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Child-Parent Centers Mobile Regional Model – Evaluation Study – Summary Report

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Executive Summary

Introduction

Child-Parent Centers

Child-Parent Centers (CPCs) are an innovative community service aimed at children at risk and their parents. They respond to the needs of children of elementary-school age suffering from emotional/behavioral problems due to poor parenting, and to the needs of their parents. The goal of the CPCs is to improve the children's emotional, social and behavioral condition, the child-parent relationship, and parental care so that the youngsters may go on living at home.

The CPCs are operated by the Children and Youth Service of the Ministry of Social Affairs and Social Services (MSASS), by municipal Social Service Departments (SSDs), Ashalim and NGO implementers. The staff is multi-disciplinary, the centers are designed as homes and function mostly in the afternoon. Children and parents attend the center together for intervention, some of which is shared and some – separate. The practices of the centers are based on current approaches to the treatment of children at risk and their parents. These include: focusing on the child-parent relationship; viewing the family as an integral unit; offering families individual treatment programs; sharing responsibility for the care of the family with municipal social services; maintaining ongoing contact with a child's school, and continuing case management by municipal social services after the intervention of the CPC ends.

The first center opened in Haifa in 1998 and, today, there are some 50 such centers countrywide. New, different models continue to be developed by MSASS and Ashalim, including mobile CPCs.

Mobile Child-Parent Centers

In the past, CPCs were not accessible to peripheral communities, because the number of people requiring care was too small to justify their own center and they were not close to localities that do have centers. To make the service accessible to small peripheral communities and pool the necessary resources, a decision was taken to establish mobile CPC offering services to four or five nearby communities.

MSASS, the National Insurance Institute (NII – the Fund for Demonstration Projects) and Ashalim launched the mobile CPC model on an experimental basis in two regions: in Arab communities in northern Israel, and in Jewish communities in the Sharon Plain. The northern center began to function in January 2005; the Sharon center – in September 2005. Implementation was in the hands of NGOs since center it is not possible to employ staff through several local authorities. Supervision was in the hands of the MSASS Children and Youth Service, as is standard practice. Every locality allocated space for the work with families one day a week. The professionals working at the center are permanent staff (the directors, social workers, expressive and creative therapists etc.) who regularly move about from one locality to another on designated days. Every locality referred some 20-25 clients to the CPCs, meaning that some 100 clients were in treatment simultaneously, similar to the basic CPC model. A joint steering

committee was established representing all the localities in which the centers were active, the MSASS Children and Youth Service, the NII, Ashalim and local social services.

Unlike the core professional staff of social workers, family therapists and expressive/creative therapists who visited a locality one day week, a housemother or social counselor was active in the locality throughout the week. The implementation of mobile CPCs warrants more resources than the basic model, particularly to finance the mobility of the professional staff. The annual cost of a mobile CPC is NIS 626,600 (NIS 523 per capita per month, as of 1.1.10). In comparison, the annual cost of a CPC of the basic model is NIS 550,800 (NIS 459 per capita per month).

The Evaluation Study

In the past, the Myers-JDC-Brookdale Institute conducted an evaluation study of the basic CPC model (published in 2009). Following the implementation of the mobile CPCs, the Institute was asked to evaluate this model as well. The study aimed to provide policymakers and service developers with helpful information regarding further development and expansion. It addressed both the implementation and outcomes for children and parents: it investigated the characteristics of the children and families at the mobile CPCs, their needs, the integration of the mobile CPCs with local services and the division of labor between them, the SSDs and education services, as well as the unique, vital components of mobile CPCs as a basis for further development in the two sectors.

Various tools were used for data collection, among them:

1. ***A questionnaire at the start of treatment at the mobile CPCs*** on family characteristics and the planning of treatment, completed for 50 families and 118 children who started at the centers in 2006-09.
2. ***A questionnaire at the end of treatment at the mobile CPCs*** for the same families and relating to the outcomes of treatment, completed for 43 families and 99 children (seven final forms from the Sharon CPCs were not handed in).
3. ***In-depth interviews and focus groups*** with key figures at the Children and Youth Service, at Ashalim, with SSD directors and social workers, with CPC directors and staff, with mothers, fathers and children treated at the centers.

Findings

Organizational Structure and Manpower of the Mobile CPCs

The Role of the Implementing NGOs in the Organization of the Mobile CPCs

Since the mobile CPCs work with several Social Service Departments (rather than just one, as in the basic model), the NGOs were to be more dominant partners in setting up the centers. The directors of the mobile CPCs expressed satisfaction with the support of the NGOs and reported that once the work of the CPCs was consolidated, the support of the NGOs became less intensive.

The Oversight Committees

Three types of committees were established alongside the CPCs: a district steering committee, a local steering committee for every locality, and an executive committee. The aim was for the committees to bring together the many parties involved in the implementation of the centers for purposes of updates on their work and discussion of the issues they faced. In the district steering committee, discussion focused on such principles as the characteristics of the target population of the centers and the use of group therapy. In the local steering committee, discussion focused on issues relevant to implementing the CPC at that specific locality. In the executive committee, the policy set by the district committee was translated into general activities in the field, regardless of the specific communities. The discussion dealt with such technical problems as the composition of the staff and the allocation of expressive and creative therapies. In the first two years that the mobile CPCs were implemented, the oversight committees convened at regular intervals; which became less frequent with time. Currently, there is a need to rethink the role, structure and frequency of the committee meetings.

The Complexity of Managing Mobile CPCs

The director's role at the mobile CPCs is complex as it entails contact with many different parties and the administration of a large staff who work part time or as volunteers. The position is thus more complex than in the basic CPC model. Nevertheless, the interviewees expressed satisfaction with the functioning and work of the directors of the mobile CPCs.

The Complexity of the Secretarial Role at Mobile CPCs

At each mobile CPC, one housemother works also as a quarter-time secretary at the CPC office in one of the localities. Part of her job is to handle contact and coordination with the families in treatment. This, too, is more complicated than in the basic model due to the component of mobility.

Mobile CPCs Employ a Larger Staff than the Basic Model

More job positions were allocated for the mobile CPCs than for the basic model due to both the additional time involved in traveling between localities and the need for staff meetings to transmit information and formulate a uniform treatment concept. At both centers, especially in the Sharon, additional therapists, volunteers and interns were employed than stipulated by the model. The additional staff enriched the range of treatments offered at the centers and expanded their scope.

Professional Staff: One Day a Week at Every Locality; Paraprofessional Staff: A Few Days a Week

The professional staff of the mobile CPCs, including social workers, offer expressive, creative and family therapy, working one day a week at each locality. The housemothers and social counselor make home visits and counsel many families in parenting. They also undertake joint activities with parents in the therapeutic kitchen or therapeutic garden. In the mobile CPC in the north, the housemothers were chosen according to their residence in a locality serviced by the CPC and their acceptability to the village population so that they could serve as cultural

mediators for the CPC staff. The work of the housemothers with families received greater emphasis in the north than in the Sharon, and they worked with more families.

More Expressive and Creative Therapy Could be Offered at the CPC in the Sharon than in the North

At the CPC in the Sharon, more expressive and creative therapy was offered by therapists trained in these fields than in the north. In the north, it was difficult to recruit Arab-speaking expressive and creative therapists with training in family therapy. Nonetheless, according to the CPC director, the social workers integrated various expressive and creative techniques in their therapeutic work. In the Sharon, the size of the staff specializing in expressive and creative therapy was larger than in the north both because there is a larger supply of Hebrew-speaking therapists and the service is located in the center of the country. Furthermore, the location of the mobile CPC in the vicinity of numerous institutions of higher learning made it possible to enlist student volunteers for the work, as part of their training.

Emphasis on Training for CPC Staff at all Levels

At both mobile centers, there was in-depth, intensive staff training at every level. Social workers were trained by the directors; housemothers and social counselors were trained by social workers; the multi-disciplinary staff were trained at staff meetings by both the directors and an external instructor, while the directors themselves were trained by an external instructor. The various interviewees noted that they were impressed by the process of staff professionalization through training. This issue is significant given the study findings for the CPC at Shfaram, where insufficient training apparently impacted negatively on staff satisfaction and led to a high turnover (Abu-Asbah et al., 2009).

Positive Feedback on the Treatment Staff and the Fruitful Interaction of Members

For both mobile centers, the therapeutic staff expressed appreciation of the fruitful cooperation of its members and noted the intimate atmosphere that had been created, enabling true partnership in professional deliberations.

Aspects of the Implementation of the Mobile CPC Model, Difficulties and Challenges

The Duration of Treatment at the Mobile CPCs was as Planned

The service model stipulated one year of treatment at the CPC with the option of extension to a year and a half. The average duration of treatment was 13.7 months, with virtually no exceptions beyond 18 months. In contrast, in the basic model, 40% of the families were treated beyond a year and a half (Rivkin, 2009, for data from 2005). Since the data on the basic model were collected soon after the inauguration of those CPCs, the findings on the mobile model may indicate overall improvement in the implementation of CPCs.

The Premises Allocated to Mobile CPCs, including Maintenance, Improved Over Time

Creating a homey, pleasant environment as per the basic CPC model proved challenging for the mobile model since every locality had to allocate premises belonging to another service. The location of the CPCs within another service was problematic at first due to tumult, noise and

inadequate privacy as reported by some therapists and parents. For two of the venues, objections were raised concerning the maintenance provided by the local authority. However, it emerged from the interviews that the physical conditions improved over time. Parents also said that, on the whole, the atmosphere at the CPC was homey, pleasant and warm. According to the therapists, the centers were accessible to the vast majority of the families.

Cooperation with Social Service Departments in the General Provision of Services and Family Casework

During the period that the mobile CPCs were being set up, there was some awkwardness in the collaboration of CPC and social-service staff. This situation also improved in time due to, among other things, confidence-building measures adopted by the directors of the two services. SSD staff were included in CPC casework as part of their normal working hours, as well as in the professional training at the CPC in the Sharon, and in the joint activities of the treatment groups in the north (which included also participants outside of the CPC population). In addition, at the start of the implementation of the mobile CPCs, difficulties were posed by the fact that the patterns of referral, reporting and follow-up on families had not been consolidated. To surmount these problems, contact persons were appointed from among the SSD social workers. Both CPC and social-service staff reported that, in time, the practices were consolidated and there was fruitful cooperation in the work with the families. According to the study findings, the SSD social workers were more involved in the stages of planning treatment than in the treatment process itself. The question of an extended period of confidence-building and the consolidation of work patterns also emerged in the evaluation of the basic model of CCPs (Rivkin et al., 2009). The evaluation of the mobile model found this period to be shorter, indicating, perhaps, that experience had been gained for the implementation of the service in general.

Emphasis on Contact with Schools Rather than with Education Departments

The basic CPC model emphasizes contact with local Education Departments. Since mobile CPCs work with several Education Departments, and only a few CPC children are registered at each, the emphasis was on contact with the schools attended by the children. Though minimal at first, the contact was strengthened through the work of the housemothers. The purpose of school contact is varied: to help parents maintain contact with the responsible school parties, to coordinate the treatment offered in parallel by the CPC and the school, and to implement a joint treatment program.

The Mobile CPC Model Works Better with Four Rather than Five Localities

The northern CPC was to serve five localities initially, due to a shortage of services and multiple population needs. Serving five localities, however, proved complicated. Interviewees who had been involved in the implementation in these localities reported on difficulties caused by the added mobility, the need to deal with five different Social Service Departments, and the lack of time for staff meetings and administrative work if the five-day work week was entirely devoted to treatment. In their opinion, the workload generated by treating five localities impaired the efficiency of the service. Following this feedback, in 2010, it was decided that the model worked better with four rather than five localities and the northern CPCs downsized to working with four

localities. Since the CPC in the Sharon began to function later, it was possible to decide in advance that it would serve only four localities.

Advantages and Disadvantages of the Mobility Component

The advantage of the mobile CPCs was that the service became accessible to small, isolated localities. The disadvantage – as cited by members of the treatment staff, particularly in the north – was that mobility detracted from the staff's sense of stability. To overcome this problem, the treatment staff at both centers was divided into two teams, each team working only at two localities, on two regular days.

The Difficulty of Working only One Day a Week at Each Locality

The families in treatment and the professional staff found it difficult that treatment was offered only on one day a week at each locality. Some families wished to meet more than once a week; some professionals said that the workload at a specific locality demanded more than one day a week. Moreover, some weeks had no treatment days due to holidays or special events. Since there was no option of rescheduling alternative appointments, a family missed their regular meeting and, through the year, this could add up to several missed meetings. To help overcome this problem, an additional day of work was added to two of the northern localities – Fridays.

Treatment at the Mobile CPCs

Characteristics of Parents and Children Treated at the Mobile CPCs

Most children in the target population of the CPCs were aged 5-12. The average age of children in a family at the start of treatment was higher in the mobile CPC model than in the basic CPC model (Rivkin, 2009, the data are for 2005): 8.7 versus 6.9 respectively. About a third of the families treated were single-parent; their proportion of the total Jewish population treated at the Sharon CPCs was higher than their proportion of the total Arab population treated at northern CPCs; the Sharon proportion was closer to that of the basic model. The average number of children per family was 3.3. The percentage of families with four children and more was higher at the northern CPCs than in the Sharon: 56% versus 16% respectively. About two-thirds of the families treated at the centers had financial problems and these were more severe among the northern CPC population. In about a quarter of the families treated at both centers, at least one of the parents suffered from one of the following: substance abuse, delinquency or prostitution, diagnosed mental illness/disorders or diagnosed retardation. In about half (52%) of the northern families, one parent suffered from a chronic illness versus 16% of the families in the Sharon. The high rate of chronic illness in the north may derive from the lack of other family-support community services. The rate of disabilities among the Arab population in Israel is higher than the corresponding rate among the Jewish population: the average rate in 2003-06 was 26% and 17% respectively (Naon, 2009). In about two-thirds of the northern families and a third of the Sharon families, the parents reportedly resorted to verbal/emotional violence; in 71% of the families at both centers, relations between the parents were cited as "not so good" or "not good at all." There were no reports of physical violence.

Planning Treatment

The working model of the CPCs calls for planned family treatment and involving the family in the stages of defining the treatment goals to ensure that they participate and show responsibility, if the treatment is to succeed. The overwhelming majority of mothers, a lower percentage of fathers, and most of the children were involved in planning treatment. The participation of children in planning treatment at the CPCs was given special emphasis in the north. The goals set for most families focused on strengthening the child-parent relationship and parenting skills. For a higher proportion of families in the north than in the Sharon, the goals focused on strengthening parents and children emotionally though separately. This finding, too, may relate to the shortage of treatment services in the north: treatment at the CPCs presents an opportunity to deal with other problems as well, unrelated to the child-parent relationship.

Input of Treatment

According to the study findings, the treatment provided to the great majority of families was conversation. In addition, the housemother was in contact with a large proportion of the families. Most families received expressive and creative therapy, which, as said, received greater emphasis at the Sharon CPCs, whereas group therapy received greater emphasis in the northern CPCs. Apart from the components of therapy, both centers held special events in which most of the target populations participated. About half the children treated in the Sharon and a fifth of the children treated in the north were referred to external services in the course of their treatment at the CPCs; these figures reflect the broader supply of services in the Sharon region.

The Involvement of Fathers in Treatment

The concept of the mobile CPCs regards the involvement of fathers in treatment as important to improving the emotional situation and functioning of the children. The study findings showed fathers to be less involved than mothers in the planning and course of treatment. They were involved less still in the north than in the Sharon either because many of them worked late hours far from home or because they did not wish to be involved. Over time, the approach to the involvement of fathers became more flexible in the northern CPCs and families were permitted to continue treatment with mothers only. Some therapists at the mobile centers in the north said that they felt that they had succeeded in treating fathers, too, through mothers who passed on the messages they absorbed at the center to the fathers. Moreover, in two localities, the centers began functioning on Fridays to enable fathers to participate.

Difficulties in Ensuring Continuity of Family Therapy after CPC Treatment Ends

For both mobile centers, there was a reported shortage of services for family referral if follow-up or further therapy was necessary after CPC treatment ended. Local social services reported work overloads that made it difficult for them to implement continuing programs. Some parents reported on problems that they and their children had after disengaging from the CPCs; the intervention ended abruptly rather than gradually and there was no referral to another treatment agency. Note that this issue was also raised in the evaluation of the basic model.

Changes in the Condition of the Children and Parents as Reported by Therapists

Improvement in the Children's Condition

Therapists completed questionnaires on the condition of the children at the time of referral to the CPCs and at the end of treatment. The questionnaires contained measures from the Achenbach questionnaire (Child Behavior Check List – CBCL), relating to the following problems: emotional, social, anti-social behavior, lack of interest in the surroundings, self-image and psychosomatic symptoms. A comparison of the condition of the children before and after the intervention, as reported by therapists, shows a clear decrease at both centers in the rate of children suffering from problems in various areas. Furthermore, therapists were asked if they thought that the children had made progress in the emotional, behavioral, scholastic and social spheres, and whether there had been improvement in their relations with parents and siblings in the course of CPC treatment. These assessments, too, indicated progress in all the above-mentioned areas.

Improvement in Some Aspects of Parental Functioning

Two measures (at the start and end of treatment) examined four aspects of parental functioning: deficient daily care of children, problems in parental contact with the school framework, emotional problems in the parental relationship with children, discipline problems with the children. The findings show a clear, significant decrease in the problems of deficient daily care of children, in the rate of children whose parents were characterized by emotional difficulties in the child-parent relationship, and in the rate of children whose parents found it difficult to enforce discipline.