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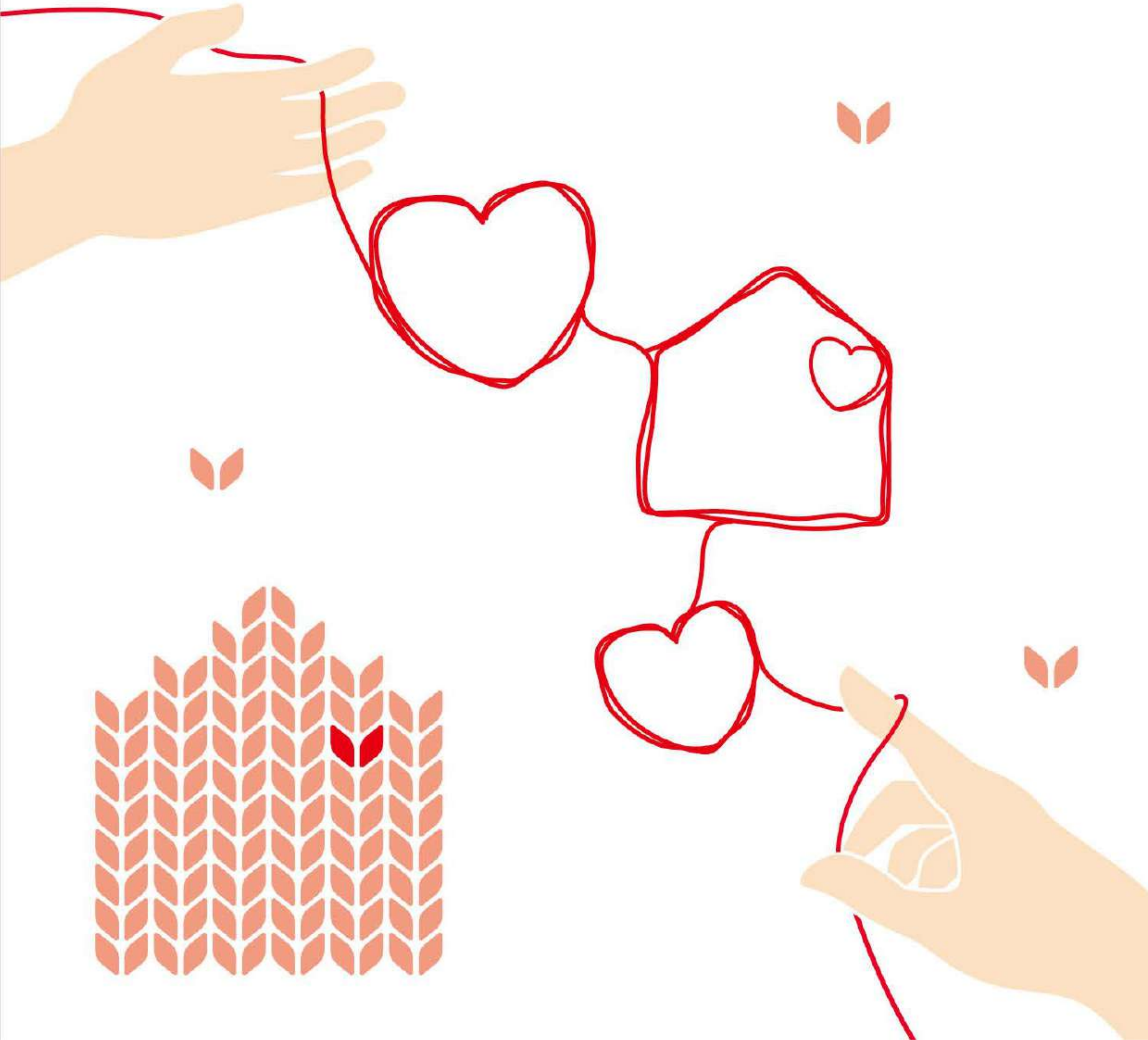
香港中文大學
The Chinese University of Hong Kong

RESEARCH REPORT ON A STUDY ON MENTAL HEALTH PROBLEMS AND THE NEEDS OF FOSTER CHILDREN IN HONG KONG (REVISED EDITION)

香港寄養兒童的精神健康情況和需要研究報告（修訂版）



Research Report on A Study on Mental Health Problems and the Needs of Foster Children in Hong Kong (Revised Edition)

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Acknowledgement

Hong Kong Family Welfare Society (HKFWS) takes a family - centered perspective and is committed to providing high quality and professional services to help people improve their lives, strengthen and support family wellbeing, and foster a caring community. For decades, we have been concerned about the welfare of families, and particularly the welfare of children. Apart from providing a range of child care services, including education and developmental programmes for children, parent education on child rearing, and assisting parents in taking care of their children at home; the Society also concerned children who could not receive adequate care from their birth families due to their special family circumstances or crisis situations. Thus, the Society started foster care service in 1984.

In view of the complicated family problems, children placed in foster care bear several disadvantages of their own families, including parental physical or mental illness, parental drug, child abuse and inadequate care. From our experience, foster children were found to be more vulnerable in mental health when compared with their peers, they manifested a range of psychological problems, school related and peer-relationship problems, as well as significant mental health issues.

We recognize the importance of understanding the phenomenon of mental health difficulties among children using foster care service to shed light on the design of our social service and formulation of relevant policy. In attempts to exploring into this area, we commissioned the research team from the Department of Social Work, The Chinese University of Hong Kong to conduct this study. Our gratitude must go to the research team for their professional and insightful recommendations on this research study.

We would like to extend sincere thanks to all those who have offered advice and support in the planning of this research study. Special thanks must go to Dr. Patrick Leung, for giving us invaluable advice during the initial planning of the study, and support from the Foster Care Service Sub- Committee throughout the study.

Our gratitude also goes to the foster parents, birth parents and foster children who participate in the study. Last but not the least, we would record our appreciation to a team of devoted staff for their commitment in the service and carrying out this study. We sincerely hope that the findings and recommendations derived from the study would provide valuable information to guide the services to address the psychological well-being of foster children, as well as the service direction and development of foster care service in Hong Kong.

Ms. Amarantha Yip
Chief Executive
Hong Kong Family Welfare Society
Jan 2021

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EXECUTIVE SUMMARY (ENGLISH)

1. This report presents the results of ‘A Study of Mental Health Problems and the Needs of FosterChildren in Hong Kong (hereinafter referred to as ‘the study’), covering the period from April 2018to October 2019 (18 months), organised by the Hong Kong Family Welfare Society.

2. This study aimed to explore: i) the phenomenon of mental health difficulties among foster children and ii) their use of and experiences with mental health services.

3. This mixed-methods study comprised both quantitative and qualitative elements. A survey of foster parents and the agency’s foster care workers was used for the quantitative study. Four measurement tools were used for data collection: a demographic information questionnaire, the Child Behaviour Checklist (CBCL, Chinese version), the Information Sheet for Mental Health Service Utilization (MHSU) and the Parents as Social Context Questionnaire (PASCQ, Chinese version). A cross-sectional multiple case study was designed for the qualitative part of the study. Five cases were selected from those of the survey respondents, and the informants included foster children, foster care workers, foster parents and birth family caregivers.

4. Key Findings

4.1. The Survey

4.1.1. The rate of mental health problem diagnosis for children aged below 6 was 24.3% and that for children aged 6-18 was 47.5%.

4.1.2. The rate of children aged below 6 to fall within the clinical range of the CBCL total score was 26.5%, and that of children aged 6-18 was 21.9%.

4.1.3. Male foster children are 3.5 times more likely to fall within the clinical range of the CBCL total scores than female foster children. Foster children who participate in extra-curricular activities, however, have a lower risk of falling within the clinical range set by the CBCL total scores. Foster children who have a better foster parent-child relationship have a lower likelihood of falling within the clinical range of the CBCL external scores.

4.1.4. The rate of mental health service use for children aged below 6 was 52.8% and that for children aged 6-18 was 49.4%.

4.1.5. Male foster children have an increased likelihood of receiving these services, and they are 3.68 times more likely to receive the services than female foster children. Foster children who participate in extra-curricular activities have a lower likelihood of receiving these services.

4.2. In-depth Interview

4.2.1. Among the five cases selected for in-depth interview, all the foster children were receiving mental health services, including specialised and developmental services, at the time of the study. “Specialised services” refer to mental health services for children with special needs, while “developmental services” refer to services designed to enhance the growth and well- being of the children. In addition, four of the foster children had previously used other mental health services. One child was waiting to receive a clinical psychology service, one child was not eligible to attend a special primary school and one was not eligible for assessment services.

4.2.2. The informants regarded the mental health services as effective at reducing the children’s negative symptoms and improving their functioning and development. They also identified barriers to and factors enhancing the accessibility and effectiveness of the assessment and treatment services. These factors were related to the service providers (i.e., systems and organization), service users (i.e., foster children) and children’s supporters, including professionals (e.g., foster care workers, referring workers, and teachers), paraprofessionals (e.g., foster care families). and biological families.

4.2.3. From the perspective of foster social workers, the barriers to the accessibility of assessment services were related to service operators (i.e., lack of resources and service fragmentation) and supporters (i.e., delayed identification, discrepancies among professionals and caregivers); while the facilitating factor was the sensitivity of the supporters. In addition, the effectiveness of the assessment services was hindered by inaccurate assessments made by professionals. With respect to the treatment services, the barriers were related to service operators (i.e., lack of diagnosis, and rigid criteria for eligibility for the services) and supporters (i.e., discrepancies among professionals and social stigmatisation perceived by the parents). A smooth access to the treatment services was achieved when there was a socially dominant view of the treatment methods and a cooperative attitude among the family caregivers. In terms of service effectiveness, a firm commitment on the part of the foster parents could maximize the positive effects of the services on the children.

4.2.4. A foster parent questioned the accuracy of the assessment of the children, which greatly affected the effectiveness of the assessment services. In terms of the treatment services, the barriers to their accessibility included the limited choice available to the children’s parents to choose from, the long waiting period, and a rigid division of labour between different professionals. Although the effectiveness of treatment services was negatively affected by the lack of support from the school and the low levels of motivation among the children, the support coming from the foster parents, helped maximise the positive effects of the services on the children.

4.2.5. The views of the biological parents on the effectiveness of the services was varied. While some parents observed that the children made great progress, other parents regarded the children's situation as being unchanged or even worse after receiving the services.

4.2.6. The children were positive about the specialised services. Moreover, they greatly enjoyed the development services such as the tutoring schemes, the Understanding Adolescent Project (UAP) and extracurricular activities.

4.2.7. These factors were related to service providers (i.e., healthcare systems and healthcare organisation), service users (i.e., foster children) and those supporting the children, such as professionals (e.g., foster care workers, referring workers and teachers), paraprofessionals (i.e., foster families) and biological families.

5. Recommendations

5.1. Mental health system

- Expand mental health resources for children in out-of-home care.
- Provide case management services to coordinate the various services from assessment through treatment.
- Provide more services and/or programmes to address foster children's developmental needs.

5.2. Care system

- Establish a databank for problem identification, service planning and policy formulation.
- Increase the frequency of case reviews for cases with a high-risk of mental health issues to facilitate the early detection of issues faced by these children.
- Provide more support, including financial subsidies, educational services, special training and extra support, for foster parents who care for children with special needs.
- Establish more services to help biological parents understand their children's situations and obtain information about their developmental needs.
- Amplify children's voices via formal channels (e.g., case review) and informal channels (e.g., casual contact).

5.3. School system

- Provide training to ensure that school-related staff members understand the special circumstances of foster children.
- Increase collaboration between schools and community services to enable foster children to participate in more extracurricular activities.

行政摘要

1. 本報告描述「香港寄養兒童的精神健康問題和需要的研究」(以下簡稱「研究」)的結果。此研究由香港家庭福利會主辦，研究時段由 2018 年 4 月至 2019 年 10 月(18 個月)。

2. 本研究旨在探討：i) 寄養兒童精神健康困難的現象 和 ii) 他們使用精神健康服務的情況和經驗。

3. 本研究採取混合研究方法，包括量性研究和質性研究。在量性研究方面，我們使用「問卷調查」方式來收集數據，應答者包括香港家庭福利會的寄養社工和寄養父母。我們使用了四種測量工具:「個案資料調查表」,「兒童行為檢核表(中文版)」,「精神健康服務使用量表」和「父母作為社會背景問卷(中文版)」。在質性研究部分，我們採用了「橫斷面多案例」的設計。在調查應答者中選擇了五個案例，受訪者包括寄養兒童，其寄養社工，寄養父母和家庭照顧者。

4. 調查主要發現

4.1. 問卷調查

4.1.1 24.3% 6 歲以下和 47.5% 6-18 歲的兒童被診斷有精神健康問題。

4.1.2 26.5% 6 歲以下和 21.9% 6-18 歲的兒童處於「兒童行為檢核表」總評分臨床範圍內。

4.1.3 接受寄養服務的男童處於「兒童行為檢核表」總評分臨床範圍內是女童的 3.5 倍。 有參與課外活動的寄養兒童比沒有參與課外活動的較少機會處於「兒童行為檢核表」總評分臨床範圍內。與寄養家長有較良好關係的寄養兒童較少機會處於「兒童行為檢核表」外顯行為臨床範圍。

4.1.4 52.8% 6 歲以下和 49.4% 6-18 歲的兒童正使用精神健康服務。

4.1.5 接受寄養服務的男童比女童有更高機會同時接受精神健康有關的服務。男童接受精神健康有關的服務是女童的 3.68 倍。有參與課外活動的寄養兒童比沒有參與課外活動的較少機會同時接受精神健康有關的服務。

4.2. 深入訪談

4.2.1 所有受訪寄養兒童為現時專業服務和發展服務的使用者。 專業服務是指服務針對兒童的特殊需要，而發展服務是指有助兒童成長和發展的服務。其中四位兒童以前曾使用過其他服務；一位兒童現正在輪候臨床心理服務；兩位兒童並未合資格獲得所需要服務，分別為特殊教育服務和評估服務。

4.2.2 受訪者認為所接受的精神健康服務能有效地減輕孩子的症狀，並改善其能力和發展。與此同時，他們提出阻礙和促進使用專業服務和其成效的因素，這些因素與服務提供者（即精神健康服務系統和精神健康機構）、服務使用者（即寄養兒童）或兒童支援者包括專業人員（例如寄養服務社工、轉介社工和老師）、輔助性專業人員（即寄養家庭） 和原生家庭有關。

4.2.3 從寄養服務社工的角度，阻礙使用專業評估服務的因素與服務提供者（即缺乏資源和整全的服務）和支援服務的人士（即延遲識別、專業人員和照顧者之間的差異）有關；而促進使用專業服務的因素是支援服務的人士對服務使用者需要的敏感度。此外，評估服務的有效性通常受礙於專業人員對於寄養兒童的服務需要掌握不足。在治療服務方面，阻礙使用治療服務的因素與服務提供者（即缺乏診斷和過於嚴格的服務使用資格的標準）和支援服務的人士（即專業人士之間的差異和父母所感受到的社會排斥）有關。一個社會主導的治療方向和家庭照顧者的合作態度是讓寄養兒童能順利獲得適當的治療服務的重要因素。在服務成效方面，寄養父母對照顧寄養孩子的承諾是最能發揮服務對兒童的積極影響的因素。

4.2.4 其中一位受訪寄養父母質疑對孩子進行評估的準確性，而這極大地影響了評估服務的有效性。在治療服務方面，阻礙使用服務的因素包括有限的父母的選擇、等候時間過長以及不同專業人士之間僵化的分工。治療服務的有效性會受到因缺乏學校的支持和兒童參與動機低下而受到負面影響。寄養父母的支持可以加強服務對兒童的正面影響。

4.2.5 親生父母對服務有效性的意見不一。有的家長看到孩子進步很大，有的家長則認為孩子在接受服務後情況沒有明顯改變。

4.2.6 寄養兒童對專業化的服務持積極態度。此外，他們非常享受參與與其成長發展相關的服務，例如功課輔導計劃、成長的天空和課外活動等。

5. 建議

5.1. 精神健康系統

- 精神健康服務應將資源擴展到照顧兒童
- 建立個案管理服務系統來協調不同的評估和治療服務
- 提供更多不同的服務和計劃來滿足寄養兒童的發展需要

5.2. 照顧兒童系統

- 建立數據資料庫以識別問題、計劃服務及修訂政策
- 增加精神健康高危個案評估的次數，有助及早發現寄養兒童的問題
- 增加對照顧有特殊需要寄養兒童的寄養父母的支援，例如財政補貼、教育服務、特別培訓及額外支援
- 增加親生父母了解其子女狀況和獲得有關子女成長需要的資訊
- 透過正式（例如個案會議）和非正式（例如日常的接觸）的渠道來加強兒童的參與及聆聽他們的聲音

5.3. 學校系統

- 加強學校工作人員培訓，以了解寄養兒童的特殊情況
- 學校應加強與社區服務單位的合作，增加兒童參加課外活動的機會

PART I INTRODUCTION

This report presents the results of ‘A Study of Mental Health Problems and the Needs of Foster Children in Hong Kong’ (hereinafter referred to as ‘the study’), covering the period from April 2018 to October 2019 (18 months). The report starts with a brief introduction to the research study. This is followed by the quantitative and qualitative results collected during the research period, and a section presenting a discussion that highlights the phenomenon of mental health problems in foster children and their use of and experience with the mental health service based on the research results. The final part of the report proposes a recommendation to promote the mental well-being of this vulnerable group in the community of Hong Kong.

PART II RESEARCH STUDY

1. RESEARCH BACKGROUND

Out-of-home care children (OOHCC) in Hong Kong refers to those children and adolescents aged 0-21 who are residing in three broad types of care facility, namely residential homes, small group homes and foster care families. Children were admitted to these care facilities as they could not receive adequate care from their biological families due to personal or family crisis (SWD, 2015). As of June 2016, there were 3,248 OOHCC in Hong Kong (HKCSS, 2017).

Mental Health of OOHCC

Previous research studies showed that these children were more vulnerable regarding mental health when compared to their counterparts (Dubois-Comtois et al., 2021; Egelund & Lausten, 2009; González-García et al., 2017; Richardson & Lelliott, 2003). The findings of local research were equally alarming. Local studies indicated that these children manifested a range of psychological, school related and peer-relationship problems, and demonstrated high levels of internalizing and externalizing problems in respect of emotions, conduct and hyperactivity/inattention (Tam & Ho, 1993; Sheng Kung Hui St. Christopher's Home; 2005).

Most overseas and local studies have used the Diagnostic Statistical Manual of Mental Disorder (DSM) set by the American Psychiatric Association to define the mental health problems of children and adolescents. The assessment is usually done by professionals such as psychiatrists, clinical psychologists, educational psychologists, and occupational and physiological therapists. However, the perspective of the out-of-home care social worker, substitute caregiver, and the parent and child might easily be overlooked. Including their views is an important way to enrich our understanding of the mental health needs of these children.

Risk and Protective Factors Affecting the Mental Health of OOHCC

The mental health problems of OOHCC were found to exist during the pre-care stage (Attar- Schwartz, 2008; Egelund & Lausten, 2009). Research studies have shown that there was a range of risk and protective factors in the levels and quality of child, family and out-of-home care services that affected the mental health of OOHCC significantly (Barth& Delfabbro, 2006; Dunn, Culhane, & Taussig, 2010; Rutter, 2000; Wong, Ma & Chan, 2019). In terms of child related factors, age and gender was associated with certain types of mental health difficulty in foster children (Jackson et al., 2011; Leslie et al., 2004). For example, developmental delays were identified in the early stages of childhood, and attention deficit hyperactivity disorder (ADHD) was more common in boys than girls (Bauermeiste et al., 2007; Huang et al., 2016). Moreover, children and adolescents who actively engaged in structured extra-curricular activities (e.g., sports teams) could foster their positive mental health and resilience (Farineau & McWey, 2011; Fong et al., 2006; Gilman, Meyers & Perez, 2003). At the familial level, most OOHCC had had traumatic pre-placement experiences such as being abused and neglected by their biological parents or significant others (Dimigen, Priore, Butler, Evans, & Ferguson, 1999; Minnis, Everett, Pelosi, Dunn, & Knapp, 2006; Oswald et al., 2010). These risk factors putting children in a high risk of psychopathological outcomes such as depression, anxiety disorder, oppositional defiant disorders, conduct disorders and aggression etc. (Cohen & Smailes, 2001; Barber & Delfabbro, 2005).

Notwithstanding the above, OOHC services could sustain or improve the state of these children's mental health by as much as 60%, as indicated by some empirical studies (Tarren-Sweeneya, 2017). In other words, OOHC services with good quality served as a protective factor for these children. These factors included continuity and availability of substitute caregivers / staff; placement stability; and regular connection with biological families (Barber & Delfabbro, 2005; Chapman, Wall & Barth, 2004; Dunn, Culhane & Taussig, 2010; Sheng Kung Hui St. Christopher's Home, 2005; Stanley, 2007)). In Barber's and Delfabbro's study (2005), foster care children, who had improvement in conduct disorder, hyperactivity and emotionality, reported a high satisfaction level with the relationship with foster parents and social workers. OOHCC also found great difficulty to adjust the changes if there were frequent changes of staff (Stanley, 2007). Furthermore, a high proportion of OOHCC, who a high level of psychological needs, had experience significant placement instability (Fernandez, 2008; McGuire et al., 2018). Conversely, a stable placement enabled a stable relationship between children and their peers, substitute caregivers and staff. Finally, there was a close association between the children's mental health and their connection with their biological parents. Children who had regular contact with their biological parents showed more satisfaction with their out of home care arrangements and were closer to their substitute caregivers than their counterparts (Chapman et al, 2004; Dunn et al., 2010). The positive connection between children and their significant others was an important contributing factor for children's mental health.

Mental health services

According to the American Psychological Association's Dictionary of Psychology, mental health services refers to "any interventions—assessment, diagnosis, treatment, or counseling—offered in private, public, inpatient, or outpatient settings for the maintenance or enhancement of mental health or the treatment of mental or behavioral disorders in individual and group contexts" (APA, n.d.). In this study, we adopted a broad definition of mental health services that refers to all services (both mental health services and social services) that work with children's and adolescent's mental health and wellbeing needs as well as services for the children's families. A board definition is used because services such as speech therapy and occupational therapy are provided by numerous entities such as the Hospital Authority, the non-government organizations and private practitioners in Hong Kong. (Please refer to 4.1.2.3. for details.)

The availability and the accessibility of mental health services was found to be significantly important for the rehabilitation of children. Many variables might affect the use of the services, including the children's demographic characteristics (e.g., age, gender, and race), family characteristics (e.g., parent's mental health history, parent's criminal history), availability of care facilities (e.g., substitute caregivers) and services (e.g., social workers), as well as ideology (e.g., stigmatization) (Leslie, Landsverk, Ezzet-Lofstrom, Tschann, Slymen & Garland, 2000; Richardson & Lelliott, 2003). In addition, the existence of a diagnosis is a criterion for mental health service use in our service system. However, it is unclear whether or not certain types of diagnosis are associated with service use in our context.

Summary

Mental health needs and the use of mental health services by OOHCC have been studied widely overseas. Nevertheless, the number of local studies is far from enough for us to understand the current mental health situations and needs of OOHCC children aged from 3 to 6 years old. Moreover, we have neither a clear picture of the factors associated with the mental health status of the OOHCC, nor a clear picture of their use of the mental health service and their help seeking experiences locally. In view of this knowledge gap, the Hong Kong Family Welfare Society (HKFWS), one of the leading local non-governmental organizations that renders foster care service to vulnerable children, commissioned our research team to conduct this study.

2. RESEARCH OBJECTIVE

This study aims to explore (1) the phenomenon of mental health difficulties among children in foster care and (2) their use of and experience with mental health services in Hong Kong.

3. RESEARCH QUESTIONS

1. What are the incidences of various types of mental health difficulties, including clinical-level difficulties, among children in foster care?
2. What factors are related to the mental health difficulties of children in foster care?
3. What is the service use rate of children in foster care who require mental health services?
4. What factors are related to the use of mental health services by children in foster care?
5. From the perspective of foster care workers, foster parents, family caregivers and children,
   - what are their lived experiences with service use?
   - how effective is the service? and
   - what barriers and facilitating factors influence service accessibility and effectiveness?

4. RESEARCH DESIGN

The research study adopted a mixed-methods approach that comprised both quantitative and qualitative elements. The quantitative study was designed to answer research questions 1 to 4, and the qualitative study was conducted to answer research question 5.

4.1. QUANTITATIVE STUDY

4.1.1 METHOD

A survey was used for the quantitative study. The respondents included foster parents and foster care workers from the Hong Kong Family Welfare Society (hereinafter referred to as 'HKFWS').

4.1.2 MEASUREMENT TOOLS

Four measurement tools were used for collecting data: the Demographic information questionnaire (Chinese version), the Child Behaviour Checklist (CBCL/11/2-5 and CBCL/6-18) (Chinese version), the Mental Health Service Utilization (MHSU) and the Parents as Social

Context Questionnaire (PASCQ) (Chinese version).

4.1.2.1. Demographic information questionnaire – (Chinese version) (Appendix I)

This form was developed by the research team to collect basic information and variables associated with the mental health problems of foster children. Basic information on the children's characteristics, mental health status, service utilisation, family background and placement history were reported by the social workers based on the information in the case file. In addition, basic information on the foster parents and the foster care workers was collected. Regarding the factors associated with the mental health problems of foster children, a literature review was conducted to develop the variables. Moreover, the research team conducted interviews with the foster children (aged 6 and over), the biological parents, the foster parents, and the foster care workers to contextualise these variables.

4.1.2.2. Child Behaviour Checklist (CBCL/1½-5 and CBCL/6-18) – (Chinese version)

The CBCL measured both internalising symptoms, including depressive/anxious and somatic symptoms and thought problems, and externalising symptoms, including rule breaking and aggressive behaviour in the children, as reported by the caregivers and teachers (Leung et al., 2006). A total problem score was also determined to indicate the overall psychopathology of the children. The CBCL is widely used in schools, mental health services and human service settings. Because the manifestation of symptoms differs in different age groups, two versions of the CBCL, the CBCL/1½-5 for children aged below 6 and the CBCL/6-18 for children aged 6-18, were used in this study. While the CBCL/1½-5 contains 100 items, the CBCL/6-18 includes 113 items. The CBCL defines scores in the 'normal' and 'clinical' ranges. Because the raw score for the CBCL could not be directly interpreted, all scores for the CBCL were transferred to T- scores, based on the CBCL scoring instructions and the scoring sheet. Originally, according to the scoring sheet, T- scores between 60 and 64 fall within the borderline range. Considering that the percentage for cases with a T score higher than 64 is low, which could make the statistical estimation biased, this study used the lower score of borderline range as the cut-off point. Hence, for this study, a T- score higher than 60 was considered to be in the clinical group. Only the test-retest reliability and criterion validity of the Chinese version of the CBCL/6-18 were available and validated for use in Hong Kong. This scale had good validity and was a reliable tool (Leung et al., 2006). The CBCL was given to both foster parents and foster care workers for rating. However, in this study, the scores rated by foster care parents were used for analysis because foster parents spent more time with the children and were more aware of the children's behaviour and status, compared to foster care workers. In addition, the foster care workers' assessments of the children relied considerably on the self-reports of the foster parents. The Cronbach's Alphas for the CBCL/1½-5 scale and CBCL/6-18 scale are 0.961 and 0.951 respectively in the present study, indicating the scales had a satisfactory internal consistency.

4.1.2.3. The Information Sheet used by the Mental Health Service Utilisation *measure* (MHSU) – (Chinese version) (Appendix II)

A self-developed information sheet for the MHSU was adopted. First, the research team reviewed the international and local literature on mental health service use for children in general and out-of-home care children (OOHCC) to develop the initial framework and questions on mental health service utilisation in Hong Kong. To further enrich the information sheet, the research team conducted 1 focus group meeting for foster care social workers (N = 8), 1 focus group meeting with foster parents (N=9), 2 individual interviews with foster children (N = 2) and 1 individual interview for a biological parent (N=1). A list of mental health services used by OOHCC for their mental health and wellbeing needs was developed. These services included mental health services for the children as well as their families. The services were subdivided into four types: i.) medical services (e.g., psychiatric medication, psychiatric assessment services), ii) educational services (e.g., kindergarten- cum-child care centers, early education and training centers), iii) rehabilitation services (e.g., speech therapy, occupational therapy) and iv) counselling services (e.g., group counselling for children – social skill training group, play therapy). For the latter one, the services mainly refer to family counselling and group counselling.

4.1.2.4. Parents as Social Context Questionnaire (PASCQ) – (Chinese version) (Appendix III)

This scale was adapted from an earlier version of the Parent as Social Context Questionnaire (PASCQ) developed by Skinner, Regan and Wellborn in 1986, which includes 31 questions in three dimensions (warmth and rejection, structure and chaos, autonomy support and coercion) and was used to measure the relationship between a foster parent and a foster child. The internal consistency of the PASCQ total scores in this study is 0.8.

4.1.3. RESPONDENTS

4.1.3.1. Foster care workers

The foster care workers of HKFWS completed the demographic information, the CBCL (CBCL/1½-5 for children below 6 and CBCL/6-18 for children aged 6-18) and the scale of the MHSU measure for each child.

4.1.3.2. Foster parents

One foster parent (the primary substitute caregiver) completed the CBCL according to the age of the foster children (CBCL/1½-5 for children below 6 and CBCL/6-18 for children aged 6-18) and the PASCQ for each child.

4.1.4. DATA COLLECTION METHOD

The foster children, aged 3 to 18 years old who were eligible for the survey, were identified by the foster care workers of the HKFWS. Consent to disclose the children’s information was sought from their guardians. Questionnaires with all study variables were disseminated to the responsible foster care worker for each child. The CBCL and PASCQ were disseminated to one of the foster parents via the responsible foster care worker. The returned questionnaires were sealed and returned to the agency. Our research assistant collected all the questionnaires from the agency in person.

4.1.5. DATA ANALYSIS

Descriptive analyses were conducted to investigate the incidences of various types of mental health difficulties and of foster children in need of mental health services.

Logistic regression analyses were performed to investigate the effects of various factors (e.g., gender, participation in extra-curriculum activities) on (a) the likelihood that the foster children fall within the clinical range of the CBCL scores, and (b) the likelihood that the foster children were receiving mental health services. Specifically these factors include (1) the foster child's gender (male vs female), (2) the foster child's age group (below 6 years old vs 6-18 years old), (3) pre-placement child maltreatment (yes vs no), (4) the foster child's participation in extra-curricular activities (yes vs no), (5) the foster parent-child relationship (yes vs no), (6) presence of a sibling in the foster family (yes vs no), and (7) placement disruption (yes vs no). These seven variables were selected based on the previous literature cited in the literature review of this research report.

4.2. QUALITATIVE STUDY

4.2.1. METHOD

A cross-sectional multiple case study was designed for the qualitative part of the study. The multiple case study approach is suitable for studying a phenomenon rooted in a social and cultural context and for answering 'what' and 'how' research questions using a small number of cases.

4.2.2. PARTICIPANTS

Five cases were selected among the survey respondents based on the following criteria:

a) Children aged 6 to 18;
b) The primary family caregiver was either a biological parent or a relative, such as a grandparent, uncle or aunt;
c) They were children currently using the mental health service (except the foster care service).

Criterion a) was set as children aged 6 and over were able to express their ideas clearly. Criterionb) was set to maximise the number of cases selected. We deliberately involved children with and without a clinical diagnosis and those currently using the service (i.e., criterion c) to explore whether there were any significantdifferences in service utilisation among them.

4.2.3. DATA COLLECTION

Semi-structured in-depth interviews were conducted by the research team from May to June 2019. To this end, interview guides developed by the research team were used (Appendix IV and V). The questions were related to 1) the informants' experiences with the mental health services that the foster children received / were receiving; 2) their perceived effectiveness of the mental health service; and 3) the barriers to and factors facilitating service effectiveness. Images of animals downloaded from the Internet were used as a supplementary tool to engage the children in communication.

All the children, foster parents and family caregivers were contacted by their respective foster care workers and invited to participate in the study. After obtaining the consent of the participants, the foster care workers organised the interviews. All interviews were audiotaped with the consent of the informants.

4.2.4. DATA ANALYSIS

The interviews were transcribed from the audio recordings in Chinese. The transcripts for each informant category were read and coded by one researcher. The common themes of the same informant categories were identified after several rounds of coding. Then, the results of different informant categories were compared to identify the common themes, if any. The final coding decisions were made by consensus of the research team. The reliability of the data was ensured by the expert review, audit trails and self-reflexivity of the researchers. For the expert review, the researchers consulted independent experts including scholars and child welfare practitioners to improve the research process and outcomes. For the audit trails, we recorded the changes in the research process that allowed others to follow and critique the research process. Self-reflectivity on the part of the researchers was ensured to minimize their views and prevent their own perspectives from unduly colouring the perspectives of the informants.

5. ETHICAL ISSUES

Ethical approval was sought from the University's Institutional Review Board. All respondents joined the study voluntarily. A general consent form with a brief introduction to the study was signed by the family caregivers or guardians of the foster children before the study began (Appendix VI). A set of consent forms was also prepared for the interviewed informants (Appendix VII and VIII). Although the survey respondents were anonymous, the personal information of the informants who participated in-depth interviews was kept confidential. All identifiable information was deleted or altered when the report was written.

PART III QUANTITATIVE RESULTS

Foster children aged 3 to 18 who were currently living in a foster home were screened for the research study. As of 30th September 2017, there were 188 children and adolescents served by HKFWS who were eligible under the sampling criteria. A total of 117 questionnaires were collected, with a response rate of 62.2%.

1. Descriptive Analysis

1.1. DEMOGRAPHIC CHARACTERISTICS OF THE CASES

The tables below show the demographic characteristics of all cases. Please note that in these tables, the total number of cases was 117. However, due to missing values, some analyses involved fewer than 117 cases.

1.1.1. Age and duration of placement

In Table 1, among the completed cases for all ages (N = 117), the mean age was 7.7 and the standard deviation was 3.6. The average total duration of the placements of the children in months was 75.8 and the standard deviation was 47.9. For children below 6 (N = 37), the mean age was 4.1 with a standard deviation of 0.9. The average total duration of the children's placement in months was 55.6 and the standard deviation was 19.8. The total number of cases in the group aged 6-18 was 80, with the mean age being 9.4 and the standard deviation 3.1. The average total duration of the children's placement in months was 85.2 and the standard deviation was 53.9.

Table 1 Age and Duration of Placement

	All ages (3-18) (N=117)		below 6 years old (N=37)		6-18 years old (N=80)	
	M	SD	M	SD	M	SD
Age	7.7	3.6	4.1	0.9	9.4	3.1
Duration of placement (months)	75.8	47.9	55.6	19.8	85.2	53.9

M = Mean; SD = Standard deviation

1.1.2. Gender

There was a total of 51 boys (43.6%) and 66 girls (56.4%). For children aged below 6 and 6-18, the profiles are similar. In Table 2, out of 51 males, 15 (29.4%) were aged below 6, and 36 (70.6%) were 6-18. Out of 66 females, 22 (33.3%) were aged below 6, and 44 (66.6%) were aged 6-18.

Table 2 Gender

	All ages (3-18)		below 6 years old		6-18 years old	
	n	%	n	%	n	%
Male	51	43.6	15	40.5	36	45.0
Female	66	56.4	22	59.5	44	55.0
Total	117	100	37	100	80	100

n = number of respondents

1.1.3. Participation of Extracurricular activities (ECA) in the past 6 months

Of the children of all ages, 41.2% had participated in some ECA during the past 6 months, whereas 58.8% had not. In Table 3, out of the 47 children who had participated in ECA during the past 6 months, 4 (8.5%) were aged below 6 and 43 (91.5%) were 6-18. Out of the 67 children who did not participate in ECA during the past 6 months, 31 (49.3%) were aged below 6 and 36 (53.7%) were aged 6-18.

Table 3 Participation of ECA in the past 6 months

	All ages (3-18)		below 6 years old		6-18 years old	
	n	%	n	%	n	%
Yes	47	41.2	4	11.4	43	54.4
No	67	58.8	31	88.6	36	45.6
Total	114	100	35	100	79	100

1.1.4. Sorts of Extra-curricular Activities (ECA)

Among the 47 foster children who had participated in ECA during the past 6 months, the most frequent sort of ECA over the past 6 months was arts (40%), followed by sports (29%). There was no difference in the sorts of ECA between children aged below 6 (total 4 foster children) and children aged 6-18 (total 43 foster children) (Table 4). Some foster children had attended more than one ECA.

Table 4 Sorts of the ECA (N=47)

	All ages (3-18) (N=47)		Below 6 years old (N = 4)		6-18 years old (N=43)	
	f	%	f	%	f	%
Academic	6	10.0	0	0.0	6	10.0
Sports	18	29.0	2	50.0	16	28.0
Service	4	7.0	0	0.0	4	7.0
Entertainment	7	11.0	0	0.0	7	12.0
Arts	25	40.0	2	50.0	23	40.0
Others	2	3.0	0	0.0	2	3.0
Total	62	100	4	100	58	100

f = frequency

1.1.5. Main caregiver

As shown in Table 5, most children were primarily cared for by their biological mother, followed by their biological father and their maternal grandmother. The involvement in child care of maternal grandparents seemed to be greater than that of paternal grandparents.

Table 5 Main Caregiver

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
Father	19	16.5	5	13.5	14	17.9
Mother	51	44.3	19	51.4	32	41.0
Paternal Grandmother	6	5.2	1	2.7	5	6.4
Maternal Grandfather	1	0.9	1	2.7	0	0.0
Maternal Grandmother	15	13.0	5	13.5	10	12.8
Relatives	11	9.6	2	5.4	9	11.5
Others	12	10.4	4	10.8	8	10.3
Total	115	100	37	100	78	100

** The sum of individual items may not add up to the total because of rounding.*

1.1.6. DSW ward's cases (Ward cases)

Among the 117 foster children, 13 were under the Wardship of the Director of Social Welfare (11.1%), with 5 below 6 years old and 8 from the 6-18 years old group (Table 6).

Table 6 DSW ward's cases (Ward cases)

	All ages (3-18)		Below 6years old		6-18 years old	
	n	%	n	%	n	%
Yes	13	11.1	5	13.5	8	10.0
No	104	88.9	32	86.5	72	90.0
Total	117	100	37	100	80	100

1.1.7. Number of biological parents having substance abuse problem

There were 51 responses on the substance abuse problem. Among these 51 responses, a total of 18 (35.3%) children's biological parents had a substance abuse problem. 6 (11.8%) children involved one parent with a substance abuse problem while the remaining 12 (23.5%) children involved both parents. In Table 7, out of these 18 cases, 6 (33.3%) were from children below 6 years old and 12 (66.7%) were from children aged 6-18 years old.

Table 7 Number of biological parents having substance abuse problem

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
none	33	64.7	14	70.0	19	61.3
one parent	6	11.8	3	15.0	3	9.7
two parents	12	23.5	3	15.0	9	29.0
Total	51	100	20	100	31	100

1.1.8. Number of biological parents having criminal record

Similar to the situation with substance abuse, there were only 48 responses collected involving parents with criminal record. Out of these 48 cases, 19 (39.6%) children had a biological parent with a criminal record. 10 (20.8%) children had one parent with a criminal record and 9 (18.8%) children had both parents with a criminal record. In Table 8, out of these 19 cases, 8 (42.1%) were from children below 6 years old and 11 (57.9%) were from children aged 6-18 years old.

Table 8 Number of biological parents having criminal record

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
none	29	60.4	11	57.9	18	62.1
one parent	10	20.8	5	26.3	5	17.2
two parents	9	18.8	3	15.8	6	20.7
Total	48	100	19	100	29	100

1.1.9. Number of times the children used the residential service (including the foster care service)

Among the children, 35 (30.2%) of them had used the residential service once, 60 (51.7%) had used it twice and 21 (18.1%) had used it three times. Most of the foster children had used the service twice. In Table 9, out of the 60 cases who used the service twice, 24 (40%) were children aged below 6 years old and 36 (60%) were children aged 6-18 years old.

Table 9 Times of using residential services (including the foster care service)

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
1 time	35	30.2	7	19.4	28	35.0
2 times	60	51.7	24	66.7	36	45.0
3 times	21	18.1	5	13.9	16	20.0
Total	116	100	36	100	80	100

1.1.10. Number of child abuse cases

Most of the cases (87.9%) were non-child abuse cases. Fourteen (12.1%) foster children had been abused. In Table 10, out of those 14 cases, 8 (57.1%) were from the younger group (children aged below 6 years old) and 6 (42.9%) were from the older group (children aged 6-18 years old).

Table 10 Number of child abuse cases

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
Yes	14	12.1	8	21.6	6	7.6
No	102	87.9	29	78.4	73	92.4
Total	116	100	37	100	79	100

1.1.11. Frequency of abuse

Among the 14 child abuse cases, 13 (92.9%) children had been abused once. Eight of them were aged below 6 years old and 5 of the children were 6-18 years old. There was 1 foster child from the group of 6-18 years old who had been abused twice (Table 11).

Table 11 Frequency of abuse

	All ages (3-18)		Below 6 years old		6-18 years old	
	f	%	f	%	f	%
1 time	13	92.9	8	100	5	83.3
2 times	1	7.1	0	0.0	1	16.7
Total	14	100	8	100	6	100

1.1.12. Types of child abuse of current cases

As shown in Table 12, of all the abuse cases (N = 14), 7 (50%) were child neglect cases, 5 (35.7%) were physical abuse cases, and 2 (14.3%) were sexual abuse cases. In the case of children aged below 6 years old, there were more neglect cases than physical abuse ones. The profile was different for those in the 6-18 years old group as the number of physical child abuse cases in this group was greater.

Table 12 Types of child abuse in current cases

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
Physical	5	35.7	2	25.0	3	50.0
Child Neglect	7	50.0	5	62.5	2	33.3
Sexual	2	14.3	1	12.5	1	16.7
Total	14	100	8	100	6	100

1.1.13. Main reason for using the foster care service

Most families used the foster care service primarily because one or both parents had dysfunctional parenting behaviour (21.4%). Others used it because one or both parents had mental problems (17.9%) or emotional problems (7.7%).

Table 13 Main reason for using the foster care service

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
Child's behavioral problem	1	0.9	0	0.0	1	1.3
Child's physical problem	1	0.9	0	0.0	1	1.3
Child abused by non-parents	1	0.9	1	2.7	0	0.0
Child's intellectual problems	1	0.9	0	0.0	1	1.3
Long absence of one or both parents form HK	2	1.7	0	0.0	2	2.5
Divorced parents	4	3.4	1	2.7	3	3.8
Parents with substance abuse problem	8	6.8	4	10.8	4	5.0
Parents with emotional problems	9	7.7	3	8.1	6	7.5
Parents with health problems	5	4.3	2	5.4	3	3.8
Parents are incarcerated	8	6.8	2	5.4	6	7.5
Parents having dysfunctional parenting behavior	25	21.4	6	16.2	19	23.8
Parents having long working hours	4	3.4	2	5.4	2	2.5
Parents with mental problems	21	17.9	6	16.2	15	18.8
Death of one or both parents	2	1.7	1	2.7	1	1.3
Parents with personality disorder	1	0.9	1	2.7	0	0.0
Child abuse by parents	3	2.6	1	2.7	2	2.5
Parents with marital problems	4	3.4	1	2.7	3	3.8
Single parent	3	2.6	1	2.7	2	2.5
parents with financial problems	1	0.9	0	0.0	1	1.3
Other problems*	13	11.1	5	13.5	8	10.0
Total	117	100	37	100	80	100

**Other problems of the parents include inadequate parenting (N=6), inadequate parenting/care (N=1), improper care (N=1), under consideration of relinquishing guardianship (N=1), and imprisonment of biological mother (N=1), lost contact with parents (N=1), parents' abuse of children's siblings (N=1) and Unknown problem (N=1)*

1.1.14. Frequency of returning home for a short-stay (home leave) in the past 6 months

As shown in Table 14, of all the children, 24 children (20.7%) had never returned home, 32 children had returned home once a week (27.6%) and 36 children had returned home twice a week (31.0%) during the past 6 months of the study. The profiles of the younger group (children aged below 6 years old) and the older group (children aged 6-18) were similar.

Table 14 Frequency of returning home for a short-stay in the past 6 months

	All ages (3-18)		3-5½ years old		6-18 years old	
	n	%	n	%	n	%
None	24	20.7	8	21.6	16	20.3
Once a week	32	27.6	8	21.6	24	30.4
Twice a week	36	31.0	14	37.8	22	27.8
Once a month	10	8.6	3	8.1	7	8.9
Twice a month	5	4.3	1	2.7	4	5.1
Others*	9	7.8	3	8.1	6	7.6
Total	116	100	37	100	80	100

** Others include 3 times per month (N=1); once in 3 months (N=3), and no fixed frequency (N=5).*

1.1.15. Main reason for using the foster care service (for families not using but needing the mental health service)

There were 21 families who did not use a mental health service but were in fact in need of support. As shown in Table 15, among these 21 families, most used the foster care service primarily because one or both parents had dysfunctional parenting behaviour (19.0%), mental problems (19.0%) or emotional problems (19.0%). Out of the 21 families, 5 (23.8%) were from the younger group (children below 6 years old) and 16 (76.2%) were from the older group (children aged 6-18 years old).

Table 15 Main reason for using the foster care service (for families not using but needing the mental health service)

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
Child's behavioural problems	1	4.8	0	0.0	1	6.3
child abused by non-parents	1	4.8	1	20.0	0	0.0
one or both parents have emotional problems	4	19.0	1	20.0	3	18.8
one or both parents have health problems	2	9.5	1	20.0	1	6.3
One or both parents are incarcerated	2	9.5	1	20.0	1	6.3
one or both parents have dysfunctional parenting behaviour	4	19.0	0	0.0	4	25.0
one or both parents have mental problems	4	19.0	1	20.0	3	18.8
Child abuse by parents	1	4.8	0	0.0	1	6.3
Single parent	1	4.8	0	0.0	1	6.3
other problems*	1	4.8	0	0.0	1	6.3
Total	21	100	5	100	16	100

**Other problem of the parents includes inadequate parenting (N=1).*

1.2. MENTAL HEALTH ISSUES

1.2.1. Presence of diagnosis

Among all the children in the sample used in the study, 47 were found to have mental problems or emotional problems (40.2%). Those with problems were found to have formal diagnosis assessment. As shown in Table 16, out of 47 children, 9 were aged below 6 (19.1%) and 38 children were 6-18 years old (80.9%). According to the Chi-square test, there is a statistically significant association between the children’s age group and the presence of a diagnosis (X2(1) = 5.65, p=0.017), indicating the older children (6-18 years old) were more likely to have a diagnosis than the younger children (aged below 6).

Table 16 Presence of diagnosis

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
Yes	47	40.2	9	24.3	38	47.5
No	70	59.8	28	75.7	42	52.5
Total	117	100	37	100	80	100

1.2.2. Types of diagnosis

As shown in Table 17, most of the children who have a diagnosis were diagnosed with attention deficit hyperactivity disorder (ADHD) (17.1%), followed by intellectual disabilities (15.4%) and specific learning disabilities (8.5%).

Regarding the children aged below 6, the diagnosis included intellectual disability (8.1%), speech and language delay (5.4%), speech sound disorder (2.7%) and other diagnoses (13.5%).

Among the children 6-18 years old, most of the children's diagnoses included ADHD (25.0%), autism spectrum disorder (ASD) (5.0%), specific learning disabilities (12.5%), intellectual disability (18.8%), speech and language delay (5.0%), childhood-onset fluency disorder (stuttering; 2.5%) and other diagnoses (3.8%).

Table 17 Types of diagnosis for children

Types of diagnosis		All ages (3-18) (N=117)		Below 6 years old (N=37)		6-18 years old (N=80)	
		n	%	n	%	n	%
ADHD	Yes	20	17.1	0	0	20	25.0
ASD	Yes	4	3.4	0	0	4	5.0
Specific Leaning disabilities	Yes	10	8.5	0	0	10	12.5
Intellectual disabilities	Yes	18	15.4	3	8.1	15	18.8
Speech and language delay	Yes	6	5.1	2	5.4	4	5.0
Speech sound disorder	Yes	1	0.9	1	2.7	0	0
Childhood-onset fluency disorder (stuttering)	Yes	2	1.7	0	0	2	2.5
Others*	Yes	8*#	6.8	5*#	13.5	3*	3.8

**Other diagnoses include limited intelligence (N=1), gross and fine motor and visual perceptual difficulties (N=1), developmental delay (N=2), global delay (N=2) and speech delay (N=3).*
 # One child had two diagnoses.

1.2.3. Number of Children within the clinical range of the CBCL scores

In Table 18, among the children in the study, 23 were found to be within the clinical range of the CBCL total scores (23.5%). Out of these 23 children, 9 were aged below 6 (39.1%) and 14 children were aged 6-18 (60.9%). According to the Chi-square test, there is no statistically significant association between children's age group and the CBCL total score categories (clinical vs normal) (X2(1) = 0.261, p = 0.609), indicating both groups of children were equally likely to be found within the clinical range of the CBCL total scores.

As shown in Table 19, among the children in the study, 20 were found to be within the clinical range of the CBCL internal scores (18.3%). Out of these 20 children, 10 were aged below 6 (50%) and 10 children were aged 6-18 (50%). According to the Chi-square test, there is a statistically significant association between the children's age group and the CBCL internal score categories (clinical vs normal) (X2(1) = 4.04, p = 0.045), indicating the younger children (below 6 years old) were more likely to be found within the clinical range of the CBCL internal scores than the older children (aged 6-18 years old).

As shown in Table 20, among the children in the study, 31 were found to be within the clinical range of the CBCL external scores (29.0%). Out of these 31 children, 8 children were aged below 6 (25.8%) and 23 children were aged 6-18 (74.2%). According to the Chi-square test, there is no statistically significant association between children's age group and the CBCL external score categories (clinical vs normal) (X2(1) = 0.717, p = 0.397), indicating both these groups of children were equally likely to be found within the clinical range of the CBCL external scores.

Table 18 CBCL total scores

CBCL Internal Scores	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
Normal	75	76.5	25	73.5	50	78.1
Clinical	23	23.5	9	26.5	14	21.9
Total	98	100	34	100	64	100

Table 19 CBCL internal scores

CBCL External Scores	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
Normal	89	81.7	24	70.6	65	86.7
Clinical	20	18.3	10	29.4	10	13.4
Total	109	100	34	100	75	100

Table 20 CBCL external scores

CBCL Total Scores	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
Normal	76	71.0	26	76.5	50	68.5
Clinical	31	29.0	8	23.5	23	31.5
Total	107	100	34	100	73	100

1.2.4. Presence of diagnosis among children within the clinical range of the CBCL

As shown in Table 21, among the 23 children who fell within the clinical range of the CBCL total scores, 14 of them reported having a diagnosis (60.9%). Out of the 14 children, 2 were aged below 6 (14.3%) and 12 were aged 6-18 (85.7%).

Table 22 shows that among the 20 children who fell within the clinical range of the CBCL internal scores, 9 children reported having a diagnosis (45%). Out of those 9 children, 3 were aged below 6 (33.3%) and 6 were aged 6-18 (66.7%).

Table 23, among the 31 children who fell within the clinical range of CBCL internal scores, there were 19 children reported to have a diagnosis (61.3%). Out of the 19 children, 1 were aged below 6 (5.3%) and 18 were aged 6-18 (94.7%).

More older children who fell in the clinical spectrum had a diagnosis.

Table 21 Presence of a diagnosis among children within the clinical range of the CBCL total scores

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
Yes	14	60.9	2	22.2	12	85.7
No	9	39.1	7	77.8	2	14.3
Total	23	100	9	100	14	100

Table 22 Presence of a diagnosis among children within the clinical range of the CBCL internal scores

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
Yes	9	45.0	3	30.0	6	60.0
No	11	55.0	7	70.0	4	40.0
Total:	20	100	10	100	10	100

Table 23 Presence of a diagnosis among children within the clinical range of the CBCL external scores

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
Yes	19	61.3	1	12.5	18	78.3
No	12	38.7	7	87.5	5	21.7
Total	31	100	8	100	23	100

1.3. MENTAL HEALTH SERVICE USE

1.3.1. Foster children currently using mental health services

Among the 115 respondents, 58 children were currently using the mental health services (50.4%). Out of those 58 children, 19 were aged below 6 (32.8%) and 39 were aged 6-18 (67.2%) (Table 24). According to the Chi-square test, there is no statistically significant association between the children's age group and the mental health service use (X2(1) = 0.115, p = 0.734), indicating both groups of children were equally likely to be currently using mental health services.

Table 24 Number of children currently using the mental health services

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
Yes	58	50.4	19	52.8	39	49.4
No	57	49.6	17	47.2	40	50.6
Total	115	100	36	100	79	100

Among the 58 children currently using mental health services, 31 of them (53.4%) were using 1 type of mental health service. Eight children were using 3 or more types of services (13.8%). Three of the children were aged below 6 and 5 of them were aged 6-18 (Table 25).

Table 25 Number of service types currently used by the children

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
One service	31	53.4	10	52.6	21	53.8
Two services	19	32.8	6	31.6	13	33.3
Three services	3	5.2	0	0	3	7.7
Four services	3	5.2	3	15.8	0	0
Five services	2	3.4	0	0	2	5.1
Total	58	100	19	100	39	51.2

Although there were only 58 foster children using mental health services, some children used more than 1 service, resulting in the sum of frequencies for all type of services being 100 (Table 26). As shown in Table 26, currently, the most frequently used service was speech therapy (18.0%), followed by psychiatric medication (13.0%) and support groups for children with learning disabilities (12.0%). There were slight differences between foster children in the younger group (aged below 6) and the older group (aged 6-18). The younger children mostly used speech therapy and the kindergarten-cum-child care centre, while the older group mostly used psychiatric medication and the support groups for children with learning disabilities.

Table 26 Types of services currently used

	All ages (3-18) (N = 58)		Below 6 years old (N = 19)		6-18 years old (N = 39)	
	n	%	n	%	n	%
Mental Health Services						
Psychiatric medication	13	13.0	0	0	13	19.7
Psychiatric assessment services	6	6.0	0	0	6	9.1
Clinical psychological services	4	4.0	0	0	4	6.1
Supporting Services						
Child assessment centre	4	4.0	2	5.9	2	3.0
Early education and training centre	3	3.0	1	2.9	2	3.0
Kindergarten-cum-child care centre	8	8.0	7	20.6	1	1.5
Special child care centre	3	3.0	1	2.9	2	3.0
Speech therapy	18	18.0	8	23.5	10	15.2
Occupational therapy	5	5.0	3	8.8	2	3.0
Physiotherapy	4	4.0	3	8.8	1	1.5
Educational psychological services	1	1.0	1	2.9	0	0
Child case counselling (e.g. play therapy)	1	1.0	1	2.9	0	0
Child group counselling (e.g. social skill training)	4	4.0	3	8.8	1	1.5
Child support groups for learning disabilities	12	12.0	0	0	12	18.2
Family counselling	10	10.0	4	11.8	6	9.1
Others*	4	4.0	0	0	4	6.1

** Other services include special schools (N = 4).*

Regarding the duration of service usage, most foster children received services for 1-10 months and over 31 months (Table 27). For foster children aged below 6, the duration of service usage was mainly 1-10 months (Table 28). For foster children aged 6-18, the duration of service usage was mainly over 31 months (Table 29).

Table 27 Duration of the service usage (All ages) (N = 58)

	1 – 10 months	11– 20 months	21- 30 months	Over 31 months
Mental Health Services				
Psychiatric medication	1	2	2	8
Psychiatric assessment services	3	0	2	0
Clinical psychological services	0	1	1	2
Supporting Services				
Child assessment centre	0	0	0	1
Early education and training centre	1	1	0	1
Kindergarten-cum-child care centre	3	4	1	0
Special child care centre	2	0	1	0
Speech therapy	4	5	1	8
Occupational therapy	1	1	1	0
Physiotherapy	2	0	0	1
Educational psychological services	0	1	0	0
Child case counselling (e.g. play therapy)	1	0	0	0
Child group counselling (e.g. social skill training)	4	0	0	0
Child support groups for learning disabilities	3	3	2	4
Family counselling	0	0	0	0
Others*	1	1	0	2
Total	26	19	11	27

** Other used services include special schools (N=4).*

Table 28 Duration of the service usage (children aged below 6) (N = 19)

	1 – 10 months	11– 20 months	21- 30 months	Over 31 months
Mental Health Services				
Psychiatric medication	0	0	0	0
Psychiatric assessment services	0	0	0	0
Clinical psychological services	0	0	0	0
Supporting Services				
Child assessment centre	0	0	0	0
Early education and training centre	0	0	0	1
Kindergarten-cum-child care centre	3	4	0	0
Special child care centre	1	0	0	0
Speech therapy	4	3	1	0
Occupational therapy	1	0	1	0
Physiotherapy	2	0	0	0
Educational psychological services	0	1	0	0
Child case counselling (e.g. play therapy)	1	0	0	0
Child group counselling (e.g. social skill training)	3	0	0	0
Child support groups for learning disabilities	0	0	0	0
Family counselling	0	0	0	0
Others	0	0	0	0
Total	15	8	2	1

Table 29 Duration of the service usage (children aged 6-18) (N = 39)

	1 – 10 months	11– 20 months	21- 30 months	Over 31 months
Mental Health Services				
Psychiatric medication	1	2	2	8
Psychiatric assessment services	3	0	2	0
Clinical psychological services	0	1	1	2
Supporting Services				
Child assessment centre	0	0	0	1
Early education and training centre	1	1	0	0
Kindergarten-cum-child care centre	0	0	1	0
Special child care centre	1	0	1	0
Speech therapy	0	2	0	8
Occupational therapy	0	1	0	0
Physiotherapy	0	0	0	1
Educational psychological services	0	0	0	0
Child case counselling (e.g. play therapy)	0	0	0	0
Child group counselling (e.g. social skill training)	1	0	0	0
Child support groups for learning disabilities	3	3	2	4
Family counselling	0	0	0	0
Others	1	1	0	2
Total	11	11	9	26

** Other used services include special schools (N=4).*

1.3.2. Foster children waiting for mental health services

Based on social workers' reports, 17 children were waiting for the mental health services (14.9%), including 9 children aged below 6 and 8 aged 6-18. Among the 17 children, 12 of them had a diagnosis, with 5 were below 6 years old (41.7%) and 7 were 6-18 years old (58.3%). Five children waiting for mental health services were without a diagnosis. Five out of the 17 foster children waiting for mental health services did not have a diagnosis. Among the 5 children without diagnosis but waiting for services, four of them were aged below 6 (80%) while 1 was in the 6-18 years old group (20%) (Table 30).

Table 30 Number of children with or without a diagnosis waiting for services (N = 17)

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
With a diagnosis	12	70.6	5	55.6	7	87.5
Without a diagnosis	5	29.4	4	44.4	1	12.5
Total	17	100	9	100	8	100

The 17 children were waiting for 10 different types of services. Some of them were waiting for more than 1 service, leading to a total of 27 awaited services among the 17 foster children. The services most in need were the educational psychological service (35.3%), the psychiatric assessment service (29.4%) and the child assessment centre (23.5%) (Table 31).

Out of the 17 children, 9 were below 6 and they were more in need of the services of the child assessment centre (27.3) and the Kindergarten-cum-child care centre (27.3). Out of the 17 children, 8 children aged 6-18 and they were more in need of the services of the educational psychological service (62.5%), followed by the psychiatric assessment services (40%) and psychiatric medication (25%).

Table 31 Types of services the children are waiting for (N = 17)

	All ages (3-18) (N = 17)		Below 6 years old (N = 9)		6-18 years old (N = 8)	
	f	%	f	%	f	%
Mental Health Services						
Psychiatric medication	2	11.8	0	0.0	2	25.0
Psychiatric assessment services	5	29.4%	1	11.1	4	50.0
Clinical psychological services	1	5.9	0	0.0	1	12.5
Supporting Services						
Child assessment centre	4	23.5	3	27.3	1	12.5
Early education and training centre	1	5.9	1	11.1	0	0.0
Kindergarten-cum-child care centre	3	17.6	3	27.3	0	0.0
Special child care centre	0	0.0	0	0.0	0	0.0
Speech therapy	1	5.9	1	11.1	0	0.0
Occupational therapy	2	11.8	1	11.1	1	12.5
Physiotherapy	0	0.0	0	0.0	0	0.0
Educational psychological services	6	35.3	1	11.1	5	62.5
Child case counselling (e.g. play therapy)	0	0.0	0	0.0	0	0.0
Child group counselling (e.g. social skill training)	0	0.0	0	0.0	0	0.0
Child support groups for learning disabilities	0	0.0	0	0.0	0	0.0
Family counselling	0	0.0	0	0.0	0	0.0
Others*	2*	11.8	2*	22.2	0	0.0

** Other services include otolaryngologist (N=2).*

1.3.3. Foster children needing a service but it was not available

Among the children in the study, 21 children (18.4%) needed a service but the service was not available. Out of the 21 children, 5 were aged below 6 (23.8%) and 16 were 6-18 years old (76.2%) (Table 32).

Table 32 Number of children needing a service that is not available

	All ages (3-18)		Below 6 years old		6-18 years old	
	n	%	n	%	n	%
Yes	21	18.4%	5	13.5%	16	20.8%
No	93	81.6%	32	86.5%	61	79.2%
Total	114	100.0%	37	100.0%	77	100.0%

The most needed but unavailable services for children aged below 6 were speech therapy, early education and the training centre and parent-child groups (e.g. parent-child parallel groups, multi- family groups). For children aged 6-18, group counselling (social skill training group), parent-child groups (e.g. parent-child parallel groups, multi-family groups) and child case counselling (e.g. play therapy) were in need but not available. (Table 33)

Table 33 Types of services needed but not available

	All ages (3-18) (N = 21)		Below 6 years old (N = 5)		6-18 years old (N = 16)	
	f	%	f	%	f	%
Mental Health Services						
Psychiatric medication	1	4.8	0	0	1	6.3
Psychiatric assessment services	4	19.0	1	20.0	3	18.8
Clinical psychological services	0	0.0	0	0.0	0	0.0
Supporting Services						
Child assessment centre	1	4.8	1	20.0	0	0.0
Early education and training centre	2	9.5	2	40.0	0	0.0
Kindergarten-cum-child care centre	0	0.0	0	0.0	0	0.0
Special child care centre	0	0.0	0	0.0	0	0.0
Speech therapy	7	33.3	5	100.0	2	12.5
Occupational therapy	0	0.0	0	0.0	0	0.0
Physiotherapy	0	0.0	0	0.0	0	0.0
Educational psychological services	3	14.3	0	0.0	3	18.8
Child case counselling (e.g. play therapy)	5	23.8	1	20.0	4	25.0
Child group counselling (e.g. social skill training)	10	47.6	1	20.0	9	56.3
Child support groups for learning disabilities	3	14.3	0	0.0	3	18.8
Family counselling	0	0.0	0	0.0	0	0.0
Sensory integration therapy	1	4.8	0	0.0	1	6.3
Parent-child groups (e.g. parent-child parallel groups, multi-family groups)	7	33.3	2	40.0	5	31.3
Others*	1*	4.8	0	0.0	1*	6.3

** Other needed services include special schools or schools for social development (N=1).*

As shown in Table 34, most children must wait for over 11 months from the time they confirmed they needed the service. The services the children waited most for were group counselling for children (social skill training group), parent-child groups (e.g. parent-child parallel groups, multi- family groups), speech therapy and child case counselling.

Table 34 Length of wait for the service from the time they confirmed they needed this service

	1 – 5 months		6 – 10 months		Over 11 months	
	Below 6 years old (n=5)	6-18 years old (n=16)	Below 6 years old (n=5)	6-18 years old (n=16)	Below 6 years old (n=5)	6-18 years old (n=16)
	f	%	f	%	f	%
Mental Health Services						
Psychiatric medication	0	1	0	0	0	0
Psychiatric assessment services	1	0	0	1	0	2
Clinical psychological services	0	0	0	0	0	0
Supporting Services						
Child assessment centre	0	0	0	0	0	0
Early education and training centre	1	0	0	0	0	0
Kindergarten-cum-child care centre	0	0	0	0	0	0
Special child care centre	0	0	0	0	0	0
Speech therapy	0	1	1	0	0	1
Occupational therapy	0	0	0	0	0	0
Physiotherapy	0	0	0	0	0	0
Educational psychological services	0	0	0	2	0	1
Child case counselling (e.g. play therapy)	0	0	1	1	0	3
Child group counselling (e.g. social skill training)	0	2	1	0	0	7
Child support groups for learning disabilities	0	1	0	0	0	2
Family counselling	0	0	0	0	0	0
Sensory integration therapy	0	1	0	0	0	0
Parent-child groups (e.g. parent-child parallel groups, multi-family groups)	0	0	0	1	2	5
Others*	0	0	0	0	0	1

** Other needed services include special schools or a school for social development (N=1).*

1.3.4. Types of services used by children without a diagnosis

For the children without any diagnosis, the most frequently used services included speech therapy (31.3%), followed by family counselling (25.0%) and the kindergarten-cum-child care centre (18.80%) (Table 35).

Table 35 Types of services used by children without a diagnosis

	All ages (3-18) (N = 16)		Below 6 years old (N = 10)		6-18 years old (N = 6)	
	f	%	f	%	f	%
Mental Health Services						
Psychiatric medication	0	0.0	0	0.0	0	0.0
Psychiatric assessment services	0	0.0	0	0.0	0	0.0
Clinical psychological services	2	12.5	0	0.0	2	33.3
Supporting Services						
Child assessment centre	0	0.0	0	0.0	0	0.0
Early education and training centre	0	0.0	0	0.0	0	0.0
Kindergarten-cum-child care centre	3	18.8	3	30.0	0	0
Special child care centre	0	0.0	0	0.0	0	0.0
Speech therapy	5	31.3	3	30.0	2	33.3
Occupational therapy	2	12.5	2	20.0	0	0
Physiotherapy	2	12.5	2	20.0	0	0
Educational psychological services	0	0.0	0	0.0	0	0.0
Child case counselling (e.g. play therapy)	0	0.0	0	0.0	0	0.0
Child group counselling (e.g. social skill training)	1	6.3	1	10.0	0	0
Child support groups for learning disabilities	0	0.0	0	0.0	0	0.0
Family counselling	4	25.0	2	20.0	2	33.3
Others	0	0.0	0	0.0	0	0.0

1.3.5. Types of services used by children with a diagnosis

As shown in Table 36 the two most frequently used services for children who were aged below 6 and had a diagnosis were speech therapy (55.6%) and kindergarten-cum-child care centre (44.4%). For children aged 6-18 having a diagnosis, the two most frequently used services were psychiatric medication (39.4%) and child support groups for learning disabilities (36.4%).

Table 36 Types of services used by children with a diagnosis

	All ages (3-18) (N = 42)		Below 6 years old (N = 9)		6-18 years old (N = 33)	
	f	%	f	%	f	%
Mental Health Services						
Psychiatric medication	13	31.0	0	0.0	13	39.4
Psychiatric assessment services	6	14.3	0	0.0	6	18.2
Clinical psychological services	2	4.8	0	0.0	2	6.1
Supporting Services						
Child assessment centre	4	9.5	2	22.2	2	6.1
Early education and training centre	2	4.8	0	0.0	2	6.1
Kindergarten-cum-child care centre	5	11.9	4	44.4	1	3.0
Special child care centre	3	7.1	1	11.1	2	6.1
Speech therapy	13	31.0	5	55.6	8	24.2
Occupational therapy	3	7.1	1	11.1	2	6.1
Physiotherapy	2	4.8	1	11.1	1	3.0
Educational psychological services	1	2.4	1	11.1	0	0.0
Child case counselling (e.g. play therapy)	1	2.4	1	11.1	0	0.0
Child group counselling (e.g. social skill training)	3	7.1	2	22.2	1	3.0
Child support groups for learning disabilities	12	28.6	0	0.0	12	36.4
Family counselling	6	14.3	2	22.2	4	12.1
Sensory integration therapy	0	0.0	0	0.0	0	0.0
Parent-child groups (e.g. parent-child parallel groups, multi-family groups)	0	0.0	0	0.0	0	0.0
Others*	4	5.0	0	0	4	6.7

** Other used services include special schools (N=4).*

1.3.6. Usage of mental health services by children within the clinical range of the CBCL total scores

Among all children in the study, there were 23 who fell within the clinical range of the CBCL total scores. As the data for the service use of three children who fell within the clinical range of the CBCL total scores were missing, the total sample used for analysis as shown in Table 37 and Table 38 was 20 children.

Out of these 20 children, 16 were users of mental health services (80%) and 13 had a diagnosis (65%) (Table 37).

Table 37 Number of children within the clinical range of the CBCL total scores using mental health services

		All ages (3-18 years old)		Below 6 years old		6-18 years old	
		n	%	n	%	n	%
In the absence of diagnosis	Received services	3	15.0	3	42.8	0	0.0
	Have Not receive services	4	20.0	2	28.6	2	13.4
In the presence of diagnosis	Received services	13	65.0	2	28.6	11	84.6
	Have Not receive services	0	0.0	0	0.0	0	0.0
		20	100.0	7	100.0	13	100.0

Of the 16 children who received services, 5 were aged below 6 and 11 were aged 6-18. The two services most frequently used by children below 6 years old were speech therapy (28.6%) and occupational therapy (28.6%). The two services most frequently used by children aged 6-18 were psychiatric medication (38.5%) and the psychiatric assessment services (30.8%) (Table 38).

Table 38 Types of services currently used by children within the clinical range of the CBCL total scores

	All ages (3-18) (N = 16)		Below 6 years old (N = 5)		6-18 years old (N = 11)	
	f	%	f	%	f	%
In the presence of diagnosis						
Supporting Services						
Early education and training centre	1	6.3	1	20.0	0	0.0
Kindergarten-cum-child care centre	1	6.3	1	20.0	0	0.0
Speech therapy	2	12.5	2	40.0	0	0.0
Occupational therapy	2	12.5	2	40.0	0	0.0
Physiotherapy	1	6.3	1	20.0	0	0.0
Child group counselling (e.g. social skill training)	1	6.3	1	20.0	0	0.0
In the presence of diagnosis						
Mental Health Services						
Psychiatric medication	5	31.3	0	0.0	5	45.5
Psychiatric assessment services	4	20.0	0	0.0	4	36.4
Clinical Psychological services	1	6.3	0	0.0	1	9.1
Supporting Services						
Child assessment centre	2	12.5	1	20.0	1	9.1
Early education and training centre	1	6.3	0	0.0	1	9.1
Special child care centre	1	6.3	0	0.0	1	9.1
Speech therapy	1	6.3	0	0.0	1	9.1
Occupational therapy	1	6.3	1	20.0	0	0.0
Physiotherapy	1	6.3	1	20.0	0	0.0
Educational psychological services	1	6.3	1	20.0	0	0.0
Child case counselling (e.g. play therapy)	1	6.3	1	20.0	0	0.0
Child group counselling (e.g. social skill training)	1	6.3	0	0.0	1	9.1
Child support groups for learning	3	18.8	0	0.0	3	27.3
Family counselling	1	6.3	1	20.0	0	0.0
Others	1	6.3	0	0.0	1	9.1

** Other needed services include a special school or school for social development (N=1)*

There were 7 children within the clinical range of the CBCL external scores who needed services that were not available. Out of the 7 children, 3 of them were below 6 (42.9%) and 4 of them were aged 6-18 (57.1%). Five out of the 7 had a diagnosis (71.4%) (Table 39).

As two pieces of data pertaining to whether or not one of the children who fell within the clinical range of the CBCL total scores needed services that were not available were missing, the total sample for analysis in Table 39 was 21 children of all ages.

Table 39 Number of children within the clinical range of the CBCL total scores who needed services that were not available (N = 21)

		All ages (3-18 years old)		Below 6 years old		6-18 years old	
		n	%	n	%	n	%
In the absence of diagnosis	Have unmet service needs	2	9.5	1	12.5	1	7.7
	No unmet service needs	6	28.6	5	62.5	1	7.7
In the presence of diagnosis	Have unmet service needs	5	23.8	2	25	3	23.1
	No unmet service needs	8	38.1	0	0	8	61.5
		21	100.0	8	100.0	13	100.0

1.3.7. Usage of mental health services by children within the clinical range of the CBCL internal scores

Among all the children in the study, 20 fell within the clinical range of the CBCL internal scores. As the data for the service use of two children who fell within the clinical range of the CBCL internal scores were missing, the total sample used for analysis in Table 40 and Table 41 was 18 children.

Out of these 18 children, 10 were users of mental health services (55.6%) and 8 had a diagnosis (44.4%). Among the remaining children who did not receive services, 7 were waiting for services (87.5%).

Table 40 Number of children within the clinical range of the CBCL internal scores using mental health services (N = 18)

		All ages (3-18 years old)		Below 6 years old		6-18 years old	
		n	%	n	%	n	%
In the absence of diagnosis	Received services	2	11.1	2	22.2	0	0.0
	Did not receive services	8	44.4	4	44.4	4	44.4
In the presence of diagnosis	Received services	8	44.4	3	33.3	5	55.6
	Did not receive services	0	0.0	0	0.0	0	0.0
		18	100.0	9	100.0	9	100.0

The types of services currently used by children who fell within the clinical range of the CBCL internal scores were quite evenly distributed. A few more children received psychiatric medication (11.1%), psychiatric assessment services (11.1%) and speech therapy than received other services (11.1%) (Table 41).

Table 41 Types of services currently used by children within the clinical range of the CBCL internal scores

	All ages (3-18) (N = 18)		Below 6 years old (N = 11)		6-18 years old (N = 7)	
	f	%	f	%	f	%
In the presence of diagnosis						
Supporting Services						
Kindergarten-cum-child care centre	1	5.6	1	9.1	0	0
Speech therapy	1	5.6	1	9.1	0	0
Occupational therapy	1	5.6	1	9.1	0	0
Physiotherapy	1	5.6	1	9.1	0	0
Child group counselling (e.g. social skill training)	1	5.6	1	9.1	0	0
In the presence of diagnosis						
Mental Health Services						
Psychiatric medication	2	11.1	0	0	2	28.6
Psychiatric assessment services	2	11.1	0	0	2	28.6
Supporting Services						
Child assessment centre	1	5.6	1	9.1	0	0
Kindergarten-cum-child care centre	1	5.6	1	9.1	0	0
Speech therapy	2	11.1	1	9.1	1	14.3
Occupational therapy	1	5.6	1	9.1	0	0
Physiotherapy	1	5.6	1	9.1	0	0
Educational psychological services	1	5.6	1	9.1	0	0
Child case counselling (e.g. play therapy)	1	5.6	1	9.1	0	0
Child group counselling (e.g. social skill training)	1	5.6	0	0	1	14.3
Child support groups for learning disabilities	1	5.6	0	0	1	14.3
Family counselling	1	5.6	1	9.1	0	0

As one piece of data regarding whether a child who fell within the clinical range of CBCL internal scores needed services that were not available was missing, the total sample used for the analysis shown in Table 42 was 19 children.

Four children within the clinical range of the CBCL internal scores needed services that were not available. Out of the 4 children, 3 of them were aged below 6 (75%) and 1 of them was in the 6-18 age group (25%). Three out of 4 had a diagnosis (75%) (Table 42).

Table 42 Number of children within the clinical range of the CBCL internal scores who needed services that were not available

		All ages (3-18 years old)		Below 6 years old		6-18 years old	
		n	%	n	%	n	%
In the absence of diagnosis	Have unmet service needs	1	5.3	1	10.0	0	0.0
	No unmet service needs	10	52.6	6	60.0	4	44.4
In the presence of diagnosis	Have unmet service needs	3	15.8	2	20.0	1	11.1
	No unmet service needs	5	26.3	1	10.0	4	44.4
		19	100.0	10	100.0	9	100.0

1.3.8. Usage of mental health services by children within the clinical range of the CBCL external scores

Among all children in the study, there were 31 who fell within the clinical range of the CBCL external scores. As the data for the service usage of two children who fell within the clinical range of the CBCL external scores were missing, the total sample used for the analysis shown in Table 43 and Table 44 was 29 children.

Out of these 29 children, 20 were users of mental health services (69.0%). Among these 20 mental health service users, 17 had a diagnosis (85%) (Table 43). Of these 17 children, 16 were aged 6-18 (94.1%). Of the remaining children who did not receive services, 6 were waiting for services (66.7%).

Table 43 Number of children within the clinical range of the CBCL external scores using mental health services

		All ages (3-18 years old)		Below 6 years old		6-18 years old	
		n	%	n	%	n	%
In the absence of diagnosis	Received services	3	10.3	3	42.9	0	0
	Did not receive services	8	27.6	3	42.9	5	22.7
In the presence of diagnosis	Received services	17	58.6	1	14.3	16	72.7
	Did not receive services	1	3.4	0	0	1	4.5
		29	100.0	7	100.0	22	100.0

Among 31 foster children who were within the clinical range of the CBCL external scores, 20 indicated the types of services they had currently used. Out of these 20 children, 4 were aged below 6 and 16 were aged 6-18. The services used by children below 6 years old included the kindergarten-cum-child care centre, occupational therapy, speech therapy, the educational psychological service, and child case counselling (e.g. play therapy). The services most frequently used by children aged 6-18 included psychiatric medication (50%), child support groups for learning disabilities (37.5%) and the psychiatric assessment service (25%) (Table 44).

Table 44 Types of services currently used by children within the clinical range of the CBCL external scores

	All ages (3-18) (N = 20)		Below 6 years old (N = 4)		6-18 years old (N = 16)	
	f	%	f	%	f	%
In the presence of diagnosis						
Supporting Services						
Kindergarten-cum-child care centre	2	10.0	2	50.0	0	0.0
Speech therapy	1	5.0	1	25.0	0	0.0
Occupational therapy	1	5.0	1	25.0	0	0.0
In the presence of diagnosis						
Mental Health Services						
Psychiatric medication	8	40.0	0	0.0	8	50.0
Psychiatric assessment services	4	20.0	0	0.0	4	25.0
Clinical Psychological services	1	5.0	0	0.0	1	6.3
Supporting Services						
Child assessment centre	1	5.0	0	0.0	1	6.3
Early education and training centre	1	5.0	0	0.0	1	6.3
Special child care centre	1	5.0	0	0.0	1	6.3
Speech therapy	2	10.0	0	0.0	2	12.5
Occupational therapy	1	5.0	0	0.0	1	6.3
Physiotherapy	1	5.0	0	0.0	1	6.3
Educational psychological services	1	5.0	1	25.0	0	0.0
Child case counselling (e.g. play therapy)	1	5.0	1	25.0	0	0.0
Child group counselling (e.g. social skill training)	1	5.0	0	0.0	1	6.3
Child support groups for learning disabilities	6	30.0	0	0.0	6	37.5
Others*	1	5.0	0	0.0	1	6.3

** Other services include a special school (N=1).*

There were 7 children within the clinical range of the CBCL external scores who needed services that were not available. Out of the 7 children, 2 of them were aged below 6 (28.6%) and 5 of them were aged 6-18 (71.4%). Five out of the 7 had a diagnosis (71.4%) (Table 45).

Table 45 Number of children within the clinical range of the CBCL external scores who needed services that were not available

		All ages (3-18 years old)		Below 6 years old		6-18 years old	
		n	%	n	%	n	%
In the absence of diagnosis	Have unmet service needs	2	6.9	1	12.5	1	4.8
	No unmet service needs	9	31.0	6	75	3	14.3
In the presence of diagnosis	Have unmet service needs	5	17.2	1	12.5	4	19.0
	No unmet service needs	13	44.8	0	0.0	13	61.9
		29	100.0	8	100.0	21	100.0

2. Results of the Research Questions

2.1. RATES FOR MENTAL HEALTH ISSUES

In sum, the results of the study showed that about 40% of the children who received foster care services had at least one diagnosis under the DSM-5 classification (APA, 2013) (Table 16). ADHD (17.1%) and intellectual disabilities (15.4%) were the two most common mental health problems among these children (Table 17). Older children (aged 6-18) were found to be significantly more likely to have a diagnosis than the younger children (aged below 6).

Of the children receiving foster care services, about 23.5%, 18.3% and 29% of them fell within the clinical range of the CBCL total scores, internal scores and external scores respectively (Table 18 to 20). About 60.9%, 45% and 61.3% of those who were within the clinical range of the CBCL total scores, internal scores and external scores, also had at least one diagnosis under the DSM-5 (APA, 2013) (Table 21 to 23). Younger children (aged below 6) were found to be significantly more likely to fall within the clinical range of the CBCL internal scores than the older children (aged 6 -18).

2.2. FACTORS RELATED TO MENTAL HEALTH ISSUES

The logistic regression model for the CBCL total scores being within clinical range was statistically significant, $X^2(7)=16.092$, $p = 0.024$. The model explained 23.6% (Nagelkerke R^2) of the variance in the CBCL total scores being within clinical range and correctly classified 78.9% of the cases. Male foster children have a higher risk of falling within the clinical range of the CBCL total scores than do female foster children ($p = 0.03$). The odds of falling within the clinical range of CBCL total scores was 3.5 times greater for male foster children as opposed to female foster children. Foster children who participated in extra-curricular activities had a lower risk of falling within the clinical range of the CBCL total scores ($p = 0.04$). The odds of falling within the clinical range of the CBCL total scores was 0.25 times lower for children who participated in extra-curricular activities than those who did not participate in extra-curricular activities (Table 46).

The logistic regression model for the CBCL internal scores being within clinical range was not significant ($X^2(7) = 7.085$, $p = 0.420$.

The logistic regression model for the CBCL external scores being within clinical range was statistically significant, $X^2(7)=16.396$, $p = 0.022$. The model explained 20.9% (Nagelkerke R^2) of the variance in the CBCL total scores being within clinical range and correctly classified 72.1% of the cases. Foster children who had a better foster parent-child relationship had a lower risk of falling within the clinical range of the CBCL external scores ($p=0.02$) (Table 46).

Table 46 Results of a logistic regression of the CBCL total and external scores being within clinical range (N = 117)

	CBCL total scores being within clinical range					CBCL external scores being within clinical range				
	B	SE(B)	OR	W	*p*	B	SE(B)	OR	W	*p*
Constant	0.97	3.61	2.63	0.07	0.79	4.97	3.00	144.4	2.81	0.09
the foster child's gender (male)	1.25	0.56	3.50	5.04	0.03*	0.82	0.48	2.26	2.91	0.09
the foster child's age (6-18 years old)	0.54	0.63	1.71	0.73	0.39	1.11	0.60	3.04	3.46	0.06
pre-placement child maltreatment (yes)	1.10	0.74	3.00	2.20	0.14	1.04	0.71	2.82	2.11	0.1
foster child's participation in extra-curricular activities (yes)	-1.40	0.69	0.25	4.13	0.04*	-0.83	0.54	0.44	2.39	0.12
the foster parent-child relationship	-1.12	1.13	0.33	0.98	0.32	-2.19	0.93	0.11	5.58	0.02*
presence of a sibling in the foster family (yes)	-0.003	0.75	1.00	0.00	1.00	0.27	0.65	1.31	0.18	0.68
placement disruption (yes)	1.00	0.69	2.72	2.11	0.15	0.33	0.54	1.39	0.37	0.54

* $p<0.05$

2.3. RATES FOR MENTAL HEALTH SERVICE UTILIZATION

In sum, the results of the study showed that about 50.4% of the foster children were receiving mental health services (Table 24). The two most frequently used services were speech therapy (18%) and psychiatric mediation (13%) (Table 26). Most of the children aged below 6 had used the services for 1-10months (Table 28), while most of the children aged 6-18 had used the services for over 31 months (Table 29).

About 80%, 55.6% and 69% of foster children who had mental health needs, as indicated by the CBCL total scores, internal scores and external scores respectively, were receiving mental health services (Table 37, 40 & 43).

Regarding the younger foster children who have a mental health diagnosis, the results of the study showed that they received speech therapy (55.6%) kindergarten-cum-child care centre (44.4%) most frequently. Older foster children who have a mental health diagnosis were found to receive services such as psychiatric medication (39.4%) and child support groups for learning disabilities (36.4%) most frequently (Table 36).

2.4. FACTORS RELATED TO MENTAL HEALTH SERVICE UTILIZATION

The logistic regression model for whether a child used mental health service was statistically significant, $X^2(7)$ =23.232, p = 0.002. The model explained 25% (Nagelkerke R^2) of the variance in whether a child used mental health service and correctly classified 63.4% of the cases. Being male was associated with an increased likelihood of receiving services (p = 0.004). The odds of receiving services is 3.68 times greater for male foster children as opposed to female foster children. Foster children who participate in extra-curricular activities have a lower risk of receiving services (p = 0.003) (Table 47). The odds for receiving services was 0.23 times lower for children who participated in extra- curricular activities, compared with those who did not participate in extra-curricular activities.

Table 47 Results of a logistic regression on mental health service utilization (N=117)

	B	SE(B)	OR	W	*p*
Constant	-4.25	2.47	0.14	2.95	0.09
the foster child’s gender (male)	1.30	0.45	3.68	8.48	0.004**
the foster child’s age (6-18 years old)	0.59	0.52	1.80	1.29	0.26
pre-placement child maltreatment (yes)	0.69	0.66	1.99	1.07	0.30
foster child’s participation in extra-curricular activities (yes)	-1.47	0.49	0.23	9.07	0.003**
the foster parent-child relationship	1.09	0.74	2.97	2.15	0.14
presence of a sibling in the foster family (yes)	0.68	0.63	1.97	1.15	0.28
placement disruption (yes)	0.29	0.47	1.34	0.39	0.53

*** p<0.01*

PART IV QUALITATIVE RESULTS

1. OVERVIEW

This section reports the findings from 20 interviews, including 5 with foster care workers, 6 with foster parents, 5 with family caregivers and 4 with foster children (Table 48). Twenty interviews were conducted. The child in Case 3 rejected the interview. As a result, his foster mother was interviewed twice, as she was very emotional during the first interview, which affected the quality of the data. On average, each interview lasted one hour.

Table 48 Number of Informants and Interviews

Case	Foster Care Worker (No. of Interview)	Foster Parent (No. of Interview)	Family Caregiver (No. of Interview)	Foster Child (No. of Interview)	Total
1	FCW_01 (1)	FP_01 (1)	FCg_01 (1)	FC_01 (1)	4(4)
2	FCW_02 (1)	FP_02 (1)	FCg_02 (1)	FC_02 (1)	4(4)
3	FCW_03 (1)	FP_03 (2)	FCg_03 (1)	FC_03 (0)	4(4)
4	FCW_04 (1)	FP_04 (1)	FCg_04 (1)	FC_04 (1)	4(4)
5	FCW_05 (1)	FP_05 (1)	FCg_05 (1)	FC-05 (1)	4(4)
Total	5 (5)	5 (6)	5 (5)	5 (4)	20(20)

1.1. GENERAL PROFILE OF THE CASES

Based on the selection criteria (please refer to 4.2.2.), 34 cases were identified for the interviews. Of them, 6 cases were children without a diagnosis while 28 cases were children with a diagnosis. Two tables that listed the cases with and without a diagnosis, supplemented with the case ID of the agency, and the age and gender of the children, were prepared by the agency. The researcher, based on a fixed interval, randomly selected 2 cases from the list of children without diagnosis and 3 cases from those with a diagnosis to balance the number of cases in both situations. If a case refused to participate in the interviews, the next case would be selected. As a result, five cases (Cases 1, 2, 3, 4 and 5) were selected from the survey respondents for in-depth interviews (Table 49).

The child of Case 1 had been living in a foster home since she was one year old due to having received inappropriate discipline from her parents. She was diagnosed with developmental delay and borderline intelligence. She had received different types of training to improve her physical functioning since birth. She studied in an early education and training centre (EETC), then changed to the integrated programme in the kindergarten-cum-child care centre (IP in CCC) during her preschool period. At the time of the study, she was studying in K3 in a special child care centre (SCCC). Due to her marginalised situation, she was not eligible to study at a special primary school the following year.

The boy of Case 2 had been receiving foster care service for 3 years. He was diagnosed with attention deficit hyperactivity disorder (ADHD) and specific learning disability. He took medication to control the symptoms of ADHD, received psychotherapy from a clinical psychological service for his attachment issues with his parents, and received support from his school to improve his learning. He attended a self-care group offered by the psychiatric hospital to improve his self-care ability.

The child of Case 3 was taken care of by his grandmother before being admitted to the foster home. He was diagnosed with a complex type of ADHD and was medicated for a few months. Because of his emotional problems, his foster care worker organised art therapy and play therapy for him. He was also wait-listed for the clinical psychological service for his attachment issues with his biological parents.

The children of Cases 4 and 5 had no special needs. Both participated in developmental services, such as tutoring groups, Understanding Adolescent Programmes (UAP) and extracurricular activities. The child of Case 5 received clinical psychological service because of a traumatic experience during her childhood.

1.2. SERVICE USAGE

All the children were currently users of services, including specialised and developmental services. Specialised services referred to mental health services for children with special needs and were further divided into two broad types: 1) assessment services (e.g. psychiatric assessment, psychological assessment, IQ test) and 2) treatment services. Treatment services included i) medication; ii) education-related services (i.e., EETC, IP in CCC, SCCC, learning support); iii) training (i.e., speech therapy, occupational therapy, physiotherapy); and iv) counselling/psychotherapy services (i.e., clinical psychological services, play therapy, art therapy). Developmental services refer to services designed to enhance the growth and well-being of the children. These services were provided to the children with and without special needs and included services such as tutoring schemes, UAP and extracurricular activities.

In addition, four out of the five children (Cases 1, 2, 3 and 5) had previously used some services. The reasons for ending their service usage were 1) completion of the service (i.e., assessment, integrated KCCC, speech therapy, occupational therapy, physiotherapy, self-care group, play therapy and art therapy) and 2) dropping out (clinical psychology service). Finally, one child (Case 3) was waiting for a clinical psychological service, one child (Case 1) was not eligible for a special primary school and one (Case 5) was not eligible for assessment services.

Table 49 General profile of the children and their service usage

Case	**1**	**2**	**3**	**4**	**5**
Sex/Age	F/6	M/10	M/7	F/6	F/7
Education level	Kindergarten	Primary school	Primary school	Primary school	Primary school
Main reason for admission to the foster care service	Inappropriate discipline	Divorce	Behavioural problem	Inadequate parenting	Inappropriate discipline
Duration of living in the current foster home	48 months	39 months	25 months	61 months	17 months
Number of placements (Including the current placement)	2	1	1	2	1
Diagnosis	Developmental delay (borderline intelligence)	ADHD and special learning disorder	ADHD (complex type)	No diagnosis	No diagnosis
Services previously used	− Assessment − EETC − IP in CCC − Speech therapy − Occupational therapy − Physiotherapy	− Assessment − Self-care group	− Assessment − Play therapy − Art therapy	Nil	− Clinical psychology service
Wait-listed services	Nil	Nil	− Clinical psychology service	Nil	Nil
Ineligible services	− Special school	Nil	Nil	Nil	− Assessment

2. FOSTER CARE WORKER

2.1. DEMOGRAPHIC CHARACTERISTICS OF THE FOSTER CARE WORKERS

Five foster care workers participated in the qualitative study. All informants were experienced social workers, with particular experience in residential child care service (work experience ranging from 31 months to 264 months).

Table 50 Demographic characteristics of the foster care workers (N = 5)

Item		N
Gender	Male	0
	Female	5
Education level	Bachelor’s degree	3
	Master’s degree	2
Work experience in social work	≤ 100 months	1
	101 months – 200 months	1
	201 months – 300 months	2
	301 months – 400 months	1
	≥ 401 months	0
Work experience in a residential care service	≤ 100 months	3
	101 months – 200 months	0
	201 months – 300 months	2
	≥ 301 months	0

2.2. RESULTS

2.2.1. EXPERIENCE WITH SERVICE UTILISATION

As service mobilisers, they described the pathway to the utilisation of children’s service as ‘not complicated’ or ‘twisted’. While the first description (‘not complicated’) referred to the process of service usage for children with a clear diagnosis (Case 2) or no diagnosis (Cases 4 and 5), the second description (‘twisted’) referred to the process for children with a borderline (Case 1) or a complex (Case 3) condition.

2.2.1.1. The not complicated path

Specialised services were based on a diagnosis, meaning that if a child had a clear diagnosis (Case 2), the path to service utilisation was simple.

> *‘The case isn’t particularly complicated, but it’s special, as normally few of our clients choose to consult private specialists, probably because of financial concerns. However, she [the child’s mother] took this extra step [private consultation], as she really cared about her son. She was eager to find quicker ways to help her son and she also valued the foster mother’s feedback. This explains why we decided to work together on this step [private consultation]’ (FCW_02).*

The children of Cases 4 and 5 used developmental services, including tutoring schemes, UAP and extracurricular activities. These services were more accessible than the specialised services, so the process of using the service was quite straightforward.

> *'Actually, the child … this child's development is quite normal, there are no major needs or problems with the child. We see this as part of the child's development milestones' (FCW_04).*

2.2.1.2. The twisted path

Conversely, the informants needed to justify the use of specialised services in cases of children with a borderline situation (Case 1) or a complex condition (Case 3). In this circumstance, the process of service usage involved many twists and turns.

> *'The child is a borderline case … Compared to a serious situation, her abilities are not so weak. But she is much weaker than most children' (FCW_01).*

> *'It's complicated … it's a complex case. Indeed, the child's condition is complex. Inattention and hyperactivity are notable issues, but not the most important ones. I believe that his past experiences and background have had a profound effect on him and his intellectual abilities. Therefore, the complexity of this child influences his emotions, behaviour, social interactions and learning …' (FCW_03).*

> *'I think that the process involved is actually quite complex. First, we must consider whether we have sufficient resources. Second, if we convince others to offer these resources, we also need to check [our own resources] and justify our choice to others [concerned parties]' (FCW_03).*

Due to the borderline and complex nature of the children's problems, the social workers made different referrals before finding a suitable one for the children.

> *'I believe that it's a path full of twists and turns. First, we attended the EETC (early education and training centre) and then the integrated programme (IP in Kindergarten-cum-Child care centre). When that didn't work, we tried the SCCC (special child care centre), then went back to a regular school. I know that all of this was done with good intentions, for the child's sake. I mean … at first, I thought that the child might not do it … and maybe we should try some [rehabilitation services] first … I didn't know if this would be better. I mean we started with the EETC first, which could have worked. But looking back, I wonder … (sigh) … whether I was actually wasting the child's time' (FCW_01).*

2.2.2. SERVICE EFFECTIVENESS

2.2.2.1. Perception of service effectiveness

The children with special needs showed one or more problems with behavioural management, emotional regulation, learning abilities, interpersonal relationships and attachment to adults (such as biological parents). An effective service could help them reduce their symptoms and restore their functioning to obtain results comparable to their counterparts.

> *‘This helps. Her foster mother said that she [the client] has improved a lot. In fact, I can also see these improvements, particularly in her self-care, self-expression and word recognition skills. The improvements in these areas are obvious; for instance, for the alphabet, she can at least recognise some of the letters now’ (FCW_01).*

> *‘Actually, this is … also important, especially since he [the client] started taking medication. He [the client] really improved his academic results. He can now learn in a more relaxed manner and get better results. His foster mother said that he has the ability to do it’ (FCW_02).*

Indeed, the children’s improvements were not only important for them, but also for their foster parents. The foster parents felt less stressed with daily care as the children progressed. The improvement was very important, as the progress of children could sustain the stability of the placement and affect the well-being of the children.

> *‘In fact, if the pressure or difficulties persist, the foster mother may consider giving up at some point. The placement will then fail, and this will affect the stability of the boy’s care’ (FCW_02).*

2.2.2.1.1. Specialised services

There were various comments on the effectiveness of specialised services. While some services helped the children, others were not effective at all.

> *‘In terms of cognitive aspects, the child does not really benefit from the integrated programme in CCC. Most homework focuses on writing and copying … there is a lot of writing and copying. Indeed, the child simply copies the text, but she doesn’t understand the meaning at all’ (FCW_01).*

> *‘[Self-care training] is conducted in a group. The foster mother did not think that it helped the child. His self-care is still very messy’ (FCW_02).*

> *‘Although the psychiatrist has adjusted the dosage of his medication [the child], it does not work for him [the child]. Actually, he has been taking it for a few months now’ (FCW_03).*

2.2.2.1.2. Developmental services

Comparatively, the informants had a more consistent view of the effectiveness of the developmental services. Overall, they considered these services as important and useful to the children, whether they had special needs or not.

> *‘He [the client] participated in a project called “333” after school, in which retirees or other tutors were invited to become the children’s tutors, teaching them how to do their homework. We have this [tutoring class] every day, and it is free of charge. He [the*

> *client] greatly enjoyed the class as he won the tutors' recognition. He was appointed as "little teacher" of the class, who was responsible for teaching junior form students. The tutors also used many rewards, which helped improve his self-esteem' (FCW_02).*

In addition to developmental services, a stable and desirable foster care environment was therapeutic for the children.

> *'Actually, she [the client] lived with an older sister in the foster home. This older sister was also a foster child, and she was 17 years old. She [the client] knew that her sister was really good at drawing and she also liked drawing. So maybe … she asked her sister questions or showed her own masterpieces. Her sister was also able to give her advice' (FCW_05).*

2.2.2.2. Factors influencing the accessibility and effectiveness of specialised services

The informants identified both barriers and factors facilitating the accessibility and effectiveness of assessment and treatment services. While service accessibility refers to whether the foster children could receive the relevant services, service effectiveness influences their outcomes. These factors were related to service providers (i.e., system and organisation), service users (i.e., foster children) and children's supporters, including professionals (e.g. foster care workers, referral workers, and teachers), paraprofessionals (i.e., foster care families) and biological families. Table 53 summarises the key factors influencing the accessibility and effectiveness of these services as perceived by the foster care workers.

Table 51 Barriers and facilitating factors influencing service accessibility and effectiveness

	Service Providers	Supporters
Barriers		
Assessment Services		
Accessibility	• Lack of resources • Fragmentation of services	• Delayed identification • Lack of coordination of pre-care information • Discrepancy between professionals and caregivers
Effectiveness	• Incomprehensive assessments	
Treatment Services		
Accessibility	• Lack of diagnosis • Rigid criteria for eligibility for services	• Discrepancy between professionals • Social stigmatisation
Facilitating factors		
Assessment Services		
Accessibility		• Sensitivity to the needs of children • Mobilising resources proactively
Treatment Services		
Accessibility	• Dominant view of treatment methods	• Good collaboration between family caregivers and foster care worker / foster parents
Effectiveness		• Commitment of foster parents

2.2.2.2.1. Barriers

Assessment Services

Eligibility for using a service was determined by the result of an assessment. If a child was diagnosed with a specific problem, he or she was able to access the relevant service. Hence, a timely assessment of the children was critically important.

> *'The EP (educational psychologist) conducted an assessment and diagnosed him [the client] with mild learning disabilities. The EP recommended the school offer support and adjust his workload' (FCW_02).*

> *'I strongly encourage children to do the assessment to identify problems, as I believe that if the assessment doesn't reveal any problem, it is great and we can all forget our worries. But if some problems are diagnosed during the assessment, we can immediately determine what we can do to help the child' (FCW_03).*

Service Accessibility

❖ *Service providers*

- Lack of resources

Although the children showed learning, behavioural, emotional or interpersonal problems, they usually waited a long time for an assessment because there is an insufficient number of assessors, such as psychiatrists, clinical psychologists and educational psychologists.

> *'The usual practice is to conduct a preliminary screening among Primary 1 students. After this screening, teachers should provide … a list of potential students [with special needs]. However, this assessment usually takes place when they [the students] are in Primary 2, as they need to wait for the test. They often have to wait until Primary 2 because there are not enough EPs (educational psychologists). Sometimes, an EP has to work with several schools, which means that if a particular school identifies a considerable number of [potential] children, the waiting time for children from another school increases' (FCW_02).*

- Fragmentation of services

Different assessment services were conducted by different professionals. Due to the long waiting time for each assessment, the children, especially those with complex situations, would experience a delay in receiving appropriate treatment.

> *'The psychiatrist believed that his [the child's] behaviour and emotions were possibly affected by intelligence. At that time, the doctor was particularly concerned about his [the child's] level of intelligence. If he [the child] was intellectually disabled, this would explain his inattention and other symptoms. Based on his/her [the doctor's] belief, the doctor refused to prescribe medication for the boy without further assessment. You know … ID and ADHD are totally different. For ADHD, you seek the help of a psychiatrist. However, intellectual problems are treated by a CP (clinical psychologist) or an EP (educational psychologist)' (FCW_03).*

❖ *Supporters*

- Delayed identification

The foster care workers believed that there was a 'golden time' for the assessment. However, many children came from complicated family backgrounds, thus their family caregivers were not able to identify the children's problems and mobilise appropriate resources in a timely manner. As a result, many problems were identified late, usually after admission to the foster care service.

> *'Actually, this was already quite late … Perhaps if he/she [the referral worker] had treated the case earlier, for instance, if society had been more proactive in understanding the [prime] time of [intervention] for family problems, the following interventions could have been much more efficient. If the case had been identified when the child was 2 or 3 years old, the [services of] the government's CAC (child assessment centre) could have been provided much earlier' (FCW_03).*

- Lack of coordination of pre-care information

As there is no prescribed practice for coordinating the pre-care information of children, it is possible to lose important information, such as assessment reports. For example, the child of Case 2 had an assessment report on his special learning needs prior to placement, but the mother had lost it. The foster care worker did not receive this report when the child was placed, which delayed treatment.

> *'Actually, when our children in foster care are confirmed with special needs, additional subsidies are provided to foster mothers. The foster mother was aware of this [arrangement], so she was really worried and asked the biological mother for the relevant reports. The biological mother told her that he [the child] had been assessed and that she had collected the reports. However, she probably lost them; thus, she had to get them from the child assessment centre' (FCW_02).*

- Discrepancies between professionals and caregivers

Disagreement among professionals on the needs of children delayed referrals for assessment.

> *'In fact, earlier [in 2016], we thought that he [the child] might encounter a number of problems like ADHD. At that time, the psychiatrist believed that maybe … I'm not sure why, but he believed that he [the child] had no significant [clinical] problems. This may be why he assessed this [the case] as a parenting problem. Well … in July 2018, we invited another volunteer from our agency, also a psychiatrist, to reassess the child. This reassessment revealed that he [the child] had ADHD and that it was one of the complex types. Therefore, later he [the child] started taking medication' (FCW_03).*

> *'For instance, during our meetings, when I or the foster mother mentioned the child's problems, the RW (referral worker) felt that they were not really important … From my observations, not only was he suffering from inattention, but he also had significant problems with his social relationships. That's why I asked the RW to refer him to the CP service. It's a pity that I couldn't contribute more in this respect, and the RW is still unable to make a referral' (FCW_03).*

> *'For example, I think that there are many students who have serious problems. However, teachers might say that "Compared with other students, her [the child's] problems are not serious at all. She [the child] will have to wait a long time to be assessed"' (FCW_05).*

Effectiveness of Assessment Services

- ❖ Service providers
  - Incomprehensive assessments

Although some children were diagnosed with special needs, they might not receive the appropriate services because the assessment results did not reflect their true conditions. For example, the child of Case 1 was not eligible to study in a special school when she started primary education. The informant criticised the quality of the assessment report, which did not fully reflect the ability of the child.

> *'CAC (child assessment centres) not only offer assessments for children, but they also have a set of questionnaires for teachers, parents, or more specifically, caregivers. Regarding these questionnaires, I believe that the diagnosis depends heavily on the answers … One time, a foster mother told me that some teachers considered that the child had no problem at all … Sometimes teachers could not observe the children's problems … thus, I think the answers weren't comprehensive and accurate enough to provide a thorough understanding [of the child's situation]' (FCW_01).*

Treatment Services

Service Accessibility

- ❖ Service providers
  - Lack of diagnosis

As mentioned earlier, most specialised services were offered to the children based on their diagnosis. When the informants suspected that a child had a mental health problem, but the child had not been assessed by a specialist, it was very difficult to mobilise the relevant services for the child. Even worse, the child received no service while waiting for the assessment.

> *'I mean it is better if there is a professional assessment. Based on it, we know what the child lacks … But as I believe, for children whose symptoms are less observable, waiting for an assessment is already a challenge' (FCW_05).*

> *[Interviewer: 'During the period from waiting for an assessment to obtaining an assessment report, is there support for the child?'] 'Not really … he/she will need to consult the EP (educational psychologist) first, as a diagnosis must be made before the school offers learning support' (FCW_02).*

- Rigid criteria for eligibility for services

Many criteria (e.g. age, IQ test scores) for eligibility for the services are rigid, preventing children with marginalised conditions from using the services.

> *'It's like assigning [children with] certain scores to one group and others to another group. For me, this is similar to prescribing medication, as it lacks flexibility' (FCW_01).*

❖ *Supporters*

- Discrepancy among professionals

The difference in views among professionals regarding the children's needs affected their 'sense of ownership' or their commitment to service coordination and monitoring.

> *'When I or the foster mother mentioned the child's problems, the RW (referring worker) felt that the problems were not really important … But I can see that the child's emotions are quite complex, not to mention his ADHD … Yet the RW is still unable to make a referral' (FCW_03).*

> *'Perhaps … I mean from my point of view, if a child is diagnosed [with special needs] after being placed, and I ask the RW (referral worker) to provide [services] for the child, obviously I feel that I'm … more involved. I will probably encourage the child to use the services. However, the situation was different; this child was already waiting [before being placed], so … I probably didn't feel so involved because of that' (FCW_05).*

- Social stigmatisation

Some parents were hesitant to allow their children to use the mental health service because of the labelling effect of mental health problems, such as disability or mental illness. The attitude of some parents could be changed with the appropriate intervention of professionals.

> *'Well … The child's mother was also reluctant to talk about it [the child's problem]. That's why she brought [the child] to the specialist alone … [The mother failed to bring the child to the next appointment because] she didn't feel that there was a need, she told herself, "Actually he/she [the child] does not need it, he/she doesn't have any problem"' (FCW_05).*

> *'Actually, by the time [the child] required a transfer to SCCC (special child care centre), her mother also hesitated. She felt that … as she did not know what it [SCCC] was, she was scared to hear the term "special" … she feared that [her child] would be labelled' (FCW_01).*

2.2.2.2.2. Facilitating Factors

Assessment Services

Service Accessibility

❖ *Supporters*

Two factors facilitating the timely assessment of the children were related to supporters: their sensitivity to the special needs of the children and their proactive attitude to mobilise resources.

- Sensitivity to the needs of children

While the knowledge of professionals, such as referring workers, foster care workers and teachers, is necessary to identify the mental health needs of the children, the experiences of foster parents are equally important. Those with rich experience in taking care of children with special needs could help identify a problem early.

> *'As she grew up, we [foster care worker and foster mother] found that she was really slow … slow in all aspects of development, including speech and self-care. At that time, she was 3 or 4 years old but still used diapers. She was unable to use the potty … We believed that she might suffer from [developmental] delay' (FW_01).*

> *'At the beginning, the foster mother found that the child's main problem was inattention, meaning that he also had learning difficulties. In fact, the foster mother had taken care of children with ADHD before, so she had an idea of these children's characteristics and their situation. Therefore, she was able to quickly identify the child's symptoms of ADHD' (FW_02).*

- Mobilising resources proactively

As the waiting time for an assessment at a government clinic was very long, support from social workers and others who mobilised resources proactively, the provision of financial support for private assessment services, and free services, could definitely shorten the waiting period.

> *'At that time, the child was already over 5 years old, it would take too long for him to wait for a CAC (child assessment centre). He would probably still be waiting after Primary 1. Therefore, we organised [these services] from our agency instead' (FCW_03).*

Treatment Services

Service Accessibility

❖ *Service providers*

- Dominant view of treatment methods

The dominant view of mental health treatment methods could easily build consensus among different stakeholders to ensure seamless access to services.

> *'There are mainstream views on the disorder [ADHD] and its treatment. The foster mother had taken care of children with ADHD before and believed that there was a "treatment path" for these children. She believed that ADHD should be treated with medication as soon as possible. According to her, the symptoms significantly affected a child's learning, social interactions, temper and self-control. Therefore, medication was the only solution, especially when the child performed better with it, further confirming her belief. This belief was also shared by the [child's] biological mother, as she found that medication helped her son's condition' (FCW_02).*

❖ *Supporters*

- Good collaboration between family caregivers and foster care worker / foster parents

The family caregivers played a key role in the children's service utilisation, including giving consent for service referrals, bringing the children to receive these services and providing financial support for these services. Therefore, the active participation of the family caregivers facilitated a smooth service utilisation process. This participation was based on a relationship of trust among family caregivers and the foster parents / foster care worker.

> *'In fact, the foster mother felt that the child's condition was similar to that of [ADHD], and she strongly encouraged the biological mother to "consult a doctor to confirm the diagnosis"… She [the biological mother] agreed with the foster mother's view and respected her suggestions, especially when these were made so firmly … As she [the biological mother] felt that the foster mother spent more time with her son than she did herself, she was willing to follow her advice' (FCW_02).*

Service Effectiveness

❖ *Supporters*

- Commitment of foster parents

Taking care of children with special needs is not easy. Foster parents have to be very committed and willing to do a lot of extra work for these children, such as escorting them to receive services, providing home-based training, liaising with teachers and attending in-service training. The more committed the foster parents, the more effective the services will be.

> *'The role [of foster parents] is really important and [the duties are] heavy. In addition to providing care and guidance, the training and escort offered are equally important … I believe that this also implies the extra role of a companion. You need to accompany the child and work with him/her to motivate him/her' (FCW_01).*

2.2.3. SUMMARY

In summary, these children used the services differently. The children with or without a clear diagnosis had a more straightforward process to follow to obtain use of the services than those with a marginalised and ambiguous condition. Service effectiveness was important not only for reducing the children's symptoms and restoring their functioning, but also for ensuring stable placements. While the informants had a consistent view of the effectiveness of the developmental services, their views differed regarding the quality of specialised services.

Various factors affected the accessibility and effectiveness of assessment services. Some barriers related to service operators (i.e., lack of resources and service fragmentation) and supporters (i.e., delayed identification, discrepancy among professionals and caregivers) prevented the children from receiving a timely assessment. Conversely, supporters who are highly sensitive to the children's needs and have a proactive attitude towards mobilising relevant resources could contribute to the timely assessment of these children. Regarding the effectiveness of the assessment, one informant commented that the scope of the assessment did not reflect the actual condition of the children, resulting in a mismatch between the needs of the children and the services offered.

The accessibility of treatment services was hindered by factors related to the service operators (i.e., lack of diagnosis and rigid service eligibility criteria) and supporters (i.e., discrepancy among professionals and social stigmatisation perceived by the parents). The dominant view of the treatment methods and the cooperative attitude of the family caregivers allowed smooth access to the services. In terms of service effectiveness, the commitment of the foster parents was significant in maximising the positive effects of the services on the children.

3. FOSTER PARENTS

3.1. DEMOGRAPHIC CHARACTERISTICS OF THE FOSTER PARENTS

All foster parents were women and were also the primary caregivers of the children in the foster home. They were experienced foster parents, with at least 48 months of being a foster mother. Their experience of taking care of these children ranged from less than a year to more than five years.

Table 52 Demographic characteristics of the foster parents (N = 5)

Item		N
Gender	Female	5
	Male	0
Age	≤ 40	0
	41 – 50	1
	51 – 60	3
	61 – 70	1
	≥ 71	0
Marital Status	Married	4
	Divorced	1
Duration of being a foster home	≤ 50 months	1
	51 months – 100 months	1
	101 months – 200 months	2
	≥ 201 months	1
Duration of taking care of the child	≤ 20 months	1
	21 months – 40 months	2
	41 months – 60 months	1
	≥ 61 months	1
Number of children currently fostered	1 foster child	2
	2 foster children	3

3.2. RESULTS

3.2.1. EXPERIENCE WITH SERVICE UTILISATION

3.2.1.1. Children with special needs

The foster parents had a general understanding of the children’s condition and understood that they had to provide additional support for these children on a daily basis, such as taking the children to receive different services, monitoring their medication at home and liaising with mental health professionals.

> *‘The child was diagnosed with developmental delay, which means that she learns slowly. She has performed slowly in all aspects, such as speaking and walking, since birth. Her problems were confirmed by the assessment results’ (FP_01).*

In addition to providing additional support, they had to discipline the children at home.

> *‘Regarding his [the child’s] habits, I told him [the child] to change his uniform after school every day, but he will throw it everywhere … He picks it up and throws it everywhere again and again … I insist that he picks it up; otherwise, he cannot have a snack. I use this way to teach him’ (FP_03).*

3.2.1.2. Children without special needs

The children without special needs were described as docile and obedient by the foster parents. They did not encounter many difficulties in daily care and parenting.

> *‘I think this child was easy to look after because she was docile when she was a little child … But she is a bit naughty as growing up. Sometimes, she does not answer when I talk to her’ (FP_04).*

> *‘She [the child] has changed. At first, she did not follow my instructions at all … I mean she was quite naughty … but she quickly adjusted her attitude’ (FP_05).*

3.2.2. SERVICE EFFECTIVENESS

3.2.2.1. Perception of service effectiveness

Service effectiveness had a direct effect on the daily care of the foster parents. An effective service helped reduce the behavioural and emotional problems of the children, alleviating the daily care and parenting stress of the foster parents. If the children had serious behavioural and emotional problems and did not improve after receiving the service, the foster parents felt helpless and hopeless, which affected their mental health and the stability of the placement.

> *‘I took care of hyperactive children before. But I really don’t know why this child’s problem is so serious … He shouts all the time … he never stops …. he likes to lean on everything, rub everything … That’s why I told [the foster care worker] that I wanted to quit. Actually, I have a hard time leaving’ (FCW_03).*

> *'I think maybe I can tolerate it for a short time… It is really difficult to take care of him…. I hope that the doctor can give a correct assessment, confirm that he has ADHD and prescribe medication … Then I will be less burdened and he will not have to leave my home' (FP_03).*

3.2.2.1.1. Specialised services

Like the foster care workers, the foster parents had differing views on the effectiveness of specialised services. Some observed that the children made great progress, while others found that the children's situation was unchanged or even became worse than before (e.g., the perception of FP_02). This foster parent had more difficulties with disciplining the child when he grew up without improvement.

> *'She made clear progress this year. In addition, this school is really good … it is a special school that offers a lot of training. The teaching method suits her abilities … it is adapted to her. This teaching approach is really good' (FP_01).*

> *'[Interviewer: What are you worried about the most?] Interviewee: Psychological health … Actually, he has no feeling, I mean he does not feel the concern of others. He does not bother with others, is not concerned about others' (FP_02)*

> *'I met the clinical psychologist once. I told him about the general condition of the child. He roughly knows about his condition. But I think the psychologist is pretty weak' (FP_02).*

> *'… getting worse … I think [the child's condition] is deteriorating. For example, I try to stop him when he fights with others. But he is strong' (FP_03).*

3.2.2.1.2. Developmental services

The foster parents, especially those of children with special needs, barely discussed the developmental services. Only the informant of Case 5 emphasised the importance of developmental services for the child. She also suggested that the children should receive more financial resources.

> *'For example, during the summer holidays, as it is a long holiday, I want the child to participate in summer activities. If her mother cannot afford it, society should give the child some support … The Social Welfare Department should offer to pay the fees. At least, the child could participate in some activities' (FP_05).*

3.2.2.2. Factors influencing the accessibility and effectiveness of specialised services

Table 53 Barriers and factors facilitating service accessibility and effectiveness as perceived by the foster parents

	Service Providers	Supporters	Users
Barriers			
Assessment Services			
Accessibility	• Inaccurate assessment		
Treatment Services			
Accessibility	• Limited decision in service selection • Long waiting period	• Clear division of labour among professionals	
Effectiveness		• Limited support from the school	• Motivation of children
Facilitating Factors			
Treatment Services			
Effectiveness		• Commitment of foster parents	

3.2.2.2.1. Barriers

Assessment Services

Service Effectiveness

❖ *Service providers*

- Inaccurate assessment

Because of an inaccurate assessment of the children's problems, they were not provided with appropriate services.

> *'I believe that his [the child] assessment was … this is just my personal opinion, not professional. For me, the assessment result was wrong. As she [the interviewee's friend] said, "How come he [the child] wasn't [diagnosed with ADHD]? If there's a 10-point scale, then the child should score well above 10!" I mean he [the child] is absolutely not … under control … I think he is unable to control himself' (FP_03).*

Treatment Services

Service Accessibility

❖ *Service providers*

- Limited decision in service selection

The parents had very limited or even no say in the choice of services, although there was a mismatch between the needs of the children and the services offered.

- Long waiting period

The waiting time for some services was very long because the eligibility criteria, such as age, were rigid.

> *'It [the wait] lasted almost two years. We had to wait a year for the first assessment. After one year, the child had to wait for another 7 months for the second assessment. [We waited a year for the second assessment] because they [the professionals] said that the assessment should be done only when the child was 6 years old and started primary school' (FP_03).*

❖ *Supporters*

- Clear division of labour between referring workers and foster care workers

The clear division of labour between referring workers and foster care workers delayed the timely service referral for children.

> *'Yes. I talked with Ms X (the foster care worker), but she told me that this [the referral] depended on the hospital and that there was not much she could do. Actually, when waiting for the government's [services], Ms X didn't really help. The one who was really helpful was the [social worker from the] government … It gave me the impression that … although they were both social workers, the referral letter written by the [government's social worker] was more convincing' (FP_02).*

Service Effectiveness

❖ *Supporters*

- Limited support from the school

Although the children had learning difficulties, they did not receive sufficient support from their schools.

> *'Because of her [the child's] low intelligence, [the doctor] recommended reducing the amount of homework … There was sometimes fewer [homework], such as an exemption for one or two "Challenge Questions" or the "Math Challenge Questions", but she still had to complete the rest of the questions. I once compared her workload with that of her classmates and they were the same' (FW_03).*

> *'At first [the teacher] insisted … insisted on asking her [the child] to do the homework. Then I told her that she wouldn't do it, I didn't want her to … If she could really do the homework, of course I'd ask her to do it. However, this was "mission impossible" for her. Why should I force her to do it? Well … after I took a stand, the teacher stopped talking about it and just dropped it' (FP_01).*

❖ *Service users*

- Motivation of the children

The children were perceived as not cooperating with the professionals. For instance, the foster mother of Case 2 said that the child did not want to live with his mother, but he deceived the clinical psychologist. Hence, the psychologist was unable to provide relevant support.

> *‘The child said, “I want to live with my mother.” He lied. I asked him, “Why did you lie?” Then, he was silent. I said, “You should not lie”’ (FP_02).*

3.2.2.2.2. Facilitating Factors

Treatment Services

❖ *Supporters*

- Commitment of foster parents

A strong commitment to taking care of the children on the part of foster parents could maximise the positive effects of the services. This support included both tangible (i.e., escorting, liaising with related parties and learning relevant training skills) and intangible (i.e., being persistence and patient with the children) aspects.

- Taking the children to receive services

As the child of Case 1 needed to receive different training because of a developmental delay, the foster mother always took the time to accompany her. She also observed the training provided by professionals and tried to provide home-based training for the child.

> *‘For speech therapy, they [the therapists] ask the parents to come. That’s why I accompanied the child, while I also … observed their training’ (FP_01).*

- Negotiation with related parties

The informants took the responsibility to liaise with different parties, such as doctors and teachers, to ensure that the children benefited from the services.

> *‘[When the child forgot to take his medication] I told him [the child], “You can’t do this. For God’s sake, you need to take at least one pill!” Then I informed the doctor [of the situation]. The doctor, Dr X, was really nice, so I asked him to prescribe him [medication with an eight-hour calming effect]’ (FP_02).*

- Learn relevant skills

Some informants were willing to spend more time to receive in-service training and acquire relevant skills to support the children at home.

> *‘After completing [the parent-child play therapy course], I tried play therapy with her [the child] at home using toys. As I continued to work on it, she became more confident and gained a greater sense of security, meaning that she was gradually less anxious around people’ (FP_01).*

- Patience and persistence

Although taking care of children with special needs was exhausting, the informants were very patient and persistent with the children.

> *‘One time, I tried to teach her [the child] something, but it took her over a year to master it’ (FP_01).*

Despite their significant role, the foster parents received limited support. Additional financial support is currently available only for foster parents caring for foster children with ADHD, autism, mental disabilities and dyslexia.

> *'For transportation costs … yes … I pay them out of my own pocket, they are not included in the subsidy. This is disappointing. Why are foster parents not eligible to apply (for a transportation fee subsidy)? Indeed, I look after [children] with special needs' (FP_01).*

3.2.3. SUMMARY

The foster parents were the primary caregivers of the children and had added responsibilities for caring for children with special needs. They were very stressed about disciplining these children, especially those with serious behavioural and emotional problems. Hence, the quality of services was significant not only with respect to restoring the functioning of the children, but also with regard to easing the burden on the foster parents. While they understood the importance of specialised services, they placed less importance on developmental services for the children.

One informant questioned the effectiveness of the assessment services as they could not reflect the actual condition of the child. With respect to treatment services, the children had difficulty accessing them because of the limited choice of their parents and the long waiting period. A clear division of labour between different professionals also delayed timely service referrals. Although the lack of support from schools and the low motivation of the children negatively affected service effectiveness, the support of the foster parents helped maximise the positive effects of the services on the children.

4. FAMILY CAREGIVERS

4.1. DEMOGRAPHIC CHARACTERISTICS OF THE INFORMANTS

Five family caregivers, including one paternal grandmother and four biological mothers, participated in the study. Four caregivers were divorced or separated. Most families lived with the support of financial aid. One parent suffered from depression and was receiving psychiatric help.

Table 54 Demographic characteristics of the informants from the biological families (N = 5)

Item		N
Gender	Male	0
	Female	5
Age	≤ 30	1
	31 – 36	1
	37 – 41	2
	≥ 42	1
Relationship with children	Biological mother	4
	Paternal grandmother	1
Marital status	Married	0
	Divorced/Separated	4
	Cohabitation	1
Work status	Full time	2
	Homemaker	3
Family monthly income	< 5,000	0
	5,000 – 9,999	2
	10,000 – 14,999	0
	15,000 –19,999	1
	≥ 20,000	0
	Unknown	2
Financial aid received*	Comprehensive Social Security Assistance (CSSA) scheme	1
	Old Age Living Allowance	1
	Financial Assistance Scheme for Students	1
	Other, such as pension	1
	Other, such as foster care allowance	1
	None	1
Mental health/physical health problems	Yes	1
	No	4
Mental health service received*	Specialist psychiatric services	1
	None	1
	Unknown	3

** Multiple choice question*

4.2. RESULTS

4.2.1. EXPERIENCE WITH SERVICE UTILISATION

All the parents tried to tackle their children's problems. However, they faced constraints such as limited intelligence (Case 1), lack of available time to spend with the children (Cases 2 and 3) and personal problems (Case 5), which prevented them from actively engaging in their children's problems. As a result, some parents struggled to discuss their experience with service use in detail.

> *'Her [the child] movements were … relatively slow. What a shame. I asked the foster mother, as she was the one who took her [to appointments] most of the time. I took her myself maybe once or twice, so auntie knew [the child's situation] better' (FCg_01).*
>
> *'It's because I do not have much contact with him [the child]. I know that he is not medicated on the weekends. He only takes medicine at school, at the tutoring centre or when he does his homework. He does not take it during the summer holidays.' [Interviewer: 'According to Mrs. X's (the foster mother's) description, is he significantly different with and without medication?'] 'He seems calmer' (FCg_02).*
>
> *'The foster mother said that he [the child] has ADHD … I am not the one taking him [to appointments]; he is mainly brought there by the foster mother and Ms Z (the foster care worker). I do not accompany him to his ADHD treatment [medical follow-up], but I monitor his medication [during a short stay]' (FCg_03).*

4.2.2. SERVICE EFFECTIVENESS

4.2.2.1. Perception of service effectiveness

4.2.2.1.1. Specialised services

Some specialised services, such as special schools, medication and the clinical psychology services, were effective in helping their children, according to the informants. They felt that their children improved their learning abilities, behaviour management and emotional regulation skills.

> *'I think the child has made great progress in speaking after living with the foster mother' (FCg_01).*
>
> *'Whenever I met his teachers, they told me that he [the child] was well behaved and obedient at school [after taking medication]' (FCg_03).*
>
> *'[The clinical psychology service] helps in a way, as I believe that he [the child] prefers to listen to others than to us' (FCg_03).*

Conversely, the informants of Cases 2 and 3 found that specialised services (i.e., self-care training and medication) were not helpful for the children. In particular, the caregiver of Case 3 felt that the child's situation was worse after taking medication.

> *'Self-care was a challenge, probably because he [the child] was a boy. Compared with his [the child's] two older sisters, his [self-care] was relatively weak. He was different from his two sisters, who could take care of themselves since they were little, putting their clothes, homework and books in their place. He couldn't do that' (FCg_02).*

> *'Regarding [the child's] ADHD, I'm not too sure … After taking medication, I suppose… but he is more or less the same. It [the child's situation] is worse than before taking medication' (FCg_03).*

4.2.2.1.2. Developmental services

Most parents were concerned about the developmental issues of their children, such as physical and mental well-being, academic performance and interpersonal relationships, whether or not they had special needs.

> *'I am worried about her health. I will be satisfied if she can grow up to be happy and healthy, without illness' (FCg_01).*

> *'I really worry about his promotion to secondary school because he is not doing well academically' (FCg_02).*

> *'For instance, I do not like her [the child] … to behave immaturely. She has outburst of enthusiasm with strangers … I try to hide it' (FCg_05).*

Some parents perceived that the services were useful for their children, but they felt burdened by the cost.

> *'Learning is so important for children … but a tutoring service is so expensive in Hong Kong. Based on our family situation, it is financially difficult to support her to attend tutoring classes … But she will be too "relaxed" if she doesn't attend them. I don't want her to be like that' (FCg_05).*

4.2.2.1.3. Foster care service

According to the family caregivers, the foster care service had a significant effect on the well-being of the children. Sometimes, the parents had emotional difficulties with disciplining their child. The support of the foster parents helped them a lot.

> *'It's getting a little bit better. I mean auntie reminds her [the child] when she stays there [in the foster home] and she is warned whenever she does it [misbehaving]. However, sometimes, when gentle reminders do not work … I become really mad and reactive. Then I tell her off when I am boiling with anger' (FCg_05).*

> *'I told the foster mother that if she [the child] is teased by her classmates, she [the foster mother] has to report it to the teachers. She has to stop it. Don't stay silent' (FCg_04).*

4.2.2.2. Factors influencing service accessibility and effectiveness

Table 55 Barriers and factors facilitating service accessibility and effectiveness as perceived by the family caregivers

	Service Providers	Supporters
Treatment Services		
Barrier		
Accessibility	• Unable to meet service eligibility criteria	
Facilitating Factor		
Effectiveness		• Mother's personal experience • Good collaboration with foster mothers

4.2.2.2.1. Barrier

Treatment Services

Service Accessibility

❖ *Service providers*

- Unable to meet service eligibility criteria

A child did not meet the service eligibility criteria due to the borderline nature of the problem.

> *[Interviewer: 'Did you feel disappointed when your child failed to study in a special school?'] Interviewee: 'I was a little disappointed, but this was something beyond our control. Following the assessment result, we could do nothing if they [the professionals] said no. If possible, of course we'd like to [send the child to a special school], as the foster mother also wanted her [the child] to study in a special school. We didn't want her to learn nothing. In a class with a large group of students, she probably won't learn properly' (FCg_01).*

4.2.2.2.2. Facilitating Factors

Treatment Services

Service Effectiveness

❖ *Supporters*

- A mother's personal experience

When the informants had a positive experience with using a specialised service, they tended to adopt a positive attitude towards the children's use of the service.

> *‘My personal experience was very positive, as a teacher only taught 10 [students]. I learnt this way and it was easier to learn’ (FCg_01).*

- Good collaboration with foster parents

Most informants perceived that both foster care workers and foster parents were very helpful and trustworthy. They usually trusted them with their children’s problems.

> *‘[The foster mother told me to let the child repeat K3.] By repeating a year, we wanted her to have a better foundation. Then when starting Primary 1 next year, it will be less painful and stressful for her … I said okay because I could see that the foster mother was … doing this for the child’s own good. That’s why she [the foster mother] asked me to do this’ (FCg_01).*

Although this collaboration enables a smooth service utilisation process, the parents tend to rely too much on professionals and foster parents, only playing a peripheral role in their children’s problems.

4.2.3. SUMMARY

The family caregivers usually delegated authority to the foster care workers and foster parents in terms of service mobilisation and monitoring due to personal constraints. Although this reflected the high level of trust in the social workers and substitute caregivers that the biological parents have, the biological parents may rely too much on them, thereby reducing their active involvement in their children’s problems.

With respect to the effectiveness of specialised services, while some informants observed that the children made great progress, other informants found that the children’s situation was unchanged or even worse after receiving the services. Aside from the mental health needs of the children, they were concerned about the children’s developmental needs and felt that the developmental services and the foster care service benefited the children and themselves. Compared to the views of the foster care workers and foster parents, only some factors affecting the accessibility and effectiveness of treatment services were highlighted by the family caregivers. This might suggest that these informants were not actively involved in their children’s use of the services.

5. FOSTER CHILDREN

5.1. DEMOGRAPHIC CHARACTERISTICS OF THE CHILDREN

Four children participated in the interviews. There was an equal number of children with and without a diagnosis. Most children (N = 2) used developmental services such as a tutoring service and the UAP. One child used a specialized service (i.e., SCCC) and one child utilized both types of service.

Table 56 Demographic characteristics of the children (N = 4)

Item		N
Gender	Male	1
	Female	3
Age	6-8	3
	9-11	
Education	Kindergarten	1
	Primary	3
Main Reason for admission to the foster care services	Child	0
	Family	4
Number of placements (including the current placement)	1	2
	2	2
Diagnosis	Yes	1
	No	4
Number of services currently used	**1-2**	3
	3-4	1
Nature of services	Specialised	1
	Developmental	2
	Both	1

5.2. RESULTS

5.2.1. EXPERIENCE WITH SERVICE UTILISATION

Although the children were the primary service users, they usually had a limited understanding of the services, such as the reasons for referral or the nature of the services.

> *'[Interviewer: Yes … so you know you are going to XX school in September, right? Did the foster mother tell you why you have to study there again, when you studied there before?]' Foster care mother: 'I didn't tell him/her [the child].' [Interviewer: 'Do you know why?'] Child: 'No' (FC_01).*

> *'[Interviewer: Why do you see the doctor?] Interviewee: Because I have a mood disorder. [Interviewer: Who told you about this?] Interviewee: Probably the hospital … earlier while playing in the playground, I was hurt and was left with a scar. In 2015, I had to take medication' (FC_02).*

5.2.1.1. Perception of service effectiveness

5.2.1.1.1. Specialised services

Overall, the informants were positive about specialised services. The child of Case 1 could not clearly remember her previous experience with using the service, but was able to tell the researcher that she was happy and learnt a lot in her current school, which was confirmed by the foster parent.

> *'I'm learning to write … writing numbers … and English … and words taught by the teachers.' [Interviewer: 'Wow! Did you know all this before?'] Interviewee: 'No' (FC_01).*

> *'You couldn't even count from 1 to 10 before, and see, now you can count to 25' (FCP_01).*

The child of Case 2 felt that his medication really helped improve his condition. He became calm and well behaved at school after taking medication. However, he also noticed a side effect of the medication on him.

> *'[Interviewer: Do you think your medication helps you?] Interviewee: It's okay, as it helps control [my emotions] and it really can cure me … treat my problem … [and] improve my concentration. But I lose my appetite after taking it. I can only eat less than half of my lunch. I always leave food' (FC_02).*

5.2.1.1.2. Developmental services

With respect to developmental activities, the children were enthusiastic when they shared their experiences with the tutoring schemes, the UAP and extracurricular activities. In addition, the children enjoyed participating in these activities with their family members. They treasured the positive views of their teachers, tutors and coaches, and they felt empowered. For instance, the child of Case 2 joined a tutoring scheme and was assigned the role of assistant to supervise the homework of other children. He shared his method of managing students who did not comply with the rules and regulations, which was very child-focused.

> *'I like it … but not to revise, because I can't memorise anything, no matter how hard I try. [I like it] because as long as you finish your homework between four and five o'clock, up to half past five, you will be rewarded' (FC_02).*

> *'But I started volunteering as "a little teacher" in Primary 3 … this wasn't [actually volunteering], it was by appointment, from the second term of Primary 3. Probably because I did my homework quickly' (FC_02).*

> *'They were exhausted and said that they were really sleepy. At that time, they were so sleepy that they fell asleep while doing their homework. I let them sleep for a while so that they could work again when they returned home' (FC_02).*

In addition, the children were satisfied with the participation of their family members in these activities. Indeed, many children expressed the wish to spend time with family members, especially their parents and siblings.

> *'[Interviewer: Oh, so do you like this activity (Understanding Adolescent Programme)?] I really like it … The best part is ... the parent-child day camp' (FC_05).*

5.2.2. SUMMARY

The foster children were the primary service recipients. However, as minors in the family and in society, the children had little say in the selection of services. With little involvement in the decision- making process, they could only receive services, especially specialised services passively. It could also be difficult for them to evaluate the quality of these services.

6. COMPARISON BETWEEN DIFFERENT STAKEHOLDERS

In a care context, the foster care workers and foster parents were the service providers, the family caregivers and the children were the service recipients. They had different roles and responsibilities regarding the children's use of the service, particularly in the case of specialised services, which also shaped their experiences with service utilisation.

The foster care workers and foster parents played an active role in service identification, mobilisation, coordination and implementation. The accessibility and effectiveness of the services were not only significant for the recovery of the children, but also for the burden of care on the foster parents. The latter was important, as it was related to their mental health, which in turn affected placement stability. Conversely, the family caregivers and the children played a relatively passive role in receiving help from professionals and foster parents. This could prevent them from actively participating in service use, and be particularly so for children as they usually play a minor role in the family and society.

In addition, the views on the importance and effects of developmental services varied between stakeholders. While the foster care workers and foster parents emphasised the value of specialised services as being essential to reducing the children's symptoms and restoring their functioning, the family caregivers attached equal importance to specialised and developmental services for their children. A holistic development of their children was very important, whether they had special needs or not. The children shared the same view as their parents. Although they treasured the support of specialised services, they enjoyed participating in developmental activities.

With respect to the barriers to and factors facilitating the accessibility and effectiveness of assessment and treatment services, it was interesting to find that both service providers and children's supporters played a more important role than the service users (i.e., the children). Moreover, the foster care workers and foster parents expressed their views in more detail than the family caregivers and children, further confirming their different roles and responsibilities.

PART V DISCUSSION

Some significant observations of the mental health needs and service use of foster children were made in this study, in relation to the mental health system, the care system and the school system in Hong Kong.

1. MENTAL HEALTH SYSTEM

1.1. DIAGNOSIS-DRIVEN

The findings from both the quantitative study and the qualitative study indicate that mental health services for foster children are currently diagnosis-driven. Moreover, as reported by foster care workers and foster parents, children are only eligible for mental health services if they have an established diagnosis. Taken together, these findings suggest that obtaining an assessment is the key to the children getting access to mental health services.

1.2. RESOURCES AVAILABILITY

The study findings also indicate that public resources are insufficient to address the mental health needs of children in foster care (Table 30 and Table 32). The qualitative study findings also demonstrate that some children who have mental health or developmental issues are placed on a waiting list for a considerable time before they can get an assessment due to an insufficient number of assessors. Even after an assessment, some children who were eligible for services were required to wait for a long time for treatment due to the insufficient provision of treatment in the public sector.

2. CARE SYSTEM

2.1. RISK FACTORS PERTAINING TO THE MENTAL HEALTH ISSUES OF CHILDREN

Our study identified several risk factors that can cause mental health issues in foster children, including gender, participation in extra-curricular activities, and the quality of foster parent-child relationship. Specifically, male foster children were 3.5 times more likely to fall within the clinical range of the CBCL total scores than female foster children. Foster children who participated in extra- curricular activities, however, had a lower risk of falling within the clinical range set by the CBCL total scores. Foster children who had a better foster parent-child relationship had a lower likelihood of falling within the clinical range of the CBCL external scores (Table 46).

In addition, our study identified several risk factors that can cause mental health service use in foster children, including gender, and participation in extra-curricular activities. Specifically, male foster children have an increased likelihood of receiving these services, and they are 3.68 times more likely to receive the services than female foster children. Foster children who participated in extra- curricular activities had a lower likelihood of receiving these services (Table 47).

2.2. ROLE OF FOSTER CARE PARENTS

Our findings also suggest that foster parents play an important role in promoting access to treatment and treatment effectiveness. The results of our qualitative study demonstrate that although professionals have limitations on their ability to obtain treatment for children with borderline cases, the ability of foster parents to engage or negotiate with the needed services helps foster children gain access to treatment. After foster children enter treatment, the foster parents' involvement in the children's treatment – in terms of taking the children to receive the services, negotiating with related parties, learning relevant skills and displaying patience and persistence with the children – facilitates treatment effectiveness.

Whilst a commitment to the treatment and involvement from foster care parents are crucial for treatment effectiveness, some factors that may have a negative influence on foster parents' involvement and commitment deserve further attention. First, a child's externalised behaviour can have a negative effect on his or her relationship with the foster parents, possibly because the foster parents are too exhausted to discipline the child or lack the appropriate parenting skills. Second, although most foster parents try their best to care for foster children with special needs, insufficient support (e.g., subsidies) might prevent them from providing quality care.

2.3. ROLE OF FAMILY CAREGIVERS AND CHILDREN

The qualitative findings show that although most family caregivers and children valued support from professionals and foster parents, they tended to place a great deal of reliance upon the professionals and foster parents and play a passive role in service selection and use. As a result, family caregivers may lack the competence to care for their children, particularly if family reunification was the permanent plan for these children. Moreover, the children, who are the actual service recipients, lack a voice in service selection and use, and without their voices, it is difficult to provide tailor-made services for them.

3. SCHOOL SYSTEM

3.1. SUPPORT FROM SCHOOLS

School is one of the most significant contexts for children's learning and development. Due to these children's disadvantaged backgrounds, their learning needs differ from those of their counterparts, whether they have a diagnosis or not. Many teachers tend to overlook their backgrounds and treat them the same as their peers. Moreover, some children who manifest learning difficulties cannot receive sufficient educational support from their schools.

3.2. FUNCTION OF EXTRA-CURRICULUM ACTIVITIES

This study reveals that the developmental services offered were highly valued by the family caregivers and children. Foster children who are excluded from extra-curricular activities are more likely to have mental health issues due to being marginalised, suggesting the importance of extra- curricular activities for promoting children's mental health and development.

PART VI RECOMMENDATIONS

Based on the study findings, several recommendations are proposed.

1. MENTAL HEALTH SYSTEM

An increase in resources for the mental health system is needed because insufficient resources lead to a delay in receiving assessments and accessing treatment. The mental health system should expand such resources to children receiving out-of-home care service because their needs differ from those of in-home children. Moreover, foster care workers are encouraged to work with foster families to advocate for more resources to be provided to assessment and treatment services from the public sector. In addition, social workers could help children and their families to explore different resources (e.g. funding) for treatment in the private sector for children who are not eligible for public services.

Case management services are needed to coordinate the services from assessment to treatment. Because inconsistent views of various parties on children's issues could lead to delays in assessment and treatment, it is suggested that case management services help all key informants gain a comprehensive understanding of the children's issues and that they clearly present those issues in the assessment. The function of case management services should also include helping foster families fill in service gaps and monitor service provision.

More services and programs that address children's developmental needs are warranted. Because mental health services for children are diagnosis-driven, foster children who have mental health or developmental issues but do not have an established diagnosis or are on a long waiting list for assessment and/or treatment cannot receive services. In such cases, the provision of more services or programs to support developmental needs could fill in the gaps created by the children's needs and service limitations.

2. CARE SYSTEM

Although the results reveal that gender, the frequency of returning home and the number of placements are the risk factors for mental health issues, it is suggested that professionals, especially child welfare professionals, should devote greater attention to high-risk cases. An increase in the frequency of case reviews for high-risk cases would be helpful for the early detection of issues in these children.

It is also necessary to establish and maintain a reliable database to help those involved make better informed decisions, plan targeted interventions that address the mental health needs of children in foster care, and support these children's development into healthy and resilient adults. As found in the present study, predictors of the mental health needs or the service utilization of foster children included both the variables at the foster child's level (gender and participation in extra- curricular activities) and the foster family's level (foster parent-child relationship). The database should not only collect information at an individual level, but also at an interpersonal level to understand any significant influence in the social environments on the mental health of the foster children. The database should be made available to the case workers and other collaborative helping professionals (e.g. occupational therapists, speech therapists) to promote an understanding of the foster children in a more holistic perspective in the mind of every involved party. A special working committee of experts in child welfare should be set up, and the key stakeholders should include children.

Furthermore, an increase in support for foster parents who care for children with special needs is urgently needed. In addition to expanding the scope of financial support, it is suggested that more educational services, special training and extra support for foster parents are needed because the foster parent–child relationship can affect the foster parents' commitment to help such children gain access to treatment. These services could include activities and training programmes designed to enhance involvement and create an awareness of mental health, child development and strength- based management among foster parents.

Because the biological parents are also key informants of the children's behavioral issues and potential careers, services for biological parents are also necessary. Services that aim to help biological parents understand their child's situation and/or gain more information about their child's developmental needs should be increased. These services could include education, parenting training and financial support to access needed services.

The children themselves should play a more active role in the selection and use of services, and professionals should treat them as work partners. Their voices must be amplified through formal (e.g., case review) and informal (e.g., casual contact) channels to make mental health services more child- centred.

3. SCHOOL SYSTEM

Many children in foster care have disadvantaged and traumatic backgrounds that have had a negative influence on their learning. School-related staff should understand their special conditions and distinguish their learning needs from those of general children. Foster children with mental health needs should receive extra support from their school to facilitate their learning. Moreover, because a lack of participation in extra-curricular activities could result in negative outcomes, children should be encouraged to participate in extra-curricular activities. To do so, it is suggested that schools increase collaboration with community services at the district level, such as Integrated Children and Youth Service Centres and Community Centres.

PART VII CONTRIBUTIONS, LIMITATIONS AND FUTURE STUDY

1. Contributions

This study contributes to recent literature on the mental health issues and service use of children in foster care in Hong Kong. The use of both quantitative and qualitative methods increased the breadth and depth of the exploration. Triangulating the findings of these methods allowed us to accurately pinpoint aspects of the phenomena under study. In addition, surveying both foster care workers and foster parents and conducting in-depth interviews with multiple key stakeholders enabled us to develop a comprehensive picture of the study topic. The voices of children, which are commonly overlooked in child-related research, were elicited.

2. Limitations

First, this study was cross-sectional and thus unable to explore the effects of children's service use and changes in children's mental health over time.

Second, we were unable to collect the views of referring workers as planned. The absence of their voices may have limited our exploration of service use by children in foster care.

Third, the study's findings regarding foster children are limited because we excluded children aged 0-3 from the overall study and child respondents from the survey, and interviewed only four children.

3. Future study

It is necessary to continue investigating the needs of children receiving out-of-home care in Hong Kong, as they are regarded as one of the most vulnerable groups in society. Two main directions for future research in this field are suggested. First, the current study could be replicated with types of care/care facilities other than foster care (e.g., small group homes, children's homes, boys'/girls' homes with/without a school component). As children in these different care facilities have different profiles, it is important to compare their mental health needs and service use. Second, a longitudinal study would facilitate further exploration of the service use of children in foster care and the impact of these services on their rehabilitation over time. This would guide and enhance the formulation of services targeting children in foster care.

PART VIII THE WAY FORWARD

From the findings of the research team, 40.2% of the foster children had a diagnosis of mental health problems and 23.5% of the foster children were within the clinical range of the CBCL total scores. Eighteen point four percent of the foster children were in need of a mental health service but the services were not available, while 14.9% of the foster children were still waiting for their mental health services. Risk factors affecting the mental health condition of foster children were found.

Regarding the mental health problems foster children experience, a history of maltreatment, various types of problems of the birth family, the number of placements (for foster children aged 3- 5½), relationships with foster parents, Extra-Curriculum Activities (ECA), and home leave arrangements were all found to be significantly correlated with foster children's mental health problems. Meanwhile, the use of mental health services was also correlated with the presence of a diagnosis, CBCL total and external scores, and home leave arrangements. Moreover, delayed identification, lack of coordination of pre-care information, and discrepancies between professionals and caregivers were found to be the barriers to assessment and treatment services.

Though some of these factors, such as a history of maltreatment, types of problems of the birth family, the number of placements and the presence of a diagnosis within the clinical range of the CBCL scores, seemed to be irretrievable, it was still believed that the impact of these factors could be remediable through different interventions during the foster placement. Some variables such as the arrangement of the ECA, relationships with foster parents and home leave arrangements were more feasible though there would be some difficulties in implementation. Furthermore, early identification of the children's problems, better coordination of pre-care information and alignments among professionals were also essential factors that would moderate the mental health condition of foster children.

Based on these findings, the research team has made several recommendations to the mental health system, the care system and the school system. The recommendations included providing additional resources for assessment / treatment services and developmental services for foster children and the establishment of a case management service with a comprehensive data base for keeping the records of the foster children in the mental health system, giving attention to high risk cases (such as boys, those with fewer home leaves and those with more changes of placements), training and support for foster parents and biological parents in the care system, enhancing understanding towards foster children, and the arrangement of more extracurricular activities in the school system. During the process of intervention, the involvement of foster children as work partners was also addressed.

To echo the findings, the Hong Kong Family Welfare Society would like to respond to the results by addressing the mental health needs of foster children and recommending the way forward for the Foster Care Service. Several areas relating to the mental health problems of foster children and their use of services were worth addressing. Having preventive and remedial measures to build up resilience and remedy the negative impacts on foster children throughout the fostering process, from the intake and matching period to placement in foster care service was suggested. (Figure 1)

Figure 1 Recommendation of Care Plan (preventive and remedial measures) for foster children

Early identification

1. Comprehensive Screening / Assessment tool

To develop/adopt a suitable screening tool (checklist) to assess the mental health condition of the foster children at intake & matching and early placement stage in order to identify foster children's needs and mental health situation. It could help identifying the needs of children, care plan and timely assessment/intervention could be arranged.

Intervention and Treatment

2. Timely Intervention

2.1. Individual Care Plan with collaboration of Multi- disciplinary professionals

To develop/strengthen Multi-disciplinary collaboration mechanism on clinical assessment and treatment plan with on-going review on the care plan was recommended.

2.2. Resilience building as protective factors for Foster children's mental health

The 7Cs – Resilience building strategy:
2.2.1. Strength based development approach
2.2.2. "Family matters" – cultivating the positive value on "Family"

3. Treatment of mental health problems for foster children with mental health conditions

3.1. Home based Training for foster child and foster parents
3.2. Utilization of ICT means for treatment/training

Management of case development & Ongoing follow-up

4. Ongoing support and Review

4.1 Facilitate Multi-disciplinary collaboration
4.2 Role of Foster parents and render continuous support

EARLY IDENTIFICATION

1. COMPREHENSIVE SCREENING / ASSESSMENT TOOL

Early identification and assessment could facilitate timely follow up and treatment for foster children with mental health problems. However, under the existing ‘diagnosis driven’ mental health services provision and the twisted path of the processing of referrals for mental health assessment and treatment services, together with the diverse views among different parties, including the foster care workers, foster parents, birth parents and the family social workers, the process was lengthy. It was suggested that a suitable screening tool / checklist be developed/ adopted to assess the mental health condition of the foster children in the intake and matching period, and that the identification of foster children’s needs and mental health situation be done early in the foster care service placement stage so that timely intervention could be arranged. As the waiting period for the assessment service and treatment service was long, the use of a screening / assessment tool could help identify the needs of foster children at the early stages of placement so that early intervention could be arranged.

INTERVENTION AND TREATMENT

2. TIMELY INTERVENTION

2.1. Individual Care Plan with the collaboration of Multi-disciplinary professionals

Based on the result of the screening and the initial assessment of the needs of the foster children, an individual care plan for each foster child after placement was recommended. The care plan would include the foster children’s daily care arrangements as in existing practice (the care system being responsible), schooling arrangements and support for specific/special needs such as tutorial classes, developmental groups and programs for the foster children (cooperate with the school system), and the preventive and remedial measures for the foster children’s mental health conditions (cooperate with the mental health system).

To facilitate better coordination among the professionals from the three systems mentioned above, the establishment of a collaboration mechanism was recommended. Multi-disciplinary professionals’ joint efforts on clinical assessments and treatment plans with on-going reviews was important. New initiatives such as regular surveys for needs assessments, phone contacts and meetings to invite different professionals including teachers, therapists, clinical psychologists, and psychiatrists to share their views and suggestions to formulate a care plan for the foster children should be undertaken.

However, due to the long waiting list for, or unavailability of, some mental health services, such as an assessment and treatment by an education psychologist or psychiatrist, or group counseling services and speech therapy, the needs of foster children could not be fulfilled and their mental health problems would be affected due to the delayed intervention. Extra resources to get voluntary or purchased professional services to provide early support to the foster children is needed.

2.2. Resilience building as a protective factor for Foster children's mental health

It was commonly found that foster children from families with complicated backgrounds had experienced different levels of insufficiency including inadequate care / parenting skills, frequent changing of carers leading to attachment problems, maltreatment, and maternal prenatal drug abuse causing neonatal complications etc. Such experiences would have a long-lasting adverse impact on the foster children and would lead to different mental, emotional, or behavioral problems. To minimize these adverse impacts of their complicated family backgrounds, building up the foster children's resilience was essential for their future lives.

Resilience was said to be made up of '7Cs', namely competence, confidence, connection, character, contribution, coping and control (John Dabell, 2018). Table 57 shows the key focus of each 'C'.

Table 57 The Components of Resilience building – The 7Cs

Components	**Key focus**
Competence	To have opportunities to develop specific skills
Confidence	To build the children's confidence
Connection	To have healthy connections with a community (family/peers/school)
Character	To understand right and wrong and the capacity to make a wise choice
Contribution	To serve others by helping them learn how to seek help
Coping	To learn healthy coping strategies for managing their stress
Control	To have a degree of control over their lives and their environment

To help the foster children build their resilience according to the 7Cs, the following measures were suggested.

2.2.1. Strength based development for foster children

Helping foster children develop their interests and abilities could enhance their competence, confidence, coping skills and self-control. From the findings and recommendation of the research team, extra-curricular activity is correlated with the children's mental health. Though the Education Bureau has promoted the 'One-life-one-art/sports Scheme', most foster children were unable to have such training for various reasons, such as the absence of regular and long-term financial support, limitations in school bus arrangements for after school extra-curricular activities, and time clashes with home leave arrangements. Resources that provide foster children with the opportunity to develop their resilience through committing to extra-curricular activities have become essential and should be further enhanced.

2.2.2. 'Family matters' for foster children

Having a connection with others is important for one's sense of security. Family is said to be the root of everyone. It is the most important unit of connection for children. Coming from families with complicated problems, foster children are more in need of family connections. Foster care families provide individualized and unique care to foster children. This serves as an important substitute for family connections to the foster children.

In this study, home leave arrangement, family problems and relationships with foster families were shown to be correlated with the mental health of foster children, reflecting the impact of the “family” on foster children. The research team also recommended that resources for supporting foster parents and biological parents should be increased.

To help foster children have a connection with their birth families, both physical (close contacts such as home leave) and psychological (positive views and attitude towards the birth families) intervention were vital. From the findings of the research, one of the services foster children were in need of but was not available was Parent-Child groups. Groups and programs for building up parent- child relationships, strengthening the birth parents’ capacity to care, and cultivating positive values regarding the family were therefore suggested.

For those foster children who are not in contact with their birth families, a replacement for this “connection” need should be considered. The foster families would become role models of a healthy family that could help foster children cultivate positive values regarding family. Other supporting programs such as mentorship and volunteer services could also help foster children develop connections with different communities.

3. TREATMENT OF MENTAL HEALTH PROBLEMS FOR FOSTER CHILDREN WITH MENTAL HEALTH CONDITIONS

For foster children with mental health problems, other than resilience building, comprehensive treatment is an inevitable step that can be taken to improve their mental health conditions. In the existing practice, during the treatment process, foster children encountered difficulties such as a long waiting list, long intervals before receiving follow up treatment, and the foster home being a long way from the clinic etc. From the research findings, it can be seen that 18.4% of the foster children were in need of mental health services but they were not available and 14.9% of the foster children were still waiting for mental health services. The research team also recommended that it is necessary to expand the assessment and treatment services. Hence, other than the clinic/hospital- based practice of the treatment services, new initiatives to fill the service gap were recommended.

3.1. Home based training for Foster children and Foster parents

As there is a long interval between treatment sessions for some services, together with the need for daily practice, having out-reaching and home-based training for foster parents to facilitate the implementation of treatment plans at home was suggested. For those foster children with greater treatment needs, home based treatment would be more practicable as children could learn in a familiar environment and the therapist could have more understanding of what could facilitate treatment in the family environment.

3.2. Utilization of Information & Communication Technology (ICT)

With the rapid development of information and communication technology (ICT), the introduction of ICT to facilitate the treatment of foster children with mental health problem is emerging. The use of training videos on YouTube, training through Zoom/Google meet, the use of Apps for games or TV games etc. have become effective means for supporting the treatment of foster children. The development of new Apps and treatments could be considered.

MANAGEMENT OF CASE DEVELOPMENT & ONGOING FOLLOW-UP

4 ONGOING SUPPORT AND REVIEW

4.1. Multi-disciplinary collaboration

Having different measures, from preventive to remedial, to improve the foster children's mental health problems, ongoing support, and review were indispensable. The review of the care plan and a re-assessment of the foster children's mental health conditions could help to develop more tailor- made interventions for the foster children. Again, multi-disciplinary collaboration for the review is a requisite. In the present practice, there are case review meetings for each foster child every 6 months to discuss their development and welfare plans. Those attending the meeting were mainly referring workers, foster care workers, foster parents, and foster children if they were aged 4 or above. The involvement of foster children as a work partner, and other professionals such as teachers, clinical psychologists and concerned therapists was highly recommended as they could provide a more comprehensive view of the performance of the intervention plan for the child concerned. Pre- meeting contacts / questionnaires could be applied to collect the views of different professionals and those unable to join the meeting. The application of ICT methods such as Zoom/Google meet could also help.

4.2. Role of foster parents and rendering continuous support

To facilitate the screening, assessment and intervention, the role of foster parents was crucial. Other than providing daily care for the foster children, they must also handle the emotional and behavioral problems caused by the mental health conditions, help the screening by observing the children's condition and reporting to the professionals, escort foster children to and from clinics/hospitals for assessment and treatment services, join review meetings and facilitate the connection between foster children and their birth parents.

Foster parents should have a clear understanding of their roles and adopt a positive attitude towards these roles. Providing resources and training to support the foster parents is also essential. Having regular structural and educational training, and mutual support groups for foster parents is deemed necessary.

Conclusion

In view of the research findings, there were several aspects worth noting and following up. Recommendations for a screening / assessment for the early identification of a foster child's needs, the design of a care plan for the foster child done as a joint effort among professionals, timely interventions with preventive and remedial measures, and on-going support and review, were made. Although it would have implications regarding the need for additional resources, for the sake of the foster children and to reduce the consumption of social capital in the future, it is worthwhile to consider such advancements.

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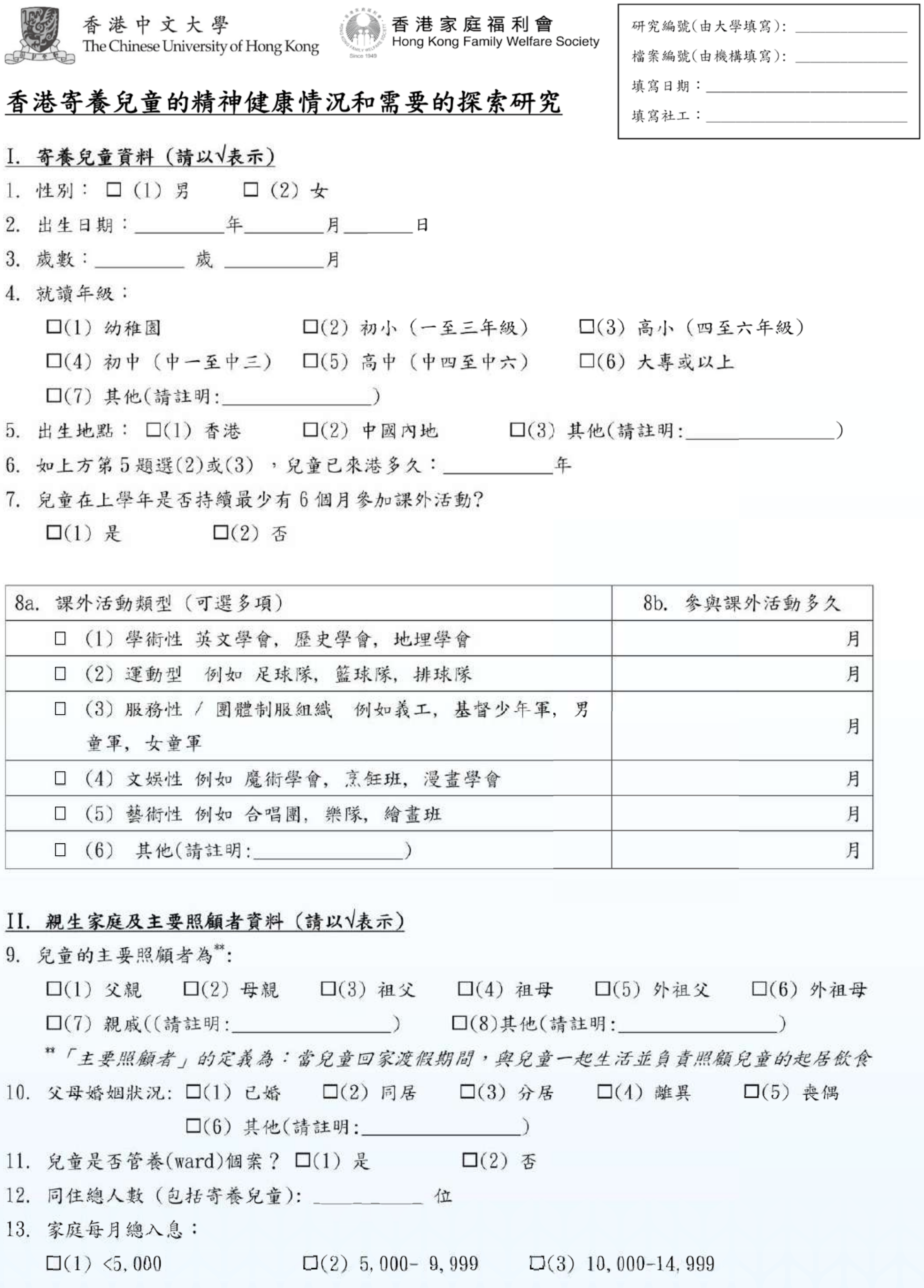
APPENDIX

Appendix I Demographic information – (Chinese version)



香港中文大學
The Chinese University of Hong Kong

香港家庭福利會
Hong Kong Family Welfare Society
Since 1949

研究編號(由大學填寫)：______________
檔案編號(由機構填寫)：______________
填寫日期：______________
填寫社工：______________

香港寄養兒童的精神健康情況和需要的探索研究

I. 寄養兒童資料（請以√表示）

1. 性別：□（1）男　□（2）女

2. 出生日期：________年________月________日

3. 歲數：________歲________月

4. 就讀年級：

□(1) 幼稚園　□(2) 初小（一至三年級）　□(3) 高小（四至六年級）
□(4) 初中（中一至中三）　□(5) 高中（中四至中六）　□(6) 大專或以上
□(7) 其他(請註明:______________)

5. 出生地點：□(1) 香港　□(2) 中國內地　□(3) 其他(請註明:______________)

6. 如上方第5題選(2)或(3)，兒童已來港多久：__________年

7. 兒童在上學年是否持續最少有6個月參加課外活動?

□(1) 是　□(2) 否

8a. 課外活動類型（可選多項）	8b. 參與課外活動多久
□（1）學術性 英文學會，歷史學會，地理學會	月
□（2）運動型　例如 足球隊，籃球隊，排球隊	月
□（3）服務性 / 團體制服組織　例如義工，基督少年軍，男童軍，女童軍	月
□（4）文娛性 例如 魔術學會，烹飪班，漫畫學會	月
□（5）藝術性 例如 合唱團，樂隊，繪畫班	月
□（6）其他(請註明:______________)	月

II. 親生家庭及主要照顧者資料（請以√表示）

9. 兒童的主要照顧者為**：

□(1) 父親　□(2) 母親　□(3) 祖父　□(4) 祖母　□(5) 外祖父　□(6) 外祖母
□(7) 親戚((請註明:______________)　□(8)其他(請註明:______________)

***「主要照顧者」的定義為：當兒童回家渡假期間，與兒童一起生活並負責照顧兒童的起居飲食*

10. 父母婚姻狀況：□(1) 已婚　□(2) 同居　□(3) 分居　□(4) 離異　□(5) 喪偶
□(6) 其他(請註明:______________)

11. 兒童是否管養(ward)個案？□(1) 是　□(2) 否

12. 同住總人數（包括寄養兒童）：__________位

13. 家庭每月總入息：

□(1) <5,000　□(2) 5,000- 9,999　□(3) 10,000-14,999

□(4) 15,000-19,999　□(5) 20,000-24,999　□(6) 25,000-29,999
□(7) 30,000-34,999　□(8) 35,000-39,999　□(9) 40,000-44,999
□(10) 45,000-49,999　□(11) 50,000-54,999　□(12) 55,000-59,999
□(13) 60,000-64,999　□(14) 65,000-69,999　□(15) >70,000

14. 家庭現有否接受任何經濟援助？(可選多項):

□(1) 獲全額資助領取綜合社會保障援助計劃(綜援)　□(2) 鼓勵就業交通津貼計劃 (交津)
□(3) 學生資助計劃(如免入息審查貸款計劃、資助專上課程及專上學生車船津貼、學費減免、學校書簿津貼計劃等)
□(4) 關愛基金，請註明類別:_______________　□(5) 長者生活津貼
□(6) 其他社會保障援助 (如：傷殘津貼)　□(7) 校本支援計劃津貼
□(8) 其他，請註明:____________________　□(9) 沒有

有關親生**父親**的資料

15. 父親歲數：__________ 歲

16. 出生地點： □(1) 香港　□(2) 中國內地　□(3) 其他(請註明:________________)

17. 如上方第 16 題已選(2) 或(3) ，父親已來港多久：___________年

18. 最高教育程度:

□(1) 沒有接受過正規教育　□(2)幼稚園　□(3)小學畢業
□(4) 初中畢業(中一至中三)　□(5)高中畢業(中四至中五)　□(6)預科畢業(中六至中七)
□(7) 大學/大專或以上　□(8)其他(請註明：________________)

19. 工作情況：

□(1) 全職　□(2) 兼職　□(3) 自僱人士　□(4) 失業/待業
□(5) 散工　□(6) 全職家庭照顧者　□(7) 其他(請註明：________________)

20. 是否與兒童同住?　□(1) 是　□(2) 否

21. 是否有藥物/毒品濫用的問題: □(1) 是　□(2) 否

22. 是否有身體健康的問題:　□(1) 是　□(2) 否

23. 是否有犯罪的紀錄:　□(1) 是　□(2) 否

24. 是否確診患有精神健康問題: □(1) 是　□(2) 否

25. 如上方第 24 題已選「是」，被確診的精神健康問題是：

□(1) 思覺失調/精神分裂症(schizophrenia)　□(2) 情感性精神分裂症(Schizoaffective disorder)
□(3) 躁鬱症(Bipolar Disorder)　□(4) 抑鬱症(Depression)
□(5) 焦慮症(Generalized Anxiety Disorder)　□(6) 強迫症(Obsessive-Compulsive Disorder)
□(7) 其他(請註明:________________)

26. **以前**接受過的精神健康服務：(可選多項)

□(1) 公立醫院精神科專科診所　□(2) 公立醫院社區精神科服務
□(3) 公立精神科醫院或公立醫院精神科住院服務　□(4) 公立醫院精神科日間中心
□(5)「思覺失調」服務計劃醫務社會服務　□(6) 精神健康綜合社區中心
□(7) 為精神病康復者而設的輔助宿舍或中途宿舍　□(8) 精神病康復者家屬資源中心

□(9) 日間訓練或職業康復服務　□(10) 社會福利署醫療社會服務
□(11) 社會福利署/非政府社福機構/私家臨床心理服務　□(12) 私家精神科專科醫生
□(13) 社會福利署/非政府社福機構綜合家庭服務中心　□(14) 私家輔導服務
□(15) 其他(請註明:________________)　□(16) 沒有

27. **現時**接受的精神健康服務：(可選多項)
□(1) 公立醫院精神科專科診所　□(2) 公立醫院社區精神科服務
□(3) 公立精神科醫院或公立醫院精神科住院服務　□(4) 公立醫院精神科日間中心
□(5)「思覺失調」服務計劃醫務社會服務　□(6) 精神健康綜合社區中心
□(7) 為精神病康復者而設的輔助宿舍或中途宿舍　□(8) 精神病康復者家屬資源中心
□(9) 日間訓練或職業康復服務　□(10) 社會福利署醫療社會服務
□(11) 社會福利署/非政府社福機構/私家臨床心理服務　□(12) 私家精神科專科醫生
□(13) 社會福利署/非政府社福機構綜合家庭服務中心　□(14) 私家輔導服務
□(15) 其他(請註明:________________)　□(16) 沒有

有關親生母親的資料

28. 母親歲數：__________ 歲

29. 出生地點： □(1) 香港　□(2) 中國內地　□(3) 其他(請註明:________________)

30. 如上方第 29 題已選(2) 或(3) ，母親已來港多久：__________年

31. 最高教育程度:
□(1) 沒有接受過正規教育　□(2)幼稚園　□(3)小學畢業
□(4) 初中畢業(中一至中三)　□(5)高中畢業(中四至中五)　□(6)預科畢業(中六至中七)
□(7) 大學/大專或以上　□(8)其他(請註明:________________)

32. 工作情況：
□(1) 全職　□(2) 兼職　□(3) 自僱人士　□(4) 失業/待業
□(5) 散工　□(6) 全職家庭照顧者　□(7) 其他(請註明:________________)

33. 是否與兒童同住?　□(1) 是　□(2) 否

34. 是否有藥物/毒品濫用的問題:□(1) 是　□(2) 否

35. 是否有身體健康的問題:　□(1) 是　□(2) 否

36. 是否有犯罪的紀錄:　□(1) 是　□(2) 否

37. 是否確診患有精神健康問題: □(1) 是　□(2) 否

38. 如上題已選「是」，被確診的精神健康問題是：
□(1) 思覺失調/精神分裂症(schizophrenia)　□(2) 情感性精神分裂症(Schizoaffective disorder)
□(3) 躁鬱症(Bipolar Disorder)　□(4) 抑鬱症(Depression)
□(5) 焦慮症(Generalized Anxiety Disorder)　□(6) 強迫症(Obsessive-Compulsive Disorder)
□(7) 其他(請註明:________________)

39. **以前**接受過的精神健康服務：(可選多項)
□(1) 公立醫院精神科專科診所　□(2) 公立醫院社區精神科服務

□(3) 公立精神科醫院或公立醫院精神科住院服務
□(4) 公立醫院精神科日間中心
□(5)「思覺失調」服務計劃醫務社會服務
□(6) 精神健康綜合社區中心
□(7) 為精神病康復者而設的輔助宿舍或中途宿舍
□(8) 精神病康復者家屬資源中心
□(9) 日間訓練或職業康復服務
□(10) 社會福利署醫療社會服務
□(11) 社會福利署/非政府社福機構/私家臨床心理服務
□(12) 私家精神科專科醫生
□(13) 社會福利署/非政府社福機構綜合家庭服務中心
□(14) 私家輔導服務
□(15) 其他(請註明:________________)
□(16) 沒有

40. **現時**接受的精神健康服務：(可選多項)

□(1) 公立醫院精神科專科診所
□(2) 公立醫院社區精神科服務
□(3) 公立精神科醫院或公立醫院精神科住院服務
□(4) 公立醫院精神科日間中心
□(5)「思覺失調」服務計劃醫務社會服務
□(6) 精神健康綜合社區中心
□(7) 為精神病康復者而設的輔助宿舍或中途宿舍
□(8) 精神病康復者家屬資源中心
□(9) 日間訓練或職業康復服務
□(10) 社會福利署醫療社會服務
□(11) 社會福利署/非政府社福機構/私家臨床心理服務
□(12) 私家精神科專科醫生
□(13) 社會福利署/非政府社福機構綜合家庭服務中心
□(14) 私家輔導服務
□(15) 其他(請註明:________________)
□(16) 沒有

有關其他照顧者(非親生父母和非管養(ward)個案)的資料

41. 與兒童之關係：____________

42. 兒童的主要照顧者歲數：__________ 歲

43. 出生地點： □(1) 香港 □(2) 中國內地 □(3) 其他(請註明:________________)

44. 如上方第 43 題已選(2) 或(3) ，已來港多久：___________年

45. 最高教育程度:

□(1)沒有接受過正規教育
□(2)幼稚園
□(3)小學畢業
□(4)初中畢業(中一至中三)
□(5)高中畢業(中四至中五)
□(6)預科畢業(中六至中七)
□(7)大學/大專或以上
□(8)其他(請註明:________________)

46. 工作情況：

□(1) 全職
□(2) 兼職
□(3) 自僱人士
□(4) 失業/待業
□(5) 散工
□(6) 全職家庭照顧者
□(7) 其他(請註明:________________)

47. 是否有藥物/毒品濫用的問題: □(1) 是 □(2) 否

48. 是否有身體健康的問題: □(1) 是 □(2) 否

49. 使否有犯罪的紀錄: □(1) 是 □(2) 否

50. 是否確診患有精神健康問題: □(1) 是 □(2) 否

51. 如上題已選「是」，被確診的精神健康問題是：

□(1) 思覺失調/精神分裂症(schizophrenia)
□(2) 情感性精神分裂症(Schizoaffective disorder)
□(3) 躁鬱症(Bipolar Disorder)
□(4) 抑鬱症(Depression)
□(5) 焦慮症(Generalized Anxiety Disorder)
□(6) 強迫症(Obsessive-Compulsive Disorder)
□(7) 其他(請註明:________________)

52. **以前**接受過的精神健康服務：(可選多項)

□(1) 公立醫院精神科專科診所
□(2) 公立醫院社區精神科服務
□(3) 公立精神科醫院或公立醫院精神科住院服務
□(4) 公立醫院精神科日間中心
□(5)「思覺失調」服務計劃醫務社會服務
□(6) 精神健康綜合社區中心
□(7) 為精神病康復者而設的輔助宿舍或中途宿舍
□(8) 精神病康復者家屬資源中心
□(9) 日間訓練或職業康復服務
□(10) 社會福利署醫療社會服務
□(11) 社會福利署/非政府社福機構/私家臨床心理服務
□(12) 私家精神科專科醫生
□(13) 社會福利署/非政府社福機構綜合家庭服務中心
□(14) 私家輔導服務
□(15) 其他(請註明:________________)
□(16) 沒有

53. **現時**接受的精神健康服務：(可選多項)

□(1) 公立醫院精神科專科診所
□(2) 公立醫院社區精神科服務
□(3) 公立精神科醫院或公立醫院精神科住院服務
□(4) 公立醫院精神科日間中心
□(5)「思覺失調」服務計劃醫務社會服務
□(6) 精神健康綜合社區中心
□(7) 為精神病康復者而設的輔助宿舍或中途宿舍
□(8) 精神病康復者家屬資源中心
□(9) 日間訓練或職業康復服務
□(10) 社會福利署醫療社會服務
□(11) 社會福利署/非政府社福機構/私家臨床心理服務
□(12) 私家精神科專科醫生
□(13) 社會福利署/非政府社福機構綜合家庭服務中心
□(14) 私家輔導服務
□(15) 其他(請註明:________________)
□(16) 沒有

有關兒童的兄弟姊妹(包括親生及繼)的資料

54a. 與兒童之關係	54b. 性別	54c. 歲數	54d. 是否與家庭同住?
1. ____________	□(1) 男 □(2) 女	______ 歲	□(1) 與家庭同住 □(2) 兒童住宿照顧服務 □(3) 其他(請註明:________________)
2. ____________	□(1) 男 □(2) 女	______ 歲	□(1) 與家庭同住 □(2) 兒童住宿照顧服務 □(3) 其他(請註明:________________)
3. ____________	□(1) 男 □(2) 女	______ 歲	□(1) 與家庭同住 □(2) 兒童住宿照顧服務 □(3) 其他(請註明:________________)
4. ____________	□(1) 男 □(2) 女	______ 歲	□(1) 與家庭同住 □(2) 兒童住宿照顧服務 □(3) 其他(請註明:________________)
5. ____________	□(1) 男 □(2) 女	______ 歲	□(1) 與家庭同住 □(2) 兒童住宿照顧服務 □(3) 其他(請註明:________________)

6.______________	□(1) 男 □(2) 女	_____ 歲	□(1) 與家庭同住 □(2) 兒童住宿照顧服務 □(3) 其他(請註明:________________)
7. ______________	□(1) 男 □(2) 女	_____ 歲	□(1) 與家庭同住 □(2) 兒童住宿照顧服務 □(3) 其他(請註明:________________)
8.______________	□(1) 男 □(2) 女	_____ 歲	□(1) 與家庭同住 □(2) 兒童住宿照顧服務 □(3) 其他(請註明:________________)
9. ______________	□(1) 男 □(2) 女	_____ 歲	□(1) 與家庭同住 □(2) 兒童住宿照顧服務 □(3) 其他(請註明:________________)
10.______________	□(1) 男 □(2) 女	_____ 歲	□(1) 與家庭同住 □(2) 兒童住宿照顧服務 □(3) 其他(請註明:________________)

III. 有關兒童成長發展的資料(請以√表示)

55. 兒童是否曾被診斷有關情緒或精神健康的問題

□(1)是(請繼續回答第 56 題)　□(2)否(請跳到第 59 題)

56. 如上題選擇「是」，請在以下表格填上相關診斷的資料：

	a. 第一個診斷	b. 第二個診斷	c. 第三個診斷	d. 第四個診斷	e. 第五個診斷
請在右方空格內填上相關診斷的編號(見附表)					
57. 確診年齡	歲	歲	歲	歲	歲
58. 評估途徑---- (1)精神科醫生 (2)兒科醫生 (3)臨床心理學家 (4)教育心理學家 (5)職業治療師 (6)其它(請註明在方格內)					

59. 根據你的了解，兒童的家庭是否曾經有家暴記錄?：□(1) 是　　□(2) 否

60. 如上題選擇「是」，第一次發生家暴時兒童的歲數: ____________ 歲

61. 現時是否虐待兒童個案？(即經過多專業個案會議後，界定為高危或確立的虐兒個案)：

□(1) 是　　□(2) 否

如上題選擇「是」，請就現時受虐紀錄填寫以下資料 (可選多項)：

62.	(1)身體虐待	(2)精神虐待	(3)疏忽照顧	(4)性虐待	(5)多種虐待	(6)其他
63. 受虐時兒童的歲數						
64. 與施虐者的關係						

如兒童有多於一次受虐紀錄，請就第一次紀錄繼續填寫以下資料 (可選多項):

65.	(1)身體虐待	(2)精神虐待	(3)疏忽照顧	(4)性虐待	(5)多種虐待	(6)其他
66. 受虐時兒童的歲數						
67. 與施虐者的關係						

如兒童有多於兩次受虐紀錄，請就第二次紀錄繼續填寫以下資料（可選多項）:

68.	(1)身體虐待	(2)精神虐待	(3)疏忽照顧	(4)性虐待	(5)多種虐待	(6)其他
69. 受虐時兒童的歲數						
70. 與施虐者的關係						

IV. 使用兒童住宿照顧服務資料:（請以√表示）

目前正在使用的寄養服務：

71. 開始使用服務時兒童的歲數：____________歲

72. 使用服務多久？________________月

73. 使用服務的原因(可選多項)：

兒童自身問題----

□(1)行為問題 □(2)情緒問題 □(3)身體問題 □ (4)精神問題 □(5)離家出走

□(6)性格問題 □(7)人際關係問題 □(8)兄弟姐妹受虐 □ (9)學業問題

□(10)受不良朋輩影響 □(11)受虐(非父母)□(12)智力有限

□(13)其他(請註明:_______________)

家庭問題----

□(14)長期離港 □(15)離異 □(16)刑事犯案紀錄 □(17)濫藥 □(18)情緒問題

□(19)健康問題 □(20)住院 □(21)監禁 □(22)不當管教 □(23)長時間工作

□(24)精神問題 □(25)父或母或雙親死亡 □(26)性格問題 □(27)欠債

□(28)虐兒 □(29)婚姻問題 □(30)未婚母親 □(31)經濟問題 □(32)住屋問題

□(33)其他(請註明:_______________)

74. 使用服務的**主要原因**(請填上以上其中一個號碼): ________________

75. 過去 6 個月內平均回家渡假的情況：

□(1) 沒有回家渡假 □(2) 一星期一次 □(3) 兩星期一次

□(4) 一個月一次 □(5) 兩個月一次 □(6) 其他(請註明:________________)

除現時寄養服務之外，如兒童曾經使用其他兒童住宿照顧服務，請回答以下問題:

第一次使用兒童住宿照顧服務的資料：

76. 兒童住宿照顧服務類別:

□(1)寄養服務 □(2)寄養服務(緊急照顧) □(3)兒童之家

□(4)緊急/短期兒童之家 □(5)留宿幼兒中心(留宿育嬰園) □(6)留宿幼兒中心(留宿幼兒園)

□(7)兒童收容中心 □(8)兒童院 □(9)男/女童院沒有/設有群育學校

□(10)男/女童宿舍 □(11)其他(請註明:________________)

77. 開始使用該服務時兒童的歲數：____________歲

78. 使用服務多久？________________月

79. 使用服務的原因(可選多項)：

兒童自身問題----

□(1)行為問題 □(2)情緒問題 □(3)身體問題 □ (4)精神問題 □(5)離家出走
□(6)性格問題 □(7)人際關係問題 □(8)兄弟姐妹受虐 □ (9)學業問題
□(10)受不良朋輩影響 □(11)受虐(非父母)□(12)智力有限
□(13)其他(請註明:________________)

家庭問題----

□(14)長期離港 □(15)離異 □(16)刑事犯案紀錄 □(17)濫藥 □(18)情緒問題
□(19)健康問題 □(20)住院 □(21)監禁 □(22)不當管教 □(23)長時間工作
□(24)精神問題 □(25)父或母或雙親死亡 □(26)性格問題 □(27)欠債
□(28)虐兒 □(29)婚姻問題 □(30)未婚母親 □(31)經濟問題 □(32)住屋問題
□(33)其他(請註明:________________)

80. 使用服務的**主要**原因(請填上以上其中一個號碼): ________________

81. 轉換住宿的**主要**原因(只選一項)：

□ (1) 超齡 □ (2) 住宿不適合兒童的需要 □(3) 家庭團聚
□ (4) 領養 □ (6) 獨立生活 □(7) 其他 (請註明:________________)

第二次使用兒童住宿照顧服務的資料：

82. 兒童住宿照顧服務類別:

□(1)寄養服務 □(2)寄養服務(緊急照顧) □(3)兒童之家
□(4)緊急/短期兒童之家 □(5)留宿幼兒中心(留宿育嬰園) □(6)留宿幼兒中心(留宿幼兒園)
□(7)兒童收容中心 □(8)兒童院 □(9)男/女童院沒有/設有群育學校
□(10)男/女童宿舍 □(11)其他(請註明:________________)

83. 開始使用該服務時兒童的歲數：____________歲

84. 使用服務多久？________________月

85. 使用服務的原因(可選多項)：

兒童自身問題----

□(1)行為問題 □(2)情緒問題 □(3)身體問題 □ (4)精神問題 □(5)離家出走
□(6)性格問題 □(7)人際關係問題 □(8)兄弟姐妹受虐 □ (9)學業問題
□(10)受不良朋輩影響 □(11)受虐(非父母)□(12)智力有限
□(13)其他(請註明:________________)

家庭問題----

□(14)長期離港 □(15)離異 □(16)刑事犯案紀錄 □(17)濫藥 □(18)情緒問題
□(19)健康問題 □(20)住院 □(21)監禁 □(22)不當管教 □(23)長時間工作
□(24)精神問題 □(25)父或母或雙親死亡 □(26)性格問題 □(27)欠債
□(28)虐兒 □(29)婚姻問題 □(30)未婚母親 □(31)經濟問題 □(32)住屋問題
□(33)其他(請註明:________________)

86. 使用服務的**主要**原因(請填上以上其中一個號碼): ______________

87. 轉換住宿的**主要**原因(只選一項):

□ (1) 超齡 □ (2) 住宿不適合兒童的需要 □(3) 家庭團聚
□ (4) 領養 □ (6) 獨立生活 □(7) 其他 (請註明:_______________)

V. 現時寄養家庭的資料: (請以√表示)

88. 已照顧寄養兒童多久: __________月

89. 已照顧該寄養兒童多久: __________月

90. 現時照顧寄養兒童的數目(包括該兒童): ________位

91. 寄養家庭子女的數目: _________ 位

92. 寄養家庭子女年齡分佈:

(1) 0-6 歲 ____位; (2) 6-12 歲 ____位; (3) 13-17 歲 ____位; (4) 18 歲或以上 ____位

寄養父親

93. 寄養父親歲數: __________ 歲

94. 出生地點: □(1) 香港 □(2) 中國內地 □(3) 其他(請註明:_______)

95. 如上題已選(2)或(3) ,寄養父親已來港多久: ___________年

96. 最高教育程度:

□(1) 沒有接受過正規教育 □(2)幼稚園 □(3)小學畢業
□(4) 初中畢業(中一至中三) □(5)高中畢業(中四至中五) □(6)預科畢業(中六至中七)
□(7) 大學/大專或以上 □(8)其他 (請註明: _______________)

97. 工作情況:

□(1) 全職 □(2) 兼職 □(3) 自僱人士 □(4) 失業/待業
□(5) 散工 □(6) 全職家庭照顧者 □(7) 其他 (請註明:_______________)

寄養母親

98. 寄養母親歲數: __________ 歲

99. 出生地點: □(1) 香港 □(2) 中國內地 □(3)其他(請註明: _____________)

100. 如上題已選(2)或(3) ,寄養母親已來港多久: ___________年

101. 最高教育程度:

□(1) 沒有接受過正規教育 □(2)幼稚園 □(3)小學畢業
□(4) 初中畢業(中一至中三) □(5)高中畢業(中四至中五) □(6)預科畢業(中六至中七)
□(7) 大學/大專或以上 □(8) 其他 (請註明:______________)

102. 工作情況:

□(1) 全職 □(2) 兼職 □(3) 自僱人士 □(4) 失業/待業
□(5) 散工 □(6) 全職家庭照顧者 □(7) 其他(請註明:_______________)

寄養社工資料

103. 兒童在使用現時的寄養服務期間，有多少位寄養社工跟進該個案(包括現時的社工)?________位

104. 現時寄養社工跟進此個案多久? ___________月

105. 性別：□(1) 男　　　□(2) 女

106. 最高教育程度：□(1)學士　□(2)碩士　□(3)博士　□(5)其他 (請註明:________________)

107. 在社福界服務多久?____________________ 月

108. 在兒童住宿照顧服務多久?____________________ 月

----- 完，謝謝----

Appendix II The Information Sheet For Mental Health Service Utilisation (MHSU) – (Chinese version)

香港中文大學
The Chinese University of Hong Kong

香港家庭福利會
Hong Kong Family Welfare Society

研究編號(由大學填寫): ______________
檔案編號(由機構填寫): ______________
填寫日期：______________
填寫社工：______________

香港寄養兒童的精神健康情況和需要的探索研究

精神健康服務使用情況問卷

請參照以下的選項來回答有關問題：

(1)精神科藥物治療 (2)精神科評估服務 (3)臨床心理學家 (4)教育心理學家 (5)物理治療 (6)職業治療
(7)言語治療 (8)聽力訓練 (9)感統訓練 (10)兒童個案輔導，例如遊戲治療
(11)兒童小組輔導，例如社交訓練小組 (12)家庭個案輔導 (13) 親子小組，例如親子平衡小組、多元家庭小組
(14)兒童體能智力測驗中心 (15)早期教育及訓練中心 (16)普通幼稚園暨幼兒中心兼收位
(17)特殊幼兒中心 (18)設有住宿服務的特殊幼兒中心 (19)學障兒童學習支援 (20)其他(請註明在方格內)

I. 現時兒童使用服務的資料:

1. 兒童現時是否有使用精神健康服務？□是(請回答下表) □否(請跳到 II)

	a. 第一種服務	b. 第二種服務	c. 第三種服務	d. 第四種服務	e. 第五種服務
2. 現時使用服務的類別 (選項列於本表上方)					
3. 已使用多久？(月)					
4. 使用以上服務是否基於診斷症狀? 請填上號碼: (1)是;(2)否					
5. 如是，請參考附表並填上該症狀的號碼:					
6. 確診年齡: ___歲					
7. 確診途徑--- 請填上號碼: (1)精神科醫生 (2)兒科醫生 (3)臨床心理學家 (4)教育心理學家 (5)職業治療師 (6)其他(請註明)					

8. 如沒有確診，請填上使用該服務的原因					

請參照以下的選項來回答有關問題：

(1)精神科藥物治療　(2)精神科評估服務　(3)臨床心理學家　(4)教育心理學家　(5)物理治療　(6)職業治療
(7)言語治療　(8) 聽力訓練　(9)感統訓練　(10)兒童個案輔導，例如遊戲治療
(11)兒童小組輔導，例如社交訓練小組 (12)家庭個案輔導 (13) 親子小組，例如親子平衡小組、多元家庭小組
(14)兒童體能智力測驗中心　(15)早期教育及訓練中心　(16)普通幼稚園暨幼兒中心兼收位
(17)特殊幼兒中心　(18)設有住宿服務的特殊幼兒中心　(19)學障兒童學習支援 (20)其他(請註明在方格內)

II. 現時兒童正在輪候服務資料:

1. 兒童現時是否正在輪候精神健康服務？□是(請回答下表)　□否(請跳到 III)

	a. 第一種服務	b. 第二種服務	c. 第三種服務	d. 第四種服務	e. 第五種服務
2. 現時輪候服務的類別(選項列於本表上方)					
3. 已輪候多久？(月)					
4. 輪候以上服務是否基於診斷症狀？請填上號碼: (1)是;(2)否					
5. 如是，請參考附表並填上該症狀的號碼:					
6. 確診年齡: ___歲					
7. 確診途徑---- 請填上號碼: (1)精神科醫生 (2)兒科醫生 (3)臨床心理學家 (4)教育心理學家 (5)職業治療師 (6)其他(請註明)					

8. 如沒有確診，請填上輪候該服務的原因：					

請參照以下的選項來回答有關問題：

(1)精神科藥物治療 (2)精神科評估服務 (3)臨床心理學家 (4) 教育心理學家 (5)物理治療 (6)職業治療
(7)言語治療 (8) 聽力訓練 (9)感統訓練 (10)兒童個案輔導，例如遊戲治療
(11)兒童小組輔導，例如社交訓練小組 (12)家庭個案輔導 (13) 親子小組，例如親子平衡小組、多元家庭小組
(14)兒童體能智力測驗中心 (15)早期教育及訓練中心 (16)普通幼稚園暨幼兒中心兼收位
(17)特殊幼兒中心 (18)設有住宿服務的特殊幼兒中心 (19)學障兒童學習支援 (20)其他(請註明在方格內)

III. 在過去兩年兒童曾接受的服務:

1. 兒童在過去兩年是否曾接受精神健康服務？□是(請回答下表) □否(請跳到 IV)

	a. 第一種服務	b. 第二種服務	c. 第三種服務	d. 第四種服務	e. 第五種服務
2. 過去兩年曾接受服務的類別(選項列於本表上方)					
3. 曾使用多久？(月)					
4. 曾接受的服務是否基於診斷症狀？請填上號碼: (1)是;(2)否					
5. 如是，請參考附表並填上該症狀的號碼:					
6. 確診年齡: __歲					
7. 確診途徑---- 請填上號碼: (1)精神科醫生 (2)兒科醫生 (3)臨床心理學家 (4)教育心理學家 (5)職業治療師 (6)其他(請註明)					

8. 如沒有確診，請填上曾接受該服務的原因：					
9. 服務停止的原因： (只選一項;請填上號碼) (1)父母拒絕帶兒童參予服務 (2)父母不認為服務對兒童有效果 (3)兒童拒絕參予服務 (4)兒童本人不認為服務有效果 (5)寄養家長未能抽空帶兒童參予服務 (6)完成服務 (7)服務地點與住處相距太遠 (8)沒有相關經濟補貼 (9)治療效果不理想 (10) 其它(請註明)					

請參照以下的選項來回答有關問題：

(1)精神科藥物治療 (2)精神科評估服務 (3)臨床心理學家 (4)教育心理學家 (5)物理治療 (6)職業治療
(7)言語治療 (8) 聽力訓練 (9)感統訓練 (10)兒童個案輔導，例如遊戲治療
(11)兒童小組輔導，例如社交訓練小組 (12)家庭個案輔導 (13) 親子小組，例如親子平衡小組、多元家庭小組
(14)兒童體能智力測驗中心 (15)早期教育及訓練中心 (16)普通幼稚園暨幼兒中心兼收位
(17)特殊幼兒中心 (18)設有住宿服務的特殊幼兒中心 (19)學障兒童學習支援 (20)其他(請註明在方格內)

IV. 現時兒童有需要但並未有提供的服務:

1. 兒童現時是否有需要但並未有提供的精神健康服務？(例如：兒童有需要接受遊戲治療以改善社交問題，但目前並無任何資源提供此服務) □是(請回答下表) □否(完成問卷)

	a. 第一種服務	b. 第二種服務	c. 第三種服務	d. 第四種服務	e. 第五種服務
2. 有需要但並未有提供的服務類別(選項列於本表上方)					
3. 需要此服務多久？(月)					
4. 需要服務是否基於診斷症狀？ 請填上號碼: (1)是;(2)否					
5. 如是，請參考附表並填上該症狀的號碼:					
6. 確診年齡: ___歲					
7. 確診途徑---- 請填上號碼: (1)精神科醫生 (2)兒科醫生 (3)臨床心理學家 (4)教育心理學家 (5)職業治療師 (6)其他(請註明)					
8. 如沒有確診，請填上需要該服務的原因:					

----- 完，謝謝 -----

Appendix III Parents as Social Context Questionnaire (PASCQ) - (Chinese version)

Parents as Social Context Questionnaire (PASCQ): assess the characteristics of parenting style 31 items (parents)

1. Warmth
2. Rejection
3. Structure
4. Chaos
5. Autonomy support
6. Coercion

答案是沒有對與錯之分的。**請回答所有問題**，不要略過任何一條。謝謝。

	你與孩子之間的關係？ * 以下項目所提及的「孩子」代表你的孩子或照顧對象。	**從來不真確**	**不是常常真確**	**有時真確**	**總是真確**
1.	我知道許多關於我的孩子的事情	**1**	**2**	**3**	**4**
2.	我不是十分了解我的孩子	**1**	**2**	**3**	**4**
3.	我清楚的讓我的孩子知道，如果他 / 她不遵守我們的規則，將會有什麼後果	**1**	**2**	**3**	**4**
4.	我的孩子做了我不允許的事情，我也不會懲罰他 / 她	**1**	**2**	**3**	**4**
5.	我鼓勵我的孩子表達他 / 她的感受，即使這些感受難以被人接受	**1**	**2**	**3**	**4**
6.	我的孩子老是與我爭辯	**1**	**2**	**3**	**4**
7.	我真的了解我的孩子對事物的看法和感覺	**1**	**2**	**3**	**4**
8.	我的孩子有時很難讓人喜歡	**1**	**2**	**3**	**4**
9.	我清楚的讓我的孩子明白我對他 / 她的期望	**1**	**2**	**3**	**4**
10.	當我的孩子惹上麻煩，我的反應是難以預測的	**1**	**2**	**3**	**4**
11.	即使我不同意我的孩子的意見，我也鼓勵他 / 她把意見表達出來	**1**	**2**	**3**	**4**
12.	我要對著我的孩子大喊大叫，才能令他 / 她做某件事	**1**	**2**	**3**	**4**

	你與孩子之間的關係？ * 以下項目所提及的「孩子」代表你的孩子或照顧對象。	**從來不真確**	**不是常常真確**	**有時真確**	**總是真確**
13.	我會與我的孩子一起做一些特別的事	**1**	**2**	**3**	**4**
14.	<u>有些時候，孩子的要求令我覺得是一個負擔</u>	**1**	**2**	**3**	**4**
15.	當我告訴我的孩子說我會做某件事，我便一定會做	**1**	**2**	**3**	**4**
16.	我的孩子似乎不太知道我對他 / 她的期望是什麼	**1**	**2**	**3**	**4**
17.	我信任我的孩子	**1**	**2**	**3**	**4**
18.	我不可以讓我的孩子自己決定太多事情	**1**	**2**	**3**	**4**
19.	我會留一些時間與我的孩子談一些對他 / 她重要的事	**1**	**2**	**3**	**4**
20.	我沒有足夠時間給予我的孩子	**1**	**2**	**3**	**4**
21.	如果我的孩子遇到困難，我會幫助他 / 她想辦法應付	**1**	**2**	**3**	**4**
22.	我在家裡經常改變規則	**1**	**2**	**3**	**4**
23.	我鼓勵我的孩子要做真正的自己	**1**	**2**	**3**	**4**
24.	有時我覺得我需要催逼我的孩子做事	**1**	**2**	**3**	**4**
25.	我總是可以騰出時間給我的孩子	**1**	**2**	**3**	**4**
26.	我有時覺得孩子需要我的時候我卻不能在他 / 她的身邊	**1**	**2**	**3**	**4**
27.	我期望我的孩子遵守我們的家規	**1**	**2**	**3**	**4**
28.	我會在沒有事先警告下對我的孩子發火	**1**	**2**	**3**	**4**
29.	我期望我的孩子說出自己的真正想法	**1**	**2**	**3**	**4**
30.	我發覺自己與孩子之間出現了權力鬥爭	**1**	**2**	**3**	**4**
31.	我讓我的孩子知道我愛他 / 她	**1**	**2**	**3**	**4**

香港寄養兒童的精神健康情況和需要的探索研究

個人訪問

(寄養服務社工 / 寄養家長 / 家長)

1. 為甚麼兒童需要使用寄養服務？

2. 你關注兒童那方面的精神健康問題？

跟進問題：

2.1. 請詳細形容問題表徵 (行為、情緒、學習、際關係等各方面的表現)
2.2 精神健康問題影響了兒童那方面的發展？

3. 你認為甚麼因素 (例如：先天、家庭、其他環境因素...) 引發兒童的精神健康問題？

3.1. 有沒有確診？

3.1.1. 若有：

- 確診了甚麼問題？
- 誰人首先發現他有這些問題？
- 誰人確診兒童的問題？何時確診？確診後如何跟進？

3.1.2. 若沒有：

- 誰人首先發現他有這些問題？
- 為甚麼沒有確診？
- 發現這些後問題如何處理？

4. 就現時使用的服務：

4.1. 兒童被診斷 / 發現有這些問題後，現時使用甚麼服務？
4.2. 為甚麼需要此服務？
4.3. 誰人轉介服務？
4.4. 請描述討論及決定轉介的過程？
4.5. 寄養服務社工 / 轉介社工 / 寄養家長 / 家長 / 兒童 / 其他重要人物擔當了甚麼的角色？

4.6. 誰是服務提供者？
4.7. 誰使用該服務？
4.8. 該服務的具體內容是甚麼？
4.9. 何時開始使用該服務？
4.10. 服務有沒有時限？若有，將會何時結束？結束後將有甚麼跟進？
4.11. 你參與服務的經驗是怎樣？
4.12. 你認為兒童參與服務的經驗是怎樣？
4.13. 你對服務的評價：那方面有效？為甚麼有效？那方面不足？
如何改善不足之處？
4.14. 甚麼因素影響服務成效？
4.15. 你對服務有沒有其他意見

5. 就曾經使用過的服務

5.1. 兒童被診斷 / 發現有這些問題後，曾經使用過甚麼服務？
5.2. 為甚麼需要此服務？
5.3. 誰人轉介服務？
5.4. 請描述討論及決定轉介服務的過程？
5.5. 寄養服務社工 / 轉介社工 / 寄養家長 / 家長 / 兒童 / 其他重要人物
擔當了甚麼角色？
5.6. 誰是服務提供者？
5.7. 誰使用該服務？
5.8. 該服務的具體內容是甚麼？
5.9. 何時開始使用該服務？
5.10. 何時結束使用該服務？
5.11. 為甚麼結束該服務？結束後有甚麼跟進？
5.12. 你參與服務的經驗是怎樣？
5.13. 你認為兒童參與服務的經驗是怎樣？
5.14. 你對服務的評價 : 那方面有效？ 為甚麼有效？ 那方面不足？
如何改善不足之處？
5.15. 甚麼因素影響服務成效？
5.16. 你對服務有沒有其他意見

6. 就輪候的服務 , 請分享以下各方面：

    6.1. 兒童被診斷 / 發現有這些問題後，正在輪候那些服務？
    6.2. 為甚麼需要此服務？
    6.3. 誰人轉介服務？誰人作服務轉介？
    6.4. 請描述討論及決定轉介的過程？
    6.5. 寄養服務社工 / 轉介社工 / 寄養家長 / 家長 / 兒童 / 其他重要人物擔當了甚麼的角色？
    6.6. 誰將會是服務提供者？
    6.7. 誰將會使用該服務？
    6.8. 輪候了該服務多久？你對輪候時段有甚麼意見？
    6.9. 在輪候服務期間 , 如何處理這個問題？

7. 就被拒絕使用的服務 , 請分享以下各方面：

    7.1. 兒童被診斷 / 發現有這些問題後，被拒絕使用那些服務？
    7.2. 為甚麼需要此服務？
    7.3. 誰人轉介服務？
    7.4. 請描述討論及決定轉介服務的過程？
    7.5. 寄養服務社工 / 轉介社工 / 寄養家長 / 家長 / 兒童 / 其他重要人物擔當了甚麼角色？
    7.6. 被拒絕使用的服務的原因？
    7.7. 被拒絕使用的服務 , 如何處理這個問題？

8. 需要的服務但未有提供

    8.1. 兒童被診斷 / 發現有這些問題後，有沒有一些服務需要但並未有提供？
    8.2. 為甚麼需要此服務？
    8.3. 如何處理這個問題？

9. 有沒有其他補充資料？

10. 你對整個面談有甚麼感受？

香港寄養兒童的精神健康情況和需要的探索研究

兒童訪問

1. (彼此認識)- 用一樣自己東西代表自己 或 用一隻動物代表自己(動物圖)

2. XX 話你有 XX 問題，你贊成嗎？為甚麼？

3. XX 安排左 XX 服務給你 , XX 服務做 D 咩架？

4. 你鐘意嗎？

5. 你覺得服務幫到你嗎？為甚麼？

6. 你以前有無用過一 D 服務？
   - XX 服務做 D 咩架？
   - 你鐘意嗎？
   - 你覺得幫服務幫到你嗎？為甚麼？

7. 你覺得咩野服務最能夠幫助到你？
   - 為甚麼？
   - 誰人知道你的想法？
   - 沒有這些服務對你有甚麼影響？

8. 有沒有其他補充資料？

9. 你對整個面談有甚麼感受？

香港中文大學
The Chinese University of Hong Kong

香港家庭福利會
Hong Kong Family Welfare Society

香港寄養兒童的精神健康情況和需要的探索研究

本研究是由香港家庭福利會委託香港中文大學社會工作學系顧問團隊負責推行的一項有關寄養兒童精神健康的研究，研究所得資料將協助機構了解寄養兒童的精神健康狀況和需要、現時所提供予兒童的精神健康服務的質素和成效，以便在將來作出合適的改進。

此研究項目分為兩個部分，分別是問卷調查和深入訪談。問卷調查主要由寄養服務社工和寄養服務家長填寫，而深入訪談對象為寄養兒童、父母、寄養服務家長、寄養服務社工和轉介社工。整個研究時段由2018年7月至2019年12月。

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香港寄養兒童的精神健康情況和需要的探索研究

父母 / 監護人同意書

1. 本人答允兒童參加由香港中文大學社會工作學系顧問團隊負責進行之香港寄養兒童的精神健康情況和需要的探索研究，並了解是項研究的目的。
2. 本人同意研究團隊收集關於兒童個人和家庭的資料，並把資料分析。
3. 本人明白在研究項目過程中，本人和兒童有絕對的權利去選擇停止和退出參與。
4. 本人明白研究項目所得的資料，將僅用於是次研究。惟一切能識別兒童個人和家庭身份的資料，將會絕對保密、不被公開，所有記錄亦將於整項研究結束後予以銷毀。

如對是次研究有任何疑問或查詢，請聯絡顧問團隊負責人黃美菁教授。

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兒童姓名：________________

父母 / 監護人姓名：________________

與兒童的關係：________________

父母 / 監護人簽署：________________

日期：________________

Appendix VII Foster Care Workers' / Foster Parents' / Family Caregivers' Consent Forms for Interview

香港中文大學
The Chinese University of Hong Kong

家福會
HKFWS

香港寄養兒童的精神健康情況和需要的探索研究

本研究是由香港家庭福利會委託香港中文大學社會工作學系顧問團隊負責推行的一項有關寄養兒童精神健康的研究，研究所得資料將協助機構了解寄養兒童的精神健康狀況和需要、現時所提供予兒童的精神健康服務的質素和成效，以便在將來作出合適的改進。

顧問團隊主要成員

黃美菁教授（香港中文大學社會工作學系助理教授）

張瀞文教授（香港中文大學社會工作學系助理教授）

馬麗莊教授（香港中文大學社會工作學系教授）

顧問團隊負責人

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香港寄養兒童的精神健康情況和需要的探索研究
寄養服務社工 / 寄養家長 / 轉介社工 / 家長同意書 **

1. 本人答允參加由香港中文大學社會工作學系顧問團隊負責進行之香港寄養兒童的精神健康情況和需要的探索研究，並了解是項研究的目的。
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3. 本人明白在訪問進行中，本人可以提出任何與研究相關的問題，或可以選擇不回答個別問題，甚至可以隨時終止參與訪問。
4. 本人明白在訪問進行中，或許會引起本人一些不愉快的經歷，本人可以選擇不回答個別問題，或終止參與訪問。
5. 本人同意把整個訪問過程錄音。
6. 在訪問中記錄的資料，將僅用於是次研究。惟一切能識別本人身份的資料，將會絕對保密、不被公開，所有記錄亦將於整項研究結束後予以銷毀。

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兒童姓名：________________

受訪人姓名：________________

與兒童的關係：________________

簽署：________________

日期：________________

** 請刪去不適

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香港寄養兒童的精神健康情況和需要的探索研究

兒童同意書

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兒童姓名 : ____________________

簽署： ____________________

日期： ____________________

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以家為本 Family Matters

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