AIMS For a better birth...

Child Protection

AIMS Journal, 2008, Vol 20, No 1

Last August Jean Robinson wrote the following letter to the Department of Health explaining the views of AIMS

20th August, 2007

Prof. Sir Liam Donaldson
Chief Medical Officer
Department of Health

Dear Liam,

ADVERSE EFFECTS OF CHILD PROTECTION ON PUBLIC HEALTH

You may recall that we sent you our analysis of our first 50 or so child protection cases when you first started looking at problems with medical expert witnesses. We read your most helpful document on supply and training of expert witnesses with interest, and responded to the questionnaire, and have seen your brief summary of responses. We are now preparing our second round of comments as NICE stakeholders on diagnosis of child abuse (greatly concerned, incidentally, at the truncated definition of the amended scope).

Medical opinions, however, are but a part of the system which impacts on children and parents. We are now so concerned at the adverse effects of child protection procedures in the UK that we felt we had to write to you. As a group which runs a national help line, we are seeing how serious, long-lasting and widespread the adverse effects of these expensive interventions are. Since, as advocates, and occasional Family Court witnesses, we see many case and court files, we know how questionable and inaccurate are the allegations, interpretation and documentation from which many investigations spring. Sometimes it is unclear where the trail began, and a surprising number seem to start after justified consumer complaints have been made about health care or other staff.

When instructions went out to all staff in contact with children to report concerns about risk, this seems to have been done with little prior thought, without consultation, and without provision for training. The result was the post-Climbie cover-your-back syndrome: 'when in the slightest doubt, report to social services.' We see a huge variety of standards, misunderstandings, prejudices, ill-informed interpretation of risk factors, cultural incompetence and even racism, in the initiation of cases from health visitors, teachers, midwives, nurses, doctors and others. Quite apart from the damage to families, each one of these reports pre-empts resources and often leads to substantial, and unnecessary, cost. Ironically, the

basic, simple help or real support families would like, is unavailable because resources are lacking, that is not the focus of social work activity, and anyway nowadays many parents are afraid to ask because any contact with social services is too risky.

Community information grapevines work, and effectively circulate information about what people see as the growing risk of being investigated or labelled as a dangerous parent after contact with medical care. The risk is not merely perceived: it is real, and the consequences are devastating. Damage to the whole family structure (sometimes the extended family network and its support structure), to parental confidence and self-esteem, to children's sense of security and safety, and their sense of security that their parents can and will protect them - these are very serious adverse effects. Often we find it is the most sensitive parents, to whom family life means everything, who are most damaged. We also have many concerns about damage we have seen to authority of black parents vis-a-vis their children, many of whom are already coping with multiple racial prejudice problems. As we have pointed out to NICE as stakeholders in their consultation of diagnosis of child abuse, such potential for harm must now be considered, and it is long overdue. The sheer cultural incompetence of many social workers has to be seen to be believed.

The following list is not exhaustive, but gives examples of typical problems. We make no claim for their being representative of the whole picture of child protection activities, of course, since we deal only with those who come to us for help. However, the problems we are finding seem to be echoed by other groups.

1. **FEAR OF ACCESSING MEDICAL CARE** -
   Nowadays parents call us and ask for advice when their children have accidents, because they are afraid to go to A & E, and they know we run a totally confidential service. We cannot give such advice as we are not qualified to do so. We have been in existence for well over 40 years and can recall no such requests until about four years ago. There is now no health professional, or official help line, parents feel they can safely ask for help. All agencies, including NHS direct, will report anything they regard as suspicious. Innocent parents who have had one brush with the system, or social services investigation, or whose friends, relatives or neighbours have, now find the risk of avoiding treatment preferable to the risk of damage to the whole family of going for help.
2. **DISTRUST OF HEALTH VISITORS** -
   Mothers are opting out of seeing health visitors, and are advising friends not to see them, after they, or someone they know, has had a similar encounter. Those who feel obliged to do so, tell them as little as possible. One incident and they tell us 'I've made sure everyone in the village knows not to trust her.' In some areas, however, merely opting out of seeing a health visitor (maybe because they don't like her, or find her advice or manner unhelpful) is cause for referral to social services in itself - thereby confirming the increasingly common perception of them as the 'health police'. Those who do see the health visitor are highly circumspect about the information they give.
3. **ADVERSE EFFECTS OF MEDICAL INVESTIGATIONS** -
   Small babies with a tiny bruise are automatically given whole-body X-rays at an early stage.

('Those who don't cruise, rarely bruise.' - 'rarely' being interpreted as 'never'). The likely cause has sometimes proved to be equipment such as a baby-carrier or push-chair. Sometimes a boisterous older sibling - a toddler - is suspected but this cannot be proved. The parents, not unreasonably, are now continually worried about the future possibility of leukaemia. As these whole-body X-rays are now so common, (there should be a database of such exposures) the likelihood of this in some children must be increasing.

4. **CONCEALMENT OF POSTNATAL MENTAL ILLNESS** -
   As at least two studies have shown, mothers are lying in response to the questions on the Edinburgh Postnatal Depression Scale and they are concealing post natal mental illness, for fear of social service intervention. We knew this from our help line, long before the research appeared. A formerly useful, validated, screening tool no longer works. This is alarming since suicide is the largest cause of deaths associated with childbirth. We are dealing with seriously ill women, and we know that contact with child protection services only worsens their state but it is as if no-one cares. One immediately suicidal mother was told by her GP 'We don't have to worry now: the baby is safely in care.' Everyone concentrates on safety of the baby, though statistically the chances of the mother killing herself are very much greater.
   The known serious long-term adverse effects for a child of losing a parent through suicide are not even considered. We seem to be the only remaining group who see mother and baby as a dyad, and think they need to be treated as such. The Confidential Enquiries into Maternal Deaths report cases of suicide which are directly related to women's fear of social services taking their children - real or imagined, and points out what a large number of children have been orphaned by post-natal suicide. These suicides are, of course, only measured for the first year post-natally, but we have clients at risk, and know of cases, long after that. We have many cases where social services intervention is intensifying and prolonging the very postnatal depression which they are seeing as the reason to take their babies. We have never yet seen a case where the mother found social worker intervention helpful or supportive. In the last fortnight I have worked with two women who I feel are suicide risks (one acute) solely as a result of social service management. As their babies are now over a year old, their deaths would not be included in the statistics, but we are prepared to give evidence to coroners if the worst happens.
   There are no Paternal Death statistics. Naturally postnatal mental illness in mothers is our major concern, but we are hearing of more and more cases of fathers tipped into depression by child protection investigations. The intervention itself is frequently toxic to mental health, and greatly damaging to self-esteem, which is particularly important where it is fragile to begin with, or families are already dealing with racism.
5. **LOSS OF BREASTFEEDING** -
   Many mothers whose babies were precipitately removed, (they, and we, suspect as potential adoption material to meet targets) but had to be returned when a case could not be made, grieve for the loss of breastfeeding, with its long term benefits for mother and child, and for the damage to bonding. If and when children are returned, they are unable to re-establish it. One woman recently told us of the profound difference in feelings towards her two children, the first of which

was affected by child protection actions and threat of removal, and the second, which had a happy normal birth. It is a story we have heard from a number of others. Even the threat of intervention or suspicion can cause serious damage in the sensitive postnatal period, and we have vivid descriptions from parents.

In a number of cases mothers have expressed breast milk and begged social workers to give it to the baby, and they have refused. Others have not openly refused but mothers later discovered it was thrown away. One baby (an adoption target) was recorded by a paediatrician as 'bottle fed from birth' though all the notes clearly indicated otherwise. More recently some breast feeding mothers have been asked to express milk by social workers (we suspect as a result of European Court human rights decision on one of our UK cases P, C and S v. UK 16 07 02). They dared not refuse since it might lessen the chance of the baby's return, but firstly this is often very difficult for the inexperienced primigravida, and the continued lactation (and oxytocin levels) added to their distress at the baby's absence (a price all lactating mothers pay). It was not a choice those particular mothers would have made. In some cases the stress has caused lactation to fail totally, and the mother is further devastated. This is NOT a case that social workers are 'damned if they do and damned if they don't', but that their ignorance and the way they use (and mis-use) information to strengthen their case often works adversely for both mother and child.

6. **INCREASED USED OF ALTERNATIVE PRACTITIONERS**-
   After a brush with the system, more families in our files are avoiding orthodox medical care and increasingly turning to alternative practitioners for their own, and their children's care. Whilst many parents are full of praise for the alternative practitioners they use, we have concerns about lack of paediatric and medical knowledge. I have never forgotten interviewing the mother of a young child who died from diabetes when parents followed such advice. Parents with ongoing medical problems are also foregoing care for themselves because they no longer trust the system.
7. **MORE CHOOSE HOME SCHOOLING**-
   An increasing number of children in our files are being removed from school and are home educated, sometimes after a fairly minor brush with 'protection' services, because the educational system (including nursery education) is now seen as part of the surveillance process, which can be influenced by the whims, prejudices and occasionally hostility of individual teachers. Another child was removed from nursery school because the teacher there was questioned by social workers about the parents and is no longer trusted, so it is at home.
8. **MORE SEPARATIONS AND MARITAL BREAKDOWN**-
   We have lost count of the number of marriages and partnerships which have broken down as a result of the intense stress caused by child protection investigations of what turned out to be innocent parents. The children now have an absent father and are largely cared for by the traumatised mother. This loss alone is far more damaging to the child than the potential harm of which parents were initially accused.
9. **REDUCED PROSPERITY AND WELL BEING**-
   We have been surprised to see how often families suffer considerable financial loss and are in reduced circumstances because of intervention. This includes both the poor and the middle class.

The stress, and time-consuming nature of trying to fight their corner, takes all their time, and often erodes their health. There is no longer time, or money, to take the children on outings they would once have had, for example. Making photocopies, postage of documents, paying for copies of their records and faxes, and so on, eats into the limited resources of those who have little to spare. Some are prevented from pursuing former careers where local well-circulated, and unproven, suspicions have made them unemployable, yet there is not a shred of evidence that they are unfit.

When social services depart and have closed the files, the family may well have turned in on itself. Sometimes they have felt they could not talk about what is happening to neighbours, friends, or even relatives. Sometimes they fear stigmatisation. Sometimes they are stigmatised. Garbled, distorted stories may have been circulated in schools, clinics, churches, etc. Contact with friends, neighbours, clubs, even relatives, may be reduced sometimes drastically. Their social capital - known to be an important factor in mortality and mortality - has been reduced.

10. **LACK OF HELP FOR THOSE IN NEED** -

    Parents whose children have behavioural or educational difficulties now feel there is no confidential, trustworthy source of help they can go to. It was sometimes those very difficulties (then undiagnosed) which led to the interventions, but when everyone else goes home, the parents are left to cope with them, often now worse than they were before, but with nowhere they can, or dare, turn to.

    Parents who cannot avoid the system, because they have disabled children, find themselves in a continual weary battle to preserve their sanity, their integrity and their self-esteem. There is a lot of black humour in our 'phone calls: we agree they are 'the lucky ones' in that their children are so seriously disabled, social services and doctors don't want to take them (they would be too expensive and risky to keep in care, and are not seen as adoption material) but the perception is that professionals just want to exert power and control everything they do, rather than listening to parents who have found out what works and helping them with basic, simple needs.

    Because we run a totally confidential service, and never report anyone to anywhere, we are told a great deal which would be helpful to professionals involved with family care, but which they will never know because now all are required to report suspicions, so none of them is trusted.

11. **CONCEALMENT OF RAPE CONCEPTIONS** -

    Women whose pregnancies are the result of rape are not mentioning this to anyone, though they are desperately in need of support and sensitive care, for fear of social service interference. We are supporting them as best we can, especially since we saw the disastrous effects after a woman confided in her midwife, who reported to social services in another case.

12. **CONCEALMENT OF SEXUAL RISK** -

    Parents who have had a brush with the system withdraw from being part of the watchful community group which helps to protect all children. For example, a number of them have told us about sexual activities of quite young fellow pupils at their children's school (which now seem surprisingly common) or grooming attempts by local paedophiles. Whereas at one time they would have acted, now they keep quiet in case any activity re-awakens interest in them or their

children. They are no longer willing to try to protect other people's children: they have pulled up the drawbridge. In view of the number of cases we have seen where women who reported paedophiles and ended up being disbelieved or vilified themselves (the assumption that these genuinely concerned mothers were making it up for their own ends, in custody battles etc) we do not blame them.

13. **CONCEALMENT OF DOMESTIC VIOLENCE**-
Women who are suffering domestic violence are continuing to conceal it for the same reason. Since we have seen cases of babies removed from such women, even after they have left their violent partners and are coping well, we are not surprised.
14. **CHILD PROTECTION AS SOCIAL CONTROL**-
Use of child 'protection' or threats thereof, are increasingly being used to control parents who are seen as unorthodox, or not completely compliant. (The social worker's ideal 'compliant' mother does not seem to be one who would have the personality to insist that other people don't smoke near her baby. Yet 'stroppy' mothers can be advantageous to children, protecting them when they live in difficult social circumstances. Heaven help the disabled child or one with special needs who does not have at least one stroppy parent to fight for him). The message is getting round quickly, and parents are opting out of official sources care even more, or being even more selective on what information they give, and what they conceal.
15. **TOXIC PSYCHIATRIC LABELS** -
Your recent report confirmed the picture we have from our cases, that psychiatrists greatly outnumber paediatricians as court experts in Family Court cases. Selected experts are invited by social workers to confirm that the parent who complained about the health visitor, or who has criticised or challenged them must have a 'personality disorder'(not uncommon); this has now replaced the rather discredited Factitious and Induced Illness (frustratingly rare) as the method of choice. Judges do not ask the simple question: what is the baseline of this in the community, and are we to remove the children of all such parents? Where is the evidence that this child is, or has been, at risk from this parent?
The result is that many parents and children, even if not separated and found guilty of no harm, have now acquired permanent damaging labels - widely circulated among shared records - which they, and we, suspect are likely to be a permanent source of prejudice, which do not contribute in any constructive way to their care, support, treatment or interaction with services. Since the condition is widely regarded as untreatable, there is no responsibility on the psychiatrist or the NHS to treat, but there is total freedom by lay and medical personal to disregard what the parents say.
There is a substantial literature on the effect on professional attitudes of any label such as 'personality disorder', for example, and how it affects attitudes to the patient and hinders diagnosis and prevents treatment. Yet many families are acquiring these labels as a result of totally unjustified intervention in the first place. In many of our cases specific psychiatrists and psychologists seem to have been called in when social workers were unable to find evidence to prove the case they wanted. Despite our strong suggestions to clients that they should obtain

copies of the psychological tests carried out on them, so that conclusions may be challenged, and their validity for different cultures assessed, so far no-one has managed to do so. (Incidentally, we are also concerned at the number of cases where these same professionals then go on to recommend to the court that the family needs exclusive private treatment by themselves at a cost of many thousands of pounds.)

As with paediatricians and Munchausen Syndrome by Proxy, experts who are knowledgeable, are seen as unbiased, and will give evidence for the parent are as scarce as hen's teeth. When a child has some physical problems, there is hope that the truth that the mother was not wrong in believing her child to be ill, will emerge eventually, through advances in medical knowledge, or even at post mortem. With psychiatric opinion of a parent's state at the time, what hope is there of rebuttal? The MSBP label carries its own unique trail of damage: anything the mother reports to any authority is not believed - or rather is automatically DISbelieved, by doctors, teachers, the police etc, and we have seen cases of actual endangerment because of this.

Medical opinions can be wrong. Has everyone forgotten that once all the paediatricians and health visitors were ordering mothers to place their babies face down to sleep? We know a number of older mothers who did not 'comply' with that - they just liked to watch their babies' sleeping faces. And maybe some of their children were saved from cot death as a result.

I could go on. But you can see why we are so concerned. Unless both professionals and the courts understand how common, and how serious, the adverse effects of child protection intervention and investigation can be, how can they balance the risks of action versus leaving well alone?

With very best wishes,

Yours sincerely,

Jean Robinson
Association for Improvements in the Maternity Services

cc: Dr. Harry Burns, CMO Scotland, Dr. Tony Jewell, CMO Wales, Dr. Michael McBride CMO Northern Ireland, Dr. Gwyneth Lewis, CEMACH, Beverley Beech, Chair AIMS.