Good Practice Points for Health Visitors

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Excellence in Practice

Working with fabricated or induced illness (FII) by carers including perplexing presentations (PP):

Recognising fabricated or induced illness in health visiting practice

This series of three Good Practice Points (GPPs) will help enhance health visitors' (HVs) understanding of Fabricated or Induced Illness (FII) and how it will impact on their role and practice.

- *GPP1: Recognising fabricated or induced illness (FII) in health visiting practice (FII GPP1)*
- GPP2: Management of FII in health visiting practice (FII GPP2)
- GPP3: Impact of FII cases on professionals: Addressing potential dilemmas in health visiting practice (FII GPP3)

Introduction

This FII GPP1 provides an evidence summary to support HVs' recognition of Fabricated or Induced Illness by carers, including perplexing presentations. FII is a form of child abuse that differs from other types of child abuse in a number of ways. This FII GPP1 should be read in conjunction with FII GPP2 and FII GPP3, as listed above.

It is widely recognised and acknowledged that child protection/child safeguarding is one of the most challenging areas of child healthcare in which to work. Fabricated or induced illness (FII) spectrum cases are, however, amongst the most exacting for professionals for a number of reasons, not least because of the professional divisiveness they can engender within and between teams, along with difficulties in identifying FII in the first instance (see FII GPP3). They are potentially the most difficult to resolve because of the complexity of such cases, whilst the unique parent-professional dynamics involved impact on the professionals associated with the case and may routinely trigger complaints (FII GPP3). Cases are resource intensive with significant potential for professional alienation. Hobbs et al[1] highlight the potential for professional 'entrapment' (p300) or the development of an 'enmeshed' (p300) relationship with the perpetrator. Davis[2] also discusses this potential for professions. There is growing awareness of cases of FII, due in part to:

1. Multi-agency training
2. The shift in focus towards earlier identification and intervention
3. Having more robust tools to successfully manage such cases in the best interests of the child victims
4. Legislation and guidance which supports early referral when FII is suspected
5. Media coverage.

[1,3-11]

Terminology

The current term, 'Fabricated or Induced Illness by Carers', was embraced by The Royal College of Paediatrics and Child Health (RCPCH) in 2002 and further elaborated upon in 2009[12,7]. In 2008, the then Department for Children, Schools and Families (DCSF) produced the national statutory FII guidance titled, 'Safeguarding Children in whom illness is fabricated or induced'[6], as supplementary guidance to Working Together, the latest version of which is Working Together 2018[9].

The 2008 national FII guidance document reinforced the key fact that the child's safety and welfare must be the primary focus of all professional activity, whilst reminding professionals that the issue is not around the terminology used but rather the impact of this form of abuse on the child's health, development and wellbeing. In 2013, the RCPCH[13] extended their terminology in relation to FII to include "Perplexing Presentations" (PP) (p113) and Medically Unexplained Symptoms (MUS)[13] (p113). This further supported the concept of a continuum, or spectrum, first introduced by Eminson and Postlethwaite[14].

More information on page 2

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Of note, the more recent papers also refer to the 'FII continuum' and to the 'FII Spectrum' RCPCH[13] (p113), as well as making the important point that PP and FII Spectrum cases are, in fact, more common in frontline practice than the full-blown more dramatic FII cases[15,2,11]. In a recent paper, Dr. Paul Davis[2] highlighted the fact that the different terminology that continues to be used in the context of a definition of FII mirrors the ongoing uncertainty as to what a definition should actually focus on, i.e. 'parental motivations, parental behaviours or harm to the child'[2] (p111). The new RCPCH FII guidance, launched in February 2021, acknowledges the ongoing professional debate around terminology whilst recommending the use of the terms MUS for presentations of medically unexplained symptoms and PP for perplexing presentations, along with providing their own definitions of them when dealing with FII spectrum cases[11].

Definitions

There is no single universally agreed definition of FII, however, a useful working definition has been developed over the years which highlights some key facts:

- FII is child abuse.
- In FII cases, the child suffers harm through the apparently deliberate actions of their main carer.
- The perpetrator is usually, but not always, the biological mother.
- It is duplicitously attributed by the carer to another cause, usually medical.
- The range of symptoms and systems involved is very wide.
- It can co-exist with a genuine illness and with other forms of abuse.
- Various motivations exist including material or other gains, erroneous parental belief and extreme parental anxiety, amongst others.
- Inadvertent iatrogenic harm can occur via unnecessary medical investigations and repeated treatments in these cases.
- It can occur in an obstetric scenario in relation to an unborn child on very rare occasions.

1-2,6-7,11-13,16-18

FII is included in the national statutory child safeguarding guidance "Working Together" under the single category of physical abuse[9]. However, it is important for HVs to be aware that in practice FII is also found in other categories of abuse, especially in emotional abuse but also in neglect and occasionally in child sexual abuse.

Fabricated and/or induced illness

The RCPCH[11] states the following:

> *'FII is a clinical situation in which a child is, or is very likely to be, harmed due to parent(s') behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health or neurodevelopment is impaired (or more impaired than is actually the case). FII results in physical and emotional abuse and neglect as a result of parental actions, behaviours or beliefs and from doctor's (other professional's) responses to these (iatrogenic harm). The parent does not necessarily intend to deceive, and their motivations may not be initially evident...'* (p11)

The inclusion by the RCPCH in their new definition of the broader range of actual and potential abuse and neglect suffered by child victims within FII spectrum cases is both useful and welcome in the ongoing national debate, as well as providing further clarity. There is ongoing, if sporadic, discourse in the international arena around the potential significance of perpetrator motivations and intention to deceive in such cases.

Perplexing presentations (PP)

The term PP describes the more common early presentations which are defined by RCPCH[11] as follows:

> *'Where there are alerting signs of possible FII (not yet amounting to likely or actual significant harm), where the actual state of the child's physical, mental health and neurodevelopment is not yet clear, but there is no perceived risk of immediate serious harm to the child's physical health or life...'* (p11)

Medically unexplained symptoms (MUS)

The RCPCH[11] recommends the use of the term MUS to describe cases where:

> *'...the child complains of symptoms which are presumed to be genuinely experienced but not fully explained by any known pathology. ...The symptoms are usually psycho-social in nature which is acknowledged by both clinicians and parents. MUS can also be described as functional disorders...The health professionals and the parents work collaboratively to achieve evidence-based therapeutic work in the best interests of the child...'* (p10)

More information on page 3

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Recognition

HVs, who are uniquely placed in the context of their broad and invaluable role with the child and family as well as their close working relationship with GPs, are frequently the first professionals to become aware of or suspect abnormal illness behaviour by the carer. There is a wide spectrum of FII behaviours and presentations which can co-exist with a genuine illness, and which may also co-exist with other types of child abuse. Having an awareness of the range of possible carer behaviours, as well as of the multiplicity of potential presentations in the context of the child, is therefore important to identifying FII spectrum cases in practice and to protecting and promoting the welfare of the child victims involved. In addition, this further enhances the role HVs can play in the wider multi-agency team within the safeguarding/child protection framework.

FII can simulate any medical presentation. However, in 2008 the then DCSF described three main ways in which a carer can perpetrate full-blown FII as follows:

- Fabrication of signs and symptoms - this may include fabrication of past medical history, exaggeration, distortion, misconstruing of innocent phenomena in the child, or invention and deception;
- Fabrication of signs and symptoms and falsification of hospital charts and records, and specimens of bodily fluids. This may also include falsification of letters and documents;
- At the extreme end, induction of illness by a variety of means[6,11].

Both the 2013 and 2021 RCPCH guidance[11,13], with the wider view of FII and the extended definitions and terminology, highlight that the:

> '*common starting point for both PP and FII is that the child's clinical presentation is not adequately explained by any confirmed genuine illness, and the situation is impacting upon the child's health or social wellbeing*'. (p113)

A number of possible presenting features to help professionals identify actual or suspected FII spectrum cases have been outlined by Hobbs, RCPCH, DCSF and others as follows:

- Reported symptoms and signs are not explained by any medical condition from which the child may be suffering; **OR**
- Physical examination and results of investigations do not explain reported signs and symptoms; **OR**
- There is an inexplicably poor response to prescribed medication and treatment; **OR**
- Over time, the child is repeatedly presented by the carer with a range of symptoms; **OR**
- Parent not allowing child to be seen or spoken to alone; **OR**
- Conversely, child not brought to appointments/ avoidance strategies; **OR**
- New symptoms are reported on resolution of previous ones, or carer reports symptoms in siblings; **OR**
- Reported symptoms and found signs are only seen or appear in the presence of the carer; **OR**
- Carer inappropriately seeks multiple medical opinions at various hospitals, 'doctor shopping', possibly in different geographical areas or may access alternative remedies[1]; **OR**
- Frequent change of GP, HV, health team, school, address; **OR**
- The child's normal, daily activities are being curtailed beyond that which might be expected from any known medical disorder from which the child might be suffering, e.g. use of apparently unnecessary special aids, poor or no school attendance; **OR**
- Concerns may be raised by other professionals, e.g. a teacher who may notice discrepancies between reported and observed medical conditions such as the incidence of fits; **OR**
- Child may develop abnormal attitudes to their own health because their health beliefs have been negatively influenced by the abusive carer[1,20]; **OR**
- At the more extreme end of the FII continuum, one may find objective evidence of fabrication, e.g. from toxicology studies, blood typing, evidence from covert video surveillance (CVS)[3]; **OR**
- The carer may actually express concern that they are under suspicion of FII[6,7,13]. Mothers who perpetrate this form of child abuse are frequently observed by staff to befriend professionals, may appear overly familiar with professionals and will be very plausible. However, they will also be quite manipulative and may attempt to 'entrap' and use staff as their tool, whilst engendering divisiveness within and between teams; **OR**
- Frequent complaints by parent/carer.

[1,6,11]

The above list is not exhaustive.

More information on page 4

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Perpetrators and potential motivations

There is no evidence to support a unique profile of carers who fabricate or induce illness in their children. Research suggests that the majority of reported cases involve the child's biological mother as the main perpetrator of this form of abuse[1-2,7,11,21-24]. Some of these perpetrators may have mental health issues, for example depression or a somatising disorder (which, simply put, is the generation of physical symptoms of a psychiatric condition or psychological distress)[6,13,23-26]. However, it is important for HVs to note that there is no clear relationship between any specific mental health disorder and FII. A small number of cases have been described where the father is the abuser[27,7], however our understanding of the role of fathers/male carers in actual and potential FII cases continues to evolve in contemporary society. Non-abusing fathers in such cases are variously described in the literature as passive, 'distant'[12] (p29), 'uninvolved'[15] (p3), 'detached from family life'[11](p13), whilst others are genuinely 'unaware'[11-12,15] or have been 'duped'[1](p313) by the abusing carer in much the same way as professionals get 'duped'[1,12](p14). More rarely, two or more carers have been found to be involved, whilst experience has shown that there has been the very occasional case where a health professional has been identified as the perpetrator. Of note, Sheridan[22] found that approximately 14% to 30% of female perpetrators of FII had links to healthcare, whilst that figure increased to 45.6% in a more recent study undertaken by Yates and Bass[24].

Carers who perpetrate FII have been described by Hobbs[1] (p312) and Davis et al[2] (p111-112) as very 'devious' and will go to great lengths to 'enmesh' the professional, and may feel quite comfortable using the complaints system as a way of controlling and manipulating the professionals they have earlier befriended. There is anecdotal and other evidence to suggest that complaints frequently occur at the point where ther health visitor/professional becomes suspicious and may well be seen as part of how FII perpetrators operate, i.e. their modus operandi. It may also potentially be a trigger to what Hobbs et al[1] and Davis et al[2] describe as 'doctor shopping'[1] (p300) and [2](p112) or moving health teams which will be more fully explored in FII GPP2[1-2,6,11-12].

The highly complex area of possible perpetrator motivations continues to inform robust professional debate, whilst there remains a dearth of information and research. There are different schools of thought and a number of possible motivations put forward over the years include: extreme parental anxiety; genuine but erroneous parental beliefs; parental attention seeking; financial or other material gain; parental dependency needs; parent's need to be recognised as very committed and caring and somatic symptom disorder, amongst others[1-2,11,15-16,24,28-29]. Whilst understanding the potential range of motivations is not critical for HVs in the actual identification of FII spectrum cases, it is extremely important in the context of assessing future risks, forward planning, and appropriate interventions for the child victims[30].

Prevalence

To date, there is limited published evidence available on the actual prevalence of FII. There are ongoing methodological difficulties with the epidemiological studies used to demonstrate prevalence rates, as well as a paucity of up-to-date research which is a concern and which therefore dictates that great care must be taken to guard against erroneous or misleading statistics.

Whilst the prevalence rate of FII is still not fully understood, there does however appear to be broad agreement within the literature that, whilst FII is still rare, it is not as uncommon as once thought. The majority of parents do present their children appropriately, however, the early presentations PP and MUS triggered by erroneous reporting etc. appear now to be more common and are potentially being under-reported and quite possibly substantially so. Of note, the new guidance by RCPCH highlights what it calls a 'new phenomenon' where parents/carers use the internet in the context of FII spectrum cases[6,2,11].

It is important, therefore, that HVs are fully aware of FII spectrum cases and their inherent complexities including the wide range of symptoms and systems involved, whilst maintaining their professional curiosity and keeping an open mind to the possibility of FII in differential diagnoses if there is no other apparent explanation, in order to better protect and safeguard the best interests of the child victims and maximise their outcomes.

More information on page 5

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