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An Evaluation of Child Protection Reform in Israel.

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Abstract

This thesis focuses on efforts to improve the provision of effective help to children and their families who are suffering or likely to suffer from significant harm from abuse or neglect through making better care plan decisions for them. The research evaluates the operation, process and outcomes of a recent national reform in the Israeli child protection decision making framework of Planning, Intervention and Evaluation Committees (PIECs) designed with the ambition of establishing a new way of working so that children and families will get the right help. A systems approach was undertaken as a conceptual framework in order to allow a whole-organisational understanding of what is happening in the field, and why. The research employs a qualitative method of inquiry and a case study design. The cases of 21 families brought before the PIECs were investigated and their situation was followed up after six months. Data were collected through interviews with professionals and parents, field observations of the committee meetings and document review. The key finding of the research is that there is a very limited realisation of the reform's aims of strengthening practice and improving the safety and well-being of vulnerable children. The reform's lack of success is explained by being ill-suited to the organisational working environment and culture. The analysis identified key systemic forces that came together to interfere with the reform having the hoped for impact across the various stages of the child protection process, including: workforce lack of skill, time, professional support, and organisational messages about practice priorities. The main conclusion of this thesis is that for good child protection work to be accomplished just drafting good reforms and telling the workforce what to do is not enough. This thesis advocates adopting systemic multi-professional working models to deliver services to children and families.

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List of Acronyms

INCC   Israel National Council for the Child

IMLW   Israel Ministry of Labour and Welfare

IMSSSA   Israel Ministry of Social Services and Social Affairs

IMWSS   Israel Ministry of Welfare and Social Services

PCTC   Parents and Children Treatment Centre

PIEC   Planning, Intervention, and Evaluation Committees

PSR   Psycho-Social Report

RSW   Reclaiming Social Work

SIC   State of Israel Comptroller

SSD   Social Services Department

SW   Social Worker

SWAL   Social Worker to the Adoption Law

SWCP   Social Worker to Court Proceedings

SWYL   Social Worker to the Youth Law

UNCRC   United Nations Convention on the Rights of the Child

Acknowledgments

Chapter 1

Introduction

1.1 Overview

This thesis deals with the issue of providing effective help and adequate standards of care to children and young people who are suffering or likely to suffer from significant harm from abuse or neglect. The rich empirical evidence about the lasting and long-term negative effects of child maltreatment, including health and mental health comorbidities, dysfunctional behaviours, relationship problems and its impact on the process of brain development[1] (e.g. Department of Health 1999; Glaser 2000; PreVail 2010) together with the global commitment to guarantee the child's right to protection from maltreatment reinforced by the United Nations' Convention on the Right of the Child (UNCRC) (United Nations 1989), secures the significance and potency of the current research.

The subject of intervention in order to preserve the safety, welfare and appropriate development of vulnerable children and to create good outcomes for them is investigated in this thesis in the context of contemporary reform introduced into the Israeli social services system.

The ratification of the UNCRC by the government of Israel in 1991, placed on the state a duty of establishing the measures required to react to incidents of maltreatment, reduce their occurrence and pervert their recurrence.

Article 19 of the UNCRC (United Nations 1989) reads as follows:

1. State parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in care of parent(s), legal guardian(s) or any other persons who have care of the child.

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[1] For example, past long-term maltreatment experience has been associated with chronic disease including heart disease, cancer; personality disorders; difficulties in forming or sustaining close relationships; establishing oneself in the workforce and maltreatment of one's own offspring in adulthood (Department of Health 1999; PreVail 2010). Research on the neurobiology of child maltreatment provides evidence of some biochemical, functional and structural changes in the brain following child abuse and neglect which make a considerable contribution to explaining the emotional, psychological, and behavioural difficulties shown in these children (Glaser 2000).

2.   Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

The process, from identifying needs to the delivery of successful help to children and young people living under detrimental family circumstances, depends on the accuracy and soundness of child protection decision making (DePanfilis and Grivin 2005). The quality of social workers' decision making is a problem that had been, and continues to be, of major political importance in Israel (Israel Ministry of Social Services and Social Affairs (IMSSSA) 2014). The priority given to the issue by the government is driven, among other things, by harsh public reactions when tragic events of child death or serious harm from maltreatment occur and extreme levels of parents' condemnation of professionals' power to make life-changing decisions, escalating in recent times to threats and violence towards individual social workers (Israel Knesset 2004; State of Israel Comptroller (SIC) 2013; IMSSSA 2014).

For over a decade the government has invested considerable efforts into formulating policy on child protection practice that will create the conditions that enable professionals to make the best decisions about what help services to provide children and young people in order to improve their safety and well-being (Dolev, Benbenishty and Timer 2001; Israel Ministry of Labour and Welfare (IMLW) 1995, 2002). These intensive endeavours have recently yielded a well-resourced reform designed with the ambition of improving intervention decisions carried out in formal committees called Planning, Intervention and Evaluation Committees (PIECs), which started to be implemented in the field nation-wide from 2008 and it is still evolving to date (IMSSSA 2004a, 2004b, 2014; SIC 2013).

The committees consist of multi-professional practitioners, representatives of the welfare, education and health systems, and family members, and serve as the key framework for consultation, assessment and decision making concerning care plans for vulnerable children, young people and their families (IMSSSA 2004a). The committees have the power to authorise the removal of a child from his or her family if it is decided that parents cannot be helped to keep their children safe from harm. If the child is in an

out-of-home arrangement, then the committee must review whether there is enough safety for the child to return home (IMLW 1995; IMSSSA 2004a).

The reform represents policymakers' conceptions of the core practice principles that underpin sound decision making and effective service delivery, including working together with various professionals, partnership with parents, children's participation, systematic documentation of practice and follow-up and review of decisions outcomes (IMSSSA 2004a, 2004b). It introduces new regulations, procedures and standardised tools that were designed as purposeful directives towards an advanced routine way of working with children, families and other professionals through all stages of the child protection process (IMSSSA 2004a, 2004b).

To date there is no systematic national data on the operation of the reform in everyday child protection work. Some small-scale investigations and evaluation schemes carried out previously, and alongside the current research taking place, have shown that the reform was still not fully adopted in practice (Dolev, Szabo-Lael and Ben-Rabi 2007; Dolev et al. 2007b; Ben-Rabi and Amiel 2013; SIC 2013).

The objective of the current research is to provide the first in-depth insight into the reform's implementation. It is designed to empirically investigate the extent to which decision making practice carried out in the field of child protection follows the reform's ways of working and why; as well as developing specific answers about the relationship of the changed practice to outcomes for children and families. The conceptual framework applied in this research to study the operation, underlining process and outcomes of the reform's implementation is the 'systems approach'. The systems approach has a vast and developing literature, its origin, progress and core concepts will be discussed in detail in the second chapter of this thesis. At this point it should be mentioned that the systems way of thinking was recognised as being highly useful for investigating the everyday performance of practitioners at the sharp end of services provision in various fields including child protection (Reason 2000; Dekker 2002; Fish, Munro and Bairstow 2008; Munro 2005a, 2010, 2011).

Principally, the systems approach "places individuals within the wider system of which they are part" (Munro 2008a p. 17) when it comes to studying their performance. This is a holistic perspective that captures individual front-line workers' practice within its

organisational context or multiple features of the workplace and seeks to identify the interconnections between the two (Reason 2000; Dekker 2002; Munro 2005a, 2011). Using a systems perspective in the current study will allow recognising the underlying organisational factors of the social services system that interact to influence as barriers or facilitators to implementation of the reform in everyday child protection work. It will thus advance the analysis from describing how changes prescribed by the reform are being acted on by social workers to understanding why.

To sum up, the aim of the research is to enhance the understanding of how and why the reform succeeds or fails to improve child protection decision making, so that children and families get the right help they need. The research therefore addresses the following three questions:

1.   What is the reform's impact on achieving the desired targets of:

  a)   Improving the decision making process.

  b)   Better working relationships with parents and carers.

  c)   Greater participation for children.

2.   How does the work environment impact on the implementation of the reform in the field?

3.   What is the reform's impact on outcomes for children and parents who were referred to the PIECs?

The research employs a case study design to explore these questions. The cases of 21 families (45 children in total) brought before PIECs were investigated and followed over six months. Data were collected through interviews with the committee coordinators, social workers and parents; field observations of the committee meetings; and document review. This is in order to obtain a whole-system perspective of the happenings.

To conclude, current policymaking actions in Israel provide the opportunity to "actively participate in the meeting of scientific knowledge and social action" (Weiss 1998 p. 17). By investigating the reform's implementation while events are still in progress this research finding can serve to signal whether, and if so, what kind of, changes are warranted

to procedures to improve policy programming so that child safety will be protected and families' well-being is improved.

The current research also seeks to fill some gaps in the existing body of literature. To date, only one nationally-scaled study conducted in the late 1990s prior the reform, rigorously and systematically explored the committees' organisation, working processes and outcomes (Dolev et al. 2001). Family members' experience of the decision making process is a significant issue that as far as is known has not been empirically investigated in the Israeli context. The local empirical inquiry typically focuses on identifying factors that influence individual social workers' judgments about risk assessments and intervention recommendations, however in isolation from their work environment (for example: Davidson-Arad 2001a, 2001b; Davidson-Arad and Benbenishty 2008; Davidson-Arad and Wozner 2001; Benbenishty et al. 2002; Gold, Benbenishty and Osmo 2001; Enosh and Bayer-Topilsky 2014). More generally, this research is aimed to contribute to debates about development of top-down reformative actions to enhance child protection decision making by raising awareness of the organisational conditions required to prescribe changes to meet expectations.

1.2   Outline of the Thesis Chapters

The Chapters of thesis proceed as follows:

In Chapter 2, a review of the literature is presented. The chapter focuses on two broad areas of research knowledge: decision making in child protection and a systems approach. The first section draws attention to the crux of the complexities of making decisions in the uncertain and ambiguous field of child protection and critically reviews key international developments to enhance practice carried out to date. In the second section, the core concepts of the systems approach are presented and discussed in terms of their advantages as a conceptual framework for exploration in this research.

In Chapter 3, the broad Israeli context of this study is introduced taking a systems approach. The chapter starts with sufficient coverage of the distinctive features of the Israeli social services system. It highlights the unique characteristics of child protection practice, services, and the working environment at the social services departments.

Attention is drawn to legislative, parliamentary and policymaking milestone developments that shape service provision for vulnerable children, young people and their families and set the ground for the reform in the committees' work. Lastly the core principles of the reform are set out and the progress of its implementation, until the data collection for the current research commenced, is described. The aim of this section is to provide a general outline of the reform while a more in-depth engagement with the prescribed new way of working is carried out in the empirical chapters by discussing the various tasks of the decision making process. Since the committees' name had been changed in the framework of the reform the term 'Decision Committees' will be used throughout the thesis when referring to the time prior to the reform and 'Planning Intervention and Evaluation Committees' (PIECs) when present practice is discussed.

In Chapter 4, the methodology of the study including the research design and methods used to conduct it are explained in light of the research's goals and objectives and reflected on in terms of both strengths and limitations. Briefly, this research adopts a case study design; data were collected using interviews, field observation and document review over a sustained period of time lasting just over two years. The chapter also accounts for the ethical considerations undertaken by the researcher; describes the process of data analysis; and concludes with discussion of the study's rigor.

In the following five chapters (Chapters 5 to 9) the findings of the thesis are presented, interpreted and discussed. Due to the substantial volume of data collected, considerable thinking had been invested in how to organise and address it to the readers in a meaningful and accessible way. The rationale behind the current structure is twofold. First, it seems essential to dedicate separate chapters to parents, children and social worker participants in order to draw attention to the particular role, experience and involvement of each distinctive stakeholder. Second, although the practice investigated is a continuous process that was carried out over a considerable period of time it became necessary to artificially break it down into consecutive primary stages. It is then that practitioners' preparation work previous to the committees, the discussions in the committees, and the follow-up practice in the aftermath of the PIECs, are mainly presented in separate chapters.

In Chapter 5, social workers' practice from the initial referral of the family to their responsibility up to the point of the discussion is explored. The chapter opens with

descriptions of workforce and organisational environment characteristics. It then focuses on practice related to the referral of a case to the PIEC and conducting family assessment. The chapter ends with content analysis of 21 family assessments reports, called 'psycho-social reports' (PSRs), which are later used to present the case before the committee. Data presented here are based on interviews with social workers and committees' coordinators as well as document review.

In Chapter 6, which is the heart of this thesis, a detailed analysis of the decision making process carried out in the committees is presented, based chiefly on observational data and also interviews with professionals. The chapter includes rich and comprehensive analysis of wide-ranging factors which have been found to have an impact on the quality of intervention decision making such as: setting arrangements; forum composition; chairing qualities; the quality of the information basis; and the availability of help solutions etc. Since the chapter covers a substantial amount of data the issue of parents' and children's participation is analysed in the following chapters.

In Chapter 7, a different perspective on practice is presented; that of the parents at the receiving end. Findings presented here are mainly derived from conversations with parents, while some practice tendencies are also supported by data from interviews with social workers and observations. The analysis focuses on the reform's ambitions to establish constructive partnerships with parents and facilitate their effective participation in the decision making process.

In Chapter 8, the imperative issue of children's right to participation in decision making is discussed. The analysis focuses on the duty placed on practitioners to listen to the child's voice and give it weight in considerations when making decisions in the PIECs. Due to the ethical considerations discussed in Chapter 4, children were not directly engaged with throughout the study. The analysis of children's involvement in practice and decision making is hence based on data collected through observations and interviews with professionals and parents.

In Chapter 9, the closing empirical chapter of the thesis, the 21 families of the research sample are followed half a year after they participated in the PIECs in order to evaluate the outcomes of the decisions on their lives. Findings presented here are based on follow-up interviews with social workers. The first section of the chapter deals with the

implementation of the intervention plans and their impact on children's safety and well-being. In the rest of the chapter the analysis of practice outcomes continues while findings are now arranged around the core practice principles the reform was hopping to achieve.

In Chapter 10, the main findings of the research are pulled together into final conclusive arguments. The chapter starts by discussing the main systemic factors identified as having cumulative impact on the reform's realisation in the field, including: heavy workloads; organisational culture; professional supervision and support; training and qualifications etc. In the rest of the chapter the thesis' implications for policy and research are discussed.

Chapter 2

Literature Review

The current chapter covers two key fields of empirical knowledge underpinning this thesis. It starts with a review of the lessons learned from international research as to the core principles of good child protection practice and decision making. The reason for heavily drawing on international literature is that Israeli research and policies in this field of child abuse and neglect are comparably young and underdeveloped. Child maltreatment started to be perceived as a universal public concern in Israel from the late 1980s (Ajzenstadt and Cavaglion 2004) and was considered as a relatively new area of research until the late 1990s[2] (Auslander 2000). Interest in practitioners' decision making had only started to blossom as from the early 2000s (e.g. Gold et al. 2001; Davidson-Arad 2001a, 2001b; Benbenishty et al. 2002; Benbenishty and Chen 2003; Davidson-Arad and Benbenishty 2008; Enosh and Bayer-Topilsky 2014). The discussion here is focused around the intellectual, emotional and relationship (with both family members and professionals) dimensions of the task and is aimed to portray both progress and long-standing challenges to sound decision making relating to factors in the individual and the organisational context. The second section of the chapter introduces the systems conceptual framework undertaken in this thesis. The account highlights the advantages of systems thinking or 'new view' in comparison to the traditional 'person-centred approach' and its applicability and contribution to investigating child protection practice and policy reformations.

2.1   Decision Making in Child Protection

2.1.1   The Context: The Challenges of Task Environment

Child protection workers are faced daily with the task of making decisions related to the most valued aspect of today's community life – the family. These decisions have a

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[2] According to Auslander's (2000) overview of the state of the art of social work research in Israel between 1990 and 1998 issues relating to child abuse and neglect gained only little attention. Studies in child protection focused on children in residential or foster care or on professionals' (e.g. social workers, teachers and physicians) knowledge and attitudes.

profound impact on the future of vulnerable children, their parents, and society as a whole (Sheehan 2001). Each stage in the child protection process, from the initial assessment of child and family circumstances, planning the appropriate intervention, through the provision of services and review of their outcomes to the case closure, is a crucial juncture where countless decisions, some of great consequence, are made (Munro 2008b). Practitioners have to make decisions and act under extremely complex and demanding conditions. Their dynamic work environment is characterised by high emotional pressures (Munro 2008b) and intrinsic uncertainties and ambiguity which are impossible to completely eradicate (Parton 1998; Munro 2011). Decisions must also be made within time constraints due to the potential danger faced by vulnerable children (Shlonsky and Wagner 2005); these confront workers with significant challenges.

The definition of maltreatment is variable, unclear and depends on social and cultural circumstances (Giovannoni and Becerra 1979; DePanfilis and Grivin 2005; Davidson-Arad, Peled and Leichtentritt 2008; Rycus and Hughes 2008; Munro 2008b). Since the concept of 'battered child syndrome' was first introduced to the public by the ground-breaking work of Kempe in the 1960's (Kempe et al. 1962), child maltreatment is often a general label for four sub-categories of abuse: physical abuse, sexual abuse, emotional abuse, and neglect (Department of Health 1999). Recently, exposure to intimate partner violence had been recognised as a fifth type of maltreatment (PreVail 2010). Yet, there is no universal agreement on accepted definitions for any category of maltreatment.

Information about the child and family situation may be incomplete and lacking key evidence (Munro 1996). Usually, facts are not available but rather an operational search for evidence can reveal pieces of information that may or may not be accurate or important. Reports may be unreliable, contradictory and/or misleading (Benbenishty and Chen 2003) yet, must be taken seriously as they might still carry substance. Parents' response to allegations of harm and neglect must be interpreted with caution; parents may avoid authority's inquiry for reasons unrelated to their parental care or use cooperation as a strategy to deceive practitioners (Broadhurst et al. 2010a). One of the most difficult decisions workers have to make is to assess the risk of future maltreatment of children referred to their services, based on the information available at present (Gambrill 2008); this involves making predictions and thus inaccuracies are unavoidable (Munro 2011). Moreover, there is still much that we do not know about what makes for an effective

prevention and treatment strategy for parents and abused or neglected children (PreVail 2010) and why intervention decisions made in what seem to be identical situations lead to different outcomes (Benbenishty and Chen 2003). Finally, effective practice depends on constructive working relationships with various stakeholders, both professional and family (Turnell and Edwards 1997), while constantly balancing competing interests, rights and needs (Bell 1999a) such as parents' right to privacy and autonomy against the responsibility to protect their children (Gambrill 2008).

In this difficult area of child protection errors are an inevitable part of the practice, and often it is not known how great the margin of error is (Munro 1999; Gambrill 2005). Mistakes can lead to serious harm to children, through either subsequent maltreatment (false negative errors) or unwarranted separation from their parents (false positive errors) (Shlonsky and Wagner 2005). When confirmed, such errors typically provoke strong public condemnation and outcry over ineffective practice (Munro 2010).

2.1.2 The Progress: Improving Child Protection Decision Making

This section is based on practice principles drawn from the rich literature concerning professional judgements, partnership with parents, children's participation and multi-professional work that provides guidelines for improving the quality of decision making in child protection. These key practice dimensions are integrated in the Israeli reform of the PIECs.

Improving professional judgment: The cognitive literature identifies two fundamental modes of reasoning: intuitive and analytical, which are used in different combinations when making decisions[3] (Hammond 1996; Gilovich and Griffin 2002; Hardman 2009). Intuitive reasoning is said to be fast, effortless, unconscious, and most likely involves parallel processing, whereas analytical reasoning is slow, effortful, deliberate, and involves serial step-by-step processing (Munro 2008c; Hardman 2009). Our intuition has a vast capacity to process a large amount of complex information and recognise patterns, based on our lifetime experience and genetic inheritance (Munro

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[3] For example, Cognitive Continuum Theory of Judgement (Hammond 1996); The Adaptive Decision Maker Approach (Hardman 2009) and Dual- Process Theories (Gilovich and Griffin 2002).

2008c). Analytical reasoning, in contrast, is very limited. Information is processed in a logical and linear fashion, one piece at a time, based on our formal knowledge (Munro 2008c).

Historically, clinical judgment and decision making procedures in the child protection practice relied largely on intuition, case studies, and professional experience (Rycus and Hughes 2003; Hughes and Rycus 2007), while analytical thinking has a subordinate status (Sheppard 1995). However, growing interest in how people make decisions in real-world situations has led researchers to question the fallibility of intuitive decision strategies. In the 1950s Herbert Simon (1956) in his seminal study identified the impact of environmental and mental constraints, such as time pressures and limited knowledge and computational power on decision making, an idea that is known as "bounded rationality" (Simon 1956). Following on from this work, the 1970s were marked by extensive study on human cognitive shortcuts, or heuristics, generating a body of research called "heuristic and biases research" (Munro 2008b). The literature[4] describes how we use heuristics, later called by Gigerenzer, Czerlinski and Martignon (2002) "fast and frugal" thinking, that whilst quickly simplifying complex cognitive tasks, could also lead to systematic errors (biases) in the decision making process (Kahneman, Slovic and Tversky 1982). Of particular relevance to the child protection context are: availability bias, fundamental attribution error, confirmation bias, and hindsight bias, which result in partial use of information and barriers to critical thinking and consideration of alternative views, and hence may dilute the quality of decisions (Howitt 1992; Munro 1999, 2008b, 2008c; Gambrill and Shlonsky 2000; Gambrill 2008).

Availability heuristic, which involves estimating frequency or probability by the ease with which instances could be brought to mind (Hardman 2009) can lead to a bias in which facts are more likely to have a greater impact on workers' judgement if they are vivid, concrete, emotion-laden and are either the first or most recent (Kahneman et al. 1982; Munro 1999). In practice this error is often manifested in case conferences, where written case records and reports are overlooked, in favour of verbal current information from testimony or interviews (Munro 1999). The fundamental attribution error, whereby

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[4] The research of Amos Tversky and Daniel Kahneman is widely recognised as the most significant work in this field. Set forth in the book Judgement under Uncertainty: Heuristics and Biases (Kahneman, Slovic and Tversky 1982).

people underestimate the influence of situational factors on other people's behaviour (Ross 1977) is a well-supported tendency found in many experimental fields of study. It involves attributing individuals' behaviour to their psychological and personal characteristics while failing to notice the contextual and environmental causes for their behaviour (Jones and Harris 1967; Ross 1977). In child protection it is demonstrated by a trend to attribute the child's condition to the mothers' emotional and functional problems, while ignoring, for example, the family's economic hardship (Surkis 2006).

Numerous researchers highlight the significance of child protection workers' skill at revising their views over the progress of a case as a key source of good decisions (Howitt 1992; Farmer and Owen 1995; Munro 1999). Yet, conformation biases involve a tendency to seek and overweight evidence that support initial beliefs and disregard or underweight evidence that might be inconsistent with them (Klayman 1995; Gambrill 2008; Hardman 2009). In her analysis of inquiries into child abuse tragedies in the UK, Munro (1999) describes this bias as a major contributor to fatal errors in child protection work. Practitioners, she argues employ a number of strategies to ignore evidence contrary to their assessments, e.g. they avoid, forget, reject as untrue and/or re-interpret new information. The term hindsight bias or "I knew it all along" bias (Plous 1993 p.35) is used to describe the observation that an uncertain outcome (e.g. the child's abuse) often seems more likely after it is known that the outcome has occurred (Hardman 2009). Practitioners can see the parents as to blame for an accident to their child, overlooking the fact that the likelihood of danger in the situation was minor (Munro 2008c). In addition, as indicated by Hardman (2009) hindsight bias is a great barrier to learning from feedback. In light of feedback people often misremember (or reconstruct) their earlier judgements, such that they believe they foresaw the future more accurately than they actually did.

Another line of evidence pertinent to child protection practice where intervention decisions are regularly made by a group of professionals relates to the debate in the literature about whether several heads are better than one. Growing evidence in psychological literature suggested that groups do not necessarily enhance the quality of decisions and may be affected by their own particular bias (Plous 1993; Kelly and Milner 1996). Such a bias put forward by Moscovici and Zavalloni (1969) is known as 'group polarization' which refers to the tendency of group discussions to amplify the initial inclinations of individuals within the group leading towards either extreme conservatism or

riskier courses of action. The landmark research of Janis in the early 1980s showed that group decision making may result in defected decisions due to the effect of 'groupthink'[5]. Groupthink is characterised 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 p. 9)

The theory of groupthink suggests that a combination of high group cohesion, structural faults in the organisation, and a provocative situational context, creates a drive to achieve consensus around an extreme position and close-mindedness to alternative views (Janis 1982). 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 (e.g. see: Kelly and Milner 1996; Corby, Millar and Young 1996; Bell 1999b, 2002; Dolev et al. 2001; Prince et al. 2005). For example, several researchers reported low levels of disagreement, a tendency to support the first sufficient solution suggested by an influential group member, shared illusion of unanimity and direct censorship of dissenters in child protection case conferences (Corby 1987; Farmer and Owen 1995; Corby et al. 1996; Bell 1999b; Dolev et al. 2001; Prince et al. 2005).

The next step in research was to suggest ways by which practitioners can "educate their intuition" using their analytical skills (Philips, Klein and Sieck 2004). Consequently, during the early 1980s more formal and analytical approaches to decision making started to be incorporated into the practice of child protection (Rycus and Hughes 2003; Gillingham and Humphreys 2010). Beginning with the pioneering study by Johnson and L'Esperance (1984), who developed a statistical predictive model for maltreatment recurrence, decision aids, guidelines, checklists, and formal risk assessment tools have become tightly woven into the fabric of child protection practice in the English speaking world and lately

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[5] Janis (1982) developed this concept to explain large-scale policy fiascos such as the Bay of Pigs and the Cuban missile disaster in the US foreign policy history.

developed into computer technology systems[6] (Shlonsky and Wagner 2005; Hughes and Rycus 2007; Peckover, Hall and White 2009). It was hoped that analytical technologies, tools and artefacts would promote a decision making process that is more reliable and accurate as well as more explicit and defensible than clinical judgement by individual workers (Hughes and Rycus 2007; Munro 2008b). Such a progressive approach is also accentuated by recent reformation of the PIECs decision making process (IMSSSA 2004a, 2009).

Unfortunately, a growing body of evidence from field studies[7] has led researchers to take a less optimistic stance on the contribution of analytical decision making aids to facilitate good practice; their utility was found to be inconsistent and their effectiveness compromised by numerous factors (Wald and Woolverton 1990; Rycus and Hughes 2003, 2008). Structured tools used by many child welfare agencies often demonstrated poor reliability and validity; had not been empirically tested first; and were fundamentally too concerned with family dysfunction and risk factors that threaten the child protection from harm while ignoring the safety side of the equation, i.e. the discovery of existing strengths and safety (Wald and Woolverton 1990; DePanfilis and Scannapieco 1994; Turnell and Edwards 1997; Rycus and Hughes 2003, 2008). Several studies conducted in the UK, the US and Australia showed that formal tools were not used in day-to-day practice as intended. For instance, workers were found to complete decision making instruments after making decisions based on personal clinical judgement; to deliberately manipulate the tools to achieve the wanted outcomes; and to have an expanded habit of noncompletion of key information (English and Pecora 1994; Lyle and Graham 2000; Hughes and Rycus 2007; Bell et al. 2007; Gillingham 2009). Furthermore, an accumulated body of research revealed that technological solutions, in fact, have negative and disrupting effects on professional reasoning processes. This includes: disturbance to the temporal and narrative flow of the information; restriction of the type and amount of information that is used; less individual and flexible response to real-life complex cases; and difficulties in inter-agency communication. Yet, most notable is evidence of the demanding and time consuming

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[6] Examples are the UK's computerised assessment system 'Integrated Children's Services' and the 'Structured Decision Making' developed by the Children's Research Center in Wisconsin and widely used in North America and Australia (Bell et al. 2007; Gillingham and Humphreys 2010).

[7] The most ground breaking papers were Wald and Woolverton's (1990) seminal article entitled 'Risk Assessment: the Emperor's New Clothes?' and the extensive review and analysis of the literature on risk assessment in child welfare, published by Rycus and Hughes (2003) known as the 'Policy White Paper – Issues in Risk Assessment'.

nature of tools and technologies coming at the expense of practitioners' direct work with families (Bell et al. 2007; Gillingham 2009; Peckover et al. 2009; Broadhurst et al. 2010b; Munro 2011; Saltiel 2015).

Another line of progress relates to the role of emotions in decision making. Child protection practice involves both thinking and feeling (Morrison 1997). The interaction between workers and the family can stimulate highly charged emotions like anxiety, fear, distress and anger on behalf of all parties involved which may interfere with practice (Bell 2002; Jones 2003; Morrison 2007). It is suggested, for example, that workers may in fact avoid engaging with children because of the painful and overwhelming emotions triggered by communicating with them (Bell 1999b, 2002; Munro 2011). Emotions are widely recognised in the literature to have a profound impact on decision making, however, traditionally they have been regarded as an obstruction (Baron 2008; Hardman 2009). The dominant view was that "emotions can and should be somehow removed or put on ice whilst rational, objective professional decision making is in progress" (Morrison 2007 p. 256). Recent empirical evidence[8] makes it clear that this is an impossible illusion, and suggests that in fact, emotions assist reasoning, assessments and decision making (Damasio 2000; Isen 2000). Contemporary researchers and thinkers recommend that in aiming to achieve good practice emotions should not be dormant, but rather recognised and utilised through every stage of the social work task, including engagement, assessment, decision making, planning and intervention (Morrison 2007; Munro 2011). The literature highlights the importance of professional supervision in helping workers to reflect on and manage emotions and to use them to best affect (Rushton and Nathan 1996; Ruch 2007; The Social Work Task Force 2010; Munro 2011). More generally, for social workers who are closely and emotionally involved with the family and hence lack the necessary detachment to apply an objective perspective, supervision is the main mechanism for minimising reasoning bias in making complex judgements by ensuring effective oversight and critical review of practice as well as openness to new evidence and explanations (Munro 1996, 1999, 2008c; Adcock 2002; Gambrill 2006, 2008; Broadhurst et al. 2010b).

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[8] An example is neuropsychology research on emotion which usually concerns patients with frontal lobe brain damage, who often demonstrate an emotional 'flatness" and poor decision making (Damasio 2000; Hardman 2009).

Partnership with parents: Helping families, at its heart, involves engaging with them and forming strong constructive relationships (Turnell and Edwards 1997; Munro 2011). The commitment to partnership with parents may be seen as an obvious matter of natural justice. Being a parent or bringing up a child necessarily holds life-long parental responsibility[9] (with the exception of legal adoption) which is retained alongside agencies' intervention (Sheppard 2001; Petrie and Corby 2002). Nevertheless, a review of the history reveals a long and varied engagement with the issue including anti-partnership times when parents of children in need were deemed to be having destructive influence over their children (Petrie and Corby 2002). A worldwide movement towards fostering participatory practice in child protection can be traced to the late 1980s (it is recently happening in Israel in the framework of the reform in the PIECs), triggered by New Zealand's endorsement of parents' participation in child welfare decision making by legislation in 1989 and the UK's Department of Health series of research projects[10] that considered the family experience in child protection processes and which had profound implications for later encouragement of participation by central government guidelines[11] (Petrie and Corby 2002; Healy and Darlington 2009). Further advocacy to partnership followed a significant body of research[12], accumulating from the mid 1990s, suggesting constructive relationships with parents play a role in ensuring the safety and well-being of children and promoting best outcomes for them (Farmer and Owen 1995; Thoburn, Lewis and Shemmings 1995; Holland 2000; Saint-Jacques et al. 2006). For example, partnership with parents was found to decrease the length of time the child was placed in out-of-home care and facilitated his/her reintegration into the family unit (Saint-Jacques et al. 2006). Additionally, evidence from various public inquiries into child protection practice in the UK and Australia highlighted how nonparticipation of families in decision making has contributed to tragic outcomes (Laming 2003; Crime and Misconduct Commission 2004).

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[9] The Children Act (1989) Sec 3(1) describes 'parental responsibility' as: "All the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property".
[10] In all 20 studies were sponsored by the Department of Health which were published individually (e.g. Farmer and Owen 1995; Cleaver and Freeman 1995; Thoburn, Lewis and Shemming 1995) and also summarised in a publication entitled 'Child Protection: Messages from research' (Department of Health 1995a).
[11] For example: 'Working Together' (Department of Health 1991) and 'The Challenge of Partnership in Child Protection' (Department of Health 1995b).
[12] This progress can be argued as being additionally stimulated by the development of the 'Working Alliance' concept in the psychiatric literature. Open, trusting and collaborative relationship developed between the analyst and patient was shown to facilitating the occurrence of positive psychological change (Bordin 1979).

Partnership is not a term with a single accepted meaning or conventional operational definition (Sheppard 2001; Forrester et al. 2008). Notwithstanding, review of the literature reveals a consensus around several key ingredients of effective partnership with parents in child protection decision making, including: provision of full and frank information about the purpose and process of decision making; access to clear information about services and the way in which they may be delivered; allowing genuine opportunity for parents to express their understanding of the problem and their desired solutions; and enabling them to influence and have an impact on the decisions made (Thoburn et al. 1995; Campbell 1997; Franklin and Sloper 2005; Forrester et al. 2008; Vis and Thomas 2009; Healy and Darlington 2009; Gallagher et al. 2012; Smithson 2014). In addition, researchers emphasise practitioners' interpersonal skills and ability to establish good relationships with parents as facilitating effective participation (Turnell and Edwards 1997; Woods and Hollis 2000; Dale 2004; Saint-Jacques et al. 2006; Forrester et al. 2008; Buckley, Carr and Whelan 2011). For example, workers' emphatic communication, warmth, friendliness and good humour were associated with less stress and resistance on parents' side and facilitated greater disclosure from them (Forrester et al. 2008; Buckley et al. 2011).

Working in partnerships with parents in child protection was described very rightly by the Children (Scotland) Act 1995 as: "One of the most difficult and sensitive tasks for all agencies" (p.1). The intrinsic conflictual nature of child protection work embedded in the inequitable distribution of power between families and agencies put great challenge on the promise of partnership (Corby et al. 1996; Turnell and Edwards 1997; Petrie and Corby 2002; Healy and Darlington 2009). Namely, children's right to protection from maltreatment may place a duty on social workers to use their statutory authority against the wishes of family members (Healy 1998; Bell 1999a, 2002; Healy and Meagher 2007; D'Cruz and Stagnitti 2008). The competing functions of the child protection system itself, create a tension between dual demands, often described as 'care and control', by which workers are required to act as both agents of social control and providers of social welfare (Campbell 1997; Bell 1999a 2002; Petrie and Corby 2002; Winter 2009). It is thus that successful engagement with parents necessitates the combination of contending skills, which means "being able to be authoritative and ask challenging questions about family

life as well as engaging with parents in order to work with them to resolve their problems and improve their parental capacity" (Munro 2011 p. 35).

Professionals can struggle in reconciling their conflicting roles. For example, a study of Dutch child welfare practice showed how senior practitioners striving to build partnership and cooperation with parents utilised several strategies to mask, moderate and obscure their statutory authority and formal power when engaging with parents (Nijnatten, Hoogsteder and Suurmond 2001). For many workers the task of exploring problems despite resistance, directly confronting parents' position regarding their parental care and communicating difficult concerns to them are considered the hardest aspects of their work (Bell 1996; Nijnatten et al. 2001; Forrester et al. 2008). For example, Regehr et al. (2010) found in their study of child welfare workers in Canada that confrontational encounters with mothers provoked in practitioners an emotional state that hindered their ability to stay focused or ask the appropriate questions when carrying out risk assessments. On the other hand, it is suggested that a major factor in the decision not to use 'family group conferences'[13] to replace the traditional case conference in the UK was social workers' reluctance to relinquish the policing aspect of their role (Marsh and Crow 1998; Department of Health 2006). From the parents' perspective, the fear of their children being removed from home can inhibit free exchange of views and worries and lead them to 'playing the game' by feigning cooperation and artificially conforming to professionals' and agencies' expectations (Farmer and Owen 1995; Corby et al. 1996; Holland 2000; Dumbrill 2006).

With greater emphasis on policies and formal practice guidelines on effective partnership with parents the literature persistently reports gaps in translating such ambitions to everyday child protection practice. For instance, studies on parents' participation in case conferences in the UK found their attendance to be more geared towards gathering information, communicating professional concerns, assessing parents' willingness to cooperate, introducing decisions that had already been taken and generally

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[13] 'Family group conference' is an approach considered more sensitive to the complexities of parental participation in conventional formal meetings with the ambition of enabling working together in a more equal environment. This decision making model has three defining characteristics: it involves the family including the wider surrounding social networks; the family always has the opportunity to consider, in private, what is best for the child free from professional interference and finally the family and professionals are expected to arrive at a consensus as to what is best for the child while allowing social workers the right to veto when this cannot be achieved (Campbell 1997; Wilson and Bell 2001).

being seen as playing fair, rather than allowing them decisional power to influence outcomes (Farmer and Owen 1995; Thoburn et al. 1995; Corby et al. 1996; Bell 1999b; Hall and Slembrouck 2001). As concluded by Farmer and Owen (1995) the purpose of participation was "not that parents would influence the conference judgement but they would be influenced by it" (p.108).

Research on parents' experience in case conferences in the UK and Ireland identified several obstacles to their meaningful participation, including: feeling intimidated by the sheer number of professionals; concern about private information being shared with unfamiliar professionals; rarely being supported by an advocate or friend; lacking assertiveness and experience talking in a formal setting; being inadequately informed about the nature, legal basis, process and participants of the meeting; being restricted to defensive, passive and reactive positions by mainly responding to what professional have to say at invited points; feeling powerless to correct factual errors or dispute professionals' interpretations of evidence and unable to put forwards their own views and concerns; and feeling pressured and rushed to reach decisions (Cleaver and Freeman 1995; Farmer and Owen 1995; Corby et al. 1996; Bell 1999b, 2002; Hall and Slembrouck 2001; Dale 2004; Buckley et al. 2011; Appleton, Terlektsi and Coombes 2013, 2015; Smithson 2014).

Another line of research shows that professional's participatory practice does not apply equality to both mothers and fathers. A well-established finding in the literature is a widespread tendency for professionals to engage mostly with mothers through the child protection process, including in case conferences. For example in Bell's (1999b) study of child protection case conferences in the UK the majority of the mothers (94%) were invited to the conference, as opposed to less than half (44%) of the fathers. The marginalisation of fathers in child protection work is a deep-rooted phenomenon that had been noted by researchers worldwide, including in the UK, Finland, Australia, Canada, the US and Israel (Farmer and Owen 1995; Bell 1999b; Scourfield and Coffey 2002; Featherstone 2006; Davidson-Arad et al. 2008). The literature suggests numerous explanations for this universal pattern, including difficulty involving both parents when the family dynamic is having crisis and dispute; a high proportion of absent fathers; difficulty of reaching out to men who avoid the system; the implication of a female dominated workplace; defensive reaction to fear of carers that are known to be hostile or have a record of violence; or a reflection of society's traditional gender role divisions (Scourfield and Coffey 2002;

Featherstone 2006; Davidson-Arad et al. 2008; Broadhurst et al. 2010a; Munro 2011). The outcome is that, too often, child protection work is focused on mothers, leaving fathers out of the picture even though their history may suggest a risk to the child (Broadhurst et al. 2010a).

Children's participation in decision making: At the heart of the discussion about children's participation in decision making lies the UNCRC (United Nations 1989). The Convention is the most widely adopted[14] human-rights treaty that has ever come before the global community (Freeman 2000; Melton 2005) and it signifies a radical shift in the legal and social status of children from objects or properties of their parents to autonomous citizens and social actors who are subjects of rights (Lansdown 1995; Freeman 2000; Ben-Arieh and Kimchi 2007). Article 12 of the UNCRC (United Nations 1989) prescribes the child's right to participate in decisions about his/her life and places on adults a duty of listening and considering the child's views when making decisions. The full text of Article 12 reads as follows:

> 1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

> 2. For this purpose the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

A growing body of evidence provides profound support for children's participation. Studies in health care and court proceedings[15] prove children, including very young children, are competent, beneficial partners in making life-changing decisions (Alderson 2000; Franklin and Sloper 2005; Raitt 2007; Schuz 2009). Using Mauthner's (1997) conclusive contention studying children's participation in social research: "when space is made for them, children's voices express themselves clearly" (p.21). Literature in the field of child protection highlights the contribution of children's participation to the

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[14] Following ten years of negotiation among government delegations, inter-governmental organisations and nongovernmental organisations the UNCRC was signed and ratified by every sovereign government in the world except the United States and Somalia (Freeman 2000).

[15] Alderson (2000) reports on examples of very young children with life-threatening illness being involved and consulted about their treatment. Scottish Judges interviewed in Raitt's (2007) qualitative study on children's participation in custody proceedings described children who offered creative solutions nobody else thought about.

effectiveness of intervention decision making. Decisions based on a more accurate understanding of the happenings in family life and their impact on the child, are more responsive to the child's needs and gain more cooperation when the time comes to put them into action, even if they are inconsistent with the child's wishes (Shier 2001; Cashmore 2002; Munro 2011; van Bijleveld, Dedding and Bunders-Aelen 2013, 2014). Some studies have shown that it is the "having a say" that is most important to children and young people rather than "getting their own way" (Thomas and O'Kane 1999; Cashmore 2002). Participation is also acknowledged for its important benefit to the child's development. For example, according to young people's reports, meaningful participation in care and protection decisions advanced their feeling of mastery and control, self-worth and self-esteem (Munro 2001; Cashmore 2002; Bessell 2011; van Bijleveld et al. 2013 2014). These elements have additional value given childhood experience of victimisation due to abuse and neglect (Weithorn 1983). Yet, the intricacy of realising participation especially in the field of child protection where it is adults' authority to coerce children's safety and well-being, is worthy of emphasis. International literature repeatedly reports on disappointing gaps between the positive tone of formal policies around children's participation and their translation into practice; so that children are still not being sufficiently included in child protection work (Holland 2001; Healy and Darlington 2009; Munro 2011; Bessell 2011; Gallagher et al. 2012; Vis, Holtan and Thomas 2012; van Bijleveld et al. 2013).

The literature identifies several individual and systemic sources of difficulty in achieving child participation in child protection. One such, is a line of research into workers' attitudes towards children, childhood and participation that shows how professionals' personal beliefs offer different opportunities to participation. Adopting views of children as vulnerable, dependent and in need of protection (known as the 'rescue' or 'clinical' position) is agreed to be an obstacle to achieving children's participation, while seeing children as autonomous with capability and rights to self-determination (known as the 'right' or 'value-based' position) increases decision making power for children (Welsby 1996; Thomas and O'Kane 1999; Shemmings 2000; Sanders and Mace 2006; Winter 2009; Vis et al. 2012; van Bijleveldet al. 2014; Ruch 2014). Furthermore, when tension arises between personal attitudes and official policy, professionals may involve children merely as a matter of paying lip service to regulation,

yet without reinforcing meaningful participation (what is called a 'bureaucratic' approach) (Welsby 1996; Shemmings 2000).

The message from research is that participation should be carried out as an ongoing process, a way of working rather than a one-off event (Archard and Skivenes 2009; Vis and Thomas 2009; Vis et al. 2012). For example, Schofield and Thoburn (1996) conclude based on a review of the literature on childrens' participation in child protection processes that leaving engagement with children until just before the case conference is unlikely to enable meaningful participation. Research findings persistently indicate that a basic requirement for children's effective participation is the establishment of consistent, long term, enduring relationships between them and their workers through which they can get to know and trust each other (Schofield and Thoburn 1996; Munro 2001, 2011; Cashmore 2002; Tregeagle and Mason 2008; Gallagher et al. 2012; van Bijleveld et al. 2013). Yet, building good and trusting relationships with children in the sensitive context of child protection takes time and sufficient skills[16] (Cashmore 2002; Jones 2003; Archard and Skivenes 2009; Winter 2009; Handley and Doyle 2014). Children present a varied range of cognitive and communication skills and have different emotional needs (Cashmore 2002; Munro 2011; Gallagher et al. 2012; Handley and Doyle 2014). Their ability to trust and confide in adults may have been seriously disturbed which imposes further obstacles to interaction and requires additional professional sensitivity (Thomas 2000; Munro 2011; Ruch 2014). It is thus, that engaging with children to elicit their views cannot be done in a single encounter and should involve critical components including seeing, observing, engaging, talking and doing activities with children in order to achieve successful outcomes (Fitzpatrick, Reder and Lucey 1995; Adcock 2002; Archard and Skivenes 2009). Social workers in Ruch's (2014) study in the UK described further challenges in communicating with children, for example the unstructured and unexpected settings; the inhibiting effect of parents' presence; and the exposure to emotionally distressing content. Evidence shows social workers' lack of necessary skills, qualification, guidance and confidence about communicating effectively with children about adverse experiences and

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[16] For example, Jones (2003) describes the complex core skills and qualities professionals need to communicate effectively with vulnerable children as: listening to the child; conveying genuine interest, emphatic concern, understanding and emotional warmth; respect for the child; capacity to manage and contain the assessment; awareness of the entire transaction between interviewer and child; self-management; and technique.

future safety and welfare (Vis et al. 2012; Ruch 2014; Handley and Doyle 2014). Raising hopes for better participation of children are contemporary developments of specific interviewing methods, including, for example, play, drawing and story telling that help elicitation of even younger children's views (D'Cruz and Stagnitti 2010; Winter 2010; Government of Western Australia 2011). Even so, research accounts for the increased priority given by organisations to bureaucratic demands and tasks compromising workers' time with children. Pre-occupation with procedural requirements of the organisation results in inadequate time to invest in getting to know and listen to children (Winter 2009; Munro 2011; Ruch 2014).

Several conceptual frameworks[17] have been offered over the years to account for children's participation (Hart 1992; Thomas 2000; Shier 2001). A review of the contemporary literature reveals a consensus around a general recipe for how to successfully involve children when it is time to make decisions about their care and protection. The participation process should start with providing clear explanations and preparing children for what is about to happen (Vis and Thomas 2009; Gallagher et al. 2012; van Bijleveld et al. 2013). A key factor in successful preparatory work is forming a shared understanding as to the purpose and process of child protection intervention as well as to the extent to which children's influence is possible (Schofield and Thoburn 1996; Cashmore 2002; Healy and Darlington 2009). Children should be supported to express their views, this may include an adult speaking on their behalf, and having a choice as to the appropriate setting to do so (Thomas 2000; Cashmore 2002; Vis and Thomas 2009; Gallagher et al. 2012; Jelicic et al. 2013; van Bijleveld et al. 2013). Enabling children the opportunity to attend meetings, reviews and case conferences was found to be an important factor affecting participation (Vis and Thomas 2009), however children may prefer one-on-one communication than talking to a group of adults. Attending review meetings for many young people was reported as a very boring, intimidating and embarrassing experience (Thomas 2000; Cashmore 2002). Factors that had been found to have a positive impact on children's experience in case conferences include: informality of the setting; skilful chairing; a respectful attitude amongst conference members; meeting with a small group of familiar people who know them well; expressing themselves through activity based

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[17] For example: Hart's (1992) 'Ladder of Participation', Shier's (2001) 'Pathway to Participation' and Thomas' (2000) 'Climbing Wall'.

communication such as writing or drawing; and having access to the same information that adults have (Schofield and Thoburn 1996; Thomas 2000; Greegan, Henderson and King 2006; van Bijleveld et al. 2013). The process also includes giving weight to children's views in considerations; and finally providing explanations about the decision making outcomes in particular when those are against the child's wishes (Thomas 2000; Gallagher et al. 2012; Vis et al. 2012; Jelicic et al. 2013).

Working together with other professionals: Relationships are fundamental to working arrangements between professionals. A wide range of services and professionals support families in the journey of bringing up their children in a way that safeguards their needs and safety or intervenes at times when these targets are not achieved or at risk. Most commonly these are the health, education and social services who work primarily with children and families. With research evidence showing the sources of stress within the family associated with damaging impact on children's care, health, safety, development and well-being (e.g. social exclusion, poverty, unsuitable accommodation, domestic violence, mental illness in a parent and substance misuse of a parent) the range of services that play a role and shape child protection work is wide (Department of Health 1999). It is thus that coordinated multi-agency working is crucial for successful helping. As put by Munro (2011): "with so many providers involved, often working with members of the same family, coordination of help is important to reduce confusion, inefficiency and ineffectiveness in service provision" (p. 77).

Good practice calls for effective cooperation between different agencies and professionals throughout all stages of the child protection process. Working together with other professionals promotes early alerting on potential or current problems; ensuring children in need do not slip through the net of services; sharing and analysing evidence so that the full picture of a family's circumstances can emerge; pulling together varied expertise, experience and resources when deciding on interventions and realising this while avoiding duplication of effort; and regular review of outcomes for the child and family. Dysfunctional multi-agency working, information sharing and communication were consistently reported in fatal child abuse inquiries and serious case reviews in countries such as the UK, the US and recently in Israel (Munro 1999; Brandon et al. 2009; State of

Israel 2010a). Researchers from the UK as well as the Israeli government[18] identify numerous systemic obstacles to constructive multi professional work in child protection, including difficulties relating to professional legal and ethical frameworks, such as principles and rules of confidentiality and data protection which may hinder information sharing; diverse organisational procedures and culture, such as the utilisation of differing assessment thresholds and definitions which may have negative impact on effective referral processes; lack of vigilance to risk and failure to connect to the impact of family stressors on children in particular in adults' services which may result in under-reporting concerns about children; administrative barriers such as lack of formal means of information sharing between professionals; and political constraints relating to territorialism, status and power which may lead to a lack of respect and mistrust amongst professionals (Shnit 2001; Munro 2005b; Broadhurst et al. 2010a; State of Israel 2010a). Researchers emphasise the psychological and interactional aspects of communication. This debate broadens the focus from how information is transferred from one person to another to how is it understood by them (Reder and Duncan 2003; Munro 2005b; Broadhurst et al. 2010a). Those who focus on the human factors underpinning effective communication stress the importance of professional training, as argued by Reder and Duncan (2003):

> Effective communication is the responsibility of both the message initiator and the receiver and, as such, is a mindset and a skill that can be learned, rehearsed and refined. Only then will policies and technological aids have their optimal benefit. (p.98)

Interestingly, increased inter-agency collaboration can in effect be an impediment to helpful practice as it may result in reducing the individual sense of responsibility for the case (Broadhurst et al. 2010a). It is thus that clear understanding as to roles and levels of involvement of all agencies involved should be established from the outset (Broadhurst et al. 2010a; Government of Western Australia 2011).

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[18] This refers to the governmental commission on Identification of Minors at Risk and the Formation of Safety Network in the Community (known as the Vinter Commission) (State of Israel 2010a).

2.2   Systems Approach

The conceptual framework of this thesis is the 'systems approach' developed in safety engineering, in industries such as aviation and nuclear power, as an alternative model to the 'person-centred approach' of inquiry into causation of accidents and disasters (Munro 2008a). Systems thinking was later adopted to study the normal activities or everyday practice of actors at the front-line of services provision (Rasmussen and Svedung 2000) and contemporarily utilised in the field of child protection to analyse contributory factors to practice and policies outcomes (Munro 2005a, 2010, 2011; Rzepnicki and Johnson 2005; Fish et al. 2008).

Starting from the beginning, the longstanding and widespread tradition, sustained during the nineteenth and early twentieth century (still dominant in medicine to date), to analyse why adverse events happened is the person-centred approach which concentrates on the unsafe acts, errors and procedural violations of individuals who are in direct contact with the patient or system (Reason 2000; Munro 2008a). Dekker (2002) summarises the three key assumptions of this approach. 1) Investigations taking a single root cause view of errors often do not look for further explanations once a human fallibility has been identified, thus, human errors are viewed as the cause of most accidents. 2) Engineered systems are perceived as intrinsically safe and successful, hence the chief threat to safety comes from the inherent unreliability of humans. Reason (2000) further emphasised people being perceived as free agents who can choose between safe and unsafe modes of behaviour; when something goes wrong, the tendency is to blame individuals[19] for aberrant mental processes such as forgetfulness, inattention or moral weakness such as poor motivation and carelessness. 3) The natural product of this logic is that if progress and safety are to be achieved human behaviour must be controlled and unwanted variability reduced. Corrective efforts derived from this 'old view' concentrate on selection, automation, training, discipline and proceduralisation, i.e. the development of procedures, regulations and tools for managing errors (Reason 2000; Dekker 2002). However, cracks in the dominancy of the person-centred approach stated to emerge. Primarily, measures to increase safety focusing on the individual origins of error were found to be ineffective i.e.

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[19] The totality and domination of blaming in child protection is a well-established problem in many countries, including the UK, US, Canada, Australia, New Zealand and recently in Israel, demonstrated by harsh public reactions to high profile cases (IMSSSA 2014; Munro 2010).

accidents continued to occur, and contributed to unanticipated new problems and errors (Munro 2008a).

Munro's original work on the English child protection system (2005a, 2010, 2011) demonstrates how approaching adverse outcomes from a person-centred perspective shaped government policies in the last decades. Inquiries into child abuse tragedies concluding the impact of human error[20] in conjunction with extreme public outcry over defective practice and political pressures yield well-intended policy countermeasures to safeguard children concentrated on increasing the automation and documentation of practice and decision making and enhancing close monitoring of workers' operation by application of rules, procedures, tools, software programs and performance indicators. Some of these policy measures are currently implemented in the framework of the Israeli reform (IMSSSA 2004a, 2004b, 2009). Unfortunately, the solutions offered to improve the quality of practice were ineffective in preventing the next tragic child death[21] and, in effect, had cumulative, unexpected and unwarranted consequences. Rapid growth in the bureaucratisation of child care work gradually deflected the workforce from opportunities to exercise professional judgement and invest time in direct work with service users.

The systems approach or the 'the new view' reconstructs human contributions to accidents. It represents a substantial shift from seeing human error as a cause to seeing it as a symptom of trouble deeper inside the levels of the system (Rasmussen and Batstone 1989; Reason 2000; Hoffman and Woods 2000; Dekker 2002). By taking into account systemic factors relating to the conditions under which individuals work this new approach could explain tendencies overlooked by the previous one: the fact that very often the best people make the worst mistakes and the fact that errors are not random, i.e. mishaps tend to fall into recurrent patterns regardless of the people involved (Reason 2000).

The basic premise of the systems approach is that safety is not inherent to systems. Systems involve contradictions between multiple goals that people must pursue and balance simultaneously (Dekker 2002). Safety is something the people have to create, given that errors are to be expected even in the best systems (Reason 2000). Human error is systematically connected to multiple features of the workplace and the organisational

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[20] In Munro's (1999) content analysis of 45 child abuse inquiry reports published over a 20-year period in Britain, in 75% of the cases human error was cited as a significant factor in the adverse outcomes.
[21] A late case where protection broke down was the death of Baby Peter Connelly in 2008 (Munro 2008d).

processes: people, tools, tasks and operating environment (Dekker 2002). Following the same line, the organisational context in which child protective service is conducted may present a variety of barriers to good decision making and performance to sufficient depth, including extensive workloads and limited time, the need to accommodate other systems, limited resources to provide solutions that match individual needs of children and families, inadequate technological equipment and administrative support, policies and procedures that do not provide sufficient guidelines for practice or discourage sound practice, lack of satisfactory training and qualification or training without opportunities and professional support for generalising new skills to everyday practice, and organisational culture that encourages workforces to engage in task short-cuts that become routinised (Rzepnicki and Johnson 2005; The Social Work Task Force 2010; Munro 2011). Progress on safety comes from understanding and influencing these interactional and multi-factorial connections between workforce operation and systems (Reason 2000). When inquiring how people acted, it is important to understand how they perceived and made sense of the situation or what their 'local rationality' was at the time a particular action was chosen (Woods et al. 1994; Woods and Cook 1999, 2002). For example, people's sense making can be shaped by missing knowledge, misconceptions and multiple interacting goals (Woods and Cook 1999, 2002; Dekker 2005; Rasmussen and Svedung 2000).

Reason's work (1990, 2000) amplifies the core idea of causation of systems thinking by distancing between two types of errors or sets of factors which, when combined together, usually produce adverse events, active failures and latent conditions. Active failures are the unsafe acts committed by practitioners at the front-line. They take a variety of forms, often hard to foresee, and have a direct short-term negative impact. Latent conditions are the inevitable 'resident pathogens' within the system which arise from decisions made by designers, builders, procedure writers, and top level management. These pathogens can turn into conditions within the local workplace that stir errors (for example, inadequate equipment, time and inexperience) or create long-lasting weaknesses in the system's defences (for example, unworkable procedures). The problematic nature of these conditions is that they may lie inactive within a system for a long time and then create an accident when interacting with active failures and local triggers. Reason (2000) uses the 'Swiss cheese' model of system accidents to demonstrate this process. Organisations are built with layers of defence against errors (active failures). In an ideal

world these layers would be intact, however, in reality they have holes in them like slices of Swiss cheese (latent failures). These holes are in continuous movement, but occasionally they line up perfectly to cause a bad outcome. On the other hand, it is possible to identify and remedy the latent conditions before an adverse event occurs. A very straightforward analogy Reason (2000) uses to make his conceptualisation more accessible, is:

> Active failures are like mosquitoes. They can be swatted one by one, but they still keep coming. The best remedies are to create more effective defences and to drain the swamps in which they breed. The swamps, in this case, are the ever present latent conditions. (p.769)

The aim of this research is to build an in-depth account of practitioners' performance that links mosquitoes and swamps, and to evaluate whether the Israeli reform's reaction is effective in swamps draining.

2.3   Conclusions

The literature described in this chapter will direct and inform the exploration of practice under the contemporary reform in the current research. The realisation of the reform's high hopes for improving decision making will be examined in light of core principles identified in the literature as the building blocks of good practice, including: accurate assessment of the child's and family's situation; effective inclusion of workers' emotional responses; valid application of critical thinking and reflective skills; and constructive working relationships with families and professionals. In adopting a systems approach this study seeks to understand how practice adapts to and evolves with the new reform by exploring how context shapes practice. The investigation's aim is to identify multiple organisational factors (latent conditions) that interact in shaping the activities and events into recurrent patterns and outcomes. In the process of evaluating, the quality of practitioners' decision making awareness will be raised, for both individual and systemic influences. The next chapter describes the unique characteristics of the Israeli social service system and child protection practice and accounts for the reform's aims, principles and implementation.

Chapter 3

Israeli Social Services System

The current chapter is the third introductory chapter of the thesis. It aims to provide readers with sufficient knowledge of the particular characteristics of the Israeli social services system and child protection services so that the research findings can be understood within their context. The chapter is divided to three sections, starting with a description of the social services departments' working arrangements where everyday child protection practice and decision making are carried out. Next, the key features of child protection policy and services provision are presented. This sets the ground for the last section of the chapter which tells the story of the reform in the committees' work, the driving forces that stimulated the reform and influenced policymakers, its ambitions and core principles, and the implementation progress carried out by the time this research field work had begun. The discussion throughout the chapter is taking the systems approach perspective. The analysis seeks to uncover the systemic latent conditions that may interconnect with practice to affect the realisation of the reform in the field, for example Social Services Departments' working conditions, workforce training and qualification, the legislative framework, resources and services available and working arrangements with other professionals. Some of these factors have already been discussed in the previous literature review chapter as having an impact on the quality of decision making.

3.1   Israel Social Services System: The Social Services Departments

The aim of the following section is to draw attention to the unique characteristic of social services provision, including child protection, in Israel. The discussion will show that although there is extensive professionalisation of social work in Israel, even from a comparative international perspective, high quality service provision is confined by both central government's welfare policy and organisational (i.e. the Social Services Departments) deep-rooted infrastructure (latent conditions) problems.

From the inception of the Israeli social service system in 1931[22], social work
practice was carried out almost entirely within local offices for social work, called Welfare
Offices, and after the state's establishment in 1948 by Social Services Departments (SSDs)
(Spiro et al. 1998). Practice at that time was established on three core principles which
guided the Israeli welfare system for many years: the family is regarded as the target unit
of assistance and intervention; the public's welfare is the responsibility of the local
community with the central governing body providing (some) budget and supervision; and
welfare services are to be delivered by trained social workers employees and volunteers
(IMLW 1992; Spiro et al. 1998; Spiro 2012). From the state's early years, the Welfare
Services Law 1958 served as the legal framework for the provision of social services by
the SSDs. The law imposed on local authorities the responsibility to establish social
services for their local community (yet the type and extent of those services is not
mentioned), to be provided by social workers and mainly financed by central government
allocations (Welfare Services Law 1958, Article 2(a)).

Today social workers are employed in varied settings in the public, private and
nonprofit sectors, yet the practice carried out in SSDs in every municipality in the country
constitutes the backbone of social services provision for vulnerable individuals, families,
groups and communities in Israel, including child protection services (Israel Ministry of
Welfare and Social Services (IMWSS) 2010; Shnit 1998). The Service for Children and
Youth, at the IMSSSA[23] is the governmental authority responsible for securing the safety
and well-being of children and young people (up to 18 years) at risk[24]. The service is in
charge of national child protection policymaking; development of interventions to meet the
needs of children and their families; workforce professional development and
qualifications; and supervision of SSDs and the services provided for the population
(Gorbatov and Ben-Simhon 2011).

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[22] The origin of social work practice in Israel is usually traced back to the time the Jewish National
Committee founded the Social Work Department, under the British mandatory reign in Palestine (Spiro et al.
1998).

[23] The IMSSSA has had different names over the years. Early names used throughout the thesis as sources
cited include, Israel Ministry of Labour and Welfare (IMLW), Israel Ministry of Welfare and Social Services
(IMWSS) and Israel Ministry of Welfare.

[24] The term "children and young people at risk" is officially used in the Israeli context to describe: children
and young people who live in risky familial and environmental circumstances which hinder the rights
prescribed to them by the UNCRC (United Nations 1989) to survival; to develop to the fullest; to protection
from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life
(State of Israel 2006).

The SSD work environment has long-standing barriers or 'pathogens' which are well-recognised for their negative affect on social services provision. The IMSSSA's commission, which was founded in mid-2008 to thoroughly assess SSDs' operation[25], portrayed in its final report a very gloomy and worrying picture and concluded that a wide-ranging reformative transformation was required. The commission's report states that SSD infrastructures were insufficient, and in some areas poor and outdated:

> The commission identified difficulties caused by a patchy and outdated legislative framework; continuous lack of resource resulting in great workloads; deficiencies in knowledge and technology back-up; and weakness in organisational management. These difficulties lead to inequality in the range of services offered by SSDs; practice responding to "firefighting" pattern with little planning or prevention measures; insufficient involvement of clients and their representatives in designing social services; difficulties in providing social services in small local authorities; and lack of clear social policy regarding intervention with poor and economically distressed clients. (IMWSS 2010 p. 7)

At the time of this writing, a far-reaching reform in the SSD infrastructure is in the advanced programming and piloting stage, but had not yet been launched nationally (Morley-Sagiv 2015).

3.1.1 *The Legislative Framework of Social Services Provision*

The binding legislative framework underlying social work practice at the SSDs is complex and extensive (Doron 2012). Israel social welfare policy is argued to be dominated by changeable and even contradicting trends over the years[26], and to be motivated by both economic and ideological considerations (Doron 2001). Many of the welfare laws were enacted as a response to urgent needs, social crises or pressures of public opinion, without sufficient preliminary arrangements; creating a patchy and inconsistent legal framework of social service provision (Shnit 1998; IMWSS 2010). To date, there are over 65 laws, along with hundreds of regulations and ordinances, which constitute social workers' roles, operations and responsibilities (Doron 2012). This volume of legislation is claimed to

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[25] The commission heavily relied on national assessment research carried out in 2008 among 48 representative SSDs, involving 723 professionals from all levels of the departments (Ofek 2009).
[26] The last decades are marked by a departure from the social-democratic, European model of social protection policies to which Israel adhered for many years and a movement towards the conservative American model of social welfare policy (Doron 2001).

have no parallel in Western counties or in the other helping professions in Israel (Shnit 1998).

The distinct, strong relationships between the law and social work practice in Israel is argued to have an influence on professional practice in the public welfare services in numerous ways. It grants social workers an exclusive occupational monopoly and powerful authority over certain fields of practice, among them child protection, adoption and domestic violence, which is unique in comparison to other countries, such as the UK, Australia and the US (Weiss et al. 2004; Doron 2012). Yet, it also makes them vulnerable to harsh public criticism over alleged misuse of their power (Shnit 1998). In many practice areas, most remarkably child protection, social workers are imposed with duties to act in cooperation with the courts or other quasi-judicial authorities, which reinforces a judicial nature of working patterns, often referred to as working in the "shadow of the law" (Rosenfeld and Kedem 1998; Shnit 1998). Additionally, workers need to balance contradicting legal demands. For example, laws concerning social protection and control may be in contrast with the Basic Law: Human Dignity and Freedom 1992[27] which sets limits to professionals' interference with families and individuals' autonomy in managing their private lives (Shnit 1998; Doron 2012). The cumulative legal framework also means that social workers are required to master and establish proficiency in a high number of laws, regulations and ordinances. However since this was found not to be the case in the field[28], some tasks are fulfilled beyond what is expected while others are not recognised (Ofek 2009).

3.1.2   SSDs' Workforce Roles

SSDs are entirely staffed by social work professionals, including at all levels of management, supervisory positions and professional front-line workers. This long established policy was legally ratified by the Social Workers Law 1996[29]. Social workers'

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[27] The Basic Law: Human Dignity and Freedom 1992 holds a legal status of constitution. It constrains the professional practice to correspond with constitutional, liberal and individualist values (Shnit 1998; Doron 2012).

[28] There is evidence for insufficient familiarity with state laws including the Social Workers Law 1996 and Social Workers Ordinances among social workers, in particular with regard to SSDs' personnel (Doron, Rosner and Karpel 2008; Ofek 2009).

[29] The Social Workers Law 1996 is a key milestone in the fortification of the Israeli social work practice as it grants official recognition of the unique status of the profession, defines the nature of the practice and

dominance in their organisations allows them to enjoy greater degree of professional autonomy in comparison to other counties, such as the US and Australia (Weiss et al. 2004). As is the case in most other countries, the majority of workplaces in SSDs are made up of women (Weiss et al. 2004; Gorbatov and Aiglstein 2007). Front-line workers are usually organised according to teams (consisting of six to eight full-time social workers and also nonprofessions), which mirror a geographical distribution of the municipality's area, and are headed by a senior social worker who functions as both a team leader and professional supervisor (IMLW 1992; IMWSS 1999). Although supervision is acknowledged by the ministry as a core mechanism for improving workforce proficiency there are no explicit regulations in regard to its provision (e.g. the frequency of the meetings) (IMWSS 2010). A recent national assessment study of SSDs' operation found it is common amongst social workers to experience their team leader's managerial requirements interfering with the quality of professional supervision provided to them. The same problem was also reported by social workers in the UK (Ofek 2009; Munro 2011).

Practice in the SSDs, including child protection, is divided between 'generalist social workers' who respond to a full range of the local authority's community needs and problems and 'specialist workers' (IMWSS 2010). According to the government's official data in 2006, for example, SSDs employed 4,263 social workers, among them 58% were generalist social workers and 42% were specialist social workers (Gorbatov and Aiglstein 2007). The generalist role had gone through some considerable changes over the years and it is still not established as a defined expertise to date (Gorbatov and Aiglstein 2007; Ofek 2009).

Initially it had been focused on the provision of fiscal and material assistance, yet as from the early 1980s financial aid was separated from the social care[30], giving more priority to therapeutic and consultation work as well as intervention development (Spiro 2012). Today, SSDs only provide supplementary material and in-kind support under pressing conditions (e.g. basic home equipment) (Shnit 1998; Spiro et al. 1998).

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conditions to receive a license, as well as legal and ethical obligations for those engaged in practice, e.g. professional confidentiality (Doron et al. 2008).

[30] This function had become the role of the National Insurance Institute which gained responsibility over the majority of income maintenance programmes under the Assurance of Income Law 1980 (Spiro et al. 1998).

According to the IMSSSA's ordinances, known as the 'Social Workers Ordinances'[31], the generalist worker's task is to improve the personal, familial and social functioning of services users through consultation, direct and nondirect therapy and referral to relevant institutes and services (IMWSS 1999). The last decades are marked by extensive governmental policy that encourages semi-privatisation of social services, demonstrated by the transference of responsibility over many institutional and communal social service provisions to nongovernmental organisations (Katan 2007). For example, in regard to services for children, out-of-home residential services in all municipalities (except one) are provided by nongovernmental organisations; so are the majority of community-based services (Horev and Kop 2009). The comprehensive and rapid process of semi-privatisation changed the pattern of activity in the SSDs. Social workers had started to engage more and more with indirect case management work, rather than with direct intervention (Horev and Kop 2009; Ofek 2009; Benish 2012). Such tendencies were not systematically supported by designated training or qualification[32] (Gorbatov and Aiglstein 2007; Spiro 2010; Benish 2012). It is thus that practice today no longer fits with the characteristics of generalist practice, i.e. that it is client centred and emphasises direct intervention. It is more of an inconsistent mishmash between family workers who respond to general difficulties of families (such as domestic violence and parental functioning) and case managers who work more for their users rather than with them by referring them to external services providers while following up and monitoring their progress (Gorbatov and Aiglstein 2007; Ofek 2009; Bar-On 2012; Benish 2012). A customary practice-based career pathway for experienced generalist workers is to move to another role within the department or other organisation or to take on an additional specialist role (Gorbatov and Aiglstein 2007; IMWSS 2010). This trend is exceptional in light of a common problem found in child protection services in other Western countries (such as the UK, Australia and Sweden) of career progression away from direct practice which hinders the accumulation of expertise and its transformation to the next generation of practitioners (Healy, Meagher and Cullin 2009; Munro 2011).

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[31] The Social Workers Ordinances do not have binding legal status but rather they are administrative guidance formulated by the IMSSSA's director that provide explanations and interpretations regarding the actualisation in practice of existing legislation (Doron 2012).

[32] According to a staff survey conducted by the ministry's Research, Planning and Qualification Division among 278 social workers and 155 SSDs managers, a quarter of the social workers and a third of the managers had no qualifications in case management (Gorbatov and Aiglstein 2007).

There are several specialist workers in child protection practice. A number of social protection laws empower social workers who are especially qualified and licensed with specialist roles and endorsements to carry different child protection responsibilities. Most pertinent to the current research are 'social workers to the youth law' (SWYLs) (known until 2010 as 'child protection officers') who hold legal duties in criminal investigation of maltreatment and representation of the child's interest in juvenile courts (Dolev, Szabo-Lael and Ben-Rabi 2008). SWYLs have the mandatory authority to investigate, intervene and, when necessary, initiate court proceedings to assure the safety and well-being of minors and the helpless who are in need of protection from harm or neglect inflicted on them by their family or others. SWYLs can ask the juvenile court for a minor to be declared 'in need', i.e. one "who's physical or mental well-being is harmed or could be harmed for any reason" (The Youth (Care and Supervision) Law, Article 2(6) 1960) and hence be placed under the court's custody and supervision as well as make recommendations to the court on intervention measures, including removal from home. SWYLs are then responsible for implementing the court's decisions and periodically reporting to the court on the outcomes. In cases when a child is in serious and immediate danger SWYLs can initiate ad hoc measures (such as issuing an emergency or interim order) to safeguard the child (The Youth (Care and Supervision) Law 1960; IMWSS 1987; The Penal Code (Amendment 26) 1989). Another type of specialist involved with the legal aspects of care is 'social workers to court proceedings' (SWCPs) (previously known as 'child protection officers to the welfare law and court proceedings'). These workers engage with the courts (e.g. family courts or religious courts) on varied issues relating to minors' safety and well-being. For example, they may recommend the court in relation to parental custody disputes over minors in divorce cases and can ask the court for protective orders against violent family members that endanger the minor (Prevention of Domestic Violence Law 1991; IMWSS 2014). SWYLs and SWCPs are integral parts of the SSDs' professional workforce and may carry, beside their specialist child protection role, other duties, roles (including generalist worker) and responsibilities placed on them by their organisations (IMWSS 1987, 2014; IMLW 1992).

In order to provide the full picture two additional child protection roles undertaken by specialist social workers should be mentioned, although they are not part of the SSDs. 'Children investigators' who are specialists in children's (under the age of 14)

investigation and testimony in court in relation to abuse, neglect and domestic violence (Evidence Amendment Law (Child Protection) 1955) and 'social workers to the adoption law' (SWALs) who are regional supervisors at the Service for the Child (the adoption services) responsible for children's adoption proceedings (Children's Adoption Law 1981). SWALs are obliged to participate in the committees' discussions in regard to children up to six years old (IMLW 1995; IMSSSA 2004b).

3.1.3 *Professional Training, Qualifications and Knowledge*

From its outset, before the state's establishment, social services at the SSDs have been delivered by trained, qualified social workers. At first training was carried out in nonacademic institutions; academic training began in 1958 with the foundation of the first School of Social Work at the Hebrew University of Jerusalem (Spiro 2010). Later, the Social Workers Law 1996 regulated the level of training required for the profession as an undergraduate degree in social work granted by a university[33] after three years of full-time study (Spiro et al. 1998; Auslander 2000; Doron et al. 2008). Additionally, professional development through advanced degrees and post-qualification programmes are highly encouraged and serve as requirements for senior roles (Ofek 2009; Weiss at el. 2004). The legacy of commitment to highly trained staff makes the Israeli social work practice stand out, for example, in comparison to the UK[34] (Munro 2011). Nevertheless, it is important to note that, distinct from many counties (such as, the UK, US, Norway, Canada and Australia), Israel has no central mechanism of control over institutions of social work education, which allows them a high degree of independence over the content of training programmes[35] (Weiss et al. 2004). Recently, several researchers raised concerns about the academic training being insufficient in qualifying graduates for the contemporary demands of the work. Social work training curricula were reported to be out of date in terms of

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[33] Today there are five universities and a number of colleges affiliated with them that offer undergraduate and advanced degrees in social work as well as long and short term post-qualification training programmes in areas such as family and group therapy (Spiro 2010).

[34] According to Munro (2011), the UK demonstrates an inconsistent approach to social workers' training, with the profession beginning as several separate occupations. Some branches require university-based training to use the title (e.g. psychiatric social workers) while others have only a few formally trained workers (e.g. welfare officers in local authorities).

[35] Schools of social work are subject to the standards determined by their universities and The Council of Higher Education, yet there is rarely any interference with the contents and methods of teaching (Weiss et al. 2004).

practice methods and research evidence, and unsatisfactorily linked to the practice in the field in terms of representing progress in legislation, policy and technology (Committee for the evaluation of social work and human services study programs 2007; Ofek 2009; Spiro 2010). Discrepancies between the training curricula and the professional skills required to work effectively were also reported in regard to post-qualification programmes provided by the ministry to its workforce (Ofek 2009).

Another problem pertinent to the body of knowledge used by Israeli social workers, relates to the limited utilisation of empirical evidence to inform practice. The term 'evidence-based practice'(EBP) is often used to describe a philosophy, and rapid evolving process, of helping professions during the last three decades, calling for "conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett et al. 1997 p. 2). EBP involves the integration of the best available research evidence with clients' unique circumstances, characteristics and values and with clinical expertise (Sackett et al. 1996; Gambrill 1999 2008). EBP is inadequately achieved within the Israeli context (Aiglstiin, Teitelbaum and Shor 2007; IMWSS 2010; Sabah and Cook-Craig 2010). A body of research on social workers' child protection decision making, for example, showed how professional judgment is not based on empirical evidence but rather on policy, experience, theory and general knowledge as well as influenced by personal attitudes and family's characteristics including, socio-economic status, demographic and ethnic background and level of cooperation with professionals (Davidson-Arad and Wozner 2001; Davidson-Arad 2001a; Gold et al. 2001; Benbenishty, Osmo and Gold 2003; Osmo and Benbenishty 2004; Davidson-Arad and Benbenishty 2010; Enosh and Bayer-Topilsky 2014).

Several explanations have been offered for the limited use of research evidence in Israeli practice: that international evidence is not easily accessible due to language barriers or lacking due to the idiosyncrasy of the Israeli social problems (e.g. rehabilitation of holocaust survivors and massive immigration waves) or that local research is still insufficiently developed due to various institutional, budgetary and political factors (Auslander 2000; Sabah and Cook-Craig 2010; Zeira and Auslander 2010). Others stress that workers are not provided with the right encouragement and support from management or the time to foster their empirical knowledge or engage in research (Auslander 2000; Benbenishty et al. 2003; Osmo and Benbenishty 2004).

In accordance with sweeping international tendencies of utilising computer technology systems with the aim of improving practice, recently the IMSSSA developed communications technology infrastructure to maximise scholarly knowledge flow and support collaborative learning and expertise development. In 2005 the online virtual communities of practice (VCoPs) on the ministry website was initiated[36] (Sabah and Cook-Craig 2010). Research evaluating the use of VCoPs and their impact on practice provides mixed results (Lev-On 2014). Overall, the use of ICT and the internet for learning, operational and managerial purposes in SSDs is very limited, due to both inadequate skills and computer equipment[37] and the lack of an encouraging organisational culture (Ofek 2009; IMWSS 2010).

3.1.4 Chronic Gap between Growing Needs and Available Resources

According to the Taub Center's[38] (Horev and Kop 2009) analysis, governmental expenditure on personal social services, including services for children and youth, care of the elderly, special population groups and SSDs' personnel had increased dramatically (nearly doubling) between 1990 and 2008. The government's share of funding for children's services indeed increased by 1.6 times in two decades, yet this growth was still secondary to the sharp rise in all other service categories[39] (Horev and Kop 2009). That is despite "difficulties in parental care or in children's and young people's functioning" being the most prevalent reason for referral to the SSDs during the last decade (The Central Bureau of Statistics 2013). In addition, the growth in resources did not catch up with the increased demand for services by populations in need; as the total rate of social services users is in steady rise[40] (Horev and Kop 2009; The Central Bureau of Statistics 2013). The

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[36] The VCoPs are an outcome of a decade-long effort to promote intra-organisational learning for social workers in various practice settings. By mid- 2008 there were eighteen online virtual communities on various professional subjects with more than 18,000 members (Sabah and Cook-Craig 2010).

[37] For example, a national assessment research found that in regard to the 48 SSDs sampled only 15% had computer equipment adequate for their needs and tasks (Ofek 2009).

[38] The Taub Center for Social Policy Studies in Israel is an independent, nonpartisan, socioeconomic research institute. Data presented in this chapter are based on the center's report on government expenditure on social services in the year 2008, published in 2009.

[39] A particularly sharp rise occurred in outlays for youth correctional services (nearly fourfold), services for the mentally disabled (approximately two and a half-fold), services for the physically disabled (threefold), and for social service department personnel (twofold).

[40] According to the Central Bureau of Statistics report, in 2011 about 520,000 families, 28% of all families in Israel were referred to the social services departments. The total rate of SSDs' service users in municipalities of 20,000 or more inhabitants increased between 2000 and 2011 by 67% in regard to the Arab population and by 22% in regard to the Jewish population (The Central Bureau of Statistics 2013).

number of children registered at the SSDs rose by 37% between 2000 and 2004, and by 51.9% between 2001and 2014, amounting that year to 441,167 individuals who represent 17% of all the children in Israel (State of Israel 2006; The Israel National Council for the Child (INCC) 2014). Furthermore, budgetary crises in many local municipalities compromised their ability to fund their share (a quarter of overall expenditure for personal social services) of the social services, leading to both financial and personnel deficits (Horev and Kop 2009).

The overall outcome of the dearth in resources is that SSDs are only able to provide limited service to only a fraction of the local population in need. This problem is particularly pertinent in regard to children and young people (Horev and Kop 2009; Ofek 2009). The government Commission on Children and Youth at Risk and in Distress (State of Israel 2006) (known as the 'Schmid Commission') reported that in 2005 nearly 15% of the total population of children and young people in Israel, which amounts to approximately 330,000 individuals at that time, were at risk or in distress (i.e. are victims of neglect, their development is abnormal, exposed to violence and abuse or to inter-parental violence or criminal activity at home), yet only half were provided with some kind of service, mostly young people aged 14 to 17, and there was only limited investment in preventive services. Another well-recognised pattern of social services allocation is inequality among localities in the variety, comprehensiveness and quality of services provided to their population due to differences in resource allocation by both government and local authorities, and other localities characteristics (Horev and Kop 2009; Ben-Arieh 2010; IMWSS 2010). It is thus that the provision of help is often determined by the place of living rather than actual need (SIC 2006). For example, a cross-sectional study[41] of the correlates of social services availability, including child protection, and child maltreatment rates in Israel, found fewer social workers in Arab and Ultra-Orthodox Jewish populations, although these localities had more children (Ben-Arieh 2010).

Personnel shortage and heavy workloads are other enduring detrimental characteristics of the SSDs which hinder the quality and quantity of social service provision (Bargal and Guterman 1997; Horev and Kop 2009; Katan 2012; Ofek 2009). According to the ministry's national data, an increase of 16% in staff capacity (80% of them social workers and the rest nonprofessionals) between 2000 and 2008 did not match

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[41] The study's findings are in regard to 173 localities in Israel (Ben-Arieh 2010).

the volume of new clients as the number of families referred to the departments rose by 29% during those years (IMWSS 2010). Katan (2012) states that the disproportion between workers and service users found in 2008 is even bigger in certain localities and that already in 2000 there were not enough social workers in many SSDs. It is estimated that in 2008 there was a shortfall of 1,000 social workers in the SSDs and an increase of 10% in workloads (Horev and Kop 2009; IMWSS 2010).

The ministry's commission on SSDs operation suggests that workloads are even heavier since, in the last decade, further responsibilities were imposed on the SSDs due to local, governmental or legal demands (including the reform in the committees' working), which have not always been congruent with allocation of sufficient additional professional personnel and financial resources (IMWSS 2010). This results in prioritisation of both financial and human resources to services which have a binding legal basis and attendance to emergencies (Shnit 1998; Horev and Kop 2009; IMWSS 2010). An early example of this trend is Amendment 26 to the Penal Code 1977 enacted in 1989 which made reporting abuse of minors and the helpless mandatory. The amendment, which imposed an obligation on any person who is aware of an act of abuse against children or the helpless to report this to the police or SWYLs, led to a dramatic increase in the number of cases referred to social services requiring investigation and assessment; that happened without SSDs having sufficient personnel to deal with them (Shnit 1998). Rosenfeld and Kedem (1998) argue that these workload pressures result in 'criminalisation' of the work, i.e. mainly those children who had come to the attention of the legal system are served.

'Firefighting' is the customary phrase used to describe the common way of working at the SSDs, meaning short-term first aid at times of urgent situations (Katan 2012; Ofek 2009; Slonim-Nevo and Lender 2004). Social workers are placed at the front line of service provision without being provided the time or resources to fulfil their tasks (Knei-Paz 2009). It is worth noting that some of the organisational characteristics described above, e.g. role ambiguity and heavy workloads, were found to make a significant contribution to burnout[42] among Israeli social workers (Bargal and Guterman 1996, 1997). This firefighting nature of professional activity at the SSDs at both the individual and

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[42] According to Maslach, Schaufeli and Leiter (2001) burnout is "a prolonged response to chronic emotional and interpersonal stressors on the job" (p.397). It is defined by three dimensions: emotional exhaustion, depersonalisation or cynicism and inefficacy.

organisational level, compromises the realisation of crucial practice components:
systematic, thorough and long-term intervention according to defined targets; intensive and
continuous working relationships with users; evaluation of outcomes; and preventative care
and reaching out measures (Horev and Kop 2009; Knei-Paz 2009; Ofek 2009; IMWSS
2010; Katan 2012).

The clearest manifestation of SSDs breakdown is their failure to respond to the
most pressing and persistent problems of Israeli society - poverty (Katan 2012). Using the
IMSSSA's minister's wording: "Poverty threatens Israel not less than a war"[43]. Israel
today is characterised by poverty rate among the highest in the world[44] (Chertoff and
Tzakid 2009; The Central Bureau of Statistics 2013). In 2008 there were 420,100 poor
families in Israel including 1,651,300 individuals, among them 783,600 children (Chertoff
and Tzakid 2009). Due to various demographic and economic factors poverty in Israel has
several characteristics: it is stable; it is more prevalent among households with four or
more children (a common feature of Arab and Ultra-Orthodox Jewish families) and single-
parent households (mostly headed by women); almost half of the poor population are
working; and the rate of children living in poverty is one of the highest in world - over a
third of all children up to the age of 18 in Israel live in poor families (State of Israel 2006;
Chertoff and Tzakid 2009; Horev and Kop 2009; The Central Bureau of Statistics 2013).
Although 'poverty, income and employment related difficulties' is the second most
frequent reason for referrals to the SSDs in the last decade, this problem is insufficiently
addressed by the majority of departments (Ofek 2009; Katan 2012; The Central Bureau of
Statistics 2013).

3.2   Child Protection Policy and Services

The current section describes some key milestones in the development of child protection
service in Israel. It is aimed to draw attention to the unique characteristics of service

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[43] The IMSSSA's spokesman message to the press on the 16 October 2013.

[44] In 2008 the poverty rate in Israel was the highest among the OECD countries; 19.9% in comparison to an
average of 10.6 %. Following Israel were Mexico with 18.4% poverty rate, Turkey with 17.5% and the US
with 17.1%. In 2011 Israel had the highest proportion of its population at risk of poverty in comparison to
the EU counties; 31% in comparison to an average of 17%, and with 20% in Spain and Greece (Chertoff and
Tzakid 2009; The Central Bureau of Statistics 2013).

provision in Israel and to highlight some systemic obstacles to the delivery of effective help which are mirrored in the committees' decision making process.

The child protection service carried out today is not a matter of systematic, thorough and well-planned programming; rather it has been shaped by several macro level influences over the years. These include policy, legislation, political considerations, pressures of public opinion (e.g. after high profile cases of children's death), social crisis (e.g. mass immigration waves) and cultural factors relating to Jewish and Zionist[45] values and ideology. These processes are the ground on which the reform is built. Until the late 1980s the idea of child neglect or abuse as a social problem and a clear arena for professional intervention was not explicit in Israeli society (Rosenfeld and Kedem 1998; Ajzenstadt and Cavaglion 2004; Faber 2009). Some researchers claim that this is due to the sturdiness of Jewish values treasuring the family unit and the Zionist ideology which priorities collective goals over individual needs (Rosenfeld and Kedem 1998; Ajzenstadt and Cavaglion 2004). It was a continuing social process by which public and professional awareness of the phenomenon of maltreatment had developed, reinforced by incidences of tragic deaths of children due serious abuse[46], and by social activist groups (e.g. The Association for Child Protection (ELI) and The Israel National Council for the Child (INCC), both led by social workers) (Rosenfeld and Kedem 1998; Ajzenstadt and Cavaglion 2004; Faber 2009). An accumulating legal framework gradually acknowledged different types of maltreatment or harmful conditions for children to live in; dealing first with neglect and household living conditions, next with physical abuse, later with emotional and sexual abuse and lastly with domestic violence (Hovav 2007; Faber 2009). Consequently, today there are multiple definitions of maltreatment. The lack of clear agreeable definitions is in particular problematic given the quantity and variety of actors both professionals and nonprofessionals in the field (encouraged by semi-privatisation policy) and the multi-cultural nature of Israeli society, i.e. distinct cultures and religions have their own child rearing norms and notions of what is considered maltreatment (e.g. the use of corporal punishment) (Goldstein and Laor 2007; IMSSSA 2014).

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[45] The ideology of the Jewish settlement movement.

[46] For example, in 1988 it was the death of three year old Moran Denemias due to her uncle's severe abuse which is often regarded as a watershed moment in the history of child protection practice (Boyer and Kadman 2007). In the summer of 2008 the country followed a police search after the 4.5 year old Ross Pizam who was later found dead in a suitcase at the bottom of a river after being missing for 3 months, she was killed by her mother's partner. This event stimulated governmental attention to the issue of early identification of child maltreatment (State of Israel 2010a).

The legal child protection framework almost exclusively[47] involves protective legislation (i.e., laws that recognise the need to protect the safety and well-being of children and young people, yet do not specify what services should be provided) as opposed to granting legislation (i.e., laws that assign legal rights to receive particular services to entitled populations according to legally defined conditions) (Shnit 1998; Hovav 2007). This means that services for vulnerable children have no legal grounds, i.e. there is no binding legal basis for the provision of help. That is even if a particular intervention measure was decided by the committees or the courts (Weissblei 2011). Several parliamentary attempts[48] by Knesset (the Israeli parliament) members in recent years to promote a legal change that would oblige the state to provide services to vulnerable children and young people, have been tangled in a long parliamentary process due to political conflicts, and have not come about to date (Weissblei 2011).

Services for vulnerable children are roughly divided into programmes in the community and out-of-home services. Services in the community are provided to children, young people and their parents, both together and separately and involve critical components including support, therapy, supervision and protection in different combinations. Range and availability of services differ between municipalities and depend on local needs and resources (IMSSSA 2014). Out-of-home services include residential placements, foster care, adoption and emergency services for short-term stay (IMSSSA 2014).

The government of Israel is committed to the principle of family preservation which sees the family as the best place for bringing up children and young people (Israel Ministry of Justice 2003). The right of children to be with their birth family is a guiding principle for practice declared in a number of the ministry's ordinances. For example, Social Workers Ordinance 8.9 from 1995 which is dedicated to decision committees, states:

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[47] An exception is the Toddlers at Risk Law (the right for day care) 2000 which prescribes the right of a toddler (up to three years old) who's appropriate development is impeded due to individual and/or familial circumstances to day care with the aim of preventing his or her removal from home.
[48] For example, the law proposals Youth Law (Care and Supervision) (Amendment No.17) (Out-of-home Arrangements for Minor In-need) 2005 and Children at Risk Right for Services 2006 (Weissblei 2011).

> Growing with in his/her birth family guarantees the child's appropriate development. Hence, efforts must be made to utilise services in the community in order to support the family in raising children. When family circumstances harm or may risk the child's physical or emotional safety and hinder his/her appropriate development the removal of the child to an out-of-home programme, whether for the short or long term, should be considered. (IMLW 1995, Article 1(c) p. 1)

However, for years, out-of-home residential placement was the prioritised intervention solution. During 1997 and 1998, for example, over half of the committees' decisions were for the removal of the child from home, mostly to out-of-home residential settings (Dolev et al. 2001). This trend manifested in both the high number of children in residential placements in comparison to other out-of-home services and in the ministry's budget allocation (State of Israel 2006; IMSSSA 2014). For example, in 2004 68% of the ministry's budget designated for children at risk was allocated for out-of-home services and only 32% was invested in community-based services (IMSSSA 2014). Given that out-of-home services are provided to only about 10% of children in need, these services are four times more expensive than programmes in the community (State of Israel 2006). Thus, for years services in the community, which should have served the majority of children, remained scarce and underdeveloped (Schmid et al. 2008). Another imbalance, which makes Israel exceptional among countries, is the low rate of children referred to foster care (20% of the children removed from home in 2010 in comparison to children referred to residential placements (75%) (Weissblei 2011). The number of children who are adopted is negligible, approximately 100 children per year between 2004 and 2011 (Hirschfeld and Segal 2013).

This tendency represents public opinion highly favouring out-of-home residential institutions, in comparison to other countries, grounded in the historical background and ideology of the state's establishment (Rosenfeld and Kedem 1998; Zeira 2004). Building on existing comprehensive infrastructure of residential institutions, originally designed for absorption of child immigrants, over the years this had become a common solution for varied populations of vulnerable children and young people (Zeira 2004; Dolev, Ben-Rabi and Zemach- Marom 2009). A movement away from this long lasting legacy started in September 2004 when the ministry adopted the 'toward the community' policy. Toward the community is a far-reaching policy which includes considerable structural and

organisational changes, all aimed at reducing the number of children in out-of-home placements. The policy is two-pronged: set a limit of four years on children's stay in out-of-home arrangements; and enable more autonomy and flexibility for local SSDs to reallocate resources at their disposal (quotas) previously earmarked exclusively for high cost out-of-home placements to services in the community for large numbers of children including those children returning back home (Schmid et al. 2008; Schmid, Dolev and Szabo-Lael 2010). Through a gradual process the policy had some remarkable impacts: the number of services and programmes in the community increased dramatically and consequently the number of children and parents receiving help, while the number of children removed from home to residential settings decreased[49] (Schmid et al. 2008; Weissblei 2011). This progress means that committees' decision makers can chose from varied help options that may be more suitable to individual families' needs (under the reform the provision of some services in the community will depend on the committee decision). Table 1 demonstrates the pattern of decline in the rate per thousand of children removed from home to residential placement, showing a sharp fall in 2005 after the policy began to be implemented and a steady rate in the following years (data are based on the INCC's annual statistical report published in 2012). The 3.4 rate per thousand children in out-of-home placement in recent years is much lower than the rate found in other countries, such as in Denmark, the UK and US (Rabinowitz 2010; Weissblei 2011).

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[49] By the end of 2006, for example, over 26,000 new service units for children and their parents were developed in the community; the number of children receiving services more than doubled from 7,000 to 15,675 and the number of parents receiving services elevated from 4,000 to 10,438 in comparison to the previous year (Dolev et al. 2008). Between 2004 and 2010 there had been a rise of 28% in the number of children provided with intervention programmes within their community and only 6% increase in out-of-home placements. The total percentage of children removed from their home, of all registered children, had decreased during those 6 years from 22.1% to 19.1% (Weissblei 2011).

Table 1: Children at Risk Removed From Home to Residential Placements between 1990 and 2012 (numbers and rate per thousand)

Year	Numbers	Rate per thousand
1990	8,685	5.0
2000	9.337	4.3
2005	7,742	3.3
2010	8,408	3.4
2011	8,861	3.5
2012	8,965	3.4

In fact, the balance between out-of-home and community services in terms of budget allocation had reversed in such a way (in 2009 45% of the budget was invested in out-of-home placements) that the availability of out-of-home placements had been negatively affected and this created delays and waits for placement (in particular in regard to post-hospitalisation, therapeutic and rehabilitation institutions) (Weissblei 2011). In recent years the ministry has targeted its efforts into encouraging the utilisation of foster care services and adoption when appropriate (IMSSSA 2014). This is embedded in adopting policy that emphasises two principles in the provision of out-of-home services: 'stable home' which highlights the importance of permanency in care (IMSSSA 2014) and 'hierarchy of care' which suggests that when removal from home takes place the solution of residential placement will be kept as the last resort (Ministry of Justice 2003).

An enduring problem of effective child protection service provision in Israel relates to the lack of the central government's 'working together' agenda. In the absence of comprehensive and integrative policy that sets clear goals, roles and responsibilities as well as constructive working arrangements, the coordination and collaboration between governmental agencies, institutions of local authorities and nongovernmental service

providers is highly defective. This state of affairs has a detrimental effect on the identification of child maltreatment incidences and the provision of early help. 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 initiated, in 2010, a multi-ministerial[50] commission, known as the Vinter Commission, targeted at formulating policy to encourage cooperation between government agencies and suggest ways to establish an effective safety net in the community. Evidence presented to the commission clearly indicated difficulties in information sharing between agencies (e.g. between the police and SSDs):

> Unfortunately, we found that very often there is no full and regular information flow between different professionals who engage with children which hinders the provision of help to children and their parents. (State of Israel 2010a,p.ii)

The commission identified several systemic barriers to information sharing among professional, e.g. the lack of a binding legal or procedural framework that entitles and enables information sharing amongst professionals; different professions having their own obligatory confidentiality laws, regulations and ethics which prevent them from sharing clients' information with external practitioners[51] and insufficient knowledge among practitioners (State of Israel 2010a). The commission's recommendations, including the establishment of multi-professional working teams at state, regional and local level, and an enactment of a new law, Law for Receiving, Giving and Sharing Information Regarding a Minor or His/Her Family, have not been fully realised to date.

Inadequate working together arrangements also interfere with the provision of help after a need has been recognised. The Schmid Commission (State of Israel 2006) found that overall the provision of services for vulnerable children is ineffective; there is duplication of services on the one hand and under-coverage of certain populations on the other hand. Finally, the high fragmentation of service provision also results in a lack of data at national-level as to the scope of the child maltreatment problem and the extent to which it is dealt with (State of Israel 2006). Since the ministry have no designated IT system for data collection in regard to child protection, as found in other countries such as

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[50] Including the following six ministries: Israeli Ministry of Social Services and Social affairs; Ministry of Health; Ministry of Education; Ministry of Industry, Trade and Labour; Ministry of Public Security; and Ministry of Aliyah and Immigrant Absorption.
[51] The Patient Rights Law 1996 for example permits information sharing, however, only between professionals within the health system.

the UK and the US, to date, there is no accurate and reliable information on the population

of children in need, the programmes and services that are provided for them or their

outcomes (Benbenishty 2009; IMSSSA 2014). Nevertheless, the data that are available,

mostly regarding the number of reports of child abuse and neglect to SWYLs, indicate a

clear and steady increase in child maltreatment[52] (IMSSSA 2014). Figure 1 demonstrates

the growth in the number of referrals to SWYLs over a period of 17 years according to the

INCC's annual statistic report published in 2012.

Figure 1: The Number of Referrals to SWYLs between 1995 and 2012
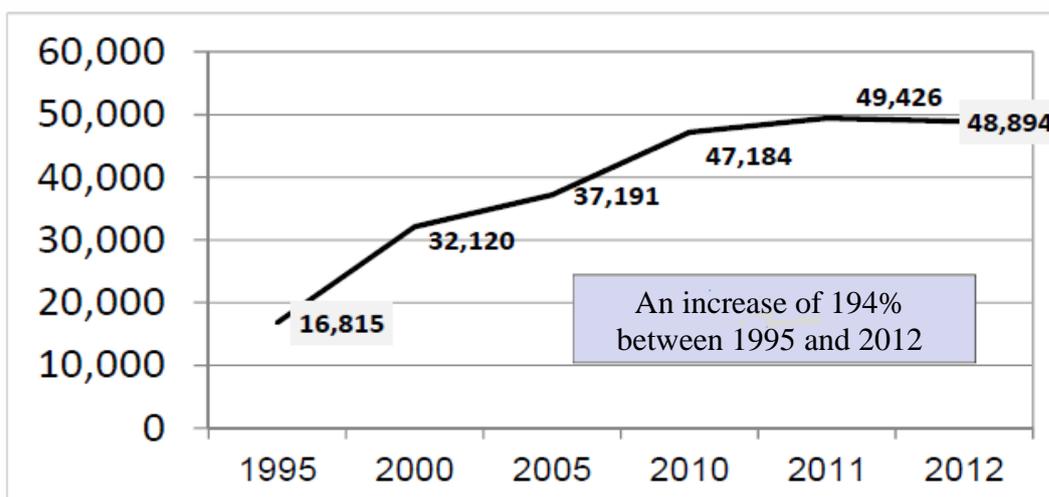
As shown in Figure 1, from 1995 to 2012 the number of children reported to

SWYLs due to claims of abuse and neglect increased by 194% from 16,815 reports to

48,894 reports. According to a recent study on SWYLs' work, most of the children are

referred by professionals and about one-third by lay persons. Relatively large percentages

of referrals are made by school/preschool/day-care agencies followed by the police, while

health workers have a lower reporting rate (Dolev et al. 2008). It is estimated that for each

report there are 3-10 cases in the general population which are not reported (IMSSSA

2014). Figure 2 shows the prevalence of sub-categories of maltreatment within the reports

to SWYLs in 2012, according to the INCC's (2012) annual statistical report.

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[52] That is even if taking into account the natural growth of the child population and the increase in reporting
of child abuse and neglect due to greater public awareness (IMSSSA 2014).

Figure 2: Referrals to SWYLs by Main Concern (per cent) in 2012
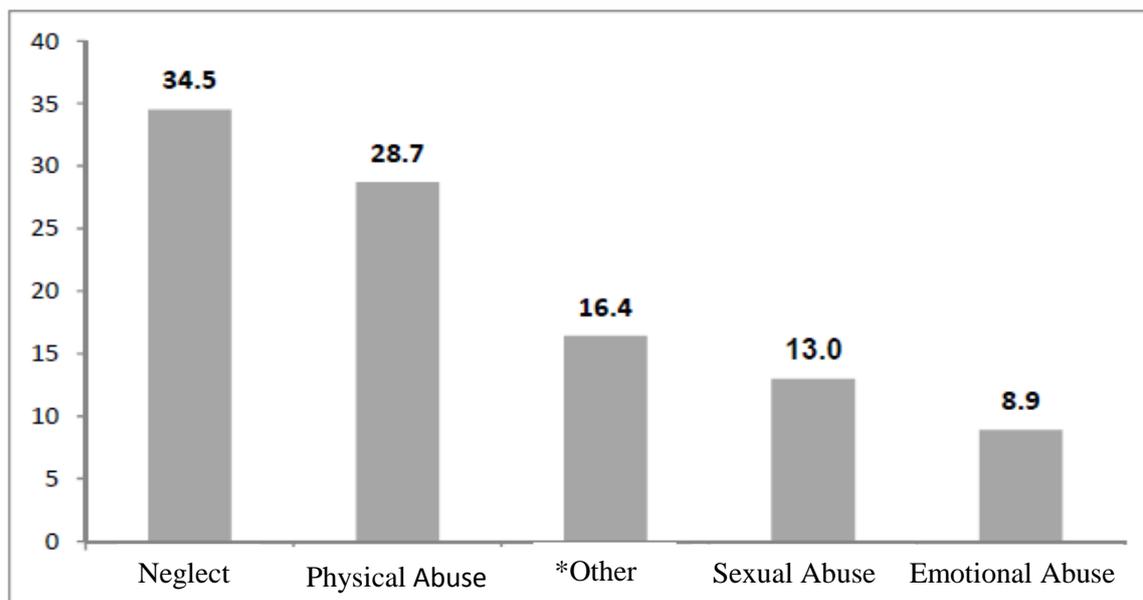
*Other refers to conditions that do not involve abuse or neglect such as involvement in criminal activity.

As shown, neglect is the most frequent type of maltreatment reported, followed by physical abuse and sexual abuse which is less prevalent. This pattern is repeatedly reported in regard to referrals to SWYLs, it also characterises the distribution of concern in regard to children discussed in decision committees and is consistent with findings regarding child protection referrals in other countries, such as the US and Canada (Dolev et al. 2001; Benbenishty 2009, 2010).

To conclude this section in a positive tone, an important step forward aimed to tackle systemic obstacles to the provision of effective help for children at risk was the establishment in 2008 of The National Programme for Children at Risk. The programme operates as a full partnership, in terms of responsibility and financial resources, of five ministries[53]. It started in several municipalities and gradually extended to about 171 localities; focusing at first on mapping the local children and young people's population, learning their needs and later developing community-based responses that better fit with those needs. In addition, the programme prioritises investment in preventative measures and services for very young children (Dolev 2014).

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[53] Israeli Ministry of Social Services and Social affairs; Ministry of Health; Ministry of Education; Ministry of Public Security; and Ministry of Aliyah and Immigrant Absorption .

3.3   Child Protection Decision Making: The Reform

In Israel there are two key authorities involved in child protection intervention decisions: the courts (the focus in this thesis is on juvenile courts) and the Decision Committees working within the SSDs in all municipalities around the country. The committee is an inter-organisational and multi-disciplinary team which serves as a forum for discussion, assessment and decision making concerning care plans for children and young people in need of intensive intervention by the social services, in particular out-of-home services (IMLW 1995; Dolev et al. 2001). The committees' responsibilities are to assess the child and family circumstances; to formulate detailed intervention plans after thorough consideration of alternative solutions; and to follow up their implementation. The committees are exceptional platforms for regular multi-professional work; the forum includes professionals of the social, educational and health systems, while family members may also participate, and they are chaired by qualified social workers, called 'coordinators', appointed by the SSD manager (IMLW 1995). The Committees are not embedded in any legislative framework (IMLW 2002; SIC 2013) rather they operate, to date, according to Social Workers Ordinance 8.9 from 1995[54]. The discipline for practice is to strive for intervention based on agreements with families; in cases of dispute between families and professionals the juvenile court will make the final ruling (The Youth (Care and Supervision) Law 1960).

For the last twenty years, the committees' work and outcomes have been at the heart of political and public debate. Significant governmental actions have been carried out over the years to evaluate the operation of the committees and to formulate policy recommendations to improve decision making practice. Their outcomes stimulated policymakers' understanding that systemic changes to the committees' way of working are required and guided them on what these changes should be. The reform at the focus of this

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[54] In 2009 the ministry drafted the Law for Children's Out-of-Home Placement (PIECs and Foster Care) as a legal framework to deal with children's placement in residential settings and foster care. One of the proposal's chapters was dedicated to the working procedures of the committees. Yet, the enactment of the law is detained to date due to political and budget considerations (IMSSSA 2014; SIC 2013). Although considerable changes to the committees' working followed the reform's implementation in 2008 the ordinance had yet to be updated accordingly (SIC 2013).

thesis continues to evolve[55] through this vigorous process. The starting point of the development is usually linked with the publication in 2001 of the concluding report of the first and only nationwide empirical study initiated by the ministry[56] to examine the committees' organisation, working processes and outcomes (Dolev et al. 2001). The study mainly focused on SSD professionals' decision making and compliance with the ordinance regulations. Its findings reflected some of the problematic aspects of the child protection service mentioned. The committees were focused on a small percentage of highly complicated cases. Most children discussed were over seven years old, and a quarter had not been provided with any service before, which indicates delays in the provision of help. Meaningful multi-professional work was not realised due to the limited participation of practitioners from the educational system and public health services, resulting in SSD professionals keeping considerable power in making decisions, and great variation in the committees' makeup across SSDs. Decisions did not correspond to individual needs due to lack of alternatives in the community and inclined towards out-of-home residential placement solutions, especially in regard to young people (aged 12 to 17 years). Other problems reported included a lack of sufficient information about family circumstances; partial participation of parents and children, in particular; inadequate chairing expertise of coordinators; an unsystematic deliberation process; and very limited follow-up on the committees' outcomes. The authors recommended adjusting referral criteria in order to include a broad spectrum of children in need; enhance coordinators' qualification; increase documentation by supplementary tools and forms; structure the discussion procedures according to principles and stages; reinforce follow-up procedures; and develop IT system for data collection to allow supervision and monitoring as well as identification of necessitated services (Dolev et al. 2001).

Following the seriously negative findings and harsh public outcry of parents at that time over their voices not being heard in the decision making process, the IMSSSA appointed a commission to review the committees' authority and their correspondence with SWYL's and SWCP's legal duties (Known as the Gilat Commission). The commission

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[55] In July 2014 the ministry initiated another commission (known as the Silman Commission) to review its policy in regard to children and young people's out-of-home placement and custody arrangement issues. The commission specifically addressed the PIECs' work; however its recommendations have not been acted on to date.

[56] The study was carried out by the JDC-Brookdale Institute over 3 years in 80% of Israel's local authorities (Dolev et al. 2001).

work was carried out in a highly conflictual and emotional atmosphere. On the one hand parents' evidence described their experiences of attending the discussions as an "unfriendly episode at times of great distress" (IMLW 2002 p. 8) and feeling pressured to approve professionals' decisions. On the other hand, social workers felt they were being too harshly criticised, (the term used was 'executed') without being able to defend their practice (Israel Knesset 2004). The commission's recommendations published in 2002 suggested far-reaching changes to the committees' work in order to actualise parents' and children's rights to effective participation. Reading through the commission's recommendations shows they are far from being innovative. That is they systematically tap into the elements of meaningful participation agreed in the literature, including transparency of information and process, mandatory participation in meetings, preparation prior participation and support through it. Yet, in the Israeli context they were quite a revolution. As an example, the commission addresses families' rights to make appeals or complaints and recommends setting up designated bodies for this purpose. This issue is totally ignored in Ordinance 8.9 (IMLW 1995) which is only concerned with resolving disagreements between professionals. The commission also emphasises the importance of a clear legal working framework and suggests establishing designated bodies for developing scientific knowledge and professional expertise in the field (IMLW 2002).

Another official advocacy for the right of children to participate in the committees' decision making came from the Children's Rights Commission (Known as The Rotlevi Commission) report published the following year. The commission was appointed by the Israel Ministry of Justice in 1997 in order to thoroughly scrutinise the Israeli law regarding questions relating to children's rights, legal status and well-being, and suggest systematic adjustments in light of the UNCRC (Israel Ministry of Justice 2003). The Rotlevi Commission prescribes a core principle of participation, which applies to all children and young people unconditionally in every decision or action which affects their lives and requires it to be recognised in all Israeli legislation relating to children (Israel Ministry of Justice 2003). One of the commission's outcomes was a draft of a new law (Law for Out-of-Home Placement 2003) that, among other things, dealt with children's participation in the committees' discussions when out-of-home placement is being considered. Although, the law was eventually not enacted, it served as a guiding principle for policymakers in the formulation of the current reform (IMSSSA 2004a).

The next step in the reform's programming was another commission appointed by the minister, headed by the director general of the IMSSSA, called The Goldberger Commission, which was originally assigned to suggest ways to implement the Gilat Commission's recommendations. The Goldberger Commission's report, Final Principal Paper, published in January 2004 and Implementation Team's Decisions Paper[57] published in April 2004 are the official texts of the reform[58]. According to the Final Principal Paper the driving forces for the reform were the growing public emphasis on partnership with services users, the state's commitment to children's rights set out by the UNCRC and a recognised necessity to develop the practice of higher professional standards through regular work with users and in regard to the committees' decision making (IMSSSA 2004a). The paper outlines the ethical framework or the principles and values that should serve as guidelines for the committees' operation, social work practice and welfare service in general. These include, for example, the right to participation, nondiscrimination, culturally sensitive practice, family preservation and partnership with users (IMSSSA 2004a). Thus, the reform's inspiration is not to provide a 'quick fix' to the identified problems in the committees' working practices, but rather to be a key milestone for the Israeli child protection services and to generate a new uniform code of good practice.

As from this point, the committee's name was changed to the Planning, Intervention and Evaluation Committee. This transformation is not merely a matter of rhetoric but prescribes the leading functions of the committees, as explained by Professor Dov Goldberger, head of the Commission, when introducing the reform before the Knesset:

> The name of the committee has been changed, they will no longer be called Decision Committees, but rather Planning, Intervention and Evaluation Committees. The idea is, so it will be clear, that the aim of the committee is not to make a decision; its aim is planning an appropriate treatment for children. To make suggestions, to offer ways what is the most right and good thing to do for the children in order for them to exit the risky condition they are in, and also evaluation. That is to say, it can't be that the committee makes a decision and afterwards forgets of what happened to the child or

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[57] This document was designed to serve as the basis for a new ordinance. It includes the detailed working procedures prescribed by the Goldberger Commission, which will be accounted for throughout the empirical chapters of the thesis.

[58] The reform's texts, the Final Principal Paper and Implementation Team's Decisions paper will be cited in the thesis as IMSSSA 2004a and IMSSSA 2004b, respectively.

from the decision, and no follow up is carried out or evaluation of the intervention plan. (Israel Knesset 2004 p. 5)

The Final Principles Paper (2004a, Section A) sets out the core principles of the reform. Some of these principles were already acknowledged by Social Workers Ordinance 8.9 (IMLW 1995) however, they were not fully realised in practice; others, in particular the way of working with families, are novel. The reform's principles are described as set out in Figure 3 below.

Figure 3: Practice Principles for Decision Making

1.	*Professional resource in the community:*
	The PIECs are part of the SSDs professional services in the community for children at risk and their parents when intervention requires multi-professional perspectives or investment of considerable resources.
2.	**Accountability for effective and high quality service for children at risk and their families in the community:**
	The PIECs are accountable for:
	• Establishing care plans that correspond, as much as possible, to children's and parents' needs and preferences.
	• Responsible utilisation of community's and SSDs' limited resources.
	• Building on familial resources in making care plan decisions.
	• Following up the effectiveness of the service provided for children and families.

3.	**Permanent multi-professional team:** Decision making in the framework of PIEC requires experience and expertise. Therefore, the PIECs should include a 'permanent panel' of professionals from the social, education and health services that are not directly involved with the family. This is in order to promote a multiple professional perspective and objective stance on the case. In addition to the permanent panel the discussion will continue to include professionals from various agencies who are directly involved with the family, now called the 'changeable panel'.
4.	**A therapeutic process:** The PIECs' discussions are an integral part of the therapeutic process and are separated from the juridical process required by the Youth (Care and Supervision) Law 1960 (with the exception of emergency intervention). The discussion involves assessment of needs; consideration of available solutions and actions that may promote the child's safety and well-being; and making decision on a specific care plan. This process should have a therapeutic quality.
5.	**Establishing intervention plans based on agreements:** The discussion and care plan decision making should be based on mutual understanding and agreements, as much as possible, between participants: professionals, parents and children.
6.	****Partnership with parents and parents participation:** The PIECs' work process should be established in partnership between professionals and parents and strive for collaboration through care plan decision making. Parents' participation in the discussions and throughout all the meeting is obligatory; exceptions will be cases where participation may hinder the committee's work. Parents may invite participants on their behalf to attend the meetings.

7.	****Hearing the child's voice and children's participation:** The PIECs should operate according to the UNCRC principles and hence, should enable participation of children and hearing their voice in decision making about them. Working procedures oblige hearing children's views and enabling them to participate in the committees, in accordance with their developmental capability.
8.	**Mechanisms for clearing disagreements:** The ministry will establish designated bodies and procedures to deal with disagreements, among professionals and between professionals and families, over the committees' decisions.
9.	**Transparency and documentation:** The PIECs' procedures and the issues discussed should be fully transparent in order to achieve partnership, mutual understanding and agreement among all stakeholders. The decision making process from its outset will follow standardised procedures and will be systematically documented. The discussion's participants, including parents, should have full access to the PIEC documents.
10.	**Scheduled practice; decision implementation; evaluation of outcomes:** Practice should follow fixed timelines. The PIECs are accountable for the delivery and the quality of the services decided on. The decision implementation and outcomes should be followed up periodically according to new set procedures.
11.	**Professionalism:** The new way of working heavily depends on skilful professionals, in particular social workers and coordinators. It is thus that the ministry will develop training programmes for the workforce.

12.	**Inspection arrangements:** In order to monitor the PIECs' operation the ministry will develop a systematic inspection framework.
13.	**IT system of data collection:** The ministry will develop an IT system for data collection about the PIECs operation at the local, regional and national levels. The database will allow monitoring of the committees' working procedures, decisions and outcomes as well as identify local and national demands for additional services.

*This definition expands the target population of the PIECs. **According to Social Workers Ordinance 8.9 (IMLW 1995) parents' and children's participation is only recommended.

A pilot programme called the Community 2000 Experiment[59], initiated in 2004 among eleven SSDs around the country, served as a launch pad for the reform implementation (Dolev et al. 2007a). During the experiment a new 'tools package' (IMSSSA 2009) which translates the reform's principles into everyday practice was developed through a bottom-up process. The tools package's great innovation is twofold: first it sets up the practice according to organised and scheduled working procedures and second it requires that practice at all stages be documented. It includes four standardised tools designed to regulate and record: family assessment; preparation proceedings; PIECs discussions and final care plan; and follow up measures (IMSSSA 2009). Through a three-year process of ongoing evaluation of the implementation of the new ways of working in the field, the new procedures and tools went through several adaptations following workers' feedback in order to support effective utilisation of the reform in practice (Dolev et al. 2007a). In addition, through the experiment, an annual qualification programme for coordinators was developed and provided to the sample departments[60] (IMWSS 2007). Also, in the framework of the experiment through 2006, a committee of policymakers and

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[59] The Community 2000 Experiment programme was developed in collaboration with the ministry, Myers-JDC-Brookdale Institute and Ashalim. It was designed to evaluate the implementation and outcomes of the toward the community policy (Dolev et al. 2007a).

[60] SSDs that participated in the Community 2000 Experiment were also entitled to budget for training on issues relating to the reform, such as early identification of children at risk. However, there is no data showing whether, or to what extent, this option was utilised (IMWSS 2007).

experts was assembled in order to study the issue of children's participation in the PIECs (Greenwald 2006). It was recognised from meeting protocols that most social workers lack confidence and sufficient qualification in communicating effectively with children (Greenwald 2006). Nevertheless, the committee's work was not further developed into detailed practice methods for working with children or a formal training programme (SIC 2013).

As of 2008 a national implementation process of the reform has been carried out in the field and from 2009 the use of the tools package in practice is compulsory (SIC 2013). In January 2008 the government allocated the ministry budget[61] for professional training, development of technological infrastructures, and additional staff including 85 positions at the SSDs, mostly social workers and coordinators and the rest administrative workers (SIC 2013). Through 2008 and 2010 the ministry initiated a nation-wide extensive training programme (based on the Community 2000 Experiment's qualification scheme) for SSD managers, coordinators and team leaders (Lev-Sadeh and Rotfogel 2010[62]; Rotfogel 2010[63]; SIC 2013). In addition, some regional supervisors initiated 'colleagues meetings' for coordinators under their responsibility, where concerns could be aired and knowledge shared (Rotfogel 2010). Coordinators and team leaders were assigned to be the driving forces of the change and steer the reform's implementation in their organisations. Beside the key roles prescribed to them by the new way of working they were given the duty of distributing the reform's principles through departmental and supervision meetings and help workers apply them regularly to their cases (IMSSSA 2008b).

By the time of the data collection of the current research, the ministry had not fully implemented all aspects of the reform set out by the Goldberger Commission (IMSSSA 2004a). Firstly, the ministry had not carried out to the full its responsibilities regarding qualifying the workforce for the new way of working. There are still no clear regulations as to the prerequisite expertise and qualifications for taking a coordinator role. The new training programme for coordinators has not been applied systematically so there are

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[61] Five-year budget of 150 million shekels (about 25 million pounds) (SIC 2013).

[62] Dalia Lev-Sadeh (Head of The Service for Children and Youth) and Vered Rotfogel (National Service for Children and Youth Supervisor), 25th October 2010, during a meeting with the researcher at Lev-Sadeh's office, Jerusalem.

[63] Vered Rotfogel (National Service for Children and Youth Supervisor), 27th December 2010, during a meeting with the researcher at Kfar-Saba.

coordinators who act in the role without participating in particular training (SIC 2013). The ministry has not developed or provided any designated qualification programme or training for front-line social workers. Secondly, no progress had been achieved to date regarding the decision to set out an accessible appeal process for families. Families, as all other service users, have the right under the Welfare Services Law 1958, to file a complaint to the ministry's regional appeal committee in cases of alleged misconduct in regard to a request for services. Yet, these committees are not authorised to change the PIEC's decisions but merely to suggest another discussion. According to the ministry's data only three families addressed these committees regarding the PIECs' work during 2011-2012 (SIC 2013). Therefore, the courts remain the key means to settle disputes between families and professionals about care plans. Thirdly, systematic inspection of the PIECs' operation in the field is another issue that has been neglected. The ministry's plan to initiate a research scheme that will follow the early stages of the reform's national implementation, evaluate outcomes and provide effective feedback for further developments or adjustments did not take off, beyond drafting a detailed research proposal (Ben-Rabi, Szabo-Lael and Tilkin 2010). Through 2009-2010 the ministry carried out a concise inspection scheme. Data collected regarding a total of 600 sampled cases reveal inadequate implementation of the reform (Rotfogel 2010). However, findings were not analysed to provide an overall picture of the situation at national level (SIC 2013). Some small-scale investigations into practice adherence to the reform were carried out in the framework of evaluation studies on the Community 2000 Experiment's outcomes taken in 2007 and 2010 as well as through the State of Israel Comptroller's independent inspection[64] conducted in 2010-2011. Findings continued to show partial realisation of the reform in everyday work, particularly in regard to utilisation of the tools package in practice and children's participation in meetings (further account of these schemes' evidence will be presented in the empirical chapters of this thesis) (Dolev et al. 2007b; Ben-Rabi and Amiel 2013; SIC 2013). An encouraging step which may lead to further progress is the appointment in 2011 of a new senior manager position in the ministry of PIECs supervisor role. However, the key problem in monitoring the reform's progress

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[64] The State of Israel Comptroller (SIC) carries out external audits on a range of activities undertaken by ministries, local government and various public organisations, in order to ensure that they comply with the law, good governance and the principles of integrity, efficiency and thrift (The State Comptroller LAW 1949; Basic Law: The State Comptroller 2005). The inspection referred to included a review of 38 case files collected in ten social services departments across the country and interviews with professionals at the local, regional and senior levels of managements (SIC 2013).

remains the lack of a central data collection system, which means that there is no systematic national data regarding the number of PIECs carried out[65]; the number of children and families discussed or their characteristics; the committees' working procedures; the intervention decisions made or their outcomes. According to the IMSSSA's planed strategy the tools package should be transformed into an electronic version and integrated into an overarching computerised system to manage, record and monitor PIEC operations and outcomes (Rotfogel 2010). In 2009 the IMSSSA began to work on a designated ICT system, called Mitve and in 2011 a pilot programme of the system (still not fully developed) started in fourteen SSDs around the country (SIC 2013). It was at this stage of the reformative transformation that field work for the current research commenced.

3.4   Conclusions

The reform in the PIECs' work is a welcomed well-informed enterprise taken by the IMSSSA with the hope of establishing high quality service for children and young people in need and their families. It is designed to adapt the workforce to a new way of working with children, families and other professionals and to set new standards of good practice through all stages of the decision making process, in order to secure the provision of effective help. However, the reform is implemented within a social services system that suffers from some crucial weakness, including a tangled and extensive legislative framework which does not mandate service provision or address the community's dearth of resources; heavy workloads or firefighting working culture; lack of clear definitions of maltreatment; insufficient professional training and knowledge (both in general and in regard to the reform); or inadequate collaborative work between agencies. These systemic factors may hinder the realisation of policymakers' expectations of the reform. This research will seek to provide understanding of whether, and how, systemic features of the Israeli social services system discussed in this chapter interact with evidence regarding the reform's operation in the field. This chapter closes the introduction section of the thesis. The next chapter describes the methodology of the current research and is followed by five empirical chapters that present and discuss the findings.

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[65] It is roughly estimated that about 30,000 PIEC discussions are carried out each year (Lev-Sadeh, 30th December 2012, during a meeting with the researcher at Lev-Sadeh's office, Jerusalem).

4. Chapter 4

Methodology

In this chapter, the research methodology, design and methods of data collection are described and their fitness for the study's conceptual framework (i.e. systems approach), questions posed and objectives, is advocated. Particular attention is given to the issue of site selection and sampling strategies due to the considerable degree of effort and time that was required to recruit participants, both professionals and family members, and secure their formal consent to take part in the study. As the research data collection methods are presented, the study's limitations are also accounted for together with procedures undertaken to reduce their possible effects. The chapter also addresses ethical considerations in operating field work and describes the process of data analysis. It concludes with an account of the means used to protect the study's rigor.

4.1 Research Strategy

Evaluation is the overarching purpose of the current study. The study's aim is to evaluate whether, and if not why, the recent national reform in PIECs' working procedures is achieving its goals of fostering sound child protection decision making processes which involve effective working relationships with parents and greater participation for children so that families can get the right help and children's safety and well-being can be improved. Furthermore, the focus of the investigation is on both the operation of the reform and its outcomes for children and parents, as service users. This research uses a qualitative strategy of inquiry to answer these questions.

Robson (2002) argues that evaluation practice is distinguished not by its methodological approach but rather by its purpose, which is to "assess the effects and effectiveness of some things, typically some innovation, policy, practice or service" (p.202). This research is guided by Weiss's (1998) work on social programmes and policy evaluation and adheres to her definition of evaluation:

The systematic assessment of the operation and/or the outcomes of a programme or policy, compared to a set of explicit or implicit standards, as a means of contributing to the improvement of the programme or policy. (p.4)

Adapting to Weiss's (1998) conceptualisations expands the scope of inquiry and allows sensible questioning regarding a variety of aspects including: How is the programme being conducted?   What is it actually doing?   How well does it follow original guidelines?   What kind of outcomes is it producing and how well do they meet the intended purposes?   Should it be continued, expanded, changed or completely abandoned? Following Weiss (1998) a qualitative approach of inquiry which seeks to understand the "whole interaction within its natural setting" (p.253), has the edge for developing in-depth answers about these questions. Qualitative evaluation is especially helpful in understanding how and why a programme succeeds or fails (Padgett 1998). Using Padgett's (1998) words: "qualitative researchers can fade into the woodwork and respond flexibly to the ebb and flow of organisational life" (p.136). The holistic approach promoted by qualitative methods and their particular sensitivity to the influence of context (Weiss 1998) is in synergy with the systems thinking employed in this thesis and will help identify the impact of the work environment on the implementation of the reform in the field.

In addition, some researchers highlight the resemblance between social work practice's principles and values and qualitative research (compared to quantitative approaches) to support its use in this context (Gilgun 1994; Padgett 1998; Weiss 1994). For example, social workers view the client as part of a wider social context, think inductively and flexibly, search for meaning and understanding, and examine information from a variety of sources before drawing conclusions. They are also very familiar with the primary data collection methods commonly used in qualitative research, i.e. in-depth interviewing, observations and document review (Gilgun 1994; Padgett 1998; Weiss 1994). Padgett (1998) also points out that qualitative approaches fit well with social work values by giving less powerful stakeholders, such as front-line workforce and service users' voices greater prominence in the findings.

4.2   Research Design

The current research uses a case study design to explore the operation, process, and outcomes of the reform in the field. Case study is one of the three most influential design traditions within the qualitative approach which hold particular pertinence for real world studies (Robson 2002). Robert Yin (1994) a leading advocate of the use of this design in the field of social research, describes the case study as:

> An empirical inquiry that investigates a phenomenon in a natural setting when the boundaries between the phenomenon and the context are not clear, using multiple sources of evidence. (p. 13)

The key element in this definition to draw attention to is that a case (or a small number of cases) is studied in its context which allows keeping the focus on the totality (Robson 2002; Weiss 1998). This merit is in balance with the systems approach applied in this thesis. The definition of what forms a 'case' is broad and open. It can be for example, one person, a small number of individuals, a local community, a service or a programme, an organisation, or a specific event (Robson 2002). Cases studied can be extreme or unique cases, as is common in clinical studies, or alternatively as in the current research representative or typical cases, where "the objective is to capture the circumstances and conditions of an everyday or common place situation" (Yin 2003 p. 41). It is thus, that case study design can be found in disparate areas and disciplines including policy implementation and evaluation (Robson 2002).

In the current research a case is a family that was referred to the PIEC. The study rigorously investigated 21 cases (with a total of 45 children) that were selected as exemplifying the implementation of the reform in practice. Following the typical features of the case study design, detailed information was obtained regarding each case via a range of data collection techniques over a sustained period of time (Stake 1994). Information was collected about each case from the time it was first referred to the social worker that was responsible for the family at the time of the PIEC until a formal follow-up point; six months after the PIEC took place. For every single case the three basic modes of data collection in qualitative research were used:

- Direct observation of the committee's discussion.

- Interviews with the responsible social worker and parents.

-       Review of case records and reports.

The research design taken in this study allows tackling the three key problematics of contemporary research inquiry in the field of social work identified by Ruch (2014). First, she argues that the complexity of the phenomena studied is not fully taken into account or understood. Child protection decision making is not an isolated event, but rather a consecutive process that starts with identification of need and finishes when safety and improvement in the child's welfare are secured. The sequential tasks practitioners need to carry out are inter-connected, so that performance at one juncture inevitably affects the outcomes at later stages. In addition, child protection work involves contributions from several professions as well as family members. Taking into account the role of the workplace or organisational conditions in shaping practice adds greatly to the complexity of the inquiry. The watchword in the current research design is holistic. The case study design allows the keeping of all the elements of child protection practice in sight at once and the investigating of them as a compound whole. Second, is the tendency to indirectly derive data from practice which is manifested in the use of interviews with children or social workers as an overriding data collection method rather than observations of relationships, communication and encounters between social works and service users in action (Hall and Slembrouck 2009; Ruch 2014). The case study design taken in this research allows going beyond interviews by incorporating additional data types, and in particular observations. Observations enable the researcher to "get at real life in the real world" (Robson 2002 p. 310), and get direct access to rich information about the PIECs care plan decision making that would not be available by other means, including arrangements; the nuance of the deliberations; nonverbal communication and behaviours; the dynamic interplay of its members; the differences in their perception of events, power and influence; and how it all interacts in the process of decision making (Farmer and Owen 1995; Padgett 1998; Sheehan 2001). The third problematic relates to the fact that social workers, and the service users they work with, are usually not engaged in the same research but rather the phenomena is studied from either perspective in isolation, which leads to a fragmentation of knowledge. The current study incorporates both social workers and families with whom they work in one case unit. The practice in regard to each family is thus investigated from both service provider and user perspectives.

To sum up, the case study design used in this research allowed capturing the complex and holistic nature of child protection practice without breaking it into individual elements of inquiry and studying it within its organisational context. Another important benefit of this design draws from the mixture of different types of data and sources of data. This provided the research a strong quality known as 'triangulation'. Triangulation entails "using two or more sources to achieve a comprehensive picture of a fixed point of reference" (Padgett 1998 p. 96). This synergy helps safeguard the study against possible threats to its validity (e.g. reactivity, researcher bias and respondent bias (Lincoln and Guba 1985)), and allow its findings to "say more and to speak more confidently" (Weiss 1998 p. 269).

4.3   Site Selection and Sampling Strategy

Before the proposed research was drafted, it was established that it was possible for it to be realised. Hence, throughout the second half of 2009 the researcher initiated consultation meetings with the management at the apex of the IMSSSA in which considerable encouragement and support for the study were found. It was decided that a senior manager from the Service for Children and Youth would act as the researcher's contact person for operating in the field. Successful meetings with senior researchers at the JDC-Brookdale Institute who were responsible for the Community 2000 Experiment were also held during that time. Together, these professionals provided the researcher with pertinent governmental records and continuous updates as to the progress and assimilation of the reform in the field. After gaining the ministry's Research, Planning and Qualification Division's official approval to carry out this study according to ethical considerations of confidentiality and the London School of Economics and Political Science (LSE) Research Ethics Committee's approval for the research, there were no further constraints on starting to carry out the field work.

4.3.1   Site Selection

As an initial stage, following senior management recommendation, the study was made known to the field through a post published by the researcher on the VCoPs on the

ministry's website during July 2010 which described the research purpose and its contribution to practice. During the following month site options were discussed with the senior manager contact person. The choice of the sites represented a balance of research interests and availability (Padgett 1998). The primary explicit criterion for site selection was that SSDs had fully implemented the new reform in everyday practice. It was thus decided to concentrate on departments which participated in the previous Community 2000 Experiment, where practice had been carried out according to the reform over a considerable period of time. Sites selection also followed 'convenience sampling' (Miles and Huberman 1994) to include sites that were easiest to get to and were known to have cooperative staff (willing to participate). At that stage three local municipalities around the country were selected to participate in the research.

Sites were approached progressively. Firstly, affiliated regional supervisors and SSD managers were engaged by the senior manager to be provided with information about the research (using a designated information leaflet prepared by the researcher, see Appendix 1) and to foster participation. Secondly, after initial support for the research was gained, throughout October 2010 the researcher travelled to sites and met with coordinators and in two departments also with the SSD manager. Through these meetings the study's objectives and design were described in detail and preliminary general data regarding the reform's implementation in each department were obtained to ensure a sufficient degree of the reform's realisation was in regular practice. Also, the researcher provided SSD leaders with a brief leaflet addressed to social workers in order to introduce the study to the workforce through departmental meetings (see Appendix 2) and a contact person in each SSD was chosen (these were the coordinators and in one site also the PIEC administrative secretary). Consequently, data collection had started in two municipalities, one in the north of Israel (Site B) and one in the centre of Israel (Site A) in which, due to the large population, social services were provided by three different SSDs according to regional division of the city, each having a different PIEC coordinator (Sites A1, A2 and A3). In the same month a pilot test was carried out at site A1. As for the third municipality that was initially considered, the SSD manager decided, soon after the meeting with the researcher, to withdraw from the study. The informal reason was that participation would impose a great burden on staff's time and energy. Notes from

meetings in Sites A and B including an example of the tools package used in each department were incorporated in later data analysis.

With the advantage of the flexibility inherent in qualitative research, field work data collection was expanded, midstream, to additional sites, due to the small number of acceptable cases the original sites were producing and also to allow greater variation of sites so that a broader scope of information could be collected. Site selection involved an ongoing negotiation process during which regional supervisors and local managers of alternative SSDs were approach by the ministry's senior manager. In regard to four sites, regional and local management opposed participation, chiefly due to considerations of present workload pressures. Eventually, during May and June 2011 three additional local municipalities were included in the study through a generally similar process. Distinct from the earlier procedure, the researcher (rather than the senior manager) communicated about the study with the regional supervisors. The engagement with local coordinators who were the sites' contact persons (one of whom was also the SSD manager and another was the former coordinator of the department), was carried out via phone conversations and e-mail correspondence. The added sites included three SSDs at a local municipality in the east (Site D), in the centre of Israel (Site E), and in the country's south (Site F). While Site D participated in the Community 2000 Experiment, Sites E and F did not. It was thus that through the initial contact with both regional supervisors and SSD leaders the researcher carefully investigated the degree to which the reform was implemented in practice to assure sites were meeting the selection criteria. Notes from conversations with coordinators of Sites D, E and F including examples of the tools package used in each department which were sent via e-mail or mail, were incorporated in later data analysis.

During June 2011 the researcher participated in a meeting held by the ministry's senior management for all regional supervisors around the country in order to advertise the research and encourage further participation. Yet, this course of action had no effective outcome, so no additional sites were included in the research beyond this point. To sum up, data were collected in seven social services departments which were affiliated to five local municipalities around the country. Table 2 summarises the number of cases collected in each site.

Table 2: Number of Case Studies Collected by Site

Site code	Total number of cases collected
Site A	11
SSD A1	8
SSD A2	2
SSD A3	1
Site B	7
Site D	1
Site E	1
Site F	1
Total	21

4.3.2   Sampling Strategy

In order to account for variations in practice and family characteristics, a heterogeneous sample of case studies was sought. Therefore, it was initially decided that case studies to be include in the research should correspond with two conditions. 1) Each case should involve a different family. 2) Each case should be under the responsibility of a different social worker. Yet, this criterion had to be compromised in four cases after an unexpectedly small sample size was established during the first data collection wave. In addition, since some homogeneity in procedures was also sought, another criterion for sampling was that the family were referred to the PIEC for the first time. Nevertheless, during early field work it was found that this condition was not definite enough, and thus it was dropped; so some cases, in which a committee had been held several years before the current data collection time, were also included in the sample.

The complexity of obtaining the sample cases was reinforced by two factors. First, the researcher's presence in the field was transitory since at that time she was living in London. Before every data collection trip to Israel the researcher engaged with the contact person in each SSD and applicable cases were selected form the departments' PIEC schedule for the up-coming period. Due to the dynamic nature of the working environment PIEC schedules were prone to last minutes changes. Hence there were occasions when a selected case was not eventually included in the sample since the committee was cancelled or postponed beyond the data collection period. Other reasons to exclude cases at this point involved parents' limited proficiency in Hebrew or intellectual incompetence to be engaged in an interview; children with severe disabilities; cases where parents seriously protested against the PIEC and there was uncertainty about whether they would attend the meeting; and when the responsible social worker knew in advance she/he could not participate in the committee.

Secondly, in compliance with ethical considerations both social workers' and parents' formal consent to participate in the research had to be achieved as a prerequisite to inclusion in the sample. Since professionals were obliged to preserve the confidentiality of SSD service users, gaining parents' consent was carried out through two sequential stages. First, social workers responsible for the selected cases were approached by either the researcher or the contact person. After being informed about the study and expressing willingness to participate in it they were asked to approach the parents, provide them with general information about the study and ask their permission for the researcher to contact them directly. In order to make this process less burdensome, the researcher provided the selected SSDs with a supplementary leaflet that included a couple of lines of text that could be used by social workers when approaching parents (see Appendix 3). Next, the researcher conversed by phone with parents who had expressed interest in participating in the research and provided a more detailed account about the study. The researcher used fixed text to introduce herself and the study (see Appendix 4) while particularly emphasising that she was an outsider to the SSD and to the PIEC's decision making process. Detailed information was provided on the basic elements of informed consent (described later) and only parents who agreed on all components were included in the final sample. Two cases were excluded at this point, one where the father refused audiotaping

of the PIEC discussion and the other where, after some thought, the father asked not to participate in order to secure family privacy.

It is important to note that this sampling strategy positioned individual social workers as key gatekeepers. Through conversations with SSD contact persons as field work continued, difficulties in gaining social workers' cooperation was reported. Workers' explicit explanations were that participation may interrupt the therapeutic process the family was involved in or that parents would refuse participation if approached. However, it was also suspected that social workers resisted having their practice made public and under systematic inspection. On the one hand, it confirmed that although expectations had been placed upon staff to cooperate with the research, participation did not involve coercion. On the other hand, social workers' resistance was starting to emerge as a grim obstruction to data collection. To tackle this problem the researcher suggested participating in SSD departmental meetings to account for the study, address workforce concerns, and answer possible questions. This procedure was carried out during June and July 2011 in three sites: E, A and B. The strategy proved very successful in encouraging social workers' participation; in the following wave of data collection during August 2011 seven new cases (a third of the total sample) were included.

The limitations of the site selection and sampling strategy adopted are obvious. The researcher was dependent on professionals, including senior management and members of the departments, to approach, and arrange access to, case studies. This presents the possibility that findings do not represent the wider picture of professional practice and the full range of service users' perspectives and experiences. While this possible sample bias should be kept in mind when interpreting the research findings, this limitation does not invalidate the study evidence or undermine their contribution in terms of offering rich insights into practice or directing future avenues of research.

4.3.3   Leaving the Field

The decision to stop data collection after the fourth wave in August 2011 was driven by several considerations. First, in regard to the applicability of cases to the sample, contact persons confirmed that in the following months PIECs would mainly discuss prolonging

educational or care arrangements for the next academic year. Second, September and October are the Jewish holiday season and so the committees' workload was expected to be dramatically reduced. Third, the researcher got the impression that professionals had achieved saturation point in their involvement in the study. This was openly articulated by two coordinators. After field work had finished all SSDs that participated in the study received a formal thank you letter (signed by the lead PhD supervisor) to express appreciation for their cooperation.

4.4   Data Collection Methods

The data collection process in this study was carried out from October 2010 until February 2012. Due to the fact that the researcher was not living in Israel at that time, the field work was arranged in four intensive waves (not including a small-scale pilot test). That was also the consideration behind carrying out some interviews (i.e. interviews with parents and follow up interviews) by phone. It should be noted that there was a six month gap between the first and second waves, which was the consequence of the researcher's health condition, and a 23 day long social workers' industrial strike in protest over their low income, during March 2011. Gaps between field trips to Israel were used to transcribe the raw data already available. More importantly, they provided a useful space to think while detached both psychically and emotionally from the field. This reflective process which involved critical consideration of research tools, outcomes and attention to some emerging themes and trends, guided, focused and refined data collection as it proceeded.

4.4.1   Data Collection Schedule

As mentioned, research methods to collect information, included observations of PIEC discussions; interviews with workers and parents; and document review. The data collection in regard to each case was conducted according to the following schedule:

First phase: direct observation in the PIEC discussion: Here was the first face-to face encounter of the researcher with the family and (in most cases) the social worker. At this point the researcher introduced herself again to participants and parents were requested

to sign a formal consent form as ratification of their informed voluntary participation (see Appendix 5). It should be emphasised that since the research initially conversed only with parents, when children attended the meeting the researcher addressed them directly and explained about the study. Documentation of the PIEC was provided to the researcher at the end of the discussion or was sent later via-email (in regard to Site D these data are missing).

Second phase: just after the committee ended: A face-to-face interview with the social worker responsible for the family was conducted, usually at the worker's office (or in a private room at the SSD). Documentary materials were collected and photocopied at the end of the interview. In eight cases, due to the social worker's busy schedule, the interview was carried out a couple of days (up to nine days) after the committee. In only one exceptional case this interview was carried out by phone. Observations were carried out before interviews with social workers for two key reasons. First, it allowed investigating social workers' perspectives and experiences of the committees. Second, it allowed the researcher to observe the events of the committees while maintaining critical distance. In effect the researcher's position was exactly that of a permanent forum member according to the reform's new forum structure, which means she had no prior familiarity with the family (beside a short phone conversation) and her understanding of the family situation was restricted to evidence presented during the committees.

Third phase: a fortnight after the committee ended: An interview with the parents was carried out by phone. A time gap from the committee was decided on to allow the expected emotional impact of the meeting to calm down. This also allowed investigating whether, and if so what, actions had been taken to implement the care plan decided on during that time. Prior to the interview the researcher talked with parents to set a convenient time which would allow private conversation.

Fourth phase: six months after the committee was carried out: A follow up interview with the responsible social worker was carried out by phone. The interview was scheduled through e-mail correspondence. In six cases, there had been a change of social worker by this time. In these circumstances the researcher initially conversed by phone with the worker to introduce herself and the study, and to gain consent for participation.

4.4.2   Research Methods

The key advantage of using qualitative methods, in the "voyage of discovery" (Padgett 1998 p. 18) is clearly the depth, creativity and originality of the insights it produces. Yet, this merit also runs the risk of amassing a large amount of data which is beyond the researcher's capacity to deal with (Robson 2002). In order to avoid this pitfall in advance the watchword when choosing and designing the specific data collection modes and tools (as well as during data analysis) is that the research questions come first. It is thus, that the tendency was towards using more formal, structured and directed approaches to data collection which still give the researcher sufficient flexibility and broad discretion in pursuing the research goals. This logic led to adopting formal observations and semi-structured interviews as data collection methods.

Observations: Direct observations were conducted in 22 PIECs; in one case two discussions were held within a week, since the mother did not attend for the first meeting. In total 24.1 hours of observations were carried out in all sites. Overall, 10 different coordinators where observed in action, since in six cases lead coordinators had to be substituted. On a continuum, where one side is informal observation and the other side is formal observation, this research tended towards the formal approach. The PIECs imposed a large amount of structure and directed what was to be observed. Following Robson's (2002) definition, observations included recording the 'linguistic behaviours' (i.e. the actual content of the words spoken and their structural characteristics) and 'extra-linguistic behaviours' (i.e. aspects of verbal behaviour other than the words, such as speaking rate, loudness and interruptions to the communication). In addition, detailed notes were taken during the event of what was seen (rather than heard) including 'nonverbal behaviours', in particular emotional reactions, as well as 'spatial behaviours' (e.g. individuals' movements inside and outside the room or within the room). Notes were also made about other aspects of the meetings such as the physical features of the committee room, sitting arrangements, use of written records, and members' implicit interactions. Peoples' actions and behaviours were recorded at the time they happened so that they could be linked to the verbatim record to provide rich and highly illuminating data. In addition to her notebook and tape the researcher used a field note scheme form that was developed prior to data collection and revised after first observation experience (see Appendix 6). Its purpose was to serve as a helpful checklist to secure attention and concentration was kept on particular

aspects. Since the PIECs were highly intensive events initial notes were very condensed and shortly after, the discussion records were developed through adding more detail. The researcher also recorded her impressions, feelings and thoughts stimulated during the meetings.

Since the committees included professional forum members that were not familiar with the research, the researcher introduced herself to the forum through the early structured introductory stage of each meeting, while specifically pointing out the purpose of the research and the consent gained by parents and SSD professionals to attend the meeting and record it. Also, the researcher made it clear from the outset that her role was merely a matter of being present rather than being involved in the discussion or decision making. After this introductory explanation the researcher had no further interaction with the members. These measures were intended to reduce as much as possible the inevitable impact of 'reactivity' or 'observer effect' which refer to "the potentially distorting effects of the researcher's presence in the field" (Padgett 1998 p.92). Also since some coordinators had been observed several times, the researcher got a sense there was some habituation to her presence so with time her being there was less noticed. Some reinforcement of the researcher becoming assimilated into the committee meetings came from SSD professional members' comments in the aftermath of the PIECs. For example, one team leader mentioned that the researcher's presence did not lead her to act differently than usual.

Interviews: All interviews carried out in this study were semi-structured. That was to ensure the conversation kept the study's objectives at its focus, while providing the researcher enough flexibility to follow the interviewees' trail wherever it led. In regard to parents' interviews, it was important that they should not be mistaken for interactions with a therapeutic purpose. The ethical problem with such a misconception of the relationship is that intensive discussion about sensitive and painful topics can consequently lead to emotional distress. The semi-structured interview model gave the conversation a more distinct systematic and controlled nature as well as allowing the conversation to remain 'child-centred', while avoiding possible drifts in focus to the parents' own pressing issues. In order to enhance an open and honest dialogue it was crucially important to build a good rapport between the researcher and the interviewees. Thus, the researcher applied her interpersonal skills drawn from her social work qualifications and experience in the field to

become a nonjudgmental, sympathetic listener as far as possible. All interviews were tape recorded with only two exceptions: a social worker and a mother who although informed in advance about intention to audiotape the conversation, when the time came to conduct the interview, requested that the conversation was only recorded using notes.

The interview guide was grounded in the reform's official guidelines regarding the new working approach. It was also inspired by the research tools used in the national study (Dolev et al. 2001) and in Bell's (1999b) study of families' participation in child protection conferences in the UK. Interview guides were pre-tested in one case (that was included in the sample) to ensure they produced reliable and valid data and continued to be refined while the data collection proceeded (e.g. questions resulting in misapprehensions were better articulated or omitted). Open ended questions were used to gain as much information as possible about facts, actions beliefs and attitudes and to create a more natural situation for respondents (Sheehan 2001). Guides were also designed to promote fluent goal-directed conversations and enhance rapport. The interview guides (see Appendices 7, 8 and 9) structured the interactions as follows, using Robson's (2002) terminology again.

Introduction: at this opening stage the researcher used fixed text to introduce herself; explain the purpose of the research and interview as well as how its results will be used; describe the structure of the conversation and its approximate duration; assure confidentiality; ask permission to tape record the conversation; and invite the interviewee to interrupt the course of conversation if questions are raised.   Since interview strategy is susceptible to respondent bias, i.e. workers may withhold or distort information to cover up poor practice it was important to promote workers' openness and honesty in the interview setting. The researcher followed Sheehan's (2001) approach when exploring children's courts magistrates' decision making, and made it clear to respondents from the outset that the purpose of the study was to contribute to knowledge and practice in the field and not to judge or expose individual decisions or decision makers. In regard to parents, it was important to assure them that the researcher is as an objective third party interested in the overall evaluation of the current reform, rather than another member of staff, hence this issue was particularly stressed through the introduction.

Warm-up: this stage involved easy, nonthreatening questions designed to reduce possible stress (of both interviewer and interviewee) and get to know the interviewee. These question involved issues such as general demographic characteristics and workers' roles, qualifications, experience etc. Through the follow-up interviews social workers that had been interviewed before were only asked very briefly to report on any changes from previous conversations and, when this was not the case, the full range of warm-up questions was used.

Main body of interview: this core section of the conversation was built according to the chronological progression of practice undertaken in the case. In general, it started when the family was referred to the social worker responsible for the case, centred specifically around the PIEC and its outcomes, and ended with predictions as to the situation in six months time. Interviews with social workers involved several questions that required making some ratings (e.g. their level of confidence or their level of agreement) and so a supplementary form in which the scales were visually shown was provided for interviewees to support the accuracy of their responses.

Cool-off: leading the conversation to its end this section included a few straightforward questions to capture attitudes about the PIECs' decision making process in general and to encourage suggestions for practice improvements. In the follow-up interview for social workers this final part of the conversation was design to engage participants in critical reflection on practice and the intervention plans decided on. At the end of the face-to-face interview social worker participants were asked to complete a brief, one page long, self-report attitude survey about the committees. The form was anonymous and included fifteen statements regarding the PIECs and interviewees were asked to rate their degree of agreement or disagreement with each statement. To allow participants adequate privacy the researcher engaged in collecting her gear during this time.

Closure: at this closing stage interviewees were offered a last opportunity to add to the conversation, were thanked for sharing their experience and the benefits of the conversation in adding important insights was highlighted. Overall, feedback from interviewees at the end of the conversation was positive and it appears the interaction was a mutually beneficial encounter. Some participants, mostly parents, even volunteered to converse again.

Finally, since this study was carried out by a single researcher, it was central that she persistently examined her performance throughout the course of the data collection. Reflexivity was thus systematically structured within the interview schedule. At the end of every interview the researcher completed an "interview reaction sheet" which required critical reflection on the interaction; i.e. impressions about the interviewee and the setting; evaluation of possible respondent bias (e.g. if the interviewee seemed eager to please, an impression of the information being withheld, any contradictions in information provided etc.) and the researcher's thoughts and feelings about the interview, as well as ideas to follow up. This process allowed the researcher to develop her interviewing skills and learn by trial-and-error from experience in the field.

To sum up, the sources of data from interviews included:

- Interviews with social workers: 17 social workers were involved in interviews after the discussion; that is since 4 workers were responsibly for 2 cases in the study. Interviews with social workers lasted between 44 minutes and 2 hours 8 minutes.

- Interviews with parents: Overall, 24 parents were phone interviewed, including 18 mothers and 6 fathers. For each case at least one parent was interviewed, while in 3 cases both the mother and the father were separately conversed with. Interviews with parents lasted between 4 minutes and 66 minutes.

- Follow-up interviews with social workers: Altogether, 22 social workers took part in follow up interviews carried out by phone. For one family, responsibility for the case was divided between a disabilities social worker and a youth social worker, so that both were interviewed. Given staff turnover and re-allocation of cases, 6 participants were new to the researcher and, in effect, interviewed for the first time. All in all, 23 social workers were interviewed through the research. Follow up interviews with practitioners lasted between 15 minutes and 1 hour 6 minutes.

Document review: Documents and records of 21 observed cases were photocopied and collected. Documentary materials were of two types: the completed tool package forms and the case records that established the database on which members of the forum rely when making their decisions. This included the PSRs and additional professional reports which were distributed to members of the forum prior to the discussion. It should

be noted that since the discussions were recorded through observations, additional professional reports that were read aloud during the meetings were also accessed and later analysed. As to the two types of written materials they were used in the analysis to supplement data from interviews and observations and to provide a useful check on information gathered through them. The synergy of information across sources (i.e. social workers, other professionals and parents) and different types of data (i.e. interviews, observations and written materials) has a particular advantage for the investigation of whether all participants in the PIECs shared the same understanding of the case and whether there were pieces of information available to some participants that were intentionally left out.

To sum up, an overview of the qualitative data collected is presented in Table 3 below:

Table 3: Summary of Data Collected

Data source	Total data collected
Conversations with PIEC coordinators	7 conversations
Observations of PIEC discussions	22 observations
Social worker interviews	21 interviews
Parent interviews	24 interviews
Follow-up interviews with social workers	22 interviews
Document materials	21 cases

4.4.3   Role of the Researcher

The pivotal role of the researcher as instrument for collecting and analysing the data of the current research, makes it necessary to clarify her stance and qualifications. Following the systems approach the traditional position of the researcher as retrospective judgemental outsider is replaced by one that sees "the world through the eyes of the protagonists at the

time" (Dekker 2002 p. 378). Real insight into the common way of working is hoped to be achieved by re-establishing practitioners' local rationality or, in other words, by striving to understand how practitioners' assessments and actions make sense for them at that time. Following the line of key systems approach thinkers and advocators it is assumed that practitioners do not intend to make mistakes, but rather "what people do, where they focus, and how they interpret cues makes sense from their point of view, their knowledge, their objectives, and their limited resources (e.g., time, processing capacity, and workload)" (Dekker 2002 pp. 382-3).

The researcher was born and raised in Israel hence she is at home with Israeli culture and fluent in the Hebrew language. She is a social worker by training and qualification and has over ten years of experience in working with vulnerable children and young people. These characteristics enabled a common language in which to communicate with practitioners and family members. Being exposed in the past to children's and young people's extremely painful life events made the researcher more resilient to the emotional burden data collection imposed. As put by Weiss (1994), the qualitative researcher does not have the protection of clinical distance, but rather "emotional middle distance" (p.123). In addition, it should be emphasised that the researcher's practice experience mostly involved informal programmes and settings; she had never been employed by the Israeli social services system. This outsider stance provided her great autonomy, essential for independent investigation of practice.

It is very obvious that when using flexible qualitative methods what the researcher brings to the situation, in terms of assumptions, preconceptions, beliefs and feelings is prone to being a possible source of distortion or researcher bias, in comparison to more structured and formal quantitative techniques of investigation (Padgett 1998; Robson 2002). Nevertheless, the researcher tends to concur with Fetterman (1998) who asserts that the researcher is obliged to enter the field "with an open mind, not an empty head" (p.1).

4.5   Ethical Considerations

The current research is dealing with extremely sensitive topics and a vulnerable population which must be handled ethically and with sufficient vigilance (Padgett 1998). As

mentioned this research complies with the LSE research ethics policy and the ministry's Research, Planning and Qualification Division's ethical requirements. As advocated throughout this thesis, communicating effectively and responsibly with children in regard to child protection issues necessitates both particular skills and investment of considerable time in getting to know them. Since these conditions were beyond the scope of this study it was decided not to involve children in direct conversation but rather to investigate their experience of practice and its impact on them through others' reports and observational data when they participate in the committees. Another key ethical concern was gaining participants' informed consent as a prelude to beginning relationships with them. In this regard the researcher followed both the LSE's and Padgett's (1998) guidance. Padgett (1998) accounts for the basic elements of informed consent to be as follows:

- A brief description of the study and its procedures as they involve participants.

- Full identification of the researcher's identity and of the supervising organisation.

- An assurance that participation is voluntary and the respondent has the right to withdraw at any time without penalty.

- An assurance of confidentiality.

- It is necessary to get explicit consent to use audiotape during the study.

- It is necessary to inform that one clear exception to the rule of confidentially will be the legal requirement of mandated reporting of child abuse and neglect.

The participants of this research, including PIEC coordinators, social workers and parents were informed of these consent elements through several means and on several occasions prior to the outset of data collection and their voluntary agreement to participate in the study was explicitly achieved. In regard to SSD professionals, this information was included in the leaflets about the study that were distributed to SSDs in advance, and was repeated verbally by the researcher in initial meetings or phone conversations as well as at the outset of interviews. As to family member participants, parents were provided with the required information first verbally during initial phone conversation; through the consent form they were asked to sign prior the discussion; and at the outset of the interview with them. Children who attended PIECs were provided with the information through the

encounter with the researcher just before the discussion. In addition to obtaining consent from family and professional participants, as mentioned, the researcher achieved the permission to carry out data collection of all gatekeepers involved, including senior, regional and local management.

A third crucial ethical concern was to guarantee confidentiality and anonymity to participants. Considerable measures were taken to ensure that respondents' identity would never be revealed or linked to the information they provided. Confidentially during data collection was secured by using code numbers rather than names as identification on all notes, interview guides and tapes. Participants' names were covered with black pen in all case records collected. While travelling raw data were kept with the researcher at all times and later kept in a small locked cupboard at the researcher's home. The researcher used her personal laptop and a hard drive (as backup) to store electronic data, both devices were protected by password. As is evident to this thesis reader, in the write-up the researcher used codes when citing particular participants in order to avoid revealing their identities. For the same reason the particular details of sites that participated in the study remain undisclosed.

4.6   Data Analysis

As mentioned above, data analysis started as soon as possible after data collection had begun; thereby emerging patterns and themes were repeatedly taken out to the field in order to help focus and shape the next data collection waves (Miles and Huberman 1994). The process of analysis provided important feedback on the researcher's performance and encouraged improvements in data collection techniques as the study continued (Padgett 1998). Fitting with common features of qualitative analysis approach, the vast amount of data collected was systematically and progressively reduced through a hierarchical movement from the raw data (i.e. observational notes, tapes and documents), through partially processed data (i.e. transcripts and comments by the researcher), and later more restricted units of codes and categories to a higher level of abstraction and conceptualisation of themes, patterns and relationships (Padgett 1998; Miles and Huberman 1994). A balance of creativity and cautious adherence to the research questions as a key focal point was the hallmark of the qualitative analysis process. Since analysis

was carried out by a sole researcher, consultation meetings with the PhD lead supervisor were very helpful at this stage of the work to establish the intellectual competence and critical reflection needed to 'separate the wheat from the chaff' while staying open to new ideas.

Starting from the beginning, first the database for analysis was created. All interviews and observations were transcribed by the researcher. Transcripts of observations were carried out very meticulously so that vital information observed would not be left out (e.g. body language, affective expressions etc.). It was important for the researcher to transcribe audiotapes on her own in order to keep "greater intimacy", as put by Padgett (1998 p. 75), with the data. Documentary materials and field notes were recorded onto a computer using word-processing. Next, all transcripts were transferred to ATLAS.ti software for the purpose of coding. This software was chosen for qualitative data analysis, even though its pervasiveness is secondary in comparison to Nvivo software, since it supports Hebrew. The researcher went through an intensive training workshop carried out at the Ben-Gurion University of the Negev, in Israel during May and June 2011 in order to achieve sufficient proficiency and confidence in using the software.

The process of analysis drew heavily on Miles and Huberman's (1994) sequential analysis process which they describe as "a fairly classic set of analytic moves" (p. 9). However, although analysis is presented by the authors as a linear step-wise procedure, in reality a constant movement back and forth among the levels of abstraction was required in order to check how well new ideas and concepts fit with data (Ritchie, Spencer and O'Connor 2003). The following stage involved giving codes to the initial set of transcripts obtained from observations, interviews and documentary materials. The researcher utilised coding frames developed to identify issues which appeared to be relevant to the quality of decision making processes, and the ways the reform fitted into them. Distinctive coding frames where used for different materials, i.e. observations, interviews with social workers, interviews with parents and follow-up interviews. In terms of documentary materials, since case records were often read a lot throughout the discussions it was more convenient to include them within the observations coding frame. The process of building up and refining the coding frames involved ongoing review of the literature, the reform's official texts and research questions while adding comments, ideas, and reflections (commonly referred to as 'memos') about what was going on in the data (Padgett 1998; Robson 2002;

Miles and Huberman 1994). The next steps included systematic induction, i.e. moving from the specific to the general (Padgett 1998). After codes were abstracted from data the researcher moved to identifying patterns, themes, relationships, sequences, differences between sub-groups etc. (Miles and Huberman 1994). The formulation of themes involved establishing similarities and differences and discovering the factors underlying the processes both between cases and within individual cases. Gradually, more generalisations that cover consistencies and trends identified in the data could be established and explanatory accounts as to the 'hows' and 'whys' of these trends and patterns could be developed (Miles and Huberman 1994). By referring to explanations, it should not be mistaken that, given the limitations of qualitative research, this study's findings do not afford the confidence to make conclusions about causation (Padgett 1998). As a final stage of analysis, generalisations were linked back to the wider body of empirical and theoretical literature. In addition, some data were also quantitatively analysed using computer assisted statistical analysis, SPSS Software. This analysis yielded for example descriptive statistics of the sample characteristics, frequencies of events and prevalence of attitudes.

4.7   Protecting the Study's Rigor

Some limitations to this research have already been discussed in this chapter and the means undertaken to reduce their effect have been presented. Other limitations of this study will be discussed more fully in the final chapter of this thesis. In this section the issue of rigor is discussed in light of the potential problems of the research design, with reference to the literature about qualitative research. Rigor refers to the degree to which qualitative study findings are authentic and their interpretation is credible (Loncoln and Guba 1985). Padgett (1998) discusses the debate in literature over standards of rigor of qualitative research and argues that criteria such as random sampling, generalisability and reliable and valid measurements do not easily apply to qualitative methods, may or may not be seen as desirable or may be viewed as unattainable or irrelevant. This study does not claim to meet these standards to a high level; cases were not randomly assigned, generalisability (or external validity) was not a priority, and although attempts were made to minimise biases their affects cannot be ruled out. The pursuit of rigor in this study is therefore focused on the 'trustworthiness' (Loncoln and Guba 1985) of its findings, and their interpretations.

Padgett (1998) describes several strategies or procedures for enhancing trustworthiness and assuring quality control in qualitative research, four of which appear to be suitable for this research. As mentioned, triangulation was broadly practiced in this study as a valuable means of enhancing rigor. 'Auditing' is another strategy undertaken in the study that involves keeping careful notes and recording each step taken and the decisions made by the researcher during data collection and analysis. Other strategies assist the process of reflexivity and encourage critical thinking and consideration of alternative perspectives. The third strategy suggested by Padgett (1998), 'peer debriefing and support' involves discussing the research with peers as a mechanism to share the emotional impact of field work; present ideas or hunches; and challenge the researcher to explore her biases throughout the study. The earliest opportunities for debriefing were presented just before commencing field work when the researcher participated in two doctoral student research conferences in Israel and the UK. These encounters contributed greatly in terms of considering unexpected challenges in data collection. All through the study the researcher benefited greatly from regular contact with other PhD students in the Social Policy Department. Another set of peers in this regard were researcher members of the JDC-Brookdale Institute with whom the researcher met during field work trips to Israel. The final strategy, 'negative case analysis', is what Padgett (1998) describes as a self-imposed 'devil's advocate' position assumed during data analysis. Meetings with the PhD lead supervisor between periods of data collection and during data analysis consciously and persistently encouraged the researcher to seek disconfirming evidence and alternative perspectives to what appear to be the emerging themes and patterns in the data.

4.8   Conclusions

This chapter has described in detail the methodology, research design, and research methods adopted in the study. It was shown that the thesis' conceptual framework, research questions and ethical issues influenced choices in relation to the research methodology. The advantages and limitations of the study were clearly laid out, and they should be kept in mind when reading the rest of the thesis. In the following five chapters (Chapters 5 to 9) the empirical findings of the research are presented, interpreted and discussed. The next chapter is dedicated to the social workers and their practice.

5. Chapter 5

The Social Workers

This is the first empirical chapter of the thesis. The empirical chapters systematically follow a similar structure. For each stage or task of the decision making process, the new regulations and procedures are presented in detail and critically reviewed followed by an analysis of the current research findings regarding their implementation. When earlier data are available, in regard to the PIECs' or Decision Committees' operation, they are accounted for in relation to this research evidence. Chapters that focus on particular participants (i.e. social workers, parents and children) begin with some descriptive statistics about the sample characteristics. Accordingly, this chapter, dedicated to the social workers, starts by introducing the practitioners who participated in the study and their working conditions. Next, social workers' practice from the time a decision was made to refer a case to discussion in the committee until the PIEC assembly, is analysed in light of the reform's guidelines. The tasks imposed on front-line workers at this stage mainly involve collecting information, analysing it and formulating an in-depth integrative family assessment report, the PSR, which is used to present the case before PIEC forum members. Social workers are also responsible for preparing family members for participation, this issue will be discussed in Chapters 7 and 8. Since the PSRs are the key information base for decision making, their accuracy and comprehensiveness is crucial. Therefore, the final part of the chapter presents findings from critical content analysis of 21 PSRs delivered to the committees.

5.1   Social Workers and their Organisation

This section presents the characteristics of social worker participants in the study and the organisational context of their professional activity, including roles in the department, professional experience and qualifications, caseloads, professional and administrative support etc. Findings show that the research sample mirror features of the Israeli SSDs'

working arrangements mentioned in Chapter 3. The following descriptive findings were derived from conversations with 22[66] social workers through face-to-face or follow up interviews. In general, dialogue with practitioners was open and lively and was carried out in a very cooperative and welcoming atmosphere. It appears that workers appreciated the significance of the research and its contribution to improving practice.

5.1.1   Social Workers' Characteristics

Social workers' ages ranged from 30 to 62 years with the average being 39.4 years (SD=8.3; Median=35). Most workers (16/22) were Israeli born and the rest had been living in Israel for between 11 and 27 years. The majority (20/22) were women. Parenthood was another prevalent feature of the sample; only 2 social workers did not have children at the time of the data collection. The make-up of the sample being almost entirely of mothers is worth drawing attention to since workers' personal experiences and feelings as mothers may play a role in their professional judgements (Davidson-Arad and Wozner 2001). On average, interviewees had 10.4 years (SD=6.2; Median=9) of experience in social work practice. Seniority in the practice varied greatly between practitioners and ranged from 1.25 to 26 years experience: 1 worker was newly qualified with less than 2 years of experience; 12 workers had 4 to 9 years experience; 6 workers had 10 to 16 years experience; and 3 workers had 18 or more years experience in social work practice.

The majority of workers in the study (16/22) were employed and acted on the cases sampled as generalist social workers. 6 workers[67] were specialists or had other roles in the department (1 was SWYL on the case). Since the child protection duties, including preparing a case for the PIEC, were incorporated within their daily practice it was hard to estimate what proportion of the work it took up. There were some indications of staff turnover within SSDs. Movement was not usually into a different role, but rather a matter

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[66] The characteristics of one practitioner who was assigned to the case after the PIEC were not included in the descriptive statistics since he was not a qualified social worker and was not working at the SSD but in other agency.

[67] Including: A SWYL, two rehabilitation workers specialists in the disabled population; a youth worker specialising in young people; a preventive social worker specialising in the young student population; and an intake social worker who is responsible for screening initial referrals for service (IMWSS 1999).

of changing distribution of cases among the workforce (due to revision of local teams or absent colleagues on maternity leave). Overall, workers stayed in their position long enough (Mean=6 years; SD=6.3; Median=4.2 years) to develop context-based knowledge and skills. Another pattern found was plurality of roles; just over half of the generalist social workers (9/16) had dual roles in the SSDs (1 worker was holding 3 different roles). In most cases these were more senior workers who took on additional specialist roles, such as SWYL and SWCP. Social workers' accounts of their everyday practice revealed role ambiguity, and evidence of practicing as a hybrid of a case manager and family worker. Here are two examples from the interviews that illustrate this point. The first, is a social worker trying to resolve the researcher's puzzlement as to the different names given by interviewees to the same practice:

> Officially from the IMSSSA's point of view it is general social worker, de facto it is family social worker. These are merely two names for the same role. (SW: Case 7, SSD A2)

The second, is a social worker who defines his role as family social worker but describes case manager practice:

> As a generalist worker and case manager you need to know who will give you the solution. I am some kind of transmitter who needs to be therapeutic and accessible. Yet, at the end of the day if the child needs to get emotional or individual therapy; then it would not be me. Hence, I need to understand what he needs and what options I can offer him in order to find the best solution for him. This is where my expertise is realised…. (SW: Case 1, SSD D)

Through the interviews, data were collect about seven components of professional skills and expertise development, including professional education and post-qualification training, access to research evidence and organisational learning opportunities. In addition, interviewees were asked to rate the contribution of each factor to their knowledge in the field of child protection (on a scale ranging from 1='very poor' to 5='very good'). Fitting with the legal entry route to the profession all social workers in the study obtained undergraduate degrees in social work (3 social workers had additional undergraduate degrees in another subject). 5 social workers held graduate degrees in social work and 5 others in related subjects (e.g. child development or education). On average academic education was rated as the second most important factor in workers' knowledge in the field of child protection (M=3.7; SD=0.98). It seems that both the workforce and management

perceived training as an ongoing aspect of professional life. Over two thirds (16/22) of the social workers in the study participated in post-qualification training programmes along their career progression. Yet, findings suggest insufficient coverage of child protection issues in training programmes offered to generalist workers. Only 6 workers (mostly SWYLs and SWCPs) took part in intensive qualification programmes on children's therapy and/or child protection. Workers voiced a need for further training on key aspects of practice, such as working constructively with difficult-to-engage parents and abused children. The average contribution of post-qualification training programmes to professional knowledge was ranked only fifth in importance (M=3.18; SD=1.94). The use of research evidence in practice was found to be negligible. It appears that the practice of reading academic journals was associated with the framework of university education and was set aside when workers got into the field. The contribution of professional journals to the knowledge was thus rated as poor (M=2.33; SD=1.91). Additionally, the majority of participants in the study (only 3 workers were exceptional) did not use the VCoPs platform, which played an insignificant role in the accumulation of professional knowledge (M=1.05; SD=1.65). In terms of departmental learning opportunities an interesting finding was the profound reliance of participants on their skilled colleagues, in particular on SWYLs, in their daily child protection work. Consultation with colleagues was rated as the most important factor in its contribution to social workers professional knowledge in the field (M=4.41; SD=0.50). Departmental meetings were reported as third in their contribution to knowledge (M=3.36; SD=1.71). Although there were variations in the frequency and content of these meetings among SSDs, when case studies were discussed they were valued as highly beneficial.

Next rated were supervision meetings, fourth in their contribution (M=3.32; SD=1.84). This finding is fairly disturbing, given the essential role prescribed by a considerable body of research to professional supervision in promoting good practice. Yet, it seems that the problem is not the triviality of supervision but rather its low availability. Only 5 participants reported meeting with their supervisors on a regular weekly basis; 11 workers had a less frequent meeting schedule, either every 2 to 3 weeks, once a month or only occasionally; 4 participants were not provided any supervision and 2 workers reported buying external supervision. Compared to supervisors, colleagues were reported to be easier to approach through informal daily interactions. In addition, colleagues were valued

for providing essential emotional support and opportunities to air distressing experiences in relation to the PIECs. Several social workers gave an account of the high emotional pressures their work involves. It seems that PIECs, in particular, imposed a considerable "emotional burden" or "emotional load" on workers as was explicitly stated by seven practitioners (as well as by one coordinator). Here are two examples from interviews of workers describing the emotional impact of their work:

> Personally, if I have something very serious and worrying, I carry it with me also when I go to sleep and also at home, it doesn't give you peace, especially the serious cases involving children. (SW: Case 5, SSD B)

> Since I don't have regular supervision, I meet with her (a colleague). If there are cases that were difficult for me and I don't agree with the decisions or if I am very happy (with the decisions) then I share it with her. Yes, I totally engage her, I say: "that was hard for me, they did or didn't agree with me, I found it hard with that person". Sometimes it is difficult for me with the SWYL, sometimes it is hard, you understand? So I definitely involve her. (SW: Case 1, SSD F)

Overall, participants stated that they feel very confident in their professional knowledge and skills when working with children at risk and their families. The average confidence level was rated 3.9 (SD=0.68) on a scale ranging from 1='not confident at all' to 5='very much confident'. In regard to the new ways of working, as mentioned, the ministry did not provide training for front-line workers. Most of the workers recalled participating in departmental or supervision meetings where the new procedures were first introduced. 2 social workers reported that through the Community 2000 Experiment they had profound training in regard to the new procedures and an active role in their development. 6 workers reported that they had not been provided with any formal explanation regarding the reform.

5.1.2 Departmental Characteristics

Practitioners were working under heavy caseloads. The average number of families under the responsibility of a single social worker was 157.2[68] (SD=84.68). Since some specific roles led either to inflation (e.g. an intake worker had 400 families) or deflation (e.g. an

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[68] The analysis involves 21 social workers; one worker's data is missing.

intensive family worker had only 40 families) of the numbers, it is thus more accurate to report that the majority of participants (13/21) were responsible for 120 to 200 families, 3 workers for over 200 families and 5 workers for up to 60 families. (Most workers worked full time or reaching full time (75-80 per cent)). The common firefighting response to heavy workloads was repeatedly described by participants in the study. Social workers voiced great frustration over having to compromise the quality of service they offer due to lack of time to invest in intensive intervention and in building ongoing relationships with users. There was a consensus amongst practitioners that the most important factor in improving child protection practice in general and in regard to the PIECs in particular, was reducing their caseloads. Here is a typical example from interview:

> To reduce the caseload. It is impossible! I cannot do a good job as I see it or as I wish to do due to the caseload. It is simply impossible. There are truly no other solutions. I always say that I had an experience for a short time, when I was doing SWYLs course, for a very short time of a few months I had only one area, only 60-70 cases. I was able to reach every family, home visits, meetings, to do the work as it should be, as we were taught (laughing) it is fun! It is because I have this experience. If I hadn't and just come up and say: it is the caseload, caseload, caseload, but I do have this very short experience , it is amazing, it is fun. (SW: Case 8, SSD B)

Organisations should provide the workforce with the technical and administrative back-up so they can concentrate on the professionally demanding aspects of their work. Interviews gave a first hand impression of the physical working environment and revealed great variations among the SSDs. One department offered working conditions to high standards where each social worker had her/his own private spacious office. Yet, the more common trend was of workers sharing their offices with other colleagues which, according to their reports, interfered with their ability to offer their clients private communication. In terms of technical equipment, most workers had computers in their offices for their exclusive use; only one SSD was lacking IT infrastructure. Access to telephones was sometimes shared among colleagues working in the same office. Fax machines were usually for the collective use of the SSDs. Finally, departments had designated administrative staff responsible for the general departmental bureaucratic demands (e.g. answering phones) however they were not formally assigned to serve social workers. Assistance when provided was sporadic and voluntary.

To sum up, interviews revealed a dedicated and experienced workforce that took their child protection responsibilities very seriously. Yet, they were working under immense daily pressures with heavy caseloads and multiple roles and with only limited organisational support to deliver high quality service. The next section describes how social workers complied with the new demands imposed on them by the reform.

5.2   The Referral to the PIECs: Functions and Accessibility

The new reform makes the committees easier to approach and highlights their multi-professional consultation purpose by setting new criteria and procedures regarding the referral of a case to a PIEC. Ordinance 8.9 (IMLW 1995) anchors the focus of the discussion around the decision to remove a child from home. Out of the seven conditions that prescribe the target population, in four the solution of out-of-home placement is the formal reason for referral and in the rest it is implied as a possible intervention (e.g. when emergency measures are needed or when the provision of services in the community hasn't achieved its targets).

The new reform applies the national study's (Dolev et al. 2001) recommendations to extend the entry standards for the committees. PIECs' maintain their exclusive role in authorising removal to out-of-home placement, yet they are established as a key arena for multi-professional consultation when extensive and expansive interventions in the community are found to be necessary or alternatively when there are considerable uncertainties as to the appropriate intervention plan. (IMSSSA 2004b). Figure 4 describes the seven conditions for making a referral to the PIECs according to the Implementation Team's Decisions Paper (2004, Article 4c: The Referral to the Committee). It shows that criteria for referral are set out very broadly and loosely by the new regulations.

Figure 4: The Conditions for Making a Referral to a PIEC

1.	[*]In complicated cases where there is significant uncertainty regarding the appropriate intervention plan for the child, which requires multi-professional consultations.
2.	[*]When considerations are made to provide 'expensive' or unique services, (in the community), such as Multi-functional Day-care Centres, Parents and Children Treatment Centres (PCTCs)[69] etc.
3.	When nonintensive services provided to parents and children have not achieved targets within a year[*]. Such services include day-care, after-school programmes, parents' and children's therapy groups etc.
4.	When out-of-home placement or adoption[*] is considered.
5.	In cases of children under 12 years old living out-of-home without the authorities approval.
6.	When emergency protection order has been used or juridical process has commenced.
7.	[*]Children in families undergoing divorce procedures that may lead to inadequate parental care and are engaged with SWCPs.

[*] These conditions are the reform's new adjustments which are not included in Ordinance 8.9 (IMLW 1995).

Another fundamental departure from prior regulations is the exclusive authority provided to social workers in making referrals to the committees. Ordinance 8.9 (Articles 3c, 9) instruct that referral to the committee is the responsibility of team leaders (an exception is emergency intervention) and in addition external professionals can address the coordinators in writing to make a referral (IMLW 1995). In contrast, under the reform the

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[69] Multi-functional Day-care Centres provide day-care services to young children aged six months to six years. The programme operates from seven in the morning until seven in the evening by educational and therapeutic professionals and it is flexible to the individual family needs. Parents and Children Treatment Centres are therapeutic units for the whole family where children can arrive with their parents up to three times a week. The centres are operated by multi-professional practitioners and provide individual, dyadic, family and group therapy (IMSSSA 2014).

family social worker is the sole route through which a case can be referred to a PIEC.
Workers are required to consult team leaders and coordinators, yet it is without doubt that
social workers are now positioned as key gatekeepers to the PIECs. New regulations also
allow family members or members of the public, in addition to professionals, to raise
(through the family's social worker) the necessity for a committee discussion and withdraw
from the requirement to make a request in writing (IMSSSA 2004b, Article 4c).

Earlier data suggest that in regard to the objective of the PIECs discussions and
their target population the desired change had been achieved. The discussions are
exploited for the purpose of consultation and intervention planning which is no longer
fixed around questions of removal from home. Consequently, the PIECs had become more
accessible for less high concern cases and their outcomes were more comprehensive and
varied care plans which consider the needs of the whole family. It is thus concluded that
the PIECs have more therapeutic and preventative function in comparison to the situation
prior to the reform (Dolev et al. 2007b; SIC 2013). The current research provides further
support for this change based on evidence regarding the characteristics of the sampled
families and the committees' outcomes (which will be discussed in later chapters) as well
as workers' accounts that the option of removal from home or prolonging the stay in
placement was the official objective of the discussion in only a third (7/21) of the cases
sampled. The PIECs were mostly utilised for two main functions: 1) as a mechanism for
provision of intensive community-based services, mainly PCTCs, in these situations social
workers were already very confident prior the meeting about the appropriate help for the
child and family; 2) as a mechanism for consultation in cases where early intervention had
not achieved any progress for considerable time and workers felt: "stuck", that they have
"reached a dead end", or "exploited all other means of help". The majority of interviewees
pointed out that the opportunity to consult on a case in a multidisciplinary forum of
professionals is where the PIECs facilitate their work. The mixture of expertise was
valued for allowing a variety of opinions and points of view that goes beyond that of social
workers. Phrases used through interviews were: "a comprehensive perspective"; "another
viewpoint"; and "thinking in terms of many factors". Social workers reports also provided
strong support for the new integration of permanent panel and changeable panel within the
forum for their distinctive contribution to improving the quality of decision making.
Members of the permanent panel were appreciated for bringing a fresh eye to the case and

an alternative professional perspective. The changeable panel was regarded as a key source for information about the child and his or her family and available services in the community. Several workers reported that the discussions also contributed to the establishment of regular cooperative working relationships with other professionals involved with the family, in particular the school system.

Interestingly, interviews revealed that PIECs also served an unofficial function which may indicate that they were not always used as intended. PIECs were reported to be highly helpful since they enabled workers "not to remain alone". The responsibility over the child's safety and well-being could be diluted and hence reduce the pressures on the individual worker. When worries about the child were publicly shared through the committees all members of the forum became accountable for his/her condition and when difficult decisions were made all members of the forum became responsible for the outcome. 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 and things are not black and white and you want to bring it for consultation and that **they** will make a decision. (SW: Case 7, SSD A2)

> First of all, in terms of the responsibility, my responsibility is shared. It (the case) was brought to the committee, everybody heard: there is difficulty; there is a family at risk here, so it helps me. That is to say, "you are alerted" whatever it is called. So when I raise it in the committee then my responsibility is projected to other people including the school. (SW: Case 3, SSD A1)

While exploitation of the committees as means for sharing case responsibility can surely be comprehended given that risk, uncertainty and ambiguity are core elements that underpin child protection practice; it can result in increased referral rates and growing burden on the committees. Earlier data as well as this study's findings suggest this is already the case (SIC 2013). For example, the average duration between the referral and the actual discussion in this study was nearly 6 weeks (M=5.7; SD=2.17; Median=6; Range= between 3 and 8 weeks) that is twice the time prescribed by the new regulations[70].

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[70] It should be to noted that the 3 weeks social worker strike during March 2011 probably had some role in the delays.

Two additional sets of findings regarding referrals to the PIECs are worthy of particular attention since they suggest that claiming the PIECs now serve therapeutic and preventive functions may be too premature. First, there was evidence of social workers using the committee's authority, and in particular the power to decide on removal of a child from home, as a measure of control and coercion directed at parents. In addition, some workers stated that there was an expectation that when concerns are echoed through a forum of professionals it will have a powerful effect on parents; they will become more alert to the severity of the situation and more compliant or committed to change it. Here are two examples from interviews to this effect:

> There is something about this event that everybody sits, and the report is read out loud in front of everyone… because, you know, even today when eventually she (the mother) told me that , I was waiting for her to say that, it (the discussion) stresses her, I wanted to hear that. That it is some kind of a threat, and yes I want to use it because there are service users who do not understand otherwise. (SW: Case 8, SSD A1)

> I see the place of the committees (for) decisions which are much more whether to remove a child from home, whether to address the court, whether to alarm the parents that: "if you won't do this and that your children will be removed". I see it as this kind of instrument, not an instrument for (approving) afterschool programme. (SW: Case 8, SSD B)

Here is an example from a worker's account, reflecting on her involvement in the discussion:

> I wasn't very much involved on purpose and didn't want to get involved. I wanted her (the mother) to hear from other people that actually said the same thing I was talking about during all the years and referred her to these places. It is just that now she was instructed very clearly that she must turn over there and continue with treatment. (SW: Case 4, SSD A1)

Further support for reliance on the committee to take a controlling function came later in the conversation when workers were asked to evaluate the discussions. It seems one of the factors in successful chairing according to their views was the coordinator's ability to be authoritative, assertive and to put things clearly on the table without hesitation.

Second, the use of PIECs to respond to families' problems was not carried out as early as possible. Findings suggest that referrals to the committees were initiated at an advanced stage of the case progress, when the child and family situation had become seriously complicated. Data show that at the time of the PIECs half of the families had

working relationships with their workers which had been going on for over 10 months, mostly a year or more, whereas only three were new cases referred to the SSD two months or less before the committee took place (M=21.29 months; SD=23.53; Mode=10 months; Median=10 months; range from one month to eight years). Interviews revealed a highly reactive practice so that in the majority of cases the referral was not initiated by the social workers themselves but rather triggered by an outside source. It was other people, professionals or family members, that alerted the workers about the worrying negative condition of the child in his family. Examples were a day-care report of a suspicion of neglect, the school team's outcry over dysfunctional behaviour within the school, or a few mothers desperately pleading to remove their children from home. With hindsight some workers admitted that help should have been provided much earlier. Here is an example from an interview with a worker reflecting on her intervention regarding a 10 year old boy:

> I was very confident regarding emotional therapy for the boy. I think it is something we should have done long ago. She (the mother) said that and I agree with her. I think it is my personal failure; maybe I should have brought it before the committee much earlier. (SW: Case 2, SSD B)

These findings regarding delays in catching up on the necessity of intervention are worth keeping in mind when reading thought Chapter 9 where PIECs outcomes six month after the committee are discussed. The combination of evidence will come to show that help is held up for considerable time while problems worsen. It will thus be argued that the PIECs function as preventive measure is very limited.

5.3   Preparing the Case for the PIECs

From the stage a decision had been made to refer a case to the committee, the new regulations structure social workers' practice by a standardised tools package to guide the preparations measures before the discussion and record them. These procedures are directly linked to PIECs capacity to make informed care planning decisions so that the most effective services can be delivered. The rest of the chapter will focus on practice requirements prescribed by the 'Tool for Collecting Information', the 'Tool for Documenting the Discussion's Preparation Procedure' and the supplementary users'

guide[71] (IMSSSA 2008a, 2009). It is important to mention that the findings revealed a tendency of delegating to workers responsibilities which, according to the Implementation Team's Decisions Paper, are the coordinators' tasks, such as in inviting professionals and family members to participate and distributing case materials in advance. In the next section the tools will be presented, their limited utilisation in practice and patterns of their misuse will be described, and the reasons discussed.

5.3.1   Family Assessment: Utilisation of Tools

Starting with The Tool for Collecting Information, it has several functions. Firstly, it is expected to promote consistent and inclusive collection of accurate information so a holistic picture of family life and its rich context can emerge. Social workers should collaborate with family members and other professionals in the community in order to collect the detailed information required and document the source of information within the tool. Secondly, the tool supports the analysis of different pieces of information collected by rating the degree of worry or strength they involve on a four point Likert Scale (ranging from 'the situation raises serious worries' to 'this is the strength of the family'). Thirdly, it is intended that workers will draw a standardised high quality PSRs from the tool as a summary of the information and their assessments[72]. The tool is an eighteen page long form organised around six main sections. Each section consists of tables to be completed and/or ticked and space for open comments. The tool includes: (1) factual data about members of the family and household (e.g. date and place of birth); (2) evaluation of the household's environment and the parents; (3) evaluation of parental care; (4) evaluation of the child's functioning; (5) information regarding children who are living in out-of-home settings including the parents' and child's stance on the option of returning home; (6)

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[71] The tool package is still going through continuous development in order to adjust to an electronic version. The analysis in this thesis is based on the tool package provided to the researcher by the IMSSSA (in January 2010) prior to data collection as the mandatory requirement. The tools are dated 16 April 2009 and the user guide January 2008. As mentioned, through data collection the tools that were in effect used in every SSD were also collected.

[72] The tool was originally designed to be presented before the committee's forum as a sole all-encompassing family assessment report. Yet, its try-out during the Community 2000 Experiment showed it was too long to be reviewed during the discussion and organised the information in a way that glossed over the family's story-line. Hence, it was later used to support the process leading to the formulation of a PSR which re-gained its dominance as the exclusive report presented before the forum (IMWSS 2007).

description of the treatment history in the five years preceding the assessment. Also, within the final section suggestions for possible interventions made by professionals and/or family members can be recorded. Parents' perspectives regarding the key areas of assessment and the child's view of his or her condition should also be elicited and reported.

The tool has several limitations which may encourage, sustain or reinforce some shared pitfalls in the way of working. Firstly, the family assessment is over-organised by notions of the child and family pathology with only limited emphasis on discovery of family strengths and resources that can be built on in the intervention planning. The way information regarding intervention history is organised within boxes gets in the way of understanding the family's progress and leaves out evidence that may stand out as an important strength or vital sign of safety, such as when parents approached social services of their own volition, were willing to make a change or were involved in cooperative proposed working relationships with professionals (Turnell and Edwards 1997; Turnell 2006). Another weakness of the tool is that it may lead to failure to look at past history. Family assessment is focused on the most immediate and pressing problems and does not involve evaluation of long-term case history. Present events and problems should be considered within their broader context and their connection to the child and family history in order to build up a comprehensive picture of the happenings in the child's life (Munro 1999; Broadhurst et al. 2010a). Finally, the tool does not include an overall conclusion or a total integrative assessment of the case, but rather it basically gathers all the judgments to a set of details that can serve other professionals in their decision making. Assessment should conclude with an analysis of the findings that can provide understanding of the child's situation and inform the intervention targets and planning of service provision (Adcock 2002). Keeping in mind these weaknesses when actual practice is described, leads to the argument that even if the tool had been used it would not have provided the workforce guidance in the tasks where they face most difficulty.

The Tool for Documenting the Discussion's Preparation Procedure is a shorter form, three pages long, designed as a checklist to allow team leaders to monitor whether workers are following the new regulations. Accordingly, preparatory actions should involve collecting information, conducting a home visit, writing the PSR, sharing the information with parents, hearing parents' and children's points of view, and meeting with parents and children in order to prepare them for the discussion. Workers are required to

give an account of the reliability of the family assessment by reporting on the professional records and professional communications which served to achieve it and an account of which family members and professional members of the changeable panel should be invited (it is the coordinator's responsibility to send a formal invitation to the PIEC members). The completed tool should be signed by the worker and the supervising team leader to certify that all preparation measures have been carried out.

The tools package's users' guide facilitates the tool's completion. It provides details on specific and worrying observable behaviours relating to assessment criteria. This has importance, since some criteria within the tool for collecting information are nebulous and meaning laden (e.g. 'non normative behaviour' and 'proper relationships between the parents'). Yet, in regard to possible positive signs of safety it only includes an overly global and ambiguous definition of strengths as: "every characteristic of the family and child or of the relationships between parents and children which can potentially help them to better deal with their difficulties" (IMSSSA 2008a p. 3). In regard to assessing the level of the family's problems, the guide only provides a principle by which a situation becomes more worrying when the amount, severity or duration of problems increase. The guide also includes a formal explanation leaflet on the PIECs which can be read or handed out to parents, and outlines the general structure of the PSR and the key information it should include.

Moving to the use of the tools in the field, findings indicate they were not satisfactorily nor appropriately incorporated within everyday practice. In general, the tools were systematically disregarded; in the few cases they were used they mainly operated to record the customary practice and thus for workers they were just another "form to fill in because they had to". Out of 21 cases[73], only 5 workers completed the tools (and 1 worker reported filling in a couple of pages in the tool for collecting information). 3 workers reported they usually complete one of the tools, yet they hadn't done so in the sampled cases. Review of the tools completed showed they were very partially and inaccurately completed. Some problems identified were also recognised in the international literature,

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[73] In regard to the review committee, regulations prescribe that when a year has passed from the prior committee meeting, the tool for collecting information should be completed again. Since all review committees included in the study fit with this requirement the use of the tools was obligatory for all 21 cases examined in the study.

as mentioned in Chapter 2. The tool for collecting information had no advantage in generating a more comprehensive and detailed picture of domestic life, since what was not known was simply left out. For example, the child's point of view on the situation that should be elicited by the social worker was reported in only one report (for another boy, his perspective based on others' reports was recorded) and in one form the boy's functioning in the out-of-home placement was not completed. As to the tool for documenting the preparations, in one form there was no record of preparation measures taken. There was also impreciseness in reports regarding the requirement to meet children prior to the discussion, leading to an impression the task was fulfilled (e.g. workers reported on a past meeting or a meeting conducted by school staff). Another pattern revealed was a trend not to use the tool for collecting information according to its intended purpose (i.e. to promote systematic compilation, recording and analysis of case information), but rather it was completed after these tasks were already carried out and the PSR was written. Utilising the tool this way was an inefficient use of workers limited time. Here is a quote from an interview that demonstrates this ineffective way of working:

> On the issue of the tool for collecting information, it is not very, it is quite troublesome (laughing) and it is not very relevant. It demands that we will fill in more and more details that usually we have already written in the Psycho-Social Report, it just oblige me to do more work. (SW: Case 1, SSD A1)

Why was the implementation of the tools so limited in practice? Previous evaluation schemes repeatedly reported on social workers' reluctance to use the tool for collecting information. It was criticised for being lengthy, not user-friendly, requiring great time to complete, especially for large families, and overall being an administrative burden (Dolev et al. 2007b; Ben-Rabi and Amiel 2013; SIC 2013). Such a critique was also voiced by interviewees in the current study. A few workers complained that the tool is complicated, not well organised or that its definitions and ranking levels are difficult to use. In addition some workers protested that the tool was unnecessary and unhelpful bureaucracy that did not advance their practice; they felt confident enough in their skills of collecting information and producing PSRs. Owing to this thesis' systems approach, the search for answers went beyond individual workers' accounts to reveal systemic barriers to utilisation of the tools in practice. First, was the lack of organisational commitment to support the change process. Overall, the use of the tools was neither encouraged nor

enforced as was expected of team leaders and coordinators. Early conversations with coordinators revealed that in the majority of SSDs (5/7) noncompletion of the tool for collecting information was deliberately overlooked. Some coordinators stated in their department it is a matter of workers' free choice; others mentioned they stopped bothering workers about it or "dropped it". A few coordinators explained their stance as adapting to workers' outcry regarding the increased bureaucratic and administrative demands imposed on them and a few also pointed to the limitations of the tool's content and structure (e.g. confusing, too theoretical, tables do not provide enough information, and it masks the family's story). As to team leaders, although according to new regulations it is their responsibility to endorse that all case materials (PSRs and professional records) including the tools had been prepared in advance, it seems that they accepted the situation of workers neglecting to use the tools or at least overlooked it. There was evidence in only one case of a team leader (and coordinator) reviewing the tools and signing off the preparations tool. Secondly, it was found that five SSDs were using non up-to-date editions of the tools package. Since these departments participated in the Community 2000 Experiment they relied on former drafts of the tools dated, for example, January 2008 and May 2006, which did not actualise the full development the tools later achieved. Prior versions of the tool for collecting information were very restricted in terms of the type and amount of information required (e.g. in one SSD the tool included only three pages) and hence were bound to lead to poor results. Crucial data were missing, such as evaluation of parental functioning, indications or suspicions of abuse, intervention history including SWYLs/court involvement, and family members' views about the help options. Two versions included a section on children's educational achievements which was later omitted from the mandatory tool. The tool for documenting the preparations was also used in its short undeveloped versions, for example without accounting for communication with professionals or invitation of family members. Another trend found was of SSDs formulating local adaptations of the tools to shorter versions. For example, two SSDs initiated their own guidelines for writing the PSR (independently of the tool for collecting information), and one SSD created their own one page version of the tool for documenting the preparations. These findings indicate that the promise that the standard tools package would promote consistency in the way of working had not been met. However, most importantly they reveal an organisational culture that encourages staff to engage in

shortcuts instead of prioritising enhanced performances and insisting on the quality of service provided.

5.3.2   *Family Assessment: Collecting Information*

The effectiveness of PIECs decisions depends on the amount and accuracy of information about family life reliably gathered. This process requires highly skilled professionals actively taking a stance of inquiry (Broadhurst et al. 2010a; Hughes and Rycus 2007). Broadhurst et al. (2010a) state in this context that "a case formulation emerges through discussion and interaction" (p.14). Effective engagement with family members and other professionals or nonprofessionals involved with the family is the crucial task at hand at this stage. In Chapter 2 some well-recognised practice mistakes that can result in critical evidence about the case remaining undiscovered were discussed. To remind the readers, these factors involved problems with information sharing, adopting a confrontational position when conversing with parents, balancing practice demands and parents' right to privacy, eliciting children's stories separately from their parents and the tendency to leave fathers or male partners out of the intervention process. The complexity of the information gathering process brings to light the key weakness of the new tools previously described; that is, they mainly guide social workers on what information they need to collect, but not how to collect it. It seems that policymakers assume that the workforce masters the complicated expertise required for this task, however the research findings show this to be a fallacious understanding of the reality in the field. The practice observed demonstrated shared misconceptions of the information gathering tasks' requirements. For workers it was a burdening bureaucratic procedure, which made their work more difficult, and mainly involved chasing after professionals involved with the family in order to obtain fresh reports. They were over-occupied with trivial, nonprofessional and administrative aspects of the task such as making calls and sending faxes (a lack of technical equipment made these administrative procedures even more time consuming) instead of investing their time in comprehensive interviews, thorough investigations and meaningful observations.

In terms of engagement with the family, workers overly focus on the mothers, with whom most workers had already established cooperative relationships, giving their voice dominance in the family portrayal. A recurrent missing voice in the information gathering

process was that of the children. Overall, in preparation for the committees, only seven children and young people were approached and engaged with. That was carried out in a single meeting conducted in conjunction with home visits or as a joint consultation with parents or in some cases other professionals (this issue will be thoroughly discussed in Chapter 8). In regard to fathers, even though there was a high proportion of single-mother families in the sample, in 12 cases fathers were involved in the children's life to varying degrees. Yet, ongoing working relationships with fathers was exceptional and reported in only three cases, in one of them it discontinued after the parents had divorced. Beside these cases, there were only a few indications of encounters with fathers prior the discussion and none were designed as a proper assessment interview. Two fathers were conversed with over the phone (one was merely invited to attend the meeting); one was invited to read the PSR; and two participated in a joint meeting with mothers. In two cases workers only learned about the fathers' involvement with their children through the mothers' statements in the committees. As a whole, fathers were regarded as minor, unimportant characters in the family story, and so the nature of father-child relationships remained mainly unexplored, even though there was in some cases a recognised history of violence towards children and/or mothers or indications of difficult relationships in the present. According to a few workers' testimony the fear of being exposed to aggressive outbursts by a violent man was a factor in the disregard of fathers. Nevertheless, it seems that the triviality of a father's role in the child's life was well-established as part of the working culture. Here is an example from an interview, of a worker's account of not reaching out to a father who had a history of verbal and physical abuse towards the mother and eleven year old son, and "great difficulties in the father-son communication" at present, after the parents had divorced:

> We will try to involve the father, because today (at the committee) a question was raised why didn't I invite the father; it is because I didn't even think about that. For two years I haven't seen him or known him, only heard from the mother. (SW: Case 3, SSD B)

Reflecting on her practice, she later suggested that her decision may have been influenced by her wish to avoid direct confrontation, if the issue of father's past violence was raised.

The over-reliance on mothers as the main source of information, led to nonconsideration of other members of the household, including extended family (mainly grandparents) or mother's partners, in the family assessment. Their role in children's upbringing and familial relationships mostly remained unknown. Disregarding these figures can be a dangerous error. For example, in one case it was the school social worker who met with a grandmother resident of the household that revealed crucial facts unknown to the family social worker, in this case ongoing serious mother-mother-in-law conflict. Here is a citation from another case of a social worker's testimony of feeling worried knowing a mother had a young boyfriend living with her and her five children that she had never met:

> There is a man in the house, there is someone around there, there is someone that was with the children through all the time she was in the hospital. He was sleeping there, he sleeps in her room, and he is present there physically. This is a 22 year old guy, it is a 22 year old guy… there is someone that we don't know, I don't know him. I don't know him, I haven't met him, I haven't spoken with him, I don't know what are his intentions, I don't know how he behaves with the children. This is something big! (SW: Case 9, SSD A2)

Although "big", this crucial fact was later deliberately concealed from the committee's forum due to the mother's request to keep her privacy.

Another problematic found in regard to parents' assessment was that suspicions of maltreatment, whether reported by professionals, family or informal sources (e.g. neighbours), were not thoroughly inspected and parents were usually not investigated about them. Unfortunately, there were too many indications of this troubling pattern, even in cases where past concerns of abuse and/or neglect had led to the involvement of the court or removal of a child to placement. For example, the parenting qualities of a single mother of a seven year old who had recently reunited with her after living in care due to her past physical abuse had not been re-evaluated, even though there were neighbours' reports of quarrels and screaming in the afternoons and there was evidence of the mother not picking up her son from the school bus on time. The worker explained that the mother's record of serious violent acts towards professionals prevented direct confrontation with her and disclosure of this information in the committee. In another case the following report made by a father regarding serious aggressive acts of behalf of his ex-

wife, diagnosed with bi-polar affective disorder, was not further explored, leaving the worker with great uncertainties:

> He claims, by the way, that she reacts with severe verbal violence. She can come home and "shout like crazy" this is what he says, to curse with swearwords that are inappropriate for children, in an unruly behaviour. For example, if the house is a mess, she can toss the clothes aside and start tidy up in a nervous and aggressive manner and blame the children. There is something that is not fully clear to me. (SW: Case 1, SSD E)

These suspicions were not discussed with the mother; home visit was not initiated; and the worker had no contact whatsoever with the children this report was about before the committee (and even six months after). In another case the worker felt extremely troubled by new information exposed by the father during the committee regarding severe neglect of six young children by his ex-wife, which led her to conduct a home visit directly after. On the whole, social workers didn't actively strive to achieve their own impression of events. Workers did not conduct observations. The few parent-children joint meetings reported on were designed for the purpose of information sharing and hence did not yield significant insight into family dynamics. Also, only four social workers conducted a fresh home visit to evaluate the family's present situation. In general, workers' accounts of their impressions from home visits showed they were mainly targeted at evaluating children's physical living conditions (e.g. the cleanliness and order of the house; food supply; sleeping arrangements; and playthings) and to interview the mothers. Children were usually not engaged with in this setting; they were either absent, departed to another room, observed watching TV, or merely not conversed with.

Some workers accounts revealed reluctance to take on an inquiring or investigating position when engaging with parents due to feeling awkward being intrusive or not wanting to jeopardise existing cooperative relationships. As a result they were left with unresolved questions. For example, one worker reported feeling uneasy probing into the issue of father-child relationships and so when details were not voluntarily provided by the mother she eventually dropped the subject. In another case a worker reported collaborating with the mother's concealment in regard to her occupation by settling for very vague answers, although neighbours reported to her the mother may be involved in prostitution. In the following quote a worker is referring to a family of a single mother to three children with a history of alcohol misuse that was new to the city and not familiar to the SSD. Due

to a delay in the transfer of case files from the former SSD, considerable information about the family history was missing.

> Personally, I will not wait for it (case files from former SSD) and I will not delay a committee because I haven't got the case files when everything is clear to me. This is not a mother that conceals (information) from me, this is not a mother that will not tell me. This is a mother that gave very basic information, very partial, but I think she was expecting that the questions will come from me. She was expecting some type of relationship that I do not provide. I am not an investigator…. As to her addiction she did not say much. It required taking an inquiring stance which I don't like very much. I like to let time do its course and allow the provision of information when it is the right time rather than an inquiry… but it didn't happen and eventually we had to extract the information from her. (SW: Case 4, SSD B)

Through the interview it was found that the worker's strategy was very ineffective. She described being surprised to find out crucial information was held back by the mother (e.g. mental disorder diagnosis, psychiatric drug treatment and alcohol intake while in a rehabilitation programme) and admitted the initial picture she portrayed turned out to be very different from what was later discovered when professional reports became available.

In terms of sources of information external to the family, information was primarily collected from professionals in the welfare and education systems. Social workers easily approached colleagues that provided services to the family in the community (e.g. social workers of after school programmes) and gathered information from them without difficulty. Communication with school staff through written reports or verbal conversations was also very straightforward. Findings indicated effective and well-established working relations between local SSDs and local school systems. Information sharing between the systems was part of the everyday work and usually carried out with great collaboration. It was found that four SSDs designed their own tool for the purpose of facilitating information gathering from schools and pre-school programmes, which were reported to be very useful in formalising the process and clearly prescribing what details were required. However, the problem with the use of these tools was that they led to overreliance on the educational systems' impressions of the children instead of workers engaging with them in order to make their own assessments. For example, in one department the tool designed for schools' teams was a five page form which was a mishmash of the official tool for collecting information.

It seems that SSDs had less association with agencies of the health system. There was no evidence of workers approaching professionals of the medical health services, such as GPs or children's clinic nurses in order to collect information which potentially could enhance the assessments' reliability and shed light on causes and implications of children's and parents' functioning. Workers did engage with mental health service professionals such as psychiatrists of local clinics or personnel of state mental hospitals in order to gather fresh evaluations of either parent's or children's conditions. However, there was evidence of mental health hospital confidentiality and data protection regulation (by which information about a patient can only be provided to SWYLs) causing delays in information sharing; and so in a few committees, reports from these sources were not available at the time of the discussion. The collection of information from out-of-home setting arrangements was also not without flaws; in two cases fresh reports were missing.

Another pattern found was that protective factors, strengths, coping abilities, successful achievements and supportive resources were not sufficiently explored. For example, families' informal support systems (e.g. Narcotic Anonymous (NA), religious communities, NGOs, extended family and friends) were overlooked and (with only one exception) ignored through the assessment. Furthermore, data revealed that workers required more guidance in identifying positive aspects of family life. Workers responses to an explicit question in the interview regarding the role of family's and child's strengths in their assessment showed they were inexpert in recognising and acknowledging the safety side of the equation. Some workers mentioned there were no strengths or simply continued to describe the difficulties. Here is a typical example of a worker's answer to this question:

> Social Worker: The mother has low frustration threshold (laughing) and difficulty to handle things. She is in a state of physical weakness due to her illness and emotional weakness due to the divorce that although it was in agreement it is still fresh, it happed half a year ago, and also the fact that she is unemployed in the last four years.
>
> Researcher: But these are the difficulties, not the strengths.
>
> Social worker: The difficulties, right. So it means that she doesn't have the strengths to deal with all these things.
>
> Researcher: OK.

Social worker: Because she is not working, because of the divorce she doesn't have the strength to deal with the children and with what is going on.

Researcher: OK.

Social worker: What strengths do they have? (long pause). The strengths, I think it is the willingness, maybe the willingness for a change; that is the strength. Maybe, yes (a pause) the willingness for a change and seeing the children's best interest. (SW: Case 1, SSD A1)

This example shows, what was also evident in other interviews, that through investment of time in reflecting, the case worker was able to expand her problem-centred perspective and identify positive aspects in the family situation. Workers who did mention strengths mainly referred to parents being loving and caring for their children, and willing to act for their children's best interest as they understood it. Yet, in the same breath workers also passed judgment on these characteristics and minimised their effectiveness in guaranteeing safety of the child. For example, mothers who were strongly acting for their sons to return home from placements were described as oppositional and argumentative: "she had defeated the system", "she fights over everything". The recognition of children's positive characteristics was even less frequent compared to their parents, and mentioned in only three workers' responses to the specific question on the family's strengths.

Finally on the practice of collecting information, interviews with social workers indicated that, in general, case history was ignored or insufficiently explored through the assessment process. Only six workers reported reviewing the case chronologies and two others mentioned approaching the former family worker in order to collect case history information. Few workers stated the family's intervention history was not a factor taken into account in their assessment. Here is an example of one worker's response on this issue:

We are looking each time on the previous year; that is to say on an annual functioning. It may be that two years ago their (parents') functioning was horrible and all (the children) were removed to an emergency setting, I don't know. We put more attention on the prior year, what happened in previous year, what was done and what was not done. Accordingly we write the report and this is what we touch on in the committee. You put the past somewhere and look mainly on the preceding year. (SW: Case 9, SSD A2)

Another citation is of a worker who, in retrospect, regretted not investigating the family history which resulted in considerable gaps in the understanding of the family

situation. Although the worker was familiar with the family for three years considerable background information was missing.

> Social worker: when we started the discussion I regretted greatly that I didn't ask her (the mother) more thoroughly about the past. I wrote it down that I should speak with her and complete information: how was the pregnancy? To dig more in the family history, I missed on that.

> Researcher: And was it relevant for the discussion?

> Social worker: Of course. The history is always relevant. Usually I try to ask about it, but honestly time pressures prevent me from doing many things that are ideal. I needed to ask: how was their marital relationships before? Was the pregnancy wished for? How was the pregnancy? How was the birth? How was he as a baby? How was his development? How was he at nursery and at school? How was his separation from the school and from his father? (SW: Case 8, SSD A1)

To sum up, on the whole, social workers gathered the information that was most easily accessible to them, consequently failing to acquire crucial evidence from some key sources. It was thus found that pieces of information that should have been given considerable weight in the assessment, such as signs of abuse and neglect and the family members' relationships with children were insufficiently clear to allow sound decision making at the end of the process. In regard to workers' fear of known-to-be aggressive parents it is important to stress that, unfortunately, the reality in recent years is of growing verbal and physical violence towards social workers in general and SWYLs and SWCPs in particular by their service users (IMSSSA 2014). A few interviewees also reported on the past experience of parents' violent behaviour during PIECs, and the researcher herself was a witness to young girl's aggressive reaction during the committee. This situation supports a common argument in the literature, in which the climate workers create for their clients is an extension and result of the climate created for them by the organisation (Schneider 1973). Workforce vulnerability to parents' reactions compromised their duty to safeguard vulnerable children.

5.3.3 Family Assessment: Analysing Information

The next task following information collection is its robust analysis, i.e. bringing together and evaluating considerable amounts of data that may be disparate and conflicting and then

synthesising their meanings and implications. It is a task of considerable intellectual effort which requires substantial professional clinical judgment, time to reflect on the case and professional support to employ critical thinking (Munro 2011).

In line with earlier descriptions of workers' characteristics and professional knowledge, when interviewees were directly asked on what grounds their family assessment was built all mentioned their professional experience, the majority mentioned their intuition or "gut reaction" (only two workers stated their intuition did not play a role), five workers also mentioned their personal experience as parents, and five their education or theoretical/empirical knowledge. Most importantly, the current research found that the task of interpreting available information and inferring its meaning did not receive enough focus and weight in the practice by either workers or their team leaders. The process of formulating the PSRs was too rushed and mistakenly oversimplified. The majority of workers reported that writing the report took a couple of hours work. Two workers even estimated it took them half an hour to write the report. Further exploration of this unexpected finding showed that writing the reports was carried out with a mechanical approach. The process primarily involved summarising and integrating the pieces of information available. Social workers selected aspects of family life and reassembled them into a narrative form of the family storyline, while leaving it for the readers to gather the implicit meanings and draw sensible inferences. Here are two examples from workers' accounts showing misconception of the reasoning task involved in generating the PSR. For them it required articulating abilities and making decisions on what information to include:

> I am so skilful in that; wake me up in the middle of the night, and tick-tick-tick. Very quickly and clear: the school cooperated very quickly, in seconds I had a report, oral conversation with (name of school's professional), conversation with the mother, I sat for 15 minutes and completed (the tools). PSRs I also fire. I like writing so I don't have a problem, so this is the part that I like. All and all it took me about an hour, I reviewed all documents. (SW: Case 2, SSD B)

> Recently what I do is for example for every child; let's say reports from the schooling system….. in order not to include everything word-by-word and then to produce a PRS of 6 or 7 pages, I write the highlights in a few words and then read aloud the school's counsellor's or the teacher's report (during the committee). (SW: Case 11, SSD A1)

None of the workers used the tools package's user guidance for writing the PSR. Instead, it was easier to carry out the task in the familiar fashion, develop a personal style of working or ask for colleagues' advice when faced with uncertainty. These patterns provide support for prior argument regarding an organisational culture that routinises practice shortcuts and discourages sound practice. The time pressures within which the reports were formulated indicated that time was not sufficiently invested in thinking about the case. It was found that in the everyday practice of excessive workloads, time was not formally prescribed for the purpose of engaging in critical reflection, not even through supervision meetings. In general, professional supervision was not delivered at the stage of preparing the case. Professional consultation, when provided through supervision meetings with team leaders (in 13 cases) or engagement with the coordinator (in 6 cases), was predominantly in relation to the decision whether to refer a case to the PIEC and usually proceed beyond this stage. In only one case the coordinator advised on what professional reports should be pursued and in only four cases team leaders (and in one the coordinator) were involved in regard to the PSRs. Yet, this was merely a matter of reviewing the final draft and making comments about wording or details that should be included or omitted.

Before turning to describe the next main finding it is important to emphasise that although PSRs are commonly used by social workers in different decision making settings (e.g. courts, governmental bodies) (Weiss-Gal, Levin and Krumer-Nevo 2012) they stand out in the context of PIECs, in that they address distinct types of audiences participating in the discussion. It is completely transparent to parents and shared with various professional groups among them professionals that have no prior knowledge of the family and thus heavily rely on the information in the PSR. On these grounds, a highly problematic practice found was that decisions regarding what information to include in the reports were affected by invalid considerations. Evidence revealed a tendency by social workers to censor delicate, yet crucial, information as a mean to avoid overt conflicts with the parents. The wish to sustain cooperative working relationships with parents was given higher priority at the expense of providing decisions makers with an accurate information base. Here is a very honest testimony of one worker admitting her difficulties revealing sensitive information in the presence of the parents (although she refers to a case that was not included in the sample, her account describes a consistent pattern):

> I had difficulties talking with the father, I don't know why it is difficult for me, and maybe I need supervision. It is sometimes difficult in front of the parents, in front of the whole committee to come and say there is also a report on violence, because it wasn't (unequivocally) reported, it was a report about evidence to blue marks. You understand? It is hard for me to do this in the forum of the PIEC with the parents. I have a problem (laughing). (SW: Case 1, SSD F)

This worker incorrectly described her difficulty as a personal disablement; findings revealed the phenomena to be alarmingly prevalent. In 11 cases social workers admitted to deliberately not including some key information within the reports which should have been given significant weight in later decision making. Suggestions, as well as factual evidence, of past or present abuse (physical, sexual, verbal and emotional), neglect, maltreatment and parents' involvement in criminal activity were not disclosed. Here is an example of a worker's descriptions of "refining" the reports by omitting factual evidence or keeping descriptions very narrow so parents will not be affronted and their cooperation will not be negatively affected:

> When I write the report I usually try to adjust it to the family, based on my intuition of what may hurt the family, how much can I put through their history, it is intuition. I had never got it wrong. (SW: Case 1, SSD E)

She then turns to discuss the specific case study:

> I had difficulty writing the report because it was very important to me not to hurt any of the sides. This is not a typical committee because it was very important to me not to irritate her (mother) and not to irritate him (father). In relation to many things I had to soften the language and didn't write as I usually do. Like the issue of the (domestic) violence, for example, so I didn't elaborate much and didn't give it a lot of focus. Like the issue of her illness (mother's bi-polar affective disorder), I knew it will annoy her and drive her crazy if I will elaborate on all the things she did like the spend thriftiness, the fact that she suddenly flow to America for a month, that she spend two days in (name of place) without informing (the father). (SW: Case 1, SSD E)

Later in the interview, this worker reported expecting the father to bring forward during the discussion the issues she intentionally excluded. There was evidence in four additional cases of workers holding back key information while counting on others (parents or professionals) to disclose it through the discussion. In none of the cases their expectations were realised and so essential details were missed.

In some cases sensitive information was not completely left out but rather concealed within the reports through explicit clues which were expected to be understood by the forum. This trend was demonstrated by the use of vague phrases such as "complicated family background", "traumatic childhood", "very big crises", without comprehensively elaborating on their meaning. For example, in the case where decisions had to be made whether to prolong the stay of two siblings in an out-of-home arrangement or approve their return home, the worker described deliberately not including the family's past history and only indirectly implying it. Consequently, evidence of the severe neglect and abuse on behalf of the mother towards her children that led to their removal was not shared and instead was only mentioned in the report: "there were times when the mother had great difficulties in her parental functioning" and "the children were removed from home after serious reports about great educational, social, behavioural, and emotional difficulties at school and reports about the mother's behaviour". Here is another example of this practice:

> Social worker: I wrote (the PSR) and in consultation with team leader omitted more things relating to past violence.
>
> Researcher: Things that were not revealed in the committee?
>
> Social worker: Not revealed in the committee. This is based on the idea that we want to involve the father in the therapeutic process and not to open things from the past that can make him say he doesn't want to take part, so we took these things off. He (father) also read the report and didn't agree with a certain sentence that I corrected before the committee. In the sentence it was written that he was violent towards the children; that according to the family file it seems that he was violent; there was defected marital communication including threats and there was violent behaviour towards the children. He didn't want it to be included as a sentence, so I had no problem taking it off because there were other things in the report that indicated his aggressive behaviour, and at the moment he had a problem with a certain sentence so of course I took it off. (SW: Case 1, SSD A1)

What is highly troubling in this last quote is the fact that the practice described was encourage by the worker's team leader. There was additional evidence to suggest that this approach was well known to agency leaders and supported by them. One coordinator mentioned through conversation that at times information is omitted from the reports to prevent its disclosure to the parents. In two cases the fact that children went through investigation due to allegations of either physical or sexual abuse (which did not lead to conclusive findings) was deliberately not shared with the committee's forum based on joint

consultation with agency leaders (e.g. team leader, SSD manager and coordinators). This issue will be further elaborated on in Chapter 6 where it will be shown to be a shared strategy among professionals participating in the discussions.

5.3.4   Family Assessment: The Psycho-Social Report

The outcomes of the way information was collected and analysed will now be presented based on attentive content analysis of the PSRs relating to the 21 cases included in the study. Figure 5 sets out how the PRS should look according to new regulations as prescribed in the tool's users' guide.

Figure 5: The PSR Outline

1.	**The first page of the tool for collecting information** Including factual data on family members and household.
2.	**Family of origin background for each parent** Including meaningful life events and history of working relationships with the SSD and present social worker.
3.	**Parents' views about the discussion**
4.	**Summary of the household environment and the parents** Including financial and accommodation condition, parents' relationships, parents' emotional and behavioural conditions and parents' perspective on the familial environment.
5.	**The child's assessment** Including: indication of meeting with social worker, summary of parental care, child's functioning, particular problems, parents' view regarding parental care, and the child's view regarding his or her situation in the family and his or her functioning.
6.	**Services provided to the family and the worker's evaluation of their appropriateness**
7.	**Intervention suggestions** Worker's intervention suggestions that have been discussed with family members and family member's suggestions.
8.	**Conclusions** A concluding paragraph that integrates all the information and summarises the strengths and worries regarding the family, communal and familial support networks, the main reason for referral to the committee and the key subjects for discussion. In cases of review committees, information regarding changes in family member's condition and changes in the intervention since prior discussion.

None of the PSRs fitted the reform's instructions. On the whole PSRs were descriptive accounts, overloaded with detail. The main avenue of presenting the case was through other professionals' records that were either summarised or copied and pasted partly or completely and weaved together into a general chronological storyline. All reports followed a habitual structure: a brief introduction, core description of the family and a short summary. Through the analysis some similarities in the content categories of the reports were identified. The following findings are organised according to these categories and show they were all missing a robust analysis of evidence and informed interpretation of their meaning and implications for the child's safety, well-being and development.

The introduction section included very short factual background information regarding the family composition (e.g. marital status, dates of birth, date of immigration), education (children's grades and schooling systems and in a few cases parents' level of education); financial condition (e.g. parents' occupation or employment, support/housing/disability benefits, alimony), parents' physical or mental health problems, parents' relationships and a general comment regarding when and why first referral to social services was made. What was mostly missing from the introduction to the family was a factual account regarding the family's economic hardship which, to different degrees, was the reality of all cases in the sample. In only 4 reports were specific details regarding the family's total income provided (in an additional report it was not updated); in only 1 the housing expenditure was also reported so that an accurate picture of the family's severe hardship could be understood. In 7 reports the issue of the housing ownership was mentioned (e.g. rental, state housing, grandmother's apartment). The family's housing conditions were also an issue almost completely ignored. In only 1 report the number of rooms in the house was mentioned in relations to the children's sleeping arrangements. Interestingly, although 11 social workers had conducted home visits at a certain point, only 5 included their impressions in the reports; focusing on the tidiness of the house and its equipment. As mentioned previously, failing to notice the contextual and environmental contributors to the family situation is a common (attributional) error in practice.

The central part of the report included the family's story and was organised around four main themes: description of the children; descriptions of parent-children relationships (children's relationships with siblings were mentioned in only four reports and

relationships with other family members were completely ignored); description of parental functioning; and a review of prior interventions and service provision. Starting with the children, bounded within the limitations of information collection, reports only revealed specific aspects of children's lives and those were mediated through adults' perspectives, mainly their mothers and educational and therapeutic professionals. The dominant aspect in children's descriptions was their performance at school. Reports included detailed and lengthy accounts of teachers, school counsellors, head teachers, after school programme supervisors as well as didactic evaluations and educational committees' recommendations, which structured and organised children's images primarily by their adaptation to the educational system. Descriptions of both difficulties and strengths were focused on six distinct aspects: cognitive and language capacities, academic achievement, attendance, general appearance, discipline and compliance with adults' authority, and social relationships with peers. Yet, as insightful as school staff reports were, they did not go beyond describing the child's behaviour in the academic sphere and mainly signalled that something was indeed wrong.

Social workers also tended to include reports from therapeutic professionals such as art therapists, occupational therapists, psychologists, youth social workers and psychiatrists. These descriptions were usually loaded with specialist jargon and technical terms which may not have been clear to all professional audiences, and parents in particular. Also, their meanings and implications outside the therapeutic setting remained unexplored. Psychiatric evaluations in particular were reported very briefly and focused around the diagnosis and prescribed treatment (usually psychiatric drugs). Yet, without discussion of the individual manifestation of conditions such as "Tourette syndrome", "high level of anxiety and emotional and behavioural difficulties" and "emotional disorders" in everyday life, they could not add to the understanding of the child's experience.

With the over-attention given to educational and therapeutic reports, it was interesting to find that with only a few exceptions workers did not include their own impressions of the children. Although none of the workers had ongoing working relationships with the children, for most there were still some random encounters which at least could have been used to describe a vivid image of the subjective child. In addition, very little was known about other aspects of the child's life that were vital to understanding

who the child is and what his or her needs are. Children's functioning in the home setting was an issue that gained negligible attention in the reports. Only 12 reports included a few very short comments about children's everyday life at home which were mostly used to indicate concerns, lack of discipline and problematic behaviours such as aggressive outbursts, violent behaviours towards parents or siblings, homework incompletion, over-occupation with the computer, or unsupervised wandering outside. Three of these reports also covered self-care skills. Children's health was another aspect rarely mentioned in the reports although it was later revealed through the discussions that some children had serious medical problems (e.g. breathing problems, cardiology problems, migraines, severe allergies or obesity). Early developmental progress was mentioned in only one report. Although particular attention should have been paid to the young age group in order to identify vulnerability or low-level problems at the earlier stage, descriptions of children under school age (i.e. six years old) were the most minimal compared to other age groups. Descriptions of the nine pre-schoolers in the sample ranged from merely one sentence to eight sentences, averaging three sentences. Within these accounts, five year old twins' one line description consisted of replicated text with the name of the children cut and pasted.

Turning to children's relationships with their parents, descriptions were mostly very short and superficial. A striking example was a very lengthy PSR which included five additional reports (two psychiatric reports, a school psychologist's report, a school counsellor's report and a psycho-didactic evaluation) adding up to 22 pages, in which the child-parent relationships were only mentioned in the following statements: "in the (educational) committee the complicated relationships between (teenager) and his father were raised", "the mother is caring and protective". Children's relationships with their fathers or the mothers' partners were briefly mentioned in 16 reports in one or two lines and mostly only indicated the limited frequency of father-child interactions, e.g. "there is contact between the father and children, they visit their father once a month". There were few comments about the quality of the relations, and they remained very flat, for example that the children call the mother's partner "father" or that the relationship is "complicated". In only one exceptional report the father's point of view on his relationship with his children was included.

Children's relationships with their mothers was also a theme that was not sufficiently elaborated on within the reports. Only a few reports included an explicit

comment on the nature of the mother-child relationship, which mostly involved judgment-laden stereotyped phrases with little elaboration on their meaning, for example: "symbiotic relationship", "ambivalence", "damaged relationships" or "overprotection". There were also few reports which mentioned parents' capacity for warmth, affection and attentiveness to the child's emotional needs. The nature of the relationships could be implicitly inferred by some comments relating to the mother's parental functioning. However, these accounts were structured around how mothers respond to the children and thus created an image of difficult to manage undisciplined children and helpless unavailable mothers, e.g. "the mother reports that since the father had left the house (name of boy) is acting aggressively at home involves breaking blinds, slamming doors and yelling. She finds herself hopeless and doesn't know how to deal with such behaviour". In addition, three social workers used detailed descriptions of episodic events to demonstrate family dynamics, yet this was carried out without drawing upon how much they represent the habitual family life or what their short term effects or possible long-term implications were.

Accounts regarding parental functioning were included in the majority of reports and focused on four issues. Most frequent was parents' discipline capacities and in particular their ability to set clear boundaries. Other topics were the provision of adequate supervision; awareness of the child's difficulties and willingness to solve them; and collaboration with service providers, mostly school teams. Parents' everyday child rearing practices were rarely mentioned (there were a few very marginal comments regarding waking up the child for school or consistency of Ritalin drug treatment provision). Parents' severe dysfunction due to mental or physical problems was not discussed in terms of its day-to-day effects on the child's upbringing. For example, statements such as, "her health is very bad, she has difficulties in every-day activities and is being hospitalised very often" or, "there are times when the mother doesn't function due to the depression she is suffering from", were included in the report without further amplification.

Overall, reports failed to provide a real sense of the day-today experience of the child in the family. This is at least in part due to the fact that they were missing the children's point of view: what they thought and felt about their life experience, upbringing and relationships with family members and others closely involved with them; what they wished to change in their life circumstances and what was working well. It required a very close investigation of the reports in order to identify the few very short accounts of the

children's points of view which were usually reported in a sentence or two. For 14 children there was some indication of their stance regarding their relationships with their parents and/or their condition and/or the option of removal from home, e.g. "…the boy claims that he is bored during the visits (at his father's) and he is not interested"; "he is not satisfied with the move to the city… expressed reluctance to be removed to an out of home placement or to any other intervention". Only five of these accounts were directly elicited by the social workers and the rest were others' reports. Another overall tendency in the practice was to focus on what is wrong, which generated a very grim and overwhelming negative picture of the family's condition. Negative comments far outweighed positive throughout the family stories. For example, for 10 children no positive comments had been made about them, while for others they only involved phrases which felt empty and artificial, e.g. "charming", "cute", "pleasant", "good" or "wise".

The heart of the reports also included descriptions of the family's intervention history. When tailoring an intervention plan to each family it is crucial to understand what was working in the past, what was not and more importantly why, in order to avoid solutions that don't help. Intervention history was reported as a list of services names organised in chronological order together with a comment on parents' and/or children's cooperation. The nature and purpose of the services was not explained and thus may have remained unclear to other professionals that participated in the PIECs. There was no meaningful discussion on whether the services achieved any change in domestic life or why. Instead, as a typical manifestation of the attribution error, intervention failure was ascribed to the parents and children and their sporadic misjudgement; this contained an element of moral judgment and formulation of blame. Here is an example from one report:

> In the past the former social worker suggested the family an after-school programme for the boy, but it didn't work out due to the mother's opposition and difficulty to include the boy in conventional programme. In the middle of last year, when I had taken over the case, parents were offered after-school programme in a community centre, it did not work out due to commuting problems, and as mentioned before there are separation difficulties between mother and child and this fact may have also contributed to the failure of this arrangement. (Case 6, SSD A1)

In addition, reports of review discussions usually did not include an account of the decisions made in former PIECs; only two reports did so while only one of them specifically described the implementation of each decision.

The end of the reports were very lacking in terms of providing a conclusive integration of all the information presented. In fact interviews showed that workers found it difficult to establish an in-depth concluding judgment on the case. When asked through conversations to interpret the information collected about the case into a summarising estimation of the child's current harm and future risk it was evident they were not used to thinking about the case in such terms. These questions usually required the researcher to further elaborate on their meaning and led workers to reflect aloud on the family situation. In their responses workers applied different definitions of the concepts, some were muddling them together and some mentioned that it was a matter for psychiatric or psychological evaluation. With the over-emphasis on details, it was vital that attention was deliberately focused on the most important risk factors so they could serve as key subjects for discussion and be given greater priority in the intervention planning. Instead, only a few reports included a couple of lines summary of the main difficulties in the family circumstances presented. Most reports ended with a sentence regarding the main reason for referral to the committee which was usually very vague, e.g. "to check help opportunities for the family"; "to achieve a therapeutic plan that will promote and assist the parents in caring for their children". Few reports included recommendations of the type of intervention or specific service that should be provided and a couple reported on the parent's point of view on the matter.

To sum up, the practice of conducting family assessment had several key weaknesses. Workers mainly avoided or bypassed the challenges of the task instead of confidently and proficiently dealing with them. This resulted in poor quality PSRs.

5.4   Conclusions

The analysis presented in this chapter was the first layer of the building blocks of the decision making process, where social workers carry considerable responsibility. The outcomes of practice at this preliminary stage will determine the effectiveness of later PIEC discussions. What became clear from this research evidence is that practice did not meet the reform's expectations of professional performance to a high standard. The way of working was rushed, superficial and fractional. It is argued that the problems revealed are not a matter of individual workers' failings. The tasks imposed on workers by the new

regulations and tools are complex and require intellectual competence, significant professional judgment, communication skills, and confident proficiency to establish constructive working relationships with families and professionals. However, the workforce was not equipped to take on these challenges and carry them out successfully. Their work environment was not one that supported, encouraged or enabled the anticipated change in front-line practice. Workers were lacking some essential skills and knowledge as well as professional support and guidance. The new tools could not have served as working guidelines since they were not meeting workforce needs, necessitated considerable expertise to be completed, and did not specifically address or resolve practice weakness. Without sufficient technical equipment and administrative support professionals' limited time was erroneously invested in bureaucratic or procedural aspects of the work instead of conducting in-depth family assessment or employing critical thinking. With their organisation leaders not fulfilling their own responsibilities and overlooking deviations from new regulations the covert message sent to staff was to carry on with business as usual. The next chapter moves on to the chronology of the actual PIEC meetings.

6.   Chapter 6

The PIECs' Decision Making Practice

The following chapter is at the heart of this thesis, it discusses the decision making practice in action. The findings presented in the chapter are mostly based on observational data from 22[74] PIECs, while information from interviews with professionals is also added. The chapter is organised around the key principles the reform endorses, as means to improve the quality of decision making. It has three main sections. First, findings in regard to the PIECs setting and arrangements are presented and their impact on decision making discussed. Second, the changes the reform initiated to the PIECs forum are specified and their realisation in practice is accounted for. In the rest of the chapter the new systematic decision making framework suggested by the reform is presented and its implementation in practice examined. The analysis is aimed at evaluating whether the way of working under the new guidelines achieves the reform's overall target: formulating effective intervention plans that are tailored to the child's and family's needs and, as far as possible, their preferences (IMSSSA 2004a). Due to the vast amount of data covered in this chapter the issue of parents and children's participation in the PIECs is analysed in Chapters 7 and 8.

6.1   The PIECs Setting and Arrangements

Before turning to the core subject matter of this chapter some findings regarding the PIECs setting, practical arrangements and schedule are worthy of emphasis. Although the reform (and Ordinance 8.9) ignores these issues they were found to have some significant implications for the quality of the decision making process. The common trend in the SSDs was to schedule a number of discussions on the same day one after the other without any breaks between. Although there were great variations in the discussions' duration,

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[74] In one case, two discussions were observed. The second committee was additional to the data collection schedule and hence the researcher missed its beginning since she had a pre-scheduled observation in another municipality.

most of them (13/21) lasted for over an hour. The average discussion time was 65.81 minutes (SD=20.3; Median=68 minutes; range from 31 minutes to 100 minutes). It was shown that this arrangement negatively affected participants' cognitive capacity to stay focused and sharp and to concentrate through such a long time, in particular in regard to coordinators and members of the permanent panel who attend all or most of the PIECs scheduled. Evidence of the professionals' cognitive exhaustion and lack of attentiveness was seen in incidences of asking for information that was already presented or involvement in distracting activities, mostly with mobile phones.

Overall the committee rooms had satisfactory facilities. The setting arrangements created a very formal environment. In most discussions participants were sitting around a big rectangular table headed by the coordinator. In five SSDs, next to the coordinator sat a secretary who was responsible for writing the protocol; in two SSDs she used a computer for this purpose. On the tables were usually mobile phones, diaries, folders and files and in 14 discussions also some refreshments (mostly water and/or one plate of pretzels/biscuits, which usually were not offered to parents). Standing out was one SSD where the atmosphere was more friendly and informal: the setting was a circle around a small coffee table covered with refreshments, while the administrative secretary was sitting at the back of the room. Through most meetings there were several sources of interruption that interfered with the conversation, including loud noises of the departments' everyday life; out-door noises (e.g. from a school nearby), noises created by members of the next meeting waiting outside, a common habit of professionals going in and out of the discussion rooms (e.g. late appearance, temporary leave to get refreshed or make a phone call or early departure); and events (20 incidents overall) of conversations on mobile phone within the room. It is important to mention evidence of common inconsiderate behaviour because they suggest a lack of respect for family members. Firstly, the majority (19/21) of the discussions did not start on time (in only six committees this was due to family members' late arrival). Delays ranged from five minutes to an hour, with an average waiting time of 18.6 minutes (SD=12.8). With one exception, SSDs had no designated waiting area for families; there were some seats available in the hallways, and in one SSD the family had to wait outdoors. Secondly, it appears that private communication and engagement with mobile phones (e.g. texting and checking messages or missed calls (34 incidents) and conversing) while the discussion was in progress was a normal, frequent habit of the

professionals (carried out also by coordinators) and very rarely evoked any criticism (in only four incidents). There were also 10 incidents of professionals eating their lunch or a snack during the discussions (most were permanent members who had no time for a proper break).

6.2   The PIECs Forum

The reform ensures multi-disciplinary and multi-agency composition of the committees which is presumed to enhance effective decisions by pooling a variety of professional expertise and resources that can contribute to more flexible and creative solutions (IMSSSA 2004a, 2007). Its innovation is in including an objective point of view on the case when it comes to making intervention decisions. The forum is organised around two groups of participants according to the level of objectivity they can apply: 'permanent panel members' are representatives of the social, educational and health systems that have no prior familiarity with the family, and include the coordinator, and 'changeable panel members', who include various professionals as well as nonprofessionals that have regular working relationships or contact with the family (IMSSSA 2004b, Article 5). The permanent 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 (IMSSSA 2004a). The permanent members are assigned significant dominant roles in the decision making process compared to members of the changeable panel: the discussions must include at least two permanent members besides the coordinator for the decisions to be valid, and they are obliged to sign off the final intervention plan in order to authorise their approval. In addition, documentary materials about the case (i.e. the PSR and the first page of the tool for collecting information) should be distributed to the permanent members by the coordinator 14 days before the PIEC, to allow participants time to think about the case in advance (IMSSSA 2004a, 2008a). The new structure and composition of the PIECs forum is described in Figure 6 as set out in the Implementation Team's Decisions Paper, Article 5: The PIEC Composition (IMSSSA 2004b).

Figure 6: Members of the PIEC Forum

1.	**Permanent members who are not engaged with the child and parents:**
	Coordinator: A SSD manager or social worker assigned by him/her with experience in interventions with children and young people. The coordinator will chair the committee.
	Team leader from the SSD
	Representative of the educational services: e.g. school psychologist or counsellor, teacher, truancy officer[75].
	Representative of the health services
	Social worker from the SSD or supervisor as follows: • For children up to 6 years old a Social Worker to the Adoption Law (SWAL) (from the adoption service). • Or SSD social worker experienced in working with children. • Or SSD social worker experienced in working with young people.

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[75] Truancy officers are employed by the Israel Ministry of Education under the Compulsory Education Law 1949, and are responsible, among other things, for students' attendance and academic persistence in the schooling system.

2.	**Additional participants who are not permanent (the changeable panel):**
2.a	**Practitioners from the SSD who are engaged with the child and parents:**
	The family social worker.
	Team leader supervising the family social worker.
	SWYL- when relevant.
	Expert social worker specialising in the field of young people, girls, teenagers or drugs - when relevant.
	Additional professionals involved with the family, e.g. after school programme social worker – when relevant.
2.b	**Other participants (may attend all or part of the discussion according to coordinator's discretion):**
	Representatives of other services involved with the family, e.g. school, psychological consultation service, health, foster family, out-of-home setting.
	Professional experts (including IMSSSA's regional or national supervisors).
	A representative of the parent, guardian or child when requested by them.

A closer look at the new arrangement reveals several issues worth calling attention to. The forum does not include representatives of the police; that is in contrast to other international case conference models (e.g. the U.K). This can be related to the reform's objective to establish the PIECs as a therapeutic process. The inclusion of outside objective experts can serve to protect against the strong tendency of groups to avoid conflict, i.e. groupthink (Munro 2008b). Nevertheless, professionals of the SSD are provided considerable influential power since they outnumber any other professionals on both the permanent and changeable panels. As a departure from prior regulations, the reform frees IMSSSA's supervisors from most requirements to participate in the committees so their time can be invested in planning and monitoring service provision

(IMWSS 2007). The roles of permanent professionals, including the coordinator, are not specified in the regulations. This allows flexibility and adaptation to local circumstances, yet it may lead to uneven decision making conditions that can be unjust for families as was argued by the Gilat Commission (IMLW 2002). Allowing the option of partial participation of members known to the family, has a good sense of moral ground to it in terms of preserving the family's privacy. There was one piece of evidence of this in the study, where a mother requested that information about her alcohol dependency not be shared with school teams and hence they joined the meeting at a later stage.

The ministry had made no progress in regard to what was identified as the predominant obstacle to establishing multi-professional work in the committees, i.e. the fact that the PIECs do not hold any legal status (Dolev at el. 2001; IMLW 2002; SIC 2013). Since they are not legally obliged to do so, corresponding agencies (e.g. the health and educational systems) do not allocate time or resources for their representatives to participate in the discussions; it remains a voluntary act. Other professionals' participation was reported in earlier studies and evaluation schemes to be affected by the quality of the working relationships between services, organisations' workloads, individuals' availability, and practitioners' good will (Dolev et al. 2001; Ben-Rabi and Amiel 2013; SIC 2013). On these grounds, the expectation that members of the permanent panel regularly attend the committees on top of their other responsibilities seems unlikely and with indications of increasing demands for PIECs, even unrealistic.

Turning to the research findings, overall 10 coordinators were observed in action; 6 were the SSDs permanent coordinators and 4 were senior social workers from the SSD who substituted for the regular coordinator who could not attend. In 6 discussions the permanent coordinator was substituted. Among the permanent coordinators, 3 participated[76] in the ministry's year long qualification programme (chairing a total of six discussions), 1 participated in the Community 2000 Experiment qualification scheme (chairing a total of 7 discussions), one had no formal qualification (chairing 1 discussion) and data are missing for 1 (who chaired 2 discussions). Their positions in the SSDs included: SWYL, senior social worker, specialist for teenage girls' population and head of the field of children at risk. Substituting professionals had no specific formal qualification

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[76] One coordinator was going through the training during the time of field work.

for the role, three were SWYLs and one was head of the department's Teenage Girls' Unit. All in all, more discussions observed were chaired by a qualified coordinator than a nonqualified coordinator, and nearly half (9/22) were chaired by SWYLs.

This study reinforces earlier data about the reform's operation in the field (Dolev et al. 2007b; SIC 2013) by discovering partial and inconsistent implementation of regulations regarding professionals' participation. The PIECs observed were usually conducted in a large forum. On Average the meetings included 7 professional members (SD=1.85; Mode=8 professionals). The number of members of the changeable panels ranged from 1 to 7 with an average of 3.68 participants (SD=1.43; Median and Mode=4 professionals). There was no resemblance between SSDs in terms of permanent participants who were routinely invited to the discussions. None of the PIECs included the prescribed core group of permanent professionals required; there was inclusion of unnecessary members or noninclusion of required professionals. In addition, in nearly half (10/22) of the PIECs observed the decisions made were actually not applicable, according to the reform, since there were less than 3 members on the permanent forum. It is suggested that a key reason for these findings is insufficient familiarity of coordinators with the reform's regulations. The majority of required professionals were not invited to participate, including the workforce of the SSDs. In all discussions but one, a noninvolved team leader was missing, and in just over a quarter, an additional objective SSD worker was missing. Only 6 professionals were invited to attend but did not, mostly due to technical problems such as illness, retirement, school holidays or misunderstandings. As mentioned there was profound disparity in coordinators' positions at the SSDs, this was also the case in regard to permanent social workers from the SSDs that were for example, SWYLs, family therapists or managers of PCTC. Since these professionals had profound influence over the discussions, their professional orientation, whether therapeutic, managerial or control, gave different colour to the happenings. For example, the SWYL role is typically associated in public opinion with the removal of children from homes (IMSSSA 2014); the participation of SWYL, in particular when this is the coordinator, may have imposed unjustified threat on families.

In terms of the qualities permanent members are expected to contribute to decision making, evidence showed that the prominent hope for bringing a fresh eye to the case was repeatedly violated, since key members had past or present engagement with the family.

For example, in nearly a third of the discussions (7/22) the coordinators were closely involved with the family, either at the time of the discussion or not long before, and in 5 discussions the supposedly uninvolved social worker from the SSD had previous or present therapeutic relationships with families. The principle of professionals' permanency was also frequently disrupted due to great turnover of participants and promoting a multi-disciplinarily perspective was very lacking too. For example, in 13 PIECs there was only 1 additional professional point of view beside that of the social services and in 3 PIECs the forums, both permanent and changeable, included only members of the SSD. A very promising finding was the high participation rate (in 13 PIECs) of representatives from the educational system, which may indicate the establishment of cooperative working relations between the two systems. Most commonly, representatives were truancy officers and, to a lesser extent, psychologists[77]. Observational data showed that truancy officers' participation usually did not add meaningful value to the discussions, and most often they were over-occupied with other activities. Social workers evaluated that in half of the committees truancy officers attended (6/12 PIECs) they made no contribution to the discussion. In the changeable panel, school staff not only participated in the majority of the PIECs (16/22) but in 9 PIECs had more than one representative. Unfortunately, this desired progress was only evident in regard to school aged children. Representatives of nurseries or other infant care programmes were not invited to participate in any of the PIECs. Also, in 3 discussions regarding children under six years old a SWAL did not participate (in 1 PIEC she arrived in the final minutes of the discussion). Together with the fact pre-schoolers were also very much missing from social workers' family assessments, younger children were given very marginal attention in the discussions. As to the health system, it seems that no progress had been achieved (Dolev et al. 2001); health services had no representation in either panel in all the PIECs observed[78]. 4 PIECs included a psychologist on the permanent panel, yet they were working for the local municipality's social services and hence did not represent the health system. It was observed that the expertise of the mental health professionals, in particular psychologists and psychiatrists, was particularly indispensable in some of the discussions, and could have served to resolve confusion around the implications of diagnostic evaluations and psychological tests; this

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[77] These psychologists were employed by the Psychological Consultation Service, an organisation that provides psychological and educational consulting services for students, parents and educators.
[78] Two coordinators reported regularly inviting nurses of children clinics to discussions concerning children under six years old, yet this was not manifested in the relevant discussions observed.

was also reported in hindsight by 9 social worker interviewees. In the next sections of the chapter it will be shown that attendance at the PIECs didn't necessarily go hand in hand with actual power to influence decisions.

6.3   The PIECs' New Systematic Decision Making Framework

Under the new reform it is the coordinators' responsibility to lead the PIECs according to a fixed systematic procedure and sequence of distinctive stages. The new orderly decision making framework is set out in the new Tool for Documenting the Discussions – PIECs (IMSSSA 2009) and the supplementary users' guide (IMSSSA 2008a). The prescription of an obligatory decision making procedure is a novel policy which follows the national study recommendations (Dolev et al. 2001). Ordinance 8.9 (IMLW 1995) has no applied workable guidelines regarding the actual process of deliberation and intervention formulation. Notably, regulations put the criteria of making sound decisions first. The coordinator is authorised to discontinue a discussion if necessary information or members of the forum are missing and to reconvene another meeting. There was only one example in the study of a coordinator taking this approach. That is although, as will be shown, the inadequacy of information on both family conditions and the available help services was a prevalent problem in all discussions. Additionally, in 10 committees the coordinator or another senior member explicitly criticised the nonattendance of a person (overall 16 missing members; half professionals and half family) whose judgement and perspective were pivotal to the comprehensive understanding of the family condition, and/or to the consideration of possible solutions to it. One coordinator merely added a comment to the intervention plan: "the discussion was lacking due to the absence of out-of-home placement representatives". Due to their absence the mother's harsh protests on the low quality of care provided to her two boys at the placement could not be taken into account, nevertheless it was decided to prolong the siblings stay for another year. Figure 7 describes the discussion process according to the tool and the users' guide. The outcomes of each stage, and in particular family members' accounts, should be recorded by the coordinator[79] within the tool.

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[79] It is important to clarify that the completion of the tool is the sole responsibility of the coordinator. The administrative secretary's responsibility is to write down the discussion protocol in addition to the tool.

Figure 7: The PIEC Decision Making Procedures

1.	**Introduction:**
	The discussion starts with the coordinator providing a brief introduction to clarify the aim of the discussion, its procedure, the obligation of professional confidentiality and the participants. Members attending as well as members that were invited but did not attend should be listed in the tool; if the later are family members reasons for their absence should be recorded.
2.	**Information sharing:**
	Available information regarding the children's and parents' condition is shared with the forum members. Assuming that the necessary information is already available to the participants prior the committee, the social worker should only summarise the main issues in the PSR. If members are not familiar with the PSR in advance, 15 minutes should be dedicated to reading it. 10 more minutes should be dedicated for clarifying uncertainties and reporting new information. It is important that this stage is restricted with specific timelines in light of a recognised problem in case conferences [80] of over-engagement with family assessment at the expense of discussing what can be done (Bell 1999b; Farmer and Owen 1995). Timelines also demonstrate the vital role given to social workers in presenting the family before the committee, it is expected that their report will be a sufficient source of information and hence only 10 minutes are allocated to additional discussion of the family condition. In addition, social workers are instructed to bring along the family file just in case further details are required. The main issues which involve disagreements, uncertainties or meaningful new information should be documented.

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[80] For example, Farmer and Owen (1995) found in their study of 120 child protection case conferences that on average only nine minutes of the discussion were left to consider the needs of the family and how they can be meet.

3.	**Information analysis:**
	The inclusion of a designated stage of information analysis is to tackle a problem evident in Decision Committees of moving directly from introducing the case to discussing solution alternatives (Dolev et al. 2001). The analysis process should be organised in two sequential steps. Firstly, the main dimensions in which parents and children require help should be discussed and defined (the tool includes a list of possible dimensions to select from, e.g. fiscal-occupational situation, marital relationships). The family is given priority over the professionals to be the first to speak on this issue. Secondly, for each dimension distinct intervention targets should be set out (e.g. helping the unemployed father to find a job, reduce the couple's verbal aggression). This stage stimulates valuable systematic analytical thinking. It fosters a greater focus and effective consideration of solution alternatives in the next stage and sounder evaluation of the intervention plan outcomes later on.
4.	**Systematic discussion of solution alternatives:**
	To promote an ordered and well managed process of discussion of possible solutions, which again was identified as defective in the Decision Committees' operation (Dolev et al. 2001), the tool includes tables where, for each dimension of concern, four possible solutions can be documented. Regulations also prescribe the specific considerations that should direct the forum when choosing between help possibilities. Weight should be given to issues such as service availability, service costs, previous experience of success or failure with specific service, and family members' preferences. The main issues of the decision into solution alternatives should be summarised within the tool and read aloud to the forum.
5.	**Formulating a detail intervention plan:**
	After deciding on an intervention solution, the tool includes a table for the specifics and practicalities of the intervention plan to be recorded (e.g. duration of service provision, expected schedule for the service to begin, number of therapeutic hours recommended, and annual cost of the intervention). It is distinctly emphasised as the coordinator's responsibility to assure that all participants have a clear understanding of the services decided on, when should they start, for how long, and who is the professional responsible for the intervention plan's implementation.

6.	**Clearing reservations:**
	The next step is that participants, both family and professionals, are invited to comment on the decisions, put forward their reservations, uncertainties and foreseeable difficulties in implementing the intervention plan.
7.	**Deciding on follow-up scheme:**
	This stage is dedicated to prescribe the follow up procedures according to specific timelines. Decisions should be made about: follow-up date (no later than three months after the discussion); a responsible professional for the intervention plan's implementation; and a date for a review committee (different timelines are prescribed according to the case characteristics and the decision made also in some cases a review committee is not obligatory). The inclusion of this stage is highly important, as giving follow-up was a weak spot of the pre-reform practice (Dolev et al. 2001).
8.	**Ratification of the intervention plan:**
	The discussion finishes by approving in writing the intervention plan decided on, using a 'decisions form' which is part of the tool. Parents and children, members of the permanent panel, the social worker in the case and the responsible team leader are required to sign the intervention plan. This procedure is another novelty of the reform and is aimed at establishing partnership between family and professionals. As stated within the form, participants' signature is an explicit declaration of joint decision making and mutual responsibility and obligation to act upon the intervention plan by both professionals and family. Parents who feel they need more time to think about the intervention plan can sign the form at a later stage after the PIEC.

The utilisation of the Tool of Documenting the Discussions - PIECs showed the same problematic patterns found in earlier tools described. In one SSD the tool was not used at all. Five SSDs created their own adaptations of the tool; in one SSD a unique shorter version of the tool was developed by the coordinator to meet her needs and four departments used a much shorter form for documenting the intervention plan which was usually completed after the PIECs. Once again, as was the case with social workers, there is evidence of misuse of the tools. The decision form, as will be later described, was not used for its intended purpose and the tool for documenting the discussion was chiefly used to record the habitual way of working and hence did not lead to the desired change in practice. Investigation of the tools that were used showed that the forms were very briefly

and not fully completed. For example, coordinators tended to write over the table designed for recording the intervention plan instead of completing its categories. Observations revealed that coordinators did not use the tool systematically throughout the discussions and overall did not manage the deliberations according to the particular steps and procedures it prescribes. It is thus, that problems found in relation to the Decision Committees' operation and identified as obstructions to sound decision making, were also evident in the current study. The research findings are neither original nor unforeseen. The Community 2000 Experiment's evaluation reports persistently account on coordinators' difficulty in managing the discussion and completing the tool at the same time (Dolev et al. 2007a, 2007b). Evidence from the current research shows that the practice of completing the tool got in the way of managing the discussion. Over-occupation with documenting resulted in inattentive coordinators and in the group being left without a leader. It is thereby questioned whether the requirement for coordinators to perform multitasking is either feasible or favourable. The rest of the chapter finally move to the actual happenings in the PIECs; practice is presented in a step-wise order according to the new discussion stages.

6.3.1 The Introduction stage

The inclusion of an introduction at the outset of the discussion was a matter of the coordinator's personal style. In a third of the committees there was no introduction and in the rest the coordinators said a few introductory sentences which varied greatly in their content. Only two coordinators referred to all topics that should be included according to the guidelines. For example, the issue of confidentiality was referred to in only two committees. Accounts regarding the committee's purpose were mostly included and usually directed at parents with the aim of reducing potential tension (e.g. that decisions had not been made in advance and will be jointly established by all participants or that the option of removal from home will not be considered). It was a common norm that participants introduced themselves in turn by their first name and position according to the seating arrangement. This procedure promoted a friendlier atmosphere and was helpful in breaking the ice. In only one discussion the forum was not introduced, and in some cases

when professionals arrived late they were not introduced to the forum and the forum was not introduced to them.

6.3.2   Information Sharing Stage

The analysis will point out some shared difficulties in how information was presented and what information was or was not presented. Staring with information sharing procedures, practice was affected by the fact that coordinators tended to disregard their responsibility for distributing the case materials in advance. In three SSDs this task was delegated to very busy social workers and in two SSDs regulations were totally ignored. Overall, in a third of the PIECs (7/21) case materials were not available to professionals, including the coordinator, prior to the discussion. When documents were distributed, it was not carried out according to instructions regarding what type of documents should be delivered, when, and to whom. In one SSD case materials were not delivered to members out-side the department with the rationale of keeping the family's privacy; in general materials were often distributed only a day or a couple of days before the discussion; some social workers provided only PSRs while others also provided experts' reports. Nevertheless, having the reports is not the same thing as reading them. In one case the coordinator and team leader delayed the start of the discussion in order to read the PSR report although it was available in advance, and in another SSD the coordinator intentionally did not read the reports wishing to keep an objective eye on the case.

The standard practice was to prescribe time at the beginning of the discussion for the participant to get familiar with the PSR. The same approach was dominant prior to the reform (Dolev et al. 2001), so no change had been achieved. In the majority of the PIECs observed (with only one exception) a hard copy of the PSR was provided to participants by the social worker and then it was mostly read aloud (10/21 cases) or summarised (8/21 cases) by the social worker or in few cases (3/21 cases) read individually. In most discussions there were fewer copies of the PSR than actual members attending and so professionals (in 14 discussions), coordinators (in three discussions) or parents (in 14 discussions) had no access to the written report. This was in particularly problematic in the 8 discussions where the PSR was only briefly summarised. In effect, 6 parents had not seen the PSR either prior the discussion (due to a lack of preparation procedures) or during

it. In regard to other written records beside the PSR, they were not handed out to the forum or consistently shared with all members. In 16 PIECs written reports or documents (e.g. reports of professionals who did not attended) that were provided either prior or during the discussion were not presented to or shared with all members of the forum and were usually only available to a few practitioners from the SSD (namely coordinators and social workers) and in some cases not even to parents. Thus, case information was not fully transparent to all participants when making decisions.

The common norm (in 13/21 discussions) was that after the social worker's account, professionals of the changeable panel were invited to take turns and bring more details of the family condition. In only a third of the discussions were parents invited to give their account before professionals. Professionals tended to provide verbal accounts and few read their full reports aloud. Among the professionals, school staff played the most dominant role in providing essential valued insight into the children's world; their everyday difficulties and their individual ways of coping with them. Yet, in some cases their accounts excessively exploited the committees' limited time, for example when several representatives of the same school presented their accounts or when information was already reported in the PSR. For example, in one case 3 different school members gave their individual accounts, a process that lasted a total of 8 minutes. The analysis showed that the practice of sharing information as established in the field considerably prolonged the duration of this stage; it took an average of about 32 minutes (M=32.24 minutes; SD=12.93) ranging from just 5 minutes to a maximum of about an hour. This stage consumed on average almost half of the total discussion time (M=48 per cent of the total discussion time; SD=0.14), which resulted in not enough time left for thoroughly discussing the intervention plan and the later post-decision stages being significantly rushed.

To sum up, during an extensive information sharing stage participants were exposed, on the spot, to a considerable amount of information, mostly verbally presented, which to some key decisions makers was in effect new. It was shown that professionals preferred listening to others' testimony rather than reading the reports and very rarely took notes at this stage. It is argued that participants, in particular permanent members, could not have fully digested the meaning and implications of the information they were bombarded with but only capture the overall outline of the case or the general picture, at

the expense of the precise details. It was evident for example in 15 PIECs that deep into the discussions permanent members asked for specific details that had already been mentioned; searched the PSR for information; or made mistakes about details that had been presented before.

The research revealed a very disturbing picture of a defective information basis on which decisions were made. There is a considerable body of evidence showing that in all discussions there were gaps in the understanding of the family condition due to inadequate information. Observational data revealed additional defects in the information collection process carried out by social workers and provided more evidence of the poor quality of the PSRs. There were also substantial indications of social workers not being familiar with essential information about the child and family conditions. For example, in 14 PIECs parents mentioned that some factual details in the reports were incorrect, in 4 PIECs they claimed reports were outdated and the circumstances had changed, and in 11 PIECs they added information (e.g. in relation to the child's health problems; history of domestic violence; parent's custody arrangements; and past or present interventions) which was new to their workers. Professionals also corrected mistakes and provided unfamiliar information, for example (in three cases) specialists' assessment reports about the children that were not available to the workers. There were incidences when workers could not answer the forum members' questions about the family, and when information (in four cases) was missing from the family's files. In nine PIECs social workers were instructed by the coordinator as part of the final recommendations to investigate and complete missing information, for example, to seek records that were not available in the discussion, conduct a home visit or meet with the children. It goes without saying that these measures should have been carried out prior to the discussion. This argument also holds for five committees where part of the intervention plan was to complete a psychiatric or neurological diagnostic assessment in order to clarify the child's condition. With the PSRs not providing a satisfactory picture of family life usually parents and professionals were repeatedly called on in the discussion to clarify and complete essential pieces of information. Nevertheless, these attempts to fill in the gaps were not always successful. In five committees members of the changeable panel came unprepared and could not provide the required details. In five committees professionals made irresponsible inferences as to the child's or mother's condition which were not within their field of expertise. For

example, a head teacher who made psychiatric conclusions and a psychologist who made neurological conclusions. Parents were a valuable source of information, however, and this is not unforeseen, their accounts mostly added to the uncertainties and misunderstandings due to disagreements over descriptions and interpretations of the occurrences. Parents tended to oppose the worrying picture of the family's condition portrayed by professionals. For example, they denied certain reports (e.g. a mother who rejects the out-of-home placement's report that she rarely and irregularly visits her sons); minimised their severity (e.g. a father who dismissed reports of severe violent attacks by an older schizophrenic son on his younger brother saying, "it was just a scratch"); or provided alternative explanations for difficulties (e.g. five parents explained their children's absence or low performance at school as an outcome of medical problems).

It is important to emphasise that the findings also showed that some gaps in the information were intentional and due to the parents presence in the PIEC. Acting on the reform's requirements for transparency of information and procedures was not a trivial matter for professionals but rather a serious difficulty; described by one worker as "walking on eggshells". The complexity of sharing information about the family when they were present was already identified by the national study which recommended enhancing coordinators' training and formulating detailed practice methods (Dolev et al. 2001). In the current research a tendency to censor delicate, yet crucial, information as a means to prevent overt conflict with the parents was shown through observation as a clear strategy of professionals, including coordinators. There were numerous indications of this pattern. In one committee a fresh psychiatric report summarising the hospitalisation of a nearly 14 year old boy which was not familiar to the mother was secretly shared between the coordinator and two other professionals seated next to her. In some committees sensitive information was shared only when the parents were not present, either before they entered or after they left the room. In one such case the teacher started to describe a recent episode in which the child's aggressive behaviour was uncontrolled and the father was urgently called to help the school team. Her portrayal of the father-son interaction she had witnessed was of a highly tempered and aggressive father and a terrified boy. As soon as the father entered the room she stopped talking and when the event was later referred to, it was to make an argument regarding the father's cooperation with the school team. In two committees sensitive issues relating to a long history of domestic violence or seriously

problematic relationships between mothers and adult daughters were only hinted at by professionals and then silenced by either the coordinator who claimed, "there is no need to get into the details" and "OK we will not open this, there is severe parental rejection" or by the SSD manager who stated, "the issue of domestic violence is something better not to get into". In addition, in two discussions, attempts to reveal the full picture were hurriedly withdrawn when it seemed they were leading to direct confrontation with the parents. In one such case the coordinator made an argument that the father's violent behaviour had an impact on his relationships with his children. The father resisted the use of the term 'violence' and hence the coordinator turned to use more inexplicit phrases that were reported in the PSR, such as "disciplinary smacking", "shouts", "high level of anger", which were accepted by the father. In addition to observational data, in interviews six social workers admitted that parents' presence in the discussion hindered free information sharing and open discussion. Some workers reported being aware that other members of the forum held back information. It would be to state the obvious that keeping parents unaware of professionals' concerns regarding their parental care does not serve them or their children. It does not allow parents the respectful right of defending their actions and prevents any chance of making a change.

Finally, it is important to note that the information sharing stage was not free of intervention recommendations. It was very common for professionals and family to include solution suggestions when giving their accounts. The troubling consequence of this practice was twofold. Firstly, in 11 committees a discussion regarding intervention alternatives was encouraged before the full picture of the family condition was clear. Secondly, in 13 committees interventions suggested at this stage were not brought up again in the following stage of discussing solution alternatives. Overall 20 intervention recommendations that were brought up at this stage were ignored, 8 were from professionals who had not attended and could not have voiced them.

6.3.3   Information Analysis Stage

The next stage according to the new regulations should be a distinct procedure of information analysis. Observational evidence showed that this stage was skipped in all committees. The common norm was to move directly from sharing and clearing

information regarding the case to the discussion of intervention alternatives. Thus, once again, no change had been made. In three committees the coordinators provided a short summary of the case details in a few general statements before turning to discuss possible intervention solutions. The lack of preliminary knowledgeable definition of the areas for intervention and the targets for intervention undermined the capability to establish a well organised and efficient discussion of intervention alternatives. As will be later described, this had a direct impact on the quality of the intervention plans decided on. They did not systematically corresponded to all the concerns regarding the family situation and were lacking explicit delineation of the intervention targets.

6.3.4   Discussion of Intervention Solutions

Before moving to the next stage of the discussions, it is important to note that in 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 a case of an 11 year old boy who had already been through the out-of-home placement's enrolling procedures and a case where arrangements had already been carried out in order to bring two siblings living in out of home placement for six years back home. In the PIECs there was no meaningful discussion of other intervention solutions, and when in the two cases mentioned an opposing stance was voiced, in one case by a father and in the other by an out-of-home placement representative, it was disregarded or silenced. Therefore, the PIECs merely served as a rubber stamp to approve intervention measures already acted on.

Observation showed that the new tool was not used by coordinators at this stage for the purpose of managing the discussion in a different way and hence what prevailed was the accustomed familiar practice (Dolev et al. 2001). Overall, this stage took the form of an open lively discussion where participants freely raised possible different courses of interventions or specific services. The conversation was not well-organised, ordered or controlled. Chairing activities were marginal and mainly involved focusing the conversation on specific topics, inviting certain members to speak or rushing the discussion to its end due to time limitations. At this stage coordinators' leadership was lacking. They were not sufficiently acting in their role in systematically guiding and

directing the discourse as a step-wise analytical process of ordered consideration of possible solutions. It was also evident that this stage was exploited for documentation, and so coordinators who did use the tool were not fully and persistently alert to the conversation.

The discourse was characterised by frequent changes of subject, interruptions, and simultaneous conversations between members of the forum. Some solution options had to be raised several times before being considered and some did not get any response, mostly due to speakers' interruptions and shifts of subject. The conversation into help alternatives moved back and forth from parents to children (in 14 discussions) or floated incoherently between various concerns about the child's condition (in 7 discussions). Another tendency in most PIECs was to quickly jump and suggest specific services before discussing and reaching an agreement on the intervention approach in general. Overall, 22 possible intervention solutions (in 12 committees) were in effect ignored, about half of them (12/22) were suggested by the parents. The disorganised nature of conversation also resulted in time and attention being allocated disproportionally between siblings and in favour of older children. The common trend found in two-thirds of the committees involving families with several children (8/12) was to discuss intervention solutions according to children's birth order starting with the oldest child. The problem was that when the younger children's turn arrived there were already time pressures to end the committee and thus decisions were rushed. The outcome was that some young children were not provided with help or protective solutions which met their needs. An example was the case of a single divorced mother with seven children (an older daughter from the mothers' earlier marriage was not discussed) who were living under conditions of severe neglect. After it was decided that the three older boys would be removed from home, the conversation turned to the three younger girls (4, 5 and 8 years old). That was in the final five minutes of an hour long discussion. Professionals suggested the option of after school programmes yet, at the same time raised substantial concerns as to the efficacy of such a solution, since the availability of the service was in question and the girls may still have been left unsupervised during the evenings and nights. The coordinator then jumped to suggesting emotional therapy for one of the girls and aiming to end the discussion scheduled a follow-up discussion in regard to the sisters in four months time. Another factor that came in the way of effective consideration of possible interventions was professionals' insufficient knowledge in

relation to the available services in the community and their characteristics. In 15 committees some details regarding the services solutions considered were missing (e.g. costs, location, availability, entrance criteria, duration). In most cases (in regard to 14 services) this eventually led to dropping the option, in some (8 services) the service was still approved, and in some (8 services) it was decided to further investigate the service and hence the intervention plan remained incomplete.

An obvious benefit of using observation was that it allowed investigation to go beyond who attended the PIECs to who had an impact on the decision making. Findings showed that the democratic attitude manifested in the early stages of the PIECs was not sustained when it came to deciding on an intervention plan; so that some members had more influential power than others. A surprising finding was the marginal role social workers played in decision making regarding help solutions. This is a dramatic change in practice given the dominant influence of social workers over decision making reported in the national study[81] (Dolev et al. 2001). Evidence showed this to be a combination of limited active participation in the deliberations on behalf of social workers and limited ability to make an impact over the decisions. For example, in six PIECs social workers were not involved at all in the discussion of intervention alternatives. Out of the 11 PIECs where they were more involved and suggested one or more solutions: in 6 discussions none of the options were accepted; in 4 some options were approved and some rejected; and in 1 social workers' recommendations were fully accepted. Through interviews workers confirmed that their contribution to the discussion into alternatives was very limited, on a scale ranging between 1='very poor' and 5='very good', the average score they rated themselves was 1.60 (SD=1.6). One line of explanation of their behaviour was to allow other professionals have a say. These workers accounts echoed the motivation to share responsibility in complex cases already mention as a reason for referral to PIECs. Another reason was that there were no options to choose from anyway (soon it will be shown this argument carries substance).

A key finding was the powerful position of coordinators in making the final decisions. In comparison to other members coordinators were the most active in terms of

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[81] In 60% of the cases examined the social worker's recommendation was the sole option considered and in only 4% of the cases the final decision was essentially different from what was recommended by the social worker.

both suggesting intervention options and rejecting intervention options offered by others. When an intervention was raised by a coordinator it was most likely to be included in the final intervention plan and when it was rejected by a coordinator it was most likely not to be approved. In addition, the point in the course of the PIECs of putting together the intervention plan was a crucial juncture where some coordinators exercised their decision making power. In eight committees at that stage the coordinators made the final call regarding issues that were still unsettled. In two additional committees the coordinator either included an intervention that was not discussed before or made a substantial change to the decisions after the 'agreed on' plan was read aloud. Other powerful participants identified were senior members of the SSD, namely PCTC and department managers. When included in the forum their stance considerably affected the intervention plan. In effect there were several indications to senior members acting in the coordinator role, including taking some chairing responsibilities through the discussions; completing the tool (in one case) and dictating the final decisions which were then written by the coordinator within the tool (in four cases). These members' influence was not always covert. In eight committees, intervention solutions were confidentially discussed between coordinators and senior members, mostly through whispers and in one case via exchange of notes. The dominance of the coordinators and senior members was also evident by the low level of opposition to their points of view and the way opposition was resolved when it occurred. There were 15 incidents of noticeable disagreements between professionals, mostly over one particular intervention. The majority of the disputes were between members of the SSDs and the coordinators or senior members. About half (8/15) of the disputes were resolved by coordinators or senior members making the final call; five disagreements were left open so there was no conclusive decision, and two were concluded with some kind of compromise (e.g. to set a time limit on service provision).

Overall, overt disagreements between professionals were evident in about half of the PIECs observed (11/21 PIECs). Usually, professionals tended to compliantly withdraw their argument about an intervention solution when it was disregarded by the forum or when some considerations of it being inapplicable were presented. This finding suggests that the PIEC decision making process was affected by groupthink bias. Another indication of the dynamic of groupthink was coordinators' and senior members' habit of speaking on behalf of the entire forum in a way that created a false sense of consensus and

significant pressure toward conformity. Here are some quotes that exemplify this communication style:

> What I suggest, in fact I suggest on behalf of all of us… (Coordinator: Case 5, SSD B)

> There is no one here who thinks there is something we can change in the house, it is therefore decided on an out-of-home placement. (Coordinator (2): Case 3, SSD A1)

> Our impression is that all three boys should go to out-of-home placement. (SSD Manager: Case 3, SSD A1)

> …I think that everyone who will read the social workers report will be very, very, very moved but also very, very stressed and worried. (SSD Manager: Case 7, SSD A2)

> …I speak on my behalf but maybe on behalf of the rest of the professionals sitting here… (PCTCs Manager: Case 7, SSD B)

When a shared illusion of unanimity is established it is less likely that any counter-opinion will be openly expressed, rather it is more probable that any opposition will go self-censored in order to keep in line with the apparent consensus (Janis 1982). Figure 8 presents a verbatim transcription of one discussion that clearly demonstrates this point. In this case professional members, including the coordinator, found it difficult to resist the enforced consensus of the PCTC manager.

Figure 8: The Effect of Groupthink

This example comes from a discussion regarding the removal of three siblings (aged 14, 11 and 8) from home; a solution asked for by the mother. In this PIEC the regular acting coordinator was replaced by a colleague and so the dominance of the PCTC manager was even more profound. Here is how it was carried out at two points in time during 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
>
> Coordinator: Yes.
>
> PCTC Manager: That it is indeed right for the children to be in placement.
>
> Team leader: I am not sure (laughing). I am not sure, OK? I am not.
>
> PCTC Manager: Just a second, if it is not, so we need to discuss this.
>
> Team leader: I don't, I don't know if the three of them. (Case 4, SSD B)

This discussion then moved on to consider intervention options for each child individually and converged again on the alternative of removing all three children to the same placement. The team leader agreed to this opinion, as long as it was recommended as a temporary solution. Next, another issue that involved disagreement was whether the current placement was indeed suitable for the middle boy who had just recently run away from there. While the manager thought it was so the coordinator was not convinced and suggested an arrangement with a more therapeutic approach and the involvement of juvenile court. The social worker zigzagged between the different opinions. It was later observed that the manager dictated the decision to the coordinator, and the latter wrote them down in the tool. The intervention plan read aloud by the coordinator reported all children should be removed to the same placement that had previously proven unsuccessful for the middle boy. The participants started to sign on the decisions form, yet the coordinator was not at ease with the final decision and continued to converse about the issue. Realising she was not the only opposing member made her more confident.

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

Coordinator: No, say it! (laughing aloud) I don't agree either. It is the control 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.

Coordinator: (Laughing).

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

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

Coordinator: But it needs to be by court order, this is the authority now.

Social Worker: OK (sighs aloud).

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

Social Worker: I think therapeutic arrangement should be checked.

Coordinator: Look, (in a loud voice) placement should be checked, I, I am writing here (in the tool) anyway. (Case 4, SSD B)

Armed with the explicit support of other members the coordinator finally makes a swift change in the decisions and includes her recommendation to a therapeutic programme and court involvement. Called to attention is the fact that this change was made after the original decisions were already signed off by all participants including the mother.

Observations also provide rich data as to the factors or considerations taken into account in the decision making process. In line with the ministry's Towards the Community policy the general norm was to favour the provision of community-based services, while the option of removal from home was regarded as a last resort after the exploitation of services in the community failed to achieve any meaningful improvement in the child's safety and well-being. This approach was clearly voiced by various coordinators. Here is an example of a coordinator's account in a case involving the removal of three brothers from home; she expresses in great despair the idea that help in the community has reached a dead-end:

…because I think, let's say, what else can we do in the framework of the community? So, this is a family that already got considerable help in the community, therapeutic of course, (help) of any type and from any direction possible. I don't know… (Coordinator (1): Case 3, SSD A1)

This finding is highly important in light of local evidence described in Chapter 3 regarding the considerable weight professionals' attitudes carry in making child protection decisions. The decision of removal from home was not a prevalent solution. It was found in a third of the PIECs observed (7/21 cases; 12/44 children), in cases of severe neglect and acute parental dysfunction and/or when the child's functioning was seriously impaired. In terms of out-of-home services, out-of-home placement was the only option considered when living at home became too harmful. Use of foster care services was not considered as a possible solution in any of the cases, although it is the ministry's policy (i.e. stable home, hierarchy of care) to encourage these services when suitable. In two cases children's homecoming from placement was approved, yet their overall stay in placement extended the four year limit set by the Towards the Community policy. In addition, a positive change in line with the ministry's policy was to formulate an intervention plan that responds to both children's and parent's needs (IMSSSA 2004a). In only two PIECs the interventions discussed and decided on were solely directed at young people and excluded the parents. This is an important departure from the common norm found prior to the reform to provide services for parents when children are young and to shift the focus to the children as they grew up (Dolev et al. 2001).

A much less promising finding was that the number and variety of programmes in the community were not enough in order to meet with the reform's principle target to prescribe intervention plans according to individual family member's needs and preferences. The help required was thus still compromised by the help available. As stated by one of the coordinators the decision making task was as a matter of fact a task of "translating the needs to available services". Overall, there was a limited selection of services in the community to choose from. An examination of the intervention decisions shows that pretty much the sole intervention offered to parents was parent training (in three cases it was decided that another service which was already provided would continue and in one case a different service was decided). This finding is sufficient to indicate that the help was not tailored to the specific case. What was of the most acute distress in regard to the majority of the parents in the sample was financial hardship. For the children, the two

primary types of interventions offered were therapy programmes and after-school care programmes for school-age children. Some young people were referred to youth social workers, another frequent service was a tutor and one toddler was referred to a multi-functional day-care centre. In regard to children, the solutions offered did not encompass all their different needs; especially disregarded was the requirement for educational support. While the help decided on did not always correspond with family members' needs it fitted even less with their preferences. A body of evidence in support of this argument will be presented in Chapters 7 and 8. At this point it will be fortified by the finding that in nine PIECs family members were provided service that had been delivered in the past and failed. For example, in six PIECs parents were referred again to parent training (three to the exact same programme) although this intervention had not achieved meaningful results before, and in two PIECs young people were referred to a youth social worker although working relationships were not successful in the past.

Most of the programmes offered had great demand and hence long waits until they could be provided. For example, favourable but yet heavily burdened, were programmes that offered both parents' training and therapy for children; these were PCTCs in some localities (offered in 6/21 PIECs) and the community mental health service (suggested in 4/21 PIECs). The prospect given for the beginning of treatment in PCTC in one municipality was six months and in another three months at the least. Local mental health services were even busier, in one locality it was a matter of up to eight months wait. It was found that even when the urgency of intervention was realised or its preventative quality acknowledged families were still referred to overloaded services where the help would be very much delayed. An exceptional practice found in only two committees was to offer an alternative treatment for the wait period, yet in both cases the availability of the optional service was unknown. The expectation that PIECs will provide feedback to senior management about gaps in services was not met rather it seems that SSD professionals had adjusted to the limited availability of services in the community, and the long queues for treatment was an adverse reality they came to terms with. For example, a problem manifested in one municipality was the lack of after school programmes for older children (from year five and upwards). This situation was taken as the starting point of discussions into possible interventions, as expressed by one coordinator: "…year seven is one of the most problematic classes in this city, there are no programmes for children in year seven".

Explanations provided to the parents about the unavoidable wait for services also demonstrate adaptation to the situation as a norm; the best thing to do was to start the wait as soon as possible, as stated by one SSD manger: "I say if you don't start the wait you don't get to the queue". A recognised strategy (demonstrated in 10 PIECs) to deal with scarce services in the community was to depend on the resources of the educational systems e.g. therapeutic programmes for student and parents training. School teams were also relied on to support implementing the intervention plans e.g. helping parents to fill in forms, make queries about services or prepare children for removal from home.

By and large, the stage of discussing intervention alternatives was stopped by the coordinator cutting in on the deliberations and announcing aloud the concluding intervention plan. One coordinator also tended (in five of the seven committees she chaired) to read aloud a summary of the key issues raised through deliberations as required by regulations. With the discussion about intervention solutions consuming most of the time left after prolonged information sharing practice, the rest of the discussion was considerably rushed. At this point most coordinators were very eager to end the committee which was already running behind schedule. Therefore, all post-decision making procedures were either skipped or performed very quickly and feebly.

6.3.5   Post-Decision Making Procedures

It should be emphasised very clearly that in none of the PIECs observed was a written summary of the intervention plan provided during the discussion. The intervention plan was only verbally presented by the coordinators. In one SSD a protocol of the committee and the decisions was provided to participants after the PIEC ended. In fact, this is a serious loophole in the regulations. The explanation leaflet for parent included in the users' guide indicates that parents should be provided with written record that summarises the discussion and the intervention plan before signing the intervention. However, there is no further account on this issue in any of the reform's documents. It should be made clear that the decision form does not include the intervention plan; it is merely an empty table in which participants should fill in their: name; role and organisational affiliation or relation to the family; and signature. The fact that participants are required to sign and approve an intervention plan that was only orally presented to them is problematic in its own right and

even more serious given the research findings as to how it was presented. In two PIECs the final intervention plan was not presented to the forum. As mentioned, there was no evidence of coordinators using the elaborate table within the tool and hence the intervention plans read aloud were very laconic and sketchy, mainly including a list of services. The most straightforward practicalities of the intervention plan, such as the schedule of when the intervention will commence and end, were left unspecified in the majority of PIECs. In two committees the intervention plans did not summarise all the services agreed on. In one of these cases the intervention plan only prescribed the visiting arrangements a divorced couple had agreed on through the discussion; this kind of decision is not within the authority or the purpose of the PIECs. Few intervention plans included additional recommendations to parents or professionals as to what needs to be changed, e.g. father should return home from work early at least twice a week to spend more time with his children or professionals need to work closely together.

A common deficit of the intervention plans was that they left loose ends. Meaning that although a need for help was recognised there was no final decision on an intervention or service to respond to it. For instance, in eight PIECs service provision depended on the child's future progress/ lack of progress or on family members' wishes and cooperation. As mentioned, there were also eight cases where more information about the service had to be collected. This tendency further delayed the provision of help. Keeping in mind that the referral to the PIECs was usually made when problems were already serious and pressing, the time spent waiting for the PIECs, and the high probability that considerable time would pass until the service would be delivered, this practice is highly irresponsible and dangerous. Here, an example of an intervention plan announced in the case of an eleven year old boy, demonstrates how decisions were left open:

> Parents training for the mother. The first priority is at the school. If it doesn't work out SWYL and social worker will check with the local mental health service and if that doesn't work out too, then to refer to PCTC. A tutor or nurturer (another tutorial programme) for the child whatever will come up. Individual and group therapy at school and contact between mother, father and school's therapist. (Coordinator: Case 3, SSD B)

Although regulations dictate a separate stage for setting an orderly and systematic follow up scheme, in practice this stage was skipped. Nine coordinators included as part of the overall intervention plan a decision about a review committee in several months' time

without a specific date and in two cases it was merely mentioned that the social worker would follow-up the decisions' implementation. There were 11 cases that met the requirements of review committee, but no such decision was made. Coordinators also skipped their responsibility to ensure the intervention plan was understood by all participants. Findings showed that most coordinators took it for granted that the intervention plan was clear to all members and did not act to verify their assumption. In five committees after the intervention was announced parents raised questions to professionals which revealed they did not fully understand some of the decisions (in one case it was after most of the participants already left the room). In only four discussions the coordinators made a very hurried attempt to check whether the intervention was indeed clear (e.g. "is everything clear?") to the participants, and to parents in particular. When specifically asked it became apparent that parents either did not understand or misunderstood the final decisions made. Here is an example where just before the forum had left the room the coordinator had a justified sense that the mother was not clear about the plan. Misunderstanding on behalf of the mother resulted in disappointment and resentfulness:

> Coordinator: Just a second, before we spread I have a feeling that within the great excitement that evoked here the plan had dissolved. (Name of mother) is the plan clear to you?
>
> Mother: What?
>
> Coordinator: Is the plan we decided on clear to you?
>
> Mother: I didn't understand any plan.
>
> Coordinator: No. This is what I felt.
>
> Mother: No. As I knew (before) I had just wasted (my time). I don't see any help and nothing. For now, I don't agree on this thing. (PIEC: Case 4, SSD A1)

Later interviews with parents confirmed there were nine parents who did not fully understand the intervention plan decided upon.

After the intervention plan was presented coordinators' strived to secure it and end the PIEC rather than encourage the forum to challenge it. There were no meaningful endeavours to invite a critical point of view on the plan. Instead, coordinators tended to raise a casual broad question that was thrown into the air or directed at the parents, such as:

"OK?", "anything else?", "agreed?", or "anyone wants to say something?"; many times, right after the conversation moved on. In some cases parents were briefly asked whether they would cooperate. One exceptional coordinator invited the parents to describe their feelings before leaving the discussion in the following way: "I want to hear the parents, you came in worried, afraid and stressed. How do you leave now?" (Coordinator: Case 1, SSD F)

There were only a couple of cases were parents expressed reservations or explicit opposition to the decided plan at this stage, yet it had no impact over the decisions and in effect resulted in a negative reaction e.g. it lead to stern criticism towards the mother, or the participants ignored the mother and started to leave the room. In a few additional cases professionals did make some comments at this stage, which mainly had to do with practical issues relating to the implementation. It is therefore argued that practice resulted in further pressures imposed on participants to comply with decisions rather than allowed a free sharing of opinions.

A final note will be made about the procedure of signing off the intervention plan. Evidence showed that the decision form was misused in practice. It is argued that how and when the form was used distorted its target and mainly achieved enforced cooperation. The tool was used in practice as a means to record participants' attendance at the committee. Its full implications as a marker of commitment and accountability to the intervention plan was something not explained to the forum in any PIEC. The habitual almost automatic procedure carried out in over half of the committees (12/20 PIECs) was that the decision form was signed by the coordinator and then sent out to the forum, each member (although it is not required) singed and moved it to the person next to him/her without any verbal account. In five committees this procedure was commented on by the coordinator. It was explained that the form is used to record which participants attended the discussion. The Decision Form was even referred to as "participation form" or "attendance sheet". In only three committees was there any further attempt to clarify what the form stood for, yet it was still lacking in terms of the shared accountability of all stakeholders. In terms of the timing of this procedure, in eight committees participants, including the parents, singed the decision form although at that point they were not knowledgeable about the complete intervention plan decided on. For example, in three discussions the procedure of signing the form started even before the complete plan was

read out. In two discussions professionals who had an early departure signed the form even though not all the intervention decisions were made at that stage. In another discussion the mother while being occupied with completing the form admitted in response to the coordinator's question that she did not understand the plan. All the same, most participants signed the decision form (except a few professionals and a mother who had an early departure).

6.4   Conclusions

The committees' new working procedures can surly be appreciated for is novelty and high aspiration. Policymakers very well identified the fundamental weaknesses of the conventional practice and provided valid potent responses to tackle them. The new regulations bear obvious potential for improving the decision making process so that children and their families will be provided with the right help. However, all in all there was very limited implementation of the reform in the field. It is argued that some of the obstructions to the reform's realisation were known in advance, but ignored. These include the lack of legal status of the PIECs; impracticable multitasking demands imposed on the coordinators; and the lack of practice methods as to involvement of family members in the PIECs. Findings also suggest that coordinators require more training in order to effectively manage the discussions. Nevertheless, the most profound hindrance to the reform's overall target was unsatisfactory availability of help options in the community. It is therefore suspected that even if the PIECs were operating in perfect correspondence with guidelines, decisions would not have improved the help solutions provided. The combination of findings from social workers' interviews can serve to advocate this prediction. On the one hand, the majority of social workers believed (18/20) that the PIEC had achieved its goals and that the final decisions were converging from their point of view (15/18). On the other hand, they were very sceptical in regard to the impact decisions would have on the children's condition. Out of 20 social workers, just a quarter expected a positive change in the child's condition in six months' time; 7 merely hoped for the best; and the rest predicted either a change for the worse, no change, or could have not made any prediction. More generally, the research findings raise questions as to the advantage prescribed to the group decision making model. The PIECs discussions clearly showed the

dominance of coordinators and SSD senior members over decision making, and powerful dynamics of groupthink which directed the discussions toward consensus and avoidance of alternative points of view. The next chapter investigates the decision making process from a new perspective, that of the parents.

7.   Chapter 7

The Parents

This chapter investigates practice through the eyes of parent service users. The analysis presented is mainly based on conversations with 24 parents about their experience, feelings and thoughts about being at the receiving end of practice. The chapter starts with a description of some key characteristics of the families participating in the study and a discussion of the impact from the parents' perspective. The rest of the chapter revolves around one of the core principles the reform was designed to establish, i.e. partnership with parents and parents' participation. The new regulations targeted to promote parents' partnership and participation in the decision making process are introduced and their implementation in practice is examined. The analysis in this section starts with the invitation of parents to attend the committee and the preparations carried out prior to participation, moves to parents' involvement during the discussions and finishes with some findings as to the happenings two weeks after the committees had taken place. In regard to several practice tendencies, data from interviews with social workers or observations are incorporated in order to strengthen the analysis and consequent arguments.

7.1   Parents and Family Characteristics

Overall, 29 parents: 21 mothers and 8 fathers participated in the PIECs. Among them 24 parents: 18 mothers and 6 fathers were interviewed by phone two weeks after participation. 5 parents who had initially agreed to be interviewed were not: the psychiatric condition of 1 mother had seriously worsened and she was hospitalised at that time, 1 mother had changed her mind and did not wish to converse and 3 parents consistently did not answer their phone at the time the interviews had been scheduled and when later attempts to contact them were made. The majority of families (19/21) had up to 3 children (Mode=3

children) which represents the general population in Israel[82] (The Central Bureau of Statistics 2013). The study's sample had a high proportion of single mother families. Only 2 families in the study were of married parents. In 1 case where a divorced father had custody over the children the couple were living together, and in another case of a divorced couple the older daughter was living with the father separately. 4 mothers (including 2 mothers who eventually were not interviewed) were diagnosed with mental illness and 1 mother also had substance dependency problems and was undergoing rehabilitation treatment. Over half the parent interviewees were immigrants, yet not new comers: 10 were born in the former Soviet Union countries, and 3 others in Romania, France and Ethiopia. The majority arrived in Israel during the 1990s waves of mass immigration; 1 in 2000; and 2 parents during the 1970s. Overall parents were fairly educated, most had secondary level education (between 9 to 12 years of education), 6 had additional occupational qualifications and 3 had higher education. Parents were primarily employed; in only 6 families was the head of the household unemployed. As mentioned in Chapter 3 the current state of affairs in Israel today is that employment doesn't secure freedom from poverty. Parents' accounts in interviews and committees revealed that financial hardship was a shared problem for all families; while in 9 families economic deprivation was particularly acute and resulted in poor housing conditions. For example, 2 mothers voiced their fear of being put on the street since they could not pay their rent; cases of children not having enough food, clothes or a bed of their own were also reported. The fact that, as mentioned in Chapter 5, there was a clear failing of social workers to fully investigate and provide evidence of families' financial situation, or even use terms such as 'poor' or 'poverty', although this was obviously the reality of several families, is used more generally to support the argument regarding SSDs' failure to address this prevalent problem. What was shown through the PIECs is a systematic tendency to disregard difficulties which the social services have no solution to. Therefore, difficulties in parental care or children's condition were in effect sterilised from their context and causality and, it is argued, also from the appropriate solution.

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[82] Most families in Israel (82.7%) have up to three children (The Central Bureau of Statistics 2013).

Findings suggest this is also the case for single parenthood, which is a growing phenomenon in Israel in recent years, particularly characterising immigrant families[83] (INCC 2014). National data show a considerable representation of single parent families in the social services departments and in the poor population[84] (Chertoff and Tzakid 2009; Kopeper, Harmel and Gorbatov 2011; The Central Bureau of Statistics 2013). Besides poverty, single parenthood is associated with difficulties in parental care and child maltreatment[85] (Dolev et al. 2001; Kopeper et al. 2011); a correlation also recognised in the international literature (Dubowitz 2006; Sedlak et al. 2010). The research findings suggest that one possible mechanism of this correlation is the fact that mothers are insufficiently supported to combine child-care and indispensable paid work[86].

Fitting with the general referral pattern described in Chapter 3, based on professionals' reports, the most frequent maltreatment problem in the sample was neglect. Problems in every-day care were reported in regard to 11 families and lack of proper parental supervision also in regard to 11 families. Physical abuse by parents was reported in 6 families, however in all cases but one it was discussed in relation to past events (in another case an event where the mother tossed a computer screen at the father that nearly hit her toddler was reported). 6 children had been suspected to have experienced sexual abuse or assault, yet information about the occurrence was missing and it was only known that in 4 cases the alleged suspect was not a family member. Domestic violence was reported in the background of 11 families, in almost all cases at the time of the committee parents were divorced and lived separately. In regard to the findings above it should be

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[83] The number of children living in single-parent families is in constant rise. In 2013 8.5% of all children were living in single parent families (228,807 children) in comparison to 6.8% (132,000 children) in 1995. Amongst the immigrant population over a quarter of families (25.8 %) are single parent, in comparison to 10% of Israeli born families (INCC 2014). In the majority of single parent families (92%) women are head of the household (The Central Bureau of Statistics 2013).

[84] In 2008 42,512 single parents families were registered in the SSDs, which made up 21% of all registered families and almost double the rate of single parent families in the general population (Kopeper, Harmel and Gorbatov 2011). In 2008 the poverty rate among single parent families was 28.8% in comparison to 19.9% in the general population (Chertoff and Tzakid 2009). In 2011 44% of the single parent households with dependent children were at risk of poverty and 90% of them were headed by women (The Central Bureau of Statistics 2013).

[85] Difficulty in parental care is the main reason (secondary to economic hardship) for single parent families' referral to the social services (Kopeper et al. 2011). Also, the national study found that 38% of children discussed in Decision Committees were living in a single parent family (Dolev et al. 2001).

[86] The Single Parent Families Law 1992, that grants particular entitlements to women caregivers (and a minority of men) disregards the issue of child-care support to allow mothers to have a full time job in relation to children over the age of five years (Helman 2011).

kept in mind that due to the limitations in family assessment described in Chapter 5 maltreatment may have been more prevalent than was known.

Over half the neglect cases were single mothers who were working long hours outside the house, being the family's sole breadwinner. With school hours for children being relatively short (usually 8am- 1pm) and after school frameworks not subsidised or not available, single mothers were faced with a serious problem when compelled to take on a job. Here is how this impossible reality was described by a single mother of five children:

> …the judge asked me what I wanted – money, but they don't give it. What help do I want… I studied (for professional qualification) until 14:00 and the children were (at day care programmes) until 12:45. I said I can't leave my studies run and pick up this one, leave work and run and pick up the other, they will not want me in any job… This is why I cleaned schools during the nights'. That was hard. I worked in the mornings and afternoons in cleaning houses and at night I went to clean schools.

She later explained the current PIEC was for her a means to get her children into afterschool programmes which were beyond her reach:

> The discussion is because the children need to be in programme and after-school programmes are very expensive, you understand? And if I am doing (this throught the) discussion less money … (Mother: Case 9, SSD A2)

Several other mothers also explained becoming dependent on social services and the PIEC in particular, because they could not afford help in supporting their children.

It is further suggested that since the ministry had no formal policy or designated recourses (workforce or budget) to support single mothers who need to face rearing and providing for their children alone (Kopeper et al. 2011; SIC 2013), the solution of out-of-home placement is used. Prior research taken from professionals' perspectives pointed out that single motherhood was a factor in social workers' decisions on removal from home (Davidson-Arad 2001a; Surkis 2006). The current research taken from the parents' perspective shows that, given mothers had not received the support they need in the community, half the single mothers in the study had suggested themselves, or agreed to the solution of, taking their children into care. Through interviews these mothers painfully described how they were drawn into a situation in which they had no other choice. Here

are two examples; first is a mother who had agreed to her two sons staying in placement for another year:

> …what can you do? The state prefers to pay 1500 Shekels to a residential placement rather than to give it to single-mothers, a small support so we can be closer to them and better help ourselves. No! They will give it to certain placements but not to the mothers, you understand *?*… What can I say; I can start to carry out of anger... overall there is no place like home, like a mother, like a mothers' love, a mother's cuddle, a mother's "good night". This is a lot, this is what shapes the child not the money they throw over there… (Mother: Case 10, SSD A1)

Criticism over the unreasonable approach of investing in highly expensive out-of-home services instead of supporting single mothers was voiced by other mothers as well. The next quote is from a mother to seven children who asked that her three older sons be removed from home (an older daughter was already living in out-of-home placement). The family was living in extreme poverty and the children (aged: 12, 11, 10, 8, 5 and 4) were left alone most of the afternoons and evenings while the mother was working in two jobs:

> …It is a very hard thing. You are talking about children that you carried for nine months each one in your tummy; you gave birth to them and raised them till today. And you want to raise them and all of a sudden you consider that somebody else will raise them because you cannot provide them on daily basis, why? (Mother: Case 3, SSD A1)

It is argued that without a strong welfare policy that sufficiently acknowledges and responds to single motherhood as a social problem, individual mothers were perceived as responsible for their family situation and blamed for not meeting their motherhood and caregiving expectations. Here is a quote from a SSD manager during the discussion about the case presented in the example above:

> I think not every mother comes here and put the things so clearly on the table and describes the reality as it is, and come from a place of wanting what is best for the children. Now if you could manage things a bit differently and try to work in the mornings, I don't know. I don't want to get into that. (SSD Manager: Case 3, SSD A1)

This is how such a stance feels like from a mother's perspective:

> …there is no approach for mothers like it should be. Because a mother that doesn't succeed, it doesn't mean that she is not a good mother, that she is not capable. They need to help her from this position and not to fight her. (Mother: Case 6, SSD B)

Before turning to the findings regarding parents' participation, it is important to emphasise a shared characteristic of the parents' sample because of its impact on the findings. The majority of parents in the study had prolonged prior experience of the social services system and half also of participating in formal professional committees. For most (only three families were new referrals), social services involvement with the family had been going on for years (between 2 and 20 years). It was found that parents were habituated to the system's bureaucratic culture and highly aware of its problems. The most common view reported was of stressed and over-occupied social workers, some were described as hard to reach, gate keeping the agency's scarce resources. It appeared that experienced parents had come to terms with the level of service provided to them and were satisfied with whatever help they could get for their family. Some also expressed sympathy towards their busy social workers having to work under difficult conditions. 20 parents reflected on their relationships with their present social workers with satisfaction; they felt listened to and understood, being respected and usually updated about any action taken in their case. 1 mother described a highly conflictual and negative relationship with her worker and 3 fathers were not involved enough to have a stance. Overall, social workers were portrayed as nice and friendly people that were keen to help and that parents could trust, consult with and rely on. Some parents were yet sceptical as to workers' ability to help change their present situation.

Half of the parents interviewed in the study had previous experience in formal discussions regarding their children; 9 had participated before in Decision Committees or PIECs and 3 in educational committees. 6 parents had also participated in juvenile court hearings. It appears that past experience contributed to parents' current experience in the PIECs. While first time participation in a formal professional committee was recalled as a traumatic, fearful and emotive event, parents described approaching the observed PIEC feeling more "matured", "immune" or "relaxed" since they knew what to expect. This helped them according to their accounts to perform better during the discussion; they were less driven by emotions and better able to express themselves. For instance, while it was expected that the size of the forum and presence of unfamiliar professionals would have and inhibiting or even intimidating effect on parents (as was reported in regard to case conferences in the UK [Corby et al. 1996; Bell 1999b; Dale 2004]) such experience was only reported by a few parents. It seems that some parents were already acclimatised to

the formality and public nature of the setting. Furthermore, it is argued the parents were also adapted to another typical characteristic of the discourse in the discussions, that it was focused on the problematics while neglecting the existing strengths. Here is an account of a single mother describing how being bombarded with professionals' assessments of her son's problems she (and of course the rest of the forum) came to forget about his extraordinary talents:

> They didn't say that he knows how to play digital organ and he is also composing music… they knew it. He plays at school and they wanted him to perform but they didn't say that. I also didn't say that, you know I tried to concentrate on what they were saying so I forgot about the good sides of my son. Yes, what can I do it is because of all the problems… (Mother: Case 3, SSD B)

7.2   Partnership with Parents According to the Reform

One of the main aspirations of the reforms is to establish a decision making process based on sincere and full partnership between professionals and family. In fact the reform wishes to establish a new way of working with families or a new language of practice, as demonstrated by the following quotation from one of ministry's key policymakers, Ms. Vered Rotfogel National Service for Children and Youth Supervisor: "We speak to the family in language that expresses concern rather than blame: 'what bothers you', 'what help would you like' (Oster- Kanev and Kai- Zadok 2011 p. 10).

The reform's recipe for achieving partnership with parents includes the key ingredients identified in the literature (as mentioned in Chapter 2) and recommended by the Gilat Commission (IMLW 2002). Partnership includes transparency of procedures, information and documentation; effective participation in family assessment; thorough preparation prior to attendance in the PIEC; mandatory participation in the PIEC which can be supported by a personal advocate, and gives opportunities to express their point of view on the family situation, desired intervention solutions and raise reservation about the final decisions; and entitlement to reject the PIEC's decisions and appeal against them (IMSSSA 2004a, 2004b, 2008a, 2009). In the rest of the chapter the reform's guidelines in regard to parents' participation will be described and their implementation in practice discussed.

7.2.1   Being Invited to Participate

Regulations about inviting parents to the PIECs are described in Article 7 of the Implementation Team's Decisions Paper (IMSSSA 2004b). Accordingly, both parents should be routinely invited to participate in the PIEC. The novelty of the change proposed is emphasised in light of the voluntary tone Ordinance 8.9 (IMLW1995) employs regarding family members' participation in the committees. According to Section 5d:

> It is recommended to invite the child's parents or the child himself to the entire or part of the discussion when it is found to be necessary by the committee's coordinator or members. (p. 4)

To tackle a common practice found in Decision Committees (and in case conferences in the UK[87]) of parents participating up until the decision making stage, then leaving and only returning to be told the final decisions by the coordinator (Dolev et al. 2001), it is clearly stated in the new guidelines that parents should participate though the whole discussion. Nevertheless, regulations create a loophole which can be used to circumvent the obligatory requirements (this is also the case in regard to children's participation). Under circumstances which are loosely defined as "interfering with the child's best interest" (Article 7d p. 5) coordinators can decide to fully or partially exclude parents from the PIECs. Regulations do require that in this situation parents will be informed by the coordinator about the PIEC or why they are not invited, be allowed to express their point of view or be updated about the final decisions.

Earlier data available on the reform's implementation reported a meaningful positive change in the field in regard to parents' attendance of the PIECs which was concluded to be the norm (Ben-Rabi and Amiel 2013; SIC 2013). The current study reinforces these findings, yet only in regard to mothers who were indeed invited to all PIECs. In five cases fathers were not invited to participate without any formal reason being provided, their views were not represented in the discussions and it is questionable whether they even knew it was taking place. The unwarranted absence of these fathers is argued to be further evidence of the general marginal role fathers are prescribed in child protection practice. Additional support for this comes from findings in two cases where great efforts had been invested to ensure the mother's attendance, including bringing one

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[87] For example, Bell's (2002) study of case conferences in the UK.

mother who was hospitalised in a psychiatric hospital to participate and rescheduling an additional discussion when the mother did not arrive.

While regulations oblige the participation of both parents, they completely ignore problems that can arise when there are serious disputes, conflicts or even aggressive and violent relationships between parents or carers. There is evidence from parents' accounts of the presence of the other parent preventing their free communication during the discussion. In all cases of divorced couples there were indications of information being held back and so the full picture of the family situation was not revealed. In one extreme case the mother rushed out of the room during the discussion. In the interview she explained her action was because she could no longer stand her ex-husband's lies and accusations and admitted: "there were things that I kept quiet about… things that I didn't want to speak about next to him." Based on her difficult experience she recommended that in similar cases parents should be heard separately. Her ex-husband admitted in the interview not coming forward about the poor standard of parental care and lack of sufficient supervision by his divorcee since he wanted this information to serve his claim for full custody when approaching the court. In another example of a couple with serious marital conflicts, the mother waited until the discussion was over and her husband had left the room, then she entered again, sat back in her chair and asked the remaining forum to recommend couples therapy as part of the intervention plan. She later explained: "I was very much... I favour we will get couples therapy but I don't want to say in front of my husband."

Guidelines require that parents be invited to participate by formal written invitation 14 days before the discussion, which is the coordinator's responsibility. In practice, coordinators were not involved in inviting parents to participate, instead this task was carried out by the social workers. The common practice was to inform parents via phone or face-to-face meeting about the PIECs date, time and location; this was done one month to a day prior the discussion. Findings suggest that a written document is essential, since verbal communication contributed to great confusion. During initial conversations with parents to introduce the study it became clear that some parents didn't know the date and time of the PIEC. One mother only knew about the discussion from the researcher and two mothers were informed about the schedule by school teams. In another case the mother arrived at the wrong SSD.

It should be mentioned that parents' accounts confirmed practice patterns reported in Chapter 5 in regard to the referral to the PIECs which further support the argument in regard to social workers' reactive position and delayed intervention. Half of the parents described a scenario in which their request for a specific service e.g., after-school or therapeutic programme; out-of-home placement or alternatively returning the child home from placement, initiated the referral to the PIEC. Thus, for some parents, the discussion was viewed as merely a formal procedure they needed to go through in order for their request to be approved. Some parents reported feeling the seriousness and earnestness of their child's condition was not fully acknowledged by professionals. These parents also described in intense frustration about how they had cried for help months prior to the PIEC. Here is an example of a father fearing his teenager son's aggressive behaviour is getting out of control:

> …Not because I am a big pessimist, it is because this is as far as I know the system here in the country, here they can wait until accidents in the family, until the moment there will be murder and then they will say: "nothing could have been done, we are sorry". (Father: Case 5, SSD A3)

One mother who described with great concern her daughter's emotional difficulties and shutting off behaviour was puzzled as to the timing of the discussion after three years of struggling with her daughter's condition. For her the discussion was about to open wounds that were already starting to heal.

7.2.2   *Being Prepared to Participate*

The tools package users' guide sets out the procedures social workers should carry out with parents prior to their participation in the PIECs. Accordingly, the preparation process should involve an open dialogue between workers and parents through which information is shared and parents are encouraged to thoroughly think about their situation and how they can be helped. Guidelines require that parents will not merely by the objects of reports but rather be collaboratively involved in the process of family assessment. All information collected and the draft PSR should be disclosed and discussed with parents and their comments should be recorded and incorporated in the final version of the PSR presented before the forum. Parents should be informed about professionals' concerns leading to the committee, the discussion procedure and the local services available, and then jointly

examine with their workers possible intervention and support options. Parents and workers should also discuss what members of the changeable forum should be invited.

Turning to the practice, evidence reveals great limitations in the preparation process which hindered parents' ability to effectively and influentially participate in the discussions. The combination of data from both social workers' and parents' perspectives showed that shortcomings were a matter of information not being provided or not being understood. Most parents had a single face-to-face meeting with their workers prior the committee, either at the SSD or at their home. Yet, two parents had no preparation at all; four parents only engaged with their workers in a phone conversation; and in two cases the meeting was carried out just before the beginning of the discussion. In 12 cases the requirement to share with the parents the PSR and allow them to comment on it was completely skipped and so parents were not familiar with the PSR prior the PIEC. In three cases parents first read the PSR close to the time the committee was about to begin and in one case the report was read to a parent over the phone. Some workers explained their practice to be due to workloads or that it was unnecessary hassle to invite parents to read the report since anyway it was mainly based on information they provided. Yet this is a very unsatisfactory explanation since parents may not have been familiar with information collected from other sources. As mentioned in Chapter 6, other professionals' reports were not always transparent to the forum, including to parents. There were also discussions in which reports were presented and revealed to the parents for the first time. For example, three parents heard about serious allegations including parental neglect, domestic violence or child sexual abuse by peers for the first time during the discussions. It is almost needless to mention that such events left parents feeling shocked and angry. Here is a mother's account of being confronted with allegations of neglect and domestic violence reported in records from a former SSD. She was reported as being absent during her son's hospitalisation following a car accident leaving him to the care of her aggressive boyfriend:

> … she wrote nonsenses there… about the hospital I was shocked, that I wasn't at the hospital and my son got there by himself, they are crazy. I was shocked; I fell to the floor… from that moment I opened my mouth, I started

to get angry and say what is on my mind. Before that I was quiet but that made my really angry. (Mother: Case 4, SSD A1)

Adding to previous findings from social workers' interviews presented in Chapter 5, it is suggested that the lack of transparency in regard to the PSR and other case records may have been motivated by workers' wish to avoid direct confrontation with parents. At the discussion, being among a forum of professionals, they may have felt more comfortable to raise conflictual and sensitive issues. From the parents' perspective what they wanted was honesty. The wanted to know what professionals think is wrong so they can respond to it. Here are two examples from interviews. The first is a father calling professionals to demonstrate courage and say without fear what is done wrongly:

> I think more courage is needed and they (professionals) need to speak, to see who is really in the wrong with all that is happening. Not about me, I speak in general about everybody this thing is done to. And to say to the person that he is wrong, and to say it to his face without fear, where are his mistakes as a parent… (Father: Case 1, SSD E)

The following is a mother describing feeling blamed for something without being given an opportunity to defend herself:

> What made me feel uncomfortable for instance… her (the coordinator's) questions were too much, how should I say? I don't know, with an intension maybe some kind of suspicion: "maybe you are not good enough, maybe you are not capable enough", this kind of indications… (Mother: Case 8, SSD B)

The question to be asked in this respect is how can parents know what is it that they need to change if they are not being clear about what is it that they are doing wrong? And indeed when asked directly through interviews many parents could not answer what they were expected to do differently.

In regard to the information that was provided, workers did not use the formal explanation form included in the users' guide but rather provided verbal explanations according to their own personal style. Recalling the preparation conversation most workers (15 workers) mentioned stating the purpose of the discussion, explanations were usually very elusive and obscure, e.g. "to think together"; "to help"; "formulate an intervention plan", and describing the forum members. Some workers (7 workers) also articulated the worries and reasons that led to the committee; a few (5 workers) directly encouraged parents to express their stance through the discussion; and a few (4 workers)

described the discussions' procedure. Interviews with parents were highly insightful in checking how much of the information provided had been understood. Nine parents reported being well prepared for the PIEC. Findings reveal, however, that some fundamental issues were not adequately clear to all parents. Over a third of the parents misinterpreted the procedure of PIEC referring to it as a "conversation", "meeting" or "introduction meeting". One mother refused to call the procedure a "discussion" claiming discussion can only be held in court. This could imply that the purpose of the discussion was not clear to parents. And indeed this was an issue most parents were not confident about. Here are some examples of parents' misconceptions as to the PIECs' authority and legal grounds. A single mother of a seven year old boy was highly worried before and during the discussion that it would be decided to place him in a different school, an authority reserved only for educational committees. Another mother confused the enforcement of mandatory schooling with the PIEC's authority. The fear that their children would be taken to care by the social services, which was often voiced by parents, was so powerful that parents felt they could not be sure about social workers' explanations as to the target of the PIEC. A divorced father was suspicious about the apparent motive of the discussion; he interpreted formal family assessment proceedings of data collection from his sons' day-care as proof of the intention to remove his children from home. A mother of three young children arrived at the committee accompanied with two solicitors believing she needed advocacy against the intention to remove her children from home, although previously assured by her worker this option would not be discussed.

Another common misconception demonstrated by a majority of parents was in regard to the professionals that participated in the discussion and their roles. Parents referred to the forum as "important people", "administrator", "all kind of social workers", "someone from the local municipality", representatives of "children's rights", and even just "old lady". Reflecting on the process, parents could not understand why certain professionals were there, particularly members of the permanent forum. More importantly, none of the parents were informed about their right for personal advocacy. In the only two cases where parents had been accompanied by their representatives (two solicitors and a charity manager) it was done on their own initiative. Moreover, a mother who requested that her adult daughter be invited was refused by her social worker due to "therapeutic consideration". With hindsight, four parents mentioned they would have benefited from

being supported in the discussion by a family member, solicitor, translator or an objective person with genuine intentions to help.

The preparation process was also very lacking in terms of informing parents about the possible solutions available to them. It is difficult to dispute the claim that parents cannot effectively participate in decision making if they do not know what options are available to them and what their implications are. It became evident from conversations with parents and observational data that insufficient information about help solutions restricted their participatory involvement in the discussions. Overall, observational data showed that parents were given the opportunity to provide their point of view as to the help they wished for themselves and their children. They were invited to play an active role in the discussion of interventions, rather than being in a reactive position where they only respond to professionals' suggestions. However, for their contribution to be meaningful and effective they must have been knowledgeable about their options. A remarkable example was one coordinator who persistently pleaded for the parents to openly share their thought about what help they want. The coordinator repeatedly asked the mother to feel comfortable and relaxed, mentioned again and again "we want to help", addressed the father several times and even suggested the mother come and sit next to her; yet, parents still could not articulate what help was required. This reaction was not exceptional, other parents too had difficulties in articulating what they thought the solution to the family situation was. Some parents indefinably asked for: "some kind of workshop"; "talks or something like that"; training or "anything that can bring improvement"; or as one mother declared "…I want to treat him (her son). It doesn't matter emotionally, psychologically, mentally, everything, everything, everything." There were also examples of parents who asked for specific services. Most of them had past experience with social services programmes, others had heard about certain services from friends, relatives, their GP or in one case read about it in the newspaper. These bits of information were usually very partial in terms of the services criteria, framework and availability, and in some cases led to misunderstanding and confusion. For example, a father who described how he was advised by a friend to appeal for custody over his children but had great misapprehensions as to the responsibilities of the courts and the social services.

7.2.3 Being Able to Have an Influence

Next, is the issue of parents' power to exercise choice and influence the decisions regarding solutions to their family's condition. One way to weigh parents' influential power is to examine the correspondence between parents' wishes, as presented through interviews and in the discussion, and the final decisions that were made. According to such an analysis it could be argued that to some extent parents' wants were taken into account. However, their ability to have an impact over the intervention plan was still secondary to the professionals. Compared with 10 committees in which parents' requests for services or interventions were approved, there were examples in 17 committees of their wishes being rejected. Also, while in 7 committees parents' resistance to a certain service was taken into account in the decision making, in 11 committees they were disregarded and the decisions included those services. It is argued that in order to get a more complete and accurate picture in regard to parents' impact over the decisions such an analysis is insufficient and partial. What should be also taken into account is the way professionals negotiated agreements and resolved disagreements with the parents. Adding these elements to the analysis reveals a picture of considerable pressure to comply with professionals' points of view. Before turning to describe the mechanisms used to promote conformity, it is important to bear in mind that, as described in Chapter 6, disagreements between professionals were usually not overtly expressed. In the context of an apparently unified professional front (whether authentic or not) it is more likely that parents' opposition was self-censored. In addition it became clear through interviews that some parents were aware of the advantage of appearing cooperative and hence they did not overtly challenge professionals during the discussion.

Looking at the endeavours to foster agreement, several strategies were found which varied in the level of cohesion they employed. For a start, when the solutions suggested by the parents matched the professionals' views, parents were positively reinforced. Professionals empathised with parents' difficulty in making hard decisions and expressed appreciation for recognising the problems and searching for help. This approach was patently noticeable when there were disagreements among family members (i.e. between parents or between parents and children) over the solution of out-of-home placement. In four discussions the side that favoured the removal, in accordance with professionals' opinion, was highly supported and encouraged. Another approach was to use marketing

strategies that are familiar from the business world, for example promotion. Interventions favoured by professionals were advertised by underlining their quality and in some cases also by downgrading a comparable alternative. Services were branded as unique, run by highly professional staff, guaranteeing positive improvement, and most importantly free of charge. In one extreme example, where professionals supported the solution of prolonging a thirteen year old's stay in the out-of-home arrangement the mothers' reports about the poor care delivered by the service (e.g. her son was violently attacked and consequently lost several teeth and his medical care when suffering from an acute skin condition was neglected) still didn't prevent professionals from promoting the service. Here is the SWYL response:

> I say, if you ask my opinion. I think that he gets everything in one place. He gets all-encompassing treatment: in a group and individual, emotional, in relation to dealing with social difficulties, psychiatric follow up, and educational support. (SWYL: Case 9, SSD A2)

A second marketing tactic was to create time pressure on making the decision. In some cases parents were stressed to make up their mind quickly due to the great competition over scarce resources. For example, in a discussion regarding the removal of a sixteen year old teenager from home it was emphasised that this is his final chance to receive help from the Children and Youth Service to which he is eligible until the age of 18 years and that the registration to out-of-home placement ends in a month's time. In another committee, also involving the removal from home, the manager of PCTC urged the father, who opposed this solution, to agree without any delay since the children may miss the good programmes. Another way to create urgency was to stress the requirement for immediate intervention in order to prevent a negative effect on the child's development. A third strategy to negotiate agreement found in seven committees can be identified as the 'give-and-take tactic', known from the practice of business transactions. Accordingly, parents would be provided with a service they desire if they agree to cooperate with another intervention or to act in order to create a certain change. Some examples were to condition the approval of tutors for two siblings with the mother's collaboration in family therapy or impose the sanction of losing the school team support if the child won't receive psychiatric drug treatment.

Next, are mechanisms characterised by increased levels of coercion and control. There were several means to exercise control; the most common was to use professionals' legal authority to address the court. In three committees SWYLs (who were the coordinators in two discussions) signalled their authority to address the juvenile court. In two cases where parents persistently opposed the option of removal from home they were repeatedly advised to cooperate or the final decision would be made by the court. In two cases of children who tended to miss school it was the truancy officers who signalled their legal authority to address the court in order to enforce student's attendance at school. Another means of control served the alternative of out-of-home placement. In five committees family members (in two cases the children) were confronted with the alternative of removal from home or delaying the homecoming from placement if they did not cooperate with the service offered to them. Here is an example how such control was used to enforce a mother to participate in individual therapy:

> Coordinator: …You have to understand that if you will not cooperate your children will remain in placement for life.
>
> Mother: I like this statement less.
>
> Coordinator: OK No, I will say it. I say it so you'll know what the alternative is. I truly don't say this to annoy you. I say this because this is the truth. (Case 10, SSD A1)

Another type of coercion found was to describe very frightening and alarming prospects for the children if parents will not act as suggested. It can be argued, that raising parents' awareness of the unwanted implications of the present situation over their children's well-being is a legitimate and effective measure to motivate change. However, in six committees this practice was adversely exploited to the point of deleterious intimidation. Here are some examples:

> Social Worker: Just a minute, I want to say that mental health (services) doesn't mean that the child is mentally ill or something like that.
>
> Father: Of course not.
>
> Social Worker: I mean don't be stigmatic. We refer to the mental health (services) but it doesn't mean that the child is mentally ill.
>
> Mother: God forbids!
>
> Social Worker: This is to prevent, god forbids.

Mother: It will simply totally crush me.

School representative: So cooperate!

Social Worker: So cooperate that he will not be under this definition. (Case 6, SSD A1)

SWYL: The friends he had chosen for himself are children that can drag him to places he is better not (be in). I just want to emphasise that under the law the age of 12 years is the age of criminal responsibility, and if, god forbid, he starts fighting on the street, it will get to the police.

Mother: Look, it can happen to every child.

SWYL: Just a second, if it gets to the police then it is a criminal record. (Case 8, SSD A1)

SSD Manager: I understand you. I want to be nasty. The alternative is that god forbids the child will end up in very bad places. If he will not get therapy and if his strong need for attention and contact in any cost will continue, we don't know who on the street will take extreme advantage of that… (Case 4, SSD A1)

Another measure found was the use of direct criticism towards the parents. In seven committees parents were criticised by professionals for being argumentative, not taking responsibility, being noncooperative or blamed for their deficient parental functioning. And finally, in five committees professionals had in fact put words in the parents' mouths. An extreme example was a coordinator who demanded that the parents repeat aloud after her that they are obligated to cooperate with the parents' training programme.

In 10 PIECs, parents' adherence to their point of view led to an overt conflict between them and the professional members. In these cases the mechanisms described above were utilised in a more rigorous and intensive manner. It was evident that more professionals participated in the persuasion process and more strategies were used. These efforts were usually efficient in leading parents to abandon most of their demands. Nevertheless, in eight committees some differences of opinion persisted when the parents firmly refused the provision of a specific service. In these situations a final decision as to

the issue in disagreement was usually delayed. For example, in three cases the intervention plan only prescribed the possible alternatives discussed and the most recommended service amongst them. In two cases it was noted that the service was recommended but its provision would depend on the parents' discretion. In one case the father was given some more time to "sleep on it" and a follow up discussion was scheduled in three months' time. Another way to deal with consistent disagreements was to delegate the decision making to the juvenile court. This approach was used in two cases where parents fiercely opposed the solution of removing their child/ren from home.

To sum up, partnership with parents in terms of allowing them the power to exercise choice and influence decisions was found to be very limited. As described above, professionals used potent mechanisms to maintain their dominance over the decision making process. This argument is further supported by evidence showing that in nine PIECs parents eventually agreed to a service they intensively criticised at the outset of the discussion. Examining the practice from the parents' perspective; reflecting on their experience, some stated unequivocally that their attendance had no influence over the decisions and some concluded decisions were already made prior the discussion. For these parents the committees were perceived as a procedure carried out "for the sake of protocol", "to tick a box" or even as a "performance", while their role in it was as spectators or objects of the process, rather than genuine participants. Here are examples of these views borne out in parents' accounts:

> …of course, I think they have decided everything in advance. Of course, everything goes before the discussion. They only do a celebration afterwards with all the diagnosis and the social workers… (Mother: Case 9, SSD A2)

The following is a father's response to the issue of pre-made decisions:

> …it was obvious, it was obvious. You didn't find it obvious? Was there any dialogue? It wasn't a dialogue. It was me against their point of view. (Father: Case 3, SSD A1)

> They allowed me to be involved but the decisions were theirs and not mine. (Mother: Case 3, SSD B)

Beside the fact that this is not the partnership experience the reform was hoping to achieve it is also suggested here, and will be further reinforced in Chapter 9, that the practice demonstrated in the PIECs, by which professionals define both the problems and

solutions for parents, is ineffective. Through the interview 11 parents, almost half of the sample, admitted they were not going to collaborate with all or some of the decisions made.

A final note as to the practice after the committees, regulations require that parents will be provided with documentation of the discussion and its final outcomes. Two weeks after the PIEC none of the parent received such records, and none except one mother were familiar with their right to ask for them. Most parents reported that two weeks had passed from the discussion and nothing had been done including any contact with their social workers. It appears this contributed to parents' feelings of frustration and deep disappointment with the process of PIEC in particular and the social services more generally. Only 5 parents (out of 15 who responded) expected a minor positive change in the family situation in six months' time, the rest believed things would stay the same or get worse.

7.3   Conclusions

Based on these research findings it is concluded that what the reform had managed to improve is parents' attendance at the PIECs, rather than their meaningful participation. Nevertheless, even in this regard it was found that practice was not equal for mothers and fathers. Parents were not sufficiently prepared in order to take an effective role in decision making. Professionals' concerns were not fully and explicitly shared with parents in advance (or during the discussions as a matter of fact) and they were not adequately informed about the possible solutions to their family's problems. They had to react and respond on the spot without being provided time to digest the information and think things through. The discussions were not carried out as an open dialogue of airing disagreements and conflicting views and working through together to a decision of what needs to be changed, rather they were directed to reaching consensus on the services professionals believed should be provided with minimal conflict or problems. Behind the 'agreed on' intervention plan were in effect considerable pressures put on parents to accept professionals' points of view. Evidence of mechanisms of control and cohesion used during the discussions makes a case that the reform has failed to establish the PIECs as a

therapeutic process. The next chapter is dedicated to the participation of the parents'
children in the decision making process.

8. Chapter 8

The Children

This chapter is dedicated to the children and young people at the focus of the PIECs' decision making. Following the accustomed format of this thesis, the chapter starts with an analysis of some key characteristics of the 45 children and young people included in the study. It then moves on to describe the reform's new guidelines regarding children's participation while arguing that they still don't demonstrate full commitment to children's rights to participation. In the rest of the chapter the way of working with children through the decision making process is presented based on interviews with parents and professionals and observational data, starting with the habitual everyday practice, then turning to the participatory work, including meetings with children before the committee and making decisions on inviting them to attend, and ending with discussion of the actual participation experience in the committees.

8.1 Children's and Young People's Characteristics

Data were collected on 45 children referred to PIECs, among them 30 were boys and 15 were girls. This reflects higher proportion of boys registered with the SSDs (Gorbatov and Ben-Simhon 2011). The children's age ranged from 1 year to 17.9 years, while the average age was just under 10 years (M=9.9; SD=3.9). Children aged from 6 to 12 years, had over-representation in the sample (22 children), with fewer young people aged between 12 and 18 (14 adolescents) and only 9 young children under 6 years old, which is the formal school age[88]. This complies with the general tendency reported both before and after the reform for very young children to be less likely to be referred to the committees

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[88] According to the Mandatory Education Law 1941, children and young people are obliged to have at least thirteen years formal education, including three years in nursery between the ages of three and five and ten years in the school system between the ages of six and fifteen.

(Dolev et al. 2001, 2007a). The majority of children were Israeli-born (2 siblings were born in America) and were living at home at the time of the discussion. 7 children were in out-of-home placement. 11 children were at the care of SWYL under juvenile court orders. Table 4 summarises the frequencies of children's problems. Most children had more than 1 problem, with an average of almost 3 problems per child (M=2.82 problems reported, SD=1.98). Since the PSRs were found very lacking the analysis here is also based on data collected through interviews and observations.

Table 4: Frequency of Children's Problems by Category

Problem type	Number of children and young people N=45
Academic failure	27
Behavioural problems	21
Emotional problems	20
School attendance problems	16
Social problems	16
Attention deficit hyperactivity disorder (ADHD)	14
Mental problems (including diagnosed conditions, psychiatric treatment and/or hospitalisation)	9
Health problems	6
Communication and speech problems	6

As shown, children's academic failure was the most common problem, and reported in regard to nearly two-thirds of the children (27/45). This may represent a high proportion of school aged children in the sample. It may also be a manifestation of the over-dominance of school system reports in family assessments. This may also be the case in regard to poor peer relations and irregular attendance at school, reported in regard to over a third of the children (16/45). Children's behaviour was also frequently (21/45) a matter of concern. Typically reported were violent outbursts and aggressive behaviours at home and school, mostly carried out by boys (and only 2 girls) and older children.

Children's emotional state (20/45) was another usually worrying problem; however this classification was very often used as an all-embracing term without further elaboration. Some detailed accounts involved fear and anxiety, anger, frustration, mood swings, crying and sadness and low self-esteem. Specific diagnosed mental conditions included: Tourette syndrome, Behaviour Disorder, Oppositional Defiant Disorder (ODD), Anxiety Disorder, and Childhood Schizophrenia.

As would be expected, due to the change in the PIECs target population the sample included children with a broad spectrum of problems at a variety of severity levels. Most of the children in the sample were presenting gradual deterioration (in some cases over years) in their condition and functioning that without appropriate intervention had harmful potential.

8.2   Participation According to the Reform

As a radical departure from prior Ordinance 8.9 (IMLW 1995) the reform makes it a mandatory duty to listen to the voice of the child and give it weight in considerations when making decisions through PIECs (IMSSSA 2004a). The guidelines set out a new working model with children in regard to the PIECs; described in Article 8 of the Implementation Team's Decisions paper (IMSSSA 2004b). Practice should follow different procedures according to the child's age. Children under twelve years of age are to meet with their social worker or the PIEC's coordinator in private, where they will be informed about the committee, their views will be elicited, documented and presented before the PIEC's forum in due time through the PSR. Following the Rotlevi Commission's (Israel Ministry of Justice 2003) recommendation, regulations recognise there may be an easier way for children to communicate and so the child can choose to write a letter that will be read to the forum. In exceptional cases, where workers and coordinators find it suitable to the child's ability, wants and best interest, children under twelve can be allowed to participate in the PIECs.

Young people, over twelve, should be routinely invited to directly participate in the committees. Deviation from this norm can be due to the young person's preference or when workers and coordinators concludes that it is in his/her best interest to be excluded

from all or part of the discussion. Factors that should be taken into account in making this decision include, forum size, child's physical and emotional state, risk imposed on the child by the forum members or being exposed to sensitive content. When not attending, the adolescent's voice should be mediated through professionals as in the case of younger children. Children should meet their social workers in advance in order to be knowledgably prepared to participate and be given full information about the committee's procedures, the participation activity, and decisions to be made (the users' guide does not include a formal explanation leaflet like the one designed for parents). In the wake of the Gilat Commission's (IMLW 2002) recommendations children are entitled to independent advocacy in the committee by representatives on their behalf to support participation. Regulations regarding the discussion's proceedings are designed to facilitate participation by placing on the coordinator the duty to ask and record the child's views in the meeting and give children precedence to speak before professionals. After the PIEC, all children should be engaged with in order to be briefed about the discussion's outcomes and implications. This should be carried out through a face-to-face meeting with social workers or coordinators.

The reform's ambition of improving children's participation in intervention decisions is welcomed progress in government policy towards recognising children as subjects of rights. However, it is argued that the right to participation is not realised to the full within the new regulations and in effect policymakers took a few steps back from recommendations made by the Rotlevi and Gilat Commissions. Regulations do not allow all children the rightful opportunity to participate in PIECs as recommended, but rather mainly older children and young people. There is also no explanation for using the age of 12 years as a chronological threshold. Direct participation opportunities are provided to younger children in other formal decision making contexts in Israel[89] (Schuz 2009; State of Israel 2010b). Regulations require that the child's best interest will be used as the paramount consideration when deciding on children's participation yet, this principle invites disparate interpretation and affords considerable latitude to social workers. According to guidelines hearing the child will be done in consultation with parents and after gaining their approval. This is a very problematic precondition as it allows parents to

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[89] For example, an experimental programme in several Family Courts which entered into force during 2007 regulates procedures for direct participation of children in court proceedings from the age of six years (Schuz 2009).

silence their children. In this regard, regulations also do not deal with circumstances where children may object to their views becoming public. The Rotlevi Commission (Israel Ministry of Justice 2003) suggests allowing coordinators to make judgments as to whether to disclose information provided by the child to other forum members. Determining how far the wishes, feelings and views of children should be given prominence in the decision is a difficult issue with no one simple answer (Handley and Doyle 2014). The guidelines do not offer a clear path through this dilemma. Nevertheless, it is implied that adults' views should be given priority. The regulation dealing with preparing children for their participation states:

> It should be made clear to the child that his right to express his view at the committee doesn't imply it will be accepted, instead the child's best interest will have overriding weight in the decision. (IMSSSA 2004b, Article 8f p. 7)

Finally, in a departure from prior commissions' recommendations the reform does not allow children access to the mechanism of complaints and appeal, this right is only granted to their parents.

8.3   Engaging with Children in Practice

8.3.1   Social Workers' Relationships with Children

The striking finding of this study is that social workers had only negligible contact with the children for whom they were responsible. None of the children in the sample had enduring meaningful relationships with their social workers. Workers' accounts of their past engagement with the children prior the referral to PIEC, revealed that five children participated in a single meeting including parents and/or other professionals at the worker's office. As to the majority of the children, workers reported having short encounters in settings such as after school programmes, professional meetings at school or home visits, which usually did not involve one-on-one conversations. For instance, several workers reported that during home visits children were too absorbed in watching TV to converse or departed to another room by their own will or parents' instructions. Here are some examples from interviews as to the nature of social workers' engagement with children.

I don't have relationships with most of the children here. It is all around parents' requests, only if there is something exceptional or (due to) reports from school or such things. (SW: Case 10, SSD A1)

The relationship was less with the children. That is, I used to come and visit them at the placement, but only as a visit not as a meeting. It means that if I was already there (at placement) for a meeting I popped in to see how they were doing, this is how they know me. (SW: Case 8, SSD B)

These quotes reveal a shared pattern of practice found. Social workers do not perceive engagement with children as part of their role, for them, the service users are the parents. The following quotes demonstrate how the interaction with children when carried out was in fact a matter of 'seeing' them rather than communicating with them:

I saw him at school but he didn't know it was me. I mean, I observed him but no, I didn't meet him, no. (SW: Case 2, SSD B)

I saw the boy during a home visit and several more times when she (the mother) brought him to my office….an older boy aged 6 I saw him too, very sweet, and the baby, well she is not a baby but she is most of the time in the buggy, she is three years old, I saw her too, sure. (SW: Case 1, SSD F)

In preparation for the committees, only seven children and young people were approached and engaged in a single meeting. Another way of reporting on this finding is that out of the majority of the children who did not attended the committee only three were met with, to be given information and express their views. Out of the seven young people who did attended the committee only four went through a preparation meeting. Two children attended the committee without being prepared in advance: a thirteen year old boy who was invited on the spot just outside the committee room, and a fourteen and a half year old girl whose mother requested that she not be informed about the PIEC's objective to discuss the option of out-of-home placement. One girl had a phone conversation with her worker prior the committee. More seriously, data revealed that five children had been referred to PIECs without their social workers ever meeting or seeing them before.

Interestingly, a third of the social workers explained why they hadn't carried on these tasks as required by referring to the children's characteristics. Children were described as introverts, avoidant, confrontational and uncooperative. It is argued that this is the outcome of practice where social workers are utterly alienated from the children and young people they were responsible for. Here are several examples from interviews:

> A conversation with the boy alone wasn't carried out but rather always together (with his mother). Also, he is not, I have not tried but his cooperation is not complete in terms of talking with professionals. (SW: Case 5, SSD A3)

> I don't have a lot of information about him because he is very, very introvert and reserved boy. (SW: Case 7, SSD B)

The following worker describes feeling uncomfortable in approaching a boy she had no past relationships with just before the PIEC:

> On the whole, he really doesn't know me. So when there is no connection between me and them, I don't want to land on them (just before the committee) and then (he will say): "why do you come for me? What do you want from me? (SW: Case 8, SSD A1)

Only four young people who had attended the discussion had an opportunity immediately after the PIEC to discuss their feeling and the decision made. This means that, all in all, only three young people had been engaged in meetings with their social workers both before and after the PIEC as required. As to the rest of the children, interviews with their parents confirmed that social workers had no communication with them during the fortnight following the committee. Data from follow-up interviews presented in Chapter 9 will show very restricted engagement with children also during the six month period after the PIECs.

The next section presents a more detailed analysis of children's involvement in the PIEC process. It will be shown that when a participatory way of working was attempted it was carried out as a detached isolated event and merely a matter of paying lip service to required procedures. It is further argued that practice was not intended in the first place to allow meaningful participation in terms of providing children an opportunity to be heard and have an impact on the decisions.

8.3.2   *Hearing the Children's Voices*

Pre-committee meetings with children were carried out in a setting that did not allow free, confidential and private communication separately from their parents. Meetings were conducted in conjunction with home visits or as a joint consultation with parents and in some cases also with other professionals. The following quote is a worker's testimony of

feeling awkward asking the child his view about the option of returning home from placement in the presence of his mother during a home visit:

> … It was less appropriate to ask this at that moment because the mother was also there. She told me: 'go on ask him'. It is obvious that he will say that he wants home, it seems pointless to me. I told her: 'it is enough; I trust what you told me'. I honestly believe that all children want to return home. (SW: Case 10, SSD A1)

There was no evidence of coordinators stepping in to engage with the children and in fact none of them met with the children either prior to or right after the committee (one exception was a case where the coordinator also acted as the child's therapist). None of the children had been offered the option of self-expressing through a letter.

Evaluating the effectiveness of these meetings in eliciting children's views, based on information included in the PSRs (the analysis was described in Chapter 5), showed they had very poor outcomes in terms of mediating the child's voice to decision makers. Given very limited past communication these meetings were therefore an encounter between strangers. Findings also suggest these encounters led children to feel distressed about the forthcoming committee meetings. For example, the teacher of an eight year old girl linked the onset of her uncontrolled crying and stomach aches to the time she had been told about the committee. A sixteen year old girl described before the committee her reaction when she was told about the PIEC: "I became frightened, I didn't sleep at night, and I haven't slept for a week". An eleven year old boy was found by the worker hiding under his parents' bed terrified she would take him away. After the PIEC he continued to fear her and hung up the phone when recognising her voice.

Most workers did not know first-hand what the children's experience was; what meaning they attributed to the happening and how they wished to be helped. When asked through interviews to describe how children understand their situation some workers honestly admitted to having no idea. When requested to evaluate their overall contribution to the discussion, representing children's views got a very low rating in social workers' responses. Over half the social workers who answered this question (9/17 social workers) reported they did not represent the children at all or only 'fairly' contributed in this aspect.

A general tendency found was to rely on school teams, who were valued for their daily interaction with the children, to represent the children in the decision making process.

This was shown by the dominance given to school staff's accounts both in the PSR and in the discussions. In two cases school professionals also conducted the pre-committee meeting with the children. For example, here is one worker's account which clearly describes this approach:

> Overall, we are discussing children that the school (staff) knows better than me. The school (staff) see them more frequently than me, I don't know the children. I saw them but I never had one-on-one conversations with them. I am familiar with the mother, I know the mother. I can work with the mother, but not with the children. They (the school's staff) see the children every day. They see how they get to school, how they are dressed, do they make their homework, achievements, grades, these are things they can present at the committee and their voice is very important. (SW: Case 3, SSD A1)

Another shared pattern indicated by this quote is a lack of sufficient confidence and skill in communicating with children.

Observational data showed that, overall, decisions were made although there was no clear understanding of the individual experience of the child in the family. It is one thing to know for example that the child's mother has a long history of alcohol misuse or severe mental problems, and another to understand how this affects the child's everyday life. The general tendency was not to investigate or discuss the effects family circumstances, difficult life events, abuse or maltreatment had on the individual child's development, safety and well-being. Instead, a universal negative impact of life circumstances on children's emotional condition was automatically inferred. When assumptions and impressions were expressed, they were laden with professional jargon and empty standardised terms. To amplify this point, here is an example of social worker's conclusive statement regarding a case of three young children living with a schizophrenic mother who tended to violent, uncontrolled acts towards them, their father and herself: "The difficult relationships between the parents created a tense atmosphere at home, exposed the children to difficult situations and risked their emotional state". This worker could not have added more since he had never seen two of the children he was reporting on.

That is not to say that children's voices were completely missing. In regard to 14 children their opinion about the intervention solution was delivered to the forum, mostly by their parents, in some cases by school staff and very rarely by social workers. Yet in some

cases, conflicts of interests between parents and/or disagreements between parents and professionals all wishing to represent the child, made it impossible to understand what the child's preferred option of help was. The reform specifically warns against these situations where children's views are presupposed, rather than discovered directly by letting them speak. Article 8c of the Implementation Team's Decisions Paper cautions decision makers to be minded about the differences between children's views and others' impressions of what they are:

> The PIEC will make sure the child's view is presented before it and distinguish between the child's views and professional's impression of his/her behaviour and wishes. (IMSSSA 2004b p. 6)

One way or the other, there was not much evidence of children's views affecting the outcomes of the decision making process. Observational data regarding professionals' deliberations about possible intervention alternatives showed that children's wishes had been given very trivial weight in the considerations. For example, in the case of an eleven year old boy, his attitude about being removed to placement was sought merely in order to evaluate whether control measures were required. A father who asked the social worker to engage with his boys in order to find out their position before a drastic decision about their removal from home was made, had been refused with the claim that: "asking the children is an unnecessary stage" and that "here it is clearly a matter of adults' decision".

8.3.3 Children's Participation in the PIECs

Only half of the 14 young people in the sample who were eligible to participate were invited to attend the discussion. In addition to them three 11 year olds had been given the opportunity to participate as well. Since three children had chosen not to participate, overall seven children and young people attended the discussions. With only one exception coordinators were not involved in the decision whether to enable children to attend committees. This was left solely to the workers' discretion. None of the children had been advised to bring along a supportive representative on their behalf. This practice serves to reinforce the claim that children were anticipated to take a very trivial role in the discussions.

On the whole, social workers voiced a very reluctant and doubtful position towards children's participation in PIECs. In conversations about their point of view in general, and in the particular case studies, there was no advocacy that children's participation matters, that it is the right of the child to be heard and have an impact over decisions concerning his or her life. In regard to young children (usually up to 12 years) it was the consensus that participation is likely to cause them distress or sufficient harm (in particular talking in front of a large forum of professionals and being exposed to very sensitive content) and hence they should be denied this experience. Here is an example of a worker explaining why an eight year old girl was not invited to participate in a discussion about her and her siblings' removal from home:

> To me it was clear that I should not have invited (name of girl) to the committee, she is too young… She is 8. She is going through enough suffering anyways. I think the move to placement is hard enough for her. I think that standing before the committee would only agitate her and turn her stomach; it will turn a lot anywise during the reception meeting and the first days at placement. (SW: Case 4, SSD B)

This quote also demonstrates another prevalent notion amongst workers, i.e. they were (very rightfully, as will be shown later) unconvinced about the contribution that children can make to the PIECs' final outcomes.

In regard to young people it seems that some workers felt compelled to follow regulations. Nevertheless, young people were not invited in order to be competent partners in the process or have an influence on the decision, but rather only if their attendance was expected to serve an instrumental function, such as: 1) to allow members of the forum direct impression of them, e.g. "you can see exactly who the young person is; you get a different impression than reading from a paper"; 2) to send them a punitive message of control and authority, e.g. "in order to shake the child and maybe give him one last chance - it is important, PIEC can be pre-juvenile court (procedure)"; 3) to promote their cooperation with adults' decision about removal from home, e.g. "if there is an issue of possible removal from home and the social worker who represents the case already knows this and had discussed it with the coordinator, if there is something like this I think that the child's opinion is very important for the sake of his cooperation, and it is important to present it"; or 4) to allow them to witness that the considerations behind the decisions were in their best interest.

A few workers argued that children, regardless of their age, should not be involved in the PIECs decision making since they are unreliable, do not know what is best for them, and tend to change their minds. Here is an example:

> I would not like to think that children can take part in such decisions because
> it is too big on them to decide such things. (SW: Case 10, SSD A1)

With the exception of a 16 year old girl, children did not participate all through the discussions. They were present for between 6 and 24 minutes, in discussions that went on from 44 minutes to an hour and a half. Hence, it would be more accurate to state they were mostly present outside the committee room; waiting for half an hour to one hour until being invited in. According to conversations with SSD coordinators, partial participation was in fact the norm, thus the findings of this study were not exceptional to the habitual practice.

Another pattern found was that children were usually asked to go in and out of the committee room several times, and so they were in fact absent at two crucial stages: when information about them and their families was shared and at the actual decision making point. For example, in two PIECs after the children initially entered and took their seat next to their parents they were asked to leave the room. They were later called in only after all reports where presented and some discussion into intervention alternatives had already started. After a short conversation they were asked to leave again returning only to be informed about the decisions made. A ten year old boy was only called in for the first time after there was already an agreement on the intervention plan and two siblings were not invited in again to be informed about the outcomes.

Children's position as outsiders to the meeting was also reinforced by the fact that throughout all stages of the discussions they did not have access to the information that adults had; so that their understanding of the issues at stake and the actual power and authority of the PIECs was compromised. Information was held up, either by not providing it, for instance in regard to details of the intervention decided on, or by over simplifying it into a more 'child-friendly' communication. For example, in the few cases where an explanation as to the discussion's objective was provided it was very abstract, e.g. "to think together what can help". When introducing themselves to the children members tended to omit their precise professional role and mostly only mentioned their

names. Explanations about the interventions decided on were also very elusive, particularly in regard to out-of-home placements. To demonstrate this point, here is a verbatim quote from a discussion in relation to a case of a nearly 16 year old boy who had already considered, prior to the committee, leaving home, and was dreaming about joining an elite military boarding school. Professionals agreed before he entered the discussion room on removal to a therapeutic placement. The parents, who feared such a programme would offer low quality of care and education, eventually agreed to allow their son to make the decision. By keeping explanations about the suggested intervention vague a direct conflict with the boy had been avoided.

> Boy: A therapeutic programme is like… (interrupted)
>
> SWYL: The word 'therapeutic' is like therapeutic community. This word is problematic.
>
> Boy: For me therapeutic is white shirts tied like this (demonstrates a strait jacket).
>
> (The comment leads to load talking of different speakers in the room).
>
> Coordinator: N-O! (Smiles) no, definitely not!
>
> Professional member: You have seen a lot of movies. He thinks it is a mental hospital.
>
> Coordinator: Definitely not!
>
> SWYL: The word 'therapeutic' to people that are not therapists like us, is a course. It is merely that there are a lot of nice people there, nice staff and social workers and psychologists, the staff is more varied, and therapists. And it costs different rate; it is translated to money at the Ministry of Social Services, how much the residential placement gets for each child if you have more staff and teachers. But basically it is a structured programme, the word 'therapeutic' means there are many therapist, plentiful of staff and then each child is seen, and each child is acknowledge according to his needs. You have your own difficulties right? It is true you have difficulties, right?
>
> Boy: (Looks at the SWYL) Right (answers in a low voice). (Case 5, SSD A3)

Here is the boy's father talking about his son's understanding of what was in effect offered to him when conversed with two weeks later:

Researcher: What do you think about the decision made? First, was it clear to you what had been decided?

Father: Yes (laughs).

Researcher: And what do you think about that?

Father: (sighs aloud) When they started the story about the (pauses)

Researcher: The military boarding school?

Father: about placement in general. Of course, the child accepted that as military. When he opened his mouth and started to say something about that immediately they answered they do not know if it is possible. You don't need to be Spinoza to understand that if they will give any kind of placement it is going to be a bad one.

Researcher: A therapeutic placement as they said.

Father: Yes. He still did not understand that. He is childish and naïve. We had already been through this process, so we do not require explanations. (Father: Case 5, SSD A3)

The PIECs were not a 'child friendly' decision making arena, but rather a very formal setting. The picture revealed before the children when they entered the committee room was of a large group of adults including between 7 and 10 professionals, among them about 4 or 5 (excluding the researcher) were unknown to the young people, sitting around a big table. The dialogue with children lacked effective chairing; it was not well organised or controlled by coordinators. Children's involvement was mostly responding to members' questions which gave the communication an interrogative nature. At times they were not given respectful attention due to members conversing among themselves or on their mobile phones.

The fact that professionals were very friendly and empathetic (e.g. some children and young people were referred to as "darling") was insufficient support. As was evident by children's verbal and nonverbal behaviours it was a distressing experience for them. Obvious stress markers demonstrated were speaking in a very low voice, avoiding eye contact, swinging legs restlessly or laughing at unsuitable times. Children's responses were sometimes merely "ok ", "yes/no", a nod, a shake of the head or no answer. Although, their very limited verbalisation (e.g., a 14 year old said only three sentences) what they did say was an honest and coherent account which shed new light on events. A striking example was the case of a 16 year old girl with long-standing problems of

attending school who disclosed during the discussion that she was going through daily sexually harassment on the bus while commuting to school. Children were incredibly aware of their difficulties and had a very clear opinion about what help they did not want. Nevertheless, with only one exception they had no influence over the decisions. Therefore, three children were facing a removal from home against their will.

The experience of participating in the PIECs was shown to have destructive effect on the children, right after the discussion and also in the long-term. After hearing the final decisions four children responded by crying, shouting, violent behaviour, and in two cases suicidal threats. The most extreme response was that of the 14.5 year old girl who came totally naïve to the PIEC and the decision about removal from home came as a dreadful surprise. She cried, screamed, cursed, banged chairs, beat her mother and spat on her. She threatened to hurt herself and was then referred to psychiatric evaluation on the spot. Follow-up data showed that children's experience of participating in the committees without eventually having an impact i.e. not getting the help they wished for, led to avoidance of engagement with professionals and harsh opposition to cooperating with the interventions decided on, or any other alternative solutions. An 11 year old boy who was only provided with what he wanted, "to have someone to talk to", after considerable delay refused to cooperate with his therapist at the first session. A 14.5 year old girl who violently protested against the PIEC's decision to be remove from home, refused any contact with her newly assigned youth worker. An 11 year old boy who failed to convince the PIEC's forum he was better off living at home refused any service while waiting for an out-of-home placement to become available and completely shut himself off avoiding any contact with others including his peers. A nearly sixteen year old boy agreed to an out-of-home arrangement as long as it had a military orientation changed his mind about leaving home after his first attempt to enter such programme failed. Another common factor for these children is that their workers either recommended, or start to take active measures, to promote their coerced removal from home.

8.4   Conclusions

This study found that procedures designed to promote participation of children in PIECs decision making were either completely ignored, partially and inefficiently carried out or

projected onto other professionals, mainly school system staff. Only seven children attended the committee meetings, most were not present through the whole discussion and had little influence on the decisions made. Children who did not attend, rarely had their views conveyed to the committee by their social workers. Findings also suggest that the way regulations were implemented in practice did more harm than good. The analysis identified a number of factors influencing the failure to give greater priority to children's views. Workforce attitudes were shown to be a powerful barrier to children's meaningful participation in decision making. They did not believe children's voices should have an impact on the decisions made. Allowing children genuine participation requires courage, giving away power and taking risks (Thomas 2000; Shier 2001) yet, it appears that professionals (social workers and coordinators) were more comfortable holding their superior position as exclusive decision makers. There were also systemic barriers to children's participation, including a lack of skills and guidance in effectively communicating with children including coordinator's insufficient chairing skills, a lack of time to invest in developing ongoing relationships with children and an organisational message that it is not a priority or an important part of everyday practice. Once again through the decision making process, social workers were left to face by themselves tasks which they were incompetent and unconfident in carrying out; they were adjusted to a way of working that did not involve engagement with children. As long as workers and their organisations fail to take children's participation seriously, children's rights will not be respected and their experience will not be improved. The next chapter is the final empirical chapter of this thesis and it follows up on the reform and the PIEC outcomes six months after the intervention decisions were made.

9.   Chapter 9

Evaluation of the Reform's Outcomes

This chapter is the closing empirical chapter of the thesis. It follows the 21 case studies sampled half a year after the PIEC's assembly. It aims to provide a comprehensive evaluation of the reform's outcomes and its effectiveness in achieving its targets. This concluding chapter is organised with a different structure to the rest of the empirical chapters presented so far. It starts with critical assessment of the reform's impact on the quality of PIECs decision making based on two indispensable criteria: 1) the degree to which decisions made were actually implemented; and 2) the degree to which decisions led to improvement in children's safety and well-being. The rest of the chapter goes back to the reform's core principles and examines their actualisation in practice in the aftermath of the PIECs. As mentioned in Chapter 3 the reform's overall aspiration was to establish a new, advanced practice culture that will become the normative way of working. Data collected through follow-up interviews with social workers will add to earlier findings and will be used to make conclusive arguments as to the realisation of the reform's discipline for practice in the field. Based on investigation of common practice for a considerable period of time this chapter's closing argument is that the way the PIECs are operating in the field, not only doesn't prevent or postpone the removal of children from their home, but rather encourages it.

9.1   The PIECs' Outcomes

9.1.1   Implementation of the PIECs' Decisions

Follow up interviews were design to rigorously explore the task of putting the intervention plan into action in the course of the six months that followed the PIEC. Social workers were also asked to report about any other changes in the family lives, extraneous to the

PIECs' decisions, which might impact on the children's condition. There were very few such examples, and they mostly related to changes in parents' workplace or working hours which resulted in a decrease or increase of parental supervision. Also, there were changes in families' accommodation, yet with only one exception, home visits were not conducted so workers could not appreciated the quality of the change. Another note before turning to the findings is that interviews confirmed there was no meaningful change in interviewees' working conditions including position, work status, caseloads, workloads, professional training and support and physical working conditions and hence these factors continued to have an impact on practice.

Research findings revealed a remarkably low implementation rate of the PIECs' intervention plans. In only 2 cases was the intervention plan fully implemented; in 13 cases it was partly implemented; and in 6 cases it was not carried out, meaning that no help whatsoever was provided to the family. A more detailed examination of the data by service type showed that interventions designed for children were more frequently provided than those proposed for their parents; and that mothers were more supported than fathers. Overall, 44[90] children had been recognised as in need of help and it was decided to provide them with one or several services. Just less than half of the children (19/44) were provided with all the services decided on; over a quarter (13/44) with only some of the services (in 1 case efforts to provide a service were unsuccessful and in 2 cases the implementation process had started but was not yet completed); and as for almost a quarter of the children (10/44) none of the decisions were implemented. In regard to 2 children their social workers could not account for whether the service was provided since they had no updated information. Turning to examine the parents' circumstances, out of the 16 mothers that were prescribed with an intervention of parents' training programmes, 10 were not provided with the service; 1 mother ceased to attend her meetings; and in 1 case the social worker had no up-to-date information. In the 3 cases that involved other services for mothers, in 1 case the service had terminated after six month; in 1 it had just begun; and in 1 case a service that started prior the PIEC had continued. None of the decisions to involve the fathers in parents' training programmes were carried out, other than that 1 father continued meeting with his social worker regularly, yet not with the frequency

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[90] PIEC's decision as to a six year old girl was that her condition did not justify her inclusion in CPTC's programme which her mother and older brother were referred to. Eventually the service was provided to her.

recommended by the committee, and 1 father continued to participate in a therapeutic programme he was engaged in prior to the PIEC. In addition, when the services were provided, either to the children or to the mothers, it was very frequently done a considerable time after the PIEC, in some cases even four, five or six months after the decisions had been made. Delays in the provision of help to children happened in some cases because some programmes only started at the beginning of the school year. However, more substantial and frequent delays were the result of popular services, in particular PCTCs, being overburdened - a problem recognised when the decisions were first made. A mother waited for parents' training at PCTC for seven months (she enrolled prior to the discussion) before being invited to start the programme, and this was not an exceptional reality.

In general, after the intervention plans had been formulated no meaningful changes in the decisions had been made. On the whole families were not provided with any substantial help in addition to the intervention plan. There were several indications of circumscribed targeted material or financial support (e.g. scholarships, food vouchers and second hand furniture); a few families were helped out in applying for housing assistance (which is under the authority of the Ministry of Construction and Housing); and two children were about to start or started a particular group therapy. It was also not within the norm to provide substitute services when the implementation of the initial interventions either failed or was delayed. Two mothers and five children were offered an alternative service, yet in only the case of one teenage girl was this option actualised.

The low implementation rate of the committees' intervention decisions is not an original finding. The national study (Dolev et al. 2001) found that only two thirds of the sampled committees' interventions were actually realised. The Community 2000 Experiment's evaluation studies indicated a slight increase in implementation rate following the reform (Ben-Rabi and Amiel 2013). The key reasons why decisions were not put into action were organisational barriers linked to limited availability of services and resources and family members' resistance and opposition to the decisions (Dolev et al. 2001; Ben-Rabi and Amiel 2013). The latter was found in another study to be a key reason for not implementing decisions about children's removal from home (Davidson-Arad et al. 2003). Social workers' accounts in the current study echoed the same two predominant obstacles to realising the interventions: dearth in resources and services and family

members', parents in particular, refusal (whether outspoken or indirectly manifested) to go along with the interventions offered. The second reason will be discussed later in the chapter. In regard to the dearth in resources, this was a systemic constraint on social services in general (as well as the public mental health services), and the PIECs' intervention plans were not exceptions to it. Findings indicate limited availably of services both in the community and out-of-home. Six months after the PIECs three children were still waiting for a suitable out-of-home arrangement (one was just recently invited to an interview at the placement); three children were still on the waiting list for individual therapy at the local mental health service or CPTC; for two children the SSD had no resources to provide them with tutorial services; and five parents were still waiting for their parents' training programme to become available. This state of affairs was very much predictable at the point in time when the decisions were first made, and usually stated out loud in the discussions. Looking at the case of a 12 year old boy, which was exceptional in that the initial intervention plan included several options for substitute services for both mother and child until CPTC's programme became available, in addition to these alternatives the social worker also put the child's name on the waiting list for individual therapy at the local mental health service. Yet, none of these services were available and the end result was that six months after the PIEC neither the child nor the mother received any help whatsoever. In the aftermath, social workers hands were tied. The infrequent attempts to provide supplementary or additional help failed for the same reason as earlier decisions. Some attempts to advance the family's position in the queue for services were unsuccessful. Through the interviews workers voiced their frustration and disappointment at not being able to execute the help that was so urgently needed. This reality was surely even more distressing for the families. When the dearth in resources was very much anticipated it is a shame that families' existing resources and informal support systems were not investigated at an earlier stage and built on when the intervention plans were formulated, as is clearly instructed by the reform's principles (IMSSSA 2004a).

9.1.2   The PIECs' Impact on Children's Safety and Well-being

In the follow-up interview social workers were asked to assess the condition of children and families. On the whole, after six months most workers were still worried about the

children's state; usually not to a lesser degree than before the PIECs. Only a fifth (9/45) of the children had reports about positive changes in their emotional and/or behavioural condition which were attributed to the help services they had been provided. For another one fifth of the children, it was mentioned, they had adjusted well to the service, yet there was still no evidence of meaningful progress in their condition. There were also a few indications of improvements in six children's safety and life circumstances which were not the direct outcome of a specific service, but still related to the PIEC. For instance, three children were more physically protected after moving to live with their father separately from their mother, a change that was advocated by the committee's forum, yet as was put by the worker "there was still more to be done" to recover their emotional well-being.

A troubling finding was that some PIECs' decisions had unfavourable and even damaging effects on the children's condition. For another one fifth of the children, their functional and/or emotional state had become worse or even considerably worse than when the interventions had been carried out. The majority of them (6/9) were children who had involuntarily been removed from home; all but one for the first time. Social workers reported very distressing negative behaviours of children who were detached from their family and home environment for the first time, including running away, refusal to return to the placement after a visit home, self-inflicted social isolation, sleeping problems and nightmares, and obsessive preoccupation with calling home. In the rest of these cases it was the reverse decision, i.e. returning home from out-of-home placement, that had negative results. It seems that in both cases not enough support had been provided to the child and family to secure the adjustment to such a drastic change in family life. For example, the sequence of events during the six months that followed the PIEC in a family where, without being supported, the looked-for return of the older boy, nearly 14 years old, after living in placement for most of his childhood, led to a crisis. Through the discussion the coordinator emphasised the importance of the mother getting consultation and even conditioned tutorial services for her two sons with her cooperation. The following is the coordinator's concluding argument:

> I think this is the time that finally all three children are at home and the parental fantasy can finally come true. In order to preserve it and in order that the mother will not have to remove the children due to her incapability to care for them, in order to prevent this situation she must go to parents training. (Coordinator: Case 6, SSD B)

To start with the family's accommodation was not fit for another person. The initial decision on family therapy with an emphasis on intensive parents' training at the PCTC was later changed so that the entire therapeutic support for both mother and children was delegated to mental health services. However, the mother eventually did not receive any service due to the service's considerable workloads. The older boy who was not self-reliant in his everyday functioning reacted with serious behavioural problems and his obsessive eating problem was not controlled or treated. The children's relationships involved violent conflicts. All these events, and the fact that his mother was now less available, also negatively inflicted the younger boy's functioning. It was later decided through a review committee to provide the mother with a semi-professional supporter at home during the evening for several months and the option of removing her older son from home again, to a rehabilitation programme, was discussed.

In cases where the interventions for the children were either not, or only partly, carried out, children's conditions either stayed stable or worsened. Six children's behavioural and emotional conditions severely and persistently deteriorated without meaningful intervention. Among them were three young people that six months after the PIEC's decision to remove them from home were still waiting (at home!) for a suitable placement. Workers reported behaviours such as: uncontrollable crying; drastic social withdrawal and reduced communication with others; aggressive outbursts; poor academic performance; and there was even one report of engagement in criminal acts. Also delays in provision or the lack of provision of services for the parents negatively influenced the children's condition. In a case of a severely disabled mother after the semi-professional support within the household that was provided for several months had terminated, it had become her seven year old daughter's responsibility to clean the house. On one occasion when fulfilling her tasks she seriously hurt her arm. This injury was described by the social worker as a cause for serious emotional and functional regression in her condition. More common examples were cases where parents' parental capabilities, judgements and relationships with their children had not changed, or even in few cases worsened. Some parents were described as not being disciplined or authoritative enough, for not being able to manage their anger, for keeping to the same harmful communication style, or for making destructive mistakes.

To conclude, very disappointing findings show that overall the intervention plans decided on in the PIECs were ineffective. Whether decisions were not implemented, delayed for considerable time or did not lead to a positive improvement the general picture after half a year was that the PIECs did not meet their objective of improving the safety and well-being of children in need and improving their family life. It is also questionable whether there is indeed value for money for the time invested by social workers and other professionals in preparing for and participating in the PIECs.

9.2   Working According to the Reform's Principles

In the rest of the chapter the employment of the reform's principles set out in Chapter 3 are discussed. It has already been mentioned that the principles which prescribe to the ministry certain responsibilities (i.e. developing workforce qualification, IT data collection system, mechanisms for clearing disagreements and inspection arrangements) were not fully acted on by the time of the data collection for this study. Here, the analysis focuses on principles relating to workforce performance with the aim of identifying shared working patterns and drawing collusive arguments about: 1) the degree to which the reform's principles have become embedded in routine practice; and 2) the outcomes of the way they had been employed through the decision making process for children and families.

9.2.1   Follow-up and Evaluation

The reform establishes the tasks of following-up and evaluating the intervention plan implementation and outcomes as a leading function of the committees as demonstrated by the change in their name. The issues of systematic and scheduled case monitoring and progress evaluation are repeatedly accounted for in the Final Principal Paper (2004a) and in the Implementation Team's Decisions Paper (2004b) that arrange the process by a set of procedures and regulations. It is also supported by a new designated tool, the 'tool for summarising the follow up of the intervention plan implementation' (IMSSSA 2009). Policymakers emphasise follow-up practice as a response to the national study's (Dolev et al. 2001) evidence showing this task to be the "Achilles' heel" (p. 78) of the practice, i.e. the most defective aspect of the committees' work processes. The study reported that

overall only very limited follow up was carried out in regard to the condition of children discussed in the committees and in fact after decisions were made and especially if they involved the removal of a child from home, the case was considered as 'closed' or 'end of treatment'. Coordinators who participated in that study attributed the defective practice to time pressures; lack of administrative support and computerised systems; and high level of staff turnover. The authors suggested prescribing clearer roles and responsibilities and developing tools and procedures to reinforce systematic follow-up practice (Dolev et al. 2001). The reform adheres to these recommendations and offers several changes to the conventional practice embedded in Ordinance 8.9 (IMLW 1995). First, the follow up task is no longer the responsibility of the coordinators but rather that of a professional who will be assigned by the committee, most usually the family's social workers, while the coordinator will be kept informed. Second, the first point in time for a formal follow-up is shortened from six months after the discussion to three months. Then the social workers should review the implementation and the results of the intervention decisions, and document and report the information. Third, as mentioned, documentation of the follow-up result is no longer recorded in the same form as the intervention plan, rather a new standardised tool has been designed for this specific purpose. Within the tool social workers are required to indicate each action or service and whether it was fully implemented, partially implemented, in the process of being implemented or will not be implemented. If the decision has not been put into full operation an explanation should be chosen from a list provided (e.g. service unavailable; family or child resistance; changes in the family condition; or it turned out that the service was unsuitable). It should also be reported if there are requirements for minor changes to the intervention decisions, future social worker follow-up or an additional PIEC, since serious implementation difficulties necessitate substantial changes to the original plan. The tool should then be signed by the social worker, team leader and coordinator. A fourth novelty of the new reform lies in that it authorises social workers the freedom to apply minor adjustments to the intervention plan (e.g. lessen the number of therapeutic hours recommended) when these are in agreement with the family, team leader and coordinator, without the need to call another PIEC. Finally, the reform does not accept recommendations made by the Gilat Commission (IMLW 2002) to routinely carry out a review discussion every six months in regard to all cases, but rather prescribe specific conditions when a review of the PIEC must be conducted. These include cases that: were referred to PIEC for the first time and ended

with a formal intervention plan; involved children in out-of-home placements or under juvenile court orders; involved a decision about the return of a child from placement; or involved delivery of complex services in the community (e.g. PCTCs). When services in the community are decided on, the reform sustains the schedule set in Ordinance 8.9 (IMLW 1995); a six month review discussion for children under six years old and within a year for the rest. As a departure from the ordinance the reform specifically stipulates follow up measures in cases where a decision was made to remove a child from home and instruct that the PIEC will continue to follow every child in placement at least once a year throughout his stay and at least a year after he returns home[91]. A formal review discussion should be conducted no longer than a year after the decision on removal or half a year after the decision on returning home (IMSSSA 2004b).

Several noticeable shortcomings of the reform's follow-up regulations should be accounted for. First, regulations do not establish follow up as part of professionals' ongoing practice but rather as a periodic task to be carried out at a specific point in time. Beside the three months official review the instruction for social workers only stipulates that "the case should continue to be followed up until the intervention plan is implemented" (IMSSSA 2008a p. 12). The new regulations withdraw from the ordinance requirement that coordinators will conduct a formal meeting with the responsible team leader every six months in order to follow up the family's progress and from the Gilat Commission's (IMLW 2002) recommendations that when a SWYL is involved in the case he/she will provide periodic reports on the child's condition every three months. It is also questionable whether in the reality of over-burdened services and long-waits for provision a three month period is indeed sufficient time to assess the execution of the intervention plan. Second, the regulations and tool are lacking in that they do not include any guidelines or instructions for how to perform the follow up. For example, guidelines could involve requirements for frequent meetings or communication with family members and service providers according to a set schedule in order to be continuously informed about the children's progress or to obligate orderly home visits. Third, it is argued that the new tool completely misses out on its purpose since it only requires information about the

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[91] It should be noted that further procedures and supervision requirements in relation to children at out-of-home placement are incorporated in a distinctive detailed Ordinance: The Social Workers Ordinance 8.17 from 2004, 'The Procedures Regarding Placing Children in Out-Of-Home Arrangements, Treating Them, and Supervising Them' (IMWSS).

implementation of intervention services rather than an up-to-date assessment of the child and family situation. The provision of services is not an objective in itself but rather a measure to achieve improvement in children's safety and well-being. For the tool to provide informed evaluation of the impact and efficiency of the PIECs' decisions it should correspond with and re-evaluate earlier assessment made about the case (that is supposed to be available within the tools utilised earlier) including level of worry, main dimensions of concern and intervention targets.

Turning to the research findings about practice in the field, a lot has been written about the very limited use, misuse and adaptation to shorter versions of the new tools package in routine practice. Unfortunately, the use of the follow-up tool was not an exception to this norm. According to professionals' interviews there was no evidence of the utilisation of the new tool. In one SSD social workers reported they did not use a specific tool but rather continued to document any new information in the family file; in two SSDs the coordinators reported that the tool is not used in their departments; and in one SSD the former coordinator reported that social workers are obliged to complete the follow-up tool every three month and present it to the relevant team leader and the coordinator, however this procedure was not carried out in the case examined. These findings do not imply that the team leaders and coordinators were kept uninformed as to the PIECs' results but rather when information was shared it was done in an informal way and without written documentation. For example, 8 social workers reported consulting their team leader and/or the PIEC coordinator in the process of employing the intervention plan. One municipality were three SSDs were sampled created its own shorter form (merely a table where the decisions were recorded and the implementation level was filled in next to each decision) and procedures. It became the responsibility of the PIECs' administrative secretary to send workers the form three months after the discussion to complete and then distribute it to the team leader and coordinator. It is therefore concluded that the reform's hope, that the tool package would establish a systematically documented practice that would allow transparency and accountability through all stages of the PIEC process and promote consistent and advanced procedures, was not accomplished.

As to review committees, it was mentioned in Chapter 6 that in regard to 11 cases no decision had been made in the PIEC about a review committee although it was required by the new regulations. Out of the 7 cases where decisions were made to arrange an

additional review discussion within 3 to 6 months[92], in only 2 cases was a review of the PIEC carried out. In regard to the 5 cases that were not reviewed, the coordinators specifically noted in the original discussion the highly worrying condition of the children and the need for close monitoring, they even scheduled the review committee earlier than guideline requirements. Here is an example of a coordinators' statement at the end of the PIEC:

> … No! There will be following up. It is impossible that we will worry, say there are problems and there will be no treatment. This cannot happen. It will not continue like this. (Coordinator: Case 4, SSD A1)

There was also no justification for not reviewing the family condition, on the contrary it was even more pressing since in all these cases the intervention plan was not fully implemented and for some children there were fresh indications of deterioration in their condition. Through interviews, social workers could not provide any convincing explanation for this poor practice (it seem that in one case the researcher reminded the worker it was time for a review discussion). Additionally, there were findings of only two cases being brought again before a review committee due to the fact that measures taken to activate the intervention plan failed, although as reported previously this adverse outcome was much more prevalent.

On the whole social workers did not carry out regular ongoing monitoring and evaluation of the family condition in the aftermath of the PIECs, confined by their firefighting work culture. After the PIECs they returned to their habitual practice which positioned them as passive recipients of information, activated by others, whether parents or professionals, in times of crisis or special necessity. As an example evidence of the follow-up practice with regard to nine children that had been removed from home subsequent to the PIECs will be presented. This is based on the argument that children who have been removed from home require even more exhaustive and regulated monitoring due to factual evidence of their highly complex condition and also because for most children (8/9) this was a first time experience and hence adjustment difficulties were very much foreseeable. Moreover, shortcomings in following up these children's condition can result in an extended stay in out-of-home arrangements, as suggested by data

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[92] In two additional cases a review committee was scheduled in a year's time which was after the data collection period.

from the early national study (Dolev et al. 2001). The failure to conduct regular and planed follow up as well as repetitive re-evaluation of children's condition resulted in very limited action aimed at promoting their return home, which implies longer (and maybe unnecessary) stays at placements (Dolev et al. 2001; IMLW 2002).

Over all, there were no noteworthy differences in the routine way of working in regard to children that had been removed from home compared to those that were not. Social worker contact with the placement staff was occasional and provoked by irregular circumstances. Visits to out-of-home placements were not regularly incorporated in the follow up practice and usually carried out when workers were called on to participate in arranged professional evaluation meetings. It seems that visits were not fully exploited as an opportunity to have meaningful contact with the children or attain a direct impression of their living conditions. On top of this staff turnover created unwarranted interruptions in the follow-up process that were manifested by gaps in the information and breaks in the professional involvement in the case. For example, a thirteen year old boy had been assigned to three different social workers and two different SWYLs in the course of six months including a one month gap between workers. Following the PIEC decision the case was transferred to the SSD Disability Department and then the responsibility over the boy was delegated to the SSD Youth Department. The disability worker could recall prior reports of the boy's rebellious behaviour, refusing to stay in placement; yet, she ceased to be informed about the boy as soon as the responsibility was transferred to another worker. This was a general trend also found in other cases; when the responsibility for a specific family member was assigned to another worker within the SSD, the family social worker completely renounced her involvement including receiving update information. A couple of days prior to the interview the youth worker had just picked up on the case after returning from maternity leave; however she had no written records in the boy's file to depend on. The outcome was that there was no evidence of when the last contact with the boy or the placement staff had been. In another example of a case of two siblings that continued their stay in the out-of-home placement, due to staff turnover the PIEC's decision to conduct a formal meeting with the social worker, mother and placement staff in order to prescribe a detailed intervention scheme for both children and the mother, was only carried out five months after it had been made and over the six months that had

passed the worker had only once met the children very briefly and without any meaningful conversation.

Disruptions in the regular flow of information prevented the recognition of children's difficulties at an early stage; and when help was not provided on time these difficulties easily escalated into to serious problems which required more drastic measures. This process was well demonstrated in the case of an 11 year old boy who was removed from home for the first time based on the PIEC decision. It was well recognised through the discussion that the separation of the boy from his mother (e.g. they used to sleep in the same bed) could potentially be a very distressing experience for him. Staff turnover in this case led to disconnection between the newly assigned social worker and the family for a long period of five months (there were a couple of unsuccessful attempts to reach out to the mother). When the case was eventually picked up again, after the boy had been living in placement for half a year, the current social worker was called on to participate in a professional meeting at the placement aimed to secure psychiatric intervention due to a worsening in the boy's condition (also in comparison to his state prior to the PIEC). He was reported to be "frightened", "anxious", "depressed", "withdrawn to himself", socially isolated and demonstrated severe sleeping problems. This working model of being alerted and subsequently urgently invested in the case when things had deteriorated too far was not solely the result of changes in staff, but rather it is argued to be the result of the passive and responsive position social workers were so used to employing in their everyday practice. There was evidence of the regular social worker of three other young people being informed for the first time about their serious adjustment difficulties, misconduct in treatment (e.g. frequent change in host families or no provision of individual therapy) and the negative affect it had on their condition, when coming to participate in a review meeting at the placement.

To conclude, the examination showed considerable failure in performing orderly follow-up practice; all in all the desired change had not been achieved. The working pattern found in the study, which will gain further support throughout the chapter, is of PIECs being the high point of SSD professionals', and in particularly social workers', involvement in a case which follows a decline in intensity and urgency of engagement with the family. The focus and priority given to the case before and during the PIECs were gradually lessened until it was off the workers' agenda. This would have been a sensible and pragmatic

practice if the intervention plans were successfully implemented; leading to the expected positive progress, and the children's condition was closely and regularly monitored. However, as was described this was not the reality found in the SSD's examined.

9.2.2   Multi-Professional Work

The previous chapter discussed the unsatisfactory implementation of the reform's guidelines regarding the PIEC forum composition. Follow-up data reinforced the importance of including professionals from the health services when deciding on an intervention plan. In two cases where a psychiatrist was missing from the PIEC, later psychiatric evaluation made the decisions about services for the child irrelevant or unnecessary.

In addition, evidence showed that the PIECs usually remained isolated episodes of multi-professional work while no endeavours were taken afterwards to sustain consistent cooperative working relations with other professionals. The PIECs' discussions in particular raised expectations for further collaboration with the educational system professionals. The schools' representatives stood out throughout the discussions as crucial players in providing both essential information and help resources; they usually expressed genuine concern and willingness to be actively involved. Yet, the everyday working relationships with them were very limited and one sided. Only six workers reported on maintaining regular communication with the school teams; 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 meeting at school, a couple of phone calls or being completely cut off. Most social workers acted on the assumption that if a serious problem at home or at school arose and the child's condition was affected, the school staff would address them. And so, as long as that didn't happen, it was safe in their opinion to presume that the children were doing ok. In one case (where working together was, in effect, one of the committee's decisions) this working principle was clearly proven wrong, after only five months the worker found out the boy regularly continued to miss school, a problem leading to the PIEC in the first place. Social workers' accounts also implied that the information flow between them and the school system was mostly one-sided. Only four workers reported up-dating school staff about the family condition. The situation in regard to other

professionals that were involved with the family was not very much different, even in cases when they were specifically instructed by the committee to approach other professionals in order to fill in missing information. To conclude, the ordinary practice prior to and after the PIECs demonstrated a strong predilection to first and foremost engage with colleagues from the SSD, rather than with outside professionals.

9.2.3   Working Relationships with Family Members

As has been repeatedly argued through this thesis, the reform's aspiration for partnership and meaningful participation of family members depends on the establishment of continuous and significant helpful relationships with them. Follow-up data added to earlier findings, leads to concluding that this was not achieved in practice. Starting with the children, the alarming portrayal of the children's condition that was generated through discussions, raised expectations that social workers' engagement with them would be strengthened or built up in the aftermath, yet findings revealed otherwise. Evidence shows that during the six month period 20 children had no contact whatsoever with their social workers. Even more troubling was the finding that among them, 11 were in fact strangers to their workers who hadn't even met with them once; for only six of these this was a matter of disconnection due to staff turnover. As for the rest of the children that had some interaction with their social worker, the most intense contact was found in regard to six children who had a couple of meetings with their workers; there were two reports about initiating one meeting or several phone calls, and other marginal interactions which did not involve one-on-one conversation.

The same prediction of increased engagement that was expected in regard to the children also holds for the children's fathers. This is in view of the fact that in eight cases fathers participated in the PIEC and had an integral role and responsibilities in the intervention plan, and in three other cases it was decided that active measures should be taken in order to reach out to the fathers and get them more involved.   However, very disappointingly, the findings showed no meaningful change in the general tendency to disregard the fathers as meaningful partners. When good cooperative working relationships were already established prior to the PIEC, as was evident in two cases, they endured after the discussion as well; when the relationships had to be built up, this task

was too easily relinquished. Furthermore, it is questionable whether fathers who did not attend the PIEC were formally updated about the decisions made. There is evidence in regard to a few committees where it was made a requirement that the father approve therapeutic programmes offered to the child, that this was not carried out. Although the discussions had the potential to create a turning point, they were not exploited to elevate the fathers' involvement. There were only scarce indications of a singular encounter or a few phone calls made between workers and fathers who participated in the discussions. An example is a case where the social worker targeted the PIEC discussion as a means to increase the father's involvement in the family's life and decisions were made accordingly; he was asked to be more present at home and to participate in a parents training programme. Yet, although it seemed that the father had made a constructive change, it was the social worker who did not. In the six months that followed he had not been approached by her and the involvement with the family continued to revolve around the mother. Workers statements also disclose another common element in the general trend to overlook the fathers; the attribution of the disengagement to the fathers' noncooperative stance. Here is an example:

> We have invited the father as well to the review discussion. But, no, no we haven't seen too much of a partner. He is busy in his own affairs. (SW: Case 3, SSD B)

In relation to workers contact with the mothers; it lost its intensity and frequency after the discussions and was usually carried out via irregular phone conversations. Only one social worker reported regular weekly meetings with the mother, yet indicated it had just "recently" started. In the rest of the cases face-to-face encounters were usually infrequent events and mostly driven by a specific objective, for example, a formal professional meeting or a home visit by a newly assigned worker. Only a few workers reported a single or a couple of one-on-one meetings at their office. Again, there was the problem of staff turnover that created interruptions in the ongoing contact with the mothers in a few cases (even for one or three months). Several workers explained it was a matter of a common case management strategy to deliberately "take a step back" and only remotely supervise the case as soon as professional treatment starts in another programme; yet this explanation was also provided in regard to mothers that had not received any service. Some workers also took it for granted that the mother would contact them in times of need.

To sum up, given the circumstances that the PIEC decisions were often not acted on, social workers should have provided parents and children with a strong steady safety net through regular contact; at least until either the service became available or an alternative was found. This would have enabled them to detect early signs that things were getting worse and provide some kind of first aid treatment to prevent further deterioration. In short, it would be a responsible practice. Left without any supportive professional involvement, it was very probable that family conditions would only deteriorate, and in some cases this was exactly what happened.

9.2.4 *Establishing Intervention Based on Agreements*

As mentioned, from the social workers' point of view another chief cause for the low level of intervention plan implementation was what they classified as family members' "opposition", "refusal" or "lack of cooperation". There were various manifestations of family members' resistance which varied in their intensity and straightforwardness, from parents' determined refusal to agree with their children's removal from home which led in two cases to the involvement of a juvenile court, to what was termed by one worker "light lack of cooperation" which was demonstrated by not initiating contact with the service as ordered, skipping meetings or cancelling meetings at the last minute. In regard to the common tendency to ascribe family members the responsibility for interventions' failure the advantage of this study in using observations came notably to light. Based on observational data the key argument of this chapter is that the problem lies in that intervention decisions did not fit with family members' points of view, wishes or preferences. The most straightforward findings that reinforce this claim come from examples of intervention decisions that ignored (although voiced) the pragmatic constraints of families' everyday life, such as parents' working hours or lack of means of transportation, which eventually interfered with the implementation of the decisions. Basically, the interventions were not workable in the first place and hence were not later carried out. For instance, one mother persisted during the discussion to be provided with services that run through the afternoons due to her morning working hours, nevertheless, it was decided on a parents' training programme at her son's school which operated during school hours, and so she did not attend. It was only in the review committee, three months

later, that it was decided to change the intervention to a more "convenient service". Meanwhile valuable time was wasted. A father who had no means of transportation did not attend the parents training programme in another city and a mother facing the same problem who was prescribed a day care programme that was remote from the family home eventually preferred, for her young daughter, a programme that included transportation to and from the service. It is argued that the feasibility of the intervention plans for the parents was not a predominant consideration in the PIECs, not only because of the problem of service availability, but also because parents were expected to go the extra mile, to make time, to cope with the obvious difficulties and in that prove their willingness to improve their situation and be worthy of help.

It is also argued that what was defined as "refusal" or "noncooperation" is a matter of judgement and can also be interpreted based on observational data as a matter of parents sticking to their point of view about what is the best solution for their family's current condition. Findings make a case that the agreements achieved with the parents through the discussions were artificial and forced, and thus were not based on a genuine change of their opinions. Parents agreed to the interventions offered (and signed the intervention plans) because the PIEC setting imposed extensive, both implicit and explicit, pressures on them to do so. When outside this setting, they persisted with their views and judgements, since they were not actually convinced otherwise. There were numerous examples that support this argument, here only a few will be described. Two mothers who refused (one of them for several years) to treat their young boys with psychiatric drugs due to a history of bad side effect reactions eventually agreed in the discussion to complete their son's either psychiatric or neurologic evaluation. During the six months that had passed one mother did in fact take hers son to psychiatric and cardiac evaluation but did not provide him with the drug treatment, and the other mother kept postponing appointments with the neurologist. This mother also consistently cancelled her parents training meetings at the same programme and with the same therapist she did not "cooperate" with in the past. A mother who was certain that psychological counselling in a private setting was the best solution for her son rather than a public mental health service where records can become accessible to others, was asked to call the service to check her suspicions. She neither made this call nor arrived when invited to a first meeting.

Moreover, it seems that it was not only family members who were (ineffectively) persuaded to accept (at least at face value) the governing point of view which they explicitly opposed, but social workers as well. A fascinating finding was that three social workers reacted in the same way as the parents to decisions they did not agree with, i.e. they did not follow them and acted based on their individual discretion. A social worker who recommended in his PSR treatment for all family members at PCTC, was unable to convince the forum the service was needed for the younger daughter. After the discussion he addressed the centre manager directly and was able to change the PIEC's decision. A social worker who rejected, along with other forum members, the coordinator's decision to provide the family service at PCTC instead of at a local mental health service, made a change in the decision according to her point of view after discussing the matter with the centre manager. In an additional case, the coordinator firmly refused the social worker's suggestion to provide tutorial services to a young boy who was about to return home from out-of-home placement, claiming it was the educational system's responsibility (representatives of which were not present at the PIEC). The social worker had already stated in her first interview that she would try to find a tutor and so she did (this was eventually unsuccessful since the service was not available). Needless to mention, when carried out by the social worker this type of conduct was not labelled as lack of cooperation but rather a matter of professional judgement.

Returning to the family members, the interpretation of their position as, somewhat arbitrarily, resistant to cooperation, has a broad negative effect on their working relationships with their social workers both at present and in the future. In the aftermath of the discussion there was much less tolerance towards family members that did not cooperate with the intervention, and less empathy for their condition. A repeated theme in the social workers' accounts was blatant criticism of family members, particularly the mothers, that had not done what they had been told to. They were judged very harshly and described as: "ungrateful", "lacking motivation", "totally uncooperative", "sabotaged the intervention", "originating serious difficulties", "antagonists", "ambivalent", "very weak", "very good in talking but not doing almost any change" and "not agreeing with anything". Overall, social workers employed two main strategies to deal with the "lack of cooperation" obstacle. One was to use more control to enforce the decisions (this will be described in the next section) and the second was, to put it bluntly, to give up on them.

There were several disturbing examples from social workers accounts of a reluctance to further invest in the family. Here is one quote which expresses this stance:

> Although, I believe that other things may help them, but they don't want so I can't change the world. Today, I am at a point of some kind of acceptance, less investment. I say that I invest less in them because there is no choice, it is their choice. I could have invested in them a lot, and as far as I am concerned they could have reached far. It is their choice. (SW: Case 1, SSD E)

9.2.5 *Therapeutic Rather Than Juridical Process*

The final argument of this chapter is that practice, through the decision making process, missed the target of establishing a therapeutic process. There is a difference between calling for help and being able to receive help. To be effectively engaged in an intervention requires motivation, commitment, dedication, and conviction. These elements cannot be forced on the individual but rather they are a matter of personal accomplishment achieved at a different pace. Yet, they can surely be encouraged. There were examples of three parents who did make a positive change in their life circumstances after the PIECs. It was difficult for social workers to identify the PIEC as the cause for such a turning point, yet it was a significant step in the road. For example, a mother who made an independent referral to the local mental health service realising she must work on her personal difficulties in order to become a better mother to her children so they could return home from placement, started to visit her children very frequently and insisted her parent training sessions be on a weekly basis rather than every two weeks. Nevertheless, it seems that for the majority of children and parents reinforcement and encouragement were still needed in order to develop their acknowledgment that things could be better and build up their confidence in their ability to make them so - and it is at this juncture that social workers could have played a crucial role. It can also be claimed that this is the crux of the social work profession. It was shown rather, that social workers expected and hoped that a change in either attitudes or actions would occur as a result of the PIEC discussion, even when no professional help was delivered. Yet, this turned out to be naïve and unrealistic. Standing out was the following, admirable in its honesty, testimony of one worker. Her reflection on the reasons for the partial employment of the intervention plan voiced something new to the standard condemning tone, something that was missing in all other accounts. She took responsibility.

Researcher: Why is it to your opinion the decision was not implemented?

Social Worker: Because I don't have the time. Let's say I would like to refer the girl to assessment or refer the boy to a speech therapist, I need to convince the mother, and I need to reach out for her. Before I refer them to a treatment I need to additionally invest in developing the mother's motivation to cooperate. That is to say, I will have to put more resources in that, more resources. We used to sit three girls in the same room, in a way that there is no privacy, no means to engage in a conversation. We don't have the facilities, only recently we have moved and now we are still two workers in the same room. (SW(2): Case 9, SSD A2)

Moreover, it was found that the problem that was classified as the family members' lack of collaboration was typically dealt with by more stern control. Social workers' descriptions of their recent or future actions revealed a pattern of steady escalation in the level of coercion employed. The starting point of this process was to involve a SWYL in the case. This was the most common means of control reported in order to impose the intervention. The next step would be to utilise the SWYL's mandatory power and refer the case to the juvenile court. Here is an exemplar of this pattern of exercising progressive measures of control as a means to implement the decision.

Many times when there is resistance of the family to the decisions and there is no cooperation then the risky situation sustains and even escalates, and then when something sets the fire it becomes easier to make the change. There will be a crisis, the girl or the mother will have a breakdown and then we will activate the Youth Law and then we will get the mother's cooperation. (SW(2): Case 1, SSD D)

What was very much problematic about this almost inevitable course of action was that it was also designed for cases were no intervention was actually provided. For example, social workers of 13 and 11 year old boys had scheduled a date for a review PIEC where they intended to recommend out-of-home placement. Both boys' conditions had indeed worsened dramatically, yet neither they nor their mothers had been provided with any means of therapy or support in the six month that followed the PIEC. Thus, these families were in fact not given a valid opportunity to be helped within their community, before the drastic solution of removal from home was employed. Furthermore, the worsening in the children's conditions was now a justification, on its own merit, to remove the children from home.

9.3   Conclusions

The findings presented in this chapter show that the PIECs create a reality that advances rather than prevents children's removal from their home. It was shown that the intervention plans decided on were usually not fully implemented since the services were not available or because they did not correspond with family members' preferences; obstacles that were well recognised through the discussions, but ignored. And so, even though the requirement for urgent provision of help was well identified, it was not, or only partially, provided. The practice in the aftermath of the PIECs fitted even less with the reform's principles of good practice and in effect families were no longer given the priority they have received through the early stages of the decision making process. Under these circumstances families' conditions continued to deteriorate until the option of out-of-home placement became the most suitable and supposedly inevitable solution. Based on the fact that an attempt to provide services in the community had been carried out, but failed, and that could be attributed to families' opposition, it became easier to justify (and even enforce) this drastic solution when coming before a review PIEC or before the juvenile court. Next, is the final chapter of this thesis which includes a conclusive discussion of the research findings.

10.   Chapter 10

Conclusive Discussion

This thesis has focused on the government of Israel's reform to enhance child protection decision making carried out in the framework of Planning, Intervention and Evaluation Committees. In the first section of this concluding chapter research findings are pulled together in a new way. The discussion identifies the key systemic forces or latent conditions that interfere with the reform having the hoped for impact a cross the various stages of the child protection process. Although, these factors will be distinctly presented it is their interaction or cumulative effect that prevents the reform from being fully and successfully implemented. Through this section operative implications of the findings, primarily aimed at policymakers are discussed. In the second section of the chapter examples of effective systemic models of service delivery that suggest fresh alternatives to the conventional way of working are presented. Finally, implications of the findings for research are discussed, pointing at both the limitations and contribution of this research as well as consequent suggestions for future research.

10.1 Systemic Barriers to the Reform's Implementation

The current research set out to meet three key targets: to examine the extent to which the changes prescribed by the reform are being implemented in the field; identify underlying factors that act as barriers or facilitators to implementation; and evaluate whether the reform is having the desired impact on improving outcomes for children and parents. Based on the relatively small number of cases followed, the conclusive finding of the research is a very limited realisation of the reform's aims for strengthening practice and improving the safety and well-being of vulnerable children. If the reform's lack of success in accomplishing its valuable ambitions is to be explained by one overall argument this is that it was designed without a realistic picture of the practice world where it was implemented, and hence was ill-suited to the organisational working environment and

culture. In this section the forces that shape practice and lead to particular patterns of outcomes for children and families are presented. These factors include: 1) SSDs working conditions, involving: workloads, time for building relationships, organisational culture and professional supervision and support; 2) insufficient training and qualifications; 3) lack of strong organisational leadership; and 4) limitations of formal working arrangements between professionals.

Before turning to discuss this thesis' conclusive arguments it is important to emphasise it is well-recognised that there is much commitment and good intention within the system. Professionals spoken to during this research, from policymakers at the apex of the ministry, through SSD leaders, to front line workers, showed great dedication, passion and commitment to do better for the benefit of children and families. Unfortunately, this research could find no significant evidence of improved outcomes for children. This research also met with caring parents, most with limited means and multiple serious problems, who were experiencing difficulties in child-rearing. They had struggled for a considerable time to provide adequate care for their children and were willing to receive external support and help. Unfortunately, their motivation to improve family life failed to turn into better parenting.

10.1.1 The Organisational Context: Working Conditions and Culture

The logic is very straightforward. For better care and protection for children to be achieved, families rely on confident and effective social workers. These professionals, in turn, rely on their organisation for providing them with the appropriate conditions, qualifications, resources and support to do their job well. This research showed that most of the ways forward suggested by the reform could not happen due to local SSDs falling short on these requirements. It is thus argued that the systems' underlying problems, i.e. latent conditions, need to be resolved in order for the practice to address the new working standards. Another way to put this, is that the reform's ineffectiveness to enhance the quality of child protection decision making and improve outcomes for children and families is because it was designed to remedy 'active failures' and overlooked the 'resident pathogens' within the system which operated as powerful obstructions to ambitions of progress.

Workloads: It is already well-recognised that social workers at the SSDs are carrying too high workloads which make it hard for them to perform well (Horev and Kop 2009; Katan 2012). This research provided very strong evidence for the widespread detrimental effect pressures of workloads have on social work practice. Heavy caseloads, an average of just over 150 families per worker, were holding back the practice from adapting to the reform's new way of working. The research identified that a key barrier to the reform's implementation was the lack of a statutory whole system approach to managing the pressures of workloads in a way that prioritises good child protection practice. Time pressures on front-line workers, and an increasing number of service users reporting to them without any systematic method for prioritising and managing referrals, resulted in a need to focus narrowly on urgent cases and tasks, at the expense of the complexity, persistence and quality of service provision. This strategy, known as firefighting, was deeply rooted in the SSD working approach. Drifting between cases according to users' sporadic burning needs and unpredictable pressing demands compromised regular ongoing direct work with families and other professionals and was a recipe for sporadic, patchy and disruptive service. Workflows (case allocation and staff turnover) also interrupted the consistency of front line practice and added disconnections between workers and families as well as between workers and the other professionals involved.

Typically, the task of helping families with serious problems was carried out in a broken and fragmented manner with the intensiveness of action and involvement rising at some points and then declining. Practice was kept dormant until workers were alerted by others that the family situation had worsened badly enough for there to be serious concerns about child safety and well-being. In these circumstances, the PIECs operated as a temporal, short-term intensive crises response in the life of high concern cases. After the decision to refer a family to the PIEC had been made, workers became more involved with families (mostly with mothers) and other professionals while preparing the case for the committee. However, the intensiveness of workers' involvement ceased shortly after the PIECs ended; then cases returned to their latent state while workers turned to the next burning task on their hands. This happened even though, in effect, the majority of discussions were not followed by any help or positive change in the children's or family's condition.

It is important to remember that policymakers' overarching aspiration for the reform was for it to be established as an advanced routine way of working. The workforce was expected to commit to its principles continuously, before, during and after every PIEC, and basically in every case. Yet, data showed that attempts to implement the new practice standards, for example to engage with children and fathers and to cooperate with professionals external to the SSD, were demonstrated to be one-off events. Furthermore, clustering practice potency mostly around the PIECs discussions showed clear confusion of means and ends which is often the outcome of child protection reformation actions that focus on procedural-based improvements (Munro 2011). The overall goal of the reform was to achieve on-the-ground improvement in children's safety and welfare; carrying out the PIECs according to prescribed procedures is a means to that end, a step in the way, not the end in itself. Since after six months the condition of only a third of the children discussed in the committees was reported to be better while for the rest it stayed the same or worsened, the PIECs' decision making process did not meet its ends.

The pressures of an over-burdened workplace were shared by professionals at all levels of the organisation and had direct negative impacts on front line workers' performance on a number of counts. Busy team leaders did not protect supervision time for their social workers. They were mostly involved in helping workers decide whether to make a referral to the committee and when to participate in the discussions. Front-line social workers were, hence, left alone to face the challenges inflicted on them by the reform's requirements. Busy coordinators coping with very stressful senior roles while struggling with increased demands for PIEC discussions, had only stretched capacity to fully act on the roles prescribed to them by the reform. Consequently, some of the tasks they were responsible for such as in relation to children's participation, invitation of participants and distribution of case materials in advance were delegated to over-occupied front-line workers. It is also argued that coordinators did not act as effective gatekeepers in relation to social workers' referrals to the committees. There was evidence of social workers not using the committees as intended and contributing to an increased referral rate due to a lack of confidence and proficiency to act on their own in complicated cases. The heavy schedule of the committees had in itself negative effects. It led to delays in PIECs' availability, yet more importantly it resulted in exhausted and cognitively drained decision makers.

This research calls for imperative reduction of workloads to allow for growth in the depth of child protection practice; otherwise professionals' duty to safeguard and promote the welfare of children and young people will continue to be compromised. Reducing workloads can be done by done in several ways: by employing more social workers so the number of cases held by each full time practitioner lessens; by involving senior professionals in scrutiny management of cases so that where no active work is being done practitioners will be encouraged to close the case; and by putting more experienced people at the front door so they turn away more inappropriate referrals.

In addition, SSDs should review the capacity of its coordinators and look at the potential to increase the number of posts in the department. The increase in coordinators' capacity should reduce the number of PIECs discussions lead by each coordinator and thus provide more time to complete pre and post discussion aspects of the role. It should also enable coordinators to spend more time supporting front-line workers.

Time for relationships: The Final Principles Paper (IMSSSA 2004a) holds the core values and principles of the reform. The Implementation Team's Decisions Paper (IMSSSA 2004b) translates these crux values and principles into tangible and straightforward working procedures. To make the reform a reality at all levels of child protection work, it is necessary to further translate procedures into time. Time is a critical resource national government should have put in place for social workers in order to make good practice possible.

As argued in Chapter 2 the first and foremost important principle of effective child protection practice is the establishment of constructive working relationships with families. It is the human and interpersonal aspect of the profession that matters and underpins the outcomes of the helping process. The present way of working in the SSDs, of generalist social workers responsible for over a hundred families acting under immense daily pressure, falls short of this most basic requirement. The research revealed a child protection system where the workforce is being deflected from spending time with families due to other pressing demands being given greater urgency. This was found especially in relation to significant adult family members, such as fathers or other carers in the household and to children. In regard to fathers, findings showed they were generally avoided and so any possibility of constructively engaging them in caring for children or of

depending on them as a resource for help and support to the child, was forfeited in advance. The most striking finding of this study was the minimal contact social workers had with children and young people through their daily work. Front line workers were adjusted to a way of working in which children are not seen as the service users. None of the children in the sample had enduring meaningful communication, not to say relationships, with their social workers. The predominant pattern of engagement with children was through sporadic brief interactions which commonly did not involve one-on-one conversation. The alarming fact that decisions had been made about five children without a social worker even seeing them is a seriously dangerous defect that should serve as a warning sign for senior management to the deep alienation of children from the practice. In failing to get to know the children, well intentioned hopes for children's participation failed, and so, for the majority of children and young people their voices were not heard when decisions about them were made. Since most social workers avoided interactions with children they could not represent their feelings, worries, views or wishes during the PIECs. Israeli children deserve what their counterparts overseas receive, recognised as the most valuable element of the help process, continuous relationships with a reliable, dedicated, kind and trustworthy social worker (Munro 2011; van Bijleveld et al. 2013).

Policymakers are called on to consider how time and resources can be reallocated to allow social workers to develop stronger working relationships with families and this should be seen as a priority. For example, increasing the number of administrative staff to support professionals can provide social workers more time and capacity to adapt a more relationship based practice approach, yet this will also require a change in the philosophy and culture of SSDs.

Organisational culture: The over stretched SSDs studied tended to cultivate a firefighting approach that had far-reaching damaging outcomes for children and families. Under a firefighting organisational culture, the practice was seriously confined to a reactive, mechanistic and automatic way of working that avoided creativity, in-depth thinking and rigor of performance at all stages of the child protection process, from identifying the problems to dealing with them effectively. Like firefighters, social workers waited to be alerted that problems had escalated before becoming involved. This responsive position contributed to delays in the provision of help when levels of difficulty

were still low. Put simply, more harm or even more serious harm, having both short and long terms negative impact, was done to the child until someone eventually intervened. Case information collected leads to the informed prediction that early help could have made some of the referrals to the PIECs and subsequent more drastic and costly measures of intervention, unnecessary.

Harried workers carried out crucial tasks in an overly simplistic and superficial way. Findings revealed workers who kept to the most accessible sources of information while evading rigor in investigating family life, produced poor family assessment reports which lacked robust analysis of evidence's meanings and implications, and automatically invited school teams and mothers to participate while failing to think 'out of the box' and involve significant others within and outside the family. The detrimental consequence of this rushed practice is that care plan decisions were made without complete understanding of the complex array of factors that influenced (positively and negatively) child safety and well-being.

Harried workers feeling there is more work to do than time available were not seeking opportunities to increase the depth of their practice and judgment, but rather ways to shortcut procedures and processes. Evidence showed over-arching reluctance to grasp the opportunities the reform's new tools and procedures offered to improve the quality of the service delivered and a tendency to preserve the conventional way of working that consumes less time and energy. Some examples for shortcut processes that become routinised within the work included, misuse of new tools and their adaptation into shorter versions, strong reliance on others' accounts instead of striving to gain first hand impressions of family life, and preference for consulting colleagues rather than searching for empirical evidence.

Harried workers who operated within an unpremeditated and messy organisational climate could not keep to an orderly, planned and scheduled practice. The reform's demands to divide the care planning process into a series of tasks to be completed and recorded one after another according to prescribed timelines is like asking the workforce to speak in an unfamiliar foreign language. Timeframes in regard to discussion schedules, participant invitations, case material distribution, follow-up measures and review committees, were usually violated.

Harried workers formulated standard and conventional intervention plans. An examination of the final decisions showed that pretty much the same solution recipe was offered in most cases: parents' training programmes for parents and therapy programmes and/or after-school programmes for children. Care plans were often not in keeping with what individual parents and children needed, or with acceptable timing and location of services for families, or with the actual availability of help, or with strength and familial resources that could have been built on. Follow-up data suggested that the fact that help was not tailored to the specific family contributed to the low implementation rate of intervention plans.

Harried workers tended to get absorbed in the present-day pressing issues and failed to carry out their responsibilities of monitoring the decision implementation and following up their outcomes in the aftermath of the PIECs. Being confined to the assumption that as long as they are not alerted it is fine to presume that children are doing ok, led to the same scenario that initiated the PIECs in the first place, i.e. intervention when the family situation or the child's condition had deteriorated too far.

The resource of supervision: The message from the literature is very simple and clear-cut: good child protection practice depends on good professional supervision (Munro 2011). Too many workers in this study did not get access to frequent supervision and some had no supervision at all. Weekly supervision meetings were the exception rather than the norm. Most social workers gained substantial help from their colleagues, in particular SWYLs, through sporadic informal interactions. Yet, as valuable as these encounters may be they cannot be a substitute for ongoing, purposive and structured supervision.

This research showed that team leaders tended to be uninvolved after a decision to refer a case to the PIEC had been made. While in 13 cases referral decisions were carried through supervision meetings, in only four cases were team leaders engaged in any preliminary tasks of preparing the case to the committee, and in only six cases in the intervention implementation process. This resulted in workers being stripped of professional supervision that could have helped them to better respond to the challenges thrown up by practice, including those inflicted by the reform's new demands.

This study identified four specific functions of supervision that were particularly missing in practice:

- Appraisal of reasoning and judgment by a fresh pair of eyes: Workers relied on their intuitive wisdom. In fact in was evident that intuition was given a higher status than an analytical way of thinking or evidence-based practice. Intuitive reasoning has considerable benefits, in particular for over-burdened workers with little time to invest in each case (Munro 2008c). However, as mentioned in Chapter 2 it also involves some obscuring biases that can make practitioners judgment distorted, misleading, superficial and overall defective. Findings showed practice that suffers from several recognised biases such as availability bias which manifested in a tendency of professionals to make their case about the children's condition by using a specific event which was used as an exemplar of the general family dynamics, or confirmation bias which was manifested in that after six months all social workers positively evaluated the care plans decided on as right and proper even though there was no strong evidence of improved outcomes for children and in some cases the situation only got worse. Yet, most prominent was evidence of attributional bias and groupthink which considerably affected decision making. A successful solution to this core practice problem, as mentioned in Chapter 2, is to involve an objective fresh eye on the case which can help to consider alternative points of view. This is precisely the function of professional supervision for social workers and the function of the permanent forum of objective experts for the PIEC decision makers. In regard to both it was not achieved.

- Promoting critical thinking: Workers need to be encouraged to think critically about their performance. They need to question the effectiveness of their practice and to seek and identify weaknesses and limitations in their own judgement and actions, and it is supervision that can ensure workers review their practice effectively (Gambrill 2006; Ruch 2007). At present, many of the persistent practice shortcomings that get in the way of delivering effectual help, mirrored the drawbacks of not applying critical and reflective thinking to the work, for example: failure to consider relevant sources of information; ignoring families' strengths and informal resources; and failure to evaluate decision outcomes and make necessary changes in care plans. In order to reinforce better help provision and outcomes a

shift should be made towards perceiving the investment of time in critical thinking as an essential part of social workers' tasks and its encouragement and accomplishment as an essential part of supervisors' duties.

- Reflection on emotions and emotional support: Another function of supervision relates to the role of emotions in practice. As argued in Chapter 2 emotions are placed in their significance alongside workers' reasoning and performance. The emotive aspect of the practice can enrich thinking, decision making, and action, yet practitioners need to work intelligently with emotions. Supervision is a space where the emotional dynamics of the work can be openly explored, reflected on and its implications understood. This research provides evidence of the impact of workers' emotions on their practice, for example, anxiety about making difficult decisions individually; fear of violent parents; dread of raising sensitive issues with parents; and blaming family members for their situation. Yet, beyond the micro context of specific performance on specific cases, working on a daily basis in the field of child protection carries considerable stresses due to the emotionally charged nature of the work. Evidence shows that the PIECs imposed a considerable emotional burden on the workforce, both social workers and coordinators. Moreover, when organisations, hopefully, move towards a more child-centred system and restore the connectedness with the children they seek to assist, management should be prepared that the workforce will be emotionally affected by the distressing content of children's communication and the painful realities exposed by them (Morrison 2007; Munro 2011; Ruch 2014). Management need to be committed to sufficiently supporting practitioners in becoming resilient to dealing with the add on emotional impact of the work.

- Managing time resources and workload: Supervisors should also take an active role in line management responsibilities. In the present circumstances of heavy workloads, workers struggle to cope with the tension between their duties and the real work realities. The workforce should be helped to productively prioritise their time and deal effectively with competing demands.

Policymakers must establish overall commitment to new standards of support for the frontline workforce. Practitioners' effectiveness depends on the provision of high

quality continuous professional supervision that encourages critical thinking, objective perspective and provides emotional support when dealing with difficult families. Increasing the numbers of team leaders can help to improve the support level for social workers. An increase in team leaders builds capacity by creating smaller teams. This change should improve team leaders' understanding of social workers workloads; provide more regular and meaningful supervision; help prepare for the committees especially where social workers need support; and allow team leaders get more involved in implementing and evaluating care plans decisions to ensure parents and children are not negatively impacted by the decisions or by delays in services provision. Cowork with supervisors can show how to manage particularly challenging families and may make some referrals to the committee redundant. SSDs' managers should monitor supervision activity in their departments to ensure social workers get regular supervision and opportunities for advice, reflecting on practice, etc.

10.1.2 Professional Training and Qualification

Another reason why professionals could not offer a better service to families and children is that they were not equipped with the appropriate skills, knowledge and qualifications to carry on the reform's over-ambitious goals. The training programme offered to SSD leaders through the reform's implementation process was proven to be ineffective in setting the practice on the right track. The nature and complexity of the tasks assigned to generalist social workers required their qualification to be given precedence over senior professionals. While not having the right knowledge and skills in order to be effective, generalist social workers could not depend on SSD leaders who in effect offered only little support and guidance on the reform's tools and procedures, which prescribed what to do instead of helping them to do so. Furthermore, evidence of coordinators unsuccessfully struggling with the same challenges as front line workers can only mean that IMSSSA overestimated the knowledge and skill of its workforce and failed identifying the key practice weaknesses. This research identified key communicational, inter-personal and analytical skills, known to make a significant contribution to sound decision making, effective service delivery and successful outcomes, where workforce, front line workers and coordinators, seriously lacked qualification and proficiency. The findings make a case

for critically improving workforce qualification and training in engaging effectively and communicating directly with family members, especially children.

Communicating effectively with children: Statutory requirements for children's participation did not fit with workforce skills and capabilities in communicating with children. However, there is more to it. It became apparent through this study that workers lack of confidence in their skills to converse face-to-face with children lead eventually to almost total disengagement. Direct communication with children was uncommon and when carried out it was only with older children and mostly jointly with their parents. Moreover, evidence from this research raises concerns about the workforce's poor quality of direct communication with children, either prior to or during the discussions, which is not only inadequate to allow understanding of children's perspective but also having distressing emotional impact on them and subsequently leading to withdrawal from further engagement with professionals and rejecting help opportunities.

Communicating with parents: the care and control dualism: As mentioned in Chapter 2 the art of communicating with parents in the child protection context lies in professionals' ability to combine care and control qualities together. It is the combination, rather than excelling in one of them, that is the key to the provision of the best help and protection possible; and it is in meeting this challenge where practice was most defective. A significant finding in this study was that practitioners reconciled the need to simultaneously work with both frames of minds i.e. authoritative and assertive as well as supportive and understanding, by adopting only the latter while projecting on other professionals including the PIEC the control function. There was clear evidence of workers using the committee's authority when working with more difficult to engage with families; as there was evidence of the use of mechanisms of coercion and control in the discussion in order to enforce agreements.

Social workers acknowledged the advantage of taking a collaborative approach to their work with parents and hence made efforts to establish positive relationships with them. Yet, they got their means and ends confused. The pursuit of collaboration, as it happens, got in the way of building effective partnerships with families. It goes without saying that when the problem is not clearly known it cannot be solved. This holds for the two key groups involved in child protection: families and professionals. When parents

were not conversed with in a fair and honest way about problem-related issues, they were not clear about what was expected of them and hence could not even attempt to make a change in that direction. Listening to parents, it became clear that the majority perceived social workers as people who care and are willing, and perhaps able, to help. However, they also wanted workers to be open and straightforward about their concerns and to be able to "put their cards on the table".

The extent to which practitioners had moved away from the authoritative position negatively influenced and distorted decision making. The danger was that professional members, including coordinators, avoided raising sensitive issues or taking a confrontational stance by persistently challenging poor parenting, and overlooked or minimised the seriousness of evidence suggesting maltreatment. No matter how well care and support intervention plans are packaged and how cooperative parents are in carrying them out, if they are not logically and accurately problem-related they are bound to have little or no outcomes in improving child safety and well-being.

Analytic reasoning and analysis: Another significant professional capability which needs urgent attention and calls for intensive training, relates to the intellectual aspect of the work. Taken together, the research finding show that the decision making process was lacking the rigor of analytical thinking. It was shown that practice was devoid of purposeful and structured analysis of case evidence both when preparing the PSRs and though the discussions. Practitioners very efficiently relied on their intuition and experience which enabled them to capture patterns or sets of evidence in regard to family life and recognise them as worrying or of high concern. Yet, they were much less capable of drawing the meaning of individual details picked up, in computing the different variables together and in deducing conclusive assessments of how the family is functioning and how this impacts, positively or negatively, the immediate and future condition of the child. Content analysis of lengthy PSRs showed them to be predominantly descriptive accounts and missing robust analysis of evidence. Observational data showed that none of the discussions included any procedure of information analysis. Analytic reasoning was also missing through the process of considering possible solutions. The discussions did not follow a systematic process in which each intervention option is considered according to its likely consequences and the best possible outcome is chosen, rather it was hardly orderly controlled or managed.

A typical formal analytical framework for reasoning in child protection work is risk assessment. Risk assessment involves the immediate danger or harm to the child and the potential for future maltreatment, and is the cornerstone of child protection care planning (Hughes and Rycus 2007). Although the phrase 'child at risk' was routinely used in the professional jargon, case situation was not analysed in terms of the risks and, in effect, practice completely withdrew from engaging in risk assessment. Workers need to be able to better articulate what they are worried about and to do so based on a clear and distinctive understanding of what the past harm and the future danger is. Their PSRs need to set out these issues clearly so that decision makers can easily understand what needs the intervention plan should address. It is recommended that policymakers consider creating a risk rating approach so that risk is more transparent to all parties, consistently applied and adjusted over the time of the care plan. The Signs of Safety approach, introduced later in this chapter can provide a useful strategy to analyse and measure elements of risk. Including a risk rating on a scale may also help parents get a better idea of the risks involved in their case and how significant they are and why it warrants a PIEC.

Furthermore, workers' reasoning was too dominated by a problem-focused approach. Families' strengths, capacities, resources and sources of support were not sufficiently explored or built on in the provision of help. Parents in the study had obvious motivation to improve their care and better their children's condition, most had networks of people such as friends, grandmothers, support groups or religious communities surrounding the family. Yet, these valuable assets were overlooked. Relying on existing informal support and resources could ease the burden on the social services system or at least provide the family with a safety net until formal over-busy help programmes become available.

The reform's advocacy of a more analytic approach to decision making was manifested by the introduction of tools packages to practice. The tools were hoped to make the work process more visible, systematic, and standardised. A consistent finding in this research was very narrow utilisation of the tools in practice. Also, there was no evidence of improved performance when the tools were used; overall their main function was to record the habitual way of working. When undertaking the systems approach point of view, the variety of factors that may influence the level of performance expands

dramatically to include for example, user's required level of knowledge and skills as well as motivation to use the tool, human cognitive activity and capacity, demands of the field of activity, constraints of the organisational context and the targets the tool was designed to meet (Hollnagel and Woods 2005; Woods et al. 1994). Findings showed that the workforce felt the tools were unnecessary and an unhelpful bureaucracy imposed on them. The tools offered little help to workers where aid was most needed, for example in engaging with others, both professionals and family, in order to collect information and in interpret its meaning and implications. Also, the expectation of the tools to increase workforce capacity for analytical reasoning seemed out of reach since in order to be completed they demanded mastering precisely this type of cognitive activity. Another issue relates to the targets the tools were meant to achieve. Similar to the general tendency in the field of child welfare, Israeli policymakers intended the tools to have a dual purpose: to allow management to monitor workforce performance and outcomes as well as to help front-line workers to better carry out their case tasks (Munro 2008a). The problematic arises when these two functions are incompatible. Looking at the tool for documenting discussions, for instance, it was designed to increase transparency and recording of practice, to provide local and senior managements information about the PIECs' operations and outcomes and to help coordinators manage discussions in a more organised, effective and democratic way. However, evidence showed that these functions could not be performed at once, when coordinators were involved in recording they were unreceptive to the group dynamics and when they were absorbed in the discussions they failed to complete the tool.

It is hoped that the workforce will be more inclined to use the electronic version of the tools through the Mitve ICT system (mentioned in Chapter 3) compared to their hard copy one since they will become more assessable and less burdensome to complete, but initial data collected through the system's pilot programme in six SSDs show that workers were experiencing great difficulties in operating the system and navigating through it (SIC 2013). Nevertheless, merely computerising the tools is not expected to resolve their inherent problematics discussed throughout this thesis. Moreover, based on these research findings it is argued that the Mitve system will not lead to enhanced services for children and families predominantly since it does not address the deep organisational sources of practice failure. For instance, as long as systemic barriers to sound investigation of family

life and children's conditions identified in this study (e.g. deficient communication with family members, insufficient multi-professional work, superficial way of working, and lack of high quality supervision) are not removed, workers will continue to produce poor quality databases for decision making; they will only be recorded differently.

The Mitve system demonstrates again the basic misconceptions of policymakers about the complexity of tasks involved and misunderstanding of workforce experience in their organisational environment. For example, the system is designed to automatically produce a PSR based on the input provided. It is argued that functions such as robust analysis of evidence and drawing sensible inferences and conclusions from it cannot be taken over by a machine. The pilot study confirms that the system produces lengthy reports which are difficult to use in the committees and which mask crucial issues such as the reason for referral, risk factors and workers' experience with the family (SIC 2013). Also, the system provides routine notifications to remind workers of the follow-up schedule. This research showed that factors relating to SSD working conditions and culture led to faulty follow-up practice. Assuming that an automatic reminder will guarantee scheduled follow up and case monitoring is highly naïve, to say the least. Moreover, what is known from research on human-computer performance warns of the danger of child welfare ICT systems not only becoming unhelpful, but rather interfering with good practice. Preliminary evidence from the pilot programme already reveals some disrupting effects on professionals' reasoning that were recognised overseas, including, disturbance to the narrative flow of family stories and restraining capacity and flexibility regarding the type and amount of information that can be used (SIC 2013). The integration of computer technology is a profound transformation of the practice world and requires considerable investment of workforce time to adjust to. It is thus, that learning the technology and experiencing it can potentially come at the expense of social workers' time with families, which is already not sufficiently prioritised in the pre-technology practice.

To sum up, policymakers should invest in improving social workers key skills to enable them make accomplishments in facing practice challenges and complexities. Critically, learning and development opportunities should be explored through all levels of the system to help workforce adapt to the new way of working. Opportunities to fulfil the skills gaps identified in this research should include: training programmes for front line workers and departmental, team and supervision meetings. In addition, this research offers

opportunities for key aspects of academic qualification and post-qualification programmes to be re-evaluated in light of evidence of practice skills not being covered with sufficient expertise and competence.

10.1.3 The Lack of Strong Leadership

IMSSSA's policymakers rightfully recognised that securing the implementation of the reform will heavily depend on strong organisational leadership and hence designated team leaders and coordinators acting as the driving force for change and qualifying them to do so. These research findings, however, make a case that this strategy did not prove to be successful. Team leaders and coordinators failed to display the underpinning leadership skills and abilities required to enhance the change processes and improve practice. In fact, the way they intervened had the opposite effect.

The changes the reform recommended to practice were not simple. They required more advanced expertise, in-depth professional judgement and greater competence in communicating with professionals and family, which practitioners were ill-equipped to exercise. In these circumstances, the reform's leaders' capacity to sign up to new standards of support and supervision that include continuous and constructive feedback to enable deeper learning and professional progress, becomes critical. Being accountable for the reform's implementation locally, they should have also increased the level of practice monitoring to ensure workforce compliance with new procedures. However, as mentioned, it was evident that team leaders' and coordinators' involvement with staff in relation to their new tasks was very infrequent, so that practice was neither supported nor closely observed. They also did not model the change or motivate staff towards the intended way of working. Findings revealed that too often, team leaders and coordinators did not fulfil the responsibilities and tasks assigned to them by the new regulations. Findings touch on, in particular, neglecting responsibilities to ensure the quality of case materials presented to the committee; to include children's voices in decision making; and to follow up intervention plans' implementation and outcomes. In addition, it was found that coordinators themselves questioned the effectiveness of the tools package, created shorter versions of it, briefly used it, and overlooked widespread incompletion. When the local organisational leadership is not committed to the change and don't put pressures on staff to

comply, it is not difficult to understand why implementation was so deficient. Reform leaders conveyed a solid message to the workforce about what they ought to be doing or not be doing. As it happens, they sent their workers the message to maintain business as usual.

The reform leaders were expected to promote a strong ownership of the core principles, values and ideology at the heart of the reform in their organisation. Yet, they failed to build a vision in their staff or in themselves that procedures are not merely an 'add on' bureaucracy to conventional work, rather essential building blocks of good practice, and it is for this reason that their implementation bears importance. This point can be demonstrated in relation to family members' restricted participation in the decision making. It is argued that the lack of collective ideological movement from the traditional all-knowing paternalistic culture towards recognising family members' right to participate was a barrier to meaningful involvement of children and parents in decision making and allowing them to have an influence. In that, this study adds up to a line of robust evidence showing professionals' personal beliefs, attitudes and views play a role in enabling service users genuine participation in decision making. Participation will occur when practitioners truthfully understand they need to be open to and influenced by the views and wishes of the people, adults and children, who know best what is wrong in their lives and experience the impact this has on them. Evidence of the establishment of Towards the Community policy within the PIECs practice shows that creating a different normative work culture is possible.

Policymakers need to strengthen organisational leadership in order to secure how the reform changes are understood, valued and acted on at all levels of the system. This should be picked up and appropriately targeted in the training programme offered to SSD leaders. Leaders need to provide their staff with a reliable and regular supply of feedback to assure continuous development of services and practice. Leaders will also need to be responsible for monitoring and reflecting on practice to identify barriers to effective social work practice, services that are unavailable and/or hard to access for families and further development areas, and to report their input back to their managers.

As previously stated, coordinators have an important and powerful role in the PIECs process. It is recommended that coordinators should have mechanisms to review

their own performance and receive feedback form professionals and families in terms of themes identified by the research. For example, colleague's observation in the committee or assessment model, which uses anonymous input from social workers, agencies and parents, may provide coordinators a helpful insight into how they can best conduct the PIECs discussions and their preparation.

10.1.4 Working Arrangements between Professionals

This research finding makes a case for further legislative actions, rules and regulations being essential to enable professionals to work together constructively. In particular, the findings suggest that legislation is required in order to guarantee multi-professional participation in the PIECs. Efforts to enhance multi-professional working should focus, in particular, and with great intensity and urgency on establishing collaborations between the social and health services where no move forward has been achieved. There is no doubt that the expertise of the health profession is indispensable to PIECs decision making. The research provides very strong evidence that in the absence of health professionals some intervention plans did not respond to or even fully realise the full range of family needs that were consequences of health related difficulties. It is also assumed that collaboration with health professionals could have advanced the immediacy of help by preventing delays due to lack of specialist assessment and by opening up more resources and intervention options, rather than overburdening local mental health services.

The highly encouraging findings of this research were the tangible improvements in collaborative working between the social services and the educational system through some stages of the PIEC process. Problems in family life had an obvious ripple effect on children's performance in the academic sphere, and hence solving these problems had become a clear incentive for both schools and social services and an important driving force for school teams to share information, participate in the discussion and contribute their system's resources for the benefit of children and families. Unfortunately, these promising findings for cooperative working relations had limited implications in the practice carried out after intervention plans had been formulated.

Policymakers should better consider and prescribe what complexity of expertise is needed for making PIEC decisions and refine regulations towards this end. At present, the new guidelines regarding the committees' composition contribute to confusion, inconsistency and inefficiency, such as the inclusion of numerous professionals to represent the same role or expertise. Policymakers need to critically re-examine what constructive composition of decision makers looks like, since at present it does not necessarily relate to effectiveness. Having more people involved was not a straightforward assured recipe for better decision making and outcomes and in fact often obstructed other core principles of the reform, including family participation and establishment of decision based on agreement and a therapeutic process. For example, a large forum had an undermining effect on children, and some parents, feeling the necessary degree of comfort to speak openly and directly; the inclusion of SWYLs added an inevitable control aspect to the process; and discussions seriously suffered from groupthink mechanisms which raises questions of whether decisions were indeed at matter of shared agreement. In addition, the research provides evidence to suggest that the decision making in the framework of PIECs led to a decrease rather than an increase in individual professional's accountability and responsibility for improving the child safety and family wellbeing. Participants could go away from the committee with a sense of confidence and direction, and a strong belief they have done their duty by participating in the committee. Follow-up data showed practitioners, including social workers, coordinators and school staff had withdrawn their strong sense of commitment to the family situation in the aftermath of the PIEC.

After the latent conditions of the SSDs had been identified and their interactional impact on practice had been uncovered the next section describes some systemic evidence-based approaches to deal with them. Implications of the research findings and recommendations for policy continue to comply with the systems thinking undertaken in this thesis.

10.2 Implications for Policy

This thesis advocates that it is time for an alternative, fresh, whole system approach to deliver services for vulnerable children and families to be considered. The focal message of this research is that the quality of SSD work environments needs to be raised

significantly if effective delivery of children's and families' services is to be achieved. The study implies that major changes are needed not just slight revisions. The conventional approach to discussing the research implications for policy would be to draw improvement suggestions in regard to each of the organisational obstacles identified in the study. However, doing so will mean failing the systems way of thinking advocated throughout this thesis which highlights the interplay between different parts of the organisational system. To better amplify this point, the findings, for example, make a strong case for radical improvement of social workers' knowledge and skills around certain child protection tasks. However, the provision of adequate training will not bear the potential results if changes in the working conditions are not changed to enable the incorporation of new learning into practice. Workers need their time to be invested in working directly with service users and ongoing supervision to in order to apply their knowledge and display its qualities in their routine work.

Grounded in a period of vast reformation in the provision of individual social services in Israel, when the reform in the PIECs is still evolving alongside efforts to design far-reaching transformations in the SSD infrastructure, this research offers a window of opportunity to re-evaluate the conventional working approach in light of recent tendencies in the UK and beyond to deliver services for children and families by working in multi-disciplinary systemic ways. The depth of change suggested by these new ways of working requires considerable investment of resources. However, evaluation of their effectiveness shows they ultimately lead to substantial improvements in services and successful outcomes and thus, in the long run are highly cost-effective.

10.2.1 The Front Door Approach: Multi-Agency Safeguarding Hub

The front door approach to manage workloads had been expanding in the UK in the last years and is proving to be highly effective in reducing repeat referrals and in closing cases which do not require further action through quick response and early intervention (Home Office 2013). Today, there is a range of such innovative models in place around England[93], all are based on strong multi-agency partnership and involve multi-agency

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[93] For example: Front Door, Access, Triage, Central Duty Team, Multi-Agency, Referral Unit, Multi-Agency Safeguarding Hub and Joint Action Teams (Home Office 2013).

information sharing, joint decision making and coordinated intervention (Home Office 2013).

One example of a highly effective programme is the Multi-Agency Safeguarding Hub (MASH)[94], which had been adopted across much of the UK since first introduced by Devon County Council in 2010 (Crockett et al. 2013). A MASH consists of a multi-professional team staffed with a whole range of agencies' representatives including: police, local authority children's social care, education, probation, health, mental health and even the ambulance service. The effectiveness of the MASH is powered by the colocation of its staff. Professionals of the team continue to be employed by their individual agencies but are colocated in one office. Colocation ensures that the agencies are sharing information and are able to respond to a child's needs quickly and efficiently. It also facilitates a culture of joint working, develops a better understanding of the work undertaken by each partner organisation, promotes mutual respect among agencies and builds trust (Crockett et al. 2013; Home Office 2013). All notifications relating to safeguarding and promoting the welfare of children go through the hub, MASH staff then gather information from every agency and information is shared securely within the hub. Based on all the information pooled, a decision is made by a social work manager as to what further action is required, including no action if decided that the child is safe. Where appropriate, the MASH team is able to immediately trigger an intervention response to the child or young person and their family to prevent harm (Crockett et al. 2013; Home Office 2013).

The MASH programme is introduced in this chapter as a solution with proved evidence-based[95] effectiveness to some crucial practice weaknesses found in this research, specifically, inconsistent multi-agency working and in particular limited engagement with health partners; delays in spotting emerging problems and early response to them; and provision of service to children which is not always appropriate to their needs (Crockett et al. 2013; Home Office 2013). Additionally, in relation to SSDs' limited resources the MASH method is cost-effective since it fosters greater efficiencies in process by avoiding duplication of procedures across agencies (Home Office 2013), which means that resources can be re-invested into developing help, and preventative services in local communities.

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[94] More information about the MASH is available online at: www.devon.gov.uk/mash.htm
[95] For example, a recent academic report from the University of Greenwich that assessed the impact of MASH in five London boroughs (Crockett et al. 2013).

10.2.2 The Systemic Unit Model: Reclaiming Social Work

Another example for a whole systems change to the way in which child and family social work is practiced and managed is the systemic unit model commonly known as the 'Hackney Model' or 'Reclaiming Social Work' (RSW)[96]. RSW is an initiative introduced in the London Borough of Hackney in 2008 which is based on a management model developed in the business sector and adapted to achieve high quality social care for vulnerable children and families (Munro 2011; Forrester et al. 2013). The systemic unit model provides the workforce with the key enabling organisational conditions required for working effectively with children and families which are very much missing in the Israeli context, including: reduced workload stress; close supervision; emotional support; sound skills, knowledge base and methodology; encouragement of reflective learning; consistency and continuity in multi-professional work; more time to build relationships with parents, children and young people; and administrative support that can free practitioners to invest their time in tasks that necessitate professional expertise.

The innovative nature of RSW is in that it departs from the conventional working structure in which families are allocated individual practitioners who are supervised by an immediate line manager. The systemic unit model allocates cases to small multi-disciplinary social work units of five to seven workers, each with specialist roles, which collectively work on the case, headed by a senior social worker (London Borough of Hackney 2008; Forrester et al. 2013). The unit consist of a consultant social worker who leads the unit, provides expertise and leadership and has ultimate responsibility for case decision making. The consultant social worker both works with families and manages cases. Also within the unit are: a social worker, a children's practitioner, a family therapist or clinical practitioner who is a qualified systemic therapist and a unit coordinator who provides enhanced administrative support and deals with many practical arrangements so that practitioners are enabled to spend more time on direct work with families (Forrester et al. 2013). Cases are held within unit, which means that each family is known to each practitioner in the unit and direct work is received by multiple practitioners as appropriate.

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[96] More information about the RSW is available at: http://tinyurl.com/cmxeewn and http://tinyurl.com/pd2dwuu

This contributes to greater consistency in service for complex families (Munro 2011; Forrester et al. 2013). Shared working involves structured in-depth discussions of every child and family on a regular basis usually through weekly unit meetings. The meetings provide a forum for: sharing information about the case, ensuring joint understanding about children's needs and family dynamics, ensuring management of risk in cases, problem solving, looking at creative solutions, decision making and updating case records (London Borough of Hackney 2008). Through the meetings, members of the unit learn from each other and provide one another with emotional support (Forrester et al. 2013). Often professions from other services or agencies working with the family participate in the discussions. The units are usually informed by two key evidence-based methodologies: Systemic Family Therapy and Social Learning Theory. These approaches allow moving from focusing on individual pathologies to relationships and interactions in the family and wider systems they are part of, such as the broader family, the neighbourhood or professional systems (Munro 2011; Forrester et al. 2013).

Evaluation studies of RSW operations and outcomes show it has strong advantages in comparison to the conventional way of working, which are manifested in: more intensive and positive relationships between workers and children and families; greater access to supervision; more informed and thought-through decision making; a higher level of agreement between families and social workers on key issues; and higher satisfaction of both parents and workers (e.g. staff days lost to sickness fell by 55 per cent) (Munro 2011; Forrester et al. 2013). RSW was also associated with lower rates of children becoming the subject of Child Protection Plans for a second or subsequent time; a decrease in the number of children becoming looked after and increased placement stability. As a direct effect of this change the overall cost of care in Hackney has fallen by almost five per cent during the course of Reclaiming Social Work (Munro 2011).

10.2.3 The Signs of Safety Approach

A final whole system approach that also requires aligning the organisation to the practice framework is the Signs of Safety approach[97]. The pertinence of this approach is

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[97] More information about Signs of Safety is available at: www.signsofsafety.net

particularly in its proved effectiveness in creating a shared focus and constructive partnerships among all stakeholders in child protection cases, both professional and family, and improving intellectual rigour and analytical reasoning (Government of Western Australia 2008, 2011). Signs of Safety is designed to be implemented across all practice domains within the organisation to create a more constructive work culture that is focused around child safety from the initial inquiry into the child's condition to the case closure. The three principles that underpin the approach are: working relationships; thinking critically and fostering a questioning approach or stance of inquiry; and landing grand aspirations in everyday practice, which basically means moving away from what is called the 'command and control' approach to social work to learning from practitioners' and service users' expressions of their own wisdom, experience and knowledge (Government of Western Australia 2008, 2011).

Central to this approach is the use of specific practice tools referred to in general as the 'Signs of Safety Assessment and Planning Framework'. Accordingly, professionals and family members engage with each other in partnership, in situations where children are vulnerable or have been maltreated, map together the circumstances in terms of harm, danger, complicating factors, strengths, and existing and required safety and make care plan decisions (Turnell and Edwards 1997). At its simplest this framework contains four domains for inquiry: 'what are we worried about?' (i.e. past harm, future danger and complicating factors); 'what's working well?' (i.e. existing strengths and safety); 'what needs to happen?' (i.e. future safety); and 'where is the case on a scale of 0 to 10?' where 10 means there is enough safety to close the case, and 0 means it is certain that the child will be (re)abused (Government of Western Australia 2008, 2011). The outcome of this very simple and easy to apply framework sets out the degree of protective elements and of actual or apprehended risks visually on a scale. There are different versions of the assessment and planning protocols some are more suited to court and more formal contexts and some are specifically designed for use with children and young people e.g. the Three Houses Tool and the Fairy/Wizard Tool (Government of Western Australia 2008, 2011).

The Signs of Safety prescribe some core disciplines for practice that underpin the effective use of the assessment and planning protocol. These disciplines are worth emphasis since they can, and should, be projected to practice in general. The disciplines are: analysing the danger information with a clear distinction between, past harm, future

danger and complicating factors; analysing the safety information with a clear distinction between strengths and protection; keeping statements in straightforward rather than professionalised language so that everyone, professionals and family, can readily understand each other; keeping statements focused on specific, observable behaviours; exercising authority and coercion skilfully; and understanding the assessment as a work in progress rather than a definitive set piece to avoid a paternalistic professional stance (Government of Western Australia 2008, 2011). Signs of Safety had been applied and utilised in many countries, across all aspects of child protection and has been evaluated by numerous empirical studies as highly effective in promoting a higher level of skills, better engagement with families, leading to better outcomes for children and families (e.g. it was associated with lower proportions of children taken into care and fewer cases of re-abuse) and significantly reducing the cost per family serviced (Government of Western Australia 2008, 2011).

The Reclaiming Social Work and Signs of Safety approaches address the type of problems highlighted in this study. For example, both approaches are aimed at providing intense help for a limited period of time rather than the intermittent brief working contacts with service users reported in this study. Both approaches recognise the expertise needed to do the job well; they focus on training and ongoing coaching, supervision and group sharing of the thinking. Signs of Safety in particular, aims to draw as much as possible on the family, extended family and social network for support. This is very valuable when formal services are scarce.

10.3 Implications for Research

In the last section of this chapter the implications of this thesis for research are discussed. Starting with the research limitations and ending with its contribution to the existing literature and future research. As mentioned in Chapter 4, this research was not designed with the intention of meeting standards of rigor such as random sampling or generalisability but rather to provide in-depth, systematic and trustworthy insight into the PIEC decision making process which was not available before, and in that it is argued that it had achieved its goal. Nevertheless, it is important to emphasise that the research findings are particularly limited in regard to distinctive populations such as Ultra-Orthodox

Jewish and Arab populations which were not included in this study. In regard to both research and child protection practice these communities pose considerable challenges due to their segregation, suspicion and strong resistance to any external interference with family life (Rosenfeld and Kedem 1998; Goldstein and Laor 2007; Katan 2007). It is important that further research draws attention to these distinctive highly deprived populations which are especially inaptly served (Ben-Arieh 2010). Another limitation of the current research, and as far as is known of the local literature, is that children have not been conversed with directly about their experience of the PIEC decision making process. It is therefore essential that children be included in future research.

It is suggested that since policymakers have yet to establish a systematic inspection framework for evaluating the reform's implementation in practice, the current research methodology can provide some important benchmarks. The message from this research is that evaluation of the quality of workforce performance should follow some key principles:

- Be focused on outcomes: Evaluation should not be narrowed to whether the workforce is following the reform programme as policymakers intended but rather whether adhering to the new work approach is leading to improved delivery of help and better outcomes for children and families. It should always be remembered that carrying out the PIECs or even providing a service to the child or family is only one temporal step in the journey to safety and enhanced well-being; it is not the final product. The ultimate goal is to achieve on-the-ground improvement in the child and family's condition.

- Include feedback of the lived experience of those at the sharp end: front-line workers and families. Managers' responsibly for quality assurance means listening respectfully to feedback from their staff. Meaningful conversations with workers held through this study uncovered systemic factors that hindered their capability to perform well. An open dialogue about what happens when workers meet families and what resources they need can improve the organisation's capacity to learn, change and develop more effective child protection services. Organisations also need first-hand information as to what contribution the service they deliver is having for children's safety and well-being. Therefore, children and families should be provided with proper channels to regularly communicate their feedback

of experiencing the service. To date there are several empirically tested simple and highly user-friendly tools[98] designed for service users, including children, to rate the outcome of a session or service (Duncan, Miller and Sparks 2003).

- Utilise qualitative methods: Qualitative methods of inquiry allow more transparency, sensitivity and rigour when it comes to inquiring into practice and the factors shaping it. The use of qualitative research methods in this study contributed to the richness of data and the thorough analysis of how and why practice unfolded the way it did. Observations of PIECs, in particular, provided the first of its kind real world insight into the happenings, which could have not been accessed through other methods.

Linking the beginning of this thesis to its end, locally, this research provides the first evidence-based understanding of crucial issues in making child protection decisions which can be draw on and inspire future research efforts. In regard to the broad international literature, this research reinforces existing findings on the building blocks of sound child protection decision making processes, including effective engagement with parents and children, intellectual rigour and emotional support. The systems approach or 'the new view' taken by this research has proved to be highly advantageous in allowing a thorough understanding of why these components are so difficult to achieve. This thesis raises questions as to the fit between the conventional working model of individual workers solely carrying cases of families with very complex problems lacking appropriate working conditions, qualifications, resources and support and the high hopes of reformative actions in providing effective and helpful services for vulnerable children. The strong message from this research is that policymakers need to stop simply telling workers what to do and direct efforts towards establishing systems that enable them to do it. It is for this quality that the research possesses the significance and pertinence to allow its implications and conclusions to be projected onto other contexts.

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[98] Examples are available at www.heartandsoulofchange.com

10.4 Conclusions

The main conclusion of this thesis is that for good child protection work to be accomplished just telling practitioners how to do things is not enough. Rather, organisations need to be geared toward providing workforce enabling conditions, such as sufficient time, skills and professional guidance to work directly, consistently and effectively with children and families. The powerful blocking nature of the 'resident pathogens' within the conventional child protection systems to progress ambitions make a case for shifting to more systemic multi-professional working models to deliver services to children and families.

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Appendices

Appendix 1: Information Leaflet for Regional Supervisors and SSD Managers

Appendix 2: Information Leaflet for Social Workers

Appendix 3: Information leaflet for Parents: Provided by Social Workers

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Appendix 1: Information Leaflet for Regional Supervisors and SSD Managers

The Service for Children and Youth in the Ministry of Social Services and Social Affairs is taking part in a study aimed at evaluating the operation and outcomes of the recent reform in the working procedures of the Planning, Intervention and Evaluation Committees (PIECs). The impact of the reform will be studied from the perspective of both social workers and families. The study is being carried out by Ravit Alfandari, a PhD researcher from the London School of Economics and Political Science in England. Ravit has obtained the necessary qualifications, and experience to undertake work of a sensitive nature and will be supervised by Professor Eileen Munro and Dr. Hakan Seckinelgin from the London school of Economics and Political Science. The results of this study will be written up as a report, to be used by the ministry to improve the quality of services provided to parents and children.

The study is to be undertaken in social services departments that will be selected for their notable leading position in regard to the implementation the reform's principles in everyday practice. The project will include a carful examination of case studies of families referred to Planning, Intervention and Evaluation Committees. Each case will be studied through:

- A nonparticipant observation in the committees' discussions. The discussions will be tape-recorded for further analysis.

- An hour interview with the responsible social worker to take place in the social services department right after the discussion in the committee.

- An hour interview with the parents to be carried out by phone two weeks after the discussion in the committee.

- A review of case records and photocopies of relevant forms and documents for further analysis.

- An half an hour follow-up interview with the responsible social worker six months after the initial discussion in the committee. To be carried out by phone.

The responsible researcher will:

1. Conduct the research in accordance with the London school of Economics' and the Ministry of Social Services and Social Affairs' ethical policy and professional guidance.

2. Follow the agreed research proposal, subject to any amendments negotiated with the Service for Children and Youth.

3. Conduct a small scale pilot programme at the outset of the data collecting process.

4. Seek formal consent from research participants to take part in the study, at the outset of the data collection process.

5. Maintain the confidentiality of participants; that is under the restrictions of mandatory reporting of child maltreatment.

6. Maintain the anonymity of participating local authorities and individuals, in the presentation of data in the public domain (e.g. final report and scientific articles).

7. Keep professionals at the Service for Children and Youth, and nominated representatives of the local authority up to date with the progress of the research.

8. Provide a leaflet explaining the research goals and procedures for participants: social workers and family members.

9. Meet obligations for data protection and ensure that research participants are not compromised by their involvement in the research study.

Social Services Departments that agree to take part in this study will be required to:

1. Agree a strategy for involving and informing social workers most likely to be involved with the project, e.g. presentations of the research at departmental and team meetings. That is according to a leaflet provided by the researcher.

2.   Identify the coordinators of the Planning, Intervention and Evaluation Committees to act as the contact persons for the various elements of the research.

        In particular, assist the researcher to:

- Select the cases to participate in the study from the committees' schedules, including identifying which cases would be unsuitable.

- Negotiate access with the social workers selected for interviews regarding both initial and follow-up interviews. Social workers are then asked to negotiate access with the families selected for interview. Social workers will contact the families via telephone, introduce the study and ask if the researcher could get in touch with them.

- Deal with queries and unexpected problems.

3.   Provide the researcher with appropriate facilities for photocopying documents.

The contribution of this research project to the improvement of the everyday practice with children and families in need is profound; hence we appreciate your cooperation in successfully carrying it out.

Thank you very much

Ravit Alfandari

Responsible Researcher

Appendix 2: Information Leaflet for Social Workers

Dear colleague,

You are invited to take part in a study carried out by a PhD researcher from the London school of Economics and Political Science in England in collaboration with the Service for Children and Youth in the Ministry of Social Services and Social Affairs.

What is the study's objective?
The study aims to thoroughly and systematically evaluate the impact of the reform in the Planning, Intervention and Evaluation Committees (PIECs) on social workers' practice in the field.

Why should I participate?
The study provides you with a unique opportunity to voice the difficulties, challenges and achievements of your work with children in need and their families. The results of this study will be written up as a report, to be used by the ministry to improve the working procedures while accounting for workforce needs, in order to enhance the quality of service provided to parents and children.

What dose participation involve?
Participation will take about **an hour and a half** of your time. The researcher would like to meet with you and discuss a case in your responsibility that had been referred to the PIEC as well as make a short phone conversation with you in order to follow up on the case after six months.

Please note that the study's participants are guaranteed that their confidentiality and anonymity will be kept, identifying information will never be revealed.

Your cooperation is the key to practice development and improvement.

Thank you very much

Ravit Alfandari
Responsible Researcher

Appendix 3: Information leaflet for Parents: Provided by Social Workers

Dear Parent,

Recently, considerable changes have been made to the working procedures of Planning, Intervention and Evaluation Committees in order to promote genuine participation of parents in the decision making relating to their children. We want to learn from you how to further improve our services to families; hence we would like to hear more about your personal experience when attending the committee's discussion.

Since, you might feel inhibited talking to your social worker about the matter, we offer you the chance to talk with an independent person who is not involved in your case and has no information about your family circumstances. This is Ravit Alfandari, a PhD researcher from the London School of Economics, England, who is conducting a study on the subject. She would like to be present in your family's upcoming discussion in the committee and to talk with you afterwards about your experience.

If you wish to take part in this study or obtain further information about it, I will inform Ravit of your contact details, and she will contact you via telephone shortly.

Appendix 4: Information for Parents: Provided by the Researcher via Phone

Hello, am I speaking with_____.

My name is Ravit Alfandari and I have received your phone number from your social worker with your permission. I am addressing you in regard to participating in a study on the Planning Intervention and Evaluation Committees. I would like to explain what it is all about. Is this a good time for a few minutes talk? Thank you.

Recently, considerable changes have been made in the working procedures of Planning, Intervention and Evaluation Committees in order to promote genuine participation of parents in the decision making relating to their children. I am a PhD researcher from the London School of Economics and Political Science in England and I am conducting a study on the subject. It is important to stress that I am an independent person who is not working at the SSD that provides services to you and your family. I want to learn from you how to further improve the services to families; hence I would like to hear about your personal experience of the committee's discussion. No previous research in Israel has focused on hearing the parents' voice about their experience attending the Planning, Intervention and Evaluation Committees, so here is your chance to influence and shape this experience for other families as well.

I would like to be present in your family's upcoming discussion in the committee and to talk with you afterwards about your experience. I will only observe the happening during the discussion without being involved in the deliberations or decision making. In addition, I would like to talk with your social worker about the procedures taken prior the discussion and later to get updates about your family's situation in six months' time. I would also like to have access to the reports presented to the committee's members.

I am guaranteeing you this:

- Your involvement is not expected to interfere in any way with the decisions in your case.

- Your confidentiality will be kept, all identifying information with regard to you and your family will never be revealed. That is under the restrictions of mandatory reporting of child maltreatment.

- The participation is voluntary and you have the right to withdraw at any time without penalty.

The results of this research will be written up as a report, to be used to improve the quality of services provided to parents and children. All information will be kept without names so that nothing in the final report will allow the identification of you or your family. If this report is to be useful, it is necessary that all interviews and the Committee's discussions will be tape recorded to gather as much information as possible.

If you agree to take part in this study I will meet you on the day of the committee. Then you will be asked to sign a consent form to approve your informed and voluntary participation in the study.

Thank you very much.

I wish you good luck.

Goodbye.

Appendix 5: Informed Consent Form for Parents

I, the person signed bellow express my approval to participate in a study about the reform in the Planning, Intervention and Evaluation Committees' working procedures. I am aware that the study is conducted by a PhD researcher from the London School of Economics and Political Science in England.

I am informed of the following issues:

1. I know that my participation in the study will have no effect whatsoever on the service I and my family receive.

2. I know that everything I say will be anonymised and all identifying information with regard to me and my family will never be revealed.

3. I know that everything I say during interview will only be used for research purposes and will have no other use.

4. I know that I can withdraw from the study at any time without this having any effect on me.

5. I know that the researcher is legally obliged to report the police or a Social Worker to the Youth Law any new information, not available before, about minors' maltreatment.

Parent's signature:

Signed: _____

Date: _____

Appendix 6: Field Note Scheme Form for Observations

Transcription Information:

Transcription date:		Comments:	

Case Information:

Case code:		Social Services Department code:	
Date of PIEC :		Name of Coordinator:	
Starting time:		Ending time:	

Panel members:

No	Name	Role	Organisation	Permanent Panel	ChangeablePanel
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					

12					
13					
Total:		Professionals:		Family:	

A sketch of the panel members' seating arrangement:

1. Physical features of the setting:

Ventilation (e.g. stuffy, cold, hot).	Lighting.	Seating arrangement (e.g. a round table, court like seating).	Room size (e.g. too crowded).
Unexpected interferences with the setting (e.g. change of room, equipment breakdown).	Refreshments (e.g. drinks, snacks).	Equipment (e.g. computer, microphone).	General noise level (e.g. street noise, air conditioning noise).

2. Preliminary activities

Introductory material (e.g. name tags; information on a board).	The seating procedures (e.g. pre-planned seating arrangements; free style).
Significant interactions between participants while getting ready to start (e.g. personal deliberations regarding the case, deliberate avoidance of other members of the panel).	Special welcoming / unwelcoming acts (e.g. offer refreshments).

3. Beginning

- A late start / started on time.

- An official beginning / just starts.

4. Special support personnel

- The role and involvement of special support personnel (e.g. administrative secretary, translator) during the discussion.

5. Traffic flow

Disruptions if people leave and return to the room.	Disruptions if people come late.
Disruptions if uninvited people enter the room.	Disruptions if people leave early.

6. Information flow

Participants are familiar in advance with written materials.	Written materials presented before the panel **during the discussion** • What is presented • by whom • how (e.g. handouts) • Specific time allocated for reading through the materials/ reading while the discussion continues.	Written materials presented before the panel **at the beginning** • What is presented • by whom • how (e.g. handouts) • Specific time allocated for reading through the materials/ reading while the discussion continues.
Participants take their own notes of the happening.	Participants use pre-prepared notes while speaking.	Confidential information sharing (e.g. exchange of notes, whispering).

7. Child's/ Parents' physical impression

Physical indicators of disability.	Physical indicator of abuse and/or neglect (e.g. obvious physical harm; failure to thrive; clothing and hygiene).

8.   The main event

The use of aids to record the discussion (e.g. the new tool, administrative secretary).	The use of aids to manage the discussion (e.g. the new tool).
Procedural indicators of different phases to the discussion (e.g. a participant leaves the room, reports are moved aside).	Discourse management (e.g. turn talking, parallel conversations).

9.   Noticeable nonverbal interaction between participants, such as:

Looking at other participant for confirmation.	Shrug.	Pat on the back.	Nod.	Eye contact.
Lips movements.	Silence.	Humming.	Hand holding.	Wink.

10.   Noticeable emotional reactions, such as:

Breathing.	Sweat.	Moan.	Tremor.	Weep.
Fixed facial expression.	Smile.	Laughter.	Sigh.	Blush.

11.   Noticeable behavioural reactions, such as:

Gazing/ Looking outside.	Surprise reactions.	Rocking.	Knock on the table.	Door slamming.
Standing up.	Head down.	Looking at one's watch.	Disruptive chatting.	Scribbling on paper.

12.   Ending

Specific time allocated for reading through the final recommendations.	Availability of the full documentation of the discussion and its outcomes to the panel members (e.g. distribution of handouts).	The use of aids to summaries the recommended intervention plan (e.g. the new tool).	Discussion kept beyond scheduled time.
Greetings.	Significant interactions between panel members while leaving the room.	Written materials presented before the panel **at the end of the discussion** • What is presented • by whom • how (e.g. handouts) • Specific time allocated for reading through the materials/ reading while the conversation continues.	Signing off the final intervention plan.

Appendix 7: Interview Guide for Parents

Introduction

First, I would like to thank you very much for your time and cooperation. My name is Ravit Alfandari, and I am a PhD researcher in a university in England called the London School of Economics. I want to assure you that I am not, in any way, working for your Social Services Department.

Recently, considerable changes have been made in the working procedures of the Planning, Intervention and Evaluation Committees in order to promote genuine participation of parents in the decision making relating to their children. This interview is part of an independent research project that wants to find out about parents' views of these changes.

So, from now on the focus of our conversation is you and your children. I would like to learn about your experience, views, opinions, and feelings. The interview will take up to an hour to conduct. It has three main parts. I'll start will a few general questions to get to know you better. Then we will turn to discuss your particular experience of the social services involvement with your family, and finally I would ask for your recommendations for the future.

The results of this research will be written up as a report, to be used to improve the quality of services given to parents and children. If this report is to be useful, it is necessary that all interviews will be tape recorded to gather as much information as possible. I assure you that all your answers are confidential, and so will not be shared with anyone at your SSD or with any member of your family. All information will be kept without names so that nothing in the final report will allow the identification of you or your family. That is under the restrictions of mandatory reporting of child maltreatment.

I encourage you to feel free to raise any question, at any time, during our discussion.

Do you have any questions, before we start?

(*At this point conduct a quick test trial of the recording*).

To be completed by the interviewer <u>at the outset</u>

Case code:		Social Services Department code:	
Date of PIEC :		Date of interview:	
Starting time:		Ending time:	
The interviewee relation to the child:			

Part I: About you

I would like to start with a few general questions, so I will get to know you better.

1. What is your country of birth:

Israel	1
Former Soviet Union	2
Ethiopia	3
Asia (excluding Former Soviet Union)	4
Africa (excluding Ethiopia)	5
Europe and America	6

2. (*Only if applicable*) When did you arrive in Israel?

3. What is your level of formal education?

No formal education	1
Elementary school education	2
Secondary school education	3
High school education	4
Above high school education	5
Academic education	6

4. What is your profession?

5. What is your current occupation?

Part II: Your experience

Thank you very much. Now, let us discuss the happenings regarding your family, step by step, from the recent involvement of social services with your family, up to the discussion in the Planning, Intervention and Evaluation Committee.

Context

6. Tell me how much experience you have had of social services in recent years?

7. What services were you and your family provided with?

8. Tell me how much experience you have had of other services providers and agencies in recent years?

9. What services were you and your family provided with?

10. Tell me about your contact with your current social worker.

11. The next question is also dealing with your contact with your social worker. I will now read to you several features of the working relationship, for each please say how well does it describes your relationships with your social worker.

Do you feel that your social worker:
Is available for you
Understands how you feel
listens to you
Believes that you can make a change in your life
Respects you
Updates you on her actions
Involves you in decisions
Is willing to provide help
Can help you to change things

12. I would like to know about the background to the recent PIEC discussion, from your point of view. Tell me about what lead to the current PIEC.

Prompts to be used if necessary:

- What were the worries about your children's and family situation?

- Was there any particular event that raised concerns about your child's condition?

- What was your view of these worries or concerns?

13. Who initiated the PIEC discussion? Were you involved in this decision?

14. Do you think your family needs the social services involvement and help? If yes, what kind of help do you need?

15. What did you think could be the result of the PIEC discussion?

16. Do you have any former experience in formal committees in regard to your children?

Attendance at the PIEC

17. How were you invited to attend the PIEC discussion?

Prompts to be used if necessary:

- When was that?

- Was the schedule of the discussion negotiated with you?

18. Did you consider not attending? If yes, please describe your considerations.

19. Describe your involvement in the decisions who to invite to the discussion?

   Prompts to be used if necessary:

- What was your stance in regard to who should be invited to participate?

- What was your stance in regard to who should <u>not </u>be invited to participate?

- Were you able to influence these decisions?

20. Did you consider inviting a representative on your behalf, such as a solicitor, a friend or a family member? Do you think it could have been helpful?

21. Describe your involvement in the decision about the participation of your children in the discussion?

   Prompts to be used if necessary:

- What was your stance in regard to your children's participation?

- Were you able to influence this decision?

Preparing for the PIEC

22. Did you meet with your social worker or converse with her/him about the upcoming discussion? If yes, please describe.

23. Did you receive any explanation from your social worker about the committee and what is about to happen during the discussion? If yes, please describe. Was the information provided helpful?

24. Did you receive any written information about what would happen?

25. Were reports to be presented before the committee's forum shared with you prior to the PIEC? If yes, were you given an opportunity to comment on these reports?

26. The next question is dealing with your understanding of what was about to happen in the PIEC, prior to your attendance at the discussion. I will now read to you several features of the PIEC, for each please say how well did you understand that before attending the discussion.

Prior to your attendance at the PIEC how good was your understanding of:
The purpose of the discussion
What might be decided
Who would be there
What concerns about the children's and family situation would be discussed
What written information would be presented
How would the discussion be managed
What you might be asked about

27. Were you given any specific support or assistance by your social worker or somebody else to facilitate your participation in the discussion? If yes, please describe.

28. Did you meet with the other professionals (excluding your social worker) before the discussion? If yes, please describe this meeting.

29. Did you have any concerns or worries in relation to the PIEC? If yes, please describe. How did you deal with it?

30. Did your children receive any explanation about the committee and what was about to happen? If yes, please describe.

31. Did your children have any concerns or worries in relation to the PIEC? If yes, please describe. How did you deal with it?

At the PIEC

Let us move on now to the PIEC discussion itself.

32. Describe your experience of the PIEC.

33. Was it as you expected it to be?

34. Were there any surprises?

35. Was there anything particular that made you feel comfortable?

36. Was there anything particular that made you feel uncomfortable?

37. What is your view about the members of the forum?

   Prompts to be used if necessary:

- Were you clear who was there?

- Do you think everyone present needed to be there?

- Did someone's presence worry you?

- Was someone missed that should have been present?

38. What do you think about what was said about your family and children during the discussion?

Prompts to be used if necessary:

- In your view, was something missed out that should have been said? If yes, please specify.

- In your view, was something said that should have been corrected? If yes, please specify.

39. Overall, would you say that the information presented revealed the real picture of the family life?

40. How did you feel when this information was shared in such a forum?

41. Would you prefer that some information wouldn't be shared in your and/or you child's presence?

42. What do you think about your participation in the discussion?

Prompts to be used if necessary:

- Did anything particular facilitate your participation?

- Did anything particular inhibit your participation?

43. What do you think about your child's participation / representation in the discussion?

44. So, looking back at the whole PIEC discussion, I will now read to you several statements about the PIEC, for each please say how well does it describes your experience.

Do you feel that professionals:
Tried to understand your point of view
Enabled your involvement in the decisions
Ignored what you said
Helped you put your side of things
Already made up their minds before the discussion
Tried to see how they could help
Were hiding their true opinions
Were influenced by the wrong considerations

45. Were there things said during the discussion that were unclear to you?

Outcomes

We are at the final stages of our conversation, and will conclude very shortly.

Before we do so, let us focus for a few moments on the outcomes of the PIEC you attended, namely the intervention plan decided upon.

46. Are the decisions made in regard to the intervention plan clear to you?

47. What is your view of the intervention plan decided upon at the PIEC?

48. Are there any services, other than what had been recommended that you think would help your family?

49. Did you understand what you should do differently as a parent?

50. Are you expecting any difficulties in implementing the intervention plan? If yes, what are you planning to do about that?

51. To sum up, do you think you're being there made any difference to the decisions that were made? Please specify.

52. (*Only if applicable*) Do you think your child being there made any difference on the decisions made? Please specify.

53. (*Only if applicable*) Do you think your representative being there made any difference on the decisions that were made? Please specify.

54. What happened from the time of the discussion to date?

55. Have you spoken with your social worker since the PIEC?

56. Did you receive the full documentation of the discussion and its outcomes?

57. How do you perceive your children and family situation in six months' time?

Part III: Recommendations

Before we end this conversation I would appreciate hearing from you about improvement recommendations.

58. Can you suggest any ways which would make the whole process easier for other parents?

59. Is there anything else you would like to add?

Well, our conversation has come to its end. Thank you very much for sharing your experience with me in the last hour. What I have just learned from you can be highly beneficial in improving the services for parents and children.

Thank you very much.

Interview reaction sheet

To be completed by the interviewer <u>at the end</u>

How the interview went? (e.g. was interviewee talkative/cooperative/ nervous)

_____

_____

_____

Comments about the setting (e.g. busy/ quiet, interruption, other people were present).

_____

_____

_____

Comments on the reliability of the interview (e.g. inconsistencies in interviewee's answers/ interviewee seemed eager to please/ an impression of information being withheld).

_____

_____

_____

Other thoughts and feelings about the interview (e.g. did it open up new avenues of interest?).

_____

_____

_____

Appendix 8: Interview Guide for Social Workers

Introduction

First, I would like to thank you very much for your time and cooperation. My name is Ravit Alfandari, and I am a PhD researcher from a university in England called the London School of Economics and Political Science. I want to assure you that I am not, in any way, working for the Ministry of Social Services and Social Affairs or for the Social Services Department.

Recently, considerable changes have been initiated in the working procedures of Planning, Intervention and Evaluation Committees to improve the quality of service provided for children in need and their families. This interview is part of an independent study, aimed at better understanding the impact of these changes on everyday practice. It provides you with a unique opportunity to share the challenges, difficulties and achievements of your everyday work with children in need and their families.

The interview has three main stages. First, I will ask you a few general questions about your qualification and role, and then we will discuss a particular case you manage that was recently consulted in a PIEC. Finally, I would like to learn about your general views of the current working procedures, as well as your suggestions for improvements in the future. I am aware that your time is highly valuable; hence this interview was designed to be as brief and efficient as possible, and will take about an hour to conduct.

The results of this research will be written up as a report, to be used to improve the quality of practice. If this report is to be useful, it is vital that all interviews will be tape recorded to enable as much information as possible. I assure you that all your answers are confidential, and hence will not be shared with anyone at your SSD. All data will be kept anonymously so that nothing in the final report will enable your identification. Participation in the study is voluntary and you have the right to withdraw at any time

I encourage you to feel free to raise any question, at any time, during our discussion. Do you have any questions, before we start?

(*At this point conduct a quick test trial of the recording*).

To be completed by the interviewer <u>at the outset</u>

Case code:		Social Services Department code:	
Name of team leader:		Interview setting:	
Date of PIEC :		Date of interview:	
Starting time:		Ending time:	

Part I: Social worker profile

I would like to start with a few general questions, so I will get to know you better.

General

1. Sex:

Female	1
Male	2

2. How old are you?

3. What is your country of birth?

Israel	1
Former Soviet Union	2
Ethiopia	3
Asia (excluding Former Soviet Union)	4
Africa (excluding Ethiopia)	5
Europe and America	6

4. (*Only if applicable*) When did you arrive in Israel?

5. Do you have children?

Qualifications

6. What is your professional qualification?

Qualified social worker holding undergraduate degree in Social Work.	1
Qualified social worker holding graduate degree in Social Work.	2
Additional academic qualification	3

7. What is your current position held?

Generalist social worker	1
SWYL	2
Other: _____	3

8. Approximately how long have you been working as a qualified social worker?

9. Approximately how long have you been working in this position?

10. Approximately how long have you been working in this SSD?

11. What is your work status in the SSD?

Less than part time	1
Part time	2
75 %	3
Full time	4

12. How many cases are you currently carrying?

13. Approximately, what proportion of your work is taken up by child protection cases?

Up to a quarter of your cases	1
Between a quarter to half of your cases	2
More than half and up to three quarters of your cases	3
Between three quarters of your cases to all of your cases	4

14. (*Use the supplement form which presents the scale*) How confident are you of your professional proficiency and knowledge in the field of child protection? Please rate your level of confidence on a scale of 1 to 5. The score 1 means that you are 'not confident at all' and the score 5 that you are 'very much confident'.

Not confident at all	1
Not very confident	2
Fairy confident	3
Very confident	4
Very much confident	5

15. (*Use the supplement form which presents the scale*) Please rate the contribution of the following factors to your professional knowledge in the field of child protection on a scale of 1 to 5. The score 1 means that the contribution is 'very poor' and the score 5 that it is 'very good'.

	Very poor	Poor	Fair	Good	Very good
Academic qualification	1	2	3	4	5
Post-qualification training	1	2	3	4	5
Departmental meetings and case studies presentations	1	2	3	4	5
Supervision meetings	1	2	3	4	5
Consultations with colleagues	1	2	3	4	5
Virtual Communities of Practice (VCoP)	1	2	3	4	5
Professional Journals	1	2	3	4	5
Other:	1	2	3	4	5

16. Do you think you require further qualification or training in relation to working with vulnerable children and their families? If yes, please specify.

The social worker and the PIECs

17. After the implementation of the reform's new working procedures, in how many PIECs have you attended until today?

0-4	1
5 - 10	2
11- 20	3
21- 50	4
Over 50	5

18. Did you receive any training or qualification in regard to the PIECs' new working procedures? If yes, please specify.

19. Do you think you require further qualification on the subject?

Part II: Social workers experience

Thank you very much. Now, I would like to learn more about your everyday experience, by focusing on the particular case under your responsibility that was discussed in the committee I observed.

The initial referral

1. How long have you known this family?

2. Why was this family referred to you?

3. What was your first impression of the children and parents?

4. Describe your working relationships with the children and parents.

5. What services had been provided for the children and parents up to the PIEC discussion?

6. Are other professionals or agencies involved with the family (e.g. SWYL, Juvenilia Court)?

The circumstances that led to the PIEC

7. Tell me about the circumstances that led to the referral of the case to PIEC.

8. Was there a particular event that raised concerns about the children's condition?

9. Were there indicators of abuse and/or neglect at that stage? If yes, please specify.

10. Tell me about the decision to refer the case to the PIEC.

11. Tell me about your engagement with the coordinator in relation to the case referral.

12. How long did it take from the time a decision was made to refer the case to the committee until the committee's assembly?

13. What did you hope the PIEC discussion would achieve?

More specifically, did you hope the discussion will facilitate:

	Yes	Partially	No	Not relevant
Making decisions whether removal from home is necessary.				
Enhance the children's safety.				
Getting resources for the children and parents.				
Promulgating long-term intervention plan.				
Progress a case where no change had been achieved for a long time				
Enhance information sharing of all parties involved.				
Ensure multi-professional responsibility				
Ensure inter-agency cooperation				
Promote family members' cooperation				
Visible agency backing for you				

Collecting information about the child and family condition

14. Tell me about the procedures you carried out in order to collect information about the family's condition.

Prompts to be used if necessary:

- Did you receive information or reports from other professionals? Did you inform the parents about this information?

- Did you meet or have a conversation with the parents?

- Did you meet or have a conversation with the children (was it carried out separately from the parents)?

- Did you meet or have a conversation with other significant adults in the children's life?

- Did you make any home visits at that stage?

15. Did you use the new tool designed for collecting and recording information about the family's condition? If yes, describe your experience using the tool.

16. Were you faced with difficulties in the process of collecting information? If yes, how did you deal with them?

Information analysis and family assessment

17. Based on the information gathered, what were, in your view, the worries in the children's condition and parental care?

18. Based on the information gathered, what was your assessment of the immediate harm imposed on the children?

19. (*Use the supplement form which presents the scale*) What was your level of confidence about this assessment that time?

Not confident at all	1
Not very confident	2
Fairy confident	3
Very confident	4
Very much confident	5

20. Based on the information gathered, what was your assessment of the future risk imposed on the children?

21. (*Use the supplement form which presents the scale*) What was your level of confidence about this assessment that time?

Not confident at all	1
Not very confident	2
Fairy confident	3
Very confident	4
Very much confident	5

22. What was the basis of your assessments?

	Yes	Partial	No	Not relevant
Forensic and/or medical evidence				
Professional diagnosis				
Professional experience				
Theoretical /empirical knowledge				
Intuition or 'gut reaction'				

23. What was the role of the children and parents strengths in your assessments?

24. What was your view, at this stage, as to the appropriate intervention in this case?

25. Did you have a view, at this stage, as to whether the child should be removed from his/her family to an out-of-home placement? If yes, please specify.

26. Was there agreement or disagreement between you and the children and parents about the assessment of worries and risk and the appropriate intervention?

27. Was there any change in your initial assessments by the time the PIEC was held? If yes, please specify.

The participants in the discussion

These questions are about the preparations of the case for the PIEC.

28. Describe the process of deciding on the forum's make-up?

29. Did you think that, in this case, the children should be invited to the PIEC? Please explain why?

30. Did you have any worries beforehand about anyone's attendance at the PIEC? If yes, please describe.

Preparation

31. What preparation work did you do with the parents before the PIEC?

Prompts to be used if necessary:

- What explanations did they receive?

- What documents and reports were shared with them?

- What support was offered to them?

32. What preparation work did you do with the children before the PIEC?

Prompts to be used if necessary:

- What explanations did they receive?

- What documents and reports were shared with them?

- Did any other professional meet the children in private prior the discussion?

- What support was offered to the children?

33. Tell me about preparing the written materials for the PIEC?

Prompts to be used if necessary:

- Who decided what written materials would be presented before the PIEC's forum?

- Are written materials distributed in advance to the PIEC's forum members?

34. Was there information you had chosen not to include in the PSR that was presented to the forum?

35. Did you use the new tool designed for recording the preparations for the PIEC. If yes, describe your experience using the tool.

36. Preparing the case for the PIEC involves considerable work. Can you estimate how much time you have dedicated for this purpose?

37. Did you get any support (e.g. administrative support, supervision meetings) from your SSD at this stage?

38. Was a professional consultation meeting held before the PIEC? If yes, please describe its purpose, participants and what was decided.

39. To your knowledge was any member of the permanent panel familiar with the family before the PIEC discussion? If yes, please describe.

At the PIEC

Let us move on now to the PIEC discussion itself.

40. So, thinking about the PIEC, how do you think it went?

41. What is your view about the make-up of the forum?

Prompts to be used if necessary:

- Do you thing everyone present needed to be there?

- Were people invited who did not attend?

- Was anyone missed that should have been present?

42. Was there information presented that was new to you?

43. Did information shared during the discussion make you re-consider your perceptions on the case? If yes, please specify.

44. To your knowledge did any participant have confidential information which was withheld during the PIEC discussion? If yes, please describe.

45. How would you evaluate the way the discussion was managed by the coordinator?

Prompts to be used if necessary:

- Could you describe any ways in which the coordinator facilitated the decision making task of the PIEC?

- Could you describe any ways in which the coordinator hindered the decision making task of the PIEC?

46. How would you describe the involvement of professionals from other agencies in the discussion?

47. How would you describe your involvement at the PIEC?

 More Specifically: Please assess your participation in the PIEC's discussion by ranking the following operations on a scale of 1 to 5. The score 1 means that your contribution was 'very poor' and the score 5 that it was 'very good'. (*Use the supplement form which presents the scale*)

	Very poor	Poor	Fair	Good	Very good
Opening presentation of the case	1	2	3	4	5
Add essential information about the children and family	1	2	3	4	5
Prescribe the main areas of concern	1	2	3	4	5
Prescribe the main targets for intervention	1	2	3	4	5
Discuss alternative intervention solutions	1	2	3	4	5
Make final decisions as to the intervention plan	1	2	3	4	5
Represent the children's and parents' point of view	1	2	3	4	5
Facilitate the children's and parents' participation	1	2	3	4	5
Facilitate the children's and parents' understanding of the happening	1	2	3	4	5

48. In your experience of case conferences, how did it feel to you with the parents (*only if applicable*) and children there?

49. In your view, did the presence of the parents (*only if applicable*) and children influence the deliberations?

50. In your view, did the presence of the parents (*only if applicable*) and children influence decisions as to the intervention plan?

51. In your view, did family members understand the PIEC procedure and its outcomes?

52. Would you agree that the parents' attendance altered the focus of the discussion from the children?

53. In your opinion, was there any conflict of interests between what the children wanted and what the parents wanted? If yes, please specify how it was handled.

Outcome

54. What do you think about the intervention plan decided upon?

55. Did it converge with, or diverge from, your views on the case? Please specify.

56. What do you think were the main considerations behind the decision regarding the intervention plan?

More specifically, do you think the considerations were:

	Yes	Partial	No	Not relevant
Availability of services				
Quality of services				
Costs of services				
Children's needs				
Parents' needs				
Children's preferences				
Parents' preferences				

57. In your opinion, did some professionals have more influence over the final decisions than others? If yes, please specify.

58. Would you agree there was pressure to support the intervention plan agreed upon by the majority?

59. Would you say the discussion served its purpose?

Post-PIEC

60. Tell me about the happening after leaving the discussion room?

61. In regard to the implementation of the decisions made, what will be your next steps in the case?

62. What do you consider as the main challenges you'll be facing when working to implement the intervention plan? How do you plan to deal with them?

63. Looking into the future, how do you see the family 6 moths form now?

64. Do you have any opportunity in your everyday work to reflect on the case and consider whether things could have been done differently?

Part III - Précis

Thank you very much. I highly appreciate your cooperation so far. We reached the final stage of the interview. There are only a few more questions left which focuses on your overall views of the new working procedures of the PIECs.

65. Could you describe any ways in which the new reforms have facilitated your own work?

66. Could you describe any ways in which the new reforms have made your own work more difficult?

67. Would you say there are any differences between your own views and your SSD on the new working procedures? If yes, specify.

68. How would you describe the fit between what you are required to do under the new reform and the organisational environment of your SSD?

Please refer to:

a)   Supervision

b)   Training

c)   Emotional support

d)   Workload

e)   Administrative support (e.g. secretary, typing services)

f)   Physical working environment (e.g. access to computers, printers, fax, telephone)

Turning to the reform's regulations regarding family participation in PIECs

69. Overall, are you in favour of the policy of parents' participation in PIECs, as a result of your experience? Why is that?

70. Have you any comments on the way in which it is being implemented in your SSD?

71. Overall, are you in favour of the policy of children's participation in PIECs, as a result of your experience? Why is that?

72. Have you any comments on the way in which it is being implemented in your SSD?

73. Overall, are you in favour of the policy of including representatives on behalf of the family in PIECs, as a result of your experience? Why is that?

74. Have you any comments on the way in which it is being implemented in your SSD?

75. Can you suggest any ways which would improve your work with children in need and their families in general and in regard to the PIECs in particular?

76. Is there anything else you would like to add?

Well, our conversation has come to its end. Thank you very much for sharing your experience with me in the last hour. What I have just learned from you can be highly beneficial in improving the quality of practice, so it will fit better with the requirements of social workers in the field. Finally, while I am collecting my gear can I please ask you to complete the following question which deals with your views about the PIEC working procedures.

Thank you.

77. In the next questions, please indicate the extent of your agreement with each of the following statements on a scale of 1 to 5. The score 1 means that you 'strongly disagree' with the statement and the score 5 means that you 'strongly agree' with the statement. How far would you say the following is true of the PIEC discussions under the new working procedures:

	Strongly disagree	Disagree	Equally and disagree	Agree	Strongly agree
Allows critical reflection of cases	1	2	3	4	5
Allows conflicts of opinion to be discussed openly towards resolution	1	2	3	4	5
Allows members to air their doubts and uncertainties	1	2	3	4	5
Allows a mix of skills which helps make more informed decisions	1	2	3	4	5
Undermines social workers' discretion	1	2	3	4	5
Allows stepping back and looking at the whole picture	1	2	3	4	5
Allows critical review from outside the SSD on some important decisions	1	2	3	4	5
Facilitates the investigation of information from other sources	1	2	3	4	5
encourages a sense of shared responsibility with other services providers in regard to care plan decisions	1	2	3	4	5
Establishes good lines of communication for joint working with other services providers	1	2	3	4	5
Serves as a rubber stamp to authorise previously agreed upon decisions	1	2	3	4	5

Allows social workers adequate support when faced with difficult or emotional decisions to make	1	2	3	4	5
Sets clear follow-up procedures over the decisions implementation	1	2	3	4	5
Increases unnecessary bureaucracy within social work practice	1	2	3	4	5
Increases other services providers responsibility over the implementation of decisions made	1	2	3	4	5

Scale for rating the level of confidence

Not confident at all	1
Not very confident	2
Fairy confident	3
Very confident	4
Very much confident	5

Scale for rating the level of contribution

Very poor	1
Poor	2
Fair	3
Good	4
Very good	5

Interview reaction sheet

To be completed by the interviewer <u>at the end</u>

How the interview went? (e.g. was interviewee talkative/cooperative/ nervous)

_____

_____

_____

Comments about the setting (e.g. busy/ quiet, interruption, other people were present).

_____

_____

_____

Comments on the reliability of the interview (e.g. inconsistencies in interviewee's answers/ interviewee seemed eager to please/ an impression of information being withheld).

_____

_____

_____

Other thoughts and feelings about the interview (e.g. did it open up new avenues of interest?).

_____

_____

_____

Appendix 9: Follow- up Interview Guide for Social Workers

Introduction

First, I would like to thank you very much for your time and cooperation. As you may remember, I am a PhD researcher from a university in England called the London School of Economics. I have experience working with children and young people at risk as well as researching the subject. I am not working for the Ministry of Social Services and Social Affairs or for the Social Services Department.

This interview is part of an independent research project, aimed at better understanding the impact of the working procedures of Planning Intervention and Evaluation Committees (PIEC) on social workers' everyday practice. The interview is designed to follow up the decisions made in regard to _____ family, at the PIEC's discussion held on the _____. The interview will take about a half an hour to conduct and will be tape recorded to enable as much information as possible.

I assure you that all your answers are confidential, and hence will not be shared with anyone at your SSD. All data will be kept anonymous in the final report. Participation in the study is voluntary and you have the right to withdraw at any time

I encourage you to feel free to raise any question, at anytime, during our discussion.

Do you have any questions, before we start?

To be completed by the interviewer <u>at the outset</u>

Case number:		Social Services Department code:	
Name of team leader:		Worker e-mail address:	
Date of PIEC :		Date of follow-up interview:	
Starting time:		Ending time:	

Part I: Social worker profile

Guidelines for interviewer:

1)   If the interviewee is the same social worker who participated in the discussion and the first interview regarding to the family: ask only question 1 in this section.

2)   If the interviewee is not the same social worker who participated in the discussion and the first interview regarding the family, but did already participate in the research (in regard to a different family): ask questions 1 – 4 in this section.

3)   If the interviewee did not participate in the research before: ask first questions 1-15 regarding the social worker profile from the Interview Guide for Social Workers, and then questions 2-4 in this section.

1. In the last 6 months, were there any changes in your:

	Yes	No	Describe
Position in the department			
Work status			
Number of cases you are carrying			
Qualification in social work			
Professional training (e.g. courses, workshops)			
Professional support (e.g. supervision, departmental meetings)			
Physical working conditions (e.g. computer, fax)			
Other: _____			

2. How long have you known this family?

3. Why was this family referred to you?

4. What was your initial impression of the family?

Part II: The family profile

5. Since the discussion in the PIEC, were there any changes in the family's condition which were not directly related to the intervention plan? (e.g. divorce, a new baby, change in the parents' occupation)?

6. Since the discussion in the PIEC, were there any changes in the children's condition which were not directly related to the intervention plan? (e.g. change of school, change in health condition, change in custody arrangements)?

7. Since the discussion in the PIEC, did you receive new worrying information in regard to the children's situation, e.g. indicators of abuse and/or neglect, which was not available at the time of the discussion?

Part III: The implementation of the decisions

On the _____ a PIEC discussion was held in regard to _____ family.

The decisions made in the discussion were:

No	Decision	Responsible body for implementation	Date for implementation

8. Were changes made in the intervention plan decided upon in the PIEC discussion?

Prompts to be used if necessary:

- What were the changes?

- Why were they made?

- Who approved these changes?

- Was there a need for another PIEC discussion?

9. Describe the implementation of these decisions to date.

Please refer to:

- The implementation by professionals.

- The implementation by family members.

10. Did the children and the parents receive or are still receiving any services that weren't decided upon in the discussion?

11. (*Only if applicable*) For how long will the services be provided?

12. Did you come across difficulties at the stage of implementing the decisions? How did you handle them?

Possible difficulties:

- A need for urgent intervention.

- The availability of the services decided upon.

- Resistance of family or child to the intervention plane.

- Conflicting interests between the child's and parents' wishes.

- The need of father approval of the intervention plan.

13. Did you use any of the following in order to help with the implementation of the decisions?

- Other resources, e.g. budgets, services.

- The law, e.g. SWYL, Juvenile Court.

- Professional experts.

- Other family relatives.

- Other: _____

14. Did you participate in professional meetings in regard to the implementation of the decisions?

Please refer to:

- Meetings with the PIEC's coordinator.

- Supervision meetings.

- Departmental meetings.

- Meetings with other services providers.

15. Describe your working relationship with the family following the discussion.

16. Describe your working relationship with the children following the discussion.

17. To sum up, would you say that the intervention plan decided upon in the PIEC discussion was:

Not implemented	1
Still in implementation process	2
Partially implemented	3
Fully implemented	4

18. (*Only if applicable*) What do you consider as the reasons for no or partial implementation?

More Specifically, what do you consider as the reason for no or partial implementation:

	Yes	Partial	No	Not relevant
Service unavailable				
Difficulty in coordination between services providers				
The service turned out not to be appropriate				
After initial implementation it turned out that there is no need to continue				
Parents' resistance				
Children's resistance				
Changes in the family's condition				
Other: _____				

Part IV: Follow-up procedures

19. Describe the follow-up procedures taken.

20. Did you <u>get</u> any feedback (written or oral) from those involved in the implementation of the intervention plan (parents, children, professional)?

21. Did you make a home visit after the PIEC discussion?

22. (*Only if applicable*) Did you visit the child at his/her out-of-home arrangement?

23. Did you <u>give</u> any feedback (written or oral) to those involved in the decisions about and implementation of the intervention plan (parents, children, professional)?

24. Did you use any formal tool for recording and reporting the follow-up procedures?

25. Was a review PIEC held? If yes, please describe:

- What was the reason for calling the review discussion?

- When was it held?

- Who participated?

- What was decided?

Part V: The decisions' outcomes

26. Describe the family's and the child's current condition.

27. What is your assessment today of the risk imposed on the child?

28. What is your level of confidence about this assessment?

Not confident at all	1
Not very confident	2
Fairy confident	3
Very confident	4
Very much confident	5

29. What is the basis of your assessment?

	Yes	Partial	No	Not relevant
Forensic and/or medical evidence				
Professional diagnosis				
Professional experience				
Theoretical /empirical knowledge				
Intuition or 'gut reaction'				

30. What is the role of the children and parents strengths in your assessments?

Part VI: thinking again about the case

31. Did you change your mind about the case since the PIEC discussion?

Please refer to:

- The main areas of concern in regard to the children's condition and parental care.

- The risk imposed on the children.

- The appropriate intervention for the children and parents.

32. What do you think today about the decisions made in the PIEC discussion?

33. Do you think today that the discussion achieve its purpose?

More specifically, did the discussion facilitated:

	Yes	Partially	No	Not relevant
Formulate long term intervention plan				
To get resources for the children and family				
Enhance the children safety.				
To promote development in a case with no progress for a long time				
To ensure multi-agency responsibility				
Improve inter-agency cooperation				
Facilitate information sharing				
Promote the family cooperation				
Visible agency backing to you				

34. Looking back, would you do anything different in this case?

35. Looking into the future, how do you see the family 6 moths form now?

36. Is there anything else you would like to add?

Well, our conversation has come to its end. Thank you very much for sharing your experience with me in the last half an hour. What I have just learned from you can be highly beneficial in improving the working procedures, so it will fit better with the requirements of social workers in the field.

Thank you.

Interview reaction sheet

To be completed by the interviewer <u>at the end</u>

How the interview went? (e.g. was interviewee talkative/cooperative/ nervous)

_____

_____

_____

Comments about the setting (e.g. busy/ quiet, interruption, other people were present).

_____

_____

_____

Comments on the reliability of the interview (e.g. inconsistencies in interviewee's answers/ interviewee seemed eager to please/ an impression of information being withheld).

_____

_____

_____

Other thoughts and feelings about the interview (e.g. did it open up new avenues of interest?).

_____

_____

_____