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ENGELBERG CENTER FOR CHILDREN AND YOUTH

## Evaluation of Child-Parent Centers

### Final Report

Dori Rivkin

*With* Smadar Shmaia-Yadgar, Michal Shemesh,  
Rachel Szabo-Lael, Yoa Sorek

The study was initiated by Ashalim and the Children and the Youth Service of the Ministry of Social Affairs and Social Services and funded with their assistance



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## Related Myers-JDC-Brookdale Institute Publications

Abu-Asba, K.; Rivkin, D.; Sharitah, F; Margolin, T. (forthcoming). *Shfaram Children-Parent Center – Evaluation Study*. National Insurance Institute, Massar Research Institute, Education Planning and Consultation, Myers-JDC-Brookdale Institute, Jerusalem

Ben Rabi, D.; Amiel, S.; Cohen-Navot, M.; Dolev, T.; Kahan-Strawczynski, P.; Rivkin, D. 2008. *Ashalim Celebrates a Decade of Activity: Accomplishments and Future Challenges*. (Hebrew and English). (Copies may be ordered from Asahlim: [www.ashalim.org.il](http://www.ashalim.org.il))

Dolev, T.; Szabo-Lael, R.; Ben-Rabi, D. 2008. *Child Protection Officers: Roles, Work Methods, and Challenges*. RR-512-08. (Hebrew)

Dolev, T.; Szabo-Lael, R.; Schmid, H.; Bar-Nir, D. 2008. *"Towards the Community" Policy – Evaluation Study*. RR-516-08. (Hebrew)

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Dolev, T; Ben-Rabi, D. (ed.); 2002/2003. *Development of Social Welfare Services for Children at Risk. Conference Book*. S-98-02 (Hebrew); S-102-03 (English)

Dolev, T.; Benbenishty, R.; Timar, A.; 2001. *Decision Committees in Israel: Their Organization, Work Processes, and Outcomes - A Summary Report*. RR-382-01 (Hebrew)

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# **Executive Summary**

## **Child-Parent Centers**

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

The centers are operated by the Children and Youth Service at the Ministry of Social Affairs and Social Services, the municipal Social Service Departments (SSDs), Ashalim and NGOs. The first center opened in Haifa in 1998, followed by others around the country. The centers have a multi-disciplinary staff; they are designed like a home and operate mostly in the afternoon. Each center serves about 100 children and parents, and the treatment lasts about a year. Families are referred to the center by the SSD; Children and parents come to the center together: some of the interventions are shared; some – separate. The centers' practices are based on current approaches in the treatment of children at risk and their parents. These include focusing on the child-parent relationship; viewing the family as an integral unit; involving the family in the treatment plan; and an individual treatment plan for each family; using creative and expressive types of therapy; dividing responsibility for the family's care between the CPCs and the social services; ongoing contact between the service and the child's school, and continuing case management at the SSDs after CPC intervention ends.

## **Evaluation Study**

The evaluation of the child-parent centers was conducted by the Myers-JDC-Brookdale Institute and initiated and funded by Ashalim and the Ministry of Social Affairs and Social Services' Children and Youth Service. The evaluation aimed to provide policymakers and service developers with information to help develop the service and to decide on further expansion. The evaluation addressed implementation and outcomes for children and parents. The study examined characteristics of the children and the families and whether they were in keeping with the target population, implementation of basic work principles, inputs for children and families, outcomes for children and parents and clients' feedback on the help they had received.

Nine Child-parent centers throughout Israel participated in the study along with their respective Social Service Departments. The study population consisted of 153 families treated at the centers during 2000-2004. The study also included a comparison group of 138 families with parenting problems, sampled from 20 SSDs in communities without a child-parent center. In addition, the characteristics of the children and parents were compared with data collected for the "Community 2000" experiment, from a sample of 1,039 children from 11 SSDs (Dolev, Ben-Rabi and Szabo-Lael, 2006).

**Research tools:**

1. *A questionnaire for SSD social workers* completed about each family and child at three points in time: at referral (145 families), at the end of treatment (109 families) and during follow-up a year later (95 families)
2. *A questionnaire for CPC therapists* completed at the end of Center treatment (139 families)
3. *A questionnaire for mothers* completed at referral (135 mothers) and at follow-up, about a year after CPC intervention (49 questionnaires)
4. *Documentation of CPC staff activities* completed over two weeks in 2002 (96 staff members)
5. *In-depth interviews and focus groups* with key figures at the Children and Youth Service and at Ashalim, SSD directors and social workers, CPC directors and staff members, mothers, fathers and children treated at the Centers.

**Family Characteristics and their Correspondence to the Centers' Target Population**

*Defining the target population:* The regulations<sup>1</sup> of the Ministry of Social Affairs and Social Services define the CPC's target population: children aged 5-12 with emotional or behavioral problems stemming from poor parenting, and parents who find it difficult to provide their children with reasonable conditions for normal development, yet have the ability to improve their parenting. In the first years, the CPCs were perceived by some SSD staff as a last resort for treating the "most difficult" families prior to placing children out of the home. In time, the definition of the target population changed and a consensus was reached that the Centers cannot benefit families lacking motivation or the ability to change. It was also agreed that the CPCs are not aimed at families in which both parents are incompetent due to intellectual disability, active addiction or active mental illness. The goal is to serve families in which parents are willing and able to commit to therapy.

*Socio-demographic characteristics:* Most of the children (78%) were within the target age category, 5-12. Some other children in the family, whether older (11%) or younger (11%) also took part in the therapy. About half the children (53%) were living in single-parent families. In 9% of the families in which the parents did not live together, the non-custodial parent was involved in therapy. Sixteen percent of the families had one child; 23% had two children, and 44% had three or more. Twenty-three percent of the children lived in families in which the head of the household did not work. Twenty percent of the children had a parent with mental illness, addiction, criminal violations or intellectual disability.

Compared with the sample of 11 SSDs, the CCPs had a higher proportion of single-parent families (36% and 53%, respectively). On the other hand, the proportion of CPC families with a non-working head of household was lower (23% versus 41%, respectively). In 20% of the CPC

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<sup>1</sup> Professional regulations for social work 8.38, "Child-Parent Centers", of 1.7.2003

families, one parent had a mental illness, addiction, criminal violations or intellectual disability; while 41% of the children treated at the SSDs had a parent with one of these conditions.

***The children's emotional, social and school functioning:*** At the time of referral, the referring social workers reported signs of sadness and anxiety in 67% of the children, low self-esteem in 29%, anti-social behavior in 34% and social problems in 47%. In school, 47% had behavior problems and 47% had below-average grades. On all of these indicators, the CCPs had a higher proportion of children with problems than the 11-SSD sample.

***Treatment of parents:*** At the time of referral to the CPCs, the referring social workers reported on various aspects of parental care. The most common problems concerned the emotional relationship with the child (79%) and appropriate discipline (69%). Less common problems were: lack of appropriate supervision (24%), lack of contact with school (24%), and physical neglect (18%). Problems in parenting were more common among CPC parents than in the 11-SSD sample; e.g., for problems in the emotional relationship, the figures were 79% versus 34%, respectively and for appropriate discipline – 69% versus 26%. The proportion of children suffering from physical neglect was similar in the two groups.

The proportion of CPC families with financial and social problems was lower than in the population treated by SSDs. On the other hand, the proportion of children with emotional problems, problematic relationships with parents, and difficulties in most areas of parental care was higher than among the total SSD population.

Most of the children (81%) were referred because of a combination of their own problems and problems in parental care. Twenty-four percent were under the supervision of a child protection officer and out-of-home placement had been considered during the year preceding the referral for 16% of the children.

The profile of the children and families corresponds to the CPCs' target population i.e. children with emotional and social problems, and parents with difficulties in relating and caring for their children, yet with the potential to change.

## **CPC Intervention**

In order to examine processes in the development of the CPCs, the families in the study were divided by the year they began treatment. The first period refers to 2000 to 2001 and the second period refers to 2002 to 2003.

***Designing a treatment plan:*** According to the CPC model, the first sessions with a family are devoted to assessment. After this, a treatment plan is designed which defines the aims of the therapy and the inputs provided to achieve them. In addition to the CPC therapist, the family and family's SSD social worker take part in formulating the plan. In fact, 77% of the mothers reported taking part in a meeting discussing the type of therapy they were to receive; 45% of them

reported that they were asked about their preferences. All of the mothers that reported being asked, also reported that their wishes had been taken into consideration. Comparing by period indicates a small increase in family participation in treatment planning: 50% of the mothers in the second period responded that they had been asked about their preferences and that these were taken into account versus 39% in the first period.

**Type of therapies offered:** The CPCs are meant to provide intensive treatment using a variety of therapies and methods according to family needs. Treatment is aimed at the child and family with special emphasis on expressive therapies<sup>2</sup>. Such techniques are suitable for both children and adults, they are considered effective for clients with difficulties in verbal communication; and they make treatment more varied and enjoyable. In addition, the CPCs offer training in home skills by the housemother, such as preparing meals together, as well as group work with individual families. The following data on CPC activities is taken from staff documentation.

- ◆ **Participants in therapy sessions:** 39% of the therapy sessions were with children and parents, 31% were only with children; and 30% were only with parents.
- ◆ **Group work:** 24% of the therapy hours involved group work; in 53% of them, both parents and children took part; in 29%, only children; in 18%, only parents
- ◆ **Types of therapy:** Non-verbal expressive therapies were used in 86% of the group sessions and in 66% of the non-group sessions. The most common non-verbal therapies were play therapy, art therapy and animal-assisted therapy. Mothers cited discussion and art therapy as the most helpful.

Most of the therapy hours for children (93%) were devoted to expressive therapy. The same was true of sessions with both children and parents (81%); in sessions for parents only, the main form of therapy was discussion (84%).

In in-depth interviews with parents, many noted the expressive therapies as being suited to the family, as fun, and as helpful in connecting parents and children. Some parents said that thanks to expressive therapy, they had managed changes that they would not have achieved in any other way.

**Family attendance:** The CPCs offer relatively intensive treatment. According to the treatment plans, 18% of the families were meant to have two sessions a week and 82% one session a week. This is a great deal of therapy compared with the treatment offered at the SSDs, where the average frequency is once a month (based on data on the comparison group). Many of the families have trouble organizing their time and committing to fixed schedules, and did not come as planned to the CPC for treatment. In fact, 14% of the families attended twice a week and 60%, once a week; 27% came once every two weeks or less often. Over time, there was improvement in the families' attendance: during the second period only 8% of the families attended therapy less than once a month, as opposed to 24% during the first period. This improvement may reflect a

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<sup>2</sup> Such as play, art, movement, gardening, animal care, skills training, psychodrama etc.

more stringent selection of families for treatment at the CPC, or changes in practice which encouraged regular attendance.

Attendance was also related to length of treatment: most families who were in therapy for more than a year (64%) attended treatment every week, as opposed to 39% of those who were in therapy less than a year. Ten percent of those in therapy for more than a year missed twice a month or more. It is unclear why these families were allowed to continue beyond the stipulated period if they had not utilized their allotted time to a reasonable extent.

***Fathers' participation in therapy:*** As in the case of other family services, fathers participated less than mothers. In about half of the families, the father was not living with the children and most were not partners to therapy. Only 47% attended regularly versus 61% of the mothers. Nevertheless, this gap is smaller than that found in SSD treatment. Thus, for instance, in the comparison group of similar families, only 35% of the fathers met with social workers in the final months versus 65% of the mothers.

***Evaluation discussions at the centers:*** The CPCs conduct interim evaluations ("evaluation discussions") during treatment in which progress is examined and programs are adjusted as needed. The CPC therapists reported conducting evaluation discussions with 81% of the families. The CPC therapist and at least one parent took part in each discussion. An SSD representative took part in 81% of the discussions; school representatives took part in 7% of them.

In addition, ***Treatment and Evaluation Planning Committees at the SSD*** convened for 82% of the families during or after therapy. Parent participation in these committees increased from 70% during the first period to 81% in the second. This trend corresponds to the efforts of the Ministry of Social Affairs and Social Service to increase client participation in decision-making committees and not only in the CPC context.

***CPC staff activities:*** Apart from therapy sessions with family members, the CPC staff's time is devoted to supervision, consultations, guidance, staff meetings, coordination with the SSD, the school and other agencies, charting etc. As part of this study, staff reported their activities every half hour for two weeks. According to this data, about a third of all CPC working hours are devoted to direct work with clients in therapy sessions, and another 16%, to contact with various agencies such as the SSD and school; 26% of their time is devoted to meetings, consultation and training; and 24% of the time is devoted to charting and administrative tasks. The division of time between different tasks predictably varies according to a staff person's position. For example, CPC directors devote 15% of their time to therapy sessions, social workers – 34%, and expressive therapists – 51%.

## **Joint CPC-SSD Work**

***Involvement of SSD family social worker in CPC treatment:*** The CPCs are part of the SSDs. They are meant to share responsibility for family care and maintain ongoing contact with the SSD

family social worker who continues to act as case manager throughout, seeing to the family's other needs. From interviews with CPC and SSD staff, it emerged that this principle is not easy to apply. Most of the staff in both services do, in principle, favor involvement by the family social worker in the treatment at the CPC. However, SSD social workers complained that the CPC staff expects them to deal chiefly with technical matters. Furthermore, they are responsible for many other families and must prioritize their work; they cannot always free themselves for CPC meetings. CPC staff contended that SSD social workers do not always perform their duties quickly; SSD social workers contended that CPC professionals are not always ready to share their deliberations about a family with them.

According to data from CPC therapists, SSD social workers were fully involved in treatment planning for 56% of the families; SSD social workers reported that this was true for only 30%. According to the CPC therapy director, for 66% of the cases SSD social workers participated in most or all CPC staff meetings concerning a specific family. According to SSD social workers, this was true for only 44% of the cases. Both sources agreed that 12-13% of the SSD social workers took part in family therapy sessions at the centers. Only 12% of the SSD social workers reported that they had encountered difficulties in working with the CPCs; the most common complaint was that the center did not report on its handling of the family and did not involve the department sufficiently. The discrepancy between the reports of CPC directors and SSD social workers indicates that there were cases in which the CPCs believed they had involved the SSD social worker though the latter did not feel that this was so. In the comparison between periods, the second period showed a decrease in the extent of involvement of SSD social workers in CPC treatment planning and discussions.

***The SSD social worker's intervention with a family during the treatment at the CPC:*** Social workers reported that in the course of CPC therapy, they spoke by phone with 94% of the families, met with 80% in their office, and paid home visits to 48%. With 16% of the families they had regular meetings and with 64%, according to need. Despite the decrease in the percentage of families for whom SSD social workers were involved in therapy planning and center discussions, the second period showed an increase in the percentage of families for whom they performed various duties. For example, in the second period, 90% of the families met with an SSD social worker in the course of CPC therapy as compared with 67% in the first period. In interviews with mothers, 75% reported that they had been in touch with an SSD social worker in the course of therapy (less than the 94% reported by social workers). When mothers were asked if the social worker had helped the family during therapy, 37% said yes, 39% said no, 12% said that they had not needed help, and 26% said that they had not been in contact.

## **Ending Treatment**

***Duration of treatment at the CPCs:*** Treatment at the CPCs is meant to be limited in time, lasting one year with an option of a six-month extension, subject to the approval of the SSD's Treatment Planning and Evaluation Committee. In practice, treatment lasted an average of 16.4 months. Forty percent of the families were in therapy for over a year and a half: 19%, for up to two years

and 21%, for over two years. The duration of therapy was similar in the two periods: in 2000-01, therapy lasted an average of 17 months; in 2002-03, it lasted an average of 15.8 months. However, there was a decrease in the proportion of families having especially long- or especially short treatment. Apparently, in the course of time, families more suited to therapy were chosen for the CPCs so that there would be less cases of dropping-out; as a result, the time limit could be better enforced and particularly long-term therapy avoided.

Most of the CPC and SSD therapists felt that the allotted treatment period was too short for most of the families and that more time was needed to build the therapeutic relationship, enter into the therapeutic process and internalize change. Nevertheless, supervisors at the Service for Children and Youth felt that the allotted time can be sufficient if therapy focused on defined goals and the time was used effectively. Mothers were asked in interviews if they thought the treatment at the CPC had ended at the right time; 35% said it had ended at the right time, 61% said it had ended too early, and only 4% stated that the therapy had gone on too long. Most of the mothers in therapy for 12-18 months thought that the length of therapy had been suitable. Interestingly, among the mothers who had been in therapy for a longer time (over than 24 months), there was a high percentage that felt that treatment had ended too soon. This group seems to find it hard to terminate treatment even if it went on for a long period or they required long-term therapy and had no other source of help.

### **SSD Treatment of Families after CPC Therapy**

According to the model, the treatment at the CPC is part of the continuous SSD treatment. Therapy is limited in time and when it is over, the CPCs and SSDs formulate a plan for continued treatment by the latter, including additional services as needed. The SSD social worker is responsible for the program's implementation. Continuity of treatment is key to the model since the CPCs are intended to serve children at risk and their families who require long-term help and support in a variety of areas.

*Planning further treatment:* CPC therapists reported that a plan for further treatment was formulated for 68% of the families (61% in the first period; 75% in the second). For half of the families, the formulated treatment plan included talks with the SSD social worker. The most common service for children was after-school programs (11%); 3% were referred to daycare residential homes and 2% to out-of-home care.

As reported by therapy directors, treatment programs were formulated without the family's involvement in few cases (5%).

The questionnaires for mothers, administered a year after therapy, present a different picture. Only 22% reported that a plan for further treatment had been formulated, 78% reported that it had not. Only one mother (2%) reported that she had been involved in the formulation of a treatment plan. The discrepancy between the mothers' and therapists' reports indicates that even if a plan for

further treatment was formulated and even if parents were involved in it, the mothers did not experience or remember formulating it and did not regard it as significant.

***Further SSD treatment after treatment at the CPC:*** In follow-up interviews with mothers, 58% reported that they met with the social worker on occasion, 2% reported that they met with her regularly, 8% were in contact with the SSD but did not meet with their social worker, and 32% reported that the family had no contact with the SSD. In in-depth interviews with parents, some said that they found it hard to turn to the SSD for further treatment, despite their need, because clients found the social workers overloaded and unavailable, and they disliked the atmosphere at the SSD, compared with the warm, homey atmosphere of the CPCs. Some said that when in need, they continue to call on CPC staff even though the treatment at the service had ended. In interviews with CPC and SSD staff, both sides acknowledged that the SSDs do not continue to monitor all the families and children who had been treated at the CPCs. They both said that the SSDs do not have a suitable response for families after treatment at the CPS.

## **CPC Treatment Outcomes**

Therapy outcomes were examined by comparing reports on the child and parents at the time of referral with corresponding data at the end of treatment. The outcomes measured were the child's emotional and social functioning, parental care, and the mothers' reports of stress and competence in parenting. At both points in time the source of information was SSD social workers, as well as mothers who reported on their attitudes. Changes in the comparison group were also examined, though the comparison is limited as the group's characteristics differed from the CPC population, notably in the lower proportion of children with emotional, social and scholastic problems.

***CPC outcomes for children:*** Six emotional and behavioral parameters were included: sadness and anxiety, low self-esteem, anti-social behavior, school behavior problems, and social problems. Two of these parameters showed significant improvement: the percentage of children with school behavior problems decreased from 61% at the time of referral to 43% at the end of treatment; anti-social behavior decreased from 46% to 34%. In the comparison group, there was no significant change for these parameters. Instead, there was a significant increase in the number of children showing signs of sadness and anxiety (from 38% to 52%) whereas for children treated at CPCs, this parameter showed a non-significant decrease (from 76% to 70%).

***CPC Outcomes in Child-Parent Relations and Parental Care:*** For parents, the outcomes were examined through eight parameters: problems in the emotional relationship with the child (father and mother), appropriate discipline (father and mother), lack of suitable supervision, neglect, lack of school involvement, involving children in parents' disagreements, physical or verbal violence. The findings showed a significant decrease in the proportion of children suffering from violence and in cases of suspected violence (from 31% to 21%), and in the proportion of children with problems in the emotional relationship with fathers (from 91% to 70%). There was a small (statistically non-significant) improvement in the mothers' emotional relationship with their children and in their use of appropriate discipline: problems decreased from 81% to 71% and

from 65% to 56% respectively. In the comparison group, problems in both these areas increased (non-significantly): the mothers' emotional relationship problems rose from 59% to 67% and their problems in using appropriate discipline increased from 41% to 51%. Among mothers treated at the CPCs, there was significant improvement in their sense of parenting competence versus the comparison group where the improvement was smaller and not statistically significant. For other parameters examined, the data did not indicate changes in the children's functioning or parental care.

## **Participant Satisfaction and Feedback**

Parents interviewed both by questionnaires and by in-depth interviews expressed great satisfaction with the treatment at the CPCs: 71% of the mothers were very satisfied with the treatment, 25% were satisfied and only 4% were not so satisfied. To compare, among mothers of the comparison group, treated at SSDs, only 38% were very satisfied, 27% were satisfied, 14% were not so satisfied, and 21% were not at all satisfied. The mothers seen at the child-parent centers were very satisfied with the CPC therapists – 100% were satisfied with the personal relationship with the therapist, 99% said the therapist was understanding, and 87% said that the therapist had helped solve problems. In the comparison group, 85% were satisfied with the personal relationship with the social worker, 74% said she was understanding, and 64% said that she had helped solve problems. In the in-depth interviews, the parents emphasized a number of aspects about the relationship with CPC staff, which they described as close, warm, understanding, non-judgmental and non-threatening. Interestingly, despite the large gap in satisfaction between the CPCs and SSDs (96% satisfied at CPCs versus only 65% satisfied at SSDs), the gap regarding satisfaction with the relationship with the therapist was smaller (100% versus 85%, respectively). Mothers treated at SSDs apparently differentiated between the personal relationship with the social worker, with whom they were on the whole satisfied, and the overall treatment provided at the SSD. Mothers were also asked about the benefit of treatment at the CPC for the children. They responded that the treatment had “great benefit” for 48% of the children, and “benefit” for 31% of the children. For 21% of the children they responded that the treatment had little or no benefit. Mothers were also asked about specific effects of the treatment: 66% of the mothers reported improvement in their relations with the child, 63% in the child's emotional condition, 62% in the child's behavior at home, 52% in the child's relations with siblings – 52%, 51% in the child's social functioning, and 46% in the child's behavior at school. In open interviews, parents spoke of how treatment at the CPC had helped them: they had learned to listen to their children, on the one hand, and to set boundaries, on the other; they had learned to pay attention to their children rather than to buy them material things. In a focus group, children emphasized the fun and warmth at the center, and the opportunity to do things with their parents. Children said that the center had helped in their relations with parents, in their self-confidence and in their ability to accept limits set by their parents. Thirty-five percent of the mothers noted that there was room for improvement at the CPCs. The most common suggestions were: more therapy hours, more special activities, and lower turnover of therapists.

## **Situation of Children at Time of Follow-Up**

Follow-up interviews with SSD social workers and with mothers were conducted about a year after the end of therapy. For 47% of the children, no information was available at the time of follow-up as they were not being handled by the SSD. This resulted in an over-representation of children requiring SSD intervention. About a quarter of the children in the follow-up had suffered some crisis requiring the intervention of a child protection officer; 17% were in out-of-home care and this was being considered for an additional 24%. In other words, for a considerable amount of the children, CPC treatment had not averted recurring crises or the need for out-of-home care.

However, no differences were found in the children's situation between the end of treatment at the CPC and at follow-up. In areas where improvement had been achieved in the course of treatment (school behavior problems and anti-social behavior), the gains had been retained at follow-up time. Nor did the rate of children with problems rise between the end of treatment and follow-up. The stable proportion of problems between the end of therapy and follow-up goes against the usual trend among children at risk who show an increase in various problems as they grow older. The significance of this finding is that despite the recurrence of situations of risk among some of the children, overall the situation of the children as a group remained stable, maintaining the center's accomplishments.

## **Strengths and Challenges**

### **CPC Strengths**

1. The CPCs' target population comprises families with children aged 5-12 who have emotional or behavioral problems stemming from impaired parenting, and their parents, provided they have the potential to improve their parenting. As the CPCs took shape, they formulated a clear understanding of the population they were meant to serve and their ability to serve them. They treat children at risk and their families who show a high rate of emotional, social and parenting problems. Nevertheless, the CPCs do not treat families with the most deep-set, enduring functional impairments who lack the potential to benefit from therapy.
2. The CPCs offer families a broad range of expressive therapies, group therapy, and enjoyable, attractive family activities.
3. The CPCs relate to the needs of children and parents by treating them in various settings: children, parents, families, and groups of every type.
4. The CPCs create a pleasant, inviting atmosphere. Parents and children experience the attitude of the staff as close and non-judgmental. The atmosphere is described as different from that of the SSDs where parents experience a less warm and welcoming attitude, and where the time they spend is less pleasant although the clients apparently understand the constraints of the social worker's workload.
5. Parental satisfaction with the CPCs is high. Apart from the atmosphere and good relations with therapists, parents appreciated the expressive therapies, the different treatment settings and the attention to the children's emotional needs. Many of them attested to insights and changes resulting from treatment at the CPC, to the positive influence of the CPCs on their

relationships with their children, and to the emotional and behavioral condition of the children. In particular, they cited their ability to set boundaries; greater attentiveness to the needs of the children; less squabbling and better communication at home. They also cited improvement in the children's behavior, in the children's social relations and in school functioning.

6. Study findings indicate a significant decrease in the children's anti-social behavior and school behavior problems. CPC treatment may also have prevented an increase in children's sadness and anxiety. There was a significant decrease in the rate of children suffering from parental violence and the cases of suspected violence. There was also significant improvement in the emotional relationship with fathers and in the mothers' sense of competence. To understand these findings, one should consider that over half of the outcome studies of programs to improve relationships in families with children at risk, found only small effects (Cedar & Levant, 1990; Chaffin et. al., 2001; Giblin et. al., 1985; Lazer et. al., 2001; Macleod & Nelson, 2000).
7. The situation of the children in the emotional, social and school areas, as well as parental care, remained stable through follow-up about half a year to a year after therapy. This counters the common trend of such problems exacerbating with age.

### **Challenges and Issues to Consider**

1. SSD social workers are only partially involved in the CPCs; in fact, their involvement decreased during the research period. The findings indicate a lack of clarity about the SSD social worker's role in CPC treatment. Given the need of the SSD family social worker to set priorities in her work, it is necessary to define her roles and the extent of her involvement clearly and realistically.
2. The principle of joint work with the children's school is only partially applied. It is necessary to define the nature of the cooperation (information or joint work), the areas of cooperation (scholastic or additional areas such as the child's social standing in the classroom), the extent of cooperation (for all or for only some of the children), and the party in charge of managing the cooperation (the CPC therapist or the SSD social worker).
3. In most cases, treatment at the CPC extended beyond the allotted time. Most of the CPC and SSD staff do not accept the principle of time-limited therapy which demands setting partial goals and focusing on these. They claim that more time is needed to form a therapeutic relationship with the family and gain their trust before the process of change can begin, and to assimilate the changes effected.
4. There is a problem with continuity of treatment between the CPCs and SSDs. Not in every case is a program for further treatment formulated; a large proportion of the families do not maintain regular contact with the SSDs after leaving the CPCs. In the view of both CPC and SSD staff, the SSDs have no adequate responses to the family's continuity needs. This may improve if the SSD repertoire of responses expands as part of "Towards the Community" policy, enabling them to convert quotas of out-of-the-home care into the development of community services.

5. The CPC physical design and atmosphere follow the model's principles. CPCs differ from SSDs; they offer an inviting atmosphere and therapists are available since they do not deal simultaneously with a large number of cases. These differences may make it difficult for families finishing at the CPCs to turn to the SSDs for further treatment.
6. Thought should be given to additional interventions or responses that may serve as further (though less intensive) treatment after the CPCs. For example: the participation of the SSD social worker in the final part of therapy at the CPC to prepare the ground for continuity; or a joint CPC-SSD follow-up group to bridge between the two. Furthermore, if there are new community responses as part of the "Towards the Community" policy or the National Program for Children and Youth at Risk, one might give more weight to referring post-CPC families to them.

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