兒童保護新觀念 Update in Fostering Health

林口長庚醫院兒童內科部 主辦

時間	演講題目	講師	主持人
07:30~08:00	報到		
08:00~08:20	貴賓致詞	衛生署 林奏延副署長 王育敏立法委員	林口長庚醫院 黃璟隆副院長
08:20~09:10	Practice for Child Abuse and Neglect	Prof. Astrid Heppenstall Heger	台北醫學大學 郭耿南教授
09:10~09:20	Discussion		
09:20~10:10	Practice for Sexually Abused Child	Prof. Astrid Heppenstall Heger	
10:10~10:20	Discussion		
10:20~10:40	Coffee Break		
10:40~11:30	Practice for Developmental and Mental Health Care	梁歆宜醫師	財團法人瑞信兒童醫療基金會 呂立執行長
11:30~13:00	Lunch		
13:00~13:50	高風險家庭的介入與服務	莫藜藜教授	監察院 尹祚芊監察委員
13:50~14:40	兒童及少年保護工作之法定程序及現有法制下之實際操作方法	劉承武主任檢察官	
14:40~15:00	Coffee Break		
15:00~15:50	台灣兒童保護的變革與現狀	余漢儀教授	兒童局 張秀鴛局長
15:50~16:40	具體落實"為兒童三個一切原則"之普世價值正確方向及方法	劉承武主任檢察官	
16:40~16:50	閉幕致詞	林口長庚醫院兒童內科部 邱政洵部長	

學會教育積分：

台灣醫學會 7 積分、台灣護理學會 7 積分、台灣急診醫學會乙類 6 積分、台灣兒科醫學會 4 積分、台灣婦產科醫學會 2 積分、台灣精神醫學會 4 積分、台灣新生兒科醫學會 2 積分、中華民國社會工作師公會申請中

─目錄─

兒童保護新觀念研習會-上午

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08:00~08:20	貴賓致詞	衛生署 林奏延副署長 王育敏立法委員	林口長庚醫院 黃璟隆副院長
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◎活動注意事項：

1. 為尊重講師授課及其他學員的學習權益，請將您的手機調整為震動或無聲。
2. 本次研習會申請各學會積分，需全程參與並親自簽到及簽退者，方可記錄學分。
3. 會場外備有飲水機，請自備環保杯，場內禁止飲食。
4. 課程結束後，請將活動滿意度調查表交給場外工作人員。

主持人簡歷

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講師簡歷

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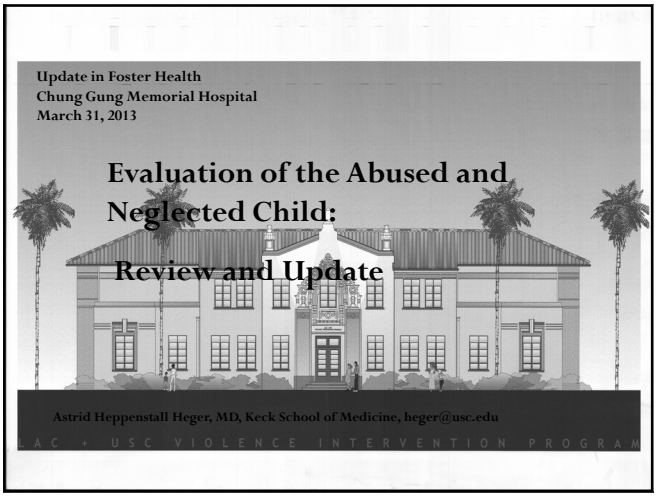


Child Abuse and Neglect:

Practice Updates

The foundation of adult life--
is built on the memories of childhood

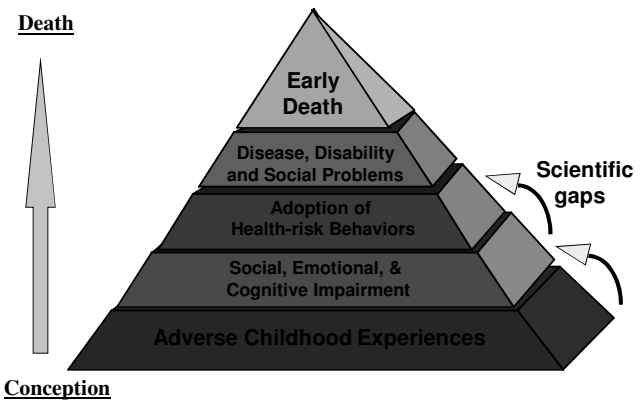
"The good old days are those days of childhood when someone else was responsible for your well-being" G.Keiller

Define Childhood:

- What ages----
- What is a happy childhood
- Consider child labor---
- Children as a commodity
- What is abuse????

Adverse Childhood Experiences

- Child Abuse and Neglect
- Growing up with DV/Parental Discord
- Substance Abuse or mental illness
- Crime



Child Physical Abuse

- 10% of all injuries <age 2 are child abuse
- 40-50% of these are head injuries
- 80% of fatal abusive injuries are head injuries
- 80% of head injury deaths are abusive

Child Abuse and Neglect

- **Statistics: Incidence 10/100; +/- 3 million casese reported per year**
  - 2000 fatal cases of abuse per year
  - 2/3 are under three years
  - Leading cause of death 6 months to 1 year.
  - 10% of all injuries <age 2 are child abuse
- **Define Abuse and Neglect:**
  - Physical
  - Neglect (Medical and Environmental)
    - Failure to Thrive
    - Munchausen by proxy
    - Substance abuse
    - Domestic Violence (exposure/failure to protect)
  - Sexual
    - o AND----------

Risk Factors

- Poverty
  - Single young mothers.
- Larger households-→4 children in family
- Domestic violence
- Corporal punishment
- Substance abuse

Assessment

HISTORY:

- Present Illness: Presenting complaints from ED or PMD
- History from Parents/Guardians;
  - Nature of injury/illness
    - Timeframe
    - Witnessed or not
  - Family Medical History
    - Bleeding disorders etc.
    - History of injury etc to other children
- System; Current and Prior Involvement
  - Social Services
  - Law Enforcement

History from the Child

- Most important part of the evaluation
- Developmentally appropriate
- Direct vs. Leading Questions
- Document in the words of the Child
- Allow Child to give information
- Purpose of forensic interview

Physical Assessment

- Emergent is Emergent and treated with life saving interventions
- Complete physical examination
- Cutaneous lesions (Bruises or burns)
- Skeletal Survey?
- CT SCAN
- ALT's and AST's

Cutaneous Signs of Abuse

- Bruises:
  - Non-abused children rarely have bruises before starting to transition to independent mobility (<1%) (no-cruising/no-bruising)
  - Child abuse victims commonly have bruises (28-98%)
    - Greater in number (10-15); varying ages and to be defensive in location.
    - Pattern injuries are common, and occur in younger children

Burns

- **Children hospitalized for burns; abuse related burns ranged from 4-16% of all cases.**
- **Recent study looking at all burns found that 6% of all children hospitalized for burns were reported for possible abuse**.
- **Abuse related burns**:
  - Liquid scalds: 78% of inflicted vs. 59% accidental
  - Inflicted tend to be larger, involve younger children, have higher risk of mortality and longer hospital stays.
  - Deeper and tend to require grafting and
  - More often involve hands and feet

Skeletal Injury

- Epidemiology: 11-31% of reported cases of child abuse found unsuspected fractures.
  - Most common in children referred for other fractures and those with head injuries
  - Usually found in children < 1 year (80%)

Skeletal Injuries

- Multiple fractures; different ages.
- Extremities: Non-walking children with fxs more likely due to abuse
  - Femur fxs are rarely due to abuse except in the very young child. (93% of abuse injuries< 1 year)
  - 67% of lower extremity fxs in under 18 months were abuse related; only 1% were in older children.
- Rib fractures: common in abuse cases and most occur in children less than one year.
  - Positive predictive value of rib fracture under 3 years of age for abuse is 95%.
  - CPR?: (3/923)Extremely rare and only anterior.

FX's/Highly Suspicious

- Classic Metaphyseal Fractures
- Rib Fractures: especially posterior
- Scapular Fractures
- Sternal Fractures

Fxs: Moderate Specificity

- Multiple Fractures; esp. bilateral
- Fractures of different ages
- Epiphyseal separations
- Vertebral Bodies
- Digital Fractures
- Complex Skull Fractures

FXS: Common/ Low Specificity

- Subperiosteal New born formation
- Clavicle Fractures
- Long Bone Fractures
- Linear Skull Fractures

Visceral Injuries

- Liver lacerations; splenic lacerations, renal contusions and hollow viscus injury.
- Children admitted for abdominal injuries:
  - 11-19%
  - More severe injuries
  - More likely to have hollow viscus injuries and extra-abdominal injuries such as bruises and fxs.
  - Emergency Department visits: 4% abuse
  - Peak age is 2-3 years of age.

Head Injuries

- Face: Facial injuries are common
  - In one series of 300 children seen for abuse 59% had oro-facial injuries. Usually under 5 years of age

  Oropharynx: Labial frenulum injury: suggestive of abuse and often seen in fatal cases of child abuse.

Head Trauma - 2

- **Epidemiology of AHT is difficult**
  - Terminology/missed cases i.e. subclinical cases etc. ; mis-classification by medical examiners etc.
  - In children with AHT; old brain injuries found in 30-45%
  - Neurologically asymptomatic children screened for Abuse--- 37% had a head injury
  - AHT in first two years: 16.1-33.8 cases per 100,000

  At risk factors: Poverty; young single mothers, multiple children in family, young male children, developmental delay and **crying.**

AHT: presentations

- **Acute symptoms: appearing within seconds, minutes or hours**
  - Soft tissue injuries; inconsolability, loss of appetite, vomiting altered sleep patters, seizures, alteration of loss of consciousness and cardio-respiratory compromise or arrest.
- **Delayed: within hours, days or weeks:**
  - Inconsolability, recurrent vomiting, loss of appetite, altered sleep patterns, seizures, alteration of consciousness and cardio-respiratory compromise
- **Late Clinical signs: weeks, months or years)**
  - Feeding difficulties, sensory deficits, motor impairments, macrocephaly, microcephaly, behavioral dysfunctions, dev. Delays, intellectual deficits, attention deficits and educational dysfunctions, pituitary dysfunctions.

AHT – 3/When to Suspect Abuse

- **Presenting illness:** Unexplained loss of consciousness, lethargy, hypotonia, seizures, coma, respiratory distress, apnea, persistent irritability, recurrent vomiting (poor feeding) when infectious, metabolic or toxic causes have been excluded.
- **Clinical Signs:** Any clear and persistent clinic signs that prompt diagnostic evaluation revealing evidence of traumatic brain injury.
  - **Nonfocal subdural or SAH hge** and or extensive, dense multilayered retinal hges; unexplained by traumatic childbirth or injury. (fall down stairs, fall from height > 6 feet) or other equivalent accidental (witnessed) trauma.
  - **Facial or scalp soft issue injuries** not overlying bony prominences, involving the external **ears** or associated with **intraoral tra**uma or bleeding (frenulum or gingival lacerations)
  - **Skull Frac**tures that are multiple, complex or diastatic that are attributed by caretakers to a short fall less than 6 feet.

Other forms of abuse:

•**Neglect:** Most prevalent: poverty, single mother with lack of support

•**Failure to Thrive: Intentional or accidental**

•**Medical Abuse (Munchausen):** Intrusive (severe) or reporting only.

What to do now that you have diagnosed abuse?

- Report??
- Placement
- Mental health services
  - FASD
  - Parenting
  - Family Reunification
- Follow-up
  - i.e. injuries, skeletal survey in two weeks
  - Medical home for abused children/urgent care and in-home services.

Long-term Impact of Child Abuse

- Head trauma: Neurological impairments; ophthalmology; learning disabled
- Substance abuse/anti-social behaviors
- Gynecological complaints/STI's
- Mental Health
- Psychosomatic illnesses
- Recurrent violence related injuries.
- Risky behaviors that impact health

Child Abuse
Barriers to Service

- Easiest group of vulnerable patients to access services.
- Major barrier is engaging medical professionals to consider the diagnosis.
- Impact of Foster Care

Real solutions:
Building a Safety Net:

1. Appropriate medical/forensic assessment 24/7; Children awaiting Placement Center
2. Health assessments and monitoring
3. Case management of all children by multidisciplinary, one-stop community based assessment and treatment centers.
4. Psychological evaluation and ongoing treatment
   - Developmental and educational assessment
   - FASD: Fetal Alcohol Spectrum Disorder
5. Parenting, family therapy
6. School-based or integrated services
7. Family preservation or reunification??? What then?

Who is your client?
Building foundations?

- What becomes of these children?
  Are they born violent or insane?
- When do they make the transition from group homes to jail.
- Who are the inmates of psychiatric facilities?
- Who live on our streets and under bridges?
- Who lives in our prisons?
- Who completes the cycle of violence--?
- Why are we building more sophisticated programs for suburban adolescent violence than we are for inner city violence?

What Services Provided?

- **Social interventions,** family preservation, foster care, termination, adoption.
- **Legal interventions**: prosecution, custody, emancipation
- **Medical**: forensic and general health assessment
- **Mental Health for every patient**
- **Educational assessment---part of MH**

Where are these services?

- **Forensic assessments/treatment**
- **Medical care for the indigent**
- **Advocacy/Psychological services**
- **Dentists/Plastic surgeons**
- **Transportation**
- **Housing**
- **Food/clothing**
- **Education**

Building a Community Response

- **Family Advocacy Center**
  - **Community Based/Culturally Appropriate**
  - **Multidisciplinary**
  - **Combines Forensic with Social and Mental Health**
  - **Solutions to keep families together whenever possible**
  - **Create Blanket of Services**
  - ← **Health**
  - ← **Social Support**
  - ← **Employment**
  - ← **Housing, transportation**

Community Assessment and Treatment Centers

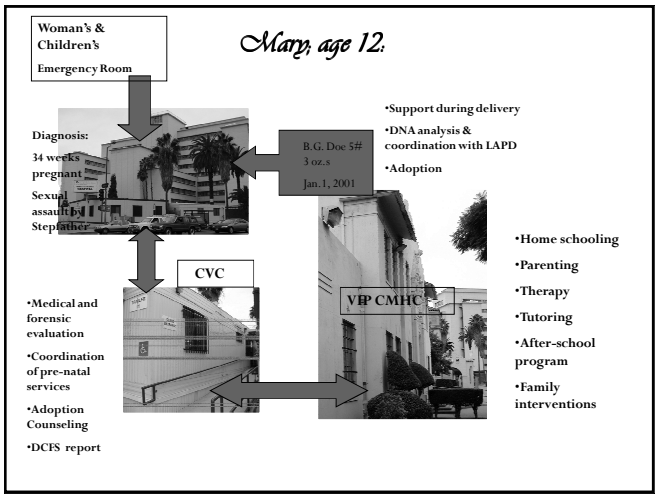
- **Regional services that include: 24/7**
  - Forensic assessment
  - Medical treatment
  - Mental health assessment and treatment
  - On-going services for treatment and family reunification
  - Schools and education
- **Prevention programs in schools et al**

Safety? Or Survival?

- Foster Care? **Los Angeles County:**
- **5,136 living in foster homes**
- **25,823 living with relatives**
- **8,138 in foster family agency homes**
- **2,300 in group homes**
- **2,487Trial visit at home with parent**
- **132 Maclaren Children's Center**
- Are they safe?
  - 108 cases of abuse, severe neglect or death in placement

Defining Safety:

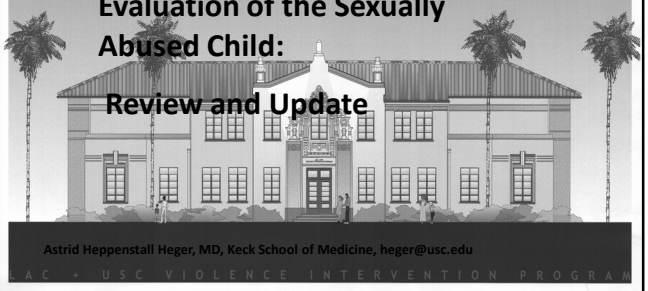
- For our children:
  - Security, invulnerability, impregnability
- For us:
  - guardianship tutelage, custody, protection, preservation
- For Society:
  - Watch, patrol and sentry


Mary, age 12:
Woman's & Children's
Emergency Room
Diagnosis:
34 weeks pregnant
Sexual assault by Stepfather
B.G. Doe 5#
3 oz.s
Jan. 1, 2001
•Support during delivery
•DNA analysis & coordination with LAPD
•Adoption
CVC
VIP CMHC
•Medical and forensic evaluation
•Coordination of pre-natal services
•Adoption Counseling
•DCFS report
•Home schooling
•Parenting
•Therapy
•Tutoring
•After-school program
•Family interventions

Update in Foster Health
Chung Gung Memorial Hospital
March 31, 2013

Evaluation of the Sexually Abused Child:

Review and Update



Astrid Heppenstall Heger, MD, Keck School of Medicine, heger@usc.edu

LAC + USC VIOLENCE INTERVENTION PROGRAM

The Victim is a Child

- **Children are taught to comply with authority.**
- **Children have little understanding of appropriate adult-child interactions.**
- **Children are curious**
- **Children see themselves as vulnerable to threats and see adults as all powerful.**
- **Children believe that they are responsible for what happens to them.**
- **Children are without power**
- **Children are not seen as credible by society.**

Defining Childhood:

- **Neglect:** Failed to provide-shelter, food etc
- **Severe** neglect: Malnourished etc.
- **Sexual Abuse:** Any sexual activity including threats, intercourse, fondling etc.
- **Physical Abuse**: Deliberate acts of cruelty
  Including burning, biting etc violence, punishment
- **Emotional Abuse:** willful cruelty
- **Exploitation:** Child made to act in a way that is inconsistent with age.

The victim is a child

Myths of Child Sexual Abuse

- Children are abused by strangers
- All Abusers are male
- Victims are always females;
- Children fantasize about sex with adults
- Children never lie
- Children always tell
- Children feel negatively about the abuser
- There are few Sequelae for the survivor

Challenges to Investigating Child Sexual Abuse

- **The victim is a child!**
- **The process: protect or prosecute?**
- **Treatment and prevention—do we provide appropriate support?**

The victim is a child!

Perpertrators

- Regressed pedophile
- Fixed Pedophile
- Undifferentiated perverse
- Juvenile offender

The Victim is a Child:
Emotional Impacts

- Secrecy
- Threats
- Fearfulness
- Guilt/Shame
- Repression

The Victim is a child:
Sequelae of Child Sexual Abuse

- Significant Variables
  - Nature of the Abusive Act
  - Age and Vulnerability
  - Relationship of the Abuser
  - Length of Time
  - When did they disclose
  - What happened after disclosure
  - Family support

The victim is a child:
Behavioral Indicators

- Acute Traumatic Response
- Regression
- Sleeping Disturbances
- Eating Disorders
- School Problems
- Social Problems
- Adult Behavioral Sequelae

The process:
Guidelines for evaluation

- Building a response
- The team approach
- Interviewing the child
- The Medical assessment: what and why
- Treatment and follow-up

The Victim is a child!
Medical Indicators

- Genital Injuries
  - Bruising, scratches, bites
- STD's
- Blood Stains in underwear.
- Dysuria, urethral discharge
- Penile swelling, injury
- Pregnancy
- Abdominal/Pelvic Pain
- History

The Process:
Abuse vs. Assault

- Known abuser/Incest
- Over long period of time
- Delayed disclosure
- Medical findings minimal if any

- Unknown assailant
- One time episode
- May involve physical violence
- Quicker disclosure
- Medical findings are minimal

The process:

History from the Child

- Most important part of the evaluation
- Developmentally appropriate
- Direct vs. Leading Questions
- Document in the words of the Child
- Allow Child to give information
- Purpose of forensic interview

The Process:

Medical Examination Equipment

- Hand-held magnifier
- Camera (macrolense)
- Colposcope
  - Still photography
  - Videocolposcopy
- Video Network/computers

The Process:

The Medical "Investigative Interview" or History

- **Who do we Interview?**
  - Age
  - Non-Disclosing
- **Previously Disclosing Child**
  - Why are you here?
  - Indicate your own knowledge of events
  - Forms of sexual contact; pain (?) and or penetration.
  - Ejaculation/forensics
  - Threats and fear
  - History of other abuse

The Process:

The Medical Diagnosis

- Examinations are usually normal
  - Nature of abuse (fondling, simulated inter-course, anal and oral penetration)
  - Delay in reporting (trauma is healed
- Protocols:
  - Emergency: <72 hours
  - Urgent:<Less than two weeks
  - Scheduled: Over two weeks

The Process:

The Medical Examination

- Explain the nature of the examination
- Give child sense of control
  - Chose support person
  - Choice of where to sit and wear
- Protect Privacy
- Need to know versus need to protect
- Answer all questions
- Go slow

The Process:

Medical Diagnosis summary

- Interpret post-pubertal findings with caution
- Sexual Assault of adolescents can occur without injuries or leave a normal appearing hymen after healing.
- Vaginal Penetration of the pre-adolescent will leave diagnostic transections.
- Pre-adolescent transections do not heal with a normal appearance unless repaired.
- Anal Trauma usually heals without scarring

The Process:

Sexually Transmitted Diseases

- Laboratory Documentation
- Use as confirmatory evidence of sexual contact
- Diagnostic of sexual contact vs. suggestive
- Reporting responsibilities and interventions

Treatment

Prevention in the Community

- School Based
  - Starts with Elementary School
  - Promotes Safety first
  - Provides information on good and bad touching
  - Continues through High School
    - Includes information on sexuality
    - Birth control information?
    - STD information

The Process:
Forensic Documentation

- Clinical documentation
  - Photography
- Laboratory documentation
  - Sexually Transmitted Diseases
  - Evidence of ejaculation
  - Trace evidence
    - Hair, blood, saliva
    - Fibers, grass, dirt, etc.

The Response:
Private Medical Professional

- Participates as part of network
- Understands resources
- Refers for expert evaluations
- Trained to identify normal anatomy
- Knows when to suspect abuse
- Reports to appropriate authorities
- Participates in prevention

Treatment:
Prevention Strategies

- Primary Medical Professional
  - Communication with Child
  - Appropriate touching
  - Who to tell
  - Good and bad secrets
  - No secret rule
  - Names for body parts

The Response:
Center of Excellence

- Forensic Medical Specialist
  - advanced sub-specialty training
  - qualifies as court expert
- Photodocumentation
- Participates as part of the multidisciplinary team
- Comprehensive assessment, treatment services

The Response
Violence Intervention Program

- Built on existing child abuse programs.
- Domestic Violence
- Sexual Assault
- Elder and Dependent Adult Abuse
- Adolescent Violence (?)

Non-Specific Findings

- Variations in Hymeneal Morphology
- Variations in Hymeneal Opening Size
- Bumps and Notches
- Peri-hymeneal/Peri-urethral Bands
- Intra-vaginal Findings
- Estrogenization
- Vascular Changes

VIP

- "What can I do to help you??"
- Each child needs personalized/"the best" services.
- Reason for being: Medical and Mental Health.
- Evolution from forensic center into complete advocacy center.

Congenital Findings

- Peri-urethral Support Bands
- Longitudinal Intravaginal Ridges
- Bumps and Tags
- Clefts: Ventral and Posterior
- Linea Vestubularis
- External Ridge
- Labial Adhesions
- Vascularity and erythema

Question # 1

What have we learned about sexual abuse and normal anatomy through the use of standardized methods, language and photodocumentation???

Hymeneal Opening Size

- Changes with:
  - Age
  - Development/Weight
  - Position
  - Traction
  - Measurement Techniques
    - Hand-held
    - Colposcope/with Caliber
    - Computer Imaging

Comparison of Hymen Anatomy

	Pokorny 1987	McCann 1990	Berenson, Heger 1991	Gardner 1991	Berenson, Heger 1992	Heger 2000	Myhre 2003
Number	124	86*	468	79	201	156	195
Median Age Months		66	Newborns	64	21	63	68
Annular/Concentric	27%	43%	73%	19%	22%	53%	6.7
Crescentric/ Posterior Rim	45%	44%	7%	62%	36%	29.2%	78.4
Sleeve-Like Redundant	20%				9%	14.9%**	Transitional 6.2
Fimbriated			19%		33%		.5
Septate		2%	1%		1%	2%	
Other or Unable to Determine	7%	9%	< 1%	5/6.7%**		<%	7.2%

* Using traction
**includes fimbriated
***Remnant

Normal/Non-specfic Perianal Findings

Findings	McCann, 1989	Berenson, 1993	Heger, 2000	Myhre, 2001
Number	267	89	155	305
Anal Dilation	130/267 49%	0	14.8%	10.8% (18.8% KCP)
Intermittant RAD	81/130 62%			2.2% (KCP)
Venous Pooling/ Congestion	83/113 73%	1	64.5%	16.7%
Thickened Folds			54.2%	Irregular folds: 2.6%
Anal Fissures		1	7%	
Diastasis Ani	21/81 26%	26%	81.3%	12.7% (KCP)
Perianal Tag	18/164 11%	3	30.2%	6.6%
Increased pigmentation	74/251 30%	10%	78%	
Flattened folds			43%	
Scar	4/240***	0	0%	0
Erythema	68/168 41%	7%		9.5%
Dimple/Depression	15/81 18%			11.2 and 19.5 (KCP)
** Not photographed				

NonSpecific Findings

	McCann 1990	Berenson, Heger 1991	Gardner 1991	Berenson, Heger 1992*	Heger 2000	Berenson Chacko 2000*	Myhre 2003
Number	86*	468	79	211	147	200	195
Periurethral Bands	50.6/16%	Frequent	19%	98%	91.8%	95%	2.3%
Longitudinal Intravaginal Ridges	90.2%	56%		25%	93.8%	87%	
Hymenal Tag	24.4%	13%	2%	3%	3.4%	5%	0/
Hymenal Bump or Mound	33.8%	<1%	11%	7%	34%	46%	23.4/
Linea Vestibularis	15.7%		23%	4%	19%	7%	2.2
Ventral Hymen Cleft/Notch at 12	1.2%	24%		8%	79%	Excluded	
Ventral Hymen Cleft/Notch	6.6%	3.3%	2%	8%	19%	Excluded	
Failure of Fusion					0.6%		
External Ridge		86%		15%		8%	2.3
Erythema	56%				48.9%	37%	
Change in Vascularity	30.9%		44%	5%	37.4%	7%	10.3
Labial adhesions	38.9%			17%	15.6%	7%	7.7
Hymenal Notch/Cleft Posterior		19%*		33%*	18.3%	3.5% * did not include fimbriated	0.6
Hymenal Concavity Posterior	5.8%**				29.5%	Inc. in Notches	Folded out 18.3

*Fimbriated Hymen (3+Notchess-were excluded)
**Angular Hymen

Question # 2:

What should we expect when we are asked to evaluate a child for possible sexual abuse?

Non-specific Anal Findings

- Reflex anal dilation; constant or intermittant
- Venous pooling or congestion
- Erythema
- Thickened folds; flattened folds
- Fissures
- Diastasis Ani (smooth area; dimple/depression)
- Perianal Tag
- Change in pigmentation

Children referred for evaluation of Sexual Abuse

- Most research reports on findings in this group
- Findings are not tested against normal studies or healed studies
- Most errors made in this group because of template errors, i.e. notches, narrowing, thickening, concavities, hymenal openings etc.
- What would be a predictable percentage of abnormal medical examinations in children who disclose abuse?

Sexual Abuse Research: 25 years

DATE	Orr 1979	Cantwell1 983	Emans 1987	Hobbs 1987	Adams 1994	Kellogg 1998	Bowen 1999	Berenson 2000	Heger 2002
Number	100	83	119	337	236	157	385	192	2384
Ages	<16 (9.2)	<13	< 15 (5.6)	<15 (8)	<17 (9)	< 14 (4.6)	<18 7.1)	<8	<1 4 (6.9; 5.5)
% Abn.	23%	84%*	30%	83% M 58 % F	23%	15% (3% definitive)	8.3%	2.5%	4%
Vagina	35%	84%	30%	58%	14%	Same	8.3%	2.5%	6% F 1% M
Anal	n/a	NA		83% M, 25% F	7%	0%		n/a	1%
Other	7% STI		6% Trauma	2.5% STI	n/a	3.1% STI		n/a	n/a

* Hymenal opening size only.

LAC+USC: Patterns of disclosure : Medical findings

	Total Sample N=2384		Disclosing Group N=1652		Non-disclosing Group N=732		Non-Disclosing Group			
							Non-disclosing N=550		Medical only N=182	
Normal examination	2296 96%		1580 96%		716 98%		549 99.8%		167 92%	
Abnormal Examination	88 4%		72 **4%**		16 2%		1 0.2%		15 8%	
Age of victim	6.6 years		7.6 years		4.4 years		4.4 years		4.4 years	
Gender:	Girls 1963 82%	Boys 421 18%	Girls 1401 85%	Boys 251 15%	Girls 562 77%	Boys 170 23%	Girls 405 74%	Boys 145 26%	Girls 157 86%	Boys 25 14%
Age:	6.9 years	5.5 years	7.9 years	6.2 years	4.3 years	4.5 years	4.3 yrs	4.5 yrs	4.4 yrs	4.5 yrs

Bowen and Aldous, 1999

History	Normal	Non-Specific [1]	Specific [2]	Definite [3]	Other [4]	Total Normal/non-Specific
Definitive or Probable	49.5%	34%	12.8%	1.6%	2.1%	98.4%
Suspicious	39.7%	54.8%	2.4%	0	3.2%	100%
NoHistory	53.5%	35.2%	2.8%	0	8.5%	100%

1. Non-specific:erythema, bumps, septa labial adhesions
2. Specific/suggestive: acute trauma, narrowing, angular deformities
3. Definite: Semen, STD's
4. Other: Medical conditions or accidental injuries

Severe and Non-Severe forms of Abuse Abnormal Medical Findings in Disclosures

	Girls N=1401	**Boys N=251**
Severe Abuse % of total	**957** 68%	**177** 70%
Abnormal Examination % of severe abuse	**61** 6%	**2** 1%
Non-severe Abuse % of total	**444** 32%	**74** 30%
Abnormal Examination % of non-severe abuse	**8** 2%	**1** 1%

Berenson and Chacko, 2000

Hymenal findings:	Abused N=192	Non-abused N=200	P-value
LIR	89%	87%	.65
Periurethral baneds	94%	95%	.83
Hymenal bands	55%	60%	.31
Tags	3%	5%	.29
Bumps	46%	46%	.92
Notches*			
Superficial	7%	5%	.52
Deep	1%	0	.24
External Ridges	8%	8%	.92
Vascular changes	8%	7%	.70
Transections	1%	0	.49
Perforation	1%	0	.49

*Excluded notches in fimbriated hymens; see original 1992 article.

Question # 3

What should we expect when a child presents with acute injuries???
How do these injuries Heal???

Genital Trauma

- Accidental Trauma: Present because of the injury.
  - Straddle injuries
  - Penetrating trauma
- Sexual Assault: Present because of the history or injury
  - May be free of trauma
  - Penetration?

Trauma of Sexual Assault

- Examinations are usually normal
  - Nature of abuse (fondling, simulated inter-course, anal and oral penetration)
  - Delay in reporting (trauma is healed)
  - Estrogen is protective
- Protocols:
  - Emergency: <72 hours
  - Urgent:<Less than two weeks
  - Scheduled: Over two weeks

Accidental Genital Trauma

- Straddle injuries
- Bruising of labia, peri-urethral and perineum
- Often presents with posterior injuries
- May be penetrating and mimic sexual assault

Reports of Ano-Genital Injury

Date	Finkel, '89	McCann,'92	Heger, 03	Kellogg, 2004	McCann 07	Anderst, '09
Number	6 Prepubertal	3 Prepubertal	94 (pre-pubertal)	36 (Adolescent)	113 Prepubertal	506 Adolescent
Accidental	3	0	27		21	Self-report penile genital penetration
NAT	3	3	67	36 (Pregnant)	73 19 unknown	
Acute	5 with superficial findings 1 Case deep laceration	2 Deep lacerations ; 1 Partial TX	See next slide		18 Hymenal lacerations	
Healed						
Normal	5	1	78%	35/36	15 healed	87% (>10 X)
Other	1 Hymen distorted and scars	2 Hymen Irregular, jagged border	22% with findings diagnostic of penetration	2/36 with evidence of penetration	3 persisted with transection	56 had positive exams--52 without history of consensual sexual activity

Accidental Trauma: Review of Literature

Reports	N	History	Location	Injury	Healed?	
West, 89	13	8 Straddle 1 uncertain 1 Stretch 3 penetrating	Labia Labia Tear PF Inner labia	Bruise Bruise Tear Bruise	N/a	
Dowd, '94	100	100 Straddle 3 With penetration	79% labia 16% PF 7% vagina 2% hymen	Minor Laceration/abr. Pen: Laceration	Note: 5 later disclosed SA	
Pierce, '92	87	74 Straddle 5 Penetrating 3 Stretch 2 Scratch 3 SA	66 Anterior 20 Posterior Penetrating	Asymmetrical Lac/Abrasion Split of perineum Tears to vestibule and vagina	Note: Accidental penetrating no PF damage PF not intact with SA	
Bond, 95	56	Straddle	Labia minora 34% Posterior 1 Hymenal	Minor (anterior or lateral to the hymen P F and Perineum Abrasion to hymen		
De San Lazaro 98	4	Straddle	Sandal injury	V ertical, linear, midline, may involve the perineum and PF	NA	
Boos, 99	1	Straddle	Labia Hymen	Tear Hymen full laceration (6) And (8) Partial Tear	Resolved Transection @ 6	
Iqbql, 10	167	70.5% Straddle 23.5% Blunt \ 6% Penetrating	64% Labia 7./8% PF 8.4% Hymen	All demonstrated lacerations with some requiring surgery		

LAC+USC Longitudinal Study

- 94 Cases of genital trauma followed to healing
  - Accidental trauma
    - 27 cases straddle and penetrating injuries
  - Sexual Abuse:
    - 19 Cases of anal trauma
    - 48 Cases of sexual assault

Healing trauma: Location and type of injury : Heger 2003

Location of Acute Injury	N	Nature of Acute Trauma		Healed Trauma
		Abrasion or Hematoma	Laceration or Tear	Vascular changes/ scars or transections, etc.
Posterior Fourchette/ Fossa Navicularis	47	12 1 healed as a vascular change	35	Lacerations: Vascular changes: 12 Surgery: 10; 6=scars/4 vascular changes Labial fusion: 2 No changes :11 Abrasions: 1vascular change
Hymen	37	12 1 healed as angularlity	25 Partial (8) Complete (17)	Transections: (17) 6=surgically repaired/2 appeared normal 15=transections persisted unchanged 6 followed through puberty+unchanged Partial tear: (8): 5 healed with notching/narrowing
Perihymenal	39	37	2	2 tears healed with vascular changes Abrasions: normal
Labia minora & majora	17	15	2	Two lacerations initially healed with change in vascularity However over time all trauma to the labia healed completely
Anus* * abrasions & tears occurred @ 6 & 12 o'clock	31	13	18 4 changes in Anal tone	2 cases developed herpes 1 skin tag 2 cases with hyper-pigmentation (one after surgery for CA)

Question # 4:
What factors must we take into account when we complete an evaluation of sexual abuse and prepare a complete report and diagnosis???
What next???

Longitudinal Study Conclusions:

1. Transections of the hymen do not heal without surgical repair. There were no transections associated with digital vaginal penetration. Surgical repair does improve appearance of "intactness" in the preadolescent through puberty.
2. Partial hymenal tears and abrasions heal with findings that are either normal or non-specific.
3. Most trauma heals quickly; victims need to be examined emergently by experts.
4. Anal trauma heals quickly and completely.
5. Sexual assault was associated with the most egregious injuries
6. Accidental trauma: hymenal trauma in 32%; posterior fourchette in over 50% of cases.

Triage: Who is the abuser? Abuse vs. Assault

- Known abuser/Incest
- Over long period of time
- Delayed disclosure
- Medical findings minimal if any

- Unknown assailant
- One time episode
- May involve physical violence
- Quicker disclosure
- Medical findings are more likely

Post Traumatic Changes Sexual Assault with History of Penetration

- **PRE-PUBERTAL**
- **Usually normal (history)**
- Transections to base of hymen
- Loss of hymen
- Usually 3 to 9 o'clock
- Posterior Fourchette lacerations/abrasions
- Anal Trauma Possible: Heals quickly

- **POST-PUBERTAL**
- Extra-genital trauma
- Normal/No Transections
- Hematomas and tran-sections....Partial or to the Base (4-8 o'clock)
- Posterior Fourchette laceration/abrasions
- Anal Trauma Possible: Heals quickly

Sexual Abuse

Indicators

- No Medical indicators at all
- Genital Injuries
  - Bruising, scratches, bites
- STD's
- Blood Stains in underwear.
- Dysuria, urethral discharge
- Abdominal/Pelvic Pain
- **History**
- **Behavior changes**
- Domestic/family Violence
- Physical Abuse

The Interview

- Value to Process

•Used as the basis of diagnosis for legal purposes
•History from Law enforcement
•Establish Rapport
•Sexual history
•Medical history
•History of assault

The Colposcope: Advantages

- Documentation
- Replaces need for Re-examination
- Magnification
- Peer Review
- Video-colposcopy
- Networks/Telemedicine
- Computer Technology

The Medical Evaluation

- Preliminary Information
- Documentation
  - Clinical
  - Laboratory
- Treatment
  - Injuries
  - Pregnancy prophylaxis
  - STD prophylaxis
  - Mental Health/advocacy

Forensic Documentation

- **Clinical**
  - Photodocumentation
  - Trauma
    - Genital
    - Extra-genital
  - History
- **Laboratory**
  - Cultures: STD'S
  - DNA and Trace evidence. (most often in young children at the site of the assault)

Photodocumentation

- Hand-held camera
- Colposcope
  - 35 mm
  - Video
  - Telemedicine
  - Peer review
  - Digital camera

Summary:

- Interpret post-pubertal findings with caution
- **Sexual Assault after puberty can occur without injuries and may leave a normal appearing hymen after healing.**
- Actual Vaginal Penetration (across the hymen) of the pre-adolescent will leave diagnostic transections.
- Pre-adolescent transections do not heal with a normal appearance unless repaired.
- Anal Trauma usually heals without scarring

SUMMARY

- Sexual assault is a dangerous diagnosis that needs to be done by experts.
- History most important
- Documentation and chain of evidence.
- Medical treatment: HIV, Hepatitis B, Pregnancy and other STD's
- Forensic experts---testimony
- Mental health

Update in Foster Health
Chung Gung Memorial Hospital
March 31, 2013

Supplemental information on Child Sexual abuse

APSAC DEFINITIONS

General terms:

Erythema:	A redness of the skin or mucous membranes produced by congestion of the capillaries.
Periurethral bands.	Small bands, lateral to the urethra that connect the periurethral tissues to the wall of the vestibule.
Perihymenal bands	Small bands of tissue lateral to the hymen, that form a connection between the perihymenal structures and the wall of the vestibule
Midline sparing (Linea Vestibularis)	A vertical pale/avascular line across the PF
Median raphe	A ridge or furrow that marks the line of union of the two halves of the perineum
Longitudinal Intravaginal Ridges	Narrow mucosa-covered ridges of tissue on the vaginal wall that may be found in all four quadrants
Labial Adhesions	adherence of the outer-most mucosal surfaces of the vestibular walls
Asymmetry of the Fossa	The asymmetrical attachment of the labia minora to the fossa (normal variant)

Changes in the hymenal edge:

Angularity of Hymen	Relatively sharp angles in the contour of the hymenal inner edge. (May be evidence of prior trauma)

Cleft/notch	An angular or v-shaped indentation on the edge of the hymenal membrane. May extend to the muscular attachment of the hymen. (may be evidence of prior trauma)
Fimbriated/Denticular	Hymen with multiple projections or indentations along the edge, creating a ruffled appearance. (a congenital variant)
Concavity	A curved or hollowed u-shaped depression the edge of the hymenal membrane
Key-hole configuration	The appearance of the hymenal orifice when the posterior lateral portions of the hymenal membrane project into the orifice creating a concavity inferiorly –(descriptive term that may be misinterpreted)
Irregular hymenal edge	A disruption in the smooth contour of the hymen
Narrow Hymenal Rim	Term used to describe the wide of the hymenal membrane in the coronal plane (an abnormally narrowed membrane may be evidence of prior trauma)

Child Sexual Abuse
Ten Step Investigative Interview

1. **Don't Know instruction**

If I ask you a question and you don't know the answer, then just say, "I don't know."
So if I ask you "What is my dog's name/" what do you say?
OK because you don't know.
But what if I ask you "Do you have a dog?"
OK because you do know.

2. **Don't Understand instruction**

If I ask you a question and you don't know what I mean or what I'm saying , you can say, "I don't know what you mean." I will ask it a different way.
So if I ask you "what is your gender?" what do you say?
That's because "gender is a hard work. So I would say, 'Are you a boy or a girl?"

3. **You're Wrong instruction**

Sometimes I make mistakes or say the wrong thing. What I do , you can tell me that I am wrong.
So, if I say, You are thirty years old," what do you say?
OK, so how old are you?

4. **Ignorant interviewer instruction**

I don't know what's happened to you
I won't be able to tell you the answers to my questions.

5. **Promise to tell the truth**

It is really important that you tell me the truth.
Do you promise that you will tell me the truth?
Will you tell me any lies?

6. **Practice Narratives**

   a. **Like to do/Don't like to do**

   First, I'd like you to tell me about things you LIKE to do
   Follow up with Tell me more questions.
   e.g. "You said you like to play soccer. Tell me more about soccer."
   Now tell me about the things you don't like to do.
   Follow up with tell me more questions.

   b. **Last Birthday**

   Now tell me about your last birthday. Tell me everything that happened.
   Follow up with What Happened Next questions e.g. "You said you played in the bouncy. What did you do next?"

7. **Allegation**

(If child discloses abuse, go directly to Allegation Follow up. Determine in advance which allegation questions you will ask.)

a. Tell me why I came to talk to you

Or, Tell me why you came to talk to me

It's really important for me to know why I came to talk to you/you came to talk to me.

b. I heard you saw

e.g. I heard you saw a policeman last week. Tell me what you talked about."

c. Someone's worried

e.g. "Is your mom worried that something may have happened to you? Tell me what she is worried about."

d. Someone bothered you

e.g. "heard that someone might have bothered you. Tell me everything about that."

e. Something wasn't right

e.g. "heard that someone may have done something to you that wasn't right. Tell me everything about that.".

8. Allegation follow up

You said that (repeat allegation). Tell me everything that happened. e.g. "You said that Uncle Bill hurt your pee-pee. Tell me everything that happened."

9. Follow up with Tell me more and What happened Next questions.

Avoid yes/no and forced-choice questions.

10. Multiple Incidents

Did (repeat allegation) happen one time or more than one time?
Tell me everything that happened the time you remember the most…
Tell me everything that happened the first time…
Tell me everything that happened the last time…
Was there another time**?**

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台灣兒童青少年精神醫學會通訊總編輯

Topic: **Practice for Developmental and Mental Health Care**

課程大綱：

安置於寄養家庭之兒童大多於幼年時期受到長期不同程度的疏忽及虐待，較易出現嚴重及行為及情緒調節之障礙、人際互動問題及負面的自我評價。穩定的養育環境有利於這些兒童或青少年短期及長期之發展及未來社會適應。心理衛生工作者之介入應包含完整心智評估及診斷及後續介入治療。

兒童保護新觀念研習會-下午

時間	演講題目	講師	主持人
13:00~13:50	高風險家庭的介入與服務	莫藜藜教授	監察院 尹祚芊監察委員
13:50~14:40	兒童及少年保護工作之 法定程序及現有法制下之 實際操作方法	劉承武主任檢察官	
14:40~15:00	Coffee Break		
15:00~15:50	台灣兒童保護的 變革與現狀	余漢儀教授	兒童局 張秀鴛局長
15:50~16:40	具體落實"為兒童三個一切原則 "之普世價值正確方向及方法	劉承武主任檢察官	
16:40~16:50	閉幕致詞	林口長庚醫院 兒童內科部 邱政洵部長	

◎活動注意事項：

1. 為尊重講師授課及其他學員的學習權益，請將您的手機調整為震動或無聲。
2. 本次研習會申請各學會積分，需全程參與並親自簽到及簽退者，方可記錄學分。
3. 會場外備有飲水機，請自備環保杯，場內禁止飲食。
4. 課程結束後，請將活動滿意度調查表交給場外工作人員。

主持人簡歷

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國立陽明大學社區護理研究所所長、兼任教授

衛生署全民健康保險醫療費用協定委員會委員

衛生署新制醫院評鑑暨教學醫院評鑑委員

台灣省政府省政委員

中華民國護理學會第 23、24 屆理事長

三軍總醫院護理部主任

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美國克里夫蘭大都會綜合醫院社工員

美國克里夫蘭兒童心理諮商中心社工員

東吳大學社會工作學系教授兼系所主任

社會工作教育協會理事長

Topic: **高風險家庭的介入與服務**

前言：

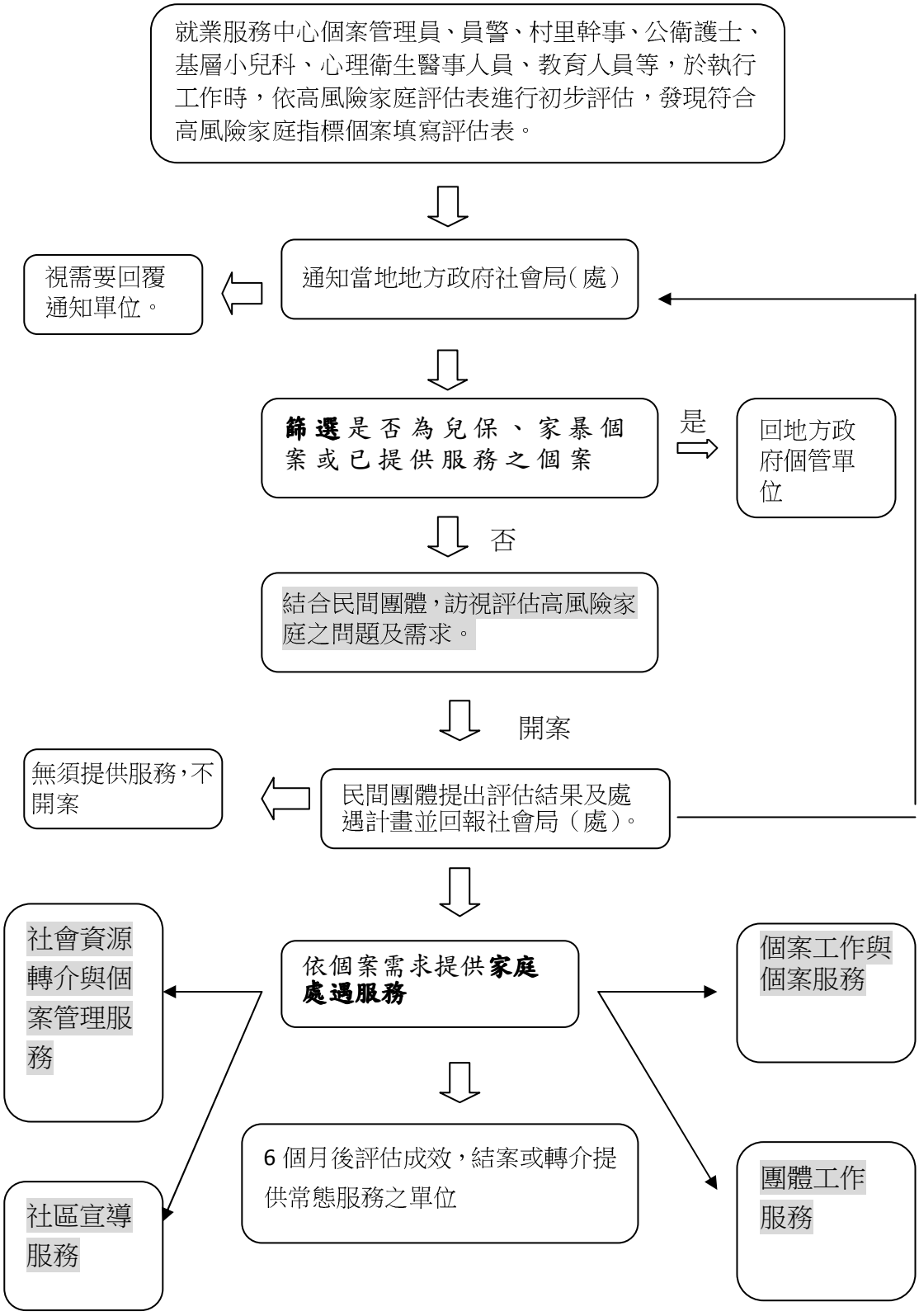
有鑑於台灣地區家庭暴力事件頻傳，兒童受虐致死的社會新聞震撼人心，顯示家庭問題惡化情況嚴重，例如：2003 年台北縣顏姓女童因有家暴疑慮而安置，社工受到民意代表壓力並質疑其專業倫理問題，新聞不斷上報，社會議論紛紛；又如：2004 年轟動全國的邱小妹人球事件，受虐女童生命垂危，醫院疏忽急救又拒絕其住院，導致對家庭暴力救治網絡的檢討等。2005 年由內政部兒童局規劃「高風險家庭關懷輔導處遇實施計畫」，實施至今已進入第八年。本文擬先介紹高風險家庭關懷輔導處遇實施的內容，其次從服務理念理解實務的理論，再看高風險家庭服務方案執行概況，最後提出問題探討與建議。

壹、高風險家庭關懷輔導處遇之實施

一、計畫宗旨

「高風險家庭關懷輔導處遇實施計畫」是希望建構高風險家庭篩選及轉介處遇機制，兒童局訂定「高風險家庭評估表」，提供社政、警政、教育、衛生、勞政及民政系統基層人員使用，包括學校老師、警察、村里幹事、戶政人員、就業服務中心個案管理員、公共衛生護士、基層小兒科醫師等，均能藉由這份評估表篩檢出高風險家庭，擴大通報來源，提供關懷訪視。由＜圖一＞之篩檢通知處遇流程可知，由各地方政府委託民間單位承接「高風險家庭」服務方案，期望經各方通報，社政單位及早介入，主動提供關懷輔導的預防性服務方案。實施至今，23 個縣市中共約有 90 個以上的據點提供「高風險家庭」服務方案；接受地方政府委託提供高風險家庭服務的各地非營利機構，其類型也十分多元，最多的可能是世界展望會、兒童福利聯盟、兒童及家庭扶助基金會等大型社會福利組織的各地方分支機構；還有，各地生命線、青年會、張老師基金會、善牧基金會、勵馨基金會，以及地方性或區域性的機構，如：台北縣兒童人權協會、台北市紅心字會、竹山衛理公會、宜蘭慈懷基金會、台南市女性權益促進會、雲林兒童少年福利保護協會等。

＜圖一＞　高風險家庭篩檢通知處遇流程



資料來源：莫藜藜等（2010 年）修訂自兒童局（2005）版本

二、高風險家庭的定義及問題類型

根據高風險家庭關懷輔導處遇實施計畫（2005），「高風險家庭」是指家中有未成年（18 歲以下）子女，因貧窮、家庭功能不良或其他不利因素致使家庭發生危機或問題，經縣市政府社會局（處）社會工作人員評估後，認為需要介入服務之家庭；如家庭中有 12 歲以下子女，則必須優先介入提供服務。這些高風險家庭往往伴隨離婚、失業、酗酒等問題，導致家庭結構不穩定，是容易發生兒童虐待問題的高危險群。因此，兒童局也提供了高風險家庭篩選指標包括：

1.家庭成員關係紊亂或家庭衝突，如家中成人時常劇烈爭吵、無婚姻關係頻換同居人等。

2.因貧困、單親、隔代教養或其他不利因素，使兒童少年未獲適當照顧。

3.家中成人罹患精神疾病，或酒癮、藥癮，並未就醫或未持續就醫。

4.非自願性失業或重複失業者，如負擔家計者遭裁員、資遣、強迫退休者。

5.負擔家計者死亡、出走、重病、入獄服刑等。

6.家中成員曾有自殺傾向或自殺紀錄者。

上述指標顯示典型的家庭危機因子，分別是：(1)家庭經濟陷入困境；(2)兒童之主要照顧者身心健康不佳；(3)家庭/婚姻關係不穩定。當家庭遭遇這些危機事件，本身又缺乏有力的社會支持系統和足夠的資源時，很容易發生虐待孩子、家庭暴力、攜子自殺等令人遺憾的悲劇。也就是說，經濟、健康、家庭/婚姻關係是支撐家庭穩定的「黃金三角」，如果家庭缺了其中任何一角，而又沒有足夠的資源可以因應危機時，很可能成為所謂的「高風險家庭」。

高風險家庭服務計畫主要是提供以兒童為中心、以家庭為對象之服務。為了因應兒童保護的需求，2012 年將「六歲以下弱勢兒童主動關懷方案」併入高風險家庭服務方案，即針對未辦出生登記、未按時預防接種、國小新生未依規定入學等特定族群，透過戶政、社政、衛政追蹤輔導，得轉入高風險家庭服務系統。由此可知，對高風險家庭的服務需要跨專業之團隊通力合作。

高風險家庭社工在接案後的重要任務是進行診斷之業務，有正確的診斷才能提出正確的「個別化家庭處遇計畫」。社會工作專業判斷的基準在於對案家「問題類型」的確認，莫藜藜等（2010）曾建議將高風險家庭的危險因子，分為四大類，即：(1)家庭因素（經濟困難、就業問題、家庭關係失調、家庭支持系統薄弱、家中有突發危機事件）；(2)照顧者因素（照顧者身心疾病問題、教養與照顧問題）；(3)兒童少年因素（兒童少年行為偏差、兒童少年身心疾病問題），以及(4)其他因素（如居住環境複雜，威脅兒少安全）。如此，問題類型共計 11 項。

三、高風險家庭服務內容

從「高風險家庭關懷輔導處遇實施計畫」的名稱、宗旨和服務流程，已知此服務方案是要求社工提供「關懷」「輔導」「處遇」的社會個案工作服務為主，不只是以個案管理方式來執行業務。由於早期發現，早期預防之服務範圍涵蓋較廣，服務內容較多元複雜，因此莫藜藜等（2010）依兒童局提出之 10 項服務內容，再加統整為四大類，前兩類是社會工作者要提供的直接服務，第三是個案管理，第四是社區宣導，茲條列如下：

(1)個案工作與個案服務：情緒支持、個別諮商與輔導、家庭諮商與輔導、親職教育諮詢、家務指導（到宅親職示範）、家庭休閒計畫與安排、就學輔導。

(2)團體工作服務：兒童成長團體、家長成長團體、家長支持團體等。

(3)社會資源轉介與個案管理服務：經濟補助（弱勢兒少扶助）、安置服務、協助就醫、就業服務、喘息服務、法律諮詢服務、課業輔導、托育服務、親職教育諮詢、心理諮商與輔導、酒癮戒治、其他資源轉介服務等。

(4)社區宣導服務：兒少保護服務宣導、家庭暴力防治宣導、緊急救災應變服務等。

＜圖一＞的通報處遇流程，是筆者與世界展望會研究團隊建議修改後的流程，因為在民間機構開案之後，會依個案需求提供家庭處遇服務，但是原先規劃之服務項目並不完整，似乎仍只有協助申請社會資源，和轉介相關單位提供服務，並無提供直接服務之個案工作服務與團體工作服務。此與服務方案計畫之主旨和初衷不符，因此建議改為上述四大類服務項目。

另外，高風險服務之補助項目與基準中，規定滿 18 個月以上之案家不予列入個案量，亦即需在 18 個月以內結案。由此可知，方案服務之理念是強調所謂「高風險」家庭應屬緊急、危急個案，需要立即服務；並希望在 6 個月，至多 18 個月以內密集地提供服務，然後積極地結案。如果事與願違，或無法於短、中期內獲得改善，而落入長期需協助與輔導之個案，則應轉至長期輔導機構或服務方案。

貳、從服務理念理解實務的理論

社會工作提供專業服務，必須有理論的依據。高風險家庭的現象可能存在於社會中許多角落，面對這樣的情境，我們應該把問題的根源看得更清楚，瞭解及掌握問題的形成因素，希望可以在危機發生前對症下藥，以「早期發現，早期處理」，達到有效預防，降低悲劇發生的可能性，讓更多家庭得到穩固與支援。以下針對高風險家庭的服務理念提出幾個相關理論：

一、以家庭為中心的社會工作直接服務模式

此種服務模式有積極性、整合性與計畫性的特色，目的不在治療家庭，而是在協助家庭以自身的力量解決問題。由「高風險家庭關懷輔導處遇實施計畫」的名稱即可知，這是一種以家庭為中心（family-centered）的服務模式，針對 18 歲以下的兒童及少年提供以家為基礎（home-based）的服務，目的在強調家庭功能的健全；同時，將服務提供到家，希望兒童及少年可以不用離開原生家庭，而是保護他們的安全，也維護家庭的完整性。

對每一個家庭提供個別化家庭服務計畫（Individualized Family Service Plan，IFSP），具體說明服務應如何滿足需求，並清楚說明服務個別兒童與家庭的目標、達到目標的方法、標準及時間。另外一個類似的方式，即積極性家庭維繫服務（Intensive Family Preservation Service，IFPS），是在案主家庭中進行，要求在一個特定的時間內極為積極性地進行對家庭支持性服務。服務的哲理亦是「以家庭為中心」的社會服務，主要目標是要保護兒童、維繫和增強家庭的連帶關係、穩定危機情況、增加家庭成員的技巧與能力、促使家庭使用各種正式與非正式的資源。

二、外展服務與早期介入

社會工作中一直強調外展（outreach）工作，認為對於問題的主動處理是預防更多、更嚴重問題之發生，此乃因問題行為往往是一種連續體的形式，若能及早發現有風險與危機的家庭，並且適時予以介入，當能協助家庭脫離或降低危機情境。故「發現與預防」是執行高風險家庭服務工作的精髓，如何建立「早期發現、及時介入」的輔導機制，可以藉由外展服務的介入，主動積極地進入社區，接觸家庭，防患家庭問題於未然，讓家庭能提供兒童及少年一個安穩生長與發展的環境。

三、增強權能策略與生活模型理論

增強權能（empowerment）的概念是看到個人的能力與優勢，或是環境中可用的資源，讓個人和其家庭都有在困難環境中展現生存下來的復原力量。近年來，社會工作從過去的實務中粹練出「優勢觀點」（strength perspectives），主要是認為每一個人有其潛能，不論在多困難的環境下，總有些人可以順利的度過難關，甚至過的比以往生活更好。因此，社會工作相信每個人與其所屬的環境中，都存在一些有利於個人適應的資源，社會工作者在協助服務對象時，必須協助他們找出這些有利的資源，並發揮這些資源的影響力，服務對象所面臨的問題就可由此角度來解決。

「人在情境中」（person-in-situation）是社會個案工作的心理暨社會學派的中心概念，用以描述個人和其周圍環境（包括人、事、物及機構組織）的互動，為了受助者的益處，社工人員透過對受助者個人和其家庭的服務，以

介入（intervention）於其情境中。因此，從「人在情境中」的觀點為基礎，認為個體發生問題時，不應以病態觀點分析，而是要考量外在環境因素，要發掘人類的日常社會生活的各種內涵和樣貌。此模型基本上認為個體不斷的適應變化無常的環境，被環境所改變，且也改變環境。因此，提供處遇服務時，最好在其生活的自然環境中與其一起作為，才易達到效果。

增強權能也注意到社會環境可能對個人的壓迫、烙印或負向評價，所以要透過增強權能的過程讓服務對象去發展與創造自己的環境，讓每個個人和家庭增強自我肯定，實踐社會工作專業所強調的「人助自助」價值。

參、高風險家庭服務方案執行概況

這個由政府所主導的關懷輔導處遇方案，主要希望提供預防性服務，引進相關社會資源，對兒童與父母的輔導服務，並舉辦家庭喘息活動以減低高風險家庭壓力，進一步降低高風險家庭兒童被虐待的情況發生，讓不幸的社會事件不再上演。因為一旦發生兒童或少年虐待、攜子自殺、家庭暴力等事件，即使投入再多的人力與資源，也未必能完全撫平受害者的傷痛，與其事後亡羊補牢，倒不如及早介入和預防，避免家庭悲劇發生。

一、服務方案執行之統計概況

此服務方案主動的提供早期介入服務，是一種兼具預防性、輔導性及支持性的家庭服務。根據兒童局（2012）的統計，高風險家庭的開案數從 2005 年的家庭戶數為 1,848 案，兒少人數為 2,843 人；至 2011 年的家庭戶數為 18,677 案，兒少人數為 42,552 人，可見個案量是逐年遞增的情況。從高風險家庭通報來源分析，兒童局的統計前五名分別是：教育單位（43.16%）、社政單位（19.66%）、社福機構（11.12%）、醫衛單位（9.36%）、警政單位（6.30%）。通報之後，由地方政府社會局派案給委託民間社福機構設置之高風險家庭服務中心的社工人員提供服務。

至於其家庭類型，2007 年統計最多的是單親家庭（占 31.24%），其次是離婚/分居家庭（占 25.26%），再次是一般家庭（占 21.65%），再依次是隔代教養家庭（占 10.59%）、同居家庭（占 4.09%）、外籍配偶家庭（占 3.66%），以及其他（占 3.50%）。

新北市政府於 2011 年成立「高風險家庭服務管理中心」，是台灣首創的一種針對高風險家庭的統一管理平台，個案服務採分級管派與服務狀況追蹤，管理中心接受通報後，以一案到底結合相關局處提供整合型服務為原則，並依問題類型派案或轉介至主責單位進行訪查，以利服務提供，並將結果回覆。新北市高風險家庭服務管理中心，由統一窗口派案至新北市政府各局處負責處理個案的單位，依次是：社政單位（58.24%）、醫衛單位（17.34%）、教育

單位（12.78%）、勞工單位（9.04%）、原民局（2.27%）。由此看出，高風險家庭問題的複雜多元，是由不同單位直接處理，而不像其他縣市一律透過社政單位提供服務。

高風險家庭的問題類型到底是何樣貌？其實很難清楚說明，因為原規劃之問題類型互斥性不足，導致如世界展望會雖研擬出工作手冊，提出建議之項目，但主管單位無法讓各地以一致標準登陸，導致向兒童局申請經費以其原有項目登錄，否則就採自認為較好方式登錄。以兒童局（2012）的統計，前六名問題類型依次為：經濟困難、照顧者婚姻關係不穩定、支持系統薄弱、就業問題、照顧者養育疏忽或管教失當、照顧者死亡、出走、重病或服刑。

筆者查閱兒童福利聯盟和世界展望會服務成果報告（2012）之統計與之相似，只是排名稍有差異。但以新北市的統計則差異較大，其前六名問題類型為：親職照顧（照顧者養育疏忽或管教失當）、經濟困難、精神疾病（照顧者罹患精神疾病，未就醫或未持續就醫）、就學輔導（其他）、自殺防治（家中成員曾有自殺傾向或紀錄）、照顧者有酒癮、藥癮問題。由此看出，在問題診斷方面較多與精神醫療有關，此也回應上述新北市派案至醫療衛生單位占第二多的現象。

二、方案服務之質性成效

服務方案推動後，部分較積極的縣市則將此服務方案建置網頁，以達宣傳目的，讓民眾知道相關訊息，例如：桃園縣高風險家庭管理中心之資料庫列出年度服務的家庭和兒童人數，苗栗縣也設置高風險家庭預防性服務網，而雲林縣政府曾舉辦高風險家庭服務網絡策略研討會，邀集地方之社政、警政和非營利組織共同討論。

此項計畫界定高風險服務方案為預防性的處遇模式，服務對象主要是以兒童和少年為主，強調恢復家庭健全之功能為主要目標，因此依據案家的需求，透過各類家庭服務的項目，提供以家庭為整體的服務，不只是經濟補助，還有情緒支持；不只是對一個案主，而是對全家人；不只是家務指導，還有心理輔導及治療等。因此服務方案推動後，由不同的社區組織發展出更多據點，增加服務的可近性，也是一種重要成果。

一項高風險家庭服務之研究（莫藜藜，2008），社工自述由服務中體認之成效有以下五方面：

（一）落實兒童少年保護的預防功能

高風險家庭服務之社工認為服務的提供有達成當初規劃服務方案的目的，有社工表示「透過密集的訪視關懷，預防兒少保案件的發生」、「針對主要照顧者與案童給予情緒性的支持與關懷，視案家的需要給予協助」、「對於有兒虐之虞的家庭可預先給予正確的教養觀念與法規告知，預防兒虐事件的

發生，並於發現兒保案件時，立即通報社會局（處）介入處理」等。

（二）提供案家社會支持

高風險家庭服務是為了是要讓兒童少年可以留在原生家庭中生活，家庭繼續擔負起照顧兒童少年的功能。社工除了情緒上的同理與支持之外，也藉著各種相關資源的結合，提供案家經濟或是其他資源上的支持，以利案家繼續運作。

1.提供資源轉介，降低家庭危機風險：許多弱勢家庭長久以來缺乏社會資源的介入，服務中能夠協助案主運用各種社會資源，增強其家庭功能，則可以降低家庭危機與風險。

2.增進及維護家庭成員間的情感：藉著關切家庭整體的幸福，促進家庭成員之間的關係，而推動的各項服務能增進及維護家庭成員間的情感。

3.協助申辦經濟補助：為數不少的高風險家庭當中需要實質的幫助，包括物質的資助和經濟補助，高風險家庭服務方案提供這方面的協助，以解案家燃眉之急，是最易讓案家感受的服務方案的誠意和善意。

4.維繫弱勢家庭功能，降低家庭危機的產生：通常高風險家庭由於家庭功能減弱而無法應付家庭面臨的困難，導致家庭陷入危機。高風險家庭服務方案透過各種服務項目，協助這些家庭找到穩定的力量，降低家庭危機的產生。

5.提供家長情緒支持、陪伴及諮詢：高風險家庭社工透過其直接服務方式，運用同理心與傾聽等會談技巧，提供家長情緒支持與專業陪伴。

（三）促進資源網絡的連結

高風險家庭服務中心分別和當地各種的資源網絡連結，共同提供對案家及案主的服務，如此對社會工作者也有很大的助益，與各相關資源單位間漸漸的有合作的共識，並發展出各種合作的工作模式，發揮更有效的服務功能。

（四）增進社會對高風險家庭的關注

透過在連結資源與提供服務的過程中，讓各個相關單位對高風險家庭有更多理解與注意，對於生活週遭或工作上所遇到的具有高風險之虞的個案即會通報。在危機事件發生之前尋求相關單位的協助，如此更能夠發揮預防的功能，即希望發現那些處在社會邊緣的高風險家庭，在嚴重的問題發生前，及時伸出援手。

（五）增進與社政主管單位的溝通

因高風險家庭服務方案是由中央規劃的服務，各縣市的社政單位主管機

關在過去並沒有類似的方案，委託民間單位時常會有些不符合實際工作上的期待，讓受委託單位在工作執行上有些困難，因此透過服務經驗的累積，並與主管機關不斷的表達、溝通，讓主管機關瞭解實際狀況，預期可發展出更適合高風險家庭服務的模式。

肆、問題探討與建議

一、問題探討

（一）在轉介作業上：開案標準仍不一致

此服務方案推動至今，經不斷宣導後社區各通報單位已逐漸關注需要服務之潛在高風險家庭；然而相關座談會討論中，仍然發現部分縣市兒童少年保護個案之開案標準嚴格，導致高風險家庭服務有兒保化現象。在不同縣市的公部門可能有不同的開案標準，同樣案情，有的就分派給高風險家庭服務，有的會被認定是兒童保護個案，尤其是疏忽型個案，因無外傷，常分給高風險家庭服務。

（二）在直接服務上的問題

1. 與非自願案主工作的困難

兒童少年保護個案服務有其強制性，但高風險家庭並非主動求助，個案問題尚未立刻危及生命安全，因此服務方案無強制力，導致服務工作的困難，例如：社工進行家庭訪視時，時常被拒絕；當主要照顧者缺乏親職能力，又無改善動機；當主要照顧者為酒、藥癮患者，經常疏忽照顧孩子，或被判刑反覆入獄；當主要照顧者有精神疾病，拒絕被診斷，或未穩定服藥等情形，這些都使社工很難單獨使力，對兒童少年的照顧只能藉由資源體系維持最低照顧水準。由此可知，對高風險家庭的服務，需有相關專業團隊共同合作才行。

2. 服務期限的問題

在相關座談會中，一些機構表示其部份個案（約 20-25%）無法於短期（6 個月內）、中期（18 個月內）內獲得改善，而落入長期需協助與輔導之個案，卻因缺乏資源或社區資源配置問題，無法轉至長期輔導機構或服務方案。不易達成 6 個月內結案的原因，多為家庭問題複雜、主要照顧者親職能力缺乏，以及後送關懷資源不足。這些長期的問題，往往不是以此短期和預防性質的服務方案可以處理完成的。

（三）經費和資源問題

1. 政府補助經費不穩定

一些機構也常於座談會中表示，因受制於地方政府年度預算審查延宕，經費還未到位，但已進行之服務不宜中斷，必須持續，則機構需承擔風險，或增加自籌款，或減少服務活動的項目與次數。如此一來，高風險家庭服務之預防成效勢必打折。

2. 醫療資源可近性低，難以形成有效服務網絡

高風險家庭中之主要照顧者因身心健康問題，需求醫療資源甚殷，例如：主要照顧者為酒、藥癮患者，戒癮治療單位未能配合網絡服務；或精神障礙個案，部份縣市沒有到宅診治，或雖有，但條件限制多；或企圖自殺個案，地方資源多僅為電話訪問後即結案等。因為資源難以到位，家庭一直處於風險邊緣的狀態，這些問題狀況都丟給社工，則常常無法積極結案。

（四）建立全國性資料庫的困難

各地對高風險家庭問題類型常有不一致的定義，導致報告成果之統計時，無法確認高風險家庭問題之趨勢，和服務項目之具體面貌。

二、建議

（一）在轉介作業上的建議：通報系統的再改善與調整

將「高風險家庭服務方案」中開案與不開案指標說明宜更為具體，不斷對外宣導，請通報或轉介單位瞭解與尊重高風險家庭服務中心的特殊功能，並尊重相關轉介業務的規範。另一方面，因高風險家庭服務方案之社工並無強制力，無法強迫個案接受服務，希望由負責篩檢之地方政府社會局（處）正式告知這些非自願案主，建議他們能接受高風險家庭服務。

（二）在診斷作業上的建議

對於社工的在職訓練仍應加強的知識與技術，包括：對經濟弱勢或結構性失業家庭的瞭解、對長期孤立案家的協助、生活模型與外展服務方式、婚姻問題的瞭解與處理等。高風險家庭社工在接案後的重要任務是進行診斷之業務，有正確的診斷才能提出正確的「個別化家庭處遇計畫」；為了有正確的診斷，需有一致的診斷指標，而專業判斷的基準在於對案家「問題類型」的確認，因此建議問題類型一致，問題類型各項目也務求周全與互斥，請社工人員詳細瞭解「問題定義」和「問題內容」，對案家問題提出正確診斷。期待社工的專業診斷有其標準，並於統計報表上予以確認。

（三）在「執行處遇」上的建議

1. 將服務項目統整分類成共同標準

前已述及，世界展望會建議將服務項目統整為四大類：(1)個案工作與個案服務。(2)團體工作服務。(3)社會資源轉介與個案管理服務。(4)社區宣導服務。但至今尚未由中央政府統一標準項目，未來希望各地服務中心能有相同的項目，將方便統計，以作為未來國家資料庫的基礎。

2. 受委託之民間單位亦建立體系內的資源

社會工作實務一再強調發掘和運用社會資源，如果缺乏社會資源，則需創造資源，以利使用。如果各服務機構內也設法準備長期的經濟補助資源，則案家亟需這類資源時，能立即滿足案家需要。

3. 依照族群特性提供服務

像是有主要照顧者親職功能不完全（單親離異、隔代教養），透過資源連結（例如當地社區與教會）進行親子成長團體，儘可能改善並且提昇案家親職功能。或是主要照顧者長期酒癮狀況或是患有重大疾病（身障、精障、慢性病），特別需要醫療相關資源，宜加強跨專業的合作。由於高風險家庭服務期限在 18 個月內，所以當判斷其屬於長期個案時，則應轉至社會福利體系中之長期服務機構。

4. 個案量在 15-30 家戶，以提供較精緻深入的服務

這個「合理個案量」的問題一直困擾實務界，要提出一個確切個案量仍是不易。本服務方案委託單位的原始構想在於早期發現案家之困難，及早處理以預防問題發生，這需要深入瞭解，並花時間處理；而高風險家庭社工亦期待提供較精緻的服務，再加上每一案家問題嚴重和複雜性不一，以及區域資源和區域幅員之條件障礙，故而建議每位社工合理個案量可放在 15-30 戶（每戶人數不等），有彈性的範圍內。

5. 結案之自我評估

為求找出服務之成效，應對結案指標再加確認，然後社工再提出結案之自我評估，需針對其「問題類型」之診斷，看其服務項目是否協助減輕、改善或解決了案家的哪些具體問題？社工者至少可在以下四方面提出具體說明：(1)家庭照顧功能；(2)家庭經濟功能；(3)家庭的支持資源；以及(4)家人關係改善等，提出具體說明；並針對其處理過的「問題類型」勾選其服務結果，包括：(1)問題完全解決；(2)問題部分改善；(3)問題未改善。如此將方便統計，作為日後國家資料庫的基礎。

（四）對公私部門協力的建議

1. 公部門應協助加強各系統間的溝通

期待未來的衛生福利部與教育部、勞委會，能確立協調合作方式與機制，預防及處理高風險家庭問題。由於高風險家庭服務是由各縣市政府社政主管單位委託民間單位提供之服務方案，受委託單位需結合各社區相關資源提供案家所需的服務資源，但在此項服務時仍是期待公部門可以作為各系統間的溝通橋樑，進行資源的連結及互相協助，同時定期舉辦跨部門的個案評估會議，建立一致的處遇目標或服務方式。

2. 公私部門之間能為真正平行的伙伴關係

通報或轉介單位宜瞭解與尊重高風險家庭服務中心的特殊功能，並遵守相關轉介業務的規範，或與社福單位的合作方式有更明確的分工，與轉介單位間能有商議空間與彈性，而非像是下屬單位只能接受指令，則與轉介單位之間能為真正平行的伙伴關係。

3. 經費力求穩定，補助項目及基準應明確化

各時代都會有高風險家庭，這類服務絕不是一時的，因此期待公部門補助之預算應破除萬難力求穩定，且希望高風險家庭輔導處遇服務補助項目及基準應明確化。如果委託單位的兒童局、臺北市政府和高雄市政府都能要求各單位採用全國一致的標準，則將來在研究此服務方案的成效時將有確定之基準；否則對服務內容的不確定和缺乏標準，任何對服務成效的研究結果都不具太大意義。

總之，高風險家庭服務期待提供繼續性和連續性服務，讓案家能脫離高風險的危機，因此政府和民間的合作非常重要，如此能相輔相成，才能克竟其功。政府單位將服務方案委託民間單位，當然會提出期待與監督；而民間單位接辦服務時，除了其原先具有的服務理念，也需承接政府單位的期許。兩方之間的合作是不斷學習溝通與調整的過程。

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Topic: 兒童及少年保護工作之法定程序及現有法制下之實際操作方法

課程大綱：

1. 因基隆長庚保母手麻造成五月大女嬰落地摔死等案，一旦進入司法機關調查程序後，醫療人員如何引用法律依據進而提供書面資料作為傳聞證據法則之例外，使之具有證據能力，而非再三出庭做證，但法律條件為何才使之具有證據能力，以免被司法官所拒，亦確實是必須教導這部分該如何協助檢方達到雙方最佳處理原則(即雙贏，能用小成本換取大效益，合乎經濟效益)。
2. 如發現人為因素，醫療人員如何與檢調單位配合，是否可直接與檢調聯繫，不經縣府社政單位？(確有建立醫療人員與檢警調單位配合，並可直接與檢警調聯繫，而不經縣府社政單位方式之必要!但如何在現有法制下實際操作確實是必須教導，並引用相驗和刑事訴訟之相關規定作依據，以免被拒)。
3. 受虐兒童經醫院社工通報縣府社政單位後，醫療人員確實有協助檢調單位受虐兒童的處置，但其依據及如何實際操作，亦確實是必須教導。
4. 受虐兒童許多後續處置事宜，如何陳報檢方及引用相驗和刑事訴訟之相關規定作依據，以免被拒。

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Topic: 台灣兒童保護的變革與現狀

課程大綱：

ISPCAN 跨國調查：通報率、虐待類型%、受案調查率、調查成案率、成案兒少家外安置率、施虐者遷出家外率、判刑率、兒虐致死統計

台灣地區兒少保護立法轉折

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弱勢家庭兒少緊急生活扶助（2006）

增聘兒少保護社工人力

1Ａ.老幹新枝熱鬧登場

1Ｂ.三足鼎立各領風騷

2A. 資源配置各展所長

2Ｂ.核銷不易、人力增添開拓服務

3. 一個方案各自表述

4. 是替代也是補充

討論及意涵

＊提供新手友善舞台，家庭/兒童服務機構作兒保的傳統改變

＊縣市政府嘗試錯誤、盤整地方資源

＊中央主導：使縣市政府投入資源服務家庭、以社福評鑑/學者專家界定開案、結案、分級處遇標準

＊個別父母不當(1993)→家庭資源不足(2003)→次級預防還是擴大污名化？

問卷調查(2012 年初)：政府 vs.民間兒少保社工、兒少保困難、兒少保離職現象、國家分擔、階層效應

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Topic: 具體落實"為兒童三個一切原則"之普世價值正確方向及方法

課程大綱：

1. 現今社會不斷有兒童遭受虐待事件發生，為了保護這些弱勢兒童，讓更多醫療人員可以在第一時間發現受虐兒及時通報司法單位，不讓受虐的兒童再度回到充滿暴力的家庭，遭受更多傷害。
2. 各級醫療機構應致力於兒童保護法制、經驗、心態及政策之建立，且兒童一旦遭受虐待、疏忽、性侵害時，立即採用正確、直接、有效及實用之方法，使受虐兒童的心理與發展能得到周全完善之照護。
3. 如何提供兒童保護之新普世價值思維，藉此提升醫療人員對於兒童保護處理之知能。
4. 醫療糾紛目前在實務上有就法理、醫理、事理常情、心理、數理（機率）、情理等各層面切入研究，希能建立具體客觀之普世標準而不斷努力，在檢察官、法官開庭的業務部分，主要為民刑事訴訟案件之起訴、判決及行政機關之鑑定，因司法官各自獨立認定事實及適用法律，依承武的經驗在開庭時有時理、勢、權、術及機智的運用較弱者，似仍吃虧，故亟須醫界法界實務應精益求精，朝認定事實及適用法律希能建立具體客觀之普世標準而不斷努力，而有所依循之方向及標準。