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Oregon Differential Response
Final Evaluation Report

June 2017

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Acknowledgements

Though only a few author names are shown on the report cover, the Children and Family Research Center's evaluation of Oregon's implementation of DR was achieved thanks to the help of numerous people.

Stacy Lake and other executive leaders in Oregon's DHS—Thank you for your commitment to evaluating a program that was often in flux. Your steady guidance must surely be a comfort to those that work for you. It helped us make sure the evaluation never paused even when some questioned DR. Thanks also to Julie LaChapelle, Tami Kane-Suleiman, Tasha Chapman, Brian Glass, Angela Long, and Maria Duryea—You shared your expertise and answered our questions with such patience. Thanks for always being there with an answer even with your busy schedules.

Oregon's IT and database staff were vital in helping us get the information we needed from myriad databases—Jeremy LeCoure, Heather Collee, Judy Helvig, Mahdi Juya, Kelley Kirsch, and the helpdesk staff who answered our calls about access to OR-Kids and other pieces. Thanks to Cathy Angco for keeping meetings on and off our calendars as schedules and attendees changed.

Thank you to all the Oregon staff, as well as community partners and others, that participated in the site visit focus groups and interviews. Your direct experience gave life to our evaluation findings. Thanks also to the anonymous staff that participated in the staff survey, and to the staff that served on our expert panel for the cost analysis.

We had help getting surveys into the hands of workers to give to parents. Thanks to these district staff that served as our "point people" for this task (in order by district): Larry Dalton, Amber McClelland, Joni Yarnell, Jody Knutson, Brenda Petersen, Samantha Lindsey, Danielle Domingue, Debby Drops, Natasha Jansen, Kellie Houghton, Jamie McMillin, Cherie Gaddis, Vicki High, Brandy Hemmer, and Stacy Hoffman.

Outside of Oregon DHS, special thanks to Emily Hutchinson from the National Resources Center for Child Protection Services. Your expertise on fidelity assessment in Oregon was useful for putting together our own fidelity assessment tool. Thank you to Anna Rockhill, Carrie Furrer, and Thuan Duong for great discussion about the Oregon Safety Model.

Thanks to Pacific Research and Evaluation, specifically Julie Murphy and Steve Rider, for their tireless site visits, where they completed focus groups and interviews with many people. Your site visits report added immeasurable color and voice to this final report.

And here at the University of Illinois, thanks to Dan Phillips and Aaron Burnett for building online versions of surveys, Becky Ponder for formatting surveys, and Heidi Meyer for scheduling interviews, sending gift cards, and generally making sure everything stayed on track. Thanks to

these students for conducting parent interviews: Emily Stratton, Caroline Murphy, Rachel Slick, Kelly Valencik, Meredith Fay, Jasmeen Wellere, and Jacquelyn Banks. We also had periodic evaluation help from graduate students, including Michelle Asbill, Seth Boughton, Jacob Goffnet, Megan Paceley, and Tad Schmitt.

Finally, thank you to the parents in Oregon that completed surveys and interviews. At a challenging time in your life, you were willing to share your experience with us in hopes of improving the system that aims to see all children grow up safely at home with people that love them. Thank you for taking time to participate.

This report is a publication of the Children and Family Research Center and is available on our website at: www.cfrc.illinois.edu. The recommended citation for the report is:

Fuller, T., Braun, M.T., Chiu, Y., Cross, T.P., Nieto, M., Tittle, G., & Wakita, S. (2017). *Oregon Differential Response Final Evaluation Report.* Urbana, IL: Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign.

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Executive Summary

Following a lengthy and thorough exploration and planning process, the Oregon Department of Human Services began implementing Differential Response (DR) in May 2014 as part of a broader reform effort aimed at safely and equitably reducing the number of children in foster care and more effectively addressing the needs of families being referred to Child Protective Services (CPS) for neglect. The Oregon DR model was developed by a DR steering committee that oversaw the work of an implementation team with multiple subcommittees. In total, over 100 staff and community partners, including representation from Oregon's tribes, were involved in building Oregon's DR model. In the two years following its initial implementation in May 2014, DR was implemented in a total of seven districts throughout the state. Although statewide implementation was originally planned, the implementation of DR was paused in May 2016 amid growing pressures within DHS to reduce the number of overdue CPS assessments.

Early in the implementation process, DHS outlined the intended results of DR through a vision statement, which was later expanded into a logic model that articulated the relationships between the DR practice components and expected outcomes. Through the implementation of DR, DHS hoped to enhance the partnerships between families reported for abuse and neglect, DHS staff, and community partners; increase the number of children who remain safely at home with their families; and reduce the disproportionate representation of children of color in the child welfare system. In order to test these hypothesized relationships, DHS hired the Children and Family Research Center (CFRC) at the University of Illinois at Urbana-Champaign to design and conduct a rigorous and comprehensive evaluation that would accomplish multiple goals, including carefully documenting the DR implementation process, examining the DR model that was being practiced in the districts, testing DHS workers' fidelity to the Oregon Safety Model (OSM), comparing the outcomes of children and families involved in DR assessments with those who received traditional CPS assessments, and examining the costs associated with practicing DR. Over the past 2.5 years, the CFRC has collected a vast amount of information from DHS staff, community partners, and families involved in the child welfare system through surveys, interviews, focus groups, case record reviews, and administrative data analyses. This *Oregon Differential Response Final Evaluation Report* contains thorough descriptions of the methodologies used and the results of the evaluation components, including the implementation, process, outcome, and cost evaluations. The methods and results of the OSM fidelity review are contained in a separate report and are not discussed in this report.[1]

[1] Braun, M., & Chiu, Y. (2017). *Oregon Differential Response Evaluation: OSM Fidelity Report.* Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

Differential Response in Oregon

At a simple level, DR is best described as an approach to child protective services that includes the use of two (or more) separate response pathways for screened-in reports of child maltreatment. In Oregon, DR consists of two CPS response tracks: Alternative Response (AR) and Traditional Response (TR). Although several changes were made to the CPS screening and assessment procedures to accommodate DR in Oregon, the similarities in CPS procedures in DR and non-DR districts in Oregon are far greater than the differences. Most importantly, there are no differences in either the response times assigned to CPS assessment or in the safety assessment process in districts that have and have not implemented DR; the Oregon Safety Model (OSM) is used to assess safety threats and determine child safety in all districts.

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 support person or community partner can be present; initial contacts with families in the TR track can also be scheduled if the assessment is assigned a 5-day response time.

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, the worker makes 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.

In both AR and TR, 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 community 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 are offered to 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 and closure of the CPS assessment, 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). Since the use of an experimental design with random assignment to treatment and comparison groups was not feasible, the outcome evaluation utilized a matched comparison group design that matched each family in the two treatment groups (AR and TR) with similar families that received a traditional CPS assessment in a district that had not yet implemented DR. Propensity score matching was used to create two sets of matched groups:

- AR families and AR-matched families in non-DR districts
- TR families and TR-matched families in non-DR districts

In order to have an adequate amount of time to observe the outcomes of the families in the treatment groups, only the first four districts to implement DR were included in the treatment groups (D5, D11, D4, and D16). Four demographically similar districts that were scheduled to implement DR later in the roll-out were selected to be the comparison group (D3, D10, D6, and D2). Families were included in the pre-match sample if their assessments closed by June 30, 2016.

There were 4,917 families assigned to AR in Districts 5, 11, 4, and 16 whose assessments closed on or before June 30, 2016. Of these, 4,898 (99.6%) were successfully matched to a similar family in a non-DR district. There were 4,238 families assigned to TR whose assessments closed on or before June 30, 2016; of these, 4,188 (98.8%) 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 (such as child race, child gender, number of children in the home, maltreatment reporter, alleged perpetrators, number of prior founded assessments, family stressors). 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.

Multiple sources of data were collected for the evaluation. Administrative data from OR-Kids were used to measure family demographics, CPS case flow, and outcomes such as maltreatment re-reports, founded re-reports, child removals, length of time in care, and disproportionate minority representation. Two rounds of site visits were conducted in each of the four districts that first implemented DR (D5, D11, D4, and D16). During each site visit, focus groups and interviews were conducted with DHS administrators, supervisors, CPS workers, permanency workers, community partners, and service providers; over 300 people participated in the site visits in total. Site visit participants were asked questions about DR implementation (training, coaching, supervision, leadership, data-driven decision-making, external system factors) and DR practice (screening and track assignment, use of the OSM, the FSNA, service provision, and relationships between DHS and community partners). A statewide 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.

Both quantitative and qualitative data were also collected from parents as well. Two parent surveys were distributed to parents; the first (the Post-Assessment Questionnaire, or PAQ) was given to all parents at the conclusion of the assessment and the second (the Service Assessment Questionnaire, or SAQ) was given to those parents who were offered services after the assessment. The parent surveys contained measures of emotional responses to the initial visit, perceptions of caseworker empathy and cultural sensitivity, parent engagement, family functioning, and service receipt. Low response rates for the PAQ (1.7% in the DR districts and 2.1% in the non-DR districts) and SAQ (17.3% and 16.5% in DR and non-DR districts, respectively) suggest that the results obtained from the parent surveys should be interpreted with some degree of caution. Finally, almost 100 parents were interviewed over the phone about their experiences with CPS, including the initial contact with workers, their involvement in decision-making, and services they may have received.

Implementation Evaluation

The main sources of information for the implementation evaluation were two rounds of site visits in the first four districts that implementation DR. During these site visits, which were conducted by evaluation partner Pacific Research and Evaluation,[2] qualitative information was gathered from a variety of DR practitioners and stakeholders about the processes used to develop and implement the DR practice model. The implementation science framework

[2] Four site visit reports have been written by Pacific Research and Evaluation and can be obtained by contacting Julie Murphy at Julie@pacific-research.org

developed by the National Implementation Research Network (NIRN) was used to guide the site visit data collection and analysis. Two rounds of data collection in each of the four DR districts permitted the evaluation to examine changes in DR implementation over time.

The most pervasive finding from this evaluation component is the negative effect that the "pause" had on the DR implementation process. Early rounds of data collection, which occurred before the pause in implementation, found that for the most part, CPS workers, supervisors, and community stakeholders were pleased with communication from DHS leadership regarding implementation and with the supports that were provided in terms of training, coaching, and supervision. The pause and changing DHS leadership led to decrease in communication, which resulted in uncertainty about whether or not DR would remain as a practice model or would be added to the list of previously abandoned child welfare practices. Forward momentum and enthusiasm diminished, as did worker morale. If the pause in implementation is lifted, it will take considerable time and effort to build momentum to previous levels.

One of the most consistent findings from both the site visits and the staff survey was the negative impact of workloads on CPS practice throughout the state, which became more noticeable over time. The climate today is one of constant turnover and burdensome workloads, something mentioned in the site visits and in the staff survey. Turnover affects the preparation of both frontline workers and supervisors. Some staff noted supervisors had been moved into DR districts but had been untrained in DR and had no time to attend the necessary training before performing their supervisory duties. The challenge of turnover is compounded by increased reports and assessments, the OSM refresh that reiterated to staff the extraordinary burden this safety model puts on worker time, and the state's crisis-driven approach to child welfare. The overall results in this report suggest Oregon remains understaffed and that this affects DR's implementation and sustainability.

Process Evaluation

The process evaluation examined the core components of DR practice and also looked at how the implementation of DR may have affected CPS practice in the rest of the state. DR practice was described by examining:

- screening and track assignment/re-assignment,
- initial contact with families (timeliness, calling ahead, offering support persons),
- family-centered practice and engagement,
- safety assessment using the Oregon Safety Model,
- use of the FSNA, and
- targeted and culturally appropriate service provision to address identified needs.

Screening and track assignment: Statewide, there has been an increase in both the number of reports received and the percentage of reports that were assigned to assessment. The increased numbers of reports were mirrored in the first four DR districts, and the percentages

assigned to assessments have increased in three of the four DR districts. About half of the reports assigned to assessment in these districts were initially assigned to AR, and 11-16% of AR assessments in 2016 eventually switched tracks and became TR assessments.

Timeliness of initial contacts with families. All assessments are assigned a response time within which the CPS worker is required to make an initial contact with the family; the two response times are within 24 hours or within 5 calendar days. Although exceptions can be made for both, the primary response time for AR assessments is within 5 days and TR assessments is within 24 hours. In 2016, between 70% and 89% of AR assessments were assigned a 5-day response time and between 83% and 92% of TR assessments were assigned a 24-hour response time. Compliance with assigned response times was about 75-80% in the four DR districts, and this was similar to or slightly better than the compliance rate for the state as a whole. Thus, it appears that the implementation of DR did not negatively impact the agency's initial response time.

Scheduled contacts. CPS workers in DR districts are encouraged to make prudent efforts to schedule initial contacts with families when a 5-day response time is assigned and to offer families the option of having a support person present for AR assessments. Staff survey results showed that these two practices were more common for AR assessments than TR or non-DR assessments. CPS workers were also more likely to use family interviewing in AR assessments. These worker reports were confirmed by the parent survey results, in which a significantly higher proportion of parents in AR assessments reported they were contacted prior to the first visit and offered the option of having a support person present. Interviews with parents suggested that calling ahead was very much appreciated; conversely, parents that did not receive a call to schedule initial contact reported feeling "confused" and "threatened" by the worker showing up unannounced.

Family engagement. The DR practice model is designed to increase parent engagement and opportunities to partner with parents in order to identify their needs and strengths more accurately. Results from the parent surveys and interviews revealed few differences in family engagement, involvement, or satisfaction between families in AR assessments and those in traditional CPS assessments in non-DR districts. Parents who received TR assessments, however, reported that their CPS workers were less likely to use family-centered practices such as showing care and compassion, listening to their concerns, explaining things clearly, and making a plan of action with them. Perhaps as a result, significantly greater proportions of parents in TR assessments reported feeling angry, afraid, and confused, and fewer felt relieved, comforted, and thankful when compared to parents who received non-DR assessments. Although these results are suggestive of potential practice differences in TR assessments compared to non-DR assessments, caution should be used when interpreting these results due to the very low response rates on the parent survey.

Safety decisions. At the conclusion of the assessment, CPS workers make a decision about the safety of the children. The results of the evaluation suggest small variations in the rates at which children were found to be unsafe among the DR districts; in AR assessments, the

percentage of unsafe children ranged from 5% to 11%, and in TR assessments, the percentage of unsafe children ranged from 8% to 13%. These percentages are consistent with statewide rates, and offer no evidence to suggest safety assessment, guided by the OSM, is different in DR compared to non-DR districts.

Family Strengths and Needs Assessments. When children are safe at the end of an assessment, the CPS worker should assess if the family has moderate to high needs; if yes, then (in DR districts) the family should be offered a Family Strength and Needs Assessment (FSNA) and both contracted (if the family completes an FSNA) and non-contracted services (for all families, regardless of whether they complete an FSNA). Focus groups with CPS workers and supervisors in DR districts revealed that the FSNA was unpopular, and viewed mostly as an extra burden rather than a useful practice tool.

Service provision. Additional data from the process evaluation suggest that the FSNA may have operated as a bureaucratic obstacle to providing services to families, rather than as useful assessment procedures to identify the services families need. The vast majority of assessments (both AR and TR) conclude that the children assessed are safe, yet the number of families with safe children offered *any* services ranged from 10% to 19% for AR assessments and 8% to 16% for TR assessments. Only 3% to 8% of families in with safe children end up accepting services. The numbers of families who received contracted services (offered after an FSNA and by opening an "admin-only" case) is even smaller: 134 families in 2016 had an admin-only case opened, only 1.5% of the 8,835 assessed families with safe children in DR districts.

Length of CPS assessments. The final measure examined was the length of CPS assessments in the four 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 both AR and TR assessments dropped significantly between 2015 and 2016. In 2016, the average length of AR assessments in the four DR districts ranged from 64 to 74 days and those for TR assessments ranged from 63 to 77 days. The average for the state as a whole was 66 days.

Outcome Evaluation

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. As a result of the assessment and services, family functioning will be increased. This, in turn, will lead to fewer families being re-reported to DHS and fewer children being removed from their homes and placed into foster care. If children are placed into foster care, the length of time until achieving permanency will be decreased. DR implementation will affect the child welfare system as a whole by strengthening the organizational culture and the relationship between child welfare and community partners, and by decreasing the disproportionate representation of minority children in the child welfare system.

Family functioning and child safety. The results of the outcome analyses revealed a few significant differences between family outcomes in the treatment and comparison groups, all in the expected directions:

- Parents in AR assessments reported higher levels of social support than parents in non-DR assessments.
- Families in AR assessments had lower rates of founded re-reports than families in AR-matched assessments.
- When outcomes were examined by race, both White families and Latino/Hispanic families in AR assessments had lower rates of founded re-reports compared to similar families in the AR-matched groups.
- Latino/Hispanic families in TR assessments had lower rates of founded re-reports compared to similar families in the TR-matched groups.

Disproportionate minority representation. DR was also expected to reduce disproportionate representation of minority groups in the child welfare system. Prior to the implementation of DR, the first four districts had proportionate representation of White and African American children at each child welfare decision point, underrepresentation Hispanic/Latino children, and overrepresentation of Native American children. After DR, these patterns remained, but overrepresentation of African American children in care for longer than 12 months and overrepresentation of Native American children at all stages noticeably declined. These patterns mirrored changes in non-DR comparison districts, making it difficult to credit DR for the improvements. Nevertheless, DHS' continued focus on racial disproportionality will hopefully continue to move all racial groups toward proportional representation.

Worker and organizational outcomes. The outcome evaluation also examined outcomes related to job satisfaction, organizational culture, and community partnerships. Consistent with the site visit summaries, the staff survey found that staff were dissatisfied with their workload, salary, opportunities for advancement, and OR-Kids. Staff were satisfied with the supervision they receive and with their agency's cultural sensitivity. Regarding organizational culture, staff survey results showed that staff feel a high degree of purpose in their work but are burdened by their workload. Staff were also asked about coordination with community partners. A majority of staff somewhat or strongly agreed that they are able to effectively coordinate with service providers. Staff that noted some hindered coordination were asked the reason, and the most common reason was lack of communication between DHS and the community partner. There were no differences between DR and non-DR districts on any of these measures.

Cost Evaluation

The cost evaluation compared the costs to serve families in AR assessments and TR assessments with those to serve similar families in the matched non-DR districts. Costs of worker time and services during both the initial assessment and a standard follow-up period were examined and the average costs per family were calculated. The cost analysis was conducted to test the theory that DR would produce higher costs during the initial assessment

and lower costs during the follow-up period. The results of the cost evaluation found no evidence to support this theory; AR and TR assessments were more expensive than AR-matched and TR-matched assessments, respectively. The primary reason for this increased cost for AR assessments was higher service costs. TR assessments showed higher costs of worker time as well as higher service costs.

Chapter 1: Introduction and Background

After a lengthy exploration and planning process, the Oregon Department of Human Services (DHS) began implementing Differential Response (DR) in May 2014 as part of a broader reform effort aimed at safely and equitably reducing the number of children experiencing foster care. Broadly speaking, DR is an approach to child protective services (CPS) that includes the use of two or more discrete response pathways for screened-in reports of child abuse and neglect. Initial response assignment can be based on a variety of factors, such as the presence of imminent danger, level of risk, number of previous reports, source of the reporter, and presenting case characteristics such as the type of alleged maltreatment and age of the alleged victim. Initial response assignment can change based on new information obtained by the agency that alters the risk level or safety concerns. In DR systems, families in the non-investigation response pathway may accept or decline child welfare services if there are no safety concerns, family members are not entered into the state's central registry as maltreatment perpetrators, and there is no formal determination of maltreatment occurrence (i.e., substantiation) at the conclusion of the CPS response.[3] DR was first implemented in Missouri and Minnesota in the late 1990s and has since been implemented in more than half of the states in the U.S.[4]

Driven in part by a desire to reduce the number of children entering foster care and address the needs of families being referred to CPS for neglect, Oregon DHS began exploring the possibility of utilizing DR in 2010. With assistance from Casey Family Programs, DHS gathered information from states that had implemented DR models (Minnesota and Ohio) that might be adapted for use in Oregon. The National Resource Center for Child Protective Services (NRCCPS) conducted a series of focus groups with various internal and external stakeholders across the state to gauge the amount of support for and concern about the adoption of DR in Oregon.[5] DHS was thorough in gathering information about how DR might be structured in Oregon, learning from the successes and challenges of other states, and sharing information with stakeholders who helped develop the basic structures of DR in the formative stages of the process.

After the decision was made to adopt DR, the details of the Oregon DR model were developed by a DR steering committee, which was responsible for overseeing the planning process and the work of the implementation team and its ten subcommittees (screening and eligibility, communication, training and coaching, provider and child welfare roles, outcomes and evaluation, strengths and needs tool, workforce readiness, information technology, rules and

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[3] Merkel-Holguin, L., Kaplan, C., & Kwak, A. (2006). *National study on differential response in child welfare*. Englewood, CO: American Humane Association and Child Welfare League of America.

[4] Child Welfare Information Gateway. (2008). *Differential Response to Reports of Child Abuse and Neglect*. Washington, DC: U.S. Department of Health and Human Services.

[5] Lake, S., Player, J., Savoy, T., Ware, M., Ainam, D., & Mason, S. (2014, November). *Oregon's community-involved approach to DR implementation*. Paper presented at the 9th Annual Conference on Differential Response in Child Welfare, Seattle, WA.

procedures, and family engagement). The implementation team and subcommittees were responsible for making recommendations about the specific structure of the Oregon DR model. In total, over 100 staff and community partners, including representation from Oregon's tribes, were involved in building Oregon's DR model.

1.1 Oregon Differential Response Practice Model

In Oregon, DR consists of two CPS response tracks: Alternative Response (AR) and Traditional Response (TR). Several changes were made to CPS screening and assessment procedures to accommodate DR (see Table 1 for a description of the similarities and differences in practice between AR, TR, and non-DR CPS assessments and see Figures 1 and 2 for process and decision flow charts for AR and TR). All CPS assessments in Oregon begin after a report has been screened by a screener who decides if the report meets the statutory criteria for Child Protective Services or Family Support Services. If so, the report is "assigned to an assessment," and if not, it is "closed at screening." Screeners in districts that have implemented DR must also use the Track Assignment Tool to determine which pathway (AR or TR) to assign the assessment. A TR assessment must be assigned when the report alleges or the information gathered indicates at least one of the following:

- The child has suffered or could likely suffer severe harm, defined as significant or acute injury to his/her physical, sexual, psychological, cognitive, or behavioral development or functioning; immobilizing impairment; or life threatening damage.
- The abuse occurred in a day care facility, the home of an open or closed Department-certified foster parent or relative caregiver, or in a private child caring agency that is not Children's Care Provider.
- The perpetrator is a day care employee, Department-certified foster parent or relative caregiver, or a DHS employee.
- There are multiple allegations in the same report, and any of the allegations meet one of the criteria outlined in the track assignment tool for a TR.
- There is a prior report of child abuse or neglect that has not been assessed because the Department was unable to locate the family and the prior allegation or current allegation meets the criteria for a TR assessment.
- There is an open TR assessment within 60 days of the date the new assessment will be assigned.
- There is an open Department case with an impending danger safety threat.

An AR assessment must be assigned when the report alleges or the information gathered indicates the child has or could likely suffer harm, but the harm is not severe and none of the criteria for a TR assessment apply.

Once it has been determined that a CPS response is required and the type of CPS assessment has been assigned, screeners in both DR and non-DR districts must determine how quickly CPS must respond, selecting between two response timelines (within 24 hours or within 5 calendar days). According to the CPS assessment manual, when making this decision, the screener must take into account the location of the child, how long the child will be in that location, and the

access that others have to the child. A TR assessment requires a "within 24 hours" response time unless the screener can clearly document how the information indicates child safety will not be compromised by the delayed response. Conversely, an AR assessment requires a "within 5 calendar day" response time unless information indicates that a child is in danger right now or a child has a current injury as a result of the alleged abuse or neglect.

According to the CPS Assessment Manual, child safety is the primary focus of all CPS assessments, and effective family engagement enhances the quality of the CPS assessment. AR and TR assessments have many of the same components as CPS assessments in non-DR districts, including:

- Making initial contact within assigned response time
- Making face-to-face contact with the alleged victim, his or her siblings, his or her parent or caregiver, other children and adults living in the home, and the alleged perpetrator
- Accessing and viewing the home environment
- Gathering safety-related information through interviews and observations
- Determining if there is a present danger safety threat
- Determining if there is an impending danger safety threat
- Developing a protective action plan when a child is determined to be unsafe due to a present danger safety threat
- Developing an initial safety plan when a child is determined to be unsafe due to an impending danger safety threat
- Determining whether the initial safety plan or ongoing safety plan is the least intrusive plan sufficient to manage child safety by identifying how the safety threat is occurring and applying the in-home safety plan criteria
- Developing conditions for return home when an out-of-home ongoing safety plan is established
- Determining whether a family has moderate to high needs when a child is determined to be safe

In districts that have implemented DR, families with moderate to high needs can be referred for a Family Strengths and Needs Assessment (FSNA), which they can either accept or decline. In addition, families in DR districts may also be provided with paid/contracted services after the CPS assessment is closed in addition to the referrals to community services that are available in non-DR districts.

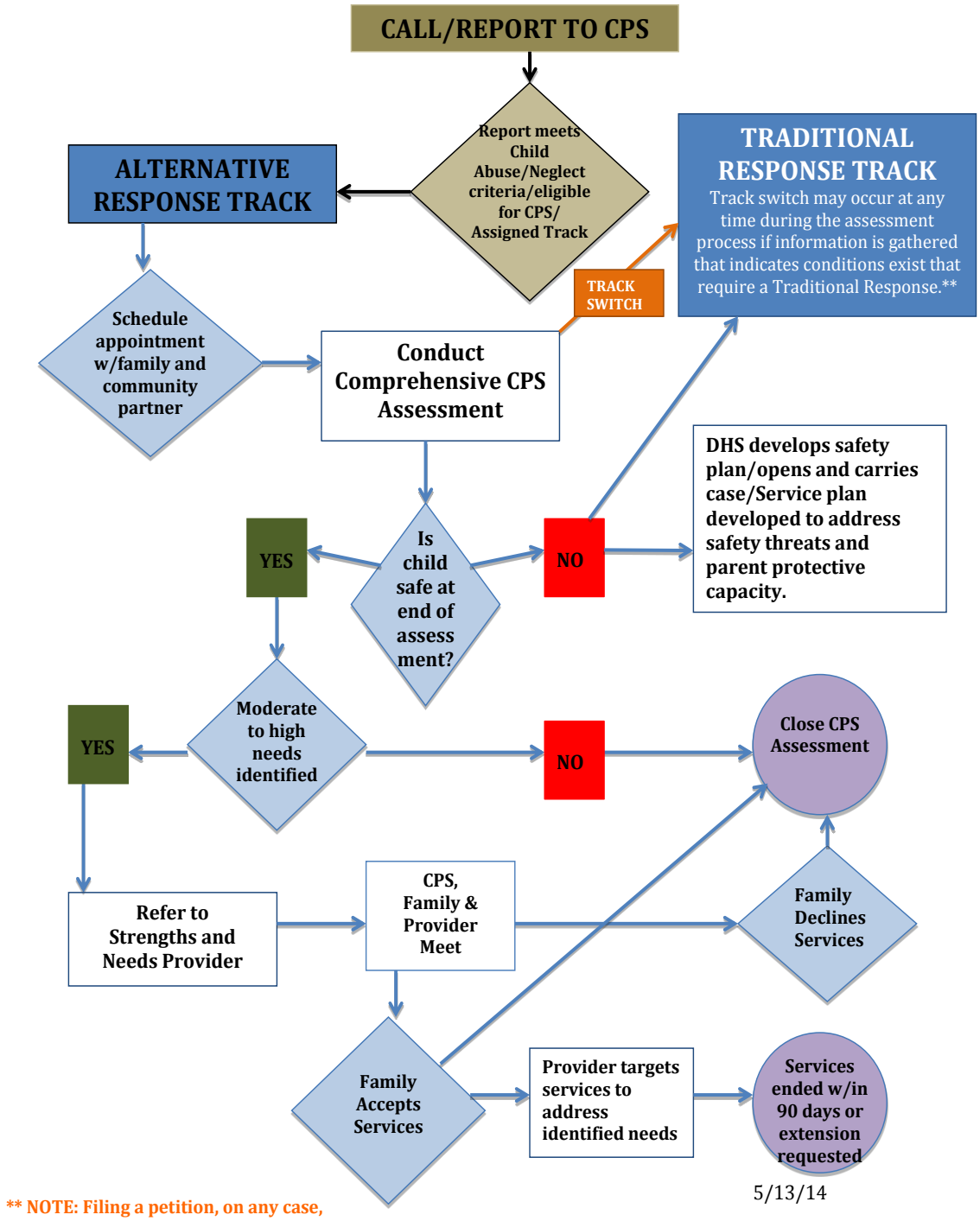
Within DR districts, there are a few differences in procedures between AR and TR assessments that are noted in Table 1:

- AR assessments more often allow for scheduled/prearranged first contact with families
- CPS workers in AR assessments must offer the family the option of having a community partner or support person present at the initial contact
- TR assessments require a formal disposition and AR assessments do not
- Perpetrator names are entered into Central Registry at the conclusion of a TR assessment but not an AR assessment

Table 1. Similarities and Differences in AR, TR, and Non-DR Assessment Procedures

	AR	TR	Non-DR
SCREENING			
Screening decision (assigned to assessment or closed at screening)	Yes	Yes	Yes
Track assignment	Yes	Yes	No
Response time assignment	Yes	Yes	Yes
CPS ASSESSMENT			
Make initial contact within assigned timeline	Yes	Yes	Yes
Make efforts to schedule initial contact with family if assigned "within 5 calendar day"	Yes	Yes	No
Offer family the option of having a support person or community partner present at initial contact	Yes	No	No
Effectively engage family members using family engagement toolkit	Yes	Yes	Yes
Face-to-face contact with alleged victims, parents, other children or adults in house	Yes	Yes	Yes
Conduct family interview if appropriate	Yes	No	No
Access and view home environment	Yes	Yes	Yes
Determine if there are present danger safety threats or impending danger safety threats	Yes	Yes	Yes
If conditions require it, change from AR to TR	Yes	No	No
If safety threats are identified, develop appropriate safety plans	Yes	Yes	Yes
If safety threats are present at the conclusion of the assessment, open a case	Yes	Yes	Yes
If no safety threats are identified, determine if family has moderate to high needs	Yes	Yes	Yes
If no moderate to high needs are identified, close the CPS assessment	Yes	Yes	Yes
If moderate to high needs are identified, refer family to non-contracted community services	Yes	Yes	Yes
If moderate to high needs are identified, offer family option of Family Strengths and Needs Assessment	Yes	Yes	No
If FSNA is accepted, refer to provider and offer contracted and non-contracted community services after CPS assessment is closed	Yes	Yes	No
Determine the disposition (founded, unfounded, unable to determine) and enter information into Central Registry	No	Yes	Yes

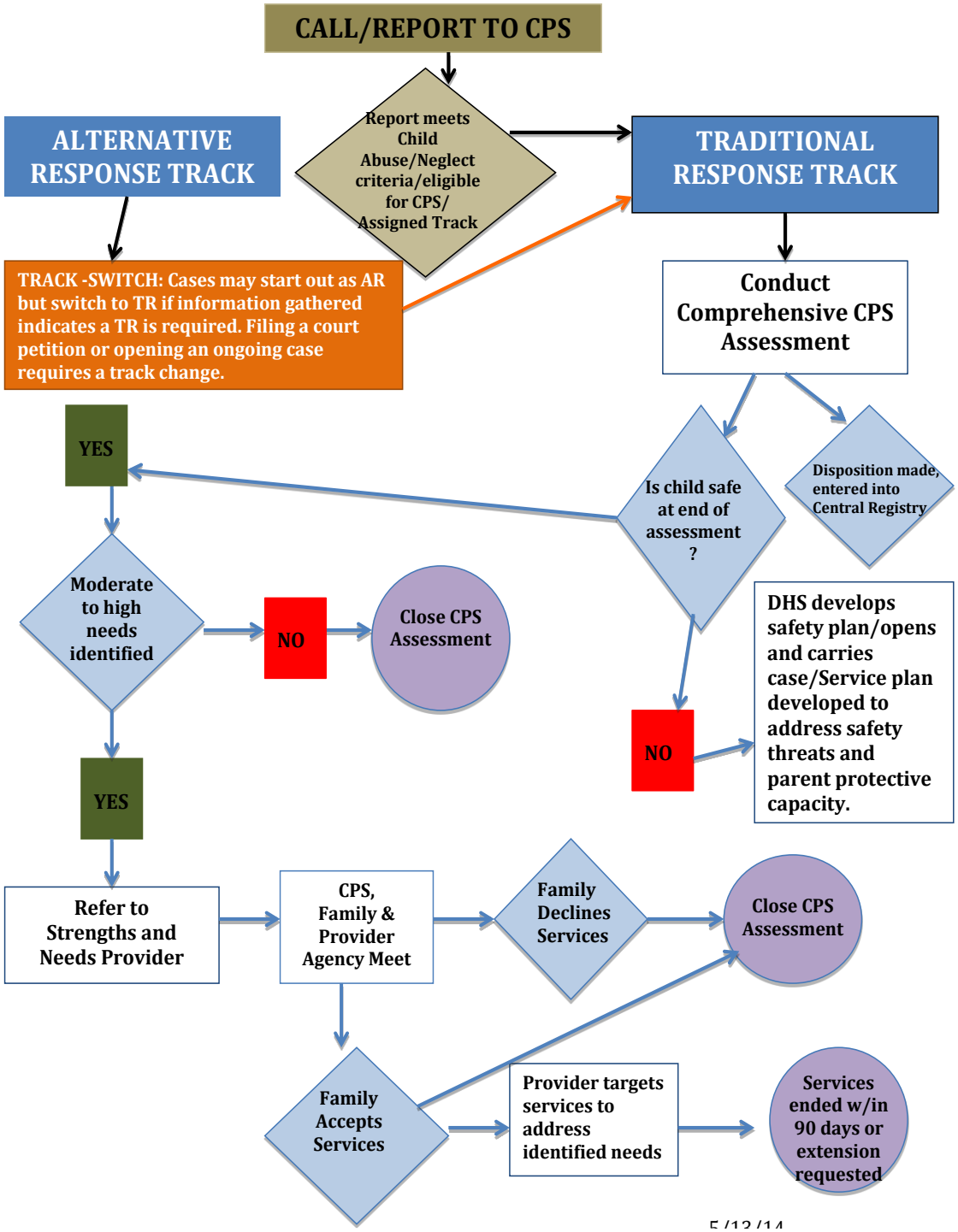
Figure 1. Alternative Response Process and Decision Flow



5/13/14

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

Figure 2. Traditional Response Process and Decision Flow



The DR Steering Committee decided to use 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 June 2017.

1.2 Oregon Differential Response Logic Model

Early in the implementation process, DHS articulated the intended results of DR through a vision statement, which states that "As a result of Oregon's implementation of Differential Response, the state will see the following outcomes:

- Children will be kept safely at home and in their communities using the Oregon Safety Model and its core concepts and tools to guide decision making.
- The community and Oregon DHS will work in partnership with a shared responsibility for keeping children safely at home and in their communities.
- Families will partner with Oregon DHS to realize their full potential and develop solutions for their challenges.
- Fewer children will re-enter the child welfare system through improved preventive and reunification services for families.
- Disproportionality will be reduced among children of color.
- Private agencies and community organizations will experience stronger partnerships with Oregon DHS on behalf of children and families."[6]

The vision statement was expanded into a logic model that articulates the conceptual linkages between the DR program inputs and activities, expected outputs, and short-term, intermediate, and distal outcomes (see Figure 3).

Inputs and activities. According to the logic model, DHS will invest numerous resources (i.e., inputs) and engage in a range of activities 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

[6] http://www.oregon.gov/dhs/children/differential-response/Documents/DR-vision-statement.pdf

families will be timely, and families will be engaged and treated with respect throughout the assessment. In addition, families will be involved in making decisions about their needs and services. 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 voluntary strengths and needs assessment to determine what services may be offered to improve family functioning. An array of voluntary 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, 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, 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 DR practice model is developed and maintained Families are assigned to appropriate track Families change tracks when appropriate Initial meetings with families are timely Families are engaged, treated with respect, and are involved in decisions The Oregon Safety Model is used with fidelity to assess child safety in the home Family strengths and needs are assessed Families with moderate to high needs are offered services Appropriate services are provided to strengthen family functioning	Informal and formal supports are increased Family functioning is improved	Fewer repeat maltreatment reports Fewer substantiated maltreatment re-reports Fewer child removals	Decreased time to permanency for children taken into foster care Reduced disproportionate representation of children of color in foster care Stronger relationship between child welfare and community partners

1.3 Overview of the Evaluation and Research Questions

In order to test the hypothesized relationships between the inputs, outputs, and outcomes that are delineated in the DR logic model, DHS selected the Children and Family Research Center (CFRC) at the University of Illinois at Urbana-Champaign (UIUC) to design and conduct a comprehensive evaluation of DR. The evaluation has several components that have been designed to answer a list of research questions that were developed by the DR Steering Committee.

An *implementation evaluation* examines the processes that DHS used to implement DR in Oregon. This evaluation component is guided by the implementation science framework developed by the National Implementation Research Network (NIRN).[7] According to the NIRN framework, implementation is a developmental process that occurs in a series of stages (exploration, installation, initial implementation, and full implementation) and is supported by implementation drivers that establish an organization's capacity to create the practice, program, and system-level changes. Competency drivers develop the competence and confidence of staff by attending to staff selection, training, coaching, and performance/fidelity assessment. Organization drivers (decision support data systems, facilitative administration, and systems-level intervention) create a more hospitable administrative, funding, policy, and procedure environment to ensure that the competency drivers are accessible and effective as well as to ensure continuous quality monitoring. Leadership drivers attend to both technical and adaptive leadership strategies.[8] When correctly aligned, these core implementation drivers can greatly influence how well a program is implemented. The implementation evaluation answers the following research questions:

1. How effectively were each of the NIRN implementation components (staff selection, training, coaching, performance assessment, decision-support data systems, facilitative administration, systems intervention) addressed during DR implementation?
2. Is DHS adequately staffed to practice the DR model?
3. Are there differences in DR implementation across districts?
4. Are there differences in DR implementation across cultural and ethnic groups?
5. Are community and external partners involved in Differential Response implementation?
6. Are culturally responsive partners involved in the implementation of Differential Response?
7. Which implementation strategies were most effective? Least effective?

[7] 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.

[8] Bertram, R.M., Blasé, K.A., & Fixsen, D.L. (2015). Improving programs and outcomes: Implementation frameworks and organizational change. *Research on Social Work Practice, 25,* 477-487.

A *process evaluation* examines the core components in the Oregon DR model, including screening and track assignments/re-assignments, initial contacts with families, family engagement and involvement in the decision-making process, comprehensive CPS assessments (including use of the Oregon Safety Model), the Family Strengths and Needs Assessment (FSNA), and service provision. The process evaluation answers the following research questions:

1. What does Differential Response in Oregon look like?
    a. What percentages of families are assigned to assessment and closed at screening?
    b. What percentages of families are assigned to AR and TR?
    c. What percentage of families initially assigned to AR switch to TR?
    d. What percentages of families are assigned a 24-hour and 5-day response timeline?
    e. Are families contacted within the assigned timeline?
    f. Are initial contacts scheduled with the families in AR and TR assessments?
    g. Are families in AR assessments offered to have a support person present at initial meetings?
    h. Are parents engaged with their CPS worker?
    i. Do parents feel respected and involved in decision-making?
    j. Do parents feel that DHS is culturally responsive?
    k. What percentages of families are found to be safe and unsafe?
    l. Are safe families referred for an FSNA?
    m. Does the FSNA help identify families' needs?
    n. What percentages families are offered and accept services? Which families are more likely to accept services?
    o. Are culturally-responsive services available?
    p. Are services available in rural regions?
    q. What types of services do families receive?
    r. What are the barriers to receiving and completing services?
    s. Are families satisfied with the services they receive?
2. Does DR practice vary across districts?
3. How has worker practice changed in districts that have implemented DR?
4. Are staff using the Oregon Safety Model with fidelity?
5. Are the roles of DHS and community partners in keeping children safe clearly defined?
6. Is the coordination between DHS and community partners effective?
7. Do workers feel supported by community partners?
8. What processes are being used to prevent entry into foster care?
9. What processes are being used to enhance permanency?

The evaluation also includes an *outcome evaluation* that examines the short-term, intermediate, and long-term outcomes that are associated with DR. Although the practice changes associated with the AR track are more comprehensive, practice in the TR track also differs from CPS practice in non-DR districts, which suggested the need for two treatment groups in the outcome evaluation: 1) families in DR districts that are assigned to the AR track

and 2) families in DR districts that are assigned to the TR track. The outcome evaluation will examine the following research questions:

1. Are there differences in family functioning between families who receive an AR or TR assessment and similar families who receive a CPS assessment in a non-DR district?
2. Are there differences in maltreatment re-reports between families who receive an AR or TR assessment and similar families who receive a CPS assessment in a non-DR district?
3. Are there differences in founded maltreatment re-reports between families who receive an AR or TR assessment and similar families who receive a CPS assessment in a non-DR district?
4. Are there differences in foster care entries between families who receive an AR or TR assessment and similar families who receive a CPS assessment in a non-DR district?
5. Are there differences in the length of time to permanency between children who entered foster care following an AR or TR assessment compared to similar children who entered foster care following a CPS assessment in a non-DR district?
6. Do child and family outcomes vary by district? By racial or ethnic group?
7. Is family engagement related to outcomes (re-reports, removals)?
8. What services are most effective in achieving DR goals?
9. Is disproportionality in the system reduced following the implementation of DR?
10. Has DR impacted worker job satisfaction?
11. Has DR impacted organizational culture?
12. How has Differential Response changed the nature of the relationships between DHS and community organizations?

The final component of evaluation is the *cost analysis*, which compares the per-case costs associated with serving a family in the AR and TR tracks with those associated with serving similar families in non-DR districts and answers the question:

1. Are there differences in the short-term and long-term costs associated with serving a family in an AR or TR assessment compared to serving similar families in a CPS assessment in a non-DR district?

1.4 Overview of the Final Evaluation Report

Work on the DR evaluation began in early 2015 and during the past 2.5 years, the CFRC and its local evaluation partner, Pacific Research and Evaluation (PRE), have produced several evaluation reports, including four site visits reports that have examined the implementation processes in the first two cohorts to implement DR (D5/D11 and D4/D16),[9] a report on the results of the statewide staff survey,[10] a report on the results of the OSM fidelity assessment,[11] and two interim evaluation reports.[12] Although the final evaluation report is comprehensive and includes findings from each of these reports, more detailed and comprehensive information about the site visit and OSM fidelity assessment findings can be obtained in the original reports.

Following this introductory chapter, the final evaluation report is organized into several chapters:

- Chapter 2: Research Design and Methodology describes the research design used in the outcome evaluation, the sample selection process and results, the data collection methods and instruments used, and the quantitative variables included in the analyses.

- Chapter 3: Implementation Evaluation Findings highlights findings from the site visit and staff survey data collections related to the implementation of DR in Oregon. Specifically, this chapter describes how Oregon DHS attended to the core implementation drivers described in the NIRN implementation science framework: staffing, training, coaching, supervision, fidelity assessment, decision support data systems, facilitative administration, and external systems interventions. Differences over time and between districts are noted, when present.

- Chapter 4: Process Evaluation Findings uses data from multiple sources to describe the core components of DR in Oregon, including screening and initial track assignments/re-assignments; initial contacts with families; family engagement and family-centered

[9] 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. Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 1 Year 2 site visit report.* Portland, OR: Author. Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 2 Year 2 site visit report.* Portland, OR: Author.

[10] Fuller, T., Braun, M.T., Chiu, Y., Cross, T.P., Nieto, M., Tittle, G., & Wakita, S. (2016). *Oregon Differential Response Evaluation: Baseline Staff Survey Results.* Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

[11] Braun, M., & Chiu, Y. (2017). *Oregon Differential Response Evaluation: OSM Fidelity Report.* Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

[12] Fuller, T., Braun, M.T., Chiu, Y., Cross, T.P., Nieto, M., & Tittle, G., & Wakita, S. (2015, 2016). *Oregon Differential Response Initiative: Annual Interim Evaluation Report.* Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

practices; safety assessments; family strength and needs assessments; and service provision.

- Chapter 5: Outcome Evaluation Findings describes the findings from the outcome evaluation, which compares the outcomes experienced by families in the two treatment groups (AR and TR) with those of matched comparison families in non-DR districts. This chapter also explores worker and system-level outcomes associated with DR implementation.

- Chapter 6: Cost Analysis Findings describes the costs to serve families in AR and TR assessments and compares them to the costs to serve similar families in districts that have not yet implemented DR.

- Chapter 7: Conclusions and Recommendations provides a summary of the evaluation findings, discusses their limitations, and offers some recommendations related to implementation and DR practice.

Chapter 2: Research Design and Methodology

Researchers at the Children and Family Research Center worked collaboratively with Oregon DHS to develop the research design, data collection instruments, and methodologies used in the evaluation. All research methods were approved by the Institutional Review Board (IRB) at the University of Illinois at Urbana-Champaign. This chapter describes the outcome evaluation research design and sample selection process, the results of the propensity score matching process, the data sources and data collection procedures, and the definitions of the quantitative variables used in the analyses.

2.1 Research Design

One of the 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 utilized a matched comparison group design that matched families who received the treatment with similar families who did not.

An important first step in designing the outcome evaluation was to define the treatment group. Families with reports that are "assigned to assessment" in districts that have implemented DR can receive either an Alternative Response (AR) or a Traditional Response (TR), while families in non-DR districts 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 (see Table 1 for a comparison of CPS practice in AR, TR, and non-DR districts). This suggested a need for two treatment groups: families in DR districts who were assigned to AR and TR. Thus, each family in the AR and TR groups was matched with a similar family who received a CPS assessment in a non-DR district. After the matching process, four groups were included in the outcome evaluation:

1. AR families
2. AR-matched families in non-DR districts
3. TR families
4. TR-matched families in 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). The outcome evaluation does not compare families in AR assessments and TR assessments, because these families are not comparable and would not be expected to have similar outcomes.

A statistical technique known as propensity score matching (PSM) was used to create the matched comparison 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.

2.2 Sampling and Matching Procedures

Because Oregon DHS is implementing DR in a staged roll-out, only the first four districts that implemented DR are included in the evaluation treatment group: 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 became smaller over time as more districts implemented 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 four 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 non-DR districts for the comparison group 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 family 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 Non-DR Districts Included in the Sample

DR Districts	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 June 30, 2016.[13] 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 is shown in Table 3.

[13] This date 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).

Table 3. Number of CPS Assessments Included in the Matching Procedures

DR District	AR Assessments	TR Assessments
5	2,169	1,616
11	692	694
4	767	827
16	1,289	1,101
Total	4,917	4,238

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 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 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.

2.2.1 Alternative Response treatment and comparison samples

There were 4,917 families assigned to AR in Districts 5, 11, 4, and 16 whose assessments closed by June 30, 2016. 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 most observed characteristics (see Table 4). Significant differences are marked with an asterisk.

Table 4. Pre-match Characteristics of Families in AR and Non-DR CPS Assessments

Variable	AR families (n=4,917)	Non-DR families (n=15,979)
Race		
White*	72.7%	66.8%
Black/African American*	4.2%	11.9%
Native American	5.0%	5.3%
Hispanic/Latino*	9.5%	11.9%
Asian*	1.2%	1.6%
Pacific Islander*	1.2%	0.8%
Gender		
Female child/ren	36.9%	37.5%
Male child/ren	41.0%	37.4%
Female and male children	22.2%	25.1%
Number of children in family*		
1	63.5%	58.7%

2	23.0%	23.8%
3 or more	13.5%	17.5%
Alleged maltreatment type		
Physical abuse*	20.1%	24.2%
Sexual abuse*	1.0%	8.2%
Neglect*	59.4%	52.1%
Medical neglect	3.1%	3.2%
Mental injury/abuse	3.5%	3.0%
Threat of harm*	33.3%	45.6%
Maltreatment reporter*		
Mental health provider	21.1%	22.2%
Health care provider	10.3%	13.2%
Law enforcement/court	23.2%	23.5%
School personnel	19.8%	19.0%
Self/relative/anonymous	20.8%	18.5%
Other/missing	4.9%	3.5%
Alleged perpetrator=mother*	65.5%	57.5%
Alleged perpetrator=father*	45.8%	48.5%
Number prior reports*	4.7	5.5
Number prior reports closed at screening*	1.8	2.2
Number prior CPS assessments*	1.9	2.2
Number prior founded assessments		
0	74.0%	71.6%
1	15.3%	15.9%
2	6.4%	6.5%
3	2.5%	3.1%
4 or more	2.2%	2.9%
Number prior open family cases*		
0	75.1%	73.9%
1	17.1%	17.0%
2 or more	7.8%	9.5%
Prior foster care episode (yes)*	12.4%	14.9%
Number of family stressors*	1.3	1.2
Parent alcohol/drug abuse*	27.8%	21.8%
Parent developmental disability	1.7%	1.4%
Parent mental illness*	9.3%	8.2%
Parent history maltreatment*	8.7%	6.9%
Head household unemployed*	6.9%	5.5%
Parent involvement law enforcement*	12.6%	10.5%
Heavy child care responsibility	1.4%	1.6%

New baby or pregnant*	7.4%	6.1%
Domestic violence*	18.4%	21.6%
Inadequate housing*	6.4%	6.1%
Financial stress*	15.1%	10.1%
Social isolation	1.4%	1.2%
Child emotional/behavioral issue*	12.9%	10.4%
Child developmental disability	2.8%	2.7%
Child mental illness	2.1%	2.1%

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 four times, in order to match families in AR assessments in each of the four DR districts with families in CPS assessments in non-DR districts. The technical details and results of each of the four separate matching procedures are included in Appendix A. After the procedures had been completed for the 4 paired districts, there were 19 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 4,898 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 six variables, which are marked with an asterisk in Table 5. Although these differences were statistically significant, most were small relative differences; for example, the number of prior reports in the AR sample was 4.7 compared to 4.5 in 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 (1.0%) than in the AR-matched sample (8.1%).

Table 5. Post-match Characteristics of AR and AR-matched Families

Variable	**AR families (n=4,898)**	**AR-matched families (n=4,898)**
Race		
White	72.8%	73.7%
Black/African American	4.2%	4.0%
Native American	4.7%	4.2%
Hispanic/Latino	9.5%	9.6%
Asian	1.2%	0.8%
Pacific Islander	1.2%	0.9%
Gender		
Female child/ren	36.9%	38.0%
Male child/ren	41.0%	40.3%

Female and male children	22.1%	21.7%
Number of children in family		
1	63.5%	64.0%
2	23.0%	22.7%
3 or more	13.5%	13.3%
Alleged maltreatment type		
Physical abuse	20.2%	21.3%
Sexual abuse*	1.0%	8.1%
Neglect	59.2%	59.0%
Medical neglect	3.1%	3.4%
Mental injury/abuse	3.5%	3.2%
Threat of harm	33.3%	32.3%
Maltreatment reporter		
Mental health provider	21.1%	21.1%
Health care provider	10.3%	10.3%
Law enforcement/court	23.2%	22.5%
School personnel	19.8%	20.1%
Self/relative/anonymous	20.7%	21.4%
Other/missing	4.8%	4.6%
Alleged perpetrator=mother	65.4%	65.2%
Alleged perpetrator=father	45.9%	46.4%
Number prior reports*	4.7	4.5
Number prior reports closed at screening*	1.8	1.6
Number prior CPS assessments	1.9	1.8
Number prior founded assessments		
0	74.1%	75.7%
1	15.0%	14.4%
2	6.3%	5.6%
3	2.5%	2.5%
4 or more	2.1%	1.9%
Number prior open family cases*		
0	75.2%	77.5%
1	17.0%	15.6%
2 or more	7.8%	6.9%
Prior foster care episode (yes)	12.3%	11.1%
Number of family stressors	1.3	1.3
Parent alcohol/drug abuse	27.7%	26.8%
Parent developmental disability	1.7%	1.5%
Parent mental illness	9.3%	8.9%
Parent history maltreatment	8.6%	7.8%
Head household unemployed	6.9%	6.1%

Parent involvement law enforcement	12.6%	12.6%
Heavy child care responsibility	1.4%	1.7%
New baby or pregnant	7.0%	6.9%
Domestic violence	18.4%	18.3%
Inadequate housing	6.4%	5.9%
Financial stress*	15.1%	13.2%
Social isolation	1.4%	1.1%
Child emotional/behavioral issue	12.8%	12.5%
Child developmental disability	2.8%	2.5%
Child mental illness	2.1%	2.3%

2.2.2 Traditional Response treatment and comparison samples

There were 4,238 families assigned to TR in Districts 5, 11, 4, and 16 whose assessments closed by June 30, 2016. Prior to the matching procedure, these families were significantly different from the families that received a CPS assessment in the four non-DR districts on almost every observed characteristic (see Table 6). Significant differences are marked with an asterisk.

Table 6. Pre-match Characteristics of Families in TR and Non-DR CPS Assessments

Variable	**TR families (n=4,238)**	**Non-DR families (n=14,717)**
Race		
White*	73.3%	68.0%
Black/African American*	4.6%	9.3%
Native American	5.4%	4.8%
Hispanic/Latino*	10.3%	12.1%
Asian	1.1%	1.4%
Pacific Islander*	0.4%	0.8%
Gender*		
Female child/ren	39.7%	37.6%
Male child/ren	36.5%	37.5%
Female and male children	23.8%	24.9%
Number of children in family*		
1	61.1%	59.0%
2	23.5%	23.6%
3 or more	15.4%	17.4%
Alleged maltreatment type		
Physical abuse*	33.4%	24.2%
Sexual abuse*	15.2%	8.2%
Neglect*	37.1%	52.5%
Medical neglect*	2.1%	3.1%

Mental injury/abuse*	5.7%	2.9%
Threat of harm*	52.5%	43.5%
Maltreatment reporter*		
Mental health provider	26.2%	21.5%
Health care provider	11.0%	12.8%
Law enforcement/court	22.7%	24.0%
School personnel	18.2%	20.0%
Self/relative/anonymous	16.9%	18.3%
Other/missing	5.0%	3.5%
Alleged perpetrator=mother*	46.3%	57.3%
Alleged perpetrator=father*	54.3%	48.2%
Number prior reports*	4.5	5.3
Number prior reports closed at screening*	1.6	2.1
Number prior CPS assessments*	1.9	2.1
Number prior founded assessment		
0	71.9%	73.1%
1	15.8%	15.4%
2	6.4%	6.0%
3	2.9%	2.9%
4 or more	3.0%	2.6%
Number prior open family cases		
0	73.8%	75.4%
1	17.6%	16.2%
2 or more	8.7%	8.5%
Prior foster care episode (yes)*	16.1%	14.2%
Number of family stressors*	1.3	1.2
Parent alcohol/drug abuse	20.8%	22.1%
Parent developmental disability*	1.9%	1.4%
Parent mental illness*	9.0%	7.9%
Parent history maltreatment*	13.3%	6.9%
Head household unemployed*	6.7%	5.4%
Parent involvement law enforcement*	19.3%	11.2%
Heavy child care responsibility	1.4%	1.6%
New baby or pregnant*	7.0%	6.0%
Domestic violence	20.3%	20.6%
Inadequate housing*	3.7%	5.7%
Financial stress*	12.6%	9.8%
Social isolation*	1.7%	1.2%
Child emotional/behavioral issue*	12.4%	10.7%
Child developmental disability	2.4%	2.8%
Child mental illness	1.8%	2.2%

The PSM procedures were completed four times in order to match families in TR assessments in each of the four DR districts with families in CPS assessments in non-DR districts. The technical details and results of each of the four separate matching procedures are included in Appendix B. After the procedures had been completed for the four paired districts, there were 50 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 4,188 TR families.

After the matching procedure, the majority of the significant differences between families assigned to TR and those in non-DR districts were eliminated; those that remained are marked with an asterisk in Table 7. Although these differences were statistically significant, most were small relative differences; for example, the mean number of prior reports for families in the TR sample was 4.5 compared to 4.2 for the TR-matched sample.

Table 7. Post-match Characteristics of TR and TR-matched Families

Variable	TR families (n=4,188)	TR-matched families (n=4,188)
Race		
White	73.2%	72.3%
Black/African American	4.6%	4.3%
Native American	5.1%	4.4%
Hispanic/Latino	10.3%	9.9%
Asian	1.1%	1.2%
Pacific Islander	0.4%	0.7%
Gender*		
Female child/ren	39.8%	39.7%
Male child/ren	36.6%	38.7%
Female and male children	23.6%	21.5%
Number of children in family		
1	61.3%	63.0%
2	23.4%	23.0%
3 or more	15.3%	14.0%
Alleged maltreatment type		
Physical abuse	33.2%	33.1%
Sexual abuse	15.1%	14.6%
Neglect*	37.0%	34.8%
Medical neglect	2.1%	2.0%
Mental injury/abuse*	5.3%	4.0%
Threat of harm	52.4%	53.1%
Maltreatment reporter		
Mental health provider	26.1%	25.9%

Health care provider	11.0%	11.3%
Law enforcement/court	22.9%	22.8%
School personnel	18.3%	20.1%
Self/relative/anonymous	16.9%	16.1%
Other/missing	4.9%	3.9%
Alleged perpetrator=mother	46.2%	45.0%
Alleged perpetrator=father	54.0%	53.5%
Number prior reports*	4.5	4.2
Number prior reports closed at screening	1.6	1.5
Number prior CPS assessments*	1.8	1.7
Number prior founded assessment		
0	72.4%	74.5%
1	15.7%	14.9%
2	6.3%	6.0%
3	2.8%	2.2%
4 or more	2.8%	2.3%
Number prior open family cases*		
0	74.2%	76.6%
1	17.3%	16.0%
2 or more	8.5%	7.4%
Prior foster care episode (yes)	15.8%	14.5%
Number of family stressors*	1.3	1.2
Parent alcohol/drug abuse	20.6%	19.1%
Parent developmental disability	1.9%	1.6%
Parent mental illness	8.9%	8.1%
Parent history maltreatment	12.9%	11.9%
Head household unemployed	6.7%	5.7%
Parent involvement law enforcement	19.1%	18.1%
Heavy child care responsibility	1.4%	1.1%
New baby or pregnant	7.0%	7.0%
Domestic violence	20.3%	20.8%
Inadequate housing	3.7%	3.6%
Financial stress*	12.6%	10.7%
Social isolation	1.6%	1.3%
Child emotional/behavioral issue	12.3%	11.7%
Child developmental disability	2.4%	2.3%
Child mental illness	1.8%	1.9%

2.3 Data Collection Methods

Several different quantitative and qualitative data collection methods were used in the Oregon DR evaluation. This section describes each data collection source, as well as sampling and response rates, if applicable.

2.3.1 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 (described earlier) 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 DR districts
- Response times assigned to assessments (24 hours or 5 days)
- Compliance with assigned response times
- Percentage of assessments that change tracks (AR to TR)
- Safety decisions
- Percentage of families offered services
- Percentage of families who accepted services
- Length of CPS assessments
- Length of Admin-Only cases

Data from OR-Kids were also used to create the following outcome measures:

- Maltreatment re-reports
- Founded maltreatment re-reports
- Child placements into substitute care
- Length of time in substitute care
- Disproportionate minority representation

2.3.2 Site visits in DR districts

Qualitative information on the DR implementation process and DR practice was collected through a series of site visits in the first four districts that implemented DR in Oregon. Two site visits were conducted in the first two districts to implement DR, Districts 5 (Lane County) and 11 (Klamath and Lake Counties) and two site visits were conducted in the second round of districts to implement DR, District 4 (Benton, Lincoln, and Linn Counties) and District 16 (Washington County). The first round of site visits were conducted approximately one year after DR implementation and the second round of site visits were conducted approximately two years after implementation.

During the site visits, data were collected through focus groups with CPS and ongoing/permanency caseworkers, supervisors, and administrators; service providers and community partners; and DR consultants. Individual interviews were conducted with DHS leadership and other individuals with unique information about DR implementation. All district staff were notified of the focus group schedule and invited to participate and individual interviews with key informants were scheduled at their convenience. Over 300 people participated in the site visit data collection across the four site visits. The number and type of participants in each round of the site visits are presented in Table 8.

The first set of questions focused on DR implementation and was based on the implementation stages and drivers outlined in the NIRN framework. Questions were categorized into several areas of inquiry:

- Exploration: impetus for DR in Oregon, contemporaneous child welfare reforms, exploration process and the decision to move forward with implementation
- Installation: DR model development, changes to agency infrastructure, and community buy-in
- Initial implementation: successes and barriers during the first year of implementation
- Full implementation: successes and barriers during the second year of implementation
- Implementation drivers: staffing, training, coaching, supervision and fidelity assessment, decision-support data systems, systems interventions, facilitative administration, leadership, and organizational and contextual factors

The second set of questions related to DR practice in the districts during the initial and full implementation stages. Participants were asked about:

- screening practice,
- track assignment and reassignment,
- CPS assessment and the OSM,
- Family Strengths and Needs Assessments,
- service provisions,
- relationships with community partners and service providers, and
- general feedback on DR practice.

Focus groups and interviews lasted between 1.5 to 2.5 hours and were audio-recorded and transcribed for analysis.

Table 8. Site Visit Participants

Round One Year One				
Role	**District 5**	**District 11**	**State**	**Total**
Administrators	7	2	7	16
Supervisors	6	6	n/a	12
CPS workers	7	8	n/a	15
Screeners	4	3	n/a	7
Community partners	7	2	8	17
Service providers	2	2	n/a	4
DR consultants	n/a	n/a	8	8
Total	**33**	**23**	**23**	**79**
Round Two Year One				
	District 4	**District 16**	**State**	**Total**
Administrators	5	6	1	12
Supervisors	5	16	n/a	21
CPS workers	20	29	n/a	49
Screeners	5	9	n/a	14
Community partners	4	3	n/a	7
Service providers	12	6	n/a	18
DR consultants	n/a	n/a	10	10
Total	**51**	**69**	**11**	**131**
Round One Year Two				
	District 5	**District 11**	**State**	**Total**
Administrators	4	2	1	7
Supervisors	8	4	n/a	12
Screeners	3	3	n/a	6
CPS workers	2	4	n/a	6
Permanency workers	3	4	n/a	7
Community partners	7	4	n/a	11
Service providers	3	3	n/a	6
DR consultants	n/a	n/a	7	7
Total	**30**	**24**	**8**	**62**
Round Two Year Two				
	District 4	**District 16**	**State**	**Total**
Administrators	2	8	1	11
Supervisors	4	15	n/a	19
Screeners	7	8	n/a	15
CPS workers	12	22	n/a	34
Permanency workers	3	10	n/a	13
Community partners	1	17	n/a	18
Service Providers	5	9	n/a	14
DR consultants	n/a	n/a	11	11
Total	**34**	**89**	**12**	**135**

2.3.3 Statewide staff survey

An online survey was developed and administered 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.[14] Characteristics of the participants in the staff survey are shown in Table 9.

Table 9. Staff Survey 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
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

[14] 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.

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.

2.3.4 Parent survey

Two parent surveys were developed 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 eight districts included in the outcome evaluation were instructed to give 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 giving 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 12,541 assessments (6,048 AR and 6,493 TR) that closed in the four DR districts and 16,056 assessments in the four non-DR districts between February 1, 2016 and February 28, 2017. During this time period, 209 PAQ surveys were received from parents in DR districts and 342 surveys were received from parents in non-DR districts, which correspond to PAQ response rates of 1.7% and 2.1%, 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 did and did not respond and found a few differences (see Appendix C for the results of the non-response comparisons). Given the low response rates and the slight differences between the parents who responded and those who did not, the results of the analyses using data from the

PAQ should be interpreted with caution and care should be taken not to over-generalize the results.

The second survey, known as the Service Assessment Questionnaire (SAQ), was mailed by CFRC to parents in the four DR and four 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, CFRC identified 1,493 families in the four DR districts and four non-DR districts who were offered services following a CPS assessment that closed prior to August 16, 2016. Of these, 1,302 were sent survey packets in the mail; 191 had incorrect mailing addresses in OR-Kids and did not receive surveys. As of May 20, 2017, 228 SAQ surveys were received through the mail or completed as part of the parent interviews (described in the next section), which corresponds to a response rate of 17.0%. Of these, 149 surveys were received from households in DR districts (17.3% response rate) and 79 surveys were received from households in non-DR districts (16.5% 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 AR families that responded to the survey (3.2%) compared to those who did not (11.6%) and higher among non-DR families who responded to the survey (20.3%) compared to those who did not (11.5%). Again, caution should be used when drawing conclusions based on the results of the PAQ and SAQ.

2.3.5 Parent interviews

In order to collect more in-depth information about parent's experiences during their CPS assessment and their views on the services that they received following the CPS assessment, qualitative interviews were conducted with two subsets of parents who received CPS assessments and services.

Two interview protocols were developed. The Post-Assessment Interview (PAI) contained questions about the initial contact with the CPS worker (whether or not they received a phone call, whether or not a support person was present, details of what happened during the initial visit), their engagement with the CPS worker, the services they received if any, and their resources and informal supports. The Service Assessment Interview (SAI) contained additional questions about service provision and helpfulness. The interviews were conducted over the phone by graduate students and were audio-recorded and transcribed for analysis.

Separate samples were drawn for the Post-Assessment Interviews (PAI) and the Service Assessment Interviews (SAI). The PAI recruitment sample was selected from the CPS assessments that were closed between June 5 and September 5, 2016 in the first four DR districts (D5, D11, D4, D16) and the four non-DR districts that were used in the propensity score matching (D3, D10, D6, D2). It was particularly important to capture the perspectives of African American and Native American parents, so these groups were over-sampled in the recruitment sample to ensure that they were adequately represented in the final sample. The goal was to complete 80 Post-Assessment Interviews, so the recruitment sample included 400 families, stratified by CPS response and race as shown in Table 10.

Table 10. Recruitment Sample for Post-Assessment Interviews

	DR		**Non-DR (n=200)**	**Total (n=400)**
	AR (n=100)	TR (n=100)		
African American	24	24	48	96
Native American	16	16	32	64
Other	60	60	120	240

Note. Other category includes Caucasian, Hispanic, Hawaiian and Pacific Islanders, Asian, and unknown.

The SAI recruitment sample was selected from families who were offered services after their CPS assessments in the four DR and non-DR districts mentioned above. Both African American and Native American parents were over-sampled to increase their representation in the SAI sample. The goal was to complete 20 Service Assessment Interviews, so the recruitment sample included 80 families stratified by districts (DR versus non-DR) and race as shown in Table 11.

Table 11. Recruitment Sample for Service Assessment Interviews

	DR (n=40)	**Non-DR (n=40)**	**Total (n=80)**
African American	10	10	20
Native American	6	6	12
Other	24	24	48

Note. Other category includes Caucasian, Hispanic, Hawaiian and Pacific Islanders, Asian, and unknown.

All families in the recruitment samples were mailed recruitment letters that informed them about the purpose of the interviews, the types of questions that would be included, and the risks and benefits of participating. The letter also encouraged parents to call the CFRC if their telephone number had changed or to schedule an appointment for an interview at a time that was convenient for them. About a week after mailing the letters, graduate students attempted to call the parents in the recruitment sample using the telephone number listed in OR-Kids. The interviewers made several attempts to call each family. The final samples included 79 parents for the Post-Assessment Interviews (Table 12) 18 parents for the Service Assessment Interviews (Table 13).

Table 12. Final Sample for Post-Assessment Interviews

Race	DR		Non-DR	Total
	AR	TR		
African American	5	3	7	15
Native American	3	2	7	12
Other[a]	12	11	29	52
Total	20	16	43	79

Note. Other category includes Caucasian, Hispanic, Hawaiian and Pacific Islanders, Asian, and unknown.

Table 13. Final Sample for Service Assessment Interviews

Race	DR	Non-DR	Total
African American	4	1	5
Native American	1	1	2
Other[a]	5	6	11
Total	10	8	18

Note. Other category includes Caucasian, Hispanic, Hawaiian and Pacific Islanders, Asian, and unknown.

2.3.6 Cost data

The cost evaluation compared the average total costs to serve a family in AR and TR with similar families in non-DR counties. The sample for the cost evaluation was created by randomly selecting 500 families from each of the four groups included in the outcome evaluation (AR, AR-matched, TR, and TR-matched). Several types of data were collected as part of the cost evaluation, including:

- the number and type of CPS and permanency worker contacts with families during the CPS assessment and follow-up period,
- the amount of time workers spent on different types of case contacts,
- CPS and permanency worker salaries, and
- the cost of services provided to families during the initial assessment and follow-up periods.

Worker contacts with families were collected from OR-Kids. Case-level data on the date and type of each worker contact was collected from the table "cw.Case_Contact."

The *amount of worker time* spent on each contact is not recorded in OR-Kids, so estimated durations for the most common types of worker contacts were derived by polling an expert panel of CPS workers and permanency workers. Workers were provided with a list of the most commonly-occurring contact types that appear in OR-Kids and were asked to estimate how long each contact type took on average. In order to present a manageable list of contact types to workers on the expert panels, only the most frequently-occurring contact types were listed in the survey; infrequent contact types were not included. The contact types included in the expert panel survey are listed in Table 14.

Table 14. Contact Types Included in the Cost Analyses

CPS Worker Contact Types	Permanency Worker Contact Types
Case Management: Plans and Services	Case Management: Plans and Services
CPS Assessment: Alleged Perpetrator	Visitation with Parents
CPS Assessment: Alleged Victim	Visitation with Relatives
CPS Assessment: Collateral	Visitation with Siblings
CPS Assessment: Custodial Parent/Guardian	Visitation (Other)
CPS Assessment: Family	Child Contact
CPS Assessment: Medical	Parent Contact
CPS Assessment: Non-Custodial Parent/Guardian	Relative/Family Contact
CPS Assessment: Police	Tribal Contact
CPS Assessment: Other Child	Medical: Substance Abuse Treatment
CPS Assessment: Other Professional	Medical: General Information
CPS Assessment: Supervisor/Worker Consultation	Legal: Court
CPS Assessment: Other	Legal: General Information
Child Contact	Certified Family
Parent Contact	Education: General Information
Tribal Contact	Non-Discovery: AAG Non-TPR Contact
Visitation with Parent	TCM
FSS Assessment: Custodial Parent/Guardian	Case Staffing
FSS Assessment: Family	Placement
FSS Assessment: Other Child(ren) in Home	FSS Assessment: Custodial Parent/Guardian
FSS Assessment: Other Professional	FSS Assessment: Family
Other Note	FSS Assessment: Other Professional
	FSS Assessment: Other
	Other Note

Information on CPS and permanency worker salaries was obtained from *Salaries of State Agencies FY2016* (see: http://www.oregon.gov/transparency/Pages/state_workforce.aspx). After consulting with DHS, the FY2016 mean salary for *Social Service Specialist 1* ($52,066.91) was used as the worker salary in the cost analysis.

Service costs were obtained from the OR-Kids table "cw.SFMAProgramExpenditure." Service costs with negative values were not included in the cost evaluation calculations.

2.4 Measures and Scoring

The quantitative data sources (OR-Kids, staff survey, and parent survey) contained information that was used to create variables used in the analyses.

2.4.1 Variables from OR-Kids

Year: A calendar year, not fiscal year, was used for the analyses. The year of the assessment initial report date was used for most of the analyses.

CPS reports assigned to assessment: Each CPS report ID listed in the CPS report file was counted as a CPS report. If the screener's decision was coded as "Closed at Screening," we concluded that the case was closed at screening and excluded from the assignment for an assessment. Similarly, if the screener's decision was coded as "Pending," the report was not included in the analysis.

Compliance with response times assigned: Compliance with assigned response time was computed by comparing the variables "initial contact date" and "initial contact due date" from the CPS investigations file. If initial contact date was on or before the initial contact due date it was considered compliant; otherwise it was considered to be not compliant.

Track assignment: Track assignment was taken directly from the CPS investigations file using the variable "initial track assignment" in districts that have implemented DR.

Track change (reassignment): Track change was taken directly from the CPS investigations file using the variable "date track changed." If a CPS assessment was initially assigned to "Alternative Track" and had a valid date on the "date track changed" variable, the assessment coded as a track change.

Safety decision: The safety decision code listed in the investigation file (i.e., safe or unsafe) was used to count the number of safe and unsafe assessments.

Length of CPS assessment: The length of initial assessment was defined as the number of days between the initial report date and the investigation disposition date (inclusive).

Services offered: The indication of whether or not the services were offered to the family was taken from the CPS investigations file using the variable of the same name, which has the response categories yes, no, or missing. The variable was used only if the safety disposition was "safe."

Services accepted: The indication of whether or not a family accepted services was taken from the variable of the same name in the CPS investigation file. Response categories include yes, no, or missing.

Admin-only service: Among the service types listed in the table *case_type_velocity*, the "other-administrative (DR-only)" service was used to compute Admin-Only service provision. The case was considered an admin-only case if services started after the CPS assessment was closed and has a "Case Type" code of 24, "Other – Administrative (DR Only)."

Maltreatment re-report: This dichotomous variable was coded as "yes" if any child in the family had a report assigned to assessment within 6 months of the initial assessment completion date.

Founded maltreatment re-report: This dichotomous variable was coded as "yes" if any child in the family had a report assigned to assessment and founded within 6 months of the initial assessment completion date.

Child removal: This dichotomous variable was coded as "yes" if any child in the family entered foster care within 6 months of the initial assessment completion date.

Length of time to permanency: Length of time to permanency was computed by subtracting the start date of a foster care episode from the end date. Given the short follow-up period available following DR implementation, a dichotomous variable was created that measured whether children exited foster care within 12 months of entry.

2.4.2 Variables from the staff survey

Training and coaching: Participants were presented with a list of practice topics (general DR concepts, Oregon Safety Model, 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).

Supervisor support: Supervisor support was measured using 6 items from Chen & Scannapieco; 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."[15] One additional item from Shim[16] was included in this measure: "There are clear job expectations and performance

[15] 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.

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

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 averaged to create a single score that could range from 1 to 4.

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 the supervision they received, 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.

Organizational culture was measured using 14 items developed by Shim[17] 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.

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,

[17] 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.

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.

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 additional 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 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.

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.[18] 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."

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:

- 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.

[18] 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.

- 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[19] 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 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."

2.4.3 Variables from the parent surveys

Emotional responses to the first 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 six positive (relieved, hopeful, respected, comforted, optimistic, thankful) and six negative (angry, afraid, worried, confused, stressed, discouraged) emotional responses. Parents were instructed to check as many of the emotional responses as applied. Each response was coded as either "present" or "absent."

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.[20] 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

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

[20] 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. When computing the scale scores, at least 80% of the items from a respondent had to be valid. If a value was missing for an item, the item mean was substituted.

Ease of contacting the CPS worker was measured with an item that asked parents "How easy was it to contact the caseworker?" Response options included very easy, somewhat easy, somewhat hard, very hard, and I didn't try to contact him/her.

Parent engagement was measured using a 19-item quantitative measure of parent engagement in child protective services.[21] The 19 items on the parent engagement scale were summed to form a total engagement score that could range from 19 (no engagement) to 95 (full engagement). The engagement measure also contained four subscales:

- Receptivity, described as openness to receiving help and contains 4 items, with potential scores ranging from 4 to 20.
- Buy-in, a perception of benefit and commitment to the helping process and contains 8 items, with potential scores ranging from 8 to 40.
- Working relationship, the interpersonal relationship with the worker characterized by a sense of reciprocity and good communication. This subscale contains 4 items and has potential scores ranging from 4 to 20.
- Mistrust, the belief that the agency or worker is manipulative or capricious, with intent to harm the client. This subscale contains 3 items and has potential scores ranging from 3 to 15. Items in this subscale were reverse coded so that higher ratings equate to higher levels of trust.

When computing the scale and subscale scores, at least 80% of the items from a respondent had to be valid. If a value was missing for an item, the item mean was substituted.

Culturally-responsive practice was measured with two items. The first asked parents "Was the caseworker sensitive to your family values and culture?" and response options were Yes or No. The second item asked parents "Did your caseworker communicate with you and your family in your preferred language?" and response options were "Yes—in English," "Yes—in another language," and "No."

Trauma symptoms were measured using the Child PTSD Symptom Scale (CPSS).[22] 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.

[21] Yatchmentoff, D. (2005). Measuring client engagement from the client's perspective in nonvoluntary child protective services. *Research on Social Work Practice, 15*, 84-96.

[22] 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.

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 indicate the age and gender of that child on the survey. Total symptoms scores were created for the parent and the child by adding the number of symptoms checked.

Overall satisfaction with CPS was measured with one item that asked parents "Overall, how satisfied are you with the way you and your family were treated by the caseworker?" Response options included "very satisfied," "somewhat satisfied," "somewhat dissatisfied," and "very dissatisfied."

Service receipt was measured through a list of 22 specific services that may have been provided to families. Parents were asked to check all of the services that they received, and for each one checked yes, they rated its helpfulness as "very helpful," "somewhat helpful," or "unhelpful."

Social support was measured using a 5-item measure developed by the Institute for Applied Research for use in previous evaluations of Differential Response.[23] 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. When computing the scale scores, at least 80% of the items from a respondent had to be valid. If a value was missing for an item, the item mean was substituted.

Family economic resources were measured using the Family Resources Scale.[24] 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 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."

[23] DR family questionnaire (n.d.) Retrieved from www.iarstl.org

[24] 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.

Chapter 3: Implementation Evaluation Findings

Information about the implementation of Differential Response was gathered in two ways. Qualitative information about the implementation drivers outlined in the NIRN implementation framework was gathered from DHS administrators, DR consultants, screeners, CPS caseworkers, supervisors, managers, permanency caseworkers, service providers, and community partners. Two rounds of site visits were conducted in the first four districts to implement DR in Oregon (Districts 5 and 11 implemented in May 2014 and Districts 4 and 16 implemented in April 2015) so that changes over time could be examined. Detailed findings from each round of site visits can be found in a series of reports written by Pacific Research and Evaluation;[25] this chapter contains summaries of the findings from these site visit reports. Additional information about implementation was gathered in the statewide staff survey administered in February 2016. Survey respondents, which included CPS caseworkers, permanency caseworkers, screeners, supervisors, and case managers, were asked about a variety of topics including training, coaching, and supervisor support. The results of both data collection activities are described in this chapter.

3.1 Staffing and Caseloads

Selecting and retaining staff with the right skills is essential for successful program implementation. In Oregon, existing staff were used to implement Differential Response, so selecting and hiring new staff was not required during the installation stage of implementation. However, interviews and focus groups during the first round of site visits revealed that DR implementation necessitated changing staffing configurations at the state and district levels, as experienced supervisors were reassigned to become DR consultants. This had the unintended effect of making it difficult to provide quality supervision, because less experienced staff members were moved into supervisory positions.

The Oregon legislature provided funding to hire additional caseworkers after a workload study indicated that the organization was operating with 67% of the resources needed to do the work. Although these positions were not for DR specifically, many districts began restructuring their positions in the anticipation of DR implementation. Administrators reported using different hiring criteria that emphasized skills needed for DR, such as ability to engage families, manage details and multi-task, though the ability to intervene to assure child safety was still an

[25] 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. Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 1 Year 2 site visit report.* Portland, OR: Author. Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 2 Year 2 site visit report.* Portland, OR: Author.

important requirement. Hiring additional caseworkers was particularly difficult in rural areas because of the lack of staff with relevant experience and education.[26]

Initially, two of the districts divided existing staff into two teams consisting exclusively of AR and TR caseworkers. But difficulties dividing staff between these two positions and internal conflict over the perception of these roles led administrators in these districts to move toward blended teams, with caseworkers trained to take cases from both tracks. Some more experienced caseworkers who had previously done TR cases had not adjusted their practices, even when dealing with AR cases. Conversely, newer caseworkers instructed in AR sometimes had difficulty not calling ahead on TR cases.[27]

Interviewees felt stressed by their caseloads at the time that DR was implemented, although it was unclear how much this was due to DR versus other concurrent system changes. High caseloads made it more difficult for caseworkers to interact thoroughly with families. Following implementation of DR, job responsibilities and workloads for screeners, CPS caseworkers, and supervisors all increased. Frontline caseworkers were trying to engage families more, gathering more information, scheduling more meetings, conducting more in-depth assessments, and completing more documentation. The group staffing sessions and RED team meetings demanded caseworker and screener time. Scheduling and participating in the FSNA meetings placed additional demands on caseworkers; consultants noted that caseworkers tended to drop the FSNA when they were overloaded. An increase in reports assigned to assessments and mounting pressure to reduce overdue assessments, two non-DR factors, also increased workload. A deficit in placement options meant that caseworkers often stayed late or even overnight. High workloads required caseworkers to multitask and make choices about which cases to prioritize. As frontline staff's responsibilities increased, so did the workload for supervisors overseeing the wider range of work caseworkers were doing.

As a result, morale decreased. This environment was especially difficult for less experienced workers who had high expectations and lacked the skill and experience needed to multitask and engage families. As one CPS workers said, new workers quickly begin to feel that "this isn't anything like what I thought it was going to be. This is so convoluted and so scary, and the problem is, there's no support. They don't feel supported." As one supervisor said, "People are trying really hard to have good engagement with families and they're just overwhelmed and burning out, and so then people are leaving because they can't do what they want to do. But I think if we were fully staffed, I think it would look very different."[28]

[26] Pacific Research and Evaluation. (2015). *Oregon Differential Response: Year 1 site visit report.* Portland, OR: Author.
[27] Pacific Research and Evaluation. (2015). *Oregon Differential Response: Year 1 site visit report.* Portland, OR: Author.
[28] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 1 Year 2 site visit report.* Portland, OR: Author.

Chronically high turnover was an additional factor increasing workload, because there were always new caseworkers who required months to be trained and carry a full caseload. Increased state funding for staffing did not necessarily result in new local positions in the districts visited. District 16 actually lost approximately 18 caseworker positions (out of approximately 100) since the implementation of DR. Some caseworkers were shifted from handling permanency to assessment, decreasing agencies' ability to meet its responsibilities around permanency.

Results from the statewide staff survey also highlight the effects of workload and job demands on workers' job satisfaction and burnout. Over half of respondents (53.7%) were dissatisfied with workload, including over a quarter (25.1%) who were very dissatisfied. Similarly, 68.6% of respondents disagreed with the statement "My overall workload is reasonable" with 33.5% strongly disagreeing. The demands of documentation were part of this; 74.1% of the workers disagreed that the amount of record-keeping and paperwork was reasonable. There were no differences, however, between staff responses in DR and non-DR districts.

3.2 Training

When a new program is implemented, practitioners are typically required to use new skills or approaches to working with clients. To maximize fidelity and effectiveness, practitioners need to learn when, where, how, and with whom to use new approaches and new skills. Pre-service and in-service training are efficient ways to provide knowledge of background information, theory, philosophy, and values; introduce the components and rationales of key practices; and provide opportunities to practice new skills and receive feedback in a safe environment.[29]

In Oregon, DHS contracted with a curriculum writer who had assisted with DR curriculum development in other states, and the DR consultants and other content experts at central office worked with the writer to develop the curriculum for Oregon. Six training modules were available for use with different groups. Protective services caseworkers attended three days of DR training.[30]

During the first round of site visits, focus group participants identified several areas for improvement in the DR training. The more experienced CPS workers felt that the information in the trainings was redundant with what they already knew, but believed it would provide good information to new CPS workers. Participants also recommended that the DR training not coincide with OSM training, and instead advised that staff should be adequately trained in the OSM before progressing to DR. Several administrators also stressed the importance of supervisor training in addition to CPS worker training.

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[29] Fixsen, D.L., Blase, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.

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

During the second round of site visits,[31] participants described the challenges that were created because DR was not incorporated into the state's CORE training for new child welfare workers. The CORE training curriculum includes a brief overview of DR, which is intentional because DR has not yet been fully implemented statewide. However, for new staff members from DR districts, CORE provides minimal exposure to DR that has not been particularly useful. One new caseworker described leaving CORE with the feeling that DR was still "a foreign language." Newer staff members said that this brief exposure to DR did not provide enough information to understand the DR model.

After new staff members complete CORE training, they return to their districts where they learn about the principles and practices of DR through a variety of local training opportunities. Prior to the pause in DR implementation, consultants offered a modified version of the DR training provided at initial DR implementation. This DR makeup training included a full day of assessment training and was offered when there was enough of a critical mass in a district or region to warrant a DR training. Consultants reportedly modified the original modules from the DR curriculum but tailored the training based on local need. The DR makeup training offered a more intensive opportunity to learn about DR than CORE offered. There were some challenges in providing the DR makeup training. First, because this training was only offered to child welfare staff members, other DHS staff and community partners do not have the opportunity to learn about the model in the collaborative learning environment that was offered when DR was first launched. Further, not all new workers have been able to attend a makeup training because consultant resources have been limited and worker turnover has been so high. Finally, DR makeup sessions have not been offered since May 2016 when DR implementation was paused. Therefore, district administrators have had to develop their own methods of training new staff members on DR.

In addition to the DR makeup training, consultants offered a variety of ad hoc training opportunities as specific needs were identified by staff members in each district. For example, consultants provided training on family engagement, motivational interviewing, moderate- to high-need cases, and group supervision. They also provided trainings to promote the value of the FSNA process. According to the DR program manager, staff members "appreciate those hands-on learning, really applicable training opportunities."

Aside from these formal training opportunities offered by DR consultants, participants described learning about DR through on-the-job experiences. One administrator said that the district had to "start from scratch" in terms of providing training about DR for new caseworkers. In theory, supervisors or consultants should mentor new workers about how the DR approach should be integrated into child welfare practice. However, because of workload and staffing

[31] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 1 Year 2 site visit report.* Portland, OR: Author. Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 2 Year 2 site visit report.* Portland, OR: Author.

issues, the capacity of supervisors and consultants to provide this on-the-job training has been limited. Many newer workers said that they relied on peer mentoring to learn about DR and see the model in action in the field. When asked about how new staff were trained in DR in the district, one administrator stated that "it's not very organized or planned out. It's more ad hoc."

New workers described the difficulty of learning about the complex practice of child welfare in this environment. One screener described shadowing peers for a couple of days and then beginning to take calls on the hotline; this screener described how difficult it was to learn new job responsibilities this way, especially because the phones rang constantly and the screening unit was understaffed. A newer CPS worker said that it was helpful to learn from peers, but CPS workloads made it difficult for experienced workers to spend time mentoring new workers. More tenured workers expressed a desire to mentor new workers, but said that they felt unable to provide the mentoring that new workers needed. CPS workers in one district said that for a short period of time, tenured staff members mentored new workers; however, this was no longer realistic, given current workloads. CPS workers in one district said that because of workloads and overdue assessments, supervisors were discouraging experienced workers from mentoring their peers in the field. Participants described mentoring as a helpful and practical source of training for new workers, but said that the lack of peer mentoring opportunities for new workers created a "really difficult situation." Finally, participants were concerned that high turnover rates could mean that more experienced workers did not have the expertise to mentor others on the new DR model. CPS caseworkers said it took one or two years to really know how and feel comfortable in that position. Current turnover rates have led to relatively inexperienced workers providing guidance to new workers.

The current work environment has also made it difficult for more tenured workers who attended the initial DR training to focus on DR practice. Multiple focus group participants discussed the need for a DR refresher training for all screening and CPS staff, in addition to new employees, to support fidelity to and the sustainability of the DR practice model. The DR program manager suggested that such a refresher would provide an opportunity to review and enhance the DR model in early implementing districts: "I want to be thinking about going back and looking at what the counties that are already practicing DR are doing and how we can not only train them to whatever new changes we make or improvements we make, but also help shore up what they might not be practicing with fidelity."

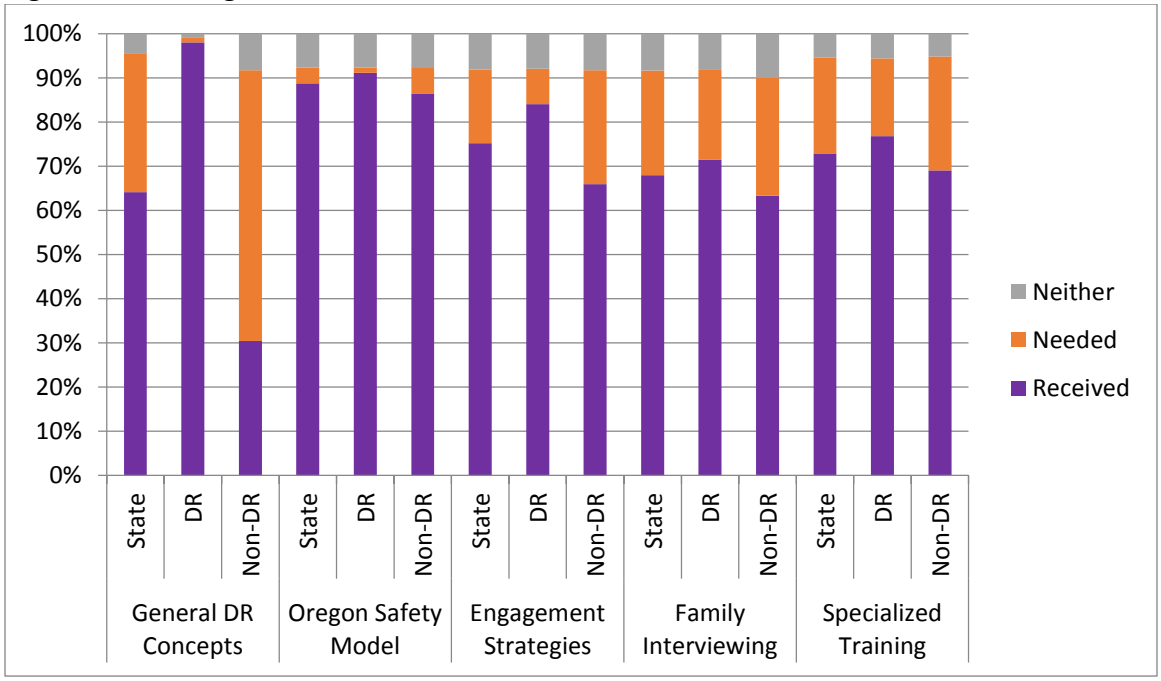
Site visit participants also discussed the importance of making sure that supervisors received adequate training on the DR model in order to provide consistent supervision to workers practicing DR. In the second round of site visits, participants expressed concern that multiple CPS supervisors were quite new and had not participated in the DR training when DR was first launched in their district. These supervisors were often workers in other units that were less affected by DR when it was launched, which reinforced the need for a more formalized DR training subsequent to implementation.

During the site visits, staff were asked if there were specific topics that they would like additional training. Although some workers expressed interest in future training opportunities,

others questioned the ability to participate given caseloads, saying that they had experienced training burnout and rarely participated in the currently offered training sessions. Consultants agreed, indicating that they wanted to provide much more training, but the field was already "saturated" and frontline workers had no time to attend trainings.

Several questions related to training were included in the statewide staff survey. Respondents were asked if they received or needed training on several different topics (see Figure 4). 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.

Figure 4. Training Needed and Received



Staff who received a training rated its effectiveness and relevance on 5-point scales (see Table 15). 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 15. 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 16). 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 16. 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 many did so (see Table 17). 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 17. 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."

3.3 Coaching

According to the NIRN implementation framework, most skills learned during training need to be transferred to daily work through the use of skillful on-the-job coaching.[32] Research has shown that coaching is most effective when it includes direct observation of practice and multiple forms of information used in an improvement cycle loop (e.g., observation, coaching, feedback, planning, observation). Coaching is especially important during the initial implementation stage when workers are developing new practice skills and need encouragement to persist in their development.[33] In Oregon, several DR consultants served as coaches and helped facilitate the transition from training to practice, making sure that the skills were being used appropriately in day-to-day activities. The DR consultants spent a considerable amount of time coaching staff in the first four districts during the initial implementation phase.

According to site visit participants, the DR consultants were in close communication with district administrators to identify specific areas where consultant support was needed. For example, in one district, screeners were having a hard time asking family-centered questions, so the consultant put on a headset and listened in on a call; after the call, the screener and the consultant discussed other questions the screener might have asked. Consultants provided coaching to caseworkers informally through daily conversations; one consultant stressed the importance of "living there and actually getting to know [the staff], and seeing where their

[32] Fixsen, D.L., Blase, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.
[33] Bertram, R.M., Blasé, K.A., & Fixsen, D.L. (2015). Improving programs and outcomes: Implementation frameworks and organizational change. *Research on Social Work Practice, 25,* 477-487.

needs are, and inserting yourself in the processes."[34] Consultants spent considerable time supporting the screening units (including piloting the track assignment tool before the DR launch), supporting supervisors to clarify the DR model, and facilitating group consultation with supervisors. The consultants were able to facilitate meetings with SPRF providers and DHS staff to fine-tune the FSNA assessment process.

When asked about their satisfaction with coaching during the site visits, districts staff were routinely pleased with the amount and quality of coaching they received from consultants, especially during the first few months after implementation. The consultants arrived onsite prior to implementation and remained for several months after implementation to ensure that staff members could easily ask for assistance when challenging situations arose. Their hands-on approach eased doubts and gave encouragement to staff; this approach was described as invaluable. Caseworkers reported that the consultants would go well beyond simply telling caseworkers what to do and would instead help them learn by asking questions.[35]

Consultant availability in the first four districts decreased after the first few months following implementation, as they moved on to other districts that were implementing DR. Although the consultants were available to district staff via telephone or email, their decreased presence in the districts during the second year of implementation led to some feelings of frustration. CPS workers reported that consultants were no longer able to provide the same level of coaching to new workers as they had in the past: "That is not what happens [now]. The minute you're out of CORE, you have a full caseload and you're on the schedule and it's like sink or swim. You might have someone the first week with you but that's maybe and that's it." Supervisors in one district said that although their consultant was very responsive, they would have liked the consultant to be able to continue attending unit meetings. Screeners said that they sometimes worried that they have reverted to old practice methods and would like more consultant feedback. Yet participants realized that the phasing out of DR consultants was expected and understandable because of resources. [36]

According to the DR implementation plan, each district was responsible for developing an exit strategy to phase out the consultant support being offered by the state. The intention was that districts would then rely on each other for continued support after the DR consultants had been assigned to other districts. It was hoped that the peer-to-peer consulting model would provide continuity of consulting and the improvement of the overall model. However, the second year site visits found that districts had not utilized the peer-to-peer support as it was envisioned. One participant said that district administrators sent a staff member to another district because the state encouraged them to do so, not because district supervisors believed it would be

[34] Pacific Research and Evaluation. (2016). *Oregon Differential Response: Round 2 site visit report.* Portland, OR: Author.
[35] Pacific Research and Evaluation. (2016). *Oregon Differential Response: Round 2 site visit report.* Portland, OR: Author.
[36] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 2 Year 2 site visit report*. Portland, OR: Author.

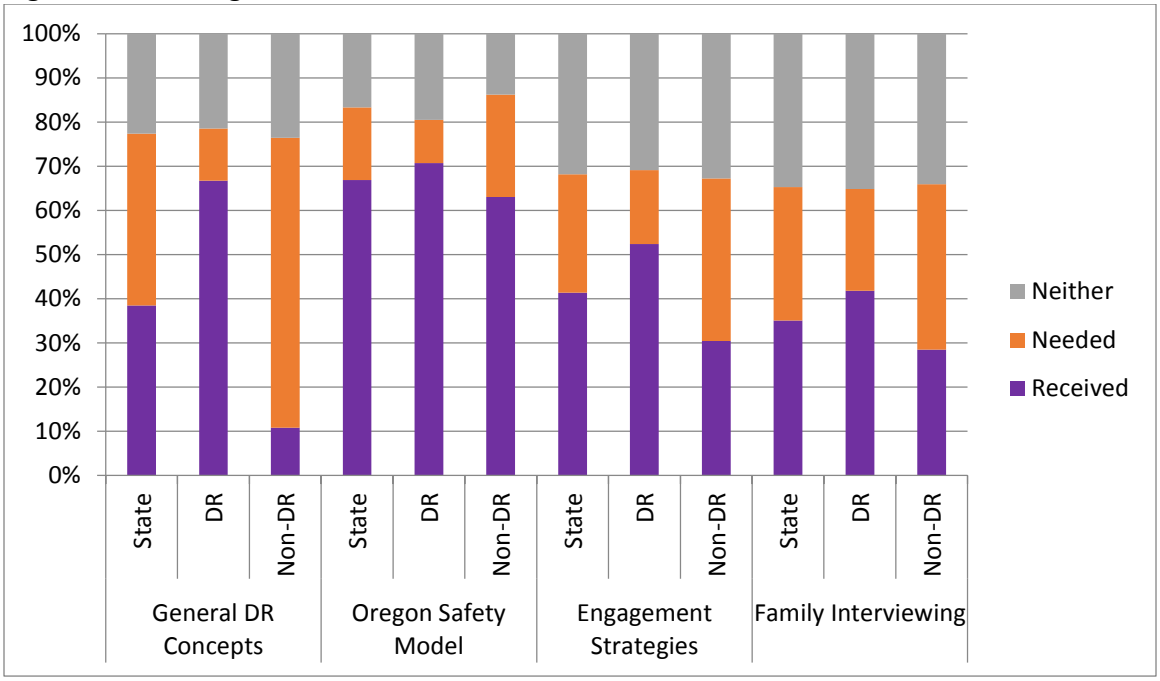
particularly helpful. Participants said that peer-to-peer support was not helpful because each district was so different. When asked if it would be helpful to visit a more similar district to receive peer-to-peer support, participants answered that even if they could find a district that was similar, they still did not believe they could learn that much from others. They reiterated that staff members can always call a consultant.[37]

At the time of the final site visits in 2017, the roles and responsibilities of the consultants had changed quite a bit since initial DR implementation. DR consultants had begun providing more generalized assistance with supervisory activities across a broader spectrum of the organization because their future role as DR consultants was still unclear. In this environment, the consultants expressed a sense of being overwhelmed and a bit isolated from their peers, as the focus on DR had faded with the pause. They said it was difficult to build relationships within their districts, given the uncertainty about the future of DR implementation. The participants expressed a clear sense of anticipation about how the future would look and the roles and responsibilities consultants would have in the current DR districts as other districts began to launch DR. One administrator stated that "having the consultants leave is going to be a huge, huge loss."[38]

Additional information regarding coaching in Oregon was obtained via the statewide staff survey; staff in both DR and non-DR districts were asked whether they needed or received coaching on four topics (see Figure 5). 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%).

[37] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 1 Year 2 site visit report.* Portland, OR: Author.
[38] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 2 Year 2 site visit report*. Portland, OR: Author.

Figure 5. Coaching Received and Needed



Survey participants who received coaching were asked to rate its effectiveness. 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 18) or staff role (Table 19).

Table 18. 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."

Table 19. 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."

3.4 Supervision

Supervision and performance assessment help workers implement and sustain new practices. Supervisors act as external monitors until workers learn and master the new practices. It is important for supervisors to be available to meet workers' varied needs and for supervisors to be experts and champions of the new processes.[39]

Across all districts and years, participants in the site visit reports spoke highly of supervisors.[40] All viewed supervisors as wanting to help workers with whatever they needed. Supervisors themselves reported the greatest passion for helping with clinical assessment and field work. They wanted to be involved in assessments and cases, helping to solve problems and strategize new solutions.

These feelings are supported by results of the staff survey. Most staff reported meeting with their supervisors at least once a month, and a sizeable portion meet with their supervisors weekly (39%; see Table 20).

[39] Fixsen, D.L., Blase, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.

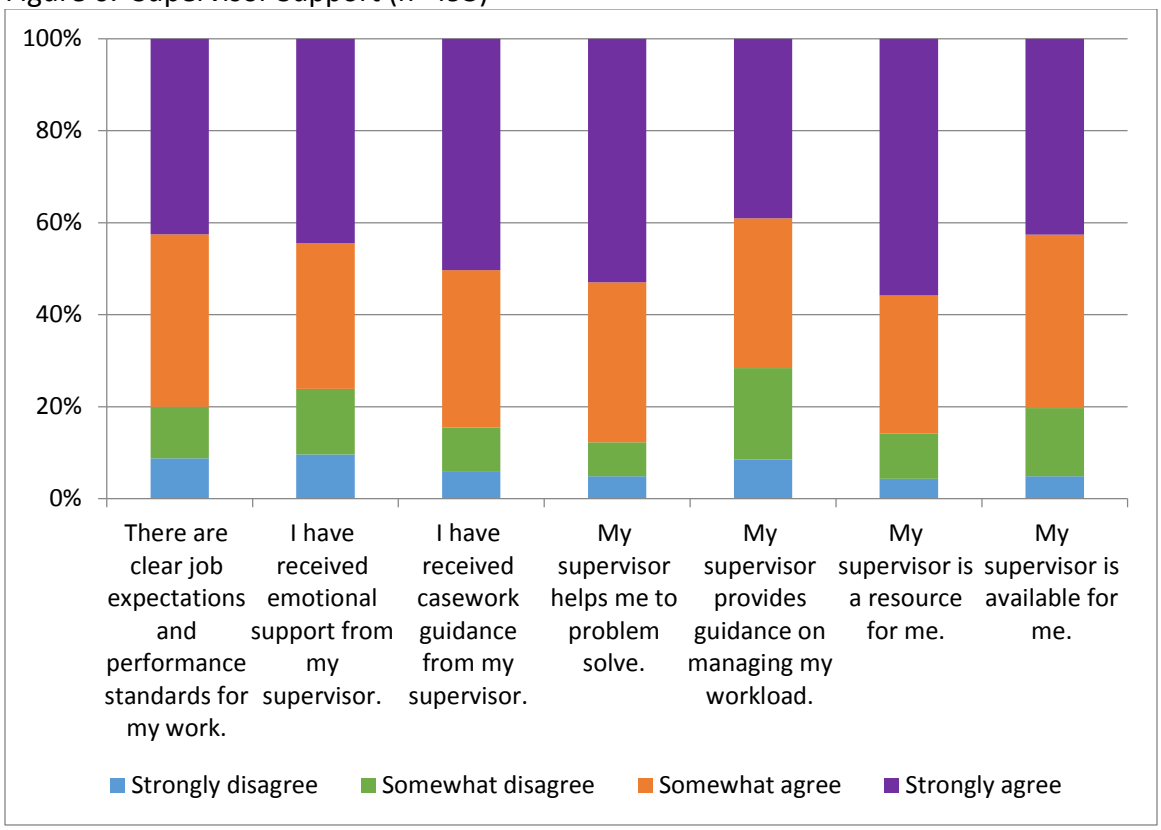
[40] Pacific Research and Evaluation. (2015). *Oregon Differential Response: Year 1 site visit report.* Portland, OR: Author; Pacific Research and Evaluation. (2016). *Oregon Differential Response: Round 2 Year 1 site visit report.* Portland, OR: Author; Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 1 Year 2 site visit report.* Portland, OR: Author. Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 2 Year 2 site visit report.* Portland, OR: Author.

Table 20. 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. The overall average of supervisor support 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).

Figure 6. Supervisor Support (n=493)



Supervisors' work to support staff was threatened by other work requirements, however, something that was first observed in the Round 2 Year 1 site visit report.[41] Here, supervisors

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

and others reported that supervisors were feeling overwhelmed by turnover, low levels of staffing (at the worker and supervisor levels), and constant required meetings. Supervisors were spending their time "putting out fires" instead of providing constructive supervision. This was exacerbated by the focus on completing overdue assessments as the first priority. Supervisors were required to focus on nothing but getting workers to catch up on this work.

In Year 2 site visits, consultants were beginning to phase out their work in districts, putting even more pressure on supervisors. Participants reported that the burden on supervisors was only increasing. One additional pressure reported at this time was a focus on fidelity to the OSM. Some participants reported that supervisors were spending all their time trying to get workers to provide the extensive documentation required by the OSM, leaving them little time to focus on the principles and practices of DR.

There were also questions about the supervisors' understanding of DR practice. Some participants reported that supervisors were too far removed from DR practice in the field to offer meaningful guidance about how to engage reticent families. This issue was compounded by supervisor turnover. Sometimes supervisors were brought in from non-DR districts, leaving them ill-equipped to offer guidance about DR. By the Round 2 Year 2 site visits, supervisors were described as in "crisis mode."[42] Supervisors were facing unsustainable levels of demand from workers who "have to consult about every little thing with their supervisor."

In sum, the results of the staff survey and site visits indicates that there is widespread support for supervisors and the work they do, but participants at all levels felt supervisors had too much work to do. This resulted in supervisors "putting out fires" instead of engaging with staff. The state's crisis-driven child welfare system also meant there was little time for supervisors to immerse themselves in DR practice to be able to support workers in their practice of this initiative.

3.5 Fidelity Assessment

Fidelity to the practice model is the consistent, accurate delivery of an intervention's components. When faithfully delivered, the program's impact can be reliably measured. Thus regular reviews of fidelity to the model are needed to ensure the program is being implemented and practiced as intended.[43]

Oregon managed their fidelity review process internally, establishing a continuous quality improvement process. Reviews included screening and fidelity to the Oregon Safety Model and were to begin in the months following DR implementation and continue at regular intervals.

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[42] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 2 Year 2 site visit report.* Portland, OR: Author.

[43] Fixsen, D.L., Blase, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.

Districts had external motivation to meet benchmarks for screening fidelity; once 80% of reports were screened with fidelity, districts no longer needed to staff a supervisor for every TR and 24-hour AR assessment.[44]

Fidelity reviews were conducted using a sample of cases and tools developed internally. A form of interrater reliability was used as part of the process, but there was no indication that tools were revised if reliability was not established, and the reports themselves indicated that, at times, interrater reliability was calculated as a check after the fidelity reviews were completed. Consultants initially guided the review process, and district administrators will guide future reviews.

These internal reviews were met with favorable responses by staff in the districts, especially the plan to turn over fidelity review to staff in the districts. One district administrator reported, "We had supervisors participating, reviewing the other county's work, and I liked it better. I think that is a better opportunity than just consultants telling us what we missed." Some caseworkers expressed concern that missing fidelity would mean they were "in trouble." Consultants were hopeful that handling fidelity internally would shift those perspectives from a possible rebuke to an improvement process.

The site visits also included discussion about DR practice, asking if participants thought their districts were practicing DR with fidelity. Many participants expressed concerns that related more to the Oregon Safety Model than to DR, suggesting participants had a difficult time separating the two concepts. These concerns began with screening, though participants reported the increased attention to screening resulted in higher fidelity in DR counties compared to non-DR counties. Some participants suggested that the state needed a centralized screening facility.

Regarding fidelity of safety assessment, the DR program manager suggested that some workers and some districts had trouble understanding the safety threshold criteria, but no other evidence suggested differences between districts. Some workers expressed concern that the amount of documentation required by the OSM was hurting the fidelity of their DR practice: "The problem is that OSM requires a tremendous amount of work, when you're talking about a comprehensive assessment. DR just requires me to engage a certain way. It's OSM in conjunction with that that's tying our hands."[45]

These concerns were compounded with the state's climate toward DHS and child welfare, exacerbated by news reports of abuse of children in care, shortages of appropriate shelters for children taken into care, firings and resignations of key leaders, and scrutiny from the state

[44] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 1 Year 2 site visit report.* Portland, OR: Author.
[45] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 2 Year 2 site visit report.* Portland, OR: Author.

legislature. These conditions meant questions about practicing DR with fidelity mostly focused on the factors that prevented DHS staff from fully engaging with the DR model.

One factor was workload. Concern about assessments not being completed on time led to a "pause" in the DR rollout. This may have increased worker attention to the elements of DR they "don't really have time to really do." One district administrator noted the extra work to stay on top of assessment timelines meant there was not time to fully engage with DR. Full staffing might alleviate this perception, and many participants expressed concern that practicing DR with fidelity was impossible when not fully staffed.

3.6 Decision Support Data Systems

Data to guide administrative decisions about organizational change and fidelity of staff performance are essential for quality improvement and program sustainability. Data systems should provide timely, valid information related to model fidelity and data reports should be useful and accessible to implementation teams that may include administrators, supervisors, and frontline staff. Data systems truly become decision support data systems by creating the conditions under which data can be understood and used to make timely decisions in order to improve implementation and target population outcomes.[46]

In Oregon, DHS Central Office provides district staff with monthly reports on screening decisions, track assignment, track changes, and admin-only cases. Districts can also pull some data themselves via the OR-Kids Report Manager on such indicators as screening decisions, track assignments, and timeliness of report referral. Early in DR implementation, district staff produced their own administrative data reports to monitor implementation progress, but over time, district personnel have begun to rely solely on monthly data provided by the state. The DR program manager has shared data during monthly updates with all child welfare program managers, to enable them to identify both areas of strong practice and practice that needs attention. District administrators use data for continuous quality improvement; for example, they examine the correctness of track assignments and look at the number of cases for each track to inform staffing decisions.[47]

DR consultants have conducted fidelity reviews within districts to assess appropriateness of case openings, closings, track assignments, response time, and decision-making on allegations. They also conducted another fidelity review examining OSM processes, looking at client engagement, adequacy of information gathering, and appropriate application of the safety threshold. Results on fidelity reviews are shared with district administrators. Consultants and district staff discuss the fidelity reviews to develop plans for program improvement.

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[46] Bertram, R.M., Blasé, K.A., & Fixsen, D.L. (2015). Improving programs and outcomes: Implementation frameworks and organizational change. *Research on Social Work Practice, 25,* 477-487.

[47] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 1 Year 2 site visit report.* Portland, OR: Author.

Findings from fidelity reviews have led to modifications, such as new guidelines for screening driving-under-the-influence reports and clarification of criteria for track assignment. Fidelity reviews have also helped the DHS Central Office determine the need for consultation support as they launch DR in new districts. Fidelity reviews indicated that screeners were closing more cases than they should, particularly in some districts: 43% to 82% of cases were appropriately closed at screening across districts. This led several participants to suggest a centralized screening function. Fidelity reviews also showed that 76% to 95% of DR track assignments were appropriate. District administrators felt that consultants' fidelity reviews were much more informative than OR-Kids data. The DR program manager said that she would like to continue fidelity reviews to create a cycle of continuous quality improvement, but lacked the resources to do so.

In the Round 2 initial site visit, district administrators were frustrated about the lack of reliability and usefulness of OR-KIDS data, which relies in part on hand calculations. Questions about the reliability and validity of data on overdue assessments led one district supervisor to describe its use as punitive; they felt that district administrators were holding caseworkers to benchmarks that could not clearly be interpreted, and did not take into account demands on resources such as colleagues being sick or on vacation. Caseworkers felt that it took more time to enter the assessment and properly document it in OR-Kids, and were concerned about the reliability of the data in the OR-Kids system. Screeners were frustrated by the slow data system and the redundancy of the paperwork.[48]

In Year 2 site visits, a different perspective on data emerged. Administrators in one district reported having access to more data than ever before, and they were more confident that state data were current and accurately measured their district's performance. Both state and district staff members described increased reliance on the Results Oriented Management (ROM) reporting system. ROM included more DR-specific reports, and was being used to compile data on DR metrics. Some valuable data collected locally in the past had been incorporated into the centralized data system. Data on disproportionality were also being analyzed. On the other hand, some frontline staff continued to express frustration that administrators were making data-driven decisions without regard for the realities of the frontline staff.[49]

Some important data were still not available in Year 2. Interviewees consistently suggested the need for data on whether FSNA referrals were being made and the FSNA was being completed consistently. District 5 recently analyzed data it collected on FSNA (from FSNA providers) and subsequent child welfare reports, and fed back the results to providers. After the pause, the

[48] Pacific Research and Evaluation. (2016). *Oregon Differential Response: Round 2 site visit report.* Portland, OR: Author.
[49] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 1 Year 2 site visit report.* Portland, OR: Author.

flow of DR data to districts ceased, and some districts did not have the staff capacity to pull the data themselves, thus making it more difficult to use DR data to inform decisions.

3.7 Facilitative Administration

Each implementation driver must be consistently monitored for quality and fidelity. Facilitative administration makes use of a range of data inputs to inform decision-making, support overall processes, and keep staff organized and focused on the desired outcomes. Policies, procedures, structures, culture, and climate are given careful attention to assure that they align with the needs of frontline staff. The goal of facilitative administration should be to adjust work conditions to accommodate and support new functions needed to implement the program model effectively, efficiently, and with fidelity.[50]

In Oregon, the Central Office DR team is the state-level group responsible for supporting districts in successfully implementing DR, providing policy and programmatic assistance with readiness, training, and coaching to districts statewide. This team included both the DR program manager and DR consultants. The DHS child welfare director also plays an important role in facilitating and advocating for DR. There was an 8-month vacancy in this position for 2 years after DR implementation, which had a significant impact on later implementation efforts as described below.

Participants in the first site visit described how DHS gathered information on implementation progress and challenges from the first group of districts to implement DR: "We meet monthly and get updates from the counties that are implementing or those that are getting ready to implement and look at some of the data from those committees or those counties. If there's places where we need to make decisions about process or procedure or implementation, we talk through those things as well." These frequent meetings and feedback loops created the opportunity to enhance the ongoing development of the DR model. Trainings, tools, and policies were adjusted over time, based on incoming data and feedback from district staff. The combination of communication and flexibility was a strength of the administrative support offered during the early stages of DR implementation. While the model was developed with rules, procedures and tools, there was still a need to gain experience in areas such as track assignment and the CPS assessment components related to DR. DR staff from central office were clear that they would be learning alongside district staff and helping to adjust tools and the model as they went. The established modes of communication and pathways to iterative change helped to ensure relatively quick adaptation as district-specific challenges became apparent.[51]

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[50] Fixsen, D.L., Blasé, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19,* 531-540.

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

Interviews with DHS central office staff in the second round of site visits reiterated the usefulness of this feedback loop in making changes to DR practice and policy. The DR program manager and DR consultants worked together to identify aspects of the model that needed improvement. These DR team members were in close communication with each other, constantly sharing successes and challenges to DR implementation along the way. In these conversations, they discussed how the model and implementation process could be enhanced, based on feedback consultants receive while in the district offices. They described that because of the constant communication within the DR team, they could sometimes identify a concern, discuss a modification, and see a shift in information being provided to districts within a matter of days.[52]

Using feedback from the districts, state-level administrators have made the following modifications to DR:

- Provided clarity of language in examples of allegation types on the track assignment tool
- Created continuous quality improvement processes, including fidelity reviews
- Emphasized that as soon as a district launches DR, they need to develop an exit strategy for when the consultants would be transferred to other districts
- Developed a menu of coaching options that highlights some of the types of supports available to districts. Specifically, the menu describes field coaching, supervisor consults, continuous quality improvement/fidelity work, and partnerships through site-specific workgroups or events.
- Developed a six-month roadmap/timeline template of specific activities to prepare for the launch of DR.
- Revised the DR training modules using feedback from attendees and drawing upon lessons central office staff have learned since DR was launched in 2014.
- Modified coaching regarding how to train caseworkers to introduce AR cases when there are concerns about calling ahead on domestic violence reports. Guidance about introducing AR on domestic violence reports is also included in the family interview guide.
- Finalized the family interview guide and provided guidance on integrating the information from the document into practice.

In response to some of the concerns from the early districts to implement DR, the Central Office made some adjustments to the FSNA process. First, they strengthened the communication to districts related to the FSNA, stressing the value of the assessment process so that CPS workers would have a better understanding of its importance. In addition, the FSNA training was expanded from an hour and a half to six hours. DR consultants encouraged districts to set up meetings between child welfare administrators and service providers after the training, so that they could provide technical assistance and address any concerns.

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

Administrators also made modifications to the FSNA tool, based on some concerns about using the FSNA with people involved in situations of domestic violence.[53]

A major theme in the site visits in 2016 involved the effects of the change in state leadership and the DR pause on district staff, both of which created a sense of uncertainty and anxiety about the future of DR in Oregon. Conversations about district leadership often turned to the effects of the changes at the state level and how local leadership tried to address the anxieties within their own offices. Site visit participants said that the vacancy of the child welfare director position had left a void, with no one to provide leadership and communication from the top of the organization. The changes in state-level leadership, along with the pause, sent a message to the district staff that DR "just doesn't feel important" and "it's not a priority."[54]

3.8 Systems-level Interventions

According to the NIRN framework, systems interventions are strategies to work with external systems to ensure the availability of the financial, organizational, and human resources required to support the work of the practitioners.[55] These strategies include the coordination of efforts and resources while aligning agencies at various levels. DHS central office staff were asked about the strategies that they used during each stage of implementation to coordinate resources both within the agency and outside the agency with community partners and external stakeholders.

Several different types of fiscal resources were used to implement DR in Oregon. The legislature allocated funding for the first five DR positions in central office and additional general funds were allocated to increase the number of DHS workers at the district level, although these positions were not designated specifically for DR. Funding provided by the legislature to build the capacity needed to implement DR proved crucial, although it accounted for only a small portion of the overall resources utilized for DR implementation. Casey Family Programs provided free consultation during the implementation process. Funding for SPRF services supported DR efforts by enhancing the foundational child welfare service array aimed at preventing children from coming into the foster care system or returning children more quickly. Overall, the legislature's financial commitment to DR was relatively small, increasing the chance that DR will continue if budget shortfalls arise at the state level.[56]

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

[54] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 1 Year 2 site visit report.* Portland, OR: Author.

[55] Fixsen, D.L., Blasé, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19,* 531-540.

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

Early on in the implementation process, DHS recognized the importance of generating support for the DR model through clear communication with district staff and community partners. Staff from Casey Family Programs worked with DHS to develop a communication plan to share information about the DR implementation with internal and external stakeholders. The focus on providing a clear message and consistent information was important because of the earlier, less successful effort to launch DR that had resulted in considerable confusion. As part of the communication plan, in November 2013 the DHS child welfare director began to send frequent emails to district offices that provided information about DR implementation and addressed frequently asked questions. Participants in the site visits found these communications to be helpful. District administrators often forwarded these emails to staff members and community partners so that they were aware of the changes that were about to occur. District staff reported that the communication process was effective and that they understood the strategies that were being used to implement DR.[57]

The second round of site visits occurred after the DHS child welfare director was fired and implementation of DR had been paused. District staff reported that the amount of communication related to DR lessened considerably after these events. They were notified about the pause in implementation via an email from the interim child welfare director in May 2016 and no further information was provided by the DHS central office. After the pause, district managers reported that most conversations related to DR ended, and DR was no longer an agenda item at statewide district manager meetings. District staff members said that the pause made it more difficult to obtain answers to DR questions. District staff members reported that they felt unable to express their concerns about how and why the decision to pause DR was made.[58]

Community partners also expressed a desire for more communication about DR after the implementation pause. When they were first learning about DR, some community partners had concerns about how DR would work for some types of cases. Now that DR had become standard practice in these districts, community partners in both districts expressed a desire to revisit these conversations and to find out how DR has been working for cases they initially had concerns about. Community partners suggested an in-person meeting or an email to offer some communication about the district's experience with DR, sharing any data about the effects of DR, and DHS plans for DR.[59]

Site visit participants were asked about the relationships between DHS and community partners and participants in all districts indicated these relationships were strong before the implementation of DR and continued to be strong following implementation. Participants in

[57] Pacific Research and Evaluation. (2015). *Oregon Differential Response: Year 1 site visit report.* Portland, OR: Author.
[58] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 1 Year 2 site visit report.* Portland, OR: Author.
[59] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 1 Year 2 site visit report.* Portland, OR: Author.

one district noted that the SPRF contracts had strengthened relationships with community partners. The FSNA providers spoke at length about how the contracts and regular meetings between DHS and contracted providers had provided valuable opportunities to learn about other organizations and devise creative solutions for families. These conversations and relationships helped make the web of family-serving agencies stronger.[60]

When asked if any suggestions from community stakeholders had been incorporated into the DR model, administrators in one district reported holding regular community meetings to allow opportunities for community partners to raise concerns and for child welfare officials to address those concerns. In the early stages of DR implementation, there were some concerns about the FSNA process. According the district administrator, they made some modifications based on this feedback along the way and at this point, most of the concerns have been addressed. Another district followed a similar process to allow for community input: DHS recently expanded its contracted respite services because there were conversations at the FSNA contract provider meetings about the demand for this service surpassing the contract's capacity.[61]

The impact of the implementation pause on community partners was a topic of concern in the final site visits. Administrators in one district described the momentum and excitement that they had developed through training, education, and outreach for DHS staff and community partners. When the pause occurred, these conversations and training opportunities ceased, leaving community partners uncertain about the future of DR. Other site visit participants stated that the news about the pause had created a loss of credibility with some community partners who already had trepidations about DR, giving these individuals validation of their concerns about DR. This sentiment was echoed by CPS workers: "It is so hard to get people to trust your agency when you are constantly shifting practice and changing the way you do things and changing labels. If we want to work on having [community partners] believe in a child welfare system, you have to give them consistency."[62]

Legislative support for DR also seemed to lessen over time. The first site visit report described how the architects of DR in Oregon decided to refrain from making a statutory change, allowing for flexibility in the evolving DR practice; however, DR proponents spent considerable time educating legislators and gaining support from the legislature when the model was first developed. The DR program manager said that the previous DHS child welfare director "did a lot of talking with the governor and legislators and sent out a message about what happens if something bad happens. She talked about that from the very beginning. That hasn't continued since she's left." The DR program manager stated that legislative support was part of the

[60] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 1 Year 2 site visit report.* Portland, OR: Author.
[61] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 1 Year 2 site visit report.* Portland, OR: Author.
[62] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 2 Year 2 site visit report.* Portland, OR: Author.

success of initial implementation and that as DR continues to be implemented statewide, DR proponents will need to direct their attention to gaining legislative support because legislators can be either vocal champions or critics of the model. Recently, legislators have raised concerns about safety and resource shifts to the front end of the child welfare system, which they have suggested are related to DR. The DR program manager said that other states have encountered similar challenges with DR sustainability and have struggled to confront and address these concerns when they arise; DR proponents in these states have therefore recognized the importance of building and maintaining legislative support.[63]

[63] Pacific Research and Evaluation. (2017). *Oregon Differential Response: Round 2 Year 2 site visit report*. Portland, OR: Author.

Chapter 4: Process Evaluation Findings

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 (in some cases)
- Timely initial contact with families
- Family engagement in decision-making
- 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

Components of the Oregon DR model were examined using a combination of data from OR-Kids, site visit focus groups and interviews, parent surveys, and parent interviews. The following sections combine the available data to describe each component of the Oregon DR model.

4.1 CPS Reports Assigned to Assessment

When a report is received by a screener, it can either be assigned to an assessment or closed at screening. The percentages of CPS reports assigned to an assessment in each of the four districts that implemented DR prior to September 2015 are shown in Table 21. Statewide percentages are shown for comparison. Statewide, there has been an increase both in the total number of reports received and in the percentage of reports that were assigned to assessment: 42-43% of reports were assigned to assessment in 2012 and 2013 compared to 50% in 2016. The percentages of reports assigned to assessment varied considerably across districts both before and after the implementation of DR; for example, 61% of report were assigned to assessment in D5 in 2012 compared to 36% in D4. Similar to the state as a whole, the percentages of reports assigned to assessments increased over the past several years in three of the districts that implemented DR (D11, D4, and D16), but not D5.

Table 21. Percentage of CPS Reports Assigned to Assessment

	D5		D11		D4		D16		Statewide	
	# reports	% assigned	# reports	% assigned	# reports	% assigned	# reports	% assigned	# reports	% assigned
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]	4,680	56%	2,305	47%	4,621	42%	4,835	35%	69,185	44%
2015[b]	5,861	55%	2,089	60%	4,505	51%	5,360	40%	70,824	47%
2016[c]	6,839	52%	2,203	64%	5,406	52%	5,692	45%	76,124	50%

[a] D5 and D11 implemented DR in May 2014

[b] D4 and D16 implemented DR in April 2015

[c] Data extracted March 31, 2017

4.2 Track Assignment and Reassignment

In DR districts, reports that are assigned to assessment must be assigned to either an Alternative Response assessment or a Traditional Response assessment. Screeners use the track assignment tool to make this decision. Table 22 shows the percentage of reports initially assigned to AR and TR in each of the 4 districts by year. In 2016, the percentages assigned to AR and TR were close to 50/50 in three of the four districts and was 45% AR/55% TR in D11.

Table 22. 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]	49%	51%	45%	55%	51%	49%	50%	50%

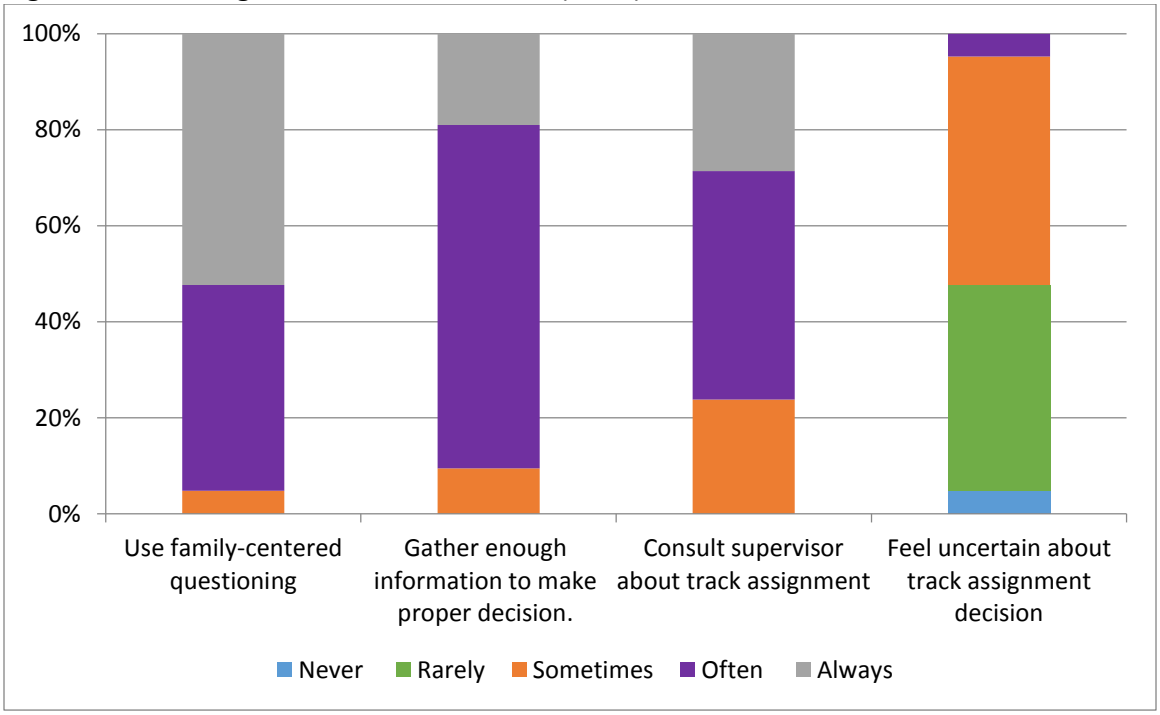
[a] Includes assessments from May 1, 2014 to December 31, 2014.

[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 March 31, 2017.

Screeners in DR districts were asked about several screening practices on the statewide staff survey (see Figure 7). 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 7. Screening Practice in DR Districts (n=21)



Note. Because the overall number of responses was small, percentages should be interpreted with caution.

Qualitative data collected during the site visits highlighted some specific areas that were difficult for screeners. Early on, the DR consultants indicated that the use of the track assignment tool was challenging for screeners because it was often used literally. Consultants wanted screeners to be less reliant on specific examples included on the track assignment tool. DR consultants also noted that one of the most challenging aspects of the tracking assignment tool was predicting whether a child will likely suffer severe harm because of a threat of harm. Screeners were asked how their job responsibilities have changed since the implementation of DR. They indicated that they are spending a greater amount of time on each case, particularly in terms of making more collateral calls and doing more research on a family's history with child welfare.[64]

In an effort to improve the difficult track assignment decisions, all four districts implemented a decision-making process known as Review Evaluation Decide (RED) Team. RED Team provides an opportunity for screeners, CPS caseworkers, and supervisors to meet, review information about a case, and make an informed screening decision regarding whether a case should be opened and if the case should be assigned to AR or TR. At these meetings, staff present cases that involve difficult screening decisions, as well as cases with recommendations for case closure (e.g., close through collateral contact, close because opened in error or because there was no allegation of abuse or neglect). Most site visit participants described the RED Team

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

positively, saying that the meetings improved the consistency of the screening decisions. Some felt that although RED Team is a good idea in theory, it was "logistically difficult." From their perspective, they are already understaffed; group staffing with RED Team intensifies their workload even more because it removes multiple staff from their normal work. It also leaves the screening unit with fewer screeners to answer the hotline during a RED Team meeting.[65]

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." [66] Additionally, if an AR assessment becomes court-involved, or if 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 23 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 over time to around 15% in 2016. 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 (11-12%).

Table 23. Percentage of AR Assessments that Change Tracks to TR

	D5	D11	D4	D16
2014[a]	19%	22%	-	-
2015[b]	19%	16%	12%	11%
2016[c]	16%	14%	12%	11%

[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 March 31, 2017.

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

4.3 Initial Contacts with Families

In addition to assigning an assessment to AR or TR, screeners also assign a response time to each assessment.[67] 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, every CPS assessment is assigned one of two possible response timelines at screening: within 24 hours or 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.

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" to allow a 5-day response time.[68]

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 across districts; in 2016, it was 70% in D4 and D5, 84% in D16, and 89% in D11 (Table 24).

Table 24. 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]	30%	70%	11%	89%	30%	70%	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] Data extracted March 31, 2017.

Most TR assessments are assigned a 24-hour response time (Table 25), although there are some variations between districts. In 2016, the percentage of TR assessments assigned a 24-hour response time ranged from 83% in D4 to 92% in D5.

[67] Response time assignment also occurs in non-DR districts.
[68] Oregon Department of Human Services. (December, 2014). *DHS Differential Response Procedure Manual. Chapter 2: Assessment-section 3 CPS Assessment response timelines.* Salem, OR: Author.

Table 25. 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]	92%	8%	90%	10%	83%	17%	86%	14%

[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 March 31, 2017.

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 has improved over time, from 68% in 2014 to 74% in 2016.[69] Compliance with the 5-day response time has also improved over time, from 64% in 2014 to 72% in 2016 (see Table 26).

Among the four DR districts in 2016, compliance with the 24-hour response time among AR assessments ranged from 72% to 79% and compliance with the 5-day response time ranged from 73% to 86% (see Table 26). A similar analysis of initial response time compliance among TR assessments revealed that compliance with the 24-hour response time ranged from 76% to 90% (D11). Similar compliance rates were observed for TR assessments assigned to a 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 or 5-day response time, compliance in DR districts was similar to or higher than that for the state as a whole.

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

Table 26. Compliance with 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]	74%	72%	74%	79%	79%	86%	73%	79%
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%	68%	87%	75%	74%
2016[c]	77%	90%	77%	76%	75%	88%	75%	78%
Statewide								
	Within 24 hours				Within 5 days			
2014[a]	68%				64%			
2015[b]	71%				69%			
2016[c]	74%				72%			

[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 March 31, 2017.

CPS workers who responded to the statewide staff survey were asked several questions about initial contacts with families, including their estimates of how often they called ahead before the initial visit, informed the family about having a support person present at the initial meeting, interviewed the family together, and interviewed family members individually (see Table 27). CPS workers in DR districts were significantly more likely to call ahead to schedule a meeting with families before the initial visit, inform the family about having a support person present at the first meeting, and interview the family together in AR assessments compared to TR assessments. They were significantly less likely to interview family members individually in AR assessments compared to TR assessments.

According to the results of the staff survey, CPS practice in non-DR districts differed from that in DR districts 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.

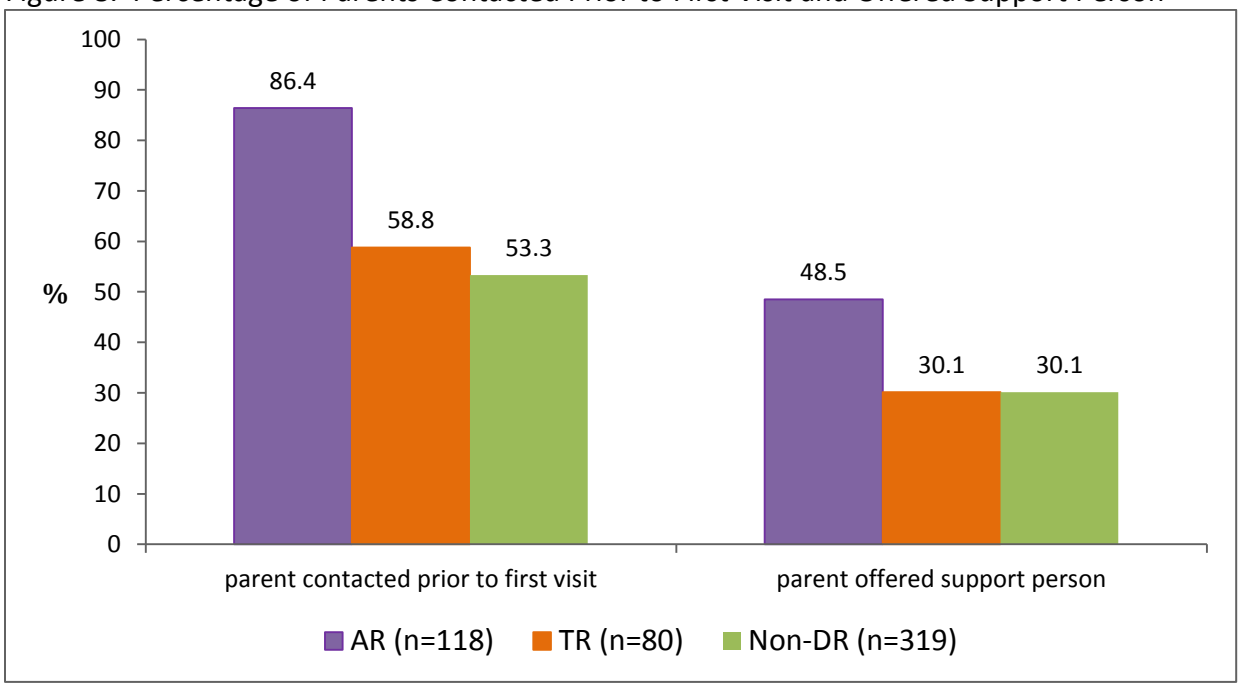
Table 27. CPS Assessment Practice

	AR		TR		Non-DR	
	Mean	**SD**	**Mean**	**SD**	**Mean**	**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

Notes. Item were scored from 1 (never) to 5 (always). Differing superscripts indicate difference between groups is significant at $p < .0167$. CPS workers in DR districts were asked these questions separately for AR and TR assessments.

The parent survey also contained questions about the first contact with the CPS worker. Parents reported whether or not the CPS worker contacted them prior to the initial meeting and whether or not they were offered the option of having a support person present at the first meeting. Figure 8 shows the percentages of parents in AR, TR, and non-DR assessments who responded "yes" to each of these questions. A significantly larger percentage of parents in AR assessments were contacted prior to the first visit and offered the option of having a support person present compared to parents in non-DR assessments ($p < .001$). The differences between parents in TR assessments and non-DR assessments were not significant.

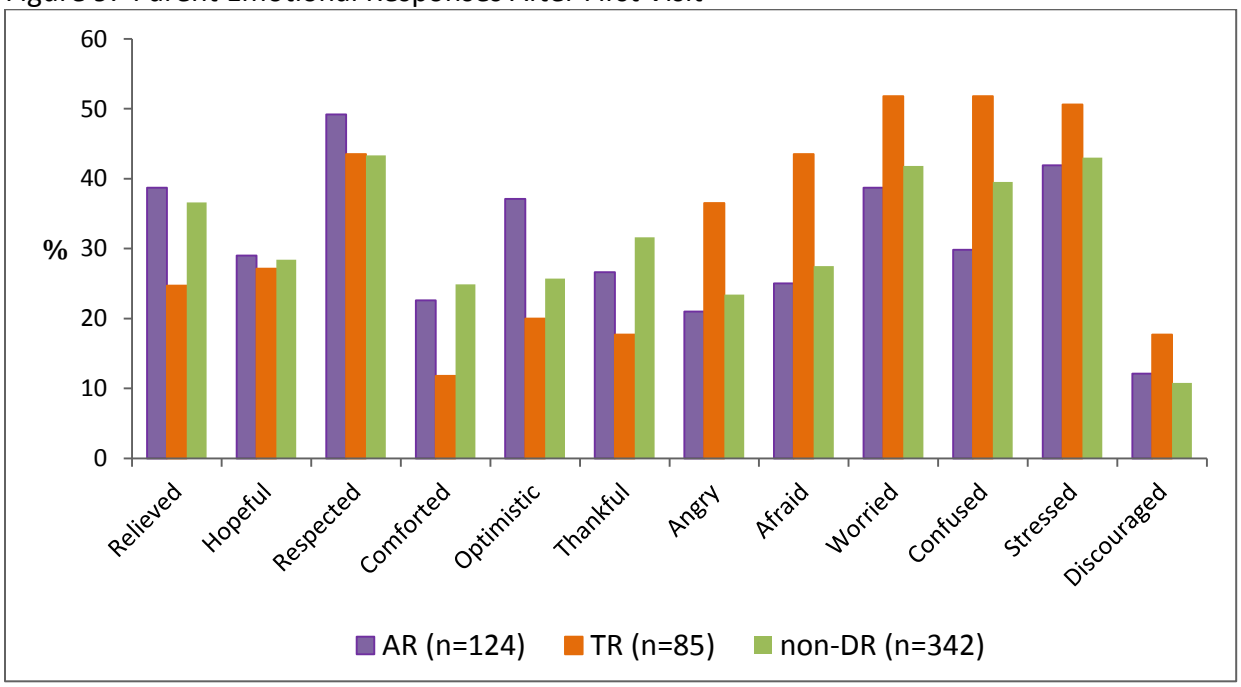
Figure 8. Percentage of Parents Contacted Prior to First Visit and Offered Support Person



Parents reported their emotional responses to the first visit on the parent survey. Parents were asked "How did you feel after the first time the caseworker came to your home," and provided with a list of 6 positive and 6 negative emotional responses that might occur following an initial visit from CPS, and asked to check as many as applied. It should be noted that parents were given the survey at case closure, which for some parents was two or three months after the first visit. Thus, parents' recall of their emotional responses to the first visit may have been influenced by later positive or negative interactions with their worker, and responses to this question may be better interpreted as capturing parents' emotional responses to their entire experience with CPS.

Figure 9 displays the percentages of parents in AR, TR, and non-DR assessments who reported feeling each of the six positive and six negative emotional responses after the initial visit. There was only one significant difference between the emotional responses of parents in AR assessments and non-DR assessments: a larger percentage of parents in AR assessments felt optimistic after the first visit compared to those in non-DR assessments (37% versus 26%, $p < .05$). There were several significant differences between parents in TR assessments and non-DR assessments: more parents in TR assessments reported feeling angry, afraid, and confused and fewer parents in TR assessments reported feeling relieved, comforted, and thankful compared to parents in non-DR assessments.

Figure 9. Parent Emotional Responses After First Visit



Parents who participated in the qualitative interviews were asked if they were contacted on the phone prior to the first visit from the CPS worker, and if so, how they responded to that call. Parents in non-DR districts who did not receive a call usually felt upset or threatened when the CPS worker showed up unannounced for the first visit:

I was confused and kind of felt threatened because I didn't understand what I did wrong and why they were wanting to check on me and my children. (Age: 21; Race: White; Non-DR)

So I told her I was upset and I said I don't like that they come to people's work. (Age: 42; Race: White; Non-DR)

I would have appreciated a phone call because, actually, before they showed up at my house, they actually went to the school and talked to my children first before contacting me. (Age: 34; Race: White; Non-DR)

4.4 Family Engagement and Family-centered Practice

For most families, the initial visit from child protective services (CPS) is an unwelcome surprise that typically elicits negative feelings of fear, anger, or shame from parents. CPS workers have the difficult task of overcoming parents' initial fears and reluctance to reveal details of their lives so that they can effectively assess child safety, determine family needs, and make decisions about ongoing child welfare services.

Alternative Response assessments represent an attempt to modify several of the forensic elements of traditional investigations that elicit negative emotional responses from parents and hinder engagement (e.g., the involuntary nature of the services, substantiation of maltreatment allegations, labeling family members as "perpetrators" and "victims"). In addition, CPS practice in AR assessments typically emphasizes the use of "family-centered" interviewing, assessment, and service provision. Although the term "family-centered practice" has held numerous meanings over the past two decades, common elements of this approach to working with families include: a focus on the family as the unit of attention; strengths-based assessments and services; and an emphasis on fully-informed family choices in all aspects of planning and care.[70] Decreased emphasis on the forensic aspects of a traditional CPS investigation and an increased emphasis on family involvement in assessment and planning are thought to increase parent engagement with the worker and with child welfare services.

The Oregon DR evaluation gathered a variety of information from parents to assess their experiences with CPS:

- Parents' ratings of their worker's use of family-centered practices, as measured by the Consultation and Relational Empathy (CARE) measure, a 10-item measure originally developed to measure the relational empathy of medical staff toward patients.[71]

[70] Madsen, W.C. (2009). Collaborative helping: A practice framework for family-centered services. *Family Process, 48,* 103-116.

[71] 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.

Individual items on the CARE measure capture parents' perceptions of how well their CPS worker listening to them, understood their concerns, explained things clearly to them, and helped them make a plan of action.

- The parent survey included question related to other aspects of family-centered service provision including the ease with which parents could contact their worker.
- The parent survey also included two questions related to culturally-responsive practice, including if the CPS worker was sensitive to the family's values and culture and communicated in their preferred language.
- Parents' ratings of their engagement with their worker and with CPS services, as measured by their responses to Yatchmenoff's (2005) measure of parent engagement in CPS.
- The parent survey contained a question that captured parents' ratings of overall satisfaction with their treatment by the worker.
- The parent survey contained a measure of parent and child trauma symptoms related to the CPS assessment.
- The parent interviews also contained open-ended questions related to parent involvement and engagement with their CPS worker and child welfare services.

4.4.1 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.[72] 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

[72] 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 parents in AR assessments was 39.9 (sd=10.1), compared to 35.1 (sd=12.5) for parents in TR assessments, and 38.7 (sd=11.3) for parents in non-DR assessments. The total scores of parents in TR assessments were significantly smaller than those of parents in non-DR assessments ($F=6.59$, $p<.05$). Parent responses to the individual items in the CARE measure were explored to see how well CPS workers were employing specific family-centered practices (see Table 28). In general, parents in TR assessments reported that their caseworkers were less skilled at family-centered practices than parents in non-DR assessments.

Table 28. Caseworker Use of Family-Centered Practices

How good was the caseworker at:	Poor	Fair	Good	Very good	Excellent
Making you feel at ease?					
AR	5.8%	7.4%	22.3%	30.6%	33.9%
TR	10.6%	21.2%	16.5%	25.9%	25.9%
Non-DR	6.3%	15.2%	21.4%	20.8%	36.3%
Letting you tell your side of the story?					
AR	2.5%	5.0%	14.2%	22.5%	55.8%
TR	7.1%	12.9%	15.3%	27.1%	37.7%
Non-DR	3.3%	8.4%	16.5%	21.3%	50.5%
Really listening?					
AR	4.2%	1.7%	15.8%	19.2%	59.2%
TR	8.2%	11.8%	16.5%	27.1%	36.5%
Non-DR	5.7%	7.8%	14.7%	23.1%	48.8%
Being interested in you as a whole person?					
AR	5.0%	9.1%	18.2%	21.5%	46.3%
TR	11.9%	15.5%	15.5%	26.2%	31.0%
Non-DR	6.9%	9.6%	18.0%	22.2%	43.2%
Fully understanding your concerns?					
AR	6.7%	5.0%	17.5%	26.7%	44.2%
TR	14.2%	14.1%	12.9	25.9%	31.8%
Non-DR	5.7%	10.8%	15.6%	24.6%	43.2%
Showing care and compassion?					
AR	6.6%	2.5%	16.5%	24.8%	49.6%
TR	10.6%	15.3%	15.3%	28.2%	30.6%
Non-DR	7.2%	9.0%	16.2%	24.0%	43.7%
Being positive?					
AR	5.0%	5.8%	14.9%	24.8%	49.6%
TR	11.9%	8.3%	20.2%	22.6%	37.0%
Non-DR	4.5%	9.8%	16.4%	23.2%	46.1%
Explaining things clearly?					
AR	4.2%	5.8%	15.8%	23.3%	50.8%
TR	9.4%	17.7%	15.3%	23.5%	34.1%
Non-DR	6.6%	6.9%	16.2%	21.9%	48.4%
Helping you to take control?					
AR	8.5%	8.5%	23.7%	22.9%	36.4%
TR	15.3%	17.7%	20.0%	18.8%	28.2%
Non-DR	10.6%	10.0%	18.5%	20.4%	40.4%
Making a plan of action with you?					
AR	9.6%	9.6%	19.1%	27.0%	34.8%
TR	15.3%	17.7%	17.7%	23.5%	25.9%
Non-DR	11.9%	11.0%	16.5%	21.1%	39.5%

Parents who were interviewed discussed the things that their CPS worker did to make them feel included in the assessment. Parents in AR and non-DR assessments had very positive things to say about their workers' practice skills:

> *"She was very personable and respectful. She made me feel – she didn't seem very threatening. I'm not sure if this is a stereotype that I'm saying but she didn't seem like she was in disbelief of what I was saying whereas I would think that somebody who works with DHS who's been involved with CPS for a long time would probably be skeptical about what it is that a parent is telling them. But I didn't ever get that feeling or impression from her." (Age: 26; Race: Native American; AR)*
>
> *Like he was honest and he was direct and he didn't sugarcoat things but he was also compassionate and yeah, I mean it was an excellent experience." (Age: 37; Race: Asian-American; Non-DR)*
>
> *"He spoke about his own family situation, and actually was very understanding of being a single parent, and being the sole breadwinner of the family. That was really cool." (Age: 41; Race: Native American, Black & White; Non-DR)*
>
> *She would rephrase what she was saying and use smaller words so I could understand what she was saying really.(Age: 21; Race: White; Non-DR)*
>
> *Yes. I felt like he really took the input of everybody that was involved. You know he had a conversation with each person that was involved – each family member on their own – and then talked to us parents together after having private conversations. I felt like everybody's input was taken in." (Age: 34; Race: White; Non-DR)*
>
> *Feel like they were very supportive. They also opened up a little bit more understanding of what CPS – who they are and what they do. I think that in the beginning if I wouldn't have done that I would have heard CPS, I would have had a heart attack. I think now that I hear those services I'm like, "Oh okay, they're there for resources and for help." So I think without them I don't think I would have gained that knowledge and for that I'm going to say I'm better off. I'm better off that they came into my life. (Age: 26; Race: Latina; AR)*
>
> *She always followed up all the time with us after the visit. She went and talked to the kids. She came and checked on us when we needed to. She gave us resources and everything that we needed. She always followed up and through and she was always available, and always got right back to us when we needed her to.(Age: 30; Race: Native American; Non-DR)*

Like I said, she talked to me until I felt better. Because I was pissed off when they got there and voiced that. But she made sure that she didn't leave until I was feeling better about the situation, and basically helped me – understanding that they weren't there to be bullies and trying to pick on me or anything. And it's standard procedure. And she made sure I felt better before they left. She didn't leave me all pissed off and like "See ya." So that was pretty cool. (Age: 42; Race: White; Non-DR)

Several parents, primarily those in TR assessments, had more negative things to say about their treatment by their CPS workers:

"And she was very condescending. She did not like – there was nothing friendly about her, okay? As you can imagine, sitting in a hospital bed with someone giving you the stink eye, and you have no idea what's going on." (Age: 26; Race: African American; TR)

And that was my, yeah, the time I was thinking oh wow, man, can't they care a little bit more?" (Age: 35; Race: White; TR)

"I didn't really like the way I was treated or talked to, or – I guess I should say the way that she made assumptions about me based on probably other stuff that she's seen." (Age: 38; Race: White; TR)

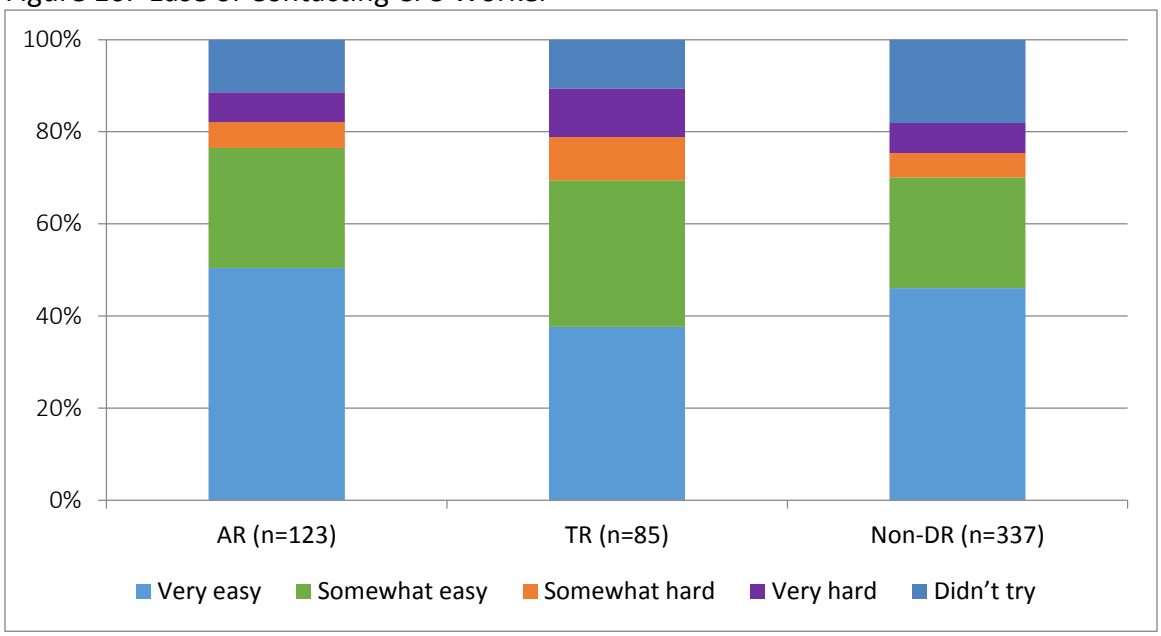
They basically threatened me saying that if they find out that I was lying and I was not telling the truth, they would be back to take my kids into custody. (Age: 37 Race: White; TR)

It was very intense. It was more or less like, 'You're a bad parent. You're this. You're that. We're taking your kids. You need to get help.'" (Age: 35; Race: White; AR)

4.4.2 Ease of contacting CPS worker

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 parent survey asked parents "How easy was it to contact your caseworker?" and the majority of parents in AR, TR, and non-DR assessments who completed a survey felt that it was very easy or somewhat easy to contact their worker (Figure 10). There were no significant differences between the groups.

Figure 10. Ease of Contacting CPS Worker



Several parents in the qualitative interviews mentioned the importance of their workers following through with contacting them and providing them with needed information:

> *The thing is, towards the end, I understand that she's busy 'cause she has a lot of caseloads, but I did contact her because when they found out the results and the whole lie detector test thing and stuff like that. I never got contacted. I actually had to find out from my friend about what the results were. I had called and left a message, but I never got a call back or anything like that. I didn't like that. I wanted to find out what's gonna happen." (Age: 26; Race: African American; Non-DR)*

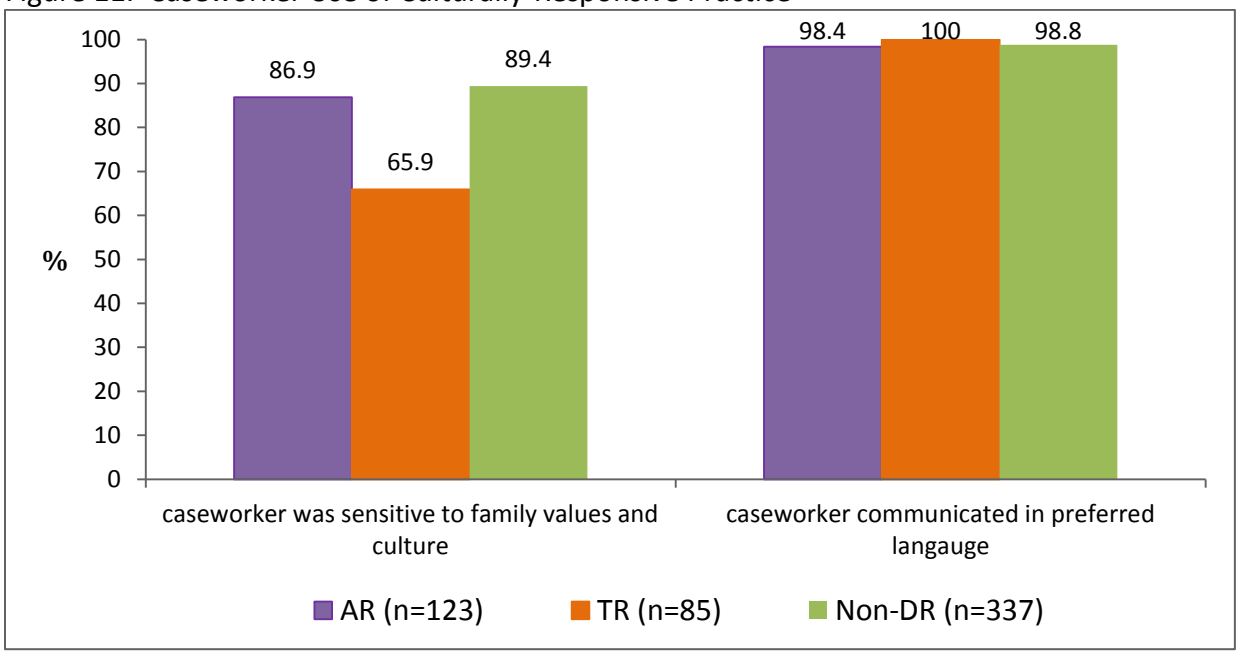
> *That's because she was busy all the time, which is understandable, but sometimes I would talk to her on the phone and she would assure that she would call me back, and she would not call me back, and I would have to keep calling her. And I don't like to really be bugging people, but if it's important, than sometimes I just have to. (Age: 30; Race: African American; Non-DR)*

> *For them to not follow through, like I said, I just got that brief phone call and was supposed to be called back and I don't know if she did or not. She probably did but no one ever came out to see me, no one ever came out to check on my kids, which it upsets me now because if there really was this issue, they did not follow through to make sure everything was okay, at all." (Age: 31; Race: Black and White; AR)*

4.4.3 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 11 shows the percentages of parents in AR, TR, and non-DR assessments that answered "yes" to each question. None of the differences between the groups were significant.

Figure 11. Caseworker Use of Culturally-Responsive Practice



4.4.4 Parent engagement

Parent engagement was measured with a 19-item quantitative measure of parent engagement in child protective services.[73] The 19 items were summed to form a total engagement score that could range from 19 (no engagement) to 95 (full engagement). The engagement measure contains four subscales:

- Receptivity, which is described as openness to receiving help and contains 4 items, with potential scores ranging from 4 to 20.
- Buy-in, which consists of a perception of benefit and commitment to the helping process and contains 8 items, with potential scores ranging from 8 to 40.

[73] Yatchmentoff, D. (2005). Measuring client engagement from the client's perspective in nonvoluntary child protective services. *Research on Social Work Practice, 15*, 84-96.

- Working relationship, described as the interpersonal relationship with the worker characterized by a sense of reciprocity and good communication. This subscale contains 4 items and has potential scores ranging from 4 to 20.
- Mistrust, described as the belief that the agency or worker is manipulative or capricious, with intent to harm the client. This subscale contains 3 items and has potential scores ranging from 3 to 15. Items in this subscale were reverse coded so that higher ratings equate to higher levels of trust.

The scores on the total engagement scale and each of the four subscales for parents who received an AR, TR, and non-DR assessment are shown in Table 29. Average total engagement scores of parents in AR (68.8) and TR (65.6) assessments were not significantly different from those of parents in non-DR assessments (68.0); all three groups reported moderate levels of engagement with their CPS workers. Average scores on the four engagement subscales were not significantly different except for the mistrust subscale; parents in TR assessments had lower levels of trust in their CPS worker (11.9) compared to parents in non-DR assessments (12.7).

Table 29. Parent Engagement with CPS

	AR (n=119)		TR (n=85)		Non-DR (n=330)	
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**
Total Engagement	68.8	15.1	65.6	16.6	68.0	14.9
Receptivity	11.6	4.4	12.0	4.4	12.1	4.3
Buy-in	27.2	7.4	25.9	7.9	27.1	7.6
Working Relationship	17.1	3.6	15.8	4.1	16.4	3.7
Mistrust	13.0	2.9	11.9^{A}	3.2	12.7^{B}	2.7

Note. Superscripts indicate difference between groups is significant at $p < .05$.

4.4.5 Trauma related to CPS assessment

Parent ratings of their own trauma symptoms following the CPS assessment were compared; there were no significant differences between parents in AR, TR, and non-DR assessments on their total trauma symptom scores or on any of the trauma sub-scales (see Table 30). Few trauma symptoms were reported by parents in any of the three groups.

Table 30. Parent Trauma Symptoms Following Assessment

	AR (n=104)		TR (n=69)		Non-DR (n=298)	
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**
Total Trauma	2.6	4.2	4.1	4.7	3.4	4.1
Re-experiencing	0.8	1.3	1.2	1.5	1.0	1.3
Avoidance	0.9	1.6	1.2	1.7	1.1	1.7
Over-arousal	1.0	1.7	1.6	2.0	1.3	1.7

Parent ratings of their child's trauma symptoms following the CPS assessment were compared; there were no significant differences between children in AR, TR, and non-DR assessments on their total trauma symptom scores or on any of the trauma sub-scales (see Table 31). There were very few trauma symptoms reported for children in all three of the groups.

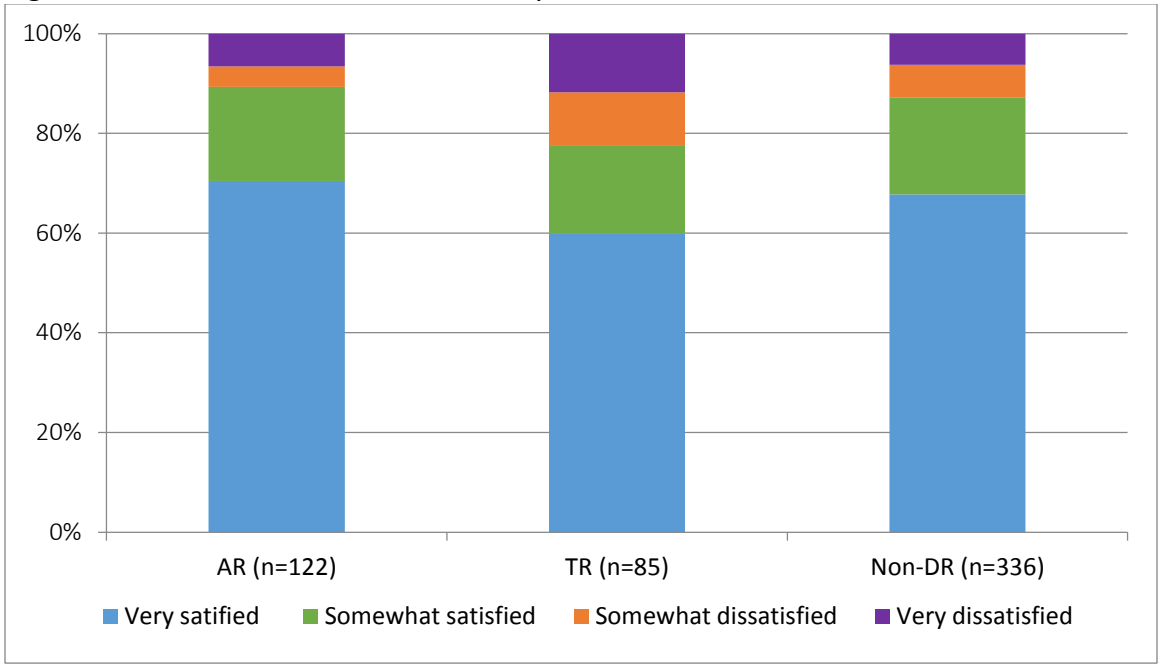
Table 31. Child Trauma Symptoms Following Assessment

	AR (n=104)		TR (n=69)		Non-DR (n=298)	
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**
Total Trauma	1.5	3.3	1.8	3.1	1.2	2.4
Re-experiencing	0.5	1.0	0.7	1.2	0.4	.8
Avoidance	0.5	1.2	0.5	1.1	0.4	1.0
Over-arousal	0.6	1.4	0.6	1.3	0.4	.9

4.4.6 Satisfaction with treatment by CPS worker

Parents were asked about their overall level of satisfaction with the way that their family was treated by the CPS worker. Almost all parents in each group reported that they were either "very satisfied" or "somewhat satisfied" with their treatment by the CPS worker (AR = 89.4%; TR = 77.7%; non-DR = 87.3%). There were no significant differences in the level of satisfaction between parents in AR or TR and non-DR assessments (see Figure 12).

Figure 12. Satisfaction with Treatment by CPS Worker



4.5 Safety Assessment

After the necessary information is gathered, the CPS worker must determine if the child is safe or unsafe. If one or more present or impending danger threats are present, including previously identified 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.[74] Table 32 and Figure 13 show the percentages of families in AR and TR assessments that were determined to be safe and unsafe in the four DR districts, with statewide percentages shown for comparison. Across the state, the percentage of assessments that were assessed as unsafe has been fairly stable for the last three calendar years (9-10%). In the DR districts, the percentage of AR assessments determined to be unsafe in 2016 ranged from 5% to 11%; the percentages of TR assessments determined to be safe were slightly higher and ranged from 8% to 13%.

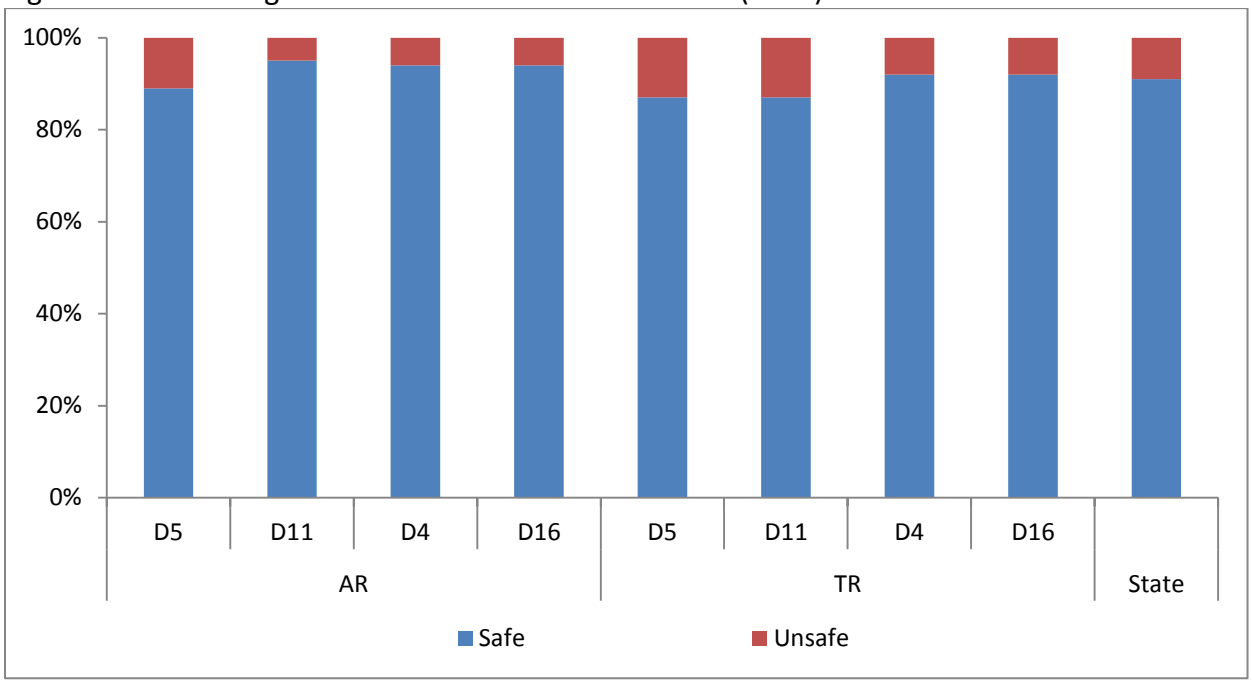
Table 32. Percentages of Safe and Unsafe Assessments

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%	94%	94%	11%	5%	6%	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]	87%	87%	92%	92%	13%	13%	8%	8%
Statewide								
	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] Data extracted March 31, 2017.

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

Figure 13. Percentages of Safe and Unsafe Assessments (2016)



Several questions related to the OSM were included on the staff survey. 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 33 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.

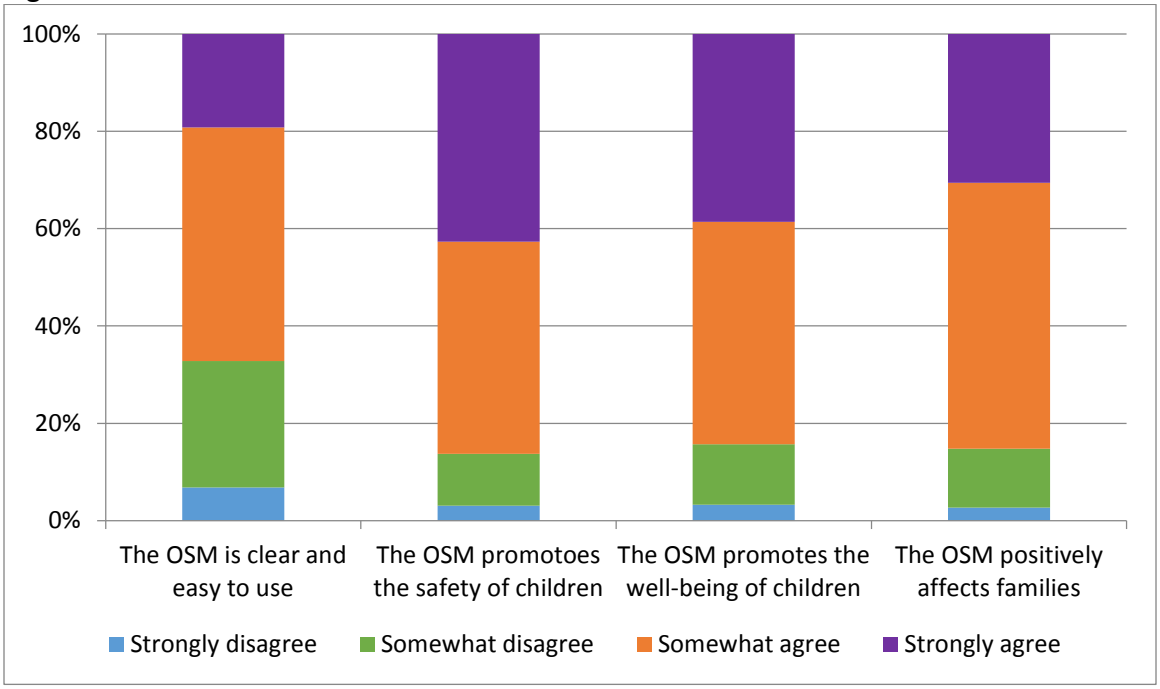
Table 33. Effect of OSM on Practice

	Statewide		DR		Non-DR	
	Mean	**SD**	**Mean**	**SD**	**Mean**	**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."

Staff were also asked their opinions about the OSM (see Figure 14). 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 14. Attitudes Toward the OSM



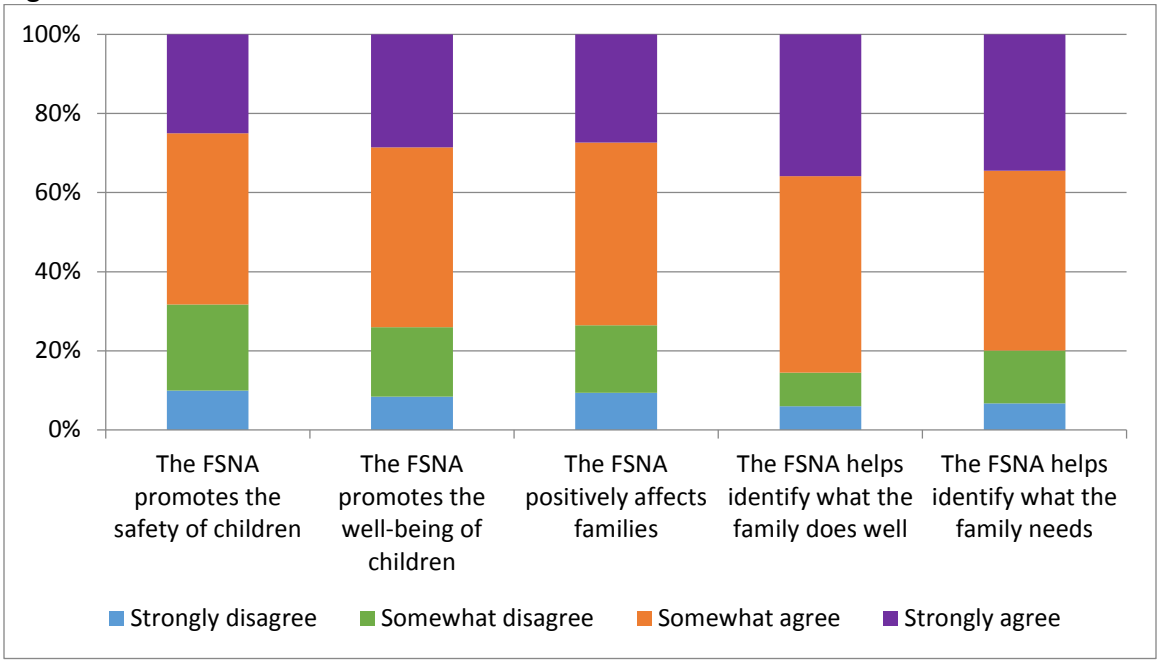
4.6 Family Strengths and Needs Assessment (FSNA)

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 refer them to non-contracted community services 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.[75] Although an indicator was added to OR-Kids in September 2015 to identify which families have moderate to high needs, these data were not available for analysis, so we therefore cannot present the percentage of safe families with moderate to high needs.

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

Information related to the FSNA was included in the staff survey and site visit data collections. CPS workers in districts that have implemented DR were asked several questions about the FSNA on the staff survey (see Figure 15). 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 15. Attitudes Toward the FSNA



Note. Only CPS workers in DR districts responded to these items (n=120).

CPS workers in the first four DR districts provided additional thoughts about the FSNA process during the site visits. From its initial implementation through the last site visit, the FSNA was unpopular with most caseworkers and supervisors. Generally, caseworkers felt the process was inefficient and duplicative from the assessment work they had already done. Supervisors concurred and also noted the FSNA stood as a barrier to timely assessment completion: FSNAs require coordinating the schedules of families, CPS workers, and community providers, which meant many took longer than the allotted 15 days. In Districts 5 and 11, during the first-year site visits (June 2015), caseworkers estimated they referred only 5 to 10% of their assessments for FSNA. In Districts 4 and 16, during the final site visits, caseworkers said the FSNA had "essentially died" and that they had not referred a family for an FSNA in "months and months."

DHS central office attempted to address some early concerns about the FSNA by emphasizing that the "warm handoff" (in which the caseworker introduces the family to the community provider before the FSNA is conducted) was optional. Another change that District 5 implemented was to use one community provider for most FSNAs because this provider was able to efficiently conduct the FSNAs. These changes were praised by workers and supervisors, but they did not change the prevailing sense that the FSNA was not needed. As one supervisor

said, “We still feel it’s a waste of time. We already know what their needs are; why don’t we just get started working with them?” Not all site visit participants were hostile to the FSNA. Some community providers expressed support for it, and district administrators suggested workers would support the FSNA if they had more training in it and better understood its purpose.

4.7 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 unavailable, Table 34 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 10% in D4 to 19% in D11 and the percentage of TR families who were offered services ranged from 8% in D4 to 16% in D11. In general, the percentage of TR families who were offered services was slightly lower than the corresponding percentage of AR families in each district.

Table 34. Families With Safe Children Offered Services

	AR				TR			
	D5	D11	D4	D16	D5	D11	D4	D16
2014[a]	14%	21%	-	-	7%	13%	-	-
2015[b]	17%	17%	14%	9%	12%	10%	10%	6%
2016[c]	15%	19%	10%	12%	12%	16%	8%	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] Data extracted March 31, 2017.

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 in 2016 is examined, the percentage ranges from 31%-54% for AR families (Table 35) and 32%-58% for TR families (Table 36). 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 8% in 2016.

Table 35. AR Families Who Accepted Services

Year	District	# Families With Safe Children	# Families Offered Services	# Families Accepted Services	% Accepting Services of Those Offered[d]	% Accepting Services of all Families with Safe Children[e]
2014[a]	D5	758	109	60	55%	8%
	D11	251	52	22	42%	9%
2015[b]	D5	1,301	218	101	46%	8%
	D11	444	77	42	55%	9%
	D4	615	88	37	42%	6%
	D16	856	80	32	40%	4%
2016[c]	D5	1,373	210	114	54%	8%
	D11	533	102	44	43%	8%
	D4	1,131	118	36	31%	3%
	D16	1,387	173	65	38%	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] Data extracted March 31, 2017.
[d] % of accepting services of those offered = (#Families Accepted Services/# Families Offered Services)
[e] % accepting services of all safe families = (# Families Accepted Services/# Families With Safe Children)

Table 36. TR Families Who Accepted Services

Year	District	# Families With Safe Children	# Families Offered Services	# Families Accepted Services	% Accepting Services of Those Offered[d]	% Accepting Services of all Families with Safe Children[e]
2014[a]	D5	482	32	22	69%	5%
	D11	191	24	14	58%	7%
2015[b]	D5	1,152	137	68	50%	6%
	D11	460	48	20	42%	4%
	D4	730	75	30	40%	4%
	D16	691	44	24	55%	3%
2016[c]	D5	1,390	161	93	58%	7%
	D11	603	94	44	47%	7%
	D4	1,058	85	31	36%	3%
	D16	1,360	117	37	32%	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] Data extracted March 31, 2017.
[d] % of accepting services of those offered = (#Families Accepted Services/# Families Offered Services)
[e] % 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 37 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 37. 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	24	40%	22	13	59%
	D11	22	2	9%	14	3	21%
2015[b]	D5	101	35	35%	66	12	18%
	D11	42	6	14%	20	3	15%
	D4	37	9	24%	30	9	30%
	D16	32	14	44%	24	10	42%
2016[c]	D5	114	45	39%	91	29	32%
	D11	44	2	5%	44	3	7%
	D4	65	21	32%	31	6	19%
	D16	49	19	39%	37	9	24%

[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 March 31, 2017.

The Service Assessment Questionnaire, which was sent to parents who were offered services following the assessment, contained a series of questions about services that their family may have received. First, parents were provided a list of services and asked to check each service that their family received. Figure 16 shows the total number of services received by families in AR, TR, and non-DR assessments. Almost all families in each of the three groups received at least one service, and a third or more of the families received 6 or more services. There were no differences between the groups in the total number of services received.

Figure 16. Parent Reports of Number of Services Received

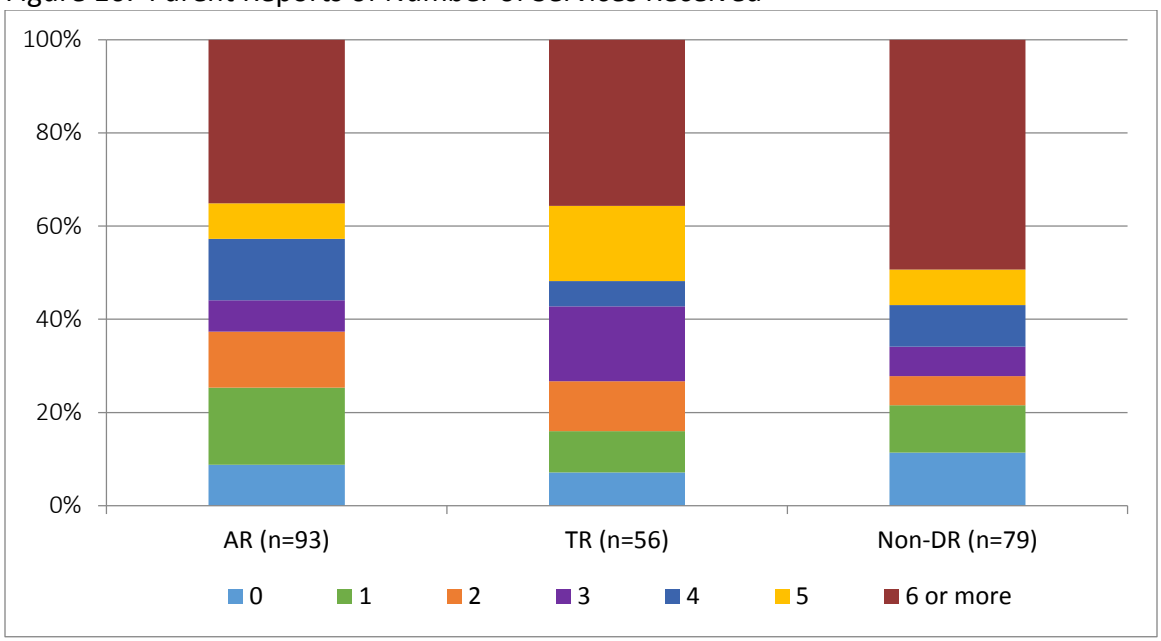


Table 38 shows the percentages of families in AR, TR, and non-DR assessments that received each specific service. The service that was most often received by families in all three groups was food or clothing; around 50% of the families in all three groups reported receiving this service. Other frequently received services included help with housing (36.6% AR, 44.6% TR, 40.5% non-DR), help with utilities (36.6% AR, 41.1% TR, 35.4% non-DR), dental or medical care (36.6% AR, 44.6% TR, 41.8% non-DR), mental health services (32.3% AR, 35.7% TR, 48.1% non-DR), and counseling (33.3% AR, 37.5% TR, 44.3% non-DR). Significant differences in service receipt were found for one service: families in non-DR assessments were more likely to receive supportive home visitors than those in AR assessments (54.4% versus 29.0%).

Table 38. Parent Reports of Services Received

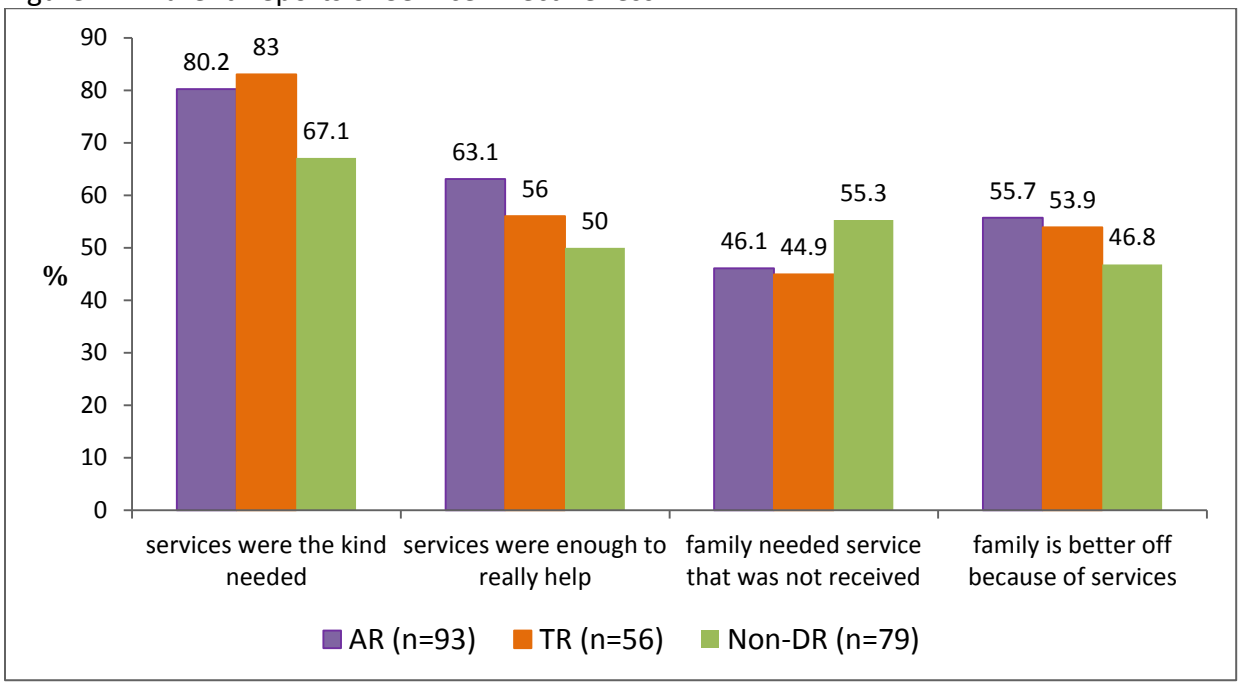
	AR (n=93)	TR (n=56)	Non-DR (n=79)
Help with housing	36.6%	44.6%	40.5%
Car repairs	16.1%	14.3%	19.0%
Food or clothing	50.5%	51.8%	53.2%
Appliances, furniture, or home repair	19.4%	21.4%	30.4%
Help paying utilities	36.6%	41.1%	35.4%
Dental care or medical care	36.6%	44.6%	41.8%
Relief nursery	19.4%	17.9%	20.3%
Supportive home visitor**	29.0%	50.0%	54.4%
Assistance with legal issues	23.7%	19.6%	26.6%
Assistance in your home (e.g., cooking or cleaning)	12.9%	10.7%	16.5%
Child care or day care	24.7%	25.0%	29.1%
Mental health services	32.3%	35.7%	48.1%
Drug or alcohol treatment	17.2%	23.2%	34.2%
Support groups	20.4%	21.4%	26.6%
Parenting classes	23.7%	30.4%	27.9%
Mentoring	14.0%	14.3%	25.3%
Counseling	33.3%	37.5%	44.3%
Employment services	21.5%	26.8%	24.1%
Domestic violence services	29.0%	21.4%	32.9%
Navigator to connect you to social services	25.8%	23.2%	26.6%
Transportation	26.9%	30.4%	34.2%
Other services	6.5%	7.1%	16.5%

*p < .05 **p < .01

Parents who completed the SAQ were asked a series of questions about the effectiveness of the services they received. Specifically, they were asked if the services they received were the kind that they needed, if the services were enough to really help them, if there were any services that they needed but did not receive, and if their family was better off because of the services they received. Figure 17 shows the percentages of parents in AR, TR, and non-DR assessments that answered yes to each of these questions. Over 80% of the parents in AR and TR assessments felt that the services they received were the kind they needed. A significantly smaller percentage of parents in non-DR assessments (67.1%) felt that the services they received were the kind they needed ($p < .05$). Between 50-63% of parents felt that they received enough services to really help them; there were no significant differences between the groups. About half of the parents in each group reported that there were services they needed but did not receive; there were no significant differences between the groups. Finally, about

half of the parents in each group felt that their family was better off because of the services they received; there were no significant differences between the groups.

Figure 17. Parent Reports of Service Effectiveness



If parents reported that there were services that their family needed but did not receive, they could specify which services were needed by filling out an additional question on the SAQ. Parent responses to this question were categorized and are listed in Table 39. The most frequently needed service that was not received was help with housing; about 39% of the parents who completed the survey reported that they needed but did not receive this help.

Table 39. Services Needed But Not Received (%)

	Total (n = 105)	AR (n = 41)	TR (n = 22)	Non-DR (n = 42)
Help with housing	39.1	43.9	36.4	35.7
Car repairs	5.7	4.9	9.1	4.8
Food or clothing	6.7	7.3	9.1	4.8
Appliances, furniture, or home repair	1.0	2.4	0.0	0.0
Help paying utilities	14.3	12.2	13.6	16.7
Dental care or medical care	1.9	4.9	0.0	0.0
Relief nursery	1.9	2.4	0.0	2.4
Supportive home visitor	1.0	2.4	0.0	0.0
Assistance with legal issues	4.8	7.3	4.6	2.4
Assistance in your home (e.g., cooking or cleaning)	2.9	0.0	4.6	4.8
Child care or day care	11.4	14.6	13.6	7.1
Mental health services	6.7	4.9	4.6	9.5
Drug or alcohol treatment	1	2.4	0.0	0.0
Support groups	1.9	2.4	0.0	2.4
Parenting classes	1.9	0.0	0.0	4.8
Mentoring	0.0	0.0	0.0	0.0
Counseling	13.3	9.8	22.7	11.9
Employment services	5.7	4.9	0.0	9.5
Domestic violence services	5.7	9.8	4.6	2.4
Navigator to connect you to social services	1.0	0.0	0.0	2.4
Transportation	8.6	2.4	27.3	4.8

Parents who participated in the Service Assessment Interview were also asked about the services that they received. Most of the parents described the services they received as very useful:

> *And life was so overwhelming for the moment, having someone say 'Here's a direction for a counselor, here's a direction for a psychiatrist, here's a direction for this,' was unbelievably helpful." (Age: 41; Race: White/Caucasian; DR)*

> *"I received medical. I received food stamps and cash assistance for a little time. The medical always is a plus just because I'm a single mom. I do have three kids and for myself, not being able to find a really good job that has good benefits to pay for everything. The medical is a plus and then the food stamps always good because that keeps food in the house for my children. The cash was what it was. I wasn't getting too much of it, but it did help me pay for bills. It kept my stress and depression at bay. Since*

they took me off of that, I've been a little stressed out about bills." (Age: 28; Race: Bi-racial/multi-racial; DR)

"The help that I did receive, which was the legal help, it's exactly what I needed because I navigated court by myself. I had to get a restraining order, I had to get an emergency protective, emergency custody order to get emergency custody of my daughter, and then filing for full custody. Oh, I forgot to say this to you. Shortly after [daughter's father] called Child Protective Services to tell them he was sober and that the case should be closed, that was shortly after he had relapsed and gotten out of treatment. He was arrested for his fourth DUI, and he landed himself in jail and so he missed that court date for the custody. So yes, doing all of those court things, I got a lawyer. It's difficult. It's language I didn't quite understand, so the legal services were the most important for me." (Age: 36; Race: White/Caucasian; DR)

"It was hospice who I was working with. CPS just referred them to me. They came and met with me on a weekly basis. Most of the meetings were at my house at my convenience. Sometimes they met with my kids. Sometimes I would meet them in town. They provided some winter clothing for my two younger kids that are in the house, shoes, winter boots, jackets, snow pants. They helped me set some goals. They offered their services to back anything that I needed for jobs because I wasn't working. Sometimes I would have to send in tax information, birth certificates, anything like that. They helped me with that. At one point they offered to help me get my driver's license here in Oregon, which I was able to do on my own. It was just services like that that they had available that if I wasn't able to do or if I was in a situation where I couldn't pay for it that they were there willing to help me do that." (Age: 48; Race: White/Caucasian; DR).

Well, at the time I was drinking way too much, and it affected my relationship with my kids. So, being able to be around people who've struggled with staying sober very similar was helpful in understanding how our brains work and why things got to the point that they did. And how to correct the situation and move forward, and continue on with preventative measures. And so we're better off, far better off, because we have become closer throughout the process, and my kids have also learned about the whole addiction process that I had gone through as well. So, we were all able to understand each other a lot better, which we grew closer because of. (Age: 38; Race: White/Caucasian; Non-DR)

Other parents described their services as either unavailable or unhelpful:

The [caseworker], he can only do so much. He had good information, he knew what to do, who to call and what might work, and stuff like that. So he was only going by what [my county] lets him use. He can't turn around and go out of [my county]. If [my county] ain't got the classes or the stuff to really help, there's not much he could do.(Age: 51; Race: White/Caucasian; Non-DR)

It was a little hard to get the services. It seems like the state of Oregon isn't very understanding about people with mental illnesses. Especially children. They don't have a lot of programs. And the programs that they do have, are a little overflowing with people. So it took a month or so. But I did finally get him into the programs that are available. It's just that we were on a waiting list.(Age: 29; Race:Bi-racial/multi-racial; DR)

I was put in with a bunch of drug addicts that had lost their children, that didn't know how to keep their house clean, or anything like that, and that totally wasn't my issue of anything that happened. And so often within my own counseling services through my employer, but I didn't receive anything from CPS. As a matter of fact, after I had talked to her and she put me on the spot, she was almost next to impossible to get ahold of and I've never even heard anything from them pretty much after that day. (Age: 36; Race: White/Caucasian; Non-DR)

4.8 Service Availability

Staff survey participants rated nine services as available or unavailable but needed in their districts (see Table 40). 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 40. 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/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. 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.

4.9 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.[76] The average (median) length of AR and TR assessments was calculated and is reported in Table 41; statewide averages are shown for comparison. There has been a dramatic decrease in the median length of AR and TR assessments between 2015 and 2016; this decrease is also seen at the state level as well. The statewide average length of CPS assessments in 2016 was 66 days and was similar or slightly higher in the districts that have implemented DR.

Table 41. Median Length of CPS Assessments (Days)

	AR				TR				State
	D5	D11	D4	D16	D5	D11	D4	D16	
2014[a]	82	128	-	-	92	99	-	-	78
2015[b]	154	103	139	119	128	102	137	111	97
2016[c]	70	64	73.5	74	69	63	77	76	66

[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 March 31, 2017.

For those families with Admin-Only cases that were opened prior to September 30, 2016, the length of the service case (in days) was measured as the number of days between the Admin-Only case open date and case close date (Table 42). In 2016, the median length of Admin-Only cases ranged from 48 days to 143 days for AR assessments and from 65 days to 101 days for TR assessments. However, because the number of cases is small in most districts, the medians should be interpreted with caution.

[76] Oregon Department of Human Services. (December, 2014.). *DHS Differential Response Procedure Manual. Chapter 21: CPS Assessment Documentation.* Salem, OR: Author.

Table 42. Length of Admin-Only Cases (in days)

Year	District	AR		TR	
		# Families with Admin-Only Services	Median # days	# Families with Admin-Only Services	Median # days
2014[a]	D5	24	105.5	13	79
	D11	2	432	3	566
2015[b]	D5	35	72	12	50
	D11	6	228.5	3	160
	D4	9	89	9	98
	D16	14	42.5	10	51
2016[c]	D5	45	48	29	65
	D11	2	143	3	72
	D4	8	47.5	6	25.5
	D16	21	80	9	101

[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 March 31, 2017.

Chapter 5: Outcome Evaluation Findings

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. As a result of the assessment and services, family functioning will be increased. This, in turn, will lead to fewer families being re-reported to DHS and fewer children being removed from their homes and placed into foster care. If children are placed into foster care, the length of time until achieving permanency will be decreased. In addition, the implementation of DR will also lead to increased worker satisfaction. Finally, DR implementation will affect the child welfare system as a whole by strengthening the organizational culture and the relationship between child welfare and community partners and by decreasing the disproportionate representation of minority children in the child welfare system.

5.1 Child and Family Outcomes

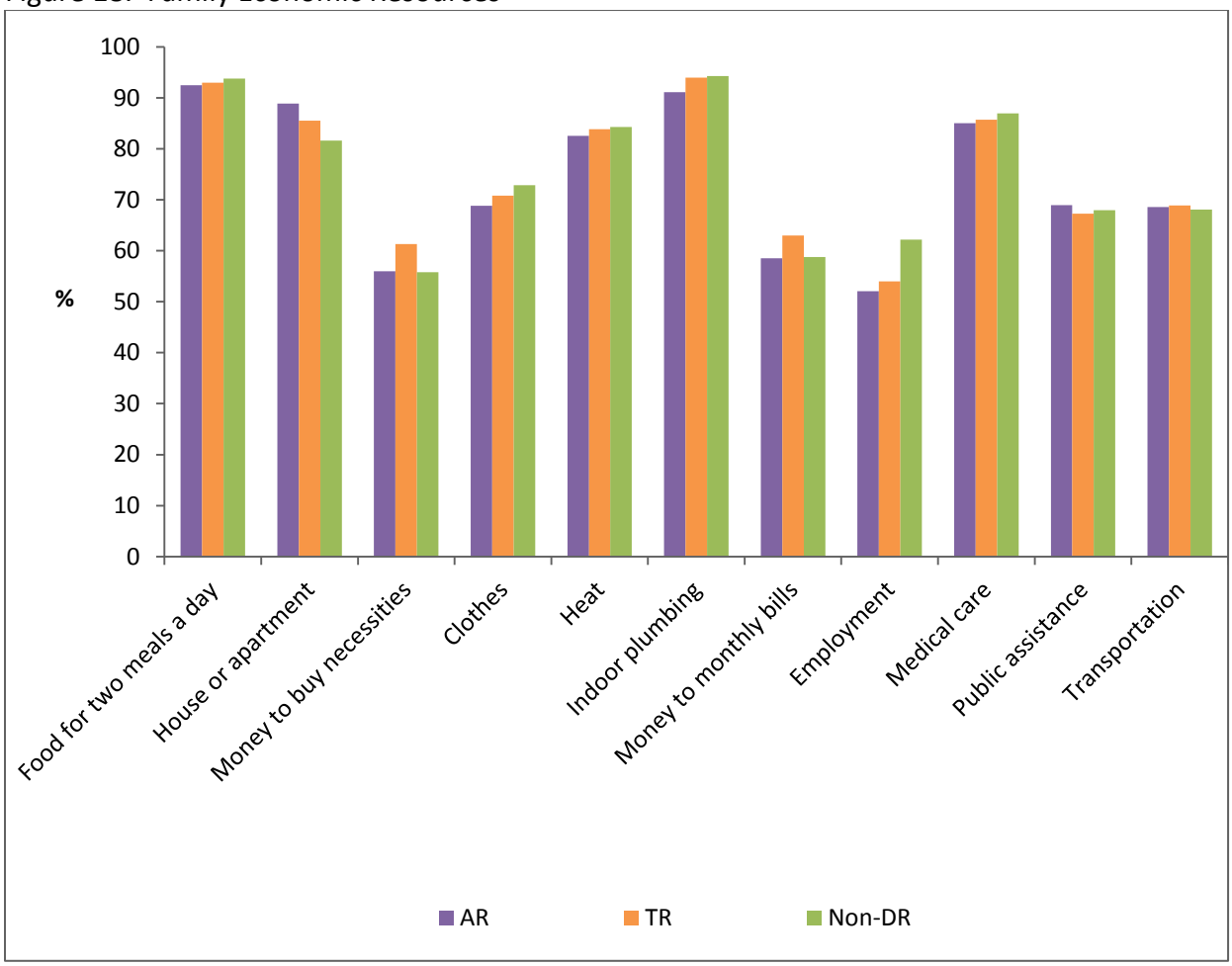
5.1.1 Social support

Total scores on the social support scale could range from 5 (no social support) to 20 (excellent social support). Parents in all three groups reported high levels of social support.
Parents who received AR assessments reported significantly higher levels of social support (M = 17.2, SD = 3.4) than parents who received non-DR assessments (M = 16.1, SD = 4.0). There were no differences between parents in TR assessments (M = 16.1, SD = 3.6) and parents in non-DR assessments.

5.1.2 Family economic resources

Parents who completed the parent survey provided information about their family's economic resources. The Family Resources Scale contains 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 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 18 displays the percentage of parents in the AR, TR, and non-DR groups who responded that their families "often" or "always" had enough of each resource. Parents in all three groups reported often or always having enough of most of the resources, including food, housing, indoor plumbing, medical care, and transportation. The three resources that parents needed the most were: money to buy necessities, money to pay monthly bills, and employment. There were no significant differences between the groups on the availability of economic resources.

Figure 18. Family Economic Resources



5.1.3 Re-reports and removals

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 initial assessment was defined as the period beginning on the date of the report was received ("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 initial assessment close date and ends 6 months after that date. If a family in a DR county was offered and accepted services following the initial assessment, this period of time was included in the follow-up period.

Families in which all of the children were removed from the home and placed into foster care during the initial assessment period were dropped from these analyses. If the family had any child remaining in the home following the initial assessment (i.e., if some children were removed but others remained in the home), they were kept in the analyses. The numbers and percentages of families in each of the 4 groups that were dropped from the analyses are shown in Table 43.

Table 43. Number of Families Included in the Analyses

	Number of families in original sample	Number of families with all children removed during initial assessment	Number of families included in the analyses
AR sample	4,898	270	4,628
AR-matched sample	4,898	256	4,642
TR sample	4,187	299	3,888
TR matched sample	4,187	213	3,974

Families that were assigned to the AR pathway following the initial screening could be reassigned to the TR pathway at any point during the initial CPS assessment if information was discovered that indicated that the children were unsafe or that the family required TR. In the evaluation sample, 446 of the 4,628 families (9.6%) initially assigned to AR were switched to TR. Although these families that switch pathways are not dropped from the analyses, their outcomes are not included in the significance tests and are reported separately.

Table 44 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 initial assessment closure. There was one significant difference between the two groups: a smaller percentage of families in the AR group had a founded re-report (3.4%) compared to families in the AR-matched group (4.7%). The results of additional analyses (not shown) that controlled for the post-match differences between the two groups did not change the pattern of the results.

Table 44. Safety Outcomes of AR and AR-matched Families

	AR (n=4,182)	**AR-matched (n=4,642)**
% families with re-report (on any child) within 6 months	15.5%	15.4%
% families with founded re-report (on any child) within 6 months*	**3.4%**	**4.7%**
% families with a child removal within 6 months	2.2%	2.3%

Note: Families that switched from AR to TR are not included. Of the 446 families that switched from AR to TR, 20.0% had a re-report, 8.5% had a founded re-report, and 12.1% had a child removal within 6 months of the initial assessment close date.

* $p < .01$

Outcome comparisons between AR and AR-matched families were analyzed by race and the results are shown in Table 45. Smaller percentages of Latino and White families in the AR group had a founded re-report compared to similar families in the AR-matched groups.

Table 45. Safety Outcomes of AR and AR-matched Families by Race

Black/African American	**AR (n=164)**	**AR-matched (n=182)**
% families with re-report (on any child) within 6 months	14.0%	21.4%
% families with founded re-report (on any child) within 6 months	3.7%	4.4%
% families with a child removal within 6 months	4.9%	3.3%
Native American	**AR (n=174)**	**AR-matched (n=183)**
% families with re-report (on any child) within 6 months	21.3%	19.7%
% families with founded re-report (on any child) within 6 months	4.6%	7.1%
% families with a child removal within 6 months	4.6%	4.4%
Latino/Hispanic	**AR (n=366)**	**AR-matched (n=440)**
% families with re-report (on any child) within 6 months	16.1%	13.2%
% families with founded re-report (on any child) within 6 months*	**3.3%**	**6.8%**
% families with a child removal within 6 months	2.5%	4.1%
White	**AR (n=2,958)**	**AR-matched (n=3,387)**
% families with re-report (on any child) within 6 months	16.8%	16.5%
% families with founded re-report (on any child) within 6 months**	**4.1%**	**5.5%**
% families with a child removal within 6 months	2.7%	2.9%

*p < .05 **p < .01

Table 46 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 initial 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 46. Safety Outcomes of TR and TR-matched Families

	TR (n=3,888)	TR-matched (n=3,974)
% families with re-report (on any child) within 6 months	13.5%	13.5%
% families with founded re-report (on any child) within 6 months	3.0%	3.7%
% families with a child removal within 6 months	2.7%	2.1%

The safety outcome comparisons between TR and TR-matched families were analyzed by race and the results are shown in Table 47. Smaller percentages of Latino families in the TR group had a founded re-report compared to similar families in the TR-matched group.

Table 47. Safety Outcomes of TR and TR-matched Families by Race

Black/African American	**TR (n=171)**	**TR-matched (n=171)**
% families with re-report (on any child) within 6 months*	11.7%	14.6%
% families with founded re-report (on any child) within 6 months	6.4%	5.9%
% families with a child removal within 6 months	5.3%	5.9%
Native American	**TR (n=191)**	**TR-matched (n=168)**
% families with re-report (on any child) within 6 months	16.2%	13.1%
% families with founded re-report (on any child) within 6 months	4.2%	3.6%
% families with a child removal within 6 months	3.7%	3.0%
Latino/Hispanic	**TR (n=390)**	**TR-matched (n=387)**
% families with re-report (on any child) within 6 months	18.7%	15.0%
% families with founded re-report (on any child) within 6 months*	**3.9%**	**7.2%**
% families with a child removal within 6 months	4.6%	4.9%
White	**TR (n=2,807)**	**TR-matched (n=2,836)**
% families with re-report (on any child) within 6 months	15.1%	14.2%
% families with founded re-report (on any child) within 6 months*	3.5%	4.3%
% families with a child removal within 6 months	3.4%	2.5%

* $p < .05$

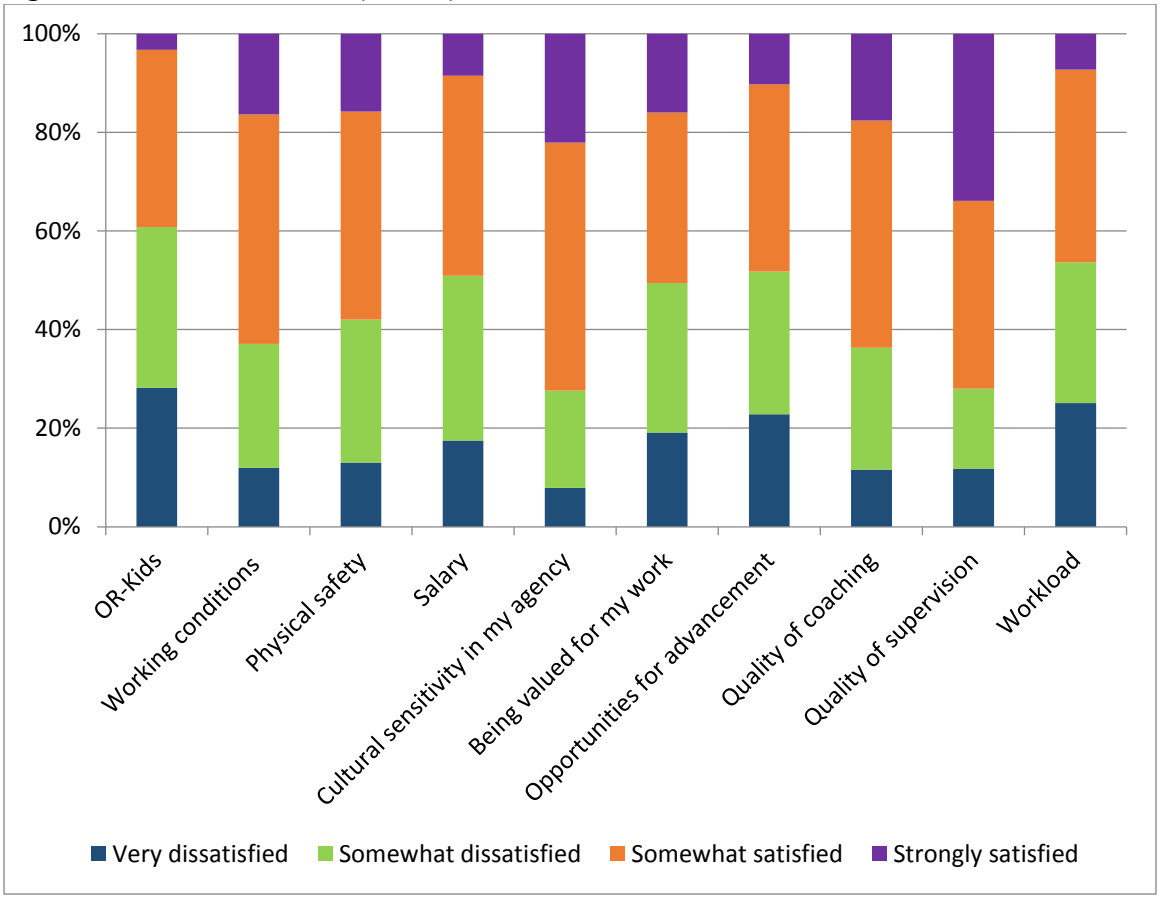
5.1.4 Length of time in care

Differences in the length of time children spend in out of home care after a CPS assessment were examined by comparing the percentages of children that exit substitute care within 12 months following an AR assessment (versus matched children in non-DR districts) or TR assessment (versus matched children in non-DR districts). Children were included in this analysis if they entered substitute care at any point between the initial report date and six months after the assessment completion. Children in families that switched tracks from AR to TR were excluded from the analysis. Of the 171 children in AR assessments that entered care, 55 exited care within 12 months (32.2%). This was not significantly different than the percentage of children in matched non-DR families who exited care within 12 months (34.0%). Of the 679 children in TR assessments that entered care, 212 exited within 12 months (31.2%), which was not significantly different than the percentage of children in matched non-DR families (31.4%).

5.2 Worker Job Satisfaction

Staff were asked to rate their satisfaction with several different aspects of their job on the statewide staff survey (see Figure 19). 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 19. Job Satisfaction (n=500)



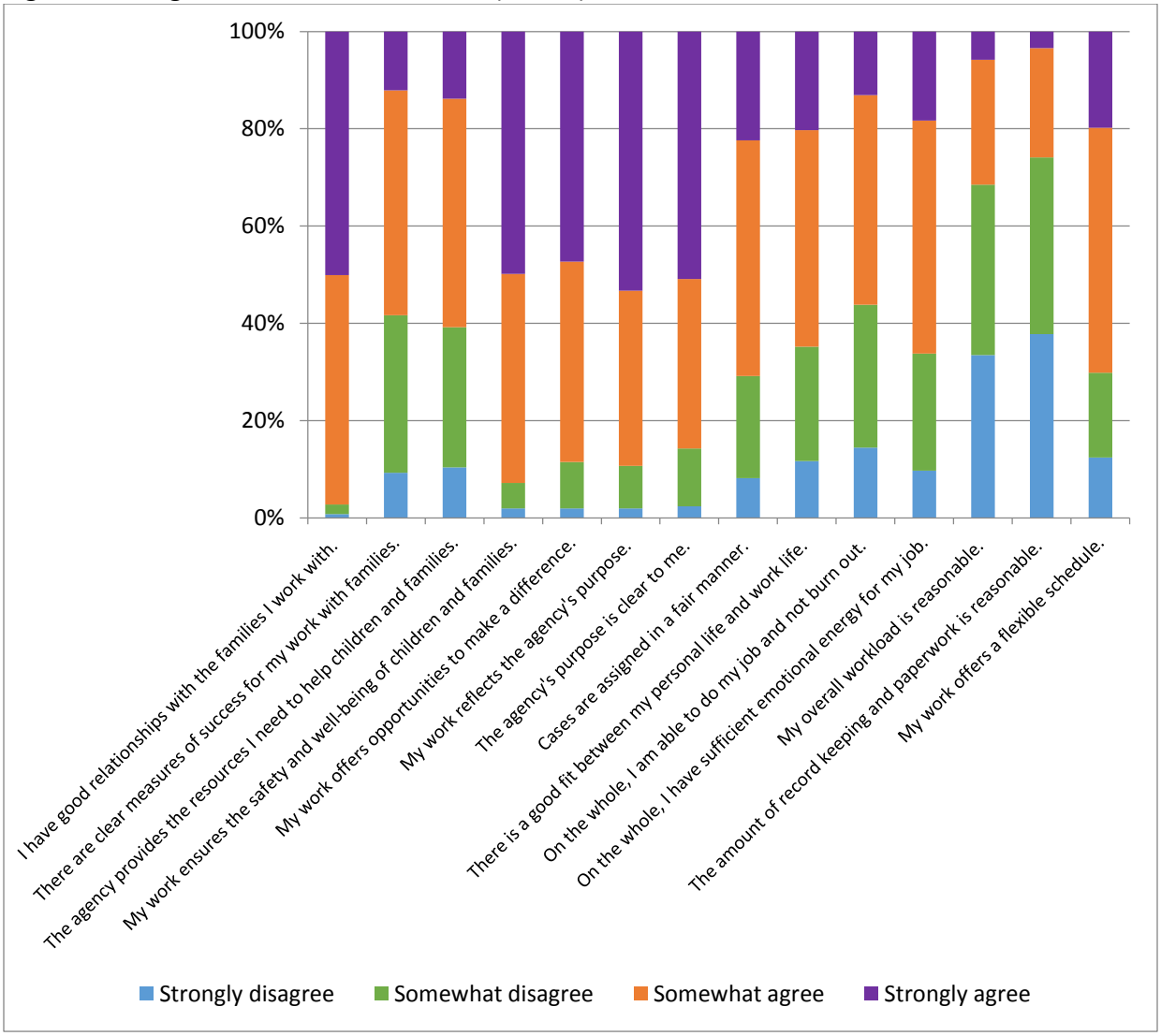
The ten items on the job satisfaction measure were summed to form an overall measure of job satisfaction. Across all staff, the average score on this measure was 2.54 (SD = .58), which falls between "somewhat satisfied" and "somewhat dissatisfied." Overall satisfaction in DR districts (M = 2.59, SD = .58) was not significantly different than in non-DR districts (M = 2.50, SD = .58).

5.3 Child Welfare System Outcomes

5.3.1 Organizational culture

Staff responses to the 14 items on the organizational culture scale are shown in Figure 20. 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 20. 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 48. Organizational Culture Sub-scales

	Statewide		DR		Non-DR	
	Mean	SD	Mean	SD	Mean	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 49). 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 49. 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

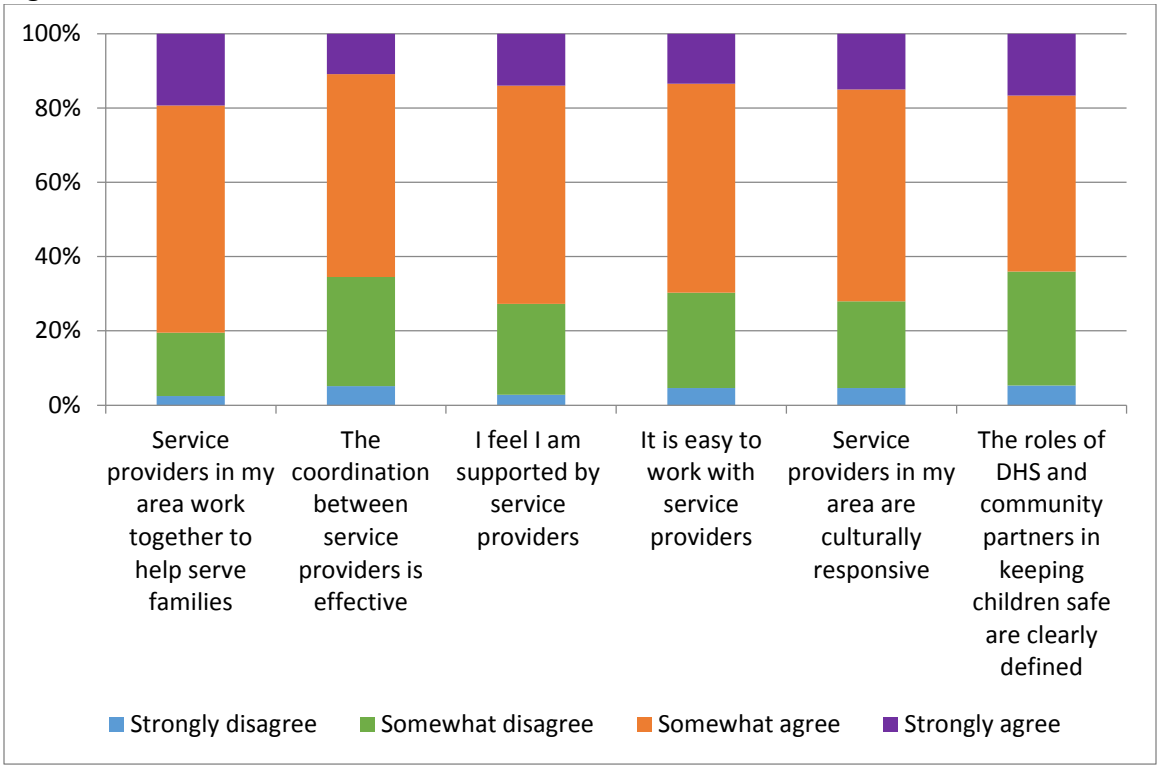
Note. Item scores have a possible range from 1-4. Differing superscripts indicate significant differences (p. < .05) between groups. Superscripted letters that differ between roles indicate those roles significantly differed from each other.

5.3.2 Relationship between DHS and community partners

Participants on the staff survey 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).

Figure 21 shows staff responses to each of the individual items related to service coordination. Over 80% of staff agreed that service providers worked 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 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 21. 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 50). The most frequently cited barrier 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 that lack of communication was a barrier to coordination of services. 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 50. 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

5.3.3 Disproportionate minority representation

Racial disproportionality refers to over- or under-representation of a racial group in the child welfare system compared to that racial group's representation in the general population. It is often represented by a Racial Disproportionality Index (RDI), in which the percentage of children in a racial group involved in some part of the child welfare system is divided by the percentage of that group in the general population. For example, if White children make up 60% of maltreatment reports but are 75% of the general population, then their RDI is 60/75 = .8. Values under 1 indicate underrepresentation; values over 1 indicate overrepresentation.

To understand the impact of DR implementation on disproportionality, RDIs are calculated for four racial/ethnic groups (Black/African American, White, Hispanic/Latino, and Native American) in the first four DR districts (D5, D11, D4, D16) at two points in time: 2013 (prior to DR implementation) and 2016 (the most recent year with complete data).[77] For comparison, RDIs are calculated for the same racial/ethnic groups in the four non-DR districts that were selected as comparison districts in the outcome evaluation (D3, D10, D6, D2) in order to test the hypothesis that any change in RDIs in DR districts were only a reflection of larger, statewide trends.

[77] RDIs were not calculated for other racial groups, including Asian and Pacific Islander, due to very low numbers in these districts.

For each racial/ethnic group in DR and non-DR districts, RDIs are calculated for several child welfare decision points, including:

- Maltreatment reports
- Maltreatment reports assigned to assessments
- Maltreatment reports assigned 24-hour response times
- Unsafe assessments
- Children entering out of home care
- Children staying in care longer than 12 months

RDIs for maltreatment reports are shown in Table 51. In DR districts, there was little evidence of disproportionate representation for White or Black children, either before or after the implementation of DR. Latino children, however, were underrepresented in maltreatment reports prior to DR implementation (2013 RDI = .49) and even more so after DR implementation (2016 RDI = .40). Native American children were overrepresented in maltreatment reports prior to DR implementation (2013 RDI = 2.00), but the RDI decreased after DR implementation (2016 RDI = 1.87). There was little change in the RDIs in non-DR districts for any of the racial groups.

Table 51. RDIs for Maltreatment Reports

DR Districts	**2013 RDI**	**2016 RDI**
White	0.87	0.88
Black	0.90	1.09
Latino	0.49	0.40
Native American	2.00	1.87
Non-DR Districts	**2013 RDI**	**2016 RDI**
White	0.85	0.86
Black	1.60	1.51
Latino	0.51	0.39
Native American	1.56	1.54

RDIs for reports assigned for assessment are shown in Table 52. White children in DR districts had RDIs close to 1 both before and after DR implementation. Black children moved from slightly underrepresented to slightly overrepresented (.91 to 1.19). Latino children were underrepresented in 2013 (RDI = .53) and were even more so in 2016 (RDI = .43). Native American children were overrepresented in reports assigned to assessment prior to DR implementation (2013 RDI = 2.47); their disproportionate representation was smaller in 2016 (RDI = 2.10) but still sizeable. A similar decrease among Native American children in non-DR districts was not observed.

Table 52. RDIs for Reports Assigned to Assessments

DR Districts	**2013 RDI**	**2016 RDI**
White	0.89	0.90

Black	0.91	1.19
Latino	0.53	0.43
Native American	2.47	2.10
Non-DR Districts	**2013 RDI**	**2016 RDI**
White	0.86	0.87
Black	1.79	1.61
Latino	0.56	0.43
Native American	1.52	1.42

We also examined the RDIs for assigned response time by looking at the percentage of reports assigned a 24-hour response time (Table 53). Similar to earlier decision points, prior to DR implementation RDIs for White and Black children in DR districts were close to 1; Latino children were underrepresented, and Native American children were overrepresented. In 2016, the RDI for Black children in DR districts increased slightly, while those for Latino and Native American children decreased. In the non-DR districts, only Latino children showed a notable difference between 2013 and 2016, falling from .60 to .47.

Table 53. RDIs for Assigned Response Time (24-Hour)

DR Districts	**2013 RDI**	**2016 RDI**
White	0.90	0.91
Black	1.01	1.15
Latino	0.53	0.45
Native American	2.46	2.18
Non-DR Districts	**2013 RDI**	**2016 RDI**
White	0.86	0.87
Black	1.70	1.75
Latino	0.60	0.47
Native American	1.59	1.53

Disproportionality in safety decisions was examined by looking at the percentage of children with unsafe safety decisions (Table 54). In DR and non-DR districts, White children had RDIs close to 1 both before and after DR implementation. Black children in DR districts were overrepresented prior to DR implementation (2013 RDI = 1.36) and this was unaffected by the implementation of DR (2016 RDI = 1.40). The RDI for Black children in non-DR districts was very high in 2013 (RDI = 2.22) but decreased substantially by 2016 (RDI = 1.24). Latino children were underrepresented in both DR and non-DR districts in 2013, and there was little change by 2016. Native American children were greatly overrepresented in DR districts prior to DR implementation (2013 RDI = 4.37), and although it decreased over time, they were still overrepresented in 2016 (2016 RDI = 3.85).

Table 54. RDIs for Safety Decisions (Unsafe)

DR Districts	2013 RDI	2016 RDI
White	1.02	0.97
Black	1.36	1.40
Latino	0.74	0.71
Native American	4.37	3.85
Non-DR Districts	**2013 RDI**	**2016 RDI**
White	0.94	1.01
Black	2.22	1.24
Latino	0.81	0.73
Native American	1.94	1.47

The disproportionality indices for children entering care are shown in Table 55. White children in both DR and non-DR districts entered care at rates consistent with their representation in the overall population. Black children entered foster care at disproportionately high rates in both DR and non-DR districts in 2013 (RDI = 1.48 and 2.22, respectively). Although the RDIs decreased over time in both, Black children still entered care at disproportionately high rates in 2016 (RDI = 1.38 and 1.48, respectively). Native American children in DR districts had the highest RDI in 2013 (4.29). The RDI decreased considerably after DR implementation, although it remained large in 2016 (3.21). There was a much smaller decrease in the RDI of Native American children in non-DR districts over time (2.92 to 2.60).

Table 55. RDIs for Children Entering Care

DR Districts	2013 RDI	2016 RDI
White	1.03	1.03
Black	1.48	1.38
Latino	0.70	0.66
Native American	4.29	3.21
Non-DR Districts	**2013 RDI**	**2016 RDI**
White	0.95	1.03
Black	2.22	1.48
Latino	0.80	0.70
Native American	2.92	2.60

Finally, the RDIs for children remaining in care longer than 12 months are shown in Table 56. White children were represented at rates equal to their rates in the general population. Latino children were underrepresented in 2013 and there was little change over time. Black children were overrepresented in 2013 and showed decreasing RDIs over time in both DR (1.53 to 1.16) and non-DR (2.14 to 1.83) districts. Native American children were also overrepresented in

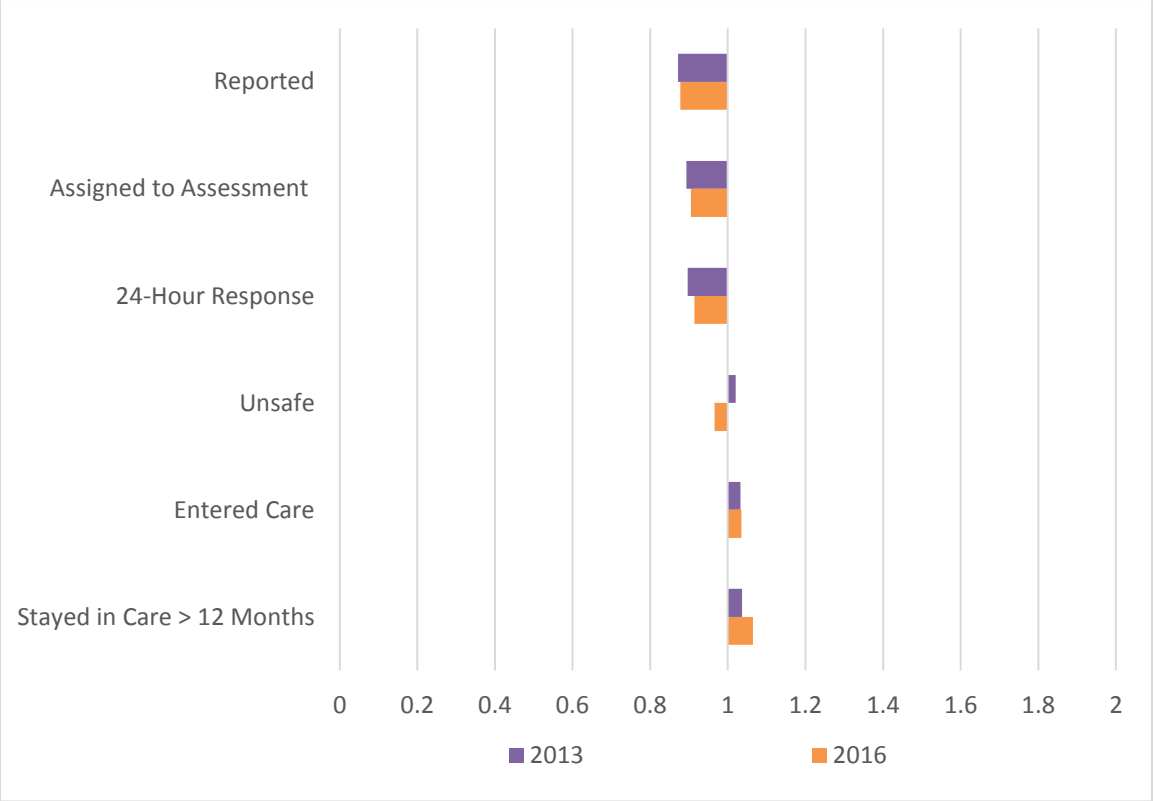
2013; RDIs decreased after the implementation of DR (4.37 to 3.91), but also decreased in non-DR districts (2.66 to 2.32).

Table 56. RDIs for Children Remaining in Care Longer than 12 Months

DR Districts	2013 RDI	2016 RDI	Change
White	1.04	1.07	-0.03
Black	1.53	1.16	0.37
Latino	0.73	0.70	-0.02
Native American	4.37	3.91	0.46
Non-DR Districts			
White	0.99	1.06	-0.05
Black	2.14	1.83	0.31
Latino	0.79	0.67	-0.12
Native American	2.66	2.32	0.34

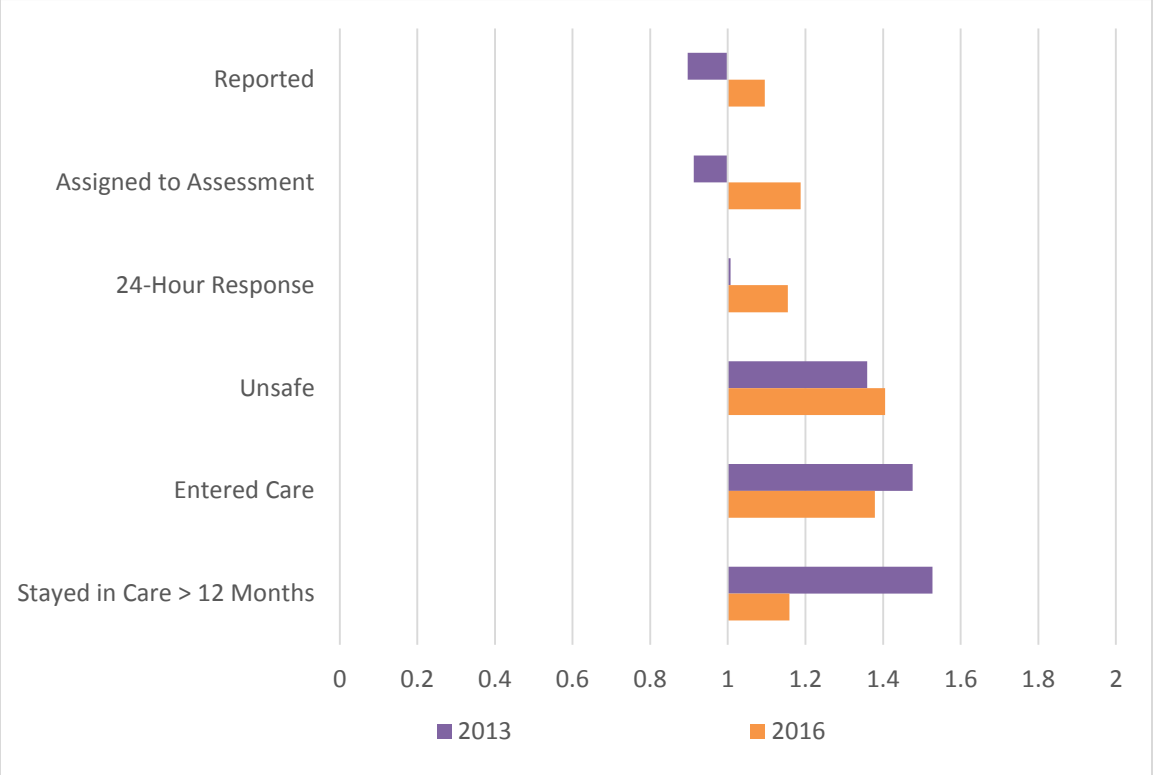
Figures 22–25 show the racial disproportionality indices for each racial group in DR districts before and after the implementation of DR. For White children (Figure 22), their RDIs are near 1 at all decision points.

Figure 22. RDIs for White Children in DR Districts – 2013 and 2016



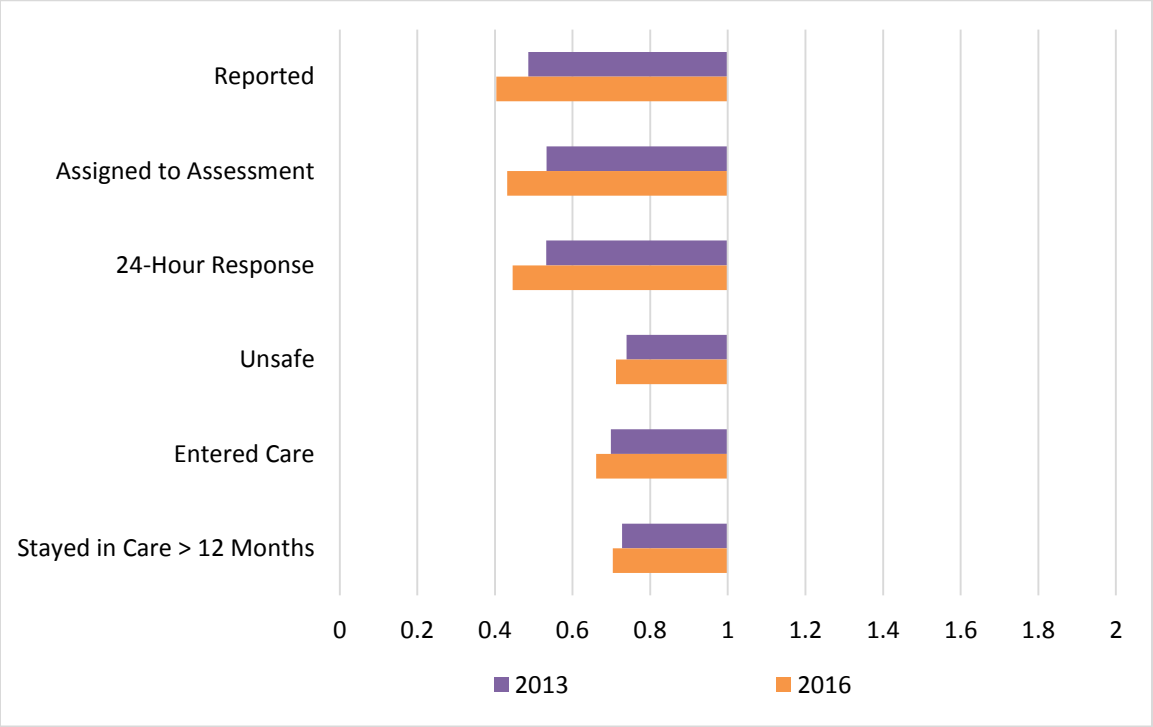
For Black children (Figure 23), RDIs were close to 1 for the first three decisions (maltreatment reports, assigned to assessment, and 24-hour response time) both before and after the implementation of DR. RDIs were higher (around 1.4) for unsafe safety assessments and children entering care and did not show much change over time. The RDI for staying in care over 12 months fell from 1.53 before DR to 1.16 after DR.

Figure 23. RDIs for Black Children in DR Districts – 2013 and 2016



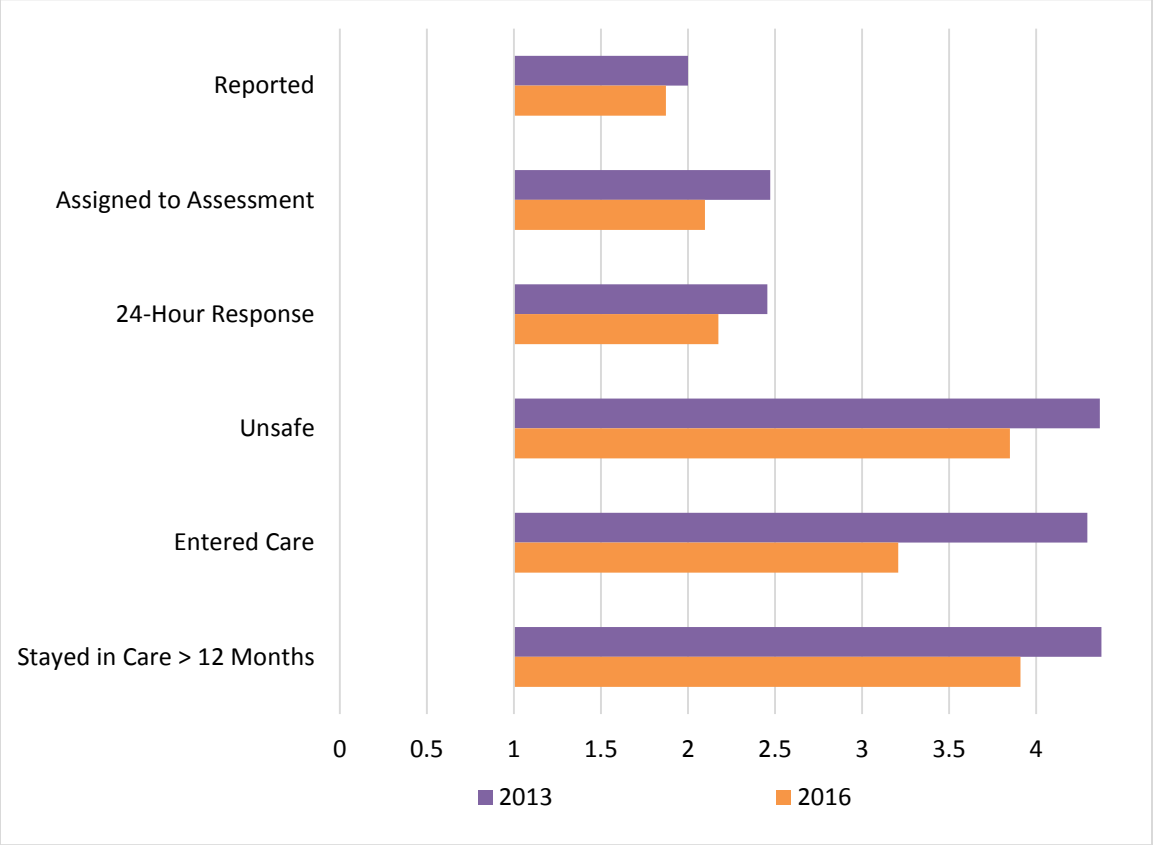
Latino children showed consistent patterns of under-representation at every child welfare decision point. There was little change in their RDIs after the implementation of DR.

Figure 24. RDIs for Latino Children in DR Districts – 2013 and 2016



Native American children showed the highest RDIs at all decision points, and all of the RDIs decreased following the implementation of DR. However, the RDIs remained substantially higher than those for any other racial group even after the implementation of DR.

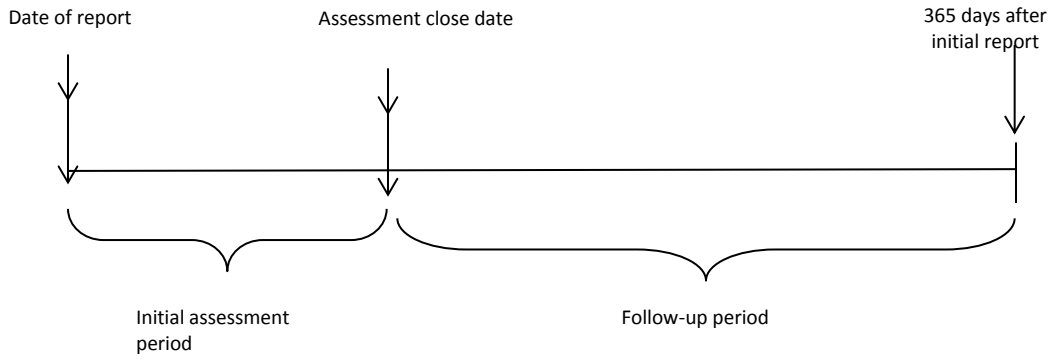
Figure 25. RDIs for Native American Children in DR Districts – 2013 and 2016



Chapter 6: Cost Analysis Findings

One of the goals of Differential Response in most states is to provide short-term supportive and therapeutic services to families reported to CPS in order to prevent repeated CPS contacts, such as additional investigations, lengthier (and more expensive) family cases, and child placements into substitute care. If this relationship holds true, it might be expected that the initial costs of providing child protective services in jurisdictions with DR would be greater than those of providing traditional CPS services, but that the longer-term costs to the child protection system would be reduced as fewer families had additional child welfare contacts. In order to test this proposed relationship in Oregon, a cost analysis was completed that compared the costs of serving families in the two treatment groups (AR and TR) to the costs of serving similar families in districts that have not implemented DR. Costs accrued during both the initial assessment and a follow-up period were examined. Similar to the analyses in the previous chapters, the initial assessment period was defined as the time from the initial report date through the assessment close date, and the follow-up period was defined as the period beginning the day after the initial assessment period and ending 365 days after the initial report date (see Figure 26). Thus, the cost analysis considers the costs to serve a family during the one year period following their initial report date.

Figure 26. Initial case and follow-up service periods for the cost analyses



For both the initial assessment and follow-up periods, two types of costs were examined: costs of worker time and service costs. Costs of worker time were estimated by calculating the amount of time (in hours) that workers spent on each assessment during the initial and follow-up periods and multiplying that by the average hourly salary for CPS and permanency workers in Oregon. The number and type of case contacts that occurred during the initial assessment and follow-up period were obtained from OR-Kids. The average amount of time spent on each type of contact was determined from estimates provided by an expert panel of CPS and

permanency workers. The costs of services paid for by DHS were obtained from OR-Kids.[78] Costs not included in the analysis include those associated with supervisors' time, caseworker time associated with travel, case documentation, infrequently-occurring contact types that were not included in the expert panel survey, and services provided to families through agencies other than DHS (for example, those provided through the school, private agencies, etc.).

Because the cost data is not normally distributed (a small number of cases are more expensive than the majority of cases), all statistical tests used the non-parametric Wilcoxon-Mann-Whitney test. This test is similar to parametric tests, but it does not assume that the data is normally distributed.

6.1 Cost Analysis Sample

The cost analyses were conducted on four samples of CPS assessments that were randomly selected from the larger samples used in the outcome evaluation. As a reminder, the outcome evaluation compared the first four districts to implement DR (D5, D11, D4, and D16) to four similar districts that have not yet implemented DR (D3, D10, D6, and D2). Propensity score matching analyses were used to match families that received AR and TR assessments in DR districts with similar families that received CPS assessments in non-DR districts. Five hundred families from each of the four groups (AR and AR-matched, TR and TR-matched) were randomly selected for inclusion in the cost analysis. Only families in assessments that were closed on or before December 31, 2015 were included in the sample, in order to allow for a 365 days follow-up period. Families that were initially assigned to AR but switched to TR were kept in the AR sample for the cost analysis.

6.2 Costs During the Initial Assessment Period

6.2.1 Costs of worker time

The first step in the analyses was to compare the number of worker contacts that occurred during the initial assessment. There was no significant difference between the average number of contacts recorded for AR assessments (M = 16.2, SD = 22.3) compared to AR-matched assessments (M = 15.8, SD = 19.8). TR assessments had a significantly larger number of contacts during the initial assessment (M = 18.0, SD = 17.9) compared to TR-matched assessments (M = 15.1, SD = 17.6), $p < .01$.

The responses from CPS workers on the expert panel were averaged to come up with the estimated amounts of time for each type of contact that occurred during CPS assessments (Table 57). For each assessment included in the samples, the numbers of contacts that occurred during the assessment were multiplied by the average amount of time that each type

[78] Please refer to Chapter 2 for more detailed information about the cost analysis data collection and methodology.

of contact required to compute the total amount of worker time spent during the initial assessment. The total amount of time that workers spent during the initial assessment did not differ between AR assessments (M = 13.0 hours, SD = 18.6) and AR-matched assessments (M = 13.2 hours, SD = 17.7). TR assessments required a significantly larger amount of worker time (M = 14.6 hours, SD = 14.6) compared to TR-matched assessments (M = 12.3 hours, SD = 13.9), $p < .01$.

Table 57. Amount of Time for CPS Contact Types (Minutes)

Contact Type	Mean	SD
Case Management: Plans and Services	43.6	18.3
CPS Assessment: Alleged Perpetrator	61.1	28.5
CPS Assessment: Alleged Victim	51.4	25.5
CPS Assessment: Collateral	20.4	9.5
CPS Assessment: Custodial Parent/Guardian	60.0	24.3
CPS Assessment: Family	40.7	28.5
CPS Assessment: Medical	42.9	59.1
CPS Assessment: Non-Custodial Parent/Guardian	33.2	8.9
CPS Assessment: Police	33.2	19.7
CPS Assessment: Other Child	39.6	21.7
CPS Assessment: Other Professional	24.6	12.6
CPS Assessment: Supervisor/Worker Consultation	27.9	14.2
CPS Assessment: Other	26.3	14.5
Child Contact	39.2	27.8
Parent Contact	40.4	21.6
Tribal Contact	25.4	9.5
Visitation with Parent	71.7	64.0
FSS Assessment: Custodial Parent/Guardian	82.5	28.7
FSS Assessment: Family	48.8	14.4
FSS Assessment: Other Child(ren) in Home	56.3	18.9
FSS Assessment: Other Professional	41.3	14.4
Other Note	33.0	24.7

Note: One survey respondent gave estimates that were much larger than the rest of the expert panel members; these outlying responses were dropped from the estimate calculations.

To translate the amount of worker time into cost data, the number of hours spent per assessment was multiple by an average hourly rate for CPS and permanency workers that was taken from the salary information obtained from the *Salaries of State Agencies FY2016*. There were no differences between the costs of worker time in AR assessments (M = $324.27, SD = $464.39) and AR-matched assessments (M = $329.31, SD = $441.80). Costs of worker time were significantly higher in TR assessments (M = $365.04, SD = $363.89) compared to TR-matched assessments (M = $307.35, SD = $347.25), $p < .01$.

6.2.2 Service costs

Direct service costs during the initial assessment period were obtained from OR-Kids. Service costs among AR assessments were significantly higher (M = $647.13, SD = $3,560.59) than those among AR-matched assessments (M = $538.94, SD = $2,755.93), p < .01. Service costs among TR assessments were also significantly higher (M = $750.27, SD = $2,139.65) than those among TR-matched assessments (M = $440.04, SD = $1,524.55), p < .0001.

6.2.3 Initial assessment total costs

The total costs during the initial assessment for the families in the four groups were computed by adding the costs of worker time and service costs. As shown in Table 58, the total costs for AR assessments ($971.39) were significantly higher than those for AR-matched assessments ($868.25, p < .01). The total costs for TR assessments ($1,115.30) were also significantly higher than those for TR-matched assessments ($747.40, p < .0001).

Table 58. Total Initial Assessment Costs

	Worker Costs		Services Costs		Total Initial Costs	
	M	SD	M	SD	M	SD
AR (n=500)	$324.27	$464.39	$647.13	$3,560.59	$971.39	$3,934.07
AR-matched (n=500)	$329.31	$441.80	$538.94	$2,755.93	$868.25	$2,938.65
TR (n=500)	$365.04	$363.89	$750.27	$2,139.65	$1,115.30	$2,326.25
TR-matched (n=500)	$307.35	$347.25	$440.04	$1,524.55	$747.40	$1,719.97

6.3 Costs During the Follow-Up Period

6.3.1 Costs of worker time

There was no significant difference between the average number of contacts recorded for AR assessments (M = 25.4, SD = 74.4) compared to AR-matched assessments (M = 32.8, SD = 103.9). TR assessments had a significantly larger number of contacts during the follow-up period (M = 37.4, SD = 93.6) compared to TR-matched assessments (M = 19.9, SD = 73.7), p < .0001.

The responses from permanency workers on the expert panel were averaged to come up with the estimated amounts of time for each type of contact that occurred during the follow-up period (Table 59). The total amount of worker time spent during the follow-up period did not differ between AR assessments (M = 25.5 hours, SD = 76.5) and AR-matched assessments (M = 32.2 hours, SD = 101.7). TR assessments required a significantly larger amount of worker time

during the follow-up period (M = 37.6 hours, SD = 96.1) compared to TR-matched assessments (M = 20.7 hours, SD = 78.3), $p < .0001$.

Table 59. Amount of Time for Permanency Contact Types (Minutes)

Contact Type	Mean	SD
Case Management: Plans and Services	94.5	70.7
Visitation with Parents	78.3	36.6
Visitation with Relatives	55.0	30.0
Visitation with Siblings	82.5	31.1
Visitation (Other)	30.0	26.0
Child Contact	54.0	12.6
Parent Contact	36.0	10.5
Relative/Family Contact	21.0	10.5
Tribal Contact	52.5	55.5
Medical: Substance Abuse Treatment	21.7	7.9
Medical: General Information	22.5	11.3
Legal: Court	86.7	56.5
Legal: General Information	31.7	19.0
Certified Family	42.9	13.5
Education: General Information	33.8	17.5
Non-Discovery: AAG Non-TPR Contact	33.0	19.7
TCM	31.5	20.6
Case Staffing	68.3	39.8
Placement	58.1	52.8
FSS Assessment: Custodial Parent/Guardian	78.0	71.5
FSS Assessment: Family	95.0	31.2
FSS Assessment: Other Professional	41.3	35.4
FSS Assessment: Other	75.0	63.6
Other Note	40.7	36.4

Note: One survey respondent gave estimates that were much larger than the rest of the expert panel members; these outlying responses were dropped from the estimate calculations.

To translate the amount of worker time into cost data, the number of hours spent per assessment was multiple by an average hourly rate for CPS and permanency workers that was taken from the salary information obtained from the *Salaries of State Agencies FY2016*. There were no differences between the costs of worker time for AR assessments during the follow-up period (M = $636.73, SD = $1,906.46) and AR-matched assessments (M = $804.63, SD = $2,537.95). Costs of worker time were significantly higher in TR assessments during the follow-up period (M = $937.52, SD = $2,397.92) compared to TR-matched assessments (M = $516.31, SD = $1,954.69), $p < .0001$.

6.3.2 Service costs

Direct service costs during the follow-up period were obtained from OR-Kids. Service costs among AR assessments were significantly higher during the follow-up period (M = $3,400.37, SD = $11,787.55) than those among AR-matched assessments (M = $2,684.13, SD = $9,521.53), $p < .05$. Service costs among TR assessments were also significantly higher (M = $4,317.01, SD = $15,863.91) than those among TR-matched assessments (M = $1,986.57, SD = $8,107.04), $p < .0001$.

6.3.3 Follow-up period total costs

The total costs during the follow-up period for the 500 cases in the four groups were computed by adding the costs of worker time and service costs. As shown in Table 60, the total costs for AR assessments ($4,037.10) were significantly higher than those for AR-matched assessments ($3488.76, $p < .05$). The total costs for TR assessments ($5,254.52) were also significantly higher than those for TR-matched assessments ($2,502.87, $p < .0001$).

Table 60. Total Follow-up Period Costs

	Worker Costs		**Services Costs**		**Total Follow-Up Costs**	
	M	SD	M	SD	M	SD
AR (n=500)	$636.73	$1,908.46	$3,400.37	$11,787.55	$4,037.10	$12,959.36
AR-matched (n=500)	$804.63	$2,537.95	$2,684.13	$9,521.53	$3,488.76	$11,565.82
TR (n=500)	$937.52	$2,397.92	$4,317.01	$15,863.91	$5,254.52	$17,227.77
TR-matched (n=500)	$516.31	$1,954.69	$1,986.57	$8,107.04	$2,502.87	$9,391.80

6.4 Total Costs

The total costs to serve a family from the initial report date through 365 days after the report date were computed by adding all costs incurred during the initial assessment and the follow-up period for each family and then averaging. Table 61 displays the average costs for each of the four groups in the sample. Both AR and TR assessments were significantly more expensive than assessments of similar families in non-DR districts (AR versus AR-matched $p < .01$; TR versus TR-matched $p < .0001$).

Table 61. Total Costs

	Initial Assessment		Follow-Up Period		Total Costs	
	M	SD	M	SD	M	SD
AR (n=500)	$971.39	$3,934.07	$4,037.10	$12,959.36	$5,008.49	$14,336.23
AR-matched (n=500)	$868.25	$2,938.65	$3,488.76	$11,565.82	$4,357.01	$13,364.99
TR (n=500)	$1,115.30	$2,326.25	$5,254.52	$17,227.77	$6,369.82	$18,380.92
TR-matched (n=500)	$747.40	$1,719.97	$2,502.87	$9,391.80	$3,250.27	$10,119.95

Chapter 7: Conclusions and Recommendations

The Oregon Department of Human Services began implementing Differential Response (DR) in May 2014 as part of a broader reform effort aimed at safely and equitably reducing the number of children experiencing foster care. At a simple level, DR is best described as an approach to child protective services that includes the use or two (or more) separate response pathways for screened-in reports of child maltreatment. More than half of the states in the U.S. have implemented DR, and there are numerous differences in the DR models that have been implemented to date, just as there are numerous differences between states in "traditional" CPS responses. In Oregon, DR consists of two CPS response tracks: Alternative Response (AR) and Traditional Response (TR). Although several changes were made to the CPS screening and assessment procedures to accommodate DR in Oregon, the similarities in CPS procedures in DR and non-DR districts in Oregon are far greater than the differences. Most importantly, there are no differences in either the response times assigned to CPS assessment or in the safety assessment process in districts that have and have not implemented DR; the Oregon Safety Model (OSM) is used to assess safety threats and determine child safety in all districts.

It is important to outline the differences in CPS practice between DR and non-DR districts, because these differences are expected to lead to differences in both outcomes and costs. As initially shown in Table 1, the differences in practice are few.

1. In DR districts, reports assigned to assessment must be assigned to either the AR or TR track using the Track Assignment Tool. If the situation requires it, assessments can later switch tracks from AR to TR. Track assignment decisions are not required in non-DR districts.
2. CPS workers in DR districts are advised to make reasonable efforts to schedule initial contacts with families when the assessment is assigned a 5-day response time; these efforts are generally referred to as "calling ahead."
3. For AR assessments in DR districts, CPS workers are asked to offer the family the option of having a support person present at the initial contact and are asked to conduct family interviews when appropriate.
4. In both AR and TR assessments in DR districts, when children are found to be safe and the family has moderate to high needs, CPS workers offer them the option of a Family Strengths and Needs Assessment (FSNA) by a community provider to help them determine what services and community connections may be helpful to them after the CPS assessment is closed. Families may then be provided with services paid for by DHS.
5. In AR assessments, there is no disposition at the conclusion of the assessment and families are not entered into the Central Registry. Both of these things are done for TR assessments and all assessments in non-DR districts.

These changes in CPS practice were expected to lead to differences in outcomes between families that received either an AR or TR assessment and families that received a traditional CPS assessment in a non-DR district. Specifically, the opportunities for enhanced partnership with families, additional strengths and needs assessment and service provision, and lack of maltreatment dispositions associated with AR assessments were expected to lead to improvements in family functioning, decreased likelihood of additional maltreatment in the future, and fewer children entering substitute care. These outcomes, in turn, would lead to lower costs to the child welfare system.

In order to test these hypothesized relationships, DHS hired the Children and Family Research Center (CFRC) to conduct a comprehensive evaluation that examined DR implementation and practice and compared the outcomes and costs of families that received assessments in districts that implemented DR to families in districts that have not implemented DR. Over the past 2.5 years, the CFRC has collected and analyzed data from a variety of sources, including OR-Kids; DHS administrators and consultants, supervisors, CPS workers, screeners, and permanency workers; community partners and service providers; and parents involved in CPS assessments. The combined results of these data collection activities provide an accurate description of the DR implementation process and DR practice model in Oregon and whether or not the changes in practice associated with DR resulted in the expected changes in child, family, and system outcomes. The following sections summarize and contextualize the results provided in this report and offer suggestions for practice and policy as well as future research.

7.1 DR Implementation

Overall, DHS's efforts to launch DR were cautious and thorough, including study of other state's DR programs and their early challenges. DHS did not limit DR innovations to only assessments assigned to AR. Instead, DHS encouraged all workers across the state to make greater efforts to engage families. Though this may have limited the overall effects of DR (as effects of increased engagement could be seen statewide), the practice itself is prudent. DHS central office was widely praised for their early communication about DR, both internally and externally.

As DR moved forward in Oregon, DHS engaged internal and external stakeholders to create support for DR. As the implementation continued, this engagement was strained by the DR "pause," shifting priorities within DHS, and legislative scrutiny. The certainty about DR as a new practice model for Oregon eroded, and stakeholders became confused about whether DR would remain or be added to the list of previously abandoned child welfare practices. We acknowledge the deleterious effect of the pause on DR implementation and practice in several of the recommendations that follow.

Early in the DR implementation process, DHS presented the findings of a workload study that indicated they were staffed at 67%; in response, the legislature authorized funding to hire new staff. This should have been an early win for DR, as the additional staff could be prepared to begin the new model. The climate today, however, is one of constant turnover and

burdensome workloads, something mentioned in the site visits and in the staff survey. Turnover affects the preparation of both frontline workers and supervisors. Some staff noted supervisors had been moved into DR districts but had been untrained in DR and had no time to attend the necessary training before performing their supervisory duties.

The challenge of turnover is compounded by increased reports and assessments, the OSM refresh that reiterated to staff the extraordinary burden this safety model puts on worker time, and the state's crisis-driven approach to child welfare. The overall results in this report suggest Oregon remains understaffed and that this affects DR's implementation and sustainability. It is challenging to offer specific recommendations to address these problems, so we offer just one here.

Recommendation: Conduct another workload study to reiterate the rate at which DHS remains understaffed, and use this as leverage with the legislature when facing budget cuts.

An additional element of DR that was carefully planned was initial DR training. DHS contracted with a curriculum writer to prepare DR training that would ensure workers could practice DR with fidelity as soon as possible. Furthermore, DHS responded to worker feedback about training and revised it accordingly. One training challenge noted in the site visits was that the CORE training did not include comprehensive information about DR because it was not implemented statewide. This required individual districts to train workers in DR, something that became less of a priority once DR implementation was paused. The same was true for initial efforts to let new workers shadow experienced workers. Shadowing and mentoring was also threatened by the high rate of turnover; experienced workers available to mentor new workers might only have months of experience themselves. To address these training issues, we offer these recommendations.

Recommendation: Integrate DR into the CORE training, and frequently offer a DR refresh training for all staff.

Recommendation: Allow new workers a period of shadowing experienced workers during or after training, and before they are assigned cases of their own.

Coaching was another support put in place for districts implementing DR, with DR consultants working in implementing districts as they adjusted to the requirements of DR. Consultants were praised for their availability and helpfulness, but it appeared that no district was able to prepare for the consultants' reduced role as they moved on to support other districts. A peer-to-peer cross-district consulting model was originally designed as an exit strategy to phase out consultant support, but districts were not able to rely on each other as expected; this occurred in part because of differences between districts and in part because the "pause" and other pressures shifted district focus away from DR. In short, it appeared that no district was able to become as familiar with DR practice as the consultants were.

One possible solution to the consultants leaving is to adequately train supervisors and program managers to take their place. These district leaders were widely praised by workers, but all noted that they faced the same workload and practice challenges as workers. Supervisors were reported to be "putting out fires" and to be too distant from daily CPS practice to understand DR any better than workers did. The result was lauded supervisors that had no time to do the work they loved (helping workers with their clinical tasks) or to support DR practice in the field. In short, supervisors were unable to fill the role of the consultants, leaving DR districts without DR expertise. To address these issues, we offer the following recommendations.

Recommendation: Provide districts a plan for reducing reliance on consultants, rather than asking districts to develop their own plans.

Recommendation: Train supervisors in DR so they can be resources for workers. This may require revised training or training with greater details on DR.

Recommendation: Consider training 1–2 supervisors per district as DR experts and to fill the role previously held by consultants.

Recommendation: Allow supervisors to shadow both workers and other supervisors during or after training, and before they are actively supervising workers.

DR practice can be strengthened via the recommendations above, but fidelity to practice must also be monitored. Districts initially attempted to establish a CQI process, and some fidelity review procedures were put in place, especially around screening. As with all other areas, the DR pause affected attention to DR practice fidelity. Workers also mentioned the extensive documentation required by the OSM left them with little time to focus on the practice changes associated with DR. To address this, we offer the following recommendations.

Recommendation: Renew focus on continuous quality improvement and fidelity reviews. This may require consultation with outside experts to ensure reliable and valid fidelity review procedures are developed.

Fidelity reviews are impossible without data to support them, and program managers reported having access to numerous metrics during the year two site visits. Two concerns about data remained. First, workers reported that "data-driven decisions" did not reflect realities in the field. Second, CFRC's own work with data found numerous areas where useful data was not populated or was not populated reliably (e.g., no place to document present danger safety threats; unreliable population of the moderate to high needs assessment). These problems were also noted in Public Knowledge, LLC's *Child Safety in Substitute Care Independent Review*, which noted, "Oregon currently has a disjointed data enterprise for tracking information about abuse of children and youth in substitute care. The data depends on multiple programs and systems that do not interface. While OR-KIDS, the DHS data system, has reporting capabilities, it does not have advanced reports set up on the data requested for this review" and said it could

not verify the reliability the data shown in its report.[79] To address these issues, we offer this recommendation.

Recommendation: Conduct an analysis of OR-Kids capabilities and shortcomings and convene a comprehensive effort to rectify them.

7.2 DR Practice

The process evaluation examined how the core components of the Oregon DR practice model were implemented, focusing on practice in the first four districts that implemented DR. DR practice was described by examining:

- screening and track assignment/re-assignment,
- initial contact with families (timeliness, calling ahead, offering support persons),
- family-centered practice and engagement,
- safety assessment using the Oregon Safety Model,
- use of the FSNA, and
- targeted and culturally appropriate service provision to address identified needs.

Statewide, there has been an increase in both the number of reports received and the percentage of reports that were assigned to assessment. The increased numbers of reports were mirrored in the first four DR districts, and the percentages assigned to assessments have increased in three of the four DR districts. About half of the reports assigned to assessment in these districts were initially assigned to AR, and 11-16% of AR assessments in 2016 eventually switched tracks and became TR assessments.

Screeners in DR districts reported spending more time with each report since the implementation of DR, and they noted their districts had put procedures in place to aid their track assignment, especially Review, Evaluate, Direct (RED) Team meetings and early help from consultants. Staff survey results indicated screeners do sometimes feel uncertain about track assignment, but that they are almost always able to gather enough information to make a decision and consult their supervisor for help.

All assessments are assigned a response time within which the CPS worker is required to make an initial contact with the family; the two response times are within 24 hours or within 5 calendar days. Although exceptions can be made for both, the primary response time for AR assessments is within 5 days and that for TR assessments is within 24 hours. In 2016, between 70% and 89% of AR assessments were assigned a 5-day response time and between 83% and 92% of TR assessments were assigned a 24-hour response time. Compliance with assigned response times was about 75-80% in the four DR districts, and this was similar to or slightly

[79] Public Knowledge. (2016). *Oregon Department of Human Services Child Safety in Substitute Care Independent Review: Final Assessment & Review Report.* Federal Way, WA: Author.

better than the compliance rate for the state as a whole. Thus, it appears that the implementation of DR did not negatively impact the agencies initial response time.

CPS workers in DR districts are encouraged to make prudent efforts to schedule initial contacts with families when a 5-day response time is assigned and to offer families the option of having a support person present for AR assessments. Staff survey results showed that these two practices were more common for AR assessments than TR or non-DR assessments. CPS workers were also more likely to use family interviewing in AR assessments. These worker reports were confirmed by the parent survey results, in which a significantly higher proportion of parents in AR assessments reported they were contacted prior to the first visit and offered the option of having a support person present. Interviews with parents suggested that calling ahead was very much appreciated; conversely, parents that did not receive a call to schedule initial contact reported feeling "confused" and "threatened" by the worker showing up unannounced.

The DR practice model is designed to increase parent engagement and opportunities to partner with parents in order to identify their needs and strengths more accurately. Results from the parent surveys indicated that parents who received AR assessments felt significantly more optimistic after the initial visit than parents who received assessments in non-DR districts; no other emotions differed between the two groups. The same was not true for parents who received TR assessments. A significantly greater proportion of parents who received TR assessments reported feeling more angry, afraid, and confused, and less relieved, comforted, and thankful than parents who received non-DR assessments. There were no differences in the levels of parent engagement between parents in AR or TR assessments and those in non-DR assessments; nor were there any differences in culturally-responsive practice, satisfaction with the CPS worker, or trauma symptoms following the assessment. A small, but statistically significant, difference was found in parent reports of caseworkers' family-centered practices (showing care and compassion, listening, explaining things clearly, making a plan of action with them); parents in TR assessments reported lower levels of family-centered practice than parents in non-DR assessments. Although these results are suggestive of potential practice differences in AR, TR, and non-DR assessments, caution should be used when interpreting these results due to the very low response rates on the parent survey.

At the conclusion of the assessment, CPS workers make a decision about the safety of the children. The results of the evaluation suggest small variations in the rates at which children were found to be unsafe among the DR districts; in AR assessments, the percentage of unsafe children ranged from 5% to 11%, and in TR assessments, the percentage of unsafe children ranged from 8% to 13%. These percentages are consistent with statewide rates, and offer no evidence to suggest safety assessment, guided by the OSM, is different in DR compared to non-DR districts.

When children are safe at the end of an assessment, the CPS worker should assess if the family has moderate to high needs; if yes, then (in DR districts) the family should be offered a Family Strength and Needs Assessment (FSNA) and both contracted (if the family completes an FSNA) and non-contracted services (for all families, regardless of whether they complete an FSNA).

Focus groups with CPS workers and supervisors in DR districts revealed that the FSNA was unpopular, and viewed mostly as an extra burden rather than a useful practice tool. DHS efforts to increase use of the FSNA by loosening its requirements do not appear to have had much effect. Additionally, CFRC's OSM fidelity review found low rates of compliance with the moderate to high needs assessment.

Additional data from the process evaluation suggest that the FSNA may have operated as a bureaucratic obstacle to providing services to families, rather than as useful assessment procedures to identify the services families need. The vast majority of assessments (both AR and TR) conclude that the children assessed are safe, yet the number of families with safe children offered *any* services ranged from 10% to 19% for AR assessments and 8% to 16% for TR assessments. Only 3% to 8% of families with safe children end up accepting services for both AR and TR assessments. The numbers of families who received contracted services (offered after an FSNA and by opening an "admin-only" case) is even smaller: 134 families in 2016 had an admin-only case opened, only 1.5% of the 8,835 assessed families with safe children in DR districts.

Given that the goal of family engagement is to encourage families to embrace the assessment process and then work to enhance their strengths and address their needs, services play a vital role in achieving the outcomes specified in the DR program logic model. If families with safe children are not assessed as having moderate to high needs and then not offered a range of services to address those needs, then the outcomes of DR will not be realized. As such, we offer the following recommendations.

Recommendation: Eliminate the FSNA or make it optional. This additional assessment step was well-intentioned, but the evidence suggests that it hinders receipt of services.

When families do receive services, most were rated as helpful in the parent surveys and interviews. Some services are needed more than others, and the parent and staff surveys both indicated that affordable housing was the most pressing need.

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 both AR and TR assessments dropped significantly between 2015 and 2016. In 2016, the average length of AR assessments in the four DR districts ranged from 64 to 74 days and those for TR assessments ranged from 63 to 77 days. The average for the state as a whole was 66 days.

7.3 DR Outcomes

In order to examine the effect of DR on outcomes, the evaluation compared the outcomes families who received an AR or TR assessment in the first four districts to implement DR (the treatment groups) with those of families who received a CPS assessment in four 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.

The results of the outcome analyses revealed a few significant differences between the treatment and comparison groups, all in the expected directions:

- Parents in AR assessments reported higher levels of social support than parents in non-DR assessments.
- Families in AR assessments had lower rates of founded re-reports than families in AR-matched assessments.
- When outcomes were examined by race, both White families and Latino/Hispanic families in AR assessments had lower rates of founded re-reports compared to similar families in the AR-matched groups.
- Latino/Hispanic families in TR assessments had lower rates of founded re-reports compared to similar families in the TR-matched groups.

DR was also expected to reduce disproportionate representation of minority groups in the child welfare system. Prior to the implementation of DR, the first four districts had proportionate representation of White and African American children at each child welfare decision point, underrepresentation Hispanic/Latino children, and overrepresentation of Native American children. After DR, these patterns remained, but overrepresentation of African American children in care for longer than 12 months and overrepresentation of Native American children at all stages noticeably declined. These patterns mirrored changes in non-DR comparison districts, making it difficult to credit DR for the improvements. Nevertheless, DHS' continued focus on racial disproportionality will hopefully continue to move all racial groups toward proportional representation.

One challenge in our analysis of racial disproportionality was the large amount of missing race data. This made it difficult to compare representation at later steps to representation at the

previous step of the child welfare process, needed to calculate relative racial disproportionality indices. To address this issue, we offer the following recommendation.

Recommendation: Expand efforts to mandate gathering race information at all stages of the child welfare process, from reports onward.

The outcome evaluation also examined outcomes related to job satisfaction, organizational culture, and community partnerships. Consistent with the site visit summaries, the staff survey found that staff were dissatisfied with their workload, salary, opportunities for advancement, and OR-Kids. Staff were satisfied with the supervision they receive and with their agency's cultural sensitivity. Regarding organizational culture, staff survey results showed that staff feel a high degree of purpose in their work but are burdened by their workload. Staff were also asked about coordination with community partners. A majority of staff somewhat or strongly agreed that they are able to effectively coordinate with service providers. Staff that noted some hindered coordination were asked the reason, and the most common reason was lack of communication between DHS and the community partner. There were no differences between DR and non-DR districts on any of these measures.

The outcome evaluation is the culmination of DR practice, in which DR may show its lasting impact on the child welfare system. Because DR rollout in Oregon was paused and pressured during our evaluation period, DR practice may not be fully instilled in DR districts, and future districts implementing DR may need to begin anew in their efforts to get staff to embrace DR. As such, we offer this general recommendation about outcomes related to DR.

Recommendation: Consider expanding evaluation efforts to review outcomes after DR implementation has resumed and districts are again earnestly using DR practices.

7.4 DR Program Costs

The cost analysis was conducted to test the theory that DR would produce higher costs during the initial assessment and lower costs during the follow-up period. We found no evidence to support this theory. AR and TR assessments were more expensive than AR-matched and TR-matched assessments, respectively. The primary reason for this increased cost for AR assessments was higher service costs, but we do not know why service costs were higher in AR assessments. One difference between DR and non-DR districts is the use of the FSNA in DR districts, but the FSNA is infrequently used. Perhaps it could be that similar services cost more in DR districts or that AR assessments are provided more services. In addition, it is possible that in the AR group there were families whose assessments were switched from AR to TR, and the costs associated with the switch tracks might have increased the expenses. Previous evaluation of DR in Minnesota found that AR assessments became more cost effective as the length of the

follow-up period increased, which suggests that the differences between the costs of the AR and AR-matched assessments could potentially shrink over time.[80]

TR assessments showed higher costs of worker time as well as higher service costs. We need to further examine what factors contributed the higher costs in AR and TR compared with their counterparts.

7.5 Conclusions

In any complex evaluation—especially one in which the state's climate toward the practice shifted over the course of the evaluation—it is easy to lose sight of the most important questions the evaluation addresses. The implementation and practice of DR is a complex process that requires commitment from stakeholders at all levels, and it is not surprising that our analysis found many areas where there were no differences between districts that had implemented DR and districts that had not.

With that in mind, we note that some lack of differences are good news for DR. For example, our analyses find *no evidence* that DR undermines the safety of children in Oregon. Children are found to unsafe at rates identical to the state as a whole, suggesting workers are not compromising safety assessment simply because an assessment is assigned to a track. Further, families assessed in DR counties (on both AR and TR tracks) were no more likely to experience a re-report within 6 months nor have a child removed; and families that received an AR assessment were significantly less likely to have a founded re-report than AR-matched families.

Our analysis also found that staff support DR; they *like* the increased focus on family engagement and have a strong sense of their agency's purpose. This, combined with the fact that children are just as safe under DR, is reason enough to suggest DR offers value to Oregon. Though workers were dissatisfied with their workload, this is not unique to Oregon, and workers have been experiencing increased reports statewide. These factors are challenges to DR because DR is a convenient scapegoat when trying to understand why staff are overworked, why turnover is high, and why the state's child welfare system seems, at times, to be driven by crises. Our evaluation, however, found no evidence to suggest that DR is responsible for any of these challenging factors. Instead, DR seems to be a practice that allows staff to interact with families in ways that they find rewarding, especially for assessments assigned to the AR track.

The pressures and pauses that DR experienced during the course of our evaluation also makes this final report feel more like an interim one. Most of the conclusions should be judged with caution, and we wish we had more time to continue the evaluation if and when DR implementation continues throughout the state. That said, we are confident in the leadership of Stacy Lake and the DR Steering Committee. These leaders have shown extraordinary

[80] Institute of Applied Research. (2006). *Extended follow-up study of Minnesota's Family Assessment Response: Final report.* St. Louis, MO: Author.

willingness to listen to the expertise of others, beginning with their study of other states' DR implementations and continuing today with their responses to worker feedback. It has been a continual joy to work with our Oregon partners on this evaluation, and it will be difficult to end this evaluation as we have many remaining questions that can only be answered once DHS has been given the opportunity to properly instill and refine the practice statewide.

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 [$\chi^2(8) = 6.3$, $p > .62$] and a concordance rate of 71.1%. All of the 2,169 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) = 6.2, p > .63] and a concordance rate of 76.4%. Since a significant number of TR families remained unmatched using calipers of .05 and .10, a caliper of .15 was used. Of the 692 families assigned to AR in District 11, all but 19 were matched with families in District 10 using a .15 caliper. The 19 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 16 iterations and the final model fit the data well, as indicated by the Hosmer and Lemeshow goodness of fit test [χ^2 (8) = 8.2, p > .41] and a concordance rate of 74.8%. Of the 767 families assigned to AR in District 4, all were matched with families in Districts 6 and 2 using a .10 caliper.

District 16 and District 2 Matching Results

The logistic regression converged after 18 iterations and the final model fit the data reasonably well, as indicated by the Hosmer and Lemeshow goodness of fit test [χ^2 (8) = 3.5, p > .9] and a concordance rate of 69.5%. All of the 1,289 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 25 iterations and the final model did not fit the data well, as indicated by the Hosmer and Lemeshow goodness of fit test [$\chi^2(8) = 17.1$, $p > .021$]. However, the concordance rate of 75.2% was in a good range. Of the 1,616 families assigned to TR in District 5, all but 5 were matched with families in District 3 using a .10 caliper. The 5 unmatched families were dropped from the sample.

District 11 and District 10 Matching Results

The logistic regression converged after 18 iterations and the final model fit the data well, as indicated by the Hosmer and Lemeshow goodness of fit test [χ^2 (8) = 4.4, p > .82] 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 694 families assigned to TR in District 11, all but 19 were matched with families in District 10 using a .15 caliper. The 19 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 17 iterations and the final model fit the data well, as indicated by the Hosmer and Lemeshow goodness of fit test [χ^2 (8) = 11.4, p > .18] and a concordance rate of 77.4%. Since a significant number of TR families remained unmatched using calipers of .05 and .10, a caliper of .15 was used. Of the 827 families assigned to TR in District 4, all but 24 were matched with families in Districts 6 and 3 using a .15 caliper. The 24 unmatched families were dropped from the sample.

District 16 and District 2 Matching Results

The logistic regression converged after 17 iterations and the final model fit the data reasonably well, as indicated by the Hosmer and Lemeshow goodness of fit test [χ^2 (8) = 9.6, p > .30] and a concordance rate of 74.6%. Of the 1,101 families assigned to TR in District 16, all but 2 were matched with families in District 2 using a .05 caliper. The 2 unmatched families were dropped from the sample.

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

Table C1. Family Characteristics in PAQ Response and Nonresponse Samples[a]

	AR			TR			Non-DR		
	Response (n=120)	**Nonresponse (n=4,743)**	**χ^2**	**Response (n=88)**	**Nonresponse (n=5,170)**	**χ^2**	**Response (n=337)**	**Nonresponse (n=12,543)**	**χ^2**
Allegation (%)									
Threat of Harm	29.2	34.1	1.25	50.0	50.9	0.03	46.9	43.9	1.23
Mental Injury	0.8	2.7	--[d]	3.4	4.8	--[d]	2.1	2.9	0.81
Neglect	55.8	58.2	0.27	45.5	37.8	2.15	53.1	53.1	0.00
Medical Neglect	3.3	2.7	0.18	1.1	1.7	--[d]	2.7	3.0	0.12
Physical Abuse	29.2	20.7	5.07*	25.0	32.6	2.30	25.8	25.1	0.09
Sexual Abuse	0.8	1.0	--[d]	17.1	15.4	0.19	5.3	8.9	5.25*
Victims' Race / Ethnicity (%)[b]									
White	72.5	72.2	0.01	73.9	73.4	0.01	67.7	67.3	0.02
African-American	6.7	4.2	1.72	5.7	4.4	--[d]	12.5	11.2	0.50
Native American	5.8	3.9	--[d]	8.0	4.7	--[d]	6.5	5.0	1.53
Hispanic	10.0	10.2	0.01	9.1	10.0	0.08	11.6	11.3	0.03
Other[c]	0.8	2.1	--[d]	3.4	1.9	--[d]	2.1	2.3	0.09
Unknown	16.7	19.8	0.72	15.9	18.3	0.33	15.1	17.9	1.68
Age of the Youngest Victim (Mean)	**Response**	**Nonresponse**	**t-value**	**Response**	**Nonresponse**	**t-value**	**Response**	**Nonresponse**	**t-value**
	5.7	6.7	2.41*	6.0	6.5	0.91	5.4	6.3	3.55**

Notes. [a]The households included in both response and nonresponse samples were those with at least one assessment closed from February 1st, 2016 through February 28, 2017.

[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. The Fisher's exact test was used instead of the chi-square test. There is not a statistically significant relationship between the victim's race/ethnicity and the survey responses.

*p < .05. **p< .01.

Table C2. Family Characteristics in SAQ Response and Nonresponse Samples[a]

	AR			TR			Non-DR		
	Response (n=93)	**Nonresponse (n=405)**	**χ^2**	**Response (n=56)**	**Nonresponse (n=306)**	**χ^2**	**Response (n=79)**	**Nonresponse (n=399)**	**χ^2**
Allegation (%)									
Threat of Harm	30.1	32.6	0.21	57.1	54.3	0.16	48.1	42.4	0.89
Mental Injury	1.1	2.7	--[d]	3.6	7.2	--[d]	2.5	4.5	--[d]
Neglect	60.2	58.0	0.15	39.3	38.6	0.01	50.6	62.2	3.66
Medical Neglect	3.2	2.7	--[d]	0.0	1.6	--[d]	3.8	5.0	--[d]
Physical Abuse	23.7	22.2	0.09	30.4	35.6	0.58	24.1	22.1	0.15
Sexual Abuse	1.1	0.3	--[d]	10.7	6.54	--[d]	5.1	7.8	0.71
Victims' Race / Ethnicity (%)[b]									
White	73.1	75.8	0.29	83.9	71.9	3.54	76.0	72.2	0.47
African-American	6.5	4.2	--[d]	8.9	3.9	--[d]	10.1	9.8	0.01
Native American	2.2	5.7	--[d]	3.6	5.2	--[d]	2.5	6.8	--[d]
Hispanic	3.2	11.6	5.88*	7.1	12.1	1.15	20.3	11.5	4.45*
Other[c]	2.2	2.2	--[d]	3.6	2.3	--[d]	0.0	1.0	--[d]
Unknown	18.3	14.3	0.93	5.4	19.0	6.25*	12.7	14.5	0.19
Age of the Youngest Victim (Mean)	**Response**	**Nonresponse**	**t-value**	**Response**	**Nonresponse**	**t-value**	**Response**	**Nonresponse**	**t-value**
	6.2	6.3	0.21	4.9	6.1	1.67	5.2	5.4	0.43

Notes. [a]The households included in both response and nonresponse samples were those with at least one assessment closed from November 1st, 2015 through August 16, 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. The Fisher's exact test was used instead of the chi-square test. There is not a statistically significant relationship between the allegation type and the survey responses.

*$p < .05$.