

Can Clinical Pathways be Developed to Offer Assistance in Child Care Cases?

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Abstract

Clinical and care pathways are increasingly being used to help with decision-making in various areas of health and social care. The value of these pathways is that they provide a standard approach to offering care, help maintain quality of delivery, and control cost. This paper reports on the first step in developing a pathway which may assist in the very difficult process of deciding the level of contact to birth parents of children after their removal from their care. The use of such a pathway in this area is fraught with difficulty, but if successful may help practitioners achieve the arrangements that are in the best interests of the child.

Keywords: Parental contact, care proceedings, care pathway, fostering, open adoption.

Introduction

There can be few more emotionally charged decisions asked of the Court than to decide if a child should be removed from their parents' care and at what level, if any; there will be future contact between them.

Children who are removed from households that are abusive or neglectful often have significant behavioural, educational and social difficulties (Shonk & Cicchetti 2001; Veltman & Browne 2001; Prasad, Kramer & Ewing-Cobbs 2005), and it has been increasingly realised that these difficulties are associated with alterations to biological stress systems (De Bellis, Baum, Birmaher, Keshavan, Eccard, Boring, Jenkins & Ryan 1999), and the underlying brain makeup. These difficulties can be longstanding in themselves, but continued exposure to negative environmental experiences (such as poor contact) may exacerbate the effects upon brain development, entrenching the problems with psychiatric and behavioural functioning (Watts-English, Fortson, Gibler, Hooper & De Bellis 2006).

For such a sensitive situation it right that each case is judged on its merits, with no tariffs or imposed legislative guidelines. However this very individual approach brings with it the difficulty of deciding what would be the best outcome in any particular case. In the United Kingdom the Children Act 1989 made what would be in the best interests of the child the pre-eminent factor in such situations. Clearly this is a decision for the Court, but the information to make it must originate from social and psychological evaluations of the specific details of the individual case. Over recent years there have been efforts to try to offer guidance about which elements are important to consider when deciding on the nature and content of contact (e.g. Sturge & Glaser 2000), but these elements are broadly drawn as a solution to achieving the delicate balance between offering guidance and being too prescriptive is attempted. In addition, each source of information is likely to be presented from a specific epistemological standpoint making the task for the Court even more difficult.

In England the courts are assisted by input from Independent Children's Guardians provided by the Children & Family Court Advisory & Support Service (CAFCASS). They are trained Social Workers who share the same values and principles as the local authority. In their reports to courts they make recommendations on the contact proposals already put forward by the local authority Social Workers. The use of the pathway approach might provide a common base from which any initial differing opinions can be resolved by the workers or the court.

In health care there has been a growing emphasis upon developing clinical pathways which offer a form of decision tree, guiding clinicians' deliberations as they seek the most appropriate intervention for that health concern (Dy & Adjei 2005; Evans-Lacko, Jarrett, McCrone & Thornicroft 2010). At each point in the tree the pathway presents specific factors that need to be considered and which dictate the next stage of assessment to undertake, until a final decision is reached. For instance in the United Kingdom the care pathway for depression in adults uses an assessment of the severity of specific symptoms to suggest which treatment option would be most suitable (National Institute for Clinical Excellence 2013). The increased usage of this approach is expected to improve care, facilitate multidisciplinary collaboration, increase the application of evidence-based practice, and help to contain costs. Could such an approach hold any merit for child care cases?

Materials and Methods

Development of a Tentative Pathway

The first stage in the development of the tentative pathway was to consider the wisdom contained in the current literature. Removing a child from their family gives them relief from the traumatic experiences but brings with it a different set of issues and difficulties. If the placement with an alternative family is to be successful the child needs to invest with their new family and loosen links with the birth family. However this shift in allegiance has to be balanced with ensuring that the child has appropriate knowledge of their birth family because it has been recognized for some time that continuing contact with birth family helps children understand their origins, improves their self-image, and is generally helpful in minimising the potential for future psychological difficulties (Sants 1964).

To some extent the age of the child exerts influence upon this. In general, children become more curious about their origins and want more information about their birth family as they get older (Morgan 2006), and on-going contact can be a positive way of addressing this growing interest in their birth family (Mendenhall, Berge, Wrobel, Grotevant & Mc Roy 2004; Berge, Mendenhall, Wrobel, Grotevant & McRoy 2006). Similarly, in the case of children who are going through the process of adoption, the time after contact with birth families can give a positive opportunity for the adoptive families to explore with the child their feelings about it, and hence address any underlying emotional uncertainties (Von Korff, Grotevant, Koh & Samek 2010; Von Korff & Grotevant 2011). However, while contact can be helpful to a child by protecting their sense of identity and well-being, the impact of contact upon children is a complex issue (Ge, Natsuaki, Martin, Leve, Neiderhiser, Shaw, Villareal,

Scaramella, Reid & Reiss 2008), and if poorly managed it can contribute to an increasing sense of anxiety, and lowered self-esteem (Schofield & Beek 2005).

The contact arrangements must also not interfere with the process of allowing the child to settle into a new, permanent family (Ji, Brooks, Barth & Kim 2010). In circumstances where contact is disrupting this process it can therefore become a damaging experience for the child (Kraft, Palombo, Mitchell Woods, Schmidt & Tucker 1985). The life experiences of these children is often heavily laden with a high prevalence of domestic and significant emotional dys-regulation in the parents (Rees & Selwyn 2009), and the contact may have a negative impact if it exposes children to on-going conflict (Pruett & Pruett 1999; Smart & Neal 2000; Smith & Gollop 2001), or is something the child does not want (Mooney, Oliver & Smith 2009).

When in an alternative placement, the child is struggling with being part of two families (birth & alternative) as well as trying to cope with such questions such as “why did those things happen to me” (Place 2003). Given the damage that has been wrought by their early life experiences, the complex nature of the child’s experiences, and their emotional responses to them, it has been argued that contact may itself be harmful and the likely cause of enduring emotional and psychological damage, even if it appears to be going well (Loxterkamp 2009).

An additional element within contact decisions is its potential impact upon the placement, because it is clear that the process of on-going contact can be stressful for the alternative family (Monck, Reynolds & Wigfall 2006), and their attitude is the key determinant of whether a pattern of continued contact will be successful (Barth & Berry 1988; Grotevant, Rueter, Von Korff & Gonzalez 2011). If contact is producing any negative changes in the child’s functioning this increases the risk of breakdown, because it is well recognized that when a child shows an increasing pattern of problem behaviours, risk of the placement disrupting increases (Chamberlain, Price, Reid, Landsverk, Fisher & Stoolmiller 2006). Although the presumption that contact generally offers benefits for the child is well established, some work has found that children’s emotional and behavioural development is not strongly related to the type of contact that they are having with their birth families (Von Korff, Grotevant & McRoy 2006; Neil 2007). Rather, it is the conclusion that it is the quality of the contact, not its frequency, which is the major factor in determining its value for the child (Hawthorne, Jessop, Pryor & Richards (2003).

Within the social work literature there are a few “principles” that have near universal appeal and these must be addressed by any pathway. The first principle is that children will have contact with their parents unless it is damaging to them especially near the beginning of the proceedings. None of the evidence has been tested by this time in the case and it is can be difficult to argue it will cause damage to the children. A second principle is that siblings will be kept together unless it is damaging to any one of them, and this usually extends to attending contact. Finally there is the assumption that each sibling will have the same level of contact.

Any potential pathway would need to reflect this information, and these themes gave the principles which underpinned the elements that gave the starting structure. The second stage of the process was to examine the factors that had contributed to recommendations made by one of the authors (MP) as to future contact arrangements in 50 cases. This information was used to expand the starting structure into a draft clinical pathway. A further 30 cases were then assessed using the pathway, and the results compared to the Court decisions. This led to minor changes in the frequency of contact which would result from certain perceived issues such as the child’s degree of upset at contact.

Results

Thus far the development had progressed along a medical model approach. To test its suitability as an approach for social child care practice, a workshop was held at which 35 child care specialist staff were asked to consider three fictitious cases and compare their

professional judgment with the suggested outcome that arose from the pathway. There was some divergence of opinion at specific decision points within the pathway, but divergent views were always held by a small minority, with the majority view at each point being as the pathway predicted. At the close of the workshop there were additional helpful comments made about layout and wording which have been reflected in the final draft shown as figure 1.

One of the issues raised by these practitioners was that in the UK system there are two distinct times when recommendations are made in relation to contact – at the commencement of the proceedings when there is a very strong presumption that a significant amount of contact is expected (so that if the children are returned to the care of the parents there will be the minimum of disruption to the child/parent bond); and as the proceedings draw to a conclusion (when the assumption is that the children will not be returning to the parents care). The practitioners posed the question – does there need to be two pathways to cover this difficulty? These two distinct points of recommendation add an additional layer of difficulty to an already complex situation, and so the focus for the present will be on the arrangements after judgment has been given. However it must be realized that this restriction holds potential bias for the algorithm because the contact arrangements agreed by the Court at the beginning of the proceedings, which can be in place for many weeks while the legal process unfolds, are regularly quoted by the parents' solicitors in arguing for high levels of contact as part of the final arrangements. The potential bias arises because being aware of this “end-game” will tend to influence recommendations made by the Social Workers at the beginning of the proceedings, and conversely, the successful legal argument can result in early contact arrangements influencing the final ones.

Secondly, the practitioners commented that in most cases there was more than one child being considered, and there is an assumption that in such cases children will be kept together, and their contact arrangements will be the same. They were concerned that this tentative pathway might give differing recommendations for the children, either because of differences in age or their life or family experiences. This may be an important role for such algorithms, because to assume that being siblings, children have the same needs clearly is doing them a great disservice, and having a mechanism that highlights individual needs can help move towards a more individualized pattern of care which will be in each child's best interest.

Discussion

Clinical and care pathways are increasingly being used to help with decision-making. The value of these pathways is seen as the way they offer a standard approach to organizing, managing, documenting and auditing care processes. However the use of a care pathway mechanism to help with decisions around the nature and frequency of contact would be a radical departure from the current practice.

Care pathways have their origin in manufacturing. Their structure allows standardisation of processes to be achieved, with a resulting maintenance of a specific quality, while reducing waste, and hence cost. From these industrial beginnings health and care spheres have developed pathways as a means by which practice can be standardised, the quality of care monitored and enhanced, and best practice and findings from research can be put into practice (Bragato & Jacobs 2003; Allen, Gillen & Rixson 2009). In addition these mechanisms offer a clear administrative benefit in permitting costs to be more predictable, and contained, as well as offering a means by which to monitor the care offered by practitioners (Zander 2002; Pinder, Petchey, Shaw & Carter 2005; Berwick & Hackbarth 2012).

Such benefits to practice and its management has seen clinical pathways being used routinely throughout the world, with pathways now available for such diverse conditions as organ donation and managing self-harm to antisocial behaviour and conduct disorders in children and young people (NICE 2013). Their routine use is fuelled by a growing body of evidence that this approach to decision-making is effective at improving outcome in many clinical situations (e.g. Lemmens, Van Zelm, Vanhaecht & Kerckamp, 2008; Barbieri, Vanhaecht, Van Herck, Sermeus, Faggiano, Marchisio & Panella, 2009; Pettie, Dow, Sandilands,

Thanacoody & Bateman, 2011; Rotter, Kinsman, James, Machotta, Gothe, Willis, Snow & Kugler, 2010; Panella, Marchisio, Brambilla, Vanhaecht & Di Stanislao, 2012).

However, despite these clear benefits in outcome the widespread use of such pathways reduces the role of clinical acumen, and there is a growing tension between such standardisation of care and the ability for clinical experience to over-ride the prescriptive pathway (Jones 2004; DeMartino & Larsen 2012; Vanhaecht, Ovretveit, Elliott, Sermeus, Ellershaw & Panella, 2012). In part this stems from the inability of pathways to reflect individual needs and circumstances, though efforts are underway to try to personalise generic pathways using computer programmes (González-Ferrer, ten Teije, Fdez-Olivares & Milian, 2013).

So would such a pathway approach have any applicability to the complex process of deciding on issues of contact? The difficulty in developing a pathway is clearly the many and varied factors that could influence such a decision. The family history, the child's temperament and the parent's emotional health and behaviour are but a few of the influencing factors. However there is clearly merit in trying to develop a mechanism that brings a degree of consistency to the decision-making process.

This tentative pathway is rooted in the English legal process, and draws upon the elements of information that would be relevant in that jurisdiction. It is planned, as the next phase of the development process, to use the pathway in parallel with, but not influencing the decision of, current routine practice to assess its potential value, and so highlight any deficits in its structure and/or content. This clearly raises many ethical issues and methodological challenges, particularly around confidentiality for the subject families, and avoiding influence on the decision-making process, and with the assistance of the ethical committees which are over-seeing the process it is hoped that these will be addressed satisfactorily.

Conclusions

This attempt to develop a care pathway to assist in decisions about contact has produced a tentative protocol that has some face validity. For this specific pathway there now needs to be further evaluation, and refinement if it is to be of practical assistance to making decisions in this emotionally fraught area. As experience from many other fields of health and social care suggests, extensive field testing and re-evaluation are essential if any pathway is to achieve positive outcomes.

Even when considered robust enough for practical use, it would still need to be only advisory, because for such a radical departure from previous practice to be accepted it would be necessary for its value to be slowly demonstrated over a long period of time.

Making decisions about contact with birth families after a child has been removed from their care has profound impact upon the child's functioning and can exert a powerful influence upon their adult mental health. Making the best decision for an individual child is a daunting responsibility, and while this type of pathway may offer only a small contribution it is important that we continue to strive to improve the process to ensure that the outcomes for individual children are as positive for their future well-being as possible.

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Figure:

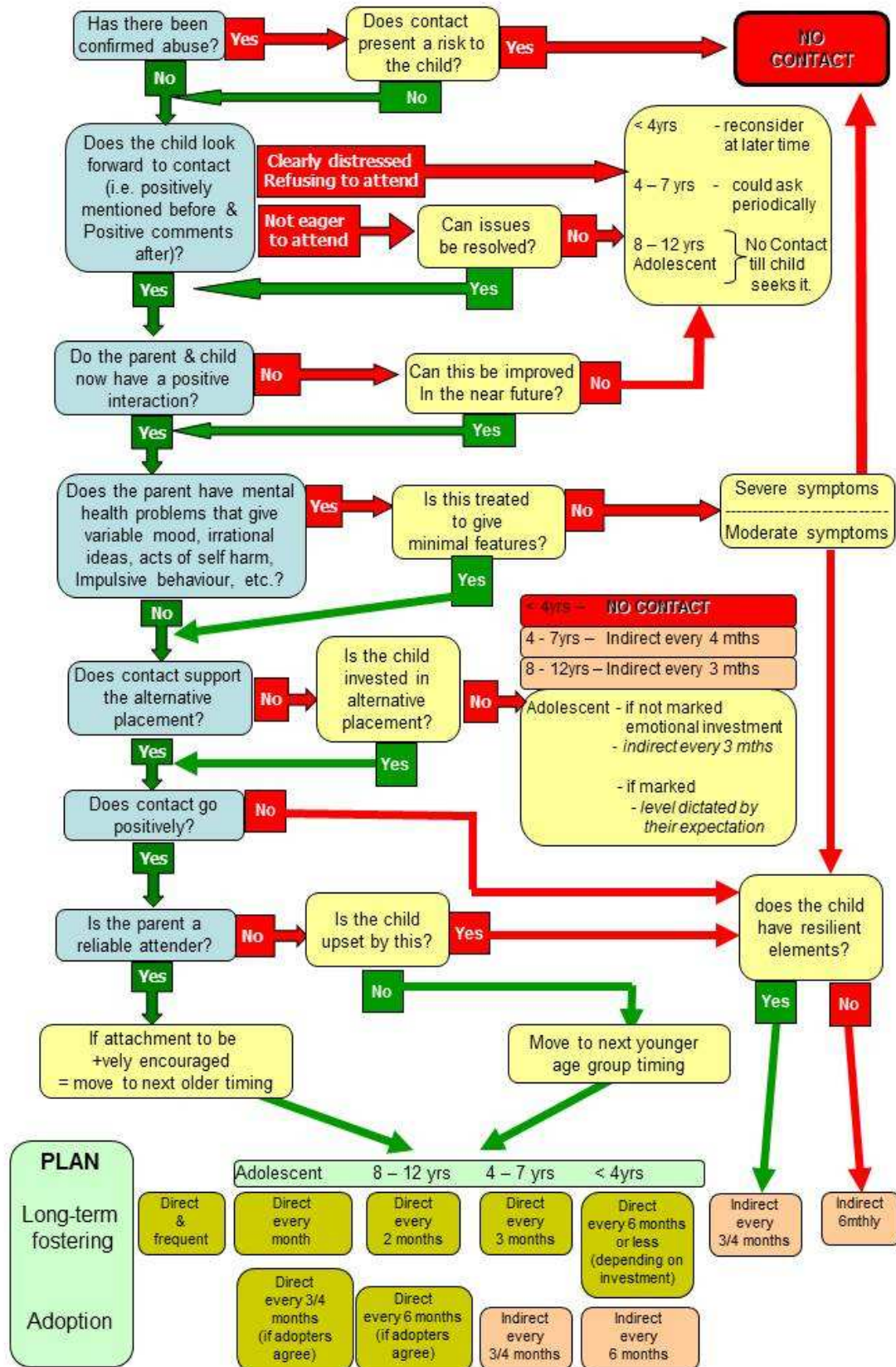


Figure 1 – Tentative Care Pathway for Child’s Contact with Birth Parent

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