

OREGON CHILDREN, ADULTS AND FAMILIES

Expert Review of the Safety Intervention System



ACTION For Child Protection

Introduction

Purpose and Objectives

The purpose of this study was to provide an expert review of the Oregon Children, Adults and Families (CAF) safety intervention system in comparison to the state of the art of Child Protective Services (CPS) safety intervention nationally. The state of the art consists of 1) the state of the knowledge base that defines, directs and supports the concept, standards and practice of safety intervention and 2) actual application occurring nationally in case practice. Notably the knowledge base is generally well formed and continuing to evolve while the nature and quality of application lags behind. Simply stated, what is known about safety intervention exceeds what currently is being done in practice.

The objectives of the study included:

- To judge the extent to which components of the safety intervention system provide sufficient guidance and support for staff to perform competently.
- To conduct an expert comparative assessment of system components related to staff self assessment.
- To identify the extent to which the design of the safety intervention system can be considered to be ahead of, consistent with or behind the state of the art.

This study considered the characteristics and sufficiency of the safety intervention system. The study did not evaluate and findings do not reflect the quality of safety intervention case practice and decision-making.

Study Approach

Overview

The study and expert review was designed and conducted primarily through the resources of the National Resource Center for Child Protective Services (NRCCPS.) NRCCPS is federally funded by the US Department of Health and Human Services, Administration for Children and Families Children's Bureau to provide no cost technical assistance to states, counties and tribes. The purpose of the technical assistance is to improve the quality and effectiveness of child welfare services consistent with the standards of the federal Children and Family Services Review (CFSR.)

The NRCCPS provided a total of ten on site days and 15 off site days to complete this study. The limits related to the no cost NRCCPS technical assistance and the need to maintain a tight time line resulted in focusing the study on the CAF safety intervention system. The CAF safety intervention system is considered central to the community

system at large that is invested in protecting children. However, due to the immediacy of needing to address the issue relating to child safety, NRCCPS has purposefully limited the study to the CAF safety system. An expanded study would need to include community leaders and other participants.

A child safety intervention system is defined and formed by seven necessary elements:

- Policy

Rules and regulations form the boundaries within which child safety intervention operates. Policy identifies in specific terms *what* child safety intervention entails, what must be done. Policy assures statutory standards are applied. Policy establishes expectations concerning acceptable practices, decision-making, and time frames. Policy sets forth the philosophy and values that support child safety intervention.

- Procedure

Procedure determines *how* child safety intervention is to be done. Procedures set forth how practice is to occur; how relationships and interactions with clients are to be maintained; what information is to be collected; how decisions are to be made; and when actions and decisions are to occur. Procedures provide methods for completing child safety intervention work and step-by-step guidance for implementing child safety intervention.

- Information System

The information system provides structure for directing child safety intervention and accountability for how child safety intervention is occurring. The information system reveals the picture of the reality of child safety intervention implementation case by case and collectively as a program.

- Staff Development

Staff development, typically in the form of training, prepares staff to implement child safety intervention. Staff development promotes policy and procedure and advances the understanding and application of acceptable child safety intervention practices and decision-making. Staff development occurs as a process of readying staff to assume responsibility for child safety intervention and continues to reinforce the development of competence and mastery.

- Supervision

Supervision assures the effective implementation of child safety intervention. Supervision provides oversight case by case to regulate practice and decision-making and evaluates individual as well as child safety intervention model

performance. Supervision supplies support and guidance to staff through case and general consultation focused on case practice and decision-making and building staff competency. The supervisor serves as the primary authority concerning the interpretation of child safety intervention and approval of actions taken and decisions made.

- Program Management

Program management provides leadership that creates the child safety intervention approach and establishes the necessary structure to carry it out. Program management puts in place the components of the child safety intervention model; promulgates that which gives child safety intervention form and function; generates sufficient resources to effectively implement child safety intervention; and assures the effectiveness of safety management across all cases.

- Quality Assurance

Continuous review and adjustment is a necessary part of assuring the effectiveness and necessary modification of a child safety intervention system. Quality assurance evaluates child safety intervention practice and decision-making against standards that form the child safety intervention model and guide casework practice and decision-making. Quality assurance provides feedback to management in order to control quality, establish benchmarks for competency, and reveal the need for adjustment or enhancement.

The study collected information related to all aspects of the safety intervention system but focused on policy, procedures and training. Expert opinion was framed by the state of the art and fifteen worker competencies that should be expected as evident and applied in an effective safety intervention system. Study limits prevented case practice and case decision making evaluation. Therefore, the study did not result in findings concerned with the actual quality of safety intervention as it is currently occurring.

Methodology

Information collection methods were varied and broad sweeping in order to generate the greatest yield possible given the limits of the study. The methods included:

Guided discussions with:

- Administration
- Governor's Office
- Child Welfare Advisory Committee
- Program Staff
- CIRT Reviewers
- Program Managers

Focus Groups

- Six worker focus groups
- Three supervisor groups
- Total of 69 participants
- Consideration of competencies as embodied in the safety intervention system

Self Assessment Staff Surveys (Total n = 523)

- General Survey (n = 378)
- Certifier Survey (n = 43)
- Social Service Assistant Survey (n = 102)

Expert Review

- Policy
- GAP procedures
- Training curriculum

The expert review considered how policy, procedures and training fit with the state of the art; whether policy, procedure and training were precise and clear in form and function; how cohesive policy, procedure and training were with respect to concepts, structure and application; whether policy, procedure and training were competency based; and whether congruence existed between what policy, procedure and training advanced and what staff perceived to be advanced.

Current State of the Art

The results of this study must be understood within the context of the current state of the art in safety intervention. As formal, structured, defined practice and decision-making, safety intervention began in 1988 following the design and testing of the first national model. While that original work became the influence of all safety models that have followed, the progression during the past fifteen years has been slow.

In 1998, 20% of the states had some version of a safety intervention model. Presently over 90% have models. Predominantly safety intervention models across states focus on initial contact with families with little or no development for practice and decision making as cases proceed further along the child welfare process. Models of safety intervention contain many of the same characteristics and all models include similar criteria (i.e., safety threats.) There are 10 safety threats common to all models.

Generally it can be concluded that states continue to be challenged in understanding the differences between risk of maltreatment and child safety. This is reflected in safety intervention models, policies and training. Policies across most states vary from marginal to limited. The absence of clear, precise and linear guidance in policy is remarkable. The clarity and sophistication of safety intervention tends to diminish as the focus moves toward planning and continuing safety management.

Supervision of safety intervention remains underdeveloped. As is true of all child welfare in safety intervention there is a lack of evidence-based practice concerned with safety assessment and safety planning. The challenge of having better understanding of what works in safety intervention is particularly obvious in areas such as methamphetamine use and domestic violence.

Training in safety intervention mirrors the deficiencies apparent in model integrity, policy, standards, definitions and so forth. Additionally competition for resources has resulted in few and brief training opportunities most of which do not address competency building in any serious manner.

It can be concluded categorically that information systems now in place provide minimal guidance or support for advancing competent safety intervention practice and decision-making.

Workload demand continues to be a defining influence nationally in reducing the effectiveness of all child welfare services including safety intervention. Worker-family contact is among the limited evidence based practice that can be trusted, yet current workload demands in most jurisdictions reduce the opportunity to support this practice.

In summary, safety intervention standards, concepts, definitions and approaches continue to evolve while acceptable implementation (i.e., practice and decision making) remains in question. Notably policy, procedures, guides, supports and training concerned with safety intervention that forms CAF's current approach to safety intervention is comparable in form and function to the state of the art (in particular what is occurring across the country.)

Expert Findings and Observations

Challenges Unique to Oregon

On the whole, the approach to safety intervention in Oregon is more similar to what is occurring nationally than different. The study resulted in a number of specific observations and findings many of which are unique to Oregon or somewhat more apparent than in other states.

■ Methamphetamine

The methamphetamine problem for CPS in Oregon is being experienced similarly by states across the country. How to effectively intervene with respect to managing methamphetamine as a safety threat or treating the user are questions being raised by all CPS agencies. Methamphetamine caregiver use and production sites are likely the most prominent CPS problems of this decade in Oregon, and perhaps nationally.

A paper on resources and emerging strategies will be published within the upcoming months. The National Resource Center for Child Protective Services is currently working on guidelines focused on methamphetamines and safety intervention. The current position that is being advanced is that caregiver methamphetamine use or production represents a present danger to children and present danger or immediate response protocol applies. Oregon's interest in and action toward addressing this growing problem is commendable.

■ Workload Demand

Current national standards for caseloads, some of which are promoted by national organizations, are outdated. Within the past decade workload demand has increased considerably as the caseworker job has become more complex and considerable activities and tasks have been added with nothing taken away. Recent workload studies confirm that current national caseloads standards may be twice what is reasonable to perform competently. Oregon's workload situation is actually beyond these outdated national standards. With caseloads exceeding twenty per worker, it could very well be that workers are being expected to do two to three times what reasonably can be expected given the complexity and demands for each case.

Unique to Oregon is the practice of workers performing duties normally accomplished by attorneys or paralegals. Beyond involving workers in areas outside their profession and for which they likely lack competence, such a practice seriously increases the demand workers experience. This is one area of significance that was noted in this study. It is suggested that worker jobs be evaluated to determine if other duties of a non-casework nature are included in their jobs.

The national standard for supervisor to worker ratio has been one to six for many years and remains as such in most states. Supervisors in Oregon supervise ten or more staff. Considering the numbers of cases each worker carries and the number of workers each supervisor is responsible for, it becomes obvious as to the probability that both case conditions and worker competence may be missed more often than desirable.

The workload demand situation in Oregon exists even though some line positions neither carry cases nor supervise staff (i.e., CETs and SSAs.) While it may be that such positions contribute to safety intervention, the contribution ought to be weighed against the obvious workload demands placed on both workers and supervisors.

■ Local Influence and Determination

Among the most prominent findings in this study was the practice of "localizing" the way things are done in safety intervention. Apparently this local influence and

determination of how things will be done is a longstanding way of conducting business and implementing policy and programs. Staff is clear in indicating that policy, procedure and intervention occur differently across the state. Furthermore they indicate that the most profound influence on their learning and development are their peers, supervisors and “the ways things are done in their office.” The local tradition of interpreting policy and practice has obvious implications for establishing and maintaining a statewide safety intervention model and for assuring consistency in application across jurisdictions.

■ Staff Configuration

Staff roles, responsibilities, assignments and relationships to each other are not systematic – do not contribute to an effective safety intervention system. The connection and interdependence of CPS (investigative) staff to ongoing service staff is not well formed or articulated; ongoing service staff are referred to by various labels some of which are archaic, do not fit or do not describe current functions; roles and relationships between caseworkers and social service assistants are not well defined; responsibilities of social service assistants with respect to safety intervention are unclear; multiple worker roles and involvement with a single case is confusing, such is not clearly defined or understood by staff and communication and responsibilities concerning safety intervention is not self evident.

■ Worker Authority to Remove

The preferred approach to removing children from their caregivers under immediate circumstances as a result of safety threats is law enforcement. There are many practical reasons why this has become the common way of proceeding throughout the country. Sometimes, Oregon child welfare workers remove children independent of law enforcement. This practice is rooted in a time when state statutes as well as the state of the art were less specific and clear about the authority, roles and responsibilities of public child welfare and law enforcement and should be reconsidered.

■ Group Decision Making

Oregon is a leader nationally in encouraging group decision making in child welfare. In particular family team meetings and team decision-making are employed routinely for case planning purposes and related to child removal and child reunification. Many states use variations of these approaches. However, the concept of group decision making, such as referred to here and used in Oregon, have not kept pace with the developing safety intervention state of the art. Standards, criteria and protocol have not been clearly established to guide CPS staff when using a family group meeting or a team for purposes of assessing and managing safety threats. Additionally the *ultimate* responsibility and accountability CPS holds for safety decisions has not been effectively stated and

articulated for staff with respect to use of group decision making options. What exists nationally concerning the absence of rigor regarding safety decision-making and group decision-making models appears to exist in Oregon as well.

■ Legal Custody and In Home

Obtaining legal custody of a child yet allowing the child to remain in his home does occur in states but is very uncommon and is not a regular practice of ensuring protection. When it occurs, there is usually an unusual case circumstance influencing the decision. In most states, in-home safety intervention occurs almost exclusively without court intervention. When conditions within the home or caregiver response is such that an in-home safety plan will not work, then legal custody is sought in order for the child to be placed. Gaining legal custody of a child who then remains home likely suggests to CPS staff that the legal status change is sufficient to protect a child. It is not a guarantee and could lead to a child remaining in a threatening environment. As a safety intervention strategy, this should be re-considered.

■ Threat of Harm

This report has emphasized that a major problem in the CAF safety intervention system is the continuing confusion apparent in concepts, definitions, procedures and practice concerned with risk of maltreatment and safety threats. The concept of *threat of harm* as a category of abuse exists as part of that problem and likely perpetuates it. It is likely in Oregon, as in other places, that threat of harm (as a basis for decision making) is open to multiple interpretations, thus the term allows the worker's decision-making to become less precise and accountable. It should be made clear that threat of harm is consistent with risk of maltreatment but not safety. Threat of substantial harm is more consistent with safety. A family condition that rises to a safety threat must meet the safety threshold, which is qualified by severity.

■ Strengths – Needs Based Intervention

The strengths – needs based philosophy of CPS intervention is among the most popular nationally. Most all states describe themselves as strength based. The movement of the strengths – needs based approach to CPS intervention began just prior to the formalization of safety intervention models. That movement originated from the mental health and family therapy fields. The strengths – needs based approach has contributed in many ways to CPS yet to date the approach has not fully addressed crucial aspects of CPS responsibility – namely, intervening with an involuntary client population; assessing and managing safety threats; and exerting necessary authority to assure child protection.

There is no question that effective safety intervention can occur within a strengths – needs based approach but better articulation of how that can be done remains

incomplete. This appears to be the case in Oregon too. It can be noted that the strengths – needs based philosophy has been emphasized in Oregon for some time; in effect much longer than the Guided Assessment Process concerned with safety intervention. Examining how these two endeavors fit and compliment each other is crucial to enhancing the safety intervention system.

Oregon Safety System Components

Policy

CAF policy concerned with safety intervention is among the better that can be found across states. This is so because it contains specific focus and emphasis on safety intervention, more so than is often observable. It attempts to provide a conceptual base and definitions. It is similar to most policies through its concentration on the beginning of safety intervention (i.e. initial case contact and the first week of intervention.) Many of the shortcomings in CAF policy are observable in policies across the country most notably the confusion between risk of maltreatment (i.e., threats of harm) and child safety (i.e., threats of severe harm.)

CAF policy is not constructed in a linear manner that provides staff step-by-step guidance concerning what is expected. Policy does not provide a seamless way of guiding staff through the safety intervention process. Policy is confusing. There are language inconsistencies and variation in quality and use of definitions. Frequently in order to understand what is required, more than one policy must be read. Policy is written in such a way that reader expertise is assumed. This is particularly problematic given that such large numbers of staff have less than a year of experience.

Safety language and terms are very inconsistent. Consistent with policies throughout the country there are no clear expectations about safety after initial contact. Policy lacks a conceptual framework for safety. There is inconsistent and somewhat cursory attention to safety assessment and safety planning. Policy is generally silent regarding ongoing safety intervention as policies everywhere in the nation are. Many procedures that should be formal, precise and consistent regulation are apparently left to local offices. Expectations regarding supervisory involvement most often are absent.

Most staff participating in the study did not believe that policy supports and guides competency based safety intervention. Staff considers policy to be disorganized and lacking cohesion. Staff expressed concern about access, what is current, variation in interpretation and shifts in conceptual thinking. Dissemination problems seem to be significant. The experts agree with the staff opinion.

Procedure

Oregon is among very few states that have designed more highly developed safety intervention models containing a conceptual base; definition of terms; identification,

categorization and description of safety threats. However, like other models the CAF Guided Assessment Process (GAP) emphasizes receipt of the report and initial intervention but does not guide safety intervention deeper into the child protection process. GAP is generally well thought of by staff and the attention given to implementing it has promoted among staff a sense of the importance of assessing and addressing threats to child safety. GAP represents a good foundation for establishing a more effective approach to safety intervention that is comprehensive, clear and provides sufficient direction throughout the child protection process.

GAP provides some direction about what must be considered in safety intervention but is limited on how to use and apply concepts and intervention expectations. There seems to be an assumption that identifying concepts or expectations is sufficient without providing specific direction and guidance about how things are to be done which fundamentally is the purpose of procedures. GAP lacks precision, which is critical when giving direction to staff about how to conduct safety intervention. For example, safety threats are the criteria that are used to complete safety assessments and are the cornerstone of a safety intervention model. GAP safety threat definitions lack precision and some safety threats are mis-categorized. GAP contains no information standards. "Information standards" refers to case and family information that is expected to be collected in order to conduct safety assessments. GAP lacks sufficient definition and guidance for safety plans. Similar to policy GAP lacks an explanation of safety intervention throughout the child protection process.

Most staff surveyed do not believe that GAP provides sufficient support and guidance to direct competency based safety intervention. Staff perception and opinion concerning GAP appear more related to how it is implemented than in its effectiveness. While the expert review cannot comment on implementation, the expert opinion of GAP is that it can be improved to more effectively establish how safety intervention is to occur in Oregon.

Staff Development

Effective safety intervention systems will contain ways to prepare staff prior to being assigned cases and will provide continuing learning and skill development opportunities to build competency. Consistent with the state of the art CAF provides topical training generally related to safety intervention but does not maintain a well planned out, sequential staff development program. Like other states, Oregon provides classroom training to staff in modules that emphasize knowledge over skill and can be considered introductory at best.

When considered in total, training curricula reviewed does not provide a step-by-step, process-oriented explanation of safety intervention. Curricula does not provide an overview of safety intervention at large or the specifics of exactly what workers are expected to do from the onset of intervention to its conclusion. Like policy and procedure, training is stronger at voicing what to do rather than how to do it. Some training perpetuates confusion regarding concepts and definitions. Often there is a

superficial coverage of key concepts terms, definitions, purpose and structure. Frequently the concepts of risk and safety are mixed and left unqualified. Virtually all curricula emphasizes the importance of safety intervention but falls short of providing clear direction and skill building concerning how it is to be done. Training programs are too short and, therefore do not include rigorous skill development opportunities. There is no curriculum for supervisors specifically addressing their distinct responsibilities in overseeing safety intervention.

Most staff surveyed do not believe that training guides and supports competent safety intervention. Trainers are not viewed as experts. A systematic and comprehensive staff development process does not exist with respect to preparing staff prior to assignment and continuing to build competence routinely over time.

Supervision

Traditionally supervision has been viewed as the best resource for advancing and regulating competent case practice and decision-making. Despite this perception the state of the art concerned with supervisory responsibilities concerned with safety intervention is largely undeveloped. Nationally supervisors receive limited training and direction concerning their role in safety intervention and specific supervisory skills necessary to guide and oversee safety intervention. It is likely that many supervisors across the country are experts in child welfare services and in safety intervention. However, expertise in this position over all is challengeable. It is common to find inexperienced, untrained personnel filling these positions. Furthermore it must be understood that supervisors struggle to be expert in an area of work (i.e. safety intervention) as it is evolving.

It can be concluded that in Oregon supervision is relied on as the most significant influence in safety intervention. Higher numbers of staff consider supervision as the best source of guidance and support for competent safety intervention compared to other safety intervention system components (such as policy or procedures.) Appropriately, staff surveyed believe that supervisors should be experts. However, given the problems across the safety intervention system it is likely that many supervisors are not expert in safety intervention. Since improvement is needed across the entire safety intervention system, it unrealistic to draw conclusions about supervisory expertise. Reportedly supervisory guidance and interpretation vary across supervisors. Workload demand clearly has a negative influence on effective supervision. For instance supervisors report an inability to maintain scheduled conferences due to the workload demand.

Information System

Most information systems across the country were built or were being built as safety intervention began its early development. Therefore information systems generally do not provide sufficient direction and support to guide safety intervention. Some of the problems that are a part of the state of the art and the application of the state of the art, such as confusion over risk and safety, are apparent in information systems too.

Generally speaking information systems do not provide prompts that carry workers along a safety intervention process. As is true of safety intervention models nationally, information systems also have little to provide related to ongoing safety management that occurs to the end of case involvement.

Most of the staff surveyed do not believe that the information system supports and guides competent practice and decision-making. The information system does not support supervision or guide casework and does not contribute to understanding case practice and decision making in a qualitative way. Like policy the information system does not set forth what kind of case information is necessary in order to assess and analyze safety threats and adequately create safety plans. The information system does not advance competency-based intervention. These observations are consistent with what one is likely to see in any state CPS information system.

Program Management

Program management is responsible for providing leadership that supports and guides the safety intervention system. Additionally program management assures that the interface between the agency's safety intervention system and the larger community system is effective. Program management is responsible for resource development and utilization and assures the quality and effectiveness of safety intervention generally. Nationally the role and responsibility for program management with respect to safety intervention has not been well developed. The kind of leadership and the necessary expertise associated with safety intervention for program management remains unstated.

Most of the staff surveyed did not consider field program managers as providing sufficient support and guidance for safety intervention. Accessibility and availability of program management appears to be the greatest concern, which likely is related to workload.

Quality Assurance

The federal Children and Family Service Review evaluates whether state quality assurance systems meet standards. Oregon's passed the review, as did most states. Quality assurance systems have come into being across the country since the early 1990's. These evaluation systems typically judge compliance with policy. For the most part quality assurance systems everywhere do not evaluate quality of practice and decision-making. Additionally these systems have been constructed during the same time that safety intervention models were being developed. Therefore, little is contained within quality assurance systems to consider the quality and outcomes of safety intervention.

Quality assurance was viewed by all the staff surveyed as having the least influence on guiding and supporting competent safety intervention. It is not clear that those who conduct quality assurance reviews are expert in judging safety intervention. Quality

assurance does not result in evaluation of the quality of case practice and decision making concerned with safety intervention. Oregon's quality assurance system is consistent with what one finds in other states.

Recommended Safety Intervention System Improvement Actions

The following are actions that NRCCPS recommends Oregon undertake to improve the safety intervention system. Many of these can be accomplished concurrently and are not listed in order of priority.

- DHS should build upon the Guided Assessment Process to develop a unified model of practice that emphasizes safety throughout a child welfare case.
- DHS should develop a procedures manual with revised policy that is clear, precise, and provides step-by-step direction.
- Statewide training based on the revised policy should be required for all child welfare staff and should replace the existing core training for new child welfare staff. Emphasis given to developing supervisors as safety intervention experts should receive priority.
- DHS should seek legal representation and paralegal support to remove non-casework tasks from the child welfare worker. Additionally, other non-casework tasks currently assigned to child welfare workers should be identified and removed.
- The existing child welfare information system should be replaced with one that is SACWIS compliant and that provides sufficient guidance and support for safety intervention.
- DHS should reconsider worker authority and responsibility to make emergency removals of children and the practice of DHS receiving legal custody of children without removal from the home.
- The state should reconsider the statutory term "threat of harm." The term lacks precision and can be applied too broadly.
- The state should reconsider the requirement of Family Decision Meetings (FDMs). The requirement must be consistent with the primary concern for child safety.
- The state must address the critical child welfare system workload. Caseload sizes and supervisor-to-caseworker ratios exceed even outdated national standards and significantly compromise the safety response capacity.

Conclusion

The Oregon – CAF safety intervention system is comparable to the state of the art as it is applied; to what is happening in other states. Some aspects of the Oregon – CAF safety intervention system demonstrate expectations and emphasis beyond what one normally observes. Other aspects of what is happening in safety intervention in Oregon fall short of the norm. However, on the whole the approach to safety intervention in Oregon is more similar to what is occurring nationally than different.

The work that has occurred in establishing safety intervention in Oregon to date represents a good foundation. The challenge is for Oregon to move more toward the national standards in critical areas of child safety by enhancing what exists rather than by creating an entirely new system. The less complicated areas for improvement are policy and procedure. The more complicated areas for improvement are: establishing an effective staff development program; enabling supervisors to become experts; articulating the role of program management in safety intervention; modifying the information system to support and guide safety intervention; and refining the approach to quality assurance to address actual practice and decision making quality. However, the most profound challenge will likely be assuring that once the safety intervention system has been improved, sufficient opportunity exists for staff to implement the system the way it is designed. This refers to balancing workload demand with workload capacity.

Appendix

The experts in the study were Wayne Holder and Therese Roe Lund.

Wayne Holder, MSW is the Executive Director of ACTION for Child Protection (ACTION.) He is considered by many to be a pioneer in the child welfare field having been instrumental in many significant developments such as risk assessment, safety intervention, workload management and CPS decision making. Much of what he has produced establishes benchmarks for continuing state of the art evolution; for current models of practice and as a continuing influence on thinking and planning in agencies across the nation. He serves as Project Advisor and Senior Consultant for the NRCCPS. He has 38 years experience in child welfare services 27 of which has been as a national consultant. Formerly he was the Director of the Children's Division with American Humane Association and served as the Director of the National Center on Child Maltreatment. He has published many articles and books. He designed the first: consensus risk assessment model; safety assessment protocol; and CPS certification training program in the country. He has authored over 50 curricula. He has designed practice and decision making models for CPS, foster care and adoption.

Therese Roe Lund, MSSW is the Director of Program and Staff Development for ACTION and Associate Director for NRCCPS. She served as Senior Staff Associate for the past several years with the National Center on Child Maltreatment. Her experience delivering technical assistance and training to states, counties and tribes is extensive. She has managed child welfare services at both the county and state level. She has 27 years experience in child welfare services including caseworker, supervisor, program director, county director and state policy director. She designed and implemented child welfare reform in Milwaukee, WI completing the establishment of that agency as an entirely new entity in 1998.

ACTION for Child Protection, Inc. is a private non profit 501C3 organization. Founded in 1985, ACTION's executive offices are in Albuquerque, NM and its business headquarters are in Charlotte, NC. ACTION is the parent organization for the National Resource Center for Child Protective Services. A statement and review of ACTION experience is available on www.actionchildprotection.org under "Capacity."