扶康會
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扶康會
就「香港康復計劃方案 - 制訂建議階段諮詢」意見書

扶康會簡介 ：
扶康會自 1977 年開始於香港提供康復服務，翌年根據《公司條例》註冊為擔保有限公司，並於 1980 年成為香港社會服務聯會的會員。本會相信殘疾人士享有一切基本人權，其中最重要的是受到認許及尊重。他們有權利接受各種必需的援助，令他們在身心各方面都得到充分的發展。過去四十多年，本會致力為殘疾人士提供各種機會，讓他們能夠發揮個人潛能，在所屬社區中，充分獨立自主，積極融入社會。與此同時，本會亦在不同渠道倡導社區教育、政策及法例的修訂，為殘疾人士爭取平等權利。

本會的主要服務對象包括輕度至嚴重智障成人、自閉症人士、精神康復者及肢體殘障人士。現時，本會設有超過四十個服務單位，核心服務包括住宿服務、日間訓練服務、職業康復及發展服務、社區精神康復服務、自閉症及發展障礙人士服務、殘疾人士社區支援服務等，均屬政府資助的服務。為回應社會需求，本會亦設立自負盈虧服務，如扶康關愛家庭服務和為有特殊需要兒童提供的早期介入服務。另外，本會著力推動社區共融，更於 2004 年獲「國際最佳老友」（Best Buddies International）美國總部邀請及授權本會於香港獨家推行「香港最佳老友」運動，每年為數以百計的社區人士與智障人士建立一對一友誼，以提升智障人士生活質素，並於社區宣揚平等共融的信息。

《香港康復計劃方案》背景 ：
政府自 2007 年發表《香港康復計劃方案》(簡稱《方案》)後，至今已有十年沒有再推出新的《方案》，令本港的康復服務欠缺詳細的檢討和進一步的規劃。時隔十二年，本港、國內，以至國際上就殘疾人士的定義、分類、服務理念及方向均出現很多轉變。為配合殘疾人士的需要、倡議殘疾人士享有一切基本人權及推廣傷健共融的理念，本會繼去年就「訂定範疇諮詢」提交意見書後，再下一城，於本次「制訂建議階段諮詢」自制簡易圖文版協助服務使用者了解是次諮詢內容，且大力鼓勵服務使用者、家屬及員工就是次諮詢進行討論及積極發表意見，期望政府能夠把本會的建議納入新方案之內，並配套資源，落實推行。

就「香港康復計劃方案 - 制訂建議階段諮詢」，扶康會有以下的建議：

1) 建議《香港康復計劃方案》就殘疾事務設定以下的指導原則 ：
以體現及實踐《聯合國殘疾人士權利公約》為制定《香港康復計劃方案》的目標，包括第九條無障礙、第十二條在法律面前獲得平等承認、第十九條獨立生活和融入社區及第二十三條尊重家居和家庭等，在全人的理念下，使殘疾人士得到應有的服務，包含法律保障、殘疾人士法定地位、安全和保護等等與其他市民一樣在社區成長和生活。本會一直秉持「以人為本」為服務理念，我們深信「殘疾人士享有一切基本的人權」，其身心障礙不應成為差別對待的原因，故《香港康復計劃方案》要為他們創造「共融」的生活環境，讓他們充分獨立自主地於社區生活，並應以「以權為本」及「能力導向」的核心價值以制訂範疇及政策。

2) 建議推行《國際功能、殘疾和健康分類》(International Classification of Functioning, Disability, and Health)
建議在本港統一推行《國際功能、殘疾和健康分類》(International Classification of Functioning, Disability, and Health)(簡稱 ICF)，用作評估及分析殘疾人士的健康、身體功能、活動參與、及環境因素的相互關係，並以全方位了解受評估的殘疾人士的需要。當掌握殘疾人士的需要後，可以提供適切的訓練或輔助，減少殘疾人士參與日常活動的困難度，改善生活質素。過往康復計劃方案只以醫療角度看殘疾人士的需要，集中提供甚麼服務，然《國際功能、殘疾和健康分類》整合了個人健康狀態在醫學與社會方面的觀點，而非單一的醫學模式評估，期望可在措施及服務等方面訂定準確的支援策略。

3) 於社區中開設『扶康關愛家庭』模式的小型家舍
於社區中開設『扶康關愛家庭』這類模式的小型家舍，並於各區善用空置公屋或單位開設小型家舍，既可讓智障人士感受真實的『家庭溫暖』，並能體驗共融的鄰里關係，而非局限於在大型院舍與數十人一起生活的疏離感【附上: 扶康會就智障人士關愛家庭模式出版之比較研究中文版及英文版 ~ 〔附件一〕「扶康會智障人士關愛家庭比較研究-簡易版_第二版_ (2019 年 3 月) 及〔附件二〕 “A Comparative Study on Family Care Home (FCH) for Persons with Intellectual Challenges: Implications for Policies and Practice in Hong Kong” (March 2019)。

4) 建議增設殘疾人士『法律權益及保障』範疇
政府應立法保障殘疾人士免受侵犯及確保他們能接受公平審訊，並保障他們的人權及財產。

5) 建立定期檢討及向公眾交代進展的機制:
i. 建立定期檢討「香港康復計劃方案」的機制，包括適時向公眾交代進展、監督相關部門跟進、並制訂跟進及推出方案的時間表。
ii. 設立專責部門監督《香港康復計劃方案》的推行進度，協調並簡化跨政府部門（如教育局、勞福局、食衞局及社署等）之間的協作及行政程序，讓方案能有效及全面地推行，避免出現支離破碎的情況。

6) 就「制訂建議階段諮詢」之十個主題提出意見如下：

主題一：殘疾人士的定義
➢ **建議在本港統一推行《國際功能、殘疾和健康分類》(International Classification of Functioning, Disability, and Health)(簡稱 ICF)** - 用作評估及分析殘疾人士的健康、身體功能、活動參與、及環境因素的相互關係，並以全方位了解受評估的殘疾人士的需要。當掌握殘疾人士的需要後，可以提供適切的訓練或輔助，減少殘疾人士參與日常活動的困難度，改善生活質素。過往康復計劃方案只以醫療角度看殘疾人士的需要，集中提供甚麼服務，然《國際功能、殘疾和健康分類》整合了個人健康狀態在醫學與社會方面的觀點，而非單一的醫學模式評估，期望可在措施及服務等方面訂定準確而全人的支援策略。

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- **檢視「唐氏綜合症」作為單獨殘疾類別的可行性**
  - 智力障礙只是唐氏綜合症人士的其中一個徵狀，唐氏綜合症人士在醫療和照顧需要上仍有其個別需要，目前歸類為智障類別中，未能反映實際需要，以配合適切的服務。

- **建議將「精神病」的名稱更改為「精神/情緒障礙」**
  - 建議將「精神病」的名稱更改為「精神/情緒障礙」，減少標籤及負面效應。

- **建議將「自閉症」的名稱更改為「自閉症譜系障礙」**
  - 自閉症只是自閉症譜系障礙其中一個項目，譜系其實包括有三個主要項目：自閉症、亞斯保加綜合症、待分類的廣泛性發展障礙（PDD-NOS），更改為「自閉症譜系障礙」能更反映實況及有助回應不同需要。

主題二：社區支援服務與院舍照顧服務的服務規劃及銜接

- **進行人口普查，提供適時及可靠殘疾人士人口數據作服務規劃**
  - 政府應定期及更頻密地進行殘疾人口普查及推算，為各類服務規劃提供適時及可靠殘疾人口數據。

- **增撥資源以強化「殘疾人士地區支援中心」服務**
  - 現有的「殘疾人士地區支援中心」所提供的服務未能滿足服務使用者的需要，每間中心服務的地域很廣，服務使用者往往要長途跋涉才能到達中心。建議政府增撥資源，將支援中心的服務延長至每星期 7 天，並且增加中心數目，加強作為「地區支援」的功能。
  - 「殘疾人士地區支援中心」應增聘一名註冊護士，以應付日益增加的護理需要。政府亦須增撥資源讓中心添置運動器材，協助殘疾人士多做運動，以延緩身體老化速度。
  - 「殘疾人士地區支援中心」難以滿足不同殘疾人士的需要，建議分拆為以下三類服務，持續發展，以回應不同服務群組的需要：i)「嚴重殘疾人士日間照顧服務」：為嚴重殘疾人士提供照顧和護理服務；ii) 「日間康健中心」：為輕、中度智障人士提供社交、康樂、閒暇、娛樂及身心靈之發展；iii)「社區支援中心」：為殘疾人士提供個案支援，擴闊社會網絡和社交生活，促進社區共融，重點關注資訊的傳遞、社交康樂、小組訓練、個人心理、生理成長、家庭及個人情緒支援等重點方向。
  - 對於自閉症譜系障礙人士，他們需要多些活動空間及較多的人手比例，建議為他們設立專門的日間中心。

- **暫宿照顧服務**
  - 受《殘疾人士院舍條例》規管，現有宿舍能提供的暫宿照顧服務名額十分有限，建議政府在規劃新院舍時必須預留一定數量的暫宿照顧名額，以滿足服務需要。政府亦可考慮在各區設立一間專門提供暫宿照顧服務的宿舍，讓家屬更便捷地使用相關服務。
  - 現時 6 歲或以上的殘疾人士需要暫宿照顧服務時，要入住為智障成人士而設的院舍，在設施配套及生活流程方面均未能對應殘疾學童的需要，建議政府應考慮設立專門為殘疾學童提供暫宿照顧的院舍。
  - 政府應增強特殊學校的配套和支援，讓有需要殘疾學童於暑假期間留校住宿，以減輕暫宿照顧服務的壓力。

- **社區支援和院舍服務的需求**
  - 社區支援服務與院舍照顧服務是兩種不同性質的服務，服務需求不應彼此掛鈎，亦不能此消彼長 ； 增加社區支援服務主要為滿足在社區內居住之殘疾人士的需要，以及紓緩正在輪候院舍服務的殘疾人士及其家人的照顧壓力。長遠而言，殘疾人士以及家屬的老齡化只會日趨嚴重，最終殘疾人士仍要接受院舍的長期照顧服務。社區支援服務的增加，不應延誤殘疾人士入住院舍的時間，政府應有長遠的殘疾人士住宿服務規劃，及早建設足夠的住宿單位。
  - 於社區中開設『扶康關愛家庭』這類模式的小型家舍，並於各區善用空置公屋或單位開設小型家舍，既可讓智障人士感受真實的『家庭溫暖』，並能體驗共融的鄰里關係，而非局限於在大型院舍與數十人一起生活的疏離感。
  - 因應智障人士老齡化，增設智障人士安老院舍，以對應智障人士老齡化的護理及照顧需要。
  - 建議設立類似「長者屋」運作的公營房屋，讓能力較高的殘疾人士可在工作員支援下，於社區內獨立生活。
  - 在公屋輪候、租住或購買房屋時，加入與殘疾人士同住家庭優先機制或稅務寬免，鼓勵家庭與殘疾家庭成員同住。

- **照顧者支援**
  - 在照顧者及自助組織的支援方面，政府應加強資助自助組織的資助、租用辦公室及聘用人手上的支援。
  - 殘疾人士對臨時日間照顧服務的需求殷切，政府可考慮加強自助組織在這方面的能力，配套資源，並提供場地及培訓等措施，鼓勵組織發揮守望相助精神，參與提供臨時日間照顧服務，並給予參與者津貼，推動參與。
  - 政府應考慮為長者的醫療券應擴大至適用於殘疾人士，以「服務資助券」型式，讓殘疾人士可在私營市場內購買驗身、物理治療、職業治療等服務，為殘疾人士提供更彈性的醫療選擇，並可減低對公營醫療和社會服務的依賴。

主題三：康復及護理服務人手供應

- **檢討資助服務的估計人手編制 (Notional Staffing)**

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- 政府現時的「資助服務的估計人手編制」(Notional Staffing)沿用已久，沒有全面檢討，例如福利工作員(Welfare Worker) 一職，學歷要求中學會考五科合格，但自「香港中學文憑考試」(HKDSE)於 2012 年推行後，將逐漸減少中學會考五科合格的畢業生，故政府應全面檢討資助服務的估計人手編制及學歷水平要求。
- 提升專業人員的水平，政府在部分服務如庇護工場及中度智障人士院舍的「資助服務的估計人手編制」(Notional Staffing)中，只配套社會工作助理及二級物理治療師或二級職業治療師，專業人員的水平未能回應社會及服務使用者的複雜需要，薪金水平亦缺乏競爭力。
- 增聘物理治療助理及職業治療助理，以協助並減輕物理治療師及職業治療師的工作量，減低招聘困難。
- 引入中醫及痛症紓緩服務，以中西醫合作方式，提升護理質素，減輕護理人手的壓力。
- 加強本地訓練及照顧人員培訓，並設晉升階梯，吸引年輕人加入康復服務行列。

➢ 全面檢討整筆過撥款政策
- 社署需要檢討現時的薪酬水平，同時檢視對社福機構實施的整筆過撥款政策，以提升招攬人手的競爭力。

主題四：殘疾人士老齡化

➢ 引入樂活老齡 (Active Aging)概念
- 引入樂活老齡 (Active Aging)概念，強調老化是人生階段之一，不應將之災難化，焦點在於增加資源，協助殘疾人士減慢退化及過一個快樂晚年。

➢ **推廣健康，減輕早發性的老化及其他健康問題的方法**
- 需界定殘疾人士老齡化的定義，增加大眾對老齡化的了解。
- 現時醫學上已明確唐氏綜合症、腦癱及多重用藥的殘疾人士會較早出現退化及退化速度較急的現象，需及早為他們提供合適的評估及介入。
- 增加資源為殘疾人士安排定期身體檢查，以及早識別健康問題並適時介入。
- 在社區推廣良好生活習慣，讓殘疾人士減低因老化而出現長期病患的機會。

➢ 在院舍內提供的專門服務的種類（例如處理吞嚥問題的專業服務、到診醫療及康復服務等）
- 考慮設立智障人士安老院舍，加強對他們的護理照顧、增加運動量，配套合適的人手，讓年長的智障人士跟年輕的智障人士，可分別獲得切合需要的服務。
- 加強言語治療師服務，以處理年長殘疾人士的吞嚥問題，並增加營養師服務，設計合適的餐膳予不同營養需要的殘疾人士。
- 除了普通的到診西醫服務，建議增設專科到診服務(如精神科)予居住在院舍的殘疾人士，一方面由於年長的殘疾人士需要定期於多個專科覆診，往返求診費時，另一方面能綜合為殘疾人士診治，相信能減少多重用藥的情況，而且醫生可於院舍實地跟職員商討為殘疾人士提供更適切的醫療服務。
- 加強殘疾人士牙科及眼科服務，現時服務並不便利殘疾人士使用，醫療人員需要更了解殘疾人士的獨特需要。
- 為殘疾人士提供生死教育，加強「預設護理計劃」及「預設醫療指示」的概念，為瀕死的殘疾人士提供合適的安寧照護。
- 加強運用科技於服務上，採用更適合的器材滿足殘疾人士的生活及照顧需要，也可減輕職員的勞損。

➢ **職業康復服務階梯的優化空間，包括庇護工場的老齡化服務使用者的訓練及照顧需要**
- 為庇護工場年長的服務使用者提供專門服務，讓他們如主流人士般有退休的出路。
- 讓年長的庇護工場服務使用者可選擇彈性上班時間，選擇以半退休方式繼續留在工場及宿舍。
- 為仍居於社區的年長殘疾人士提供「殘疾人士社區照顧服務券」，讓他們購買合適的服務以支援他們在社區中繼續生活。

➢ 原居安老的實踐
- 研究於現時的院舍內推行原居安老的可行性及配套的需要，例如增加資源協助現時院舍轉型為殘疾人士安老院舍。

主題五：預防、鑑定及醫療康復

➢ 及早識別
- 增撥資源加強衛生署兒童體能智力測驗服務的人手，以減低識別和評估的輪候時間。

➢ 提供持續及終生評估
- 政府應引入持續及終生評估，為不同人生階段的殘疾人士提供全面的醫療支援，而非只著重於年幼階段的單一預防評估。

➢ 院舍的醫療服務
- 現時私家醫生外展到診計劃（VMP）津助協議缺乏彈性，較難吸引私家醫生願意到單位提供服務。政府應提升此計劃的津貼金額，或協調公營醫院，向社福單位提供所需的醫療支援，並建議增設精神科、牙科及眼科醫生到診服務。

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➢ **服務門診服務**
- 為了縮短殘疾人士輪候醫療服務時間，建議在門診設立專供殘疾人士輪候的隊伍。

主題六：暢道通行

➢ **便利殘疾人士使用公共設施**
- 政府應加強執法，避免商場及酒樓的傷殘人士洗手間常被佔用或刻意封閉停用。
- 道路上的視障人士引路徑經常損壞，建議加強檢查及維修。
- 政府加強巡查建築物，確保設有無障礙通道及設施。
- 落實跟進『殘疾人權利公約』，實現無障礙環境及通道。
- 政府提供資助予私人物業及商業機構設置及增設無障礙通道及設施，方便不同類型殘疾人士使用。

➢ **殘疾人士交通**
- 由於部份智障人士健康較差，輪椅的輔助配件較多，以至體積較大，較難使用的士或公共交通工具，要依賴「復康巴士」作為運輸工具，建議加強「復康巴士」的服務。
- 不少使用高身輪椅的殘疾人士未能使用復康的士，建議撥款資助，提供誘因，推動業界引入高身的復康的士，以符合市場的需要，並同時提供車費資助，減低乘坐的士負擔，以鼓勵殘疾人士走入社區。
- 提供津貼予殘疾家庭購買可供輪椅上落的私家車(福祉車)，以鼓勵殘疾家庭成員陪同殘疾人士走入社區。
- 推動小巴全面轉用低地台，便利輪椅上落。
- 鼓勵公共交通機構如港鐵及巴士公司加強配套，以協助有需要人士在繁忙時間使用公共交通工具。
- 進一步放寬殘疾人士使用汽車首次登記稅豁免的上限。

主題七：就業支援

➢ **政府補貼殘疾人士在接受「生產能力評估」後的最低工資差額**
- 政府補貼殘疾人士的最低工資差額是一種權利的彰顯，雖然他們因各種殘疾的限制，未必能完全應付一個崗位內所有要求的工作，或者效率有所不及；然而這並不構成必然要將他們應得的薪酬按生產力評估而作出扣減，為平衡僱主的財務負擔，及殘疾人士享受最低工資的權利，建議由政府補貼殘疾人士的最低工資差額。

➢ **設立殘疾人士創業基地(孵化器)**
- 殘疾人士或因各種殘疾限制而未能如主流人士般合適外出公開市場工作，建議考慮推行先導計劃，讓社福機構於各區推行「孵化器」，並設立創業基金，協助有才能的殘疾人士創業，並由專業人士提供顧問、法律、行政及其他方面的支援，協助他們連結市場上各行業的專家，讓殘疾人士有自僱的機會，同時也能配合他們身體及生活上的各種限制。

➢ **探討另設庇護性業務(Sheltered Business)的可行性**
- 現時本港的殘疾人士於庇護工場中只是「服務使用者」的身份，當中並無僱員及僱主關係；建議政府探討另設庇護性業務(Sheltered Business)的可行性，並參考台灣設立庇護性業務(Sheltered Business)，讓殘疾人士既能接受庇護性就業，又能享受應有僱員權益。

➢ **加強對社企的支援**
- 社企對於支援殘疾人士就業的成效是顯著的，然而他們在技術上、業務規模上、資本上未必具十足的競爭力，建議政府提供協助，並引入商界有經驗的商家為社企的持續發展和規劃作出支援。同時，政府亦宜為延續社企發展提供持續的資金支援，避免社企單純因資金不足而結業。
- 社企的營運成本較高，政府為社企提供更多支援，例如:以較低廉的租金，出租部分政府物業予社企營運，籍此讓社企能提供更多就業機會予殘疾人士。

➢ **優化庇護工場**
- 增加資源優化庇護工場訓練，並進行現代化工程，讓庇護工場提供進階職業訓練，提升殘疾人士的就業機會及訓練津貼。

主題八：精神健康

➢ **及早識別、盡早介入**
- 建議將精神健康教育納入學校的正規課程，從小開始灌輸對精神健康的正確知識及態度。
- 建議將「精神健康急救」訓練納入社工及教師入職培訓課程，作為必修科目，增加專業人員對精神健康的認識，以發揮及早識別的作用。
- 建議設立「醫、教、社同心協作先導計劃」，遇有識別受精神健康問題困擾的高危學生，由到校的精神科護士先為他們進行初步評估，如有需要可安排「急症快隊」，及時治療用藥，初步移除潛在危機，並減少延誤診斷的機會，令社工及教師可進一步

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提供個人及家庭輔導、學校調適等提供最佳的介入跟進。
- 於小學及中學增設「精神健康」科目，以提升學生對精神健康的認識及關注，內容包括壓力處理、認識情緒、抗逆力等，以上內容可列入通識教育或獨立成科，讓市民自小認識精神健康。

➢ 加強精神科門診服務
- 醫管局增設夜間門診服務，為精神康復者提供較彈性的診治時間，減少精神康復者因各項醫療程序而要額外請假。
- 建議向私家精神科醫生以買位形式，為精神康復者提供精神科夜診服務。
- 增加精神科專科門診之精神科醫生數目，讓醫生與病人在診症時能有足夠時間溝通，作更準確及詳細的診治；並增加精神科專科門診藥劑部門之人手，以減少等候取藥的時間。
- 增加精神科專科門診之不依期籌名額，並增設電話預約服務。

➢ 探討公私營合作
- 建議推行公私營合作計劃，以轉介較輕微及穩定的公立精神科病人到私營醫療系統接受服務，並探討由私家醫生跟進較嚴重但穩定的公立精神科病人的可能性。

➢ 藥物及非藥物治療
- 建議醫管局提升精神科藥物的質素，採購並提供副作用較少的新一代針藥。
- 建議加強非藥物介入，以處理前期或輕性的精神健康問題，亦建議增加藥物治療以外的選擇，如增加提供心理治療、輔導及小組服務，及探索以中醫藥進行治療的可能性。

➢ 促進精神復元人士的復元及融入社會的措施
- 建議推廣服務寵物(Service Animals) 概念，服務寵物可合法陪同精神康復人士使用公共設施及交通工具。
- 加強社區支援，讓更多有能力獨立生活的精神復元人士返回社區生活。
- 開拓精神康復暫宿服務，讓精神復元人士於病患期間，選擇不入院治療，透過暫宿支援面對困難。

➢ 加強精神健康綜合服務中心的服務
- 增加「精神健康綜合社區中心」會址的空間比例，以迎合服務需求和服務對象層面的擴張。此外，應長遠規劃新增專門為年輕人及長者而設的精神健康綜合社區中心，使服務及配套能更適切及更到位。
- 建議社會福利署於精神健康綜合社區中心推行「一中心一臨床心理學家」，避免出現 0.5、0.34 等職位，減少招聘困難。
- 建議於精神健康綜合社區中心增加一名護士，並增設營養師，強化服務使用者的藥物管理及飲食健康，改善情緒。

➢ 加強醫療、社福及教育界別合作
- 建議於社區成立跨專業團隊（由社工、醫護人員、臨床及教育心理學家、言語、物理及職業治療師組成），支援社福服務單位及家庭，接觸已離校的兒童及青少年及主動求助的家長，透過適切的服務及支援措施，為有精神健康支援需要的兒童及青少年營造共融環境。

主題九：特殊需要

➢ 學前支援服務及與小學銜接
- 先支援，後評估：參考中小學為有特殊學習需要支援之「先支援後評估」模式，先發放津貼予經「母嬰健康院」初步評估後，而需作轉介往接受「兒童體能智力評估」的殘疾幼兒，讓兒童可先接受服務，以達至及早介入及識別。
- 縮短輪候期：由於排期等待學前評估需要最少六個月，建議增設兒童體能智力測驗中心和增聘人手，落實執行兒童體能智力測驗中心 6 個月內為兒童作評估的承諾，以達至及早介入及識別。
- 增加家長資源中心：家長情緒支援，教育提升家長的識別能力及教導照顧技巧。
- 增加津貼：增加輪候資助學前康復服務的兒童的學習訓練津貼作，以便讓輪候服務的幼兒能接受更多的訓練時數 ; 並取消「學習訓練津貼」的資助上限，以人為本，按個別幼兒的需要酬情發放津貼。
- 學前服務對象由六歲提升至七歲：以便一些遲遲未獲評估而升讀小學的特殊需要兒童仍可接受支援服務，避免服務出現斷層。

➢ 特殊教育的支援模式
- 增設訓練過渡平台：跨服務機構個案管理系統 (參考醫健通)，使特殊學校更易了解學生在學前時期訓練；加強學前康復服務與主流學校之間的銜接，讓兒童升讀主流學校後，學校可即時認識兒童的個別需要和特性。
- 增加相關科目的學額及設為專修科 ： 增加特殊教育需要之大學學位名額，將特殊教育需要設為教師培訓課程的必修科目。

主題十：共融文化

➢ 教育宣傳
- 政府就重大報告及文件 (如《施政報告》、《財政預算案》、《香港康復計劃方案》及各項社福服務單張及文化設施等)設立簡易圖

文版，促進殘疾人士了解及掌握當中內容。
- 加強推廣《殘疾人士權利公約》，以推廣殘疾人士的權利。
- 建議共融教育納入中小學常規課程，甚至可於幼稚園階段開始。
- 建議學校在「其他學習經驗(Other Learning Experience) 」中加入與殘疾人士接觸和互動的經驗。
- 將共融、《殘疾人士人權公約》等內容列為相關專業訓練(如社工、心理學家、護理及、教育治療師)等必修內容。
- 加強對傳媒的教育及監察，避免以標籤及負面手法報導有關殘疾人士的新聞，並鼓勵以正面的手法處理相關新聞。

➢ **殘疾人士使用文化/藝術/康體設施**
- 資助殘疾人士成立劇團/藝術會等，並協助他們參與公開表演，讓更多人認識殘疾人士的才能。
- 建議在體育館和表演場地預留較理想的位置作輪椅座位。
- 建議在所有康體場地及博物館等設立共融專職人員，以便在場地安排活動或提供導賞時考慮殘疾人士的需要。此外，康體導師亦應接受相關訓練，加強他們帶領殘疾人士參與活動的能力。
- 政府應撥款予社福機構聘用藝術及或康體導師，以加強殘疾人士參與藝術和康樂文化活動的機會。

〔附件一〕「扶康會智障人士關愛家庭比較研究-簡易版_第二版_ (2019 年 3 月)
〔附件二〕 “A Comparative Study on Family Care Home (FCH) for Persons with Intellectual Challenges: Implications for Policies and Practice in Hong Kong” (March 2019)

2019 年 4 月 4 日

完

若對此「香港康復計劃方案 - 訂定範疇諮詢」意見書 有任何查詢，
請致電 2307-7043 或 電郵至 silvia.mak@fuhong.org 與 扶康會副總幹事 (能力發展) 麥潤芸女士聯絡。

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扶康會
Fu Hong Society

智障人士關愛家庭比較研究：對香港政策和實踐的啟示

(簡易版)

扶康會

第二版(2019 年 3 月)

目的

1. 本文旨在：

i. 研究香港、國內和海外關愛家庭或類近服務的模式和運作;

ii. 找出可供香港參考的關愛家庭實踐模式;

iii. 討論扶康會在香港推行扶康關愛家庭服務所遇到的挑戰;

iv. 向政府提供立法及政策建議，以支持香港的關愛家庭服務，包括向社會福利署署長於二零一七年六月成立的「檢視院舍實務守則及法例工作小組」提供意見。

香港殘疾人士院舍服務：發展及改善機會

2. 「殘疾人士院舍條例」(第 613 章)於二零一一年六月頒布，在二零一一年十一月十八日生效，並已於二零一三年六月十日全面實施。根據「殘疾人士院舍條例」第 2 條，殘疾人士院舍定義為任何慣常有超過 5 名年滿 6 歲的殘疾人士獲收容在其內以獲得有照顧的住宿的處所。

3. 社會福利署署長根據「殘疾人士院舍條例」第 23 條編訂全新的「殘疾人士院舍實務守則」(2011 年)，對於經營、料理、管理及以其他方式控制一間殘疾人士院舍訂立原則、程序、指引及標準，以便營運者遵守。所有超過五名殘疾人士居住的院舍，均需根據殘疾人士院舍發牌制度領取牌照或豁免證明書(COE)。殘疾人士院舍的營辦人應參照「殘疾人士院舍實務守則」的規定，在建築及居住、消防安全及預防措施、管理、醫護服務以及人員配置方面符合規定。

4. 截至 2018 年 11 月，香港 315 間殘疾人士院舍中，共有 205 間未取得有關牌照。過去幾年，有關殘疾人士院舍的虐待及騷擾個案，引起了立法會議員及社會大眾的關注。為此，社會福利署(社署)已採取多項措施，加快發牌程序，以便於二零一九年底前為所有院舍完成發牌。此外，社會福利署署長在二零一七年六月特別成立檢視院舍實務守則及法例工作小組。

5. 在實踐方面，可以理解特小規模和大規模的院舍在服務要求和操作上有明顯差異。在規範大型院舍和小型家舍的護理質素和其他牌照許可要求方面，應該有利於支持小型家舍的措施，因為小型家舍是世界發達國家的首選模式。此外，為保障有住宿需要的殘疾人士，於第 613 章範圍以外的小型家舍的護理質素，亦須由政府採取其他有效措施加以適當監察。

關愛家庭共同特點及其護理質素的調查結果

6. 扶康會參考了英國、美國、澳洲、日本、內地及台灣等多個地區的例子，結合出關愛家庭的共同特點，並比較了各地關愛家庭的護理質素。這些地區的政府政策及措施均支持小型家舍的建立，並設立了為數不小的智障人士小型家舍以滿足他們融入社會的需求。

(i) 以社區為基礎

所有關愛家庭的形式方式都是以社區為本，以家庭為導，旨在加強家庭成員(院友)之間的相互支持，在自然情況下推動社會融合。

(ii)　面積細小，貼心和高效率的員工支援

住宿的規模從 3 人到 14 人不等，取決於服務方式和當地文化。家庭中的家長或健康工作員會幫助服務使用者照顧自己，培養他們的獨立生活技能。

(iii)　個案管理

一些服務模式採用個案管理方法。例如，紐約 IRA (Individualized Residential Alternative)計劃的醫療保障服務協調員(Medicare Service Coordinator)擔任個案經理的角式，負責為發展/智力障礙人士制定個人護理計劃，並將其需求與社區資源聯繫起來。

(iv)　促進殘疾人的權利

大多數服務模式都是推動和實踐聯合國《殘疾人權利公約》第 19 條和第 23 條。

<u>關於關愛家庭護理質素的調查結果</u>

7. 一般來說，與大型院舍相比，關愛家庭被認為是一種有效的服務選擇。它們推動了殘疾人士生活質素的改善和促進社會共融。扶康會的專業及前線員工，曾於 2018 年 12 月前赴日本，探訪當地的智障及自閉症服務機構，進行交流學習。日本的關愛家庭除了積極鼓勵院友融入社區外，在住宿環境方面亦提供家庭的感覺，針對院友的文化需要安排各類設施，院舍員工與院友的關係並不是一種訓練員與學員的模式，而是彼此建立一種同伴的關係。

8. 英國照護品質委員會(CQC)在 2010 年的報告中表示：「提供 10 個床位或以下的院舍，比起提供 40 床位以上的院舍，更大機會獲得優秀或非常優秀的評級。」CQC 指出小型院舍對癡呆或學習障礙的院友特別有好處，由於小型院舍沒能力聘請質素保證經理來協助改善服務，所以以上的成效就顯得更可貴。它還指出，小型院舍不一定比大型護理院更昂貴。而照顧較小人數的服務單位往往對院友的回應能力較佳，例如能夠按個人興趣安排活動。

9. 美國 Maisto 和 Hugues(1995)報告指出，早於 20 世紀 90 年代初，當殘疾人士入住關愛家庭後，他們的整體適應能力顯著加強。Qian 等人(2015 年)確定，在高能力員工協助提供服務的情況下，居住在社區小組家庭的殘疾人士擁有明顯較高的社會參與度、家居及康樂技能水平。台灣 Chou 等人(2011 年)報告，殘疾人士在關愛家庭住宿 2 年後，其生活質素和家庭聯繫有明顯改善，適應不良的行為亦有所減少。

10. Shipton 和 Lashewicz(2017 年)進行的一項研究中，顯示社會共融和自決是優質家庭照顧服務的核心組成部分。關愛家庭被認為是一種更好的服務選擇，殘疾人士可以在家庭形式的環境中被理解，而且，在關愛家庭中獲得的安全及自由的經驗，可以進一步幫助殘疾人士融入社會。

扶康會營辦的關愛家庭

11. 扶康會關愛家庭服務的名稱是「Casa Famiglia」。「Casa Famiglia」是義大利文，在當地被理解為一個「住宅」或「家庭」，專門收容一些有特殊需要的人士(包括有殘障的人、街童、濫藥人士等)。入住成員人數不多，他們在處所內獲得關心和照顧，被視作為家庭成員的一份子，其身分有別於院舍內的服務使用者，又或者是一個個案。於 1997 年，扶康會成立首所扶康關愛家庭「邂逅軒」，關愛家庭服務的名稱被命名為「Casa Famiglia」，以避免與宿舍和制度化的院舍混淆。關愛家庭之目的是於共融社區內為智障人士提供家庭照顧，關愛家庭在香港是一項獨特的服務，並沒有獲得政府資助。

12. 關愛家庭的服務目標是： i) 讓孤兒或父母年老而無能力照顧的智障成人享有家庭生活；ii) 透過增加社區人士與智障人士的日常接觸，提高他們對智障人士的認識及接納，協助智障家庭成員融入社會。

13. 截至 2017 年 11 月，扶康會設有三所扶康關愛家庭，分別是「邂逅軒」、「婉明軒」及「超瑩軒」，共有二十七名家庭成員。由於政府產業署在二零一七年三月需收回威爾斯親王醫院空置職員宿舍，設於該處所的「和諧軒」已暫時關閉。 超瑩軒及婉明軒已分別於二零一七及一八年獲發牌照，婉明軒及超瑩軒均設於房委會以優惠租金提供的單位，邂逅軒則位於扶康會擁有的私人住宅單位。

14. 扶康關愛家庭的一般規劃是容納最多 8 名智障人士作為家庭成員共同生活，全年由職員提供 24 小時支援。他們在日間進行有意義的工作，如日間康復服務、培訓工作坊及輔助就業服務，視乎個人能力而定，部份更正在公開就業。

15. 關愛家庭的核心工作人員是家姆，她們輪班工作，為家庭成員提供日常照顧和個人指導。家庭成員在周末和假日的閒暇時間，可以在義工陪同下享受社區散步、主日學和下午茶等各種活動。除了由家姆在家庭環境中提供日常照顧外，更有家兄扮演著父親的角色，在每個家庭中提供社交和靈性方面的指導。扶康會指派的社工會制訂定並跟進個人康復和發展計劃。

16. 扶康關愛家庭是一項自負盈虧服務，並沒有政府資助。當中 38%的收入來自收費，27%來自香港賽馬會慈善信託基金資助，其餘 35%來自捐款。香港馬會慈善信託基金的社區資助計劃自二零零五年起一直是服務的主要捐助者。本服務最近獲得香港馬會慈善信託基金繼續提供為期三年的資助，由二零一七年至二零二零年，總金額約為港幣 3,721,000 元。

扶康會關愛家庭護理質素調查結果

17. Eria at al(2005)的報告表示，與政府資助的、居住 50 人的標準院舍相比，關愛家庭服務使用者喜歡其居住環境，能讓他們感到安靜，安全，舒適，並可以獲得更多的個人關注。他們與其他舍友、家姆和家兄擁有密切的互動，他們都喜歡這種穩定的關係，讓他們可以得到適當的社交和情感支持。

18. 能力較高的家庭成員可以幫助其他能力較低的家庭成員，他們十分享受這種互相幫助和關懷的關係。

19. 家庭成員本身的親屬表示，關愛家庭可以為家庭成員提供居家般的環境，他們很欣賞家庭安排的各種社區活動。

<u>在香港營辦關愛家庭所遇到的挑戰</u>

20. 缺乏政策和政府支持

目前，政府沒有相關政策支持小型、家庭式的智障人士家舍。舉例說，由於政府產業署(GPA)需收回物業，令扶康會的和諧軒須暫時關閉。社會福利署(社署)並沒有就此提供解決方案或協助尋找位於政府物業或可供用作福利租賃的公共屋邨空置單位，以供和諧軒作出調遷。

21. 難以尋找合適的地點

過去十年，公屋單位的興建數目減少，引致房屋委員會所提供的福利設施處所數目有限。社署轉而重建空置小學、兒童院和有關機構作為綜合康復服務大樓，例如前小欖項目。估計大型康復住宿照顧機構將繼續主導康復服務的未來發展，但是，這個服務發展方向有違「去機構化」、融入社區和社會共融的世界潮流。

22. 私人樓宇單位面積及大廈住宅單位公契

大部分私人住宅樓宇的單位面積較小(介乎四十至八十平方米)。此外，住宅單位的使用受到公契限制，公契中的某些條款可能包括限制住宅單位進行福利和商業活動。雖然有些單位可作商業用途，但其逃生、通風及無障礙通道等外在條件卻不能符合建築物規例及牌照的規定，並不是營辦關愛家庭的可行地點。

此外，「殘疾人士院舍條例」(第 613 章)規定居住超過 5 人的院舍須有嚴格的發牌要求。但對於自負盈虧的關愛家庭來說，開辦一間只能居住 5 人以下的家舍在財務上並不可行。再者，香港大部分私人住宅單位的條件都未能符合發牌要求。

<u>在香港營辦關愛家庭的機遇</u>

23. 執行聯合國殘疾人權利：提供關愛家庭服務將顯示出香港特區政府致力執行《殘疾人權利公約》的承諾和決心，同時也提供一個具有更佳護理質素和更高效率的院舍選擇。

24. 彈性設立新服務：香港殘疾人士的住宿服務模式多年來一直沒有改變。院舍化仍然是主要的服務提供模式，大約 40-50 個殘疾人士居住在一個高度結構化的社會服務機構。關愛家庭可以在日常工作和培訓活動方面提供更大的靈活性。它提供了一個像家一樣的環境，組織各種活動來促進服務使用者融入社會。它的小型面積為尋找合適的處所開辦服務提供靈活性。

25. 縮短住宿服務的輪候名單：香港約有七萬至十萬名智障及發展障礙人士。目前，在社會福利署的資助下，非政府機構總共提供約七千八百個住宿服務名額。截至二零一七年九月三十日，至少有 4,660 人(註: 嚴重弱智人士及中度弱智人士宿舍)正在輪候相關服務。中度弱智人士宿舍及嚴重弱智人士宿舍的輪候時間估計至少十年或以上。關愛家庭可以為仍在等候名單上人士之家長提供另一選擇。

26. 扶康會統計數字顯示關愛家庭的需求：現時住宿服務的輪候時間較長，按社署最新(二零一七年九月)數字顯示，現有 2,188 名申請人正在等候中度弱智人士宿舍(HMMH)(中等照顧程度宿舍，與關愛家庭程度相約)，扶康會每月平均接獲五次有關關愛家庭空缺的電話查詢，大部分需要住宿服務的人士最後都會進入私營院舍。在部分地區，社署仍在處理二零零三年提交的申請，雖然上述數字未能完全反映對關愛家庭的巨大需求，但已清楚地顯示出現有的中度弱智人士宿舍供應遠遠未能滿足需求。如前段所述，關愛家庭將為仍在等待名單上人士的家長提供另一選擇。

27. 應對雙重老齡化-智障人士老齡化及其家長老齡化：智障人士及其照顧者(家長)均面臨老齡化問題，越來越多的智障人士在他們的年邁父母死亡後將會成為孤兒，一些年邁的家長也可能難以照顧智障子女，關愛家庭是應對老齡化問題的住宿服務選擇之一。智障人士可以繼續在關愛家庭享受家庭生活。通過參與家務，他們可以維持自理能力，這可以大大減少他們對昂貴院舍化住宿服務的需求。

28. 為特殊需要人士而設的公共信託服務：部份中等收入家長擔心，在他們過世之後，有特殊需要的子女，特別是智障子女得不到妥善照顧。勞工及福利局在二零一七年的「施政報告」中再次強調設立「特殊需要信託」，為有特殊需要的家長提供負擔得起的信託服務。香港大學最近進行的一項研究顯示，在香港設立特殊需要信託基金(SNT)的需求強烈，而按照家長的回應，優先考慮是由政府擔任 SNT 受託人。SNT 的特點之一，是在父母去世後，指定的個案經理會進行監督，根據護理計劃保障受益人獲得所需的基本和額外支出。關愛家庭將成為那些加入 SNT 的中等收入家長的住宿照顧選擇。

29. 服務券：社署於 2013 年 9 月，推出第一階段「長者社區照顧服務券試驗計劃」，採用「錢跟人走」的資助模式，讓合資格長者因應個人需要，使用社區照顧服務券。隨著計劃取得成功，計劃的另一階段已於二零一六年十月推出。政府可考慮把此方式延伸至殘疾人士院舍服務，如果實現的話，關愛家庭將會是家長的一項選擇。

30. 買位計劃：社會福利署於 2010 年 10 月推出為期四年的私營殘疾人士院舍買位先導計劃，以鼓勵私營殘疾人士院舍提升服務水平，包括提升員工人手比例及提高人均空間標準。截至二零一七年十二月三十一日止，共有十間私營殘疾人士院舍參與買位計劃，共提供六百個買位。估計每個買位每月的平均成本為港幣 8,759.00 元。買位計劃自二零一四年十月起已成為一項常規服務。我們強烈建議社會福利署考慮將買位計劃擴大至包括那些由擁有豐富殘疾人士住

宿服務經驗的非政府機構營辦的自負盈虧院舍，為康復服務中央轉介系統(CRSRehab)上的輪候人士提供選擇。

<u>智障人士及家屬的選擇 – 在香港營辦關愛家庭的建議模式</u>

31. 關愛家庭應以社區為基礎，以家庭為本。家庭成員作為居住在該社區的平等公民，在得到所需的支持下參與日常活動，以提升社會融合。

32. 關愛家庭為中度到輕度智力障礙的家庭成員提供中等照顧水平，以培養他們的獨立生活技能，促進家庭成員之間的相互凝聚力。在決定關愛家庭的規模時，必須在個人和個性化護理以及服務的財務可行性之間取得平衡。扶康會的經驗是，不超過 8 名家庭成員的家庭規模在經濟上是可行的，不會對護理質素造成影響。附錄 2 是 FHS 關愛家庭的年度預算以供參考。

33. 為了提供二十四小時中等照顧水平的家庭護理服務，以滿足營運需要，核心員工編制包括 0.5 名保健員(Health Worker)，4.5 名家姆(House Mother)，而關愛家庭的服務經理及文員則由中央行政部門支援，以支持服務運作。保健員作為舍監，不僅為殘疾家庭成員提供適當的健康和日常照顧，而且還協助服務經理督導家姆的日常工作及監督藥物管理。此外，保健員還應培訓家姆具有基本護理知識和妥善保存文件。

34. 每個家庭成員都有專門的個案經理，負責照顧他們的福利需要，並與家庭成員及其家屬合作制定照顧計劃，特別是在有需要時將他們轉介到其他類型住宿服務。

35. 為容納 8 名男性和女性服務使用者以及護理人員，處所內至少設有 4 個分區：1 個男性四人臥室，一個四人女性臥室，一個照顧人員起居室和一個客飯廳。處所內也應該有共享設施包括洗衣房和廚房。以私人住宅樓宇為例，一間面積約 120 平方米的單位可以符合關愛家庭用途。

36. 扶康會關愛家庭的居住人數不超過 8 名成人，期望可豁免受第 613 章的規管，但關愛家庭仍會遵守社署發出的護理質素規例。如關愛家庭能夠在社署註冊，扶康會就有資格申請福利用途處所，讓服務使用者得到政府支援。倫敦護理標準委員會(Care Quality Commission London)能夠為社署提供一個類似服務模式的參考。

37. 基於以下原因，建議關愛家庭可設於公共屋邨地下面積較小的空置單位：
    - 租約穩定，租金合理
    - 節省物業維修成本
    - 加強社會共融
    - 基於私人樓宇公契的規定，能夠成功尋找合適私人樓宇單位的機會相當渺茫。

38. 扶康會將大力發展義工網絡，除了提倡互助精神外，這也是一個社區教育的過程。義工的參與對於關愛家庭的發展非常重要，各界義工可以成為額外的人力資源，定期探訪家庭、照顧家庭成員，成為家庭成員的固定朋友。

<u>扶康會提交以下建議希望香港特區政府支持關愛家庭</u>

39. 扶康會誠懇地要求:

- **香港康復計劃方案檢討督導小組加以研究，訂定具體政策支持在香港營辦關愛家庭。**
- **「殘疾人士院舍條例」檢討工作小組為所有居住少於 9 名成年人的關愛家庭的發牌規定進行檢討，並建議合適的發牌條件及照顧審核。**
- **社署牽頭與政府有關部門及法定機構，包括房屋委員會聯繫，為關愛家庭尋找合適的處所。**

<u>總結</u>

40. 本文分析了世界部分國家和地區的住宿照顧院舍，並參考了其他研究和護理質素審計報告。總括而言，關愛家庭符合小型住宿照顧服務的世界趨勢，切合《殘疾人權利公約》的要求。此外，本文亦探討在香港推行關愛家庭的相關事宜，所遇到的挑戰和機遇，並向香港特區政府提交具體建議以供審議。

41. 扶康會營辦關愛家庭超過 20 多年。我們認為，這種獨特的服務模式已經證明能有效地為智障人士提供一個享受家庭照顧的環境，讓他們能在家庭中貢獻自己，充分發揮他們的能力。扶康會關愛家庭充滿愛心及關懷的環境，讓他們可以享受高品質的生活。我們應大力倡議及支持關愛家庭服務模式，為有需要的殘疾人士家長提供選擇，並且讓公眾人士透過成為關愛家庭成員的固定朋友，共同參與建造共融社會。

若對扶康會關愛家庭服務有任何查詢或英文版全文有興趣，請致電
2307-7036 或電郵至 frankie.tsui@fuhong.org 與扶康會副總幹事(服務運作)聯絡

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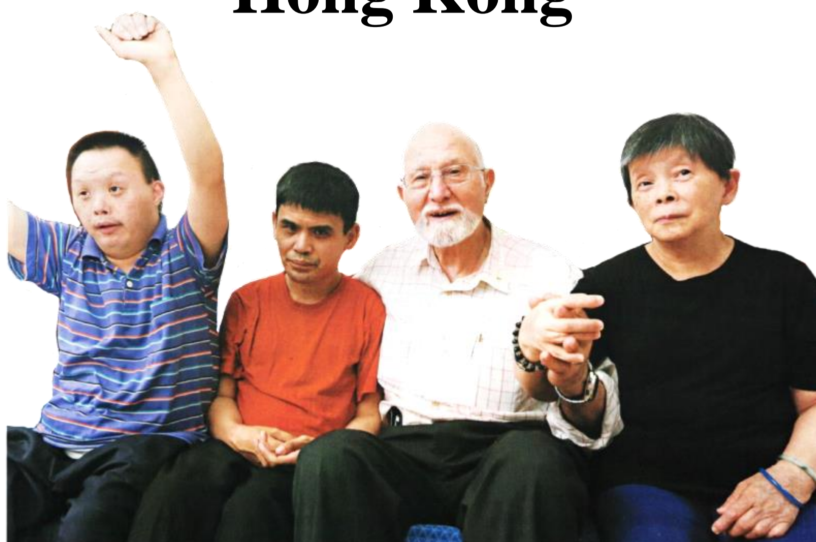
A Comparative Study on Family Care Home (FCH) for Persons with Intellectual Challenges: Implications for Policies and Practice in Hong Kong



Fu Hong Society[1]

2nd Edition (March 2019)

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[2] This appendix supersedes the 2017/18 Annual Budget for FHS Family Care Homes appended to the 1st edition of this paper.

Executive Summary

This paper aims to identify useful Family Care Home (FCH) practice models relevant to Hong Kong and propose legislative and government policies to support FCH in Hong Kong by making reference to FCH practices of selected countries and cities, as well as relevant research studies. It reveals that small residential care home and FCH have many common features, such as community-based, small in size and with caring and efficient staff support, case management, and promotion of rights of persons with disabilities. FCHs are also considered as an effective service alternative relative to large institutions. They facilitate the improvement in quality of life and social inclusion of persons with disabilities. Drawing on the findings, it is apparent that FCH meets the world trend for small size residential care homes as well as the requirements of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) which states that persons with disabilities have the opportunity to choose their home on the basis of equality with others, to choose where and who to live with and to live and integrate into the community.

The provision of FCH is a unique service in Hong Kong with the aim to provide family care to persons with intellectual disabilities in an inclusive community. The general planning of a FCH is to accommodate up to 8 adults with intellectual disabilities ranged from moderate to mild intellectual disabilities living together as family members, with 24-hour staff support. They are engaged meaningfully in the daytime with support for respective case manager. The core staff of the FCH are the Housemothers who work shift to provide daily care and personal guidance to family members. The Elder Brothers act as a father figure to offer guidance socially and spiritually in each Family. Apart from

providing a safe and comfortable environment for the residents, FCH enables residents get more individual attention through close contact with other residents, Housemothers and Elder Brothers.

At present, there is no governmental policy supporting small-sized and family-like residential care homes for persons with intellectual disabilities. It is difficult to find suitable location to setup the FCH due to the lack of welfare premises, and most private residential units cannot fulfill the strict licensing requirements for residential care homes. The provision of FCH as proposed in this paper would demonstrate the commitment and determination of HKSAR Government in implementing the UNCRPD. Noting the estimated waiting time for hostels for persons with intellectual disabilities was around 10 years or even longer, FCH would therefore provide a choice for parents with children on the waiting list.

FHS submits to the HKSAR Government the following concrete proposal: i) the Rehabilitation Program Plan Review Steering Group to study FCH with a view to promulgating concrete and supportive policies for FCH in Hong Kong; ii) the Residential Care Homes (Persons with Disabilities) Ordinance Review Working Group to review and recommend appropriate licensing requirements and care audit for all FCHs of less than 9 adults; and iii) the Social Welfare Department to be the lead department in liaising with relevant government departments and statutory bodies, including the Housing Authority, to identify and mobilize suitable premises for FCHs.

I. Purpose

1. This paper aims to:
   1.1 examine similar models and operation of FCH in Hong Kong, Mainland China, and overseas communities;
   1.2 identify useful FCH practice models relevant to Hong Kong;
   1.3 discuss the challenges encountered by Fu Hong Society in the operation of FCH in Hong Kong; and
   1.4 propose legislative and government policies to support FCH in Hong Kong, including providing input to the Working Group on the Review of Ordinances and Codes of Practice for Residential Care Homes set up by the Director of Social Welfare (DSW) in June 2017.

II. Residential Care Homes for Persons with Disabilities (RCHDs) in Hong Kong: Recent developments and opportunities for improvement

2. Social Welfare Department issued a Code of Practice for Residential Care Homes for Persons with Disabilities first in March 2002[3], which sets out principles, procedures, guidelines and standards for the operation, keeping, management or other control of residential care homes for persons with disabilities. This Code referred "Residential Care Homes for Persons with Disabilities" (RCHDs) as any premises at which more than 8 persons with disabilities over the age of 15 are habitually received for the purpose of care while resident therein. The Code of Practice sets out the minimum standards and guidelines for hygiene, fire, building safety, and the level of care required, which aims at ensuring that residents in these homes receive services of acceptable standards that are of benefit to them physically, emotionally and socially.

3. The Residential Care Homes (Persons with Disabilities) Ordinance (Cap. 613) was enacted in June 2011. It came into operation on 18 November 2011 and was fully implemented on 10

[3] Social Welfare Department. Code of Practice for Residential Care Homes for Persons with Disabilities (March 2002). Retrieved from https://www.swd.gov.hk/doc/downsecdoc/code_rchpd.pdf on 27 December 2017.

June 2013[4]. Under section 2 of the Residential Care Homes (Persons with Disabilities) Ordinance, a residential care home for persons with disabilities is defined as any premises at which more than 5 persons with disabilities, who have attained the age of 6 years, are habitually received for the purpose of residential accommodation with the provision of care.

4. A new code, The Code of Practice for Residential Care Homes (Persons with Disabilities) (2011)[5], was issued by the DSW under section 23 of the Residential Care Homes (Persons with Disabilities) Ordinance, setting out principles, procedures, guidelines and standards for the operation, keeping, management or other control of RCHDs for compliance by operators. All RCHDs with a capacity of more than 5 persons with disabilities should obtain a License or Certificate of Exemption (COE) under the Licensing Scheme for Residential Care Homes for Persons with Disabilities. The operators of RCHDs should comply with the requirements in Building and Accommodation, Fire Safety and Precautions, Management, Health Care Services, and Staffing referring to the Code of Practice of RCHDs.

5. As of November 2018, 205 out of 315 RCHDs in Hong Kong did not obtain the License. In the past years, reported cases of abuse and harassment in RCHDs have aroused the concern of the Legislative Councilors and general public. In response to community concern, Social Welfare Department (SWD) has implemented various measures to expedite the licensing process with a view to facilitating all RCHDs to be licensed by the end of 2019[6]. Further, a Working Group on the Review of Ordinances and Codes of Practice for Residential Care Homes convened by the DSW was set up in June 2017[7].

6. Both Codes (2002 and 2011) apply same requirements and standards to all RCHDs under its definition. One major difference between the two is that Code 2002 covers RCHDs with more than 8 persons, while Code 2011 covers RCHDs with more than 5 persons. Another major difference is the age coverage, in which Code 2002 was 16 and above, and Code 2011 is 6 and above. However, no explicit reasons are given as to the change of applicable

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[4] Social Welfare Department. Licensing Scheme for Residential Care Homes for Persons with Disabilities. Retrieved from https://www.swd.gov.hk/en/index/site_pubsvc/page_lr/sub_rchdtop/id_rchd/ on 27 December 2017.

[5] Social Welfare Department. Code of Practice for Residential Care Home (Persons with Disabilities) 2011. Retrieved from https://www.swd.gov.hk/doc/LRB/LORCHD/CoP%20Eng_a.pdf on 27 December 2017.

[6] Legislative Council Paper No. CB(2)1975/16-17(01) "福利事務委員會需要跟進事項的進展". Retrieved from https://www.legco.gov.hk/yr16-17/chinese/panels/ws/papers/ws20161212cb2-1975-1-c.pdf on 27 December 2017.

[7] Social Welfare Department. Working Group on the Review of Ordinances and Codes of Practice for Residential Care Homes. Retrieved from https://www.swd.gov.hk/en/index/site_pubsvc/page_lr/sub_working/ on 27 December 2017.

accommodation size of defined RCHDs.

7. In practice, it is well recognized that there are significant differences in service operation requirements between very small and very large residential homes. A differential treatment in stipulating quality of care and other licensing requirements between the large and small residential homes should be beneficial to support small homes, which is the preferred model in developed countries.

8. Further, for protection of persons with disabilities in need of residential care, quality of care of small homes outside the boundary of Chapter 613, should also be duly monitored by the Government through other effective measures.

III. Global Trend on Residential Services for Persons with Intellectual / Developmental Disabilities (IDDs)

9. Article 19 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) states that[8], "persons with disabilities have the opportunity to choose their home on the basis of equality with others, to choose where and who to live with, not to be forced to live in a particular living arrangement, to obtain access to a variety of home, shelter and other community support services, including the necessary personal assistance, in the community to live and integrate into the community, to avoid isolation or isolation from the community". Article 23 Respect for home and the family states that, "1. States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others. … 5. States Parties shall, where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting."

10. Long before the adoption of the UNCRPD, de-institutionalization of residential care homes

[8] United Nations. The United Nations Convention on the Rights of Persons with Disabilities. Retrieved from https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/the-convention-in-brief.html on 27 December 2017.

for IDDs has already become a major trend in most western countries[9]. Many institutions had been closed down and IDDs moved into small group homes in the community. Studies in Australia[10] and Canada[11] respectively reported that community settings are more preferable to institutional ones for most IDDs. In a systematic review of 69 international studies, Kozma, Mansell and Beadle-Brown (2009)[12] concluded that IDDs presented better adaptive behaviors in the community settings. There were also improvement in community participation, social networks and friends, family contact, self-determination and choice, quality of life, and greater satisfaction for IDDs and their families.

11. In many countries and cities such as Taiwan, Japan, New York State, Australia and North Carolina, polices and regulations have been enforced to facilitate the development of small residential care homes. Concerned polices and regulations have been established to support the setting up of small and family-like residential care homes. A variety of small residential care homes for persons with intellectual disabilities have been set up in order to fulfill their needs for social inclusion.

IV. A Review of Small Residential Care Homes in Selected Countries and Areas

Regulating Adult Home Facilities by Care Quality Commission[13] in England

12. Care Quality Commission (CQC) is the independent regulator of health and adult social care in England.

    12.1 Its purpose is to make sure health and social care services provide people with safe,

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[9] Kim, Sheryl A., Larson K., &Charlie Lak, S. (2001). Behavioural outcomes of deinstitutionalisation for people with intellectual disability: a review of US studies conducted between 1980 and 1999. *Journal of Intellectual and Developmental Disability*, *26*(1), 35-50.

[10] Young, L., Sigafoos, J., Suttie, J., Ashman, A., & Grevell, P. (1998). Deinstitutionalisation of persons with intellectual disabilities: A review of Australian studies. *Journal of Intellectual and Developmental Disability*, *23*(2), 155-170.

[11] Lemay, R. A. (2009). Deinstitutionalization of people with developmental disabilities: a review of the literature. *Canadian Journal of Community Mental Health*, *28*(1), 181–194.

[12] Kozma, A., Mansell, J., & Beadle-Brown, J. (2009). Outcomes in different residential settings for people with intellectual disability: a systematic review. *American Journal on Intellectual and Developmental Disabilities*, *114*(3), 193–222.

[13] Source of information for this section is based on (a) Dr. Joseph Kwok's interview on 12 December 2017 with Mr. James Bryant, Interim Government Engagement Manager, Parliamentary, Government and Stakeholder Engagement Team, Care Quality Commission in his London Office; and (b) websites: Legal information/overview: http://www.cqc.org.uk/guidance-providers/regulations-enforcement/legislation ; handbooks and frameworks: http://www.cqc.org.uk/guidance-providers .

effective, compassionate, high-quality care and encourage care services to improve. Its role is to monitor, inspect and regulate services to ensure they meet fundamental standards of quality and safety and publish what it finds, including performance ratings to help people choose care services.

12.2 It works independently of politics and the system, regulates across all sectors, clinically driven with expert teams, evidence-based judgement, not regulatory compliance, highlights excellence and exposes poor care with transparent ratings, and always on the side of people who use services.

12.3 Scope of CQC's remit: care homes and domiciliary care, hospitals and clinics, primary medical services, ambulances, and primary dental care. England has a population of 55 million, and 25,500 care homes are under the regulation of CQC.

12.4 CQC's journey is to move away from regulatory compliance to fundamental standards. Fundamental standards include: professional and intelligence-based judgements; ratings - clear reports about safe, effective, caring, well-led and responsive care; five key questions (with key lines of enquiry); expects all providers to continuously improve; providers and commissioners clearly responsible for improvement; specialist inspectors with teams of experts; focus on services, groups, pathways; individuals at board level also held to account for the quality of care.

12.5 Key lines of enquiry for adult social care services operated by organizations prompts and sources of evidence in this section help our inspectors to answer the five key questions: is the service safe, effective, caring, responsive and well-led?

12.5.1 Is it safe? Safeguarding and protection from abuse, managing risks, suitable staff and staff cover, medicines management, infection control, learning when things go wrong;

12.5.2 Is it effective? Assessing needs and delivering evidence-based treatment, staff skills and knowledge, nutrition and hydration, how staff teams and services work together, supporting people to live healthier lives, accessible premises, consent to care and treatment;

12.5.3 Is it caring? Kindness, respect and compassion, involving people in decisions about their care, privacy and dignity;

12.5.4 Is it responsive? Person-centred care, concerns and complaints, end of life care;

12.5.5 Is it well-led? Vision and strategy, governance and management, engagement and involvement, learning, improvement and innovation, working in partnership.

12.6 CQC regulates adult homes based on the fundamental standard and merits and characteristics of each organization. As small adult homes are the norms across England with varieties of characteristics, CQC's approach allows flexibility and ensures quality of care.

12.7 CQC reported in 2010 that "the average size of a care home is growing despite larger homes offering lower quality care. The average size of a residential care home or nursing home increased from 23 beds in 2004 to 25 beds in 2010. However, care homes with 10 beds or less are more likely to be rated as good or excellent than those with 40 beds or over. In April 2010, 15% of homes with 40 beds or more had a rating of one or zero stars under the CQC's star quality ratings system, while only 10% of small homes had the same."[14]

12.8 CQC's approach will provide very helpful references to Hong Kong in supporting and developing small residential care homes and family care homes, where such facilities are not operated on purpose built premises.

United States of America

13. In USA, a number of residential options for persons with intellectual/developmental disabilities (IDD) are available. The Individualized Residential Alternative (IRA) in New York State[15] and Group Home in North Carolina[16] are comparable services for inclusion in this paper.

[14] Vern, P. (November 8, 2010). Adults, Domiciliary care, Inspection and regulation, Older people, Residential care. Retrieved from http://www.communitycare.co.uk/2010/11/08/cqc-report-reveals-care-home-size-is-increasing/ on 25 December 2017.

[15] Office for People with Developmental Disabilities, New York State. Individualized Residential Alternative. Retrieved from https://opwdd.ny.gov/opwdd_services_supports/residential_opportunities/individualized_residential_alternative on 27 December 2017.

[16] Adult Care Licensure Section, NC Division of Health Service Regulation. License a Family Care Home (2-6 Beds). Retrieved from https://www2.ncdhhs.gov/dhsr/acls/flofch.html on 27 December 2017.

Individualized Residential Alternative (IRA) in New York State of USA[17]

14. The IRAs are one of the community residential options licensed by the Office of People with Developmental Disabilities (OPWDD). They are operated by the OPWDD or non-profit making agencies. The IRAs provide 24-hour staff support and supervision for up to 14 residents per unit. Day services are also available for residents living in IRAs which may include day habilitation, prevocational services and supported employment depending upon their level of skill. Some of them may enroll in open employment. Residents are usually living in a house which is owned by a non-profit making agency. Able2 is one of the service providers of IRA in New York State.

15. OPWDD is monitoring the operation of the IRAs, ensuring their fiscal monitoring, agency governance, and the compliance to the regulations in the program level. Most residents living in the IRA Program are supported by a Medicaid Service Coordinator (MSC). MSCs provide a vital link to information about service options. MSCs also work with individuals and their families in developing the care plan so as to ensure that these individuals and families can access to the services of OPWDD whenever eligible.

Group Homes in North Carolina[18]

16. The Group Homes in North Carolina are licensed and monitored by the North Carolina Division of Health Service Regulation (DHSR). These group homes provide 24-hour personal care and rehabilitation programs for adults with intellectual/developmental disabilities. The services include the development of self-help skills, enhancement of work capacity, and participation in community activities. Group homes are usually owned or leased by the welfare agencies. The provision of the residential services is bounded by their service contract with Alliance Behavioral Healthcare. In general, each group home accommodates 3-6 residents. The fee charged is generally paid by a combination of the resident's Social Security Income (SSI/SSDI) and a Medicaid service called Special Assistance granted by the local Department of Social Services.

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[17] One of the service providers is ABLE2 ENHANCING POTENTIAL, INC. 1118 Charles Street Elmira, NY 14904. Executive Director: Mark Peters, Agency Phone: (607)734-7107; Agency Website: http://www.able-2.org/what-we-do/our-residences.html

[18] One of the service providers is Building Independence - Raleigh, NC which is providing safe, affordable housing for nine low-income adults with intellectual and/or developmental disabilities. For more information, please visit the websites of Habitat for Humanity of Wake County (https://www.habitatwake.org/) and the Serving Cup (http://www.servingcup.org/building-independence/).

17. The strengths of the IRAs and Group Homes lie in their capacity in addressing the residents' abilities rather than their deficiencies. Residents of these programs are empowered to engage and contribute to community life. The values of individual independence, interdependence, community inclusion, individuality and productivity are highly emphasized. These core values in service provision all contribute to the resident's quality of life and life satisfaction.

Group Homes in Japan[19]

18. FHS organized a study tour to Kanto, Japan in December 2018. A total of 15 staff members paid visits to two local NGOs to learn about their experience in running group homes for persons with autism spectrum disorders (ASD). Highlights of the visits are as follows.

社會福祉法人油菜花會 [20]

19. "社會福祉法人油菜花會" is located in Chiba prefecture. It is committed to promoting social inclusion by creating a favorable environment for persons with ASD and facilitating their connection with the community. This NGO operates nine group homes, which serve a total of 38 persons with ASD (around 4 to 5 residents in each group home). Each of them strives to create a home-like living environment and respects their indigenous culture by establishing well-designed facilities to cater for the individual needs of residents. For instance, if a resident loses his/her temper and would like to stay alone without interruption, he/she can hide inside a high cabinet with simple furniture to calm down in a "safe place". In the group homes, staff members act as residents' companions, rather than trainers to take care of their daily living. One of the impressive activities is that the staff members join in the Furo (a type of bathtub used in Japan) together with the residents instead of helping them shower. The above examples show how the group homes make use of different facilities/ activities to

[19] The session of Group Home in Japan is added to the 2nd edition of the Study.
[20] Official website of 社會福祉法人油菜花會 is https://www.nanohanakai1988.com

promote individualized living.

20. The monthly cost per service user in a group home is approximately 43,000 yen, of which half of the expenses are covered by the Chiba Prefecture Government and a subsidy of 10,000 yen is provided by the Central Government. Each resident is therefore charged a monthly fee of around 10,000 yen.

横浜やまびこの里 [21]

21. "横浜やまびこの里" is located in Yokohama. This NGO operates 14 group homes and each accommodates 5 to 7 persons with ASD. These group homes attach great importance to independent living and home-like living environment. Each service user lives in an independent small unit with a living room and a bedroom; and some room layouts may vary according to individual user characteristics. These show their efforts to provide a supportive and user-friendly environment for service users.

22. In Hong Kong, persons with ASD comorbid with developmental delay are mixing with persons with intellectual disabilities in RCHDs. Because of the significant differences in terms of their characteristics, it is inevitable that the existing arrangement in the RCHDs may hardly meet their needs in full. Such a practice differs from the group homes in Japan, which put strong emphasis on the principle of "individualization" and the unique needs of persons with disabilities.

Mainland China

23. In Mainland China, the Huiling Guangzhou (廣州慧靈) was established in 1990, which is

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[21] Official website of 横浜やまびこの里 is http://www.yamabikonosato.jp/

one of the pioneering philanthropic organizations. Its family care home was first launched in Guangzhou, Guangdong Province in 2000. The promotion of community integration is the core mission of Huiling's Family Care Home. As of April 2017, a total of sixteen family care homes were established in Guangzhou[22]. Each home accommodates 5 to 6 residents under the care of the housemothers. Staff and residents in each home are treated as family members, and they share the household chores, such as house cleaning and meal preparation. It is useful to note that Huiling Guangzhou has a close collaboration in professional exchange with FCH of Fu Hong Society since its founding, and has benefitted from making reference from the family care home practices of our FCH. Huiling's Family Care Home is now well recognized by local authorities and has been expanding to meet the needs of people in need.

24. The operation of Family Care Home by Huiling is governed by a government license. No explicit or specific fire safety and building regulations are issued as requirements for licensing. The residential fee collected is around RMB 3,000 / month[23], and accounts for about 20% of total costs. Financial support from local government accounts for 10%. The remaining 70% of costs are covered by fundraising. Huiling Guangzhou is seeking an increase in government subvention from 10% to 30%.

25. The Council and staff of Fu Hong Society visited Ark-Nanjing Special Education Centre (南京方舟啟智中心)[24] in Nanjing, Mainland China in January 2018. The Ark-Nanjing Special Education Centre has started a small family care home service in a residential community in Wuxi city (無錫市), Jiangsu Province (江蘇省) since 2017. Its service model and operation is making reference to family care home of Fu Hong Society. This is a pioneer project in Nanjing. There are 5 family members with intellectual challenges and with self-care abilities living together as a family unit under the care of a social worker. All of the family members engage in meaningful daily vocational activities in a rehabilitation facility also operated by the Ark-Nanjing Special Education Centre, and return home after work in the evening to enjoy family life. The monthly charge is around 1,600 RMB per person.

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22 嚴蓉(2017 年 4 月 10 日)。慧靈獨創"家庭管理"模式幫助心智障礙者重新融入社會。網易新聞。檢自：http://news.163.com/17/0410/00/CHKELL3K00018AOP.html

23 中評社北京(2017 年 3 月 24 日)。大齡自閉症家庭焦慮：我死了，孩子怎麼辦。中國評論通訊。檢自：http://hk.crntt.com/crn-webapp/touch/detail.jsp?coluid=209&kindid=9572&docid=104622381

24 Official website of Ark-Nanjing Special Education Centre: http://njark.cn/

Taiwan - The Community Housing Program（社區居住方案）

26. In Taiwan, the Community Housing Program was first implemented in 2004[25]. It provides support for persons with physical and psycho-social challenges, and aims to facilitate their independence. It accommodates a maximum of 6 residents in each unit. In 2014, the Community Housing Program was enforced as one of many types of residential services by law.

27. Local social welfare organizations interested in launching a Community Housing Program can apply for the operation after securing a residential flat available for the program, either in a rental flat or self-owned property. Once the application is approved, the Program is eligible to receive the subvention of the Central Government. The subvention system adopts a "money-following-the-user" approach. The income of the operating organizations is determined by the number of residents admitted to the Community Housing Program.

28. Service operators may apply for funding support from the local government by means of rental subsidy or staffing subvention. Local government will conduct assessment on the service quality (grade) of the Community Housing Program annually to decide on the level of subsidy.

29. As of October 2015, there were around 100 community housing units in Taiwan where more than 400 persons with physical and psycho-social challenges were benefitted from the Community Housing Program. The municipal governments of Taichung and Hsinchu participate actively in this project and operate most of the community housing units in Taiwan.

Australia – Supported Accommodation

30. Supported Accommodation is community residential support to provide around the clock support in a small group home setting with services tailored to meet unique requirements of each individual[26]. The location is usually accessible to services and supports to meet their needs, including education, medical, employment and recreational facilities. The staffing

[25] 李婉萍 (2008)。臺灣「社區居住與生活」服務發展歷程。社區發展季刊，121，147-159。

[26] Retrieved from website : https://www.lifestylesolutions.org.au/disability-supports/wa/Pages/Supported-Accommodation.aspx

level is based on the assessed need of the group of people living in the home.

31. WA Blue Sky is an organization providing licensed group homes and community support to people with disabilities in West Australia. Each resident of the group homes is granted ASD$200,000 per year under the National Disability Insurance Scheme (NDIS) to support his/her living in the community with the aims to offer people with disabilities the opportunity and support to live independently, to contribute and participate fully in society and to live a life of choice.

32. The service is with policy and legislation support. Service operators should comply with Accommodation Support Policy and Person Centred Guiding Principles which align with the principles of the United Nation's Convention on the Rights with Disabilities with the aim to guide the planning and provision of support to people who are eligible for accommodation support. The Disability Inclusion Act is the significant legislation to govern the Policy and Principles.

V. Common Features of Family Care Homes (FCHs) and Findings on Their Care Quality

33. Small residential care home and family care home have many common features, except that family care home puts strong emphasis on forming a "family" with concerted efforts from all members: people with disabilities, staff and volunteers. Key features of family care home will be presented in the section on Family Care Home operated by Fu Hong Society. For purpose of this section, family care home includes also small residential care home. The common features are presented below.

Community-based

34. All the modalities of FCHs are community-based and home-like oriented which aims at enhancing the mutual support among the family members (residents) and promoting the social integration in a natural setting.

Small in size and with caring and efficient staff support

35. The size of the homes ranges from 3 to 14 residents, depending on the mode of service delivery and cultural context. House parent(s) and/or health worker(s) of the home will help the service users to take care of themselves and cultivate their independent living skills.

Case Management

36. A case management approach is adopted in some service modalities. For example, the Medicare Service Coordinator of IRA program in New York State acts as a case manager in developing individual care plan for persons with developmental/intellectual disabilities and linking up their needs with the community resources.

Promotion of rights of persons with disabilities

37. Most of the service modalities promote and practice the Articles 19 and 23 of UN CRPD[27].

Findings on care quality of Family Care Homes

38. Generally, FCHs are considered as an effective service alternative relative to large institutions. They facilitate the improvement in quality of life and social inclusion of IDDs.

39. In England, Care Quality Commission reported in 2010 that "Care homes with 10 beds or less are more likely to be rated as good or excellent than those with 40 beds or over. In April 2010, 15% of homes with 40 beds or more had a rating of one or zero stars, under the CQC's star quality ratings system while only 10% of small homes had the same. In its report, Market profile, quality of provision and commissioning of adult social care services, the CQC acknowledged that smaller homes prove particularly advantageous for residents with dementia or learning disabilities. This achievement is made stronger by the fact that smaller homes are unlikely to have the resource of quality assurance managers to help improve services… It also remarked that smaller care homes may not necessarily be more expensive than larger ones, which achieve economies of scale."[28] CQC reported a similar finding in 2017, that "Our [CQC] analysis of our inspections shows that there is variation in

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[27] ECCL European Coalition for Community Living (2009) FOCUS REPORT 2009 - Focus on Article 19 of the UN Convention on the Rights of Persons with Disabilities. Retrieved from http://community-living.info/wp-content/uploads/2014/02/ECCL-Focus-Report-2009-final-WEB.pdf on 27 December 2017.

[28] Vern, P. (November 8, 2010). Adults, Domiciliary care, Inspection and regulation, Older people, Residential care. Retrieved from http://www.communitycare.co.uk/2010/11/08/cqc-report-reveals-care-home-size-is-increasing/ on 25 December 2017.

performance depending on the size of services. Generally, smaller services that are designed to care for fewer people were rated better than larger services. In both nursing and residential homes, there is a trend that smaller homes are rated better than larger homes, with 89 per cent of both small (1-10 beds) nursing and small residential homes rated as 'good' or 'outstanding', compared with just 65 per cent of large (50+ beds) nursing homes and 72 per cent of large residential homes. Services that care for smaller numbers of people often found it easier to demonstrate a good level of responsiveness – for example, by being able to offer activities that are based on people's individual interests." [29]

40. In US, Maisto and Hugues (1995)[30] reported as early as the beginning of the 1990s that IDDs experienced a significant increase in overall adaptive functioning subsequent to a placement in FCH. Qian et al. (2015)[31] confirm that IDDs living in community group homes could achieve significant higher levels of social engagement, domestic and recreational skills while competent staff are provided to support the services.

41. In Taiwan, Chou et al. (2011)[32] reported a significant improvement in quality of life and family contacts, and a decrease of maladaptive behaviors in IDDs after two years' accommodation in FCH.

42. The work satisfaction of staff working in FCH was also addressed. A study in Australia clearly reported that frontline staff felt that they were valuable contributors in FCH who knew the service settings and IDDs well (Quilliam, Bigby, & Douglas, 2017)[33]. The role of government in service provision was also examined. The feasibility for contracting-out the FCH services was addressed (Bigby, 2006)[34].

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[29] Angeline, A. (July 6, 2017). Size matters in care homes with small doing better than large, says CQC. Retrieved from https://www.carehome.co.uk/news/article.cfm/id/1586130/Size-matters-in-care-homes-and-home-care-with-too-many-people-getting-care-thats-not-good-enough on 25 December 2017.

[30] Maisto, A. A. & Hugues, E. (1995). Adaptation to group home living for adults with mental retardation as a function of previous residential placement. *Journal of Intellectual Disability Research*, 39(1), 15-18.

[31] Qian, X., Ticha, R., Larson, S. A., Stancliffe, R. J. & Wuorio, A. (2015). The impact of individual and organization factors on engagement of individuals with intellectual disability living in community group homes: a multilevel model. *Journal of Intellectual Disability Research*, 59(6), 493-505.

[32] Chou, Y. C., Pu, C., Kroger, T., Lee, W. & Chang, S. (2011). Outcomes of a new residential scheme for adults with intellectual disabilities in Taiwan: a 2-year follow-up. *Journal of Intellectual Disability Research*, 55(9), 823-831.

[33] Quilliam, C., Bigby, C., & Douglas, J. (2017). Being a valuable contributor on the frontline: the self-perception of staff in group homes for people with intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, 00: 1-10. Retrieved from https://doi.org/10.1111/jar.12418.

[34] Bigby, C. (2006). Shifting models of welfare: issues in relocation from an institution and the organization of community living. *Journal of Policy and Practice in Intellectual Disabilities*, 3(3), 147-154.

43. In a recent analysis conducted by Shipton and Lashewicz (2017)[35], it was concluded that social inclusion and self-determination are the central constituents of quality home care. FCH is considered to be a better choice of service provision while it allows the IDDs to be understood in a family setting. Moreover, the experience of security and freedom in FCH could further promote the social inclusion of IDDs.

VI. Family Care Home Operated by Fu Hong Society (FHS)

44. In FHS, "Casa Famiglia" is the service name for family care homes. Casa Famiglia is an Italian phrase, literally means "House" (casa) "Family" (famiglia). People with special needs (disabled, street children, drug addicts etc.) are welcomed, in small numbers, into a house where they are cared and treated as family members, rather than as service users inside an institutional hostel, as in the case of group-home hostels. In 1997, when FHS started the first FCH, the "Encounter Family", the overarching name of the family care home service was named "Casa Famiglia", so as to avoid the confusion with hostel and residential care institutions; and with the aim to provide family care to persons with intellectual disabilities in an inclusive community. The provision of the FCH is a unique service in Hong Kong, and without government subvention.

45. The service objectives of the FCHs are: i) to enable adults with intellectual disabilities who are orphans, or with aging parents who cannot take care of them to enjoy family life; ii) to enhance the community's understanding and acceptance of persons with intellectual disabilities, and better integration through increased daily contacts with community members.

46. As of November 2017, FHS has three FCHs, namely: Encounter Family, Splendor Family and Radiance Family, with a combined capacity of 27 family members. The "Concordia Family", which used the vacant staff quarters of Prince Wales Hospital, was temporary closed due to the retrieval of the premises by the Government Property Agency in March 2017.

[35] Shipton, L., & Lashewicz, B. M. (2017). Quality group home care for adults with development disabilities and/or mental health disorders: yearning for understanding, security and freedom. *Journal of Applied Research in Intellectual Disabilities*, 30, 946-957.

47. The Radiance Family and Splendor Family were licensed in 2017 and 2018 respectively. They are both situated in premises on concessionary rate offered by the Housing Authority. Encounter Home is located in private residential unit owned by FHS.

48. The general planning of a FCH is to accommodate up to 8 adults[36] with intellectual disabilities living together as family members, with 24-hour staff support throughout the year. They are engaged meaningfully in the day time, such as day rehabilitation services, workshop training and supported employment, depending upon the individual's ability; some may be in open employment.

49. The core staff of the FCH are the Housemothers who work shift to provide daily care and personal guidance to family members. During the leisure time at weekends and on holidays, family members enjoy various activities, such as community walk, Sunday school and afternoon tea, with the companion of regular volunteers. In addition to providing daily care by the Housemothers within a family setting, the Elder Brothers act as a father figure to offer guidance socially and spiritually in each Family. An individual rehabilitation and development plan is formulated and followed up by a designated social worker of FHS.

50. FCH is a self-financed service, without government subvention. 38% income source is from fee charging, 27% from the donations of Hong Kong Jockey Club (HKJC) Charities Trust, and the remaining 35% from fund-raising. The HKJC Charities Trust has been the major donor of FCH through its Community Project Grant since 2005. The HKJC Charities Trust continues to support Casa Famiglia project for a further three-year term from 2017 to 2020 with a total sum of around HK$3,721,000.

Findings on the care quality of FCH operated by FHS

51. Eria et al. (2005)[37] reported that resident members of FCH liked the living environment as it was quiet, safe and comfortable and they could get more individual attention compared to those residential units under government subvention with a standard capacity of 50. They

[36] Each FCH accommodated up to 8 adults with intellectual disabilities in the past, but now it has increased to 10 - 12 to provide extra accommodation for members of Concordia Family affected by the recall of premises by the Government Property Agency.

[37] Eria P.Y. Li, Jenny M.C. Hui-Lo, & Maria P.Y. Chik (2005). *Psychosocial Wellbeing and Social Inclusion of Fu Hong Society Casa Famiglia Residents in Hong Kong.* Hong Kong: Fu Hong Society.

also had close interaction with other residents, Housemothers and Elder Brothers and they liked this kind of stable relationship where they could get appropriate level of social and emotional support.

52. High functioning residents had helped the other resident members who had lower functional capacity and they enjoyed this kind of helping and caring relationship.

53. Comments from natural family members of residents indicated that the FCH were able to provide home-like living environment for the residents and they appreciated the variety of community activities arranged by the Families.

54. Appendix I gives the statements from various stakeholders affirming the care quality of FCH of FHS at the 20th Anniversary of Family Care Home Service.

VII. Challenges Encountered in Operating Family Care Home in Hong Kong

Lack of policy and government support

55. At present, there is no governmental policy supporting small-sized and family-like residential care homes for persons with intellectual disabilities. For example, the Concordia Family of FHS was temporarily closed because of the recall of premises by Government Property Agency (GPA). FHS had been trying hard, but failing to find alternative premises for relocation. The Social Welfare Department (SWD) is not offering solutions or assistances in locating government premises and/or welfare premises in public housing estates for the relocation of Concordia Family.

Difficulty in locating suitable site in public sector

56. A reduction in construction of public housing units in the past decade results in limited provision of vacant premises from Housing Authority for welfare purposes. Instead of public housing estates, SWD has turned to reconstruct vacant primary schools, used boy homes and institutions for integrated rehabilitation services complex, such as the Ex-Siu Lam Project. As expected, large scale rehabilitation residential care institutions will continue to be dominating in the future development of rehabilitation service. However, this direction of service development is against the world trend in deinstitutionalization, community

integration and social inclusion.

Size of flat in the private sector and the Deed of Mutual Covenant of residential flats

57. Most of the flats in private residential buildings are relatively small in size (range from 40 to 80m^2), and therefore difficult or costly to find a suitable location in private buildings for a family care home. Besides, the use of residential flats is bounded by the Deed of Mutual Covenant (DMC). The DMC is a document containing terms that are binding on all flat owners of a multi-unit or multi-storey building. Some of the terms in a DMC may include clauses that restrict residential flats for welfare and commercial activities. FHS has been trying hard to look for residential flats that can be used for welfare and commercial activities, but failed. Though some proposed flats can be used for commercial activities under their DMC, the physical conditions, such as the means of escape, ventilation and barrier free access etc. cannot meet the building regulations and licensing requirements. Because of these restrictions and price affordability, residential flats in private premises are not the feasible alternative for installing Family Care Home.

58. Further, the Residential Care Homes (Persons with Disabilities) Ordinance (Cap. 613) requires strict licensing requirements for residential care homes with more than 5 persons. Self-financed FCH cannot be financially viable for a home just with 5 and less persons. Under this circumstance, most private residential units in Hong Kong would be excluded because of the licensing requirements.

VIII. Opportunities in Operating Family Care Home in Hong Kong

59. *Enforcement of UN's Convention on the Rights of Persons with Disabilities (UNCRPD):* Provision of FCH would demonstrate the commitment and determination of HKSAR Government in implementing the UNCRPD, and also offering a residential care home alternative model with better care and higher efficiency.

60. *Flexibility in Establishment of New Services:* The residential service model for persons with disabilities in Hong Kong has remained unchanged for many years. Institutionalization

remains the major service delivery models, with around 40-50 IDDs living in a highly structured social service institution. FCH provides more flexibility in daily routine and training activities. It provides a home-like living environment and organizes various activities to promote social inclusion. Its small-sized feature also gives a flexibility to locate suitable premises to set up the services.

61. *Shorten the Waiting List for Residential Services:* There are approximately 70,000 to 100,000 persons with intellectual/developmental disabilities (IDDs) in Hong Kong[38]. At present, around 7,800 placements are provided by NGOs under the subvention of the Social Welfare Department[39]. As at 30 September 2017, there were at least 4,660 persons with IDDs on the waiting list for corresponding services[40]. The estimated waiting time for Hostel for Moderately Mentally Handicapped Persons (HMMH) as well as Hostel for Severely Mentally Handicapped Persons (HSMH) was around 10 years or even longer[41]. FCH would therefore provide a choice adequately responsive to the needs of parents with children on the waiting list.

62. *Demand for FCH as indicated by FHS admission statistics*: Due to the long waiting time for residential services, there were 2,188 applicants waiting for the Hostel for Moderately Mentally Handicapped Persons (medium care level home like FCH) with reference to the recent statistics of SWD (as at September 2017). Telephone enquiries on possible vacancies of FCH are also received by FHS staff, averagely five telephone calls per month. Most of them in need of a residential placement will go the private RCHDs finally. In some districts, SWD is still proceeding with the applications submitted in 2003. Though the above figures cannot accurately illustrate the huge demand for FCH, they clearly reflect that the existing supply of HMMH services is far from adequate to meet the service demand. As mentioned in the foregoing paragraph, FCH would be a feasible alternative and hope for parents with children on the waiting list.

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[38] Legislative Council Paper No CB(2) 90/16-17(01) "建議就長期護理政策成立聯會三組委員會" Retrieved from https://www.legco.gov.hk/yr16-17/chinese/panels/ws/papers/ws20161114cb2-90-1-c.pdf on 27 December 2017.

[39] Social Welfare Department. Residential Care. Retrieved from https://www.swd.gov.hk/en/index/site_pubsvc/page_rehab/sub_listofserv/id_residcare/ on 27 December 2017.

[40] Social Welfare Department. Information on Cases Selected for Services through Central Referral System for Rehabilitation Services (excluding CRSRehab-PS) as at 30.9.2017. Retrieved from https://www.swd.gov.hk/storage/asset/section/687/tc/Annex_I_Eng_20170930.pdf on 27 December 2017.

[41] 香港社會服務聯會(2017)。*妥善規劃復康服務，還殘疾人士一個選擇*。*社情*，頁 10-11。

63. *Response to double aging, aging of Persons with Intellectual Disabilities, and aging of their parents:* Persons with intellectual disabilities as well as their care givers (parents) are now faced with the aging issue. More and more persons with intellectual disabilities will become orphans while their aged parents deceased. Other aging parents may also face the difficulty in taking care of their children with intellectual disabilities. The FCH is one of the residential alternatives responding to the needs induced by the aging problem. Through living in FCH, persons with intellectual disabilities can continue to enjoy their family life and their self-care ability can be sustained by sharing housework together. This can greatly reduce their demand for costly institutionalized residential services.

64. *Public trust services for persons with special needs:* Some of middle-income parents are concerned that after their passing, the care for their children with special needs, particularly those with intellectual disabilities, would be upset[42]. This initiative is again emphasized in the 2017 Policy Address that the Labour and Welfare Bureau would set up a "special needs trust" to provide affordable trust services for parents with special needs[43]. The Special Needs Trust Office was established in December 2018 and the Trust will be fully implemented in March 2019. A recent study conducted by the University of Hong Kong[44] revealed that there is a strong demand for a Special Needs Trust (SNT) to be established in Hong Kong and the parent respondents' top priority is to have the Government acting as the trustee of the SNT. One of the expected features of the SNT is that funds will be available to maintain the beneficiaries' basic and extra spending in accordance to the care plan under the monitoring of a designated case manager after their parents passed away. FCH will be one of the residential care home options for those middle-income parents who have joined the SNT.

65. *Service Voucher:* In September 2013, Social Welfare Department launched the First Phase of the Pilot Scheme on Community Care Service Voucher for Elderly. It adopts a new funding

[42] Hong Kong SAR. (2016). *2016 Policy Address*. Retrieved from https://www.policyaddress.gov.hk/2016/eng/p155.html on 27 December 2017.

[43] Hong Kong SAR. (2017). *2017 Policy Address*. Retrieved from https://www.policyaddress.gov.hk/2017/eng/pdf/Agenda_Ch6.pdf on 27 December 2017.

[44] Hong Kong Law Society. *HKU Study Reveals Strong Demand for a Special Needs Trust for People with Intellectual Disability*. Retrieved from http://www.hk-lawyer.org/content/hku-study-reveals-strong-demand-special-needs-trust-people-intellectual-disability on 27 December 2017.

mode, namely the "money-following-the-user" approach, where eligible elderly persons may choose community care services (CCS) that suit their individual needs with the use of Community Care Service Voucher. With the initiate success of the scheme, another phase of the scheme has been launched in October 2016.[45] There is no reason why this approach cannot be extended to cover residential care homes for people with disabilities. If realized, FCH will be a choice for some parents.

66. *Bought Place Scheme:* In October 2010, a four-year Pilot Bought Place Scheme was launched to encourage private RCHDs to upgrade their service quality by enhancing the staffing ratio and per capita space standards. As at 31 December 2017, there were ten private RCHDs participating in the Bought Place Scheme (BPS), providing a total of 600 bought places. The estimated average cost per place per month is HK$8,759.00. The pilot BPS has become a regular service since October 2014. It is strongly recommended that the Social Welfare Department should consider extending the BPS to self-financing homes operated by Non-governmental organizations with proven experience in providing residential services for persons with disabilities with a view to offering an option for those waitlisted in the Central Referral System for Rehabilitation Services (CRSRehab).

IX. A Choice for Persons with Intellectual Disabilities and their Families – A Recommended Model of FCH in Hong Kong

67. FCH should be community-based and home-like oriented. The family members live in the local communities as equal citizens, with the support that they need to participate in everyday life as to enhance social integration.

68. The FCH is to operate with a medium care level for family members ranged from moderate to mild intellectual disabilities, with a view to cultivating independent living skills and fostering mutual cohesiveness among family members. In deciding on the size of a FCH, a balance has to be made between individual and personalized care and service financial

[45] Social Welfare Department. *Second Phase of Pilot Scheme on Community Care Service Voucher for the Elderly (Pilot Scheme)*. Retrieved from https://www.swd.gov.hk/en/index/site_pubsvc/page_elderly/sub_csselderly/id_psccsv/ on 27 December 2017.

viability. The experience of FHS is that a size of not more than 8 resident family members would be financially viable without affecting care quality. The 2018/19 annual budget for FCHs of FHS is appended to this paper for reference.

69. To allow round the clock service for a family care home with medium care level and to meet operational needs, the core staffing establishment shall include 0.5 Health Worker (HW), 4.5 Housemothers (HM), while the Manager of FCH service and the Clerk are from the central administration to support the service operation. The HW as the home warden not only provides appropriate health and daily care for family members with ID but also assists the Manager to supervise the HM in daily operations and monitor drug administration. In addition, the HW shall train up the Housemothers the knowledge on basic health care and proper documentation keeping.

70. Projected annual expenditure and fee charging strategy options for a typical family care home (FCH) operated by FHS are set out in Appendix 2.

71. Each resident family member should have a case manager to take care of their welfare needs and to work with individuals and their families to develop a plan of care, particularly to refer them for alternative residential service when necessary.

72. To accommodate 8 male and female residents and care staff, the premises should have at least 4 partitions: 1 bed room for four males, 1 bed room for four females, 1 bedroom for care staff, and a sitting and dining partition. The premises should also have space for common facilities including laundry and a kitchen. Making reference to private residential premises, a flat with a saleable area of around 120 square meters may suit the purpose.

73. The FCH, to be exempted from Chapter 613, will have to comply with care quality regulations issued by the SWD, for all adult residential care homes of not more than 8 persons. Once registered with the SWD, the FCH will be eligible to apply for welfare premises, to admit users receiving government support. The Care Quality Commission London would offer a good reference for the SWD.

74. Relative small vacant premises on ground floor of public housing estate blocks are

recommended for establishment of FCH due to the following reasons:

- Stable tenancy agreement with affordable monthly rental
- Cost savings in property maintenance
- Greater promotion of social inclusion
- Under the Deeds of Covenant of private buildings, the chance of success in seeking suitable premises is rather bleak.

75. FCH should devote vigorous efforts to develop networks of volunteers. Apart from promoting the spirit of mutual assistance, it is also a process of community education. Participation of volunteers is crucially important to the sustainable development of FCH. Volunteers from all walks of life, who regularly visit and care for the family members, would definitely serve as extra manpower resources supporting FCH and develop genuine friendship with the family members.

X. FHS Submission to HKSAR Government to Enlist Support for FCH

FHS humbly requests that:

71. The Rehabilitation Program Plan Review Steering Group to study FCH with a view to promulgating concrete and supportive policies for FCH in Hong Kong;

72. The Residential Care Homes (Persons with Disabilities) Ordinance Review Working Group to review and recommend appropriate licensing requirements and care audit for all FCHs of less than 9 adults;

73. The Social Welfare Department to be the lead department in liaising with relevant government departments and statutory bodies, including the Housing Authority, to identify and mobilize suitable premises for FCH.

XI. Conclusion

74. This paper analyses residential care homes from selected countries and areas in the world, and makes references to research studies and care quality audit reports. In conclusion, FCH

meets the world trend for small size residential care homes as well as the requirements of the UNCRPD. The paper also discusses the relevance of implementing FCH in Hong Kong, the challenges encountered and opportunities available. The paper submits concrete proposals as contained in Sections IX and X to the HKSAR Government for consideration.

75. FHS has been operating FCH for more than 20 years. FHS submits that this unique service model has proven effectiveness in enabling persons with intellectual disabilities to enjoy family-like living environment where their capacity can be fully developed through their contribution in the family and participation in the community. They can also enjoy high quality of life while care and love are witnessed in the FCH. The service model of FCH should be advocated and supported as a choice for needy families with children with disabilities, and also as a means for the public to participate in the building of an inclusive community by being regular friends of FCH members.

Appendix 1
Statements from Stakeholders at the 20th Anniversary Celebration Ceremony of Family Care Home Service

持份者的話

引言

2017 年 12 月 2 日是扶康關愛家庭成立 20 周年慶典。當日，不同的持份者皆分享了他們的心聲及感受。家屬的分享反映了扶康關愛家庭是有效協助智障成員成長，減輕了家屬的照顧壓力；家姆認為扶康關愛家庭不單是一個工作的地方，更是一個大家在愛內互相學習、互相幫助下成長的家庭；義工朋友在參與服務時，理解到與智障成員的相聚不單是一項社會服務，而是建立一份互相關懷、互相學習、向對方開放的雙向友誼關係。本文記錄了部份持分者的精華內容。

（圖中前排左四為當日出席嘉賓陳日君樞機、後排左四是本會主席郭鍵勳博士、後排左六為本會神師暨扶康關愛家庭兄長方叔華神父。）

余先生(關愛家庭成員的父親)

(余先生現年 82 歲，有一子一女，其妻子已去世。兒子余國偉現年 46 歲，因家人未能照顧他，故於 2008 年入住超瑩軒。圖中為余先生。)

我的兒子不經不覺在「超瑩軒」住了九年了。有一次，去完彌撒之後，我和家人請扶康關愛家庭成員去飲茶，每個人可揀選自己想食的食物。家姆安排兩位成員坐於她的身旁。其後，我知道其中一位成員有糖尿病；另一位成員最近肚子不舒服。我見家姆先洗過食物的油膩，才給肚子不舒服的朋友吃；而有糖尿病的成員則食少少，照顧得非常細心! 在扶康關愛家庭做工作的

職員，除了要帶鎖匙、銀包、電話之外，還要帶幾個心。壹個是好大的愛心； 壹個好細的細心；壹個是忍耐心；還有包容之心；憐憫之心。他們非常之專業。晚上職員安排家庭成員服藥時，務必核對清楚服食藥物的份量和時間，並記錄簽名。朋友們，如有親戚朋友，或家人在扶康會接受服務，大家大可放心。

呂女士(關愛家庭成員的姐姐)

(呂女士現年約 60 歲，有一位妹妹及一位弟弟，父母已去世。妹妹呂容貞現年 59 歲，因家人未能照顧她，故於 1997 年入住邂逅軒。圖中為呂女士。)

我妹妹亞貞入住扶康關愛家庭「邂逅軒」已經 20 年。邂逅軒提供一個如家庭般的家舍：有兄長，弟兄姊妹，家姆一同生活。辛苦哂一腳踢的家姆們! 多謝你們盡心盡力，特別對亞貞的照顧及包容。

沒有人比我更清楚我妹妹入住邂逅軒前的分別，以前她沒什麼笑容，十分自卑，沒有什麼信心。當亞貞為成邂逅軒成員一刻開始，不單為亞貞帶來了人生最大的改變，我和我弟弟的兩個家庭也是受惠者。

亞貞失去了父母，方神父為她安排了另一個家庭，為她提供體貼的照顧，教識了她與人相處，自從亞貞入住邂逅軒，我們覺得她笑容多左，信心大左，比以前「醒目」，有時還會主動幫助人。方神父又因應亞貞情況，給予她很大的自由度。方神父還帶她到香港以外不同地方遊歷、見識，令她增廣見聞，開闊視野，這些一切一切，是我們未曾想過會發生的，都在亞貞身上發生了。

亞貞以前的牙齒很差，吃東西都有困難，多謝邂逅軒轉介給劉德華醫生，義務幫亞貞整牙，她牙齒外觀漂亮了許多，食野食得好開心滋味，連講說話都比以前清楚。又多謝扶康會介紹一份半日清潔工給亞貞，工作令她更有自信，覺得自己有工作能力，她好鍾意返工，佢返 9 時，每日早上 6:30 就起床準備。

母親大概在 30 年前去世，她好錫我妹妹好保護她，她在生時常掛在口邊的一句話:「第日我死左，就冇人理亞貞。」講時語帶擔心。我想今日如果她在，見到亞貞改變，她一定感到非常安慰，並會多謝每一個曾幫助過我妹妹的人。二十年過去，因邂逅軒成立，方神父盡心盡力的付出，在他身上我們看到了基督之大愛，他用愛改寫了很多生命，幫助了受惠者背後很多家庭，亦感動了無數人的心！謹代表我們已離世的雙親，向方神父說聲多謝！

在此，再次多謝扶康關愛家庭一班義工和上上下下工作人員! 多謝大家，你們的付出非常有價值，值得表揚。

梁先生(關愛家庭成員的哥哥)

(梁先生現年 52 歲，有 2 兄 2 姊 1 弟，父母已去世。弟弟梁兆才現年 50 歲，因家人未能照顧他，故於 2011 年入住超瑩軒。圖中為梁先生。)

回想 2010 年，我弟弟亞才剛接受完大腸手術，需要休養。因為父母親已經過身，亞才當時是獨居的，沒有合適的人可以照顧他，為此我們家人都感到十分徬徨。我唯有按照社署給我們的殘疾人士院舍資料篩選出一些服務提供者，然後逐一打電話及造訪他們。首先去了一些大機構、大院舍，外面就像一間小型醫院，先嗅到的是一陣強烈的漂白水氣味，然後就看到一個個穿着白色制服的工作人員，穿梭於一列又一列坐著或躺臥著的院友。詢問之下，原來這些宿舍都已全部爆滿，要輪候的話也是以年來計的。看完大型院舍，就去看一些小規模的。朝着地址去找，原來是鬧市之中隱蔽的舊樓。按門牌找到，門一打開，內裡的境況就像落後國家的臨時收容所。幾百尺的地方，放滿了碌架床，一排椅子上坐滿了面無表情的人，他們的眼光，就像向我發出求救的訊號。心想，怎麼樣也沒可能要呀才在這裏「接受服務」。

之後陸陸續續看了遠遠近近、大大小小的院舍，結果都是失望而回。直至我打電話聯

絡上扶康關愛家庭——超瑩軒，幸運的事情似乎要發生在我身上。我道明亞才的情況，對方說剛好有一個男生的床位，着我到超瑩軒一看。照地址找到了，一踏進大廳，就看到兩張大沙發 L 型排開，然後是一張 10 人的大圓枱，一陣陣餸菜的香味還由廚房裏傳出來。我立時明白為什麼這裏不叫「宿舍」、不叫「中心」，而是叫「家舍」，它們甚至有「家姆」，有「兄長」提供服務。我深深明白到，亞才在超瑩軒可以得到的不單止是康復的服務、醫療上的照顧，而是像一個普通人在普通的家庭所得的溫暖，而且可以融入社區生活。我想，這甚至是我作為哥哥也未必可以給予亞才的，因為扶康關愛家庭有着很多專業人員，對服務弱智人士有很好的經驗。希望扶康關愛家庭可以繼往開來，設立更多家舍，令更多有需要的人受惠。

湯女士(家姆)

(湯女士已為人母親及祖母，並曾於和諧軒參與義工服務多年。現時，她於超瑩軒担任全職家姆工作。她的工作理想是把對親人的關愛，同樣地，去關心扶康家庭成員。圖中為湯女士。)

五年前，剛退休的我，開始在沙田「和諧軒」做義工。主要安排及陪同學員外出活動及參與彌撒。多年來，不知不覺間種下深厚的感情。由於家舍要搬遷，擔心學員未能適應新環境，毅然應徵擔任家姆一職。在這個轉變中，其實很感恩，也是天主的安排，引導我加入扶康關愛家庭。為了更加深入了解扶康會，徹夜不眠地看完整本書 《用愛啟航家是岸》 。閱讀後，被扶康會家庭的理念及精神深深地感動，尤其會徽的三個[H]及「以求為導」。當中尤其欣賞扶康會的信念是以人為本，以愛為綱，就算細微的地方也關顧週到。

擔任家姆的工作與做媽媽的角色分別不大，但同樣視家庭成員如親人及孫兒，要愛護及照顧他們，亦會想想給什麼他們才是最好的。偶然成員間相處時會鬧情緒，我會擁抱安慰她們。溫暖的感覺令她們容易平復情緒。有時她們因開心便走過來攬攬我。她們將快樂

傳遞給我，使我很窩心。有時她們又會哭著找我。我便拿張紙巾幫她抹眼淚，再錫錫攬攬，再給她一杯暖水，然後靜靜聽她申訴。

我個人也從家庭成員身上體會到簡單就是美。一句簡單的讚美，他們已開心了半天，流露出純真的性情。在一個充滿温暖的家，自己會明白到，只要有「關愛」、「感恩」 ，便可融化很多問題。與他們相處中，自己也學識忍耐和包容，在扶康關愛家庭工作，不單讓我感到滿足、開心和健康，更豐盛我的人生!

Julia (義工朋友)

(Julia 女士是在婉明軒參與義工服務，是一位天主教徒。她除了協助成員參加彌撒聚會外，亦協助他們參加不同的社區活動。圖中為 Julia)

修女的介紹，讓我有機會接觸扶康關愛家庭。在參與義工計劃前，一位曾經在婉明軒做義工的教會姊妹告訴我：扶康家庭的成員各自有本身的生活習性，較難與人相處。因此囑咐我要有心理準備，因家舍成員對我的態度不會太友善。

當上義工之初，發覺扶康關愛家庭的成員雖然有自己的脾氣，但他們卻能完全融入家舍的生活。家姆告訴我，他們日常的反叛、過激的行為，只是因為當天心情不好罷了。起初我以為要把自己的身段放下，去作出遷就，但其實是他們在遷就我，雖然有些事情我做得不合他們心意，除非真的接受不了，否則他們都願意配合。

當上家舍的義工，有喜亦有担心。家舍成員樂意與我分享每天發生的事情（特別是另一個成員秘密），毫不吝嗇與我分享食物，還替我按摩呢! 在排練表演項目的時候，他們顯得特別興奮，亦十分聽話。何來這麼大的信心呢？我相信這是家姆、家兄給他們最大的支持。他們亦會像我們一般，為自己爭取自身的福利，這亦是一件好事。另一方面，家姆告訴我，很多家舍成員以前可以做這做那，但現在他們年紀漸長，很多動作或自理能力已

大不如前。我雖然當上義工不太久，亦已看到他們的能力與年齡不相稱，有心有餘而力不足之慨。雖然如此，他們仍盡力去做好自己的事。

在扶康關愛家庭有家姆、家兄悉心照顧家舍的成員，加上我們義工的輔助，這份義務工作十分有義意，所以我是會繼續的。香港作為一個共融的社會，大家何妨走訪家舍，去探望家舍的成員，從而認識和接納他們。

Appendix 2
Projected Annual Expenditure and Fee Charging Strategy Options For a Typical Family Care Home (FCH) Operated by Fu Hong Society

Assumptions:

1. Number of resident family members per FCH: 8
2 Admission criteria: resident members require not more than medium care level support based on SWD assessment scheme
3. Annual average occupancy: 95%
4. Staff cost based on mid-point of the FHS pay scale

Projected Annual Expenditure for a typical FCH (HK$)

I. EXPENDITURE:

A. Personnel emolument

1. 0.5 Health Worker (Act as the Home Supervisor, and working 22 hours per week) = $17,645 x 12 x 0.5 = 105,870
2. 4.5 Housemothers = $13,000 x 12 x 4.5 = 702,000
3. Provident fund: 5% 40,394

Subtotal for item A = 848,264

B. Other Charges:

1. Programmes expenses
   1.1 Elder Brother allowance: $150 x 365 days = 54,750
   1.2 Programmes activities: 15,250
2. Utilities (electricity, water and gas): 42,000
3. Food for users, Housemothers: $7,500 x 12 = 80,000
4. Repair & maintenance: 18,000
5. Minor stores: cleaning materials, P&S, etc. : 20,000
6. Administrative expenses
   6.1 Telephone & broadband: 9,000
   6.2 Central administrative support cost: 61,700 (Note 1)
   6.3 Audit fee: 2,000
   6.4 Staff medical check-up, recruitment expenses, etc: 1,000
   6.5 Insurance (workmen compensation): 33,000

6.6 Insurance (public liability): 1,000
6.7 Staff medical subsidy (out-patient + hospitalization): 6,000
6.8 Transportation and travelling: 1,500
6.9 Sundries (including medical supplies, escort expenses, staff development etc.): 4,456

Subtotal for Item B = 349,656

C. Rent & rates based on welfare premises:
1. Rent: $55 x 120 sq, m. x 12 months = 79,200
2. Government rent: $680 x 12 months = 8,160
3. Rates: $810 x 12 months = 9,720

Subtotal for Item C = 97,080

Gross Total for Items A, B and C = 1,295,000

II. Cost per resident per month based on 95% occupancy: 14,200

II. Options for monthly fee charging strategies

A. Full fee charging for residents members with affordable family support: 14,200

B. Resident members on CSSA receiving around $6,000 per month
Fees charged: 6,000
Subsidy from FHS fund raising: 8,200

C. If FCH is admitted to the SWD Bought Place Scheme and based on current scheme subsidy at around $8,759
Fees charged: 8,759
Subsidy from FHS fund raising: 5,400

D. If supported by Family Trust through the new Disability Public Trust
Fees charged: 14,200 or less, and balance to be subsidized by FHS

E. Resident members NOT on CSSA and with weak family support
Fee charged: 14,200 or less, and balance to be subsidized by FHS

Note 1: The Head Office will provide support such as human resources, finance, IT and general administration. To avoid cross-subsidization of the subvented central administration to self-financed services, apportion of the central administration for self-financed services is calculated according to SWD's formula, i.e. Central Administration cost x self-financed services cost / Society's total cost. 5% is the average based on past figures.

Appendix 3

Annual Budget and Forecast of 3 family care homes (FCH) in 2018/19

Assumptions:

1. Number of resident family members per FCH: 27
2. Admission criteria: resident members require not more than medium care level support based on SWD assessment scheme
3. Annual average occupancy : 95%
4. Staff cost based on FHS new pay scale

				Budget HK$	Forecast HK$	per 1 FCH HK$
I. EXPENDITURE:						
A.	Personnel emolument					
	1 Manager $35,800 x 12	429,600				
	2 Health Workers $19,030 x 12 x 2	456,720				
	13 Housemothers: $13,870 x 12 x 13	2,163,720				
	1 clerk $13,300 x 12	159,600	3,209,640		3,230,000	
	Provident fund: 5%		160,482		161,500	
				3,370,122	3,391,500	1,130,500
B.	Other Charges:					
b.1	Programmes expenses					
	Elder Brother allowance: $150 x 365 days x 2	126,000			109,500	
	Programmes activities	84,000	210,000		84,000	
b.2	Utilities: electricity, water and gas		145,170		136,000	
b.3	Food for users, Housemothers		377,200		356,000	
b.4	Repair & maintenance, minor purchases		140,100		150,000	
b.5	Minor stores: cleaning materials, P&S etc		48,500		48,000	
b.6	Administrative expenses					
	Telephone & broadband	29,140			29,200	
	Central adminstrative support cost	140,000			135,000	
	Cleaning charges	4,800			1,200	
	Audit fee	2,000			2,000	
	Staff check up, recruitment expenses, etc	3,600	179,540		3,800	
b.7	Insurance					
	Insurance: workmen compensation	128,000			148,000	
	Insurance: property, money, medical, etc	9,000			9,000	
	Insurance: public liability	5,000	133,000		5,002	
b.8	Medical subsidy (out-patient + hospitalization)		24,000		24,000	
b.9	Trsansportation and travelling		6,000		8,400	
b.10	Sundries:					
	Dining & kitchen utensils	6,660			5,400	
	Bedding & clothings	3,600			3,000	
	Medical expenses	6,540			4,000	
	Staff development	5,000			9,820	
	Escort out-source expense	24,000			27,600	
	Others	6,288	52,088		7,078	
				1,315,598	1,306,000	435,333
C.	Rent & rates based on welfare premises:					
	Rent: $55 x 280 sq. m. x 12 (SP & RD)		184,800		184,800	
	Government rent:		8,300		8,300	
	Management fee		24,840		25,400	
	Rates:		30,340		15,000	
				248,280	233,500	77,833
	Total expenditure	(a)		4,934,000	4,931,000	1,643,667
D.	Cost per resident per month based on 95% occupancy			16,030	16,020	
			say:	16,000	16,000	

II.	INCOME:					
A.	Fee income			1,305,720	1,280,000	
B.	HKJC Charities Trust grant			1,240,373	1,240,373	
C.	Designated donation to FCH			430,000	450,000	
		(b)		2,976,093	2,970,373	
	Deficit	(c=b-a)		(1,957,907)	(1,960,627)	
III.	Options for fee charging					
				Fee charged	Subsidies from HKJC Charities Trust	Subsidies from FHS fund raising
				HK$	HK$	HK$
A.	Full fee charging on cost recovery : no users			16,000	0	0
				100%		
B.	Fee charges for 23 users at $4,030 per month			4,030	3,828	8,142
				25.19%	25.52%	50.89%
C.	Fee charges for 2 users at Radiance with $4,600 per month			4,600	3,828	7,572
				28.75%	23.93%	47.33%
D.	Fee charges for 1 user at Radiance with $5,000 per month			5,000	3,828	7,172
				31.25%	23.93%	44.83%
E.	Fee charges for 1 user at Radiance with $6,000 per month			6,000	3,828	6,172
				37.50%	23.93%	38.58%