State of Israel
Ministry of Welfare and Social Services

Rashi Foundation
קרן רש"י

National Insurance Institute
Fund for Children and Youth at Risk

Treatment Centers for Children Victims of Sexual Abuse

Evaluation of Activity 2011/12

Evaluation Report – Executive Summary

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The Partners

The Ministry of Welfare and Social Services is the government agency responsible for protecting children and youth who are victims of sexual abuse and for their treatment. This responsibility is expressed in integrating the inter-ministerial activity, in professional guidance and in gradual adoption of the initiative in organizational, professional and financial terms.

The Fund for Children and Youth at Risk was established as part of the Division for Service Development of the National Insurance Institute. The Fund works to develop unique, innovative and sustainable services for the benefit of at-risk children and youth. Its goal is to develop services in the fields of social welfare, education and employment that will prevent or remove risk factors affecting children and youth. The Fund's participation in the initiative from its inception is a step towards achieving this goal.

The Rashi Foundation is an independent family foundation working since 1984 to realize the vision of a stable and prosperous Israel that draws its strength from a society in which every individual can realize his or her true potential. The Foundation takes part in the initiative from the start out of its belief in the importance of supporting the development of unique services that affect the lives of the children and youth at risk, particularly in the geographic and social periphery.

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Executive summary

As part of a partnership between the Ministry of Welfare, the Rashi Foundation and the National Insurance Institute's Fund for Developing Services for Children and Youth at Risk, we began planning in 2007 an initiative for treating children and youth victims of sexual abuse. The main goal was to establish a nationwide network of centers that will offer emotional therapy for children and their families and will run educational and training programs in the community. The professional, organizational and financial involvement of the Welfare Ministry from the start has enabled the development of a model that can be adopted by the Ministry at the end of the structuring process. At present the initiative includes 12 regional centers, each with several branches. With the establishment of 7 more centers in the next few years, the nationwide spread of treatment centers will be completed. This report was written in preparation for the expected handover of the initiative to the responsibility of the Welfare Ministry in mid-2013.

The partnership

The initiative was launched with joint funding and management of the National Insurance Institute's Fund for Developing Services for Children and Youth at Risk, the Rashi Foundation and the Ministry of Welfare. The partnership has created an ad-hoc professional body that pools knowledge and leads service development with regard to treatment of minors who are victims of sexual abuse. Thanks to this partnership, the initiative developed gradually from a partial, unregulated solution addressing an acute need to a structured service that will soon become fully funded and supervised by the State.

Budgeting

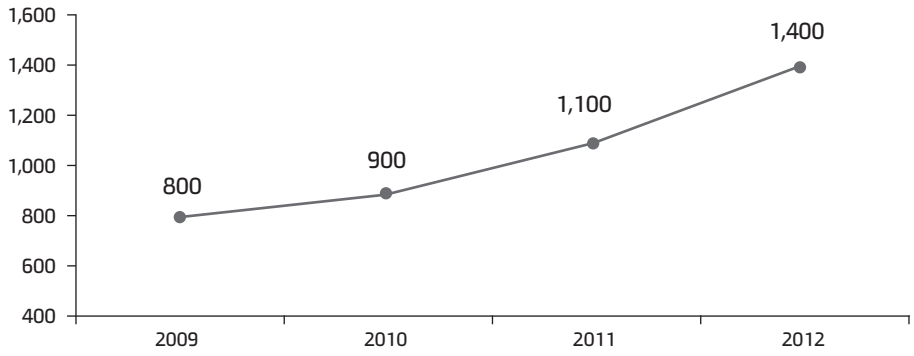
The unique dunique development of the budgeting model was based on "planned" trial and error: the initiative began operating in several models, accompanied with an evaluation study, and by drawing conclusions we determined the preferred organizational and professional model. The budget was then derived from the model, instead of the other way around. Finally we built a multi-year budget for gradual expansion up to a budget of one million NIS per year for a typical center. In the first stage (2007-2010), Rashi and the National Insurance Institute invested 20 million NIS in the initiative. In the second stage (2011 until June 2013), the Welfare Ministry joined as a funding partner and the budget increased to 25 million NIS with each

partner investing a third. The last stage will be implemented by the funds while the Welfare Ministry covers the operating costs from now on.

General data

Over the years, the initiative grew in all parameters – its geographic span, the number of applicants and number of children being treated, and the community-oriented activities. In 2012 the centers provided 25,048 hours of treatment to 1,400 children and youth. 931 of them received a full treatment at the centers and the others came only for consultation or a few intake sessions, after which it was decided on treatment at another time or in another framework. The number of service recipients increased last year by 30%, and the number of treatment hours increased twofold.

Chart 1: **Number of applicants 2009-2012**



The average number of treatment hours per patient (whether they completed treatment or not) was 28; an average treatment took 35 hours to complete this year. Many of the patients experienced complex abuse; about half of the applicants experienced incest, rape and sodomy; more than half were abused repeatedly and at least 15% were assaulted by more than one person. Most of the centers that were established in the first stage met the goal of 3,000 annual treatment hours, while the newer centers are not required to reach this goal yet.

Table 1: **Comparison between the centers in main parameters, 2012**

Location	Total therapy hours per center	Average therapy hours per child*	Average length of full treatment	Number of children treated**
Lod	5,770*	29	30	204
Tzfat	2,715	30	24	91
Hadera	2,753	29	45	96
Bnei Brak	3,336	25	36	141
Be'er Sheva	2,212	30	43	76
Kiryat Malachi	2,984	31	52	96
Nazareth	906	17	25	53
Holon-Rishon LeZion	1,175	26	14	47
Haifa	226	23	41	13
Afula	655	23	37	28
Netanya	1,513	24	22	63
Carmiel	803	38	11	23
Total	**25,048**	**28**	**35**	**931**

* Not including children who went through intake only
** Including children who went through intake only
*** Including more than 2,500 hours that were funded from the balance of stage 1 budget

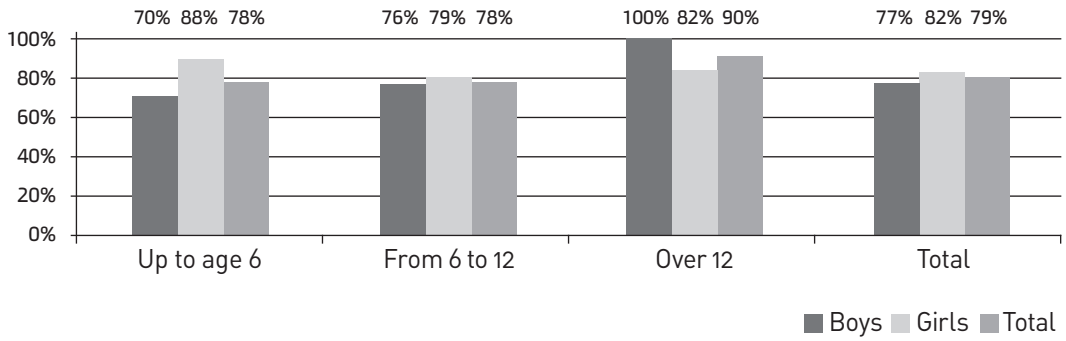
The table shows big differences between the centers in the average number of therapy hours per child. These are due mainly to the fact that the new centers don't offer long treatments yet.[1]

Quality of the treatment

The centers specialize in treating trauma; they rely primarily on the dynamic treatment approach, but use also short-term methods to complement the therapeutic solution. Approximately 80% of the patients that were treated through the initiative showed an improvement.

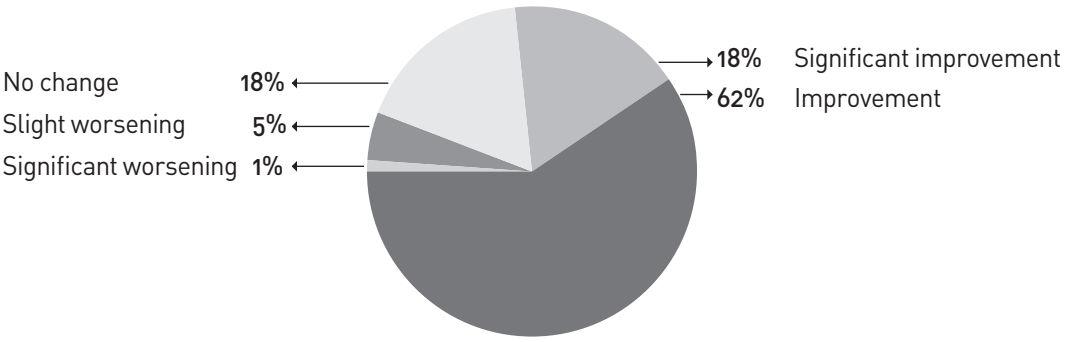
1 The Carmiel center is an exception, probably due to the small number of patients or because the therapists define the completion of treatment differently than in other centers, at least in some cases.

Chart 2: **Total improvement in treatment, by age and gender**



An assessment of the intensity of the symptoms of injury through the treatment period indicates that it started at a level of 7.7 and went down to 5.6 by the second assessment[2]; patients who continued to a longer treatment displayed a further decrease to 4.4. The quality of the treatment is reflected also in the responses of professionals working in association with the centers: approximately 90% of the social workers who work with the centers were satisfied with the treatment they provide. The dropout rate went down from 10.5% in 2011 to 7.5% in 2012, possibly due to the ongoing cooperation between the centers and the community, which allows the referral of the most suitable cases to the centers, or due to the improvement of the intake process, which also helps to tailor an optimal treatment plan for each patient.

Chart 3: **Quality of treatment, based on the effect on the main symptom**



2 The first assessment took place between the 4th and 8th sessions and the second – between the 20th and 24th sessions. A small group of children whose treatment was longer was assessed again between the 36th and 40th sessions. The intensity of the symptoms was measured on a scale of 1-10 (10 = high intensity, 1 = low intensity)

Quality of the service

The provision of high-quality service is part of the basic concept of the centers. This is expressed in the high satisfaction of all the parties (social workers, therapists and parents) with the quality of the service. 96% of the therapists said that the quality is discussed by the team and that the center's director stresses the importance of providing a good service to the patients and their parents. The centers offer a first-rate service, highly accessible with regard to the hours of activity and the physical environment at the centers, and fairly good with regard to the waiting period for an initial response and for the treatment to begin: approximately 80% of the social workers are satisfied with the service and 70%-75% of them are satisfied with the waiting period for initial response and for treatment. The geographic expansion of the centers has not been completed yet and their spread is still partial. The service meets very high ethical standards, protects the patients' privacy and treats them with proper respect and discretion as defined in the standards document; 99% of the social workers feel that the centers keep the patients' confidentiality.

Staff development

The management of the initiative and the directors of the centers hold the belief that the quality of the treatment and the service are directly connected to the therapists' working conditions, including guidance, in-service training, emotional support and adequate pay. Most of the therapists receive individual and group guidance and participate in staff meetings. The therapists' level of satisfaction with the guidance is 70% for the group guidance and 90% for the individual guidance. However, about 20% of the therapists don't attend individual guidance regularly and only two thirds attend the group guidance regularly[3]. The quality of management is a major key to staff development, and their satisfaction with the various elements of management is very high (over 90%). Many of the directors feel that the therapists' wages are inadequate: for example, they cannot pay a higher fee to experienced therapists, and the wages of self-employed (freelance) therapists are low in absolute terms since they don't get paid for "extra" hours.[4]

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3 Possibly because self-employed therapists cannot be made to attend all the guidance sessions, and because therapists in general are not required to attend both types of guidance sessions.

4 It was decided that salaried therapists will devote 60% of their time to actual treatment and the other 40% to "extra" tasks: contact with professionals in the community, education and prevention activity, instruction and team work. Consequently, self-employed therapists cannot be required to do these tasks, or they do them without being paid. It should also be noted that the therapists' wages depend mainly on the operating bodies.

Connection with the community

One of the basic premises of the initiative is that an optimal treatment requires the involvement of different community agencies (welfare services, education system) as well as the parents, and the centers' work is based on this premise. The connection with the community includes consultation with the center, referral of patients, training and publicity activities, and "implementation committees"[5] . 84% of the social workers connected with the older centers and 48% of those connected with the new centers consult with the center regularly. 80% of them referred patients to the center in the three months preceding the study. The centers' directors devote much of their time to initial consultation with regard to victims in the community, and also advise professionals during the treatment, cooperate with them and participate in professional committees in the community. The connection with the community has developed over time and it now takes place regularly and continuously. All the centers together carried out 186 community activities in 2012. As can be expected, the new centers focused on publicity while the older centers focused on study and training activities. It should be noted that despite the resources being invested in this area, only 25% of the social workers connected with the old centers and 39% of those connected with the new centers took part in this activity. Evidently it is important even for an established center to continue offering training and study days to professionals in the community, in order to keep the contact with them (although the existing work relations and the meetings of the implementation committees clearly fulfill part of this need).

Advantage of the centers over "treatment funds"

Until the establishment of the centers, victims of sexual abuse were treated through "treatment funds".[6] There is almost no data for making a purely economic comparison between the two models. However, it is possible to define the added value of the centers and try to estimate its economic implications.

5 Implementation committees have regular joint meetings to discuss referrals and decide on the appropriate treatment.

6 Treatment funds are budget allocations that the local welfare departments can use to pay self-employed therapists for treating children victims of sexual abuse; this system still exists in places where there are no centers yet.

Table 2: **Comparison between treatment centers and treatment funds**

	Treatment centers	Treatment funds
Waiting period	Negligible	A month or more
Control and supervision	Close supervision	Difficulty in supervising
Focus of the treatment	The treatment focuses on the injury caused by sexual assault; follow-up treatment takes place at the community, enabling more children to be treated	Part of the budget actually goes to fund other therapeutic needs of the children, without control of its length
Community-oriented work	Community work is an essential part of the model, improves the treatment and sometimes shortens it	Individual therapists often avoid working with community agencies
Education and prevention activity	The centers are required to work towards increasing awareness and prevention of sexual abuse	Individual therapists are not being compensated for educational activity
staff guidance, training and development	Staff development is part of the centers' responsibility and it is being supervised	The scope and quality of training are difficult to supervise
Accumulation of knowledge	The knowledge is accumulated within the public service and used to enrich and improve the service	The knowledge is not accumulated within the public service

The table shows that the centers provide high-quality professional treatment that is being supervised and takes place through pooling of resources with the community. Moreover, the length of an average treatment is monitored and there is an emphasis on focused treatment of the sexual assault. All this allows the treatment to be more precise, and probably more economical. The data we could find in the professional literature with regard to the economics of sexual abuse of children indicates that the estimated cost of non-treatment of these victims ranges between $9,206 and $135,000 per child[7], since a lack of treatment increases the probability of delinquency, crime, behavior problems etc. Sexual abuse in childhood is a significant risk factor in psychopathology. The victims are liable to develop a wide range of disorders – emotional, psychological, behavioral, health-related and sexual. Therefore

7 Gelles, R.J, & Perlman, S. (2012). Estimated Annual Cost of Child Abuse and Neglect, Chicago, Illinois

it seems that a quick and focused treatment is also economical, since a lack of appropriate response will cause future damage whose cost is much higher. In summary, although the main goal of the initiative is social, namely: realizing the responsibility of the State for the well-being of children and youth who experienced sexual abuse, and it is not motivated by economic considerations alone, it has an added value in comparison with the treatment funds model from an economic perspective too. It should be noted that although the social workers are highly satisfied with the service and the treatment at the centers, 20% of them still prefer the treatment funds model.[8]

Table 3: **Agreement between the model and the centers' actual work, December 2012**

	Range of therapies	Therapists' qualifications fit the standards	Specific training	Individual\group guidance	Staff meetings	In-service training	Community-oriented activity	Implementation committees	Contact with regional social worker
Lod	8	73%	100%	✓	✓	✓	✓	✓	✗
Bnei Brak	7	71%	71%	✓	✗	✗	✓	✓	✓
Tzfat	4	67%	100%	✓	✓	✓	✓	✓	✓
Kiryat Malachi	14	80%	60%	✓	✓	✓	✓	✓	✓
Be'er Sheva	10	33%	44%	✓	✗	✓	✗	✗	✓
Hadera	7	86%	100%	✓	✓	✓	✓	✓	✓
Nazareth	6	66%	100%	✓	✓	✓	✓	✓	✓
Holon-Rishon leZion	7	75%	100%	✓	✓	✓	✓	✓	✗
Haifa	3	60%	100%	✓	✓	✓	✗	✓	✓
Carmiel	10	88%	100%	✓	✓	✓	✓	✓	✓
Afula	11	88%	88%	✗	✓	✓	✓	✓	✓
Netanya	9	100%	100%	✓	✓	✓	✓	✓	✓

8 Possible reasons for this preference are the workload associated with the community-oriented model on one hand and the lack of resources on the other; or the fact that in the centers model the social workers no longer have control over the treatment.

Handover to the Welfare Ministry

In preparation for the handover, planned for July 2013, the budgeting model and the rationale behind it were presented to the financial team of the Ministry; its approval ensures that the initiative for treating sexually abused children will enjoy government funding and support for many years to come. All the parties believe that the initiative is ready for the handover, while the Welfare Ministry needs to make more preparations for its incorporation. Not surprisingly, there are concerns among the various bodies about the handover, mainly due to the differences in organizational culture between a government ministry and nonprofit organizations. For example, there is uncertainty with regard to the transfer of funding from the Ministry to the centers, and concern about the implications of the budgeting system on the management of the centers and the quality of the service. The autonomy of the directors and the regional social workers could also be affected. In order for the initiative to be handed over in the best possible way and preserve its unique character, it is recommended to try and preserve the special features during the transition process, insisting that the initiative must enjoy more flexibility than other services. Based on the conclusions of the study, we made a number of recommendations for implementation in preparation for the handover and afterwards.

Recommendations in preparation for the handover

Concerning budgeting, it is recommended to define work procedures with regard to budgeting and to have a period of overlap between the present heads of the initiative and the future team at the Welfare Ministry. Concerning professional operation, it is recommended to define the role of the regional social workers and the nature of supervision and to keep the flexibility in some areas, for example in employing good therapists who don't have all the required qualifications. Other recommendations are to define in detail the roles of the Ministries of Education and Health, and to have a dialogue with the Welfare Ministry to clarify the unique needs of the initiative and their relevance to the quality of service it provides.

Recommendations for after the handover

These recommendations are based on the conclusions of the evaluation study, and require long-term attention.

- The initiative has one structural weakness: the quality of service and treatment at the branches. The branches have a smaller staff (sometimes only one therapist) and they

are often "guests" in other services' premises. This situation limits their freedom with regard to the hours of operation and their ability to match therapist and patient in gender, language etc. Although the branches provide a good therapeutic solution in absolute terms, they do not match the centers in these parameters. This negatively affects the quality of the service and its availability. Consequently, it is recommended to appoint a person to manage all aspects of the service and treatment at the branches. It is further recommended that this person will also be responsible for recruiting therapists from specific population groups and for them; since although the initiative makes an effort to serve different populations (Arabs, ultra-orthodox Jews), therapists who speak Arabic and Amharic are hard to find.

- Adolescents over the age of 15 comprise now only a sixth of the applicants, although in all probability they are assaulted at a higher rate; it is recommended to try and encourage them to seek treatment.
- Despite the importance of early treatment, only a small proportion of the abused children reach the centers soon after the assault has been discovered. It is recommended to try and encourage earlier application.
- As noted above, not all the therapists participate in individual instruction. It is recommended to insist on biweekly instruction at least, even for self-employed therapists.
- It is recommended to consider raising the therapists' wages gradually and changing the nature of supervision of the operating bodies with regard to the therapists' wages. It is also recommended to examine a different system for measuring the time devoted to community-oriented work.

Other recommendations:

- The study found that 17% of cases of sexual assault take place in educational settings. It is recommended to develop a specific response for this type of assault in cooperation with the education Ministry.
- Thought suppression was found to be a very common and persistent symptom among patients. Due to its high incidence, it is recommended to place a special emphasis on developing a treatment method to deal with thought suppression.[9]

9 Thought suppression can be defined as the cognitive effort invested by the patient in avoiding thinking about any part of the assault. See Wegner, D.M, Schneider, D.J, White, T.L. & Carter, S.R (1986). "Paradoxical Effects of Thought Suppression" In: Attitudes And Social Cognition, http://www.communicationcache.com/

In summary

The study that accompanied the initiative over the last three years shows it to be a very impressive case of cooperation between the nonprofit sector and the government. The unique development process of the initiative created a model of practical cooperation that focuses on the injured child. In fact, the initiative provides very good treatment for the effects of the sexual abuse, maintains a high standard in service provision, supervises the therapists and also nurtures them. The initiative is well-managed and the directors of the centers display excellent management capabilities in varied areas. Implementing the recommendations derived from the success of the initiative as well as its difficulties, and those intended to facilitate its handover to the Ministry of Welfare, will ensure the continuity of this valuable service and its improvement.

As expected in a study with such a large database, only part of the information could fit into the current report, while many questions that arise from it remain unanswered. We hope that this report will serve as the basis for continued research and learning in the important field of treating sexually abused children and youth.

פרישת מרכזי המיזם ברחבי הארץ

Nationwide distribution of the centers