

Healthy Families Oregon Maltreatment Prevention Report Program Year 2013-14

Submitted to:

Megan Irwin

Early Learning Systems Director
Oregon Early Learning Division
775 Summer Street NE, Ste. 300
Salem, OR 97301

Submitted by:

NPC Research

Portland, OR



June 2015



NPC Research
5100 SW Macadam Ave., Ste. 575
Portland, OR 97239
(503) 243-2436
www.npcresearch.com

Healthy Families Oregon Maltreatment Prevention Report Program Year 2013-14

Submitted by

NPC Research

Beth L. Green, Ph.D.

Katherine Kissick, B.A.

Anna M. Malsch, Ph.D.

Jerod M. Tarte, M.A.

For questions about this report or project,
please contact Beth Green, beth.green@pdx.edu,
or Jerod Tarte at (503) 243-2436 x 103 or tarte@npcresearch.com.

June 2015



Informing policy, improving programs

ACKNOWLEDGMENTS

N PC Research would like to thank the following individuals and agencies for their co-operation and assistance in providing information for this report: Judy Helvig and others at the Oregon Department of Human Services, Children Welfare; Pam McVay at the Oregon Department of Human Services Office of Forecasting, Research, & Analysis; Erin Dean and Linda Jones at the Oregon Early Learning Division; and all of Healthy Families Oregon program staff and families who contributed information and participating in the program.

TABLE OF CONTENTS

HEALTHY FAMILIES OREGON: MALTREATMENT PREVENTION REPORT 2013-14.....	1
Scope of the Problem	1
Child Maltreatment in Oregon.....	1
Key Factors Influencing Maltreatment	1
Children’s Age	1
Family Poverty & Parental Stress.....	2
Cumulative Risk.....	2
Addressing Risk & Protective Factors To Prevent Child Maltreatment.....	3
Home Visiting Programs Can Prevent Maltreatment	4
METHODOLOGY	7
Child Maltreatment Data	7
Research Sample	7
Healthy Families Oregon Group	7
Comparison Group.....	8
RESULTS	9
Healthy Families Oregon vs. Non-Healthy Families Oregon Children	9
Families Receiving Intensive Home Visiting.....	10
Types of Maltreatment	12
SUMMARY & DISCUSSION.....	13
REFERENCES.....	17
APPENDIX A: HEALTHY FAMILIES OREGON OF OREGON 2013-2014 MALTREATMENT REPORT DATA TABLES	21
LIST OF TABLES	
Table 1. Children Aged 0-36 Months Free from Maltreatment (FY 2013-14)	23
Table 2. Children Aged 0-36 Months Free from Maltreatment by Service Type (FY 2013-14)	25
Table 3. Likelihood of Child Maltreatment Based on Number of Risks (FY 2013-14).....	27
Table 4. Child Maltreatment Victims by Stress Level	28
LIST OF FIGURES	
Figure 1. Rate of Maltreatment for Healthy Families Oregon vs. Non-Healthy Families Oregon Children	10
Figure 2. Likelihood of Maltreatment by Number of Risks on the New Baby Questionnaire	12

HEALTHY FAMILIES OREGON: MALTREATMENT PREVENTION REPORT 2013-14

One of the primary goals of Healthy Families Oregon is to ensure that children are free from maltreatment, including physical and emotional neglect and abuse. This report presents data on reported child maltreatment among families participating in the Healthy Families Oregon program during the program year July 1, 2013 – June 30, 2014. Information on other important outcomes of the Healthy Families Oregon program, such as parenting and child health and development, can be found in the Healthy Families Oregon Annual Status Report:

<http://npcresearch.com/wp-content/uploads/HFO-Status-Report-Narrative-plus-Tables-2013-14.pdf>

Scope of the Problem

Child maltreatment is a significant public health issue in the United States. An estimated 3.7 million children experience child abuse and neglect each year (U.S. Department of Health and Human Services, 2012), costing over \$103.8 billion annually (Wang & Holton, 2007). At least four children die every day as a result of maltreatment (Child Welfare Information Gateway, 2008) and substantial scientific literature documents adverse developmental outcomes for children who experience abuse and neglect, including neurological impairments, learning deficits, difficulties forming relationships, behavior problems, mental health issues, substance abuse, poor physical health, and adolescent pregnancy (Edwards et al., 2005; Chalk, Gibbons, & Scarupa, 2002). Population studies indicate that maltreatment during childhood is associated with poor health

outcomes for adults, including increased risk of heart disease, alcohol and drug abuse, depression, and suicide attempts (Edwards et al., 2005). Further, the number of times an individual experiences maltreatment appears to have a dose-response relationship to the presence of a number of serious adult diseases, such as cancer, liver disease, and chronic lung disease (Edwards et al., 2005). Thus maltreatment and the trauma experienced by its victims pose a very real threat to public health in the United States.

Child Maltreatment in Oregon

Both nationally and in Oregon, the rate of child maltreatment has remained relatively stable. Nationally, rates have fallen slightly from 9.3 victims per 1,000 children in 2009 to 9.1 victims per 1,000 in 2013. In Oregon, the annual victimization rate in 2009 was 12.5 victims per 1,000 children; following national trends, this decreased slightly to 12.3 victims per 1,000 in federal fiscal year 2013, the most recent year for which Oregon's data are available.

Key Factors Influencing Maltreatment

CHILDREN'S AGE

Young children are clearly the most vulnerable to abuse and neglect. For example, in Oregon during 2013:

- 48.7% of all substantiated victims of abuse or neglect were under age 6;
- 34.7% (3,686 victims) were under age 3;
- The overall victimization rate for children under age 3 was 19 per 1,000;

- 12.8% (1,360 victims) were children under 1 year of age;
- Children ages 0 to 5 comprise 38.7% of the children served in foster care in Oregon;
- Of 10 child fatalities related to abuse and neglect in Oregon in 2011, 70% were younger than age 5 (OR DHS, 2014).

Consistent with Oregon statistics, national data also show that very young children (birth through age 3) are at highest risk of maltreatment, suffer the most pervasive and severe consequences, and represent the fastest growing segment of the nation's foster care population. These very young children are more vulnerable for a variety of reasons, including their inability to defend themselves, their small size, their relative social isolation, and the fact that infancy is a sensitive period of brain development that may be severely disrupted by trauma (De Bellis, 2010; Easterbrooks, Bartlett, Beeghly, & Thompson, 2012).

The vulnerability of these youngest children underscores the importance of programs like Healthy Families Oregon that aim to prevent maltreatment in the earliest years of the child's life.

FAMILY POVERTY & PARENTAL STRESS

While child abuse and neglect occur across the socioeconomic continuum, poverty has been consistently found to be a key risk factor associated with child abuse and neglect (Sedlak & Broadhurst, 1996; Lee & George, 1999). Research has found that serious abuse and neglect are 22 times more likely in very poor families, with lowest income families disproportionately represented in national statistics (U.S. Department of Health and Human Services, 2002). Findings from NIS-4 (Sedlak et al., 2010) showed that children from the

poorest families (earning less than \$15,000 annually) were 3 times more likely to be abused and 7 times more likely to be neglected than children living in higher income households (Marcenko, Hook, Romich, & Lee, 2012).

The effects of being low income are difficult to isolate, however, as poverty is associated with multiple other stressors that increase the risk of abuse, such as homelessness, unemployment, single parenting, lower education, social isolation, and community violence (Brooks-Gunn & Duncan, 1997). While poverty in and of itself is likely not a direct cause of maltreatment, poverty may compound the influence of other stressors and contribute to increased risk, especially if other factors are present. Socioeconomic conditions that increase poverty, or increase the stressors associated with poverty (e.g., by decreasing support services to those most in need) are likely to be associated with increased rates of child maltreatment (Marcenko et al., 2012).

Theoretical models of child maltreatment often focus on the role of parenting stress as a key risk factor for maltreatment, emphasizing that the multiple chronic stressors of poverty contribute to higher parental stress and increased risk of abuse (Abidin, 1990; Rutter, 2007). Comprehensive programs such as Healthy Families Oregon that help reduce parenting stress, improve family self-sufficiency, increase parenting skills, provide social support, and link families to other needed services have been postulated to being critical to the prevention of maltreatment, especially among at-risk families.

CUMULATIVE RISK

While a number of independent risk factors have been associated with increased risk of maltreatment (e.g., poverty, substance

abuse, domestic violence, family conflict, etc.), what is particularly clear is that children in families with greater numbers of risk factors are most vulnerable (Appleyard, Egeland, van Dulmen, & Sroufe, 2005; Nair, Schuler, Black, Kettinger, & Harrington, 2003). This model of “cumulative risk” suggests that the odds of maltreatment increase as the number of family, social, and child risk factors increase, and has been supported in a number of large-scale studies. Despite innumerable efforts to identify specific indicators that can accurately predict which children are most likely to be maltreated, or which adults are most likely to maltreat, models of cumulative risk have, to date, been shown to be the most predictive (although even these models lack precision; Green, Ayoub, et al., 2013; Stith et al., 2009).

In Healthy Families Oregon, the role of cumulative risk has been documented in numerous evaluation reports, which consistently show that the odds of a founded maltreatment report increase as the number of family risk factors increases (Green & Lambarth, 2009).

Protective Factors

Risk and protective factors often represent opposite ends on a continuum (e.g., poverty versus financial security), co-occur (e.g., a difficult child is born to a depressed mother), and aggregate in children’s lives. Whereas greater numbers of risk factors increase the risk of maltreatment and other negative outcomes for children, an accumulation of protective factors is associated with resilient child trajectories (Masten, 2006). The Children’s Bureau, the federal office that oversees funding and research related to child welfare services as well as a number of maltreatment prevention programs has developed a framework that lays out the

protective factors identified in theory and research as important for reducing children’s risk and promoting their well-being (USDHHS, 2003). These include:

- Parental resilience
- Nurturing and attachment
- Social connections
- Knowledge of parenting and child development
- Effective problem solving and communication skills
- Concrete support in times of need
- Social and emotional competence of children
- Healthy marriages

These factors represent a number of the key short-term outcomes for the HFO program.

ADDRESSING RISK & PROTECTIVE FACTORS TO PREVENT CHILD MALTREATMENT

The Centers for Disease Control and Prevention (CDC) has identified child maltreatment as a public health issue, and called for programs that promote Safe, Stable, and Nurturing Relationships (SSNRs) between children, caregivers, and communities to prevent and ameliorate the effects of child abuse and neglect (Hammond, 2003; CDC, 2008, 2011). This model is based on empirical evidence that a multitude of factors influence caregiving quality, including risk and protective factors at the child, parent, family, and environmental level (Bronfenbrenner & Morris, 2006). Preventive interventions are thought to be more effective when they attend to both the family’s social environment (e.g., social support, economic stability, housing, neighborhood conditions, parental mental health, community linkages and resources) as well as to the quality of parent-child relationships (CDC, 2011). HFO’s

strong two-generational program model that focuses on improving parent-child relationships while helping families achieve self-sufficiency and family stability, coupled with its community-based approach is promising in this regard. HFO programs work in cooperation with other key community services and systems (e.g., early intervention systems, health care providers, domestic violence, substance abuse, and mental health treatment services, child welfare agencies), in addition to providing direct parenting education and parent-child relationship support to families with young children. Further, HFO is one of a number of early childhood services that work together to enhance young children's development and support well-being and school readiness for children.

Home Visiting Programs Can Prevent Maltreatment

There is growing evidence that home visiting is an effective means of preventing abuse and neglect. High-quality, intensive home visiting services delivered to those most at risk of poor child and family outcomes has been found to reduce the incidence of child maltreatment (Sweet & Appelbaum, 2004; Green, Lambarth, Tarte, & Snoddy, 2009; Harding, Galano, Martin, Huntington, & Schellenbach, 2007; Olds et al., 1999). In their meta-analysis of more than 60 home visiting research studies, Sweet and Appelbaum (2004) concluded that programs that were more successful at reducing the risk factors for child maltreatment were those programs that: (1) identified preventing child abuse as an explicit program goal; and (2) focused on high-risk parents.

Conversely, home visiting programs that have not been well implemented, and that are less successful at identifying and working

with serious problems such as parental substance abuse, mental illness, and severe parenting stress have been less successful (Aos, Lieb, Mayfield, Miller, & Pennucci, 2004).

A recent review by the Home Visiting Evidence for Effectiveness project (HomVEE, Avellar, Paulsell, Sama-Miller, & Del Grosso, 2012) reviewed hundreds of studies of programs designed to promote child development and prevent negative child outcomes, and identified Healthy Families America, Nurse-Family Partnership, and several others as meeting their criteria for positive evidence of program benefits across eight key outcome areas, including parenting, child development, family stability/self-sufficiency, and health (Howard & Brooks-Gunn, 2009).

Evidence regarding the impact of home visiting programs in terms of directly impacting rates of maltreatment, however, has been elusive (Selph, Bougatsos, Blazina, & Nelson, 2013). This is likely due to a combination of challenges in using substantiated maltreatment reports as a primary indicator of child maltreatment, variability in the quality of program implementation, and the paucity of rigorous, long-term follow-up studies that have evaluated program effectiveness in this area.

There is controversy over the use of actual reported maltreatment rates as an outcome in studies of the effectiveness of home visiting programs (Olds, Eckenrode, & Kitzman, 2005). The primary concern is that because home visitors are mandated reporters of maltreatment, the very act of providing home visits for very at-risk families may increase, rather than decrease, reported maltreatment. Home visitors work closely with very high-risk families and thus may identify neglect or abuse that would

otherwise have gone unreported, a consequence sometimes referred to as a “*surveillance effect*.” Because of this possibility, many studies have elected not to measure actual maltreatment rates. A more common approach is to measure a program’s ability to strengthen family protective factors and reduce family risk factors that are associated with increased risk for maltreatment. Healthy Families Oregon program does conduct an annual evaluation of these risk and protective factors and finds positive results (Green, Tarte, Lambarth, Snoddy, & Nuzzo, 2009).

A further complication in evaluating child abuse prevention is the overall low incidence of child maltreatment in the population (State of Arizona Office of the Auditor General, 2000). For example, in Oregon, only about 2% to 3% of the age 0-3 population is maltreated. Detecting reductions in these so-called “low frequency events” is challenging for statistical reasons, and requires extremely large research samples. However, given the potential costs to individuals and society, even small reductions in maltreatment incidents can have significant and cost-beneficial long-term effects (Miller, Cohen, & Wiersema, 1996).

Finally, at least two major studies have found that the impact of home visiting programs on substantiated abuse may not emerge until children are age five or older (Green, Ayoub, et al., 2013; Zielinski,

Eckenrode, & Olds, 2009). This research suggests that early home visiting, by reducing family risk and promoting protection, puts families on a more positive trajectory that prevents more serious abuse and neglect over the long term. Child maltreatment represents one extreme (negative) end of the continuum of parenting quality, and it may be that the long-term benefits of programs such as Healthy Families Oregon are best assessed in the short term by more proximal outcomes related to reductions in risk factors and promotion of positive parenting and child development. The Healthy Families Oregon Annual Status Report (Green et al., 2015) presents results for parenting and child outcomes for Healthy Families Oregon families.

However, because reducing incidents of child maltreatment is one of the primary goals of the Healthy Families Oregon program, the program has elected to examine actual reported maltreatment rates as a benchmark of program success. The reader should keep in mind, however, that for Healthy Families’ high-risk families, rates of maltreatment may be higher than general state or community maltreatment rates both because of the families’ higher risk status as well as because of the “surveillance” effects described above. This report presents the analyses of the effects of Healthy Families Oregon program on child maltreatment for fiscal year 2013-14.

METHODOLOGY

Child Maltreatment Data

Through collaborative data-sharing agreements between the NPC Research, the Oregon Department of Human Services (Child Welfare), and Oregon Department of Human Services (Office of Forecasting, Research, and Analysis), data regarding substantiated reports of child abuse and neglect for children served by Healthy Families Oregon were obtained. All HFO families included in the evaluation have provided written consent for this information sharing.

To obtain this information, NPC Research provides a dataset comprised of Healthy Families Oregon participant identifiers. This dataset is, in turn, provided to staff at the Office of Forecasting, Research and Analysis, who have developed an Integrated Client Database that compiles information about participants in various state-funded programs into a single dataset. HFO families are then linked to their Department of Human Services identification numbers. This file is submitted to Child Welfare research office analysts, who match the Healthy Families Oregon sample with records of substantiated maltreatment reports. The dataset is then stripped of identifiers except for numeric Healthy Families Oregon ID numbers and returned to NPC Research for analysis.

Research Sample

HEALTHY FAMILIES OREGON GROUP

The results presented in the next section of the report include data for Healthy Families Oregon children ages 0 to 3 years during the program year July 1, 2013, through June 30,



2014.¹ Maltreatment reports were included in the analysis if they occurred during this period. Analyses include all children served through Healthy Families Oregon's screening and referral process, as well as those served through Intensive Home Visiting.

Because the outcome of interest for the Oregon Healthy Families Oregon program is *prevention* of child abuse and neglect, families who had open child welfare cases prior to being screened by Healthy Families Oregon were eliminated from these analyses. Additionally, families in which the Family Support Worker indicated that a Child Protective Services report had been made by the program at the time of family enrollment were also removed from these analyses. A total of n=216 children were eliminated from analyses because of child welfare involvement prior to enrollment by Healthy Families Oregon. This number is considerably higher than in previous years, likely due to the fact that several programs began to serve families for whom the

¹ The analyses include children who were under the age of 3 by July 1, 2014, and who were **ever** served by Healthy Start; they may not have been served during FY 2013-14.

identified focus child was not the first child born²

COMPARISON GROUP

The primary comparison group for this report is composed of children ages 0 to 3 years of age who were *not served* by Healthy Families Oregon. Because Healthy Families Oregon screened only about half of all eligible children during the FY 2013-14 biennium, children born during this period but not served by Healthy Families Oregon comprise a naturally existing, although not ideal, comparison group. Several differences between served and non-served families are important to note. First, the Healthy Families Oregon group includes primarily first-born children, while the general non-served population includes subsequent births. Parents of multiple children may be somewhat more likely to abuse or neglect their children (Berendes, Brenner, Overpeck, Trifiletti, & Trumble, 1998), and children from families with more than four children appear to be particularly at risk (Sedlak et al., 2010).

Second, because of an increased emphasis on reaching and serving high-risk families, Healthy Families Oregon programs have focused their screening and outreach on higher risk populations. As described in the most recent Healthy Families Oregon Annual Status Report (Green et al, 2015), families screened and served by Healthy Families Oregon are significantly higher on multiple risk indicators than the Oregon general population. For example, Healthy Families Oregon parents are significantly more likely to be teenage, single, unemployed, and have

less than a high school education, compared to other first-time parents in Oregon.

Finally, using this general population comparison group does not allow an analysis of the effects of the home visiting component of the program specifically. Because Healthy Families Oregon home visiting services are offered only to those families at highest risk of maltreatment and other negative outcomes, families receiving intensive home visiting services are much higher in risk factors compared with the general population. However, in the general population, where there is likely to be a combination of both higher and lower risk families, it is not possible to identify the high-risk families who are most similar to those served by Healthy Families Oregon. For this reason, it is most appropriate to use the entire Healthy Families Oregon population (both families that received intensive home visiting services and those that received only screening, information, and service referrals) as the point of reference for comparison.

² During 2013-14 this was a small number of MIECHV-funded programs; however, Oregon statutes were amended to allow much broader services not restricted to first births starting in 2014-15.

RESULTS

Healthy Families Oregon vs. Non-Healthy Families Oregon Children

The first set of analyses compares all families served by Healthy Families Oregon (both screening- and referral-only and intensive home visiting families) to all Oregon children up to three years of age who were not served by Healthy Families Oregon. As described previously, Healthy Families Oregon is not able to reach all families with newborns within each county. Hence, non-served families provide a naturally existing comparison group for examining the incidence of child abuse.

As shown in Figure 1, children served by Healthy Families Oregon had lower victimization rates compared with similar-age non-served children (11 per 1,000 compared with 20 per 1,000; county-level data are shown in Table 1 in Appendix A).

The rate of victimization for Healthy Families Oregon children free from maltreatment has been relatively stable for the years that data are available, ranging from 11 to 16 victims per 1,000 children, with the lowest rate documented in 2007, and the highest in

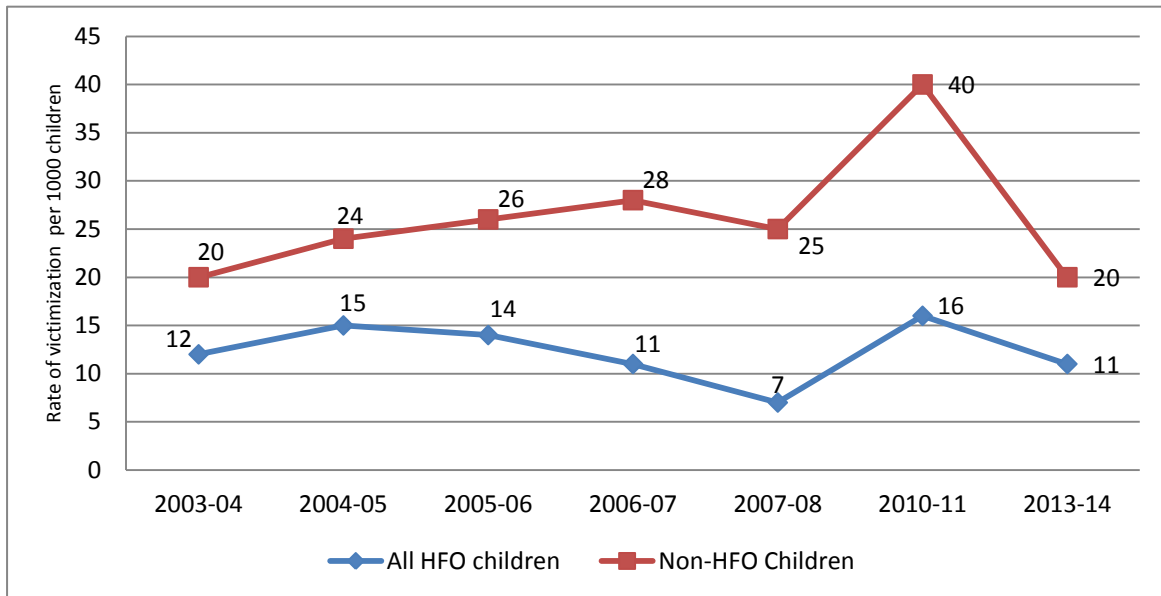


“Children who are not in Healthy Families Oregon are almost twice as likely to be maltreated than children who are served by the program.”

2010-11. Statewide rates for children not served by HFO have also fluctuated, from a low of 20 per 1000 to a high of 40 per 1000 (also in 2010-11). In all, the majority of children screened or served by HFO were free from maltreatment (98.9%).

Although there was a spike in maltreatment rates for both groups in 2010-11 (the last report date), rates for both groups fell dramatically this year, compared to what was seen three years ago. Reasons for the “spike” during the 2010-11 period are not clear, but could have to do with the economic recession and related reductions in state budgets for prevention and treatment services, as well as for other services to support higher risk families.

Figure 1. Rate of Maltreatment for Healthy Families Oregon vs. Non-Healthy Families Oregon Children



Families Receiving Intensive Home Visiting

As expected, and consistent with prior years, rates of maltreatment for families who received Healthy Families Oregon home visiting services were higher (24 per 1,000) than those for families who were served only with screening, information, and referral services (10 per 1,000, see Table 2 in Appendix A). While this is somewhat higher than the overall population rate of 20 per 1000, it is notable that the rate of victimization for HFO's highest risk families (24/1,000) is not markedly higher than the overall rate for children not screened or served by Healthy Families Oregon (20/1,000). This pattern is consistent with what has been seen in prior years. Additionally, as shown in Table 4 in Appendix A, the number of HFO families who were assessed as having high or severe levels of stress was high this year (45.6% of all families), higher than most previous years (e.g., 41.1% in 2010-11, and 33.5% in 2007-

08). Given the significantly higher number of risk factors for HFO children and families, one might expect that these home visited families, absent supportive services, would have even higher rates of maltreatment.

Maltreatment and Risk Factors

Child maltreatment rates were strongly related to families' level of risk as assessed by the New Baby Questionnaire (NBQ). As shown in Figure 2, and in Table 3 in Appendix A, the more risks families have, the more vulnerable their children are to abuse and/or neglect³. In 2014, the more risk factors family had, regardless of which specific risks had been indicated, the greater their risk for maltreatment. For example, in 2013-14, families with just two risk factors were 6.5 times more likely to have a substantiated abuse report. Even more strikingly, those with more than four risk

³ Risks measured by the NBQ include demographic factors (e.g., marital status) as well as parents' report of well-being (e.g., depression, substance abuse concerns).

factors in 2013-14 were between 24 and 76 times more likely to be abused or neglected.

Analyses also showed that, controlling for other risk factors, some risk factors appear to be particularly important to understanding the risk for maltreatment. Specifically, controlling for all other risk factors, children whose families were headed by a single parent, whose parents were not employed, and whose parents reported substance abuse were more than twice as likely to have an abuse report as families without these risk factors. Additionally, children whose mothers did not receive timely prenatal care, had difficulty paying for basic expenses, and whose mothers reported family relationship concerns were at somewhat elevated risk for maltreatment (odds ratios 1.5-1.7, $p < .05$).⁴

In addition to risk screening, families that are enrolled in intensive home visiting services

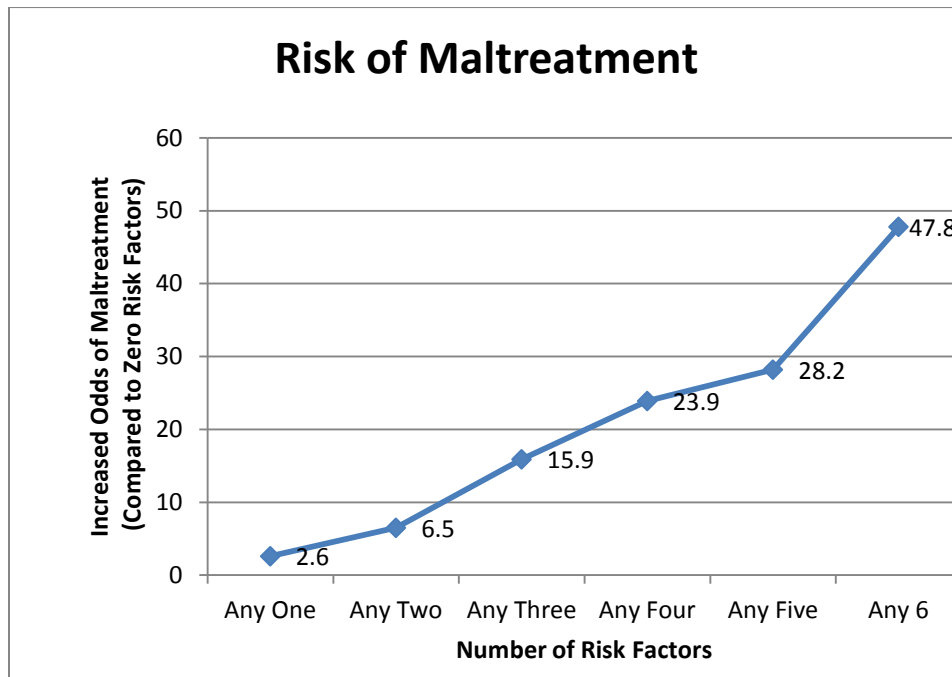
are interviewed using an in-depth assessment tool focusing on family and parenting stress, called the Kempe Family Stress Interview (Korfmacher, 2000). As shown in Table 4, Appendix A, families whose Kempe assessments indicate that they are experiencing more family and parenting stress are more likely to engage in child maltreatment. Families assessed at low stress had no reports of maltreatment (0 per 1,000); families with moderate stress had a rate of 17 per 1,000, and families with high stress had a rate of 31 per 1,000. Those with the highest family stress scores had the highest maltreatment rates, 134 per 1,000.

As noted above, a larger percentage of families served in 2013-14 appeared to be experiencing high or severe levels of stress, compared to prior years.



⁴ Regression models predicting abuse status included all NBQ risk factors simultaneously (models also controlled for race and county of service); odds ratios for single parent, mother with less than a high school education or GED, lack of timely prenatal care, parental unemployment, difficulty pay for basic needs, , and relationship problems were significant, $p < .05$.

Figure 2. Likelihood of Maltreatment by Number of Risks on the New Baby Questionnaire



Types of Maltreatment

Contrary to popular belief, the vast majority of reports of maltreatment do not involve physical or sexual abuse. In Oregon, during federal FY 2013-14, only 14% of reports involved physical or sexual abuse; more common were neglect (40.6% of founded reports) or “threat of harm” (44% of founded reports). A determination of “threat of harm” indicates that there is a substantial danger to the child, often because of witnessing domestic violence or being at substantial threat of harm due to parents’ drug or alcohol issues. Threat of harm is the single most frequent type of maltreatment recorded in Oregon.

Among Healthy Families Oregon families, 10.3% of founded reports involved physical or sexual abuse, 55.1% involved child neglect, and 55.4% involved reported threat of harm.⁵ Thus, it appears that HFO families were somewhat less likely to experience physical or sexual abuse (10.3%) compared to the overall population of child maltreatment victims in Oregon (14%).

⁵ Note that more than one type of abuse may be reported for each victim.

SUMMARY & DISCUSSION

Results for the 2013-14 program year continue to support the effectiveness of the Healthy Families Oregon program in reducing children's risk of maltreatment. The vast majority of HFO children, 98.9%, were free from abuse and neglect. Even among the highest risk families, 97.7% of children are free from maltreatment. Consistent with prior years, HFO children were *almost two times less likely to be maltreated*, compared to children not screened or served by HFO. It should be noted that there is considerable variability in rates of substantiated maltreatment from county to county, and that this variability is also seen in differences among HFO programs in maltreatment outcomes. County-level results, however, continue to suggest the effectiveness of the program. For example, in just 5 out of 34 counties was the percentage of maltreated children served by HFO higher than 2%; in those same counties, 20 had rates of maltreatment greater than 2% among those children **not** served by HFO.

Ideally, it would be possible to compare the rates of child maltreatment for the higher risk families receiving intensive home visiting services to a similarly high-risk group of families who did not receive intensive home visiting services. At this time, such a comparison is not possible, given current evaluation structure and program resources. However, an ongoing federally funded evaluation of the HFO program that involved randomly assigning families eligible for home visiting component to either receive HFO services or to receive non-HFO community services may shed further light on this issue. Preliminary results from this study found that HFO parents had lower



parenting stress, compared to the control group, a key factor related to risk for maltreatment (Green & Tarte, 2013). Results from this study examining maltreatment rates for both groups will be available in Fall 2015.

It is possible, however, to compare the maltreatment rates for families who received HFO home visiting to the rates found in other studies of high-risk populations. Generally, these comparisons suggest that home visited families have lower rates of abuse and neglect than these comparable populations. For example, a randomized trial of the Nurse-Family Partnership program (NFP) found that 96% of higher risk teenage mothers who were visited by a nurse for 2 years were free of maltreatment, compared with only 79% of impoverished, unmarried teens who received no home visiting (Olds, 1997). Among teen parents in HFO, 96.3% were free from maltreatment, a rate similar to that found among teenagers served by the NFP program. It should be noted, however, that reported maltreatment rates vary across communities due to differences in such factors as child welfare reporting/investigation systems and

community demographics, and thus these comparisons should be made with caution.

Specifically, participating in the Healthy Families Oregon program was associated with the following differences in maltreatment rates between children served by Healthy Families Oregon and Oregon's general 0-3 population:

- FY 2002-03: 45% difference in founded abuse reports
- FY 2003-04: 40% difference in founded abuse reports
- FY 2004-05: 38% difference in founded abuse reports
- FY 2005-06: 46% difference in founded abuse reports
- FY 2006-07: 61% difference in founded abuse reports
- FY 2007-08: 72% difference in founded abuse reports
- FY 2010-2011: 60% difference in founded abuse reports
- FY 2013-2014: 45% difference in founded abuse reports

It is important to understand both program and statewide context for this year's results, compared to the last maltreatment report produced in 2010-11. One of the most notable trends has been increasing expansion of early childhood home visiting services beyond the HFO model. These expansions, primarily due to increased federal support for home visiting programs, may have the effect of reducing the rates of maltreatment in the general population (e.g., the 'comparison group' for HFO). Thus, as the overall rates of maltreatment are reduced because of other effective interventions across the state, the differences between results for HFO and the general population will decrease. Through

2014, more than \$1.5 billion dollars in funding for evidence-based programs being provided to 54 states and territories through the Maternal, Infant, & Early Childhood Home Visiting (MIECHV) program of the U.S. Department of Health and Human Services (USDHHS, 2012). Oregon has received over \$11.9 million dollars in federal home visiting funds (starting with a \$1.4 million dollar formula grant in 2011), including two rounds of competitive grant funding to support HFO, NFP, and Early Head Start programs, as well as basic funding provided on a population basis to all states. The first round of competitive funding was used to expand HFO services in three of Oregon's neediest communities (Multnomah County, Tillamook County, and Malheur County). A second round of funding brought resources to an additional 10 HFO programs; these funds expanded services in Clatsop, Jackson, Jefferson, Klamath, Lane, Lincoln, Marion, Morrow, Umatilla and Yamhill counties.

Moving forward, it will be increasingly important to understand both the extent and level of home visiting services received by families outside of HFO, as well as to understand effects of changes in the statutorily defined target population (specifically, expanding services to non-first time parents) and how these influence evaluation results. For example, as programs screen the larger number of families who may be potentially eligible, current program policy directs programs to offer services to those most in need. This is likely to increase the general level of risk and trauma among those receiving HFO home visiting. While it is clear that these families may benefit the most from HFO services, they also may be more difficult to serve, and require higher rates of mandated reporting among home visitors. These factors may influence results of future evaluation reports, especially those focused on child abuse and neglect. At the

same time, some research has shown that home visiting may be particularly effective with these very high risk families, as long as staff continue to receive additional training, support, and coaching in how to best meet these families' needs. Taken together, these factors suggest that for HFO to continue to show positive results in reducing risk for maltreatment, ongoing quality improvement, training, and technical assistance to programs will become even more important. Ultimately, program quality depends on having high-quality, well-supported and trained staff without whom the desired outcomes of reducing family risk, building resilience, and, ultimately, protecting children from abuse and neglect cannot be achieved..

REFERENCES

- Abidin, R. R. (1990). The stresses of parenting. *Journal of Clinical Child Psychology, 19*, 1-7.
- Aos, S., Lieb, R., Mayfield, J., Miller, M., & Pennucci, A. (2004). Benefits and Costs of Prevention and Early Intervention Programs for Youth. Washington State Institute for Public Policy document #04-07-3901. Available: www.wsipp.wa.gov
- Appleyard, K., Egeland, B., van Dulmen, M., & Sroufe, L. (2005). When more is not better: the role of cumulative risk in child behavior outcomes. *Journal of Child Psychology and Psychiatry, 46*(3), 235-245.
- Avellar, S., Paulsell, D., Sama-Miller, E., & Del Grosso, P. (2012). *Home visiting evidence of effectiveness review: Executive summary*. Washington, D.C.: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.
- Berendes, H. W., Brenner, R., Overpeck, M., Trifiletti, L. B., & Trumble, A. (1998). Risk factors for infant homicide in the United States. *New England Journal of Medicine, 339*(17), 1211.
- Bronfenbrenner, U., & Morris, P. A. (2006). The Bioecological model of human development. In R. M. Lerner and W. Damon (Ed.), *Theoretical models of human development*. Vol. 1 of the *handbook of child psychology* (5th ed.; pp. 793-828). New York: Wiley.
- Brooks-Gunn, J., & Duncan, G. J. (1997). The effects of poverty on children. *The Future of Children, 7*(2), 55-71.
- Centers for Disease Control and Prevention (2008). *Strategic direction for child maltreatment prevention: Preventing child maltreatment through the promotion of Safe, Stable, and Nurturing Relationships between children and their caregivers*. Retrieved March 11, 2013, from http://www.cdc.gov/ViolencePrevention/pdf/CM_Strategic_Direction--Long-a.pdf
- Centers for Disease Control and Prevention (2011). *Preventing child maltreatment through the promotion of safe, stable, and nurturing relationships between children and caregivers*. Retrieved March 11, 2013, from http://www.cdc.gov/ViolencePrevention/pdf/CM_Strategic_Direction--OnePager-a.pdf
- Chalk, R., Gibbons, A., & Scarupa, H. J. (2002). The multiple dimensions of child abuse and neglect: New insights into an old problem. Washington, D.C.: Child Trends. Retrieved March 11, 2013, from www.childtrends.org/Files/ChildAbuseRB.pdf
- Child Welfare Information Gateway (2008). Long-term consequences of child abuse and neglect. Retrieved March 11, 2013, from https://www.childwelfare.gov/pubs/factsheets/long_term_consequences.pdf
- De Bellis, M. D. (2010). The neurobiology of neglect. In R. A. Lanius, E. Vermetten, & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic* (pp. 123-132). New York: Cambridge University Press.

- Edwards, V. J., Anda, R. F., Dube, S. R., Dong, M., Chapman, D. F., & Felitti, V. J. (2005). The wide-ranging health consequences of adverse childhood experiences. In K. Kendall-Tackett & S. Giacomoni (Eds.), *Victimization of children and youth: Patterns of abuse, response strategies*. Kingston, NJ: Civic Research Institute.
- Easterbrooks, M. A., Bartlett, J. D., Beeghly, M., & Thompson, R. A. (2012). Social and emotional development in infancy. In R.M. Lerner, M.A. Easterbrooks, & J. Mistry (Eds.), *Handbook of psychology: Vol. 6. Developmental psychology* (2nd ed.). Editor-in- Chief: I. B. Weiner. Hoboken, NJ: Wiley.
- Green, B. L., Lambarth, C. H., Tarte, J. M., & Snoddy, A. M. (2009). Oregon's Healthy Start Maltreatment Prevention Report 2007-08. NPC Research: Portland, OR.
- Green, B. L., & Tarte, J. M. (2013). Testing the Effectiveness of Healthy Families Oregon: One Year Parent Interview Outcomes. Presentation for the Healthy Families America National Research Advisory Council, August 2013.
- Green, B. L., Ayoub, C., Bartlett, J. D., Furrer, C. J., VonEnde, A., Chazan Cohen, R., Ryan, B., & Valloton, C. (2013). *Results from the Early Head Start Child Welfare Study: Final Report*. Report to the Centers for Disease Control and Prevention, submitted March 2013.
- Green, B. L., Tarte, J. M., Lambarth, C. H., Snoddy, A. M., & Nuzzo, W. (2009). Healthy Start of Oregon 2010-2011 Status Report. A report to the Oregon Commission on Children and Families.
- Green, B. L., & Lambarth, C. H. (2009). Oregon's Healthy Start Program: Report on the Effects on Child Maltreatment Prevention 2007-08. A report to the Oregon Commission on Children and Families.
- Hammond, W. R. (2003). Public health and child maltreatment prevention: The role of the centers for disease control and prevention. *Child Maltreatment*, 8, 81-85.
- Harding, K., Galano, J., Martin, J., Huntington, L., & Schellenbach, C. J. (2007). Healthy Families American effectiveness: A comprehensive review of outcomes. *Journal of Prevention and Intervention in the Community*, 34(1/2), 149-180.
- Howard, K. S., & Brooks-Gunn, J. (2009). The role of home-visiting programs in preventing child abuse and neglect. *The Future of Children*, 19(2), 119-146.
- Korfmacher, J. (2000). The Kempe family stress inventory: A review. *Child Abuse & Neglect*, 24(1), 129-140.
- Lee, B., & George, R. (1999). Poverty, early childbearing, and child maltreatment: A multinomial analysis. *Child and Youth Services Review*, 21(9/10), 755-780.
- Marcenko, M. O., Hook, J. L., Romich, J. L., & Lee, J. S. (2012). Multiple Jeopardy Poor, Economically Disconnected, and Child Welfare Involved. *Child Maltreatment*, 17(3), 195-206.
- Masten, A. S. (2006). Promoting resilience in development: A general framework for systems of care. In R. J. Flynn, P. M. Dudding, & J. G. Barber (Eds.), *Promoting resilience in child welfare* (pp. 3-17). Ottawa: University of Ottawa Press.

- Miller, T. R., Cohen, M., & Wiersema, B. (1996). *Victim Costs and Consequences: A New Look*. Washington, DC: U. S. Department of Justice, National Institute of Justice.
- Nair, P., Schuler, M. E., Black, M. M., Kettinger, L., & Harrington, D. (2003). Cumulative environmental risk in substance abusing women: early intervention, parenting stress, child abuse potential and child development. *Child Abuse and Neglect*, 27(9), 997-1017.
- Olds, D. (1997). The prenatal/early infancy project: Fifteen years later. In G. W. Albee & T. P. Gullotta, (Eds.) *Primary Prevention Works*, 41-67. Thousand Oaks, CA: Sage.
- Olds, D., Eckenrode, J., & Kitzman, H. (2005). Clarifying the impact of the Nurse-Family Partnership on child maltreatment: response to Chaffin (2004). *Child Abuse & Neglect*, 29, 229-233.
- Olds, D. L., Henderson Jr., C. R., Kitzman, H. J., Eckenrode, J. J., Cole, R. E., & Tatelbaum, R. C. (1999). Prenatal and infancy home visitation by nurses: Recent findings. *The Future of Children*, 9(1), 44-65.
- Rutter, M. (2007). Resilience, competence, and coping. *Child Abuse and Neglect*, 31(3), 205-209.
- Sedlak, A., & Broadhurst, D. (1996). *Third national Incidence Study of Child Abuse and Neglect: Final Report*. Washington, DC: U. S. Government Printing Office.
- Sedlak, A. J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., & Li, S. (2010). *Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.
- Selph, S., Bougatsos, C., Blazina, I., Nelson, H. (2013). Behavioral Interventions and Counseling to Prevent Child Abuse and Neglect: A Systematic Review to Update the U.S. Preventive Services Task Force Recommendation. *Annals of Internal Medicine*, 158(3), 179-190.
- State of Arizona Office of the Auditor General (February 2000). *Performance Audit. Healthy Families Program*. Available: www.auditorgen.state.az.us/Reports/State_Agencies/Agencies/Economic%20Security,%20Department%20of/Performance/00-1/00-1.pdf
- Stith, S. M., Liu, T., Davies, L. C., Boykin, E. L., Alder, M. C., Harris, J. M.,...Dees, J. (2009). Risk factors in child maltreatment: A meta-analytic review of the literature. *Aggression and Violent Behavior*, 14(1), 13-29.
- Sweet, M. A., & Appelbaum, M. I. (2004). Is home visiting an effective strategy? A meta-analytic review of home visitor programs for families with young children. *Child Development*, 75(5), 1435-1456.
- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect (2003). *Emerging Practices in the Prevention of Child Abuse and Neglect*. Downloaded September 1, 2013, from: <https://www.childwelfare.gov/preventing/pdfs/riskprotectivefactors.pdf>

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau (2012). *Child maltreatment 2011*. Retrieved June 18, 2015, from <http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2013>

Wang, C. T., & Holton, J. (2007). Total estimated cost of child abuse and neglect in the United States. Chicago, IL: Prevent Child Abuse America. Retrieved March 12, 2013, from http://www.preventchildabuse.org/about_us/media_releases/pcaa_pew_economic_impact_study_final.pdf

Zielinski, D. S., Eckenrode, J., & Olds, D. L. (2009). Nurse home visitation and the prevention of child maltreatment: Impact on the timing of official reports. *Development and Psychopathology*, 21(2), 441-453.

**APPENDIX A: HEALTHY FAMILIES OREGON OF
OREGON 2013-2014 MALTREATMENT REPORT
DATA TABLES**

Table 1. Children Aged 0-36 Months Free from Maltreatment (FY 2013-14)

Site	Healthy Families Oregon Children ¹				Non-Healthy Families Oregon Children ²			
	HFO child abuse victims in FY 13-14 ³	Total Healthy Families Oregon children, aged 0-36 months	% free from maltreatment ⁴	Incidence rate per 1,000	Child abuse victims in FY 13-14 ³	Number children, 0-36 months not served by HF Oregon	% free from maltreatment ⁴	Incidence rate per 1,000
Baker	0	31	100%	0	16	491	97%	33
Benton	0	322	100%	0	18	1,844	99%	10
Clackamas	34	2,691	99%	13	97	9,182	99%	11
Clatsop	0	23	100%	0	23	1,235	98%	19
Columbia	7	276	97%	25	32	1,154	97%	28
Coos	6	161	96%	37	64	1,709	96%	37
Crook					22	499	96%	44
Curry	0	18	100%	0	7	533	99%	13
Deschutes	9	740	99%	12	62	4,369	99%	14
Douglas	8	689	99%	12	86	2,572	97%	33
Gilliam	0	20	100%	0				
Grant								
Harney	0	11	100%	0	8	218	96%	37
Hood River					13	696	98%	19
Jackson	23	838	97%	27	212	6,040	96%	35
Jefferson	0	53	100%	0	12	796	98%	15
Josephine	9	464	98%	19	57	1,992	97%	29
Klamath	11	556	98%	20	93	1,785	95%	52

¹ **Total Healthy Families Oregon** children include both screened/referred families (no home visiting) and home visited families.

² **Non-Healthy Families Oregon Children** are the total number of children born in each county from July 2011 to June 2014 according to the Oregon Health Department (OHD) birth statistics (found at <http://www.dhs.state.or.us/dhs/ph/chs/data/birth/birthdata.shtml>) minus the number of children screened/served by Healthy Families Oregon. Similarly, child abuse victims among non-Healthy Families Oregon children are the total number of child maltreatment victims, aged 0 – 36 months old, for each county minus the number of Healthy Families Oregon victims.

³ The Oregon Department of Human Services, Children, Adults, and Families Division (CAF) electronically checked records of 26,686 Healthy Families Oregon children born between July 1, 2011, and June 30, 2014, for confirmed incidents of child maltreatment during FY 2013-14. These results exclude reports that occurred prior to the family's involvement with Healthy Families Oregon, and/or because the Family Support Worker indicated on the Family Intake Form that a Child Protective Services report had been made by the program at the time of enrollment.

⁴ Percentages are affected by sample size and can be misleading when sample sizes are small.

Note: Due to DHS restrictions on reporting data about small samples, shadowed data are unavailable for reporting.

	Healthy Families Oregon Children ¹				Non-Healthy Families Oregon Children ²			
Site	HFO child abuse victims in FY 13-14 ³	Total Healthy Families Oregon children, aged 0-36 months	% free from maltreatment ⁴	Incidence rate per 1,000	Child abuse victims in FY 13-14 ³	Number children, 0-36 months not served by HF Oregon	% free from maltreatment ⁴	Incidence rate per 1,000
Lake	0	0	100%	0	8	232	97%	34
Lane	36	3,290	99%	11	224	7,273	97%	31
Lincoln	■	■	■	■	35	951	96%	37
Linn	12	951	99%	13	59	3,326	98%	18
Malheur	■	■	■	■	47	1,042	95%	45
Marion	36	3,123	99%	12	249	9,829	97%	25
Morrow	■	■	■	■	10	350	97%	29
Multnomah	58	8,049	99%	7	482	20,207	98%	24
Polk	■	■	■	■	9	2,119	99.6%	4
Sherman	0	2	100%	0	■	■	■	■
Tillamook	■	■	■	■	13	516	97%	25
Umatilla	■	■	■	■	38	2,990	99%	13
Union	■	■	■	■	22	732	97%	30
Wallowa	■	■	■	■	■	■	■	■
Wasco	■	■	■	■	21	710	97%	30
Washington	14	1,413	99%	10	146	20,101	99%	7
Wheeler	0	1	100%	0	Missing	28		
Yamhill	■	■	■	■	12	3,000	100%	4
Total	303	26,470	98.9%	11	2,208	108,831	98.0%	20

¹ **Total Healthy Families Oregon** children include screened/referred families (no home visiting) and home visited families.

² **Non-Healthy Families Oregon Children** are the total number of children born in each county from July 2011 to June 2014 according to the Oregon Health Department (OHD) birth statistics (found at <http://www.dhs.state.or.us/dhs/ph/chs/data/birth/birthdata.shtml>) *minus* the number of children screened/served by Healthy Families Oregon. Similarly, child abuse victims among non-Healthy Families Oregon children are the total number of child maltreatment victims, aged 0 – 36 months old, for each county *minus* the number of Healthy Families Oregon victims.

³ The Oregon Department of Human Services, Children, Adults, and Families Division (CAF) electronically checked records of 26,686 Healthy Families Oregon children born between July 1, 2011, and June 30, 2014, for confirmed incidents of child maltreatment during FY 2013-14. These results exclude reports that occurred prior to the family's involvement with Healthy Families Oregon, and/or because the Family Support Worker indicated on the Family Intake Form that a Child Protective Services report had been made by the program at the time of enrollment.

⁴ Percentages are affected by sample size and can be misleading when sample sizes are small.

Note: Due to DHS restrictions on reporting data about small samples, shadowed data are unavailable for reporting.

Table 2. Children Aged 0-36 Months Free from Maltreatment by Service Type (FY 2013-14)

Site	Children in Healthy Families Oregon Screened/Referred Families ⁵				Children in Healthy Families Oregon Intensive Service Families ⁶			
	Child abuse victims in FY13-14 ⁷	Screened/ referred children, 0-36 months	% free from maltreat- ment ⁸	Incidence rate per 1,000	Child abuse victims in FY 13-14 ⁷	Intensive ser- vice children, 0-36 months	% free from maltreat- ment ⁸	Incidence rate per 1,000
Baker	0	2	100%	0	0	29	100%	0
Benton	0	283	100%	0	0	39	100%	0
Clackamas	27	2,521	99%	11	7	170	96%	41
Clatsop	0	0	100%	0	0	23	100%	0
Columbia	■	■	■	■	■	■	■	■
Coos	■	■	■	■	■	■	■	■
Crook	0	22	100%	0	■	■	■	■
Curry	0	2	100%	0	0	16	100%	0
Deschutes	■	■	■	■	■	■	■	■
Douglas	■	■	■	■	■	■	■	■
Gilliam	0	16	100%	0	0	4	100%	0
Grant	■	■	■	■	■	■	■	■
Harney	0	4	100%	0	0	7	100%	0
Hood River	0	116	100%	0	■	■	■	■
Jackson	20	760	97%	26	■	■	■	■
Jefferson	0	30	100%	0	0	23	100%	0
Josephine	8	407	98%	20	■	■	■	■

⁵ **Screened/Referred Families** are those families who were screened by Healthy Families Oregon and received basic information and referral services, but did not receive home visiting services. These families may or may not have been eligible to receive home visiting services.

⁶ **Home Visited Families** include all families born during FY 2011-2014 who received home visiting services; these families may not have been enrolled during 2013-14.

⁷ The Oregon Department of Human Services, Children, Adults, and Families Division (CAF) electronically checked records of 26,686 Healthy Families Oregon children born between July 1, 2011, and June 30, 2014, for confirmed incidents of child maltreatment during FY 2011-13. These results exclude reports that occurred prior to the family's involvement with Healthy Families Oregon, and/or because the Family Support Worker indicated on the Family Intake Form that a Child Protective Services report had been made by the program at the time of enrollment.

⁸ Percentages are affected by sample size and can be misleading when sample sizes are small.

Note: Due to DHS restrictions on reporting data about small samples, shadowed data are unavailable for reporting.

	Children in Healthy Families Oregon Screened/Referred Families ⁵				Children in Healthy Families Oregon Intensive Service Families ⁶			
Site	Child abuse victims in FY13-14 ⁷	Screened/ referred children, 0-36 months	% free from maltreat- ment ⁸	Incidence rate per 1,000	Child abuse victims in FY 13-14 ⁷	Intensive ser- vice children, 0-36 months	% free from maltreat- ment ⁸	Incidence rate per 1,000
Klamath	9	498	98%	18	■	■	■	■
Lake	0	0	100%	0	0	0	100%	0
Lane	32	3,119	99%	10	■	■	■	■
Lincoln	■	■	■	■	■	■	■	■
Linn	11	899	99%	12	■	■	■	■
Malheur	■	■	■	■	■	■	■	■
Marion	26	2,835	99%	9	10	288	97%	35
Morrow	0	73	100%	0	■	■	■	■
Multnomah	50	7,396	99%	7	8	653	99%	12
Polk	■	■	■	■	0	42	100%	0
Sherman	0	0	100%	0	0	2	100%	0
Tillamook	■	■	■	■	■	■	■	■
Umatilla	■	■	■	■	■	■	■	■
Union	■	■	■	■	0	21	100%	0
Wallowa	■	■	■	■	■	■	■	■
Wasco	■	■	■	■	0	33	100%	0
Washington	10	1,118	99%	9	■	■	■	■
Wheeler	0	0	100%	0	0	1	100%	0
Yamhill	■	■	■	■	■	■	■	■
Total	237	23,666	99%	10	66	2,804	97.7%	24

⁵**Screened/Referred Families** are those families who were screened by Healthy Families Oregon and received basic information and referral services, but did not receive Intensive Home Visiting services. These families may or may not have been eligible to receive intensive home visiting services.

⁶**Home Visited Families** include all families born during FY 2011-2014 who received the home visiting component; these families may not have been enrolled during 2013-14.

⁷The Oregon Department of Human Services, Children, Adults, and Families Division (CAF) electronically checked records of 26,686 Healthy Families Oregon children born between July 1, 2011, and June 30, 2014, for confirmed incidents of child maltreatment during FY 2013-14. These results exclude reports that occurred prior to the family's involvement with Healthy Families Oregon, and/or because the Family Support Worker indicated on the Family Intake Form that a Child Protective Services report had been made by the program at the time of enrollment.

⁸Percentages are affected by sample size and can be misleading when sample sizes are small.

Note: Due to DHS restrictions on reporting data about small samples, shadowed data are unavailable for reporting.

Table 3. Likelihood of Child Maltreatment⁹ Based on Number of Risks¹⁰ (FY 2013-14)

	Parameter estimate	Odds of child victimization¹¹
Any one risk vs. none (Sample = 4,723) ¹²	0.95	2.58*
Any two risks vs. none (Sample = 4,466)	1.86	6.45**
Any three risks vs. none (Sample = 3,953)	2.76	15.85**
Any four risks vs. none (Sample = 2,577)	3.17	23.85**
Any five risks vs. none (Sample = 1,303)	3.34	28.15**
Any six risk vs. none (Sample = 536)	3.87	47.75**
Any seven or more risks vs. none (Sample = 224)	4.33	75.70**

* p < .05; **p < .001

⁹ A logistic regression model was used to model the effects of the total number of risk characteristics shown by each family on the likelihood of child maltreatment for children aged 0 to 3 years during FY 2013-14, for which there was child victimization information.

¹⁰ The numbers of risk factors were recorded on the New Baby Questionnaire. Risk factors include: being single at the child's birth, being 17 years or younger, experiencing poverty, having a spouse/partner who is unemployed, not receiving early comprehensive prenatal care, having unstable housing, experiencing marital or family conflict, having a history of substance abuse or mental health problems, and having less than a high school education.

¹¹ Odds ratios show the likelihood of child maltreatment occurrence for families with risk characteristics in comparison to families with no risk characteristics. For example, among families screened by Oregon Healthy Families Oregon, children whose families have three risks at the time of birth are nearly 16 times (15.85) more likely to have been confirmed victims of child maltreatment than children whose families had no risks.

¹² Sample sizes reflect the number of families within the targeted risk grouping (e.g., 4,723 families had only one risk factor); 7,806 families had no risk factors.

Table 4. Child Maltreatment Victims by Stress Level¹³

Kempe Assessment¹⁴	Assessed at low stress	Assessed at moderate stress	Assessed at high stress	Assessed at severe stress	Total families
2004-2005					
N (%)	830 (18%)	2,046 (45%)	1,508 (33%)	125 (3%)	4,509
Free from abuse	99.4%	98.3%	95.7%	91.2%	97.4%
Victims	6/1,000	17/1,000	43/1,000	88/1,000	26/1,000
2005-2006					
N (%)	620 (16.5%)	1,766 (47.1%)	1,270 (33.9%)	94 (2.5%)	3,750
Free from abuse	99.2%	98.2%	96.6%	92.6%	97.7%
Victims	8/1,000	18/1,000	34/1,000	74/1,000	23/1,000
2006-2007					
N (%)	767 (19.1%)	1,846 (46%)	1,309 (32.6%)	90 (2.2%)	4,012
Free from abuse	99.7%	99.3%	96.7%	96.7%	98.5%
Victims	3/1,000	7/1,000	33/1,000	49/1,000	15/1,000

¹³ Statistics describe confirmed reports of child maltreatment for Healthy Families Oregon children aged 0 to 3 years where families have both screening and assessment information. First, families are screened using the New Baby Questionnaire. Families with positive screens who accept intensive service are interviewed by trained assessment workers using the Kempe Family Stress Assessment.

¹⁴ Kempe Family Stress Assessments are rated on a scale of 0 - 100. Low family stress is rated as 0 - 20, moderate family stress as 25 - 35, high family stress as 40 - 60, and severe family stress as 65 or higher.

Kempe Assessment¹⁴	Assessed at low stress	Assessed at moderate stress	Assessed at high stress	Assessed at severe stress	Total families
2007-2008					
N (%)	687 (23.1%)	1,292 (43.4%)	931 (31.3%)	64 (2.2%)	2,974
Free from abuse	99.7%	99.2%	98.0%	100%	99.0%
Victims	3/1,000	8/1,000	20/1,000	0/1,000	10/1,000
2010-2011					
N (%)	511 (25.6%)	663 (33.3%)	708 (35.5%)	111 (5.6%)	1,993
Free from abuse	98.6%	98.8%	93.6%	87.4%	96.3%
Victims	14/1,000	12/1,000	64/1,000	126/1,000	37/1,000
2013-14					
N (%)	430 (21.8%)	643 (32.6%)	782 (39.6%)	119 (6.0%)	1,974
Free from abuse	100%	98.3%	96.9%	86.6%	97.4%
Victims	0/1,000	17/1,000	31/1,000	134/1,000	26/1,000