS data management system

The data management system served to collect service statistics and client characteristics on the four CCDS components:

- Identification and holistic management of at-risk pregnant women – data on

characteristics of mothers and children of at-risk pregnancies were collected.

- Identification and management of mothers with PND – the information included demographic characteristics of identified clients, types of services recommended, services usage and referral. The coverage of PND screening by EPDS was also monitored.
- Identification and management of families with psychosocial needs – the information included demographic characteristics of clients assessed, reasons for assessment, recommended services, reasons for referral (where applicable) and service usage at one month after initial identification.
- Identification and management of pre-primary children with physical, developmental and behavioural problems – the information included demographic characteristics of referred children and their families, reasons for referral, diagnosis and recommended services.

3.3.2 Feedback from clients and staff

Semi-structured interviews were conducted with clients to obtain their perceptions and experiences of the CCDS. The clients included at-risk pregnant women identified for intervention during the antenatal period, those referred to psychiatric nurse for further support, those recommended for referral to social services (including those who accepted the referral, declined the referral and defaulted the appointment), parents of pre-primary children referred to MCHCs, and principals/supervisors of pre-primary institutions who referred children for assessment. Phone interviews were conducted with supervisors/principals of pre-primary institutions in the four communities on their knowledge and usage of the referral system, their knowledge and attendance in the briefing and training sessions.

Staff focus groups or interviews were also conducted to collect their views and experience of the CCDS. Separate focus groups or individual interviews were carried out for MCH nurses, social workers, visiting psychiatric nurses and the CCDS midwife.

3.3.3 Client outcome

Information was available for the target clients of two of the components: mothers with PND and clients requiring social services intervention.

A randomized controlled trial on the effectiveness of PND screening using EPDS was being conducted. The study commenced in October 2005 and data collection would continue until December 2006 (2008 for 18 month data collection).

For social service intervention, at case termination or 6 months after referral (whichever the earlier), social workers would complete a service termination form for each client. The information included the type of services provided and issues dealt with. In addition, for clients referred for casework, pre- (at referral) and post- (at case termination or 6 months after referral) intervention measures on client mental health were collected. This involved clients completing the General Health Questionnaire-12 (GHQ-12) at the respective time points. The GHQ-12 was a measure of psychological distress. A Chinese version with 12 items was developed out of the original 60-item English version (Pan & Golding, 1990).

Furthermore, the progress of clients referred for tangible services such as financial assistance, employment and housing was tracked. These services were selected for tracking as they were particularly relevant for the socially disadvantaged clients. In addition, using the extreme case sampling approach[6], the progress of clients referred to social services whose needs were met or unmet was tracked to shed light on success in services provision and

[6] "This approach focuses on cases that are rich in information because they are unusual or special in some way" (Patton, 1990, p. 169). The logic for using this approach is that lessons for improving the programme may be learnt from these unusual or extreme cases.

service gaps.

3.3.4 Training evaluation

Training courses were provided for MCH nurses and pre-primary educators (see chapters 5, 6 and 7). Evaluation forms on the usefulness of the courses were completed by the participants.

References

Gilliam, W.S., Ripple, C.H., Zigler, E.F., & Leiter, V. (2000). Evaluating child and family demonstration initiatives: lessons from the Comprehensive Child Development Program. *Early Childhood Research Quarterly, 15*, 41-59.

Last, J.M. (2001). *A dictionary of epidemiology* (4th ed.). Oxford, England: Oxford University Press.

Pan, P.C., & Golding, D.P. (1990). A comparison of the validity of GHQ-12 and CHQ-12 in Chinese primary care patients in Manchester. *Psychological Medicine, 20*, 931-940.

Patton, M.Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage Publications.

Patton, M.Q. (1997). *Utilization-focused evaluation: the new century text* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Chapter 4
Identification and Holistic Management of At-risk Pregnant Women

4.1 Service provision before CCDS

4.1.1 Obstetrics service

Before implementation of the CCDS, there was no standardized mechanism to screen for or identify pregnant women with psychosocial risks like drug abuse, mental illnesses, domestic violence, teenage pregnancy, etc. during the antenatal period. Case identification would depend on individual clinician's sensitivity and skills or client's self disclosure of relevant information. Obstetrics services for at-risk pregnancy were mainly provided on a need basis and there was no designated staff responsible for assessing and following up these cases. The antenatal and postnatal care of these at-risk cases was shared with MCHCs like most of the other low-risk cases, and there was inadequate coordination between the two parties. In addition, there was no standard mechanism to refer these cases to social workers or HA specialties such as psychiatry and paediatrics for follow-up after delivery. Cases would be referred as necessary based on individual clinician's assessment and there was inadequate communication among the involved parties. Moreover, a formal referral and feedback system was non-existent.

4.1.2 Paediatrics service

Although all newborn babies were assessed by paediatricians in the postnatal ward, there was no systematic identification of newborns with psychosocial risk factors. Newborns with risk factors were usually referred to paediatrics departments had these been identified during the antenatal period by obstetricians. More babies or young children from families with these risks were seen in paediatrics departments at a later stage, after having been referred by MCHCs, family doctors or private practitioners when physical, developmental or behavioral problems occurred. On the other hand, there was no established channel for the referral of children from at-risk families to paediatrics departments by social workers (of SWD or NGOs) who often came into contact with these clients. Although a referral system had been established between the FHS of DH, IFSCs and MSWs of the HA for pregnant women with psychosocial risk including lone mothers and those with substance abuse, the effectiveness of monitoring the progress of these families was variable. Meanwhile, there was also a paucity of communication among paediatrics departments, MCHCs, and community social services.

4.1.3 Psychiatry service

Before the implementation of CCDS, psychiatric services were provided to pregnant women identified to have mental problems during the antenatal period. Although most obstetric departments had implemented some form of screening for PND, there was no agreed protocol for managing women with this condition. Not uncommonly, women identified with depression or other mental health problems by MCHCs, the obstetric staff or family doctors, refused to attend psychiatric clinics and there was no mechanism for arranging psychiatric consultation in the community. There was not much communication, let alone a system for information sharing, among the psychiatry, O&G and paediatrics departments, which were actively involved in the care of pregnant women or mothers with mental illness and their families.

4.2 Changes in service provision under the CCDS

4.2.1 Changes in structure

CCDS midwives

One midwife from each of the three HA clusters were deployed for the identification of at-risk pregnant women, coordination of services for these women and monitoring of their progress.

Visiting CP to MCHCs

To provide easy access and minimize default on clinic attendance due to inconvenience, a CP would visit the MCHC during child health sessions. Clients would then be able to receive paediatric services provided by the visiting CP, including assessment and counselling, at the same time when they received vaccination and other routine child health services in the MCHC, instead of having to attend the hospital specialist outpatient clinic on separate occasions.

Training of staff

To equip staff of the relevant HA specialties, including psychiatry, obstetrics and paediatrics, with the necessary knowledge and skills for the early identification and holistic management of at-risk pregnant women and their children, structured training was provided before and during the implementation. This included knowledge on physiological changes of pregnancy and the psychological preparation for a pregnant woman, principles of intervention in early life, child protection issues, workflow related to the referral and management of at-risk cases and use of relevant checklists and questionnaires.

Training was given to CCDS midwives on the skills of conducting in-depth interviews with at-risk clients, management during the antenatal and postnatal periods and the use of the EPDS during postnatal visits. Briefing on MCH service was also provided to NGOs involved, for example, the Society for the Aid and Rehabilitation of Drug Abusers (SARDA).

4.2.2 Changes in process

Collaboration between organizations

In order to enhance early identification and holistic management of at-risk pregnant women and their children, close collaboration between different departments of HA, MCHCs and the social service sector was crucial. This had proceeded at the institutional, district and hospital levels:

- **Institutional level** – several meetings were held among the division head of the HA, heads of the O&G, Paediatrics and Psychiatry Services of HA, head of the FHS of DH, and head of the Family Service Team of SWD to discuss various programme design, implementation and service co-ordination issues.
- **District level** – in the District Coordinating Committee (DCC) meetings, the O&G, paediatrics and psychiatry departments of the cluster hospital and the MCHC(s) in the district discussed the various logistic issues, in particular those related to the selection of target risk-group(s), mechanism of identification and referral of at-risk clients between different parties, arrangement of postnatal follow-up for at-risk pregnant women and allocation of community paediatrician sessions in MCHCs.
- **Hospital level** – regular meetings were conducted among O&G, paediatrics and psychiatry departments of the cluster hospitals in order to facilitate communication, improve the efficiency of the identification and referral system for at-risk families and to

solve practical problems arising from the implementation of CCDS in the hospitals. Frequent case discussion was held among the CP, CCDS midwives and psychiatrists to enhance the holistic care of individual cases.

Identification and management of at-risk pregnant women

To achieve early identification of at-risk pregnant women during the antenatal period, systematic identification procedures were set up. Pregnant women found to have risk factors (for example, teenage pregnancy, drug-abuse, mental illness) would be referred to the CCDS midwife in the antenatal clinic for more in-depth assessment and counselling as well as subsequent follow-up. Issues related to healthy pregnancy, safe birth, and childcare would be discussed during antenatal and postnatal visits. They would be referred to MSW for assessment and management if deemed necessary.

Depending on the target risk group(s) of the cluster (see 4.3), families with risk factors identified by social workers of SWD or NGOs, e.g., SARDA for heroin/methadone user, Centre for Psychotropic Substance Abusers (PS-33) for soft drug user, New Life Society for mental illness, could be referred directly to the obstetrics department of HA hospitals during the antenatal period. The subsequent management would follow an agreed care plan.

After delivery, these babies would be followed up by the CP at the same time when they received routine child health services at the MCHC.

4.3 The pilot programme in the three clusters

As there were variations in community characteristics, different clusters had decided to target different risk groups. They also commenced the pilot programme at different times. The pilot programme in the three HA clusters and the service statistics up to October 2006 are detailed as follows:

4.3.1 Kowloon West Cluster

In collaboration with SARDA and PS-33, the KWC hospitals mainly focused on the identification and management of pregnant women with substance abuse, which had a comparatively higher rate in the district. To get an idea of the profile and kind of problems encountered in children of women who were using illicit drugs, a survey on the health and development of 35 children of these mothers was conducted in late April 2006 in the SSP Methadone Clinic. The details are in Appendix 4.1.

The intervention

Under the new initiative, women heroin or methadone users of reproductive age registered in the methadone clinics were closely monitored by the SARDA social workers. Once confirmed pregnant, they were referred to the special antenatal clinic in the PMH through a fast channel. Thorough assessment and counselling were provided. Those who opted for discontinuation of pregnancy had the pregnancy terminated and intrauterine contraceptive device (IUCD) inserted, after counselling. Women who chose to continue with the pregnancy were followed up in PMH through an Integrated Service Programme (ISP) (Appendix 4.2). Their newborns were managed in the neonatal ward and monitored closely for drug-withdrawal symptoms. They were then followed up regularly in the WK MCHC by the visiting CP for health and developmental progress. Mothers were given guidance in childcare and encouraged to receive detoxification and reduce other high-risk behaviours like smoking and drinking. They were also followed up by social workers from the IFSC for family support and other social services as appropriate.

Case reports

Two pregnant women with illicit drug use recruited by SARDA into the ISP were interviewed. Their case history is described below as an illustration of the profile of clients and their management under this component.

Case 1

A 26-year-old unmarried mother had her first baby with her boyfriend. She was a known heroin addict for more than 10 years without her boyfriend's knowledge. She used methadone since 2001 and attended the SSP Methadone Clinic since 2004. She practiced no contraception and became pregnant. This was an unplanned but wanted pregnancy. She was first introduced to the ISP by the SARDA social worker at 6 weeks of pregnancy. Upon her consent to join the programme, she was accompanied by the social worker to see an obstetrician at PMH for antenatal check-up. The same obstetrician followed her up for most of the antenatal visits and the dose of methadone was carefully reduced from 75 to 50 mg during the second trimester. A baby girl was delivered full-term in PMH and closely monitored for drug abstinence syndrome. The baby was scheduled for follow up at the WK MCHC by the community paediatrician, while the mother would be admitted to Kwai Chung Hospital (KCH) for detoxification.

Case 2

A 33-year-old client had her second baby delivered at a maturity of 30 weeks. She was a heroin addict for more than 6 years. She had her first child (an unplanned pregnancy but a wanted baby) with her ex-boyfriend about 2 years before the birth of this child, soon after she had arrived in Hong Kong from the Mainland. She switched from heroin to methadone during her first pregnancy with the advice from a private doctor and attended the methadone clinic in Yaumatei. Without much antenatal support, she delivered a term baby in Queen Elizabeth Hospital (QEH) but discharged herself with the baby as there was miscommunication with the staff about keeping the baby in hospital for observation. She resumed heroin use after the delivery.

She moved to the SSP district after marriage and her husband encouraged her to abstain from drug use when she was pregnant (planned and wanted child). She then attended SSP methadone clinic and was recruited into the ISP by the SARDA workers at around 4 months of pregnancy. She had been seen 3 times at the antenatal clinic in PMH before giving birth to a preterm baby at 30 weeks' gestation. The baby was observed in hospital for 8 weeks for drug abstinence syndrome before discharged home. The baby was thriving well and had been followed up by the community paediatrician once in WK MCHC. Meanwhile, the mother had successfully undergone detoxification and was being seen regularly in the detoxification centre in KCH.

Comments on the services

The views of the two clients on the programme are described below. The quotes are in appendix 4.5. Both clients were appreciative of the CCDS service, especially the caring attitude and the professional advice from workers (1, 2, 3, 4). However, there was some concern about the antenatal visits by one of the clients. She felt that some obstetricians did not understand her situation and was less satisfied with their management. She preferred to be followed up by the same obstetrician throughout (5).

4.3.2 New Territories West Cluster

This component of the CCDS was introduced in TM and TSW by phases since May 2006. These two satellite towns had a younger population, with a comparatively higher

number of lone parent households and child abuse cases. Teenage pregnancy was a prevalent problem and in TMH, there were around 150 cases per year. Teenage pregnancy was therefore selected as the main target risk-groups in NTWC.

The Intervention

Pregnant teenagers aged below 16 and lone pregnant teenagers between 16 and 18 years were recruited into the programme. They were referred to the CCDS midwife of TMH for management. Thorough assessment and counselling were provided by the midwife during the antenatal period. The CP was also actively involved in the education and formulation of childcare plan in the antenatal period as well as providing subsequent follow-up of their babies in MCHCs.

Pregnant women with mental illness were referred for psychiatric management and their children would be followed up by the CP in MCHCs. A management flow chart of the CCDS clients in NTWC was followed (Appendix 4.3). To facilitate assessment, counselling and data collection, a CCDS record form and checklist was used so that the information could be shared between all parties involved.

Case Reports

Two pregnant teenagers recruited into the antenatal programme of TMH were interviewed. Their case histories are described below as an illustration of the profile of clients and their management under this component.

Case 1

An 18-year-old unmarried mother was recruited into the antenatal care programme for teenage pregnant women in TMH since mid-June 2006 (at 20 weeks of gestation) by the CCDS midwife. Her pregnancy was unplanned. She delivered the baby in November 2006. The baby attended TSW MCHC for routine child health services. The CCDS midwife had provided detailed advice on antenatal care, childcare, breastfeeding and contraception for the mother. The mother had also been referred to IFSC by the CCDS midwife and was seen by a social worker once but no service need was identified. She had been cohabitating with her boy friend and living with his family. They planned to get married later.

Case 2

An 18-year-old mother had two children. The first was a 2-year-old daughter with her ex-boyfriend and the second was a baby girl born in October 2006 in TMH. Both pregnancies were unplanned. The mother had postnatal depression after the first delivery and was followed up at the Psychosomatic Clinic in TMH. She was recruited into the antenatal care programme in TMH since June 2006 at 18 weeks' gestation. The baby had been attending TSW MCHC for routine child health services since birth. The mother had emotional problems after delivery but became stable with counselling. The mother then got married in November 2006 and had since lived with her husband, the two children and other maternal family members.

Comments on the services

The views of the two clients on the services are described below. The quotes are in appendix 4.5. Both clients praised the friendliness and openness of the midwife and were willing to talk to her (6, 7). One of them contrasted this with her less satisfactory experience during her previous pregnancy (8). They were positive about the professional advice on childcare and contraception provided by the midwife and the CP (9, 10, 11, 12, 13).

However, one of them was less satisfied with the cursory service provided by some doctors during the antenatal checkups (14).

4.3.3 Kowloon East Cluster

The CCDS was first launched in the KEC in the TKO district. The UCH was the only HA hospital providing obstetric and neonatal service in the cluster.

The Intervention

Six at-risk groups including pregnant women with mental illnesses, substance abuse, domestic violence, teenage pregnancy, lone motherhood and other important clinical conditions were included. They were identified in the antenatal period through the maternity booking history checklist, a self-administered questionnaire and enquiry of their demographic profile and risk-taking behaviour. At-risk cases were managed according to the flow chart in Appendix 4.4. They were referred to the CCDS midwife for more in-depth assessment, counseling and education. Phone consultations and home visits were conducted where necessary. At-risk pregnant women who opted to receive services in TKO MCHC would be referred for postnatal care after delivery and their children followed up by the visiting CP in MCHCs. Those who opted for Lam Tin and Ngau Tau Kok MCHCs[7] would be counted but not considered as CCDS cases and routine services were provided.

In addition, pregnant women in three other risk groups including those from families on Comprehensive Social Security Assistance (CSSA) or with unemployed father; those with sexually transmitted diseases (STDS) and those with either parent as non-entitled person (NEP) were not considered as core CCDS cases at the pilot stage in view of the limited manpower, but they were counted in the KEC statistics for future planning and implementation.

4.4 The formative process

This section focuses on describing factors deemed to have contributed to the success as well as issues that have arisen from the implementation of this component, from the perspectives of the CP, CCDS midwives and SARDA social workers. Measures undertaken to improve the implementation issues (in italics) are described where appropriate. The quotes are in Appendix 4.6.

4.4.1 Structure

Facilities

There were difficulties for HA staff to gain immediate access to clients' clinical information from the HA Clinical Management System (CMS) in MCH premises. This might cause inconvenience in the clinical management of some clients.

The technical solutions for gaining access into the HA CMS system from non-HA sites were being explored to enhance the client clinical management process.

Manpower/workload

The SARDA worker commented that the ISP for pregnant women with drug use was worth running but they had a heavy caseload and the manpower was tight. For every client, they had to deal with many emerging problems related to childbearing and drug use (1, 2).

This issue was largely resolved through the re-engineering of existing service provision

[7] Besides serving the TKO area, which was part of the Sai Kung District, the UCH also served the Kwun Tong district. Lam Tin MCHC and Ngau Tau Kok MCHC were the 2 MCHCs in the Kwun Tong District.

e.g. the development of the ISP and re-deploying existing resources to target clients most in need.

The CCDS midwife claimed that her workload was heavy. She found it hard because of the lack of understanding and support from other staff (3).

There was also increased workload for down-stream services, e.g. referral of antenatal clients with mental health problems to the psychiatry service.

Staff Role

The role of CCDS midwives, originally designated as screening and identification of at-risk women, was considered inadequate.

The role of CCDS midwives has gradually evolved into that of case co-ordination. For example, the CCDS midwife in NTWC has developed a management protocol for following up teenage pregnant women, including making referrals, co-ordinating service and monitoring client progress (4, 5).

During the pilot stage, the CP had to work with the paediatrics, obstetrics and psychiatry departments of three HA clusters, oversee the planning, implementation and evaluation of different pilot projects of the three clusters, and visit 5 MCHCs in the four communities to follow-up children of at-risk families.

To make the best use of the CP's expertise, the possibility of re-defining his role and re-prioritizing his duties was under consideration.

4.4.2 Process

Staff attitude

It was reckoned that for the pregnant teenagers, a trusting relationship was essential to engage them. This relationship was established through the midwife's acceptance of and respect for the clients, willingness to listen, and treating them as mature persons (6).

Client management

Frontline workers reckoned that it was important to catch the "critical moment" to motivate the at risk pregnant women to change their health behaviour. For example, SARDA workers emphasized that there were two "critical moments" for women with illicit drug use: at diagnosis of pregnancy and at childbirth. The SARDA workers made use of the moment of diagnosis of pregnancy to get clients' commitment to join the ISP. Immediately after childbirth, clients were most receptive to advices on childcare and family planning (7). To increase the awareness and knowledge of contraception by teenage pregnant women, CCDS midwife also made use of the "critical moment" when clients were most receptive, i.e. within few days after delivery, to give contraceptive advice. (8)

Procedure/protocol

There was a lack of consensus in the protocol for the antenatal components among the three HA clusters. The number and nature of at-risk groups targeted for identification and intervention were not agreed across clusters. The definition of individual risk groups was not clear. Consensus among different clusters was considered vital for smooth service implementation.

Collaboration

In the NTW cluster, a direct referral system to IFSCs by CCDS midwife was also established. She would refer all pregnant teenagers to IFSCs to facilitate early identification of their social service need (9).

The mismatch in the catchment area between HA hospitals and MCHCs across all clusters caused some confusion in the referral and follow-up of pregnant women and their babies, as well as collection of service statistics.

The confusion over the catchment area issue was resolved in the interim by clarifying with HA hospitals that all MCHCs territory-wide would provide routine follow-up service to pregnant women and their babies. This issue would be solved when the CCDS had completely rolled out to all MCHCs.

4.4.3 Summary

To serve marginalized clients such as mothers with illicit drug use, the resource-intensive, integrated and one-stop service like the one provided by SARDA, was imperative. The caring and empathic attitudes of the frontline workers, as well as their enthusiasm and passion were also significant factors contributing to the success of the service. Good inter-sectoral collaboration and co-operation among staff of different medical specialities were also important. There was, however, a need to re-define the roles of staff like the midwives and the CP. The selection of the target risk groups also required further deliberation.

4.5 Service statistics

The relevant outcome measures for the pregnant women included the adoption of effective contraceptive practices, drug detoxification and smoking cessation etc. The child outcome indicators included gestation at birth, birth weight, development, vaccination status etc. The details are in Table 4.1. In addition, a group of children whose mothers had risk factors as defined in the various clusters were recruited from the MCHCs and followed up by the visiting CP. The service statistics are summarized in Table 4.2.

4.6 Summary and conclusions

This component targeted at-risk pregnant women. Access was enhanced through bringing the service to the clients, for example, the ISP for heroin users. The clients were highly appreciative of the integrated service, the accepting, and caring attitudes of the health and social workers, and their professionalism. Many of the clients were able to make informed decisions on their pregnancy, drug use and lifestyle such as the practice of contraception and smoking.

Table 4.1: Service statistics for the identification and management of at-risk pregnant women in the three HA clusters

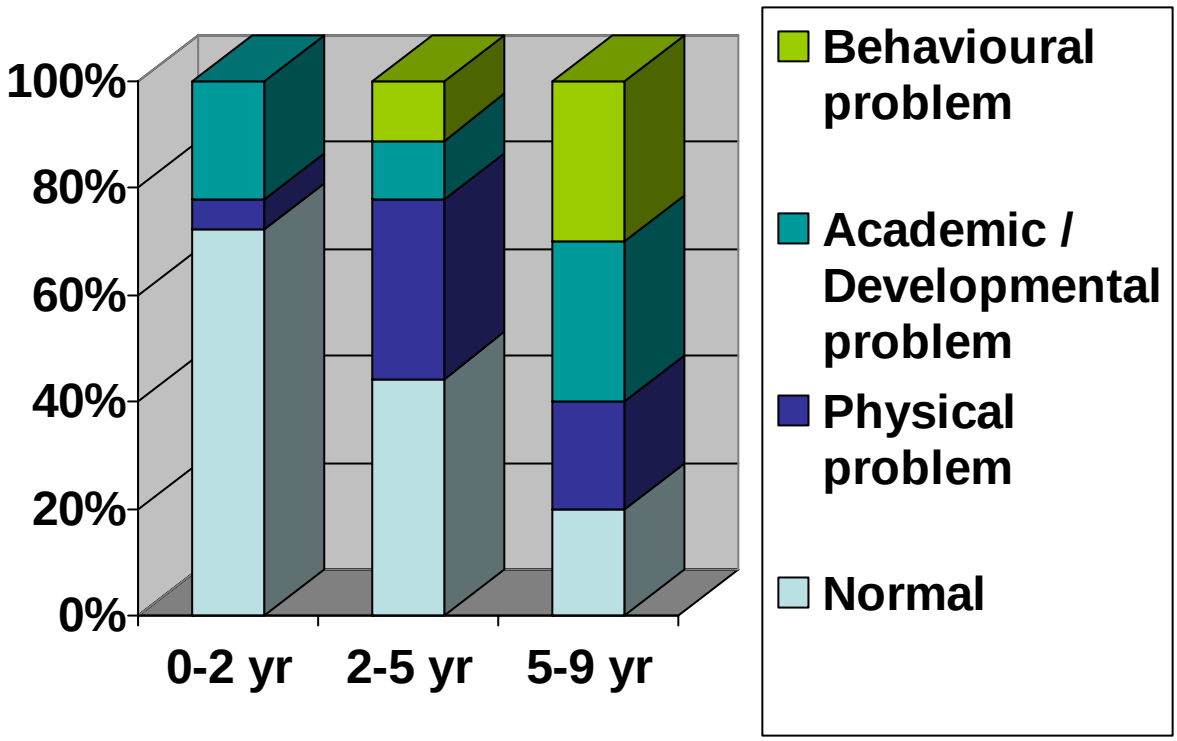
Cluster	**KWC (November 2005 – October 2006)**	**NTWC (May – October 2006)**	**KEC (August – October 2006)**
The target at-risk group(s) of pregnant women	Pregnant women with illicit drug use recruited in methadone clinic by SARDA	Pregnant teenage <16 Unmarried pregnant teenagers 16 to18 years	6 risk groups: mental health problem, lone mother, substance abuse, domestic violence, teenage pregnancy, other clinical conditions
Intervention programme	ISP for pregnant women with heroin use (Appendix 4.2)	Antenatal care programme for pregnant teenagers (Appendix 4.3)	Antenatal care programme for at-risk pregnant women (Appendix 4.4)
Total no. of pregnant women recruited	**24**	**41**	**26**
No. opted out	(9 with termination of pregnancy)	3	3
No. still pregnant	4	10	15
No. with babies born	11	28	8
Details of mothers with babies delivered and their outcomes	11 mothers aged 22 to 36 years; 6 had addicted partner	6 aged < 16 years; 22 unmarried, aged 16 to18 years; (co-morbidities: 1 psychosis, 2 depression, 3 substance use)	3 lone mothers; 2 depression; 1 anxiety; 1 ketamine abuse; 1 teenage pregnancy
Duration in programme	4 to 7.5 months	2 to 6 months	1 to 2.5 months
Drug detoxification	3 mothers with successful detoxification; Stable methadone user increased from 2 to 8 (out of 11)	All 3 teenagers with substance abuse stopped drug use	The mother with ketamine abuse stopped drug use since 12-week pregnancy

Contraception practice: • Before pregnancy	8 had no contraception; 2 partners use condom improperly; 1 used safety period	13 had no contraception; 15 partners use condom improperly	4 had no contraception; 2 OC pills; 2 male condom (one with improper technique)
• After delivery (counselling)	3 agreed for IUCD; 4 male condom with proper technique taught; 2 oral contraceptive (OC) pills; 2 hormone injection	10 would use OC pills; 13 male condom with proper technique taught; 5 other methods	1 for IUCD; 4 OC pills; 3 male condom with proper technique taught
Smoking cessation	9 current smokers – 5 had reduced smoking to < 50 % of the original amount	18 current smokers – 13 had reduced smoking to < 50 % of the original amount	4 current smokers – 2 stopped smoking; 1 reduced to < 50 % of the original amount
Outcomes of the baby:			
Age of infant	1-7 months	1-5.5 months	0.5-2 months
Maturity	2 preterm babies (34 and 36 weeks)	4 preterm babies (34, 35, 36, 36 weeks)	1 preterm baby (34 weeks)
Small for gestational age (SGA)	3 SGA	4 SGA	1 SGA (mother with ketamine use)
Special medical problems	9 drug abstinence syndrome 1 nutrition problem (financial reason), improved after intervention	1 fracture clavicle and Erb's Palsy with good recovery 1 with slow weight gain due to unsatisfactory feeding technique	1 baby (of lone mother) with ventricular septal defect and left preaxial polydactyly
Development	10 normal development 1 (7m) with mild gross motor delay	All 28 with normal development	All 8 with normal development
Vaccination	100% vaccination compliance	100% vaccination compliance	100% vaccination compliance
Psychosocial problems	1 at-risk for child neglect and required institution care	1 required foster home care	1 baby of teenage mother required foster home care

Table 4.2 : Service statistics for children of at risk mothers recruited and managed in MCHCs within the 3 HA cluster catchment areas

Clusters / High risk categories	KWC (May - October 2006)		NTWC (May - October 2006)		KEC (August – October 2006)	
Mothers with mental health problems	18	˙15 PND ˙3 Adjustment disorders	35	˙28 PND ˙5 Adjustment disorders ˙2 Psychosis	10	˙6 PND ˙3 Anxiety ˙1 Schizophrenia
Mothers with illicit drug use	70	˙49 Heroin / methadone addicts ˙21 Soft drug use	28	˙ 6 < age 16 ˙ 22 age 16-18	4	
Teenage pregnancies	2		(3 Drug use, 3 Mental health problems)		4	
Other risk groups	5 STDS		---		9 Lone mothers 1 Mother with left hemiparesis	
No. of children followed up by CP in MCHCs	95 children followed up in WK MCHC		63 children followed up in TSW, YO and TMWH MCHCs		28 children followed up in TKO MCHC	

Appendix 4.1: Major problems in children of mothers using methadone



Appendix 4.2: ISP for heroin-abused pregnant women in KWC

醫院管理局 瑪嘉烈醫院

香港戒毒會 美沙酮輔導服務

「兒童早期發展計劃」服務流程

合資格服務對像包括 a)有濫用海洛英問題，並已登記服用美沙酮，及於PMH & KWH進行產檢之孕婦； b) 12 個月以下嬰兒，其母親已登記服用美沙酮，嬰兒並由西九龍母嬰健康院跟進者。

第一部份 ---本計劃產前服務內容

工作階段	服務流程	跟進事項
1. 個案來源及招募	♦ 自我轉介； ♦ 美沙酮診所招募； ♦ 由政府醫院(PMH & KWH)及母嬰健康院(W.Kln. Center)轉介； ♦ 由其他社會服務單位轉介。	➢ 由美沙酮診所社工接見，進行初步評估； ➢ 社工招募懷孕婦女爲輔導個案。
2. 初步評估	♦ 由美沙酮診所醫生及社工接見	➢ 由政府醫生或私家醫生確診懷孕； ➢ 由美沙酮醫生寫轉介信往瑪嘉烈醫院婦產科(PMH)； ➢ 美沙酮社工取病人同意書及填寫「懷孕婦女初次評估表」；
3. 懷孕初期輔導	♦ 由美沙酮診所醫生及社工接見	➢ 由美沙酮醫生講解濫藥對懷孕的不良影響及懷孕婦女服用美沙酮需知； ➢ 案主接受輔導後，決定繼續懷孕者，將由美沙酮醫生寫轉介信往 PMH，作產前檢查； ➢ 若案主決定終止懷孕者，亦由美沙酮醫生寫轉介信往 PMH，接受進一步檢查； ➢ 產前檢查或申請終止懷孕，均由美沙酮社工傳真有關文件往 PMH 安排登記事宜，並陪同案主往首次產檢。
4. 懷孕中期輔導-----	深化評估 由美沙酮診所社工，每二星期接見案主一次，並進行以下評估：	➢ 美沙酮社工填寫「懷孕婦女及幼兒需要評估問卷」； ➢ 有需要下，美沙酮社工將作進深輔導服務跟進及適切服務轉介。

深化評估	♦ 濫用海洛英情況； ♦ 濫用其他物質狀況 ♦ 財政狀況； ♦ 家庭關係； ♦ 情緒、精神狀況； ♦ 其他問題評估。	
5. 懷孕中期輔導----個人輔導 (I)	**個人輔導跟進(I)** ♦ 一般問題及 ♦ 濫藥問題； ♦ 服用美沙酮相關問題。	➢ 美沙酮社工將每二星期接見案主，以作輔導。 ➢ 協助案主定期往醫院作產檢。
6. 懷孕中期輔導----小組輔導(II)	**小組輔導跟進(II)** ♦ 案主將被邀請參加美沙酮小組輔導	➢ 美沙酮婦女自助組； ➢ 美沙酮婦女健康講座； ➢ 美沙酮飲藥講座； ➢ 幼兒健康講座等。
7. 懷孕中期輔導----轉介服務(III)	**轉介服務(III)** ♦ 濫用海洛英問題； ♦ 濫用其他物質問題； ♦ 居住問題及財政困難； ♦ 家庭問題； ♦ 情緒困擾及精神病； ♦ 其他問題評估。	➢ 鼓勵接受美沙酮治療計劃； ➢ 或轉介往其他門診式或住院式戒毒治療；或轉介往葵涌醫院； ➢ 轉介往社會福利署； ➢ 轉介往社會福利署； ➢ 轉介往葵涌醫院； ➢ 轉介往其他適切服務。 (各轉介服務，社工均須取得案主同意書)
8. 臨產前跟進	♦ 產前四至八週，美沙酮社工及女同輩輔導員往家訪； ♦ 商討家庭計劃。	➢ 贈送物資； ➢ 過來人分享服用美沙酮心得； ➢ 社工評估家居狀況及協助案主及其家人迎接新生兒； ➢ 商討日後家庭計劃 e.g. 轉介產後避孕服務。
9. 產前個案會議	♦ 在產前 30-32 週，由產科醫生、精神科醫生、兒科醫生、社會福利署家庭服務中心及美沙酮社工召開個案會議	➢ 商討產婦情況，嬰兒福利； ➢ 嬰兒出院生活安排(由母親帶返家；或由其他親友照料；或寄住托兒所；或交由社合會福利署照顧。)

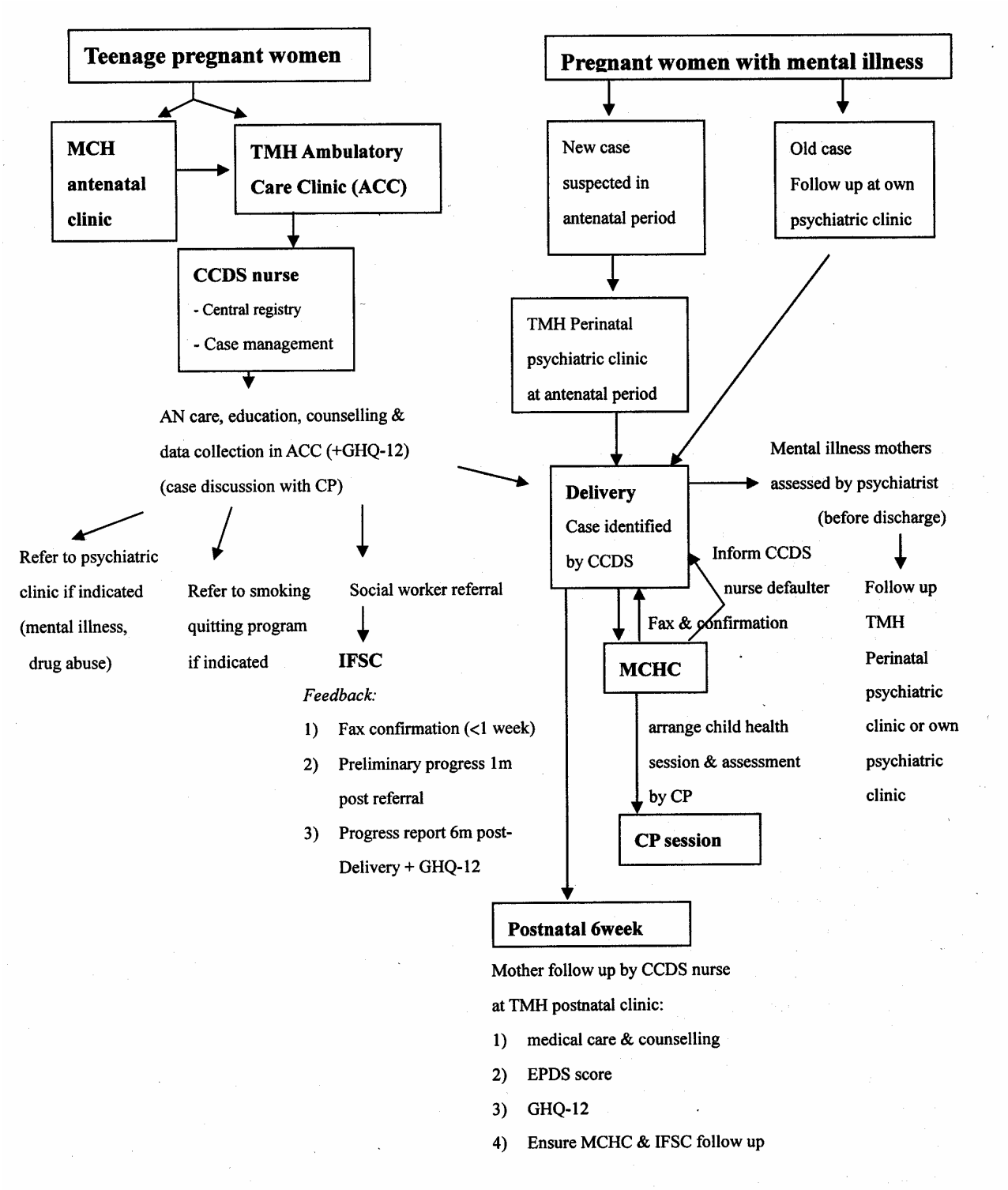
第二部份 ---本計劃產後服務內容

工作階段	服務流程	跟進事項
10. 母親生產後嬰兒出院前	♦ 美沙酮社工陪同案主探望初生嬰兒 ♦ 嬰兒出院安排	➢ 美沙酮社工協助案主商討日後嬰兒養育計劃及制訂嬰兒出院安排；
11. 產後個案會議	♦ 在嬰兒出院前 1-2 週，由兒科醫生、精神科醫生、社會福利署家庭服務中心、醫務社工及美沙酮社工召開個案會議。	➢ 商討嬰兒福利； ➢ 嬰兒出院生活安排(由母親帶返家；或由其他親友照料；或寄住托兒所；或交由社合會福利署照顧。)
12. 母子返家(首四星期)	♦ 若母親獲安排嬰兒出院帶返家一同生活，在嬰兒返家一至四週內，美沙酮社工及女同輩輔導員往家訪； ♦ 案主每星期接受美沙酮個人輔導服務。	➢ 過來人分享育嬰心得； ➢ 贈送物資； ➢ 協助案主穩定服用美沙酮； ➢ 社工與案主重整戒毒計劃，提升戒毒動機，商討合適治療方案，如美沙酮門診股服務或其他住院模式戒毒服務，以作轉介。 ➢ 協助案主定期帶同嬰兒往母嬰健康院作體檢。
13. 嬰兒滿一歲前	♦ 戒毒輔導跟進； ♦ 嬰兒保健及育兒困難支援跟進； ♦ 每月定期接受美沙酮個人輔導。	➢ 協助案主定期帶同嬰兒往母嬰健康院作體檢。 ➢ 跟進家庭計劃 e.g. 轉介避孕服務； ➢ 過來人分享育嬰心得； ➢ 協助案主穩定服用美沙酮； ➢ 邀請案主參加育嬰講座； ➢ 美沙酮婦女自助組； ➢ 美沙酮婦女健康講座； ➢ 美沙酮飲藥講座； ➢ 贈送物資。

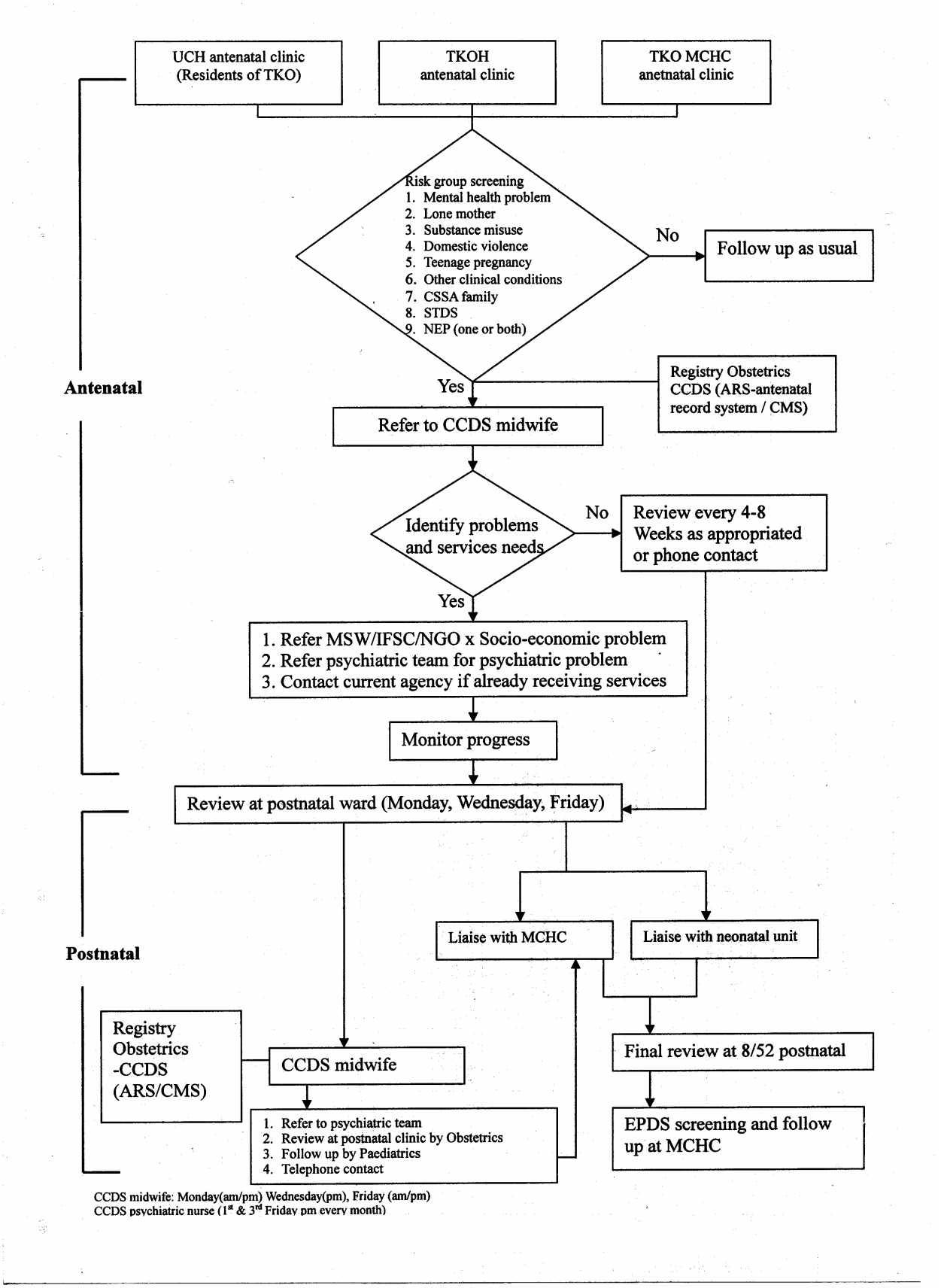
##嬰兒滿週歲後，母親及嬰兒均推薦接受美沙酮輔導服務部推行之另一計劃，名爲「**美沙酮 1-5 歲兒童早期發展計劃**」，以繼續接受適切跟進。

Revised on 9-1-05

Appendix 4.3: Flow chart of the antenatal care programme for high risk pregnant women in the NTWC



Appendix 4.4: Workflow of the CCDS Midwife in the KEC



Appendix 4.5: Views of SARDA clients and pregnant teenagers on the services

1	姑娘(social worker)都會久唔久打電話俾我“妳點呀？落咗嚟食藥未呀？如果妳落嚟過嚟傾吓計呀”……我覺得佢好 nice……	A1-1
2	佢話會有個兒科醫生會跟到個 BB 三歲呀，即係專飲美沙酮嘅媽咪，睇吓個 BB 大個會唔會有問題呀？或者係會遲緩呀？如果有問題就會即刻 send 去專科呀，即係再睇吓點樣跟進。	A2-1
3	我有乜計劃都會同佢講，佢亦都會俾番啲建議我，例如我話我生完兩三個月後會出嚟做嘢，咁佢會問番我“妳應唔應付得嚟呀？妳身體係咪 ok 呀？”	A1-2
4	姑娘會解釋吸毒對孕婦嘅影響。…葵涌醫院有義工，教我照顧 BB 嘅方法。	A2-2
5	可能係出面登記嘅問題定係點？有陣時會俾咗我個 file 俾啲完全唔知我個情況嘅醫生睇，咁我覺得睇嚟都冇用，其實有幾次都試過。咁其實我知道陳醫生喺隔離，但係我就去咗另一個病房，所以見咗等於冇見，我最想就係睇番嗰個，因爲我嘅情況比較特殊啲，其他醫生又唔知，好似有一次，我問番我減藥嘅情況，咁葵涌個醫生就叫我問番瑪嘉烈個醫生我個 BB 嘅情況我適唔適宜再減落去，咁啱啱嗰兩次咁唔係見陳醫生，咁個計劃就拖延咗少少….如果瑪嘉烈會有個醫生專係跟開我地依啲咁嘅 cases，我諗我會好啲囉，起碼佢了解得到，妳咁樣做可能會有乜影響呀？自己嗰心都放心啲。	A1-3
6	佢好似普通朋友咁同佢傾計。	B1-1
7	…..蔣姑娘乜都肯同我講，又教識我咁多嘢，開始對佢無咁抗拒，開頭第一二次都好少對佢講咁多嘢，跟住我慢慢至越嚟越多嘢講。	B2-3
8	(生完第一胎)嗰陣時呀，乜都唔識囉…跟住又成日屈埋自己喺屋企呀，無嘢做成日諗得自己好唔開心…我以前嗰啲社工，因爲佢地都有其他 case 跟，所以我費事麻煩佢地，所以好少同佢地講囉。	B2-1
9	傾 BB 啲嘢呀，即係教你點樣做呀，有乜問題同佢講，有乜問題佢會教番你呀，即係唔舒服嗰啲。	B1-2
10	佢叫我餵人奶呢，佢真係幫咗我好多囉。	B2-4
11	佢叫我如果唔生住，問我會點去避孕嗰啲囉，跟住我話咁會食藥呀，跟住就話比我聽呢種方法會點樣，講得好詳細囉。	B2-4
12	好好多，因爲之前又唔識呀，唔識點湊，又無人好可以幫到我呢，但係反而依家就好啲啦，有乜唔明，就問個兒科醫生。	B2-5
13	(之前)係完全無知，因爲可能嗰啲藥嘅說明書呢，係英文我唔識睇呀，跟住我又唔走去問人囉…以前我唔知吖嘛，即係依家知咗，我原來要日日食嘅。	B2-2
14	醫生□完(肚)唔出聲，得啦，你出去。佢又唔講都唔知發生乜事。	B1-3

Appendix 4.6: Views of SARDA social workers and the midwife on identification and management at risk pregnant women

Manpower/workload		
1	我地同事都覺得值得推行嘅，但推行都要資源呀，好似人手呀、物資同聯帶關係喎，咁聯帶關係就要上頭去開展。而我地因爲依個嘅關係亦都申請咗啲基金去繼續 Run 依個計劃……我地亦都會用依啲基金去請一個人過嚟專係搞啲 talk 呀，做啲探訪呀，去減輕我地依家嘅工作。	A-17
2	我地四個(社工)做過其實有三十個 cases，三十個其實唔係淨包孕婦，仲有啲啱啱出咗世，…..人手都幾 Tense……你認識佢多咗，你發覺可以多咗好多問題湧出嚟，以往佢有，但你個 contact point 係好少嘅時候，其實你發覺唔到，咁多咗 contact point 你陪佢做產檢，家訪呀，你會發現好多其他衍生問題，有財務家庭嘅問題，無足夠食物俾小朋友食啦，或者其他情緒，樣樣都發掘多咗問題，所以每隻 case 花時間係多咗。	A- 4
3	我覺得就做都幾辛苦嘅，因爲好多時同事就未必知你做緊乜囉，但係就自己知自己做緊乜，但係個 support 就好少囉。	B-30
Staff role		
4	我每次喺 Antenatal 見佢嘅時候，都會問返社工有冇見你地，又或者問下佢有乜需要…另一個 system 就係同 psychi(psychiatry)嗰邊…咁我都會同返我地 OBS 嘅醫生傾一傾睇返個 case 有冇需要 refer 去 psy(psychiatry)。	B-2
5	我地會 phone follow 佢嘅，睇返佢各樣情況係點樣，跟唔跟得到，首先佢有冇 attend 到 MCHC 啦	B-9
Staff attitude		
6	很多人覺得你(pregnant teenager)咁後生就生你梗係好曳啦，俾訊息佢我(midwife)唔係咁睇，我唔 label 佢你梗係好壞啦，當佢係一個 mature 嘅大人咁傾	B-17
Client management		
7	另外經驗話我地知覺得愈早介入同埋喺 critical moment（即係就嚟做媽媽嘅時候）嘅改變能力係最大嘅。反而佢生咗一年兩年嘅時候再介入，咁個改變嘅動機就會細咗嘞。其實我地開組時都會知道，懷緊孕嚟開組咁個 turn-up rate 就會高啲啦，生咗 BB 又會個 turn-up rate 又會高啲啦…但如果個 BB 大啲(例如四、五歲)，咁就要俾多啲心機，因爲佢已經覺得定咗啦。	A-12
8	尤其佢地生完同佢地講下(contraception)，尤其 NSD(normal spontaneous delivery)係痛得咁緊要嘅時候，我第一件事係問佢你仲諗唔諗住生，咁佢好易真心同你講，咁有時過咗依啲時間，個感覺冇咗咁 strong 的時候	B-16
Collaboration		
9	咁我同 IFSC 嗰邊都 develop 咗個 direct referral system 嘅，咁係之前無嘅…我希望早少少去介入到，對佢地嚟講會好啲囉。	B-1

Chapter 5
Identification and Management of Mothers with PND

In this chapter, the service provision for mothers with PND prior to CCDS is described, followed by changes introduced under the CCDS and the formative process. The resulting impact on the quality of service is then examined.

5.1 Service provision before CCDS

5.1.1 MCHCs

Prior to the introduction of the CCDS, the usual practice in MCHCs in detecting PND was through nurse clinical assessment during mothers' visits (mothers' postnatal visit at 6 weeks as well as during child health visits) to MCHCs. Clients considered by nurses as requiring further management would be seen by MCH doctors who would then recommend follow-up counselling in the MCHCs or referral for psychiatric management, as appropriate. Clients requiring psychiatric management were referred to the psychiatric service in nearby HA hospitals. In case of emergency, they were referred to A&E services. Clients in need of social services were also referred to the appropriate agencies.

5.1.2 O&G departments in HA hospitals

Most O&G departments used EPDS for postnatal screening, usually at 6 weeks, though in some hospitals, EPDS was also administered a few days after delivery, in addition to the 6-week one. Patients were usually followed up by telephone and specialist (e.g. psychiatrist, clinical psychologist) consultations were arranged where necessary. There were variations in follow-up practices among hospitals.

5.2 Changes in service provision under the CCDS

To improve the identification and management of probable PND cases, structural and process changes were introduced under the CCDS. These changes were guided by scientific theories, research evidence and informed clinical experience.

5.2.1 Changes in structure

The structural changes were guided by theories on help-seeking behaviour.

Staffing

MCHCs were easily accessible primary health care settings and there was little stigma associated with MCHC attendance. To minimize the labelling effect and to provide easy access, a psychiatric nurse visited MCHCs regularly to provide assessment and counselling service on site. Clients could receive psychiatric service in MCHCs instead of hospital specialist

outpatient clinics. Two visiting psychiatric nurses were allocated to MCHCs in TM and TSW, while SSP and TKO was each allocated one visiting psychiatric nurse.

Training

Training was provided to MCH staff to enhance their competence in the identification and support of clients with probable PND. All MCH nurses involved in the management of clients with probable PND had undergone a 12-hour training course, including a 3-hour lecture on PND and a 9-hour workshop on PND counselling, conducted by a psychiatrist and a clinical psychologist respectively.

A seminar titled "Life Events and Postpartum Depression" was delivered by specialist psychiatrists and a nurse specialist of the three pilot HA clusters to all MCH staff and HA nurses involved in the CCDS in February 2006. In addition, there were regular case-sharing sessions between MCH staff and visiting psychiatric nurses where difficult cases were discussed for educational purpose.

HA visiting psychiatric nurses involved in CCDS received weekly training in the hospital psychiatry departments where principles and strategies of assessment and intervention as well as individual case management were discussed.

Standardization of practices

To ensure the quality of PND counselling by MCH nurses, a standardization exercise was conducted. MCH nurses involved in the counselling of clients with probable PND would go through a standardization exercise, where they had to demonstrate the necessary counselling skills for PND management. The standardization team comprised of two medical doctors and two psychologists. The number of nurses who undertook training and standardization in PND counselling up till October 2006 is shown in Table 5.1.

Table 5.1: No. of nurses who have undertaken training and standardization in PND counselling

	WK	TSW	YO	TMWH	TKO	Total
Training	17	16	16	9	21	79
Standardization[a]	7	4	7	5	8	31

[a] The standardization exercise was ongoing. The figures reported here were nurses who had completed training before July 2005.

5.2.2 Changes in process

Identification and management of probable PND cases

- **Identification** – procedures for systematic identification of mothers with probable PND were set up to coincide with child immunization schedules, so mothers did not have to make separate visits to MCHCs. Mothers who were able to read Chinese or English and had not completed EPDS administered by other hospitals at about 6 weeks postpartum

were requested to complete the EPDS when they returned for the 2-month child health visit. The EPDS, a ten-item self-report questionnaire, was the most frequently used PND screening test though its sensitivity, specificity and predictive values depended on the cut-off scores (NSC, 2001; NHMRC, 2000; Scottish Intercollegiate Guidelines Network, 2002). The Chinese version of the EPDS had been validated in Hong Kong on a group of postnatal women who delivered in a public hospital over a three-month period (participation rate: 67%). The criterion validity was tested against clinical diagnosis using the Structured Clinical Interview for DSM-III-R. The concurrent validity was tested by correlation with the GHQ and Beck Depression Inventory (BDI). Using the original cut-off point of 12/13, the sensitivity[8] was 41% and the specificity[9] was 95%. With 9/10 as cut-off, the sensitivity was 82% and the specificity was 86%, with a positive predictive value[10] of 44% (Lee et al., 1998). In addition, clinical assessment was conducted at one month and six month postnatal and at other times as appropriate.

- **Management** - mothers with scores between 10 and 12 were assessed and counselled by MCH staff (and would be referred to the visiting psychiatric nurse if deemed necessary), whereas those with scores ≥ 13 were referred directly to the visiting psychiatric nurse for assessment and management after clarification by MCH nurses. In the Lee et al. (1998) study, the recommended cut-off for psychiatric support was 9/10. However, due to the workload involved, only those with scores ≥ 13 would be directly referred to the visiting psychiatric nurse. This 2-level, graded care approach was based on informed clinical experience, where the intensity of treatment provided depended on the severity of depressive symptoms. Apart from MCH counselling and psychiatric support, clients were also referred for other MCH services such as parenting workshop and breastfeeding coaching, or to IFSCs for social services, as appropriate. This approach was also applicable to clients identified through clinical assessment. Those with less severe problems were counselled initially by MCH staff whereas those with more severe problems were referred directly to the visiting psychiatric nurse. The working details were negotiated between MCH frontline staff and the visiting psychiatric nurse. Normally, an appointment had to be made and the client would have to make a separate trip to MCHCs for the session with the visiting psychiatric nurse, though same-session/walk-in arrangement might be possible depending on the urgency of the case and the schedule on that day.

Collaboration between organizations

To enhance the collaboration between MCHCs and HA, co-ordinating mechanisms were set

[8] Sensitivity is the proportion of truly ill people in the screened population who are correctly identified as ill by the screening test. (Last, 2001, p. 166)

[9] Specificity is the proportion of truly healthy people in the screened population who are correctly identified as healthy by the screening test. (Last, 2001, p. 166)

[10] Positive predictive value is "the proportion of patients with positive test results who are correctly diagnosed". (Altman, 1991, p. 411)

up at institutional and district levels:

- **Institutional level** – there were several meetings between head of psychiatry services of HA and the head of FHS of DH to discuss various programme design, implementation and service co-ordination issues.
- **District level** – in each district, prior to the launching of the CCDS, meetings were held between the psychiatry department of the hospital and the MCHC(s) to discuss various logistic issues. These included the number of visiting psychiatric nurse sessions, sharing of information, record keeping, client referral procedures, etc. Broader service interface issues were discussed in the DCC meetings.

5.3 The formative process

This section focuses on describing issues arising from the implementation of this CCDS component, from the perspectives of the clients, MCH nurses and visiting psychiatric nurses. Improvement measures taken are described (in italics) where appropriate. The quotes are in Appendix 5.1.

5.3.1 Structure

Facilities

Room shortage for assessment and counselling was a concern shared by all nurses. The visiting psychiatric nurses were concerned about having to use different rooms at different times (1, 2) whereas MCH nurses were concerned about the lack of individual rooms and privacy (3, 4).

To provide more privacy and to solve the room shortage problem, renovation work including setting up of high partitions between interviewing stations and construction of interviewing rooms, has commenced in MCHCs. Other measures to improve the situation included re-arrangement of interviewing and consultation room usage and layout, and service sessions to allow for more flexible room usage.

Manpower/workload

MCH nurses were concerned about the extra time involved in assessment and counselling, and pointed out that the time required for PND assessment had implications on waiting time for other clients and workload for fellow colleagues (5, 6).

The issue was partially resolved by deploying existing trained staff from other MCHCs and adjustment of the appointment booking arrangement in the interim, while waiting for the recruitment of new staff.

Training

Though MCH nurses agreed that the training on PND counselling was useful (7), some reckoned that it was inadequate and they lacked the basic background knowledge (8). This

perceived sense of inadequate training had led to a lack of confidence in conducting PND assessment or counselling among nurses in some MCHCs, and they found the counselling process stressful (9, 10). For the visiting psychiatric nurses, prior to their participation in CCDS, they were trained for the work through reading, supervision from psychiatrists, practicum and liaison with MCHCs (11, 12, 13).

To provide more support to the MCH nursing staff, a structured training course, with more practical aspects was being developed. More support would be provided by doctors, in terms of taking up cases which nurses were concerned with.

5.3.2 Process

Client management

For clinical assessment, nurses in some MCHCs reported that they could manage as they could follow established criteria (14, 15), while in others, the response ranged from a feeling of mild pressure (16) to extreme stress (17). Some nurses felt that they had to be able to detect PND at the first encounter with clients and this somewhat unrealistic expectation caused them considerable stress (18). For assessment using EPDS, nurses were concerned about caseload (19). The general PND detection rate was 10.7% after CCDS implementation, which was nearly three times the rate of 3.8% in 2005 (see Table 5.4), and about half of the probable PND cases in CCDS were identified through EPDS screening.

Nurses in some MCHCs found counselling of mothers very stressful as they felt that they did not have the background training (20) or adequate support (21) to do so. Nurses in other MCHCs felt that they could manage with support from the visiting psychiatric nurse and MCH doctors (22).

To reduce the stress due to unrealistic role expectation, a briefing session was held to clarify nurses' role in PND identification and initial counselling in a primary care setting. Arrangement was made to increase the number of sessions of visiting psychiatric nurses so they could take up more clients earlier, especially those with more significant problems. This could serve to ease the workload and stress of MCH nurses.

Collaboration

Nurses in all MCHCs were positive about the contribution by the visiting psychiatric nurses. They commended the professional skills and knowledge of the visiting psychiatric nurses and believed that they were able to help clients (23). In recommending a referral for the client, MCH nurses used the term "specialist nurse" to describe the visiting psychiatric nurse (24). It was thought that this arrangement might reduce client's perception of stigma in using psychiatric services.

MCH nurses and the visiting psychiatric nurses pointed out that they could learn a lot from each other (25, 26, 27, 28), and the collaboration was smooth (29, 30). MCH nurses would like to have the visiting psychiatric nurses on site in MCHC full-time (31). Visiting psychiatric

nurses in some MCHCs, however, suggested that in the long run, MCH nurses could take up some follow-up counselling of clients, while they could focus on assessment and counselling of more difficult cases (32, 33).

Procedures

Besides, nurses in some MCHCs were concerned about the extra paper work involved in making referrals, and keeping case records and service statistics (34, 35).

The extra workload due to data collection and record keeping was being taken over by research assistants employed to support CCDS evaluation, who reported duty between May and August 2006. Each community was assigned one research assistant to handle data collection, entry and checking.

5.3.3 Summary

Overall, having visiting psychiatric nurses to MCHCs was most welcomed by MCH nurses. There was good collaborative relationship between MCH nurses and visiting psychiatric nurses. As for the experience of MCH nurses in the identification and management of probable PND cases, nurses in some MCHCs felt being supported and found the tasks manageable. In other MCHCs, nurses felt that they did not have adequate training and found the work stressful. Some visiting psychiatric nurses reckoned that, in the long run, MCH nurses could follow-up clients after initial assessment by visiting psychiatric nurses.

In general, there were logistic concerns about caseloads and time constraints, and lack of privacy in interviewing clients across all MCHCs. There were also concerns about the extra clerical and paper work involved in data collection. As much as possible, improvement measures were being put in place.

5.4 Service statistics

Service statistics on the identification and management of postnatal depression are shown in Tables 5.2.

Table 5.2: Service statistics on the identification and management of mothers with probable PND in MCHCs (from official commencement date[a] until September 2006)

	WK	TSW	YO	TMWH	TKO	Total
Total no. of newly registered children under age one	4797	1675	1933	766	2531	11702
Total no. of mothers with probable PND identified	561	212	201	110	173	1257
Services Recommended[b]						
No. of mothers recommended for MCH nurse counselling						
Total	428	140	105	72	86	831
No. of mothers recommended for visiting psychiatric nurse service						
No. accepted referral	164	42	39	27	78	350
No. declined referral	59	10	6	1	10	86
Total	223	52	45	28	88	436
No. of mothers recommended for referral to psychiatrists[c]						
No. accepted referral	2	4	6	1	11	24
No. declined referral	0	1	0	0	0	1
Total	2	5	6	1	11	25
No. of mothers recommended for referral to A&E						
No. accepted referral	2	1	4	0	13	20
No. declined referral	0	1	0	0	0	1
Total	2	2	4	0	13	21
No. of mothers recommended for social service referral						
No. accepted referral	51	17	19	15	18	120
No. declined referral	23	14	23	6	8	74
Total	74	31	42	21	26	194
No. of mothers recommended for other MCH services						
Total	196	59	53	49	64	421

[a] Official commencement date for WK was July 2005 and that for the other four MCHCs was January 2006

[b] More than one service might be recommended for each client

[c] Referred directly by MCH staff or through visiting psychiatric nurses

5.5 Change in the quality of service

Both quantitative and qualitative information were used in the analysis. Quantitative information was based on service statistics and qualitative information was based on focus groups and interviews with service users and providers.

5.5.1 Access

Access was examined in terms of EPDS coverage, number of clients referred for various services and client feedback. Comparison with baseline statistics, where available, was made to examine changes in access. Baseline statistics (2005 service statistics) were available for the number of probable PND cases identified, referral to psychiatric services, referral to IFSCs (social service agencies) and counselling by MCH nurses. For SSP (WK MCHC), statistics collected between January and June 2005 were used as the baseline as CCDS commenced in SSP in July 2005. For the other three communities, baseline statistics were based on those of January to December 2005. The CCDS statistics covered the period since CCDS implementation until September 2006.

EPDS coverage

The use of EPDS for PND screening was introduced in phases in different MCHCs and the coverage figures are shown in Table 5.3. The EPDS coverage referred to the proportion of babies turned up at the 2-month child health visit whose mothers had completed the EPDS. The number of babies turned up at the 2-month child health visit was used as the denominator here, instead of the number of babies registered, because a fair proportion of newborn babies had parents who were residents of mainland China (about 11%). The EPDS coverage statistics indicated that among children who returned for the 2-month child health visit, about 20% of the mothers did not participate in the EPDS screening. In TKO MCHC, there was a lower percentage of mothers completing EPDS because a significant proportion of mothers had completed EPDS administered by hospitals at about 6 weeks postpartum and they were not required to complete EPDS again during the 2-month child health session. Clinical assessment would be performed for these mothers instead.

Among the non-participants, the mothers were absent for the child health session in about 60% of the cases. The main reasons for their absence were working mothers or mothers being residents in China. Other reasons for non-participation included the problem of literacy in Chinese or English, and both parents being NEP (see Table 5.3).

Table 5.3: EPDS coverage for postnatal mothers at two-month child health visits from the date of the full implementation of EPDS screening to September 2006

	WK	TSW	YO	TMWH	TKO	Total
Date of full implementation for EPDS screening	Jan 2006	Mar 2006	Jun 2006	Mar 2006	Sept 2006[a]	
No. of babies turned up at 2-month visit	1 649	816	654	489	99	3 707
No. (%) of mothers completing EPDS	1 406 (85.3%)	612 (75.0%)	508 (77.7%)	421 (86.1%)	45 (45.5%)	2 992 (80.7%)
No. (%) of mothers *not* completing EPDS	243 (14.7%)	204 (25.0%)	146 (22.3%)	68 (13.9%)	54 (54.5%)	715 (19.3%)
EPDS results for mothers completing EPDS						
EPDS score ≤ 9 and negative on the question about self-harm	1 067 (75.9%)	503 (82.2%)	406 (79.9%)	354 (84.1%)	33 (73.3%)	2 363 (79%)
EPDS score ≥ 10 or positive on the question about self-harm	339 (24.1%)	109 (17.8%)	102 (20.1%)	67 (15.9%)	12 (26.7%)	629 (21%)
Reason for mothers not completing EPDS[b]						
EPDS done already	24(9.9%)	9(4.4%)	3(2.1%)	2(3%)	34(63%)	72(10.1%)
Mother refused to complete	2(0.8%)	0(0%)	0(0%)	0(0%)	0(0%)	2(0.3%)
Both parents as NEP	0(0%)	67(32.8%)	37(25.3%)	0(0%)	6(11.1%)	110(15.4%)
Illiterate in Chinese/ English[c]	40(16.5%)	20(9.8%)	22(15.1%)	13(19.1%)	2(3.7%)	97(13.6%)
Mother was absent due to:	173(71.2%)	101(49.5%)	78(53.4%)	53(77.9%)	10(18.5%)	415(58%)
• At work	88(50.9%)	41(40.6%)	35(44.9%)	39(73.6%)	7(70%)	210(50.6%)
• In China	72(41.6%)	49(48.5%)	25(32.1%)	12(22.6%)	3(30%)	161(38.8%)
• At home	8(4.6%)	11(10.9%)	17(21.8%)	0(0%)	0(0%)	36(8.7%)
• Other reasons for absence	5(2.9%)	0(0%)	1(1.3%)	2(3.8%)	0(0%)	8(1.9%)
Other reasons	4(1.6%)	7(3.5%)	6(4.1%)	0(0%)	2(3.7%)	19(2.8%)
Total	243 (100%)	204 (100%)	146 (100%)	68 (100%)	54 (100%)	715 (100%)

[a] Full implantation commenced on 18 September 2006

[b] Percentage was calculated using the number of mothers not completing EPDS as denominator.

[c] Could not read Chinese or English

Changes in access to MCH nurse counselling, psychiatric services and social services

Compared with baseline statistics, there has been an increase in the number of probable PND cases identified, number of clients recommended for MCH nurse counselling, number of referrals to psychiatric services, and number of clients referred to IFSCs since the implementation of CCDS. The majority of referrals to psychiatric service were clients referred to visiting psychiatric nurses who saw them in MCHCs. The figures are shown in Table 5.4.

Apart from referral to MCH nurse counselling, psychiatric service for mood problems or IFSC for social issues, clients were also referred for various MCH services, including parenting workshop, breastfeeding coaching etc. No baseline statistics was available and the service statistics since CCDS implementation are presented in Table 5.4.

Table 5.4: Monthly average number of mothers identified with probable PND and recommended for MCH nurse counselling, referral to psychiatric service, social service, and other MCH services

		WK[a]	TSW	YO[b]	TMWH	TKO	Overall[c]
Monthly average no. of newly registered children under age one	2005	281.2	195.8	214.5	84.3	281.0	203.6
	CCDS[d]	319.8	186.1	214.8	85.1	281.2	229.5
Monthly average no. of mothers with probable PND identified	2005	7.3	4.9	15.3	2.8	7.8	7.6
	CCDS	37.4	23.6	22.3	12.2	19.2	24.6
Percentage of mothers with probable PND	2005	2.6%	2.5%	7.1%	3.4%	2.8%	3.8%
	CCDS	11.7%	12.7%	10.4%	14.4%	6.8%	10.7%
Monthly average no. of mothers with probable PND recommended for MCH nurse counselling	2005	6.0	2.6	3.2	2.1	4.3	3.4
	CCDS	28.5	15.6	11.7	8.0	9.6	16.3
Monthly average no. of mothers with probable PND referred to psychiatric services[e]	2005	0.8	2.1	0.2	0.8	2.7	1.4
	CCDS	11.1	5.1	5.3	3.1	10.4	7.5
Monthly average no. of mothers with probable PND referred to social services	2005	0.8	0.6	0.4	0.4	0.8	0.6
	CCDS	3.4	1.9	2.1	1.7	2.0	2.4
Monthly average no. of mothers with probable PND recommended for parenting workshop	2005	Data not available					
	CCDS	10.7	6.1	5.2	4.9	3.8	6.7
Monthly average no. of mothers with probable PND recommended for breastfeeding coaching	2005	Data not available					
	CCDS	2.0	0.2	0.4	0.4	1.2	1.0
Monthly average no. of mothers with probable PND recommended for other MCH services[f]	2005	Data not available					
	CCDS	0.3	0.2	0.2	0.1	2.1	0.6

[a] For WK MCHC, the 2005 figures were based on service statistics from January to June 2005.

[b] The 2005 numbers included 176 cases assessed by a senior medical officer stationed in the MCHC. The cases were identified through EPDS between 1 January and 22 September 2005.

[c] The *overall monthly average number* is a notional figure / index for comparison. Overall monthly average number of cases = (total number of cases recorded in five pilot MCHCs during their respective period of implementation or reference period) - (the total number of months of implementation or reference period for the five pilot MCHCs).

[d] CCDS figures referred to statistics complied from the official commencement date until September 2006.

[e] Including visiting psychiatric nurse service, psychiatric department and A&E department.

[f] Other MCH services included health workshops and health information giving.

Client feedback

The access to the service was also examined through clients' feedback on the service. On the whole, clients commended the provision of visiting psychiatric nurse service in MCHCs and considered the service easily accessible (1, 2, 3). The quotes are in Appendix 5.2.

Summary

Overall, there has been an increase in the number of mothers with probable PND identified, number of clients referred to MCH nurse counselling, psychiatric and social services, suggesting increased access to treatment and support services.

5.5.2 Acceptability

The acceptability of the service to clients can be reflected through the number of clients accepting or declining referral to visiting psychiatric nurse service, the number of clients defaulting appointments with visiting psychiatric nurses and client feedback.

Acceptance and attendance of visiting psychiatric nurse service

The acceptance rate for referral to visiting psychiatric nurse service ranged from 70% to 100% and the attendance rate was about 80% (Table 5.5). As there was no baseline statistics on acceptance and attendance rates, it was not possible to compare these rates to examine change in acceptability.

Table 5.5: Monthly average acceptance and attendance rates for visiting psychiatric nurse service from the date[a] of commencement of visiting psychiatric nurse service till September 2006

	WK	**TSW**	**YO**	**TMWH**	**TKO**	**Overall**[b]
Monthly average no. (%[c]) of clients accepting psychiatric nurse referral (Acceptance rate)	10.9 (73.5%)	4.7 (80.8%)	4.3 (86.7%)	3.0 (96.4%)	9.8 (88.6%)	7.0 (80.3%)
Monthly average no. (%[c]) of clients declining psychiatric nurse referral (Decline rate)	3.9 (26.5%)	1.1 (19.2%)	0.7 (13.3%)	0.1 (3.6%)	1.3 (11.4%)	1.7 (19.7%)
Monthly average no. (%[d]) of clients attending scheduled psychiatric nurse appointments[d] (Attendance rate)	9.4 (82.5%)	4.7 (88.7%)	3.6 (78.3%)	2.2 (78.6%)	8.1 (74.3%)	6.0 (80.9%)
Monthly average no. (%[d]) of clients defaulting all scheduled psychiatric nurse appointments[e] (Default rate)	2.0 (17.5%)	0.6 (11.3%)	1.0 (21.7%)	0.6 (21.4%)	2.8 (25.7%)	1.4 (19.1%)

[a] The commencement dates were July 2005 for WK, January 2006 for TSW, YO and TMWH, and February 2006 for TKO.

[b] The *overall monthly average number* is a notional figure / index for comparison. Overall monthly average

number of cases = (total number of cases recorded in five pilot MCHCs during their respective period of implementation or reference period) - (the total number of months of implementation or reference period for the five pilot MCHCs).

[c] Percentage was calculated by using the no. of mothers with probable PND recommended for referral to visiting psychiatric nurse service as denominator.

[d] Percentage was calculated by using the no. of mothers booked for psychiatric nurse appointments as denominator.

[e] The attendance and default numbers did not add up to the acceptance number because some clients recommended for visiting psychiatric nurse service might have their appointments scheduled after September 2006. Furthermore, some clients initially seen by MCH nurses for counselling might be referred to visiting psychiatric nurse and their numbers were not reflected in the acceptance number, but were counted in the attendance number. The acceptance number was based on clients recommended for visiting psychiatric nurse service at initial PND assessment.

Client feedback

Prior to referral to visiting psychiatric nurses, clients were first assessed/counselled by MCH nurses. Clients were positive about their interviews with MCH nurses. They described MCH nurses as caring, skilful and patient (4, 5). The quotes are in the appendix 5.2.

Among those who consented to the referral, the initial response to MCH nurses' suggestion of referral was quite varied. Some clients were positive and even initiated it (6). Some were neutral or passive, just following the suggestion of MCH nurses (7, 8). Others needed reassurance from MCH nurses before agreeing to see the visiting psychiatric nurse (9).

Most of the clients seen by visiting psychiatric nurses were positive, claiming that the psychiatric nurse could help them in various different aspects, such as gaining insight about their own problems, marital relationship, childcare, relaxation techniques and emotional management (10, 11, 12). However, when psychiatric nurses recommended referral to psychiatrists, the clients' responses were more varied. Some were reluctant because of the stigma associated with seeing a psychiatrist and inconvenience (13, 14), while others found the medication useful (15).

Summary

Clients were positive about the PND screening, assessment and counselling services provided by MCH nurses and visiting psychiatric nurses. They welcomed the provision of visiting psychiatric nurse service in MCHCs and the acceptance rate was generally about 80%. However, clients were still reluctant to attend psychiatrist services in HA psychiatric departments because of stigmatization and inconvenience.

5.5.3 Equity

The EPDS coverage figures in Table 5.3 revealed that some client groups might not be accessing the service. These included those who did not turn up at the 2-month child health visit in person and those with literacy/language problems. Among those who did not return in

person, they were mainly working mothers or mothers living in China. Under these circumstances, MCH nurses could only ask the caretakers who brought the child to the MCHC about mother's mood. Those with literacy problems or difficulties in reading Chinese/English were not deprived of the service because clinical assessment was used instead. However, for ethnic minority mothers who could neither communicate in English nor Chinese, clinical assessment was more difficult.

5.5.4 Effectiveness

A randomized controlled trial[11] was conducted in four of the five pilot MCHCs to examine the effectiveness of the PND screening programme as compared to the usual practice (detection by clinical assessment). Preliminary results of three MCHCs were available at the time of writing[12]. The results indicated that, at 6 months postnatal, the mental health status of clients under the EPDS screening programme was better than those under clinical assessment[13].

5.6 Summary and conclusions

Service statistics indicated an increase in the number of clients being identified as having probable PND and that being referred for MCH nurse counselling, psychiatric and social services, suggesting an increase in access.

In terms of acceptability, clients commended the provision of visiting psychiatric nurse service in MCHCs and they found the services helpful. Clients found MCH nurses professional and caring. On the other hand, clients were reluctant to accept referral to psychiatrists because of perceived stigma and inconvenience. These may be reduced by the provision of consultation by psychiatrist in MCHCs, which may in turn lead to an increase in acceptability and access.

This component was designed as a universal screening programme. However, it was observed that clients who did not personally attend MCHCs could not access PND screening and assessment. These were mainly mothers who were working or residing in China.

References

Altman, D.G. (1991). *Practical statistics for medical research*. Washington, D.C.: Chapman & Hall/CRC.

[11] The trial was conducted before full implementation of EPDS screening in the respective MCHCs.

[12] A detailed report will be available when the study is completed.

[13] Using the cut-off score of 9/10 on EPDS, there was a statistically significant difference between the two groups, $\chi^2(1) = 7.23$, $p < .01$. Among the EPDS screening group, 15 (10.6%) of the clients still had EPDS score above the cut-off at 6 month follow-up and the corresponding figure for the clinical assessment group was 31 (22.6%). There was a statistically significant difference in the 6 month EPDS scores between the EPDS screening group and the clinical assessment group, $t(276) = 3.53$, $p < .001$. The 6-month mean EPDS score of the EPDS screening group was 4.79 (95% confidence interval (CI): 4.20 – 5.38) and that for the clinical assessment group was 6.40 (95% CI: 5.71 – 7.09). There was a statistically significant difference in the 6-month Parenting Stress Index scores between the two groups, $t(276) = 2.12$, $p < .05$. The mean score of the EPDS screening group was 80.31 (95% CI: 77.30 – 83.31) and that for the clinical assessment groups was 84.77 (95% CI: 81.89 – 87.64).

Last, J.M. (2001). *A dictionary of epidemiology* (4th ed.). Oxford, England: Oxford University Press.

Lee, D.T.S., Yip, S.K., Chiu, H.F.K., Leung, T.Y.S., Chan, K.P.M., Chau, I.O.L., et al. (1998). Detecting postnatal depression in Chinese women. Validation of the Chinese version of the Edinburgh Postnatal Depression Scale. *The British Journal of Psychiatry, 172*(5), 433-437.

National Health and Medical Research Council (2000). *Postnatal depression: a systematic review of published scientific literature to 1999.* Canberra: Commonwealth of Australia.

National Screening Committee (2001). *Evaluation of screening for postnatal depression against the NSC handbook criteria*. Retrieved 19 November, 2003, from http://www.nelh.nhs.uk/screening/adult_pps/shakespeare_final_paper.pdf

Scottish Intercollegiate Guidelines Network (2002). *Postnatal Depression and Puerperal Psychosis: A National Clinical Guideline.* Scotland: Scottish Intercollegiate Guidelines Network.

Appendix 5.1: Views of MCH nurses and visiting psychiatric nurses on identification and management of mothers with probable PND

Facilities		
1	加我 psy(psychiatric) nurse 嘅 session 落去，其實係幫到好多 client…但係講番個(MCHC) physical setting 係冇可能容納到我咁多時間喺度，呢個冇辦法喇，資源上嘅問題大家解決唔到嘅喇。	PN1-24B
2	似乎係好睇個別(MCH) centre，environment 方面唔係好理想，例如無電話喺房呀，無特定一間房，如果配合好啲，運作上會暢順啲，銜接上好啲。	PN1-7C
3	環境喇…..有時環境狹窄，interview room 太窄，一間房三個姑娘，有時(client)都未必肯講呀，咁樣有時都會有影響。	1-57B
4	淨係間房都死喇，一間房三個同事坐係度，個 case 你 counsel 佢，佢(client)又喊，佢喊，又行吓一個人行入嚟，佢望吓，另一個又偷聽你講乜嘢呢。	2-384E
Manpower/workload		
5	試過一個 session，我地有四個同事見 case，有三個同事 jam 咗，一人一個 PND 霸咗個位，得番一個同事係度踩，嗰個同事真係想去死呀。好慘呀真係，門口怨聲載道，你估我地冇壓力，我地都有壓力。	2-248E
6	時間用多咗喇。	1-56A
Training		
7	唔會話無幫助嘅。但係你諗吓人地要一個 course 咁多嘅時候，我讀嗰一日，你可以幫到我啲乜嘢喇。	4-55D
8	Training 得 9 個鐘實在有時都唔係話太過足夠，喺 practical 同 clinical 方面，或者係個 lecture 方面，應該都係要多啲。	1-88B
9	我地根本唔係讀呢樣。	2-365H
10	但係如果你話從未讀過 counselling，佢嗰個 PND，我就覺得好似跳咗，好似無咗個打底，然之後去做 PND 啦。	4-56L
11	所以 boss 都會幫手 develop 個 package 出去，之前準備嗰時，都見多啲 community case 例如產婦，做咗一個 mini survey…做咗一啲 intervention plan，如果將來 MCHC 有同樣啲 services，都可以用得番，另外都有同 MCHC 聯絡…可以知道點配合，令流程順暢一啲。	PN1-5D
12	同埋喺裡面我想知啲乜嘢資料，佢(seniors)都盡量帶我出去見，去認識或者去介紹，等我深入體會，咁至於我 personal 嘅 study 就好 open 嘅，我啲阿 head 呢就會話你想知道有乜嘢 workshop 呀或者有乜嘢 study 你想申請呢，佢地會鼓勵我，亦都會俾機會，俾時間俾資源我。	PN1-6B
13	我地依度(hospital)有個 SMO，有個醫生佢會，我(visiting psychiatric nurse)之前已經係參與好多呢方面 seminar，workshop 呀同埋亦都係有 update paper，書籍關於呢方面，因爲基本上我地本身個 training 都會有。	PN2-10A

Client management		
14	我有 criteria 去跟番住，個 case 去到乜嘢情況去到邊一度呢。	1-52A
15	其實做就唔難嘅，我(nurse)覺得真係唔難，即係如果有嘢，你(client)一入嚟坐低，睇到個樣係咪謝哂呀	5-113D
16	或者…assess 個人(client)有事呀，即有時會有啲心理壓力，即 PND 個啲。	3-167H
17	Clinical assessment…，講就話好似好容易，問四句嘢，但問題上就係話，撩到佢 (client)出嚟，越多就越戰戰兢兢…，一但問到佢有事，你就慘喇，係咪?	4-200L
18	有陣同事們都會擔心就係話，上次見佢好似我又見唔到，今次呢，嘩原來咁高分，或者係今次呢，見第二個佢喊到死吓死吓，咁變咗就令到佢地都增加一啲好大嘅壓力，係咪我自己做得唔夠好，撩得人地唔夠深，或者係咪我即係遺漏咗人地，咁變咗都係唔經唔覺係會有啲壓力。	4-201D
19	老實講，PND…其實過去幾年嚟講我地嘅 statistic，一年頂隆得個四十幾至五十幾個 case 嘅…但我地上半年嚟講已經做到一百五十個 cases 喇喎，double 哂。	2-242C
20	因爲每個姑娘嘅 background 都唔同，但如果我地嘅經歷唔足夠嘅時候，你根本無咁嘅 ability 去同個 client 去 counsel，呢樣我地會覺得好吃力。	4-199G
21	佢地(nurse)已經咁大壓力啦，如果…其他嘅人唔係比多 D 體諒，唔係比多啲 support，剩係識得去埋怨呀…咁佢地(nurse)就會更加艱難囉!	4-213L
22	因爲個合作好喇，所以好好多，問題唔係話個壓力咁重，…有醫生去承擔，又有精神科姑娘去承擔，變咗就會好 smooth 咁囉。	1-68B
Collaboration		
23	佢地(visiting psychiatric nurse)個專業 counselling skill 可以幫到個 client。	3-135G
24	咁因爲我地用嘅 term 係專科護士，一般如果佢(client)想都好樂意。	1-63E
25	佢(visiting psychiatric nurse)會同我地 case review，佢(visiting psychiatric nurse)睇咗咁大家可以睇番，佢睇咗之後佢俾番個 feedback 我地呢個 case 係點呀，佢有乜嘢 plan 呀，有乜嘢 management 呀，咁其實我地從中學到好多嘢囉。	1-61D
26	即係個溝通我(MCH nurse)覺得做得唔差囉…總之(visiting psychiatric nurse)一定會有交帶….最近有時我地(MCHC) i/c 都會 arrange 一啲 meeting 同番 psy(psychiatric) nurse 去開會，咁變咗大家可以係當中都可以學到嘢囉，睇番佢(visiting psychiatric nurse)個 technique 點樣。	5-140D
27	其實 case sharing 好重要…睇到 MCHC 嘅 nurse 係欠缺 experiences，欠缺啲信心，case share 可以留意多啲個問題係邊度，	PN1-13C

	problem solving。	
28	亦都互長囉…其實佢地(MCH nurse)一路有 feedback，喺 feedback 我(visiting psychiatric nurse)…知道好多 child development 裡面啲同事(MCH nurse)會 work on 啲乜嘢，咁有時有啲新 idea 佢地(MCH nurse)會 throw 俾我囉，等我都可以 refresh 一下我自己。	PN1-12B
29	喺 MCHC 裡面我(visiting psychiatric nurse)相當滿意。無論 setting 呀，合作呀各方面囉，同埋覺得都好成功呀，…大家合作裡面，大家個 expectation，share 意見點樣可以幫個 client，無論醫生呀，同事呀，各方面，比如我想個 case 有啲乜嘢隨時要做 assessment，physical assessment，blood test 各方面都配合得到，所以好滿意。	PN1-8B
30	咁呢個運作係要大家去傾，其實呢啲係小問題囉，可以 settle 到，咁你話如果係大問題嘅話 so far 嚟講都冇乜嘢好大，如果講我地同 MCHC 運作嘅話。	PN2-17B
31	但如果姑娘(visiting psychiatric nurse)係長駐喺度，即 psy(psychiatric)姑娘，佢番親嚟有呢個 case，可以即刻彈到俾佢，我地又可以做到一啲其他工作，其實咁樣係安排最好囉,最好長駐喺度。	2-339E
32	其實睇下，psy(psychiatric) nurse 同 MCH counselling nurse 嘅角色介定，睇下 MCH counselling nurse 嘅 level，可以點配合，in long run provide 一啲 basic counselling，即可否完全接晒呢?會否啲 risk case 留番比 psy(psychiatric) nurse?	PN1-30C
33	因爲如果(MCH) counselling nurse somehow 可以做到一啲嘢，我地 psy(psychiatric) nurse 可以專注係 assessment 度，未必需要去 follow up 一啲 case，做咗 assessment 之後呢，咁然後我地可以真係好清晰咁樣俾哂所有意見，咁睇下 somehow MCHC 嘅 counselling nurse 可唔可以 work on 落個 client 度。	PN1-27B
Procedures		
34	一個 PND case，如果又要 IFSC，你要填一張 IFSC 嘅 referral，PND referral，加埋要開一個 5.1、5.2、6.1、6.2，仲要開個 PND 嘅牌版，你幾多 paper work 做呀，如果比我真係唔熟手，我真係要兩個鐘頭先做起啲 paper work。	4-65F
35	我都覺得(PND) counselling 係以往不嬲都做緊嘅，就算無 CCDS 都係做緊嘅…，亦都係對 client 有幫助嘅，而家問題係 CCDS 加咗之後呢，其實就係啲 form 先係大問題囉。	5-137D

Appendix 5.2: Quotes from clients about PND related service

Visiting psychiatric nurse service on site in MCHC		
1	而家配套已好好，媽咪都容易見到兒科醫生、精神科姑娘，資源充足。	1-06_3
2	喺健康院見精神科姑娘較容易接受，自然啲。	1-06_1
3	估唔到健康院唔只可以幫到 BB，仲可以幫到大人。	4-05_2
MCH nurse assessment		
4	姑娘問啲生活情況，遇到啲問題，湊兩個 BB 未必咁多時候做到嘢。姑娘幾次引導我我講出嚟，關心我，好有技巧，幫咗我令我鬆好多。	2-06_2
5	佢地肯聽你講啲家庭問題，姑娘有耐性。	4-05_1
Response to suggestion for visiting psychiatric nurse service referral		
6	我覺得好有需要，其實見精神科姑娘都係我自己半提出來，因爲覺得辛苦。	1-06_3
7	無乜點，姑娘叫咪去見。	3-03_2
8	都可以，無問題。	2-06_1
9	當時覺得精神科姑娘，姑娘就解釋唔係有病，係同你傾計，我以爲個個當我有病，姑娘就解釋產後抑鬱唔係咁嚴重嘅病。	4-05_2
Counselling by visiting psychiatric nurse		
10	有幫助，睇下自己點諗嘢。可能姑娘係專業啲，佢見我嗰陣傾得好詳細，又幫我諗，有時有啲嘢我自己唔多覺，佢講多啲就叮一叮我，等我知道問題喺邊，原來好多問題一直都係咁多年都存在緊，只係我唔發覺。	4-05_3
11	夫妻之間啲問題，湊 BB，傾計，教啲放鬆嘅方法，主要都係傾計，都幫到嘅。	2-06_5
12	無乜可以幫到，但覺得姑娘教嗰啲正面發洩情緒方法都有用，唔會將脾氣發喺 BB 身上。	3-03_1
Referral to psychiatrist		
13	無睇精神科醫生，因幾抗拒，會被人歧視。	3-03_2
14	精神科地方病人多，對 BB 唔好，因抵抗力弱…精神科候診時間好長，唔方便。	3-03_1
15	佢地有幫我，加上又去明心樓睇醫生，開咗啲藥，好瞓啲。	4-05_2

Chapter 6
Identification and Management of Families with Psychosocial Needs

The development of children is affected by their families and the community. In this chapter, procedures for the identification and referral of families with psychosocial needs before implementation of the CCDS are described, followed by changes introduced in the structure and process, and the formative process. The resulting change in the quality of service (intermediate outcome) will then be examined.

6.1 Service provision before CCDS

Prior to April 2003, there was no formal mechanism for the identification and referral of families with psychosocial needs. When client needs were identified by MCH staff, or when clients themselves raised concerns, MCH staff would advise clients to seek help from social service agencies, or make a verbal or written referral, depending on the individual practices of the MCHCs and social service agencies. Since April 2003, a mutual referral system had been established between DH and the then FSCs/IFSCs of SWD to provide early intervention and timely assistance for families in need of welfare services and/or child health care services.

With the full implementation of the IFSC model in April 2005, the referral mechanism was extended to NGO IFSCs/Integrated Services Centres (ISCs). A set of revised referral and reply forms was agreed upon between DH and SWD/NGOs, to facilitate mutual referral of clients between MCHCs and IFSCs/ISCs. There was an undertaking to acknowledge receipt of the referral within 7 days and issue a reply within one month to indicate the service(s) provided to the client. Named contact persons for each MCHC and IFSC were nominated. This referral mechanism, together with the regularly updated contact list, has facilitated the mutual collaboration and cooperation of MCHCs and IFSCs/ISCs, particularly in achieving early identification and intervention for needy families.

6.2 Changes in service provision under the CCDS

To facilitate the early identification and referral of families with psychosocial needs, structural and process changes were introduced. These changes were guided by the theory of help-seeking behaviour, which suggested that knowledge/awareness of available services and perceived accessibility of service (Leong & Lau, 2001) were important elements affecting the use of services.

6.2.1 Changes in process

Under the CCDS, a new set of identification procedures were in place to enhance the identification of clients with psychosocial needs and referral to social services for support.

Identification

Clients were assessed for their psychosocial needs at three-month postnatal or other times as necessary. This particular timing was chosen for two reasons: (i) to coincide with the child immunization schedule so as to cover more clients; and (ii) many parents might face initial adjustment problems with the birth of the baby. By three months, it was reckoned that difficulties faced by families were more than initial adjustment problems and these families would need more support. A two-stage process was adopted to systematically identify clients with psychosocial needs. The two-stage process is illustrated in Figure 6.1.

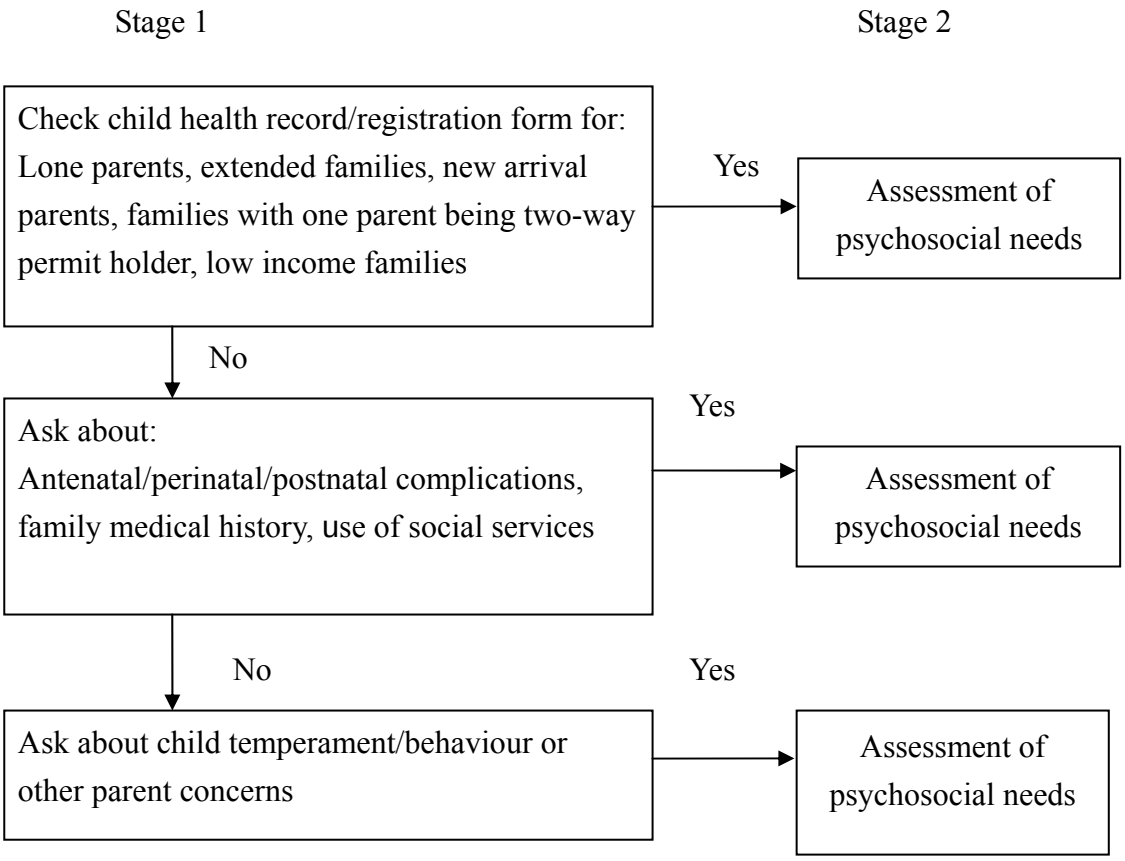


Figure 6.1: Two-stage process in the identification of clients with psychosocial needs

- **Stage 1** – clients with selected risk factors were identified for further assessment. These were known risk factors for child and family well-being (Olds, 1988; Dunn, 1994; Webster-Stratton & Taylor, 2001; Leung, Leung, Chan, Tso & Ip, 2005), including low income families, new arrival families, one parent being on two-way permit, lone parent families, extended families[14], family and child medical condition, and child temperament. The risk factors could be identified by checking the child health record or asking the client.
- **Stage 2** - detailed assessment of psychosocial needs was conducted for clients belonging to one or more of the above risk categories. A semi-structured interview guide (SSIG) with

[14] Extended family could be a risk or protective factor. While extended family members could be a source of social support, various studies have shown that in-law relationship was a predictor of probable postnatal depression (Leung, Martinson & Arthur, 2005; Lee, Yip, Leung & Chung, 2004)

a number of open-ended questions covering the key areas to be explored was prepared for MCH nurses to ensure the consistency of practice. The interview guide was developed by a team of doctors and psychologists.

Referral

Clients requiring social services were referred to IFSCs, using the referral and reply system described above. To make services more accessible, for clients who were reluctant to go to IFSCs, social workers could meet them in MCHCs on request, or conduct home visits to them. Some IFSCs also set up counters in MCHCs to inform clients of their services and to answer questions or make arrangement for further services as required.

Collaboration between organizations

To ensure the smooth functioning of the identification and referral system, co-ordination mechanisms were set up at institutional and district levels:

- **Institutional level** – there were several meetings between the Family and Child Welfare Branch (SWD), District Offices (SWD) of the four districts, and FHS (DH) to discuss issues related to the referral and feedback system, implementation and evaluation.
- **District level** – in each district, prior to launching of the CCDS, meetings were held between the IFSCs and the MCHC(s) to discuss various logistic issues, such as the nature of problems of clients to be referred and handling of referral forms. After the implementation, meetings between IFSCs, MCHCs and the medical social service were also held to discuss the referral and management of clients who were referred for both social and psychiatric services. There was also sharing of IFSC and MCHC service information to enable both parties have better knowledge of each other's work.

6.2.2 Changes in structure

Facilities

To enhance client knowledge about available services and community resources in the health, social and education sectors, a PRC was set up in WK MCHC. Apart from information leaflets, there were also computer terminals for clients to access audio-visual material and internet information. PRCs would be set up in other MCHCs in due course (for other information on the PRC in WK MCHC, see Appendix 2.1 in Chapter 2).

Staff training

To enhance MCH nurse' skills in interviewing and assessing clients' psychosocial needs, two training courses were organized.

- **"An empowerment and family-focused approach to interviewing"** – this was a whole-day workshop for all MCH nurses. The objective was to provide the theoretical

framework and practical skills for interviewing and assessing client needs. The content included key concepts (such as empowerment, positive psychology, prevention and early intervention, systems perspective, family-oriented approach), self-understanding and perspective taking, mental and emotional health, parenting, domestic disharmony, brief introduction of the SSIG and case discussion. The trainers were clinical psychologists. In addition, a half-day course was organized for MCH doctors. A total of 459 nurses and doctors attended the course. The evaluation results based on 366 participants (nurse = 357, doctors = 9) (response rate = 79.7%) are in Figure 6.2.

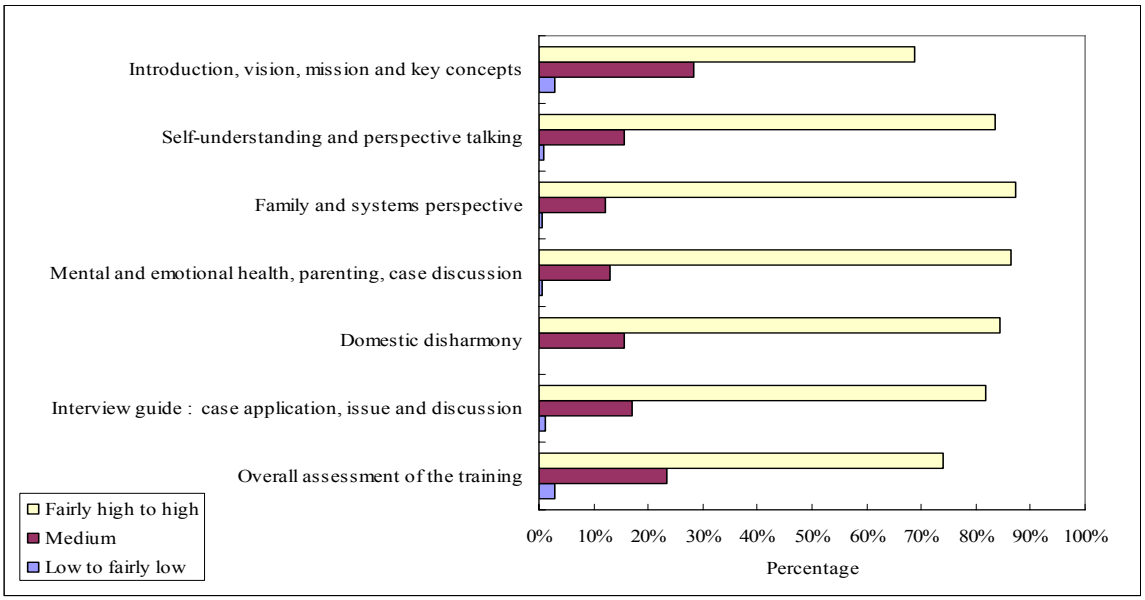


Figure 6.2: Evaluation of the usefulness of different topics of the training course on "An empowerment and family-focused approach to interviewing" attended by MCH staff (n=366)

- **The SSIG** – this was a half-day seminar for nurses on the practical aspects of using the SSIG in identifying clients with psychosocial needs. The trainers were the team of doctors and psychologists who developed the SSIG.

6.3 The formative process

This section focuses on describing issues arising from the implementation of this CCDS component, from the perspectives of MCH nurses, social workers and visiting psychiatric nurses. Measures to improve the implementation issues (in italics) are described where appropriate. The quotes are in Appendix 6.1.

6.3.1 Structure

Facilities

All pointed out that lack of privacy due to shortage of interviewing rooms in MCHCs was a

major issue in conducting the assessment (1, 2).

As mentioned in Chapter 5, to provide more privacy and to solve the room shortage problem, renovation work has commenced in MCHCs and other measures to allow for more flexible room usage were being put in place.

Manpower/workload

Nurses in all MCHCs maintained that there was increased workload with the implementation of the assessment (3, 4) and pointed out that much time was required (5, 6, 7, 8). Besides, some nurses reckoned that it would be best to have social workers stationed in MCHCs to deal with client psychosocial problems (9).

As mentioned in chapter 5, the manpower/workload issue was partly resolved by redeployment of existing staff between MCHCs and adjustment of number of clients booked for each MCH service sessions to control caseload in each session.

Training

Though some nurses were positive about the training in general, most would like specific and concrete examples in relation to their work, for example, demonstration of interviewing with particular types of clients (10, 11, 12, 13, 14). Some expected the training to deal with completion of record forms or counselling (15, 16, 17, 18).

To make the training more practical and relevant, role play was incorporated into the refresher training programme. A supervision programme was being piloted where nurse interviews were tape recorded and trainers (a psychologist and a doctor) could discuss the interview process with nurses.

6.3.2 Process

Client management

In terms of the SSIG manual, nurses in some MCHCs found the guide useful (19, 20) for them to focus on possible areas of concern for various categories of clients (21) and asking open-ended questions (22). In other MCHCs, nurses did not find it useful (23).

As for conducting the interviews, nurses in some centres emphasized that with a caring attitude towards clients, most were willing to talk about their problems, though some clients would need more persuasion (24, 25, 26). In some other centres, nurses found the process difficult. They seemed to equate the interview process with the completion of the record forms required for service statistics, and they admitted that they could not see the rationale behind the interview (27, 28). Some felt that they could not help clients solve their problems (29).

Regarding the referral process, all MCHCs were faced with the task of managing clients who declined referral. For these clients, nurses in some MCHCs would try to give them information about IFSCs and follow them up in subsequent visits (30, 31). Nurses in other

MCHCs, on the contrary, felt frustrated and helpless, and admitted that they were not clear about IFSC services (32, 33, 34). They also mentioned that some clients did not find social workers helpful (35).

Apart from the supervision programme mentioned above, briefing sessions on the use of the transtheoretical model (Velicer, Prochaska, Fava, Norman & Redding, 1998) to assess client readiness for change and strategies to enhance client motivation for change were being conducted. Social workers from IFSCs were also invited to explain their services to MCH workers in more details, e.g. the range of services that could be offered to clients with marital problems or family relationship problems. This would enable MCH nurses to tell clients in more concrete terms what services could be offered to meet their needs.

The roles of nurses in the identification process were clarified in training programmes and clinic meetings. It was stressed that the roles of nurses were to identify clients' needs and make referral to appropriate services, rather than solving all their problems.

Procedures

There were concerns across MCHCs regarding the amount of paper work required for record keeping, but there were also variations by MCHCs. Nurses in some MCHCs reported that they could manage better as they became more familiar with the task (36, 37), while others could not see the rationale for record keeping (38, 39, 40, 41). Visiting psychiatric nurses also expressed concern about the paper work involved in making IFSC referrals (42, 43).

As mentioned in chapter 5, the extra workload due to data collection and record keeping was being taken over by research assistants employed to support CCDS evaluation. A preliminary meeting was held with SWD and HA to explore the possibility of setting up a computer platform to share information and track client progress.

Collaboration

After the clients were referred to IFSCs, communication between IFSCs and MCHCs was important in ensuring that clients were actually accessing service and the services were meeting their needs. The communication could be formal or informal. Formal communication included the standardized 7-day and one-month reply forms etc (see 6.1) and informal communication was through phone contacts between IFSCs and MCHCs. Nurses in most MCHCs reported some delay in getting the reply forms from IFSCs (44, 45). IFSC frontline workers in some districts expressed some concern about the reply forms and queried the rationale of the system (46), while others considered the reply system acceptable (47).

For informal communication, both MCH nurses (48, 49) and IFSC social workers (50, 51, 52, 53) in some districts reported good collaborative relationship. In other districts, there were communication problems between IFSC workers (54, 55) and MCH nurses (56, 57, 58). Visiting psychiatric nurses also reported some difficulties in collaboration with some IFSCs because of differences in case focus and approach (59, 60). There were also difficulties with

IFSC boundaries issues (61). This issue was raised by MCH nurses and IFSC social workers as well. Each IFSC served clients residing within its service boundary but there was no boundary limitation for MCHCs. This created a difficult situation for MCH clients attending CCDS MCHCs but not residing in the same locality. They had to be referred to other IFSCs in the area of their residence and some clients did not like this kind of arrangement (62, 63).

For formal communication, the reply forms were re-sent to all IFSCs to ensure that they had access to the necessary forms. For other collaboration issues, case discussion, sharing sessions, visits and district level ad hoc meetings were arranged. For example, as mentioned above, meetings between IFSCs, MCHCs and medical social service were held to discuss the referral and management of cases referred for both social and psychiatric services. MCH doctors also gave feedback to nurses on successful cases.

Service gaps/ difficulties encountered

Some of the client issues that could not be resolved easily were eligibility problem for housing (64), and 'hard-to-reach' clients (65). Others included parents on two-way permits or visitor visas, which was mentioned by both MCH nurses and IFSC social workers. There were eligibility criteria for various services which two-way permit holders were not entitled, e.g. financial assistance (66, 67, 68).

A briefing session on cross-border social services for clients normally residing in China was arranged for frontline MCH staff to enhance their knowledge of available services and resources.

6.3.3 Summary

Nurses in some MCHCs were positive about conducting interviews to assess clients' psychosocial needs and there was good collaboration between IFSCs and MCHCs. Nurses in other MCHCs were frustrated with the task and there were also difficulties in collaboration. Visiting psychiatric nurses also reported some collaboration difficulties.

However, all MCHCs were concerned about the amount of paper work involved in the referral process and collection of service statistics, increased workload and lack of privacy in MCHC premise for conducting interviews. They also reckoned that the training should have been more practical.

IFSC and MCH staff also identified a number of problem areas in service provision, including service for parents holding two-way permits, IFSC boundary issues, eligibility problems for some specific welfare services, and "hard-to-reach" clients, etc.

Various improvement measures were put in place to facilitate the implementation of this component.

6.4 Service statistics

Table 6.1 shows the service statistics for clients being assessed and referred for social

service in five MCHCs. Table 6.2 shows the demographic characteristics of clients being assessed by SSIG. The majority of the clients interviewed were mothers and non-working clients. About 60% of them were either new arrivals or visitors from China or other places. About half of them had education level of Form 3 or below. The majority had monthly income at or below $19 999.

Table 6.1: Service statistics for clients assessed and referred for psychosocial needs from official commencement date[a] until September 2006

	WK	**TSW**	**YO**	**TMWH**	**TKO**	**Total**
Total no. of new registered children under age one	4 797	1 675	1 933	766	2 531	11 702
No. of cases assessed using SSIG	1 503	637	705	300	537	3 682
No. of clients recommended for social service referral						
No. accepted referral	222	59	47	44	49	421
No. declined referral	79	23	54	11	13	180
Total	301	82	101	55	62	601

[a] Official commencement date for WK was July 2005 and that for the other four MCHCs was January 2006

Table 6.2: Demographic profile of clients assessed for psychosocial needs from official commencement date until September 2006

	WK		TSW		YO		TMWH		TKO		Total	
No. of clients assessed using SSIG	**1 503**		**637**		**705**		**300**		**537**		**3 682**	
Client's relationship with child	**n**	**%[a]**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Father	52	3.5	32	5.0	37	5.2	20	6.7	34	6.3	175	4.8
Mother	1 367	91.0	541	84.9	615	87.2	260	86.7	468	87.2	3 251	88.3
Others	21	1.4	56	8.8	45	6.4	19	6.3	32	6.0	173	4.7
Antenatal clients or unknown	63	4.2	8	1.3	8	1.1	1	0.3	3	0.6	83	2.3
Number of clients included[c]	**1 419**		**573**		**652**		**280**		**502**		**3 426**	
Residential status	**n**	**%[b]**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Hong Kong resident (>= 7 years in Hong Kong)	406	28.6	256	44.7	323	49.5	122	43.6	245	48.8	1 352	39.5
New arrival from China or other places (<7 years in Hong Kong)	444	31.3	142	24.8	161	24.7	59	21.1	77	15.3	883	25.8
Visitors from China or other places	548	38.6	169	29.5	165	25.3	99	35.4	178	35.5	1 159	33.8
Others	17	1.2	3	0.5	2	0.3	0	0.0	1	0.2	23	0.7
Unknown	4	0.3	3	0.5	1	0.2	0	0.0	1	0.2	9	0.3
Marital status												
Married	1 204	84.8	533	93.0	581	89.1	262	93.6	474	94.4	3 054	89.1
Cohabited	45	3.2	17	3.0	26	4.0	7	2.5	11	2.2	106	3.1
Never married / Separated / Divorced / Widowed	158	11.1	19	3.3	42	6.4	11	3.9	15	3.0	245	7.2
Unknown	12	0.8	4	0.7	3	0.5	0	0.0	2	0.4	21	0.6
Family type												
Nuclear	780	55.0	325	56.7	405	62.1	147	52.5	142	28.3	1 799	52.5
Extended	591	41.6	246	42.9	242	37.1	133	47.5	359	71.5	1 571	45.9
Lone parent	18	1.3	0	0.0	0	0.0	0	0.0	0	0.0	18	0.5
Reconstitute	1	0.1	1	0.2	1	0.2	0	0.0	0	0.0	3	0.1
Institute	4	0.3	0	0.0	1	0.2	0	0.0	0	0.0	5	0.1
Others	0	0.0	0	0.0	2	0.3	0	0.0	1	0.2	3	0.1
Unknown	25	1.8	1	0.2	1	0.2	0	0.0	0	0.0	27	0.8
Education												
Form 3 or below	808	56.9	267	46.6	349	53.5	122	43.6	201	40.0	1 747	51.0
Form 4 or above	605	42.6	302	52.7	300	46.0	158	56.4	297	59.2	1 662	48.5
Unknown	6	0.4	4	0.7	3	0.5	0	0.0	4	0.8	17	0.5
Occupation												
Managers/administrators	15	1.1	8	1.4	10	1.5	6	2.1	15	3.0	54	1.6

Professional/associate professional	36	2.5	14	2.4	11	1.7	19	6.8	24	4.8	104	3.0
Service worker/sales worker	70	4.9	39	6.8	52	8.0	25	8.9	45	9.0	231	6.7
Crafted and related worker	5	0.4	4	0.7	5	0.8	3	1.1	4	0.8	21	0.6
Plant/machine operator/assembler	7	0.5	5	0.9	11	1.7	4	1.4	2	0.4	29	0.8
Elementary occupation	30	2.1	13	2.3	21	3.2	4	1.4	15	3.0	83	2.4
Clerk	59	4.2	44	7.7	46	7.1	29	10.4	73	14.5	251	7.3
Unemployed/housewives	1 185	83.5	444	77.5	491	75.3	187	66.8	319	63.5	2 626	76.6
Others	4	0.3	0	0.0	0	0.0	0	0.0	0	0.0	4	0.1
Unknown	8	0.6	2	0.3	5	0.8	3	1.1	5	1.0	23	0.7
Family income												
$9 999 or below	855	60.3	243	42.4	316	48.5	107	38.2	134	26.7	1 655	48.3
$10 000 to $19 999	418	29.4	214	37.4	235	36.0	102	36.4	185	36.8	1 154	33.7
$20 000 or above	109	7.7	87	15.2	88	13.5	63	22.5	174	34.7	521	15.2
Unknown	37	2.6	29	5.1	13	2.0	8	2.9	9	1.8	96	2.8
CSSA recipient												
Yes	223	15.7	71	12.4	65	10.0	16	5.7	25	5.0	400	11.7
No	1 186	83.6	502	87.6	584	89.6	263	93.9	474	94.4	3 009	87.8
Unknown	10	0.7	0	0.0	3	0.5	1	0.4	3	0.6	17	0.5
Past history of psychiatric illness												
Yes	47	3.3	22	3.8	20	3.1	13	4.6	9	1.8	111	3.2
No	1 366	96.3	551	96.2	625	95.9	267	95.4	490	97.6	3 299	96.3
Unknown	6	0.4	0	0.0	7	1.1	0	0.0	3	0.6	16	0.5
Receiving psychiatric treatment now												
Yes	41	2.9	13	2.3	13	2.0	11	3.9	7	1.4	85	2.5
No	1 372	96.7	560	97.7	632	96.9	269	96.1	492	98.0	3 325	97.1
Unknown	6	0.4	0	0.0	7	1.1	0	0.0	3	0.6	16	0.5
Language used at home												
Cantonese	1 355	95.5	500	87.3	604	92.6	273	97.5	449	89.4	3 181	92.8
Other Chinese dialects	39	2.7	60	10.5	33	5.1	7	2.5	45	9.0	184	5.4
Others	19	1.3	12	2.1	12	1.8	0	0.0	6	1.2	49	1.4
Unknown	6	0.4	1	0.2	3	0.5	0	0.0	2	0.4	12	0.4

[a] Percentage was calculated by using number of clients assessed using SSIG as denominator.

[b] Percentage was calculated by using number of clients included as denominator.

[c] Only data on fathers or mothers were included. Data from "others" or "Antenatal clients/unknown" under "Relationship with child" were excluded.

6.5 Change in the quality of service

Both quantitative (service statistics) and qualitative (client interview results) information were used to examine the change in the quality of service. In addition, outcomes of social

service intervention would be assessed through case termination information, client mental well-being measures before and after referral, and case progress reports.

6.5.1 Access

Access was examined in terms of the number of clients assessed using the SSIG and the number recommended for social services referral, as well as client feedback. The CCDS statistics was compared with baseline statistics (2004 service statistics) to examine changes in access. The 2004 service statistics were used as baseline measure in this case because the 2005 service statistics was confounded by the new referral and feedback system between DH and SWD and the trial of SSIG in MCHCs prior to the CCDS implementation.

Comparison of statistics before and after CCDS implementation

An increase in the number and percentage of social service referral was observed. The figures are shown in Table 6.3.

Table 6.3: Monthly average identification and referral statistics from full implementation[a] to September 2006

		WK	TSW	YO	TMWH	TKO	Total/ Overall[b]
Number of new registered children under the age of one	2004	2 846	2 099	2 329	947	2 950	11 171
	CCDS	4 797	1 311	1 142	617	1 715	9 582
Monthly average no. of new registered children under the age of one	2004	237.2	174.9	194.1	78.9	245.8	186.2
	CCDS	319.8	187.3	228.4	88.1	285.8	239.6
Monthly average no. (percentage) of new cases with SSIG conducted	2004	Data unavailable					
	CCDS	100.2 (31.3%)	76.1 (40.7%)	90.0 (39.4%)	36.7 (41.7%)	62.2 (21.7%)	77.9 (32.5%)
Monthly average no. (percentage) of new cases with referral to social services	2004	0.3 (0.1%)	3.9 (2.2%)	0 (0%)	0.8 (1.1%)	2.0 (0.8%)	1.4 (0.8%)
	CCDS	14.8 (4.6%)	6.0 (3.2%)	6.0 (2.6%)	5.1 (5.8%)	6.0 (2.1%)	9.2 (3.8%)

[a] Full implementation was July 2005 for WK, March 2006 for TSW and TMWH, April 2006 for TKO, and May 2006 for YO to September 2006.

[b] The *overall monthly average number* is a notional figure / index for comparison. Overall monthly average number of cases = (total number of cases recorded in five pilot MCHCs during their respective period of implementation or reference period) - (the total number of months of implementation or reference period for the five pilot MCHCs).

Characteristics of clients interviewed using SSIG

Before CCDS implementation, clients were explored for psychosocial needs only if they

raised concerns. With the implementation of the CCDS, clients with selected risk factors were identified for further systematic assessment using the SSIG. Table 6.4 gives information on the categories of clients identified for assessment. The majority of clients were selected for assessment because of their family type, income level and residential status.

Table 6.4: Categories of clients assessed by SSIG from official commencement date to September 2006

Categories [a]	**WK**	**TSW**	**YO**	**TMWH**	**TKO**	**Total**
	n	n	n	n	n	**n**
Extended family	452	235	242	134	368	**1 431**
Low income	549	214	435	133	36	**1 367**
One parent on two-way permit	581	195	187	107	187	**1 257**
New arrival	391	115	151	41	62	**760**
Antenatal / perinatal / postnatal complications	116	42	55	10	29	**252**
Lone parent	142	20	39	12	17	**230**
Concerns raised by clients	125	19	39	34	12	**229**
Family medical history	76	19	35	8	4	**142**
Child temperament	17	6	6	1	1	**31**
Others[b]	102	39	49	17	19	**226**

[a] Clients might belong to more than one category

[b] Others included marital problem, financial assistance, family relationship, in-law conflicts, emotional stress, lack of social support, teenage pregnancy etc.

Client feedback

Among clients who consented to referral, some reported that social workers were quick to contact them and offer them appointments (home visit or office interview) (1, 2) while others claimed that the social workers were busy and not easily accessible (3). The quotes are in Appendix 6.2.

Summary

In general, the service statistics indicated an increase in number of clients referred to social services, suggesting an increase in access. The reasons for assessment were mainly due to family type, income level, and residential status. Clients reported different degrees of satisfaction with social worker encounter.

6.5.2 Acceptability

Acceptability was assessed in terms of acceptance and decline figures, reasons for declining social service referral and client feedback.

Acceptance and decline statistics of social service referral

Table 6.5 shows the acceptance and decline figures for social service referral. Overall, about 17% of clients assessed by the SSIG were recommended for social service referral. The percentages of clients accepting and declining referral were about 70% and 30% respectively. The common reasons for declining referral were (i) being able to manage problems on their own, (ii) perception of no service need, and (iii) preference for approaching IFSC directly (Table 6.6).

Table 6.7 summarizes the reasons for referral among clients who accepted and declined referral. Overall, the most common reasons for referral were emotional problems, marital problem and childcare. Those who were referred for tangible services such as childcare and financial assistance were more likely to accept referral. Those referred for marital or family relationship problems were more likely to decline.

Table 6.5: Monthly average acceptance and decline figures for social service referral from full implementation[a] to September 2006

	WK	**TSW**	**YO**	**TMWH**	**TKO**	**Overall**[b]
Monthly average no. of clients assessed using SSIG	100.2	76.1	90.0	36.7	62.2	77.9
Monthly average no. (%[c]) of clients recommended for social services	20.1 (20.0%)	8.6 (11.3%)	14.2 (15.8%)	6.6 (17.9%)	7.5 (12.1%)	13.1 (16.8%)
Monthly average no. (%[d]) of clients accepting social service referral	14.8 (73.8%)	6 (70.0%)	6 (42.3%)	5.1 (78.3%)	6 (80.0%)	9.2 (70.0%)
Monthly average no. (%[d]) of clients declining social service referral	5.3 (26.2%)	2.6 (30.0%)	8.2 (57.7%)	1.4 (21.7%)	1.5 (20.0%)	3.9 (30.0%)

[a] Full implementation was July 2005 for WK, March 2006 for TSW and TMWH, April 2006 for TKO, and May 2006 for YO

[b] The *overall monthly average number* is a notional figure / index for comparison. Overall monthly average number of cases = (total number of cases recorded in five pilot MCHCs during their respective period of implementation or reference period) - (the total number of months of implementation or reference period for the five pilot MCHCs).

[c] Percentage was calculated using number of clients assessed using SSIG as denominator

[d] Percentage was calculated using number of clients recommended for social services as denominator

Table 6.6: Reasons for declining referral

Reasons	**n**
Could manage on one's own	56
No need	33
Preferred to approach IFSC directly	18
Refused to disclose to others	17
Had support from family/friend	16
Went back to China	13
Perception that social workers could not help/service not useful	9
Already receiving service somewhere	9
No time	7
Family members did not like referral	7
Preferred MCH service for follow up instead	3
Others	7
Total	195[a]

[a] Since official commencement date, there were 180 clients who refused referral but 15 clients gave more than one refusal reason.

Table 6.7: Referral reasons for all clients, with reasons for accepting and declining referral and the total ranked in order of frequency (the first three bolded) from official commencement date to September 2006

Referral reasons	**Frequency of reasons**		
	Total	Accept	Decline
Emotional problems	**237**	**180**	**57**
Marital problem	**199**	140	**59**
Childcare	**198**	**159**	39
Financial assistance	190	**148**	42
Family relationship	142	89	**53**
Employment	39	21	18
Accommodation	38	31	7
Premarital pregnancy / promiscuity	33	25	8
Interpersonal relationship	16	12	4
Drug abuse / alcoholic / gambling	14	9	5
Study problem	8	6	2
Residential service	3	2	1
Adoption	1	1	0
Rehabilitation	1	1	0
Elderly abuse	1	1	0
Others[a]	80	53	27

[a] Other reasons including lack of social support, teenage mother, husband imprisonment etc.

Types of IFSC service recommended by MCH staff and one-month reply from IFSC on the follow up action for clients accepting referral

Among clients who accepted referrals to social services by MCH staff, the majority were referred for casework or counselling service (Table 6.8).

Table 6.8: Types of social services recommended by MCH staff for clients accepting referral (n=421)

Service[a]	WK	TSW	YO	TMWH	TKO	Total
Casework	179	58	42	44	44	367
Group	52	0	3	1	0	56
Developmental programmes	13	1	3	0	1	18
Others[b]	24	4	13	2	5	48

[a] Client may have more than one service recommended

[b] Others included accommodation arrangement, financial assistance, childcare service, home helper service etc.

Based on the available one-month reply from IFSC, about 70.5% of referred clients were receiving casework/counseling/group/programme services. However, about 17% of clients declined IFSC service although they initially accepted referral (Tables 6.9 and 6.10).

Table 6.9: One-month reply from IFSC on follow up action for clients accepting referral from official commencement date

	WK	TSW	YO	TMWH	TKO	Total
No. of clients accepting referral	222	59	47	44	49	421
No. of replies received from IFSC	197 (88.7%)	57 (96.6%)	46 (97.9%)	37 (84.1%)	49 (100.0%)	386 (91.7%)
No. of non-reply cases	25 (11.3%)	2 (3.4%)	1 (2.1%)	7 (15.9%)	0 (0.0%)	35 (8.3%)

Table 6.10: Type of interventions by IFSC staff for clients with one-month reply (n = 386)

Interventions for clients	WK	TSW	YO	TMWH	TKO	Total
Casework/group/programme	132	41	32	30	37	272
Declined IFSC services after having been contacted	34	11	8	1	10	64
Assessed to have no service need	17	1	0	1	2	21
Could not be contacted	7	1	1	0	0	9
Others[a]	7	3	5	5	0	20

[a] Others included case closed, client being active cases of MSW/IFSC/psychiatric services, clients transferred to other IFSCs or service sectors for follow up.

Client feedback

This included feedback on the assessment by MCH nurses, their perception of IFSC

services, reasons for accepting and declining IFSC referral. The quotes are in Appendix 6.2.

MCH nurse assessment

In terms of the MCH nurse assessment, the clients were satisfied with the interview process, the environment, the duration of the interview and the content. They were very appreciative of MCH nurses and described them as professional, caring, patient and nice (4, 5). However, in terms of giving information about IFSCs, client responses were varied. Some clients reported having been given sufficient information by MCH staff (6). Other clients, particularly those who declined referral, indicated that they were told very little about IFSC services when MCH staff suggested referral (7). Furthermore, some clients maintained that they had the impression that only people with problems should see social workers (8, 9).

IFSC services

Many of the clients were very positive about the IFSC social workers, describing them as caring, understanding, willing to listen, and trying hard to help them with their concerns (10, 11). However, as mentioned before, some clients found the social workers too busy.

Reasons for accepting referral

When asked about their reasons for accepting referral, many clients claimed that they would like to have someone to talk to (12). Others mentioned specific problems that they thought social workers could help them solve (13, 14). Some were interested in services offered by IFSCs (15).

Reasons for declining referral

The reasons for refusing social service referral, as indicated by clients during semi-structured interviews, were similar to those listed in Table 6.6. The reasons included a perception that they could deal with the problem themselves (16), or that the service could not help, unwillingness to talk to someone (17), no perceived need for service (18), and the lack of time (19).

Among clients who first consented to social service referral, but later refused, four were interviewed. Two had babysitting problems and the other two claimed that the social workers appeared to be busy and uninterested, or were concerned about service boundary issues (20, 21). There were also concerns about disclosure to other family members the client's contact with social workers. In this case, arrangement was made for the client to see the social worker during her regular MCHC visit.

Summary

About 70% of clients who were recommended for referral to social services accepted the referral. Clients were positive about the caring attitudes of MCH nurses and social workers.

However, about one-third of clients identified to have psychosocial needs were reluctant to seek help from social services. In addition, about 17% of clients who initially accepted referral by MCH staff declined the services afterwards. Barriers to accepting services included difficulties with babysitting arrangements and the perceived attitudes of social workers.

6.5.3 Equity

For this dimension of quality, the rationale was to ensure that socially disadvantaged clients, who might not otherwise have access to services due to lack of knowledge or other barriers, could be served. Clients from socially disadvantaged backgrounds were being systematically identified and assessed for their psychosocial needs, and referrals made where appropriate (see table 6.2). The problems or barriers were those parents who were unable to turn up for interview.

6.5.4 Effectiveness

Effectiveness was examined through pre-referral and case termination information, as well as client feedback.

Pre-referral and case termination information

For clients referred to IFSCs for casework or counselling service, social workers were requested to complete a form at case termination or 6 months after referral (whichever was earlier). Clients had to complete the GHQ-12 (see chapter 3) prior to referral and at case termination or 6 months after referral.

Due to various logistic reasons, it was not possible to collect pre- and post-intervention GHQ-12 scores for all clients. Based on the available data of 61 clients (WK = 39, TKO = 4, TSW = 7, TMWH = 5, YO = 6), clients reported lower GHQ-12 scores after social service intervention, which indicated better mental health[15]. The majority of the clients received brief or intensive counselling and the main nature of problems handled by IFSCs were childcare, emotion, marital problem and financial assistance. The results are summarized in Table 6.11.

It should be pointed out that the above results was based on the data of clients who had completed pre- and post-intervention results and this was likely to be a biased sample who were more positive about the service and the involved social workers might have been more enthusiastic. The results should be interpreted with caution.

[15] Dependent t test indicated that there was a significant difference in pre- and post-intervention GHQ-12 results, $t(60) = 12.119$, $p < .001$.

Table 6.11: Pre- and post- GHQ-12 scores, services rendered and nature of problems handled by IFSC social workers

	All centres	
GHQ-12 scores	**n**	**Mean (95% CI)**
Pre- intervention GHQ-12 scores	61	6.80 (5.97 to 7.64)
Post-intervention GHQ-12 scores	61	1.26 (0.64 to 1.89)
Services rendered[a]	**n**	
Brief counselling	19	
Intensive counselling	18	
Group programme[b]	7	
Supportive casework	5	
Educational/developmental programme	1	
Problems handled[c]	**n**	
Childcare	23	
Emotion	20	
Marital problem	15	
Financial assistance	13	
Family relationship	11	
Accommodation	10	
Employment	4	
Premarital pregnancy/promiscuity	3	
Drug abuse/alcoholic/gambling	2	
Suspected family violence/child abuse/elderly abuse	2	
Others[d]	3	

[a] Information was available for 48 clients only. Each client might have more than one service rendered.

[b] Including therapeutic group, support/educational/developmental group and mutual help group programmes.

[c] Information was available for 48 clients only. Each client might have more than one problem handled by IFSC.

[d] Including interpersonal relationship, study problem, child discipline and emotional control.

Client feedback

For clients with emotional and relationship problems, some were glad to have someone to talk to and felt better afterwards (22, 23), while others commented that their relationship problems were not resolved (24). For clients requiring tangible services such as financial assistance, accommodation and childcare, some clients were satisfied (25) but others claimed that they could not get the assistance they needed for various reasons (26, 27). The quotes are in Appendix 6.2.

Referral outcome for clients with financial assistance, accommodation and employment needs

This component was designed to identify and manage families with psychosocial needs. Many under this umbrella were socially disadvantaged families, and tangible services such as financial assistance, employment, and accommodation were likely to be relevant. Very often, these types of assistance involved onward referral to other government departments. To evaluate the outcome of clients referred for these services, the outcomes of SSP clients referred during the first 6 months of CCDS implementation were specifically examined. The rationale for choosing this group was that at the time of writing, there should have been sufficient time for the application to be processed. Social workers were requested to supply information in relation to the outcome of referral and clients were interviewed to obtain their feedback. Most of the referrals were related to financial assistance and the outcomes were positive, except where clients declined the service or were not eligible. Altogether there were 16 clients referred for these reasons during the aforementioned period. Three of these were referred to IFSCs outside SSP and their referral results were not available. The progress of the remaining 13 clients is summarized in Table 6.12.

Case progress reports

IFSCs in the four districts provided progress reports of clients with successful outcomes and those where service gaps existed for illustration. The progress reports were summarized in Tables 6.13 and 6.14. Among the clients with successful outcomes, client's emotional status, parenting skills, family relationship and knowledge of community resources had improved. A wide range of services were offered to clients by IFSCs. These included counselling, family aide service, group programmes and outreach service. Collaborations among different sectors in handling referral cases was also noted, especially for cases with multiple or high risks. Examples of collaborations included the setting up a booth in the MCHC by an IFSC for receiving clients referred and case discussion among different service providers. However, there were still some service gaps arising from language barrier and ineligible residential status.

Table 6.12: Referral outcome for clients referred for financial assistance, accommodation and employment

	Background	Referral reason	Outcome achievement	Services offered	Client feedback
1	HK resident Separated Employed	Emotional problem **Financial assistance** Divorce procedure	NO/Financial	The client did not think that she needed to apply for financial assistance at that stage but relevant information was provided. Counselling on emotion and childcare was given.	Could not be contacted for phone interview.
2	HK resident Cohabitated Unemployed On CSSA "Husband" in prison	Drug abuse **Financial assistance**	NO/Financial	The client had already approached the Field Unit before case referral. Some supermarket coupons were provided to the client. Counselling on childcare and drug detoxification was provided.	Could not be contacted for phone interview.
3	Visitor from China Separated Unemployed Low income Not on CSSA Previous husband (father of baby) with drug use	**Financial assistance**	NO/Financial	The client was handled on enquiry level only. Since the client was not a HK resident, she was not eligible for applying for financial assistance.	Could not be contacted for phone interview.
4	New immigrant from South Asia Married Unemployed Low income Not on CSSA	**Employment** **Financial assistance**	YES/Financial	CSSA with effect from 1.9. 2005.	Language barrier No phone interview conducted.

Table 6.12 (continued): Referral outcome for clients referred for financial assistance, accommodation and employment

	Background	Referral reason	Outcome achievement	Services offered	Client feedback
5	HK resident Never married Employed	Childcare Emotional problem **Financial assistance** Interpersonal relationship problem Premarital pregnancy	YES/Financial	Emergency fund granted on 31.10.2005. CSSA granted on 1.11.2005.	Could not be contacted for phone interview.
6	HK resident Married Employed Low income Not on CSSA	**Financial assistance** Drug abuse	YES/Financial	CSSA granted on 27.10.2005.	Language barrier. No phone interview conducted.
7	HK resident Married Unemployed Low income Not on CSSA	Child care Emotional problem **Employment** **Financial assistance**	NO/Financial NO/Employment	Employment: due to family situation, client decided not to look for employment. Financial assistance: family decided not to apply for CSSA for the time being.	無咩實質幫助 同女女相處技巧: 都有用
8	Visitor from China Married Unemployed Low income Not on CSSA	Child care **Financial assistance** Residential service Drug abuse	YES/Financial	CSSA granted in February 2006.	幾好, 可以幫屋企一步一步睇下有咩幫 社工任勞任怨, 盡責, 尊重自己 因當時未有綜援, 即時提供米, 罐頭

Table 6.12 (continued): Referral outcome for clients referred for financial assistance, accommodation and employment

	Background	Referral reason	Outcome achievement	Services offered	Client feedback
9	HK resident Married Unemployed Low income Not on CSSA	Child care Emotional problem **Financial assistance**	YES/Financial	Employment secured.	Mother refused phone interview.
10	HK resident Never married Unemployed On CSSA	**Accommodation** Others	YES/Accommodation	Moved to a new unit on 5.6.2006.	Could not be contacted for phone interview.
11	New immigrant from China Divorced Unemployed Low income Not on CSSA	**Financial assistance** Others	NA/Financial	Client declined service.	Declined service. No phone interview conducted.
12	New immigrant from China Married Currently receiving psychiatric treatment Not on CSSA	**Financial assistance** Childcare	NO/Financial	Client was referred to SSP(West) IFSC for follow-up as client resided in the catchment area of the said IFSC. Client was handled by SSP(West) IFSC at intake level where information was provided. It was reported that no further service was required by the client.	No phone interview conducted as client was handled only at intake enquiry level.

Table 6.12 (continued): Referral outcome for clients referred for financial assistance, accommodation and employment

	Background	Referral reason	Outcome achievement	Services offered	Client feedback
13	New immigrant from China Lone mother Unemployed Not on CSSA	**Accommodation**	YES/Accommodation	Accommodation was settled when client rented a room in a private building in December 2005. The client was also assisted to apply for public housing through the general waiting list. Other services provided included discussion of childcare arrangement and introduction of relevant childcare services, teaching of proper budgeting skill and referral to employment service for seeking part-time employment.	社工態度好好，社工會開解自己。 BB 綜援金額可以交房租 因自己未符合資格申請住公屋，現時房租貴，生活有點困難。

Table 6.13: Clients with successful outcomes

Case	Referral Reasons	Case background	Problem assessment	Services rendered	Client progress	MCHC/IFSC collaboration
1	Childcare problem Emotional problem	First-time mother Nuclear family	Childcare problem Emotional problem Financial problem In-laws relationship problem	Family aide service arranged and community resources introduced Counselling on emotion, in-laws and marital relationships given Psychiatric appointment arranged through MCHC	Better emotional status More competent child care Attending community groups Better relationship with husband	Client was referred to the social worker when IFSC set up a booth in MCHC. Upon social worker's request, MCHC arranged an early appointment for mother to see the doctor and was subsequently referred for psychiatric service.
2	In-laws relationship problem Housing Emotional problem	First time mother Living with husband and in-laws in a rented flat (husband's sister was mentally retarded)	Marital problem In-laws relationship problem Housing problem Mild emotional problem	Counselling on in-laws and marital problems given Phone contact with husband and mother-in-law to discuss the situation and possible solutions Contacted Housing Authority for early approval of public housing	Early approval of public housing granted Client was transferred out to another IFSC	Social worker consulted MCH staff about the client's suitability for applying for compassionate re-housing.
3	Depression Parenting problem Suspected child abuse	Housewife with two sons (7-year-old and 9-months-old) Husband worked in China as engineer and returned on weekends	Depressive symptoms Episodes of suicide with two sons Suspected child abuse case	Outreach service offered Counselling and emotional support provided Social investigation and multi-disciplinary case conference on suspected child abuse conducted Day foster care service and group on communication skills to the elder son.	Care and Protection Order was not required Day foster care service was applied and the elder son was transferred to Family and Child Protection Service Unit (FCPSU) for follow up services	NA

Table 6.13 (continued): Clients with successful outcomes

4	Marital problem Childcare problem Emotional problem	Client was two-way permit holder Had history of PND Had three children (13-year-old son with hyperactivity, 3-year-old son with autism, 1-year-old daughter)	Marital problem Emotional problem Childcare problem Parenting problem	Counselling given on suicidal thought and parenting burden Recruited client to join IFSC group programme about positive thinking Referred the youngest daughter to residential home Referred the oldest son for clinical psychologist assessment and contacted principal for school arrangement.	Client status improved Parenting burden was reduced Husband was willing to seek help from social worker when mother returned to China for visa re-application.	MCH staff found out that the client had suicidal thought and contacted social worker immediately for management.
5	Childcare problem Financial assistance Lone mother with history of drug abuse and currently on methadone from SARDA	Lone mother First time mother Unexpected pregnancy On CSSA Living with her baby in a rented flat	At risk mother due to drug abuse history Financial assistance Childcare was not a problem	Social worker contacted SARDA worker to update client progress Social worker contacted Social Security Field Unit to speed up CSSA application and approval Contacted other organizations to offer free furniture and formula milk Home helper scheme, residential home arrangement and application for public housing were recommended.	Mother's self coping skill was strengthened Social worker planned to close the case as client was then on CSSA and could handle childcare issue	NA

Table 6.14: Clients with service gaps noted/ difficulties encountered or clients who declined IFSC service

Case	Reasons for referral	Case background	Problems assessment by IFSC	Services rendered	Client progress	Service gaps/ difficulties encountered
1	Parenting problem	Nuclear family with two children Client (mother) could not read/write Chinese	Behaviour problem of elder child after birth of second child	Individual counselling to client on parenting technique Family counseling Phone contact to follow up Parent support group	Ongoing	Parenting programme for parents who could not read/write Chinese
2	Accommodation problem	Client on two-way permit Extended family Poor in-laws relationship Client had a pair of twins Low income	Husband long working hours Request for compassionate re-housing because of stressful relationship with in-laws	Supervisor discussed compassionate re-housing application with SWD supporting unit but was turned down as client was not a Hong Kong resident	Client did not feel the need for counseling on her emotional problem	Two-way permit holders not eligible for compassionate re-housing under existing housing policy
3	Arrangement of school placement for children Financial assistance	Nuclear family with three children Mother and the two older sons were multi-entry permit holders (NEP) Husband was new arrival from Mainland	Poor social support network Unemployment	Advice on childcare arrangement and family planning Strengthened supportive network by referring to church fellowship Provided some clothes	Elder sons attended private tutorial class funded by their aunt Husband looking for job Church fellowship had approached the family to offer necessary assistance.	Need of school placement fell beyond IFSC service scope The children were not entitled to free education in Hong Kong

6.6 Summary and conclusions

This component was set up to address specifically the care needs of the socially disadvantaged clients. The aim has largely been achieved as the service statistics indicated that most of the clients assessed belonged to this group, and there has been an increase in the number of referrals. However, clients who could not personally turn up at MCHCs might not be able to access the service.

Around 70% of the clients accepted referral to social services, though a fair proportion (about 17%) of these subsequently declined. Some clients still perceived the use of social services as a stigma. More information on the various preventive and supportive services, including groups and programmes, of IFSC was needed to encourage clients to accept referral.

Clients were appreciative of MCH nurses' caring and professional attitudes in conducting the assessment (SSIG). Most clients found the social workers caring, understanding, willing to listen and help. There were some clients who would like their social workers to show more concern for their problems.

Though there was an increase in the overall access to service, most of the referrals were for casework or counselling services. Referrals to group and developmental programmes could be increased.

In terms of referral outcome, for tangible services, clients would be arranged the required services as far as possible or else alternative arrangement would be made. However, some clients might not be able to receive certain services as they did not meet the eligibility criteria under existing policy. For example, a two-way permit holder was not eligible for compassionate re-housing application. Regarding emotional or relationship problems, many clients were satisfied and claimed they felt better emotionally, while others found that their relationship problems had not resolved. Further indications of effectiveness included improvement in mental health among a group of clients assessed by pre- and post-intervention GHQ-12, and improvement in emotional well-being, and parenting skills etc., as revealed by case progress reports.

References

Dunn, J. (1994). Family influences. In M. Rutter & D. Hay (Eds.), *Development through life*. (p.112-133). Oxford, England: Blackwell Science.

Lee, D.T.S., Yip, A.S.K., Leung, Y.S., & Chung, T.K.H. (2004). Ethnoepidemiology of postnatal depression. *British Journal of Psychiatry, 184*, 34-40.

Leong, F.T.L., & Lau, A.S.L. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research, 3*, 201-214.

Leung, C., Leung, S., Chan, R., Tso, K., & Ip, F. (2005). Child behaviour and parenting stress in Hong Kong families with young children. *Hong Kong Medical Journal, 11*(5), 373-380.

Leung, S.S.K., Martinson, I.M., & Arthur, D. (2005). Postpartum depression and related psychosocial variables in Hong Kong Chinese women: findings from a prospective study. *Research in Nursing & Health, 28*, 27-38.

Olds, D.L. (1988). The prenatal early infancy project. In R.H. Price, E.L. Cowen, R.P. Lorion & J. Ramos-McKay (Eds.), *14 ounces of prevention: a casebook for practitioners* (p. 9-23). Washington DC: American Psychological Association.

Velicer, W.F., Prochaska, J.O., Fava, J.L., Norman, G.J., & Redding, C.A. (1998). Smoking cessation and stress management: applications of the transtheoretical model of behaviour change. *Homeostasis, 38*, 216-233.

Webster-Stratton, C., & Taylor, T. (2001). Nipping early risk factors in the bud: preventing substance abuse, delinquency, and violence in adolescence through interventions targeted at young children (0-8 years). *Prevention Science, 2*, 165-192.

Appendix 6.1: Views of MCH nurses, visiting psychiatric nurses and social workers on identification and management of families with psychosocial needs

Facilities		
1	比如我 (client) 講我婚外情，講我自殺，咁好多 expose 個個知道…有得隔聲，淨係隔啲咁 dur，坐係隔離一定聽到。	2-390E/ 391E
2	兩個人一間房好細呀，即我做亞媽，我想講俾你聽我都唔講…或者人地個亞爸企咗係度，完全無哂私隱。	3-161C
Manpower/workload		
3	我地 (nurse) 真係唔係淨係做一個 CCDS，我地係做七辦嘢，我地做好多嘢。	2-430N
4	你知唔知我地 (nurse) 除咗做 clinical 嘅嘢之外呢，我地 hold 一個 case 成個鐘呀。	2-111L
5	或者你話有 family problem 或者 marital problem 要 refer IFSC 嗰啲，你無四十五分鐘，半個鐘頭至四十五分鐘都做唔起一個 (interview)。	4-16F
6	咁我 (nurse) 間房得三個姑娘，如果我係全身投入做咗個 case 做咗個幾鐘，我嘅同事要分擔我嘅工作，咁我會好內疚，死啦我做咗咁耐係咪我能力不逮。	4-93F
7	可能我(nurse) expect 每個 case 係見 15 至 20 分鐘，咁有時傾吓傾吓就 more than 呢個時間囉…佢 (client)有時傾開有　　…真係需要傾　　…咁就多　我　　workload，咁一定　啦。	1-36D
8	你做 semi structure 你 detail 啲嘅 interview 咁樣呢，要時間好多。	3-146A
9	其實最好我諗…係有個社工坐係度…如果我地覺得有問題有 social problem 直接 refer 俾佢(social worker)…同埋佢(social worker)係好快俾到個 service…俾個 client，不如佢(social worker)直情坐喺度，即刻俾埋個服務佢(client)啦，咁咪好完美做得。	2-127E/ 130E
Training		
10	個次嗰個講者係講得好活潑好生動　，咁都俾咗好多知識我地囉。	3-1A
11	想有個 model answer…或者幾個 scenario，single parent，extended family 呀呢啲咁嘅 scenario，佢想點樣問呀，佢應該做返個 demonstration 就好啲囉。	3-6F
12	時 CP(clinical psychologist)呢同我　(nurse)上堂　時呢覺得講書就好好聽，都有　role play　，但如果 practical 方面呢…上完堂之後　同事　feedback，啊!好似好抽象。	1-82C
13	覺得之前嗰個我地未真正開始好實行嘅時候，佢其實講呢，你去聽你只係覺得好片面，又唔到肉，咁跟住番到嚟用嘅時候都唔係好記得。	2-3I
14	我(nurse)唔覺佢(the trainer)有，比如持雙程証 (client)背後帶咗咩問題呢？**…**冇一個實質嘅 role play 做番出嚟。	5-9D

15	個 training 梗係有用啦，因爲起碼呢個 criteria recruitment 會清楚好多，咁同埋 張 form 點填呢起碼有個基本 簡介啦。	1-1A
16	因爲一開頭我期望…佢會同我講吓啲 form 個啲嘢嘛，咁但最後做埋個 role play 盛，番到嚟好似上同唔上都差唔多。	2-5I
17	如果比我去 counselling 平時我地去做應該唔止呢個層次。	4-11L
18	因爲佢做 role play 出嚟嗰啲呢，嗰啲 case 即係唔係實質見 client 嗰陣啲情況，嗰個係可以控制得到，你做即係好似 model answer 咁答你。但係你呢啲見 client 嘅時候就唔係囉。	4-12H
Client management		
19	我覺得至有用係 本嘢 (SSIG manual)。	3-20H
20	幫當然有幫。但…唔係話一次過就識晒囉，我覺得。	4-25C
21	但初初開始行 (CCDS) 時候， 本 manual 如果睇過就有 幫助囉…因爲佢(manual) 唔同 case 佢都有 比較特別 問題要我 (nurse) focus，睇過有個印象，guide 住我 。	1-7C
22	佢(manual) 提番我地 (nurse) …點樣爲之 open ended question，佢(manual)有個實例咁樣，咁變咗就 個 client elaborate 多啲。	3-27A
23	我覺得 本 manual 係完全冇用，因爲我地上堂(training)都冇講本 manual，係完全冇講架，所以我番屋企打開都唔知做咩嘢，到我番嚟開工都唔知自己做咩。	2-18K
24	媽媽覺得好似我 都關心 佢多 ，我 行 (CCDS)咁耐都冇咩遇過邊個媽媽話好唔鍾意講呢 (psychosocial needs)，你 (nurse) 俾阿媽感覺到你 (nurse) 係關心佢(client)呀，佢(client)自然會講出佢自己想講 囉。	1-9D
25	即基本上如果個父母願意將自己 expose 出嚟同人傾呢…係 interview 期間你 (nurse) 去關心佢 (client)呀，你(client)湊仔點呀，你屋企問題點，其實都會當一個傾計形式大家去關心佢(client)咁解。	5-23E
26	我諗係因爲大家個關係建立，咁你(nurse)透過問佢(client) ， 咁然之後佢講番 俾你聽，咁覺得你 care 佢嘅 concern。	3-26H
27	同埋做咁多 ，背後個意思點，其實我自己都唔係咁清楚…特別係填嗰一個 semi-structure (SSIG)，填咗一個 (record form for service statistics) 好順利填完一個十分鐘嘅 (interview)，十分鐘填完之後覺得佢 (client) 唔需要 refer，咁呢個叫做大工告成。	4-57A
28	你(nurse)一打開嗰張粉紅色 form(record form for service statistics)出嚟，我(nurse)同你(client)問小小資料，佢(client)都望住你 (nurse)喇…唔係人人都樂意將你 (client) 嘅私隱講俾人聽。	2-77E
29	我都唔知解決到啲乜嘢…啲 client 話俾你聽,姑娘你咩都幫我唔到。	2-158/159B
30	如果佢(client)今次唔 ready，其實我地(nurse) 都可以比定啲資料佢，或者話定比佢聽，如果你(client)而家暫時決定唔到，返屋企諗吓先，	3-42I

	我地會俾番個 chance 佢，佢有啲真係需要，佢會返番嚟，咁佢返番嚟，我地又可以另一個 chance 再提供， 咁佢第一次唔接受，但可能 subsequent 嗰啲佢可以接受呢一樣嘢。	
31	咁如果佢(client)話唔肯 ，第二次我 (nurse)再 interview 再見到，咁我 又會再傾番，如果都係解決唔到 ，我 再問多次啦，駛唔駛搵人幫 你手呀。	1-21B
32	即係話要 refer 個 client 去 IFSC，但佢去到 IFSC 佢做咗啲咩嘢，佢個成果係幾多呢，我 (nurse)其實根本而家就無資料。	4-57A
33	唏，唔得閒啦，仲鼓勵。你(nurse) resolve 佢囉，即係你(client)有咩需要搵返我 (nurse)。	4-108J
34	我 (nurse) 咪又要搽面懵膏，叫佢 (client)去喇，好好架，唔緊要啦，去吓睇吓點啦。	2-153N
35	有 d case 覺得同 social worker 關係唔好，唔鍾意佢 (social worker) ，佢 (social worker) 幫唔到佢 (client)。	3-96F
Procedures		
36	初初填梗係唔係好熟，填填 就慣…都冇咩困難。	1-25A
37	而家熟咗，smooth 咗好多，因爲開頭辛苦啲，因開頭好多(head office 的) interpretation 可以同我地 (MCH nurse) 唔同。	3-141H
38	真係好多嘅 paper work，你(nurse)撩咗個 case 出嚟之後呢，你(nurse)個手尾係好長。	5-48A
39	一次過填咁多張 form，…淨係對住張 form 猛填猛填咁，都唔知爲乜咁。	2-32G
40	我都唔明點解要填咁多 form。	4-62D
41	我想知而家我地係 total patient care 定 total paper care？	2-444K
42	IFSC referral 要填埋 form 都幾複雜，個 complete process 要五至十分鐘，最好搵 MCHC staff 幫手填，有時花咗好多時間落 documentation。	PN1-7C
43	之後就要填一 form，咁要同埋要得個 patient consent，仲要個 patient 填一個 questionnaire，其實呢方面真係好花時間。	PN2-25A
Collaboration		
44	有人 (IFSC) 俾番張七日之內收唔收到 (MCHC referral) 呀，或者一個月之內佢 (IFSC)做過 咩 service 俾佢 (client)呀咁樣，咁有陣時見到番 result 呢，唔係咁準時番到 囉。	1-28B
45	一個禮拜(reply)，一個月(reply)都冇呀，我(nurse)淨係知道邊個係 social worker 但係就打咗過去 (IFSC)，留低個 message 叫佢(social worker)fax，但到而家佢(social worker)都仲未 fax 到。	5-41D
46	我 其實年中都收埋好多唔同 referral，我又唔覺得點解 MCHC case 要 special attention…我就要咁多 written reply。	HQ-74A
47	我覺得可以保留番個 referral form，standard 佢 時候，keep 住	HQ-79M

	一個大家合作　關係，…咁(referral)　到　時候都知道 referral，有咩 service 可以 provide 到。	
48	so far 都幾好，即我　(nurse)問佢 (social worker)　俾到都有跟進到喇。	1-33D
49	我地果 4 間 (IFSC) 幾好，同埋你(nurse) call 親佢 (IFSC) 都覆，你留名都會答返呀咁樣樣，即幾好，個 connection。	3-66H
50	我會感覺上佢　(MCHC)係幾 helpful，好想去做好　，除　係份工作　assessment，真係有心想去做，我　有　真係可以去 discuss，有　真係可以去俾到意見點樣可以。	HQ-100K
51	度 MCHC　nurse 係幾有心，開頭 pilot　時大家醫生都 push 呀，令到　nurse 基本上都盡量熟我　IFSC　service，所以佢(MCHC) refer 俾我　時候都，可能佢 (MCHC) 已經做　一渣功夫喇，少量 case 係 unmotivated 都過　，但大部份過到　時候都因爲　nurse 真係俾 effort 落去　，咁我諗睇到佢　俾　幾多心機落去做，比時間去做 assessment…咁　過去年"零"做緊龍頭作用其實 so far 都 positive。	HQ-102M
52	因爲個對口…個 NO i/c，我　i/c 之前經常有溝通，所以搵番佢(NO i/c)都好快幫我　搵到　資料呀或者係配合都 OK。	HQ-103P
53	我自己經驗裡面我覺得當然有呢 project (CCDS)，有　by product 好處，例如我　(IFSC)　i/c 會同佢　(MCHC)去開會啦，變　有對口　人出現　，因爲以前係無　。	HQ-66P
54	咁我覺得搵　度　MCHC 係難，電話　好耐都唔聽，有個錄音咁樣，佢　好忙…同埋我　感覺係 distant　囉，限於 referral　去，又好少有電話交流…或者問　個　(case) 進展呀，好少呢　咁 conversation。	HQ-104/ 105E
55	因爲我初初同護士交流得唔好…咁收尾可能溝通　一輪，即係大家又新呀　一月先開始行 (CCDS)，唔知係咪啦，大家都 stressful，可能佢　都 stressful 覺得好似好多　做，我覺得即係溝通好緊要。	HQ-107B
56	有時我地(nurse) contact social worker 個度呢…social worker 就覺得我地彈緊 case 過去…我 (nurse) 諗佢 (social worker)都好憎我地，佢都有少少□，即係 social worker 個邊囉，因爲幾煩□我地。	2-105/ 108L
57	譬如話有啲 PND 呀，refer 去 psychi (psychiatric service)呀，而同時又 refer 去 IFSC 呀，(IFSC) 就唔係好想接囉…咁 (nurse) 就話返比 Chief Project Officer (CCDS) 知道，即係佢 (CPO) 自己高層去溝通…除咗嗰一次之都無話有 CASE 唔接囉。	4-144L/ 145L
58	雖然我地 (MCHC & IFSC)會係喺電話果度有啲 case 問題會傾，但係就都唔話可以好直接呀，如果能夠定時嘅 case conference 呀…再進一步能夠就住 special 嘅 case 去傾，討論嘅話就更加理想。	5-55G

59	mainly 係 IFSC，個 collaboration 係有問題出現，困難在就係大家個 approach 唔同。	PN1-19B
60	我覺得 expectation 上面 difference，IFSC 有時會比較 focus 落一啲 tangible outcome 例如 housing，financial，佢地(IFSC)會將我地 (visiting psychiatric nurse) 等如落 refer 去 psychiatrist，由於呢個誤解，佢地 (IFSC)成日問點解唔寫 letter，等佢地 (client)去攞 housing 佢地 (IFSC) 以爲搞掂佢地 (client) 攞錢，攞屋都搞掂。	PN1-22D
61	調番轉 social worker IFSC…係我 professional 之間呢…我 (visiting psychiatric nurse)覺得係 logistic 問題，出現得我覺得大 ，…我會覺得有個 impression 就係 refer 個 case 去 IFSC 好麻煩，係 個手續上，首先呢我自己承認我就一 都唔熟 ，唔熟 意思就係 even 一個咁細 MCHC，佢 (IFSC)都分四度 (IFSC)，唔知邊條街以南，又邊條幾多號之前又屬於邊度 (IFSC)…我 會覺得好複雜。	PN2-24A
62	個 client 真係唔想去個區，(IFSC)係都要佢 (client)去指定個間。	2-157E
63	因爲 MCHC 個 boundary 同我 (IFSC) 個 boundary 唔同…可能佢 (MCHC) 要 understand 我 (IFSC) 呢樣 ，我 (IFSC) 係有 boundary 問題。	HQ-131A
Service gaps/difficulties encountered		
64	想 屋 唔到。	3-92H
65	我覺得 gap…會唔會係 motivation case，甚至 小朋友都未入學 (case)，入 學可能有 老師 identify 得到。如果好無 motivation (case)又唔去 MCHC 亦都唔肯去我 中心 (IFSC) 度， (client)唔知咩人可以搵到佢 (client)出 。	HQ-127H
66	可能係我 (IFSC) 區會多 ，新移民 case，雙程証，…我 (social worker)覺得係好難做，係涉及到講緊錢 問題，你 (client) 睇任何 service…佢 (service) 全部都要錢，就算去睇任何，A&E 要俾錢。…因爲錢 問題。呢 人 (client) 我 (social worker) 無任何 funding 可以申請到俾佢，變 個 case “click”住係度。	HQ-120F
67	其實我地呢區真係重災區，好多都係雙程啦…即係兩個都係 (雙程證)嘅，佢 (client)都見住話俾你 (nurse) 聽我 (client) 都想死呀，…因爲 IFSC refer 係幫唔到佢 (client)，我 (nurse) 都唔知點樣幫佢 (client)，去 A&E 又要錢，我 (client)而家住酒店個度又冇錢交，我 (client)個仔而家要入院呀，…我 (client)而家住緊個屋企人個度又覺得好大負擔，又已經俾咗錢去俾我 (client)生咁，咁呢啲 case 我地 (nurse)真係唔識點 handle 囉。	2-174C
68	搵嘢做搵唔到，個仔合資格，但亞媽唔合咪 唔到，幫唔到，但生活係兩個一齊□麻。	3-93I

Appendix 6.2: Quotes of clients on assessment of psychosocial needs and their experience of social services

Accessibility of social work service		
1	好快，一個禮拜社工已經打電話比我，社工就問我急唔急見佢，之後，好快就可以 book 到期見社工。	4-SSIG_9
2	佢打電話，叫我去中心，但係嗰日落雨，又無人湊 BB，所以我就無去，之後佢就過嚟我屋企。	2-SSIG_1
3	但係佢太忙啦，成日都有啲突發嘢。社工都唔係傾得咁多嘢。	2-SSIG_2
Semi-structured interviews		
4	姑娘好關心，好有耐性…姑娘願意傾，亦好專業。	3-SSIG_7
5	好過以前，因爲以前無問得咁深入。	4-SSIG_9
Information on IFSC		
6	有介紹，佢話需唔需要見社工幫你，同開解你。	2-SSIG_1
7	冇咩點介紹。只係俾咗啲單張我。	1-SSIG_4
Stigma		
8	好似人地覺得自己好有問題。	3-SSIG_9
9	初時會覺得係咪自己有問題要見社工，不過見咗先算。	3-SSIG_1
Social worker services		
10	好好，可以幫到。	3-SSIG_10
11	好好，因社工好了解我情況，社工亦好積極解決問題，好肯同我傾。	3-SSIG_1
Reasons for accepting referral		
12	有人傾吓計，舒服啲。	3-SSIG_17
13	心情唔好，同老公有啲唔開心。	4-SSIG_3
14	想知道社工係咪可以幫到，尤其住屋方面問題。	3-SSIG_1
15	原先唔知有呢啲服務、後來知道覺得好好，例如免費嘅 「齊走新路」。	3-SSIG_15
Reasons for refusal		
16	自己情緒可以搞掂。	2-SSIG_4
17	因爲有些事好難講出口，唔想同人講…唔知社工實質可以幫到什麼，如只係傾吓，覺得用處不大。	3-SSIG_6
18	自己覺得唔需要，唔覺得自己有咩大問題。	4-SSIG_7
19	唔得閒。	1-SSIG_4
Comments from clients who defaulted service		
20	要湊 BB，覺得疲倦、精神亦唔好，唔想用時間見社工。	3-SSIG_9
21	覺得社工好敷衍，何解整個對話中只強調分區服務，並沒有理會我婚姻問題，無理我需要，所以對社工印象大打折扣，亦會暫時拒絕用 IFSC 服務。	3-SSIG_8
Referral outcome		
22	傾咗，之後心情無咁沉重。	2-SSIG_1

23	有人傾吓。	1-SSIG_1
24	我同我奶奶的關係都係無改善。	2-SSIG_1
25	用 BB 資格申請綜援…BB 綜援金額可以交房租。	3-SSIG_12
26	社工都話無咩可以做，無咩建議，都係要等到有證件，我啲仔女先有書讀。	4-SSIG_2
27	申請唔到津貼幫哥哥買電腦。	3-SSIG_19

Chapter 7
Identification and Management of Pre-primary Children with Physical, Developmental and Behavioural Problems

Some developmental and behavioural problems might only become manifest after children had started pre-primary education. In collaboration with CCCs and KGs, a referral and feedback system has been developed to enable pre-primary educators to identify and refer these children to MCHCs for assessment and management in a timely manner.

7.1 Service provision before CCDS

Before the introduction of CCDS, there was no formal procedure in pre-primary institutions for the identification and management of children with physical, developmental and behavioural problems. Parents were requested to take their children to MCHCs according to schedule and children with various problems were identified during these scheduled visits. Besides the scheduled visits, parents were encouraged to bring their children to MCHCs for assessment whenever they were worried about their development. Pre-primary educators who were concerned about children's development could discuss with the parents and advise them to approach MCHCs for assistance. However, many pre-primary educators were unfamiliar with the child health services of the MCHCs.

7.2 Changes in service provision under the CCDS

To enhance the identification and management of pre-primary children with physical, developmental and behavioural problems, changes in structure and process were introduced. These changes are described below:

7.2.1 Changes in structure

Staff training

To enhance pre-primary educators' knowledge and skills in the identification, referral and management of children with physical, developmental and behavioural problems, several briefings and workshops were organised for them.

Briefing on MCH services and the CCDS

District based briefing sessions were organised for pre-primary institutions to inform them of the MCH services and the relevant component of the CCDS, to familiarise them with the services offered by MCHCs and the referral and feedback mechanism. In some districts, one large scale briefing was organised, followed by group visits to MCHCs. In others, the briefing and MCHC visits were combined. In some cases, IFSCs in the district also

provided a briefing on their services.

Training course

A 7-hour training course was organised by DH, in collaboration with EMB, for pre-primary educators. The training was conducted by a clinical psychologist. The aims were to (i) enhance the knowledge and skills of pre-primary educators in identifying children requiring referral; and (ii) strengthen pre-primary educators' skills in classroom management of children with physical, developmental and behavioural problems. The content was designed with input from pre-primary educators. The topics included:

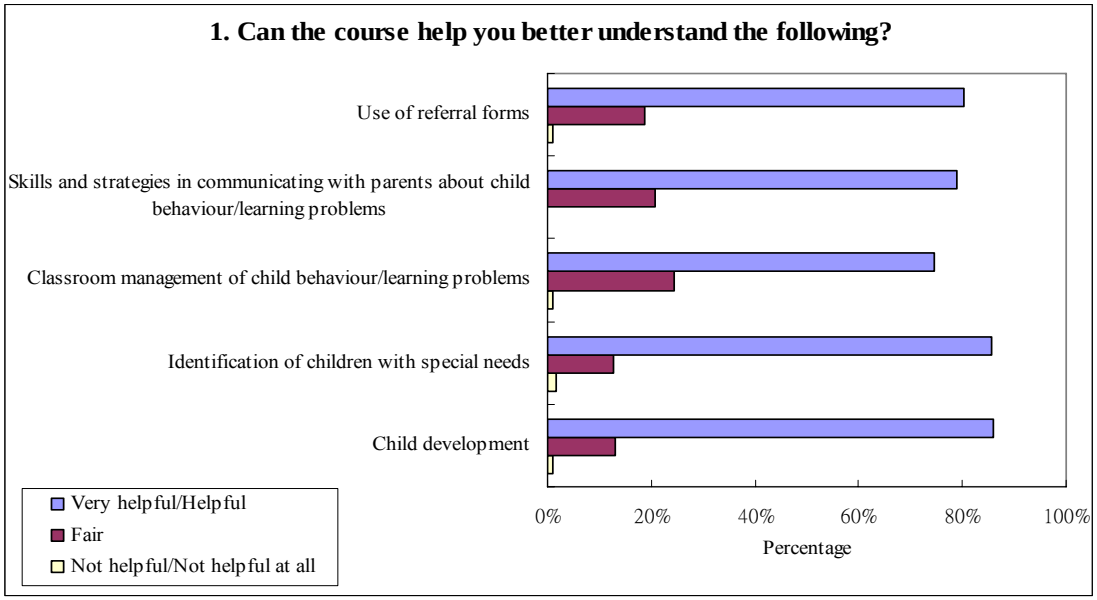
- Child development at different stages
- Identification of children with special needs and problems
- Supporting and working with children with problems in the classroom
- Communicating and working with parents
- Use of the CCDS referral forms

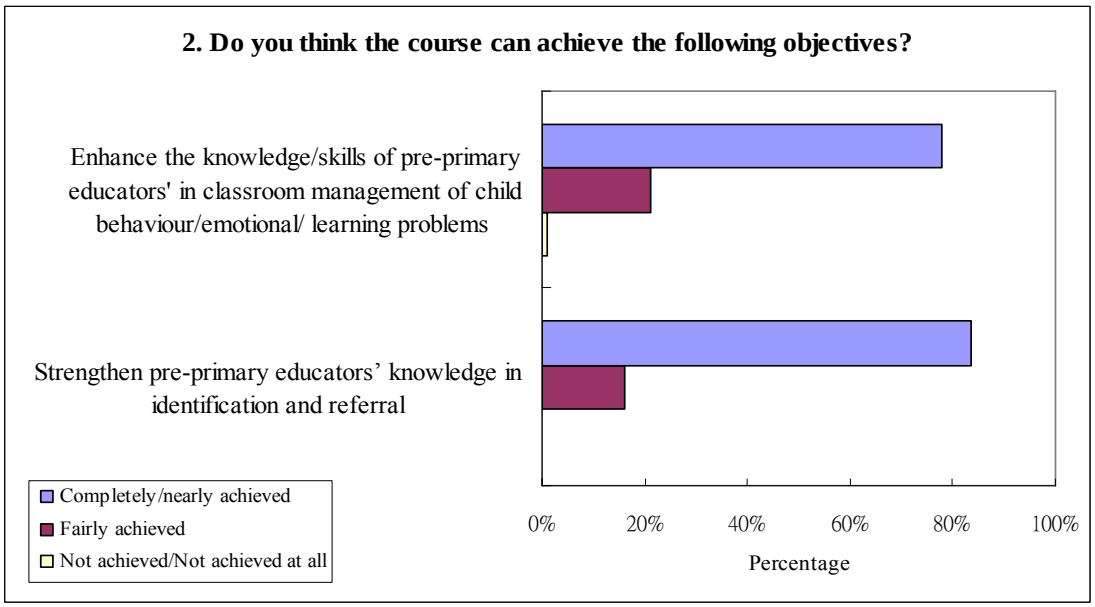
Invitations to the briefing and training courses were sent directly to pre-primary institutions or via EMB and SWD. The attendance and evaluation results of the briefing and training course are in Table 7.1 and Figures 7.1 respectively.

Table 7.1: Attendance figures (percentages) for pre-primary institutions in the briefing and training course

District	No. of pre-primary institutions in the district[a]	No. participated in MCHC briefing	No. participated in the training course
SSP	50	33 (66.0%)	20 (40.0%)
TSW	47	21 (44.7%)	24 (51.1%)
TM	87	43 (49.4%)	38 (43.7%)
TKO	58	33 (56.9%)	29 (50.0%)

[a] Number of pre-primary institutions in the district at the beginning of 2005 excluding special child care centres and mutual help child care centres.





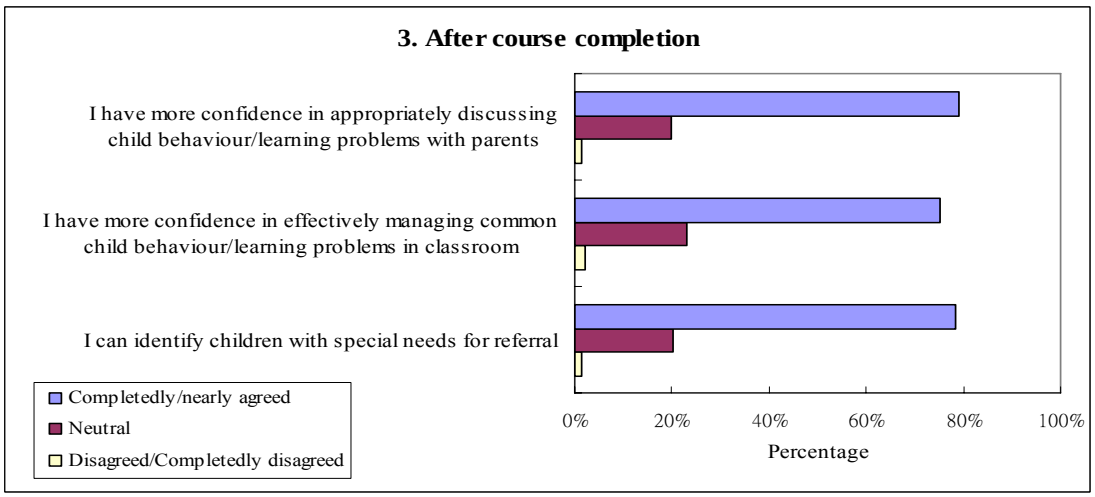


Figure 7.1 : Evaluation results of the training course for pre-primary educators

7.2.2 Change in process

Referral

A referral and feedback system was set up whereby pre-primary institutions could, with parental consent, refer children with physical, developmental and behavioural problems to MCHCs, using a referral form, indicating the reason(s) for referral and the child's performance. MCHCs would acknowledge receipt of the referral within 7 days and inform pre-primary institutions of the assessment results as soon as possible.

Management

Upon receiving the referral, the child would be offered an appointment for assessment. Depending on the assessment results, the child/family would be offered MCH services (e.g. parenting programme), referred to specialist service (e.g. speech therapy) or CAS for further assessment.

Collaboration between organisations

Several mechanisms were set up at the district level to enhance collaboration between the health and education sectors.

- **DCC** – representatives from the EMB attended the committee meetings to discuss relevant issues.
- **District working groups** – two working groups, consisting of representatives from pre-primary institutions, were formed to provide advice on the design of the referral and feedback system and the content of training programmes.

7.3 The formative process

Issues arising from the implementation of this component, from the perspectives of the pre-primary institutions and MCH nurses, along with improvement measures taken (in italics), where appropriate, are described.

Participation of pre-primary institutions

In view of the varied attendance of pre-primary institutions (Table 7.1) in the briefing and training course (ranging from about 40% to 60%), a telephone survey was conducted in 2006 with pre-primary institutions in the four districts to find out about their knowledge and utilization of the service, and their participation in the briefing and training course. Results of the survey on pre-primary institutions are shown in Table 7.2. A total of 172 were contacted and among them, 68 (39.5%) claimed that they were not aware of the CCDS. Of the 104 pre-primary institutions which knew about the CCDS, 77 (74%) had not made referrals to MCHCs. The main reasons for not making referrals were (i) not having any

children requiring referral, (ii) children having attended assessment in other settings and (iii) pre-primary institutions having own professional support for such children. About 14% of pre-primary institutions claimed that parents had refused referrals. It was remarkable that about 17% of pre-primary institutions preferred telling the parents to go to MCHCs directly, instead of using the CCDS referral system.

Among pre-primary institutions that did not attend the briefing or training course, the main reasons were (i) not being aware of the briefing, (ii) clashing with other activities and (iii) inability to release teachers due to a lack of manpower.

Table 7.2: Survey statistics for pre-primary institutions

	SSP	**TSW**	**TM**	**TKO**	**Total**
No. of pre-primary institutions in the district[a]	50	47	87	58	242
No. of pre-primary institutions surveyed	36	42	64	30	172
No. of pre-primary institutions being aware of CCDS	25(69.4%)	22(52.4%)	40(62.5%)	17(56.7%)	104(60.5%)
No. of pre-primary institutions *not* being aware of CCDS	11(30.6%)	20(47.6%)	24(37.5%)	13(43.3%)	68(39.5%)
No. of pre-primary institutions having made referrals	6(24%)	6(27.3%)	13(32.5%)	2(11.8%)	27(26.0%)
No. of pre-primary institutions *not* having made referrals	19(76%)	16(72.7%)	27(67.5%)	15(88.2%)	77(74.0%)
Reasons for pre-primary institutions *not* having made referrals[b]					
Not having any children requiring referral	7	5	10	7	29
Child having attended assessment elsewhere	12	1	4	2	19
Pre-primary institutions with own professional support	2	7	6	2	17
Parents told to attend MCHC directly	3	4	4	2	13
Parents refused referral	3	0	6	2	11
Ignorant of referral details	0	2	4	1	7

[a] Number of pre-primary institutions in the district at the beginning of 2005 excluding special child care centres and mutual help child care centres.

[b] Pre-primary institutions might give more than one reason

Having identified pre-primary institutions which had not been aware of the CCDS, the DH contacted them directly through telephone and sent them the relevant information.

In view of the less than satisfactory participation, an additional briefing cum training course was organized for pre-primary institutions in the pilot districts. The briefing and training were condensed into a one-day course, to facilitate participation of more

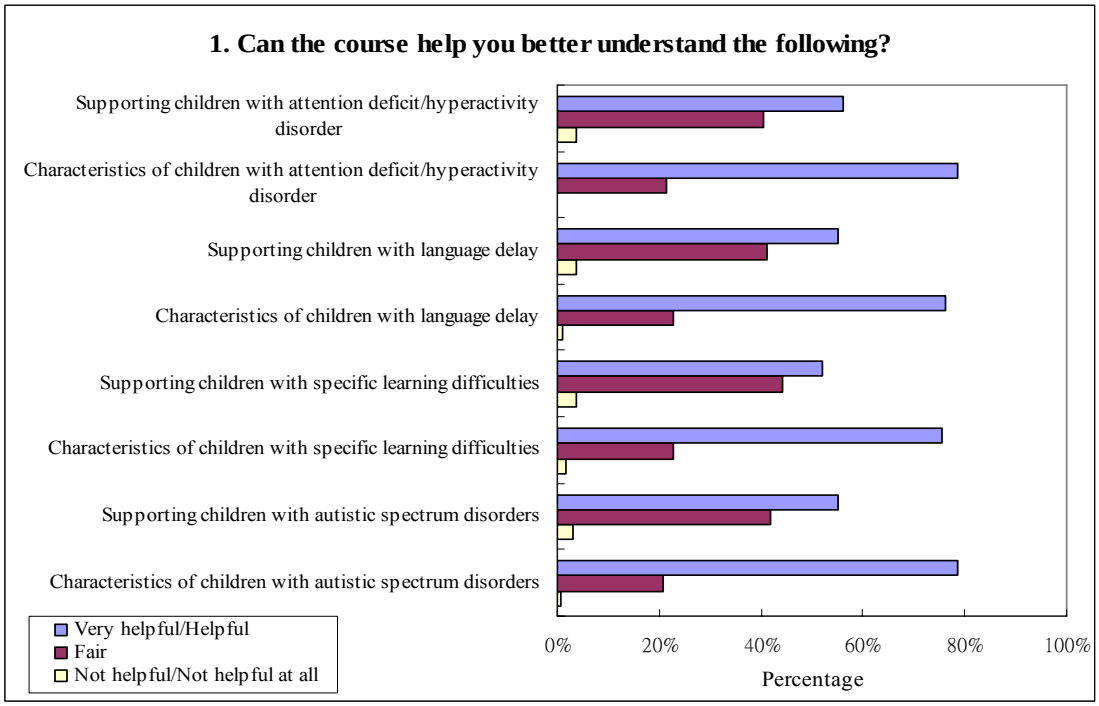
pre-primary educators.

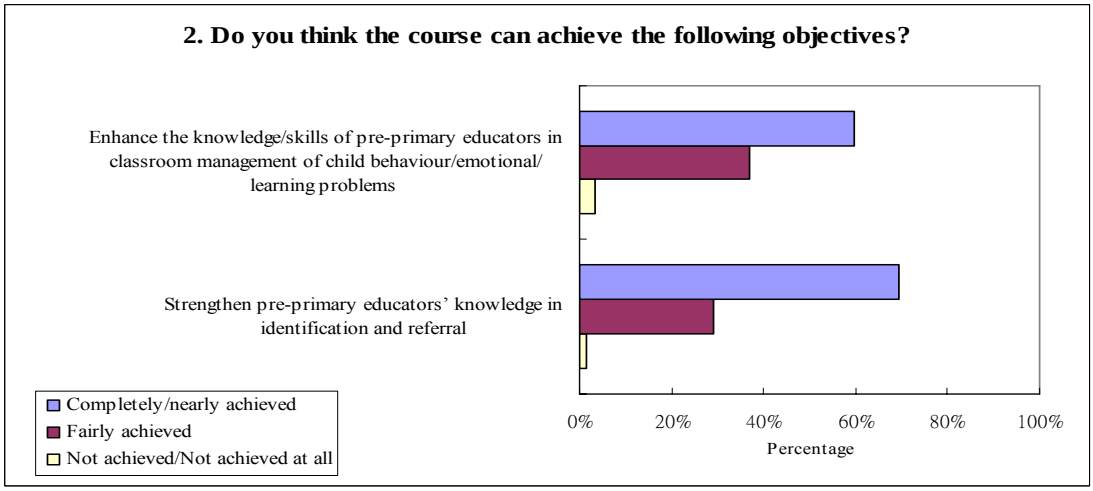
Based on the feedback of pre-primary educators that the training course might not have been able to meet the needs of those who had had basic training in special educational needs, an advanced training course was thus organised. The content focused on characteristics and management of children with specific conditions including autistic spectrum disorders, specific learning difficulties, language impairment and attention deficit/hyperactivity disorder. The duration of the course was 4 hours and the training was conducted by a paediatrician and a clinical psychologist. The attendance and evaluation results of the advanced training course are shown in Table 7.3 and Figure 7.2 respectively.

Table 7.3: Attendance figures (percentages) for pre-primary institutions in the advanced training course

District	**No. of pre-primary institutions in the district[a]**	**No. participated in the advanced training course**
SSP	50	22 (44%)
TSW	47	26 (55.3%)
TM	87	23 (26.4%)
TKO	58	9 (15.5%)

[a] Number of pre-primary institutions in the district at the beginning of 2005 excluding special child care centres and mutual help child care centres.





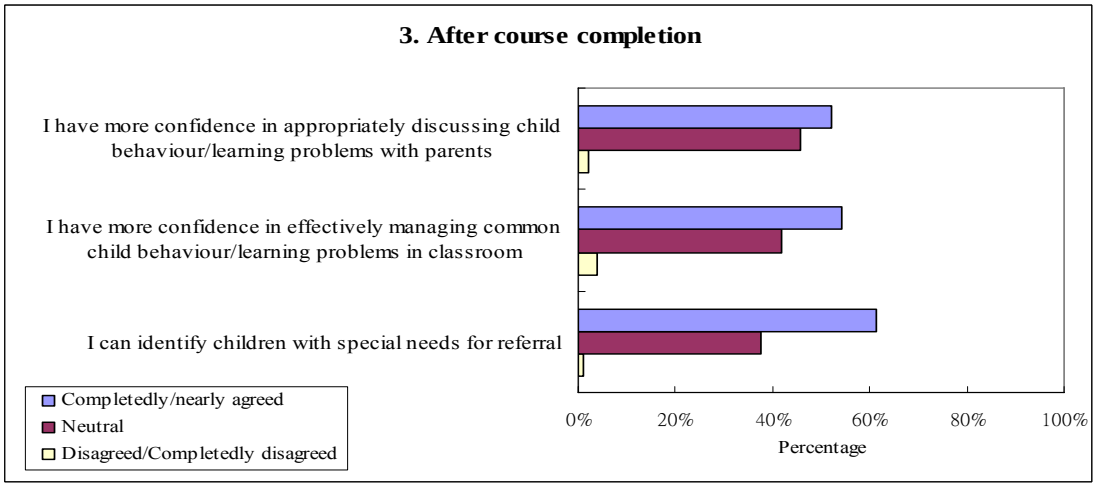


Figure 7.2 : Evaluation results of the advanced training course

The referral & feedback system

MCH nurses commented on the nature of referrals and the logistic issues in relation to the referral and feedback system. The quotes are in Appendix 7.1.

Nurses reported that there were not too many referrals from pre-primary institutions (1, 2, 3). In terms of the nature of the referral, most were children with behaviour and developmental problems, which were consistent with the objectives of the CCDS (4, 5, 6). However, they also reported that some pre-primary institutions did not have a thorough understanding of the various services and the referral system, and they referred cases which had already been assessed by the CAS (7). Some pre-primary institutions were not familiar with the referral forms and did not follow the procedures (8) while others were unaware of the availability of the referral forms (9). One MCHC maintained that pre-primary institutions tended to ask parents to bring their children to MCHCs, instead of completing the referral forms (10).

Concerning reply to pre-primary institutions, nurses in some MCHCs said there was no problem (11) but nurses in other MCHCs opined that it was extra work for the staff (12). Nurses in some MCHCs were concerned about the paper work involved in compiling service statistics (13, 14). For referral, there were concerns about the long waiting time for appointments or reply from specialist services (15, 16).

Summary

The participation of pre-primary institutions in briefing and training activities among the districts was variable. A survey of the pre-primary institutions as well as feedback from MCH nurses revealed that some were not aware of the CCDS while others were unfamiliar with the referral system. Improvement measures were instituted as appropriate. There were also concerns about the extra paper work involved in replying to pre-primary institutions and keeping service statistics as well as the waiting time for appointments or replies from downstream specialist services.

7.4 Service statistics

Table 7.4: The number of and reasons for referral from official commencement date[a] to September 2006

	WK	TSW	YO	TMWH	TKO	Total
No. of referral	48	16	14	10	11	99
Reasons[b] for referral						
Emotional/behavioural problems	21	6	6	4	9	46
Learning problems	20	10	8	3	4	45
Language problems	18	3	3	4	0	28
Parenting problems	6	0	2	3	0	11
Physical health problems	4	0	1	1	1	7
Others	2	1	0	0	0	3

[a] The WK MCHC figures were referrals received between July 2005 and September 2006; the other MCHCs figures were referrals received between January and September 2006.

[b] There could be more than one referral reason for each case

Table 7.5: Diagnoses[a] made after assessment at MCHCs

	WK	TSW	YO	TMWH	TKO	Total
Articulation problems	13	5	3	2	1	24
Parenting problems	6	5	1	5	1	18
Emotional/behavioural problems	6	4	1	1	2	14
Autistic spectrum disorders	5	1	3	0	4	13
Developmental delay	5	2	4	1	0	12
Language delay	4	1	2	2	0	9
Suspected specific learning difficulties	2	2	3	0	2	9
Normal	9	2	0	2	1	14
Others[b]	8	1	1	0	3	13

[a] There could be more than one diagnosis for each case

[b] "Others" might include motor delay, clumsiness, physical health problem, short attention span, attention deficit, suspected ADHD, or being gifted

Table 7.6: Service recommended after MCHC assessment [a]

	WK	TSW	YO	TMWH	TKO	Total
CAS	15	7	9	2	8	41
HA Speech therapy	8	4	2	1	1	16
HA Orthopaedics	0	1	0	0	0	1
MCHC Parenting Programme	11	3	2	5	2	23
Follow-up by MCH doctors	1	0	1	0	0	2
Other MCH services[b]	10	2	0	3	1	16
No service recommended as client was already receiving services	4	0	2	0	0	6

[a] Each case might have more than one service recommended.

[b] Other MCH services including routine follow-up, e.g. comprehensive observation service, developmental surveillance programme.

7.5 Change in the quality of service

Quantitative and qualitative information were used to assess changes in the quality of service.

7.5.1 Access

As there was no baseline data, it was not possible to assess the change in access. The number of referrals was not significantly high. The most frequent referral reasons were emotional/behavioural problems, learning problems and language problems (Table 7.4). The main problems diagnosed were articulation problems, parenting problems and emotional/behavioural problems (Table 7.5).

Most pre-primary institutions which had used the referral and feedback system were satisfied. They reckoned that this was a good initiative to help their pupils. They commended the quick response of MCHCs in arranging appointments (1, 2). Some maintained that the referral form was simple to complete (3) while others claimed that too much information was required (4). The quotes are in the Appendix 7.2.

7.5.2 Acceptability

Heads of pre-primary institutions claimed that most parents would accept referral, after having been given explanations (5, 6). Many pre-primary educators would like to have more detailed assessment results, including children who had been further referred to specialist services (7, 8). They would also like the assessment results to be written in Chinese (9).

Only one out of the 99 children referred defaulted the MCHC appointment and only two

of the parents declined the recommended services/referral after assessment.

7.5.3 Equity

Among children referred for MCHC assessment, 26% had one or both parents being new arrivals, as compared to 9% of children in the general population in the 2001 census (Census and Statistics Department, 2002). The demographic profile of families of children referred is shown in Table 7.7.

Table 7.7: Demographic profile of families whose children attended MCHC assessment (n=98)

	WK		**TSW**		**YO**		**TMWH**		**TKO**		**Total**	
Number of cases	47		16		14		10		11		98	
Family type	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Nuclear family	33	(70.2)	14	(87.5)	11	(78.6)	9	(90.0)	8	(72.7)	75	(76.5)
Extended family	12	(25.5)	0	(0.0)	1	(7.1)	1	(10.0)	3	(27.3)	17	(17.3)
Lone parent family	2	(4.3)	2	(12.5)	2	(14.3)	0	(0.0)	0	(0.0)	6	(6.2)
Parents marital status												
Married/cohabited	45	(95.7)	14	(87.5)	12	(85.7)	10	(100.0)	11	(100.0)	92	(93.9)
Never married separated/divorced/widowed	2	(4.3)	2	(12.5)	2	(14.3)	0	(0.0)	0	(0.0)	6	(6.1)
Parents residential status												
Both parents as Hong Kong permanent residents	29	(61.7)	11	(68.8)	6	(42.9)	9	(90.0)	11	(100.0)	66	(67.3)
One or both parent(s) as new arrivals	13	(27.7)	4	(25.0)	8	(57.1)	1	(10.0)	0	(0.0)	26	(26.5)
Both parents as visitors	0	(0.0)	0	(0.0)	0	(0.0)	0	(0.0)	0	(0.0)	0	(0.0)
One parent as Hong Kong permanent resident and one parent as visitor	5	(10.6)	0	(0.0)	0	(0.0)	0	(0.0)	0	(0.0)	5	(5.1)
Unknown	0	(0.0)	1	(6.2)	0	(0.0)	0	(0.0)	0	(0.0)	1	(1.0)
Father education												
Form 3 or below	24	(51.1)	10	(62.5)	7	(50.0)	2	(20.0)	5	(45.5)	48	(49.0)
Form 4 or above	23	(48.9)	6	(37.5)	7	(50.0)	8	(80.0)	6	(54.5)	50	(51.0)
Mother education												
Form 3 or below	25	(53.2)	5	(31.3)	7	(50.0)	2	(20.0)	3	(27.3)	42	(42.9)

Form 4 or above	22	(46.8)	10	(62.5)	7	(50.0)	8	(80.0)	8	(72.7)	55	(56.1)
Unknown	0	(0.0)	1	(6.2)	0	(0.0)	0	(0.0)	0	(0.0)	1	(1.0)
Parents employment												
Both parents working	19	(40.4)	3	(18.8)	3	(21.4)	7	(70.0)	9	(81.8)	41	(41.8)
One parent working	22	(46.8)	11	(68.8)	10	(71.4)	3	(30.0)	2	(18.2)	48	(49.0)
Neither parent working	5	(10.6)	1	(6.3)	1	(7.1)	0	(0.0)	0	(0.0)	7	(7.1)
Unknown	1	(2.1)	1	(6.3)	0	(0.0)	0	(0.0)	0	(0.0)	2	(2.0)
Family income												
$19 999 or below	35	(74.5)	12	(74.9)	10	(71.4)	5	(50.0)	3	(27.3)	65	(66.3)
$20 000 or above	12	(25.5)	3	(18.8)	2	(14.3)	4	(40.0)	7	(63.6)	28	(28.6)
Unknown	0	(0.0)	1	(6.3)	2	(14.3)	1	(10.0)	1	(9.1)	5	(5.1)
Language used at home												
Cantonese	46	(97.9)	16	(100)	12	(85.7)	10	(100)	11	(100)	95	(97.0)
Other Chinese dialects	0	(0.0)	0	(0.0)	2	(14.3)	0	(0.0)	0	(0.0)	2	(2.0)
Other languages	1	(2.1)	0	(0.0)	0	(0.0)	0	(0.0)	0	(0.0)	1	(1.0)

7.6 Summary and conclusions

The number of referrals from pre-primary institutions was not significantly high though those that had used the service were appreciative. Most parents were willing to accept referrals for assessment in MCHCs. Pre-primary institutions, however, would like more detailed assessment results so they could better support children in class. Among the referred children, there was a higher percentage of children from new arrival families suggesting that this component could increase access for children from socially marginal groups.

Reference

Census and Statistics Department (2002). *Thematic report – persons from the mainland having resided in Hong Kong for less than 7 years*. Hong Kong SAR Government.

Appendix 7.1: Views of MCH staff on the identification and referral of pre-primary children

Number of referrals		
1	Preschool (referral)唔係好多,其實應該係 under 未 refer。	5-88A
2	因爲唔係太多，…有幾間 (pre-primary institution)有幾個 (referral)。	3-127A
3	其實我地(MCHC)暫時唔係太多，不過原來佢地 (pre-primary institution)老師好多都唔係咁清楚可以有咁個途徑 (CCDS referral system)。	2-184C
Nature of referrals		
4	Behavioural，情緒、行爲…學習 發展各方面。	1-39E/ 40A
5	language，developmental，發展慢咗，佢地 (pre-primary institution)覺得(children)跟唔到學校，比如脾氣好燥，跟唔到學校規矩。	3-109A
6	而家暫時收到呢一係就 behavioural problem，係學校好活躍呀，搞唔掂 ，第二就係 話好似追唔上 ，比同期細路仔好似有 delay 。	5-75A
Confusion about the system		
7	我就覺得啲校長可能對我地呢個服務唔清晰嘅…亦都唔識得分我地健康院同我地嗰個智能測驗中心，佢會將呢兩達地方撈亂嘅…亦都有 case 佢已經去咗智能測驗中心，評估咗返嚟□喇，排緊隊去…特殊學校，又或者嗰啲所謂兼收學位…但係個校長仍然係會叫佢返嚟健康院，參加我地啲先導計劃。	4-186I
Problems with referral forms		
8	唔知係咪有 老師唔係好知正式 程序係點，因爲發覺有時有 阿媽就咁交低封信，擺低就走 去， 都唔係好齊。咁我 (MCHC) 就要搵番個阿媽，再問番多 我 需要 資料， 幼稚園 details 呀，有時連幼稚園 fax number 都冇，因爲我 都要話番俾佢聽，我 (MCHC) 已經收到 fax 喇。就係得老師寫封好簡單 信 ，基本幼稚園聯絡 資料都冇。	1-41D
9	最近…我 fax 張 referral 俾個校長，fax 問佢 (head of pre-primary institution)有冇…(the head of pre-primary institution said) !有張 form，乜我 (head of pre-primary institution)都唔知。	5-81D
10	因爲其實你 (CCDS) 嗰份 referral 都幾多嘢塡架，我 (nurse)諗佢幼稚園先生睇到之後。佢地 (pre-primary institution educator)都唔想做咁多嘢，老老實實咁就，不如叫佢 (parents) 自己行嚟喇，老老實實，因爲其實佢 (parents) walk in 同埋佢 (pre-primary institution) refer，我 (MCHC) 都係一樣要做。	4-173I
Reply forms		
11	我 (MCHC) 答番佢 (pre-primary institution)，話俾佢 (pre-primary institution)聽依家 refer 去邊呀，係我 中心 (MCHC)度有 乜服務提供 俾佢 (child)呀，都冇乜問題。	1-46D

12	同埋我地 (MCHC) 又要 reply，其實我地 (MCHC) 多咗工序，佢 (pre-primary institution)俾咗我地 (MCHC) 喇就要 fax 俾學校我 (MCHC) 收到你 (pre-primary institution)份嘢囉喎，咁跟住醫生做咗啲嘢，我地 (MCHC)又要寄番份 reply 俾佢 (pre-primary institution)…我地 (MCHC) 俾咗啲乜 service 佢 (child)喇，點啦再 follow up，呢啲工序可能係落咗個 nurse 度囉。	2-190C
Paper work		
13	有啲醫生嗰啲 Preschool 嘅 Referral (service statistics record form)夾埋喺度呀，都好多時啲醫生又唔識填呀，咁彈返出來呢，就幾乎要我地做文書咁嘈呀!	4-180L
14	都係又係個張 form(service statistics record form)喇，老實個句，因爲其實番嚟我地係會 refer 俾見醫生啦，醫生見完佢之後…俾我地填佢個份 form(service statistics record form)啦。	2-187C
Waiting time for appointment for further service		
15	Reply 佢地會俾嘅 CAC (Child Assessment Centre)，不過可能一段時間之後,因爲 CAC 係幾個月先做番囉。	2-215C
16	其實 CAC 都好快有得睇，佢即刻都會 arrange 個 prelimin(ary)嘅 Interview 比佢地 (child)咁樣，都一個月倒咁樣都有，speech therapist 就 14 個月倒咁樣樣，要 book HA 嗰啲。	3-126A

Appendix 7.2: Quotes from pre-primary institutions

	Referral process	
1	好滿意，時間比我預期中快，上午 fax referral，下午有電話安排幾時見。	4-PS_1
2	幾好，比以前冇門路好，以前叫家長自己搵醫生，家長費事，我地即時做。	3-PS_1
	Referral form	
3	OK，不必太詳盡，可以解答。	3-PS_2
4	好多嘢填，複雜啲，重複。	2-PS_2
	Parent acceptance	
5	好開心有咁嘅服務，有少少問題可即時跟進，家長冇咁擔心，同家長講容易接受，幫到小朋友。	4-PS_2
6	(parent)慢慢明白，(child)開學一段時間無改善，(parent)接受，肯去見(MCHC)。	2-PS_1
	Information about assessment results	
7	報告詳盡啲會好啲。	3-PS_2
8	想知道(referral)之後係點，幾時有言語治療，點樣跟進。	3-PS_3
9	跟進，(assessment report)英文爲主，中文好啲，terms 唔識。	2-PS_2

Chapter 8
Discussion

To recapitulate, the CCDS was an initiative using MCHCs as a community-based service platform, with inter-disciplinary and inter-sectoral collaboration, to achieve early identification of the varied needs of children and their families and timely referral to appropriate services for management. The ultimate aim was the improvement of health and social outcome of children and families. However, between 9 and 15 months after piloting the CCDS project among the 5 MCHCs, it was only possible and appropriate to measure the intermediate outcome, i.e. the quality of service in terms of access, acceptability, equity, effectiveness and efficiency (Maxwell, 1992).

This chapter is divided into two main sections. First, we attempt to answer the question: "Did the CCDS work?" in terms of whether the CCDS could achieve the anticipated improvement in service quality, based on service statistics and client feedback on each of the four components reported in chapters 4 to 7 respectively. We will then go on to answer the questions: "What worked?" and "Why and how did it work?", in terms of the structural and process issues that had contributed to the success or otherwise of the CCDS, based on analysis of the aforementioned results, along with what staff members involved in the four components had identified and described under the heading of "formative process" in the same chapters (Figure 8.1).

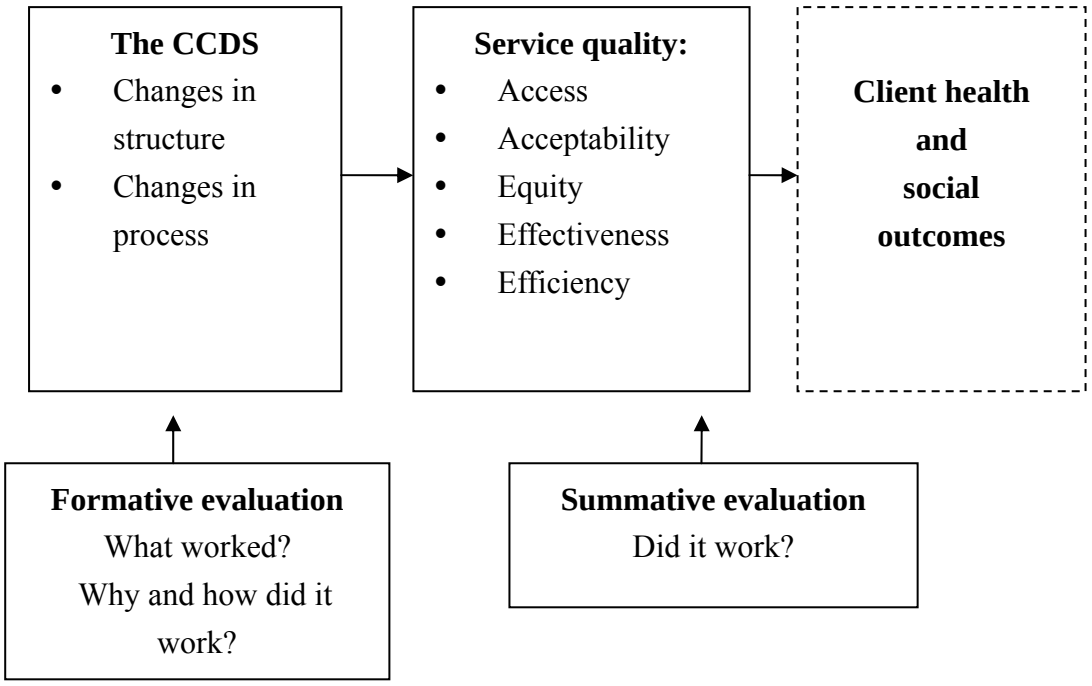


Figure 8.1: Formative and summative evaluation

8.1 Did the CCDS work?

8.1.1 Access and acceptability

All four components demonstrated an increase in access to various health and social services as shown by service statistics, client feedback and client progress reports, although there was still room for improvement in the use of the service by pre-primary educators. In terms of acceptability, clients commended the provision of various health and social services and they found the services helpful.

8.1.2 Equity

Inequities in health are inequalities or differences which are unfair or unjust. Inequalities in health care is one of the contributors to the larger issue of health inequalities. The two components designed specifically to address inequity in health care were able to achieve this objective to a large extent. In the component on the identification and management of at risk pregnant women, women with regular heroin use were identified as the target group in SSP. Preliminary results showed that through the ISP, many of the women heroin users who got pregnant were identified early enough for them to make an informed decision on their pregnancy and adopt effective contraceptive measures afterwards. The component on the identification of families with psychosocial needs was designed to identify among others, socially disadvantaged families for further exploration of their needs, based on predetermined demographic indicators. The service statistics showed that this was largely achieved. Furthermore, in the component on the identification of pre-primary children, many of the children referred had one or both parents being new arrivals. This suggested that this component had provided access for this disadvantaged group.

However, it was also recognized that some groups were less able to access service. For example, for the identification of mothers with PND and families with psychosocial needs, clients who could not turn up at MCHCs personally, such as working mothers, could not access the service.

8.1.3 Effectiveness

At this stage, there was some limited information on effectiveness. For the component on the identification of mothers with PND, the available data suggested that the PND screening programme using EPDS was more effective than the usual practice of clinical assessment, in terms of the mental health outcome of the clients. For social service referral, data collected so far suggested that there was an improvement in mental health outcome, as measured by GHQ-12, after social service intervention, among those who returned the pre- and post-intervention questionnaires. However, it is likely that this represented a group of more motivated clients and/or social workers.

8.1.4 Efficiency

It was anticipated that children's and families' problems identified and dealt with effectively at an early stage would save more resource-intensive interventions at a later stage. However, at the time of writing of this report, there was no data to show whether the CCDS could achieved this aim because of the short period of trial.

8.2 What worked? Why and how?

There were common factors identified in the process of formative evaluation that were considered to have contributed to the success or otherwise of the CCDS across all components and all communities. These are described as follows.

8.2.1 Structural issues

Facilities

Provision of visiting psychiatric nurses in MCHCs and the flexible arrangement for social workers to see clients in MCHCs on request had helped to reduce stigmatization and increase convenience, which were vital in increasing client access to psychiatric and social services. On the other hand, the lack of privacy for clients during MCH nurse interviews might have hampered the interviewing process, making clients reluctant to disclose their personal difficulties.

Staffing / Workload

The increased workload generated as a result of the pilot CCDS and the related data collection, against a background of manpower deficiency due to difficulties in recruitment, especially for nurses and clerical staff, might have led to higher stress for the staff and lower morale.

Staff competence

Clients' perception of staff competence and professionalism contributed significantly to their confidence in the staff; whereas staff members who lacked a sense of self-efficacy, or those with unrealistic expectation about their roles, experienced more stress and frustration in their work. Adequate staff training and psychological preparation, along with ample opportunities for continuous professional development were therefore crucial for the success of the programme.

8.2.2 Process issues

Workers' attitude, knowledge and behaviour in service delivery

With empathy, a caring attitude and perseverance of the worker, a good rapport with clients could be established, which would enable clients to willingly share their problems with the worker. Moreover, with good knowledge of services available in other institutions or sectors, clients could be persuaded to accept referrals between services. However, when workers appeared to be busy or pre-occupied with other things all the time, clients would perceive the workers as unhelpful.

For the socially marginalized or economically deprived groups who had the greatest need for health or social services, but were least able to access them (inverse-care law), unless more was done on the part of the provider to render services more user-friendly, they might not have been able to benefit from services available to the population at large. The out-reaching and one-stop service provided by the SARDA social workers, where clients were made to feel respected and unprejudiced, was exemplary.

Teamwork

Team spirit and close teamwork between doctors and nurses in MCHCs were essential in boosting staff morale and contributing to their sense of competence, especially during the early period of implementation of some components, such as the management of mothers with probable PND.

Inter-sectoral collaboration

Harmonious working relationship between workers of the various sectors and disciplines, in terms of mutual respect, open communication, responsiveness and flexibility in service delivery, and mutual sharing of experience, were instrumental in ensuring that clients receive the most appropriate services.

8.3 Limitations of the evaluation study

First, at the time of writing, the CCDS has been implemented for a period of between 9 to 15 months in the 4 communities. Therefore only short-term outcome data could be collected. Collection of data for evaluation of the long-term outcome, in terms of child and family well-being, was not possible at this stage. The results should not be interpreted as representing the long-term effectiveness of CCDS.

Second, the report was based on data collected from the commencement of the CCDS in July 2005 to the time of writing the report. This period could be regarded as a formative stage where teething problems were likely to occur. Based on data collected through formative evaluation, steps had been taken to improve and refine the programme. Ideally, summative evaluation should be conducted after formative evaluation when the programme had been refined and was being implemented smoothly. However, due to the time limitation, for the present exercise, summative evaluation was being conducted at the same time as

formative evaluation. It was possible that the data collected during this period might not be a true representation of the usefulness of the CCDS.

Third, there was no control community in the present evaluation. Ideally, a cluster randomized trial design (in which randomization is applied to clusters of people such as communities, rather than individuals)[16] should be employed in the evaluation of the CCDS. However, this was not possible in the present study, where service statistics after CCDS implementation were compared with baseline information before CCDS implementation instead.

Fourth, the qualitative data from clients was based on a convenience sample and they might not represent the full range of client responses. The quantitative data on the effectiveness of social service intervention was based on clients who returned the pre- and post-intervention questionnaires and they were likely to be more motivated clients/social workers. Those who were less satisfied with the service might choose not to complete the questionnaires.

Fifth, though care was taken in data management, there might still be ambiguities due to different implementation schedules, different interpretation of terms, and variation in centre practices etc. However, the overall pattern was consistent in indicating an improvement in service quality.

8.4 Conclusions

Despite the aforesaid limitations, evaluation of the pilot CCDS implemented so far did provide evidence for an increase in access, equity and acceptability to health and social services by the target service recipients. These achievements were probably attributable to the design of two of the components intended to address health care inequities by targeting the socially marginalized and economically disadvantaged groups; as well as changes in aspects of the structure and process of service delivery which had encouraged and facilitated clients to seek help from various services, especially those commonly considered stigmatised. The goodwill, dedication and close collaboration of professionals from all involved disciplines and sectors had been instrumental in bringing about these changes. There was also promising, albeit preliminary evidence on the effectiveness of the pilot CCDS in improving the mental well-being of service recipients. However, the evidence on the efficiency of the service remains to be substantiated.

For the purpose of evaluating the pilot CCDS, in terms of determining whether CCDS did achieve its objectives and exploring factors associated with success or otherwise, an evaluation plan had been designed before its implementation. Baseline and service data were collected, and focus groups/individual interviews with staff/clients were conducted. Many

---

[16] Kirkwood, B.R., & Sterne, J.A. (2003). Medical statistics (2nd Ed.). Cornwall: Blackwell Science (p.403)

frontline staff members found the process laborious, but this was unavoidable. In the long term, an inbuilt evaluation and quality management mechanism within all involved services are essential for useful information to be regularly fed back to the services and actions taken accordingly for continuous quality improvement, as well as ensuring that service objectives are met.

References

Kirkwood, B.R., & Sterne, J.A. (2003). *Medical statistics* (2nd Ed.). Cornwall: Blackwell Science (p.403).

Maxwell, R.J. (1992). Dimensions of quality revisited: from thought to action. *Quality in Health Care, 1*, 171-177.

Chapter 9
Recommendations

In this report, the summative evaluation provided information on whether improvement in the quality of service had been achieved through implementation of the CCDS, while the formative evaluation gave insights on the factors contributing to the success or otherwise of the CCDS. Based on these evaluation results, the following recommendations are made:

9.1 Recommendations on structural and process issues applicable to all or more than one components

9.1.1 Facilities

Interviewing rooms

To ensure privacy of clients during interview, renovation of MCHCs before implementation of CCDS, like construction of interviewing rooms and bidding extra spaces for site extension of MCHCs, etc. should be pursued.

Information technology

- To increase the efficiency of programme evaluation, the current manual process of data collection, entry and analysis should be computerized.
- To enhance the effectiveness and efficiency of the referral-feedback systems and tracking of defaulters, a computer platform for sharing of information between MCHCs, IFSCs and HA should be actively explored.

PRC

Each community should have at least one of its MCHC(s) equipped with a PRC, as parents found the comprehensive information about child/family issues, services and resources in the community useful.

9.1.2 Manpower

- There should be adequate professional staff to meet the increased workload for down-stream services, e.g. increased referral of mothers with PND who may need treatment from the psychiatrists; increased referral of pre-primary children with developmental problems who may need assessment from the CAS or treatment from the HA hospitals.

9.1.3 Team building

To enhance staff morale and to ensure smooth implementation of the service, enough attention should be given to the building of team spirit and teamwork among the staff before and during the process.

9.1.4 Staff training

- Nurses should be adequately informed beforehand about their roles in the various CCDS components so as not to cause undue stress due to unrealistic expectations.
- To enhance the clinical competence of the professional staff in handling psychosocial issues of the clients and their families, preparation should start early. It is recommended to develop a more structured training programme, comprising basic theories, practical training in the form of role play and clinical attachment to more experienced staff; and an enhanced support system for MCH nurses.
- Nurses should be trained to apply the transtheoretical (stages of change) model of health promotion to enhance their competence in motivating clients to recognise their problems and accept referrals.
- The staff should be given adequate training to increase their awareness, sensitivity and skills to approach the disadvantaged or socially marginalized groups in a respectful and accepting manner.

9.1.5 Inter-sectoral collaboration

To enhance collaboration between various professionals and agencies, the following are recommended:

- There should be mutual visits and information sharing between different services to familiarize staff with services provided by other sectors, so they can better link clients to appropriate services.
- There should be more case discussion and sharing to enable the staff to gain better understanding of case management practices in different services and knowledge of client outcome after referral.
- There should be more flexible management of service boundary issues to better meet client needs.

9.1.6 Procedures

Referral procedures and record keeping should be streamlined to reduce workload.

9.2 Recommendations specific for individual components

9.2.1 Identification and management of at-risk pregnant women

- For the differences in service boundaries between MCHC and HA, it is expected that this will be resolved when CCDS is implemented territory-wide. In the interim, it is recommended that all parties involved should adopt a flexible approach that could best meet clients' needs.
- To provide intervention of adequate intensity to the most severely disadvantaged groups of clients and to yield the best results, HA clusters should re-consider the number and the nature of at-risk groups to be targeted.
- The midwives should consider taking up the role of case manager so that the needs of clients could be better met and progress more closely monitored. This would only be possible if the number of at-risk groups to be targeted could be reduced.
- To improve the efficiency of the service, the follow-up service for children of at-risk families, currently provided solely by the CP could be shared by the MCH staff after having received adequate training and when conditions of the child and family had become stable, while the CP could take up the leading and a more strategic role in overseeing the implementation and further development of this component.

9.2.2 Identification and management of mothers with PND

- The number of visiting sessions by psychiatric nurses should be increased to meet client needs and provide ample support to MCH nurses, especially in the initial period of implementation, both in the assessment and management of mothers with probable PND.
- To further reduce the barrier for women with PND to receive the psychiatric service they need, the possibility of having psychiatrist visit MCHCs could be explored.
- To improve service efficiency, there should be a gradual shift from the secondary to the primary care level in the client management continuum. With experiences accumulated over time, MCH nurses could be expected to assess increasingly difficult cases and take up more of the counselling services, while the psychiatric team would be focusing its efforts in assessing and managing more difficult cases.
- To include more working mothers in the EPDS screening, it is recommended to advance it from 8 weeks (at the 2-month child health visit) to 6 weeks (at the postnatal visit), as more mothers would probably be still on maternity leave at 6 weeks postnatal.

9.2.3 Identification and management of families with psychosocial needs

- To include more working mothers in this component, the process of exploring psycho-social needs could be performed earlier in the postnatal period, e.g. together with the administration of EPDS.

9.2.4 Identification and management of pre-primary children with physical, developmental or behavioural problems

To enhance pre-primary institutions' participation and utilisation of the service, the following are recommended:

- The coordination through school development officers of the EMB could be strengthened.
- All pre-primary educators should be adequately trained to recognise developmental / behaviour problems and briefed about the referral mechanism. It is recommended to produce and distribute to all pre-primary institutions a training VCD, introducing the MCHC child health services and the referral and feedback mechanism, together with the lecture on the recognition and support of children with developmental needs. In the longer term, aspects of the training for pre-primary educators related to the recognition and classroom management of children with development problems might need to be reviewed or enriched.

9.3 Continuous evaluation and service quality management

To ensure that service is evidence-based and to continuously improve service quality, rigorous evaluation and quality management mechanisms should be inbuilt. The use of information technology could help to make the process more efficient and less labour intensive.

9.4 The way forward

As the pilot CCDS results indicate that there is an improvement in the quality of service, in the dimensions of access, acceptability, equity and effectiveness, it is recommended that the initiative be rolled out territory-wide so as to benefit more children and their families, subject to the availability of resources. The schedule of extension can be prioritized on the basis of the social need as defined by demographic characteristics and the operational preparedness of the various implementing agencies in different districts. Ongoing evaluation and quality management of the CCDS by all service providers involved are considered vital for continuous programme refinement and service quality improvement.