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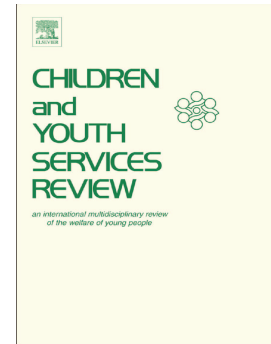
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Multi-Professional Work in Child Protection Decision-Making: An Israeli Case Study

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Abstract

Based on the premise that functional, multi-professional work in the child protection process is crucial to the delivery of effective service, this article reports on a qualitative study carried out to evaluate inter-agency and multi-disciplinary practice in Israeli decision-making committees. The investigation was directed by the systems approach and looked at practice in the context of the work environment. It examined the cases of 21 families referred to the committees of one of seven social services departments, with follow-up after six months. Data collection involved observations of the discussions and interviews with social workers. According to the findings, school representatives were the only professionals outside of the social service system to participate in the committees, and the committee chairs and senior social workers were dominant in making intervention decisions. Indication of groupthink bias was also found. The follow-up data revealed partial implementation of intervention plans and limited improvement in the children's condition. The analysis identified several systemic sources of difficulty towards achieving meaningful interagency working, including a lack of legislation and departmental organizational conditions. The study advocates an alternative, fresh, whole system approach to the delivery of services for vulnerable children and families.

Keywords: child protection; social worker; multi-professional work; decision making; systems approach; groupthink bias

1. Introduction

A wide range of services and professionals support families in childrearing to secure children's safety, health, development, and well-being or intervene at times when these targets are not achieved or at risk. Good practice calls for the effective cooperation and coordination of different agencies and professionals throughout the child protection process. The joint work with other professionals promotes early alerts to potential or emerging problems; safeguards that children in need will not slip through the net of services; sharing and analysis of evidence for a fuller picture of a family's circumstances; the pulling together of varied expertise, judgments, and resources when deciding on solutions of help; and regular evaluation of outcomes for the child and family (Department for Education, 2015; Munro, 2011; Thompson, 2013). Dysfunctional multi-agency working, information-sharing, and communication have consistently been reported in fatal child-abuse inquiries and serious case reviews in countries such as the UK, the US, Canada, Australia, and Israel (Brandon et al., 2009; Munro, 1999; Reder, & Duncan, 2003; State of Israel, 2010; Thompson, 2013).

1.2 Multi-professional working in Israel

One persistent impediment to the provision of effective child protection services in Israel, which is the context of this study, concerns the lack of the central government's 'working together' agenda (State of Israel, 2006, 2010). In the absence of integrative policy or legislation to set clear goals, roles, working arrangements, and responsibilities, the collaboration between government agencies, local-authority institutions, and non-government organizations had proved to be defective (State of Israel, 2006, 2010). In 2010, in the aftermath of 36 high-profile cases of children's deaths at the hands of their parents within a four-year period, the government appointed a multi-ministerial commission to recommend ways to establish effective, collaborative practice. Evidence presented to the commission

clearly indicated difficulties of information sharing between government agencies, and revealed several systemic barriers to multi-professional working. Some of these difficulties have also been reported internationally and include obstacles involving professional legal and ethical frameworks, such as principles of confidentiality; failure to connect to the impact of family stressors on children due to insufficient knowledge; administrative barriers such as a lack of formal means of information sharing; and political constraints relating to territorialism, status and power which may lead to lack of respect and mistrust among professionals (Appleton, Terlektsi, & Coombes, 2013; Broadhurst et al., 2010; Shnit, 2001; State of Israel, 2010).

The current study focuses on platforms for regular inter-agency and multi-disciplinary work in Israel's social service system – formal decision-making committees known as the Planning, Intervention and Evaluation Committees (PIECs). These committees operate in the Social Service Departments (SSDs) of every municipality, serving as a crucial juncture in the child protection process when professionals from different services and family come together to decide on the intervention plane required. Not covered under any comprehensive legislative framework, PIECs operate by administrative ordinance. Should family members and professionals fail to agree on intervention, the final ruling is made by the juvenile court. Over the past 20 years, the government has invested considerable effort in formulating policy on the PIECs work with the aim of strengthening decision-making and improving the safety and well-being of vulnerable children (Israel Ministry of Social Services and Social Affairs (IMSSSA), 2004, 2017). However, despite this meaningful transformation in practice, the lack of a central data-collection system has made it difficult to evaluate change or progress in the field.

This article presents findings from a broader pioneering, policy-evaluation study of the operation, process, and outcomes of the PIECs work (more findings are reported elsewhere, for example, authors' own 2016, 2017a). The specific focus here is an examination of the dynamic properties of working with other professionals through the PIECs. More precisely, the questions this article set out to answer are: How is the benchmark of working together implemented in the field, and why? As well as, what are the outcomes of the practice for children and families?

In general, there is very little local or international evidence of interactional, collaborative practice by professionals in conventional child protection, multi-agency discussions (discounting the 'family group conference', the 'family team meeting' or some other unique decision-making model).

1.2 Conventional group decision-making forums

The framework of formal multi-agency discussions as an arena where care plans are decided is well-established in several European child protection systems and in the UK. The rationale behind these group decision-making settings is fairly the same: 1) crucial decisions should not be left to the discretion of an individual social worker and; 2) a group of professionals can contribute diverse information, perspectives, and solutions to the deliberations and hence promote a decision's soundness and effectiveness (Burns, Pösö, & Skivenes, 2017; Gilbert, Parton, & Skivenes, 2011; Hitzler, & Messmer, 2010; IMSSSA, 2004, 2017). Nevertheless, the review of the literature does reveal variation across countries in some key features of the composition and processes of the decision-making body (author's own, 2017b; Burns et al., 2017; Gilbert et al., 2011). Let us look at some of these distinct PIEC features.

To start with, unlike other countries where forum members are not required to have any special knowledge of, or expertise in, child welfare such as the Swedish Social Welfare Committee and the Norwegian County Social Welfare Board which are made up (partly or completely) of laypersons (Skivenes, & Søvning, 2017; Svensson, & Höjer, 2017), PIECs consist of professionals from the social, education and health systems. Additionally, unlike UK case conferences, PIECs exclude police representatives (Department for Education, 2015) in order to reinforce the therapeutic aspects of the decision-making process and separate it from the juridical procedure (IMSSSA, 2004). For the same reason, the attendance of attorneys at PIEC discussions is highly controversial whereas in countries such as Norway, Finland, Sweden, Denmark, and England attorneys' participation is prescribed by state legislation or regulations (author's own, 2018). In terms of structure, PIECs are divided into two levels of practitioners distinguished by the objectivity or 'fresh eye' that they are able to bring to a case: 1) a permanent panel of professionals who have no prior engagement with the family and include the committee's chair, senior social workers from the SSD, and representatives of the education and health systems. This panel should include fixed personnel that through routine participation in PIECs are expected to accumulate experience and knowledge that could be built upon for competent membership; 2) a changing panel of various professionals and non-professionals who do have regular working relationships or contact with the family, including the family social worker and his/her supervising team leader (IMSSSA, 2017). Lastly, since PIECs do not have any legal status – unlike the Norwegian child protection practice for example, (Berrick, Dickens, Pösö, & Skivenes, 2016; Skivenes, & Søvning, 2017) – corresponding agencies are not legally obliged to allocate time, resources or personnel to the discussions, rendering their participation voluntary (State of Israel Comptroller (SIC), 2013).

Earlier evidence from field studies suggests that child protection formal discussions do not necessarily establish meaningful multi-professional work or enhance the quality of the decisions. For example, group decision making may result in defected decisions due to the effect of ‘groupthink’ which is characterized as: “A mode of thinking that people engage in when they are deeply involved in a cohesive in-group, when members’ striving for unanimity overrides their motivation to realistically appraise alternative courses of action (Janis, 1982 pp. 9).” The powerful dynamic of groupthink to avoid open conflicts and create pressures towards conformity around one course of action was found in child protection case conferences in the UK, including in the Israeli committees. Several researchers have reported low levels of disagreement; a tendency to support statements and solutions suggested by an influential group member; shared illusion of unanimity; and direct- or self-censorship of dissenters (e.g., see: Appleton et al., 2013; Bell, 2002; Broadhurst, Holt, & Doherty, 2011; Dolev, Benbenishty, & Timer, 200; Kelly, & Milner, 1996; Prince, Gear, Jones, & Read, 2005). Other reported obstacles to constructive, multi-agency decision-making relate to the professionals' characteristics, education, organizational position, and beliefs (Jent et al., 2011; Thompson, 2013); to the style and skill of chairing, notably the chairs' retention of considerable power in decision-making (Appleton et al., 2013; Prince et al., 2005); the limited communication and interaction between professionals prior to and during the discussion (Appleton et al., 2013); and the way that the discussions are organized and run, for example, the location and duration of a meeting, and the size and layout of the room (Appleton, Terlektsi, & Coombes, 2015; Dickens, Masson, Young, & Bader, 2015).

1.3 The systems approach

The literature offers several conceptual frameworks to explore multi-agency, decision-making practices in child protection (Appleton et al., 2013; Hitzler, & Messmer, 2010; Kelly,

& Milner 1996; Thompson 2013). This study novelty is in the application of the systems approach developed in safety engineering. The systems perspective calls for practice-centered observations and thorough investigation of front-line practitioners' experience in the face of the complexities of their work environment (Dekker, 2002, 2003; Reason, 2000). As Woods and Cook (2002) put it: "The issue is finding systemic vulnerabilities, not flawed individuals" (pp.140). The study of practice in context makes it possible to uncover the numerous contributing system factors that, taken together, interact with and influence human performance (Dekker, 2003; Reason, 2000; Woods, & Cook, 2002). In addition, systems scholars will seek to comprehend practitioners' 'local rationality' or sense making of the situation at the time they acted (Dekker, 2002; Reason, 2000).

There is some recognition that underlying organizational forces of the SSDs have a cumulative negative effect on the quality and quantity of service provision. These include a dearth of resources, heavy workloads, insufficient training, and inadequate professional supervision and support (author's own, 2017a). To sum, adopting the systems approach framework for investigating the PIECs multi-professional work and outcomes for children and families will broaden the analysis of the factors that influence practice, with greater attention paid to the organizational arrangements.

2. Methods

To explore the PIECs work in the field, a qualitative strategy of inquiry was used along with case-study design. Although, the systems approach does not specify methods, when targeting the inquiry at understanding people's sense making of their behavior in particular context, qualitative methods are expected to be used (Dekker, 2002; Woods, & Cook, 2002). Furthermore, the key elements of a case-study design, namely studying the phenomenon in context from a holistic perspective (Yin, 1994), correspond perfectly with the systems

thinking (Munro, 2010). The study was conducted at seven SSDs of five local municipalities across the country, the choice of sites followed convenience sampling (Miles, & Huberman, 1994). A case constituted a family referred to a PIEC; overall, 21 cases selected by SSD professionals were rigorously investigated.

2.1 The sample and data collection

For each case, detailed information was obtained by two data-collection techniques: direct observation of the committee discussion, and semi-structured interviews with the responsible social worker. The data analysis also included early communication with PIECs chairs to introduce the study objective. In total, the qualitative data comprised seven conversations with PIECs chairs; 22 observations of PIECs discussions (in one case, two discussions were held within a week as the mother did not attend the first meeting); 21 interviews with social workers immediately after the PIEC meeting; and 22 follow-up interviews with social workers six months later (for one family, responsibility for the case was divided between a disabilities social worker and a youth social worker). The mixture of different types of data and sources of data provided the study a strong quality of ‘triangulation’: “using two or more sources to achieve a comprehensive picture of a fixed point of reference” (Padgett, 1998 pp. 96). The study was approved by the research ethics committee of the London School of Economics and Political Science and the IMSSSA Research, Planning and Qualification Division. The informed consent of participants was obtained prior to initiating contact with them.

2.2 Data analysis

The data analysis was guided by the work of Padgett (1998), Robson (2002), and Miles and Huberman (1994). It began as close as possible to the start of data collection so that emerging patterns and themes could be re-examined in the field to help focus and shape

the next round of data collection. At the outset of the sequential analysis, all the interviews and observations were transcribed by the researcher to retain – what Padgett has called (1998, pp. 75) – ‘greater intimacy’ with the data, which were subsequently transferred to ATLAS.ti coding software. Coding frames were constructed and refined through ongoing review of the literature, including the safety engineering systems literature, and research questions, alongside the addition of ideas and reflections. After the codes were abstracted from the data, the researcher moved on to identifying patterns, themes, relationships, sequences, differences between sub-groups etc. Gradually, it became possible to establish more generalizations about the consistencies and trends identified in the data, and link them back to the existing empirical and theoretical literature.

3. Findings

3.1 The PIECs setting and arrangements

There was great variation in the duration of the PIECs discussions. Most PIECs (13/21) lasted for over an hour (M= 65.8 minutes; SD=20.3; Median=68 minutes; range, from 31 to 100 minutes). The common tendency of the SSDs was to schedule a number of consecutive discussions without any breaks in-between. This arrangement seemed to have an adverse effect on the focus and concentration of the chairs and other permanent members who attend all or most the PIECs meetings: participants erred over details or asked for specifics already presented; appeared distracted or preoccupied with their mobile phones; or ate their lunch or a snack during the discussions.

3.2 The PIECs forum

On average, the meetings were attended by seven professionals (SD=1.85; Mode=8 professionals). A total of 10 PIECs chairs were observed in action; six were the SSDs permanent chairs who held other senior positions in the department, and four (chairing six

discussions) were SSDs social workers temporarily replacing the regular chairs. One permanent chair (chairing one discussion) and all the substitute chairs had no formal qualifications for the role. On the whole, of the discussions observed, more were conducted by a qualified rather than a non-qualified chair.

Apart from the chairs, there was no resemblance between SSDs in terms of the permanent participants who were invited to the discussions. None of the PIECs included the prescribed core group of permanent professionals required. As regards the qualities that the permanent members were expected to contribute to the decision-making –case objectivity was recurrently disappointed since key members were or had been engaged with the family in question. This was true, for example, of the chairs of seven discussions that were closely involved with the family, either at the time of the discussion or not long before. Furthermore, the principle of permanent professionals was often violated due to great turnover, and the promotion of a multi-disciplinary perspective also fell short of expectations. For example, in 13 PIECs, there was only one professional point of view in addition to that of the social services, and in three PIECs, the forum consisted solely of SSD professionals.

In terms of the makeup of non-SSD professionals attending the discussions, school system representatives participated in the permanent panel of 13 PIECs; in the changing panel, school staff did not only participate in 16 PIECs but in 9 discussions had more than one representative. No representatives of preschool or infant-care programs were invited to the PIECs. Nor were the health services represented in either panel of the observed PIECs (four PIECs included a psychologist on the permanent panel who, however, was the local municipality social services' personnel and did not represent the health system). According to the observations, the presence and expertise of mental-health professionals, particularly psychologists and psychiatrists, was sorely lacking in some of the discussions as they might have been able to resolve the confusion surrounding the implications of diagnostic

evaluations and psychological tests. In fact, in their interviews, nine social workers mentioned this in hindsight.

3.3 Information sharing

Chairs tended to disregard their responsibility to distribute case material to the permanent professionals in advance. Overall, in a third of the PIECs (7/21), case materials were not available to the professionals, including to the chair, prior to the discussion. One SSD did not deliver case materials to non-departmental professionals as a matter of principle, the rationale being to protect the family's privacy. When documents were distributed, in some cases they were limited to the social worker's family assessment, called Psycho-Social Report (PSR), in other cases, they also included the reports of other experts. During the discussions, case records were often not fully transparent to all participants: in 14 PIECs, professionals had no access to the PSR due to insufficient copies and, in 16 PIECs, to other written reports that were not handed out to the forum or shared consistently with all the members. Usually, they were only available to a few of the SSD participants (namely, the chairs and social workers). To illustrate, the discussion ignored eight intervention recommendations that were mentioned in the written reports of professionals who did not attend and could not voice them.

3.4 Discussion of intervention solutions

Firstly, as regards six committees, there was evidence that some intervention decisions were not only decided prior the PIEC by social workers and mothers, but were already at the initial stage of implementation at the time of the discussion. The most striking examples were the case of an 11-year-old boy who had gone through enrolment procedures for out-of-home placement, and a case in which arrangements had been carried out to bring home two siblings after six years of out-of-home placement.

Another main finding was the marginal role played by social workers in deciding on help solutions. According to the evidence, this was due to a combination of their limited active participation in the deliberations and their limited ability to have an impact. For example, in six PIECs, social workers were not involved at all in the discussion of intervention alternatives. Out of 11 PIECs, where they were more involved and suggested one or more solutions – in six, none of their options were accepted; in four, some options were approved and some rejected; and in one, their recommendations were adopted in full. In the interviews, the social workers confirmed that their contribution to the discussion of the alternatives had been very limited; on a scale of 1-5 (*very poor* to *very good*, respectively), the average self-rating score was 1.6 (SD=1.6).

One explanation for their behavior, as voiced in the interviews, was that there were no options to choose from in any case. This argument carries substance. Generally, the selection of community services was limited, most programs were in great demand, and necessitated long waits (for example, in one municipality included in the study, the projected start of treatment in a mental-health service was eight months). As one chair stated, it was a matter-of-fact “translating needs into available services”. One discernible strategy of dealing with scarce community services, demonstrated by 10 PIECs, was to rely on the resources of the school system, for example, therapeutic programs for students and parental training. School staff were also relied on to support the implementation of intervention plans, for example, helping parents to fill in forms, inquire about services or prepare children for removal from home.

Another reason cited by social workers for their limited input was the desire to allow other professionals a say. This was consistent with the aspiration to share responsibility in complex cases, which was mentioned in the interviews as a reason for the initial referral to

the PIEC. The committees were reported as highly helpful since they enabled workers “not to remain alone”. Here are some typical examples from interviews which demonstrate that referring a case to the PIEC was less risky for workers than carrying sole responsibility:

There are cases like this one that are very complicated, things are not black and white, and you want to present it for consultation and have **them** make a decision.

First of all, in terms of responsibility, my responsibility is shared. It [the case] was brought to the committee, everybody heard that there is difficulty, there is a family at risk here; so it helps me. That is to say [to the forum], ‘you are alerted’ whatever it is called. So, when I raise it at the committee, responsibility is projected onto other people, including the school.

One key finding was the powerful position of chairs in making the final decisions. If an intervention was broached by a chair in the stage of discussing help alternatives, it was most likely to be adopted in the final plan; if it was rejected by a chair, it was most likely to be dropped. By and large, the deliberations about possible solutions came to a halt when the chair announced the concluding intervention plan. This was a crucial juncture at which some chairs exercised their decision-making power: in eight committees, the chairs made the final call on issues still outstanding; in two additional committees, they either included an intervention not previously discussed or made a substantial change to the “agreed-on” decisions. In a few cases, professionals offered comments after an intervention plan was presented, yet these mainly concerned the practicalities of implementation.

Other participants identified as powerful were senior SSD staff, such as managers of the departments or of Parent and Children Therapeutic Centers (PCTCs). In four cases, senior staff dictated the final decisions, which were then written out by the chairs in the prescribed form. In eight committees, intervention solutions were discussed confidentially between chairs and senior staff, mostly in whispers or, in one case, by an exchange of notes. The

dominance of the chairs and senior staff was also evident in the low level of opposition to their points of view and in the way that opposition was resolved when it did occur. Overt disagreement between professionals was evident in 11 discussions, about half of the PIECs observed. Usually, the other professionals tended to withdraw their argument against an intervention if it was disregarded by the forum or upon the presentation of considerations of inapplicability. There were, however, 15 incidents of enduring dispute, mostly over particular solution proposal, between members of the SSD and chairs or senior staff. Eight of the disagreements were resolved by chairs or senior staff making the final call; five were left open with no conclusive decision, and two ended in some form of compromise (for example, by setting a time limit on service provision).

Another indication of the influence of chairs and senior SSD staff was their habit of speaking as if they represented the entire forum, creating a shared illusion of consensus. For example:

What I suggest, in fact I suggest on behalf of all of us... (Chair)

There is no one here who thinks that there is something we can change in the home; the decision is therefore out-of-home placement (Chair)

Our impression is that all three boys should go to out-of-home placement (SSD Manager)

...I think that everyone reading the social worker's report will be very, very, very moved but also very, very stressed and worried (SSD Manager)

...I speak on my behalf, but maybe on behalf of the rest of the professionals sitting here... (PCTC Manager)

The following is a verbatim transcription of a discussion that demonstrates self-censorship of a counter-opinion in order to fall in line with the apparent consensus. In this case, professional participants including the chair – a colleague replacing the regular chair – found it difficult to resist the enforced consensus of the PCTC manager. The example comes

from a discussion on the removal from home of three siblings (aged 14, 11, and 8), the solution requested by their mother. Here is how it proceeded at two points in the discussion:

PCTC Manager: OK, I want to say, first of all before the ‘what’, meaning what out-of-home placements; I think it is obvious to all of us...

Chair: Yes.

PCTC Manager: That it is indeed right for the children to be in placement.

Team Leader from the SSD: I am not sure (laughing). I am not sure, OK? I am not.

PCTC Manager: Just a second, if not, so we need to discuss this.

Team leader: I do not, I do not know if the three of them.

The discussion then moved on to consider intervention options for each child individually and converged again on the alternative of removing all three to the same placement. The team leader agreed to the latter opinion, as long as it was recommended as a temporary solution. Next, another issue involved disagreement; what was the suitable placement for the middle boy? While the manager thought he should return to the placement he had just recently run away from, the chair suggested an arrangement with a more therapeutic approach and addressing juvenile court for a court order. The social worker zigzagged between the different opinions. It was later observed that the PCTC manager dictated the final decisions to the chair, and the latter wrote them down in the prescribed form. The intervention plan was then read aloud by the chair reporting that all the children should be removed to the prior placement of the middle boy. But the chair was not at ease with the final decisions and continued to talk about the matter. Realising she was not the only opposing member made her more confident:

PCTC Manager (addresses the team leader): You can say it.

Chair: No, say it! (laughing aloud) I don’t agree either. It is the authority of the law [that is needed]. I think that we need here a therapeutic out-of-home placement.

Team Leader: If I will say so, it doesn't mean that I am right.

Chair: (Laughing).

PCTC Manager: No, but it has to be said, is it not?

Team Leader: I said! I am trying. I think.

Chair: But it [the middle boy's placement] needs to be by a court order, this should be the authority now.

Social Worker: OK (sighs aloud).

PCTC Manager: (addresses the social worker) Do you think the issue of therapeutic placement should be checked?

Social Worker: I think a therapeutic arrangement should be checked.

Chair: Look, (in a loud voice) a therapeutic placement should be checked, I, I am writing here [on the form] anyway.

The chair ultimately makes a swift change in the decisions to include her recommendation for a therapeutic program and court involvement in regards to the middle boy.

A common shortcoming of the intervention plans of most of the PIECs was that they left loose ends; the basic technicalities of the service – for example, when it was to begin and when end, were not specified or – although the need for help was recognized, there was no final decision on an intervention or service in response. For instance, in eight PIECs, more information about a service had to be collected.

3.5 The situation six months after the PIECs convened

Half a year after the PIECs convened, intervention plan was fully implemented in two cases; partly implemented in 13 cases, and not implemented in six cases. In a few cases, the decisions taken had been changed significantly, for noteworthy reasons. In two cases, a psychiatrist had not attended the PIEC meeting and a subsequent psychiatric evaluation had rendered the decision on service provision irrelevant or unnecessary. In three cases, social

workers were observed to fall in with a dominant point of view that they explicitly opposed and, ultimately, did not follow through on the decisions but acted at their own discretion. For example, a social worker who with other forum members had rejected the chair's decision for family care at a PCTC instead of the local mental-health service, revised the decision according to her own standpoint after discussion with a PCTC manager. Overall, six months later, the condition of only a third of the children had improved whereas for the others, it had remained stable or deteriorated.

Additionally, the follow-up data revealed that the PIECs forums usually constituted isolated episodes of multi-professional work with no attempt afterwards to sustain consistent, cooperative working relations. For example, only six social workers reported that they maintained regular communication with school staff; in only two cases was this carried out on an orderly monthly basis. In the rest of the cases, it was a matter of participating in one formal school meeting, a couple of phone calls or total disconnection. Nor was the situation with the other professionals very different, even when the committee had specifically instructed the social workers to be in contact with them in order to fill in missing information.

4. Discussion

This article focuses on the multi-professional work of conventional child protection decision-making forums in Israel. The working assumption was that to protect children and ensure their well-being, the necessary professionals of relevant agencies should work in concert. Based on the relatively small number of cases followed, the routine PIEC practice demonstrated very limited and superficial multi-professional work. In general, the final intervention plans were very loose and ill-defined; not successfully implemented; and not resulted in consistent progress in the children's condition. It would thus appear that having more people involved is not a sure recipe for better decision-making or the improved safety

and well-being of vulnerable children. Owing to the system approach of the study, the problems revealed in practice are not construed as the failings of individual workers; instead, the discussion identifies underlying systemic forces that, together, interfered with the hoped-for, inter-agency impact. These include: the lack of a legislative framework, inadequate supervision activity in the SSDs, and a paternalistic culture.

To begin with, none of the PIECs comprised the prescribed group of permanent professionals. In effect, in nearly half of the PIECs observed, the decisions made were not actually applicable according to regulation since the permanent forum had fewer than three members. The multi-disciplinary composition was weak and ineffectual since social-service personnel outnumbered other professionals in both the permanent and changing panels, lending them considerable power and influence. One highly encouraging finding was the collaborative working relationship between the social and education systems. School representatives were prominent in their readiness for active involvement in the PIECs discussions and important actors in the provision of resources of help. Unfortunately, this finding related only to education professionals and school-age children. The expertise of health professionals, particularly mental-health specialists, was indispensable to decision-making in some PIECs and their greater presence could have opened up more resources and services. However, very disappointingly, at the time of writing, a change in regulations stipulates that as to agencies of the health system only children's clinic nurses are invited to act as permanent members and only when discussing very young children.

Evidence from the current study reinforces what has repeatedly been identified as the predominant obstacle to establishing multi-professional work in the PIECs, namely, that they have no legal status and the participation of other professionals is therefore a matter of discretion and good will (Ben-Rabi, & Amiel, 2013; Dolev et al., 2001; SIC, 2013).

Arguably, problems of family life have an obvious ripple effect on scholastic performance. Hence, the resolution of these problems was a clear incentive for both the schools and the social services, and a driving force for school representatives to participate in the discussions and contribute system resources for the benefit of children and families. The findings make a case for legislative action to mandate constructive professional cooperation. Any step forward in this direction should go beyond the mere attendance of outside professionals; it should aim to establish consistency and continuity in multi-professional work throughout the child protection process. The working pattern found in the study marks the PIECs as the high point of SSD engagement with school professionals, which lessened considerably in the aftermath of the discussions. That being said, the findings suggest that putting a legislative framework in place to set clear working arrangements between professionals will not in itself be a successful strategy. It does not offer solutions to other systemic problems impeding meaningful multi-professional working.

The practice uncovered leads to the conclusion that the PIECs serve social workers as a means of sharing case responsibility. A surprising finding was the negligible influence social workers had in the decision-making on help solutions. This is a dramatic change given their dominant role reported in the one and only national study conducted on the committees' operations, in the late 1990s (Dolev et al., 2001). Interestingly, a similar pattern of social workers taking a back seat in child protection discussions was reported by Appleton and her colleague (2013) in the UK. There, the authors interpret their finding as a positive indication of shared decision-making powers with the other participants. However, an alternative explanation is suggested here. Interviews revealed that the committees served an unofficial function for social workers; sharing the responsibility for a child's safety and well-being relieved the pressure on individual social workers. When worries about a child were publicly shared in the discussion, all the forum members became accountable for the child's condition

and when difficult decisions were made, all the forum members became responsible for their outcomes. The evidence that social workers may not be using the committees as intended may indicate a lack of confidence and proficiency to act on their own in complex cases. Elsewhere, the author has reported that social workers are not provided with adequate, continuous, professional supervision in their routine work, particularly at the pre-committee stage (author's own, 2017a). Co-work with supervisors could prove instructive in the management of challenging families to the point of rendering some referrals to committee superfluous.

Interestingly, case responsibility was shared without diluting SSD professionals' decision-making power. An obvious benefit of using observations in this study was that it allowed the investigation to see beyond mere PIEC attendance to the players impacting the actual decision-making. I would argue that professionals' participation was adversely affected by some shared difficulties in how the information was presented, and what information was or was not presented. The combined evidence showed that case information was not fully transparent to all the professionals when making decisions, whether because it was not distributed in advance or not shared in the discussions. Moreover, participants were usually exposed on the spot to a considerable amount of information, mostly verbal, and partially even new to key decision-makers. Presumably, they – particularly the permanent members – could not have fully digested the meaning and implications of all these data, but only receive a general outline or picture of the case. In addition, the powerful dynamics of groupthink directed the discussion towards consensus and away from alternative points of view, often obstructing a decision's adoption based on agreement and democracy. The inclusion of objective outside experts can protect against this strong group tendency to avoid conflict (Janis, 1982). Nevertheless, it is uncertain that the requirement of case non-involvement by professionals of the permanent panel would have made a difference. Observational data

clearly showed that the chairs and SSD senior staff were dominant in the discussions and powerful in influencing decisions. There was disturbing evidence, too, that the PIECs served as a rubber stamp for intervention measures already adopted and implemented.

To pull together the study findings into a final argument – it appears that the non-SSD professionals are not expected to significantly influence the decision-making on intervention plans. The all-knowing position – characteristic of the SSDs organizational culture – has already been cited as an obstacle to the effective working partnership with service users (authors' own, 2016; Kromer-Nevo, & Barak, 2006). Unsurprisingly, it also proved itself a barrier to strong, meaningful, multi-professional cooperation with other agencies. Efforts to enhance multi-professional work should start with social workers developing an overarching commitment to collaboration based on genuine openness and respect for the expertise and experience of other professionals. Until this is achieved, it is doubtful that the time invested by social workers and other professionals in preparing for and participating in the PIECs offers value for money. Given that the unsatisfactory availability of community help options has proved to be a profound hindrance to effective decision-making, it may be more sensible and pragmatic to invest these resources in increasing service availability and intervention options.

Finally, I would like to address the study limitations. Apart from the obvious one of the small number of cases, it is important to note that the sampling strategy positioned individual social workers as key gatekeepers. The author was dependent on SSD professionals to arrange access to case studies, which presents the possibility that the findings do not represent the broader picture of practice. Another weakness to be overcome in future studies concerns the non-SSD professional forum members; they were not approached and no

discussions were held with them. Yet, it is highly important to acquire a clear understanding of their experience and sense of involvement in the decision-making process.

5. Conclusion

To conclude, this study offers a window of opportunity, which can be projected into other contexts, to re-evaluate the conventional working approach, of individual workers solely carrying cases of families with very complex problems, in light of recent tendencies in the UK and beyond to deliver services for children and families by working in multi-disciplinary systemic ways. Examples of programs which proved evidence-based effectiveness to deal with some crucial weaknesses found in this study, are the Multi-Agency Safeguarding Hub (MASH) and the systemic unit model commonly known as 'Reclaiming Social Work' (RSW), both adopted in the UK (Crockett et al., 2013; Forrester et al., 2013). The depth of change suggested by these new ways of working requires a considerable investment of resources. However, the evaluation of their effectiveness shows that, ultimately, they lead to substantial service improvement and successful outcomes so that, in the long run, they are highly cost-effective.

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Highlights

- Limitations to multi-professional work were found in Israeli child protection decision making committees.
- Indication of groupthink bias was also found.
- The follow-up data revealed partial implementation of intervention plans and limited improvement in the children's condition.
- The analysis identified several systemic sources of difficulty towards achieving meaningful interagency working, including a lack of legislation and departmental organizational conditions.

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