# Synopsis

This research project explores shared decision-making between parents, children, and social workers in planning, intervention, and evaluation committees (PIECs). PIECs form part of the work of social services departments, and, according to Israeli social work regulations, their role is to decide on treatment plans for children in at-risk situations that raise concerns that their normal development could be impaired. The committees discuss the circumstances surrounding the children’s conditions, evaluate the level of risk and the family's difficulties, needs, and strengths, and examine possible interventions. Ultimately, PIECs are expected to formulate an optimal treatment plan that maximizes the parternship with family members and establishes agreements between professionals and the family (Ministry of Welfare and Social Services, 2017). In Israel, 18,000–22,000 committees are convened annually to consider treatment plans for 30,000–35,000 children.

The project comprises two successive studies addressing the following questions of to what extent, in what form, and under which conditions does shared decision-making take place in the context of PIECs. The first study is based on a content analysis of 73 PIEC protocols. The second study measures shared decision-making by using survey questionnaires completed by parents and social workers who participated in PIECs.

**Background:** Client participation in decision-making is a well-recognized principle in social work theory and practice. Over the past 20 years, it has gained popularity in additional areas, such as health, education, and urban planning. This growing trend is driven by both the perception that people have the right to be involved in decision-making about their lives and by the proven benefits of client participation: Client participation contributes to clients’ sense of empowerment, increases their willingness to cooperate with the designated plan, enhances their ability to exercise their social rights, and improves outcomes. In addition, client participation is a core value in the social work code of ethics and now is a significant element in Ministry of Welfare declarations, regulations, and instructions concerning most social services. Client participation is based on creating a better balance between the more powerful professionals and the less powerful clients or families. Proactive power-sharing is crucial to achieving client participation.

Researchers have yet to agree upon a definition of client participation among researchers. The literature describes a variety of behaviors ranging from a paternalistic approach to varying degrees of power-sharing. Nonetheless, professionals and researchers do agree that certain measures can contribute to effective participation by social work clients, such as trust and respect-based relations, good communication, the provision of clear, detailed information to the client, and support in preparing for decision-making processes. Participatory practices in social work are usually based on a long-term relationship of trust between the social worker and the client, and the discourse between them is characterized by such terms as “hearing the clients' voice,” “cooperation,” “standing by the client,” and “empowerment.”

In light of recommendations by Knesset committees that have examined the issue, the past two decades have seen a reform in PIECs, including the revision and improvement of regulations, instructions, training, and tools for PIEC management. All these elements emphasize the importance of parents’ and children’s participation in the committees to the success of the process, as well as the professional duty of social workers to promote such participation. Despite these developments, however, studies and Knesset committees have repeatedly pointed to gaps between the declared principles and the situation on the ground, where decision-making on treatment is often far from participatory. Such gaps are not unique to Israel; in fact, they receive frequent mention in studies from numerous Western countries with welfare systems that include processes comparable to PIECs. Several studies have identified systemic factors that inhibit client participation, the primary ones being complicated bureaucracy and chronically heavy caseloads – conditions that do not leave much time for building trust. Such conditions are typical of various welfare systems around the world, especially in Israel. Another significant inhibiting factor is social workers’ paternalistic approach toward clients. Unfortunately, there has been no systematic data collection on PIECs, and therefore the research in this field is limited.

Family-focused interventions are based on the assumption that the solutions and powers needed to change the circumstances of at-risk children lie with the family. Accordingly, their implementation requires a high degree of partnership. Israel’s Ministry of Welfare and Social Services has adopted a policy that encourages family-focused approaches. In addition, over the past decade, the Ministry has been undergoing a reform that emphasizes systemic changes and the formulation of plans that promote family-focused interventions. This, in turn, should have an impact on PIEC treatment plans and, consequently, on shared decision-making with parents and children as well.

In this research we relied on the theoretical approach of the shared decision-making (SDM) model in order to conceptualize and measure shared decision-making. The model, which originated in the medical field, represents a process in which the doctor and patient jointly decide on a treatment plan for the sake of the patient’s health. The assumptions behind the SDM approach are identical to those upon which the principle of participation in social work are based: the right of individuals to participate in decisions relating to their lives, and the positive implications of such participation for decision-making on matters that affect them and on the intervention outcomes. The model focuses on four elements of the medical decision-making process that are the basic conditions for shared physician-patient decision-making: the physician’s and patient’s engagement; their exchange of information on the medical condition and prognosis and on the patient’s lifestyle; the provision of information about various treatment options and their advantages and disadvantages; and the physician and patient both voicing their preferred treatment options. SDM is an extensively researched, evidence-based model that has yielded good results. Patients whose physicians used the SDM model demonstrate better health results, cooperate with treatment plans more consistently, and report higher levels of satisfaction with the decision-making process and their treatment. In contrast to social work theories and practices that view cooperation as conditional on long-term relations of trust and emphasize listening to clients, the SDM model is intended for brief decision-making processes focused on creating an opportunity for equalizing physician-patient knowledge regarding the medical problem, treatment options, and potential repercussions of each option. Recent years have seen the emergence of research on the suitability of the SDM model for shared decision-making in the welfare system, in light of its success in promoting shared decision-making with clients in the healthcare system.

# Study 1

**Research questions:** To what extent and in what form does a participatory dialogue take place between the PIEC professionals and the family and child regarding a decision about removing the child from the home, and how is it reflected in the meeting records? To what extent and in what form does a dialogue take place to assess alternatives to the child’s removal in the form of community-based measures, and how is this reflected in the records?

**The research approach:** This study employed a critical paradigm that conceives of reality as a social construct shaped by power dynamics. Accordingly, the purpose of research is to expose those mechanisms that perpetuate inequitable power relations between the social hegemon and the underprivileged population. The data-collection approach used here is known as clinical data mining (CDM): the use of data collected and documented in the field in the course of practice, and its analysis for the purpose of evaluating and advancing work methods.

**Sample:** Seventy-three sets of records from PIECs held throughout Israel during 2012–2014, in which a decision was made to remove at-risk children and youths from their homes.

**The research process:** The process included enlisting Ministry of Welfare personnel to help with our request for copies of the records, approaching PIEC coordinators in 50 social services departments, and coordination and follow-up to receive the records.

**Quality and reliability:** All the steps and decisions taken during in the course of our analysis were documented, quotes from the records were presented alongside their interpretations, and feedback on the findings was provided by professionals and youths who had participated in the PIECs.

**Ethics:** Identifying details of families and professionals were deleted from the records before we received them. In presenting examples and quotes, potentially identifying details were concealed.

**Data analysis:** A qualitative and quantitative content analysis was performed by identifying recurring patterns in the text and examining how they reflect the outlooks of professionals on the committees, identifying themes and sub-themes, classifying similar issues by category, and examining these categories in relation to the research questions.

**Main findings and discussion:** Half the committees documented their proceedings using an official documentation protocol. The remainder were documented by means of a protocol unique to the given department, a summary of the main points, or a transcript of the entire proceeding. The official protocol contains three sections intended to promote parents’ and children’s participation: an obligation to explain a parent’s absence from the committee, thus underscoring the requirement of making an effort to locate and invite the parents; a provision stipulating that the family members’ position be presented in their own words, thereby promoting the inclusion of their authentic voice; and a provision stipulating that the parents’ and child’s view of the designated treatment plan be documented. The official protocol specifies a particular order for PIEC proceedings, beginning with the chair asking the parents to describe their perception and view of the situation, as well as their preferred solution. Those PIECs documented by means of a summary or transcript usually did not strictly adhere to hearing from the parents and the child at an early stage of the proceeding, and their records presented the parents’ and child’s position far less clearly. Consequently, committees documented by the officially designated protocol have the potential to promote participation more effectively than committees documented by other means.

The PIEC records provide very little information about the preparatory stage. The vast majority did not use the form designated for preparations, and only rarely did the records contain information about a preparatory meeting having taken place. In most cases, no information was available about the subjects discussed at the preparatory meetings. Preparation for the proceedings is the first phase of participation because it has a decisive impact both on the parents’ and children’s understanding of the situation and of their rights, and on their ability to formulate a clear position on the treatment planned for them. The lack of data about preparatory procedures may constitute a significant inhibiting factor in promoting SDM in PIECs.

The findings indicate that mothers were nearly always present during the committee meetings and fathers were present in about half the meetings. When the mother was absent, the records explained her absence in detail and presented her view on the children’s removal from home. Conversely, a father’s absence did not always receive an explanation, and even when it did, it was evident from the reasons listed that in many cases not much effort was made to secure his presence. For the most part, if the father was absent, the records did not indicate his view. These data may point to a gender bias on the part of PIEC organizers. Adolescents were present in about two-thirds of the discussions about them. When adolescents were absent from PIECs, their absence usually was not explained, nor was their view on being removed from home by PIEC members represented.

In about half the records, the position of family members who attended the proceedings is mentioned once in a concise manner. The remaining records mention family members’ positions more than once or in greater detail. The findings indicate that in many committees, when a family member’s outlook differs from that of the PIEC professionals, that member is described as uncooperative, in denial about problems, and resistant – a description that serves as an “excuse” to adopt a decision aligned solely with the professionals’ outlook, without discussing the possibility of assistance that accords with the family members’ outlook. The findings highlight the perpetuation of power discrepancies between family members and professionals.

The findings reveal widespread use by professionals of the terms “consent” and “cooperation” in describing the parents’ and child’s attitudes toward the PIEC’s designated treatment plan. The use of these terms may indicate paternalistic outlooks, according to which the power to determine a treatment plan lies exclusively with the expert professionals, while family members are in a weaker, inferior position that allows them only to agree or disagree, cooperate or not cooperate, with the professionals’ decision. Clearly, such approaches do not promote participation or facilitate more of a balance in the inequitable power dynamics between family members and professionals.

In most committees, according to the findings, not a single professional referred to the parents’ powers. More attention to their powers could enhance parental participation because it would indicate respect, trust, and empowerment. The parents’ view of a child’s removal from home also plays a part. When the parents or child are interested in removal, the professionals tend to mention their powers and present them as people who know what is good for them. When they object to removal, the discussion makes no mention of their powers, focusing instead on the parents’ pathology and “denial of the problem.” These findings imply a perception that equates parents’ and children’s participation with cooperation on the matter of removal from home, which in turn fosters an illusion among social workers that shared decision-making is taking place.

One-third of the records contained no evidence that a community-based alternative had been proposed or attempted prior to discussing removal from the home. In those cases where the records indicate that alternatives had been tried and had failed, all the reasons cited by the professionals held the family members responsible: lack of cooperation, refusal, or a poor fit for the proposed solution. This finding implies an institutionalized approach on the part of the professionals, according to which the families must adapt themselves to the service rather than the other way around.

**Limitations of the study:** The information available in the records does not provide a complete picture of parents’ and children’s participation in PIECs, as these records omit undocumented remarks that could point to cooperation or lack thereof. Furthermore, no conclusions can be drawn about families’ participation in committees that did not decide on removal from home and instead focused primarily on community-based care.

# Study 2

**Research question:** Which variables are significantly related to parents’ and children’s cooperation with social workers in PIEC decision-making? Are there differences in the perception of SDM between social workers, on the one hand, and between parents and children, on the other?

**The research approach:** We used the SDM model to measure shared decision-making. This choice rests on extensive research-based evidence of its effectiveness and on our identification of principles and characteristics that are common to both medical decision-making and PIEC decision-making about treatment.

**Research hypotheses:** We hypothesized that social workers would attest to a higher degree of shared decision-making when the parents perceive the problem as more severe, when communication in the PIEC is better, and when the social workers have relayed more information to the parents in preparation for the committee proceedings and have conducted more preparatory meetings. We posited that the parents would attest to a higher degree of shared decision-making when the social worker perceives the problem as less severe, when communication in the PIEC is better, when they receive more information in preparatory meetings before the proceedings, and when more such meetings take place. In addition, we hypothesized that both sides would attest to a higher degree of shared decision-making in those committees that decided on family-focused (as opposed to child-focused) responses and in committees where the parents had a higher level of education.

**Sample:** Forty-two parents and 37 social workers who participated in 43 PIECs held during 2016–2020. The sample was selected on the basis of “convenience sampling.”

**Research tools**: The degree of participation in PIEC decision-making was measured using SDM-Q-9 and SDM-Q-DOC questionnaires based on the SDM model and translated into Hebrew for the study. Three additional questionnaires were developed for the purposes of this study: a questionnaire on preparing for the PIEC, which measured the number of issues raised during preparatory meetings using the list of issues named in the PIEC instructions; a questionnaire on the quality of communication in the committee, which measured the extent to which parents’ and children’s voices were heard during the PIEC proceeding and the degree of attention professionals paid to family members’ strengths and successes; and a questionnaire on the severity of the problem, which measured the severity that parents and social workers ascribed to the problem.

**The research process:** Parents were recruited for the study through employees of social services departments. A total of 141 welfare departments were approached via email and 67 by telephone. In all, ten departments provided contact information for parents who expressed a willingness to participate in the study, and whom we contacted by phone. Ultimately, 42 parents and 37 social workers completed the research questionnaire.

**Ethics:** The questionnaires were anonymous, and no use was made of the participants’ personal details. All participants signed an informed consent form, confirming that they were participating in the study voluntarily and could decide to stop answering the questionnaire at any time. The University’s Ethics Committee and the Ministry of Welfare approved the study.

**Data analysis:** We used SPSS statistical processing software for coding and analysis. First, we quantified the occurrences of the committee’s characteristics and the participants’ background characteristics. Second, we performed correlations to examine relationships and differences between groups and then we performed regressions.

**Main findings:** The 43 committees discussed cases involving 107 children. Most of these were follow-up sessions rather than initial meetings, and most of the families had been in contact with the welfare services long before the committee met. About half discussed cases involving only one child, and the remainder addressed cases of a few children in one family. The 43 committees decided on 108 responses. Most of the proceedings resulted in exclusively child-focused responses, with family-focused responses accounting for one-fourth. The most frequent responses included referring the children to community-based treatment or extending their stay in a facility outside the home.

The parents reported a higher degree of participation in SDM when communication within the committee was better, when more preparatory meetings had taken place, and when they received more information during these meetings. Like the parents, social workers reported a higher degree of SDM when communication in the committee was better. Additionally, and in contrast to the parents, social workers reported a higher degree of SDM when the parents perceived the problem as more severe, when the parents were more educated, when there were more frequent preparatory meetings, and when the responses provided by the committee were solely child-focused rather than family-focused. The social workers reported a higher degree of participation in decision-making with parents who had higher levels of education. At the same time, parents with low levels of education reported receiving less information in preparation for the discussion.

**Partnership practices:** Most parents and social workers had similar assessments of the quality of communication in the committee, and most linked better communication with increased participation in decision-making. That is, being heard and having one’s strengths noticed – practices that contemporary social work recognizes and implements – contribute to increased participation in PIECs. However, the transfer of information, a practice that essentially transfers power to parents, faces resistance from social workers. In a high percentage of the committees, social workers do not provide parents with information about their right to bring a representative of their choice, or about their right to propose what they consider a preferable treatment plan. Contrary to the explicit regulations on providing information, social workers unilaterally determine what information is relevant or irrelevant for the parent. The significant relationship between parents’ perception of a problem’s severity and the degree of SDM reported by social workers implies that the amount of information conveyed to parents is determined by the social workers’ judgment of the parents’ view of the problem and its solution. Parents who perceive the problem as severe and “align themselves” with the welfare workers’ perception enjoy more participation in decision-making, whereas parents who view the problem as less severe are likely to be labeled “uncooperative” and excluded from the decision-making process by having information concealed from them and their voices silenced.

**Education and poverty:** The PIEC instructions pay almost no attention to the issue of poverty, and thus their responses do not reflect any consideration of it. Unsurprisingly, therefore, parents with low levels of education are included less in decision-making and receive less information in preparation for committee proceedings. This situation perpetuates the exclusion of people living in poverty from decision-making that affects them, which, for a welfare system that has adopted the poverty-awareness paradigm, is unacceptable.

**Use of the SDM model:** This study tested the SDM model for the first time in relation to shared decision-making in PIECs. The use of this model to measure SDM allowed us to perform a quantitative analysis of factors that may account for the (low or high) degree of participation in PIEC decision-making. The results obtained have the potential to enhance both the applied and the theoretical knowledge about SDM in PIECs. Parents as well as social workers were easily able to understand the model as conceptualized in the research questionnaire. Apparently, therefore, the model was clear and accessible to them. In addition, the basic hypotheses of the model are consistent with Ministry of Welfare policies and instructions relating to PIECs and social services generally. In light of the above, it appears that SDM model has significant potential to serve as a tool for the measurement, evaluation, and implementation of shared decision-making in PIECs.

**Limitations of the study:** The sampling method and sample size do not allow us to draw conclusions regarding PIECs as a whole. There is a high probability of bias in the sample, and the small size of the sample limited our ability to perform complex quantitative analyses. No previous studies have tested the use of the SDM model for welfare services, and even though it is considered an evidence-based model in healthcare services, its suitability to welfare services has not been sufficiently established.

**General discussion:** The combined data from the 116 committees sampled across both studies show a consistent pattern, whereby fathers were absent from about half the committees and mothers were nearly always present. Both samples revealed a very limited presence of representatives on behalf of the family. Most committees had an external professional present, most often a social worker from a community-based facility or a school representative. A low percentage of the responses decided upon by the committees were family-focused, whereas a high proportion were child-focused. In contrast to the research hypotheses, the degree of SDM in committees that decided on family-focused responses was lower than in committees that decided on solely child-focused responses. Almost none of the committees sampled decided on material responses or responses based on the exercise of rights.

**Preparation for the committee proceedings – a point of weakness:** Vital information, which social workers are expected to provide in preparation for the proceedings, does not reach parents. The withholding of information poses a significant barrier to SDM implementation. It prevents parents from understanding their rights, the legal force of decisions, or what happens if they do not accept a decision. Under these circumstances, the vast majority of power remains in the hands of social workers.

**Responses:** The committees’ emphasis on child-focused responses indicates that PIECs still have a long way to go toward implementing a core principle of the Ministry of Welfare reform – namely, viewing the family, rather than the child, as the intervention unit. The committees operate under the ever-present principle of “the best interests of the child,” which, as interpreted by social workers, is prioritized over the family and SDM.

**A therapeutic or a formal process?** The literature and studies 1 and 2 point to a persistent conceptual barrier among social workers that prevents the implementation of SDM, and which is centered on the assumption that SDM is not possible unless parents take responsibility for the problem as perceived by welfare officials. This is comparable to the underlying assumption of classical psychodynamic therapy. That is, for change to take place, the patient must recognize the problem and generate insights on the basis of this recognition. The PIEC, however, is no more than a short-term, structured process, as explicitly outlined in regulations. By definition, it is more of a formal process than a form of treatment. Parents should not be required to “align themselves” with the welfare officials’ conception of the problem’s severity as a condition for participation.

**Who decides on a treatment plan?** According to the regulations, PIEC decisions are simply recommendations, with no legal force. The regulations refer disputes between parents and welfare officials to an appeals process, and, ultimately, it is the court that decides. Social workers and parents alike can benefit from a more participatory decision-making process if they explicitly and reciprocally acknowledge that PIECs can only make recommendations and have no mandate to impose treatment plans on parents.

**How do we move forward?** To overcome the gap between the desired and the actual degrees of partnership in PIECs, we must try to eliminate both the practice of blaming the parents and the assumption that a good SDM partnership requires that parents “align themselves” with welfare officials’ view of the problem, its severity, and its solution. We must shift the emphasis from viewing parents as the source of the problem to viewing them as an integral part of the solution. Such a reconceptualization would indicate a shift from paternalism in social work and from the notion that PIECs have a social oversight role, to a more critical view of social work that is consistent with contemporary values and theories, and which the welfare system in Israel aspires to adopt and integrate. In conjunction with skills, theories, and practices that promote partnership, the SDM model can contribute to generating the desired conceptual shift and fostering more effective SDM practices.

**Theoretical conclusions:** The main obstacle to SDM in PIECs is a narrow and dichotomous conceptual approach to the assessment of risk and evaluation of parents. The existing social work tools are of limited potential in promoting SDM in PIECs because most of these tools are based on long-term relations of trust. The trust social workers place in parents is based on how parents view the severity of the problem, and the result is dichotomous labeling of parents either as cooperative, who “deserve” to be partners in decision-making, or as opponents who should be excluded from the decision-making process.

**Practical conclusions:** Despite the Ministry of Welfare’s stated intention of adopting family-focused approaches, the committees and their responses remain child-focused. A possible explanation is that when the child is at the center of both the problem and the solution in a decision-making process, the issue of blaming parents is deferred, and a potential conflict between social workers and parents is avoided. To overcome the conceptual barrier to SDM, we should seek decision-making models suited to the unique nature of PIEC work – that is, decision-making in treatment conducted within a brief span of time. Such models would focus on parents as equal partners with decision-making rights, regardless of the extent to which they agree or cooperate with committee’s social workers on the problem and its solution. The SDM model used in healthcare might suit this need. It is a concrete, evidence-based model built on the assumption that the best decision-making takes place when professionals and patients share clear information equally.

**Practical recommendations:** The legal regulation of PIECs should include a duty to provide parents with all the information contained in the regulations and should establish enforcement mechanisms. The reservations noted in the regulations, which allow social workers to withhold information in cases of potential harm to a child, should include an explicit definition of “potential harm to a child” and should differentiate between the provision of information about rights, which is not sensitive and cannot harm the child, and the provision of sensitive information to which the above reservations are relevant. The suitability of the SDM model to shared decision-making in welfare services should be assessed. Despite the chronic gap between the stated intention and actual practice, it is important to ensure client participation in the committees. Participation should be a matter of high priority, with skills training, guidance, and a budget allocated toward this end. Data on the committees should be widely available for research purposes, research tools should be developed to learn about SDM with children in PIEC work, and future training could focus on the preparatory process.

**Future research:** Possible topics for further research include a comprehensive study based on a large sampling of committees; a study that will provide new information about partnering with children in PIEC work; a study focused on preparatory processes for PIECs and inherent barriers to the provision of information to parents; and a study examining the theoretical and practical advantages and disadvantages of the SDM model for PIECs and similar procedures around the world.

**Keywords:** Planning, intervention, and evaluation committee; client participation; shared decision-making; at-risk children; parent participation; partnership practices; social work; parental involvement.