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Oregon Differential Response Initiative: Interim Evaluation Report

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Executive Summary

The Oregon Department of Human Services (DHS) began implementing Differential Response (DR) in 2014, using a carefully planned and staged roll-out strategy that began with implementation in two districts (D5 and D11) in May 2014 and two additional districts (D4 and D16) in April 2015. DHS hired the Children and Family Research Center (CFRC) to conduct comprehensive process, outcome, and cost evaluations in order to answer a lengthy series of research questions related to the DR implementation process, CPS practice throughout the state, fidelity to the DR model, fidelity to the Oregon Safety Model (OSM), and the impact of DR on a variety of child, family, and child welfare system outcomes, including costs. In order to answer these research questions, CFRC has collected and analyzed a variety of data from DHS staff, parents involved in CPS assessments, and OR-Kids. The purpose of this *2016 Interim Evaluation Report* is to describe the findings of the process and outcome evaluations **as of December 2016**. Data collection for the process, outcome, and cost evaluations will continue through early 2017 and the final, comprehensive evaluation report will be completed in June 2017. As with any interim report, the findings presented within this report should be considered preliminary, and a fuller picture of program functioning and outcomes will emerge once all the data have been collected and analyzed. A degree of caution should therefore be used when making programmatic decisions based on findings of an interim evaluation report. Separate reports have been written that describe the methods and findings of the implementation evaluation and OSM fidelity review.

Differential Response in Oregon

In Oregon, DR consists of two CPS response tracks: Traditional Response (TR) and Alternative Response (AR). In districts that have implemented DR, once a report is assigned to an assessment, screeners must assign the assessment to either the AR or TR track using the Track Assignment Tool. Screeners must also assign a response time of either 24 hours or 5 days to each assessment; CPS workers are supposed to make an initial contact with the family within that time frame. CPS workers attempt to schedule the Initial contacts with families in the AR track at a time when a community partner can be present; initial contacts with families in the TR track are unscheduled and the community partner is not present. Both AR and TR require a comprehensive CPS assessment using the OSM to guide safety decision-making. An AR assessment can be switched to a TR assessment at any time if the worker obtains information that the family meets the criteria for a TR assessment. At the conclusion of the CPS assessment, workers make a decision about whether the children are safe or unsafe. If the children are unsafe, the AR assessment is switched to a TR assessment (if applicable), and the CPS worker develops a safety plan and may open a case. If the children are safe, the CPS worker assesses whether or not the family has moderate to high needs. If not, the CPS assessment is closed. If moderate to high needs are identified, the family is offered the option of having a Family Strengths and Needs Assessment (FSNA) completed by a strengths and needs provider. If the family declines the FSNA, the CPS worker offers referrals to non-contracted community

services as available and then closes the CPS assessment. If the family accepts the FSNA, the CPS worker refers the family to the strengths and needs provider and meets with the family and provider after the assessment to discuss service options. If they agree, the family is either referred to non-contracted community services or an "Admin-Only" case is opened and contracted services are provided through DHS for up to 90 days. AR assessments differ from TR assessments in several ways:

- Families assigned to AR receive a phone call to schedule the initial visit and may have a community partner present during the visit.
- Family members are often initially interviewed together, rather than individually, in AR assessments.
- No disposition is required in AR assessments.
- Family members are not entered into the Central Registry in AR assessments.

CPS practice in districts that have implemented DR is different from that in non-DR districts in several ways:

- Screeners in DR districts use the Track Assignment Tool to assign each assessment to AR or TR.
- In DR counties, safe families with moderate to high needs are offered the option of an additional Family Strengths and Needs Assessment, which is completed by a community provider.
- Following the FSNA, families in DR counties may be provided with up to 90 days of contracted services paid for by DHS.

Evaluation Design and Methodology

One of the main goals of the Oregon DR evaluation is to compare the outcomes of children and families who receive a CPS assessment (either AR or TR) in districts that have implemented DR (the treatment groups) with those of children and families who receive a CPS assessment in districts that have not yet implemented DR (the comparison groups). Because the families in the treatment and comparison groups lived in different districts, there may have been differences between them that may be related to differences in outcomes. To reduce the pre-existing differences between families in the treatment groups and the comparison groups, a method known as Propensity Score Matching (PSM) was used to match each family in the two treatment groups (AR and TR) to a family with similar demographic and case characteristics in the comparison group. Families in the first four districts to implement DR are included in the treatment groups (D5, D11, D4, and D16) and were matched to families who received a CPS assessment in four districts that have not yet implemented DR (D3,D10, D6, and D2). There were 2,638 families assigned to AR whose assessments closed on or before December 31, 2015. Of these, 2,603 (99%) were successfully matched to a similar family in a non-DR district. There were 2,155 families assigned to TR whose assessments closed on or before December 31, 2015; of these, 2,109 (98%) were successfully matched to a similar family in a non-DR district. After conducting the matching procedures for the AR and TR groups, the resulting AR-matched and TR-matched comparison groups were indistinguishable on almost every observable

characteristic. Therefore, any differences in outcomes between the treatment and comparison groups can be attributed to the effects of the treatment rather than pre-existing differences in the groups.

Three primary sources of data were used in the analyses included in this report. Administrative data from OR-Kids were used to measure family demographics, measures of DR fidelity, and intermediate outcomes, including maltreatment re-reports, founded re-reports, and child removals. A staff survey was sent to all DHS caseworkers, screeners, supervisors, and managers in February 2016 to gather data on staff perceptions on training and coaching; supervision; job satisfaction; organizational culture; differences in CPS practice in AR and TR assessments; attitudes toward Differential Response (DR), the Oregon Safety Model (OSM), and the Family Strengths and Needs Assessment (FSNA); local service availability, and service coordination. A family survey was distributed by CPS workers to parents at the conclusion of the assessment. It contained measures of emotional responses to the initial visit, perceptions of caseworker empathy and cultural sensitivity, parent engagement, and family functioning. Very low response rates for the parent survey (1.6% in the DR districts and 2.3% in the non-DR districts) suggest that the results obtained from the parent survey should be interpreted with some degree of caution.

CPS Practice

The staff survey was used to measure several aspects of CPS practice throughout the state, including worker satisfaction, organizational culture, the effectiveness of the training and coaching offered, supervisor support, differences in practice between AR and TR assessments, attitudes about DR, the OSM, and the FSNA, local service availability, and service coordination with other agencies. Analysis of the survey data revealed several noteworthy findings:

- Most staff perceived training and coaching to be both relevant to their needs and effective. Staff were very satisfied with the quality of supervision they receive and also reported feeling that their supervisor is a resource for them who provides practice guidance and emotional support. Workers were similarly satisfied with the cultural sensitivity of DHS. Staff reported high levels of work purpose and most find a great amount of personal meaning in the work that they do at DHS.

- Staff were less satisfied with some other areas of their work, including OR-Kids and their workload, salaries, and opportunities for advancement; over half of the staff that responded to the survey reported that they were dissatisfied with these aspects of their jobs. Job satisfaction also differed by role, with staff in supervisory positions generally reporting higher satisfaction than CPS caseworkers, permanency caseworkers, and screeners.

- Staff had very positive opinions of DR – over 80% felt it promotes child safety and well-being, positively affects families, and values families' cultural and ethnic backgrounds,

and over 90% agreed that it involves families in decision-making. Staff also held positive opinions about the OSM: over 80% felt it promotes the safety and well-being of children and positively affects families. Around 70% of the respondents felt that the FSNA promotes the safety and well-being of children and positively affects families.

- Staff were asked questions about specific CPS practices, depending on their role. Screeners often or always felt they were able to gather enough information to make a proper decision regarding screener and typically consulted with a supervisor or other person before making their decisions. About half of the screeners reported "sometimes" feeling uncertain about their track assignment decisions; the other half reported "rarely" feeling uncertain.

- CPS workers reported significant differences in their practice in AR assessments and TR assessments, and were much more likely to call ahead and schedule an appointment, inform the family that they can have a support person present, and interview the family as a whole in an AR assessment. CPS workers in non-DR districts reported that they offered services to families during an assessment more frequently than CPS workers in DR districts.

- CPS workers in DR districts were asked if DR had a positive, neutral, or negative effect on specific areas of their practice such as initially contacting families, interacting with children and parents, offering services to families, and making decisions about child removals. Majorities of CPS workers felt that DR had a positive impact on 6 of the 8 practices and a neutral effect on the other two (staying in contact with families and making decisions about removals).

- In general, there were very few differences between staff in DR and non-DR counties on the measures included in the survey, including job satisfaction and organizational culture. Staff in DR counties reported more favorable attitudes toward the OSM than staff in non-DR counties. Additionally, staff in DR counties reported higher rates of service availability than staff in non-DR counties.

Overall the survey results suggest the staff training and coaching programs are supported by staff, that staff understand and support the goals of DHS, and that staff feel positively about the goals of DR and the OSM. Still, staff feel a heavy burden from their workload and overall low satisfaction with their compensation. Few differences between DR and non-DR counties suggest DR implementation has not created additional burdens for staff and may increase support for DR and the OSM.

DR Fidelity

To examine DR fidelity, data from OR-Kids were used to examine several CPS decision points that occur in DR districts, including 1) the percentage of reports assigned to assessment; 2) the percentage of assessments assigned to AR and TR; 3) the percentage of AR assessments that switch to TR; 4) the percentage of AR and TR assessments that received an initial contact from the CPS worker within the assigned response time (24 hour or 5 days); 5) the percentage of safe and unsafe assessments; 6) the percentage of safe families who were offered services; 7) the percentage of families who accepted services; 8) the percentages of families who accepted contracted services (Admin-Only cases); and 9) the length of the CPS assessments and Admin-Only cases. Ideally, the percentage of families determined to have moderate to high needs would also be examined, but the data were not reliable enough to analyze for this report.

- Statewide, the percentage of reports assigned to assessment has increased slightly since DR was implemented, from 44% in 2014 to 48% in 2016. Larger increases (over 10%) in the percentages of reports assigned to assessment were seen in 3 of the 4 districts that implemented DR in 2014 or 2015. The increases have been fairly gradual over time; it is not possible to attribute them directly to the implementation of DR, although that may be a contributing factor.

- Since DR implementation, the percentage of assessments initially assigned to AR has declined slightly in two districts (D11 and D16), declined moderately in one district (D5), and increased slightly in one district (D4). In 2016, about half of assessments were assigned to AR in each of the 4 districts. The percentage of AR assessments that switch tracks to TR has also decreased over time in both D5 and D11, which suggests that screeners in these districts are getting more accuracy in their initial track assignments. Between 10-15% of the assessments initially assigned to AR in 2016 switched tracks to TR.

- CPS procedures state that the primary response time for AR assessments is 5 days, and that a 24-hour response time is only required when there is an indication that a child may be in danger right now or has a current injury as a result of the alleged abuse or neglect. There were wide variations between the 4 districts in the percentage of AR assessments that were assigned a 5-day response time: 68% in D4, 69% in D5, 84% in D16, and 88% in D11. These differences may be due to actual differences in the types of reports that occur in the districts, or they may be caused by differences in screener practice. Response time assignment may be one area where additional training or coaching is needed.

- A finding in the 2015 interim evaluation report highlighted low levels of compliance with assigned 5-day response times; only 20% of the assessments in the state assigned a 5-day response time in either 2014 or 2015 received an initial visit from a CPS worker within 5 days. Compliance with the 5-days response time in the 4 districts that

implemented DR was slightly better than the statewide rate. Results in the current report, however, indicate a significant improvement in the compliance with the 5-days response time; statewide rates in 2016 were 68% and rates in the 4 DR districts ranged from 62% to 90%. Compliance rates in 2014 and 2015 also improved, which suggests that the apparent non-compliance with response times was actually non-compliance with data entry into OR-Kids.

- Statewide, about 90% of assessments are determined to be safe. There was some, but not a lot, of variation in the percentage of safe and unsafe assessments in the 4 districts that have implemented DR. Within districts, the percentages of AR assessments determined to be safe was slightly higher than the corresponding percentage of TR assessments.

- In the 4 DR districts, the percentage of AR families who were offered services in 2016 ranged from 9% in D4 to 20% in D11; the percentages of TR families who were offered services in 2016 were slightly lower, ranging from 7% in D4 to 18% in D11. About 40-50% of the AR families who are offered services accept them; between 33-63% of TR families accept services. Of the families that accepted services, only small percentages were contract services (Admin-Only cases). For example, in 2015, there were 64 families in AR assessments and 33 families in TR assessments that accepted contracted services following their assessment.

- Initial assessments in DR counties should be completed within 45 days, with the possibility of a one-time extension of 15 days. The average length of AR and TR assessments in 2015 was much longer than that, however, ranging from 113 to 164 days for AR assessments and from 110 to 150 days for TR assessments.

Child and Family Outcomes

According to the DR logic model, families that receive either AR or TR will be engaged with and feel respected by their CPS worker, will be involved in making decisions about their services, and will receive appropriate services that increase their social support and improve their family functioning. These short-term outcomes will lead to fewer families with re-reports and child removals.

The results of the outcome analyses revealed almost no significant differences between the AR and AR-matched groups or the TR and TR-matched groups on either short-term or intermediate outcomes. The only differences were on the percentage of families who reported having enough clothing (AR < AR-matched and TR < TR-matched) and employment (AR < AR-matched).

The lack of meaningful differences in outcomes between the AR treatment group and AR-matched comparison group is not without precedence in previous DR evaluations. In fact, the majority of DR evaluations that have used either experimental designs or rigorous quasi-

experimental designs (such a propensity score matched comparison groups) have found either non-significant differences in outcomes between families assigned to AR and their comparison groups or significant but small differences (see, for example, the results of outcome evaluations in Colorado,[1] Ohio,[2] Illinois,[3] New York,[4] and the District of Columbia[5]). The Oregon DR evaluation is the first to compare the outcomes of families assigned to TR and a comparison group of similar families, so there are no previous evaluation findings to compare the current results to. However, the lack of differences between the TR and TR-matched groups is not surprising, given the more subtle differences in CPS practice in these two groups. It is also important to remember that the outcome analyses included families in CPS assessments that were closed on or before December 31, 2015 in order to track their outcomes for a full 6 months. Thus, DR was still a developing practice in two of the districts included in the evaluation (D4 and D16). It is possible that the results of the outcome evaluation will change as DR practice transitions out of the initial implementation stage and into full implementation.

The lack of differences in short-term outcomes between families in DR and non-DR districts does not mean that DR is performing poorly. A closer examination of parents' feedback on their CPS experience indicates that parents in *both* DR and non-DR districts describe their experience very positively. For example, average ratings on the CARE measure were 41.5 (out of a possible 50 points) for parents in the AR groups and 40.5 for parents in the AR-matched group, which indicates that both groups of parents felt high levels of empathy and respect from their CPS workers. Another example is parents' ratings of their CPS workers' cultural sensitivity: 92% of parents in the AR group and 93% of parents in the AR-matched group felt that their CPS worker was sensitive to their family values and culture. Nearly 100% of parents in both groups reported that their CPS worker communicated with them in their preferred language. Thus, the lack of differences in short-term and intermediate outcomes may be due to the fact that many of the CPS worker practices typically associated with AR, such as enhanced engagement and family involvement in decision-making, have spread beyond only those districts that have implemented DR.

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[1] Winokur, M., Orsi, R., Rogers, J., Gabel, G., Brenwald, S.,Holmquist-Johnson, H., & Evans, M. (2014). *Program evaluation of the Colorado Consortium on Differential Response*: Final report. Fort Collins, CO: Social Work Research Center, School of Social Work, Colorado State University.

[2] Murphy, J., Newton-Curtis, L., & Kimmich, M. (2013). *Ohio SOAR project: Final report.* Tualatin, OR: Human Services Research Institute.

[3] Fuller, T., Nieto, M., & Zhang, S. (2013). *Differential Response in Illinois: Final evaluation report.* Urbana, IL: Author.

[4] Ruppel, J., Huang, Y., & Haulenbeek, G. (2011). *Differential Response in child protective services in New York State: Implementation, initial outcomes, and impacts of pilot program.* Albany, NY: Office of Children and Family Services.

[5] IAR Associates. (2016). *Family assessment in the District of Columbia program evaluation: Final report to the Child and Family Service Agency. St. Louis, MO: Author.*

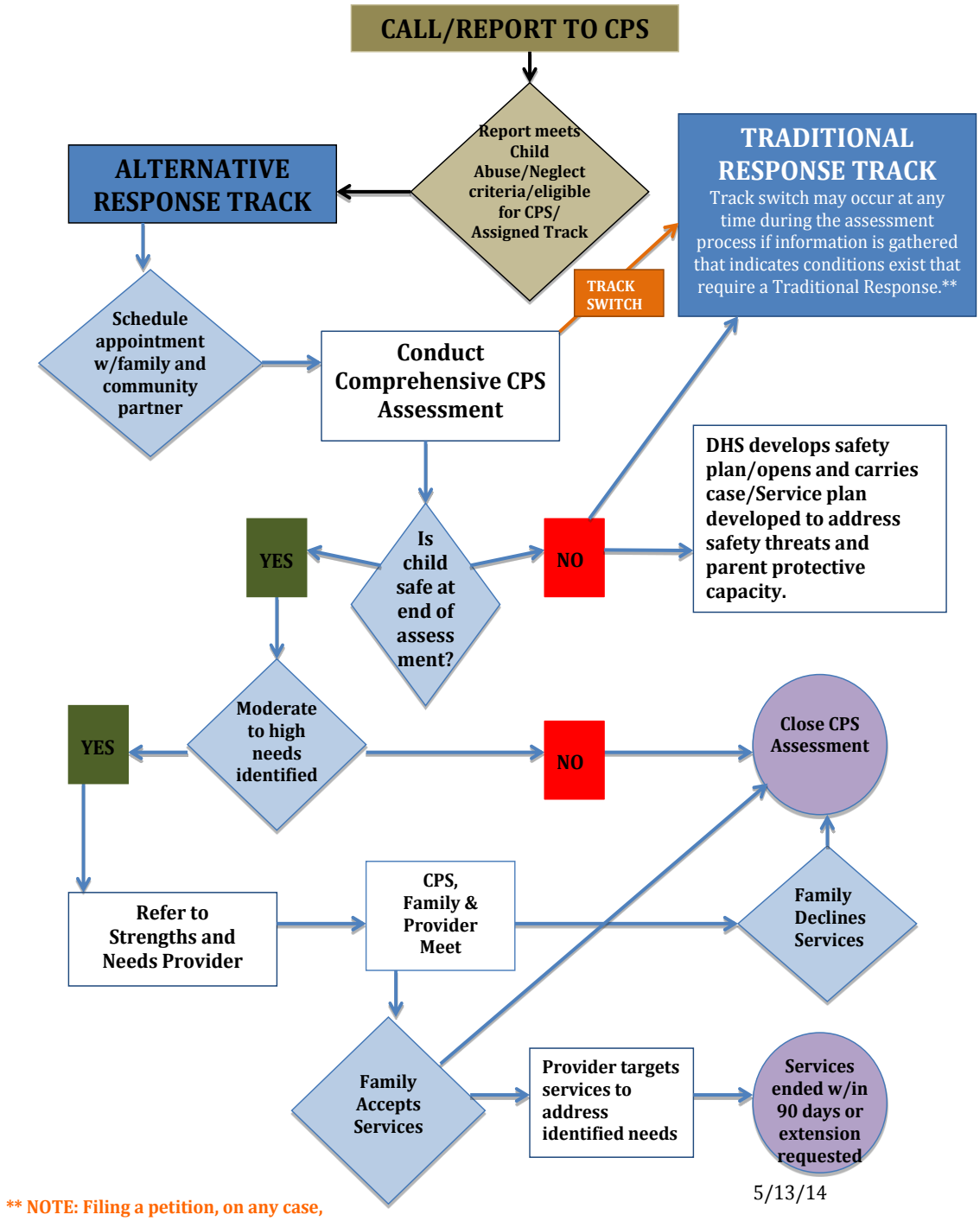
Chapter 1: Introduction and Background

Broadly speaking, Differential Response (DR) is an approach that allows child protective services (CPS) to respond differently to screened-in reports of child abuse and neglect. In Oregon, DR consists of two CPS response tracks: Traditional Response (TR) and Alternative Response (AR). Both TR and AR require a comprehensive Child Protective Services (CPS) Assessment using the Oregon Safety Model (OSM) to guide safety decision making. Traditional Response devotes substantial attention and resources to evaluating allegations of maltreatment and determining whether these allegations are substantiated. Alternative Response focuses on assessment of family needs through enhanced engagement strategies and de-emphasizes forensic interviewing, and sets aside fault-finding, the substantiation of maltreatment allegations, and entries into the Central Registry. Both response types offer optional services to families identified with safe children and moderate to high needs. Table 1 highlights the differences between the TR and AR tracks in Oregon and Figures 1 and 2 show the process and decision flow charts for each response.

Table 1. Differences between Traditional Response and Alternative Response Tracks

Traditional Response	Alternative Response
Comprehensive Safety Assessment on allegations of physical abuse, sexual abuse, and severe harm	Comprehensive Safety Assessment on allegations of neglect and no severe harm
Typically 24 hour response	Typically 5 day response
No scheduled joint first contact with community partner offered	Scheduled joint first contact with community partner offered
Agency driven	Family driven
Individual interviews	Family interviews
Disposition/finding required	No disposition/finding required
Central Registry entry as indicated	No entry in Central Registry

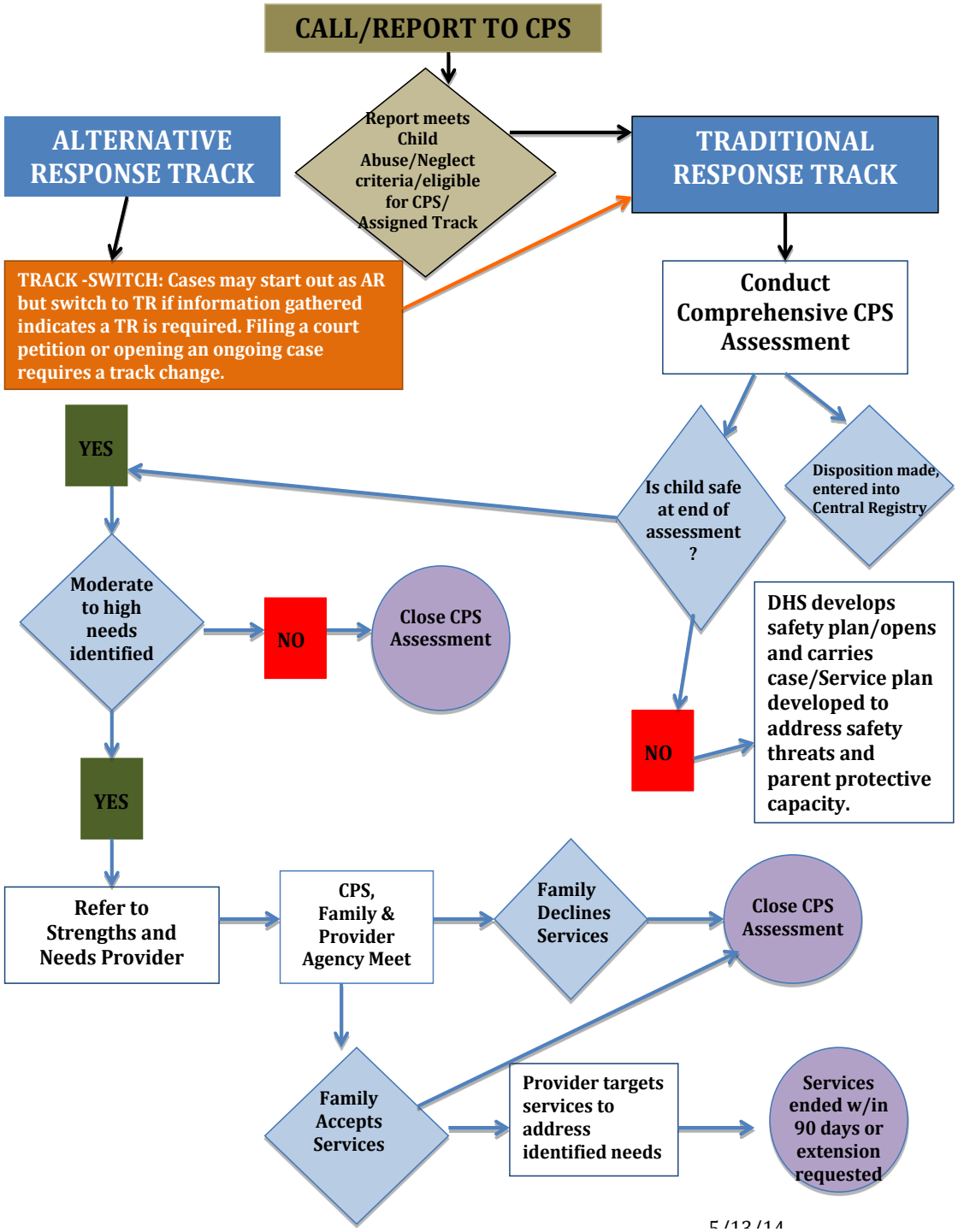
Figure 1. Alternative Response Process and Decision Flow



** NOTE: Filing a petition, on any case, also requires a track change.

5/13/14

Figure 2. Traditional Response Process and Decision Flow



The Oregon Department of Human Services (DHS) is using a staged roll-out to implement DR: Districts 5 and 11 implemented DR in May 2014, followed by Districts 4 and 16 in April 2015, and Districts 7, 8, and 15 in November 2015. The original plan was to complete full implementation by the end of 2017, but DR expansion was paused in May 2016 and has not yet been resumed as of December 2016.

DHS selected the Children and Family Research Center (CFRC) at the University of Illinois at Urbana-Champaign (UIUC) to design and conduct a rigorous and comprehensive evaluation of DR with three major components:

1. A process evaluation, which describes the program implementation process, examines fidelity to both the DR model and the Oregon Safety Model (OSM), and examines CPS practice throughout the state.

2. An outcome evaluation, which compares the outcomes of children and families in the treatment group, defined as those that receive a CPS assessment in districts that have implemented DR, with the outcomes of children and families in the comparison group, defined as those that receive a CPS assessment in selected districts that have not yet implemented DR.

3. A cost analysis, which examines the costs incurred by the system during the DR implementation process, and also compares the per-case costs associated with serving a family in the AR and TR tracks as well as those served in districts that have not yet implemented DR.

To date, the CFRC and its local evaluation partner, Pacific Research and Evaluation (PRE), have produced several evaluation reports, including two site visits reports that have examined the initial implementation processes in the first two cohorts to implement DR (D5/D11 and D4/D16) and an annual evaluation report in December 2015 that examined early findings from the DR fidelity assessment. Findings from these evaluation reports have been used to make adjustments to DR practice as needed.

The purpose of this *2016 Interim Evaluation Report* is to describe the findings of the process and outcome evaluations **as of December 2016**. Data collection for the process, outcome, and cost evaluations will continue through early 2017 and the final, comprehensive evaluation report will be completed in June 2017. As with any interim report, the findings presented within this report should be considered preliminary, and a fuller picture of program functioning and outcomes will emerge once all the data have been collected and analyzed. A degree of caution should therefore be used when making programmatic decisions based on findings of an interim evaluation report.

The report is organized into several chapters:

- Chapter 2: Logic Model and Research Questions provides a description of the Oregon DR logic model and the research questions that are guiding the evaluation.

- Chapter 3: Research Design and Methodology describes the research design that is being employed in the outcome evaluation and the data collection methods used for the process and outcome evaluations.

- Chapter 4: Assessment of CPS Practice describes the findings of the statewide staff survey, which includes measures of staff perceptions of training, coaching, supervisor support, job satisfaction, organizational culture, screening practices, CPS assessment practices, attitudes toward DR, the Oregon Safety Model (OSM), and the Family Strengths and Needs Assessment (FSNA), service availability, and service coordination.

- Chapter 5: DR Fidelity Assessment describes the findings of the DR fidelity assessment, including measures of CPS reports assigned to assessment, initial track assignments and re-assignments, the timeliness of initial contacts with families, safety decisions, families offered and accepting services, and length of the CPS assessment and Admin-Only service cases.

- Chapter 6: Outcomes describes the early findings from the outcome evaluation, which compares the short-term and intermediate outcomes experienced by families in the two treatment groups (AR and TR) with those of matched comparison families in non-DR districts.

- Chapter 7: Summary and Recommendations provides a summary of the findings from the assessment of CPS practice, the DR fidelity assessment, and the outcome evaluation and offers some preliminary recommendations based on the interim findings.

The findings of the implementation evaluation are included in the site visit reports prepared by Pacific Research and Evaluation,[6] and the findings of the OSM fidelity assessment are included in a separate report prepared by the Children and Family Research Center.[7] Findings of these companion reports may be referenced in this report and readers are encouraged to review them.

[6] Pacific Research and Evaluation. (2015). *Oregon Differential Response: Year 1 site visit report.* Portland, OR: Author. Pacific Research and Evaluation. (2016). *Oregon Differential Response: Round 2 site visit report.* Portland, OR: Author.

[7] Chiu, Y., & Braun, M.T. (2016). *Oregon Differential Response Initiative: Interim OSM fidelity report.* Urbana, IL: Children and Family Research Center.

Chapter 2: Logic Model and Research Questions

2.1 Oregon Differential Response Logic Model

A logic model clearly articulates how specific activities or services are expected to produce or influence their associated outcomes. It illustrates the conceptual linkages between the program components; expected outputs; and short-term, intermediate, and distal outcomes. The goals of the Oregon Differential Response initiative are to reduce repeat maltreatment and foster care entries; strengthen families and increase their functioning; reduce disproportionate representation of children of color in foster care; and strengthen the relationship between child welfare, families and the community. The logic model in Figure 3 presents the conceptual linkages between the Oregon Differential Response intervention components and expected outputs and outcomes.

Inputs and activities. The Oregon Department of Human Services (DHS) will invest numerous resources and engage in a range of activities (i.e., *inputs*) to develop Differential Response. Inputs include a supportive and inclusive leadership team; DR advisory workgroups and committees; child welfare staff; service providers; development of a DR practice model; development of screening and assessment tools to guide decision-making; development of rules, policies, and procedures; modification to existing IT systems; engagement with community partners; program evaluation; funding; staff training; and staff supervision and coaching.

Outputs. As a result of these inputs, the necessary components of the intervention will be implemented (*outputs*). Staff will be selected and adequately trained, supervised and coached so that they develop and maintain a high level of fidelity to the DR practice model that is specified in rules, policies, and procedures. Through the use of the track assignment tool, families will be assigned to the appropriate CPS response track (AR or TR). Initial meetings with the families will be timely, and families will be involved in the assessment and decision-making process. The Oregon Safety Model will be used to assess child safety and guide worker decision-making. If the assessment reveals that families initially assigned to AR have ongoing safety threats, they will be reassigned to the TR track, a case will be opened by DHS, and appropriate services will be provided to the family. If no safety threats exist and the family is identified as having moderate to high needs, a service provider will engage them in a strengths and needs assessment to determine what services may be offered to improve family functioning. An array of services can be provided to address these needs and build on existing strengths.

Outcomes. The outputs of the intervention are expected to produce short-term, intermediate, and long-term changes in families', workers', community partners', and the child welfare system's *outcomes*. Within the short term, parents will feel fewer negative emotional responses and more positive emotional responses during the intervention, will feel respected during their interactions with the workers, and will be engaged in the assessment and decision-

making process. In addition, as a result of the assessment and services, formal and informal supports will be increased and family functioning will improve. These short-term changes will lead to intermediate changes: fewer families will be re-reported to DHS and fewer children will be removed from their homes and placed into foster care. In particular, the number of children removed from their homes who stay in foster care for short periods of time before being returned home may be reduced as more children are served safely in their own homes. The implementation of DR will also lead to distal outcomes, including a stronger relationship between child welfare and community partners, reduced disproportionate representation of children of color in foster care, fewer children who are taken into substitute care and decreased time to permanency for children taken into substitute care.

Figure 3. Oregon Differential Response program logic model

Inputs	Activities	Outputs	Outcomes		
			Short-Term	*Intermediate*	*Distal*
Leadership Advisory workgroups CW staff Service providers Practice model Assessment tools Policy, procedures, and legislation IT modification Community partners Evaluation Funding	Clear communication with staff, community partners Staff selection Staff training Supervision Coaching Screening and track assignment Comprehensive CPS assessment Strengths and needs assessment Service provision	Staff are assigned reasonable caseloads Staff are adequately trained Staff receive adequate supervision and coaching Agency leadership supports program Community partners are engaged Fidelity to practice model is developed and maintained Families are assigned to appropriate track Families change tracks when appropriate Initial meetings with families are timely The Oregon Safety Model is used with fidelity to assess child safety in the home Family strengths and needs are assessed as specified in rules and procedures Families with moderate to high needs are offered services Appropriate services are provided to strengthen family functioning	Parent negative emotions are reduced Parents feel respected Parents are engaged in planning and decisions Parents are satisfied with services Informal and formal supports are increased Family functioning is improved	Fewer repeat maltreatment reports Fewer substantiated maltreatment re-reports Fewer child removals	Reduced disproportionate representation of children of color in foster care Stronger relationship between child welfare and community partners Decreased time to permanency for children taken into foster care

2.2 Research Questions

In order to test the hypothesized relationships between Differential Response inputs, outputs, and outcomes, DHS is conducting a program evaluation that will include a process evaluation, an outcome evaluation and a cost analysis. The evaluation will attempt to answer the following research questions:

Research questions related to DR implementation:

1. How was each of the implementation components described in the framework developed by the National Implementation Research Network (NIRN) [8] addressed during the stages of the implementation process?
2. Is the coaching strategy effective in supporting staff in obtaining and maintaining fidelity to the DR model?
3. Is DHS adequately staffed to practice the DR model?
4. Are there differences in DR implementation across districts?
5. Are there differences in DR implementation across cultural and ethnic groups?
6. Are community and external partners involved in Differential Response implementation?
7. Are culturally responsive partners involved in the implementation of Differential Response?
8. Are the roles of DHS and community partners in keeping children safe clearly defined?
9. Is the coordination between DHS and community partners effective?
10. Do workers feel more supported by community partners?
11. How has Differential Response changed the nature of the relationships between DHS and community organizations?
12. Are service providers available for all families, including those in rural regions?
13. Are available services culturally responsive?
14. Are culturally responsive providers available for all families, including those in rural regions?
15. How is the service array, including Strengthening, Preserving, and Reunifying Families services, System of Care, In-Home Safety and Reunification, and other child welfare contracted services supporting the vision and goals of Differential Response?
16. Which implementation strategies were most effective? Least effective?

Research questions related to DR model fidelity:

1. What does Differential Response in Oregon look like?
2. How has worker practice changed in districts that have implemented DR?

[8] Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI#231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. The National Implementation Research Network.

3. To what degree is each of the core components of the Differential Response Initiative implemented with fidelity to the practice model? Does fidelity vary across districts?
    a. Are families involved in decision-making about services?
    b. Does the Strengths and Needs Assessment help identify families' needs?
    c. Are identified strengths being utilized?
    d. Are families utilizing available services?
    e. Are the services offered consistent with the assessed needs and interests of the family?
4. Who are the families that decline services, and how do they differ from families that accept services?
5. What are the barriers to receiving and completing services?
6. What processes are being used to prevent entry into foster care?
7. What processes are being used to enhance permanency?
8. How has Differential Response influenced families' perceptions of the cultural responsiveness of DHS and child welfare?

Research questions related to Oregon Safety Model fidelity:

1. Are DHS staff using the Oregon Safety Model with fidelity?
2. Does fidelity to the Oregon Safety Model vary by county? By district?

Research questions related to CPS practice:

1. How satisfied are workers with the amount of training they have received? Are there areas in which they would like to receive additional training?
2. How satisfied are workers with the amount and type of supervision they currently receive?
3. How satisfied are workers with the amount and type of coaching they currently receive?
4. How do caseloads affect worker practice?
5. How satisfied are staff with their jobs overall? Do they intend to remain in their current positions or within their current agency?
6. Does CPS practice vary between districts and has it been affected by the implementation of Differential Response?
7. Does organizational culture vary between districts and has it been affected by the implementation of Differential Response?

Research questions related to outcomes:

1. Are there differences in engagement between families who receive an alternative response (AR) and similar families who receive a CPS assessment in a non-DR county?
2. Are there differences in satisfaction with CPS between families who receive an alternative response (AR) and similar families who receive a CPS assessment in a non-DR county?
3. Are there differences in formal and informal community supports between families who receive an alternative response (AR) and similar families who receive a CPS assessment in a non-DR county?

4. Are there differences in family functioning between families who receive an alternative response (AR) and similar families who receive a CPS assessment in a non-DR county?
5. Are there differences in the rates of maltreatment re-reports between families who receive an alternative response (AR) and similar families who receive a CPS assessment in a non-DR county?
6. Are there differences in foster care entries and re-entries between children in families that receive an alternative response (AR) and children in similar families that receive a CPS assessment in a non-DR county?
7. Are there differences in engagement between families who receive a traditional response (TR) in a DR county and similar families who receive a CPS assessment in a non-DR county?
8. Are there differences in satisfaction with CPS between families who receive a traditional response (TR) in a DR county and similar families who receive a CPS assessment in a non-DR county?
9. Are there differences in formal and informal community supports between families who receive a traditional response (TR) in a DR county and similar families who receive a CPS assessment in a non-DR county?
10. Are there differences in family functioning between families who receive a traditional response (TR) in a DR county and similar families who receive a CPS assessment in a non-DR county?
11. Are there differences in the rates of maltreatment re-reports between families who receive a traditional response (TR) in a DR county and similar families who receive a CPS assessment in a non-DR county?
12. Are there differences in foster care entries and re-entries between children in families that receive a traditional response (TR) in a DR county and children in similar families that receive a CPS assessment in a non-DR county?
13. Are there differences in the length of time to permanency for children who entered foster care following an alternative response (AR) compared to similar children who entered foster care following a CPS assessment in a non-DR county?
14. Are there differences in the length of time to permanency for children who entered foster care following a traditional response (TR) compared to similar children who entered foster care following a CPS assessment in a non-DR county?
15. Do child and family outcomes vary by geography? By racial or ethnic group?
16. Is family engagement related to outcomes (re-reports, removals)?
17. What services are most effective in achieving DR goals?
18. Is disproportionality in the system reduced following the implementation of DR?
19. How has the implementation of DR affected agency timeliness?
20. Has DR increased or decreased the number of families involved in the child welfare system?

Research questions related to the costs associated with DR:

1. What are the short-term and long-term costs and benefits of a DR approach?
2. What resources are needed to establish DR as a sustainable practice in Oregon?
3. Does resource need and availability vary by region (urban versus rural)?

Chapter 3: Research Design and Methodology

Researchers at the Children and Family Research Center worked collaboratively with staff at the Oregon Department of Human Services to develop the research design and data collection instruments and methodology. All research methods used in the evaluation were approved by the Institutional Review Board (IRB) at the University of Illinois at Urbana-Champaign. This chapter describes the research design, the sample selection process, data sources and data collection procedures used in the process and outcome evaluations. The data collection and analysis methods used in the implementation evaluation are described in the site visit reports produced by Pacific Research and Evaluation and are not covered in this report.

3.1 Research Design

One of the main goals of the Oregon DR evaluation is to compare the outcomes of children and families who receive a CPS assessment in districts that have implemented DR (the treatment group) to those of children and families who receive a CPS assessment in districts that have not yet implemented DR (the comparison group). Since the use of an experimental design with random assignment of participants to the treatment and comparison groups was not feasible, the outcome evaluation utilizes a matched comparison group design that matches families who received the treatment with similar families that did not receive it.

An important first step in designing the outcome evaluation was to define the treatment group. Families with screened-in reports in districts that have implemented DR can receive either an Alternative Response (AR) or a Traditional Response (TR), while families with screened-in reports in districts that have not implemented DR receive a CPS assessment. Although the practice changes associated with DR are more extensive in the AR track, practice in the TR track also differs from CPS practice in districts that have not yet implemented DR, including an enhanced emphasis on engagement and additional family strengths and needs assessment. This suggested a need for two distinct treatment groups: families in DR districts who were assigned to the AR track and those who were assigned to the TR track. Each eligible family in the AR group will be matched with a similar family in a non-DR district. In addition, each family in the TR group will be matched with a similar family in a non-DR district. Once the two-step matching process is completed, there will be four groups in the outcome evaluation:

1. AR families
2. AR-matched families from non-DR districts
3. TR families
4. TR-matched families from non-DR districts

The outcome evaluation compares the outcomes of the AR families (group 1) with the AR-matched families in non-DR districts (group 2), and the TR families (group 3) with the TR-matched families in non-DR districts (group 4).

A statistical technique known as propensity score matching (PSM) is being used to create the matched comparison groups for the AR and TR groups. PSM is a two-step procedure. First, a propensity score is calculated for each family in the treatment and comparison groups. The propensity score is a numerical representation of the likelihood that families would receive the treatment (AR or TR), regardless of whether or not they actually did. In the second step, each family in the treatment group is matched with a family in the comparison group that has a similar propensity score. Once each family in the treatment group has been matched with a family in the comparison group, the two matched groups should be equivalent on all observed characteristics.

3.2 Sampling and Matching Procedures

Because Oregon DHS is implementing DR in a staged roll-out, only the first 4 districts that implemented DR are included in the matching procedures: Districts 5 and 11, which implemented DR in May 2014, and Districts 4 and 16, which implemented DR in April 2015. The staggered roll-out schedule also meant that the number of non-DR districts in the comparison group is shrinking over time, as more districts implement DR. This fact, paired with a desire to increase the similarities between the treatment and comparison groups prior to the matching procedures, led to the decision to pair each of the 4 DR districts in the treatment group with a demographically similar non-DR district that was scheduled to implement DR in the later stages of the roll-out. Another consideration when selecting the matched non-DR district was the number of CPS assessments conducted each year. In general, the pool of potential comparison group cases should be at least 3 times bigger than the size of the treatment group in order to increase the likelihood of finding suitable matches for each case in the treatment group. The non-DR districts that were selected for each of the DR districts in the sample are shown in Table 2. Because the number of assessments in District 6 was not large enough to adequately match with the number of the assessments in District 4, the matching pool was supplemented with assessments from District 2 in the AR matching procedures and District 3 for the TR matching procedures.

Table 2. DR and matched non-DR districts included in the sample

DR District	Matched non-DR districts
District 5	District 3
District 11	District 10
District 4	District 6
District 16	District 2

In each DR district, the treatment group was defined as all CPS assessments with an initial report date after the DR implementation date (May 2014 for D5 and D11, April 2015 for D4 and D16) and an assessment close date on or before December 31, 2015.[9] If a family had more than one CPS assessment during that time period, the first CPS assessment was selected for inclusion in the matching procedures. The number of AR and TR assessments included in the matching procedures in each district using this definition is shown in Table 3.

Table 3. Number of CPS assessments included in the matching procedures

DR District	AR Assessments	TR Assessments
5	1,396	990
11	498	463
4	284	312
16	460	390
Total	2,638	2,155

All data used in the matching procedures were obtained from OR-Kids. Although the matching procedures were done separately for the AR and TR groups, the variables used to create the propensity scores for each family were the same. Matching was done at the family level rather than at the child victim level, so variables that were available at the individual level were modified to be examined at the family level as described below.

- Child race/ethnicity was defined as a series of dichotomous (yes/no) variables for each racial group (White, Black/African American, Native American or Alaskan Native, Asian, Pacific Islander, and Hispanic/Latino). Each child in a family could be characterized as more than one race/ethnicity. A family could be included in more than one racial/ethnic category if it included children with different racial/ethnic groups or a single child with more than one racial/ethnic group.
- Child gender was coded as either male or female for each child in the family. It was then aggregated at the family level into one of three mutually-exclusive categories: female (if the family contained only one female child or all female children), male (if the family contained only one male child or all male children), or both male and female (if the family contained at least one male and one female child).
- Number of children in the family was calculated by counting all the alleged victims in each CPS assessment (1, 2, 3 or more).
- Maltreatment allegations were defined as a series of dichotomous (yes/no) variables for each of the following allegation types: physical abuse, sexual abuse, neglect, threat of harm, and medical neglect. Each alleged victim in the family could be categorized in more than one group if multiple allegations were present. If a family had more than one

[9] December 31, 2015 was selected to allow a full six month follow-up period in which to observe whether or not the outcomes occur (maltreatment re-reports and child removals).

alleged victim, the allegation type was coded as "yes" if it was present for any child. A family could therefore have more than one allegation type per assessment.

- Maltreatment reporter was defined the source of the maltreatment report and contained 6 mutually exclusive categories: mental health professional (psychologists, psychiatrists, social service workers, volunteers), health care provider (doctors, nurses, hospital personnel), law enforcement/court personnel (police, lawyers, judges), school personnel, self/relative/anonymous, and other/missing.
- A dichotomous (yes/no) variable indicated if the mother was an alleged perpetrator.
- A dichotomous (yes/no) variable indicated if the father was an alleged perpetrator.
- Number of prior CPS reports was a count of all prior reports on the family (defined by their case ID), regardless of whether they were assigned to a CPS assessment or not.
- Number of prior CPS reports screened out was a count of the number of reports on the family/case ID that were closed after screening.
- Number of prior CPS assessments was a count of the prior CPS assessments involving the family/case ID, regardless of their disposition.
- Number of prior founded CPS assessments on a family/case ID was categorized as 0, 1, 2, 3, or 4 or more.
- Number of prior family cases was defined as the number of ongoing service cases per family/case ID where no children were removed and placed in foster care. The counts were categorized as 0, 1, or 2 or more.
- Prior foster care episode was a dichotomous (yes/no) variable that was coded "yes" if any of the children in the family had been placed into foster care.
- Family stressors were taken from the "family stressors" checklist in OR-Kids. A dichotomous (yes/no) variables was created for each individual stressor (parent alcohol/drug abuse, child emotional/behavioral disability, parent developmental disability, parent mental illness, domestic violence, heavy child care responsibility, inadequate housing, financial stress, social isolation, head of household unemployed, child developmental disability, child mental illness, pregnancy or new baby, parent history of maltreatment as child, parent involvement with law enforcement) and a count was computed of the total number of stressors per family/case ID.

3.2.1 Alternative Response treatment and comparison samples

There were 2,638 families assigned to AR in Districts 5, 11, 4, and 16 whose assessments closed by December 31, 2015. Prior to the matching procedure, these families were significantly different from the families that received a CPS assessment in the 4 non-DR districts on almost every characteristic examined (see Table 4). Significant differences are marked with an asterisk.

Table 4. Pre-match comparison of families in AR and non-DR CPS assessments

Variable	AR (n=2,638)	Non-DR families (n=10,395)
Race		
White*	74.5%	67.1%
Black/African American*	3.9%	12.5%
Native American	6.2%	5.6%
Hispanic/Latino*	9.4%	12.6%
Asian	1.0%	1.5%
Pacific Islander	1.1%	.8%
Gender		
Female child/ren	37.2%	40.0%
Male child/ren	41.1%	38.2%
Female and male children	21.7%	21.9%
Number of children in family*		
1	63.3%	58.6%
2	23.5%	23.7%
3 or more	13.2%	17.7%
Alleged maltreatment type		
Physical abuse*	17.4%	23.7%
Sexual abuse*	.9%	7.9%
Neglect*	63.0%	52.9%
Medical neglect	3.2%	3.2%
Threat of harm*	31.7%	42.3%
Maltreatment reporter*		
Mental health provider	22.0%	22.2%
Health care provider	11.1%	13.0%
Law enforcement/court	23.8%	24.8%
School personnel	15.7%	16.9%
Self/relative/anonymous	22.8%	19.4%
Other/missing	4.6%	3.8%
Alleged perpetrator=mother*	68.2%	58.4%
Alleged perpetrator=father*	43.3%	48.1%
Number prior reports*	4.9	5.8
Number prior reports closed at screening*	1.7	2.4
Number prior CPS assessments*	2.1	2.4
Number prior founded assessments		
0	70.8%	69.3%
1	16.6%	16.9%
2	7.4%	7.2%
3	2.8%	3.4%

4 or more	2.5%	3.2%
Number prior open family cases*		
0	71.8%	71.5%
1	19.5%	17.9%
2 or more	8.8%	10.6%
Prior foster care episode (yes)*	14.4%	16.1%
Number of family stressors*	1.5	1.2
Parent alcohol/drug abuse*	30.6%	21.6%
Parent developmental disability	1.8%	1.5%
Parent mental illness*	10.8%	8.0%
Parent history maltreatment*	10.2%	7.0%
Head household unemployed*	8.8%	6.0%
Parent involvement law enforcement*	14.5%	10.8%
Heavy child care responsibility	1.4%	1.8%
New baby or pregnant*	7.9%	6.5%
Domestic violence*	18.1%	21.7%
Inadequate housing*	7.8%	6.1%
Financial stress*	17.4%	10.4%
Social isolation	1.6%	1.2%
Child emotional/behavioral issue*	12.6%	10.3%
Child developmental disability	3.0%	2.6%
Child mental illness	1.7%	1.9%

The goal of the propensity score matching procedures was to reduce the differences between the AR sample and the non-DR sample, so that any differences in outcomes can be attributed to the treatment rather than to pre-existing differences between the two groups. The PSM procedures were completed 4 times, in order to match families in AR assessments in each of the 4 DR districts with families in CPS assessments in non-DR districts. The technical details and results of each of the 4 separate matching procedures are included in Appendix A. After the procedures had been completed for the 4 paired districts, there were 35 families in AR assessments that could not be matched to a similar family in a CPS assessment in a non-DR district. These families were dropped from the AR sample in the outcome analyses, which resulted in a sample of 2,603 AR families.

After the matching procedure, all of the significant differences between families assigned to AR and those in non-DR districts were eliminated with the exception of three variables, which are marked with an asterisk in Table 5. Although these differences were statistically significant, most were very small relative differences; for example, the percentage of families in the AR sample with financial stress was 17.4% compared to 14.6% of the AR-matched sample. The characteristic that was notably different between the two groups after the match was the percentage of families with sexual abuse allegations in the initial report, which was much

smaller in the AR sample (.9%) than in the AR-matched sample (8.0%). The effect of the post-match differences will be examined in the outcome analyses.

Table 5. Post-match comparison of AR and AR-matched families

Variable	AR families (n=2,603)	AR-matched families (n=2,603)
Race		
White	74.7%	75.1%
Black/African American	3.9%	3.3%
Native American	5.3%	4.2%
Hispanic/Latino	9.3%	8.8%
Asian	1.0%	1.2%
Pacific Islander	1.0%	.7%
Gender		
Female child/ren	37.2%	40.0%
Male child/ren	41.1%	38.2%
Female and male children	21.7%	21.9%
Number of children in family		
1	63.5%	63.9%
2	23.4%	22.8%
3 or more	13.1%	13.3%
Alleged maltreatment type		
Physical abuse	17.6%	19.2%
Sexual abuse*	.9%	8.0%
Neglect	62.5%	62.7%
Medical neglect	3.3%	3.2%
Threat of harm	31.9%	29.7%
Maltreatment reporter		
Mental health provider	22.1%	22.1%
Health care provider	11.0%	11.0%
Law enforcement/court	23.9%	22.5%
School personnel	15.8%	17.9%
Self/relative/anonymous	22.7%	22.1%
Other/missing	4.6%	4.4%
Alleged perpetrator=mother	67.8%	67.7%
Alleged perpetrator=father	43.6%	44.7%
Number prior reports	4.9	4.7
Number prior reports closed at screening	1.7	1.7
Number prior CPS assessments	2.1	2.0
Number prior founded assessments		
0	70.8%	72.7%

1	16.7%	15.4%
2	7.3%	6.8%
3	2.8%	2.8%
4 or more	2.5%	2.4%
Number prior open family cases		
0	72.0%	74.1%
1	19.3%	18.1%
2 or more	8.7%	7.8%
Prior foster care episode (yes)	14.1%	14.3%
Number of family stressors*	1.5	1.4
Parent alcohol/drug abuse	30.5%	29.4%
Parent developmental disability	1.8%	1.7%
Parent mental illness	10.8%	10.3%
Parent history maltreatment	9.8%	8.9%
Head household unemployed	8.7%	8.0%
Parent involvement law enforcement	14.2%	13.7%
Heavy child care responsibility	1.3%	1.8%
New baby or pregnant	7.7%	7.4%
Domestic violence	18.3%	17.2%
Inadequate housing	7.8%	7.3%
Financial stress*	17.4%	14.6%
Social isolation	1.6%	1.3%
Child emotional/behavioral issue	12.5%	12.6%
Child developmental disability	3.0%	3.3%
Child mental illness	1.7%	2.0%

3.2.2 Traditional Response treatment and comparison samples

There were 2,155 families assigned to TR in Districts 5, 11, 4, and 16 whose assessments closed by December 31, 2015. Prior to the matching procedure, these families were significantly different from the families that received a CPS assessment in the 4 non-DR districts on almost every characteristic examined (see Table 6). Significant differences are marked with an asterisk.

Table 6. Pre-match comparison of families in TR and non-DR CPS assessments

Variable	TR families (n=2,155)	Non-DR families (n=9,003)
Race		
White*	75.2%	68.8%
Black/African American*	5.1%	8.2%
Native American*	6.2%	4.9%
Hispanic/Latino	11.2%	12.6%

Asian	1.0%	1.2%
Pacific Islander	.4%	.7%
Gender		
Female child/ren	38.7%	37.7%
Male child/ren	37.5%	37.1%
Female and male children	23.8%	25.2%
Number of children in family*		
1	61.3%	59.0%
2	23.2%	23.3%
3 or more	15.6%	17.8%
Alleged maltreatment type		
Physical abuse*	31.8%	23.6%
Sexual abuse*	14.4%	7.9%
Neglect*	41.0%	54.2%
Medical neglect*	2.0%	3.1%
Threat of harm*	52.2%	42.7%
Maltreatment reporter*		
Mental health provider	27.4%	21.1%
Health care provider	12.3%	12.6%
Law enforcement/court	22.1%	25.4%
School personnel	14.6%	18.0%
Self/relative/anonymous	18.5%	19.3%
Other/missing	5.1%	3.7%
Alleged perpetrator=mother*	49.7%	58.5%
Alleged perpetrator=father*	54.8%	47.3%
Number prior reports*	4.9	5.6
Number prior reports closed at screening*	1.7	2.3
Number prior CPS assessments	2.1	2.2
Number prior founded assessment*		
0	68.2%	71.3%
1	17.8%	16.2%
2	6.9%	6.5%
3	3.3%	3.1%
4 or more	3.9%	2.9%
Number prior open family cases*		
0	69.6%	74.1%
1	20.4%	16.9%
2 or more	10.1%	9.0%
Prior foster care episode (yes)*	19.0%	15.4%
Number of family stressors*	1.5	1.2

Parent alcohol/drug abuse	23.9%	22.1%
Parent developmental disability*	2.1%	1.5%
Parent mental illness*	10.9%	7.6%
Parent history maltreatment*	15.4%	7.2%
Head household unemployed*	8.4%	6.0%
Parent involvement law enforcement*	22.8%	12.0%
Heavy child care responsibility	1.9%	1.8%
New baby or pregnant*	8.9%	6.5%
Domestic violence	20.0%	19.9%
Inadequate housing	4.6%	5.6%
Financial stress*	14.9%	9.8%
Social isolation	1.5%	1.1%
Child emotional/behavioral issue*	12.3%	10.5%
Child developmental disability	2.1%	2.8%
Child mental illness	1.6%	2.0%

Similar to the AR sample, the PSM procedures were completed 4 times, in order to match families in TR assessments in each of the 4 DR districts with families in CPS assessments in non-DR districts. The technical details and results of each of the 4 separate matching procedures are included in Appendix B. After the procedures had been completed for the 4 paired districts, there were 46 families in TR assessments that could not be matched to a similar family in a CPS assessment in a non-DR district. These families were dropped from the TR sample in the outcome analyses, which resulted in a sample of 2,109 TR families.

After the matching procedure, all of the significant differences between families assigned to TR and those in non-DR districts have been eliminated with the exception of three variables, which are marked with an asterisk in Table 7. Although these differences were statistically significant, most were very small relative differences; for example, the mean number of prior reports for families in the TR sample was 4.8 compared to 4.4 for the TR-matched sample. The effect of the post-match differences will be examined in the outcome analyses.

Table 7. Post-match comparison of TR and TR-matched families

Variable	TR families (n=2,109)	TR-matched families (n=2,109)
Race		
White	74.9%	74.5%
Black/African American	4.8%	4.6%
Native American	5.9%	5.9%
Hispanic/Latino	11.2%	10.5%
Asian	1.0%	1.1%
Pacific Islander	.4%	.7%
Gender		

Female child/ren	39.0%	40.5%
Male child/ren	37.7%	37.2%
Female and male children	23.3%	22.4%
Number of children in family		
1	61.6%	62.1%
2	23.1%	23.4%
3 or more	15.4%	14.6%
Alleged maltreatment type		
Physical abuse	31.4%	31.6%
Sexual abuse	14.1%	13.2%
Neglect	41.0%	38.5%
Medical neglect	2.0%	2.2%
Threat of harm	51.7%	53.2%
Maltreatment reporter		
Mental health provider	27.2%	27.4%
Health care provider	12.4%	12.2%
Law enforcement/court	22.3%	22.6%
School personnel	14.8%	16.6%
Self/relative/anonymous	18.4%	17.3%
Other/missing	5.0%	4.0%
Alleged perpetrator=mother	49.4%	48.7%
Alleged perpetrator=father	54.5%	54.0%
Number prior reports*	4.8	4.4
Number prior reports closed at screening	1.7	1.6
Number prior CPS assessments	2.1	1.8
Number prior founded assessment*		
0	68.9%	71.7%
1	17.7%	16.8%
2	6.5%	6.7%
3	3.2%	2.5%
4 or more	3.7%	2.4%
Number prior open family cases		
0	70.2%	73.3%
1	19.8%	18.3%
2 or more	10%	8.4%
Prior foster care episode (yes)	18.6%	18.0%
Number of family stressors*	1.5	1.4
Parent alcohol/drug abuse	23.7%	23.0%
Parent developmental disability	2.0%	2.0%
Parent mental illness	10.7%	11.1%

Parent history maltreatment	14.7%	12.7%
Head household unemployed	8.3%	6.9%
Parent involvement law enforcement	22.4%	19.7%
Heavy child care responsibility	1.8%	1.7%
New baby or pregnant	8.8%	8.5%
Domestic violence	20.2%	19.7%
Inadequate housing	4.5%	4.4%
Financial stress	14.2%	12.9%
Social isolation	1.5%	1.8%
Child emotional/behavioral issue	12.2%	11.9%
Child developmental disability	2.1%	2.3%
Child mental illness	1.5%	1.4%

3.3 Data Collection Methods

Three primary data collection activities have been used to obtain the data that are used in the current report: administrative data from OR-Kids, a statewide staff survey, and parent surveys that were completed by a parent at the conclusion of the CPS assessment.[10]

3.3.1 OR-Kids

Oregon's Statewide Automated Child Welfare Information System (SACWIS), known as OR-Kids, was implemented in August 2011. CFRC was given access to data tables contained within OR-Kids in order to complete the propensity score matching procedures and compute several measures used in the process and outcome evaluations. Specifically, data from OR-Kids were used to examine process measures that include:

- Percentage of CPS reports assigned to assessment
- Initial track assignment (AR and TR) in Districts 5, 11, 4, and 16
- Response times assigned to CPS assessments (24 hours or 5 days)
- Compliance with response times assigned
- Percentage of assessments that change tracks (AR to TR)
- Safety decisions
- Length of CPS assessments
- Percentage of families offered services
- Percentage of families who accepted services
- Length of "admin only" cases

[10] The site visit reports produced by Pacific Research and Evaluation describe the data collection methods used in the implementation evaluation; and the OSM Fidelity Assessment Report describes the methods used in that study. Parent interviews are currently being conducted and will not be included in this report.

In the current report, data contained within OR-Kids were also used to create the following outcome measures:

- Maltreatment re-reports
- Substantiated maltreatment re-reports
- Child placements into substitute care

3.3.2 Statewide staff survey

An online survey was developed and administered in order to measure staff perceptions of several aspects of CPS practice, including the effectiveness of their training and coaching opportunities, supervisory support, job satisfaction, organizational culture, screening practices, CPS assessment practices, attitudes toward DR, the OSM, and the Family Strengths and Needs Assessment (FSNA), service availability, and service coordination. The survey was distributed to 1,638 DHS staff, including screeners, CPS workers, permanency workers, supervisors, and program managers, on February 17, 2016. Two reminder emails were sent to staff that had not completed the survey. At the end of the data collection period, the survey was sent to 1,588 DHS staff with valid email addresses who were not on extended leave or vacation. Of these, 558 staff completed at least part of the survey, for a 35% response rate.[11] Characteristics of the participants in the staff survey are shown in Table 8.

Table 8. Participant characteristics

	N	**%**
Gender (n=449)		
Female	353	78.6
Male	89	19.8
Other	7	1.6
Race (n=439)	N	%
White	368	83.8
Black	11	2.5
Hispanic	40	9.1
Asian	8	1.8
Alaska Native	1	0.2
Native American	16	3.6
Native Hawaiian or Other Pacific Islander	6	1.4

[11] 558 participants began the survey, and most participants completed the entire survey. Around 450 participants entered some demographic information, the last page of the survey. Our analysis includes all participants who answered each question, regardless of whether that participant completed the entire survey. For example, a participant who answered questions about training will be included in that section of the analysis, whether or not that same participant answered later questions.

Biracial/Multiracial	9	2.1
Other Race/Ethnicity	10	2.3
Highest Education Achieved (n=448)	N	%
Bachelor's Degree	334	74.6
Master's Degree	110	24.6
Other Degree	2	0.4
Role (n=558)	N	%
CPS Worker	185	33.2
Screener	42	7.5
Ongoing/Permanency Worker	223	40.0
Supervisor	85	15.2
Program Manager	23	4.1

Note. Race percentages do not sum to 100% because participants could select multiple races.

3.3.3 Parent survey

Two parent surveys were developed in order to measure several variables included in the DR logic model. The first survey, known as the Post-Assessment Questionnaire or PAQ, contained questions related to the initial contact with the CPS caseworker, parent emotional responses following the initial CPS visit, caseworkers' use of family-centered practices and cultural sensitivity, parent satisfaction with services, parent engagement with their caseworker, parent and child trauma symptoms, social support, family economic resources, and demographic information. Beginning on February 1, 2016, CPS caseworkers in the 8 districts included in the outcome evaluation were instructed to hand out the PAQ to one parent in each household at the last face-to-face meeting of the CPS assessment. Caseworkers were provided with a suggested script to use when handing out the PAQ that informed parents that they were selected to participate in a study of child protective services in Oregon being conducted by the University of Illinois (not DHS) and that their decision to participate would not affect their case in any way. Caseworkers were instructed not to complete the survey with the parents, as their presence could affect the parents' answers to some of the questions. Included with the survey was a cover letter that explained the purpose of the study in more detail and provided parents with a link so they could take the survey online if they preferred, as well as a consent form, and a pre-paid envelope to return the survey to the Children and Family Research Center. Parents who completed the survey received a $25 gift card.

There were 9,078 assessments that closed in the 4 DR districts and 11,138 assessments in the 4 non-DR between February 1 and October 4, 2016. During this time period, 148 PAQ surveys were received from parents in DR districts and 252 surveys were received from parents in non-DR districts, which corresponds to PAQ response rates of 1.6% and 2.3%, respectively. Because those response rates were so low, it was important to examine whether the parents that

completed and returned a survey were systematically different than those who did not. If a non-response bias was present, it would limit our ability to generalize the results obtained from the parent survey to the entire population of families in the study. We therefore compared the characteristics of families that responded and those who did not and found that they did not differ on child race, age of the youngest child, or allegation types, with one exception: a smaller percentage of parents with sexual abuse allegations in non-DR counties responded to the PAQ compared to parents who did not complete the survey (see Appendix C for the results of the non-response comparisons).

Because the response rates for the PAQ were so low, very few of the families in the AR and TR matched samples completed and returned surveys. Thus, in order to reduce the differences in family characteristics between the families that returned surveys in DR and non-DR districts, additional PSM procedures were completed to match the AR and TR families that returned surveys (n=89 and n=59, respectively) with families from non-DR districts that returned surveys (n=252). All of the AR families were successfully matched and 56 of the 59 TR families were matched; these matched samples are used in the analyses of the parent survey data.

The second survey, known as the Service Assessment Questionnaire (SAQ), was mailed by CFRC to parents in the 4 DR and 4 non-DR districts who were offered services following the CPS assessment. The SAQ contained measures of service receipt and helpfulness, use of family-centered practices by the service provider, satisfaction with services, family economic resources, social support, and demographic information. Each survey packet that was mailed contained a cover letter that explained the purpose of the study and offered online and telephone options for survey completion, a consent form, the survey, and a pre-paid return envelope addressed to the Children and Family Research Center. Parents who completed the SAQ received a $25 gift card.

Using data from OR-Kids, we identified 729 families in the 4 DR districts and 431 families in the 4 non-DR districts who were offered services following a CPS assessment that closed prior to July 21, 2016. Using the addresses available in OR-Kids, each household was mailed a survey; 131 of the survey packets that were mailed were returned to CFRC as undeliverable and no alternative address could be located. Of the 1,160 surveys with valid addresses, 155 SAQ surveys were received as of November 13, 2016, which corresponds to a response rate of 13.4%. Of these, 102 surveys were received from households in DR districts (14.0% response rate) and 53 surveys were received from households in non-DR districts (12.3% response rate). Although the response rates for the SAQ were greater than those for the PAQ, they were still low; therefore, the characteristics of the families that responded and did not respond were compared (see Appendix C for the results of the non-response comparisons). The only significant difference between the two groups was the percentage of Hispanic/Latino families, which was lower among families that responded to the survey (3.1%) compared to those who did not (11.1%).

3.4 Data Collection Schedule

To complete the process, outcome, and cost evaluations, data are being collected from several sources and through multiple methods. Data collection began in May 2015 and will conclude around February 2017. Table 9 lists each of the data collection activities that will occur, their anticipated collection timeframes, and reporting schedules. The final report will be cumulative, and will contain information from the two prior reports, as well as findings from additional analyses completed during 2017.

Table 9. Data collection and reporting schedule

Data collection	**Timeline**	**Reporting**		
		2015 Interim Report	2016 Interim Report	2017 Final Report
Administrative data	Ongoing	✓	✓	✓
Site visits in DR counties (interviews and focus groups)	May 2015 (D5, D11) Feb 2016 (D4, D16) Sep 2016 (D5, D11) Feb 2017 (D4, D16)	✓		✓ ✓ ✓ ✓
Parent survey	Feb – Dec 2016		✓	✓
Staff survey	Feb 2016 Feb 2017*		✓	✓ ✓
OSM case review	July 2016 – Feb 2017			✓
Parent interviews	Oct – Dec 2016			✓
Cost data collection	Jan – Feb 2017			✓

*tentative

Chapter 4: Assessment of CPS Practices

4.1 Measures of CPS Practices

All measures of CPS practice were included in the staff survey.

4.1.1 Training and coaching

Participants were presented with a list of practice topics (general DR concepts, Oregon Safety Model (OSM), engagement strategies, family interviewing, specialized training) and asked to indicate if they had a) received training in that area, b) needed training in that area, or c) neither needed nor received training in that area. For each training received, participants rated its effectiveness and relevance on 5-point Likert scales (1=not at all effective to 5=very effective). Participants were also asked to list any areas in which they felt that they needed additional training. Responses to this open-ended question were independently coded by two researchers.

The staff survey also asked participants to identify whether they received or needed coaching on DR concepts, the OSM, engagement strategies, and family interviewing. For each area that they received coaching, respondents then rated its effectiveness and relevance using 5-point scales (1=not at all to 5=very).

4.1.2 Supervisor support

Supervisor support was measured using 6 items from Chen & Scannapieco[12]; example items include "My supervisor is available for me," "My supervisor helps me to problem solve," and "I have received casework guidance from my supervisor." One additional item from Shim[13] was included in this measure: “There are clear job expectations and performance standards for my work.” Participants rated each item on a 4-point scale that ranged from “strongly disagree” to “strongly agree” and ratings on the 7 items were summed and then averaged to create a single score that could range from 1 to 4.

4.1.3 Job satisfaction

Using a 4-point scale that ranged from “very dissatisfied” to “very satisfied,” participants rated their satisfaction with 10 specific aspects of their work, including their workload, the quality of

[12] Chen, S., & Scannapieco, M. (2010). The influence of job satisfaction on child welfare worker's desire to stay: An examination of the interaction effect of self-efficacy and supportive supervision. *Children and Youth Services Review*, *32*, 482-486.
[13] Shim, M. (2010). Factors influencing child welfare employee’s turnover: Focusing on organizational culture and climate. *Children and Youth Services Review*, *32*, 847-856.

the supervision they receive, quality of the coaching they received, opportunities for advancement, being valued for their work, cultural sensitivity at the agency, salary, physical safety, working conditions, and OR-Kids. In addition to reporting levels of satisfaction with specific aspects of their job, scores on the 10 items were averaged to form a single measure of overall job satisfaction.

4.1.4 Organizational culture

Organizational culture is a broad concept with many components. In the current survey, it was measured using 14 items developed by Shim[14] to assess overall workload, work/life balance, emotional energy, and making a contribution at work. Participants rated their level of agreement with each item on a 4-point scale that ranged from "strongly disagree" to "strongly agree."

Participant responses on these 14 items were subjected to factor analysis to determine the underlying domains within the larger concept of "organizational culture." The factor analysis revealed three distinct factors. The first factor contains seven items ("The agency's purpose is clear to me," "My work reflects the agency's purpose," "My work offers opportunities to make a difference," "My work offers opportunities to ensure the safety and well-being of children and families," "Cases are assigned in a fair manner," "The agency provides me with the resources I need to help children and families," and "There are clear measures of success for my work with families."). These seven items had acceptable reliability and were thus averaged into a measure of "Work Purpose" with scores that could range from 1 to 4.

The second factor contains three items ("I have sufficient emotional energy for my job," "I am able to do my job and not burnout," and "There is a good fit between my personal life and work life"). These items had acceptable reliability and were thus averaged into a measure of "Work-Life Balance" with scores that could range from 1 to 4.

The third factor contains two items ("The amount of record keeping and paperwork is reasonable" and "My overall workload is reasonable"). These items had acceptable reliability and were averaged into a measure of "Overall Workload" that could range from 1 to 4.

4.1.5 CPS practices

Participants were asked a series of questions about their current practice based on the role that they selected at the beginning of the survey. Using a 5-point scale that ranged from "never" to "always," *screeners* in DR districts were asked to indicate how often they:

- use family-centered questioning,
- feel [they] can gather enough information to make the proper decision about a report,

[14] Shim, M. (2010). Factors influencing child welfare employee's turnover: Focusing on organizational culture and climate. *Children and Youth Services Review*, *32*, 847-856.

- consult [their] supervisor or another person about what track to assign, and
- feel uncertain about the track assignment decision [they] made.

CPS workers in all districts were asked how often they performed a variety of actions related to an assessment. Along a 5-point frequency scale that ranged from "never" to "always," CPS workers rated how often they:

- call ahead or otherwise contact the family before meeting face to face,
- let the family know they can have a support person present,
- interview the family as a whole,
- interview family members alone,
- determine that a family has high to moderate needs, and
- offer services to families.

CPS workers in DR districts were asked two additional questions about how often they offer families a Family Strengths and Needs Assessment and decide the case needs to switch from the AR to TR track. These questions were asked twice, once for AR assessments and once for TR assessments.

CPS workers in DR districts were also asked to assess the impact of DR on several areas of CPS practice, including how they:

- initially contact a family,
- stay in contact with a family,
- interact with the family as a whole,
- interact with parents,
- interact with children,
- offer services to families,
- make decisions about whether a child should be removed from the home, and
- interact with community partners.

For each item, participants rated whether DR had a "very negative," "somewhat negative," "neutral," "somewhat positive," or "very positive" effect on each practice. For analysis, the scale was collapsed into three categories: negative, neutral, and positive effect.

Three groups of workers (*CPS workers, permanency workers, and supervisors*) rated the degree to which the Oregon Safety Model had affected their practice by making it:

- less/more thorough,
- less/more safe,
- less/more clear,
- harder/easier,
- more/less complicated, and
- more/less time consuming.

Items were rated on a 5-point scale.

4.1.6 Attitudes about DR, the OSM, and the FSNA

All participants in all districts answered a series of questions to measure their attitudes toward DR and the OSM, and participants in DR districts answered questions related to their attitudes toward the Family Strengths and Needs Assessment (FSNA). The DR attitudes items measures how strongly they agreed or disagreed (on a 4-point scale) with the statements that DR:

- promotes the safety of children,
- promotes the well-being of children,
- positively affects families,
- values the uniqueness of every family's cultural and ethnic background, and
- involves families in decision-making.

The OSM attitude items measured how much participants agreed or disagreed with statements that the OSM:

- is clear and easy to use,
- promotes the safety of children,
- promotes the well-being of children, and
- positively affects families.

The FSNA attitude items measured how much agreed or disagreed with statements that the FSNA:

- promotes the safety of children,
- promotes the well-being of children,
- positively affects families,
- identifies what the family does well, and
- identifies what the family needs.

4.1.7 Service availability

To measure the availability and need of services, participants were asked to rate 9 services as available or unavailable but needed in their districts.[15] Participants who indicated a service was unavailable were asked to indicate how many families they had worked with in the past 6 months had need of the service on a 4-point scale that ranged from "none" to "all."

4.1.8 Service coordination

Perceptions of service coordination were measured through 6 items developed specifically for this survey. On a 4-point scale that ranged from "strongly disagree" to "strongly agree," participants indicated their level of agreement with the following statements:

[15] Belanger, K., & Stone, W. (2008). The social service divide: Service availability and accessibility in rural versus urban counties and impact on child welfare outcomes. C*hild Welfare*, *87*(4), 101-124.

- Service providers in my area work together to serve families.
- The coordination between service providers is effective.
- I feel I am supported by service providers.
- It is easy to work with service providers.
- Service providers in my area are culturally responsive.
- The roles of DHS and community partners in keeping children safe are clearly defined.

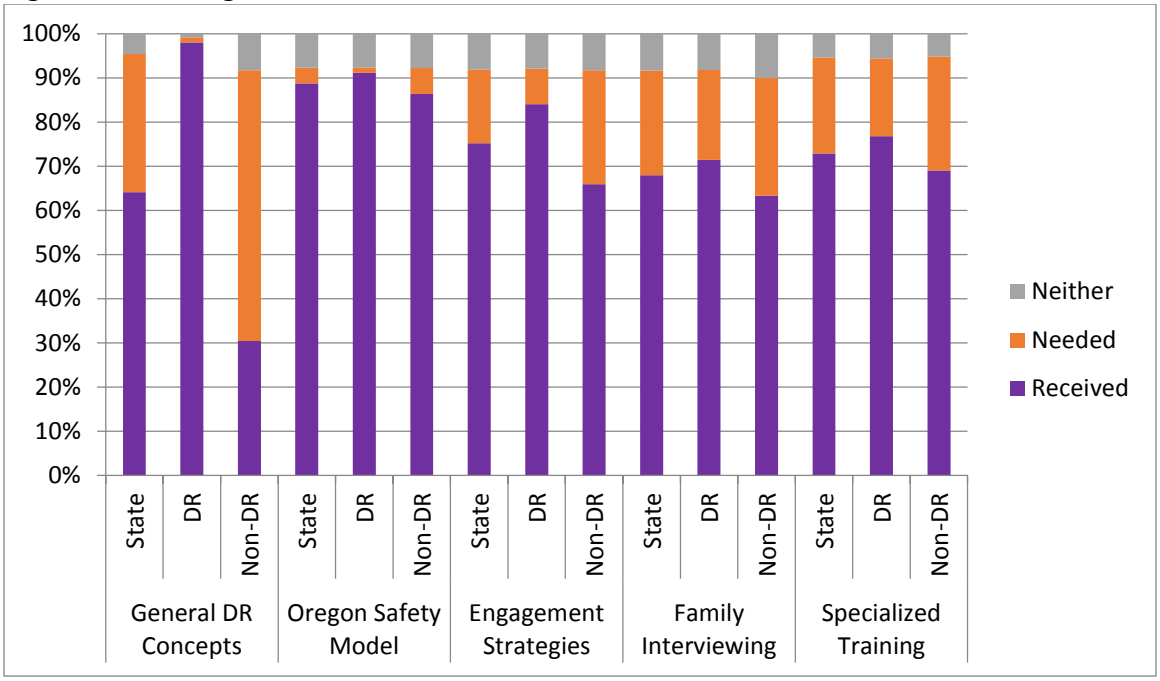
In addition, a modified scale from Frey, Lohmeier, Lee, and Tollefson[16] was used to assess how much community institutions (schools, courts, law enforcement, utility companies, property management companies, healthcare providers, city or county agencies, and other state agencies) coordinated with the child welfare agency (DHS). Participants rated the level of coordination between each agency and child welfare on 5-point scales that ranged from "no coordination" to "lots of coordination." If a participant reported only "some" coordination or less, they were asked to identify what hinders coordination with the institution. Options included "privacy requirements," "lack of communication," "not enough time," "uncooperative," and "other."

4.2 Training

Figure 4 displays the percentage of participants who indicated that they received or needed training on several practice topics. As might be expected, fewer staff in DR districts compared to non-DR districts reported the need for training on DR concepts (1.2% versus 61.3%). Compared to those in non-DR districts, staff in DR counties also reported less need for training on engagement strategies (8.4% in DR districts versus 25.8% in non-DR districts) and specialized training (17.6% versus 25.8%). Across the state, almost a quarter of participants felt they needed training on family interviewing, and there was not a significant difference in need between DR districts (20.5%) and non-DR districts (26.7%). Very few participants in either DR (1.2%) or non-DR districts (6.3%) felt a need for additional training on the Oregon Safety Model.

[16] Frey, B. B., Lohmeier, J. H., Lee, S. W., & Tollefson, N. (2006). Measuring collaboration among grant partners. *American Journal of Evaluation*, *27*, 383-392.

Figure 4. Training Needed and Received



Staff who received a training rated its effectiveness and relevance (see Table 10). Statewide, ratings of effectiveness varied from 3.60 (family interviewing) to 3.86 (Oregon Safety Model). Ratings of relevance were higher and varied more, from 3.97 (DR concepts) to 4.48 (specialized training). Staff in DR districts rated the DR concepts training as significantly more effective and more relevant than participants in non-DR districts. There were no differences between staff in DR and non-DR districts in their ratings of the effectiveness or relevance of the training on the OSM, engagement strategies, family interviewing, or specialized trainings.

Table 10. Training Effectiveness and Relevance

	Statewide		DR		Non-DR	
Effectiveness	Mean	SD	Mean	SD	Mean	SD
General DR Concepts	3.64	.950	3.76	.861	3.25	1.11
Oregon Safety Model	3.86	.943	3.97	.873	3.74	1.29
Engagement Strategies	3.63	.946	3.59	.960	3.69	.926
Family Interviewing	3.60	.946	3.52	.978	3.68	.905
Specialized Training	3.78	.875	3.77	.868	3.80	.885
Relevance						
General DR Concepts	3.97	1.15	4.05	1.09	3.73	1.29
Oregon Safety Model	4.37	.926	4.42	.892	4.32	.960
Engagement Strategies	4.44	.828	4.41	.851	4.49	.796
Family Interviewing	4.37	.882	4.31	.908	4.44	.851
Specialized Training	4.48	.760	4.46	.754	4.49	.769

Note. Each item was scored from 1 to 5, in which 1 indicates "not at all effective/relevant" and 5 indicates "very effective/relevant."

When ratings of training effectiveness and relevance were examined by worker role, some significant differences were found (see Table 11). Program managers rated the effectiveness of the DR concepts training significantly higher than CPS workers, permanency workers, and screeners; and permanency workers rated it as significantly less relevant than CPS workers, supervisors, and program managers. For the OSM training, supervisors rated it as significantly more effective than CPS workers, permanency workers, and screeners. Additionally, program managers rated the OSM training as more effective than permanency workers and screeners. Program managers also rated the training on engagement strategies as significantly more effective than CPS workers, permanency workers, and screeners. Supervisors viewed the family interview training and the specialized trainings as more relevant than screeners.

Table 11. Training Effectiveness and Relevance by Worker Role

	CPS Worker		Permanency Worker		Screener		Supervisor		Program Manager	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
DR Concepts										
Effectiveness	3.62	.93	3.50	.93	3.35	1.07	3.86	.92	4.58	.52
Relevance	4.20	1.00	3.45	1.19	3.96	1.22	4.42	.95	4.92	.29
OSM										
Effectiveness	3.83	.98	3.74	.92	3.58	.84	4.24	.89	4.54	.66
Relevance	4.46	.79	4.24	.99	4.08	1.08	4.57	.89	4.77	.60
Engagement Strategy										
Effectiveness	3.40	.99	3.68	.89	3.56	.82	3.80	.97	4.50	.52
Relevance	4.36	.86	4.47	.80	4.00	1.12	4.68	.60	4.71	.47
Family Interviewing										
Effectiveness	3.46	.96	3.60	.96	3.65	.67	3.69	.95	4.29	.61
Relevance	4.33	.92	4.38	.85	3.85	1.04	4.59	.79	4.57	.76
Specialized Training										
Effectiveness	3.63	.94	3.79	.85	3.88	.61	3.89	.89	4.36	.63
Relevance	4.40	.82	4.46	.76	4.12	.90	4.73	.55	4.79	.43

Staff were able to suggest other training areas they needed, and 113 did so (see Table 12). These additional training areas were coded into five categories: advanced training (for topics related to DR, the OSM, engagement strategies, and family interviewing); specialized training (for topics like domestic violence, mental health, drugs and alcohol, trauma, etc.); policy, procedure, and documentation; practice (a general category covering work that did not fit into the first three categories); and other/critique. A response could be coded in multiple categories.

Table 12. Other Trainings Needed

Training	Statewide N	DR N	Non-DR N	Example
Advanced Training (DR, OSM, engagement, family interviewing)	28	15	13	"Refresher on OR Safety Model"
Specialized Training (domestic violence, mental health, drugs and alcohol, etc.)	35	13	22	"…drug and alcohol and recognition of substances and side effects."
Policy, Procedure, and Documentation (OR-Kids, case notes, legal requirements, etc.)	22	6	16	"All the legal documents and legal processes."
Practice (self-care, self-defense, managing employees, etc.)	23	7	16	"I am a meeting facilitator. I have received some training on meeting facilitation, but there is a need for more."
Other/Critique	30	18	12	"I still feel like the OSM is convoluted with unnecessary verbiage making it difficult to understand as a whole—it should be simplified."

Specialized training was the most frequently requested training (n=35). For example, a permanency worker wrote this: "Opportunities to continue to learn about domestic violence or other issues that affect many of our cases." A CPS worker noted drugs as a major issue: "Training on drugs and the effects on children and families." Several staff (n=28) also suggested that they would like more advanced training on topics already covered in prior trainings. For example, a supervisor suggested needing more training on family interviewing: "During the assessment module we discussed family interviewing but that is an area I feel that additional training could have been beneficial as that is a complex skill." A CPS worker wanted more training on the Family Strength and Needs Assessment, as well as refreshers on other topics: "There has been significant confusion by our agency and community partners regarding the strengths and needs assessment process. Additionally, it would be helpful now that we are at almost 1 year of DR to have some refresher/advanced training regarding DR and how it works with OSM to increase worker competency."

Training on policy, procedure, and documentation was mentioned by 22 people. One CPS worker was adamant that more training was needed on OR-Kids: "ORKIDS, WE RECIEVE NO (NONE) TRAINING ON THIS $40 MILION DOLLAR COMPUTER PROGRAM. NONE!" Others were less emphatic but still noted the need for help with documentation, like this CPS worker: "What is needed is typing successful assessments."

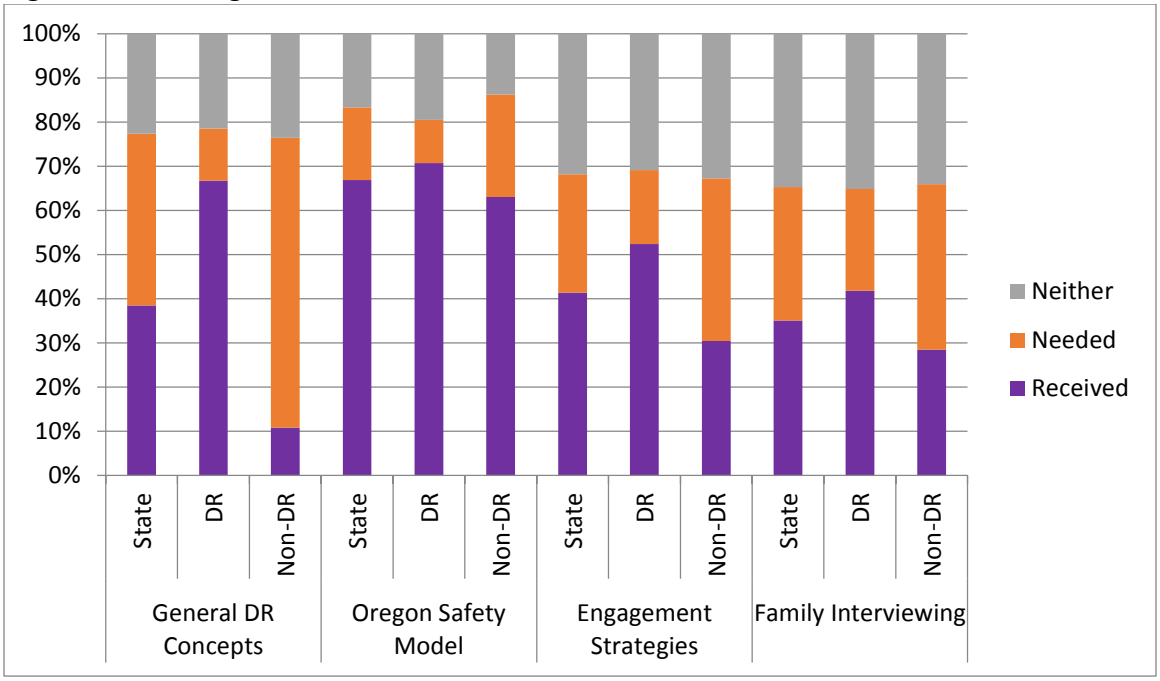
Several staff (n=23) noted a need for additional training on issues that affect practice, particularly self-care. One permanency worker believed burnout was an important topic to cover: “Focusing on burnout. It's a huge problem! I've worked for the agency for over 6 years and I just now figured out on my own how to handle my own burnout.” Another permanency worker noted the importance of self-care in a time of large caseloads: “Self-care, organization (systems/helpful hints, time management - too much work and not enough hours).”

Finally, some staff (n=30) responded to the question with critiques of current training. One noted dissatisfaction with messaging around certain initiatives, like this CPS worker: “There needs to be consistency in the message given about OSM. We continue to be told different things by different supervisors and consultants.” Some felt the current trainings were too rushed: “I feel that CORE had good ideas but due to having to learn a large amount of information in 4 weeks and not being able to relate this to work, the training I have received has now been lost.” Others felt the trainings took too long: “I think the trainings could be more effective by being quicker and more direct.”

4.3 Coaching

Staff were asked whether they needed or received coaching on each of four topics. Figure 5 shows the coaching received and needed statewide and in DR and non-DR county. Statewide, the most common type of coaching received was on the Oregon Safety Model (66.9%). Need for this type of coaching was significantly higher in non-DR districts (23.2%) than DR districts (9.8%). Statewide, about the same number of staff indicated receiving coaching and needing coaching on DR, but need was significantly related to whether or not a county had implemented DR. The need for coaching in DR districts was low (11.8%) and high in non-DR districts (65.6%). About 26.8% of staff in the state reported that they needed coaching on engagement strategies; the percentage was higher in non-DR districts (36.8%) than in DR districts (16.7%). Statewide, about 30.2% of staff reported needing coaching on family interviewing; the need was higher in non-DR districts (37.4%) than in DR districts (23.0%).

Figure 5. Coaching Received and Needed



Participants who reported receiving coaching were asked to rate its effectiveness.[17] In general, staff rated the coaching on each topic between "somewhat effective" and "very effective." There were no differences in coaching effectiveness between staff in DR and non-DR districts (Table 13) or staff role (Table 14).

Table 13. Coaching Effectiveness

	Statewide		DR		Non-DR	
	Mean	SD	Mean	SD	Mean	SD
General DR Concepts	3.87	.90	3.88	.89	3.85	.99
Oregon Safety Model	4.00	.91	4.09	.85	3.89	.97
Engagement Strategies	3.84	.86	3.85	.84	3.82	.90
Family Interviewing	3.77	.88	3.73	.88	3.84	.87

Note. Each item was scored from 1 to 5, in which 1 indicates "not at all effective" and 5 indicates "very effective."

[17] Participants were also asked to rate coaching relevance. Due to a database error, these responses were not recorded.

Table 14. Coaching Effectiveness by Staff Role

	CPS Worker		Permanency Worker		Screener		Supervisor		Program Manager	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
DR Concepts	3.73	.94	3.63	.86	4.00	1.1	4.23	.75	4.36	.51
OSM	3.99	.92	3.88	.89	3.72	.94	4.22	.92	4.46	.52
Engagement Strategies	3.68	.89	3.79	.83	3.87	.63	4.12	.95	4.27	.65
Family Interviewing	3.69	.89	3.75	.91	4.00	.67	3.82	.91	4.14	.69

Note. Each item was scored from 1 to 5, in which 1 indicates "not at all effective" and 5 indicates "very effective."

4.4 Supervisor Support

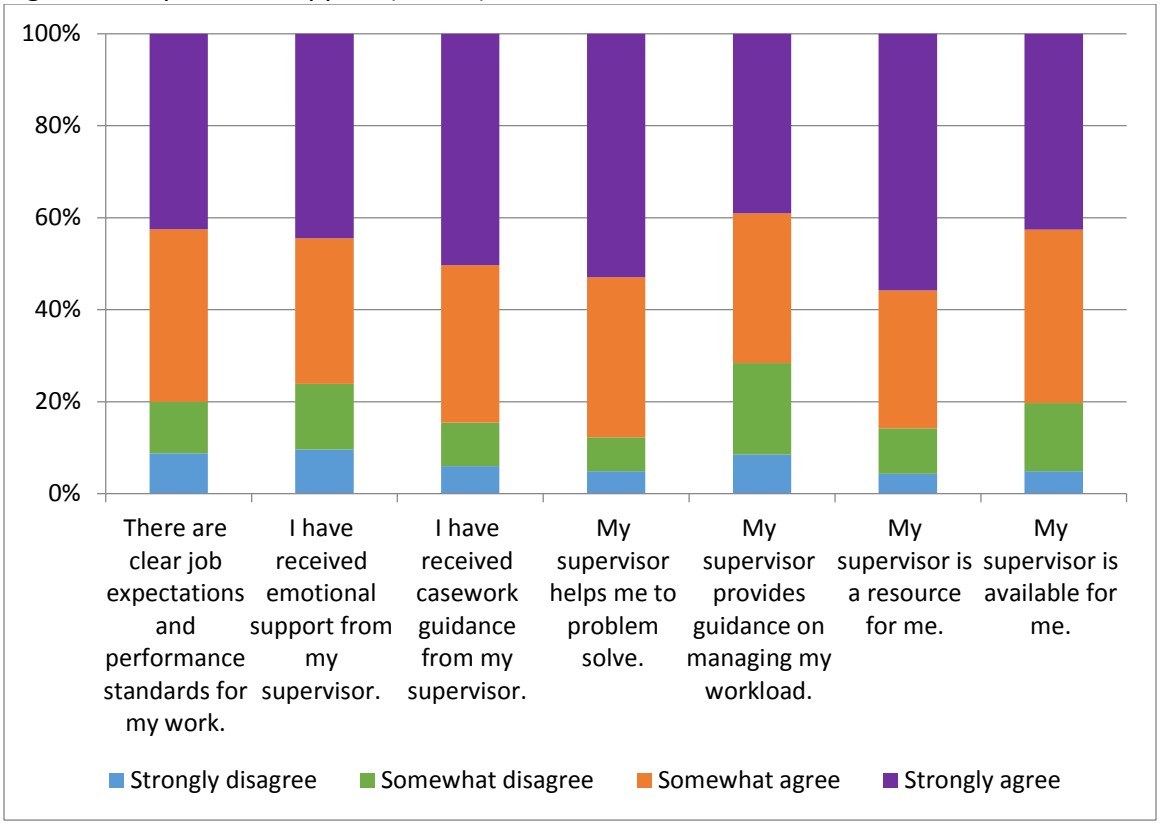
Table 15 shows how frequently staff meet with their supervisors. Most staff meet with their supervisors at least once a month, and a sizeable portion meet with their supervisors weekly (39%).

Table 15. Frequency of Supervisor Meetings (N=476)

	n	%
Weekly	186	39.1
2-3 times a month	102	21.4
About once a month	122	25.6
A few times per year	62	13.0
Never	4	0.8

Figure 6 shows the frequency distribution of staff responses to each of the seven items on the supervisor support scale. Over 70% of participants "somewhat" or "strongly" agreed with every item that makes up the supervisor support scale.

Figure 6. Supervisor Support (n=493)

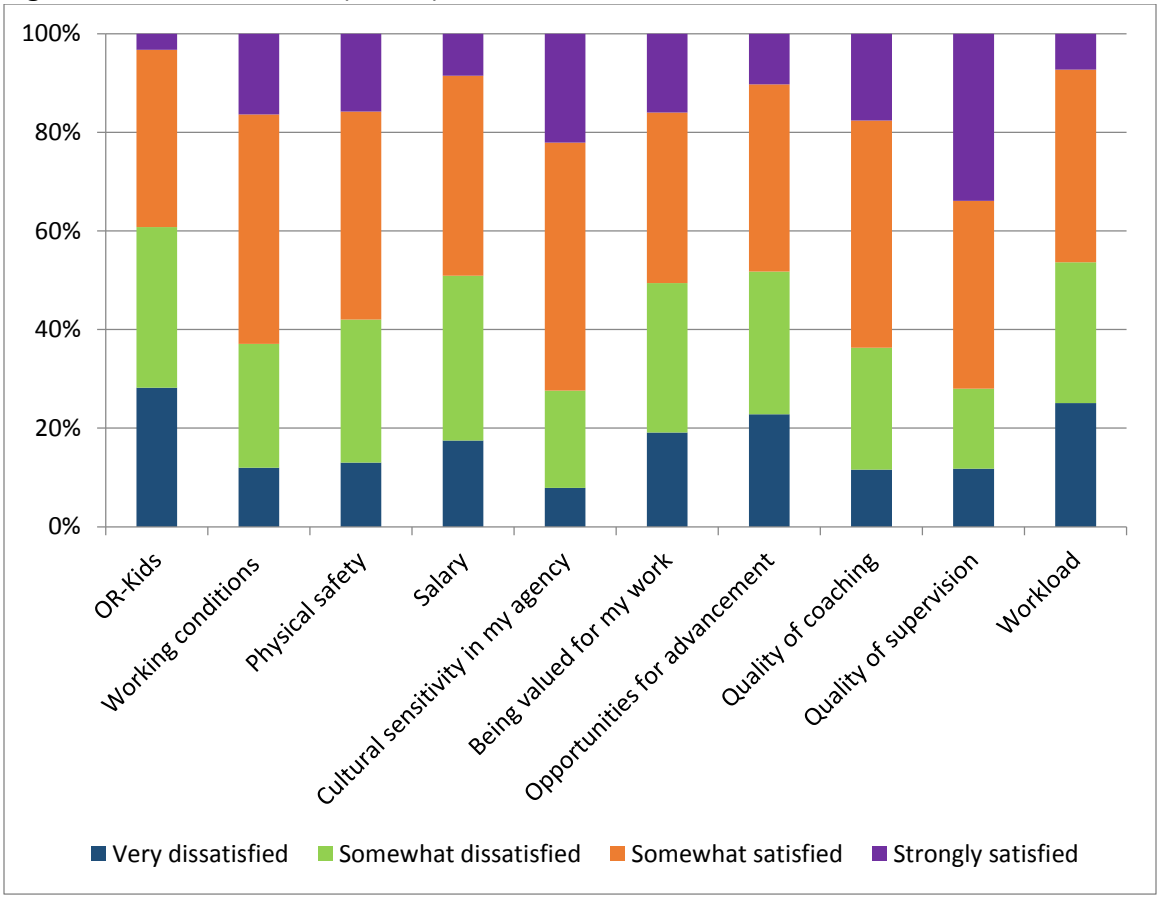


When the seven items are summed to create an overall measure of supervisor support, the average score for all staff across the state was 3.20, indicating a high degree of perceived supervisor support across the state. There were no significant differences in overall supervisor support between staff in DR (3.26, SD = .74) and non-DR districts (3.16, SD = .74).

4.5 Job Satisfaction

Staff were asked to rate their satisfaction with several different aspects of their job (see Figure 7). The area of work that received the lowest satisfaction rating from participants was OR-Kids: over 60% of staff were either very dissatisfied or somewhat dissatisfied with OR-Kids. Over 50% of staff were also dissatisfied with their workload (53.7%), salary (50.9%), and opportunities for advancement (51.7%). Staff were most satisfied with the supervision they receive (72.0% were satisfied) and with their agency's cultural sensitivity (70.3% were satisfied).

Figure 7. Job Satisfaction (n=500)



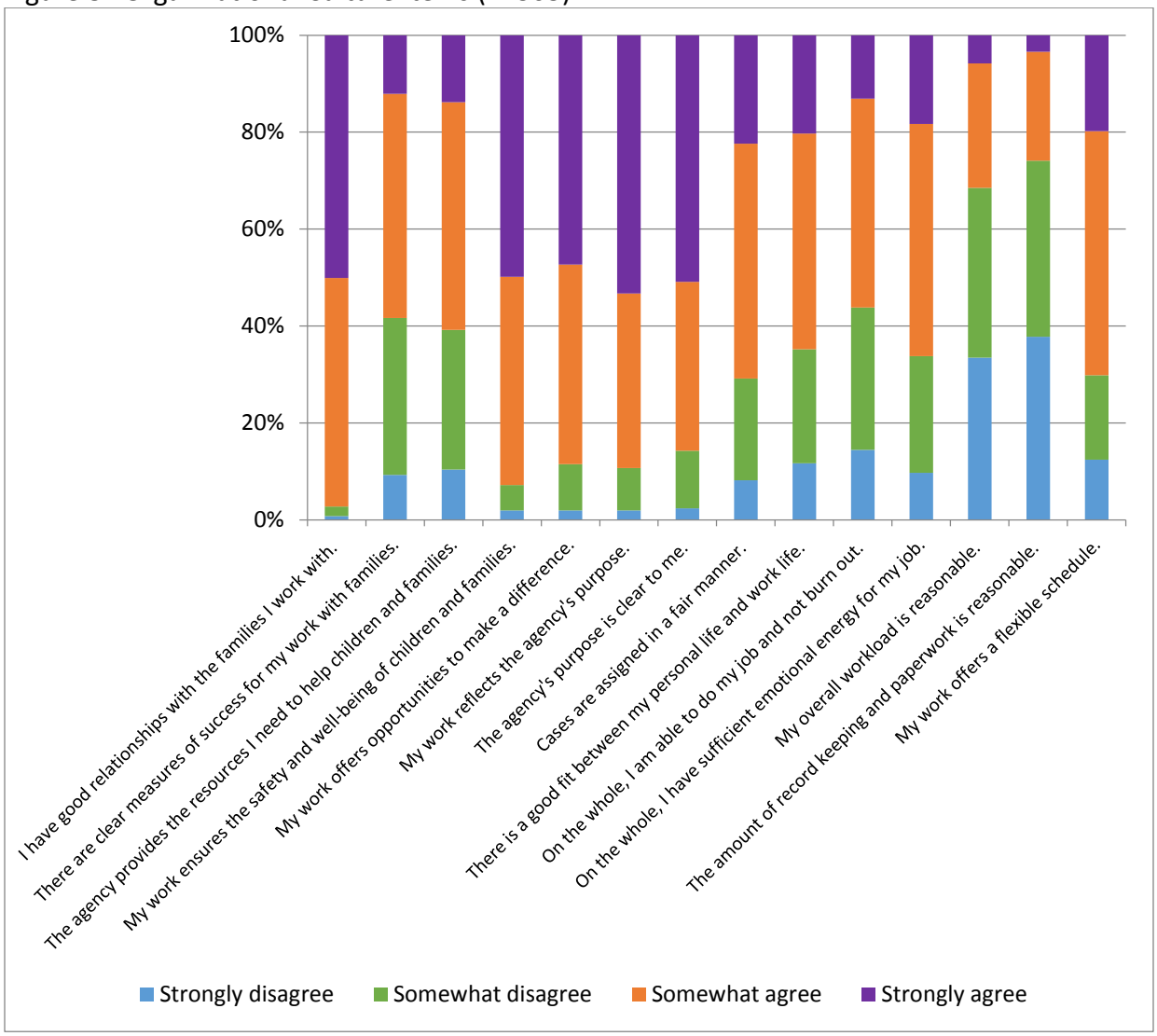
The ten items on the job satisfaction measure were summed to form an overall measure of job satisfaction. Across all staff, the average score on this measure was 2.54 (SD = .58), which falls between "somewhat satisfied" and "somewhat dissatisfied." Overall satisfaction in DR districts (M = 2.59, SD = .58) was not significantly different than in non-DR districts (M = 2.50, SD = .58). However, there were differences in overall job satisfaction by staff role: CPS workers reported lower overall work satisfaction (M = 2.45) than supervisors (M = 2.68) and program managers (M = 2.99), and permanency workers (M=2.53) had lower work satisfaction than program managers. Job satisfaction among screeners (M = 2.51) did not differ significantly from any other group.

4.6 Organizational Culture

Staff responses to the 14 items on the organizational culture scale are shown in Figure 8. Almost all staff who responded to the survey agreed that they have good relationships with the families they work with (97.2%). Over 85% agreed that the agency's purpose was clear to them, their work reflects the agency's purpose, offers opportunities to make a difference, and offers opportunities to ensure the safety and well-being of children and families. At the other end of

the scale, only 26% of the staff who responded felt that the amount of record-keeping and paperwork was reasonable, and only 31.5% felt their workload was reasonable.

Figure 8. Organizational Culture Items (n=503)



The three components of organizational culture measured in the staff survey were work purpose, work-life balance, and workload. Statewide, staff ratings suggest that workers feel a high degree of purpose in their work but feel somewhat burdened by their overall workload. There were no significant differences between DR and non-DR districts.

Table 16. Organizational Culture Sub-scales

	Statewide		DR		Non-DR	
	M	SD	M	SD	M	SD
Work Purpose	3.09	.559	3.09	.550	3.09	.569
Work-Life Balance	2.68	.785	2.69	.756	2.67	.815
Overall Workload	1.98	.808	1.91	.759	2.05	.849

Note. Item scores have a possible range from 1-4.

There were significant differences in perceptions of organizational culture between staff in different roles (see Table 17). Supervisors and program managers had significantly higher perceptions of their work purpose than CPS workers and permanency workers; program managers also had higher perceptions than screeners. CPS workers reported significantly lower levels of work-life balance than screeners and program managers. Screeners rated their overall workload significantly more favorably than CPS workers, permanency workers, and supervisors.

Table 17. Organizational Culture by Role

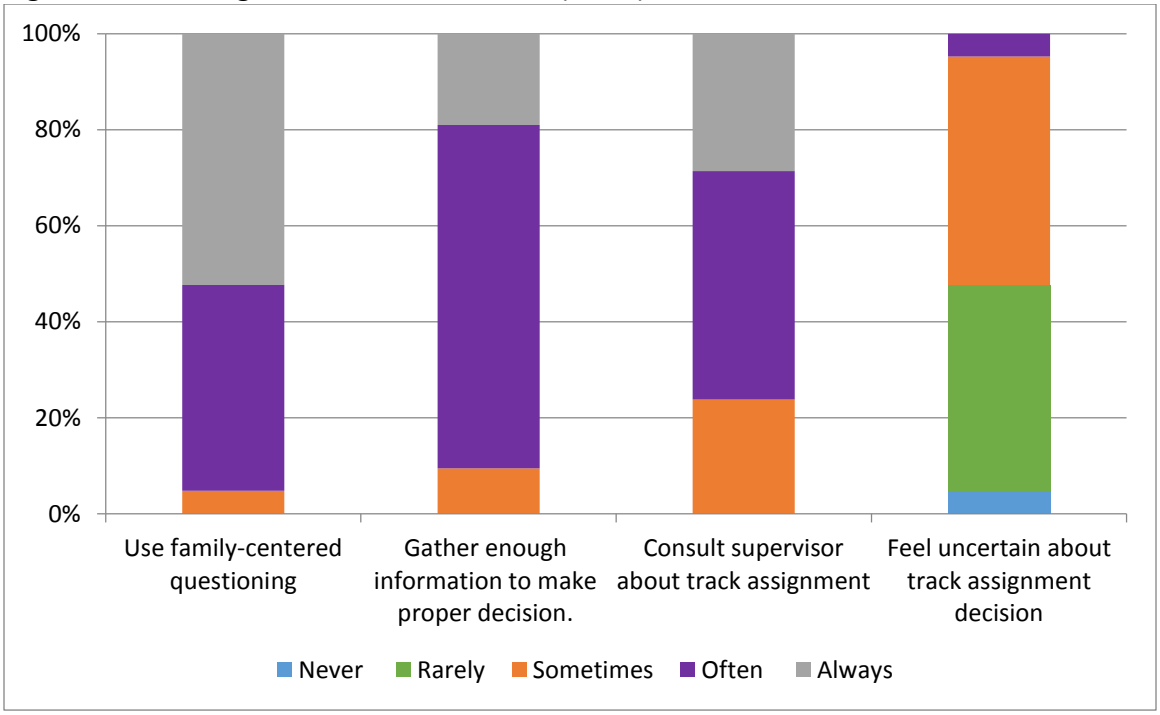
	CPS Workers		Permanency Workers		Screeners		Supervisors		Program Managers	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Work Purpose	2.97^{A}	.63	3.06^{A}	.51	3.04^{AB}	.60	3.32^{BC}	.44	3.53^{C}	.30
Work-Life Balance	2.51^{A}	.87	2.67^{AB}	.72	3.01^{B}	.83	2.77^{AB}	.66	3.17^{B}	.72
Overall Workload	1.80^{A}	.79	2.01^{A}	.81	2.44^{B}	.79	1.98^{A}	.77	2.26^{AB}	.61

Note. Item scores have a possible range from 1-4. Differing superscripts indicate significant differences ($p. < .05$) between groups. Superscripted letters that differ between roles indicate those roles significantly differed from each other.

4.7 CPS Practices

Screeners in DR districts were asked about the frequency of various screening practices (see Figure 9). Screeners reported often (42.9%) or always (52.4%) gathering information about all family members, often (71.4%) or always (19.0%) feeling they could gather enough information to make a proper screening decision, and often (47.6%) or always (28.6%) consulting with supervisor or other person about screening decisions. Screeners sometimes (47.6%) felt uncertain about the track assignment decision they made for a case, but many others rarely (42.9%) felt this way.

Figure 9. Screening Practice in DR Districts (N=21)



Note. Because the overall responses are small, percentages should be interpreted with caution.

CPS workers were asked how often they performed a variety of actions related to an assessment using a 5-point frequency scale from 1 (never) to 5 (always). In DR districts, workers answered these questions twice, once for AR assessments and once for TR assessments (see Table 18).

Table 18. CPS Assessment Practice

	AR		TR		Non-DR	
	M	SD	M	SD	M	SD
Call Ahead	4.39^{A}	.61	2.81^{B}	.81	3.37^{C}	.87
Inform about Support Person	4.37^{A}	.77	2.84^{B}	1.16	3.34^{C}	1.17
Interview Whole Family	3.73^{A}	.61	2.55^{B}	.78	2.81^{B}	.89
Interview Individual Family Members	3.04^{A}	.63	3.81^{B}	.66	3.99^{B}	.63
Determine Family has Moderate to High Needs	3.17^{A}	.97	3.03^{A}	.80	3.25^{A}	1.08
Offer FSNA	3.14^{A}	.96	2.66^{B}	.89	--	
Offer Services	3.59^{A}	.84	3.58^{A}	.77	4.13^{B}	.91
Switch Track to TR	2.52	.86	--		--	

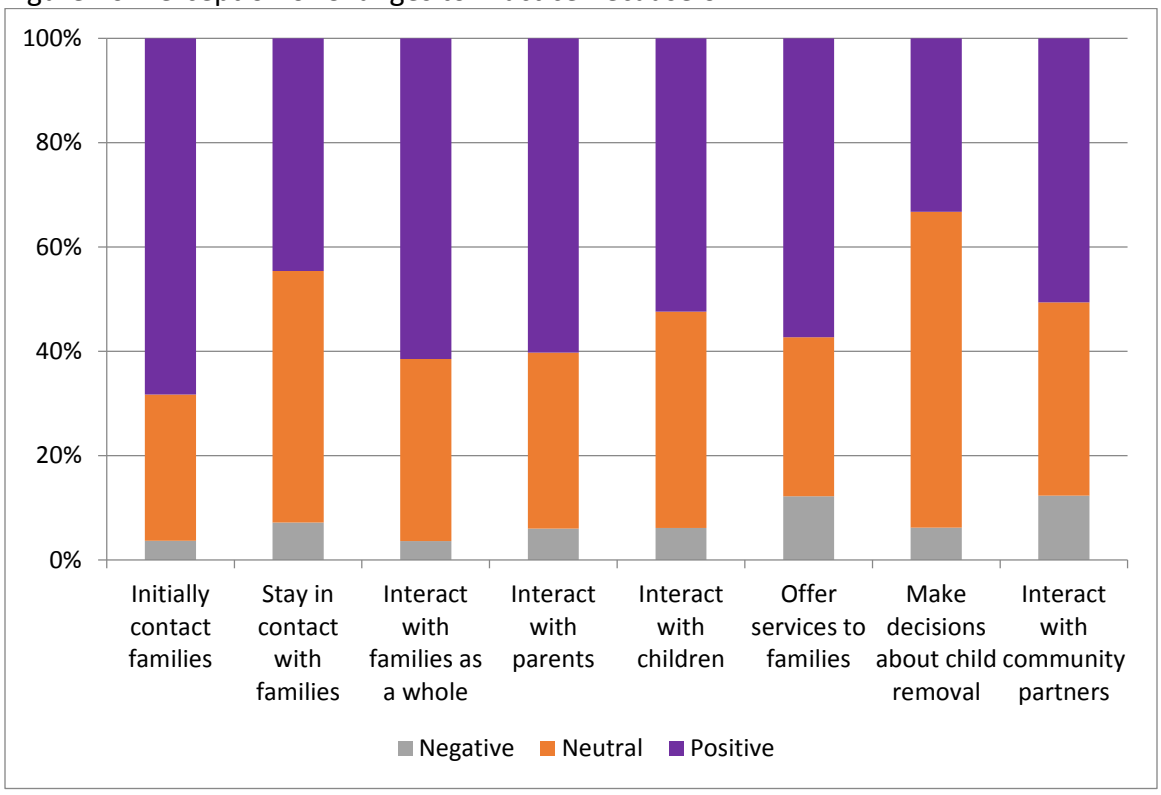
Note. Differing superscripts indicate difference between groups is significant at $p < .0167$. Questions about AR and TR cases were asked to CPS workers in DR districts; thus the responses are not independent of each other.

CPS workers in DR districts were significantly more likely to use several CPS practices in their AR assessments compared to their TR assessments: calling ahead to schedule a meeting with families before the initial visit, informing the family about having a support person present at the first meeting, interviewing the family as a whole, and offering a Family Strengths and Needs Assessment. They were significantly less likely to interview family members individually in AR assessments compared to TR assessments. CPS workers in DR districts were equally likely to determine a family has moderate to high needs and offer services in their AR and TR assessments.

CPS practice in non-DR assessments differed from AR and TR assessments in several ways. CPS workers in non-DR districts were less likely to call ahead and were less likely to inform parents about the availability of a support person than CPS workers in AR assessments and more likely to do so than CPS workers in TR assessments. CPS workers in non-DR districts were less likely to interview the whole family than CPS workers handling AR assessments and more likely to interview individual family members. CPS workers in non-DR districts were more likely to offer services to families than CPS workers handling AR assessments.

CPS workers in DR districts were asked to assess if DR had a negative, neutral, or positive impact on several practice areas (see Figure 10). Overall, majorities of participants indicated that DR had a positive impact on 6 of the 8 practices and a neutral effect on the other two (staying in contact with families and making removal decisions).

Figure 10. Perception of Changes to Practice Because of DR



Three groups of workers—CPS workers, permanency workers, and supervisors—rated how the OSM had changed their practice (1—negative effect, 3—no effect, 5—positive effect). Table 19 shows the average response on each of the 6 items. Overall, staff felt that the OSM has had no effect or a somewhat positive effect on their safety assessment practice. Staff in DR districts reported more positive effects of the OSM than staff in non-DR districts.

Table 19. Effect of OSM on Practice

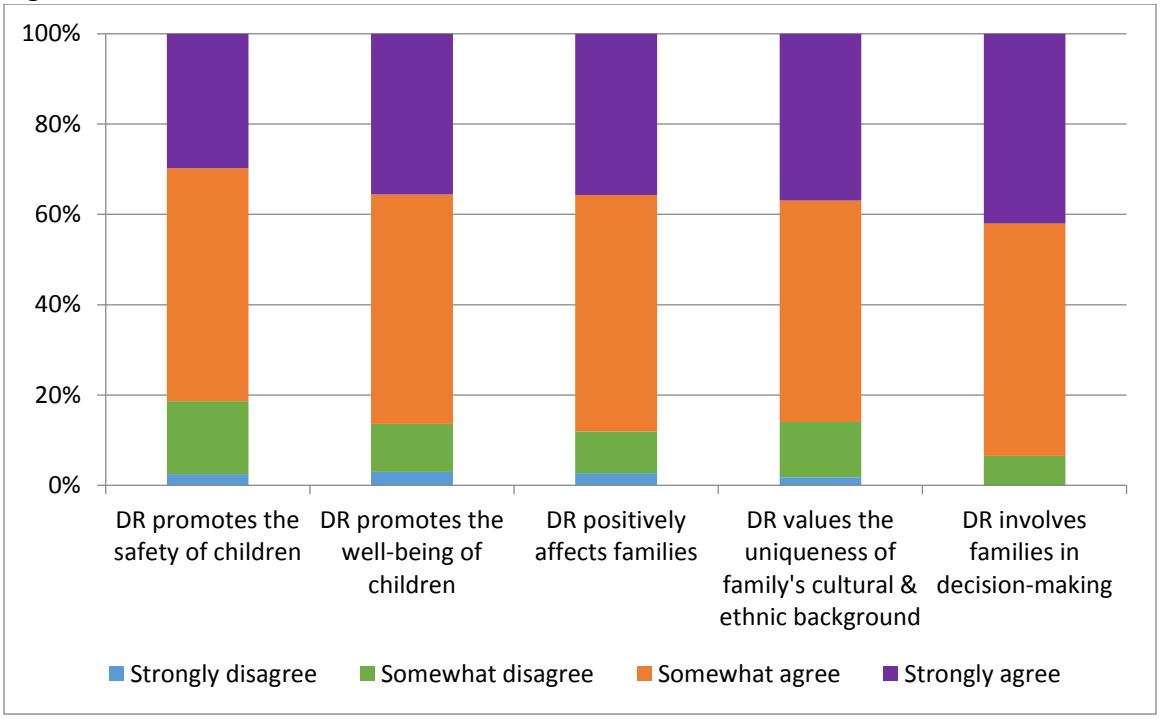
	Statewide		DR		Non-DR	
	M	SD	M	SD	M	SD
Less/More Thorough	3.90	0.93	3.99	.83	3.80	1.01
Less/More Safe	3.72	0.94	3.81	.84	3.61	1.03
Less/More Clear	3.68	1.01	3.87	.84	3.48	1.13
Harder/Easier	3.10	1.13	3.40	1.03	2.77	1.15
Less/More Complicated	2.96	1.88	3.25	1.11	2.65	1.20
Less/More Time-consuming	2.57	1.22	2.82	1.21	2.30	1.18

Note. Each item was rated on a scale where 1 indicates "made it worse," 3 indicates "no effect,' and 5 indicates "made it better."

4.8 DR, OSM, and FSNA Attitudes

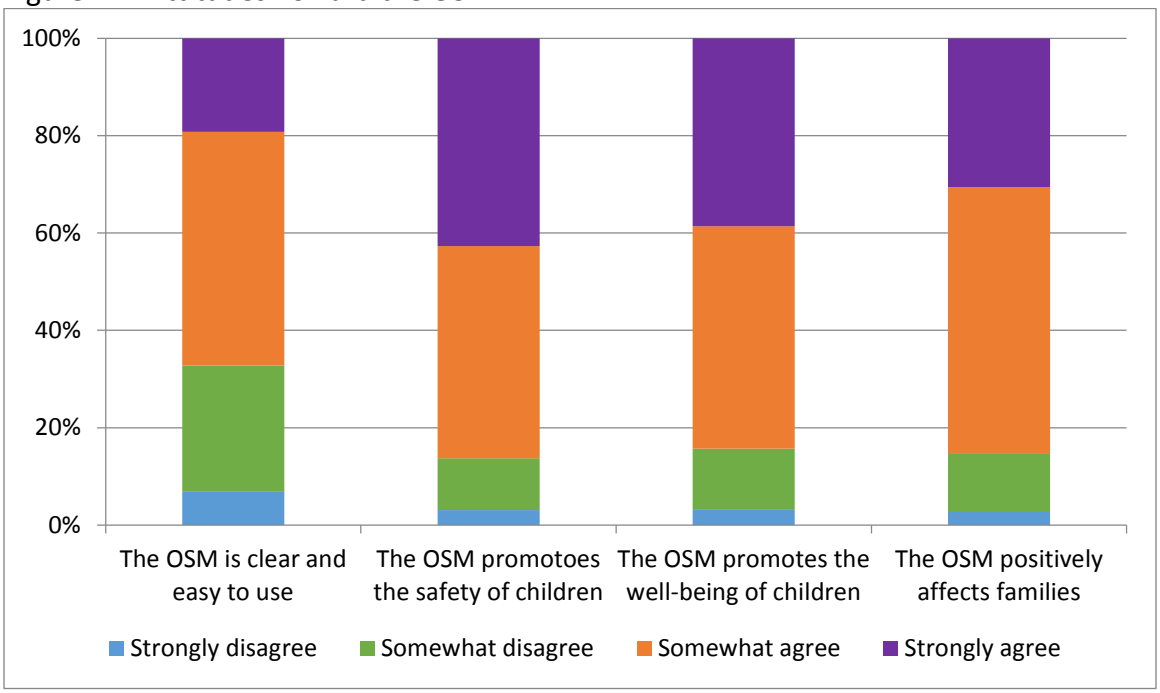
Participants were asked for their attitudes about DR, the OSM, and the FSNA (DR districts only). Over 80% of staff agreed that DR promotes the safety of children, promotes the well-being of children, positively affects families, and values the uniqueness of every family's cultural and ethnic background; and over 90% agreed that DR involves families in decision-making (see Figure 11). There were no differences in attitudes toward DR between staff in DR (M = 3.22, SD = .62) and non-DR districts (M = 3.17, SD = .65).

Figure 11. Attitudes Toward DR



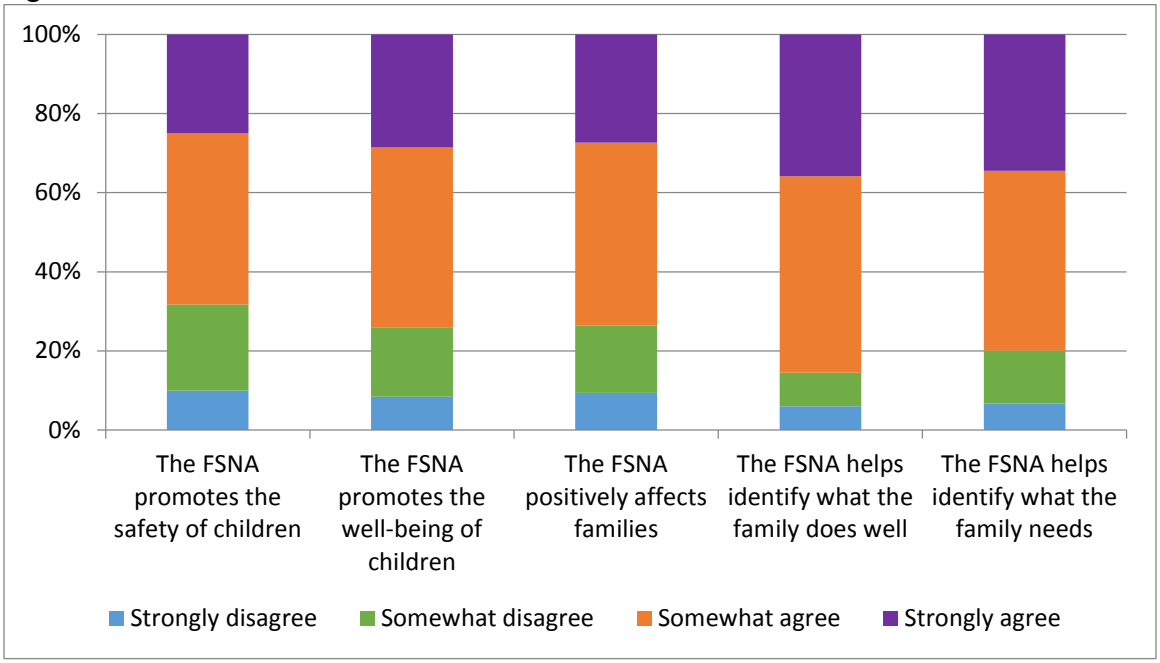
Staff were also asked several questions about the OSM (see Figure 12). Over 80% of staff felt that the OSM promotes the safety and well-being of children and positively affects families; slightly less (67%) agreed that the OSM is clear and easy to use. Staff in DR districts had more positive attitudes toward the OSM (M = 3.27) than staff in non-DR districts (M = 2.92).

Figure 12. Attitudes Toward the OSM



Finally, we assessed attitudes about the Family Strengths and Needs Assessment (FSNA; see Figure 13). Because the FSNA is not used in non-DR districts, we excluded this question from participants in these districts; screeners and permanency workers were also excluded because they are not involved with the FSNA. Nearly three-quarters or more of the staff who responded to these questions agreed that the FSNA promotes the safety (68.3%) and well-being (74.0%) of children, positively affects families (73.6%), identifies what the family does well (85.5%), and identifies what the family needs (79.9%).

Figure 13. Attitudes Toward the FSNA



Note. Only CPS workers in DR districts responded to these items.

4.9 Service Availability

Participants rated nine services as available or unavailable but needed in their districts (see Table 20). The services identified as most available were alcohol and drug treatment and parenting classes. The services identified as least available were housing, reconnecting families, front end interventions, relief nursery, and trauma and therapeutic services. Additionally, over half of participants who identified these services as unavailable said that housing, trauma services, and front end interventions were needed by “a lot” or “all” the families they serve.

Table 20. Available and Needed Services

Service	Available	Unavailable But Needed	% Families Needing Service ("A Lot" or "All")
Navigators	377	105	54.4%
Parenting Classes	450	32	68%
Parent Mentoring	356	122	--
Relief Nursery	290	154	31.1%
Alcohol and Drug Treatment	471	20	53.3%
Housing	357	174	75.0%
Front End Interventions	279	166	56.9%
Reconnecting Families	232	172	35.7%
Trauma and Therapeutic Services	350	142	66.4%

Note. Due to a database error, the percentage of families needing parent mentoring services was not available.

There were significant differences in perception of service availability between staff in DR and non-DR districts.[18] Staff in non-DR districts identified navigators, parent mentoring, front end services, and reconnecting families services as needed but unavailable more frequently than staff in DR districts. There were also significant differences in perception of service availability between staff in urban and rural counties. Staff in rural counties identified parenting classes, parent mentoring, relief nursery, housing, front end services, and reconnecting families services as needed but unavailable more frequently than staff in urban counties.

4.10 Service Coordination

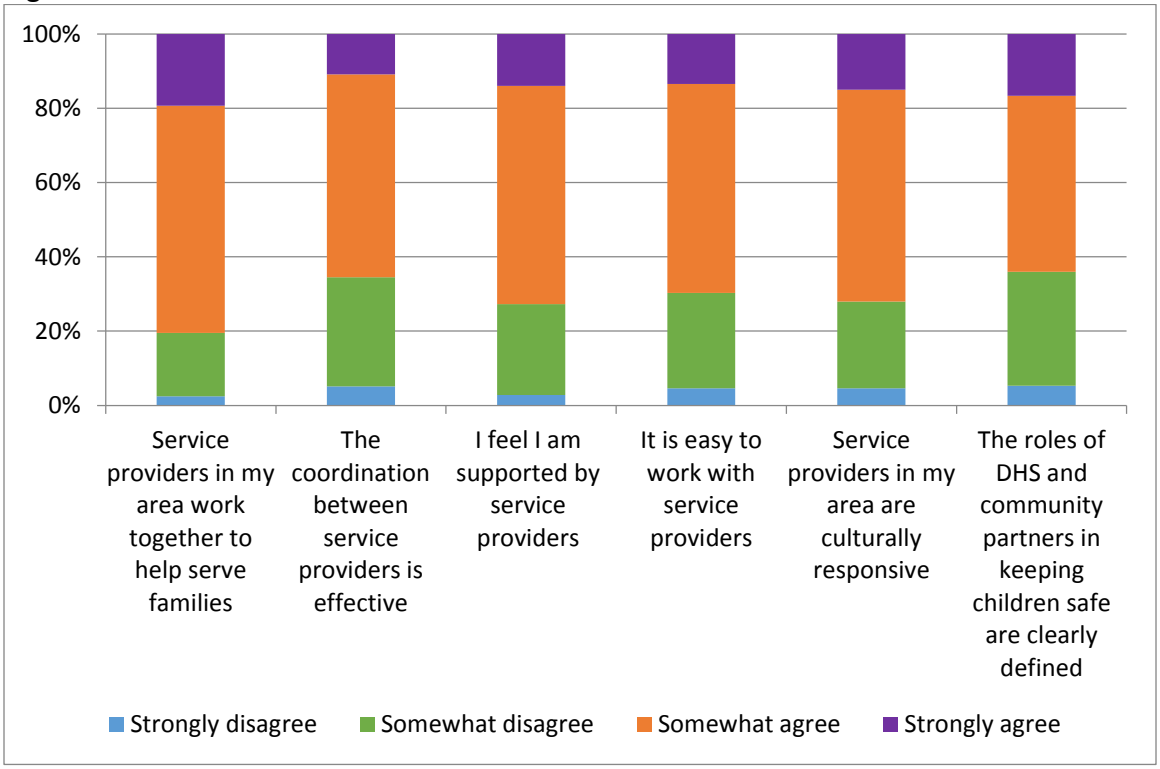
Participants were asked to respond to several items related to working with service providers; this measure of service provider coordination could range from 1-4 with higher scores indicating greater coordination. The statewide average score was 2.82. There were no significant differences between staff in DR districts (M = 2.88, SD = .59) and staff in non-DR districts (M = 2.77, SD = .59), nor between staff in urban (M = 2.83, SD = .57) and rural counties (M = 2.82, SD = .66). There were significant differences between roles, however. Screeners reported significantly lower perceptions of service provider coordination than program managers.

Figure 14 shows staff responses to each of the individual items related to service coordination. Over 80% of staff agreed that service providers work together to help serve families and about 73% felt supported by service providers in their area. Almost three-quarters of the staff (72.0%) felt that culturally responsive service providers were available in their area. There were

[18] A small number of staff identified the same service as both available and unavailable. These responses were excluded.

no differences in the availability of culturally sensitive services between DR and non-DR districts or between urban and rural districts. Another item of interest asked about the clarity of roles for DHS and community partners in keeping children safe; 62% of staff agreed that agency roles were clearly defined. There were no differences between DR and non-DR districts or urban and rural districts on this item.

Figure 14. Coordination with Service Providers



Staff were also asked how much coordination existed between DHS and several community partners. If coordination was marked as "some" or less, staff were asked about the barriers to coordination (see Table 21). The most frequently cited barrier to coordination was lack of communication between DHS and the community partner. For example, 70.2% of participants who rated coordination with schools at "some" or "less" indicated lack of communication was a barrier to coordination with DHS. No other barrier showed a consistent pattern. Privacy was only a major concern when working with healthcare providers (49.4%), and no community partner was flagged as uncooperative by more than 35% of participants.

Table 21. Coordination with Community Partners and Barriers to Coordination

Community Partner	Coordination Rating		Privacy		Lack of Communication		Not Enough Time		Uncooperative	
	Mean	SD	N	%	N	%	N	%	N	%
Schools	3.39	1.02	64	25.1	179	70.2	107	42.0	87	34.1
Courts	3.95	.93	10	7.4	54	39.7	41	30.1	43	31.6
Law Enforcement	3.89	.92	8	5.8	67	48.2	70	50.4	31	22.3
Utility Companies	2.07	1.00	110	26.0	190	44.9	76	18.0	54	12.8
Property Management Companies	2.21	1.02	117	28.5	195	47.4	71	17.3	101	24.6
Healthcare Providers	3.27	1.02	133	49.4	124	46.1	78	29.0	52	19.3
City or County Agencies	3.21	1.03	54	19.8	139	50.9	94	34.4	37	13.6
State Agencies	3.31	.97	43	16.6	135	52.1	93	35.9	27	10.4

Chapter 5: DR Fidelity Assessment

5.1 Measures of DR Fidelity

In any program evaluation, it is critical to assess whether the intervention was implemented with fidelity, that is, as originally designed or intended. Core components of the Oregon Differential Response model include:

- Screening and track assignment/re-assignment
- Scheduled initial appointments with family and support persons (AR only)
- Timely initial contact with families
- Safety assessment using the Oregon Safety Model
- Identification of family needs and strengths using the FSNA
- Targeted and culturally appropriate services to address identified needs

These components of the Oregon DR model were measured using data from OR-Kids and the parent surveys.

5.2 CPS Reports Assigned to Assessment

When a report is received by a screener, it can either be assigned for an assessment or closed at screening. The percentage of CPS reports assigned for an assessment in each of the four districts that implemented DR prior to September 2015 is shown in Table 22. Statewide percentages are shown for comparison. Statewide, there has been a slight increase in the percentage of CPS reports assigned to assessments in more recent years – from 44% in 2014 to 48% in 2016. Similar increases in the percentage of reports assigned to assessments are seen in D11, D4, and D16, but not D5.

Table 22. Percentage of CPS reports assigned to assessment (2011-2016)

	D5		D11		D4		D16		Statewide	
	# reports	% assigned	# reports	% assigned	# reports	% assigned	# reports	% assigned	# reports	% assigned
2011	5,416	51%	2,251	48%	4,787	41%	5,371	44%	71,358	43%
2012	4,637	61%	1,855	50%	4,808	36%	5,278	38%	67,470	43%
2013	3,922	56%	2,047	47%	4,475	40%	5,098	37%	64,544	42%
2014[a]	4,679	56%	2,305	47%	4,621	42%	4,835	35%	69,185	44%
2015[b]	5,861	55%	2,089	60%	4,496	51%	5,360	40%	70,818	47%
2016	5,217	54%	1,712	63%	4,209	54%	4,591	48%	59,941	48%

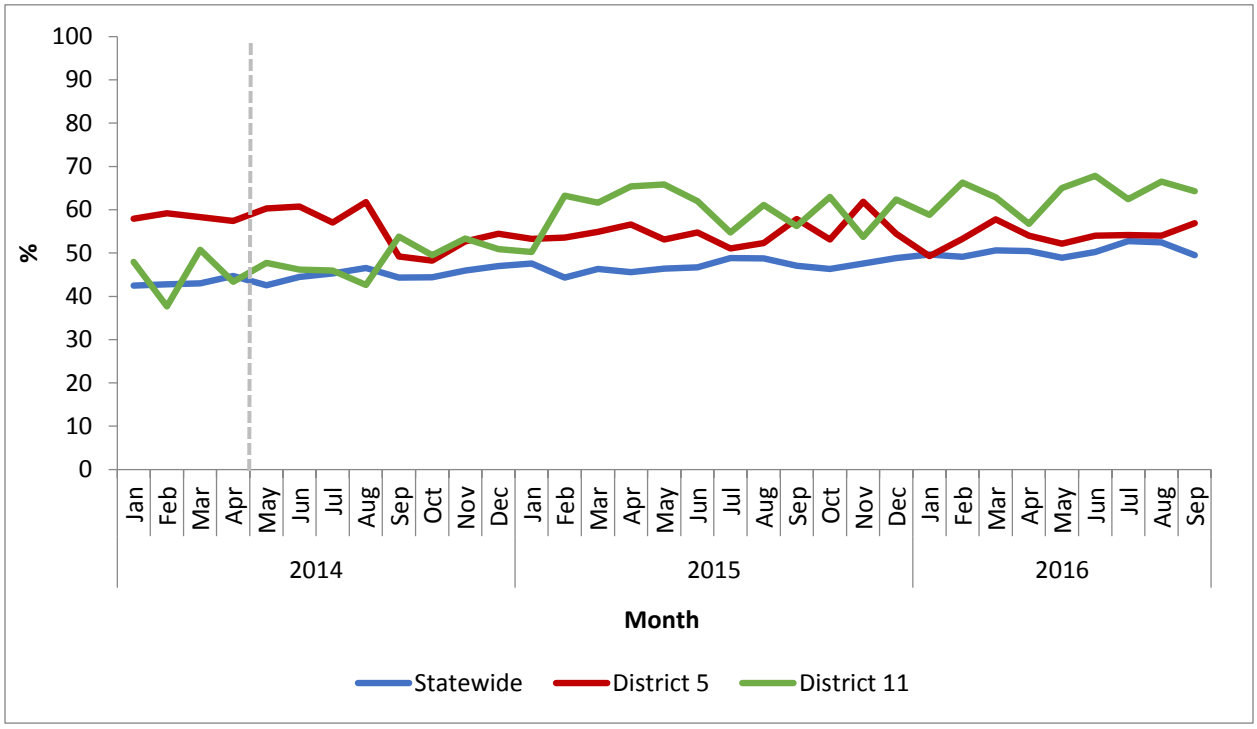
[a] D5 and D11 implemented DR in May 2014

[b] D4 and D16 implemented DR in April 2015

[c] Data extracted October 5, 2016.

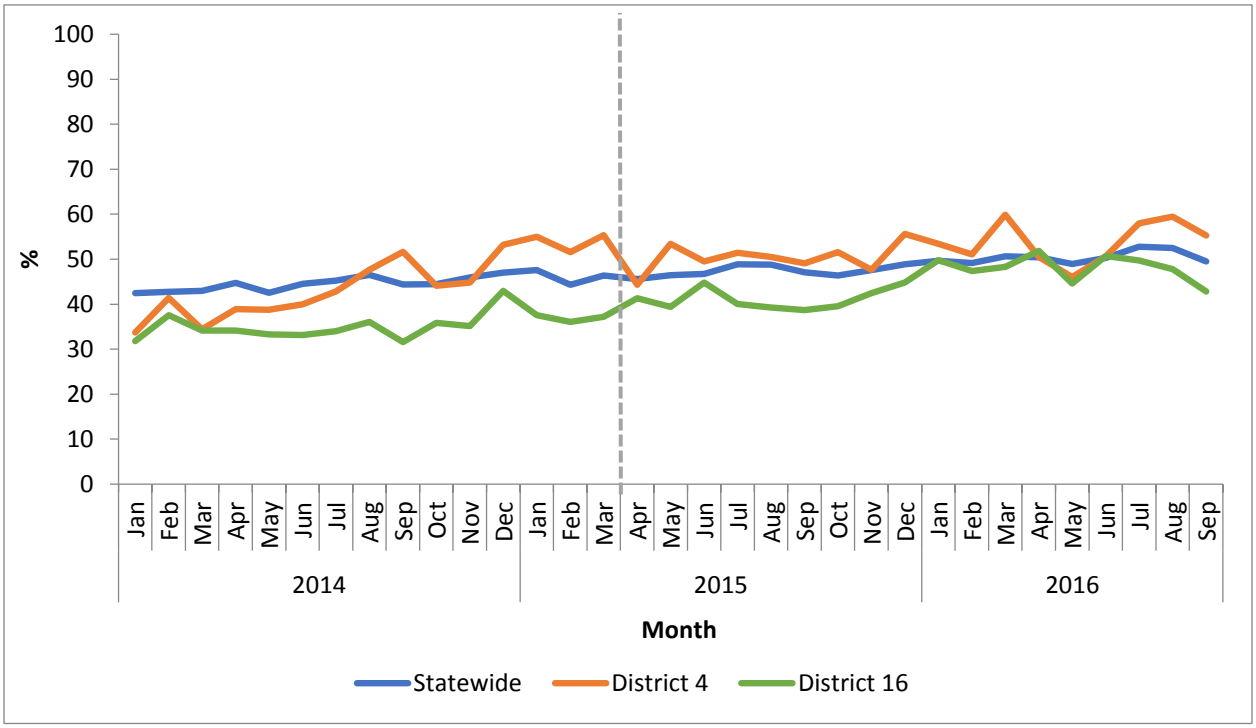
The percentage of reports assigned to assessment during the months before and after DR implementation was examined to determine whether changes occurred following the DR implementation date. The results for D5 and D11, which implemented in May 2014, are presented in Figure 15 and compared to the percentage of reports assigned to assessment statewide. The percentage of assigned reports in D5 was much higher than the statewide percentage prior to DR implementation in May 2014 and for several months following implementation. Around September 2014, the percentage declined to a level closer to the statewide rate. Conversely, the percentage of reports assigned to assessment in D11 has increased since DR implementation. At the district level, percentages show a great deal of month to month variation.

Figure 15. Percentage of Reports Assigned to Assessment in D5, D11, and Statewide



The percentage of reports assigned to assessments before and after DR implementation in D4 and D16, which occurred in April 2015, is shown in Figure 16. Although the percentages of reports assigned to assessment have increased over time in both D4 and D16, the increases are gradual and it is unclear whether they are related to the implementation of DR.

Figure 16. Percentage of Reports Assigned to Assessment in D4, D16, and Statewide



5.3 Track Assignment and Reassignment

The percentage of reports initially assigned to AR and TR over time in each of the 4 districts is shown in Table 23. In D5, the percentage of reports initially assigned to AR has decreased over time, from 60% to 2014 to 48% in 2016. The percentage has also decreased in D11, from 52% in 2014 to 47% in 2016 and in D16, from 54% in 2015 to 51% in 2016. Screeners in D4 have increased the percentage of reports initially assigned to AR from 45% in 2015 to 51% in 2016.

Table 23. Percentage of Assessments Initially Assigned to AR and TR

	D5		D11		D4		D16	
	AR	TR	AR	TR	AR	TR	AR	TR
2014[a]	60%	40%	52%	48%	-	-	-	-
2015[b]	52%	48%	46%	54%	45%	55%	54%	46%
2016[c]	48%	52%	47%	53%	51%	49%	51%	49%

[a] Includes assessments from May 1, 2014 to December 31, 2014.
[b] D5 and D11 include assessments from January 1, 2015 to December 31, 2015. D4 and D16 include assessments from April 1, 2015 to December 31, 2015.
[c] Includes assessments from January 1, 2016 to September 30, 2016.
[d] Data extracted October 5, 2016.

The conditions and procedures for changing an AR assessment to a TR assessment are defined in Oregon DHS Differential Response Procedure Manual. The procedure manual states that "if during the initial contact or in the course of gathering information throughout the CPS assessment, the worker obtains information that meets the Traditional Response Assessment criteria, a change in the type of CPS assessment is required." [19] Additionally, if an AR assessment becomes court-involved or the child is unsafe at the conclusion of the CPS assessment and an ongoing safety plan will be established and the case will be opened for services, a track change to TR is required.

Table 24 shows the percentage of reports initially assigned to AR that were changed to TR between the initial report date and assessment close date. In both D5 and D11, the percentage of AR assessments that switch to TR has decreased between 2014 and 2016, from 19% to 15% in D5 and from 22% to 13% in D11. The percentages of AR assessments that switched to TR were lower in the second cohort of districts to implement DR (Districts 4 and 16) and have remained approximately the same over time (10-11%).

Table 24. Percentage of AR Assessments that Change Tracks from AR to TR

	D5	D11	D4	D16
2014[a]	19%	22%	-	-
2015[b]	19%	16%	12%	11%
2016[c]	15%	13%	11%	10%

[a] Includes assessments from May 1, 2014 to December 31, 2014.
[b] D5 and D11 include assessments from January 1, 2015 to December 31, 2015. D4 and D16 include assessments from April 1, 2015 to December 31, 2015.
[c] Includes assessments from January 1, 2016 to September 30, 2016.
[d] Data extracted October 5, 2016.

5.4 Initial Contact with Families

In addition to assigning an assessment to AR or TR, screeners also assign a response time to each assessment.[20] Response time is an important element of Oregon CPS assessment to ensure child safety in a prompt manner. According to the Oregon DHS Differential Response Procedure Manual,[21] every CPS assessment is assigned one of two possible response timelines at screening: within 24 hours and within 5 calendar days. The timeline refers to "the amount of time between when the report is received at screening and when the CPS worker is required to make an initial contact."

[19] Oregon Department of Human Services. (May, 2014). *DHS Differential Response Procedure Manual. Chapter 2: Assessment-section 10 change from alternative response assessment to traditional response assessment*. Salem: Oregon Department of Human Services.
[20] Response time assignment also occurs in non-DR districts.
[21] Oregon Department of Human Services. (December, 2014.). *DHS Differential Response Procedure Manual. Chapter 2: Assessment-section 3 CPS Assessment response timelines.* Salem: Oregon Department of Human Services.

The primary response time for AR assessments is 5 days; a 24-hour response is only required when there is an indication that a child may be in danger right now, or a child has a current injury as a result of the alleged abuse or neglect. Conversely, a 24-hour response time applies to TR assessments unless "a screener can clearly document how the information indicates child safety will not be compromised"[22] to allow a 5-day response time.[23]

Analysis of administrative data indicates that most AR assessments are assigned a 5-day response time, although the percentage of assessments assigned to this response timeline varied significantly across districts (Table 25). The percentage of AR assessments assigned a 5-day response time has increased in D11 (from 76% in 2014 to 88% in 2016), D4 (from 62% in 2015 to 68% in 2016), and D16 (from 77% in 2015 to 84% in 2016).

Table 25. Response Times Assigned to AR Assessments

	D5		D11		D4		D16	
	24 hours	5 days	24 hours	5 days	24 hours	5 days	24 hours	5 days
2014[a]	29%	71%	24%	76%	-	-	-	-
2015[b]	34%	66%	14%	86%	38%	62%	23%	77%
2016[c]	31%	69%	12%	88%	32%	68%	16%	84%

[a] Includes assessments from May 1, 2014 to December 31, 2014.
[b] D5 and D11 include assessments from January 1, 2015 to December 31, 2015. D4 and D16 include assessments from April 1, 2015 to December 31, 2015.
[c] Includes assessments from January 1, 2016 to September 30, 2016.
[d] Data extracted October 5, 2016.

Most TR assessments are assigned a 24-hour response time (Table 26). The percentages of TR assessments assigned a 24-hour response time have remained fairly stable within district, with the exception of D5, where the percentage has increased from 83% in 2014 to 91% in 2016.

[22] Oregon Department of Human Services. (December, 2014.). *DHS Differential Response Procedure Manual. Chapter 2: Assessment-section 3 CPS Assessment response timelines.* Salem: Oregon Department of Human Services.
[23] Regarding the procedure of CPS assessment response time in non-DR districts, see Oregon Department of Human Services. (May, 2014.). *DHS Child welfare Procedure Manual. Chapter 2: Assessment-section 2 CPS Assessment response timelines.* Salem: Oregon Department of Human Services.

Table 26. Response Times Assigned to TR Assessments

	D5		D11		D4		D16	
	24 hours	5 days	24 hours	5 days	24 hours	5 days	24 hours	5 days
2014[a]	83%	17%	93%	7%	-	-	-	-
2015[b]	90%	10%	91%	9%	80%	20%	85%	15%
2016[c]	91%	9%	90%	10%	84%	16%	85%	15%

[a] Includes assessments from May 1, 2014 to December 31, 2014.
[b] D5 and D11 include assessments from January 1, 2015 to December 31, 2015. D4 and D16 include assessments from April 1, 2015 to December 31, 2015.
[c] Includes assessments from January 1, 2016 to September 30, 2016.
[d] Data extracted October 5, 2016.

Compliance with the assigned response time was measured by calculating the percentage of assessments that had an initial contact within the assigned response time. For comparison, statewide compliance for assessments assigned a 24-hour response time ranged between 68% in 2014 and 71% in 2015.[24] The previous interim evaluation report found very low rates of compliance (20%) among assessments assigned a 5-day response time. Compliance with the 5-day response time has improved significantly since then; 68% of assessments had an initial contact within 5 days in 2016 (see Table 27).

When compliance rates were examined in the districts that implemented DR, the results revealed that rates vary considerably across districts, but were now similar for assessments assigned a 24-hour and 5-day response time (see Table 27). Among AR assessments that were assigned a 24-hour response time in 2016, the percentage that received an initial contact within the timeline ranged from a low of 67% in D4 to a high of 78% in D16. Compliance among AR assessments assigned a 5-day response time in 2016 ranged from 60% in D4 to 79% in D5.

A similar analysis of initial response time compliance among TR assessments is also shown in Table 27. Of the TR assessments that were assigned a 24-hour response time in 2016, the percentage that received an initial visit within 24 hours ranged from 66% (D4) to 83% (D11). Unlike the previously reported results, compliance rates were similar for TR assessments assigned to a 24-hour and 5-day response time.

A comparison of compliance rates between DR districts and the state as a whole suggests that the introduction of DR did not negatively impact response time compliance rates. For assessments assigned a 24-hour response time, compliance in DR districts was similar to that for the state, with the exception of D11, which has compliance rates much higher than the state. For assessments assigned a 5-day response time, compliance in DR districts was similar to or higher than that for the state as a whole.

[24] Statewide calculations include all districts, regardless of whether they have implemented DR or not.

Table 27. Compliance within Assigned Response Times

AR Assessments								
	Within 24 hours				Within 5 days			
	D5	D11	D4	D16	D5	D11	D4	D16
2014[a]	68%	70%	-	-	68%	83%	-	-
2015[b]	73%	84%	75%	72%	72%	89%	71%	76%
2016[c]	69%	69%	67%	78%	75%	79%	60%	74%
TR Assessments								
	Within 24 hours				Within 5 days			
	D5	D11	D4	D16	D5	D11	D4	D16
2014[a]	59%	84%	-	-	50%	78%	-	-
2015[b]	67%	91%	78%	76%	69%	87%	75%	74%
2016[c]	70%	83%	66%	71%	72%	90%	62%	72%
Statewide Assessments								
	Within 24 hours				Within 5 days			
2014[a]	68%				64%			
2015[b]	71%				69%			
2016[c]	70%				68%			

[a] Includes assessments from May 1, 2014 to December 31, 2014.
[b] D5 and D11 include assessments from January 1, 2015 to December 31, 2015. D4 and D16 include assessments from April 1, 2015 to December 31, 2015.
[c] Includes assessments from January 1, 2016 to September 30, 2016.
[d] Data extracted October 5, 2016.

5.5 Safety Assessment

After the necessary information is gathered for the CPS assessment, the CPS worker must determine if the child is safe or unsafe at the conclusion of the assessment. If one or more impending danger threats are present, including previously identified impending danger safety threats that have not been eliminated, the CPS worker must conclude the child is unsafe. If the child is determined to be unsafe, the CPS worker must develop an ongoing safety plan, complete the CPS assessment, and open a child welfare case. If there are no present danger or impending danger safety threats and any previously identified safety threats have been eliminated, the CPS worker must conclude that the child is safe.[25] Table 28 and Figure 17 show

[25] Oregon Department of Human Services. (December, 2014.). *DHS Differential Response Procedure Manual. Chapter 2, Section 13.* Salem: Oregon Department of Human Services.

the percentages of AR and TR assessments that were determined to be safe and unsafe in the 4 DR districts, with statewide percentages shown for comparison.

Although there is some variation between districts, the majority of AR assessments closed in 2016 were determined to be safe: 95% in D11 and D4, 94% in D16, and 89% in D5. The percentages of TR assessments determined to be safe at the conclusion of the assessment were slightly smaller during the same time period: 86% in D5 and D11 and 92% in D4 and D16.

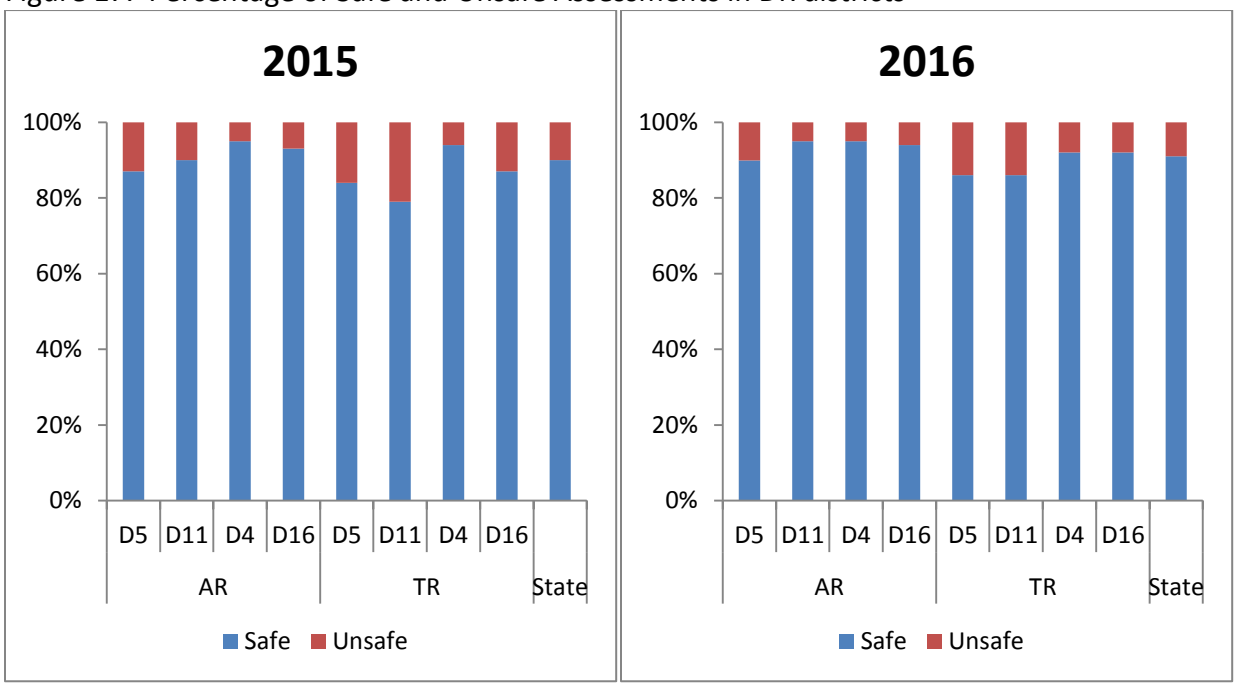
Table 28. Percentages of Safe and Unsafe Assessments in DR Districts

AR Assessments								
	Safe				**Unsafe**			
	D5	D11	D4	D16	D5	D11	D4	D16
2014[a]	86%	90%	-	-	14%	10%	-	-
2015[b]	87%	90%	95%	93%	13%	10%	5%	7%
2016[c]	89%	95%	95%	94%	11%	5%	5%	6%
TR Assessments								
	Safe				**Unsafe**			
	D5	D11	D4	D16	D5	D11	D4	D16
2014[a]	83%	74%	-	-	17%	26%	-	-
2015[b]	84%	79%	94%	87%	16%	21%	6%	13%
2016[c]	86%	86%	92%	92%	14%	14%	8%	8%
Statewide Assessments								
	Safe				**Unsafe**			
2014[a]	90%				10%			
2015[b]	90%				10%			
2016[c]	91%				9%			

[a] Includes assessments from May 1, 2014 to December 31, 2014.
[b] D5 and D11 include assessments from January 1, 2015 to December 31, 2015. D4 and D16 include assessments from April 1, 2015 to December 31, 2015.
[c] Includes assessments from January 1, 2016 to September 30, 2016.
[d] Data extracted October 5, 2016.

http://www.dhs.state.or.us/caf/safety_model/differential_response_pm/assessment/ch2-assessment-section13-dr.pdf

Figure 17. Percentage of Safe and Unsafe Assessments in DR districts



5.6 Moderate to High Needs Determination

If the CPS worker determines that a child is safe at the conclusion of the CPS assessment, he or she must then determine if the family has moderate to high needs. If the family does not have moderate to high needs, then the CPS assessment is closed. In districts that have implemented DR, families with moderate to high needs are offered the option of having a family strengths and needs assessment (FSNA) completed by a provider. If the family declines the offer of an FSNA, the CPS worker may offer them referrals to non-contracted community services as available before closing the CPS assessment. If the family accepts the offer of an FSNA, the CPS worker must refer them to a provider, meet with the family and provider after the FSNA is completed, discuss contracted and non-contracted community service referral options, and identify their preference for services. If they do not accept services, the CPS assessment is then closed. If they accept services, the CPS worker refers the family to relevant contracted and non-contracted community services.[26]

Although an indicator was added to OR-Kids in September 2015 to identify which families have moderate to high needs, these data were not reliably available in OR-Kids at the time this report was written, so we therefore cannot present the percentage of safe families with

[26] Oregon Department of Human Services. (December, 2014.). *DHS Differential Response Procedure Manual. Chapter 2, Section 13.* Salem: Oregon Department of Human Services. http://www.dhs.state.or.us/caf/safety_model/differential_response_pm/assessment/ch2-assessment-section13-dr.pdf

moderate to high needs. In addition, lack of available data prevents us from examining the percentage of families with moderate to high needs that are offered and accept the FSNA.

5.7 Service Provision

In order to calculate the percentage of families who were offered services, the number of safe families with moderate to high needs should be used as the denominator. Since this number was not available, Table 29 shows the percentage of safe families who were offered services, which includes families with and without moderate to high needs. In 2016, the percentage of AR families who were offered services ranged from 9% in D4 to 20% in D11 and the percentage of TR families who were offered services ranged from 7% in D4 to 18% in D11. In general, the percentage of TR families who were offered services was lower than the corresponding percentage of AR assessments in each district.

Table 29. Percentage of Families With Safe Children Who Were Offered Services

	AR				TR			
	D5	D11	D4	D16	D5	D11	D4	D16
2014[a]	14%	21%	-	-	7%	13%	-	-
2015[b]	17%	18%	14%	9%	12%	11%	10%	6%
2016[c]	17%	20%	9%	12%	13%	18%	7%	9%

[a] Includes assessments from May 1, 2014 to December 31, 2014.
[b] D5 and D11 include assessments from January 1, 2015 to December 31, 2015. D4 and D16 include assessments from April 1, 2015 to December 31, 2015.
[c] Includes assessments from January 1, 2016 to September 30, 2016.
[d] Data extracted October 5, 2016.

Families in both the AR and TR tracks choose to accept or decline the offered services. Administrative data were analyzed to determine the number and percentage of families who accepted services. When the percentage of families that accept services out of those who were offered services is examined, the percentage ranges from 37%-54% for AR families in 2016 (Table 30) and 33%-63% for TR families in 2016 (Table 31). When the percentage of families that accept services is examined as a portion of all CPS assessments, however, it is clear that a relatively small percentage of families are receiving services following a CPS assessment, ranging from 3% to 10% depending on district.

Table 30. AR Families Who Accepted Services

Year	District	# Families With Safe Children	# Families Offered Services	# Families Accepted Services	% accepting services of those offered[e]	% accepting services of all families with safe children[f]
2014[a]	D5	757	109	60	55%	8%
	D11	251	52	22	42%	9%
2015[b]	D5	1,293	215	100	47%	8%
	D11	440	77	42	55%	10%
	D4	612	88	37	42%	6%
	D16	849	80	32	40%	4%
2016[c]	D5	836	139	75	54%	9%
	D11	345	68	28	41%	8%
	D4	700	60	22	37%	3%
	D16	945	117	49	42%	5%

[a] Includes assessments from May 1, 2014 to December 31, 2014.
[b] D5 and D11 include assessments from January 1, 2015 to December 31, 2015. D4 and D16 include assessments from April 1, 2015 to December 31, 2015.
[c] Includes assessments from January 1, 2016 to September 30, 2016.
[d] Data extracted October 5, 2016.
[e] % of accepting services of those offered = (#Families Accepted Services/# Families Offered Services)
[f] % accepting services of all safe families = (# Families Accepted Services/# Families With Safe Children)

Table 31. TR Families Who Accepted Services

Year	District	# Families With Safe Children	# Families Offered Services	# Families Accepted Services	% accepting services of those offered[e]	% accepting services of all families with safe children[f]
2014[a]	D5	482	32	22	69%	5%
	D11	191	24	14	58%	7%
2015[b]	D5	1,153	139	68	49%	6%
	D11	456	48	20	42%	4%
	D4	727	75	30	40%	4%
	D16	691	44	24	55%	3%
2016[c]	D5	796	103	65	63%	8%
	D11	353	65	31	48%	9%
	D4	635	45	20	44%	3%
	D16	853	73	24	33%	3%

[a] Includes assessments from May 1, 2014 to December 31, 2014.
[b] D5 and D11 include assessments from January 1, 2015 to December 31, 2015. D4 and D16 include assessments from April 1, 2015 to December 31, 2015.
[c] Includes assessments from January 1, 2016 to September 30, 2016.
[d] Data extracted October 5, 2016.
[e] % of accepting services of those offered = (#Families Accepted Services/# Families Offered Services)
[f] % accepting services of all safe families = (# Families Accepted Services/# Families With Safe Children)

In DR districts, if a family accepts services, these services can be paid for by DHS through contracts with local service providers in what are called "Admin-Only" cases. Alternatively, the CPS worker can refer families to local non-contracted service providers but not open an Admin-Only case. Table 32 shows the number of families that received services following a CPS assessment and whether or not the services were paid for by DHS in an Admin-Only case.

Table 32. Number and Percentage of Admin-Only Cases

Year	District	AR			TR		
		# Families Who Accepted Services	# Admin-Only Cases		# Families Who Accepted Services	# Admin-Only Cases	
			N	%		N	%
2014[a]	D5	60	23	38%	22	13	59%
	D11	22	2	9%	14	3	21%
2015[b]	D5	100	35	35%	66	11	17%
	D11	42	6	14%	20	3	15%
	D4	37	9	24%	30	9	30%
	D16	32	14	44%	24	10	42%
2016[c]	D5	75	27	36%	64	18	28%
	D11	28	1	4%	31	1	3%
	D4	22	6	27%	20	1	5%
	D16	49	19	39%	24	7	29%

[a] Includes assessments from May 1, 2014 to December 31, 2014.
[b] D5 and D11 include assessments from January 1, 2015 to December 31, 2015. D4 and D16 include assessments from April 1, 2015 to December 31, 2015.
[c] Includes assessments from January 1, 2016 to September 30, 2016.
[d] Data extracted October 5, 2016.

5.8 Length of CPS Assessments and Admin-Only Cases

In districts that have implemented DR, the CPS worker must complete the CPS assessment, including OR-Kids input and electronic transmission, for review within 45 days of the day the information alleging child abuse or neglect is received by the screener. The CPS supervisor may approve a one-time extension of an additional 15 days.[27] The average length of CPS assessments assigned to AR and TR in 2014 and 2015 was calculated and is reported in Table 33. The length of an average CPS assessment varied considerably between districts, and in

[27] Oregon Department of Human Services. (December, 2014.). *DHS Differential Response Procedure Manual. Chapter 21: CPS Assessment Documentation.* Salem: Oregon Department of Human Services. http://www.dhs.state.or.us/caf/safety_model/differential_response_pm/assessment/ch2-assessment-section21-dr.pdf

some districts, between AR and TR assessments. Assessments took the most time in D5: the average AR assessment took 164 days and TR assessment took 150 days. In each of the 4 districts, the average length of time to complete an assessment was well above the maximum length of time defined in the DR procedure manual.

Table 33. Average Length of CPS Assessments (days)

	D5				D11				D4				D16			
	AR		TR		AR		TR		AR		TR		AR		TR	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
2014[a]	107	92	135	119	134	69	112	75	-	-	-	-	-	-	-	-
2015[b]	164	108	150	63	113	63	110	63	150	95	148	90	120	51	116	50

[a] Includes assessments from May 1, 2014 to December 31, 2014.
[b] D5 and D11 include assessments from January 1, 2015 to December 31, 2015. D4 and D16 include assessments from April 1, 2015 to December 31, 2015.
[c] Data extracted October 5, 2016.

For those families with Admin-Only cases that were opened prior to September 30, 2016, the length of the service case (in days) was calculated (Table 34). For cases closed prior to September 30, 2016, the case length was measured as the number of days between the Admin-Only case open date and case close date. If the case was still open on September 30, 2016, that date was used as the case close date. Because the number of Admin-Only cases in each district was small, the variability in the average length of the cases was high.

Table 34. Length of Admin-Only Cases (in days)

		AR			TR		
Year	**District**	# Families with Admin-Only Services	Mean # Days	SD	# Families with Admin-Only Services	Mean	SD
2014[a]	D5	23	101	67	13	98	66
	D11	2	378	264	3	483	285
2015[b]	D5	35	87	59	11	54	48
	D11	6	212	179	3	194	77
	D4	9	82	59	9	105	46
	D16	14	44	40	10	58	34
2016[c]	D5	27	41	35	18	50	32
	D11	1	204	-	1	90	-
	D4	6	40	24	1	21	-
	D16	19	50	33	7	60	35

[a] Includes assessments from May 1, 2014 to December 31, 2014.
[b] D4 and D16 include assessments from April 1, 2015 to December 31, 2015.
[c] Includes assessments from January 1, 2016 to September 30, 2016.
[d] Data extracted October 5, 2016.

Chapter 6: Outcomes

According to the Oregon DR logic model, implementing DR with fidelity will result in several short-term, intermediate, and long-term outcomes for children, families, and communities. Within the short term, parents will feel fewer negative emotional responses and more positive emotional responses following the initial contact with the CPS caseworker, will feel respected and valued during the CPS assessment, and will be engaged in the planning and decision-making process. In addition, as a result of the assessment and services, formal and informal supports will be increased and family functioning will improve. These short-term changes will lead to intermediate changes: fewer families will be re-reported to DHS and fewer children will be removed from their homes and placed into foster care. The implementation of DR will also lead to distal outcomes, including a stronger relationship between child welfare and community partners, reduced disproportionate representation of children of color in foster care, and decreased time to permanency for children taken into substitute care.[28]

6.1 Short-term Outcomes

The Post-Assessment Questionnaire (PAQ) was used to gather information from parents about their short-term outcomes including:

- positive and negative emotional responses following the initial visit from the CPS caseworker;
- perceptions of their caseworker's use of family-centered and culturally-responsive practice;
- engagement in the assessment and decision-making process;
- social support;
- trauma symptoms; and
- economic resources.

Although we opted to include the results obtained from the PAQ in the report, very low response rates for the survey (1.6% in the DR districts and 2.3% in the non-DR districts) suggest that the results should be interpreted with some degree of caution.

6.1.1 Emotional responses after initial visit

To measure the positive and negative emotional reactions to the initial visit, parents were asked "how did you feel after the first time the caseworker came to your house" and provided with a list of 6 positive (relieved, hopeful, respected, comforted, optimistic, thankful) and 6 negative (angry, afraid, worried, confused, stressed, discouraged) emotional responses. Parents were instructed to check as many of the emotional responses as applied.

[28] Distal outcomes are not examined in this report.

Figure 18 displays the percentages of parents assigned to AR and their matched comparison families from non-DR districts who reported feeling each of the 6 positive and 6 negative emotional responses after the initial visit. Looking first at the positive emotional reactions, 36% of the parents who received AR felt relieved, 29% felt hopeful, 45% felt respected, 19% felt comforted, 36% felt optimistic, and 27% felt thankful. These percentages were not significantly different from those reported by parents in the AR-matched comparison group: relieved (37%), hopeful (30%), respected (45%), comforted (29%), optimistic (30%) and thankful (33%). There were no significant differences in the percentages of parents in the AR and AR-matched groups who reported each of the negative emotions: angry (15% versus 16%), afraid (20% versus 30%), worried (36% versus 46%), confused (30% versus 36%), stressed (36% versus 44%), and discouraged (10% versus 3%).

Figure 18. Parent Emotional Responses (AR versus AR-matched)

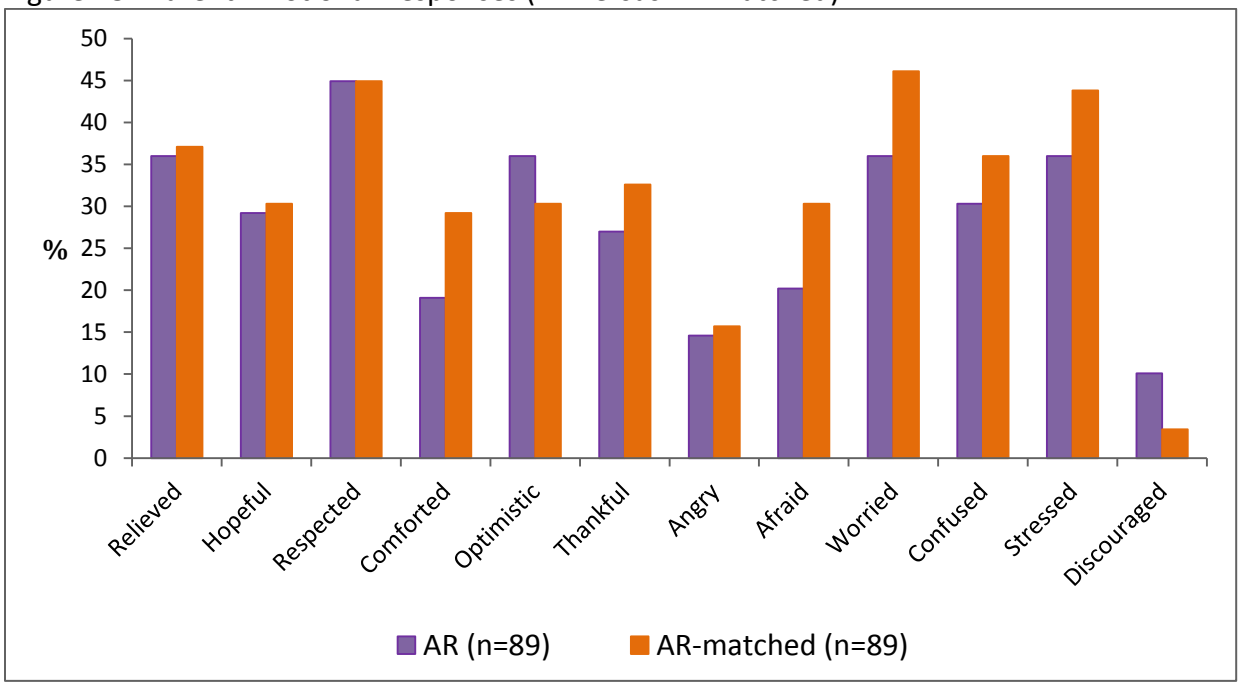
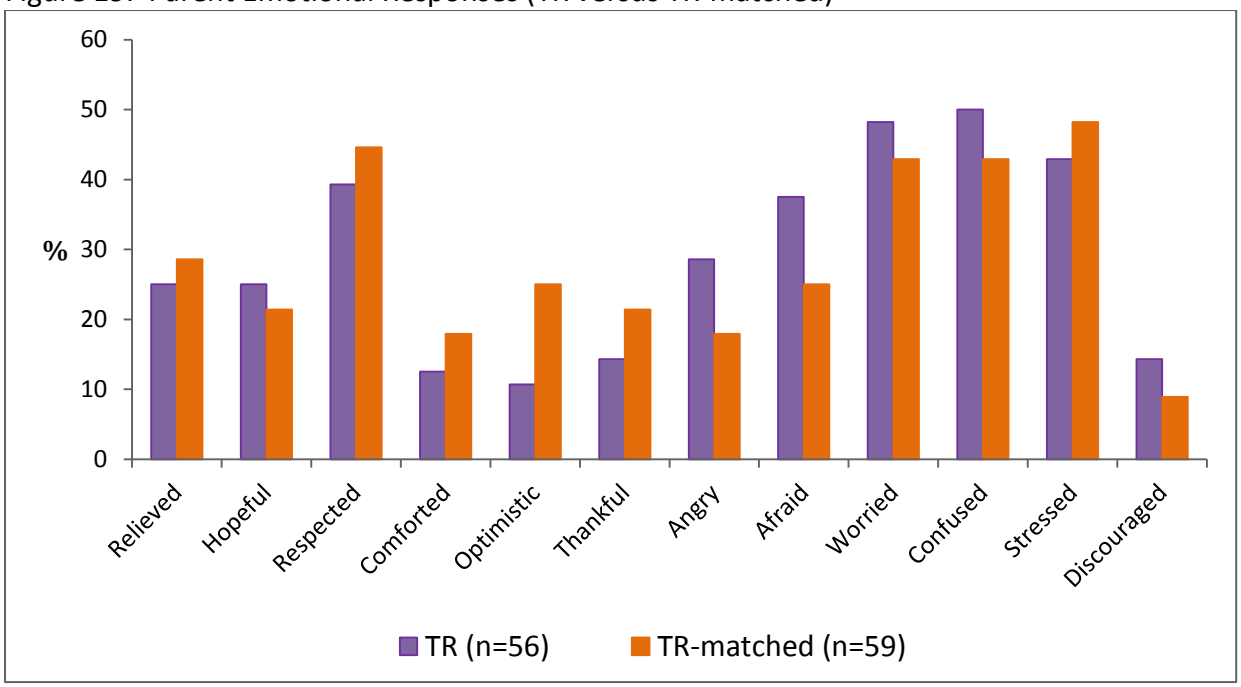


Figure 19 displays the corresponding data for the parents assigned to TR and their matched comparison families in non-DR districts. There were no significant differences between the TR parents and their matched comparisons in the percentages who reported each of the positive emotions: relieved (25% versus 29%), hopeful (25% versus 21%), respected (39% versus 45%), comforted (13% versus 18%), optimistic (11% versus 25%) and thankful (14% versus 21%). There were also no significant difference between these two group in the percentages who reported each of the negative emotions: angry (29% versus 18%), afraid (38% versus 25%), worried (48% versus 43%), confused (50% versus 43%), stressed (43% versus 49%), and discouraged (14% versus 9%).

Figure 19. Parent Emotional Responses (TR versus TR-matched)



6.1.2 Family-centered practices

Parents' perceptions of their caseworkers' use of family-centered practices were measured using the Consultation and Relational Empathy (CARE) measure, a 10-item measure originally developed to measure the relational empathy of medical staff toward patients.[29] Using a 5-point Likert scale that ranged from "poor" to "excellent," parents rated how good their caseworker was at:

- making them feel at ease
- letting them tell their side of the story
- really listening
- being interested in what they had to say
- fully understanding their worries
- showing care and compassion
- being positive
- explaining things clearly
- helping them take control
- making a plan of action with them

[29] Mercer, S.W., Maxwell, M., Heaney, D., & Watt, G.C.M. (2004). The Consultation and Relational Empathy (CARE) measure: Development and preliminary validation and reliability of an empathy-based consultation process measure. *Family Practice, 21,* 699-705.

The items were summed to form a total score, which could range from 10-50. The mean score for the AR group was 41.5 (sd=8.8) and that for the AR-matched group was 40.5 (sd=10.1), which was not a statistically significant difference. The average scores on the CARE measure for the TR and TR-matched groups were 36.9 (sd=11.9) and 38.7 (sd=10.1), which were not significantly different from each other.

Previous research with parents who have received child protective services reveals that a common complaint is not being able to contact their CPS worker. A question on the PAQ asked parents "how easy was it to contact your caseworker?" and the majority of parents in both the AR and AR-matched groups who completed a survey felt that it was very easy or somewhat easy to contact their worker (Figure 20). Corresponding percentages for TR and TR-matched groups are presented in Figure 21. There were no significant differences between either of the matched groups.

Figure 20. Ease of Contacting CPS Worker (AR versus AR-matched)

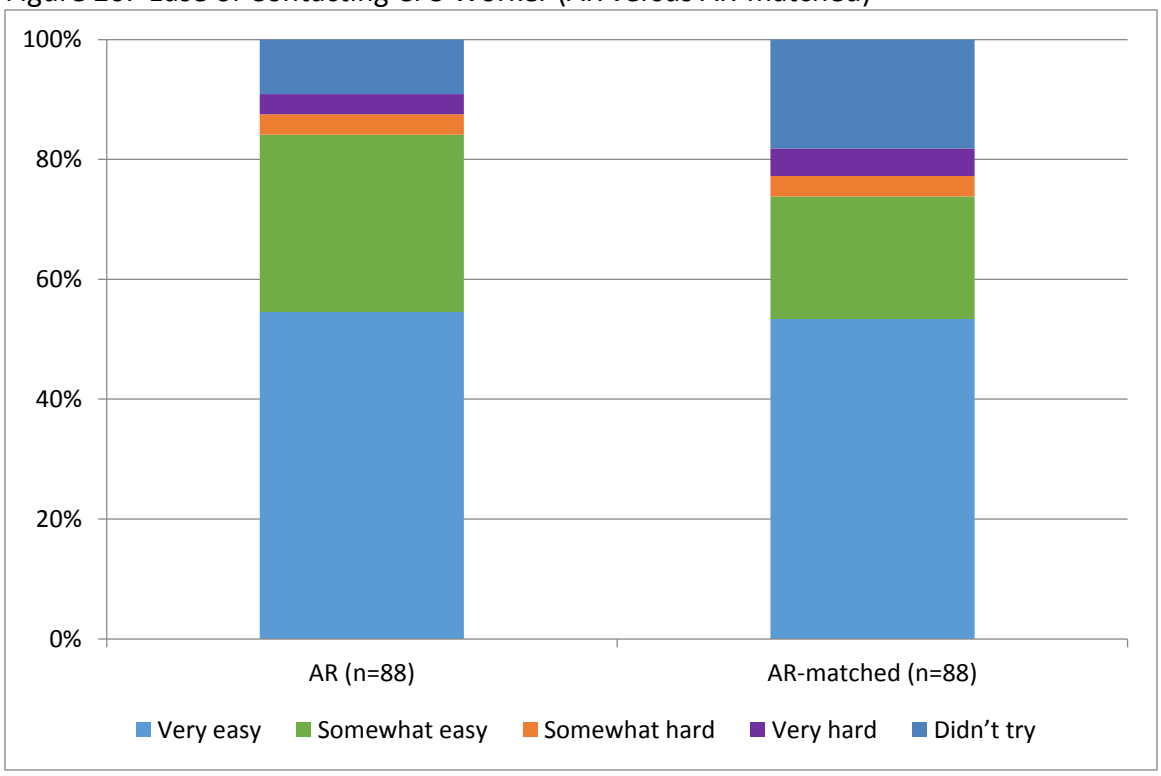
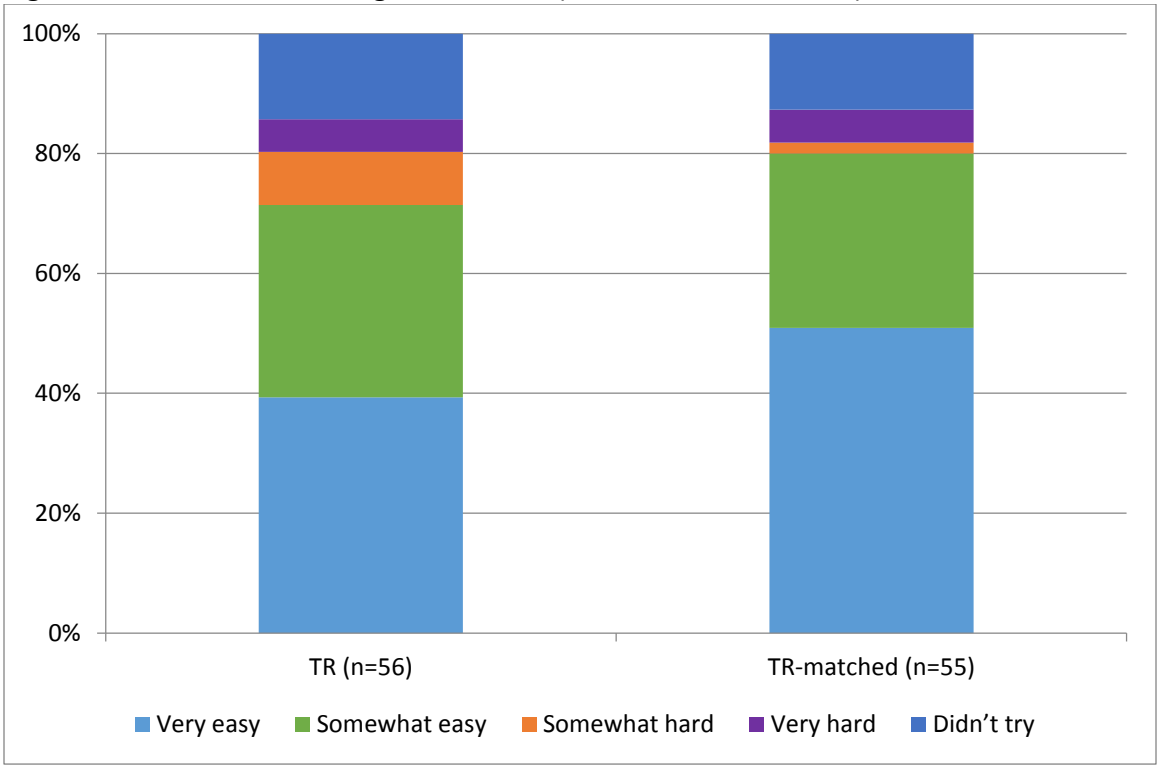


Figure 21. Ease of Contacting CPS Worker (TR versus TR-matched)



6.1.3 Culturally-responsive practices

Parents' perceptions of their caseworkers' use of culturally-responsive practice was measured with two items. Parents were asked if their caseworker was sensitive to their family's values and culture (yes/no) and if their caseworker communicated with them in their preferred language (yes/no). Figure 22 shows the percentages of AR and AR-matched parents[30] that answered "yes" to each question and Figure 23 shows the corresponding percentages for TR and TR-matched parents.[31] None of the differences between the groups were significant.

[30] 69% of the parents in the AR group who responded to the survey were White, 6% were Black, 6% were Native American, 9% were Hispanic/Latino, 2% had another racial background, and 21% were unknown. Parents could be categorized in more than one racial category, so the percentages do not add up to 100%

[31] 74% of the parents in the TR group who responded to the survey were White, 2% were Black, 7% were Native American, 9% were Hispanic/Latino, 5% had another racial background, and 20% were unknown. Parents could be categorized in more than one racial category, so the percentages do not add up to 100%

Figure 22. Caseworker Use of Culturally-Responsive Practice (AR versus AR-matched)

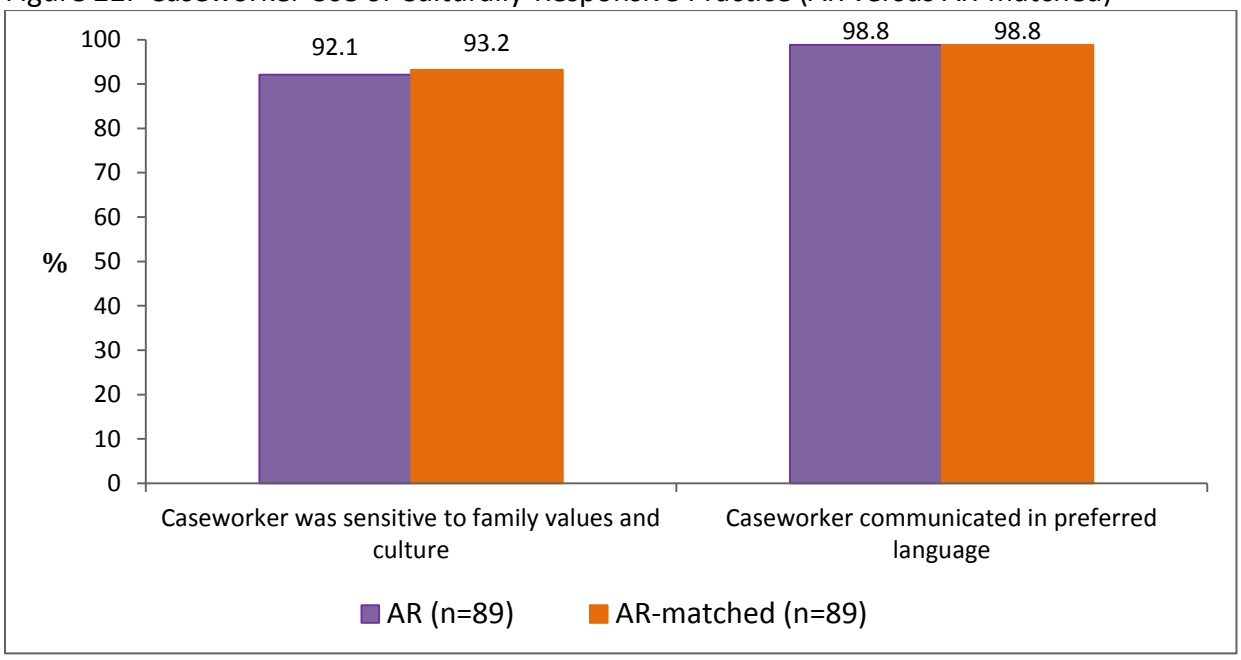
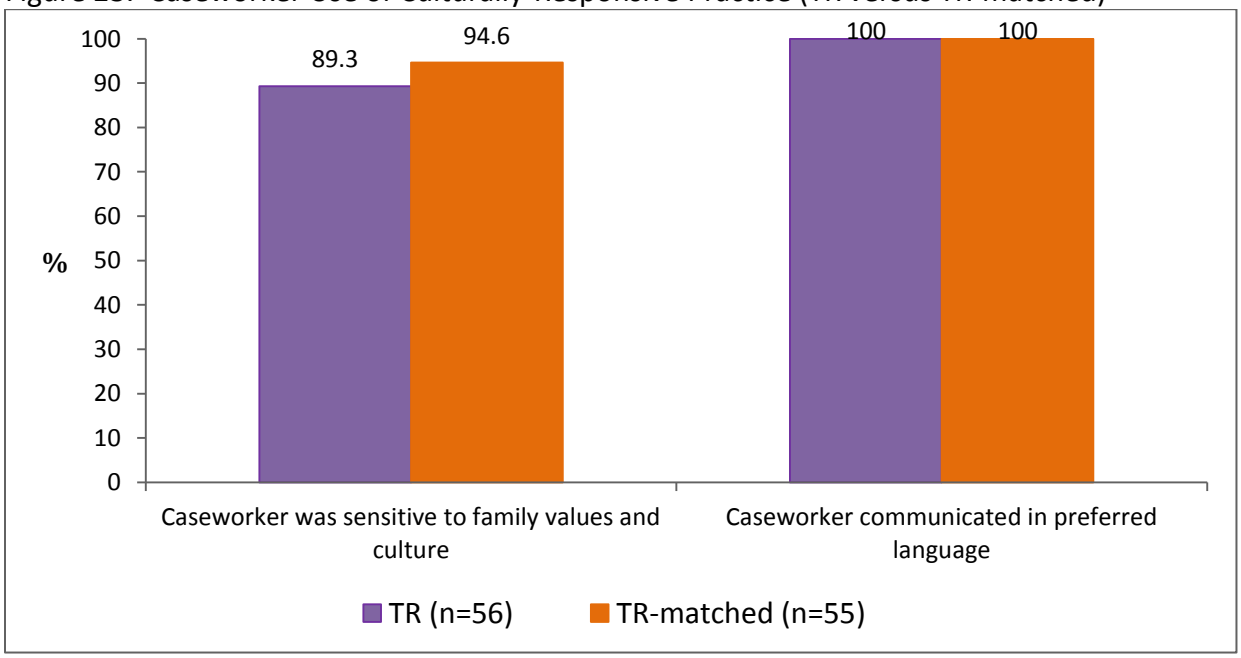


Figure 23. Caseworker Use of Culturally-Responsive Practice (TR versus TR-matched)



6.1.4 Parent engagement

Parent engagement was measured using a 19-item measure of parent engagement in child protective services developed by Yatchmenoff.[32] Sample items include: "My worker and I agreed about what was best for my family" and "My caseworker helped me take care of some problems in my life." Parents responded to the items on a 5-point scale that ranged from strongly disagree (1) to strongly agree (5). The items were summed to form a total score, which could range from 19 to 95. The mean total engagement score for the AR group was 69.8 (sd=15.2) and that for the AR-matched group was 70.1 (sd=14.6), which was not a statistically significant difference. The mean total engagement scores for the TR and TR-matched groups were 66.9 (sd=16.2) and 69.2 (sd=14.3), which were also not significantly different from each other.

6.1.5 Social support

Social support was measured using a 5-item measure developed by the Institute for Applied Research for use in previous evaluations of Differential Response.[33] Parents indicated if they had anyone in their life that they:

- can talk to about things going on in their life
- know will help them if they really need it
- can ask to care for their children when needed
- can ask to help with transportation if needed
- can turn to for financial help if needed

Response options were: "yes, whenever I need," "yes, occasionally," "yes, but rarely," and "no, I have no one." Responses were coded on a 4-point scale with lower scores indicating lower levels of social support. The items were summed to form a total score, which could range from 5 to 20. The mean total score for the AR group was 17.4 (sd=3.5) and that for the AR-matched group was 16.6 (sd=3.5), which was not a statistically significant difference. The mean total scores for the TR and TR-matched groups were 15.8 (sd=3.4) and 16.2 (sd=3.3), which were not significantly different from each other.

6.1.6 Family economic resources

Economic resources were measured using the Family Resources Scale.[34] This short-form version of the scale contained 11 items that described specific economic resources (e.g., food for two meals a day, heat for their apartment or home, dependable transportation) and asked parents

[32] Yatchmentoff, D. (2005). Measuring client engagement from the client's perspective in nonvoluntary child protective services. *Research on Social Work Practice, 15*, 84-96.
[33] DR family questionnaire (n.d.) Retrieved from www.iarstl.org
[34] Dunst, C.J., & Leet, H.E. (1987). Measuring the adequacy of resources in households with young children. *Child Care, Health, and Development, 13,* 111-125.

to indicate if their family had enough of each to meet their needs on a daily basis. Parents rated each item on a 5-point scale that ranged from "not at all enough" to "almost always enough." Figure 24 displays the percentage of parents in the AR and AR-matched groups who responded that their families "often" or "always" had enough of the individual resource. There were two significant differences between the groups: parents in the AR group less often reported that their families often or always had enough clothes and employment compared to parents in the AR-matched group.

Figure 24. Family Economic Resources (AR versus AR-matched)

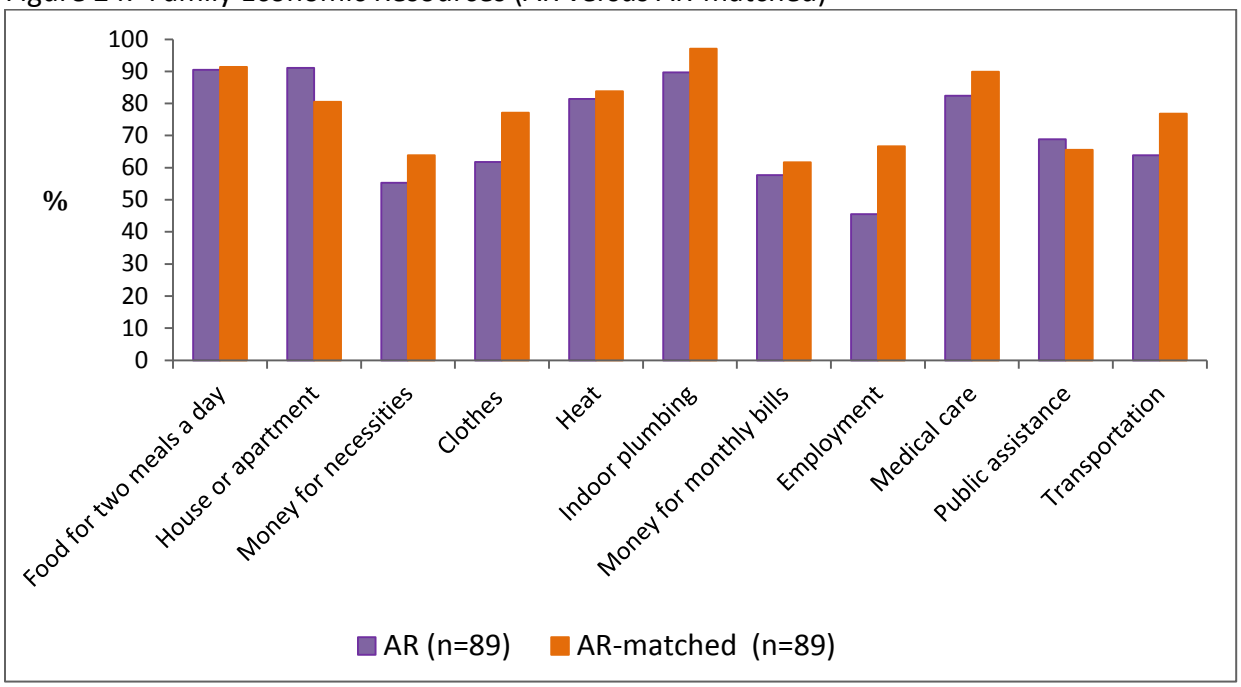
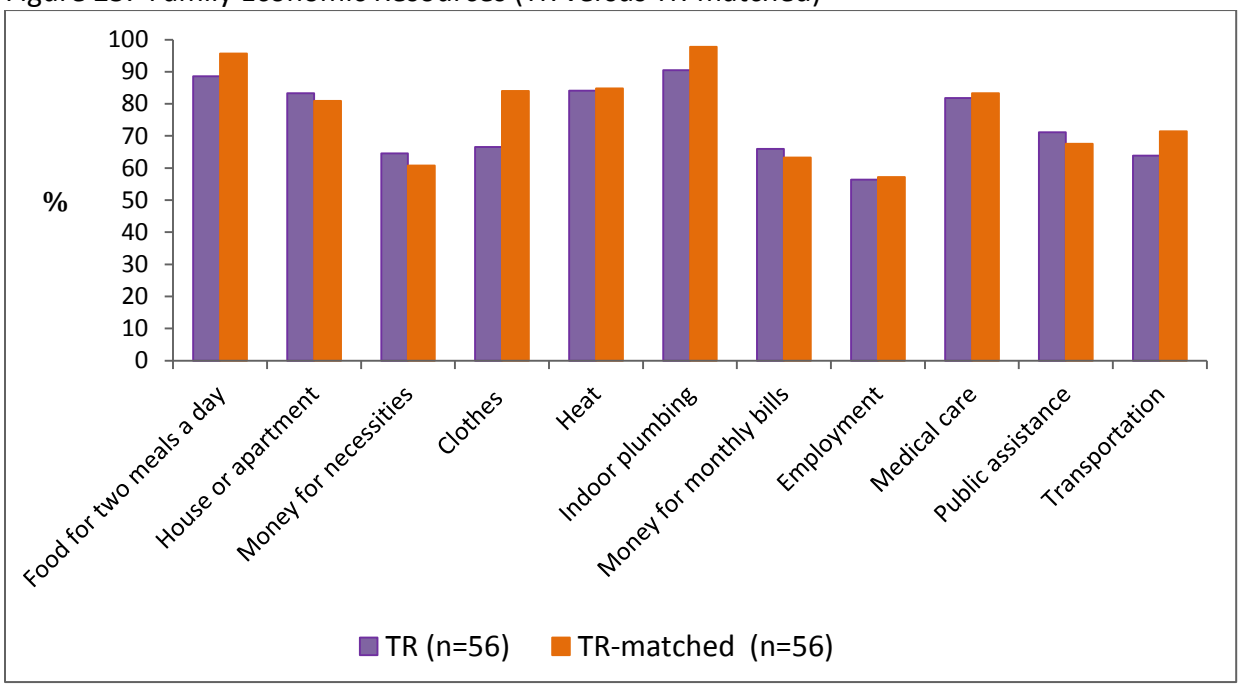


Figure 25 displays the percentage of parents in the TR and TR-matched groups who responded that their families "often" or "always" had enough of the individual resource. There was one significant difference between the groups: parents in the TR group less often reported that their families often or always had enough clothes compared to parents in the TR-matched group.

Figure 25. Family Economic Resources (TR versus TR-matched)



6.1.7 Child and parent trauma symptoms

Trauma symptoms were measured using the Child PTSD Symptom Scale (CPSS).[35] This scale contains 17 items that assess the presence of the post-traumatic stress disorder (PTSD) symptoms included in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The CPSS assesses the three clusters of PTSD symptoms that may be present following a traumatic event, including re-experiencing, avoidance, and arousal. Although the CPSS was designed for administration with children, it was adapted for the current study for inclusion in the parent survey. The instructions stated: "Parents and children can have different kinds of reactions and feelings after being contacted by and talking to a CPS caseworker. Below is a list of feelings and behaviors that you and your child might have had after the caseworker visited you. Please check the box if YOU (first column) or YOUR CHILD (second column) had the feeling or behavior listed." If there was more than one child in the home, the parent was instructed to select one child to focus on and indicated the age and gender of that child on the survey. Total symptoms scores were created for the parent and the child.

When the parents rated their own trauma symptoms, the mean total score for parents in the AR group was 2.7 (sd=4.2) and that for the AR-matched group was 3.0 (sd=3.7), which was not a statistically significant difference. When parents rated their children's trauma symptoms, the

[35] Foa, E.B., Johnson, K.M., Feeny, N.C., & Treadwell, K.R.H. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology, 30*, 376-384.

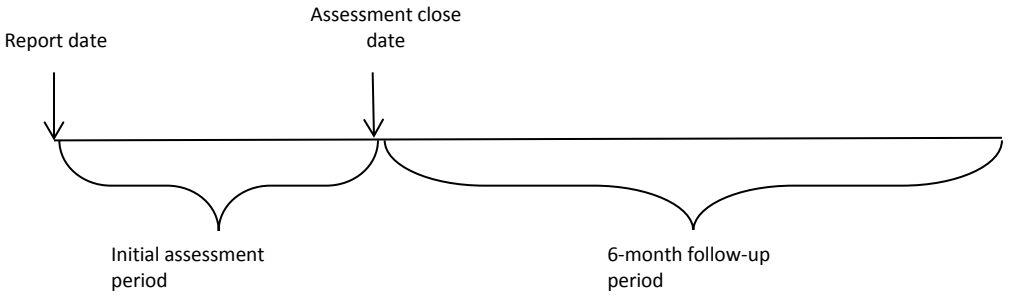
mean total score for children in the AR group was 1.4 (sd=2.9) compared to 1.1 (sd=2.2) for children in the AR-matched group, a non-significant difference.

The mean total score for parents in the TR group was 4.3 (sd=4.7) and that for the TR-matched group was 3.3 (sd=3.6), which was not a statistically significant difference. When parents rated their children's trauma symptoms, the mean total score for children in the TR group was 1.8 (sd=3.1) compared to 1.1 (sd=1.7) for children in the TR-matched group, a non-significant difference.

6.2 Intermediate Outcomes

The three intermediate outcomes (maltreatment re-reports, founded maltreatment re-reports, and child removals) were examined, using data from OR-Kids. In defining these outcome measures, the terms "initial assessment" and "follow-up period" are used. The assessment was defined as the period beginning on the date of the report was assigned to assessment ("report date") and ending on the date the assessment was closed in OR-Kids ("close date"). The follow-up period begins on the day after the assessment close date and ends 6 months after that date (see Figure 26). If a family in a DR county was offered and accepted services following the assessment, this period of time was included in the follow-up period.

Figure 26. Assessment and Follow-up Periods



Families in which all of the children were removed from the home and placed into foster care during the assessment period were dropped from the outcome analyses. If the family had any child remaining in the home following the assessment (i.e., if some children were removed but others remained in the home), they were kept in the sample for the outcome analyses. The numbers and percentages of families in each of the 4 groups that were dropped from the outcome analyses are shown in Table 35.

Table 35. Number of Families Included in the Outcome Analyses

	Number of families in original sample	Number of families with all children removed during assessment	Number of families included in the outcome analyses
AR sample	2,603	197	2,406
AR-matched sample	2,603	169	2,434
TR sample	2,109	207	1,902
TR matched sample	2,109	120	1,989

Families that were assigned to the AR track following the initial screening could be reassigned to the TR track at any point during the CPS assessment if information was discovered that indicated that the children were unsafe or that the family required TR. In the evaluation sample, 296 of the 2,406 families (12.3%) initially assigned to AR were switched to TR. Although these families that switch tracks are not dropped from the analyses, their outcomes are not included in the significance tests and are reported separately.

Table 36 compares the percentages of families in the AR and AR-matched groups that had a re-report, founded re-report, or child removal within 6 months of the assessment closure. Although the differences are in the expected direction (lower rates for all three outcomes in the AR group compared to the AR-matched group), none of the differences were statistically significant. The results of additional analyses (not shown) that controlled for the post-match differences between the two groups did not reveal any significant effect for the treatment (AR) on the three outcomes.

Table 36. Outcome Comparison of AR and AR-matched Families

	AR (n=2,110)*	AR-matched (n=2,434)
% families with re-report (on any child) within 6 months	14.8%	15.5%
% families with founded re-report (on any child) within 6 months	4.1%	5.1%
% families with a child removal within 6 months	2.7%	3.0%

*Families initially assigned to AR that switched to TR are not included. Among families that switched tracks form AR to TR, 16.2% had a re-report, 9.1% had a founded re-report, and 15.2% had a child removal within 6 months of the assessment close date.

Table 37 compares the percentages of families in the TR and TR-matched groups that had a re-report, founded re-report, or child removal within 6 months of the assessment closure. None of the differences were statistically significant. The results of additional analyses (not shown) that controlled for the post-match differences between the two groups did not reveal any significant effect for the treatment (TR) on the three outcomes.

Table 37. Outcome Comparison of TR and TR-matched Families

	TR (n=1,902)	TR-matched (n=1,989)
% families with re-report (on any child) within 6 months	15.7%	14.7%
% families with founded re-report (on any child) within 6 months	4.3%	4.8%
% families with a child removal within 6 months	3.6%	2.7%

Chapter 7: Summary and Recommendations

The Oregon Department of Human Services began implementing Differential Response in 2014, using a carefully planned and staged roll-out strategy that began with implementation in two districts (D5 and D11) in May 2014 and two additional districts (D4 and D16) in April 2015. DHS hired the Children and Family Research Center to conduct comprehensive process, outcome, and cost evaluations in order to answer a lengthy series of research questions related to the DR implementation process, CPS practice throughout the state, fidelity to the DR model, fidelity to the Oregon Safety Model, and the impact of DR on a variety of child, family, and child welfare system outcomes, including costs. In order to answer these research questions, the CFRC has collected and analyzed a variety of data from DHS staff, parents involved in CPS assessments, and OR-Kids. This interim report presents findings from the process and outcome evaluation components using data collected through October 2016, and as such should be considered preliminary.[36] The final evaluation report, due in June 2017, will be comprehensive and include findings from each of the data collection activities that have been conducted over the past 2.5 years. This chapter provides a summary of the major findings from each chapter and concludes with a list of recommendations.

7.1 CPS Practice

A staff survey was created to gather data on staff perceptions on a variety of topics related to CPS practice, including training and coaching; supervision; job satisfaction; organizational culture; differences in CPS practice in AR and TR assessments; attitudes toward Differential Response (DR), the Oregon Safety Model (OSM), and the Family Strengths and Needs Assessment (FSNA); local service availability, and service coordination. The survey was sent to all DHS caseworkers, supervisors, and managers in February 2016; 558 staff members completed at least part of the survey, which equated to a 35% response rate.

The results revealed several areas of widespread satisfaction. For example, most staff perceived training and coaching to be both relevant to their needs and effective. Staff were very satisfied with the quality of supervision they receive and also reported feeling that their supervisor is a resource for them who provides practice guidance and emotional support. Workers were similarly satisfied with the cultural sensitivity of DHS. Staff reported high levels of work purpose and most find a great amount of personal meaning in the work that they do at DHS.

Staff were less satisfied with some other areas of their work, including OR-Kids and their workload, salaries, and opportunities for advancement; over half of the staff that responded to the survey reported that they were dissatisfied with these aspects of their jobs. Job satisfaction also differed by role, with staff in supervisory positions generally reporting higher satisfaction than CPS caseworkers, permanency caseworkers, and screeners.

[36] Findings from the site visits in DR counties and OSM fidelity review are presented in separate reports.

Staff in all districts were asked their opinions about DR and the OSM, and CPS caseworkers in DR districts were asked their opinions about the FSNA. Staff had very positive opinions of DR – over 80% felt it promotes child safety and well-being, positively affects families, and values families' cultural and ethnic backgrounds, and over 90% agreed that it involves families in decision-making. Staff also held positive opinions about the OSM: over 80% felt it promotes the safety and well-being of children and positively affects families. Around 70% of the respondents felt that the FSNA promotes the safety and well-being of children and positively affects families.

Staff were asked questions about specific CPS practices, depending on their role. Screeners often or always felt they were able to gather enough information to make a proper decision regarding screener and typically consulted with a supervisor or other person before making their decisions. About half of the screeners reported "sometimes" feeling uncertain about their track assignment decisions; the other half reported "rarely" feeling uncertain. CPS workers reported significant differences in their practice in AR assessments and TR assessments, and were much more likely to call ahead and schedule an appointment, inform the family that they can have a support person present, and interview the family as a whole in an AR assessment. CPS workers in non-DR districts reported that they offered services to families during an assessment more frequently than CPS workers in DR districts.

CPS workers in DR districts were asked if DR had a positive, neutral, or negative effect on specific areas of their practice such as initially contacting families, interacting with children and parents, offering services to families, and making decisions about child removals. Majorities of CPS workers felt that DR had a positive impact on 6 of the 8 practices and a neutral effect on the other two (staying in contact with families and making decisions about removals).

In general, there were very few differences between staff in DR and non-DR counties on the measures included in the survey, including job satisfaction and organizational culture. Staff in DR counties reported more favorable attitudes toward the OSM than staff in non-DR counties. Additionally, staff in DR counties reported higher rates of service availability than staff in non-DR counties.

Overall the survey results suggest the staff training and coaching programs are supported by staff, that staff understand and support the goals of DHS, and that staff feel positively about the goals of DR and the OSM. Still, staff feel a heavy burden from their workload and overall low satisfaction with their compensation. Few differences between DR and non-DR counties suggest DR implementation has not created additional burdens for staff and may increase support for DR and the OSM.

7.2 DR Fidelity

There is an increasing emphasis in child welfare on implementing evidence-based practice (EBP) in order to improve outcomes for children and families. Before evaluating the impact of an intervention on outcomes, it is critical to assess fidelity, in order to determine the extent to which the intervention was implemented "as intended." If the intervention was implemented in ways that differ from the prescribed practice model (in other words, without fidelity), then it makes interpretation of the outcome evaluation findings much more difficult. Fidelity assessment can also help to pinpoint specific areas of practice that require additional refinement in order to meet expected standards.

Certain interventions lend themselves to fidelity assessment better than others. Measures of fidelity to treatment interventions with clearly defined practice models, such as trauma-focused cognitive behavioral therapy (TF-CBT), are relatively easy to define. Other interventions, like Differential Response, that are more heavily focused on systemic or policy-related practice change, are more difficult to assess for fidelity. DR is a CPS practice that allows for more than one initial response to screened-in reports of child abuse and neglect; most commonly, the CPS responses are an investigation or traditional response (TR) and an assessment response (AR).[37] Thus, one required practice change in systems that implement DR is the initial screening and track assignment of screened-in reports and the ability to switch families from AR to TR if circumstance change or additional information emerges that indicates TR is necessary to ensure child safety. CPS practice for AR assessments differs from that for TR assessments in several ways, including the initial contact with the families and the presence or absence of a disposition at the conclusion of the disposition (see Figures 1 and 2 in this report for sequence of CPS processes that occur in AR and TR assessments, respectively).

Examination of Figures 1 and 2 reveals that in Oregon, the primary CPS processes and decision points that occur in DR districts are: 1) the screener's decision to assign a report to assessment or close after screening; 2) the screener's decision to assign a 24-hour or 5-day response time to reports assigned to assessment; 3) the CPS worker's ability to meet with the family within the assigned response time; 4) the CPS worker's decision to switch the family from AR to TR if necessary; 5) the CPS worker's decision about the child's safety in the home; 6) if the child is safe, the CPS worker's determination if the family has moderate to high needs; 7) if the family has moderate to high needs, the worker's decision to refer them to a strengths and needs provider for additional assessment; 8) the family's decision to accept or decline the strengths and needs assessment; and 9) the family's decision to accept contracted or non-contracted services as available. Thus, the examination of DR fidelity assessment consists of an examination of the numbers and percentages of families that flow through each of these decision points. The more difficult task, and one that the evaluators cannot complete, is to assign benchmarks to these measures of CPS processes. To our knowledge, there are no implicit

[37] Child Welfare Information Gateway. (2008). *Differential Response to reports of child abuse and neglect*. Washington, DC: U.S. Department of Health and Human Services.

or explicit expectations about the percentages of families that should be assigned to AR versus TR, switch tracks from AR to TR, or be offered or accept services. Therefore, we merely report the percentages of families that reach each stage of the flowchart in the first 4 districts to implemented DR in Oregon, and discuss changes over time or variations between districts.

Statewide, the percentage of reports assigned to assessment has increased slightly since DR was implemented, from 44% in 2014 to 48% in 2016. Larger increases (over 10%) in the percentages of reports assigned to assessment were seen in 3 of the 4 districts that implemented DR in 2014 or 2015. The increases have been fairly gradual over time; it is not possible to attribute them directly to the implementation of DR, although that may be a contributing factor.

Since DR implementation, the percentage of assessments initially assigned to AR has declined slightly in two districts (D11 and D16), declined moderately in one district (D5), and increased slightly in one district (D4). In 2016, about half of assessments were assigned to AR in each of the 4 districts. The percentage of AR assessments that switch tracks to TR has also decreased over time in both D5 and D11, which suggests that screeners in these districts are getting more accuracy in their initial track assignments. Between 10-15% of the assessments initially assigned to AR in 2016 switched tracks to TR.

CPS procedures state that the primary response time for AR assessments is 5 days, and that a 24-hour response time is only required when there is an indication that a child may be in danger right now or has a current injury as a result of the alleged abuse or neglect. There were wide variations between the 4 districts in the percentage of AR assessments that were assigned a 5-day response time: 68% in D4, 69% in D5, 84% in D16, and 88% in D11. These differences may be due to actual differences in the types of reports that occur in the districts, or they may be caused by differences in screener practice. Response time assignment may be one area where additional training or coaching is needed.

A finding in the 2015 interim evaluation report highlighted low levels of compliance with assigned 5-day response times; only 20% of the assessments in the state assigned a 5-day response time in either 2014 or 2015 received an initial visit from a CPS worker within 5 days. Compliance with the 5-days response time in the 4 districts that implemented DR was slightly better than the statewide rate. Results in the current report, however, indicate a significant improvement in the compliance with the 5-days response time; statewide rates in 2016 were 68% and rates in the 4 DR districts ranged from 62% to 90%. Compliance rates in 2014 and 2015 also improved, which suggests that the apparent non-compliance with response times was actually non-compliance with data entry into OR-Kids.

Statewide, about 90% of assessments are determined to be safe. There was some, but not a lot, of variation in the percentage of safe and unsafe assessments in the 4 districts that have implemented DR. Within districts, the percentages of AR assessments determined to be safe was slightly higher than the corresponding percentage of TR assessments. In both DR and non-DR district, if the CPS worker determines that a family is safe, he or she must then determine if

the family has moderate to high needs. This is an important decision, because only families with moderate to high needs are offered services. Prior to September 2015, there was no indicator in OR-Kids to identify which families have moderate to high needs. Although one was added in September 2015, the data since that time were unreliable and could not be analyzed to determine the percentage of safe families that had moderate to high needs.

However, an indicator exists that identifies the families that were offered either contracted or non-contracted services; since service should only be offered to families with moderate to high needs, it may be used as an estimate of the percentage of families with moderate to high needs. In the 4 DR districts, the percentage of AR families who were offered services in 2016 ranged from 9% in D4 to 20% in D11; the percentages of TR families who were offered services in 2016 were slightly lower, ranging from 7% in D4 to 18% in D11. About 40-50% of the AR families who are offered services accept them; between 33-63% of TR families accept services. Of the families that accepted services, only small percentages were contract services (Admin-Only cases). For example, in 2015, there were 64 families in AR assessments and 33 families in TR assessments that accepted contracted services following their assessment.

The final measure examined was the length of CPS assessments in the 4 DR districts. Initial assessments in DR counties should be completed within 45 days, with the possibility of a one-time extension of 15 days. The average length of AR and TR assessments in 2015 was much longer than that, however, ranging from 113 to 164 days for AR assessments and from 110 to 150 days for TR assessments.

7.3 Child and Family Outcomes

According to the DR logic model, families that receive either AR or TR will be engaged with and feel respected by their CPS worker, will be involved in making decisions about their services, and will receive appropriate services that increase their social support and improve their family functioning. These short-term outcomes will lead to fewer families with re-reports and child removals (intermediate outcomes).

In order to examine the effect of DR on short-term and intermediate outcomes, the evaluation compared the outcomes families who received an AR or TR assessment in the first 4 districts to implement DR (the treatment groups) with those of families who received a CPS assessment in 4 similar districts that have not yet implemented DR (the comparison groups). Because the families in the treatment and comparison groups lived in different districts, there may have been differences between them that may be related to differences in outcomes. To reduce the pre-existing differences between families in the treatment group and the comparison group, a method known as Propensity Score Matching (PSM) was used to match each family in the two treatment groups (AR and TR) to a family with similar demographic and case characteristics in the comparison group. After conducting the matching procedures for the AR and TR groups, the resulting AR-matched and TR-matched comparison groups were indistinguishable on almost every observable characteristic. Therefore, any differences in outcomes between the

treatment and comparison groups can be attributed to the effects of the treatment rather than pre-existing differences in the groups.

A parent survey called the Post-Assessment Questionnaire (PAQ) gathered information about parents' short-term outcomes (emotional reactions, engagement, social support, family functioning). CPS workers were given instructions to give parents the PAQ at the last face-to-face meeting of the CPS assessment, and parents could then complete the survey and mail it to CFRC. The response rates for the parent survey were 1.6% in the 4 DR districts and 2.3% in the 4 non-DR districts included in the outcome evaluation, which are much lower than the response rates for parent surveys done in other DR evaluations. Because the response rates were so low, there is some concern that the parents who completed a survey may be different than parents who did not, which would bias the results of the survey. Although there were no differences in basic demographic characteristics of the families who responded and those who did not, response bias is still a concern, and the results obtained from the parent survey should therefore be interpreted with some degree of caution. Intermediate outcomes (maltreatment re-reports, founded re-reports, and child removals during the 6 months after the assessment close date) were measured using data from OR-Kids.

The results of the outcome analyses revealed almost no significant differences between the AR and AR-matched groups or the TR and TR-matched groups on either short-term or intermediate outcomes. The only differences were on the percentage of families who reported having enough clothing (AR < AR-matched and TR < TR-matched) and employment (AR < AR-matched). The lack of meaningful differences in outcome measures between the AR treatment group and AR-matched comparison group is not without precedence in previous DR evaluations. In fact, the majority of DR evaluations that have used either experimental designs or rigorous quasi-experimental designs (such a propensity score matched comparison groups) have found either non-significant differences in outcomes between families assigned to AR and their comparison groups or significant but small differences (see, for example, the results of outcome evaluations in Colorado,[38] Ohio,[39] Illinois,[40] New York,[41] and the District of Columbia[42]). The Oregon DR evaluation is the first to compare the outcomes of families assigned to TR and a comparison group of similar families, so there are no previous evaluation findings to compare the current

[38] Winokur, M., Orsi, R., Rogers, J., Gabel, G., Brenwald, S.,Holmquist-Johnson, H., & Evans, M. (2014). *Program evaluation of the Colorado Consortium on Differential Response*: Final report. Fort Collins, CO: Social Work Research Center, School of Social Work, Colorado State University.

[39] Murphy, J., Newton-Curtis, L., & Kimmich, M. (2013). *Ohio SOAR project: Final report.* Tualatin, OR: Human Services Research Institute.

[40] Fuller, T., Nieto, M., & Zhang, S. (2013). *Differential Response in Illinois: Final evaluation report.* Urbana, IL: Author.

[41] Ruppel, J., Huang, Y., & Haulenbeek, G. (2011). *Differential Response in child protective services in New York State: Implementation, initial outcomes, and impacts of pilot program.* Albany, NY: Office of Children and Family Services.

[42] IAR Associates. (2016). *Family assessment in the District of Columbia program evaluation: Final report to the Child and Family Service Agency. St. Louis, MO: Author.*

results to. However, the lack of differences between the TR and TR-matched groups is not surprising, given the more subtle differences in CPS practice in these two groups.

The lack of differences in short-term outcomes between families in DR and non-DR districts does not mean that DR is performing poorly. A closer examination of parents' feedback on their CPS experience indicates that parents in *both* DR and non-DR districts describe their experience very positively. For example, average ratings on the CARE measure were 41.5 (out of a possible 50 points) for parents in the AR groups and 40.5 for parents in the AR-matched group, which indicates that both groups of parents felt high levels of empathy and respect from their CPS workers. Another example is parents' ratings of their CPS workers' cultural sensitivity: 92% of parents in the AR group and 93% of parents in the AR-matched group felt that their CPS worker was sensitive to their family values and culture. Nearly 100% of parents in both groups reported that their CPS worker communicated with them in their preferred language.

Thus, the lack of differences in short-term and intermediate outcomes may be due to the fact that many of the CPS worker practices typically associated with AR, such as enhanced engagement and family involvement in decision-making, have spread beyond only those districts that have implemented DR. Two-thirds of the workers in non-DR districts reported on the staff survey that they received training on engagement strategies, and the results of the parent survey suggests that they are doing a good job engaging parents during the assessment. If such "practice diffusion" has occurred, then the "outputs" listed in the DR logic model look largely the same for families in DR and non-DR districts, which makes it less likely that there will be significant differences in outcomes between the two groups.

7.4 Interim Recommendations

The findings in this report, along with those in the site visit reports and OSM fidelity report, suggest that there may be ways to change DHS policy and procedure to improve CPS practice, fidelity to the DR model, and child and family outcomes. Because DR is still in the formative stage of development, the following recommendations focus on small to moderate changes in practice that may yield the biggest benefits. More comprehensive recommendations will be attached to the final evaluation report.

1. Response time assignments for AR assessments varied substantially between districts. This may be the result of real differences between the types of cases assigned for assessment in the districts, or it may indicate a level of uncertainty about which AR assessments should be assigned a 24-hour response time. Additional training or coaching with screeners on response time assignment for AR assessments improve consistency in this area.

2. Similarly, the percentage of assessments initially assigned to AR varied between districts. Although the percentage of assessments that switch tracks from AR to TR has gone down in the past year, which suggests that screeners are getting better at deciding which reports to assign to AR, almost half of the screeners who responded to the staff

survey indicated that they sometimes feel uncertain about the decisions they make regarding track assignment. This may be another area for additional coaching.

3. The length of time to complete an assessment has grown and is well over the recommended timeframe outlined in the DHS procedure manual. This was true across districts, although some are struggling more than others. This issue has been the attention of much scrutiny already, and although the number of overdue assessments has been reduced, this indicator should continue to be monitored to determine what impact, if any, the implementation of DR has on the length of assessments.

4. Although staff are satisfied with many areas of their jobs, they expressed dissatisfaction with their current workloads on both the staff survey and during the site visits. OR-Kids and the amount of documentation and paperwork were other areas of dissatisfaction. CPS workers and screeners had the lowest levels of satisfaction. The results of the workload study may identify ways in which the perceived workload burden of staff can be eased.

5. If a family is determined to be safe and has moderate to high needs, then services should be offered to those families to address their needs and reduce the risk of future maltreatment. Data from the fidelity assessment suggest that between 10-20% of safe families in DR districts were offered services (either contracted or non-contracted), and that about half of those who are offered services accept them. The impact of DR on child and family outcomes may be limited by the small number of families being provided with post-assessment services. We therefore offer some suggestions to increase the number of families that are offered and accept services.

    a. Only families with moderate to high needs may be offered services at the conclusion of the CPS assessment, which means that the moderate to high needs determination may serve as a potential barrier to service provision among families if CPS workers are not accurately identifying family needs during the assessment. Prior to September 2015, there was no indicator in OR-Kids for this determination, and although an indicator was added at that time, documentation related to this determination is still fairly unreliable. Results from the OSM fidelity review[43] found that of the 40 safe assessments randomly selected for review, only 6 contained documentation about why the families did or did not have moderate to high needs. In the majority of cases, the worker marked that the family did not have moderate to high needs and provided no further documentation. Although additional information about the moderate to high needs determination is needed, this is one practice area that may benefit from additional training or coaching.

[43] Chiu, Y., & Braun, M.T. (2016). *Oregon Differential Response Initiative: Interim OSM fidelity report.* Urbana, IL: Children and Family Research Center.

b. In districts that have implemented DR, families with moderate to high needs are offered the option of having a Family Strengths and Needs Assessment (FSNA) completed by a strengths and needs provider. In order to receive contracted services from DHS, families must accept the offer for the FSNA. Parents who just completed a CPS assessment may be hesitant to complete yet another assessment, regardless of their desire to obtain services to help their family. In addition, results of the site visit reports suggest that CPS workers find the FSNA referral process burdensome and time-consuming, which may act as a barrier to getting services to families. Although DHS has made changes to improve the FSNA process based on the results of the site visits, we would suggest additional discussion of the benefits of the FSNA relative to its potential costs. If the goal is to get services to families with moderate to high needs, adding an additional step in the flowchart usually serves to impede progress toward the end goal rather than expedite it.

c. Approximately half of the families that were offered services in the 4 DR districts accepted them and most of the services they accepted were referrals to non-contracted community services rather than contracted services paid for by DHS. Previous studies with families involved with CPS suggest that these families can be reluctant to accept services, despite their significant needs.[44] Although few DHS staff felt that they needed additional training or coaching on engagement techniques, there may be specific techniques that can be used to overcome families' reluctance to accept services from DHS.

[44] See, for example, Schreiber, J.C., Fuller, T., & Paceley, M.S. (2013). Engagement in child protective services: Parent perceptions of worker skills. *Children and Youth Services Review, 35,* 707-715.

Appendix A: AR Matching Results

Each of the four DR districts was paired with a similar non-DR district prior to the matching procedures, and the procedures were completed separately for each DR/non-DR pair. There were two steps in each matching procedure:

1) A logistic regression procedure was run to predict the likelihood that a case would be assigned to the AR track (the treatment group). The initial list of variables entered as predictors included child race, child gender, number of alleged child victims in the family, alleged maltreatment types, maltreatment reporter, mother as alleged perpetrator, father as alleged perpetrator, number of prior reports, number of prior reports closed at assignment, number of prior assessments, number of prior founded assessments, number of prior family case openings, number of prior foster care episodes, number of total family stressors, and individual family stressors. The regression procedure was run with step-wise variable selection so that only variables that significantly related to the outcome variable (assignment to the AR track) were kept in the model. Once an acceptable model was reached, it was used to compute a propensity score for each family in the AR sample and non-DR sample, which represented their probability of being in the AR group regardless of whether or not they actually were.

2) The PSM procedure was performed in STATA-SE 14 using the PSMATCH2 procedure. The procedure was first run using a caliper of .05, meaning that each family in the AR group would be matched with a family in the non-DR group that had a propensity score that was within .05 of their score (in either direction). For example, if a family in the AR group had a propensity score of .45 and a .05 caliper was selected, then they could be match to a non-DR family with a propensity score between .40 and .50. If more than one family fell within the range of scores defined by the caliper, then one was randomly selected as the match. If the number of matches obtained using the .05 caliper was too small, the PSM procedure was rerun using a caliper of .10, and then .15. Any families that could not be matched using the largest caliper necessary were dropped from the sample.

District 5 and District 3 Matching Results

The logistic regression converged after 24 iterations and the final model fit the data well, as indicated by the Hosmer and Lemeshow goodness of fit test [χ^2 (8, n=5,060) = 9.6, p > .1] and a concordance rate of 73.7%. All of the 1,396 families assigned to AR in District 5 were matched with families in District 3 using a .10 caliper.

District 11 and District 10 Matching Results

The logistic regression converged after 21 iterations and the final model fit the data well, as indicated by the Hosmer and Lemeshow goodness of fit test [χ^2 (8, n=2,049) = 9.6, p > .1] and a concordance rate of 74.8%. Since a significant number of TR families remained unmatched using calipers of .05 and .10, a caliper of .15 was used. Of the 498 families assigned to AR in District 11, all but 30 were matched with families in District 10 using a .15 caliper. The 30 unmatched families were dropped from the sample.

District 4 and Districts 6+2 Matching Results

The original plan was to match the AR assessments in District 4 with the non-DR assessments in District 6, but there were not enough assessments to perform an adequate match. Therefore, the non-DR assessments in District 2 that were not matched to families in District 16 were combined with those in District 6 to form the pool of potential matched for District 4. The logistic regression converged after 13 iterations and the final model fit the data well, as indicated by the Hosmer and Lemeshow goodness of fit test [χ^2 (8, n=2,775) = 5.3, p > .1] and a concordance rate of 77.4%. Of the 284 families assigned to AR in District 4, all but 5 were matched with families in Districts 6 and 2 using a .05 caliper. The 5 unmatched families were dropped from the sample.

District 16 and District 2 Matching Results

The logistic regression converged after 19 iterations and the final model fit the data reasonably well, as indicated by the Hosmer and Lemeshow goodness of fit test [χ^2 (8, n=3,149) = 8.4, p > .1] and a concordance rate of 72.0%. All of the 460 families assigned to AR in District 16 were matched with families in District 2 using a .05 caliper.

Appendix B: TR Matching Results

Each of the four DR districts was paired with a similar non-DR district prior to the matching procedures, and the procedures were completed separately for each DR/non-DR pair. There were two steps in each matching procedure:

1) A logistic regression procedure was run to predict the likelihood that a case would be assigned to the TR track (the treatment group). The initial list of variables entered as predictors included child race, child gender, number of alleged child victims in the family, alleged maltreatment types, maltreatment reporter, mother as alleged perpetrator, father as alleged perpetrator, number of prior reports, number of prior reports closed at assignment, number of prior assessments, number of prior founded assessments, number of prior family case openings, number of prior foster care episodes, number of total family stressors, and individual family stressors. The regression procedure was run with step-wise variable selection so that only variables that significantly related to the outcome variable (assignment to the TR track) were kept in the model. Once an acceptable model was reached, it was used to compute a propensity score for each family in the TR sample and non-DR sample, which represented their probability of being in the TR group regardless of whether or not they actually were.

2) The PSM procedure was performed in STATA-SE 14 using the PSMATCH2 procedure. The procedure was first run using a caliper of .05, meaning that each family in the TR group would be matched with a family in the non-DR group that had a propensity score that was within .05 of their score (in either direction). For example, if a family in the TR group had a propensity score of .45 and a .05 caliper was selected, then they could be match to a non-DR family with a propensity score between .40 and .50. If more than one family fell within the range of scores defined by the caliper, then one was randomly selected as the match. If the number of matches obtained using the .05 caliper was too small, the PSM procedure was rerun using a caliper of .10, and then .15. Any families that could not be matched using the largest caliper necessary were dropped from the sample.

District 5 and District 3 Matching Results

The logistic regression converged after 22 iterations and the final model fit the data well, as indicated by the Hosmer and Lemeshow goodness of fit test [χ^2 (8, n=4,654) = 9.9, p > .1] and a concordance rate of 75.8%. Of the 990 families assigned to TR in District 5, all but 22 were matched with families in District 3 using a .05 caliper. The 22 unmatched families were dropped from the sample.

District 11 and District 10 Matching Results

The logistic regression converged after 16 iterations and the final model fit the data well, as indicated by the Hosmer and Lemeshow goodness of fit test [χ^2 (8, n=2,049) = 9.6, p > .1] and a concordance rate of 74.8%. Since a significant number of TR families remained unmatched using calipers of .05 and .10, a caliper of .15 was used. Of the 463 families assigned to TR in District 11, all but 12 were matched with families in District 10 using a .15 caliper. The 12 unmatched families were dropped from the sample.

District 4 and Districts 6+3 Matching Results

The original plan was to match the TR assessments in District 4 with the non-DR assessments in District 6, but there were not enough assessments to perform an adequate match. Therefore, the non-DR assessments in District 3 that were not matched to families in District 5 were combined with those in District 6 to form the pool of potential matched for District 4. The logistic regression converged after 16 iterations and the final model fit the data well, as indicated by the Hosmer and Lemeshow goodness of fit test [χ^2 (8, n=2,775) = 5.3, p > .1] and a concordance rate of 80.4%. Since a significant number of TR families remained unmatched using calipers of .05 and .10, a caliper of .15 was used. Of the 312 families assigned to TR in District 4, all but 9 were matched with families in Districts 6 and 3 using a .15 caliper. The 9 unmatched families were dropped from the sample.

District 16 and District 2 Matching Results

The logistic regression converged after 12 iterations and the final model fit the data reasonably well, as indicated by the Hosmer and Lemeshow goodness of fit test [χ^2 (8, n=3,149) = 8.4, p > .1] and a concordance rate of 74.5%. Since a significant number of TR families remained unmatched using calipers of .05, a caliper of .10 was used. Of the 390 families assigned to TR in District 16, all but 3 were matched with families in District 2 using a .10 caliper. The 2 unmatched families were dropped from the sample.

Appendix C: Parent Survey – Analysis of Non-Response Bias

Table 38. Family characteristics in PAQ response and nonresponse samples[a]

	AR			TR			Non-DR		
	Response (n=90)	Nonresponse (n=3,810)	χ^2	Response (n=57)	Nonresponse (n=3,813)	χ^2	Response (n=245)	Nonresponse (n=9,341)	χ^2
Allegation Type (%)									
Threat of Harm	26.7	35.3	2.89	52.6	51.7	0.02	48.6	44.2	1.88
Mental Injury	1.1	2.9	--[d]	7.0	5.5	--[d]	1.6	2.8	1.20
Neglect	56.7	56.9	0.02	45.6	36.6	1.97	50.6	51.9	0.16
Medical Neglect	1.1	2.9	--[d]	1.8	1.9	--[d]	2.9	3.2	0.07
Physical Abuse	30.0	21.4	3.88*	28.1	33.4	0.71	24.1	24.8	0.06
Sexual Abuse	1.1	0.9	--[d]	15.8	15.5	0.00	4.5	8.7	5.44*
Victims' Race / Ethnicity (%)[b]									
White	68.9	71.1	0.21	73.7	73.1	0.01	69.4	67.1	0.59
African-American	5.6	4.3	--[d]	1.8	4.4	--[d]	11.0	11.2	0.01
Native American	5.6	4.1	--[d]	7.0	4.6	0.71	5.3	5.2	0.00
Hispanic	8.9	9.6	0.06	8.8	9.8	0.07	10.6	11.1	0.06
Other[c]	2.2	2.0	--[d]	5.3	1.6	--[d]	1.6	2.3	0.53
Unknown	21.1	20.3	0.03	19.3	19.0	0.00	15.5	17.8	0.83
Age of the Youngest Victim (Mean)	**Response**	**Nonresponse**	**t-value**	**Response**	**Nonresponse**	**t-value**	**Response**	**Nonresponse**	**t-value**
	6.1	6.7	1.11	5.2	6.4	1.92	5.5	6.2	2.43*

[a]For both response and nonresponse samples the households included in this sample were those with at least one assessment closed from February 1st through October 4, 2016.

[b]The race/ethnicity categories are not mutually exclusive. Therefore, the percentages do not sum to 100%.

[c]"Other" includes Asians, Hawaiian natives, and other Pacific Islanders.

[d]The chi-square may not be a valid test since we have cells with expected values less than 5.

*P < .05

Table 39. Family characteristics in SAQ response and nonresponse samples[a]

	AR			TR			Non-DR		
	Response (n=65)	**Nonresponse (n=351)**	**χ^2**	**Response (n=37)**	**Nonresponse (n=276)**	**χ^2**	**Response (n=53)**	**Nonresponse (n=378)**	**χ^2**
Allegation Type (%)									
Threat of Harm	24.6	35.6	2.96	56.8	54.0	0.10	43.4	42.3	0.02
Mental Injury	0.0	2.9	--[d]	2.7	6.2	--[d]	3.8	4.5	--[d]
Neglect	63.1	55.8	1.17	37.8	38.0	0.00	52.8	61.4	1.42
Medical Neglect	3.1	2.3	--[d]	0.0	1.8	--[d]	1.9	5.3	--[d]
Physical Abuse	26.2	21.9	0.56	37.8	37.0	0.01	26.4	23.3	0.25
Sexual Abuse	0.0	0.3	--[d]	10.8	8.3	--[d]	3.8	8.2	--[d]
Victims' Race / Ethnicity (%)[b]									
White	83.1	74.1	2.40	81.1	73.6	0.97	77.4	72.2	0.62
African-American	6.2	3.4	--[e]	8.1	3.6	--[e]	9.4	10.9	0.10
Native American	1.5	5.7	--[e]	5.4	4.4	--[e]	3.8	5.8	--[e]
Hispanic	3.1	11.1	3.98*	10.8	12.3	--[e]	17.0	11.6	1.23
Other[c]	1.5	2.0	--[e]	5.4	2.5	--[e]	0.0	1.3	--[e]
Unknown	12.3	16.2	0.64	8.1	18.5	2.46	13.2	12.4	0.03
Age of the Youngest Victim (Mean)	**Response**	**Nonresponse**	**t-value**	**Response**	**Nonresponse**	**t-value**	**Response**	**Nonresponse**	**t-value**
	5.9	6.5	0.91	5.8	6.0	0.26	5.0	5.4	0.53

[a] The households included in both response and nonresponse samples were those with at least one assessment closed from November 1st, 2015 through July 20, 2016 and services were offered.

[b] The race/ethnicity categories are not mutually exclusive. Therefore, the percentages do not sum to 100%.

[c] "Other" includes Asians, Hawaiian natives, and other Pacific Islanders.

[d] The chi-square may not be a valid test since we have cells with expected values less than 5.

*P < .05