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# Assessment and management of adults and children in cases of fabricated or induced illness (FII)

COLLEGE REPORT

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# Disclaimer

These Guidelines have been prepared by members of the College's ERG and represent a reasonable body of medical opinion on what is a complex behaviour and the medical disorders known to be associated with it. Any views expressed in the Guidelines are those of the members of the ERG, and not of their employing Trusts. The Guidelines are for general information only. They do not constitute medical, legal or other professional advice, and appropriate advice should be sought on the facts and circumstances of any specific case. You should not take any action, or refrain from acting, based solely on these Guidelines.

# The consultation group

## The FII Expert Reference Group

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# Executive summary

This document provides guidance for mental health professionals (MHPs), including psychiatrists, who may be asked to assess and manage adults and children where there is evidence of or concerns about abnormal illness-related behaviour by care-givers. It also discusses why this behaviour may have occurred, guides the assessment of present and future risks, and explores the possibility of a change in behaviour. For the purpose of this document, we refer to this behaviour as fabricated or induced illness (FII).

This information supports professionals who are involved in court proceedings and general clinical practice by providing guidance on how to recognise FII presentations, and how to assess and manage them. It applies to all situations in which adult care-givers (usually parents) are suspected of reporting (or do report) exaggerated, falsified or fabricated accounts of symptoms with respect to a vulnerable person who is dependent on them, or who induce illness in the vulnerable person, in order to make them appear to be genuinely ill.

A brief background account of these behaviours is provided, together with general advice about assessment, management and preparation of reports for the family and/or criminal court. It should be read in conjunction with the General Medical Council's guidance on child protection *Protecting Children and Young People: The Responsibilities of All Doctors* (General Medical Council, 2018) and their guidance on expert testimony *Acting as a Witness in Legal Proceedings* (GMC, 2013).

Readers are also advised to consult the Royal College of Paediatrics and Child Health guidance on this issue *Fabricated or Induced Illness (FII) by Carers – A Practical Guide for Paediatricians* (Royal College of Paediatrics and Child Health (RCPCH), under review – to be published early 2020) and the Department for Children Schools and Families 2008 guidance *Safeguarding Children in whom Illness is Fabricated or Induced* (HM Government, 2008).

Note that throughout this document, any reference to 'child' also applies to vulnerable adults. The terms 'carer' and 'care-giver' are all used to describe the perpetrator; in some cases they are interchangeable, and may refer to a parent or another person with similar responsibilities.

# Key messages from this guidance

- 1 The recognition of FII is made in children and is based on paediatric assessment with exclusion of other disorders. The only exception is when the presentation is in the context of CAMHS (Child and Adolescent Mental Health Services), whereby the factitious 'symptoms' are related to a mental health diagnosis in a child.
- 2 MHPs – including psychiatrists – should ensure that they stay within their field of expertise, and should remind other professionals that FII is not a mental-health diagnosis in adults but a description of symptoms in children caused by the adult's behaviour.
- 3 When assessing adults, MHPs should not provide an opinion about what has taken place until there has been a definitive paediatric or child mental health opinion about the presence or likelihood of FII. Other than cases involving a mental health diagnosis in children, adult MHPs should not refer to FII or determine whether adults have demonstrated FII behaviour.
- 4 Where there are family court or criminal proceedings, it is essential that psychiatrists do not provide opinions on disputed facts because these will be determined by the court in a fact-finding hearing.
- 5 For many carers, the underlying focus of these behaviours is based on a belief that there is 'something wrong' with the children in their care, and this belief is associated with psychological gain when the children's illnesses are recognised (or the children are perceived to be more ill than they actually are). Among parents, this differs from normal parental anxiety because they fail to be reassured by healthcare professionals, and they have an increased risk of dysfunctional relationships with healthcare professionals. For other parents, there can be a belief that only healthcare professionals can provide the care which the child needs.
- 6 FII can arise in association with other forms of child maltreatment such as physical abuse and neglect.
- 7 FII-related behaviour in adults may be associated with a range of psychiatric diagnoses or no psychiatric diagnosis. Where FII-related behaviour is suspected, a psychiatric diagnosis does not provide evidence of wrong-doing.
- 8 Any opinions on present and future risks for these children must consider the literature on child maltreatment – not just the literature on risk related to mental disorders in general.

- 9 Cases of FII can occur in children who do actually have a physical of psychiatric disorder, and concerns about FII may arise while children are being treated for a verifiable condition. Thus it is essential that psychiatrists do not make an assessment in an adult before the child's health has undergone extensive paediatric or CAMHS scrutiny.
- 10 All health professionals working with care-givers, especially GPs, perinatal and liaison psychiatry teams and adult MHPs as well as paediatricians and CAMHS should consider the possibility of abnormal illness-related behaviour involving children or other dependents. If FII is suspected, national and local safeguarding policies should be implemented and responsible professionals – especially named doctors and the health safeguarding team – should be informed and involved.



# Definitions

In this guidance we describe highly abnormal illness behaviours by care-givers, which cause direct psychological and physical illness or injury in children and indirectly from doctors. These behaviours have been given different names (e.g. Munchausen syndrome by proxy, or medical child abuse). For ease we will refer to it as Fabricated or Induced Illness (FI).

FDIoA (factitious disorder imposed on another) is defined in DSM5 (American Psychiatric Association, 2013; p.325) using the criteria set out below.

“ The identification of the behaviour is based on the following criteria:

- Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.
- The individual presents another individual (victim) to others as ill, impaired, or injured.
- The deceptive behaviour is evident even in the absence of obvious external rewards.
- The behaviour is not better explained by another mental disorder such as delusional disorder or another psychotic disorder.

This diagnosis is applied to perpetrators, not victims. ”

The FDIoA criteria however are not applicable in all potential cases of FI because deception is not always present. Whether or not the care-givers' behaviours meet all the criteria above, behaviour leading to FI is still a form of abuse of a child or vulnerable adult. The abnormal care-eliciting behaviour of the care-giver usually also manifests as an abnormal relationship with healthcare professionals that has an adverse effect on the child (Bass *et al.*, 2014).

# 1. Background and context

## Fabricated or induced illness (FII) and abnormal health-related behaviours

Adults in caring roles can demonstrate unusual, risky forms of behaviour that involve repeatedly presenting a child or dependent adult as being ill or disabled and in need of treatment, even when there is no evidence of illness or disability. In cases of genuine illness, the extent of the illness is exaggerated. Despite being told that there is no illness or disability, these carers continue to seek care for the child. This behaviour has also been reported among professional carers of vulnerable adults and elderly people.

The incidence of this behaviour is unknown but is widely believed to be under-recognised (Bass *et al.*, 2014). An early UK-based study (McClure *et al.*, 1996) estimated a combined annual incidence of FII, non-accidental poisoning and non-accidental suffocation of 0.5 per 100 000 children aged under 16, of 1.2 per 100 000 in those under 5, and of 2.8 per 100 000 for those under 1, and these figures are probably underestimated.

A more recent population-based prospective study (Ferrara *et al.*, 2013) in Italy, found that 14 out of 751 children (2%) who were referred to a paediatric unit were diagnosed with factitious disorder; when applying strict criteria, FII was identified in four (a prevalence of 0.53%).

Comparatively little is known about the normal range of illness-related behaviours demonstrated by parents and care-givers in general community settings. The average number of GP consultations by parents for children up to the age of 4 is 7.5 per year, dropping to 2 or 3 per year for children aged 5 (Hippisley-Cox and Vinogradova, 2009).

Although first-time parents tend to consult GPs more often, frequent consultations are also associated with anxious attitudes of parents to illness, and somatising behaviour (Garraida, 2010). Many cases of FII begin with increasing levels of consultations. High levels of consultations (especially if associated with other concerns) may trigger child-protection investigations, and these cases have little in common with the more frequent consultations related to maternal anxiety.

It is often not appreciated that cases of FII can occur in children who already have a physical disorder. Concerns about FII may arise while they are being treated for a verifiable condition. This is why it is vital that psychiatrists do not assess adults in the context of FII before the

child's health has been fully assessed by a paediatrician or CAMHS. FII involves a wide spectrum of abnormal illness-related behaviour by the care-giver, comprising a variety of forms that differ in severity and complexity. According to Bass *et al.* (2014), the following features may be present:

- very high rates of consultation with healthcare professionals (compared to normal rates)
- refusing or failing to be reassured by the results of investigations relating to their child that are normal, or by the reappearance of 'symptoms' after apparently effective treatment
- refusing to comply with suggested treatments of the child, and persistently reacting antagonistically towards healthcare professionals (this often leads to repeated presentations to different health services, sometimes known as 'doctor shopping')
- exaggerating the child's existing symptoms when they already have a diagnosed illness; the history may involve reports of unusual or life-threatening symptoms that do not appear to respond to interventions
- resisting medical diagnoses of common treatable conditions, and 'investing' in the child having a life threatening or rare condition (on which they alone are the 'expert')
- providing false accounts of non-existing symptoms (e.g. having fits or stopping breathing; exhibiting out-of-control behaviour; abnormal development; being unable to walk, be toilet trained or eat normal food)
- falsifying specimens taken from the child (e.g. contaminating body fluids; adding substances to urine samples to simulate a problem)
- tampering with lines and other hospital equipment (e.g. injecting medications or other substances into intravenous lines)
- actively inducing symptoms and signs of illness in the person they are responsible for (e.g. direct behaviour that causes physical harm such as administering medications inappropriately and smothering to simulate attacks of apnoea)
- claiming benefits and gaining financial support on the basis of the child's poor health.

Most cases of FII involve false or exaggerated reports of illness or symptoms. Illness induction is far less common, and it is not known whether false or exaggerated reporting progresses to illness induction. However, it is known that erroneous reporting, falsification of specimens and illness induction can co-exist and can stop and restart over time.

The false or exaggerated reports may not entail active deception or a conscious intention to mislead health professionals. Determining such intention is difficult and mental healthcare professionals are not trained to do it, so they should be circumspect when commenting about it, especially in the context of care proceedings wherein a judge will make a 'finding of fact' as to what happened.

If there is the possibility of criminal proceedings, mental-healthcare professionals must not comment on intention at all – this is the role of the jury. It may be that the care-giver has multiple and conflicting motives and significant anxieties about the child, and/or they do intend to deceive (e.g. to gain disability benefits). Illness induction and tampering with equipment or investigations (using their hands) nearly always involves deception.

You should bear in mind that some of the harm caused by FII often occurs with the inadvertent – but active – involvement of health professionals and the healthcare system. Excessive medical investigations and unnecessary interventions affect normal functioning of children, possibly causing anxiety and confusion, as well as occasional physical harm. They may also cause children to develop false beliefs about health status.

## Detection and recognition by professionals

There are a number of signs that are not *definitive* but may be *alerting signs* for FII. Chief among these are:

- discrepancies in the clinical picture (something does not quite 'add up') or a perplexing presentation in primary care, paediatrics or CAMHS
- non-existence of reported symptoms, when the care-giver is not present, and signs that are not observed by independent observers unrelated to the care-giver
- symptoms that improve or disappear when children are apart from the care-giver (e.g. at school, when staying with friends or relatives, or alone in hospital)
- reported symptoms and signs that are not explained by any existing medical condition
- inability of physical examinations and investigations to explain the reported symptoms or signs
- poor responses to medication or procedures that cannot be explained
- repeated reporting of new symptoms by the care-giver

- repeated presentation by the care-giver to different doctors (and selective failure to attend particular appointments)
- insistence from the care-giver for more investigations, continuation of (unwarranted) treatment, or demands for new treatment
- impairment in the child's daily life that is unrelated to any known disorder
- a past history of factitious disorder in the care-giver.

Both detection and recognition should be carried out by paediatricians or child MHPs following published guidelines (currently *Safeguarding Children in whom illness is Fabricated or Induced*; HM Government, 2008).

It is not the role of adult mental health care professionals to state if such behaviour is happening or has happened.

Detection depends on a low threshold for suspicion among healthcare professionals having good-quality information, and direct observation of the child. Induced illness results in greater morbidity or death, and may be more easily detected, and there are concerns that some types of sudden death in children may be associated with this form of child abuse (Craft and Hall, 2004; Galvin *et al.*, 2005).

It is very important to consider whether a care-giver presents as someone who could perpetrate other forms of abuse, such as neglect or physical abuse, and whether there are other risk factors for harm, such as severe mental illness, substance misuse or antisocial attitudes/personality disorder.

## Prognosis

A number of risk factors that are associated both with care-givers and children can inform prognosis (see Table 1).

## Adult care-givers as perpetrators

In most cases of FI, the mother is involved – either on her own or supported by the father. Fathers have only very rarely been found to perpetrate FI on their own

In all societies, the role of caring is seen as a valuable and important social duty, and care-givers are expected to provide 'good enough' parenting and care to the people who depend on them, especially children. We have conventional expectations of their 'illness behaviours', in terms of seeking advice swiftly, complying with professional advice, and following recommended and agreed treatments.

Table 1: Prognostic factors in adult cases of fabricated and induced illness (FII) (based on Bools and Jones, 1999).

Domain	Poor prognosis	Better prognosis
Maltreatment	Induced harm Sadistic element Accompanying childhood sexual abuse or physical abuse Deaths of previous children Harm to animals	
Child	Developmental delay Physical sequelae of FII Development of somatising behaviour	Absence of delay Absence of sequelae of abuse
Parent	Personality disorder Denial Lack of compliance Alcohol or substance misuse Abuse in childhood unresolved Somatisation	Personality strengths Acknowledgement of abuse Compliance Treatment-responsive mental illness Adapted to childhood abuse
Parenting and parent-child interaction	Insecure attachment Lack of empathy for child Puts own needs before those of child	Secure attachment Empathy for child Positive co-parenting
Family	Multigenerational abuse Interparental conflict/violence	Supportive extended family
Professional	Lack of resources Poorly informed and/or prejudiced	Partnership with parents Long-term psychological treatment and social casework
Social setting	Violent, unsupportive neighbourhood	Local child-support facilities
Isolation	Social support Involvement with false allegation network	

Indeed, the carers and parents of sick children and elderly or dependent people are socially and emotionally ‘rewarded’ – they receive public support for their ‘virtue’, and social sympathy for the demands put on them by someone else’s illness.

Carers may also qualify for tangible rewards in terms of benefits, employment conditions and financial compensation. Abnormal illness-related behaviours are more common in women, probably because of their caring roles in most societies, and various case series show that mothers who have healthcare or professional caring backgrounds

have been over-represented in this group (Yates and Bass, 2017). Perpetrator care-givers often make use of the internet and social media to publicise their 'case' and gather 'evidence' for their position.

Some parents who carry out this behaviour are apparently 'good enough' care-givers in other ways, and may be reported to be highly attentive and attuned to the emotional (and other) needs of their children, and other children, but some parents have a history or demonstrate current evidence of other concurrent forms of child abuse and neglect.

Siblings of affected children are known to be at higher risk of the same behaviour and increased mortality rates, but the behaviour may also be confined to one child. However even when other forms of child maltreatment have been identified, these perpetrators do not always resemble the usual stereotype of maltreating parents, and their histories may lack evidence of known risk factors for causing harm to others.

## Psychiatric diagnoses in adult care-givers

There is no consistent, predictable or functional link between any specific psychiatric disorder and such abnormal illness behaviour. However, there is some evidence that some perpetrators exhibit behaviours that are an extension of a somatoform or factitious disorder (Bass and Glaser, 2014; Bass and Jones, 2011; Marshall *et al.*, 2007; Schraim *et al.*, 2013). A diagnosis of personality disorder is also common, usually relating to emotional instability rather than an antisocial dimension (Bass and Glaser, 2014; Bools *et al.*, 1994; Sheridan, 2003).

It is rare to find psychotic illness in these cases, but associations with mood, anxiety, autism spectrum and eating disorders have all been reported. Some parents have experienced perinatal loss or unresolved bereavements, and some began to demonstrate abnormal behaviour during pregnancy, in terms of visits to antenatal clinics and admission to obstetrics and gynaecology services (Jureidini, 1993).

It is not unusual for the abnormal illness behaviour to start within weeks of a child's birth, and it may be associated with postnatal anxiety and depression.

FI is rarely an impulsive behaviour, but sometimes has a compulsive quality. The behaviour may be related to distress of the care-giver, manifest, for example, by taking a child to an accident and emergency department whenever they themselves feel anxious about anything relating to the child.

Exaggerated or false accounts of symptoms may reflect a desire to deceive healthcare professionals, but it may also reflect poor

management of anxiety, or low self-esteem or confidence levels. The active induction of illness in a child usually indicates a severe disturbance in the parent–child relationship, and is associated with the care-giver’s own insecure attachment and a hostile–helpless state of mind, as sequelae of childhood trauma.

It is important to remember that this behaviour may take place *in the* absence of any identifiable psychiatric disorders, and that the issue of FI and associated diagnoses among adults (such as factitious disorder and personality disorder) may be highly stigmatising.

## Understanding motivation: the role of attachment and illness narratives

The motives for this behaviour are subject to much speculation and research. It appears that these care-givers have an underlying need for the child to be recognised and treated as having ‘something wrong’ with them, and therefore in need of treatment.

The need may be based on a gain for the care-giver, or to confirm the care-giver’s erroneous belief and justify their anxiety about the child’s state of health.

The frequency of dysfunctional relationships with healthcare professionals suggests abnormal attitudes to care-eliciting and neediness, generally.

Care-giving and care-eliciting behaviours are known to be influenced by attachment in the child–parent relationship (George and Solomon 1999; Henderson 1974). Dysfunctional attachment can also lead to complex relationships with healthcare professionals, characterised by emotionally charged behaviour that is contingent on the response of a professional to both child and parent.

Such parents can become increasingly emotionally unstable unless the level of care they receive is high, and under their control. There may be real confusion in the parent’s mind about the boundaries between themselves and the child.

The key psychological issues that contribute to the development of abnormal illness-related behaviour appear to be associated with a history of attachment problems or other difficulties in the caregiver’s own parent–child relationship, and/or hostile and anxious attitudes towards vulnerability and illness in themselves and their child.

Hostility and anxiety related to distress may manifest as a preoccupation with illness, or as ambivalence or anger expressed in



relation to healthcare professionals and/or other care-givers.

One possible mechanism for the behaviour relates to care-givers projecting their anxiety onto the child, who in turn receives the attention and care that they either consciously or unconsciously crave.

Another possibility relates to an inability to tolerate normal anxiety or distress in a child; they 'medicalise' the situation so they can justifiably demand that doctors and nurses take care of the child, while they remain a 'good carer'.

Alternatively, they may respond to vulnerability and neediness in children with hostility, whereby constructing an illness narrative means they can get health professionals to take care of the child. The illness narrative protects them from the shame of not meeting cultural expectations of being a good carer, and relieves them of an anxiety that they cannot care for their children and will be criticised as 'bad parents'.

Fundamentally, the presence of FIJ suggests that the care-giver has either lost (or never acquired) a capacity to mentalise the vulnerable person's mind and experience. They develop an illness-in-others narrative in order to cope with distress and to shore up a fragile identity. Their behaviour usually helps keep the narrative coherent.

## Harm to the child

This care-giver behaviour carries a high risk of harm to children. Illness induction is known to carry a 6–9% mortality rate (Flaherty and MacMillan 2013; Sheridan, 2003), with similar rates for long-term disability. In over half of children affected, there is indirect psychological harm (relating to emotional abuse or neglect), which can result in anxiety, behaviour problems, and poor daily functioning, for example, poor school attendance.

Unnecessary investigations and treatments are unpleasant for children, and further impair their normal daily functioning. Furthermore, the siblings of these children are known to be at increased risk of illness and mortality.

# 2. Assessment of the child and family system

## Overall assessment and the management process

Assessment is usually stimulated by a 'perplexing' presentation (Davis *et al.*, 2019; Glaser and Davis 2019). Once medical professionals have made sufficient investigations to rule out an organic pathology, a clear message about this lack of diagnosis must be given to care-givers, in positive or reassuring tones. This is known as a 'good news interview'. The interview is then followed up with a letter to other relevant professionals and family members, again giving a clear message that the child is not unwell. This is shown diagrammatically in Figure 1 (overpage).

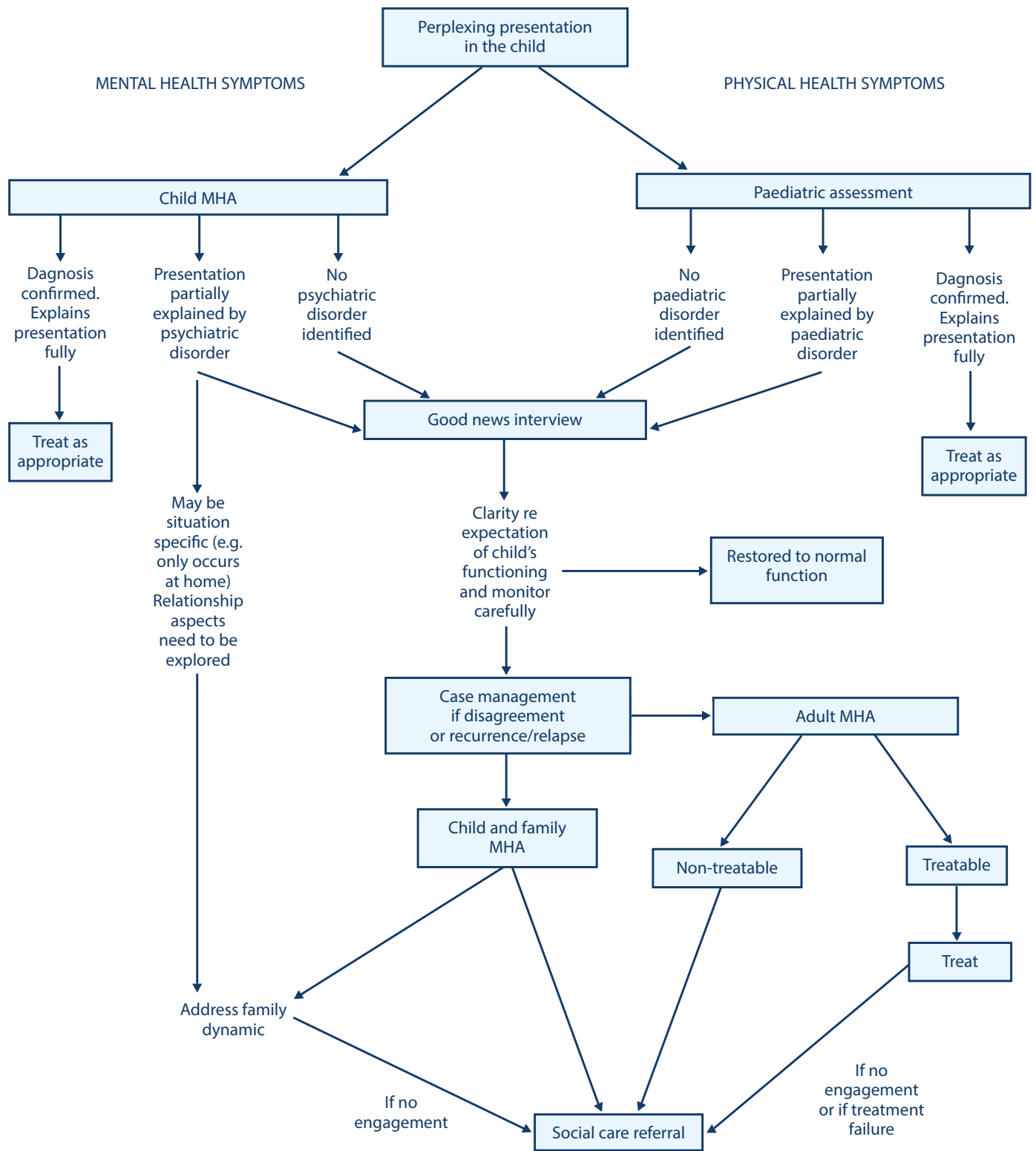
## Guidelines for child mental health workers for suspected FII

CAMHS workers may receive psychiatric referrals which suggest an FII pattern of behaviour, such as a discrepancy between parental report and independent observation. In such cases the assessment will place less reliance on standard parent-reported questionnaires and developmental history.

If reported psychiatric symptoms are situation-specific, occurring only at home, a careful assessment of family relationships is indicated. If there is a diagnosable psychiatric condition, the extent of impaired function should be entirely explained by the diagnosis.

CAMHS liaison psychiatrists may be asked by paediatricians to consult on management, where there are perplexing aspects to the presentation or a concern about over-medicalisation. Here they must support good paediatric practice to identify any underlying organic pathology, initiating treatment as necessary.

Figure 1: Assessment and management process for mental and physical health symptoms in perplexing presentations among children



(MHA = mental health assessment).

Where loss of function and other symptoms is not entirely explained by a diagnosis or alleviated by suitable treatment, a family assessment by liaison mental health professionals is indicated. However, prior to any mental health involvement there must be paediatric feedback to the family, orally and in writing, about any diagnosis and appropriate management.

Clear paediatric expectations about level of functioning for the child, including mobility and attendance at school, should be set out. Note that findings such as hypermobility may not explain fully the extent of loss of function.

Successful liaison work in these cases relies on paediatricians maintaining their involvement. It is vital that the family witness the close collaboration between paediatrics and mental health. This requires strong case management and clinical leadership with clear role definitions and good communication within the professional network. (See MDT working section).

CAMHS professionals may also receive referrals from social workers with similar concerns. In most cases the referral is not appropriate as it needs to be dealt with by paediatrics before any CAMHS involvement, the exception being where a psychiatric diagnosis is the subject of concern.

## Assessment of children and family

The referral for assessment of a child and family may have several aims, including assessment of the child's development and functioning, harm to the child, the functioning of the family, and the family and care-givers' capacity to change. This information also relates to non-parental care-givers. Independent observations of the child's symptoms and functioning, such as at nursery or school, are of crucial importance.

Medical over-investigation and treatment can lead to iatrogenic harm. In rare cases the child's physical health may be put at immediate serious risk by parental behaviour. These concerns indicate the need for a referral to children's social care, without notifying the parents about the referral.

Harm and the risk of harm to the child should be considered with respect to:

- relentless parental distortion of the child's identity and self-beliefs
- the impact of school non-attendance on social and academic development
- the child's physical health (in rare and extreme cases this may be at risk)

- risks as a result of continued doctor-shopping (e.g. over-investigation and overtreatment, i.e. iatrogenic harm)
- the need for a child protection plan, pending assessment of the family's capacity to change.

The child's understanding and beliefs regarding their state of health and their wishes in relation to health and daily functioning (e.g. attendance at school and hospital appointments) should be explored. Assessment of harm and risk should be assessed in regard to parental distortion of the child's identify and self-beliefs and the impact on development (e.g. social and academic) of restricted school attendance.

A comprehensive assessment of family functioning should be carried out looking closely at attitudes and beliefs around health issues. The couple relationship, including the extent of shared beliefs around health issues and care of the index child, should be explored.

Parent-child relationships, including the nature of attachment patterns, are very important. All siblings should be seen and assessed regarding possible impact on them of parental behaviour towards the indexed child, and also the possibility that the parental behaviour of concern extends to other siblings in the family.

The father's role, if the mother is the perpetrator, should be assessed carefully for possible collusion or for signs of independent and healthier psychological functioning and parenting.

Mental health issues in a parent may indicate the need for a referral to an adult psychiatrist. The adult psychiatrist should explore both psychological maintaining factors in a parent and any financial or material gain (Disability Living Allowance or Personal Independence Payment, or modifications to the home for a child with disability).

The assessment of family functioning covers many factors in all members of the child's immediate family, including:

- parental understanding and agreement about the child's health and management
- the couple relationship
- the relationship of the child with one or both parents
- the impact of parental preoccupation with the child's health matters on other children in the family
- extension of the health behaviour to other siblings
- the family's functioning and the impact of their attitude to health issues
- factors that maintain the parental behaviour (e.g. attention from professionals that satisfies unmet parental needs, or parents' avoidance of other significant stressors)

- parental mental health (e.g. anxiety, delusional beliefs, autism spectrum disorder, which may require assessment by an adult psychiatrist)
- financial and material gain (e.g. Disability Living Allowance, modifications to house).

During assessment of the family's capacity to change, any parental mental health disorders must be adequately treated. It is important to assess the level of insight, which may vary and fluctuate. The assessment should cover issues such as:

- negotiating and obtaining agreement of clear, measurable goals for behavioural and functional change that relate to the child's functioning (e.g. school attendance, use of a wheelchair or helmet)
- gaining agreement not to seek further medical or surgical opinions
- inappropriate parental reinforcement of the child's health status (e.g. claiming disability allowances, inaccurate statements of special educational needs, inappropriate use of disability resources)
- therapeutic work that acknowledges that change will entail losing any gains provided by the maintaining factors
- a time-limited trial of 3–6 months, in line with the child's developmental needs
- non-compliance with recommended treatment (that indicates a lack of capacity to change) or further long-term treatment if the assessment is positive.

It is essential that this assessment of the parent–child interaction and assessment of capacity to change is carried out before continuing contact between parent and child is planned, if the child has been separated from the parent.

## Assessment of adults suspected of FII behaviour

Adult mental-health professionals may come across possible FII/FDloA cases in various ways. The assessment may be complicated because the adults are often identified and sent for assessment in the context of stressful investigations and legal proceedings that involve children.

## Assessment when abnormal illness-related behaviour is suspected but no formal legal proceedings are underway

This is an unusual situation because most mental health assessments are sought in the context of legal or social-care proceedings. It is possible, however, for adults to be referred for a general psychiatric opinion by their GP when a paediatric team or CAMHS has concerns about a parent's presentation or relationship with them.

Mental healthcare professionals need to take steps to find out whether abnormal illness behaviour is truly suspected because this usually triggers a child protection investigation. It is vital for MHPs to ensure that:

- they have full information about any ongoing legal processes, whether civil, child protection or criminal
- they liaise using standard policies and procedures in relation to the safeguarding of children
- they do not take on roles outside their remit
- the person they are assessing knows the reason for their referral
- there is agreement and consent about how the outcome of any assessment will be shared, and with whom, especially if information is to be shared without consent or if refusal to disclose is to be over-ridden.

A detailed history is essential and it should be longer than usual, and cover the following aspects:

- a complete developmental history covering the care-giver's own experiences of childhood trauma, illness or hospital treatment
- full details of any experience of illness, hospital treatment or bereavement in the family (including grandparents)
- an assessment of their attitude to care-giving and eliciting care for themselves (e.g. how they relate to their own GP or other care-givers and dependants)
- a detailed history of any allergies, medically unexplained pains and symptoms, and experience of long-term conditions
- their attitudes to becoming a parent, and (if female) of their experience of pregnancy and labour
- evidence of behaviours or attitudes that might indicate the presence of antisocial behaviour or attitudes, cluster B personality dysfunction, or eating disorders.

If the adult has been referred for an ordinary psychiatric assessment, with no legal structures or procedures involved, then there are key questions to address with the patient, relating to:

- the nature of the concerns

- who has the concerns.

The assessment with the psychiatrist may be the first indication to a parent that there are concerns about their parenting, or that their view of their child's 'symptoms' or 'illness' is not supported by paediatricians or GPs. In these circumstances, parents may become angry, anxious and distressed.

It is important to be frank about the purpose of the assessment and the concerns that have been raised. It is also important to be clear about the limits of confidentiality in relation to the welfare of children.

Referral to the psychiatrist may also be made via liaison psychiatry, due to concerns raised by a medical or surgical team about abnormal illness behaviour.

For example, a general medical team may refer a case of severe somatisation and highly abnormal illness behaviour on a general medical ward or in the accident and emergency department.

While no risks to children may have been identified, it may become clear at assessment there are dependent children who might be at risk.

The assessment interview may be an opportunity for the care-giver to talk about their anxieties and distress and any psychological care needs they may have. For some, this may be the first time they allow themselves to see that they are in need (as opposed to their children), and it may allow them to think about what their lives would be like if they were not caring for a sick child. Psychiatrists may need to use all their supportive skills to help them think about and take their own distress seriously.

Direct challenges about exaggeration or misrepresentation are not advisable at the initial interview – they can come later, when rapport and trust have been established.

Formulation is important in complex cases like this because the behaviours may reflect a dysfunctional attempt to deal with distress. It is also helpful to formulate both the origin and maintenance of the behaviour, as well as the potential risks to other people.

## Assessment in medico-legal contexts

It is vital that the MHPs understand what legal question is being asked of them, and in what context (some advice about the provision of court reports is set out in the Recommended Reading section; and detailed ethical guidance from the College is set out in Council Report 193 (RCPsych 2013).



The health professional may be asked to provide a professional opinion or an expert opinion. If an expert view is required, they need to consider carefully whether they have sufficient experience to provide an expert report. If they feel they cannot do so, they should refuse any instructions.

It also matters whether the proceedings are in a family court or a criminal court. In practice, the family court usually takes place first to address child welfare and protection, and it makes findings based on the balance of probabilities. They will certainly ask for expert advice about risk to children and possible treatment of the caregiver.

Any criminal investigation and proceedings may only be initiated once the family court has made its findings, and it may seek psychiatric evidence from MHPs and experts. The criminal court may also seek testimony about what treatment is indicated for convicted perpetrators, and whether they should be sent to hospital or prison. In practice, it is rare for perpetrators to be detained in secure psychiatric care.

The nature of any professional's opinion depends on the circumstances of the case and the age and welfare of the child. It is good practice for a psychiatrist assessing an adult to have sight of their primary-care notes, and they must obtain and consider any paediatric findings. They should also consider the views of any CAMHS professionals, who may need to be asked for their view on the child's psychological needs, and whether there is any possibility of family therapy or reunification.

The family court must put the welfare of any children as paramount, and adult psychiatric opinions need to take this into account.

# 3. Management

## Multidisciplinary working

The multidisciplinary team may involve many organisations and professionals, depending on the specific case, and may include GPs, health visitors, school nurses and other school professionals, as well as children's social services. It is vital for adult psychiatrists to liaise, wherever possible, with any paediatric or CAMHS services involved with the children, as well as their GPs. It is especially helpful if they share formulations and advice about treatment.

Children's social services may or may not be involved in the children's care, and MHPs need to establish in each case the exact role and function of social services, both in the short term and the long term. MHPs are expected to work with local child protection services in relation to child safe-guarding, and it is vital that there is good liaison and communication.

These safeguarding processes both call for information and allow that information to be shared between all professionals on the multidisciplinary team.

Some cases of concern do not reach the threshold for management or intervention by social care services, and they can be particularly challenging. In such situations, a professional lead should be chosen, with clear delineation of everyone's roles.

Goals for progress need to be agreed and monitored by the lead professional, and all professional meetings should be carefully documented. To ensure all professionals stay focused, action points should be agreed within a reasonable timeframe, and progress should be reviewed regularly, not only by hospital-based professionals but also by community-based professionals such as GPs, health visitors and school nurses.

If an adult's abnormal behaviour persists, the professionals must make their concerns clear, pointing out any negative impacts on the children involved. They must agree goals for change: examples include school attendance or agreement with the adults not to seek further unnecessary medical appointments or medical opinions.

## Child protection

If an adult mental health assessment finds evidence that supports concerns about the safety of children, the child and any associated concerns must immediately be reported (according to local safeguarding children guidelines) to the children's social care services, in addition to the child-safeguarding leads, GPs and health visitors.

The Children's Social Care Emergency Duty Team (EDT) may need to be involved out of hours, if necessary.

If the EDT is used as the initial contact, then follow up is essential, within working hours, by telephone and in writing. Note that if a named child is identified as being at risk, other children may also be at risk, and information on all potentially vulnerable minors should be provided.

When there is uncertainty, especially if a professional is inexperienced, an initial discussion should be conducted with a senior colleague and/or line manager. The local named doctor for safeguarding can provide information and advice. Designated officers (DOs) may also be of assistance, providing advice on the necessary safeguarding actions.

Protocols for child protection in cases of FII vary between local authorities. In some safeguarding policies, the family should not be informed before children's social care services have conducted an initial safeguarding assessment. This is because there is the possibility of an escalation of risk to children, of physical or emotional harm, or that the parent(s) might abruptly remove the child and flee elsewhere to avoid investigation.

It is essential to consult local safeguarding policy information and the duty social worker. Guidelines provided by National Institute for Health and Care Excellence (NICE) and the RCPCH are also useful. All safeguarding policies should be taken in consideration. Remember that the child assessment may be carried out when children are subject to a Child Protection Plan, or Care Proceedings.

## Treatment of children and their families

An emerging consensus based on expert opinion is described by Sanders and Bursch (2019). This model integrates child, adult and family treatment with transparent acknowledgement of child protection risk. Sometimes the treatment is carried out in the context of ongoing court involvement and removal of the child from the home. Successful treatment will then be necessary for any successful rehabilitation to take place.

All treatment takes place in close collaboration with the wider multidisciplinary network including social workers, medical professionals and other mental health workers.

Treatment must address the general parent–child interaction and family relationships, underpinned by a formulation of the psychological drivers behind the parent or carer’s needs to present the child as being ill or more disabled than they are. Separate psychological treatments for the carer may be indicated. The carer may, however, refuse to engage, even if treatment is available.

Therapy for carers may also not be available in a time frame that helps the child. Interventions aimed at the parent–child relationship can be successful even without treating the adult specifically – if there are sufficient indications of treatability, such as acceptance of the medical findings or an agreed child health-management plan.

Adults must show some awareness and acknowledgement of the harm caused to the child, as well as motivation and the ability to change their behaviour and interactions with the child.

Trial for change interventions begin with two or three sessions to assess the capacity for change, and are ideally carried out by a child mental health professional with appropriate experience in the area, who liaises and works jointly with adult MHPs as needed.

Trial for change interventions work best when they are underpinned by a statutory child protection framework (such as a Supervision Order) to ensure compliance, and should be carried out if continuing contact between the care-giver and child is planned.

The core intervention addresses the parent–child interaction with the illness-reinforcing parent. However, several problematic interactions commonly need to be addressed, including:

- poor psychological boundaries between the adult and the child
- over-exposure of children to parental anxiety, especially when there is illness
- attachment issues (e.g. insecure, disorganised types)
- poor emotional attunement (e.g. misreading or ignoring the child’s cues)
- failure to encourage the child’s developing individuality and autonomy.

The parent–child work aims at reaching a point when the parent can give the child a true account of the child’s state of health. However, disguised compliance by the care-giver needs to be guarded against.

A variety of other treatments may be helpful, such as

- parenting courses or attachment-focused interventions, depending on the findings of the assessment. Family work may be ineffective if there is collusion by the partner or extended family members.
- In pre-adolescent children, individual work is unlikely to be effective without addressing parental behaviour. Therapy needs to address the child's distorted self-belief regarding illness and identity as well as addressing a range of psychological issues resulting from abusive parental behaviour.

Some children will need a great deal of support to relinquish the role of 'sick child' and many will struggle to come to terms with a more realistic understanding of their parent, which involves integrating positive aspects of the relationship with new knowledge of harmful behaviours. Help with coping strategies to manage anxiety is often needed.

## Treatment of adult care-givers

Many factors must be considered in the treatment of abnormal illness-related behaviour in adults, and there is a lack of an evidence base from which to advise.

A general over-view is provided by Sanders and Bursch (2019) who note that the lack of evidence is caused by the fact that so few perpetrators are offered treatment.

In the USA and other jurisdictions, treatment for perpetrators can be mandated by a court, but in the UK this is rarely used because community mental health services will not take such people on for treatment.

It is rare for a parent or carer to admit straight away that they have behaved abnormally – the process of accepting the reality of their behaviour usually takes many months. This need not be a bar to treatment, as insight may develop when therapy is offered.

Given what is known about the severity of the psychopathology of these adults, most therapeutic interventions take 12–18 months to complete.

Most of those who are identified as having carried out risky behaviours in relation to their children or dependants are separated from them, thus losing their caring role. They may undergo both civil and criminal proceedings, which can lead to delays in assessment and engagement in treatment.

A significant number of women disappear in these circumstances, to try and make a new life elsewhere, perhaps by getting pregnant, without having a chance to think about what happened.

Perinatal services should be aware of situations like this and make detailed enquiries about mothers who have had children removed, and the reasons for removal.

General services may be reluctant to offer therapy in cases that are too complex or risky (yet not risky enough for forensic services); furthermore, the majority of perpetrators are female, which is a situation that may be unfamiliar to general psychological therapists.

Treatment also involves treating other psychiatric conditions, such as depression, anxiety and obsessive–compulsive disorder, which should be delivered by local psychiatric/psychological services, according to current guidelines. Treatment entails the adult ‘giving up’ their previous illness narrative, and taking their own distress seriously. It also requires that they change their relationship with their own bodily symptoms as well as those of others, and to learn how to relate to professional care-givers in a new way.

Thus therapies that improve mentalising and perspective-taking can be helpful, as are those that allow them to change how they relate to their bodies and articulate distress.

## **What treatment entails**

Therapy for adults should be based on both a diagnosis and a risk assessment. Full disclosure of their behaviours may take some time and it is not likely to occur unless they have a trusting, non-judgemental relationship with the therapist. In early sessions, it is not necessary for every detail to be disclosed or admitted before therapy can start.

Some degree of ambivalence and denial is to be expected, and needs to be worked with. This does not mean that harm is condoned or that collusion is encouraged, but the therapist must allow time for the adult to engage and feel safe.

Therapists must be able to deliver a range of therapeutic techniques, depending on the specific symptom profile, and need to think systemically about the family and social systems around the adult and their children.

They must be experienced, confident and fully aware of the complexity of illness-related behaviour (e.g. personality dysfunction and somatoform disorders), as well as parent–child relationships and attachment theory.

Therapy for personality disorders and associated mood or eating disorders may be necessary, and provide an opportunity to talk about risk behaviours. Any treatment may focus on managing any risks to the child, especially when no other mental disorder is identified.

Attitudes to explore include those relating to:

- distress and coping style (especially maladaptive strategies such as substance misuse, eating disorders, self-harm, dysfunctional relationships)
- caring for themselves and others (especially when caring is coercive or controlling) or evidence of attachment difficulties or anxiety control
- neediness and vulnerability (especially in relation to children, elderly people and pets).

There may also be historical exposure to neglect and rejection, and discussions might address any illness and access to care and attention.

## Treatment options

Therapy for personality disorders and associated mood or eating disorders may be necessary, whereby engagement with such therapies provides an opportunity to talk about their risk behaviours. Any treatment may focus on managing any risks to the child, especially when no other mental disorder is identified.

Evidence-based therapies should be offered for any other problems or illness that is identified, such as:

- affect and arousal dysregulation
- poor impulse control
- medically unexplained symptoms
- any eating disorder.

Consider dialectical behaviour therapy (DBT), mentalisation-based therapy (MBT) and the judicious use of medication for affect and arousal dysregulation, and DBT for poor impulse control. For medically unexplained symptoms, short-term psychodynamic psychotherapies (Abbass et al., 2009) and mindfulness-based stress reduction (MBSR) may be appropriate. For perpetrators with eating disorders, appropriate NICE guidelines and clinical advice should be followed.

Interventions that promote mentalising about children's experiences depend on the degree of contact of the adult with the child. Specialist interventions include those which help parents reflect better about their child's mind (e.g. Byrne et al., 2018; Slade et al., 2005).

Among the poor prognostic factors in the treatment of adults are aggressive denial, non-engagement and pre-existing severe mental health conditions, such as severe factitious disorder, personality disorder, somatising disorder or OCD. Organisational limiting factors

include time taken for referral and assessment; lack of experienced clinicians leading to rejection by general services; and failure of specialist services (such as forensic psychiatry, liaison psychiatry or perinatal services to offer therapy).

While there are some case reports of successful treatment (e.g. Sanders and Bursch, 2019), there are others reporting that the FII resumed when the therapy was withdrawn. Jones (1987) suggests that such parents are very difficult to work with, particularly if there is entrenched deception and denial. Other poor prognostic factors relate to the child and include:

- a previous history of abnormal illness behaviour in the adult or child
- a child who is in a very unwell (medically unexplained) state, or has undergone repeated surgeries and interventions
- a child who is hospitalised and has an intravenous line or feeding tube inserted
- a child who is repeatedly taken to the accident and emergency department, with an escalating pattern of presentation
- a child with a known medical condition (e.g. diabetes) and a history of management concerns
- a child with a history of non-accidental injuries (NAI) or other safeguarding concerns



# 4. Future developments and research questions

There are many potential areas for research into this troubling behaviour. The lack of research and evidence to date is testimony to how complex the behaviour is, and to the huge confusion that can arise when so many different health services and professionals are involved.

For example, research based in specialist paediatric centres is not likely to pick up milder forms of abnormal illness behaviour by parents at the level of primary care.

Potential areas for future research must include aspects of the child experience, aspects of the parent's experience and aspects of the extended family (fathers and siblings and other family members).

Research should also address organisational and systemic blocks to detection and intervention.

The following areas are priorities for research:

- psychological outcomes for children affected by FII in the medium term and the long term
- identification of antenatal risk factors such as maternal health anxiety, somatisation and factitious disorders
- the efficacy and outcome of management interventions for AIB/FII (including engagement of care-givers in treatment)
- how to improve parent-child interaction and relationships after such behaviour has been detected
- psychological interventions for adult perpetrators
- the effects of adult somatoform disorder on children (prospective studies)
- the range of normal parental illness behaviour and contributing parental variables.

# 5. Further advice

## Part I: General advice for MHPs acting as experts in cases involving children or families

Extensive guidance is available for mental health professionals who provide medico-legal reports. We advise consulting the [College advice on expert testimony \(CR193\)](#), and refer those providing court reports generally to the GMC guidance (2018).

There has been much media criticism of experts of all professional backgrounds who are involved in child protection cases. Not all of the criticism is well founded, but there are real concerns about experts who:

- give evidence beyond their level of expertise
- give testimony that is out of date, not properly evidenced, or lacking an empirical knowledge base
- address questions that are the province of the judge, jury or other fact-finding body
- provide biased testimony, through intrusion of personal values into the substance of expert testimony.

Before preparing any type of report for court, it is essential to be clear about the following:

- the type of proceedings in which the report is to be used (e.g. criminal, civil, family)
- the issues under consideration
- the role of the witness (i.e. professional witness or expert witness).

Note that a professional witness gives testimony about their professional experience of a patient (usually as a treating clinician). An expert witness gives testimony on a subject on which they are expert, which is then applied to the individual involved in the litigation.

It is essential to the expert's objectivity that they do not have a personal or clinical relationship with the individual involved.

Experts may be instructed on behalf of an individual involved in the case, or by all parties on behalf of the court. All clinicians should be aware of their obligation to assist the court in respect of professional evidence, and their obligations to their patient in respect of confidentiality.

They should also understand their obligations to the 'public interest' and any ongoing child safeguarding process. If there is any doubt, seek legal advice from those instructing, and consider the GMC guidance and the practice advice to experts (GMC, 2013).

In respect of proceedings involving the Children Act (2004), the expert is instructed on the basis that the interests of the child are paramount.

It is unwise for treating clinicians (e.g. of a parent) to accept this form of instruction because it creates a conflict between their duty to the court and their duty to the patient.

In general, it is not good practice for treating clinicians to provide expert testimony about one of their patients. However, they may provide *professional* testimony.

Those giving evidence in a family court must be able to show that they have the necessary training and expertise to do so. Psychiatrists and psychologists who work primarily with adults cannot assume to comment on parenting capacity, and child psychiatrists may be unable to comment on adult risk.

## **Cases involving suspected false or exaggerated accounts of illness, suspected fabrication of symptoms, or induced illness in another**

### **Accepting instructions**

In general, MHPS who work with adults have no role in proceedings concerning FII until the child has been fully assessed by a paediatric expert who then presents their conclusions about the origin of the child's presentation or 'symptoms'. You should not contribute to any debate over the child's medical condition unless you are a qualified paediatric expert.

When a paediatrics expert offers an opinion that the child's presentation has been exaggerated, induced or fabricated, it is likely that their view will be contested, and the mental health expert cannot proceed on an assumption of guilt until the judge has provided a 'finding of fact' based on the paediatric evidence.

It is not unusual for mental health experts to be instructed at the same time as paediatric experts. The instructing solicitors must be made aware that any conclusions are tentative, pending the court's judgment. For cases that have to be concluded within 12 weeks, it is increasingly common to be asked to provide a variety of opinions to cover various alternative findings in the case (e.g. if the court finds for or against the expert paediatric evidence).

Time spent in discussion is valuable. Before accepting instructions, discuss with the lead solicitor what type of case it is. Also discuss the issues before the court, and the type of questions asked of the expert.

Solicitors may have an unrealistic expectation of what information the care-giver psychiatric assessment can provide. It is not uncommon for instructions to contain unanswerable or inappropriate questions (e.g. Does the parent have FII or FDIoA? Is the parent deceptive?).

Solicitors may also confuse the professional roles of psychiatrists and psychologists, and may, for example, ask a psychiatrist to respond to questions about a child's behaviour, the family dynamic, or psychometric tests.

Experts are likely to be criticised by the court if they accept instructions that have not been adequately considered, or if certain questions are deemed to be beyond their expertise when the report is due for submission.

In an effort to save costs, the Ministry of Justice has issued the Legal Aid Agency (LAA) with guidance on the fees due to experts in court proceedings.

The most recent guidance can be found on the LAA website. Up to 15 hours are allowed by the Ministry of Justice for a psychiatric report, and usually this timeframe is adequate. In FII cases, however, reports often take far longer than this, especially if there is evidence of factitious disorder in a parent – their medical records may run to hundreds or thousands of pages.

It is essential to revise the time and cost estimates on receipt of the court bundle and medical records, and to ensure that the instructing solicitors obtain additional time or certified funding (from the Court or LAA) before work commences. The instructions should be accepted on the basis that these parameters may change when the full extent of the work becomes evident.

## **Information required**

Evidence should be considered from as many sources as possible. The medical records of the person involved in proceedings (including primary care notes and hospital notes) must be reviewed in advance of the clinical interview, so that the findings and any discrepancies can be considered.

It is helpful if there is a chronology of hospital attendances, especially if the notes are extensive, or when factitious disorder is suspected. If the notes are late, the right to re-examine the client when notes are received should be reserved.

A paediatric review of the child's notes with a detailed chronology are essential for understanding which medical treatments were necessary, and which were based on false or misleading accounts. Adult psychiatrists who act as experts should not express their views about abnormal illness-related behaviour until they have reviewed such information.

It is equally important for paediatric experts not to exceed their level of expertise and give opinions about the mental state of the adults involved in proceedings, or their intentions. This is a matter for the family court or the criminal court (or both). For example, they should not give statements suggesting that (by virtue of a particular mental health diagnosis) the adult is more likely to have harmed the child.

All experts should be reminded of their duty not to go beyond their expertise. In the event that a paediatric expert does overstep their remit, for example, it may be necessary to challenge misleading statements about the adult's mental state and its relationship to the findings in the children.

While it is often useful to review children's medical records to put the paediatric analysis into perspective, this is not an invitation to comment on issues outside one's own area of expertise.

### **Engaging with the care-giver during assessment**

Although FII represents a range of behaviours that may appear bizarre to professionals and non-professionals alike, thus warranting a psychiatric explanation, no single psychiatric disorder has been associated with it.

In fact, there are many cases in which the care-giver has no apparent psychiatric disorder (although there may be psychological disturbance).

Those who ask for a psychiatric opinion must be made aware from the outset that a psychiatric diagnosis will not 'prove' that a parent or caregiver has carried out FII, nor will the absence of mental illness preclude it.

Parents (usually), who are the subject of these assessments, need to be approached with sensitivity, with recognition of the pressure they are under. They often feel they have been 'judged as guilty' so it is helpful to explain carefully the basis of the assessment and reassure them that the expert is independent of all parties in the case (especially the local authority).

It is also helpful to clarify that the mental health practitioner is not in a position to take a view on whether or not the child has come to harm, because this is being done elsewhere.

## **Capacity and consent of the care-giver**

The care-giver's capacity and consent to participate at the assessment should be formally recorded. They need to know that when they are being seen by a clinician, their confidentiality is limited; the interview will be used to prepare a report for submission to the Court, and will be shared with all parties to the case – and possibly be made available more widely, depending on the decision of the judge.

If the care-giver asks for sensitive details not to be disclosed (e.g. explicit details about sexual abuse), the expert must decide whether disclosure is necessary for the report. It may be reasonable to note only the broad themes and state that the specifics were disclosed during interview and not considered necessary to report on in detail.

It is important to tell the care-giver that the Court has the power to compel experts to disclose such information. This should be borne in mind when writing up any clinical records, including expert reports.

## **The assessment process**

Psychiatric experts should take the carer's full history, as normal, as well as a detailed developmental history, paying careful attention to their early childhood, any childhood illnesses, and any history of family illness and bereavements.

There is good evidence that childhood attachment dynamics influence attitudes to the experience of illness and help-seeking in adulthood. Abnormal illness-related behaviour can occur in the parents of children who have been ill in the past or who have an ongoing condition.

Commonly there will be no obvious signs of mental disturbance. It is also likely that the care-giver will deny, or seek to explain away, everything claimed by paediatricians or social services. It is unwise to assume that there is no mental disorder because the parent is denying issues or seems calm.

Where there is evidence in the notes that contradicts their account, approach the issue with them as 'neutrally' as possible, in a 'spirit of enquiry'. It is vital for the expert to appear impartial and objective, and to be as empathic as possible. Confrontation and challenge are likely to generate defensiveness and complaints. Where facts are disputed resolutely, the carer's view must be accepted as one possibility, with the other party's view at the opposing pole of truth.

Experts must not give their view before there has been a 'finding of fact' by the court and, in the absence of this, it is important that they offer a range of opinions in the event of the court finding in favour of

the parents or the Local Authority. Hypotheses may be set out in the opinion sections of any report.

The examination should carefully explore any history of physical illness and any investigations. This includes exploring anything suggestive of somatising disorder and medically unexplained symptoms, including periods of sick leave and treatment, and tactfully exploring any aspect of the history that indicates factitious disorder or deceptive behaviour.

It is important to remember that a small proportion of care-givers and parents have antisocial or criminal backgrounds. It is best to review their medical records in advance to compile a chronological record of the documented evidence, and to bring up any anomalies with them. If this is not possible, another interview may be necessary at a later date.

### **Diagnosis of personality disorder**

A diagnosis of personality disorder is commonly found in cases of child maltreatment. It is therefore wise to screen for personality disorder using either the SAPAS (Standardised Assessment of Personality – Abbreviated Scale) (Moran, 2003) or IPDE (International Personality Disorder Examination) (Loranger et al., 1997). When personality disorder is suspected, it may be helpful to obtain a psychological assessment using more formal measures.

### **Other sources of information**

The paediatric and primary-care notes for both the care-giver and the child will have been requested, and scrutinised before meeting the caregiver.

Examination of the paediatric and GP records, in the light of the conclusions of the paediatric expert, may provide detailed information about the behaviour of the care-giver, and the way they interact with healthcare professionals.

This is especially useful for identifying any attempts to deceive, or contemporary accounts of distress, anger or lack of cooperation with staff. Clues to such behaviour may also be found in the trial bundle of statements, but these need to be treated as matters of ‘disputed fact’ until the court has made its ‘findings of fact’.

## **Recording interviews**

Some experts find it useful to tape-record interviews. This is not usually necessary as the courts generally accept contemporary written notes of the interview (which must be retained according to GDPR regulations). Recording is also useful when adult care-givers are aggressive or litigious. A transcript of the recording may be sought by the court.

Sometimes the adult undergoing proceedings asks for the interview to be recorded, and the decision to do so should be taken on its merits. In these circumstances, it is good practice for the psychiatrist to make their own recording and obtain a transcript.

Alternatively, the interviewee could be advised to make their own notes. Because it is extremely easy to make covert recordings using a mobile phone, experts should be scrupulously professional from start to finish – both in and out of the office.

## **Third-party support**

In some circumstances, the care-giver may ask for a third party to be present for ‘support’, which should be considered on its own merits. There is no obligation to allow a third party into the room, but in such cases it is important to note their identity, their relationship to the evaluatee (if any) and their reason for attending.

Make it clear from the outset that this person will have no involvement in the assessment, and that their presence and behaviour will be in the report to the court. If they are a family member, you may ask them to leave the room (or get consent for them to remain) when intimate or family issues are discussed.

## **Parenting ability**

Assessment of the carer’s parenting is generally outside the expertise of an adult psychiatric evaluation, but it is regularly carried out by child psychiatrists and psychologists. Parenting assessments must be carried out only by experts with appropriate experience. It is not possible to provide a parenting assessment simply by seeing the person and making a diagnosis.

There is no established evidence for a functional link between mental state and parenting ability, and absence of mental illness is not evidence of safe parenting. Some adults may be good parents in every respect except for health care.



## Writing psychiatric reports

The general format for a court report is familiar to all experts, in which all sources of information must be specified and all opinions linked to the evidence provided. When facts are disputed – and it is not possible to wait for the fact-finding hearing – different opinions should be set out in the report with respect to different sets of ‘facts found’ (e.g. ‘If the court finds for, my view is x; if the court finds against, my view is y.’).

Commenting too strongly on motive and intention should be avoided – this is the province of the criminal court, especially in cases where it is alleged that the care-giver has falsified accounts of illness for financial gain – so unless the care-giver describes their motivation, it is best to stick to general comments about what is reported in the literature in similar cases.

A summary or overview of the findings in the report should be provided, after the introduction and before the body of the report, and explain any medical terms or conditions (e.g. personality disorder) using current classification systems (ICD or DSM) where possible.

If asked to assess risk, a review of the known risk factors for violence in adult carers should be carried out, with discussion of which factors are or are not present.

It is also helpful to review the risk factors for child abuse and discuss which of those are present. If there are no risk factors, it is important to state this. Ensure that you proofread the report and respond to any questions as fully as possible. When it is not possible to answer a question, or a question is outside your area of expertise, say so.

## Expert meetings

A meeting of experts can be valuable, but funding for doing this is denied increasingly, so that one cannot take place. Sometimes the court requires two or more experts to communicate by telephone and prepare a joint statement on issues that are agreed and disagreed.

Remember that these are not adversarial cases – experts must work together to establish the best information possible in the interests of the child. Any differences in opinion should be discussed seriously and the reasons for the differences explored.

Differences between experts often relate to one or more taking ‘a position’ on the disputed facts. If a judgment is made in respect of findings of fact, read and annotate it carefully. This will form the basis of the expert opinion when combined with the examination record and the other material. The judgment of the court is final, subject to any

appeal, and any opinion must form around what the court establishes as fact, regardless of the expert's views.

### **Giving expert psychiatric evidence in court**

The rules for giving evidence are the same as in any other case. Preparation is vital. In general, these cases may be difficult, but they are not hugely adversarial, and the courts are keen to have good-quality professional assistance.

It is entirely acceptable to answer 'I do not know' to questions, but explain why (e.g. 'It is outside my expertise'). It is sensible to do this, to avoid being drawn into a view that you are not qualified to offer.

Do not comment on new pieces of evidence that you have not seen or had time to consider. You can ask the court for time to look at any new material.

Crucially, do not be drawn into giving an opinion on disputed facts, especially regarding the identity of an unknown perpetrator or the motives and intentions of a suspected perpetrator. It is acceptable to say: 'I understand these facts are disputed: if x is found, this is my opinion: and if y is found, this is my opinion.'

Where finding of fact has been relied on, it is helpful to repeat this, for example: 'The court has found x, so I take this view.'

When asked about treatment, be honest about the limited services available. Most areas lack any NHS service, or expertise, in addressing the complex issues that arise in these cases. In relation to the specific diagnosis of personality disorder, no psychiatric expert should state: 'This person has a personality disorder and no treatment is possible.'

In fact, this view is contradicted by the current evidence base, and saying this in court amounts to serious professional misconduct.

There may be no services available to help the person undergoing proceeding, but that is a different matter. At the very least, there should be a reference to the NICE guidelines on the treatment of personality disorder and intelligent comments on what treatments should be available.

## Part II: Further recommended reading

### Practice directions and standards for expert witnesses in the family court

These are the Ministry of Justice Practice Directions and standards for those practising as expert witnesses in family proceedings (Ministry of Justice, 2017).

### Perplexing presentations

Information on perplexing presentations is provided in Chapter 13 of the RCPCH Child Protection Companion (Paediatric Care OnLine, 2015).

### Safeguarding frameworks

- The Common Assessment Framework (CAF): *Every Child Matters*, published by the Department of Children, Schools and Families in September 2003, introduced the Common Assessment Framework (CAF) as a process for gathering and recording information about children for whom a professional has concerns. It was designed to be a shared assessment across services, to gather together all relevant information and enhance collaboration of all professionals involved.
- Working together to safeguard children: When working with children who are at risk or harm, an important document is *Working Together to Safeguard Children* (Department for Education, 2018).
- It provides statutory guidance for all professionals involved in the welfare of children, and replaces the 2015 guidance.
- Safeguarding children in whom illness is fabricated or induced: This specific guidance (Department for Children, Schools and Families, 2008) for healthcare professionals who identify a potential case of FII was published in 2008 as a supplement to a 2006 version of *Working Together to Safeguard Children*. It should be read in conjunction with the most recent 2018 guidance (DfE, 2018).

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