



# Signs of Safety Comprehensive Briefing Paper

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## **The Signs of Safety® Child Protection Approach and Framework: Comprehensive Briefing Paper**

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3rd edition

### **Most significant updates in the 3rd edition:**

- New outcome and data information in chapter 5
- Entirely new Chapters 9 and 10 on implementation and leadership.

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The Signs of Safety is an evolving approach, which means that this briefing paper needs to be constantly updated to capture changes in practice, in thinking and in research. The latest version of this briefing paper can always be found at [www.signsofsafety.net](http://www.signsofsafety.net).

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### **Cover artwork: Katrina Etherington**

The cover artwork was created with pencil, paint and photography by West Australian Social Worker, Katrina Etherington. The picture uses images of Nicki Weld's Three Houses and Susie Essex's Family Safety Circles tools to create an image representing the complexity and richness of engaging a family in the Signs of Safety practice.

VERSION 3.1

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## Introduction: A Constantly Evolving Approach

The Signs of Safety approach to child protection casework is widely recognised internationally as the leading available progressive approach to child protection casework. Although the approach has been developing since Steve Edwards and Andrew Turnell began to collaborate in the late 1980s, the last six years have seen an explosion of interest and engagement with the approach all around the world. This momentum has come about because the Signs of Safety approach is first and foremost grounded in, and continues to evolve from, what works for the frontline practitioner. Currently there are nearly 200 agencies in 13 countries undertaking some form of implementation of the Signs of Safety. This includes large-scale, long-term, system-wide implementations in Australia, New Zealand, Japan, Europe, Canada and the USA.

To be effective, child protection services must be structured and systematic in their organisational and casework responses to child maltreatment. Anyone who was influenced by the open, almost anything-goes arrangements in place in the 1970s knows that, while there was extraordinarily good child protection work happening at that time, correspondingly appalling work was occurring as well. Since the 1970s, as the poorest organisational and casework practices were increasingly exposed through critical case reviews and death inquiries, proceduralisation and audit have become the dominant mechanisms for reforming child protection practice around the world. (Ferguson, 2004, 2013; Munro, 2004, 2010, 2011.) Unfortunately, proceduralisation has not created the transformation that was hoped for. The following words from the US government's 1991 National Commission on Children are probably truer today than they were when penned:

**“If the nation had deliberately designed a system that would frustrate the professionals who staff it, anger the public who finance it, and abandon the children who depend on it, it could not have not done a better job than the present child welfare system.”**

(Cited in Thompson, 1995: p. 5.)

Framing the child protection task primarily as a procedural challenge has led almost universally to systems across the developed world becoming increasingly expensive and defensive, with rapidly escalating numbers of children in care for longer periods, increasing numbers of parents being taken to court, and increasing staff turnover, alongside decreasing staff morale. (This should not be taken to mean that rates of actual child abuse have increased in these countries. Determining that is a much harder analysis.) The Sacramento Grand Jury (2010), inquiring into child protection services in Sacramento County, released a report entitled *Child Protective Services: Nothing Ever Changes—Ever*. While that title appears pessimistic, it is actually very easy to mount an argument that it is actually 'Pollyanna-ish'. The reality is that almost all child protection jurisdictions everywhere in the developed world have indeed changed - they have all become worse!

The expanding international Signs of Safety community of agencies and professionals has taken a different route to reform child protection practice. The change strategy that animates the Signs of Safety, in its model development as well as its pursuit of improved outcomes, is to ground the evolution of the approach in what actually works for workers and service recipients in everyday practice. The Signs of Safety approach has been created on the shoulders of giants. Those giants are the frontline practitioners from all over the world who have taken up the Signs of Safety approach and then made a conscious commitment to describe what they are doing, what they are struggling with and, most importantly, what is working for them. This is the collaborative, appreciative inquiry method that is the driving force behind the ongoing evolution of the Signs of Safety approach.

As a named entity, the Signs of Safety is now 20 years old. It is a mature and yet evolving professional approach. The practice approach and its methods continue to grow in their acuity and applicability across the entire continuum from intake and assessment to closure, within alternative care and permanency work and across the full spectrum of abuse profiles, complicating factors and populations that child protection work encompasses. The following are five of the most notable changes that have occurred within the Signs of Safety since the release of Turnell's and Edwards' 1999 book.

- Creating a second, more widely used three-column version of the Signs of Safety risk assessment and planning framework. (Turnell, 2009.)
- Evolving and locating rigorous risk assessment process at the heart of the Signs of Safety practice framework. (Turnell, 2009.)
- Creating and evolving numerous straightforward tools to place the child's voice at the centre of Signs of Safety practice, which involves children directly in assessment and planning. (Turnell and Essex, 2006; 2013; Turnell, 2011; Weld, 2008.)
- Integrating and refining much more rigorous and systematic collaborative safety planning processes and tools. (Turnell and Essex, 2006, 2013; Turnell, 2010, 2013.)
- Evolving and integrating appreciative inquiry processes for learning what works for frontline practitioners.

Alongside these changes, major companion developments are underway growing the applicability of the Signs of Safety practice model in all child protection agencies and contexts. The most important of these are:

- Supporting research and evidence base
- Formalising the practice model for research, practice and training purposes
- Standardising training programmes and arrangements
- Formalising organisational leadership and implementation processes that enable optimal use of the approach in practice. (Turnell, Munro and Murphy, 2013.)

This third edition of the Signs of Safety Briefing Paper offers a comprehensive overview of the Signs of Safety approach and its underpinning theory, as well as detailing the research and implementation science that supports it. Chapter one begins by underlining what the whole endeavour is about: child safety. Chapter two locates the Signs of Safety within its values base by exploring the three core organising principles of the model. Chapter three offers a brief history of the Signs of Safety to provide context of how and why the model was created. Chapter four details the international use of the approach together with the evidence base that supports it. Chapter five goes to the heart of the Signs of Safety practice framework describing how it frames and undertakes the core child protection task of risk assessment and planning. Chapter six identifies the practice disciplines that are required to use the Signs of Safety collaboratively with parents and children. Chapter seven looks at the tools the approach draws upon to locate children in the middle of the practice. Chapter eight looks at safety planning, which is the crux of the approach and of all child protection work. The final two chapters focus on organisational culture leadership and structures that support implementation of the Signs of Safety approach.

Like the model, this briefing paper continues to evolve and is regularly updated. These updates are available at <http://www.signsofsafety.net/>.

## 1 Safety Organised Practice – The Goal is Always Child Safety

One of the biggest problems that bedevils child protection work, identified in many child death inquiries, is the Tower of Babel problem, where participants in the child protection process are effectively speaking a different language. (Munro, 2002; Reder, Duncan and Gray, 1993.) The Signs of Safety framework is designed to create a shared focus and understanding among all stakeholders in child protection cases, both professional and family. It is designed to help everyone think their way into and through the case from the 'biggest' person (such as a CEO, judge or child psychiatrist) to the 'smallest' person (the child).

However, completing the Signs of Safety assessment and planning process is only a means to an end, even when it is done collaboratively between the parents and children and all the professionals involved in the case. Large child protection systems, with their bureaucratic tendencies, can often get means and ends confused, and thus the completion of assessment documents can become a highly prized, over-valued performance indicator. While consistency of assessment is a critical factor in good outcomes in child protection casework, it does not, in and of itself, equate to on-the-ground child safety.

Completing the Signs of Safety assessment and planning is simply a process of creating a map of the circumstances surrounding a vulnerable child. As with all maps, the Signs of Safety map needs always to be seen as a mechanism to arrive at a destination. That destination is rigorous, sustainable, everyday child safety in the actual home and in other places where the child lives their daily life.

The Signs of Safety approach provides principles, disciplines and fit-for-purpose tools that equip practitioners and supervisors to build observable everyday safety for children, together with parents and their naturally connected networks. Alongside this, because the Signs of Safety focuses closely on what is actually decided and done in practice, this creates a context where organisational leadership can access practice and decision-making itself, and thus more closely analyse and shape the organisational arrangements that strengthen or inhibit good practice. In this way, Signs of Safety grows whole-of-agency acuity to the realities of frontline practice, which better enables the organisation and its leaders to improve safety and outcomes for vulnerable children.

## 2 Three Core Principles of Signs of Safety

Child protection practice and culture tend toward paternalism. This occurs whenever professionals adopt the position that they believe they know what is wrong in the lives of service recipient families and they know what the solutions are to those problems. A culture of paternalism can be seen as the 'default' setting of child protection practice. This is a culture that both disenfranchises the families that child protection agencies work with and exhausts the frontline professionals that staff them.

The Signs of Safety approach seeks to create a more constructive culture around child protection organisation and practice. Central to this is the use of specific practice tools and processes where professionals and families members can engage with each other in partnership to address situations of child abuse and maltreatment. Three principles underpin the Signs of Safety approach.



## 2.1 Working relationships

Constructive working relationships between professionals and family members, and between professionals themselves, is the heart and soul of effective practice in responding to situations where children suffer abuse. A significant body of writing and research suggests that best outcomes for vulnerable children are achieved when constructive relationships exist in both these arenas. (Cashmore, 2002; de Boer and Coady, 2007; Department of Health, 1995; Lee and Ayón, 2004; MacKinnon, 1998; Maiter, et. al., 2006; Trotter, 2002 and 2006). Research with parents and children who have been through the child protection system delivers the same finding. (Cashmore, 2002; Cossar, 2011; Farmer & Owen, 1995; Forrester et.al., 2008a, 2008b; Jensen et. al., 2005; Teoh et al., 2004; Westcott & Davies, 1996; Woolfson et.al., 2010; Yatchmenoff, 2005.)

It takes only a few moments reflection to grasp the truth that relationships are the bedrock of human change and growth, but this reality makes many very nervous in the fraught domain of child protection. The concern is that when a practitioner builds a positive relationship with abusive parents, that professional will then begin to overlook or minimise the seriousness of the abuse. The literature describes such relationships as 'naïve' (Dingwall, 1983) or 'dangerous' (Dale et. al., 1986; Calder, 2008).

While concerns about a relationship focus in child protection practice usually centre on working with parents, relationships between professionals themselves can be equally, if not more, problematic. Child death inquiries consistently describe scenarios where professional relationships and communication are dysfunctional. Meta-analyses of child death inquiries, such as those by the Department of Health (2002), Munro (1996 and 1998), Hill (1990), and Reder, Duncan & Grey (1993), reveal that poorly functioning professional relationships are as concerning as any situation in which a worker overlooks or minimizes abusive behaviour in an endeavour to maintain a relationship with a parent.

Any approach to child protection practice that seeks to locate working relationships at the heart of the business needs to do so through a critical examination of what constructive child protection relationships actually look like in practice. Too often, proponents of relationship-grounded, child protection practice have articulated visions of partnership with families and collaboration amongst professionals that are overly simplistic. To be meaningful, it is crucial that descriptions of child protection working relationships closely reflect the typically messy lived experience of the workers, parents, children and other professionals who are doing the difficult business of relating to each other in contested child protection contexts.

## 2.2 Munro's maxim: thinking critically, fostering a stance of inquiry

In the contested and anxious environment of child protection casework, the paternalistic impulse to establish the truth of any given situation is a constant. As Baistow suggests:

**“Whether or not we think there are absolute perpetrators and absolute victims in child abuse cases, and whether or not we believe in a single uncontaminated ‘truth’ about ‘what happened’, powerful forces pull us towards enacting a script, which offers us these parts and these endings.”**

(Baistow et. al., 1995: vi.)

The difficulty is that as soon as the professional decides they know the truth about a given situation, this begins to fracture working relationships with other professionals and family members, all of whom very likely hold different positions. Moreover, the professional ceases to think critically and tends to exclude or reinterpret any additional information that does not conform to their original position (English, 1996).

Eileen Munro, who is internationally recognised for her work in researching typical errors of practice and reasoning in child protection (Munro, 1996, 1998), states:

**“The single most important factor in minimizing errors (in child protection practice) is to admit that you may be wrong.”**

(Munro, 2008: p.125.)<sup>1</sup>

Restraining an individual's natural urge to be definitive and to colonise one particular view of the truth is the constant challenge to the practice leader in the child protection field. Enacting Munro's maxim requires that all organisational, policy and supervisory processes that support and inform practice foster a questioning approach or a spirit of inquiry as the core professional stance of the child protection practitioner.

## 2.3 Landing grand aspirations in everyday practice

Just about everybody, from taxi drivers to parliamentarians, wants to tell child protection workers how to do their job. The problem is that most of these people have never knocked on a door to deliver a child abuse allegation to a parent and most of the advice comes across like ‘voices from twenty-seven thousand feet’<sup>2</sup>.

In an exact parallel to the all-knowing way a paternalistic frontline practitioner approaches a family, supervisors, academics and head office managers have a proclivity to try to impose their views on the frontline practice practitioner. At all levels this is ‘command and control social work’<sup>3</sup> and it rarely delivers a constructive outcome. This command and control approach alienates those at the frontline and erases the notion and expression of their wisdom and knowledge. Seeking to antidote this problem, the Signs of Safety approach to child protection practice has been developed hand-in-hand with practitioners, first in Western Australia and then in North America, Europe, Australasia and Japan. In every location the approach has developed more rigour, more skilfulness and greater depth of thinking by finding and documenting practitioner and service recipient descriptions of what on-the-ground good practice with complex and challenging cases looks, smells and lives like.

<sup>1</sup> *Italicised text added for contextual clarity.*

<sup>2</sup> *This is an expression used by Russell Martin, Director of Open Homes Foundation New Zealand.*

<sup>3</sup> *An expression coined by another New Zealander, former Child Youth and Family Chief Social Worker, Craig Smith.*

## 3 History: How Signs of Safety Evolved

The Signs of Safety approach to child protection casework was developed through the 1990s in Western Australia. The approach was created by Steve Edwards and Andrew Turnell in collaboration with over 150 West Australian child protection workers and is now being utilised across 15 countries in Europe, North America and Australasia.



Signs of Safety Approach to Child Protection Casework—illustration by Mary Brake

The impetus to create the Signs of Safety approach arose from Steve Edwards' experience of 16 years as a frontline statutory child protection practitioner, eight of these working primarily with Aboriginal communities. Edwards was very dissatisfied with most of the models and theory regarding child protection practice that he encountered. He felt that most of the policy, guidance and books he read, and most of what he learnt at university and in training (essentially the theory), had little correspondence with his experience of actually doing child protection work (undertaking investigations, deciding when and how to remove children, working with wards of the state, dealing with angry parents, etc.).

As a result of this, throughout his child protection career, Edwards always sought out new ideas that might better describe and capture his experience of practice. In 1989 Edwards and Turnell began to collaborate after Edwards became interested in the brief therapy work Turnell was doing with families referred to a non-government counselling agency by the then Department of Community Welfare. Each week, for more than three years, Edwards would observe the brief therapy work from behind a one-way mirror and then began to apply these solution-focused and problem resolution brief therapy ideas and techniques (Berg, 1994; de Shazer, 1984, 1985, 1988, 1991; Weakland and Jordan, 1990; Watzlawick et.al., 1974) into his practice as a child protection worker.

Edwards' and Turnell's collaboration, and Edwards' use of the brief therapy ideas in his own child protection practice between 1989 and 1993, were the beginnings of the Signs of Safety approach. In 1993 Edwards and Turnell began the process of working with other child protection practitioners, training them in what they had learnt from the previous three years of collaboration. Between 1994 and 2000, Edwards and Turnell led eight separate six-month projects with over 150 West Australian practitioners.

During this first seven years, the initial formulation of the Signs of Safety approach to child protection practice evolved and was refined. During the first month of each six-month training and action-learning project, Edwards and Turnell would provide five days training in the Signs of Safety approach, as it had evolved and was then articulated. The project groups usually comprised 15 to 20 workers, but sometimes involved considerably more. The initial five-day training was grounded in practice and would always involve other workers who had used the approach describing their experiences to the current group of trainees.

Following this initial training, each six-month project shifted into action learning mode. (Marquardt and Yeo, 2012; Revans, 1998.) Edwards and Turnell would spend at least one day a month with the workers looking closely at where they had been using the approach and where it had made a difference, as well as exploring and helping with cases in which the practitioners were stuck. By focusing on where workers were using the approach and making progress in the case, Turnell, Edwards and the participants learnt directly from the practitioners themselves about where, when and how they were actually able to successfully make use of the Signs of Safety approach. Edwards had always insisted that only ideas, skills and practices that workers actually used would be included in the Signs of Safety model. This collaborative, action-learning process used in all follow-up sessions was the basis of what Turnell has come to describe as 'building a culture of appreciative inquiry around frontline practice'. (Turnell, 2006a, 2007a and 2007b.) This is the core practice and organisational change strategy underpinning the Signs of Safety approach and is explored in greater detail in chapter 10.

Edwards and Turnell brought two publications to press which directly describe the West Australian 1990s period of the evolution of the Signs of Safety approach. (Turnell and Edwards, 1997, 1999.)

## 4 International Use and Data

### 4.1 International use

Since the 1999 publication of Turnell's and Edwards' Signs of Safety book, international interest in the approach has grown steadily. Turnell has undertaken a considerable amount of international work providing training and consultancy since 2000 and there are now licensed trainers and consultants well equipped to lead and train the Signs of Safety approach in Europe, the United Kingdom, North America, Japan, Australia and New Zealand. By this process tens of thousands of child protection practitioners have been trained in Finland, Sweden, Denmark, Austria, Belgium, The Netherlands, France, the United Kingdom, Canada, the USA, Japan, Australia and New Zealand. There are sustained implementations of the Signs of Safety being undertaken in about 200 jurisdictions and agencies in these countries. More information is available at [www.signsofsafety.net](http://www.signsofsafety.net).

During this period, the Signs of Safety model has continued to evolve as it has been applied and utilised in many countries, across all aspects of the child protection task, and as it has been consistently used in increasingly higher risk cases. (BJZD, 2013; Bunn, 2013; Chapman and Field, 2007; Fleming, 1998; Hogg and Wheeler, 2004; Gardestrom, 2006; Lohrbach and Sawyer, 2004; Inoue et. al., 2006a; Inoue et. al., 2006b; Inoue and Inoue, 2008; Jack, 2005; Keddell, 2014; Koziolok, 2007; Lwin et.al., 2014; Myers, 2005; Shennan, 2006; Simmons, Lehman and Duguay, 2008; Turnell, 2004, 2006a, 2006b 2007a, 2007b, 2008, 2009a, 2009b, 2011, 2013; Turnell, Elliott and Hogg, 2007; Turnell and Essex, 2006, 2013; Turnell, Lohrbach and Curran, 2008; Turnell, Vesterhauge-Petersen and Vesterhauge-Petersen, 2013; Weld, 2008; Westbrock, 2006; Wheeler, Hogg and Fegan, 2006.)

The Signs of Safety approach has also been used as the organising framework within collaborative conferencing procedures in numerous jurisdictions. (See Appleton et.al., 2014; Christianson and Maloney, 2006; DCP, 2009, 2011; Lohrbach and Sawyer, 2004a, 2004b; Lohrbach et. al., 2005; West Berkshire Council, 2008.)

### 4.2 Current major international research initiatives

The research and evidence base supporting the Signs of Safety during the 1990s and 2000s, while compelling, is derived primarily from data from implementing agencies and jurisdictions. While this is important evidence, the approach requires an independent research foundation and evidence base to enable it to maximise its potential to reform child protection practice and organisation and to further grow the model.

Two important international research efforts are currently underway to secure a strong evidence base from which to continue building the Signs of Safety and to support practitioners and agencies using the approach. These initiatives are focused on results logic and fidelity.

#### 4.2.1 Results logic

The Western Australian Department for Child Protection and Family Support (CPFS) has commissioned comprehensive independent research of the Signs of Safety implementation and outcomes through the Australian Centre for Child Protection (ACCP) at the University of South Australia. Dr Mary Salveron is the post-doctoral research fellow for this project and Associate Professor Leah Bromfield is the project director. Further description of this work is provided in the Western Australian section below. Central to the research project is the development of a Signs of Safety theory of change and results logic.

A results or programme logic formalises what the Signs of Safety actually is and how it works for research purposes. (For more information see <http://www.theory-of-change.org/what-is-theory-of-change/>.) Defining what the model is provides the foundation for establishing a robust evidence base regarding the impact and the extent to which the Signs of Safety approach delivers reliable improvements and outcomes. (Bromfield et.al., 2014.) Once completed in 2014, the results logic will be available for information and for use in all international Signs of Safety research initiatives.

The ACCP is already collaborating with research projects being established in other countries — particularly The Netherlands, Canada and England — to enable them to use the results logic work in their research endeavours.

#### **4.2.2 Fidelity research**

Once the Signs of Safety model is defined for research purposes, the next question that inevitably follows is “Are the agency, the practitioner, supervisors, managers and leadership doing it right?” This is the core question of fidelity. Before it is possible to determine the effectiveness of a service or intervention, it is essential to make sure it was implemented or completed as directed, by qualified professionals and/or according to the required protocols. For more information about fidelity research, go to <http://www.yftipa.org/pages/what-is-fidelity>.

Drawing on the expertise, vision and leadership of Casey Family Programs (CFP) in the USA, the Signs of Safety Fidelity Research Project began in mid-2012. The project has been established to create a series of validated assessment tools that will enable agencies to evaluate in real-time the fidelity of Signs of Safety practice of workers, supervisors, leadership and the supporting organisational climate. The project will also incorporate a parent’s fidelity tool to provide real-time feedback from parents about their experience of the approach from the receiving end. Measuring how well and to what degree the Signs of Safety approach is implemented is critical to facilitating improvements in quality and effectiveness, ensuring accountability, and reflecting progress toward attaining the shared goals of providers, individuals, and families served within the system.

The fidelity project working group is being co-ordinated by Professor Peter Pecora, CFP, Managing Director of Research Services, with Mike Caslor from Manitoba, Canada, taking the lead for the Signs of Safety community. Eric Bruns from the University of Washington and Professor Eileen Munro are serving as project advisors. The fidelity project and the tools that will arise from it are being developed with the active participation of child protection agencies in the USA, Canada, The Netherlands, England and Australia.

For more information on both the results logic and fidelity initiatives, see <http://www.signsofsafety.net/signs-of-safety-research/>.

### **4.3 Evidence base / supporting data**

#### **4.3.1 Professional identity and job satisfaction**

In the 1990s Andrew Turnell and Steve Edwards undertook two follow-up studies, with participants in the first two six-month Signs of Safety development groups, focused on professional identity and job satisfaction. Participants rated their sense of professional identity and job satisfaction as frontline child protection workers at the beginning and end of the six-month project and then again in a follow-up survey 12 months after the completion of the six-month project. These studies involved 31 participants and showed an almost two point increase average (on a ten point scale) in the workers’ sense of professional identity and job satisfaction over the 18 months from project commencement to 12-month follow-up. While

this was a low key and informal study of workers' experiences, the same findings are reflected in all the jurisdictions where the Signs of Safety approach has been applied systematically. Two separate worker and supervisor descriptions of the impact of using the Signs of Safety can be found in Turnell, Elliott and Hogg (2007) and Turnell, Lohrbach and Curran (2008). A video interview of 15 crisis, investigative, long-term and treatment child protection staff from Carver County, Minnesota, in which the staff describe their experience of the approach and its impact on their practice and experience of the role, can be found at <http://www.signsofsafety.net/briefing-paper-resources/>. Systems that implement the Signs of Safety consistently find increased worker morale and job satisfaction. In particular, see information from Minnesota, Western Australia, Drenthe in The Netherlands, and Copenhagen presented below.

### 4.3.2 Case and system change data

#### Western Australia

Until the Canadian province of Alberta formally began its implementation in early 2014, the Department for Child Protection and Family Support (CPFS) in Western Australia was undertaking the largest system-wide implementation of the Signs of Safety. CPFS serves a state of 2.5 million people that covers one third of Australia's landmass, stretching almost 4000 kilometres from north to south. The agency employs over 2300 staff. While the Signs of Safety approach was created in Western Australia in the 1990s, the approach was not adopted as CPFS's child protection assessment and practice framework until 2008. The following outcome data has been gathered through internal and external evaluation.

The number of children in care across Australia almost doubled between 2000 and 2010. The average increase being 9.7 percent each year. (Lamont, 2011.) The rate of increase in the Western Australian system was above the average in the four years to 2007, running at 13.5 percent. With the implementation of the Signs of Safety, that rate has been cut to an average of 5 percent between 2009 to 2013 (just a little above the population growth rate of 4.4 percent). Alongside this, the percentage of child protection assessments that have been referred to intensive family support has almost tripled, increasing from 1411 in 2009 to 4558 in 2013. The percentage of protection and care applications taken out has increased by only 16 percent during 2009-2013, while child protection notifications themselves doubled. In this same period re-referral rates declined slightly from 6.9 to 6.5 percent, suggesting the more collaborative approach to families has not increased the risk to vulnerable children.

In both 2010 and 2012 (DCP, 2010, 2012), CPFS conducted a survey of staff regarding the Signs of Safety implementation. The surveys found the Signs of Safety approach had provided the majority of staff with greater job satisfaction due to:

- Families' better understanding of issues and expectations
- Framework providing clarity and focus for child protection work
- Useful tools
- Encouraging more collaborative work including with partner agencies
- Better decision making
- Practice valued by practitioners as more open, transparent and honest.

As part of its system-wide implementation of the Signs of Safety, CPFS uses Signs of Safety meetings as a key mechanism for building and focusing professional and family collaboration on child safety. Signs of Safety meetings, with graduated degrees of formality, include pre-birth and pre-hearing court conferences. The promotional brochure used to explain to professionals and family how these meetings work and what they will achieve is available at <http://www.signsofsafety.net/briefing-paper-resources/>.

CPFS evaluated the first year of using Signs of Safety meetings for pre-birth planning with pregnant mothers facing high-risk situations. The outcomes were im-

pressive, including a 30 percent reduction in child removals for this cohort and a significantly improved working relationship between CPFS and Western Australia's primary maternity hospital. (DCP, 2009.)

The use of Signs of Safety meetings as a court diversionary process through structured pre-hearing conferences has been similarly successful. The independent evaluation found the pre-hearing meeting process has improved collaboration between professionals and families and has received resounding endorsement from attorneys, judges, CPFS and other professionals. Matters referred to a conference resulted in 300 percent fewer court events and less time spent from the initial application to finalisation of the matter. Cases brought to conference also resulted in fewer matters proceeding to trial and more consent orders and negotiated outcomes. (DCP, 2011.)

As described above, CPFS has commissioned comprehensive independent research of Signs of Safety implementation and outcomes through the Australian Centre for Child Protection (ACCP). As well as the results logic work already mentioned, the project includes the following:

- Children's study to test a rating tool to gather the views of children and young people about the degree to which their case workers engaged them and enabled their participation in child protection investigations. The first part of this study was completed in 2013. Six children under the age of twelve were interviewed about their experience of child protection investigation and subsequent casework. (Salveron et. al., 2014a.) This work is the first time research has been done anywhere in the world with children about their experience of child protection investigations. This methodology will be repeated and the research widened to actively look at the impact of the Signs of Safety children's tools.
- Using the methodology of Implementation Science to describe the system wide implementation process of the Signs of Safety within CPFS. (Salveron et. al., 2014b.)

### **British Columbia, Canada**

Ktunaxa Kinbasket Child and Family Services (KKFCS) delivers statutory child protection services to Aboriginal children and their families in four geographic areas of the Ktunaxa Nation within the Kootenay Region of British Columbia. KKFCS adopted the Signs of Safety as its practice model in 2008 for all aspects of its work, from prevention through to protection services, as a means of working rigorously while also practicing collaboratively with the communities and families they serve.

The rapid growth of KKFCS's work over recent years raises difficulties in analysing the precise impact of the Signs of Safety implementation. However, the most significant statistic seen is that, in communities where KKFCS has had full responsibility for delivery of protection services over a number of years, there is a substantial decrease in the number of children entering care. There is also a corresponding decrease in the number of contested court matters. There have been fewer child protection re-notifications and when families have re-engaged it has often been due to the family requesting support rather than a report of child protection.

Additionally, KKFCS has undergone two external practice reviews since the Signs of Safety implementation began, measuring compliance to Provincial Government Aboriginal Practice Standards. Findings from these reviews show increased compliance, as follows:

- Overall compliance with child protective investigations standards increased from 73 to 92 percent.
- Overall compliance with family services standards increased from 81 to 94 percent.
- Determining if a child needs protection increased from 67 to 93 percent.
- Recording and reporting the results of an investigation increased from 50 to 90 percent.



- Meeting timelines for investigation increased from 33 to 75 percent.
- Completed Support Service Agreements with families increased from 45 to 95 percent.
- File documentation increased from 48 to 82 percent.

The overall increase in compliance is attributed to two main variables:

- Implementation of Signs of Safety as the practice model, and
- The creation of a complementary information management system.

The following is an excerpt from the Provincial Director responsible for overseeing delegated Aboriginal Agencies in British Columbia:

*One of the significant strengths is the Agency's use of the Signs of Safety approach to child protection practice. The Agency has made a significant commitment to training the staff in using this approach in the delivery of child protection and child welfare services. Within the Family Service files many positive aspects were found including documenting or accepting appropriate request for service, obtaining information and making appropriate requests for service, and involving the Aboriginal Community.*

### **Toronto Children's Aid Society (TCAS), Ontario, Canada**

As part of their implementation of the Signs of Safety, Toronto Children's Aid Society (TCAS) has undertaken research and published on the application of Signs of Safety to front-end investigation and assessment work. (Kwin, 2014.) This study found the use of the Signs of Safety assessment mapping process together with families:

- Reduced caseworker time
- Reduced the number of investigations
- Increased case closure rates compared with the other teams in the agency and broader Ontario province averages.

### **Olmsted County, Minnesota, USA**

The first system-wide implementation of the Signs of Safety occurred in Olmsted County Child and Family Services (OCCFS), Minnesota, USA, beginning in 2001 as part of a broader reform agenda. OCCFS has utilised its version of the Signs of Safety framework to organise all child protection casework since 2000 and all casework is focused around specific family-enacted safety plans. Reforms with which the Signs of Safety were integrated included:

- Extensive use of participatory conferencing processes involving immediate and extended family, including rapid response conferencing in high-risk cases where removal is likely and court diversionary conferences
- Structured Decision Making (SDM) actuarial risk assessment
- Differential response initiatives.

In the 14 years to 2008, when the number of children OCCFS worked with tripled, the agency halved the proportion of children taken into care and halved the number of families taken before the courts. It would be possible to suggest that this may have been the result of a system that focused on cost cutting or was lax on child abuse, except that in 2006, 2007 and 2008 the county recorded a recidivism rate of less than 2 percent, as measured through state and federal audit. The expected federal standard in the US is 6.7 percent and very few state or county jurisdictions meet that standard. The Olmsted data set is significant as most child protection agencies around the world increased the proportion of children in care and families taken to court in that period. For example, see UK data during the supposed 'Refocusing' era 1992-2002 in McKeigue and Beckett (2004). For more information on the OCCFS work see Christianson and Maloney (2006); Idzelis Rothe (2013); Lohrbach and Sawyer (2003, 2004); Lohrbach et. al. (2005); Turnell, Lohrbach and Curran (2008), Skrypek et. al (2010, 2012).

### Carver County, Minnesota, USA

Following the lead of Olmsted County, a second Minnesota county, Carver County Community Social Services (CCCCS), began implementing the Signs of Safety approach in late 2004. Westbrook (2006) undertook a 'before and after' in-depth, qualitative study at Carver, with nine randomly chosen cases, looking at the impact of the Signs of Safety practice for service recipients in the first year of the County's implementation. The study found an increase in service recipient satisfaction in most of the cases and the research helped CCCCSS practitioners to improve their skills, particularly in providing choice and in involving parents in safety planning. As of the spring of 2014, Carver County is showing significant improvements in several meaningful data measures. Initially incidences of six- and twelve-month repeat maltreatment, which had been two to three percent per year before Signs of Safety, more than doubled in 2006 and 2007 as the agency was learning safety planning. Such incidences then quickly declined to far fewer as safety planning became more rigorous, and the County's last recorded incident of repeat maltreatment was almost three years ago. Removals during child protection assessments dropped from around 60 per year before Signs of Safety to fewer than 30 per year for each of the past six years. Termination of parental rights and permanent transfers of custody have been reduced by 30 percent over the same period. Before implementation of the Signs of Safety, six to eight youth per year remained in foster care; this number has been reduced to a total of only four youth in the past four years. The most significant improvement has been a two-thirds reduction in the number of families determined to need ongoing casework services due to the robust development of safety plans and networks as an integral part of the County's assessment process.

More information about the Carver implementation can be found at <http://www.signsofsafety.net/implementations/>. It includes video-recorded interviews with 15 staff and a long-term alcoholic mother describing her experience of the Signs of Safety approach. (Koziolek, 2007; Idzelis Rothe, 2013; Skrypek et. al., 2010, 2012.)

### Other Minnesota Counties

With the ongoing and sustained system-wide implementations in Olmsted and Carver counties, the Minnesota State Department for Human Services together with Casey Family Programs jointly funded a process for training and implementing Signs of Safety through 19 other counties in Minnesota. Sherburne County was one of the first to undertake this and in the years 2007 to 2009 it halved the use of the courts in child protection cases. Furthermore, in 2009 the county reduced its placement of children by 19 percent.

Wilder Research Group (Skrypek, Otteson and Owen, 2010) undertook a substantial independent evaluation of the successes and challenges experienced by the 19 Minnesota counties involved in the statewide project. Then it conducted a follow-up study interviewing 24 parents who had been on the receiving end of Signs of Safety child protection practice. The sample for the parent study was drawn from five Minnesota counties with considerable experience with Signs of Safety, these being Olmsted, Carver, Scott, St. Louis, and Yellow Medicine Counties. The study findings present a picture of consistently good practice. For instance:

- 83 percent of parents interviewed felt that their caseworker had been honest and "straight up" with them about their case
- two-thirds of respondents reported that their caseworker had taken the time to get to know them and their situation
- 71 percent reported that during the process of safety planning, their caseworker had helped them identify both strengths and challenges within their family. (Skrypek, Idzelis & Pecora, 2012.)

Perhaps most usefully this study explores the complexity and tensions of direct practice in a rich and nuanced manner. The following are two parental quotes that illustrate this:

*We didn't always see things the same way, but you knew where she stood with things with our grandson and he was the priority. I'm not going to say we loved her but we had respect for her and what her position did and believed that she was doing the best that she could do. She laid out what had to change and we would talk about how I was doing and what I could do to change. And if I did not like some of what they wanted me to do, she would work with me to try to find ways to compromise so that it would work for me.* (Skrypek et. al., 2012, pp. 20 and 22.)

### **Sacramento, California, USA**

Since 2006, Sacramento County Child Protective Services (SCCPS) has been working with Casey Family Programs to reduce the rate of African American children entering foster care. In this period SCCPS decreased the rate by an impressive 53 percent. In comparison, the statewide decrease for those same years was 5 percent. (Casey Family Programs, 2014.)

This was achieved in tandem with a systematic programme to achieve reductions in foster care entry rates across all cases. The outcomes were achieved by:

- Creating a theory of change to reduce entry rate of children and then implementing that logic model
- Explicitly analysing the disproportionality of African American children in care
- Implementing and integrating both the Signs of Safety and SDM.

### **The Netherlands**

Bureau Jeugdzorg Drenthe (BJZD) in The Netherlands has been implementing the Signs of Safety since 2007. The agency surveyed its staff regarding the benefits of using the approach. Workers reported:

- Feeling that responsibility for the child's safety is shared with the family and their support network as well as the professional network
- More openness among practitioners about their practice and providing each other with more support
- Practice is more transparent because professional anxieties are talked about openly
- Families understand better the decisions workers make
- Using the Signs of Safety framework makes work faster and leads them to focus on plans clients make with their own support network
- Focusing on good practice brings energy, connection and enables practitioners to learn from each other
- Greater pride and joy in the work they do with families.

In the period BJZD has been implementing, the total number of long-term statutory child protection cases (the agency also works with voluntary cases) has increased from 426 to 702, while the percentage of children taken into care from these cases has reduced from 54 to 34 percent and continues to trend downward. In The Netherlands the average length of agency involvement in long-term statutory cases is 2.9 years, and between 2006 and 2008 BJZD operated at that average. Since 2008 average involvement reduced by 17.5 percent to 2.4 years. In 2007 the investigative arm of BJZD, the AMK, directed 18.5 percent of its cases to the court. By 2013 this percentage had reduced to only 3 percent.

In October 2013 the Dutch National Government provided funding for a two-year comparative research study to compare the outcomes of the Signs of Safety in Bureau Jeugdzorg Drenthe and Bureau Jeugdzorg Groningen (implementation started 2013). The research will be undertaken by Dutch social research organisations TNO and ZonMw. More information will be posted progressively at <http://www.signsofsafety.net/signs-of-safety-research/>.

William Shrikker Groep (WSG) has almost 1000 staff and 4000 children in care and is the principal Netherlands agency providing statutory child protection services to families with developmentally delayed parents or children, or both. WSG

commenced a system-wide implementation of the Signs of Safety in 2011. The implementation began as part of a reform agenda following evidence of poor practice and adverse outcomes, including high rates of placement and the longest case involvement rates in the country. As a result WSG has been under a comprehensive two-year review by the national government's audit commission.

While WSG undertook its rollout of the Signs of Safety, the initial implementation was focused on four pilot teams in Amsterdam, The Hague and Rotterdam. Nationally funded independent research is being undertaken to track outcomes within those pilot teams. The research focuses on 200 new cases per year being undertaken by those pilot teams. The research began in April 2012 and was scheduled to conclude in April 2014. In October 2013 the data for the first 18 months of the project were analysed and showed that, of the 303 new cases commenced within the four pilot teams, there had been a reduction of more than 50 percent in 'out placement' of children. The rate of placement within the pilot teams was averaging 19 percent compared with 40 percent of cases for the control group. Of the cases already closed, the re-referral rates compared with the usual rates had been halved and the ongoing contact rates of other professional agencies regarding the open cases had been significantly reduced within the pilot cohort. Across the agency there had been a 20 percent decrease in placement rates during this same period, which WSG management see as a direct result of the broader Signs of Safety rollout. The results of this work will be published within The Netherlands and also internationally with careful analysis of the data.

### **Copenhagen, Denmark**

Between 2005 and 2008 the Danish Borough of Copenhagen undertook a three-year 'Families in the Centre' project to equip the city's child protection workers with a higher levels of skills to better engage families. This project involved training and ongoing support for 380 workers in three successive, one-year programmes in solution-focused brief therapy and the Signs of Safety. The project was independently evaluated (Holmgård-Sørensen, 2009), interviewing 171 practitioners, and the results were as follows.

- The project provided practitioners with more useful tools and skill sets than were previously available to them (75 percent).
- There was increased practitioner focus on the family's resources (72 percent).
- There was an increase in practitioners including families' strategies and solutions (55 percent).
- Practitioners gave families more responsibility (49 percent).
- There was regular use of the Signs of Safety at team meetings (79 percent).
- The Signs of Safety framework was used together with families (69 percent).
- The Signs of Safety framework was used at network meetings with other professionals (66 percent).

Since 2009 most Copenhagen boroughs have been implementing the Signs of Safety approach with particular focus on creating safety planning teams within their child protection services. This work has been researched through citywide funding and reported by Holmgård-Sørensen (2013). This study looked at a cohort of 66 cases, finding that the safety planning work has led to an almost 50 percent reduction in the placement of children, compared with equivalent cases, and has contributed to significantly reduced professional involvement. Like Keddel's work from New Zealand (described below), this report provides considerable information about the challenges and rewards experienced by the practitioners as they delivered the safety planning work, as well as feedback from parents.

### **City and County of Swansea, Wales**

Swansea Social Care Children and Families Services (SSCS) began its implementation of Signs of Safety at the end of 2011 following preparatory training for staff in solution-focused brief therapy skills. SSCS has published a comprehensive review

of the first two years' work, including its system-wide application of the approach, along with case examples and vignettes describing implementation strategies, arrangements and outcomes for 2013. (SSCS, 2014.) Despite working in the context of staff and budget cuts, SSCS saw 2013 re-referral rates lowered to 21 percent, compared with nearly 30 percent in 2012. 2013 also saw best ever results achieved by frontline and specialist teams in completing initial assessments (90 percent) and core assessments (75 percent) in timescale. In 2013 only 122 children were taken into care, a reduction from 164 children in 2012. SSCS has reduced its rate of entry into care by 13.6 percent and the number of children on the child protection register has fallen to 178, compared with 235 at the end of 2012. SSCS leadership has undertaken extensive internal audits that, together with external inspection, confirmed their belief that these outcomes reflected safe practice.

### English Research

Two English reviews of practice (Gardner, 2008 and DSCF, 2009) have identified the problem that the 'recent emphasis on strengths-based approaches and the positive aspects of families (for example in the Common Assessment Framework) arguably discourages workers from making professional judgments about deficits in parents' behaviour which might be endangering their children'. (DSCF, 2009: p.47.) Both reviews suggest the Signs of Safety is the one approach they are aware of that incorporates a strengths base alongside an exploration of danger and risk.

Gardner's research focuses on working with neglect and emotional harm. It reports that, in England, some children's departments are adopting Signs of Safety to improve decision making in child protection. Police, social care with adults and children, and children's guardians all thought it especially useful with neglect because:

- Parents say they are clearer about what is expected of them and receive more relevant support
- The approach is open and encourages transparent decision making
- The professionals had to be specific about their concerns for the child's safety
- The approach encouraged better presentation of evidence
- The degree of protective elements and of actual or apprehended risks could be set out visually on a scale easier for all to understand than lengthy reports
- Once set out, the risks did not have to be revisited continually
- The group could acknowledge strengths and meetings could focus on how to achieve safety. (Gardner, 2008, p 78.)

*Also in the English context:*

- Wheeler and Hogg (2011) published a book chapter reviewing and summarising the evidence base supporting the Signs of Safety approach available to 2010.
- The NSPCC commissioned a report looking at the use of the Signs of Safety in England, including a review of the supporting evidence, called *Signs of Safety in England* (Bunn, 2013).

### New Zealand

Dr Emily Keddel from Otago University, New Zealand, undertook an in-depth qualitative study of 10 cases with 10 families, involving 19 children in care. The study looked at the Signs of Safety work of Open Home Foundation social workers in building safety plans to be able to reunify the children into the care of their families of origin. 16 of the 19 children were reunified in 9 families. Keddel's study (Keddel, 2011a and 2011b) found that the key elements in enabling the successful reunification work were:

- Strong working relationship between worker and parents
- Strong focus on parental and family strengths
- Sustained and detailed exploration of exactly what constituted everyday safe care of the children and how it could be achieved

- Time to build the relationship, do the casework and ensure the safety plans were sustainable.

Keddel's writing, and the 2014 publication in particular, offer a critical examination about risk, authority and power relationships with Signs of Safety practice and safety planning work.

#### 4.4 Research on working with 'denied' child abuse

The Signs of Safety approach draws upon and utilises the pioneering Resolutions safety planning work of Susie Essex, John Gumbleton and Colin Luger for working with 'denied' child abuse. The Resolutions work is described in Essex, et. al. (1996 and 1999); Essex, Gumbleton, Luger and Luske (1997); and Turnell and Essex (2006).

Gumbleton (1997) studied outcomes for 38 children from the first 17 families that had undertaken the Resolutions programme in the UK. The follow-up data was derived from child protection registers and social service files. The families involved in the study had completed the programme between 8 and 45 months prior to participating in the study, with an average time since completion of 27 months. The study found that the Resolutions programme had been successful in helping protect the vast majority of the children in the sample, with only one child known to have experienced further abuse. Depending on whether the re-abuse calculation is made relative to the number of families or number of children in the study, this equates to a re-abuse rate of 3 or 7 percent. There are many methodological issues involved in interpreting and comparing child maltreatment re-abuse rates derived from different studies (Fluke and Hollinshead, 2003), however a wide range of studies suggest re-abuse rates in 'denied' child abuse cases generally fall in a range between 18 and 40 percent.

#### 4.5 Constructive working relationships

As stated above, constructive relationships between professionals and family members, and between professionals themselves, are the heart and soul of effective child protection practice. However, research has demonstrated that professional relationships and attitudes toward service recipients are very often negative, judgmental, confrontational and aggressive. (Cameron and Coady, 2007; Dale, 2004; Forrester et. al., 2008a and b.) A significant difficulty is that little attention is given, within the literature of social work and the broader helping professions, to how to build constructive helping relationships when the professional also has a strong coercive role. (Healy, 2000; Trotter, 2006.) The Signs of Safety approach seeks to fill this vacuum. It is very likely that a significant contributing factor to the model's success described above is how it provides clear, detailed guidance to assist practitioners to exercise their statutory role rigorously while also being able to work collaboratively with parents and children.

#### 4.6 Towards practice-based evidence

There is increasing emphasis being placed on the importance of evidence-based practice in the helping professions and child protection. Quite apart from philosophical debates about evidence-based practice, there are significant challenges in undertaking research and garnering evidence in child protection work. Within the psychotherapy field, for example, it is at least sometimes possible to undertake 'gold standard' randomised trials to access the efficacy of particular models. Such research is impossible within child protection services, since it is neither ethical nor professionally responsible to randomly assign cases of child abuse to service

and non-service research groups. Further, in child protection services, particularly in high-risk cases (these being the cases usually of most interest), there is almost always so much going on (e.g., family involvement with multiple services, court proceedings, police involvement, etc.) that it is effectively impossible to stake a definitive claim for the causative impact of any particular policy, model or practice.

A significant problem with most child protection research is that large data sets and key performance indicators hold limited import for frontline practitioners and offer them little inspiration about how to change their practice. This has led some child protection thinkers to call for research that has closer ties with the direct experience and 'smell' of practice. Thus Professor Harry Ferguson has proposed research focused on 'critical best practice'. (Ferguson, 2001, 2003, 2004; Ferguson et al., 2008.) Ferguson's work can be interpreted as one expression of the growing movement toward 'practice-based evidence'. The following websites offer more information:

- <http://www.practicebasedevidence.com>
- <http://www.pathwaysrtc.pdx.edu/proj-5-findingourway>

The Signs of Safety approach to child protection practice has been created and evolved by researching what actually works for the service deliverer and service recipient. Broadly this locates the Signs of Safety evidence and theory base within the traditions of action research, collaborative and appreciative inquiry, practice-based evidence and critical best practice. (e.g., Cooperrider and Whitney, 1999; Ferguson, 2008; Reason and Bradbury, 2006.) Because it has drawn on over twenty years' experience of thousands of child protection practitioners from around the world, the Signs of Safety approach is grounded in the strongest single knowledge base of what works in actual child protection practice of any approach in the field. (See, for example: Christianson and Maloney, 2006; Lwin et al., 2013; Teoh et al., 2003; Turnell, 2004, 2006, 2007, 2011, 2013; Turnell and Edwards, 1997, 1999; Turnell, Elliott and Hogg, 2007; Turnell and Essex, 2006, 2013; Turnell, Lohrbach and Curran, 2008; Turnell, Vesterhauge-Petersen and Vesterhauge-Petersen, 2013.)

The Signs of Safety model continues to evolve, through the application of practice-based appreciative inquiry into practitioner and recipient-defined best practice. Building an organisational culture of appreciative inquiry and research around frontline practice is also crucial to the successful implementation of the approach. This will be considered further in chapter nine Drawing on implementation science and action research methodologies, the international Signs of Safety community will, in the coming years, also increasingly research and publish on effective leadership and implementation processes and practices that lead to better child protection outcomes. The first publication of this ilk looks at effective leadership following a child fatality. (Turnell, Munro and Murphy, 2013.)

## 5 Signs of Safety Assessment and Planning – Risk Assessment as the Heart of Constructive Child Protection Practice

### 5.1 Risk as the defining motif of child protection practice

Child protection practice is probably the most demanding, contested and scrutinised work within the helping professions, primarily because the endeavour focuses on a society's most vulnerable children. Professionals must constantly consider and decide whether the family's care of a child is safe enough for the child to stay within the family or whether the situation is so dangerous that the child must be removed. If the child is in the care system, the practitioner must, until permanent out-of-home care becomes the priority, continually review whether there is enough safety for the child to return home.

All of these decisions are risk assessments and demonstrate that the task is not a one-off event or periodic undertaking. Rather, the assessment of risk is something the worker must do constantly, after and during each successive contact, with every case. Risk assessment is the defining motif of child protection practice.

### 5.2 Risk assessment as a constructive practice

One of the key reasons that more hopeful, relationally grounded approaches have often failed to make significant headway within the child protection field is that they have failed to engage seriously with the risk assessment task. Child protection risk assessment is often dismissed as too judgmental, too forensic and too intrusive by proponents of strengths and solution-focused practice (for example, see Ryburn, 1991). This usually leaves the frontline practitioner who hopes to practice collaboratively caught between strengths-based, support-focused aspirations and the harsh, problem-saturated, forensic reality that they have ultimate responsibility for child safety. In this situation a risk-averse interpretation of the forensic child protection imperative consistently leads to defensive intervention and the escalation of a defensive case culture. (Barber, 2005.)

Risk does not just define child protection work in isolation. It is in fact an increasingly defining motif of the social life of western countries in the late 20th and early 21st centuries. (Beck, 1992; Giddens, 1994; Wilkinson, 2001.) The problem in all this is that risk is almost always seen negatively. Risk must be avoided because everyone is worried about being blamed and sued for something and institutions have become increasingly risk-averse to the point of risk-phobia. Risk is almost always only seen in terms of the BIG loss or the BIG failure, almost never in terms of the BIG win.

If we change the lens to sport it is easier to consider risk differently. Usain Bolt does not hide from the world championships, Roger Federer does not avoid Wimbledon, Dawn Fraser did not run from Tokyo in 1964. Sports figures like these champ at the bit to get to these places because, while they may fail spectacularly on the biggest stage in front of millions, it is actually very possible they will succeed gloriously. The analogy is not exact, particularly because no one dies at Wimbledon, the Olympics or World Championships, and no matter how successful, the outcomes in a high-risk child abuse case are rarely glorious. But in sport we can clearly see the vision of the BIG win.

In child protection work, that vision – the possibility of success – is so often extinguished. With the erasure of a vision of success within the risk equation, a professional's only hope is to avoid failure and the key motivation then readily defaults to the oft-repeated child protection maxim 'protect your backside'.



Signs of Safety seeks to revision this territory and reclaim the risk assessment task as a constructive solution-building undertaking - a process that incorporates the idea of a win as well as a loss. Signs of Safety does not set problems in opposition to strengths and solution-focus, nor does it set forensic, rigorous professional inquiry off against collaborative practice. Quite simply, the best child protection practice is always both forensic and collaborative and demands that professionals are sensitive to, and draw upon, every scintilla of strength, hope and human capacity they can find within the ugly circumstances where children are abused.

## 5.3 Comprehensive risk assessment and Signs of Safety assessment and planning

The Signs of Safety seeks always to bring together the seeming disjunction between a 'problem and solution' focus within its practice framework by utilising a comprehensive approach to risk that:

- Forensically explores harm and danger and, with the same rigour, simultaneously elicits and inquires into strengths and safety
- Brings forward clearly articulated professional knowledge while also equally eliciting and drawing upon family knowledge and wisdom
- Is designed to always undertake the risk assessment process with the full involvement of all stakeholders, both professional and family, from the judge to the child, from the child protection worker to the parents and grandparents
- Is naturally holistic since it brings everyone - both professional and family member - to the assessment table. (Some assessment frameworks trumpet their holistic credentials but often do so by slavishly and obsessively gathering vast amounts of information about every aspect of a family and child's life that then swamps the assessment process and everyone involved with too much information.)



*Comprehensive balanced child protection risk assessment*

The Signs of Safety grounds these aspirations in a one-page assessment and planning protocol. The protocol or framework maps harm, danger, complicating factors, strengths, existing and required safety, and a safety judgment in situations where children are vulnerable or have been maltreated. The Signs of Safety Assessment and Planning Protocol, and the questioning processes and inquiring stance that underpin it, is designed to be the organising map for child protection intervention from case commencement to closure.

At its simplest, this framework can be understood as containing four domains for inquiry:

1. What are we worried about? (Past harm, future danger and complicating factors.)
2. What is working well? (Existing strengths and safety.)
3. What needs to happen? (Future safety.)
4. Where are we on a scale of 0 to 10 where 10 means there is enough safety for child protection authorities to close the case and 0 means it is certain that the child will be (re)abused? (Judgment.)<sup>4</sup>

The four domains operating in the Signs of Safety assessment and planning are simply and clearly identified in the 'three columns' Signs of Safety assessment and planning protocol as follows.

### Signs of Safety<sup>®</sup> Assessment and Planning Framework

What are we Worried About?	What's Working Well?	What Needs to Happen?

On a scale of 0–10 where 10 means everyone knows the children are safe enough for the child protection authorities to close the case and zero means things are so bad for the children that they can't live at home, where do we rate this situation?  
*Locate different people's judgements spatially on the two-way arrow.*

**0** ←————→ **10**

<sup>4</sup> Zero on this safety scale is often also described as meaning the situation is so dangerous the child must be permanently removed.

# Signs of Safety Comprehensive Briefing Paper

This 'three columns' format at its simplest can also be used as a strategic planning framework that is useful for thinking through any human or organisational issue and can be adapted as a review and planning tool across the full range of agency activity including supervision, staffing, management or policy issues.

The Signs of Safety assessment and planning framework incorporates the risk assessment analysis categories described in the illustration below. (The shading is used to link with the case example that follows it.)

## Signs of Safety® Assessment and Planning Framework

What are we Worried About?	What's Working Well?	What Needs to Happen?
<b>HARM:</b> Past hurt, injury or abuse to the child (likely) caused by adults. Also includes risk-taking behaviour by children/teens that indicates harm and/or is harmful to them.	<b>Existing Strengths:</b> People, plans and actions that contribute to a child's well-being and plans about how a child will be made safe when danger is present.	<b>SAFETY GOALS:</b> The behaviours and actions the child protection agency needs to see to be satisfied the child will be safe enough to close the case.
<b>DANGER STATEMENTS:</b> The harm or hurt that is believed likely to happen to the child(ren) if nothing in the family's situation changes.	<b>EXISTING SAFETY:</b> Actions taken by parents, caring adults and children to make sure the child is safe when the danger is present.	<b>Next Steps:</b> The immediate next actions that will be taken to build future safety.
<b>Complicating Factors:</b> Actions and behaviours in and around the family, the child and by professionals that make it more difficult to solve danger of future abuse.		


On a scale of 0–10 where 10 means everyone knows the children are safe enough for the child protection authorities to close the case and zero means things are so bad for the children that they can't live at home, where do we rate this situation?  
*Locate different people's judgements spatially on the two-way arrow.*

0 ←————→ 10

## 5.4 Case example

The following is a straightforward example of a completed Signs of Safety 'map' involving a 19-year-old mother 'Mary' and her 18-month-old son 'John'. The Signs of Safety assessment and planning for this example is an amalgamation of two fairly equivalent Western Australian cases. In both cases the worker completed the assessment together with the mother while the infant was in hospital following an assault by the mother<sup>5</sup>.

### Signs of Safety® Assessment and Planning Framework

What are we Worried About?	What's Working Well?	What Needs to Happen?	
<ul style="list-style-type: none"> <li>• CPS have reports of five times where Mary (19) has hit and hurt John (18-months) in the past 8 weeks.</li> <li>• John needed hospital treatment for a fractured cheek and bruising to head and shoulders after Mary hit him so hard he was knocked into a wall yesterday.</li> </ul>	<ul style="list-style-type: none"> <li>• Mary open in talking to CPS social worker (SW)</li> <li>• Mary clearly loves John; SW has seen that he goes to her, they cuddle, she responds to him being upset.</li> <li>• Mary admits hitting John at least 4–5 times in 8 weeks and that she caused the current injuries.</li> <li>• Mary is most concerned about her anger and violence making John afraid of h</li> <li>• John meets 'developmental milestones' for size, weight; he's talking and active.</li> <li>• John's immediate safety is assured through hospitalisation and imminent alternative placement.</li> <li>• Mary wants someone to talk to re sadness/anger and sees this as a cause of the problem.</li> <li>• Mary has separated from her violent ex-partner Gary; she says he's not good for her or John.</li> </ul>	<ul style="list-style-type: none"> <li>• CPS wants John back living with Mary because it is clear she loves and wants him. For this to happen CPS need Mary and some support people to make a plan that shows everyone, including John, what Mary will do when she becomes sad and frustrated so she doesn't lose it with John and hurt him, or if she can't control herself, who she will ask to come and help.</li> </ul>	
<ul style="list-style-type: none"> <li>• DCP are worried because the doctor says it is possible John could be more badly hurt in the future, suffering brain damage or death from a future incident of this type.</li> </ul>	<ul style="list-style-type: none"> <li>• Mary describes one incident where she did not hit John when she easily could have 'lost it'.</li> </ul>	<ul style="list-style-type: none"> <li>• Establish John in foster placement.</li> <li>• Contact visits established for Mary and John, focused on Mary doing something different when stressed.</li> <li>• Mary starts seeing someone she can talk to.</li> </ul>	
<ul style="list-style-type: none"> <li>• Mary doesn't want contact with her family or Gary's and she can think of no friends to help her.</li> <li>• Mary has history of 'depression' which she calls being sad.</li> <li>• Mary is not taking prescribed medications or attending appointments with psychiatrist.</li> <li>• To control herself on one occasion Mary had to leave John unsupervised.</li> <li>• Mary describes a history of violence in her family.</li> </ul>			
<p>On a scale of 0–10 where 10 means everyone knows the children are safe enough for the child protection authorities to close the case and zero means things are so bad for the children that they can't live at home, where do we rate this situation?  <i>Locate different people's judgements spatially on the two-way arrow.</i></p>			
0			10

While the above assessment looks simple, it is a form of simplicity that synthesises considerable complexity. There are many disciplines involved in using the Signs of Safety to arrive at the sort of assessment and plan which are described in the next chapter.

<sup>5</sup> *The DVD: Introduction to the Signs of Safety (Turnell, 2009) explores this case example in closer detail and describes the relational and investigative processes involved in creating this assessment and case plan together with the mother.*

## 6 Signs of Safety Practice Disciplines

Together with the application of the principles listed in chapter two, the Signs of Safety disciplines that underpin the effective use of the assessment and planning framework include the following.

- **A clear and rigorous understanding of the distinction between past harm (shaded yellow, above), future danger (shaded red) and complicating factors.**

This way of analysing the danger information is informed by significant research regarding the factors that best predict the abuse and re-abuse of children. (Boffa and Podesta, 2004; Brearley, 1992; Child, Youth and Family, 2000; Dalgleish, 2003; Department of Human Services, 2000; English, 1996; English and Pecora, 1994; Fluke et. al., 2001; Johnson, 1996; Munro, 2002; Parton, 1998; Pecora and English, 1992; Reid et.al., 1996; Schene, 1996; Sigurdson and Reid, 1996; Wald and Wolverton, 1993.)

- **A clear and rigorous distinction made between strengths and protection, based on the working definition that 'safety is regarded as strengths demonstrated as protection (in relation to the danger) over time'.**

This definition was developed by Julie Boffa (Boffa and Podesta, 2004), the architect of the Victorian Risk Framework, and was refined from an earlier definition used by McPherson, Macnamara and Hemsworth (1997). This definition and its operational use are described in greater detail in Turnell and Essex (2006). Utilising this definition to interpret the constructive risk factors captured in the example just presented, it can be seen that there is only one known instance of existing safety (shaded red) related to the danger statement.

- **Rendering all statements in straightforward, rather than professionalised, language that can be readily understood by clients.**

This practice is based on an understanding that the parents and children are the most crucial people to think themselves into and through (assess) the situation and that the best chances of change arise when everyone (professionals and family) can readily understand each other.

- **All statements should focus on specific, observable behaviours (e.g. 'Mary is not taking prescribed medication or attending appointments with the psychiatrist') and avoid meaning-laden, judgment-loaded terms (e.g., 'she is controlling', 'he is in denial', 'she's an alcoholic').**

The Signs of Safety approach seeks always to tease out facts from judgments by describing events and evidencing opinions with observable behaviours. The process of arriving at judgment is held in abeyance to be brought forward in a straightforward fashion within the safety scaling activity.

- **Skilful use of authority.**

Mapping or assessing child protection cases together with family members almost always involves some level of coercion, which needs to be exercised skilfully. In both the cases that the above example is drawn from, each worker asked the mother if she would prefer to work on the assessment together with the practitioner or prefer the worker doing it with her supervisor back

at the office. Both mothers chose immediate involvement. This is a concrete demonstration of the sort of skilful use of authority that is always a central part of garnering service recipient involvement in the Signs of Safety assessment.

- **An underlying assumption that the assessment is a work in progress rather than a definitive set piece.**

Assessment is often viewed in the helping professions as a 'one-off' activity undertaken when a form or protocol is completed. In reality, assessment is a dynamic process punctuated by critical decision-making points. The greatest challenge of assessment is to actively engage parents, children and their support people in the ongoing cycle of information gathering, analysis and judgment. To achieve this requires that professionals approach the assessment task from a stance of humility about what they think they know, rather than a paternalistic stance that asserts 'this is the way it is'.

The disciplines and principles underlying the use of the Signs of Safety assessment and planning are more fully described in Turnell and Edwards (1999) and Turnell and Essex (2006).

## 7 Involving Children

A considerable body of research indicates that children and young people caught up in the child protection system feel like they are 'pawns in big people's games' and that they have little say or contribution in what happens to them. (Butler and Williamson, 1994; Cashmore, 2002; Gilligan, 2000; Westcott, 1995; Westcott and Davies, 1996.) Particularly disturbing is the fact that many children in care tell researchers that they do not understand why they are in care. The same message is told when visiting CREATE's<sup>6</sup> website (<http://www.create.org.au/>) or listening to any young people who speak publicly through this Australian organisation representing children in care, or similar organisations internationally, about their experience living in care.

There is considerable discussion, writing and policy in the child protection field about privileging the voice of the child, but this is more often talked about than operationalised. A primary reason practitioners fail to involve children is the fact that they are rarely provided with straightforward tools and practical guidance that equip them to involve children in a context where there is fear that involving them can create more problems than it solves.

Since 2004 one of the key growing edges of Signs of Safety has been the development with practitioners of tools and processes designed to more actively involve children in child protection assessment, to involve them in understanding why professionals are intervening in their lives, and to involve them in safety planning. These tools and processes include:

- Three Houses tool
- Fairy/Wizard tool
- Words and Pictures explanations
- child relevant safety plans.

### 7.1 Three Houses tool



<sup>6</sup> CREATE is a uniquely Australian organization that provides support and a direct voice for young people in the Australian care system so they can influence governments and professionals.

The Three Houses tool is a practical method created by Nicki Weld and Maggie Greening from Child Youth and Family, New Zealand. (Weld, 2008.) The Three Houses method takes the three key assessment questions of Signs of Safety as assessment and planning ('What are we worried about?', 'What's working well?', 'What needs to happen?') and locates them visually within three 'houses' to make the issues more accessible for children.

Steps for using the Three Houses tool:

- i. Wherever possible, inform the parents or carers of the need to interview the child, explain the three houses process to them and obtain permission to interview the child.
- ii. Make a decision if parents or carers should be present when working with the child.
- iii. Explain the three houses to the child, often using one sheet of paper per house.
- iv. Use words and drawings as appropriate and anything else useful to engage the child in the process.
- v. Often start with the 'House of Good Things', particularly where the child is anxious or uncertain.
- vi. Once finished, obtain permission from the child to show others - parents, extended family and professionals. Address any safety issues for the child in doing this.
- vii. Present the Three Houses assessment just as the child said, wrote or drew it. For parents/caregivers it is often helpful to begin with the 'House of Good Things'.

The following is an anonymous English example of the Three Houses tool used by Sue Robson, Gateshead Referral and Access social worker, in a case of emotional abuse with boys 'Craig' and 'Martin' and their mother 'Carol'.

This case was referred by a health worker who reported concerns about Carol's deteriorating mental health, saying she was shouting at the children, smacking them and no longer wanted to play with them. During and following a meeting attended by Carol and workers from several agencies, the professionals expressed concerns about the mother's mental health and the impact of this on her children. Carol was very agitated and angry and said she refused to work with the professionals any more.

Professionals reported that Carol's children Martin (5), Craig (7) and Timmy (2) all appeared frightened of Carol. When the health visitor visited the home, Timmy was always in the playpen and there were no toys in the house. Sue decided to use the Three Houses with Craig and Martin and completed two sets of drawings with them. With the boys' permission, these were then shown to Carol and the boys' assessments of their own situation changed Carol's response entirely. Looking at the boys' experience meant Carol was willing to face the problems and work with the professionals to put things right for her children.



## Craig



### House of good things

I don't get shouted at when I am with dad.  
I like living with daddy because I get lots of hugs.  
When I'm with daddy I can play with my toys.



### House of worries

I was not happy at my mam's house because she shouted at me a lot.  
Mam locked all of my toys away and I didn't get all of my Christmas presents they were put in mam's wardrobe.



### House of wishes

My wish has come true. I'm living with my daddy and brothers.  
I wish we had a big house so we had our own room and didn't have to share our beds.

## Martin



### House of good things

I like playing with toys at dad's house.  
I have lots of toys to play with.  
I like it when mam makes veggies for me. I love my veggies.  
I like it when dad makes me nice things to eat at his house.  
I like playing with my brother on the computer.



### House of worries

I worry that my dad won't have batteries for my toys.  
I'm scared of dad, shhh no, it's not dad it's mam. Don't tell her she'll put a spell on me, shhh! She's a witch, don't tell her.



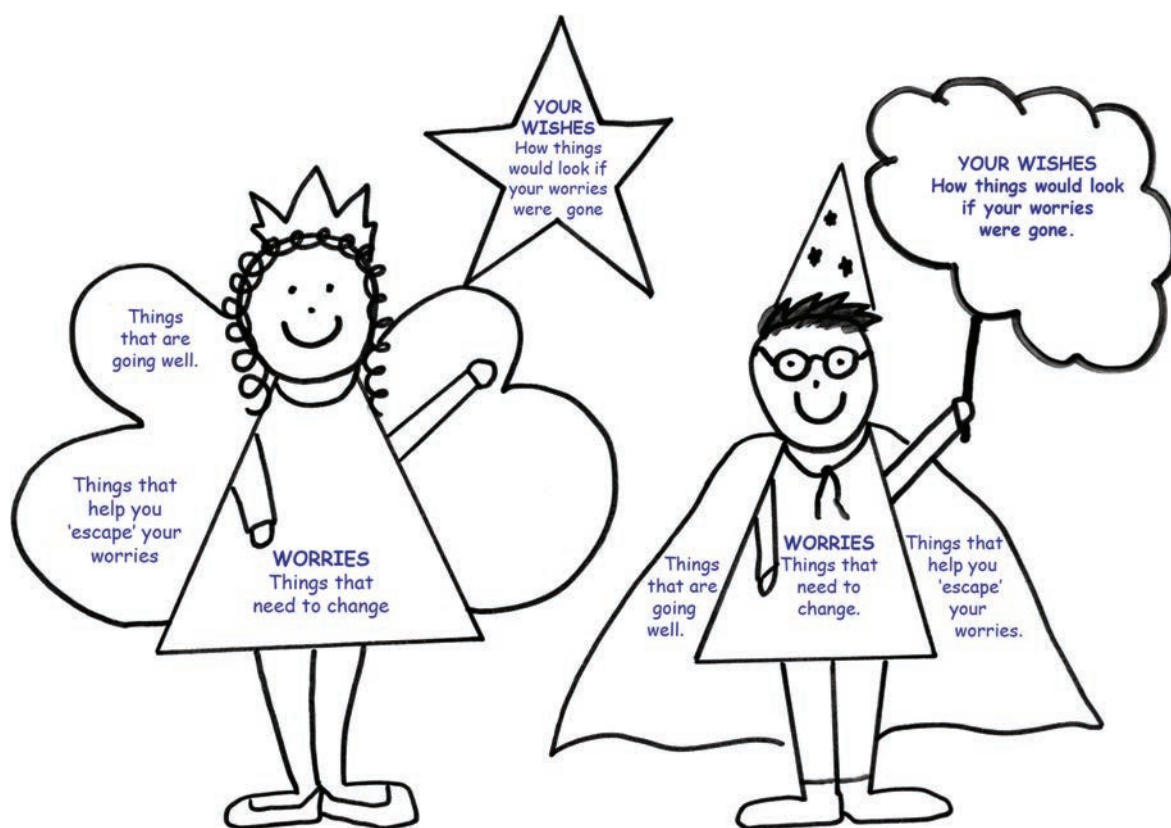
### House of wishes

We would have a big family holiday-mam, dad, Timmy and me and Craig would all go to the beach and love each other.  
I wish I could live at my dad's house. I'm happy there and can play with my toys and no one shouts at me so I'm not scared.

## 7.2 Fairy/Wizard tool

Child protection professionals around the world have found that the Three Houses tool, with its direct focus on the child's experience and voice, time and again creates a breakthrough of this sort with parents who are 'resisting' professional perspectives and interventions.

Vania Da Paz, a Western Australian child protection practitioner, was involved in the 1990s development of the Signs of Safety. (An example of her practice is presented in Turnell and Edwards, 1999: p.81.) Da Paz has always been determined to find ways to involve children and young people in her child protection practice and, following the initial training in Signs of Safety, she developed a very similar tool that serves the same purpose as the Three Houses tool but utilises a different graphic representation. Rather than Three Houses, Da Paz explores the same three questions using a drawing of a fairy with a magic wand (for girls) or a wizard figure (for boys) as below.



Da Paz uses the fairy's/wizard's clothes to explore problems by saying to the child, 'You can always change your clothes, so let's write down here the things you think need to be changed.' The fairy's wings and the wizard's cape represent the good things in the child's life, since the wings enable the fairy to 'fly away' or 'escape' her problems, while the cape 'protects' the young wizard and 'often makes his problems invisible'. On the star of the fairy's wand, and in the spell bubble at the end of the wizard's wand, the worker and the child write the child's wishes and vision of their life the way they would want it to be with all the problems solved. The wands represent 'wishes coming true' and hope for the future.

A comprehensive exploration of the Three Houses and Wizard and Fairy tools is available in Turnell, 2011.

Creating everyday safety for children is the primary aim of the Signs of Safety and the approach draws on numerous specific methods and tools to directly involve children in safety planning, which are explored in the next section.

## 8 Safety Planning

### 8.1 Description

Safety planning within the Signs of Safety approach is a proactive, structured and monitored process that provides parents with a genuine opportunity to demonstrate that they can provide care for their children in ways that satisfy the statutory agency. Child protection professionals will often claim they have created a safety plan when what they actually have is a list of services family members must attend. It is a maxim of the Signs of Safety that a service plan is NOT a safety plan. A safety plan is a specific set of rules and arrangements created by the parents and support people that describe how the family will live its everyday life to show the children, the family's own network and the statutory authorities that the children will be safe in the future.

The question 'What needs to happen to be satisfied the child will be safe in his/her own family?' is the most challenging question in child protection casework. Working together with the parents, children and a network of their friends and family to answer this question requires the professionals to lead the safety planning process with equal measures of skilful authority, vision-building and purposive questioning. The following describes key steps in the Signs of Safety safety planning process.

#### 8.1.1 Preparation

The more complex and risky a child protection case, the greater the number of professionals that tend to be involved. When child protection professionals are considering undertaking a safety planning process with parents, it is vital that all key professionals have discussed, are committed to, and know their role in the process.

#### 8.1.2 Establishing a working relationship with the family

Building safety plans that are meaningful and will last requires a robust working relationship between the child protection professionals and the parents/family. The simplest way to create a good working relationship with parents is for the professionals to continually identify and honour the parents for everything that is positive in their everyday care and involvement with their children. In this way, parents will be much more likely to listen to the workers' views about the problems and more likely to work with them through the challenges involved in building a lasting safety plan.

#### 8.1.3 A straightforward, understandable description of the child protection concerns

Beginning the safety process depends on child protection professionals being able to articulate the danger they see for the children in clear, simple language that the parents (even if they do not agree) can understand and will work on with the professionals. Clear, commonly understood danger statements are essential since they define the fundamental issues that the safety plan must address.

#### 8.1.4 Safety goals

Research with parents involved with child protection services repeatedly reports that parents want to know what they must do to satisfy child protection authorities in order to get them out of their lives. Once the child protection agency is clear

about its danger statements, these form the basis to articulate straightforward behavioural safety goals to tell parents what the agency needs to see to be satisfied the children will be safe.

### **8.1.5 Bottom lines**

The easiest way to distinguish between safety goals and bottom lines is to think of the difference between what and how. The goal articulates what must be achieved; the bottom line requirements are the professional conditions of how this must be achieved. As much as possible, it is best that the family and their network come up with the details of how the safety goals will be achieved so professionals can keep their bottom line requirements to an absolute minimum. This in turn creates maximum opportunity for the family to develop as much of the specific detail of the safety plan as possible. Typical bottom lines in Signs of Safety safety planning are the requirement of a safety network and a clear explanation of the problems for the children. Many child protection cases involve parents struggling with damaging drug or alcohol use. It is usual in these cases that professionals seek to impose a bottom line of sobriety and are thereby caught up in monitoring sobriety rather than safety. In the Signs of Safety approach the preferred bottom line is to say to the parents, 'Our issue is child safety, so you get to choose if this is a safety plan based on sobriety or on plans for who will do what when one of you drinks or uses.'

### **8.1.6 Involve an extensive, informed friend and family safety network**

Every traditional culture knows the wisdom of the African saying 'It takes a village to raise a child'. A child who is connected to many people who care for him/her will almost always have a better life experience and be safer than an isolated child. So safety planning work almost always involves requiring that the parents get as many people as they can involved in helping them create a safety plan. One of the most important aspects of involving an informed and naturally occurring network around the family is that this breaks the secrecy and shame that typically surrounds situations of child abuse.

### **8.1.7 Negotiating the how: developing the details of the safety plan**

When developing the details of any given safety plan it is important to give parents and everyone else involved (both layperson and professional) a vision of the sort of detailed safety plan that will satisfy the statutory authorities. With this done, the professionals' role is then to ask the parents and network to come up with their best thinking about how to show everybody, including the child protection agency, that the children will be safe and looked after well.

This is an evolving conversation as the professionals constantly deepen the parents' and networks' thinking about all the issues the professionals see, while at the same time exploring the challenges the parents and network foresee. The trick here is for professionals to break the habit of trying to solve issues themselves and instead explain their concerns openly and see what the parents and the network can suggest and do.

### **8.1.8 Successive reunification and monitoring progress**

Within the Signs of Safety approach, safety is defined as 'strengths demonstrated as a protection over time'. (Boffa and Podesta, 2004.) As the safety plan is being developed it is important that opportunities are created for the family to test, refine and demonstrate the new living arrangements over time. As this occurs, their success and progress in using the plan is monitored and supported initially by the

child protection professionals, but increasingly this role is handed over to the safety network. Most safety plans in the highest risk cases are created when the family is separated, either with the children in alternative care or the alleged abuser out of the family home. As the parents and family members engage in, and progress with, the safety planning process, it is important that the child protection agency reward the parents' efforts and build their hope and momentum by successively increasing their contact with their children and loosening up the professional controls on the contact arrangements. Once a safety planning process has begun, it is important that momentum and focus is maintained and that a completion date is identified. Safety planning usually takes between 3 and 12 months.

## 8.2 Involving children in safety planning

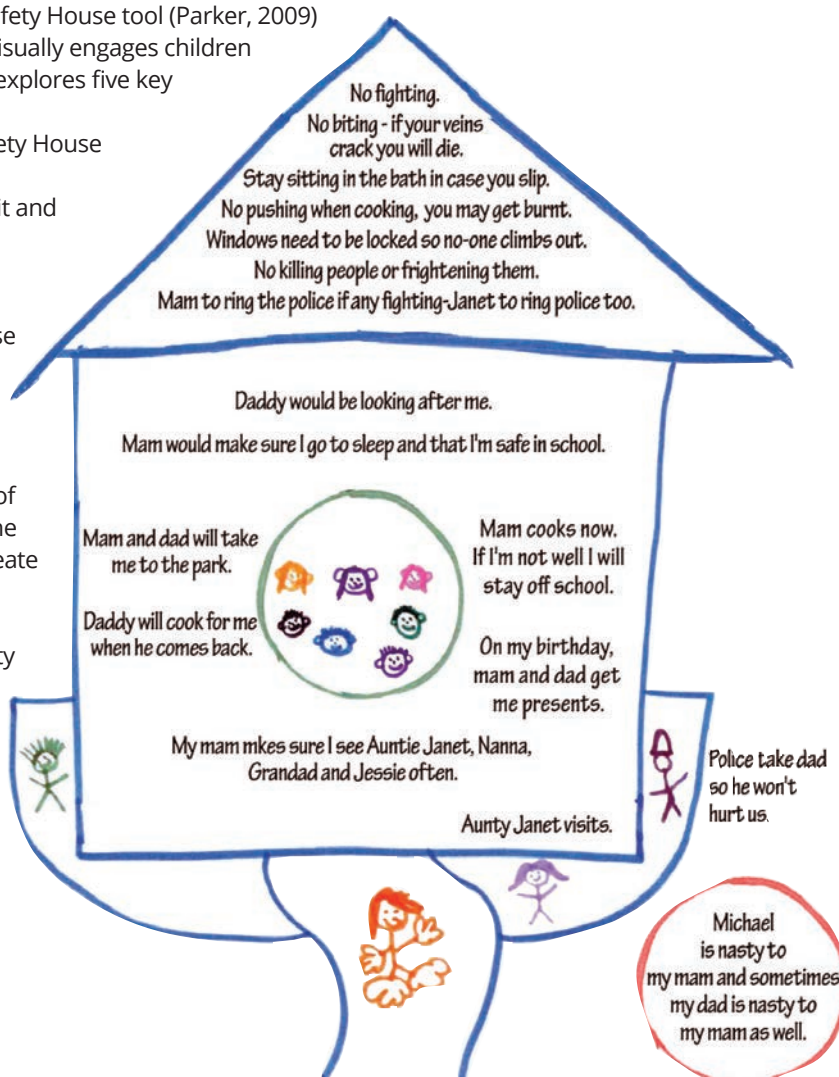
### 8.2.1 Safety House

Sonja Parker from Perth has developed a Safety House tool (Parker, 2009) that extends the Three Houses process and visually engages children in creating the safety plan. The Safety House explores five key elements with the child:

- i. What life will look like in the child's Safety House and the people who will live there.
- ii. People who the child thinks should visit and how they should be involved.
- iii. People the child sees as unsafe.
- iv. Rules of the Safety House.
- v. Safety Path: using the path to the house as a scaling device for the child to express their readiness to reunite or their level of safety in the family.

Undertaking the Safety House process with children should be done with full knowledge of the adults and with the children fully aware the parents are working with 'safety people' to create a new set of rules for their family so everyone knows the children are happy and safe.

This creates a context where the child's safety house can readily be brought to the parents and network and their ideas can contribute directly to growing the plan. This also underlines for the parents and network that the people they are ultimately most accountable to is not the statutory authorities but the children themselves.

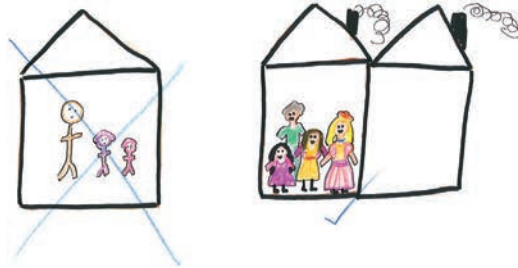


### 8.2.2 Words and Pictures explanation and child relevant safety plans

Turnell and Essex (2006) describe a Words and Pictures explanation process for informing children and young people about serious child protection concerns and a safety planning method that involves, and directly speaks to, children. The following illustrations are one example of each. They are presented to give a feel for age-appropriate explanations and safety plans that locate children in the middle of the practice picture and do this without trivialising or minimising the seriousness of the child protection concerns.

The Words and Pictures example presented here relates to an injured infant case and is excerpted from Turnell and Essex (2006). The Words and Pictures method also offers a powerful method of creating a meaningful explanation for looked-after children and young people who are typically very confused or uncertain why they have come into the care system. One example of this adaptation of the words and pictures method can found in Turnell and Essex, 2006, pp 94-101; another in Devlin, 2012.

1. Daddy is never to be alone with Amelia & Alexandra.



2. When you visit Daddy, there will always be someone else there like Rebecca, Daddy's neighbours, Dan & Carol, or Daddy's friends, Mary & Fred.



**SAFETY PLAN** for Amelia & Alexandra when they are visiting Dad so everyone knows they're safe.

4. If Alexandra or Amelia need help with personal things. Daddy won't help them. Rebecca will.

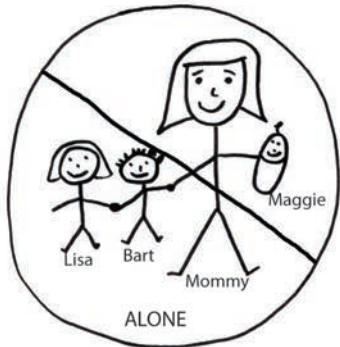
3. When Alexandra & Amelia go to the beach or pool with Daddy, he won't come into the water with them.



# Signs of Safety Comprehensive Briefing Paper

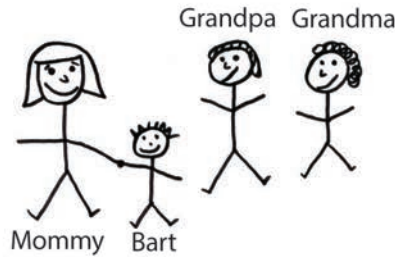
Given that safety plans are about the children and also about setting up family living arrangements so everyone knows the children will be safe and cared for, it is important to involve the children in the safety planning and make the process understandable to them. The following four-rule safety plan prepared by the parents and network together, with the professionals in a Munchausens-by-Proxy case, is a good example of this work. This plan was distilled from a much more detailed safety plan created with the parents, 15 support people and professionals over almost two years and was prepared for children aged four years, two years and six months. This plan is the work of professionals from Connected Families and Carver County Community Social Services, Minnesota.

1. Mommy is never to be alone with Lisa, Bart or Maggie.

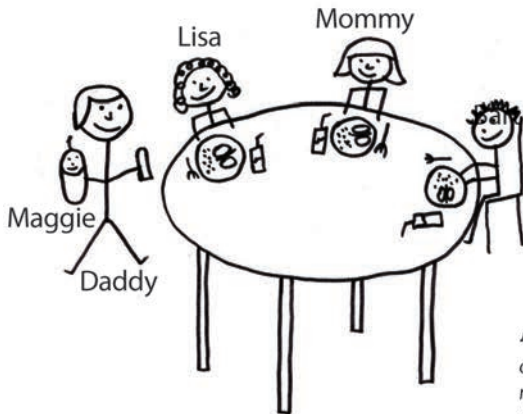


2. When you spend time with Mommy there will always be someone else there like Auntie Kate, Bill, Fred, Mary, Joe, Lyn – the pastor's wife, Margaret, Grandpa or Grandma. These are the safety people who love you and want to be sure you're safe.

### With Mommys safety people



3. When Mommy cooks or prepares food, everyone will eat the same food. Daddy or a safety person will get drinks for Maggie or Bart and prepare bottles for Maggie.



4. When Lisa, Bart or Maggie are sick, Daddy or one of the safety people will prepare the medicine. When Lisa, Bart or Maggie need to go to the doctor, Daddy will take them and Mommy will stay back or Mommy will take them and bring a safety person along.



### 8.3 A safety plan is a journey, not a product

The most important aspect of Signs of Safety safety planning is that the plan is co-created with, and owned by, the family and an informed safety network. For this to happen the plan must be implemented, monitored and carefully refined over time. Ownership is deepened further as the details of the plan are made, and committed to, by the parents in front of their own children, kin and friends. These are not things that can be done in one or two meetings and a safety plan that will last certainly cannot be created by professionals deciding on the rules and then trying to impose them on the family. Above all, meaningful safety plans are created out of a sustained learning journey undertaken by the family together with the professionals focused on the most challenging question that can be asked in child protection: 'What specifically do we need to see to be satisfied this child is safe?'

Just as the implementation of a family-owned safety plan is best understood as a journey, for a child protection agency to consistently implement the Signs of Safety approach and achieve the sort of safety planning just described, the organisation needs to build its vision, capacity and skill base in using these methods through a whole-of-agency, multi-year learning journey. The following chapters look at the issues of implementation.



# 9 Three Key Learning Approaches Applied to Signs of Safety

## 9.1 Creating a culture of appreciative inquiry

### **Competency is quiet; it tends to be overlooked in the noise and clatter of problems.**

(William Madsen, 2007.)

Child protection above all else has suffered from a crisis of vision. Many commentators have observed that the defining motif of child protection work is 'risk' in the negative sense of risk avoidance or risk aversion. If this is true, then the primary motivation of the field is not what it is seeking to achieve constructively but rather what it is seeking to avoid, namely any hint of public failure. This, in the words of Dr Terry Murphy from Teeside University, Middlesborough, is like 'trying to design a passenger airliner based solely on information gathered from plane wrecks—do this for long enough you'll have a plane that never gets off the runway'.

As well as being over-organised by fear of failure, child protection thinking tends to be dominated by the 'big' voices of researchers, policy makers, academics and bureaucrats. In this environment, constructive frontline practice tends to be overlooked and practitioners can feel alienated from the views of head office and the academy. Practitioners often experience these views as 'voices from 27,000 feet' and academics and policy makers tend to act as if field staff are themselves 'problems' to be guided and managed. (There is a considerable volume of writing on the burgeoning domination of managerialism within the helping professions, including Munro, 2004, and Parton, 2006.)

While this is an all too familiar story, there is another story that can be told:

*Child protection workers do in fact build constructive relationships, with some of the 'hardest' families, in the busiest child protection offices, in the poorest locations, everywhere in the world. This is not to say that oppressive child protection practices do not happen, or that sometimes they are even the norm. However, worker-defined, good practice with 'difficult' cases is an invaluable and almost entirely overlooked resource for improving child protection services and building a grounded vision of constructive statutory practice. (Turnell, 2004: p.15.)*

The Signs of Safety approach has evolved progressively by first teaching practitioners the approach and then shifting from training to action-learning mode by asking the workers how using the approach has been useful to them.

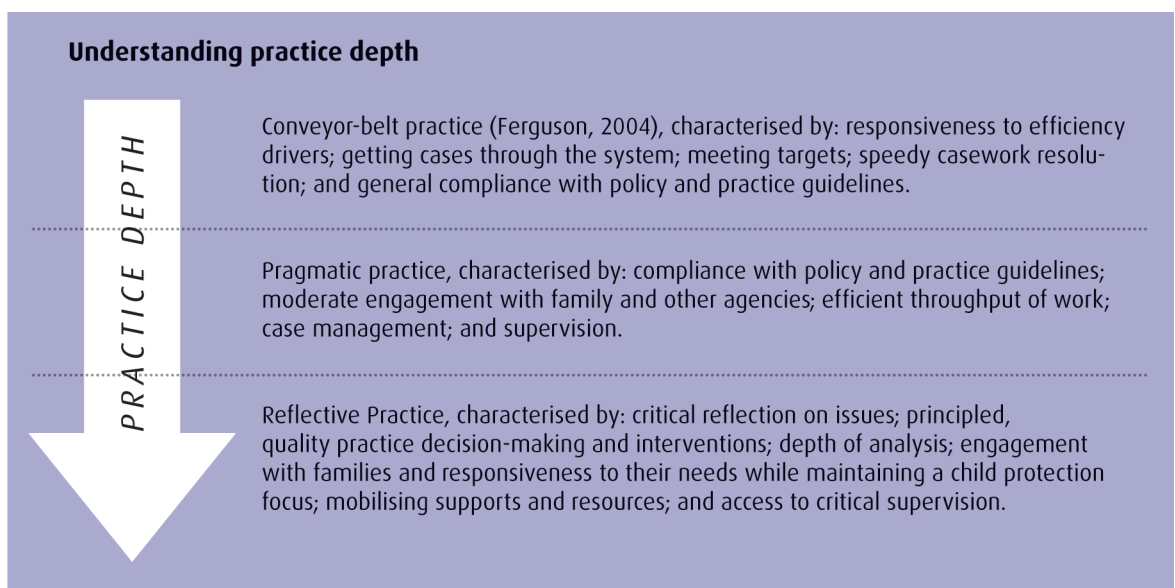
Steve Edwards and Andrew Turnell drew the inspiration to inquire into worker-defined successful practice from solution-focused brief therapy methods of focusing on what works for clients. Applied within a work context, this methodology can also be seen as a form of appreciative inquiry. Appreciative inquiry is an approach to organisational change first developed by David Cooperrider. (Cooperrider, 1995; Cooperrider and Srivastva, 1987; Cooperrider and Whitney, 1999.) Cooperrider and his colleagues found that focusing on successful, rather than problematic, organisational behaviour is a powerful mechanism for generating organisational change and one appreciative inquiry author describes the approach as 'change at the speed of imagination' (Watkins and Mohr, 2001). Perhaps the title would be more accurately framed as 'change at the speed of grounded, detailed and shared attention to best practice'.

To sharpen the thinking and practice supporting Signs of Safety implementation,

Andrew Turnell drew together solution-focused brief therapy and appreciative inquiry, integrating the questioning methods and technology of the former and the organisational change agenda of the latter. From these foundations, the engine room of any Signs of Safety implementation involves embedding a culture of appreciative inquiry around frontline practice across the organisation. This is a radical paradigm shift from the usual anxiety-driven defensiveness and obsession with researching failure that bedevils the child protection field.

While the process of building a culture of appreciative inquiry around frontline practice must be embedded in regular individual and group supervision, it is vital that senior management replicate this process and practice, particularly when crises occur. When a fatality happens, practitioners hold their breath, the underlying organisational culture is exposed, and this is when agency leaders must demonstrate they can lead appreciatively and rigorously. Eileen Munro, Andrew Turnell and Terry Murphy have written about this in a recent paper called *Leading for Learning in Child Protection Following a Fatality* (Turnell, Munro and Murphy, 2013).

In a direct parallel to what the Signs of Safety approach asks workers to do with families, the process of focusing forensically on the detail of what works does not, as some fear, minimise problems and dysfunctional behaviour. Quite the reverse. Inquiring into and honouring what works (with families and practitioners) creates increased openness and energy to look at behaviours that are problematic, dysfunctional or destructive. Child protection work is too difficult and too challenging to overlook even the smallest scintilla of hope and creativity that can be found in instances of even partial success.



Megan Chapman and Jo Field, two highly experienced child protection social workers, have written an invaluable paper about implementing strengths-based practice and the Signs of Safety within Child Youth and Family Services, New Zealand (Chapman and Field, 2007). This paper describes some of the organisational and strategic issues involved in shifting a child protection agency toward relationship-grounded, safety-organised practice and introduces the notion of 'practice depth'.

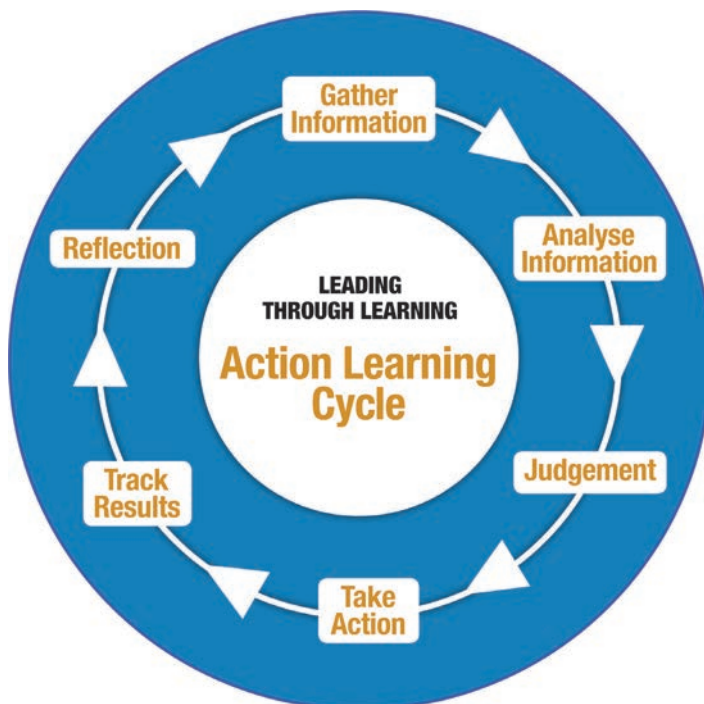
Too often child protection organisations fall into perpetuating what Chapman and Field describe as 'conveyor-belt' or 'pragmatic' practice. Practice of this form may seem expedient and may be necessary for all sorts of pragmatic reasons, but it rarely makes any significant difference in the lives of vulnerable children and it ignores the experience of the practitioner. When frontline workers and supervisors become overly focused on compliance, their working lives in child protection will

inevitably be short or their work will be overtaken by cynicism.

Placing successful practice at the centre of the Signs of Safety implementation directly addresses this problem by challenging practitioners to stake a claim for work they are proud of. Building 'practice depth' within the team, the office and the agency as a whole is truly challenging work. Appreciative inquiry enables child protection staff to reclaim pride and confidence in their work. This becomes the foundation from which the agency and its leaders can deliver services that are valued more highly by service recipients and, even where intrusive statutory interventions are necessary, will deliver safer outcomes for vulnerable children.

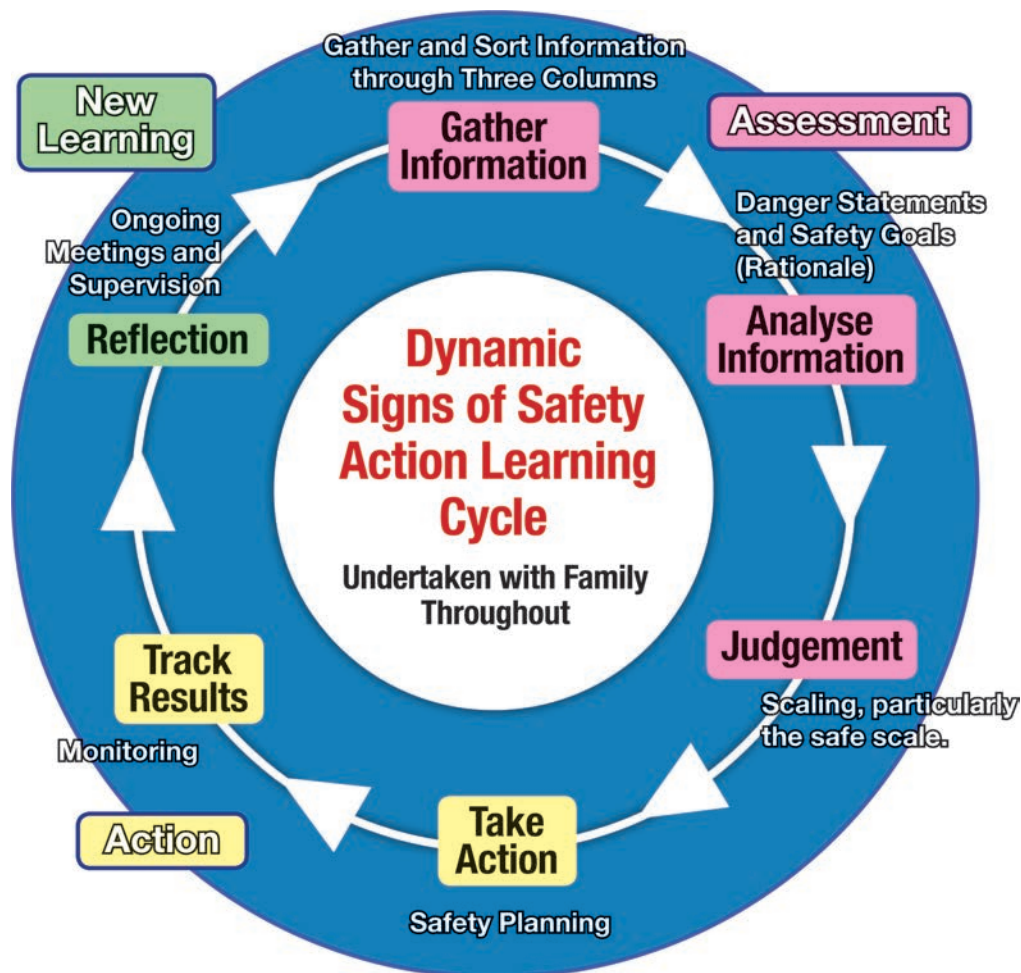
## 9.2 Action learning

In child protection, team leaders or supervisors are the primary leaders of learning and of the agency's learning culture. Through no fault of their own, however, supervisors rarely identify learning as a priority activity. Supervisors usually prioritise 'doing' over learning since they typically feel like the meat in the organisational sandwich with practitioners constantly coming to them for help with practice and managers pressuring them about compliance, standards and timelines. They typically respond to these relentless day-to-day demands on their time by defaulting to telling practitioners what to do and this becomes the implicit embedded learning culture of the organisation.



For learning to be an effective driver of organisational development, an agency must establish and sustain clear processes for action learning around frontline practice. While there will always be times when supervisors (and all child protection leaders) must lead by directing, the agency must actively engage supervisors in their own reflective learning to enable them to lead predominantly through action learning. This is a huge organisational challenge as supervisors are always busy and managers tend to explicitly or implicitly support this. So while supervisors will readily attend initial training, they will typically be less involved in ongoing learning. Managers must use their authority compassionately and purposefully to engage all supervisors in their own action learning so they can deepen their understanding of the model and also grow their capacity to lead through inquiry and reflection.

The following diagram visually represents the action learning cycle. As the name suggests, action learning posits that meaningful learning is always embedded in action as time is given to reflect on the outcomes of that action. The learning theory that underpins action learning resolves the tension between theory and practice and this is refreshing news for child protection that demands action as its defining motif. Integrating the Signs of Safety assessment and planning processes and action learning can be represented as follows:



Implementing the Signs of Safety requires action-based learning across the agency to build and sustain a clear vision of what constructive practice and organisation actually looks like.

### 9.3 The learning organisation

The concept of the 'learning organisation' was first articulated by Peter Senge in his book *The Fifth Discipline* (1990). Senge describes learning organisations as places "where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning to see the whole reality together".

While Senge's writing can seem abstract and feel somewhat disconnected from the day-to-day reality in a large bureaucratic organisation, the idea of the learning organisation is important. Senge argues that organisational change and development is not a product but rather a process of bringing forward peoples' best thinking and energy.

The approach has important implications for Signs of Safety learning and the child protection agency as a whole. Learning organisations recognise that they are systems of interrelationships and that these require deliberate attention to eliminate the obstacles to learning. The approach emphasises personal mastery, the drive that personal development holds for individuals, and the need to grow, and work on, one's own goals. It also recognises that organisational culture, as reflected in the mindsets of individuals, has a marked impact on learning and performance. A common vision shared by all staff is emphasised to bring personal goals in line with the goals and vision of the organisation. Dialogue and group discussion among staff members are clearly indicated in this context. For a team to learn, they must be in sync and reach agreement.

Senge invokes the notion of the 'learning journey' to suggest that organisational (and individual) change and development cannot be bottled, or disbursed, especially not in a training program. Rather it is a relational process of continual inquiry, reflection and learning that needs to be fostered in the culture, procedures and habits of the organisation.

Meaningful implementation of the Signs of Safety always requires a sustained organisation-wide 'learning journey' that embeds clear processes of action learning within an organisation that is itself in sync with the Signs of Safety.

## 10 The Signs of Safety Implementation Framework – Alignment of the Organisation and the Practice

Jurisdiction-wide implementations have highlighted the role of Signs of Safety in transforming not only child protection practice but also the child protection agency as policy, learning and leadership become aligned to the approach. Achieving this alignment is, in turn, fundamental to embedding, sustaining and growing Signs of Safety practice.

If the challenges of alignment are met, Signs of Safety offers the opportunity to be the core and the driver of organisational transformation.

The Signs of Safety implementation framework reflects the fundamental but perennially overlooked fact that the practice and organisational transformation sought by the adoption of Signs of Safety must be built on multi-faceted reforms, with each of the parts aligned and reinforcing the whole. It has been developed from the experience, the successes and the struggles in leading and consulting for the implementation of Signs of Safety in jurisdictions around the world. It particularly reflects the experience of five years of implementation in Western Australia, which has been critically reviewed and found to be consistent with the tenets of implementation science (Salveron et.al., 2014).

### 10.1 The challenges of implementation

*"Implementing a practice framework, Signs of Safety, is fitting a complex social system into a complex social system." (Munro echoing Pawson, 2006)*

The challenges are significant. Child welfare agencies are almost invariably mature organisations. As such they are likely to have layers of policy and procedures, adopted over a long time, that are rarely considered afresh and rarely effectively integrated, streamlined and culled. They are also likely to have strongly ingrained cultural mores and implicit values, some of which will be positive and reflect the organisation's stated goals and values, and others that may be antithetical. This becomes particularly evident when considering the extent to which workers feel they would be supported in the face of a tragedy occurring to a child in a case they are managing.

The cultural change potential of Signs of Safety practice has been emphasised throughout this briefing paper – working with families, as opposed to investigating them and dictating to them; families finding their own solutions rather than being told what to do, with child protection spelling out expectations and bottom lines and families choosing how they achieve these; returning power and responsibility to families without being naïve about doing so. This is a fundamental cultural shift in child protection work, both in the practice and the organisation.

It is a shift because the history of child protection over the last thirty years has been characterised by organisational requirements becoming the central focus in the mistaken belief that compliance with detailed procedures will create safety. Until the Munro Review in England in 2011, and still in many jurisdictions, organisational reviews and reforms have recommended predominantly structural and procedural solutions, and then lots of training for workers.

The centre of the work - the actual practice - is lost when organisational arrangements and prescribed procedures are seen as the way to control child protection practice and outcomes. The real impact of organisational factors on worker's behaviour, their skills and approach to risk is overlooked. As Wiggerink (2013) puts it with respect to practice, "We have been telling families what to do for years and they have been ignoring us for years." Similarly, management has been telling

workers what to do for years and they have been largely doing their own interpretation of what is best while being kept busy following procedures and doing paperwork.

The development of a disjuncture between the practice and the organisation is understandable. It occurs in response to child protection being a highly scrutinised and contentious area of public service, and it has only become more so in recent decades. This is because tragedies are inherent in the work, yet western political and social culture expects highly accountable action and solutions to issues so as to prevent every tragedy. Consequently, anxiety is a constant - for workers, managers, politicians and the community. For workers and managers who must actually make the assessments and the decisions, this anxiety is both a real fear for the safety of children as well as a real fear about the personal consequences of getting it wrong, or simply being the one on whose watch a tragedy occurs.

Put all the factors together - complex and mature organisations, the anxiety inherent in the work, and cycles of reform that have resulted in more procedures and accountabilities, and hence more complexity and more anxiety - and aligning child protection organisations with how the practice occurs is not easy. Like the Signs of Safety practice itself, effective organisational reform is a journey that must be pursued with vigour, agility and adaptability over time.

## 10.2 The implementation framework

The Signs of Safety implementation framework encompasses a series of inter-linked developments for whole system change, with Signs of Safety practice at its intellectual and operational centre providing the catalyst for organisational transformation.

The key activities are set out in terms of structural arrangements, learning strategies and leadership imperatives. Following these is managing the politics to stay the journey of reform and the impact of national and international engagement.

### 10.2.1 Structural arrangements

The structural arrangements encompass:

- planning and reviewing progress regularly,
- governance arrangements
- the practice model itself as a key organisational policy
- alignment of the detailed policies and procedures that guide practice and accountability to Signs of Safety, and
- constantly drawing on practitioner experience and input.

#### *Planning, governance structure and policy document*

To start, it is essential to have a plan, a governance structure (usually a committee or oversight group) and a policy document.

A number of jurisdictions have adopted the implementation framework as the basis for their plans for the whole organisation implementation. Planning then occurs in a cascade to include workplace plans, with whole-of-organisation reviews and implementation plans being adjusted each year or two and more frequently at the workplace level.

Governance arrangements need to be visible and active. A single steering committee provides focus and an opportunity to draw together key leaders and practice managers as well as policy and learning support sections of the organisation. Its role should be to plan, review, solve problems and initiate direct action at points where that may need to occur. Executive level leadership is recommended.

It is fundamental that a single, accessible, frequently promoted policy document set out the Signs of Safety child protection practice approach. Staff need to be able to point to, and understand, the approach through a single document. The framework should explain its history, evidence, theory, core practice elements, and the organisation's approach to implementation.

This comprehensive briefing paper has served as the core policy document for some organisations. It is, however, lengthy and therefore may not be as appealing to staff as an organisation would want. The policy document may be more accessible for all staff by having a brief summary paper backed by the more comprehensive briefing paper as an appendix.

### *Aligning policies and procedures*

Critical to success over time is the alignment of policies and procedures to Signs of Safety, as well as case recording and information systems.

Organisations tend to have developed layers of policy, procedures, guidelines, instructions, accountability requirements, and reporting arrangements. These are often complex, prescriptive and time consuming. Adding the practice model to this mix can be regarded as just more requirements and something extra to do.

The Signs of Safety approach is how to do the work, not another layer of work. This can be difficult for workers to see because they are busy, are following detailed procedures, and are being audited regularly. So, the system must shift and make space for the way of working to be realised. The challenge is to have fewer prescribed policies and procedures and to support the work to be done in alignment with Signs of Safety.

Child protection organisations are amazingly reluctant to let go of complex policies and procedures. Because the work is so complex, anxious and uncertain, almost invariably policies and procedures have attempted to capture all the diverse elements of the work and to prescribe actions accordingly. However, the nature of the actual human experience that occurs between staff and clients means that this is simply not possible and results in suffocating many workers, stifling their creativity and keeping them at their desks.

A deliberate commitment to streamlining policy, and continually looking at what to streamline, must be the corollary to rewriting policies and procedures to align with Signs of Safety. This means simplifying, combining and culling policies. It may mean identifying and letting go of policies that give an illusory sense of security to the organisation, particularly those that may have been developed after a crisis. These tend to be retained largely because of public perception and they add only to the process and not to outcomes.

Aligning and streamlining policy and procedures with Signs of Safety is critically important. It takes time and will likely occur in stages.

### *Aligning information management*

Most difficult to achieve is aligning information management systems because this involves large capital investments. This kind of adjustment is expensive and has knock-on effects for the entire system. Stopgap measures are important, as is a longer-term commitment by an organisation to revise the system.

In line with practice-led evidence, it must be the experience of workers that informs the alignment of policies and procedures. This is fundamental if policies and procedures are to be beneficial and not impede the capacity of workers to be with families, to work effectively and to record their work in a manner that is helpful. However, in their anxiety and in the midst of the work's complexity, some of the people who do the work can also be as susceptible to prescribing complexity as central bureaucracies.

Nevertheless, as Steve Edwards said as Signs of Safety was being developed, "If workers use it, it's in the model; if they don't use it, it's not in the model." The chal-



lenge for organisations is to live this phrase. If policy is not useful, if it cannot be explained to staff how it is necessary for working effectively with the families and children, it should be culled.

There needs to be deliberate effort to access continuous feedback from staff and families about how Signs of Safety is working. Sharing successes through appreciative inquiries in workplaces is fundamental and must be driven by the key leaders. Most basically, managers and supervisors must pay attention to key aspects of Signs of Safety practice – for example, the mappings with families, the harm statements and danger statements in the assessments, and the resultant safety goals and safety plans, with attention to the plain language and focus on behaviours. The realisation of this as action learning is best achieved by building the processes for deliberately seeking and acting on feedback into new methods for quality assurance.

### *Robust intake and assessment capacity*

There are two key parallel organisational reforms to support effective practice.

First is having a robust front end, the point at which work enters the organisation and assessments occur. As the approach gains traction, all jurisdictions experience an increase of work occurring at their assessment and intake stages. This front end workload may grow further as Signs of Safety meetings with families occur at an earlier point and increasingly involve their networks of extended family and social supports - and other professionals engaged with the family - and safety planning is brought to bear at an earlier stage. This means that it is necessary to have a well resourced front end, staffed with a good balance of senior practitioners, and effectively integrated client pathways. This is likely to involve shifting existing resources or directing growth resources disproportionately to the assessment and intake functions of the agency. Alignment of policy and procedures, and streamlining these, is also critical for an effective and increasingly consistent front end service response.

### *Formal partner agency engagement.*

The second key reform is formal partner agency engagement. Child protection work is not undertaken by statutory child protection agencies alone. Their role is fundamental, and has the greatest impact for a family that is subject to child protection intervention, as Signs of Safety practice returns child protection intervention to being the catalyst and driver of behavioural change. However, work often occurs in tandem with law enforcement, many families are (or have been) working with multiple welfare agencies, all have relationships with universal education and health services, and many will have or need engagement with specialist services like mental health, drug and alcohol services.

Harnessing and co-ordinating this complex interdependency of different professional services is complex. Each professional service has its own etiological and philosophical foundations, language and priorities. Child protection may be regarded by other services as either to be avoided or solely responsible when there is risk of harm to children, as a direct result of their experience of paternalistic and authoritarian child protection practice, gatekeeping and weak partnerships. Therefore, real issues encountered by other social services can be either overlooked or exaggerated. As the first principle of Signs of Safety emphasises, working relationships are fundamental, and this applies to relationships between professionals as well as with families.

England is the most formally 'joined up' jurisdiction in the world and others often look to it for example. Even there, poor working relationships can undermine formal coordination and collaboration, while elaborate structural arrangements can themselves become a blockage.

What is required is a combination of:

- the effort to achieve working relationships, in line with
- the principles, disciplines, shared language and processes of Signs of Safety, together with
- formal structural arrangements for meeting, exchanging information and collaborating.

Briefing key partners, shared training, inclusion through workplace-based learning activities, and formal agreements for partnership are all effective and necessary strategies.

Most important, though, is that partner agencies actually participate in Signs of Safety meetings, the assessment and planning and safety planning process, along with families and child protection authorities.

## 10.2.2 Learning strategies

The most frequent reoccurring error that organisations make in implementing new initiatives is to mistake training for implementation. Training is only one facet of learning. It is essential but by itself has little impact. Training provides exposure to the new way of working. Some people will be enthused and grasp enough of the content to begin working this way. Others may be uncertain about the approach, for a variety of understandable reasons, not least of which is that any new approach implicitly devalues previous work. Others may feel they have insufficient knowledge to begin and some will not be confident enough in their own skills.

As the key learning approaches to Signs of Safety introduced in the previous chapter indicate - appreciative inquiry, action learning and the learning organisation - learning needs to be multifaceted and continuous and become built into the fabric of the everyday experience of staff.

### *Core learning*

Essential to start are the core learning strategies for implementation. These comprise the following elements:

- Basic training for all staff, including senior and other managers, generally comprising a two-day course.
- Advanced training for supervisors and other staff designated as practice leaders, generally comprising a five-day course.
- Ongoing coaching for supervisors and other practice leaders, ambitiously allowing for six sessions per year (through a mixture of face-to-face and video conferences).

Key objectives for each area of core learning emphasise the experiential nature of learning, consistent with adult learning principles, and a continuous focus on actual case examples, particularly to highlight good practice but also to be open about struggles. These are as follows.

### *Basic training*

- Provide an overview of the principles, disciplines, tools and processes of Signs of Safety practice.
- Experience the application of Signs of Safety practice to case examples.

### *Advanced training for supervisors and other practice leaders*

- Experience application of each of the Signs of Safety tools in case examples through full case trajectories.
- Explore and experience the application of the principles and disciplines of Signs of Safety in applying the tools in case examples.

- Experience and apply the key skills of questioning, facilitation and appreciative inquiry working with colleagues.
- Identify key areas for personal development.

### *Coaching for supervisors and other practice leaders*

- Review current complex case examples held by participants.
- Practice applying Signs of Safety tools and key skills in progressing case examples.
- Conduct and participate in appreciative inquiries.
- Explore specific professional development areas.
- Explore leadership challenges and solutions in leading teams in Signs of Safety practice.

The advanced training and ongoing coaching for supervisors and other practice leaders places a strong emphasis on the role of these leaders as being strong practitioners, leading by example and able to provide hands-on coaching to their teams and colleagues. It is especially critical that supervisors receive the recognition and support they need to realise this role. The support of other natural leaders of practice can be a great complement to supervisors' formal role. Care must be taken though to ensure that learning and key parts of case management are not devolved to the other practice leaders while supervisors remain enmeshed in the busyness of their jobs.

The overarching purposes of ongoing coaching for supervisors are to bring them together, build their individual and collective vision of good practice, and learn from each other.

These activities that constitute core learning have been refined over time. While they are defined in a consistent way in this paper and are increasingly being applied in this way by licensed trainers and consultants, and internal learning departments of agencies, it is also essential that learning is responsive and adaptive to the specific needs of the organisation.

### *Integrating core learning into the organisation*

Integrating basic training and other aspects of core learning into the organisation's internally provided formal learning needs to occur over time. Doing so effectively requires that practitioners become engaged in providing training and that trainers are well versed in contemporary practice.

Organisations also need to broaden the nature and availability of learning activities. While the core learning is comprehensive, formal learning is only part of how staff actually develop their practice. The 70:20:10 approach described by Jennings (2013) and others asserts that training accounts for only 10% of all learning, while 20% occurs when talking about practice with colleagues, and 70% happens when people are working in the field with clients. This means that a range of deliberate activities that also includes supervision, workplace based learning activities and structured exposure to practice experience, with review and feedback, are necessary for effective learning.

### *Skills training workshops*

Skills training workshops focusing on specific aspects of the practice should be regularly available, both in workplaces and through formal programmes. These may include practice elements such as the analysis of assessments into the succinct and plain language statements of harm and danger, developing safety goals based on the statements of danger, developing safety plans, using children's tools, and the broad skills underpinning the approach such as leading by questioning.

### *Workplace learning sessions*

Workplace learning sessions are particularly important to emphasise and realise the importance placed on learning and to encourage collaborative learning between colleagues. They provide an important opportunity to bring regular appreciative inquiries into workplaces, driving the vision for good practice and the confidence that can be achieved.

### *Supervision using a Signs of Safety format*

Supervision using a Signs of Safety format, essentially using the three column approach, should recognise that supervision supports both case planning and workers' growth and development. This will effectively align the way that supervision occurs with the practice. Using a questioning approach is critical. This includes the hard questions that need to be addressed and does not preclude making statements about issues in an open and clear way, again mirroring how Signs of Safety practice occurs.

### *Group supervision*

Group supervision is a key strategy for supporting workers' growth and development. It involves all participants actively working on real, usually current, cases. It may involve undertaking or reviewing case mappings or working on particular aspects of case practice. These aspects might, for example, include case analysis through developing danger statements or questions for areas of practice that appear stuck.

Group supervision generally occurs in established teams. However, working across teams, with supervisors as a group, and open sessions for whole workplaces will also provide substantial learning opportunities. Leading group supervision is an important role for supervisors and one that can be shared with other practice leaders.

The learning that can be achieved in a group is generally greater than through individual supervision because it benefits from the skills, analysis and experience of the whole group and involves actively practising analysis and applied casework skills. As it can facilitate intense learning and development, group supervision can also provide a sense of empowerment that is essential to building the emotional and psychological health and resilience of staff. Group supervision is also a means of sharing the anxiety inherent in casework, a strategy to deal with working with uncertainty, and a means of sharing the emotional support a team can provide.

### *Signalling and amplifying the centrality of learning*

It is desirable that the centrality of learning is both signalled and amplified by significant learning events and supported by dedicated positions supporting case practice across the organisation.

There have been eight international Signs of Safety Gatherings between 2005 and 2014 as the approach has developed and been showcased. These predominantly involved practitioners presenting work of which they were proud using appreciative inquiries with families and staff. Increasingly, implementing jurisdictions have been holding similar events internally as part of their learning calendars.

Many jurisdictions have implemented positions dedicated to practice learning - for the whole organisation and/or at the workplace level - that can coach staff as well as review, advise on and participate in difficult practice activities. These have titles like practice coaches, senior practice development officers, practice specialists and quality assurance officers. Some of these positions may predate the implementation of Signs of Safety and may be re-oriented to support Signs of Safety practice.

This involves a change process that has the attendant challenge of appearing to undervalue the previous work of these positions, as occurs for all practitioners, but is intensified for these leaders who have been drivers for achieving quality practice.

As well as being hands-on coaches and leaders of practice, these positions are useful drivers of organisation-wide learning and development priorities, particularly with like groups of practitioners.

### 10.2.3 Leadership imperatives

The complexity of child protection, and the contentious environment in which it operates, means that there is enormous potential for confusion and lack of clear direction, as well as over-reliance on policy and procedures. This tends to lead to workers following (most) procedures but doing their work in various ways based on differing individual values and beliefs, and too often in a muddled way that defaults to being either directive, naive, or authoritarian and paternalistic.

#### *Clarity and focus*

If there is to be a new way of working across the organisation, and not just among the best and most robust child protection workers in pockets of the organisation, there needs to be maximum possible clarity and focus, both regarding the commitment to working with Signs of Safety and what constitutes its core practice. This demands constant reiteration and clarification for staff from leadership.

#### *Strong, visible and engaged senior management*

The experience of many child protection organisations is that leadership is remote and not focused on the frontline work of the agency and its staff. Aligned to clarity and focus, organisational transformation demands strong, visible and engaged senior management. This means being engaged in the service delivery work of the agency above all else.

Senior management is pulled in many directions. Managing the political environment, building and sustaining relations with partner agencies, executing the formal bureaucratic and organisational processes of planning, managing finances and reporting, steering through perennial crises, and managing public relations can be all-consuming for senior managers. If this is so, then the main reason why senior managers exist, to support and guide and to lead the service delivery work of the agency, can be lost.

Being strong, visible and engaged means, above all else, leading for practice. Knowing, learning the practice and leading in a manner congruent with the practice gives critical attention to where the most opportunity for transformation actually exists - the core business of the agency.

#### *Fostering a safe organisation*

Perhaps the most fundamental and testing role of leadership in a child welfare organisation is fostering a safe organisation - building staff confidence that workers will be supported through anxiety, contention and crises.

All child protection organisations have stories of when workers have not been supported by managers, and when workers and managers have not been supported by executive and political leadership. These stories, and the experiences on which they are based, drive anxiety and risk aversion in practice. They corrode the trust that is essential to embrace the inherent risks of child protection work. A fearful, untrusting workforce will focus on compliance and defensive practice rather than on outcomes for families. A perception that workers will not be supported is difficult to shift. That shift will only occur with experience and time.

Two imperatives are essential to fostering a safe organisation for the effective implementation of Signs of Safety and the demands it makes of staff in their practice.

The first is that anxiety is to be shared upwards through the organisation, so that workers and immediate supervisors are never left feeling that they are carrying alone the risk inherent in cases. Staff need to believe that managers at all levels of the organisation share the everyday anxiety in all casework, rather than only getting involved with the high profile contentious cases in which they give direction from afar driven by protecting the organisation. In practice, this means having a good flow of contentious case briefings through management and ensuring there is rigorous questioning at each stage. When senior management does intervene in decision making, it is important to support and involve the staff with the decision making. The means of doing so is to continue the Signs of Safety process of analysis throughout.

Second is that there be an explicit commitment by executive leadership that, should a tragedy occur, they will fully back up workers who have done their best, within the capacity of the organisation, and have been frank and open.

Sadly, tragedies are part of the child welfare landscape. Child welfare organisations deal with a segment of the population in which tragedies occur due to a variety of causes, in which there is not always effective engagement with families and in which there can be active avoidance by families.

This commitment will be tested. With every test handled well, trust and resilience increases. Any failed test has an exponentially greater negative impact. Progress is incremental because the large or small stories (of whatever objectivity) of staff being blamed when adverse events occur are likely to be deeply ingrained in the organisation.

An explicit and realised commitment to backing staff through tragedies is not to be confused with a lack of responsibility or accountability. It is a fair and reasonable contract for both workers and executive leaders in the organisation. It requires workers to do their best within the capacity of the organisation and this must include meeting essential policy requirements. In turn, for this contract to work, executive leadership must have the courage to assume the personal professional risk that is inherent in child protection organisations.

Exercising this leadership imperative can mitigate the extent to which political leadership is driven by the media's and political opposition's search for blame. One should not be naïve about the dynamics of politics and the media, but courage is contagious, just as fear is.

Turnell, Munro and Murphy (2013) describe leading for learning through a child fatality, based on a case study, and set out a step-by-step approach that exemplifies leadership fostering a safe organisation.

### *Parallel process*

The core theme of the implementation framework is aligning organisational arrangements with the Signs of Safety practice approach.

The leadership of the organisation should drive concrete and identifiable parallel process, where management mirrors Signs of Safety processes. Key processes that are highly visible are the questioning approach in leadership and supervision, referencing and applying the Signs of Safety principles and disciplines in everyday interactions, and deploying the three column assessment and planning framework across the organisation for operational and strategic review and planning exercises.

## *Distributed leadership*

The final critical leadership imperative is distributed leadership. To be effective in an organisation where frontline and supervisory staff hold substantial authority and power, leadership must be distributed. Distributed leadership means both conferring an organisational leadership dimension to all roles throughout the organisation and expecting leadership to be exercised from all roles. Each person, from the front counter to the chief executive, has to be leading the organisation “to be what we want it to be”, clear and focussed about how we work, with practice and management and leadership congruent. Ghandi’s exhortation for each of us to be the change we want to see captures this sentiment and its possibility to occur if leadership supports this.

### **10.2.4 Bringing it all together in the learning organisation**

The concept of becoming a “learning organisation” (Senge, 1990, 2006), introduced in the previous chapter, can encompass these structural arrangements, learning strategies and leadership imperatives, and is a useful parallel commitment to the implementation of Signs of Safety.

The theory of learning organisations emphasises tenets that are clearly consistent with the Signs of Safety implementation framework. These include:

- the way in which individuals work and interact being fundamental to meeting complex work challenges;
- systems thinking, recognising how all parts of the organisation affect the whole;
- personal mastery, with the organisation supporting each and every staff member to meet their own learning goals;
- the importance of the conceptual models that workers hold in their minds about the organisation influencing how they behave;
- the necessity for shared vision throughout the organisation; and
- the centrality of team learning.

For child welfare organisations, the key day-to-day implications of the commitment to becoming a learning organisation are explicitly realised through communicating and driving:

- constant learning as being essential for personal professional growth and organisational development;
- every interaction, with families and colleagues alike, as being an opportunity for reflection and thus learning;
- the recognition that mistakes occur and that each of these is an opportunity for learning and will be treated as such.

### **10.2.5 Politics and staying the journey**

Organisational transformation does not occur all at once or quickly. It is a journey that requires perseverance, agility and creativity next to clarity and focus. Staying the journey is likely, at times, to require managing politics with executive government, partner agencies, oversight authorities and with the media, occasioned by inevitable setbacks. Being positioned to do so successfully requires:

- building recognition that tragedies and contention are inherent in child protection;
- building recognition that growing people and organisations takes time;
- building ‘capital’ with partners and politicians through helping them to understand the nature of the work and the practice; and
- being credible and reliable, and demonstrating the early and continuing good practice and outcomes that come with Signs of Safety.

## 10.3 National and international engagement

There are significant benefits of national and international engagement supporting the journey of Signs of Safety implementation. The international network of agencies implementing Signs of Safety drives the continuing evolution of the practice and creates a powerful shared learning environment, as outlined throughout earlier chapters of this briefing paper. It also provides the means for sharing policy resources and organisational implementation experience with like organisations. Critically too, the commitment to a framework of practice that is in place in multiple jurisdictions around the world is protective during crises, as agencies draw on the international experience of staying on course through and beyond crises to continue achieving great results for children and their families.

## 10.4 Monitoring and evaluation

In individual workplaces and also centrally, formal processes for feedback from staff, managers and families are essential to action learning, along with organisational review and planning processes. Effective supervision, group supervision, and management strongly engaged with practice are important characteristics of an organisation knowing how its practice is impacting outcomes.

A limited set of KPIs that are already being measured are recommended for the overall monitoring of impact, rather than establishing new elaborate data collection and reporting processes. These might include monitoring the interrelated trends in the following indicators:

- cases referred to child intervention
- child intervention assessments
- cases managed through intensive family support
- child intervention court orders
- children being brought into care
- re-substantiation of abuse
- staff separation rates.

Also recommended are surveys to assess staff satisfaction, the extent and nature of use of Signs of Safety practice elements, and the areas in which staff feel confident in their skills and those in which they do not.

Jurisdictions should also look to be involved in the international research efforts that are underway—and are continuous—as a means of independently evaluating their implementation and practice outcomes.



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